ALSO INSIDE:

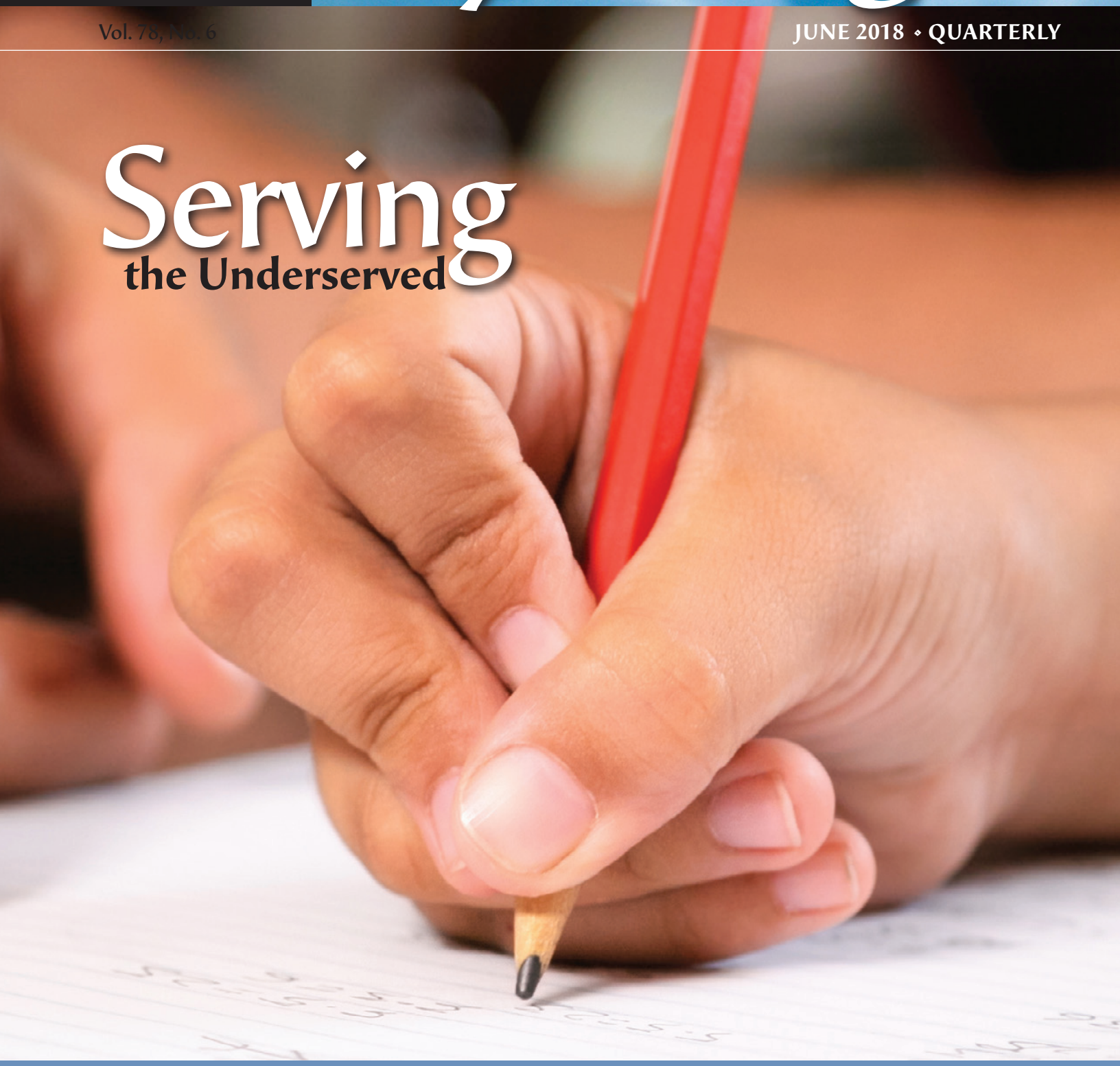
- Medical marijuana in PA
- PPA's new executive director
- School-based mental health services

The Pennsylvania Psychologist

Vol. 78, No. 6

JUNE 2018 • QUARTERLY

Serving the Underserved



Take advantage of ***easy*** and ***accurate*** online assessment. The CEFI Adult is the modern clinician's solution to measuring Executive Function in our increasingly digital world.

Find out more at:
MHS.com/OnlineAssessments

- ***Save time*** and increase your efficiency through the convenience of online assessment
- Assess online ***three ways*** — email a link, print out the forms, or assess on any device from the comfort of your home or office
- Access three ***easy-to-read***, ***highly visual report options*** included with each online evaluation

MHS® ASSESSMENTS

MHS.com/CEFIadult

Special Offer!

Receive a FREE copy of Dr. Naglieri and Dr. Goldstein's "Handbook of Executive Functioning" ($90 value) with purchase of any CEFI Adult Kit*

Available for a limited time while supplies last.

Go to www.mhs.com/CEFIAdult for more details or contact your MHS consultant

Pennsylvania Psychological Association
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112
717-232-3817
papsy.org

The Pennsylvania Psychologist is the official bulletin of the Pennsylvania Psychological Association and the Pennsylvania Psychological Foundation. PPA dues include member subscriptions. Articles in the *Pennsylvania Psychologist* represent the opinions of the individual writers and do not necessarily represent the opinion or consensus of opinion of the governance or members or staff of PPA or PPF.

The Pennsylvania Psychologist Quarterly is published in March, June, September, and December. The copy deadline is the eighth of the second month preceding publication. Copy should be sent to the PPA Executive Office at Pennsylvania Psychological Association, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112.

Copy Editor: Karen Chernyaev
Graphic Design: Graphtech, Harrisburg

Vol. 78, No. 6

The Pennsylvania
Psychologist

Editor: Shannon Len Deets, PhD

June 2018 • QUARTERLY

REGULAR FEATURES

GET 1 CE CREDIT FOR THIS ISSUE! PAGE 20

SPECIAL SECTION—SERVING THE UNDERSERVED

SCHOOL PSYCHOLOGY SECTION

ETHICS IN ACTION

ALSO INSIDE

What a Year!

David L. Zehrung, PhD


Dr. David L. Zehrung

Do you ever procrastinate? Put things off? Me too. I've been putting off writing this final presidential article. Part of it has been that good things keep happening that I want to share with you. Part of it is the difficulty in summarizing this busy past year. And, frankly, part of it is avoiding saying farewell to you all. Well, enough procrastination!

Celebrating 85 years

We are concluding our 85th year! Despite a year of transitions, PPA continues strong and healthy. Membership increased modestly despite many associations having suffered losses. Our finances are stronger now than a year ago. Innovation is alive and well, including in areas such as continuing education delivery, advocacy, and member networking. Our new executive director, Ann Marie Frakes, is settling in nicely.

Throughout this year, I shared bits of PPA's early history. During preparations for a recent trip to address Penn State clinical psychology doctoral students, I discovered that our second president, Robert G. Bernreuter, was a Penn State professor. The link features a 1988 photo of Dr. Bernreuter with another PPA past president, Dr. Joe French, who passed away this past year. They are holding a letter from 1937, a few months after Dr. Bernreuter completed his term as PPA president. The letter authorized Dr. Bernreuter to open a clinic for evaluating school children. While the letter came from the Pennsylvania Department of Public Instruction, I wondered whether Florentine Hackbusch might have played some sort of role, as part of her job with the state was to open psychology clinics.

PPA was founded by influential psychologists—people such as Florentine Hackbusch, Lightner Witmer, and Robert Bernreuter. PPA members continue in that tradition. I believe that just as I highlighted PPA influencers from 80-plus years ago, future generations of PPA members will note the contributions of current members, whether in academia, the APA, their practice, or perhaps even politics. Thank you for being a PPA member, and thank you for using psychology to serve the public in your unique way!

Aspiring Toward Community & Growth

The Aspire Task Force is wrapping up their work and will be presenting to the Board information and suggestions regarding enhancing PPA's community and growth. Recently, task force members followed up on the member survey they conducted, calling a number of respondents to glean further understanding of member experiences. We appreciate your generosity in sharing your thoughts!

I'd like to thank those additional members who have donated to our Aspire 85 celebration! We've listed donors here: papsy.org/?page=ASPIRE85Club. If you don't see your name there yet, make your donation today: papsy.org/?page=85Years.

Regarding community, over the past few months, I've written on "the other," and the hazards and potential solutions to the polarization in our society, families, clients, and colleagues. Since then, a wonderful thing has happened. I've discovered more and more resources and initiatives regarding improving community while preserving diversity.

Recently, I ran across a segment from *American Creed*, a PBS documentary. In the clip, Joan Blades, founder of MoveOn.org, and Mark Meckler, founder of the Tea Party, talk about how they became friends and how their initial living room conversation grew into Living Room Conversations, an organization that encourages starting conversations between very different people in the casual setting of a living room. Their motto is Respect. Relate. Connect. I think psychologists have something to offer to this kind of movement. We know something about having difficult conversations and healing!

Thanks

What a year! I'd like to express my deep appreciation for our Executive Committee, Board of Directors, and wider General Assembly. My youngest son recently interviewed me about boards in nonprofits, and I got to describe how well our board functions. Volunteer leadership members stepped up and shared their wisdom in important decisions throughout this year.

Thank you to David Rogers, who mentored me during my president-elect year, which helped immensely. Thank you to Vince Bellwoar, who chaired our DPA Task Force and our Executive Director Transition Task Force. We all owe you a debt of gratitude for your tireless work on PPA's behalf.

Thank you to Don McAleer, for heading up the Aspire Task Force, helping PPA aspire toward growth in both numbers and community. Thank you to Judy Blau for your energetic leadership of the Membership Committee, helping fulfill my membership goals despite my limited time to help. Thank you to Kim Wesley for your great work on a membership-related project. Thank you to David Palmiter for your great work on a leadership-related project. Thank you to every member who took the time to reach out to me to share ideas, concerns, or questions. You are PPA!

Thank you to Ann Marie Frakes, Iva Brimmer, Sam Knapp, Rachael Baturin, Judy Huntley, Erin Brady, and Justin Fleming for your tireless and expert work fulfilling PPA's vision and mission! What an honor to have served with you this year!

Finally, thank you to Nicole Quinlan for your willingness to serve as PPA's next president. We stand with you as you lead PPA into this propitious next year. To you, and to PPA, I say: "You are stronger than you believe" (Antiope).

Work Hard and Dream Big

Ann Marie Frakes, MPA

Ann Marie Frakes

Thank you for such a warm welcome to the Pennsylvania Psychological Association. It is my honor and privilege to serve as the new the executive director of PPA. I send a special thank-you to Drs. David Zehrung and Vince Bellwoar, the search committee, the PPA Board of Directors, and the staff for having confidence in me to serve in this important leadership role. This column in the *Pennsylvania Psychologist* provides a wonderful opportunity for me to introduce myself to you. So here goes!

I am so happy to be back in Pennsylvania after being away for more than 25 years. I was born and raised near Selinsgrove, just 50 miles north of Harrisburg on the west side of the Susquehanna River. It has been an extreme joy reconnecting with my family and friends throughout the state over the past several months. I look forward to many more reunions, visits, and holiday celebrations.

Psychology has been an interest of mine since seventh grade, when I entered my first science competition with the Pennsylvania Junior Academy of Science. I have been a student of psychology ever since. I was a psychology major at Penn State and graduated with a bachelor of science degree. I continued my education at Penn State as a Patricia Roberts Harris Fellow in the Department of Public Administration and received a master of public administration degree soon after.

I have worked in the nonprofit sector for the past 25 years or so and have happily served as an executive director for many years. I find much joy in leading and motivating volunteers and staff to work together to achieve common goals.

Some of the professional skills that I bring to PPA are: fundraising/resource development, grassroots advocacy/coalition building, and volunteer/staff development and coaching. I believe that these skills will enhance the already strong work of the Board of Directors, volunteers, staff, and members and move the association to the next level of excellence.

I want PPA to continue to be recognized nationally as an organization that makes a difference in the practice of psychology in Pennsylvania and the overall mental health of its citizens. I want PPA to be the professional association that every psychologist wants to be a part of and support. I want young people to recognize that being a psychologist is a great career path to serving others and being part of an important intellectual endeavor.

Thank you for such a warm welcome to the Pennsylvania Psychological Association.

During my first few months as PPA executive director, I am connecting with as many people within PPA as I can. I am immersing myself in the organization's culture: values, mission, goals, and strategic plan. I am working to understand who the members of the team are and the strengths they bring to the table. I am working hard to make connections and build strong relationships with staff, board leadership, volunteers and our members.

I am observing PPA in action at the most granular level. I am attending programs, meetings, and events. I am experiencing everything PPA offers to its members, volunteers, and the public. I am studying how things operate and am looking for ways to execute flawlessly. I am working to ensure that the business model and daily operations support the organization and effectively serve members and volunteers. I am taking time to focus on procedural simplification, process improvement, and other efficiencies that will make PPA even more consistent and reliable.

I have worked in the nonprofit sector for the past 25 years or so and have happily served as an executive director for many years. I find much joy in leading and motivating volunteers and staff to work together to achieve common goals.

Later this year, I will focus on developing marketing, strategic growth, and revenue opportunities. I look forward to finding new ways to increase non-dues revenue and control costs that will allow us to fully fund PPA initiatives and impact more members and the public.

Thank you again for this opportunity to serve PPA. If you would like to meet with me individually to share your PPA experiences and ideas, please do not hesitate to call, e-mail, or invite me to coffee. I look forward to seeing many of you at our annual convention: PPA2018 in Valley Forge! Until then, *work hard and dream big*!

Pennsylvania's Medical Marijuana Act

Samuel Knapp, EdD, ABPP; Director of Professional Affairs

Rachael L. Baturin, MPH, JD; Director of Government, Legal, and Regulatory Affairs

Pennsylvania's Act 16 of 2016 (Medical Marijuana Act) will allow certain physicians in Pennsylvania to prescribe marijuana for medical purposes. Pennsylvania is the 24th state to allow medical marijuana. The first medical marijuana prescriptions in Pennsylvania were issued earlier this year.

According to the original law, physicians may prescribe medical marijuana for amyotrophic lateral sclerosis (ALS; Lou Gehrig's disease), autism, cancer, Crohn's disease, spinal cord damage, epilepsy, glaucoma, HIV/AIDS, Huntington's Chorea, inflammatory bowel disease (IBS), intractable seizures, multiple sclerosis, neuropathies, Parkinson's Disease, post-traumatic stress disorder, severe chronic or intractable pain, sickle cell anemia, or other diseases. Since the first law was passed, pain from opioid withdrawal has been included in the law.

Medical marijuana in Pennsylvania can only be dispensed in the following forms: pill, oil, liquid, tincture, as a topical application, or in a form appropriate for nebulization, excluding dry leaf or plant form. Some have criticized the restriction on smoking marijuana, noting that the processing required for the alternative modes of application greatly increases the prices (Goldstein, 2017). As this article goes to press, the Pennsylvania Secretary of Health is considering allowing the sale of dry leaf medical marijuana. The percentage of tetrahydrocannabinol and cannabinol in the product must be labeled.

Physicians who prescribe medical marijuana must have a medical license in Pennsylvania, complete a 4-hour training course delivered by the Pennsylvania DOH, enroll with the DOH, assume medical responsibility for the patient, and document the qualifying condition in the patient's records.

The Pennsylvania Department of Health (DOH) may issue permits for up to 50 dispensaries in the state; each dispensary may have up to three locations. DOH has been conducting studies to determine the optimal locations for the dispensaries.

Pennsylvanians with qualifying conditions and a certificate from a physician may enroll in the medical marijuana program and, if approved, will receive an identification card that will allow them to purchase medical marijuana from an approved dispensary. The identification card will be good for one year. Those under the age of 18 may qualify to receive medical marijuana.

Dr. Samuel Knapp

Rachael L. Baturin

Caregivers who undergo a criminal background check and register with the Pennsylvania DOH may receive permits that allow them to pick up medical marijuana for patients. The latest data showed that 11,000 Pennsylvanians have been approved to receive medical marijuana, although another 14,000 are pending (Schmitt, 2018).

Physicians who prescribe medical marijuana must have a medical license in Pennsylvania, complete a 4-hour training course delivered by the Pennsylvania DOH, enroll with the DOH, assume medical responsibility for the patient, and document the qualifying condition in the patient's records. Physicians must notify the DOH if the patient no longer has the serious medical condition, no longer needs the medical marijuana treatment, or has died. The latest data showed that more than 900 physicians have applied to prescribe medical marijuana and 514 have completed the necessary requirements (Schmitt, 2018).

The process requires that the physician verify the identity of the patient (name, date of birth, and address) and determine, upon the review of past treatments, that the "patient is likely to receive therapeutic or palliative benefit from the use of medical marijuana" (Section 403 (a) (4)). The physician must also contact Pennsylvania's Prescription Drug Monitoring Program to learn of the patient's history with controlled substances before recommending the certificate or changing the amount or mode of administration of the drug. The Prescription Drug Monitoring Program will determine whether the patient is also being treated by another professional.

Currently, the FDA only approves two medications based on marijuana. Because insurance companies typically only reimburse FDA-approved drugs, it is expected that most patients will have to pay out of pocket for most medical marijuana prescriptions.

Patients who have a certificate to access medical marijuana are exempt from prosecution for the possession of marijuana. Physicians are immune from prosecution solely because of their participation in the program. The U.S. Department of Justice,

acting on a directive issued during the Obama administration, has a policy of not prosecuting those acting in accordance with state medical marijuana laws. The Pennsylvania law prohibits the prosecution of or disciplinary actions against health-care licensees for using legally prescribed medical marijuana. Patients may not grow marijuana, drive under the influence of marijuana, give or sell marijuana to anyone, use marijuana in a public place, or use medical marijuana in the workplace while performing dangerous activities.

Physicians who prescribe medical marijuana may not conduct an examination using telemedicine technology, receive a fee for referring patients to a certain dispensary, have any economic interest in a dispensary, advertise a cultivation center or dispensary, or help patients obtain marijuana. They may not prescribe medical marijuana for a family member.

Pennsylvania requires growers to use an extensive tracking program and independent laboratories to verify the quality of their product. Growers will be subject to a 5% tax; some of the proceeds will go to reimburse patients with financial hardships, provide treatment for the misuse of alcohol or other drugs, and fund research into the serious medical conditions enumerated in the legislation. Pennsylvania's law is unique in funding research, and academic research centers are already preparing research projects.

On a related note, Rep. Eugene Gainey, a sponsor of the Medical Marijuana Act, has proposed legislation that would decriminalize the possession of small amounts of marijuana. Many cities in Pennsylvania already have a policy not to prosecute those who have been arrested with small amounts of marijuana. A recent Franklin and Marshall poll showed that 59% of Pennsylvanians support the legalization of marijuana (Deto, 2017).

References

Deto, R. (2017, September 21). Poll shows support for legal recreational marijuana, Pennsylvania auditor general says time to legalize is now [Blog post]. Retrieved from https://www.pghcitypaper.com/Blogh/archives/2017/09/21/poll-shows-support-for-legal-recreational-marijuana-pennsylvania-auditor-general-says-time-to-legalize-is-now

Goldstein, C. (2017, July 6). Pa's medical cannabis law legalized only the priciest treatments. *Philadelphia Inquirer. Retrieved from* http://www.philly.com/philly/business/cannabis/pa-medical-cannabis-law-legalized-only-expensive-treatments-20170706.html

Schmitt, B. (2018, April 9) Pennsylvania Board recommends sale of leaf medical marijuana. Retrieved from http://triblive.com/news/healthnow/13516550-74/pennsylvania-board-recommends-sale-of-leaf-medical-marijuana

The Bill Box

Selected Bills in the Pennsylvania General Assembly of Interest to Psychologists
As of February 20, 2018

Bill No.	Description and Prime Sponsor	PPA Position	Senate Action	House Action	Governor's Action
SB 134	Provides for Commonwealth support for a Mental Health and Intellectual Disability Staff Member Loan Forgiveness Program and an Alcohol and Drug Addiction Counselor Loan Forgiveness Program. - Sen. Mario Scavello (R-Monroe)	For	In Education Committee	N/A	N/A
SB 383	Amends the Public School Code, in duties and powers of boards of school directors, providing for protection and defense of pupils. - Sen. Don White (R-Indiana)	Against	Passed 28–22 on 6/28/2017	In Education Committee	N/A
SB 554	Safe Harbor bill for child victims of human trafficking. - Sen. Stewart Greenleaf (R-Montgomery)	For	Passed 50–0 on 4/25/2017	In Judiciary Committee	N/A
SB 599	Provides for Assisted Outpatient Treatment programs in the Mental Health Procedures Act. - Sen. Stewart Greenleaf (R-Montgomery)	Against	In Health and Human Services Committee	N/A	N/A
SB 780	Act providing for telepsychology and for insurance coverage. - Sen. Elder Vogel, Jr. (R-Beaver)	For	Voted favorably from Banking & Insurance Committee on 1/30/2018	N/A	N/A
HB 414	Act establishing a bill of rights for individuals with intellectual and developmental disabilities; and conferring powers and duties on the Department of Human Services. - Rep. Thomas Murt (R-Montgomery)	For	N/A	In Human Services Committee	N/A
HB 440	Requires insurers to make their behavioral health benefit no more restrictive than their physical health benefit. - Rep. Thomas Murt (R-Montgomery)	For	N/A	In Insurance Committee	N/A
HB 525	Safe Harbor bill for child victims of human trafficking. - Rep. Mark Rozzi (D-Berks)	For	N/A	In Judiciary Committee	N/A
HB 1233	Amends the Mental Health Procedures Act, further providing for scope, definitions, treatment plan & assisted outpatient treatment by counties; for persons subject & for court-ordered involuntary treatment; & adding provisions. - Rep. Tim Briggs (D-Montgomery)	Neutral	Reported as amended from Health & Human Services on 3/20/2018	Final Passage 189-0 on 6/21/2017	N/A
HB 1648	Act providing for telepsychology and for insurance coverage. - Rep. Marguerite Quinn (R-Bucks)	For	N/A	In Insurance Committee	N/A
HB 1912 HB 762	Amends Public School Code, in preliminary provisions providing for study of secondary school start times. -Rep. Alex Charlton (R-Delaware)	For	N/A	In Education Committee	N/A
HCO 130	Authorizes licensing boards to expunge disciplinary records for certain technical violations after four years. - Rep. Kate Harper (R-Montgomery)	For	N/A	N/A	N/A

HCO denotes House Cosponsor Memo

Availability and Acceptability of Behavioral Health Services in a Rural Pediatric Primary Care Setting

Monika Parikh, PhD

Rural residents, especially children, are considered a vulnerable population in regard to mental health care (Lutfiyya, Bianco, Quinlan, Hall, & Waring, 2012). Janicke and Davis (2011) suggest that although behavioral health (BH) concerns are common among pediatric primary care (PC) clinics, they are likely more prevalent in rural areas due to health disparities and barriers to service delivery. Polaha, Dalton, and Allen (2011) found that 21.1% of parents reported clinically significant behavioral and emotional concerns for their children in a rural pediatric PC clinic. This is double the national estimate of youths with significant mental health concerns (U.S. Department of Health and Human Services, 1999). However, only 20% of families who sought out BH services received services that adequately met their needs (Smalley et al., 2010).

Human and Wasem (1991) proposed a conceptual framework of barriers to utilization of BH including three components: availability, accessibility, and acceptability. Availability refers to the existence of mental health professionals to provide BH services. Accessibility refers to whether individuals have access to these services (i.e., knowledge of need for services, transportation, and financial coverage). In general, there is a paucity of BH providers in rural areas, which, by definition, restricts accessibility. However, even available BH providers are not being utilized due to issues of access and stigma (or accessibility and acceptability). Acceptability refers to whether services are provided in alignment with local values and the delivery of BH services are appropriate for the rural setting. The stigma associated with mental health disorders, seeking mental health services, and lack of anonymity are substantial barriers to utilization and acceptability of BH services among rural residents.

Research has shown that integrating psychologists into PC settings not only increases patient access to skilled mental health professionals but also increases the likelihood of patient follow-through with mental health referrals (Valleley et al., 2008). Similarly, Kolko and colleagues found that families prefer receiving mental health services within a PC setting and reported higher satisfaction with these services compared with a standard outpatient BH setting (Kolko, Campo, Kilbourne, & Kelleher, 2012).

Research has shown that integrating psychologists into PC settings not only increases patient access to skilled mental health professionals but also increases the likelihood of patient follow-through with mental health referrals (Valleley, Clarke, Lieske, & Gortmaker, 2008).

Further, the Asarnow, Rozenman, Wiblin, and Zeltzer (2015) study supports the conclusion that availability of BH services in PC offices improves access, illustrating that there may be greater acceptability of BH visits in a pediatric PC setting versus a traditional mental health setting. The observed differences in BH service utilization may be explained by a reduction in the social stigma associated with receiving BH services. Although nascent, initial support of the effectiveness of integrated pediatric PC is promising.

Given that rural youths may be at higher risk for mental health problems, there is a significant need to better understand factors that contribute to utilization patterns of BH services of children, adolescents, and their families who live in rural areas. Geisinger Medical Center's unique model of integrating psychologists into PC allows researchers to examine how the presence of a BH provider within a pediatric PC setting can assist with increasing awareness of BH services and reducing stigma associated with utilization of these services. This study focused on determining caregiver knowledge of availability of a BH provider within a pediatric PC setting, assessing caregiver-reported acceptability with utilizing BH services and exploring factors that reduce the likelihood of accessing BH services in a rural community.

Monika Parikh, PhD

Participants. Participants in the study included 128 caregivers of pediatric patients (ages 1–17 years old) who presented with their child in a rural integrated PC clinic located in Pottsville, Pennsylvania, for a well or acute visit with a pediatric primary care provider (PCP). In addition, chart review of the pediatric patients whose caregivers participated in the study was completed to obtain demographic information (e.g., gender, age at time of enrollment, race/ethnicity). Families served by this clinic are generally from a region characterized by a low socioeconomic status, coal-region culture, working class, predominantly Caucasian, and low educational attainment.

Methods. Families were notified about the study by a member of the BH team upon arrival for a medical visit. Written informed consent and parental permission to collect data from the child's medical chart was obtained. Caregivers completed a five-item self-report questionnaire in-person. The questionnaire included open-ended questions.

Data Analysis. Quantitative and qualitative data was collected from caregivers of pediatric patients who were referred by a pediatric PCP. Descriptive statistics were analyzed. A qualitative review of data was conducted to evaluate

Continued on page 8

AVAILABILITY AND ACCEPTABILITY OF BEHAVIORAL HEALTH SERVICES IN A RURUAL PEDIATRIC PRIMARY CARE SETTING

Continued from page 7

themes evident on caregiver-reported perceptions of BH services.

Results. Results from the study indicated that more than half of the caregivers (55%) were aware that BH providers were on-site. In addition, caregivers generally had positive attitudes toward BH treatment. Specifically, 95% of the participants were willing to arrange BH services for their child's emotional/behavioral concerns and 97% of the participants felt comfortable discussing their child's concerns with a BH provider. Evaluation of qualitative responses regarding caregiver-reported perceptions of BH services indicated that participants (88%) were generally comfortable with friends/family members knowing that they were arranging behavioral health services for their child. Additional themes included viewing their child's emotional or behavioral concerns as personal/family business or a private matter (7%), concern of stigma with arranging BH services (2%), fear of embarrassment (<1%), and feelings of ambivalence (2%) with arranging services.

Implications/Future Directions. Overall, families reported more willingness to arrange BH services than prior literature suggests for this population. Similar to previous studies, it is possible that the presence of BH providers within PC may contribute to the increased level of comfort or willingness to utilize services. Specifically, integration of BH services in PC provides increased access to quality services and may contribute to reduction in social stigma associated with receiving BH services. Future studies should focus on developing methods of enhancing awareness and acceptability of pediatric BH care in a rural setting, as well as identifying factors that may assist with reducing stigma associated with utilization of BH services and how this interacts with regional utilization patterns.

References

Asarnow, J. R., Rozenman, M., Wiblin, J., & Zeltzer, L. (2015). Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. *The Journal of American Medical Association Pediatrics, 169, 929–937.*

Human, J., & Wasem, C. (1991). Rural mental health in America. *American Psychologist, 46, 232–239.*

Janicke, D. M., & Davis, A. M. (2011). Introduction to the special section: Rural health issues in pediatric psychology. *Journal of Pediatric Psychology, 36, 647–651.*

Kolko, D. J., Campo, J. V., Kilbourne, A. M., & Kelleher, K. (2012). Doctor-office collaborative care for pediatric behavioral health problems. *Archives of Pediatrics & Adolescent Medicine, 166, 224–231.*

Lutfiyya, M. N., Bianco, J. A., Quinlan, S. K., Hall, C. & Waring, S. C. (2012). Mental health and mental health care in rural America: The hope of a redesigned primary care. *Disease-a-Month, 58, 629–638.*

Polaha, J., Dalton, W. T., & Allen, S. (2011). The prevalence of emotional and behavior problems in pediatric primary care serving rural children. *Journal of Pediatric Psychology, 36, 652–660*

Smalley, K. B., Yancey, C. T., Warren, J. C., Naufel, K., Ryan, R., & Pugh, J. L. (2010). Rural mental health and psychological treatment: A review for practitioners. *Journal of Clinical Psychology: In Session, 66, 479–489.*

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Valleley, R., Clarke, B., Lieske, J., Gortmaker, V., Foster, N., & Evans, J. H. (2008). Improving adherence to children's mental health services: Integrating behavioral health specialists into rural primary care settings. *Journal of Rural Mental Health, 32,* 18–34. http://dx.doi.org/10.1037/h0095955

The SNAP Challenge

Jeanne M. Slattery, PhD

Early this year, I received an e-mail describing the work that a student group at my university was doing relative to the SNAP Challenge. The e-mail challenged my university community "to spend [on food] only the amount allotted to Pennsylvania residents receiving Supplemental Nutrition Assistance Program benefits."

That e-mail captured my attention. I thought for 30 seconds about what I would need to give up to eat on $4.73 per day, before deciding against joining the Challenge. I'm a vegetarian and cook with whole grains rather than prepared or processed foods, so I eat relatively inexpensively. We do not scrimp, though. My husband and I probably spend 30–50% more than the $66.22 per week we would be allotted by SNAP. That does not include eating out. We would need to add another $75–$100 for dinner Friday, my husband's lunches through the week, and my lattes six days a week. No going out to eat *ever.* And no lattes, either.

My time in graduate school might count toward the SNAP Challenge experience, although that period of poverty was different, being the exception rather than the rule for my life. While I lived on $3,500 per year, couldn't afford milk, and didn't have a phone or own a car or stereo, my poverty was a short-term problem that I knew would end when I left graduate school.

University students reported high rates of food insecurity (36%) in the 30 days preceding a recent national survey (Goldrick-Rab, Richardson, Schneider, Hernandez, & Cady, 2018). Food insecurity is even more common among community college students. Homelessness affects about one third of college and community college students.

My time in graduate school might count toward the SNAP Challenge experience, although that period of poverty was different, being the exception rather than the rule for my life. While I lived on $3,500 per year, couldn't afford milk, and didn't have a phone or own a car or stereo, my poverty was a short-term problem that I knew would end when I left graduate school.

How does food insufficiency and homelessness affect my college students' ability to come to class, engage meaningfully with the ideas raised in class, and succeed in school? Do these problems—more accurately, attempting to avoid them—increase their time to graduation?

Poverty is a real issue in my county (Clarion). According to the US Census Bureau (2017), Clarion County's per capita income is $22,451; 15.2% of our residents live in poverty. In 2016, children and teens under 18 years of age nationwide were significantly more likely to live in poverty than adults 18–64 or adults 65 and older—respectively, 18%, 11.6%, and 9.3% of these populations (Semega, Fontenot, & Kollar, 2017). Children and teens were almost twice as likely to live in poverty as older adults. These numbers have improved significantly since 1959, however. In 1959, 35% of older adults were living in poverty, as were 27% of children and teens.

Jeanne M. Slattery, PhD

How do these problems contribute to attentional and behavioral problems in the classroom? How do they contribute to absences from school? How do they increase other inequities in education, if these children and teens are also less able to attend after-school activities and field trips, as I suspect they are?

I see a significant number of families from the working poor in my role as an evaluator for Behavioral Health and Recovery Services and family-based therapy programs. People working in the fast-food industry, for example, may need to miss a half or full day of work for an hour appointment. Which should they prioritize? Food, housing, or mental health care? Can they afford the gas to make it to their appointments? Do they even have a car or do they need to arrange for a ride to their appointment? Can they afford a second trip into town?

Simply engaging in this thought experiment made me recognize the amount of privilege I have. I can afford to take off work when needed. I can flex my schedule to attend my children's activities. I can afford to travel for health care without any significant loss in income or worries about an unreliable vehicle. I experience a significant sense of control in my life as a result. I am allowed to do things that some of my clients and students cannot even imagine and to appear committed to therapy in ways that many of the working poor are unable to do.

Just taking 30 seconds to imagine completing the SNAP Challenge was thought provoking. It was an exercise in empathy.

References

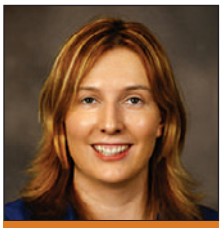
Goldrick-Rab, S., Richardson, J., Schneider, J., Hernandez, A., & Cady, C. (2018). Still hungry and homeless in college. Wisconsin HOPE Lab. Retrieved from http://wihopelab.com/publications/Wisconsin-HOPE-Lab-Still-Hungry-and-Homeless.pdf

Semega, J. L., Fontenot, K. R., & Kollar, M. A. (2017). Income and poverty in the United States: 2016. US Census Bureau, Current Population Reports. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2017/demo/P60-259.pdf

U.S. Census Bureau. (2017). QuickFacts: Clarion County, Pennsylvania. Retrieved from https://www.census.gov/quickfacts/fact/table/clarioncountypennsylvania/PST045216

Diversity: More Than a Number— A Story of Individual Lives

Shannon Len Deets, PhD


Shannon Len Deets, PhD

Quotes have an inspiring, healing, and most importantly a felt sense of *truth* to me. I find that for any aspect of my life, I can find a quote to encapsulate the phenomenology of the experience. The same was true when I was selected to participate in the inaugural class of the Emerging Leaders Program (ELP) for the Pennsylvania Psychological Association (PPA) in 2017. As part of the ELP experience, I was able to select a project to complete with my mentor, Dianne Salter PhD, JD, throughout the year. I chose the category of "underrepresented populations in psychology." The central quote at that point in my life (and in truth, still today) was "we have before us the glorious opportunity to inject a new dimension of love into the veins of our civilization," by Dr. Martin Luther King Jr.

As an aspiring licensed psychologist, I am a firm believer that the ultimate task of our profession is to help civilization grow and evolve. I believe we are on the frontline of societal change and must use our skill set of compassionate understanding to light the way for others. However, with the overwhelming deluge of human struggle, it is often difficult to know where to shine our light first.

In my professional development, the importance of self-reflection, awareness of internal motivations, and emphasis on taking up the mantel of personal responsibility has guided me to start all change within myself. It is probably evident that another important quote in my life is by Mahatma Ghandi: "Be the change you wish to see in the world."

With all of this in mind, I knew that I wanted to understand those underrepresented individuals within the discipline of psychology. Diverse individuals have always been a part of the history of psychology, even before Francis Cecil Sumner, known as the father of black psychology, became the first African American to receive his doctorate in psychology from Clark University on June 14, 1920.

Psychology as a field has found a focus in diversity containing a myriad of aspects since the 1960s, beginning with the development of various multicultural therapies and theories. The American Psychological Association (2002) implemented "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists." A quick search in the database PsycARTICLES will produce at least 4,000 articles when you use the phrase "diversity in psychology."

Invariably, undergraduate general psychology textbooks include a pie chart (usually chapter 1) discussing the various ethnic and racial makeup of psychologists. We have charts that display the growth in numbers of member psychologists who consider themselves diverse across various publications (APA, 2015; Golding & Lippert, 2016). However, what struck me was the limited knowledge of the actual lived experience of diverse psychologists.

Methods. As a fervent supporter of qualitative study, I felt that a vital component of understanding this experience lay beyond the face value of the number of self-reported ethnically and racially diverse psychologists rising from 8.9% in 2005 to 16.4% in 2013 or that 58.2% of active psychologists reported a female gender in 2005, growing to 68.3% in 2013 (APA, 2015). I wanted to know about the day-to-day experience of those diverse psychologists in their interactions with other professionals, supervisors, and the public.

I created a 31-question survey to explore this information. Twenty-seven individuals completed the survey questions. For purposes of this study, diversity was not predetermined and one survey question asked participants to self-identify areas of diversity. Among the responses, diversity was identified as racial, ethnic, religious affiliation, gender, veteran status, and socioeconomic status. These questions sought to understand the experience of diverse psychologists concerning the personal and professional issues they faced. Other researchers (Green & Hawley, 2009; Pedrotti & Burnes, 2016) have found that diverse psychologists report struggles with work-life balance, occupational satisfaction, and systems of social support differently than do their dominant culture counterparts.

Results. The results of this study support the findings of previous research in this area. Diverse participants consistently reported that they were expected to work harder (participating on more committees, being the diversity officer, or the go-to diverse clinician) than their white, male counterparts. This expectation was often tied to advancement and promotion and participants reported feeling that if they declined to put in this extra work that they would be seen as less professional or less competent.

Participants often reported these expectations were the result of cultural taxation. That is, because of their diverse identifiers, it was assumed they should educate the rest of the agency on diversity issues and thereby complete all the extra work associated with this role. One participant reported that due to a lack of other diverse individuals, she was often put in the position as the "ONLY black professional and this meant [she] always had to be the VOICE." She further elaborated that "white fragility prevented the surfacing of necessary discussions."

The additional work demands placed on diverse individuals also meant that participants had less time to participate in self-care or other meaningful personal or professional pursuits. One participant stated: "I always had to work twice as hard to be considered half as good. Self-care suffers in that equation big time!"

Female participants reported feeling that they would be seen as less professional than their male peers. One participant

stated that her veteran status was not believed due to her gender. Another stated that she was told, "that's the price for being cute" when she discussed the harassment she was receiving.

If women missed work for childcare tasks, they reported feeling that this was negatively viewed as an indication of a poor work ethic. Male participants did not express a similar conflict between work and family. Participants reported feeling that they received limited support as a mother and were mistreated in the field and work culture.

Participants also discussed the impact of socioeconomic status as a measure of diversity. Increasingly, early career psychologists (ECPs) are accruing more student debt for their education, required to spend more time in training, and find starting salaries decreasing (Green & Hawley, 2009). Participants reported feeling that they must hide their lower socioeconomic status from clients and colleagues alike. One participant reported, "I try to remain invisible, under the radar. I have worried that people will be able to tell about my social class based on how I talk."

Participants discussed experiences of subtle biases as well as overt racism or sexism. One participant discussed having to see clients that made her uncomfortable because of the derogatory comments about women and sexuality made by those clients. Other participants also provided overt examples of racism as well as examples of microaggressions. Participants discussed being exposed to jokes about slavery, the n-word on multiple occasions, and even harassment for voting for President Obama.

Conclusion. The APA has documented their commitment to increasing the number of ECPs from diverse backgrounds (Pedrotti & Burnes, 2016). As such, the findings from this qualitative study are very important to our understanding of best practices to make the field of psychology inclusive with diverse psychologists.

First, it is evident that merely attracting an increasing number of individuals who consider themselves diverse into the field of psychology will not help it to evolve into a pluralistic and inclusive field. Participants in this study discussed the impact of changing themselves to fit the mold of the psychology field instead of changing the field to be more open to diverse individuals. Having more diverse individuals in the field of psychology does nothing to change the field in a way that better prepares it to meet the needs of diverse clients.

It is imperative we understand the unique individual experience of aspiring psychologists and rebuild the profession in a manner that honors and supports these experiences. Qualitative study is not simply a nice addition to quantitative studies of diversity but is instead a vital and imperative component. We must also ensure that educational, organizational, or systemic procedures do not place diverse professionals in a position of sacrificing their health, identity, or culture to attain professional milestones or accomplishments.

To meet the needs of our clients, create a psychology that is pluralistic and inclusive, and use the field of psychology as a light for the rest of society, we must focus on changes to the field that support individual differences. Instead of forcing aspiring psychologists into a predetermined mold, we need to understand their stories and honor them.

References

American Psychological Association. (2002) Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. Retrieved from http://www.apa.org/about/policy/multicultural-guidelines-archived.pdf

American Psychological Association. (2015). Demographics of the U.S. psychology workforce. Retrieved from https://www.apa.org/workforce/publications/13-demographics/index.aspx

Golding, J. & Lippert, A. (2016, January 19). The status of minorities in psychology-related careers. *Psychology Today.* https://www.psychologytoday.com/us/blog/careers-in-psych/201601/the-status-minorities-in-psychology-related-careers

Green, A. G. & Hawley, G. C. (2009). Early career psychologists: Understanding, engaging, and mentoring tomorrow's leaders. *Professional Psychology: Research and Practice, 40,* 206–212.

Pedrotti, J. T. & Burnes, T. R. (2016). The new face of the field: Dilemmas for diverse early-career psychologists. *Training and Education in Professional Psychology,* 10, 141–148.

PPA Member Spotlight

Scott Browning, PhD, ABPP

PPA would like to congratulate Scott Browning, PhD, ABPP, on receiving the Division 43, 2017 Distinguished Contribution to Family Psychology Award. Dr. Browning was the corecipient of the award with his colleague, Patricia Papernow, EdD. The two have dedicated a great deal of their careers to the understanding and treatment of stepfamilies. Dr. Browning is a full-time professor at the APA-approved clinical psychology program at Chestnut Hill College. He has cowritten, with Elise Artelt, a book on treating stepfamilies entitled *Stepfamily Therapy: A 10-Step Clinical Approach,* published by APA Books in 2012. Since then he has written articles and encyclopedia entries on the stepfamily and step-grandparenting, in particular. Outside of the stepfamily, Dr. Browning is interested in: Families on the Spectrum, Families of Addiction, and Families of Homicide. He has an upcoming (June) article coming out in the Journal of Psychotherapy Integration on using the genogram to integrate systemic and psychoanalytic treatment. Dr. Browning is board certified in Couple and Family Psychology from the American Board of Professional Psychology, and he serves on that board, as well as on the board of National Stepfamily Resource Center.

English Learners: An Underserved Group of Students

Shirley A. Woika, PhD, saw194@psu.edu;
Rebecca F. Bertuccio, MEd, rqb5439@psu.edu

The number of English learners (ELs) in Pennsylvania has grown significantly over the past few decades. According to the Migration Policy Institute (Ruiz Soto, Hooker, & Batalova, 2015), Pennsylvania had 52,054 students classified as ELs in the school year 2012–2013. This population of students is not homogenous. Rather, EL students speak many languages, come from different cultural backgrounds, and vary in English proficiency and acculturation.

Although more and more students are culturally and linguistically diverse (CLD), this same trend is not seen among practicing school psychologists. While the Migration Policy Institute (Ruiz Soto, Hooker, & Batalova, 2015) reported that 57% of Pennsylvania's EL students speak Spanish as their first language, the National Association of School Psychologists' Directory of Bilingual Psychologists lists only 24 Pennsylvania school psychologists who speak Spanish.

Due to the low numbers of bilingual school psychologists, it is important that school psychologists strive to improve their competence in working with CLD populations to include ELs. Because more than half of Pennsylvania's EL population are Spanish speakers, this article will focus on providing suggestions for working with Spanish speakers in order to help school psychologists take steps to improve their skills with this population of underserved students.

Student Challenges

EL students may experience difficulties in school for various reasons. Some students have previously been diagnosed with a disability as noted in academic records from their native country. It is logical to presume that such students would also be eligible for special education services in Pennsylvania, where academic difficulties are further compounded by limited English proficiency.

Other students may have performed adequately in school prior to relocating to the United States but now find that they are performing below their peers in academic areas despite receiving ESL services. Although students may gain conversational skills (Basic Interpersonal Communication Skills, or BICS) in a second language quickly, studies suggest that it may take as long as 7–10 years to gain academic competence (Cognitive Academic Language Proficiency, or CALP) in the second language (Thomas & Collier, 1997). Thus, students who have not had years to adapt are unlikely to be found eligible as students with a specific learning disability because limited English proficiency cannot be ruled out as a contributing factor for inadequate achievement. Of course, other disability categories such as intellectual disability, autism, social or behavioral challenges, or other health impairment may warrant consideration.

The following is a list of suggestions to aid school psychologists' evaluative work with EL students:

Use your resources. Monolingual school psychologists can complete various tasks for an EL evaluation process without the help of a translator. Valuable resources are free and available online to support school psychologists' work with ELs, including translated documents and checklists.

The Pennsylvania Training and Technical Assistance Network (PaTTAN; n.d.), for example, has translated special education documents for infants/toddlers, preschoolers, and school-age students in Spanish and more than 15 other languages. Forms on the PaTTAN website include documents such as procedural safeguards, waiver agreements, and permission requests.


Shirley A. Woika, PhD


Rebecca F. Bertuccio, MEd

Monolingual school psychologists can also find documents with topics and information specific to special education translated from English to Spanish on the Center for Parent Information and Resources (CPIR, n.d.) website. Resources are listed alphabetically in English; for each English document is a Spanish document that contains identical or similar information. School psychologists can print off relevant documents or send families direct links to the Spanish list of resources.

Additionally, Dr. Catherine Collier developed several acculturation checklists and screeners available online at no cost. The following tools are simple to find through any search engine: the Acculturation Quick Screen, Third Edition (AQS III); the Classroom Language Interaction Checklist (CLIC); Resiliency Checklist (RCII); and the Sociocultural Checklist (SCII).

Gathering sociocultural and acculturation information may provide useful baseline data for monitoring students' cultural development and may also identify their strengths and needs (Collier, 2001). School psychologists can ask teachers to respond to the various acculturation checklists at the start of an EL evaluation, as this may help inform the student's current adjustment and comfort level in the United States. After the evaluation is complete, the student's

Continued on page 14

A Well-Deserved Spotlight on School-Based Mental Health Services for Underserved Students

Lucia Dwyer, PhD, ldwyer@nbme.org;
Michelle M. Goldberg, PhD, mgoldberg@nbme.org

In the wake of the school shooting that occurred at Marjory Stoneman Douglas High School on February 14, 2018, in Parkland, Florida, more attention is being paid to the concept of mental health services within the schools. In fact, amidst unprecedented gun control legislation that was recently passed in Florida, the state also approved $69 million dollars of state funding to improve and increase the availability of mental health services within the public school systems. Notably, the idea of integrating mental health care into the school setting is not a new one but has long been limited and impacted by funding and resources, resulting in geographic and socioeconomic disparities in who gets the services.

Now more than ever, meeting the emotional and behavioral needs of our nation's most underserved youths deserves to be at the forefront of the conversation regarding school-based resources. Children and adolescents living in urban and racially segregated areas lack access to mental health services (Anakwenze & Daniyal, 2013). Yet, these students are more likely to be exposed to child welfare, the juvenile justice system, chronic poverty, residential instability, violence, and crime and are at an increased risk for chronic stress and mental health problems (Anakwenze & Daniyal, 2013).

While accessibility to mental health services is important for all students, numerous recent studies of the impact of untreated mental health conditions provide strong support for more readily available services for students who face adversity (Bains & Diallo, 2016; Acosta Price, 2016). Untreated mental health conditions lead to poor economic and health outcomes, and children with mental health conditions are more likely to fail or drop out of school and have a greater involvement in the criminal justice system (Bains & Diallo, 2016; Stagman & Cooper, 2010).

One approach for decreasing the disparities in mental health care and treatment among youths comes from the School-Based Health Center (SBHC) model of pediatric primary care delivery (Larson, Spetz, Brindis, & Chapman, 2017).

One approach for decreasing the disparities in mental health care and treatment among youths comes from the School-Based Health Center (SBHC) model of pediatric primary care delivery (Larson, Spetz, Brindis, & Chapman, 2017). The SBHC is a model for providing primary and mental health care services via an integrated multidisciplinary team of individuals within a school setting or on school grounds (Bains & Diallo, 2016; Keeton, Soleimanpour, & Brindis, 2012; Larson, et al., 2017). The School-Based Health Alliance (2016) promotes SBHCs as a successful model of care, but fewer than 2% of U.S. schools have one. Even more startling is that only one third of SBHCs have a mental health provider on staff (School-Based Health Alliance, 2016).

Larson and colleagues utilized data from the National School-Based Health Care School Year 2010–2011 Census Report to compare SBHCs with and without mental health providers (Larson et al., 2017). SBHCs with mental health providers offered a variety and greater number of mental health services to students by being open longer hours and having prearranged after-hours care; were more likely to utilize electronic billing records, which can assist with the coordination of care among external agencies; and were more likely to have the resources to employ other health-care providers (Larson, et al., 2017).

Lucia Dwyer, PhD

Michelle M. Goldberg, PhD

Additionally, SBHCs that employ mental health providers may be better able to serve underprivileged students who frequently experience trauma, poverty, and other negative disruptions in their lives (Larson, et al., 2017). SBHCs provide consistent access and eliminate barriers to mental health services such as crisis intervention, evaluation and intervention, case management, classroom behavior and learning support, substance use disorder counseling, peer mediation, anger management, and management of behavioral health medications (Lofink et al., 2013; Bains & Diallo, 2016, p. 8).

Moreover, children and youths spend a significant portion of their time in school. It provides a natural and familiar environment where students can readily access services and care. Families and caregivers may also be more readily inclined to accept services from the school-based setting, which is often closely rooted in the larger community.

A 2013 publication by the U.S. Department of Health and Human Services Office of Adolescent Health

Continued on page 15

ENGLISH LEARNERS: AN UNDESERVED GROUP OF STUDENTS

Continued from page 12

subsequent teachers can be asked to respond to the checklists to evaluate any change in the student's acculturation.

Collaborate with translators or interpreters. Upon receiving a request to evaluate an EL student, monolingual practitioners often intuitively seek help from bilingual psychologists. If bilingual psychologists are not able to complete the evaluation, interpreters may be able to help.

The National Association of School Psychologists (NASP, 2015) recommends that monolingual psychologists be well informed on how to properly collaborate with interpreters to support their work with ELs. Interpreters may be particularly helpful in translating previous records and facilitating interviews and conversations with the student and his or her family, especially if a bilingual school psychologist is unavailable.

Monolingual school psychologists may consider using online translation tools to independently translate written online interview questions from English to Spanish. Practitioners, however, must be wary that online translation tools do not always accurately capture meaning and grammar.

Nonverbal testing may not always provide valid results due to cultural loading. Monolingual practitioners, therefore, may want to consider using "ancillary examiners" to aid in the evaluation process (Noland, 2009). Ancillary examiners are bilingual individuals trained on test instruments to help psychologists with EL evaluations (Noland, 2009). While ancillary examiners may be a helpful solution, it is important to note that student performance may differ in a setting with a bilingual school psychologist compared to a setting with a monolingual psychologist and an ancillary examiner (Noland, 2009).

Use appropriate test instruments. Many commonly used rating scales are available in Spanish for parents, and they do not require any Spanish proficiency on the part of the examiner. For example, the Behavior Assessment System for Children, Third Edition (BASC-3); Social Skills Improvement System (SSiS); Autism Spectrum Rating Scale (ASRS); Conners Rating Scale, Third Edition (Conners 3); Vineland Adaptive Behavior Scales, Third Edition (VABS-3); and the Adaptive Behavior Assessment System, Third Edition (ABAS-3) are all available in Spanish. These rating scales would allow Spanish-speaking parents to provide information to the multidisciplinary team in a systematic manner. Additionally, the self-report form of the BASC-3 and the Conners-3 along with the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory, Second Edition (BDI-2), are available in Spanish for students' use.

When an ability measure must be administered, the Wechsler Intelligence Scale for Children, Fifth Edition (WISC-V), is available in Spanish; however, this if of limited use for school psychologists who are not fluent in Spanish. The Wechsler Nonverbal Scale of Ability (WNV) was developed for such situations. The WNV includes pictorial directions so that the examiner does not need to have any proficiency in another language.

Other nonverbal ability measures include the Test of Nonverbal Intelligence, Fourth Edition (TONI-4); Primary Test of Nonverbal Intelligence, Second Edition (PTONI-2); Comprehensive Test of Nonverbal Intelligence, Second Edition (CTONI-2); Leiter International Performance Scale, Third Edition (Leiter 3); Universal Nonverbal Intelligence Test, Second Edition (UNIT2); and the Pictorial Test of Intelligence, Second Edition (PTI-2). The Kaufman Brief Intelligence Test, Second Edition (KBIT-2), may be appropriate in some situations. The KBIT-2 must be administered in English, but Spanish responses are listed on the protocol and are credited as correct.

The Woodcock-Johnson IV Tests of Oral Language contains three subtests that can be administered in both English and Spanish. These subtests include Picture Vocabulary/Vocabulario sobre dibujos, Oral Comprehension/ Comprensión oral, and Understanding Directions/Comprensión de indicaciones. By administering these subtests in both languages, evaluators can compare an individual's level of academic achievement in English to his or her oral language ability in Spanish. When administered the subtests in Spanish, the WJ IV OL includes procedures for the use of an ancillary examiner, which allows evaluators who are not proficient in Spanish to train and utilize a Spanish-proficient examiner. A comparison of English oral language ability to Spanish oral language ability can be an important step in a comprehensive evaluation for a Spanish-speaking student.

Curriculum-based assessments in Spanish are available through commonly used resources such as easyCBM and aimsweb, but they require some level of Spanish proficiency on the part of the administrator. Because administration procedures for such assessments are straightforward, these measures could be appropriately administered and scored by a trained Spanish speaker.

The number of EL students is increasing with the largest proportion of EL students speaking Spanish as a first language. There is a shortage of bilingual school psychologists, and school psychologists should work to increase their competency in working with this group of students. Recognizing that each student is unique, monolingual school psychologists should look for ways to broaden their role in working with this student population.

References

Center for Parent Information and Resources. (n.d.). *Spanish to English: Index to resources in Spanish (for English speakers)*. Retrieved from http://www.parentcenterhub.org/spanish-to-english/

Collier, C. (2001). Separating difference & disability. Retrieved from https://files.eric.ed.gov/fulltext/ED456667.pdf

Gutierrez, A. P. (2009). Culture, diversity, and language: What is culturally competent translation? *Communique, 37,* 10–11.

National Association of School Psychologists. (2015). *The provision of school psychological services to bilingual students* [Position statement]. Bethesda, MD: Author.

Noland, R. M. (2009). When no bilingual examiner is available: Examining the use of ancillary examiners as a viable testing solution. *Journal of Psychoeducational Assessment, 27*(1), 29–45. http://dx.doi.org/10.1177/0734282908319666

Pennsylvania Training and Technical Assistance Network (n.d.). *Special education forms.* Retrieved from http://www.pattan.net/category/Legal/Forms/Browse

Ruiz Soto, A. G., Hooker, S., & Batalova, J. (2015). Top languages spoken by English language learners nationally and by state. Washington, DC: Migration Policy Institute. Retrieved from *https://www.migrationpolicy.org/research/top-languages-spoken-english-language-learners-nationally-and-state*

Thomas, W. P., & Collier, V. P. (1997). School effectiveness for language minority students. Washington, DC: National Clearinghouse for English Language Acquisition.

A WELL-DESERVED SPOTLIGHT ON SCHOOL-BASED MENTAL HEALTH SERVICES FOR UNDERSERVED STUDENTS

Continued from page 13

suggests that adolescents like the idea of accessing both health and social services in a single convenient location, prefer a culturally positive and welcoming setting, and want more access to health-care services through school-based clinics (U.S. Department of Health and Human Services, Office of Adolescent Health, 2013).

Despite growing evidence demonstrating their success, only 20 SBHCs of the 2,500 nationwide are located in Pennsylvania (Abraham, 2018). Education Plus Health, a nonprofit national affiliate of the School-Based Health Alliance organization, would like to increase the number of SBHCs in the underserved communities of Philadelphia and throughout Pennsylvania. The organization serves over two hundred students at the 21st Century Program at north Philadelphia's Building 21 high school and those students have seen increased grades in reading and mathematics (Abraham, 2018).

Julie Cousler Emig, executive director of Education Plus Health, attributes the students' achievement to a decrease in absenteeism as a result of properly treating students with asthma (Abraham, 2018). By addressing chronic health and mental health conditions, SBHCs might be the "missing piece of the child health puzzle in Philadelphia and Pennsylvania" (Abraham, 2018, p.1). In spite of the lack of funding and support for SBHCs in Pennsylvania, Education Plus Health is looking forward to expanding SBHCs into more schools and is hopeful that Philadelphia's Community Schools initiative will also promote the SBHC model (Abraham, 2018).

Ethnic minority students and students living in poverty are less likely to receive mental health services yet are more likely to be exposed to trauma, develop mental health disorders, and drop out of school (Larson et al., 2017). SBHCs increase access to high quality mental health and primary cares services, especially for underserved populations (Larson, et al., 2017). SBHCs staffed with trained school psychologists may be one approach to addressing mental health care disparities (Larson, et al., 2017).

School psychologists who maintain competencies consistent with National Association of School Psychologist (NASP) standards are trained and qualified providers of mental and behavioral health services and their familiarity with the school climate makes them key SBHC members (NASP, 2015). Addressing mental health disparities is essential as mental and behavioral wellness is linked to positive student achievement, school climate, high school graduation rates, and the prevention of risky behaviors, disciplinary incidents, and substance abuse (Center for Health and Healthcare in Schools, 2014).

References

Abraham, T. (2018, February 1). School-based health centers could improve Philly kids' educational outcomes. Retrieved from https://generocity.org/philly/2018/02/01/school-based-health-centers-education-philadelphia/

Acosta Price, O. (2016). School-centered approaches to improve community health: Lessons from school-based health centers. *Economic Studies at Brookings*, 5.

Anakwenze, U., & Daniyal, Z. (2013). Mental health and poverty in the inner city. *Health & Social Work, 38*, 147–157.

Bains, R. M., & Diallo, A. (2016). Mental health services in school-based health centers: Systematic review. *The Journal of School Nursing, 32*(1), 8–19.

Center for Health and Healthcare in Schools. (2014, May). *The impact of school-connected behavioral and emotional health interventions on student academic performance: An annotated bibliography of research literature*. Washington, DC: Author. Retrieved from http://www.healthinschools.org/wp-content/uploads/2016/10/CHHCS_2014-Annotated-Bibliography-FINAL1.pdf

Keeton, V., Soleimanpour, S., & Brindis, C. D. (2012). School-based health centers in an era of health care reform: Building on history. *Current Problems in Pediatric and Adolescent Health Care, 42*(6), 132–156.

Larson, S., Spetz, J., Brindis, C. D., & Chapman, S. (2017). Characteristic differences between school-based health centers with and without mental health providers: A review of national trends. *Journal of Pediatric Health Care, 31*(4), 484–492.

Lofink, H., Kuebler, J., Juszczak, L., Schlitt, J., Even, M., Rosenberg, J., & White, I. (2013). *2010–2011 School-Based Health Alliance census report*. Washington, DC: School-Based Health Alliance.

National Association of School Psychologists. (2015). *School psychologists: Qualified health professionals providing child and adolescent mental and behavioral health services* [White paper]. Bethesda, MD: Author.

School-Based Health Alliance (2016). *2013–14 digital census report*. Washington, DC: Author. Retrieved from http://censusreport.sbh4all.org

Stagman, S., & Cooper, J. L. (2010, April). *Children's mental health: What every policymaker should know* [Policy brief]. Mailman School of Public Health, National Center for Children in Poverty, Columbia University.

U.S. Department of Health and Human Services, Office of Adolescent Health. (2013). *In their own words: Youth perspectives on health care*. Washington, DC: Author.

Assessing the Mental Capacity to Choose to Die

Jeanne M. Slattery, PhD; Linda K. Knauss, PhD; and Donald McAleer, PsyD

This vignette is part of a regular series looking at clinical dilemmas from an ethical perspective. In addition to the three of us, the respondents to this vignette included Drs. Fran Fettman, Claudia Haferkamp, Sam Knapp, Chris Molnar, Jeff Pincus, Max Shmidheiser, Geoffrey Steinberg, and Ed Zuckerman.

Dr. Solomon is a staff psychologist at a large medical center. The hospital's ICU requested a consult for Mr. Thanatos (age 69), who ingested antifreeze in a suicide attempt. Mr. Thanatos has a history of alcohol abuse, paranoid schizophrenia, multiple suicide attempts, and pulmonary fibrosis. He had been involuntarily hospitalized only days before this current attempt.

Mr. Thanatos was placed on a ventilator and treated for respiratory and kidney failure, pneumonia, and possible seizures. Treatment was effective, although he still requires dialysis and is in the process of being weaned from a ventilator. He wants to have the ventilator discontinued and dialysis stopped. He does not want to be reintubated if he again experiences respiratory distress.

Dr. Solomon is asked to assess Mr. Thanatos for his capacity for medical decision making. He appears clear and lucid, confirms the history as known, and is able to discuss his understanding of the consequences of these decisions. What ethical issues should Dr. Solomon consider? Would it make a difference if Mr. Thanatos had been given 6–12 months to live due to pulmonary fibrosis?

As Dr. Solomon meets and assesses Mr. Thanatos's request to be removed from life-sustaining technologies, he would need to consider whether the request was temporary and related to Mr. Thanatos's suicidality, was related to his physical condition, or both. If this conclusion were unlikely to change as his cognitive and emotional state improved, then, as Drs. Fettman and Zuckerman suggested, we might act guided by Principle E, respecting "the rights of individuals to privacy, confidentiality, and self-determination" (American Psychological Association [APA], 2017, p. 4).

The difficulty, however, and the reason that Dr. Solomon was called to consult on this case, comes from the question of whether Mr. Thanatos is a person whose "vulnerabilities impair autonomous decision making" (APA, 2017, p. 4). Either Mr. Thanatos's physical or psychological health might interfere with his mental capacity to make an informed decision.

Psychologists often use a semistructured interview such as the MacArthur Competence Assessment Tools for Treatment to assess mental capacity (Grisso & Appelbaum, 1998). Drs. McAleer and Shmidheiser reminded us that mental capacity to make a decision is comprised of four abilities: factually understand the information, appreciate the consequences of the decision, engage in rational processing, and express a choice. While Mr. Thanatos understood the facts and could clearly express a choice, as Dr. McAleer observed, it wasn't as clear that he could "*emotionally* contribute to the process."

Suicide and Illness

This vignette is complicated because there are two intertwined issues: suicidality and illness. Dr. Knapp spoke for most of us in saying, "If the only issue were suicidality, then I have no doubt that an effort should be made in protecting his life. If there were no suicidality, then there is a legitimate issue concerning his right to die. If it is impossible to tell the difference, then my preference is to err on the side of life."

Would it matter if Mr. Thanatos had been given 6 months to a year to live? Would that lead us to assess capacity differently? It might affect whether we—physicians or psychologists—would choose to fully inform Mr. Thanatos and impact his right to self-determination. Several of us talked about the impact of our parents' illnesses and how this affected how we saw this case—and even whether we would feel competent to respond to such a countertransference-influenced request. Nonetheless, prognosis should not directly impact our decision of capacity.

Risk Management

Dr. Pincus asked who the client was. Was it the referring physician, the treatment team, or the patient? If it were the patient, what is in the best interest of this patient? Dr. McAleer noted that about half of the time that he is called to assess mental capacity as part of a physician's risk management strategy, physicians are rather insistent on providing continuing treatment. This can often lead to "earnest and occasionally heated discussions" of the psychologist's findings and recommendations.

Dr. Knapp asked, "But you don't let that influence your opinion?" Dr. McAleer agreed that he did not. Dr. Pincus, though, wondered about the difficulty a new professional might have in standing up to the demands of a consulting physician, who might pressure a patient to make the desired decision out of their own countertransference—and death pulls this in most of us. We might rightly ask about anyone's ability to stand firm in the face of pressure to do differently, although Dr. McAleer noted that doing so can, counterintuitively, earn one respect.

Acting to manage possible risk sometimes has a bad reputation, as though one were doing something only to avoid negative consequences. As Dr. Knapp concluded, however, the best risk-management strategy is to offer good clinical services and a quality assessment (Knapp, Younggren, VandeCreek, Harris, & Martin, 2013). Dr. McAleer added that being data driven is an important part of a strong risk-management strategy, as is developing and maintaining the competence to complete a capacity evaluation with this population.

As always, we were interested in the number of complications raised by our vignette. Further, this vignette highlights the various roles that psychologists find themselves in: We are not just mental health professionals but also health-care professionals. It also highlighted the range of competencies that we might need in working with Mr. Thanatos. We might be competent to work with his suicidality and psychotic symptoms yet not be competent to assess his capacity to make medical decisions.

References

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct. Retrieved from http://www.apa.org/ethics/code/ethics-code-2017.pdf*

Grisso, T., & Appelbaum, P. S. (1998). MacArthur Competence Assessment Tool for Treatment (MacCAT-T). Sarasota, FL: Professional Resource Press/Professional Resource Exchange.

Knapp, S., Younggren, J. N., VandeCreek, L., Harris, E., & Martin, J. (2013). *Assessing and managing risk in psychological practice: An individualized approach (2nd ed.). Rockville, MD: The Trust.*

Would you like to be involved in future discussions of vignettes? Let us know by e-mailing jslattery176@gmail.com

Classifieds

Welcome New Members!

We offer a wild, wonderful, whopping welcome to the following new members who joined the association between February 14, 2018, and May 16, 2018!

NEW MEMBERS

Jeffery Allen, PhD
Shippenville, PA

Meredith Armbrust, PsyD
Sewickley, PA

Christina Barrera, PsyD
Media, PA

Marie-Judith Bijoux-Leist, PsyD
Wynnewood, PA

Tabitha Brown, PsyD
Aspinwall, PA

Brittany Caro, PhD
Myerstown, PA

Ann Coia, MS
Glenmoore, PA

Eliza Costoso, PsyD
West Chester, PA

John DeHart, PsyD
Cumberland, MD

Virginia Dikeman, MA
Clarks Summit, PA

Stephen Donahue, MA
Quakertown, PA

Hannah Ford, PhD
Pittsburgh, PA

Michael Gotlib, PsyD
Philadelphia, PA

Michelle Hobby, PhD
Center Valley, PA

Robert Jann, PhD
Washington Crossing, PA

Ruth Kauffold, PhD
Centerville, OH

Joseph Kelly, MA
Wayne, PA

Meridith Kim, PsyD
Philadelphia, PA

Ronald Kline, PhD
Bethlehem, PA

Susan Koons Slamka, PsyD
Muncy, PA

Shawn Kraemer, MS
Paoli, PA

Agnes Lenda, PsyD
Allentown, PA

Leslie Lenox, MSW
Philadelphia, PA

Jessica Levenson, PhD
Pittsburgh, PA

Janelle Maloch, PhD
Pittsburgh, PA

Gerrie Marz, MA
Erie, PA

Julia Mayer, PsyD
Swarthmore, PA

Nicole Mayo, PhD
Philadelphia, PA

Kathleen McDonalad, PsyD
Philadelphia, PA

Patrick McElwaine, PsyD
Willow Grove, PA

Michael Melczak, PhD
Oakmont, PA

Melanie O'Neill, PsyD
Newtown Square, PA

Kristen Parys, PhD
Hershey, PA

Rachel Petts, PhD
Danville, PA

Mary Pillow, MSW
Washington, PA

Candice Post, PsyD
Bryn Mawr, PA

Megan Rescinito, EdS
Blacksburg, VA

Erin Roemer, PsyD
Horsham, PA

Susan Schack, PhD
Wyndmoor, PA

Erik Sprohge, PhD
New Freedom, PA

Linda Welsh, EdD
Philadelphia, PA

Julia West, PhD
Allentown, PA

Brittany Williams, PhD
Danville, PA

Joel Winnick, PhD
Downingtown, PA

Michael Wolff, PhD
State College, PA

Joanne Zager, PhD
Ithaca, NY

NEW STUDENT MEMBERS

Eguono Akpoduado, MS
Philadelphia, PA

Kelsey Allison, BA
Scranton, PA

Amanda Anderson, MA
New Castle, DE

Noormehak Badechha, BA
Burlington, NJ

Siedah Cazaubon, BA
Douglassville, PA

Dermot Curtin, MS
Wexford, PA

Mary Kathryn Deacon, BS
Buffalo, NY

Sandra DiBitetto, BA
East Brunswick, NJ

Sarah Edelman, MA
Scranton, PA

Jordan Guthrie, BS
Pittsburgh, PA

Erin Guty, MA
State College, PA

Dalice Hess, BS
Nescopeck, PA

Katerina Istomin, MS
Pittsburgh, PA

Celina Joos, MS
State College, PA

Philip Kaplan, MA
Philadelphia, PA

Rebecca Kornberg, MS
Doylestown, PA

Christina Kuo, MSEd
Wayne, PA

Erica Liebman, MEd
Philadelphia, PA

Brittany Lippert, MA
Edwardsville, PA

Sean Malone, MA
Philadelphia, PA

Clarice Mendonca, MA
Chester, PA

Kaitlin Riegler, BA
State College, PA

Bree Riley, BS
Scranton, PA

Keyoni Rogers, BS
Philadelphia, PA

Kelsey Roper, MS
Philadelphia, PA

Allison Rozovsky, MS
Philadelphia, PA

Laura Rubalcava, MA
Philadelphia, PA

Jila Rusavage, MA
Peckville, PA

Beau Samonte, BS
Scranton, PA

Megan Samples, MS
Malvern, PA

Regan Summers, MSEd
Elkview, WV

Victoria Taggart, MS
Philadelphia, PA

Jacob Wadsworth, MSEd
Pittsburgh, PA

Loise Waller, MA
Philadelphia, PA

Trisha Whitmer, BS
Newport, PA

Karen Wolff, MS
West Chester, PA

Kebei Zhao, MA
Philadelphia, PA

CE Questions for This Issue

The articles selected for 1 CE credit in this issue of the *Pennsylvania Psychologist* are sponsored by the Pennsylvania Psychological Association. PPA is approved by the American Psychological Association to sponsor continuing education for psychologists. PPA maintains responsibility for this program and its content. The regulations of the Pennsylvania State Board of Psychology permit psychologists to earn up to 15 credits per renewal period through home study continuing education. If you have more than 30 continuing education credits for this renewal period you may carry over up to 10 credits of continuing education into the next renewal period.

You may complete the response form at the end of this exam, making certain to match your answers to the assigned question numbers. Each question has only one right answer. Be sure to fill in your name and address, sign your form, and return the answer sheet to the PPA office with your CE registration fee (made payable to PPA) of $20 for members ($35 for nonmembers) and mail to:

Continuing Education Programs
Pennsylvania Psychological Association
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112

To purchase and complete the test online, visit our online store at papsy.org. Passing the test requires a score of at least 70%. If you fail, you may complete the test again at no additional cost. We do not allow more than two attempts at the test.

Allow one to two weeks for notification of your results. If you successfully complete the test, you will receive an email confirmation. The response form must be submitted to the PPA office on or before June 30, 2020.

Learning objectives: The articles in this issue will enable readers to (a) assess and explain current issues in professional psychology and (b) describe and act on new developments in Pennsylvania that affect the provision of psychological services.

Parikh

1. The presence of behavioral health providers in a primary care clinic may increase the likelihood of those living in rural settings to utilize behavioral health services.
   True
   False

2. The three A's proposed by Human and Wasem (1991) are:
   a. Affordability, adaptability, and alignment
   b. Availability, accessibility, and acceptability
   c. Affordability, accessibility, and availability
   d. Acculturation, alignment, and acceptance

Slattery

3. The author questions the degree to which food insecurity may affect a student's:
   a. Attentional and behavioral problems in the classroom
   b. Truancy
   c. Ability to attend after-school activities and field trips
   d. All of the above

4. Engaging in the SNAP Challenge, or contemplating it, may be a helpful exercise in empathy for those who live with privilege.
   True
   False

Deets

5. Current psychologists now report no incidences of overt racism but do report continued subtle racism.
   True
   False

6. This type of study is imperative to creating real change in the field of psychology
   a. Quantitative
   b. Qualitative
   c. Mixed-Methods

7. What is cultural taxation?
   a. Additional money that diverse individuals must pay for their education.
   b. An expectation that diverse individuals will lead all diversity initiatives.
   c. Money paid from a dominant culture to oppressed people.

Woika & Bertuccio

8. Due to the high numbers of bilingual school psychologists, fewer school psychologists are striving to improve their competence in working with CLD populations.
   True
   False

9. Research suggests that it may take this length of time to gain academic competence in a second language:
   a. 1–3 years
   b. 2–5 years
   c. 7–10 years
   d. 8–12 years

Dwyer & Goldberg

10. SBHCs can be effective in addressing the primary and mental health of students in underserved populations.
    True
    False

11. Ability to _____ is assessed during an evaluation of mental capacity.
    a. Communicate a treatment decision
    b. Understand information received
    c. Appreciate and reason about the information impacting a decision
    d. All of the above

12. When conducting an evaluation of mental capacity, which of the following is most important?
    a. Agree with the treating physician
    b. Be responsive to the treatment team's goals
    c. Confirm the patient's preferred outcome
    d. Offer good clinical services and a quality assessment

Continuing Education Answer Sheet

The Pennsylvania Psychologist, June 2018

Please circle the letter corresponding to the correct answer for each question.

1.	T	F			**8.**	T	F		
2.	a	b	c	d	**9.**	a	b	c	d
3.	a	b	c	d	**10.**	T	F		
4.	T	F			**11.**	a	b	c	d
5.	T	F			**12.**	a	b	c	d
6.	a	b	c						
7.	a	b	c						

Satisfaction Rating

Overall, I found this issue of the *Pennsylvania Psychologist:*

Was relevant to my interests	5	4	3	2	1	Not relevant
Increased knowledge of topics	5	4	3	2	1	Not informative
Was excellent	5	4	3	2	1	Poor

Comments or suggestions for future issues _____

_____

Please print clearly.

Name _____

Address _____

City _____ State ____ZIP _____ Phone ( ) _____

I verify that I personally completed the above CE test.

Signature_____ Date_____

A check or money order for $20 for PPA members ($35 for nonmembers) must accompany this form. Mail to: Continuing Education Programs, PPA, 5925 Stevenson Avenue, Suite H, Harrisburg, PA 17112

Now available online, too! Purchase the quiz by visiting our online store at papsy.org. The store can be accessed from our home page. Please remember to log in to your account in order to receive the PPA member rate!

Vol. 78, No. 6

The Pennsylvania Psychologist

June 2018 • QUARTERLY

5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112-1788

2018 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2018, we are expanding the options. We hope you'll join us for one or more of these programs!

Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

June 7, 2018
PPA Webinar Series: Ethical Considerations When Retiring From Private Practice
noon–1:30 p.m.
Virtual Webinar

June 13–16, 2018
PPA2018—PPA's Annual Convention
Doubletree Valley Forge
King of Prussia, PA

October 18–19, 2018
Erie Ethics, Suicide Prevention, and Advocacy Program
Sheraton Erie Bayfront Hotel
Erie, PA

November 15, 2018
The Trust Risk Management CE Program
Sequence VII: Legal and Ethical Risks and Risk Management in Professional Psychological Practice
The Desmond Hotel
Malvern, PA

November 16, 2018
PPA Fall Continuing Education Conference
The Desmond Hotel
Malvern, PA

For CE programs sponsored by the Pennsylvania Psychological Association, visit papsy.org.

Registration materials and further conference information are available at papsy.org.

Home Study CE Courses

Act 74 CE Programs

Essential Competencies When Working With Suicidal Patients—1 CE

Older Adults at Risk to Die from Suicide: Assessment, Management, and Treatment—1 CE

Assessment, Management, and Treatment of Suicidal Patients (Extended)—3 CE

The Essentials of Treating Suicidal Patients—1 CE

Patients at Risk to Die from Suicide: Assessment, Management, and Intervention (Webinar)—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Poverty and Psychology—1 CE

Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)—1 CE each

*Introduction to Ethical Decision Making**—3 CEs

*Competence, Advertising, Informed Consent, and Other Professional Issues**—3 CEs

*The New Confidentiality 2018**—3 CEs

This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.

For all Home Study CE courses above, contact: Judy Huntley, 717-232-3817, judy@papsy.org.