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Problem-Solving Courts Bill Passed by General Assembly

State Senate Bill 383, which will promote problem-solving courts at the county level in Pennsylvania, was passed by the state legislature on May 26. Though it had passed both the House and Senate in different forms, both chambers came to an agreement and signed the final bill. Governor Rendell signed the bill on June 3, whereupon it became Act 30 of 2010.

This bi-partisan bill, introduced by Senators Jane Orie (R-Allegheny) and Daylin Leach (D-Montgomery), will allow the Pennsylvania Supreme Court to create rules for the establishment of problem-solving courts and to appoint a statewide problem-solving courts coordinator and advisory committee. Such measures will allow local courts to apply for federal start-up grants. The term "problem solving courts" is used to describe mental health courts, drug courts, DUI courts, or other treatment courts in which nonviolent offenders are diverted from prison into appropriate treatment. This issue has been PPA's top legislative priority this session.

The goal of problem-solving courts is to respond more effectively to the issues presented to courts. The unifying principles of problem solving courts is that they involve judicial staff (judges, probation officers, prosecuting attorneys) who have specialized training; work collaboratively with local agencies; and require accountability and monitoring of offenders. Many gather data to monitor their effectiveness and suggest ways to improve.

It is not surprising that more local courts are looking at a problem-solving model. Not only are they more humane from the standpoint of helping people with serious mental illnesses. Data suggests that these programs are fiscally prudent. For example, a 2007 study of the fiscal impact of the Allegheny County Mental Health Court (MHC) showed that in the first year "the decrease in jail expenditures mostly offsets the cost of treatment services," and that over time, "the drop in jail costs more than offset the treatment costs, suggesting that the MHC program may help decrease total taxpayer costs over time."

What Will Health Care Reform Mean for Psychologists?

Samuel Knapp, Ed.D., Director of Professional Affairs

Dr. Sam Knapp

I have heard every prediction about the passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (President Obama's health care reform law) imaginable. Some praise it as the greatest piece of American legislation since Medicare in 1964, while others claim it will ruin American health care.

My predictions of the impact of health care reform on psychology are cautious because, among other things, we do not know the final shape of this health care reform. Many of the key ingredients, such as universal coverage, will not occur until 2014. Also, there is the possibility, or perhaps the likelihood, that some elements of it will be modified between now and 2014 (although I have been informed that the constitutional challenges being brought by several state attorneys general are likely to fail). Finally, many of the actual decisions about implementation of legislation of this nature depend on the regulations developed by the appropriate government agency, and many of these will not be issued for several years. Perhaps most importantly, however, changes in Medicare and mental health parity will probably impact the practice of psychology more than this health care reform package.

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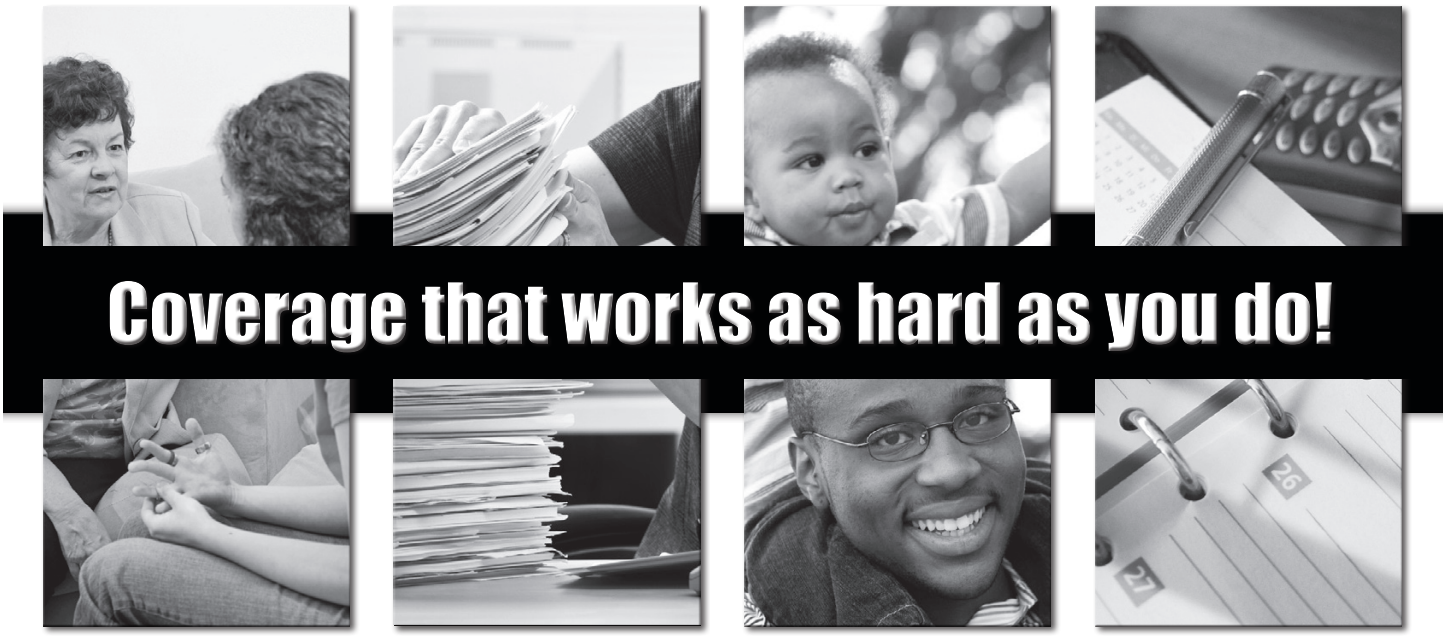

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Interim Final Rules on Mental Health Parity Lead to Substantial Improvements

The interim final rules on mental health parity were issued on February 2, 2010. These regulations, if approved, have the potential to substantially alter the way that insurers administer mental health and substance abuse services, including the possibility that authorizations may have to be restricted and that payment for providers may have to be increased, at least for some insurers. This article describes the issues involved and the potential for mental health parity to have such a wide impact beyond parity in copayments, deductibles, and other quantitative benefits. The process for this to come to fruition is complex, however, as described below.

Statutes have to be written in general terms, and there is no way that a statute can anticipate every issue that will come up in the implementation of a law. Consequently, administrative agencies (in this case three agencies: the federal Departments of Treasury, Labor, and Health and Human Services, hereinafter referred to as the Department) must write regulations which expand upon, but which may not contradict, legislation. Within the federal government, the administrative agency must write an interim regulation and then accept public feedback before it can issue a final regulation. The interim regulation for mental health parity was issued in February 2010 and will become effective on January 1, 2011. Until January 1, 2011, insurers are required to show "good faith" compliance with the law. That is, they will be allowed to have some procedures in place until January 1, 2011, that would violate the interim final rules, unless they were egregious or obvious violations of the parity law.

The law applies to policies with more than 50 employees and permits insurers to exclude certain diagnoses. However, the Obama administration interpreted the law as broadly as it could to ensure patient access to treatment in terms of both quantitative and nonquantitative treatment limitations. This article describes those limitations and their implications for psychologists.

Quantitative Treatment Limitations

The parity law will continue to require equity with annual and lifetime benefits limits that were established in 1996. In addition, the regulations make it clear that copays, deductibles, and out-of-pocket benefit maximums have to be the same for mental health as physical health. Although it was not stated explicitly in the parity law, the regulations state that, for purposes of parity, mental health professionals are not considered specialists, and the copays for their visits should be comparable to primary care physicians, not medical specialists. (For issues other than copays or beneficiary obligations, insurers can consider psychologists specialists, so they could, for example, list psychologists as specialists in their provider directory.) Insurers may not create a separate deductible for mental health, or a separate out-of-pocket maximum for mental health. So, for example, if a patient has a $500 yearly deductible, any medical expenses should accumulate toward that deductible and the insurer cannot create a separate deductible for mental health services. Again, until January 2011 when the interim regulations go into effect, insurance policies covered by parity will be required to comply only with obvious violations of parity, and it is possible that some insurers will have copays at the specialist level until the effective date of the regulations.

Nonquantitative Treatment Limitations

The original parity law was less clear about the extent to which nonquantitative treatment limitations would apply to mental health and substance abuse benefits. The law, for example, did permit insurers to continue to use medical management procedures for mental health and substance abuse benefits. However, the interim regulations stated that "nonquantitative provisions are also treatment limitations affecting the scope or duration of benefits under the plan" (p. 5416) and that "any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in a classification must be comparable to, and applied no

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- Members-only password: keystone

Medicare and Advocacy

Efforts Complicated by Partisanship and Complexities of Medicare Reimbursement

Samuel Knapp, Ed.D., Director of Professional Affairs

Editor's note: As we go to press legislation was moving in the U.S. House and Senate to address Medicare reimbursement problems. The House Ways and Means and Senate Finance committees released the "tax extenders" bill on May 24; among other things, it would raise providers' Medicare reimbursements 1% to 2% through 2013. "If enacted the bill would increase physicians' payments by approximately $60 billion over the next three years and offset the planned 21% cut, resulting from the Sustainable Growth Rate (SGR) calculation, which was approved [in April] and scheduled to take effect on June 1" (Medicare: Congressional Tax Committees Release Bill with SGR Fix).

Reimbursement rates in Medicare are important for at least two reasons. First, Medicare is an important payer of health care, especially in Pennsylvania, where 16% of the population receives Medicare. Second, commercial insurance companies often base their reimbursement on a percentage of Medicare. If Medicare payments were to drop, or increase, it is likely that payments by commercial insurers would do the same.

Few advocacy efforts are as complicated as those dealing with Medicare. Psychologists will receive alerts asking them to act to write to their Congressional Representatives to block cuts in Medicare only to receive notice a few weeks later of success, and then more notices to contact their representatives about potential other cuts. This article will describe how Medicare determines reimbursement rates and explain the complexities of advocating for adequate Medicare reimbursement.

Reimbursement rates in Medicare are determined through the Resource Based Relative Value Scale (RBRVS), which is a formula based on three factors: practice costs, malpractice, and work value. Physicians, who invest heavily in medical equipment, have higher practice costs than psychologists and higher malpractice costs. Also, RBRVS considers the work value or the amount of education and skill needed to perform the service, higher for physicians than for psychologists, although I believe they are wrong in doing so, at least for most medical specialties.

At least two different payment mechanisms have been in place to attempt to control the growth of Medicare expenditures for provider services. The first, the Sustainable Growth Rate (SGR) formula, which was enacted as part of the Balanced Budget Act of 1997, tied the Medicare reimbursement rate for all providers to a formula based on changes in the national economy (GNP) and Medicare costs. In almost every year since 2002, this would have led to a cut in the reimbursement rate. However, the American Medical Association has led of coalition of health care providers that has been able to delay the costs for one year and get modest increases. Because of the deferral of accumulated decreases over the years, if the SGR were to go into effect in 2010, providers would see a 21% decrease in their Medicare payments.

The second payment mechanism is the Five Year Rule in which CMS, which oversees Medicare, reviews the payment formula for providers. In the most recent Five Year Review, CMS determined, with wide professional consensus, that Evaluation and Management (E & M) codes, which involve direct patient contact, were undervalued and needed to be increased. However, CMS could increase the rate of E & M codes only by reducing overall payments to providers across the board because of the requirements in the Balanced Budget Act of 1997, which requires stability in the amount of money paid to Medicare providers.

The reduction in payments was made through an across-the-board reduction in the work value portion of the RBRVS, thus leading to an across-the-board decrease in payments under Medicare. However, almost all providers were minimally impacted by this change because they received increases in E & M codes. Psychologists and licensed clinical social workers, however, are not permitted to bill for E & M codes under Medicare and therefore received all of the decrease in Medicare payments and none of the increases, resulting in an overall 7% decrease in Medicare payments.

APA's goal is to get the Five Year cuts deferred until the next Five Year Review (scheduled to occur in 2010 and to become implemented around 2012). APA has reason to believe that the work value of psychologists will be reviewed in the next Five Year Review and that the work value of psychologists will be increased to a more appropriate level.

The cuts under the Five Year Rule went into effect in 2008. APA successfully advocated for the passage of a bill that restored those cuts, but the bill was vetoed by President Bush because it had other provisions that the president found objectionable. Later Congress passed the bill over the president's veto. However, congressional supporters of psychology had to compromise in response to concerns of fiscal conservatives so that the restoration would not be the full 7% that psychologists lost, but would restore 5% out of the 7% lost. Also, the restoration was for only 18 months and would expire in January 2010. In the last year psychologists have been asked to promote a bill that would restore the cuts caused by the Five Year Rule and also to restore the 21% cut that would have occurred because of the SGR. In January, psychology won

a 2-month reprieve in the Five Year Rule and in March achieved another 1-month reprieve.

On the surface it would seem that these piecemeal strategies to defer the cuts is needlessly inefficient and burdensome. I am certain that everyone at APA would agree. However, the reality is that Congress is difficult to deal with in this highly politicized environment, and presently is far more difficult to deal with than I have ever seen it. In the 23 years that I have been going to Washington, DC, to advocate for psychology, it has always been necessary to consider party affiliation and partisanship as a factor in advocacy. However, the partisanship is so extreme and so strident at this time that members of Congress are reluctant to advocate for even basic modifications to bills, such as a modification that would extend the deferral of the Five Year Review cut until 2012.

Another of APA's goals is to get psychologists included as eligible to bill for E & M Codes, which pay slightly more than regular psychotherapy codes. For example, the procedure code 90806 deals with psychotherapy, but the procedure code 90807 deals with psychotherapy plus E & M. E & M refers to evaluating and managing a patient's physical condition. In reality psychologists already do E & M services in that they keep an eye on any co-morbid conditions the patient might have, their reactions to medications, and communicate their concerns to physicians and other health care providers dealing with the patient. The only goal is to allow psychologists to be reimbursed for the services that they already provide.

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Medicare: Congressional Tax Committees Release Bill with SGR Fix. (2010, May 24). Retrieved May 26, 2010, from http://nchc.org/content/medicare-congressional-tax-committees-release-bill-sgr-fix

INTERIM FINAL RULES

Continued from page 3

more strictly, than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical benefits in the classification" (p. 5416). The commentary to the rules recognized that mental health and substance abuse treatments are unique from physical health and implies that they do not have to be identical to those used with physical health. The Department invited comment on nonquantitative provisions, suggesting that they are open to revising or further clarifying how they would interpret them.

As it applies to authorizations, for example, a case could be made that an insurer could not require authorizations for mental health and substance abuse services unless such requirements were also imposed on physical health care. As it applies to reimbursement, an argument could be made that an insurer that has a small panel because of its low reimbursement rates (compared to physical health providers) could be accused of violating parity. Again, we cannot guarantee that the Department would accept this logic and the wording in the commentary on the interim final regulations is not always clear, but such interpretations are possible.

PPA Action Steps

1. Comment on interim rules and urge greater clarity on the nonquantitative limitations.
2. Solicit support from Senators Specter and Casey on our position on nonquantiative limitations.
3. Seek meeting with the Pennsylvania Insurance Department concerning the implementation of parity rules.
4. Alert PPA members to implications of law and solicit input on possible appeals.

	Parity law	Action steps
annual or lifetime benefit limits	little change from previous law	none
quantitative equity	Financial requirements such as deductibles, copays, coinsurance, or out-of-pocket maximums, limits on frequency of treatment, number of visits, etc. have to be the same for mental health as physical health.	PPA members should be alert to differentials in the financial requirements under parity and notify the PPA office.
nonquantitative equity	limitation that is not expressed numerically, but which otherwise limits the scope or duration of the benefit	PPA members should be alert to differentials in the non-financial requirements under parity and notify the PPA office.

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Psychology in Pennsylvania: Current Status and Future Directions

This article describes the state of psychology in Pennsylvania and identifies current trends based on data from the PPA annual surveys and other sources. Psychologists are generally satisfied with their careers, although income remains a continual source of dissatisfaction. Most PPA members work in outpatient mental health settings, either as solo practitioners or in groups, and most have more than one place of employment. A majority of psychologists are now women, compared to 10 years ago when a majority of psychologists were men. Racial and cultural minorities comprise less than 5% of PPA's membership, although the trend is moving slowly toward a more representative composition of psychologists. Psychologists continue primarily to deliver mental health treatment, although there is a movement towards health psychology, assessments with external consequences, and performance enhancement psychology.

Professional Satisfaction

Table One presents data from PPA annual surveys showing that PPA members report satisfaction with their careers and optimism about the future of psychology. Levels of satisfaction and optimism was lowest in the late 1990s, probably in reaction to managed care. However, it has rebounded in recent years.

Table One: Satisfaction and Optimism Among Psychologists

Satisfaction with Psychology as a Career				
	1998	2000	2005	2008
Low/Very Low	7%	7%	5%	3%
Unsure	10%	8%	9%	8%
High/Very High	83%	84%	87%	89%

Level of Current Optimism for Psychology				
	1998	2000	2005	2008
Low/Very Low	17%	12%	8%	10%
Unsure	26%	25%	22%	24%
High/Very High	57%	63%	70%	66%

Satisfaction with Psychology Income				
	1998	2000	2004	2008
Low/Very Low	33%	38%	32%	24%
Unsure	18%	16%	15%	31%
High/Very High	46%	44%	51%	45%

One point of understandable dissatisfaction is with income. Although psychologists are the highest paid of the non-medical mental health professions (in 2003 psychologists averaged incomes of $75,000 compared to an average of $44,000 for social workers, $55,000 for marriage and family therapists and $47,000 for mental health counselors), they are the lowest paid of the other doctoral level professions with whom they commonly compare themselves. Pharmacists averaged $87,000 a year, podiatrists $114,000, and optometrists, $120,000 (Earnings of Health Care Professionals, 2006).

As measured by APA surveys, income levels of psychologists declined approximately 10% in terms of real purchasing power from 1991 to 2003, although they have increased in recent years. Of course, the income changes varied across work locations and specialties. For example, the salaries of school psychologists did decline (see Table Two). Since reimbursements from insurance companies have not increased in recent years, the likely reasons for the increase in income for clinical psychologists are because they are either working more or doing work that does not depend on insurance reimbursements.

Nonetheless, the debts of recent licensees is high. "80% of recent doctorates in the health-service provider subfields reported debt, which averaged $58,885 upon graduation" (Dittman, 2004, p. 38). Also, for the last several years the number of students seeking internships has exceeded the number of internship slots available, increasing the burden on students and recent graduates in getting the required supervised experience.

Table Two: Salaries of Psychologists over the Years

Year	Clinical	School	Cost of living adjustments[1]	Clinical in 2009 dollars
1991	$53,000	$55,000	1.57	$83,200
1995	$56,000	$59,000	1.40	$78,400
1999	$65,000	$71,000	1.28	$83,200
2003	$75,000	$78,000	1.16	$75,400
2007	$85,000	$87,000	1.03	$87,000

Work Location and Demographics of the Profession

Over the last 10 years the work locations of PPA members have remained stable, although the percentage of PPA members in independent practice has increased slightly, and the percentage of PPA members who work in hospitals has decreased (see Table Three).

[1]This was determined by looking at the Consumer Price Index calculator from the Federal Reserve Bank of Minneapolis (http:woodrow.mpls.frb.us/research/data/us/calc).

Table Three: Work Locations of Psychologists

	1998		2008	
	Primary	Secondary	Primary	Secondary
Solo Independent Practice	38%	28%	41%	32%
Group Practice	20%	15%	23%	14%
College or University	9%	16%	11%	16%
CMHC	6%	7%	3%	2%
Public or Private School	6%	5%	3%	7%
Hospital	10%	7%	6%	6%
Correctional facility	1%	2%	1%	1%
Other	10%	16%	9%	20%
Retired	2%	5%	2%	6%

Approximately 54% of licensed psychologists in Pennsylvania are women, whereas in 1998, approximately 53% of licensed psychologists were men. Minorities continue to be under-represented in psychology. Data from PPA's 2002 survey showed that 96% of the PPA membership considered themselves Caucasian, not of Hispanic Origin. However, 82% of Pennsylvania's population is Caucasian, not of Hispanic Origin. (According to U.S. Census data in 2000, Pennsylvania has 10% African-American, 3% Hispanic/Latino, 2% Asian, LT 1% Native American, and 3% other or mixed). The ethnic distribution of psychologists is slowly changing as 33% of doctoral students identify themselves as members of an ethnic minority group (Kohut & Wicherski, 2009). Nationwide, Greenberg and Jesuitus (2003) found that 89% of psychologists licensed after 2000 identified themselves as Caucasian, not of Hispanic Origin, while 95% of psychologists licensed before 2000 did.

Professional Interests of Psychologists

Data from a variety of sources showed that the big three areas of interest for mental health care remain anxiety, depression, and marital problems (Borkovec et al., 2001; Neimeyer, Taylor, & Wear, 2009; Whitehead, 2001). Nationwide about 3% of American adults have an anxiety disorder and 7% have depression (Kessler et al., 2005).

There are two ways to look at changing areas of emphasis for psychologists. The first is to look at where data suggests services are most needed. The second is to look at what different things psychologists are doing. The areas of growing need for psychological services include health psychology, treatment of substance abuse, improving cross-cultural relationships, services at the "ends of life" (geropsychology and child and adolescent psychology), correctional psychology, military psychology, forensic psychology, college counseling centers (although the expansion of services has not kept pace with the demand for services), and any practice of psychology in rural areas or with traditionally disenfranchised populations including persons with serious and persistent mental illnesses.

Although substance abuse is the third most common source of behavioral health referrals (Elhai & Ford, 2007), psychologists treat only a small percentage of the patients with these disorders. For example, only 2% of the patients seen in PPA's first Practice-Research Network study had a substance abuse problem (Borkovec et al., 2001). Greenberg and Jesuitus (2003) found that 7%-8% of psychologists had a self-described expertise in substance abuse.

As far as what psychologists are actually doing, the professional interests of psychologists were measured by looking at their preferences for continuing education (see Table Four). Despite some minor differences in the wordings of the surveys, psychologists appear to be showing an increased interest in health psychology.

Table Four: Continuing Education Interests

TOPIC	2009	Neimeyer et al., 2009	1996
psychiatric medications	29%	25%	19%
child/adolescent	25%	28%	n.a.
psychological assessment	27%	47%	22%
ethics	23%	51%	19%
marital therapy	26%		18%
health psychology	27%	22%	17%
differential diagnosis	22%		15%
neuropsychology	23%		22%

Assessment, especially assessments with external consequences, are becoming a more important part of practice (e.g., assessments related to child custody, child abuse, employment, entrance into religious denominations, eligibility for bariatric surgery or organ transplants, permission to carry lethal weapons). The wording of the questions on the PPA surveys reported above may have under-represented the interests in assessment because one of the items also asked about differential diagnosis and another item not reported above asked about interest in "specialized assessments." Although assessment as part of treatment is declining due to restrictions on funding placed by managed care companies, assessment still continues to be a major area of interest and activity for psychologists. Finally, there are reports of greater involvement by psychologists in life coaching, executive coaching, sports psychology, or other performance enhancement activities (Knapp, 2009).

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Is Psychotherapy Evolving?

Tim Barksdale, M.A.


Tim Barksdale

Imagine sitting down and discussing social psychology with Dr. Phillip Zimbardo, riding the elevator and discussing vicarious learning with Dr. Albert Bandura, chatting with Dr. Irvin Yalom about his next novel, or overhearing Drs. Judith Beck and Christine Padesky reminisce about playfully fighting for the affections of Dr. Aaron T. Beck. No, these are not the inner workings of a psychology geek's daydream. For the second week of December 2009, this was the experience of seven members of a clinical psychology doctorate cohort who traveled across the country from Pennsylvania to California to attend the Evolution of Psychotherapy International conference that has taken place every 5 years since 1985. Past presenters have included Drs. Rollo May, Arnold Lazarus, Carl Rogers, and Albert Ellis. These seven third-year students from the Philadelphia College of Osteopathic Medicine were joined by more than 6,000 attendees representing every state of the U.S. and more than 50 other countries. For 5 days the students observed their textbooks come to life with scholars like Dr. Marsha Linehan letting them in on cutting edge news such as her declaring a conceptual error and replacing the concept of validation with communication when teaching about dialectical behavioral therapy. Dr. Donald Meichenbaum was declared a rock star with his electric, humorous, and well researched presentations on therapeutic techniques and innovations. Crowds waited in line to get books signed by the likes of Drs. David Burns, Martin Seligman, Daniel Siegel, & Robert Sapolsky.

It was an amazing time for the students who discussed how energized and inspired they were becoming by the experience until the third day when reality hit for one of the seven students. On day 3, December 11, one student decided to see Drs. Christine Padesky, Derald Wing Sue, and Michael Yapko present, at an interactive event, on the subject of training therapists. After Drs. Padesky and Yapko completed their presentations, Dr. Wing Sue took the microphone and asked to speak off topic. He spoke of sitting with the esteemed faculty of the conference at a dinner and wondering to himself, "Is psychotherapy White men?" That one student of the cohort could hear and feel a screeching halt of a figurative needle on a melodic album. In other words, a major buzz-kill occurred.

Reality rushed in as he was reminded that of the 49 presenters the only people of color were Drs. Deepak Chopra, Salvador Minuchin, and Derald Wing Sue. The student was reminded that, however energized he was feeling, there was not one presenter who looked remotely like him. The student was reminded that of his cohort of 28 students he was the only African American male. He was reminded that he was one of only three male Black students

in the entire psychology department of his current school as well as in former schools (Immaculata and LaSalle Universities). The student wondered about the absence of captivating speakers like his local mentor, Dr. Thomas Gordon, as licensed psychologist, professor, psychotherapist consultant, and public speaker who graduated *cum laude* from Harvard University and who currently provides counsel to Fortune 500 companies among his many other accomplishments (http://www.tagaconsulting.com/tgordon.html). Acknowledging that the five African American women in his cohort are indicative that the women of his culture are better represented in psychology, the student wondered about the absence of noted award-winning author, psychologist, and current president of Spellman College, Dr. Beverly Daniel Tatum, or past president of the Pennsylvania Psychological Association, psychologist and attorney Dr. Dianne S. Salter. Were they or any of their other colleagues of color even considered when this list of psychotherapists was developed? The African American male student wondered why, of more than 135 presentations at the conference, only three discussions were held on diversity issues, all led by Dr. Wing Sue.

When the student was able to talk to Dr. Wing Sue in the lobby later that day, he asked him about his comments. Dr. Wing Sue said that he was concerned about the low representation of women psychologists and the absence of representation by minorities as he rattled off a list of psychologists from ethnic groups that should be represented. He said that the lack of diversity calls into serious question whether or not psychotherapy has advanced at all through the years.

The student reflected on his career choice and how he had vowed not to be a stereotype by writing about diversity when it appears that this is all minority psychologists appear to ever write about or study. However, when getting into the field and finding that many of today's privileged students speak so poorly of community behavioral health and of the people, many of color, who seek these services, he realizes why representation is needed. When he sees that the field that he admires and pursues looks nothing like his community, the student realizes that writing about issues of diversity and being actively involved in creating multicultural awareness is not really a choice when there are so few advocates. Active involvement becomes a mandate.

Upon reviewing the events of the conference the student realizes that the messages that Dr. Linehan has learned through researching people with borderline personality disorder is a universal message. It is not enough merely to validate a group that has been alienated. Communication is needed so that group's voice and perspectives can become included in the larger social discourse in order for positive (actual evidence-based) development to occur. Once the people being served are better represented by the psychotherapists studying and treating them, then it may be said that psychotherapy has evolved.

Tim Barksdale is an experienced psychotherapist who is completing his third year in the clinical psychology doctorate program of the Philadelphia College of Osteopathic Medicine. He serves on the Committee on Multiculturalism and is chair of the PPA Student Multicultural Award subcommittee.

HEALTH CARE REFORM

Continued from page 1

However, here are some general statements about the likely impact of the 2010 health care reform package.

In the short term there is more training money for psychology, especially through the National Health Service Corps. In the long run, health care reform will impact the practice of psychology in at least three major ways. First, eventually about 10% of the population currently without insurance will have health insurance by 2014. About half will be covered by the expansion of Medicaid. This will increase the number of people with the resources to receive psychological services. Second, if the plan is implemented as intended, beneficiaries will have better insurance coverage at least in terms of continuity of coverage. Finally, the plan will eventually require all insurers to offer some prevention programs with no copays. This could be important for psychologists who conduct smoking cessation, weight reduction, or other health promotion activities. Other trends toward performance measures or electronic health records have been implemented gradually for several years, and it yet remains to see how comprehensive health reform will impact them.

Of course, a question which has yet to be answered is the sustainability of these reforms. Americans spend far more on their health care than any other industrialized nation, and the high health care costs are a major drain on the American economy as well as our ability to compete economically in the world economy. If the predictions of cost savings from the plan materialize, then this plan will likely be the foundation for American health care for many years. If this plan does not save the money anticipated, then difficult choices may have to be made concerning another overhaul of American health care.

Improving BHRS Evaluations

Daniel Warner, Ph.D.

Dr. Daniel Warner

In the early 1990s, the Pennsylvania Department of Public Welfare formalized a new service into its fee structure: Behavioral Health Rehabilitation Services (BHRS). Since that time, BHRS has become a huge part of Pennsylvania's public mental health system, and increasing numbers of psychologists currently make a substantive part of their living performing assessments on clients for BHRS services, and then referring them to a master's- or bachelor's-level clinician who actually designs and implements treatment. For the most part Medicaid funds the program, and private Managed Care Organizations (MCOs) contracted by the counties administer it.

As "evaluator-prescribers," licensed psychologists can establish a nice professional niche if they are willing to pack their days with clients seeking BHRS. Some travel from agency to agency as "independent prescribers," acting as a sort of outside consultant to a BHRS provider. Others work under an "in-house" model, and act much like a hospital's intake division. Often, in-house prescribers are assumed to take on some responsibility for the carry-through of the treatment they prescribe, while independent prescribers typically check in once every 4 months, monitor progress, and recommend the next BHRS regimen, without the expectation that they lead the clinical team in any meaningful way.

BHRS and BHRS evaluations have emerged as clinical needs independent of any academic or research base. There are very few academic courses on in-home behavioral work, few tools designed for assessment of its kind, nor many protocols for prescribing hours of care from a BHRS service. No journals are dedicated to its clinical or professional issues, and there is little formal research on any of its questions. Without any guidance from professional systems, evaluator-prescribers typically draw on basic behavioral science to formulate their prescriptions. This has led to a wide diversity of what one expects from an evaluator-prescriber. To point out just a few axes upon which BHRS evaluations can differ: some are syndromally focused, spending great care identifying the exact diagnoses operating within the child; while others are more focused on functionality questions—elucidating the structures in which the child is embedded, and how the child responds to them. Some evaluators stress the clinical moment as an opportunity to consult with the client and give their own "two cents" about treatment directions; others would never dare offend the progress of treatment already in place with the provider, and instead track clinical progress and then facilitate a treatment planning session for the next 4 months.

One of the important takeaway points from these differences is that all of them are "right." There are well established traditions in mental health that approach syndromal questions as central, and others more focused on behaviors and functionality; likewise there is precedent for an outside consultation with the client, as well as for not interfering with the treatment of another professional and simply monitoring progress. All of these approaches could produce favorable outcomes, as long as all of the players involved are on the same page.

This "diversity" is exacerbated by some of the structural realities of being an evaluator-prescriber. First, it is a very isolated job. The prescribers may see as many as 12 clients a day and often work with several agencies. They write reports whose destination is not always clear, and it is not uncommon to see a client once and never have the opportunity to follow up on the treatment's progress. Evaluator-prescribers rarely get to read the reports of peers doing similar work in order to compare and improve. In short, although it is an essential part of BHRS treatment, it is mostly ungrounded from other professionals doing similar work, and from the bulk of the actual treatment it prescribes.

Second, the accountability chain for psychologist prescribers is unclear and varied. Who exactly am I writing this report for? The client? The report is often too technical for clients to find helpful. Further, if it weren't for the fact that the evaluation makes Medicaid dollars available for services, it is unlikely that so many people would be seeking out these evaluations in the first place. The provider? The general rule is that unless the psychologists are in-house prescribers with the explicit understanding that they are responsible for the care they prescribe (an increasingly rare position), the provider may not be interested in the opinion on how care should proceed, but simply wants the prescription so that they can go on and do their work as they see fit. This tension plays out differently from case to case.

Without any guidance from professional systems, evaluator-prescribers typically draw on basic behavioral science to formulate their prescriptions.

Some might answer that the real audience is the MCO, which carefully scrutinizes the evaluation to see if medical necessity criteria have been established. This, of course, reduces the clinical evaluation to little more than an administrative role: translating the clients' various ailments into the right "medical language" to access resources. This is a slightly cynical stance, but one that the current structure of the service draws out of many evaluator-prescribers.

Third, though the field mostly started with psychologists prescribing regimens of BHRS services, today an evaluator-prescriber has a larger host of clinical

services to prescribe. Gone are the days when evaluator-prescribers simply chose between TSS 6 hours a week or MT for 2. Today a psychologist is increasingly expected to consider everything from partial hospitalization, to weekly outpatient psychotherapy, to any one of the smattering of specialized "BHRS exception" programs such as Strengths-Based, Multi-Systemic Therapy, or Hi-Fidelity Wrap Around. Evaluator-prescribers need to stay informed on what services are available in every area, what the entrance criteria are for each of them, as well as have an understanding of which services just sound good, and which actually are good. This "systems" knowledge is certainly not a part of the conventional psychologist education, but is absolutely at the heart of good "community prescribing," a label that I think better captures the expectation put on evaluator-prescribers today.

Fourth, the field is so fractured, and the role of the evaluator-prescribers so isolated, that outcomes monitoring is rarely done. Thus prescribers rarely have an idea of whether they made a difference in the life of the client or not. I can speak from direct experience here to note that this breeds cynicism and demoralization, turning a relatively high level clinical role into what one evaluator-prescriber friend called, "making hamburgers on an assembly line."

Amid this isolation and ambiguity, the psychologist prescriber struggles to do good work, even though what exactly "good" looks like is at issue. This ambiguity has its strengths: it allows good community prescribers to individualize their approach to the local needs and resources in their community. I have observed many hard-working and creative "community prescribers" weave beautifully structured plans that unite clients and their local resources in strengths-based, recovery-oriented, client-centered regimens that gave all of the members direction and ownership of the healing process. Some of these psychologists were very focused on testing and diagnosing, others knew the local resources so well that they would flatteringly refer to themselves as "failed social workers." Many of these evaluator-prescribers like the freedom of the position, and fear that any standardization of our approach would compromise the clinical creativity, and thus efficacy, of their work.

However, the ambiguity also comes with costs. Quite simply: Without a well defined mission for the role, and without a stable academic or professional base, there is little to fend off professional encroachment from other forces with their own agendas.

I have heard reports of a few unscrupulous providers who take advantage of the ambiguities in the clinical evaluation to pressure their evaluator-prescribers to recommend excessive treatment regimens simply because it pads their bottom line. The ambiguity also allows MCOs discretion in evaluator prescribing that at times can feel like clinical "over-stepping." To give just one common example, MCOs regularly provide "peer reviews" in which an outside physician or psychologist reviews an evaluation and takes issue with its concluding recommendation. While many of these peer reviews can be very helpful (it is, after all, one of the rare moments where an evaluator-prescriber actually speaks to a peer about his or her work), they have had, in my experience, a tendency to recommend lesser care, and at times highlight the ignorance the peer reviewer has of the case's clinical realities. (For instance, I have had several instances where peer reviewers recommended non-existent services.)

I do not note this example in order to demonize peer reviews, nor MCO efforts to do their taxpayer-appointed task of distributing scarce public resources efficiently and equitably. The point is that without a strong academic and professional basis that establishes scientific norms for evaluator-prescriber decisions, other criteria will come into play, and psychologist evaluators find themselves without the necessary "ammunition" to defend their claims or advance a clinical agenda. Where can an evaluator-prescriber point to argue against an MCO claim that a prescription does or does not meet medical necessity? What research base or professional organization has established evidence that clearly defends his or her position against an aggressive reviewer?

As chair of the Medical Assistance Subcommittee of PPA's Insurance Committee, I have become aware of the importance of psychologists coming to some united conclusions on the clinical work of the evaluator-prescriber. Unless professional psychology establishes standards for psychologist prescribers, we will find our work increasingly defined by the needs and interests of others, and our professional authority will erode. The difficult task before us is to come to decisions that allow the clinical flexibility that is at the heart of good mental health work, but which buttresses us against undue non-clinical influences.

Towards this end, I am interested in holding a continuing education workshop in which evaluators from around the state bring examples of their evaluation templates, and discuss what a good BHRS template should possess. This workshop will be the first step in establishing important dialogue among us as professional "community evaluators" and can start us in the process of researching the scientific base for our work and delineating best practices.

If you are interested in such a meeting, and have experience in BHRS evaluation, or are a BHRS provider or a researcher interested in relevant questions, please e-mail me at arendt_1@yahoo.com. We are hoping to put together a course on this topic in October, so sooner contact is preferred.

Consulting the Great Doctor Sigmund Freud: An Irreverent Recollection of Electrotherapy

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Bloomsburg University of Pennsylvania

Abstract

Archival oral history material is presented which describes the experiences of a boy who was taken by his mother to consult with Sigmund Freud and which suggests that Freud was still using electrotherapy as late as 1927.

Dr. Eric H. Affsprung

The material presented here is taken from the oral history transcript of Sidney Roger (1914-1994) titled: *A Liberal Journalist on the Air and on the Waterfront: Labor and Political Issues, 1932-1990* (Courtesy, The Bancroft Library). This material is interesting in that it provides a description of one youth's encounter with Sigmund Freud in the early twentieth century and a firsthand account of a patient who was treated with electrotherapy. More importantly, the material provides evidence to suggest that Freud was still using electrotherapy as late as 1927.

Sidney Roger was a well known liberal radio commentator. He was born in Paris, France, on May 24, 1914, just prior to the start of the First World War, to American parents of Russian-Jewish heritage and socialist sympathies. During his long life he also worked as a ship clerk, labor organizer, political activist, and actor. He died on August 18, 1994, at the age of 80.

When he was about 10 years old Sidney Roger began to develop facial tics – a difficulty that caused him great emotional anguish and with which he would struggle for the rest of his life. In an effort to find a cure, his mother took him to a number of specialists. In 1927, when he was a young adolescent, she took him to consult with Sigmund Freud. Mrs. Roger was a physician and, like many American doctors of that day (Affsprung, unpublished manuscript; Gay, 1988), was furthering her education in Vienna at the time.

Electrotherapy was a widely used treatment for "hysteria" (e.g., tics, unexplained pain, hallucinations, limb paralysis) (Breger, 2000; Decker, 1991; Gay, 1988) and various other disorders during the latter half of the nineteenth and the early- to mid-twentieth century (Decker; Gilman, 2008). In this type of treatment "electrodes were applied to parts of the body and a mild electric current used to produce a tingling sensation or a muscle jerk" (Clark, 1980, p. 98).

It is surprising to discover evidence that Freud may still have been prescribing electrotherapy in 1927, because it contradicts the view held by scholars who state that, during the late 1800s, Freud became disillusioned with this form of treatment and turned his attention to hypnosis and, later, the "talking cure" (e.g., Breger, 2000; Clark, 1980; Ferris, 1997; Gay, 1985, 1988; Gilman, 2008; Jones, 1953). Sidney Roger's report of his treatment for facial tics in Vienna suggests that Freud continued to use electrotherapy with at least some of his patients into the late 1920s.

Roger: I wasn't an adolescent when it [the tics] started...
Interviewer: You told me that your mother went so far as to take you to Sigmund Freud.
Roger: No. Let's start – Sigmund Freud came a lot later.... Later, I'll tell you what he did. My mother took me right away to other doctors. First, there was a so-called famous doctor, Rappaport; then on to a neurologist. Then to see this famous psychiatrist. I can still remember going to this guy who examined me carefully.... He said he was going to prescribe so and so. I took so and so. Whatever it was. Once or twice a day. When I got up in the morning and once at night. It was called Luminal [i.e., Phenobarbital – an anticonvulsant]. Something they don't use at all anymore.... Luminal would stop the twitch. All day long in school I didn't twitch. I slept. I would go to sleep at the desk. Pretty soon I'd [laughs] be waking up and I didn't even know I was asleep...[laughter]. So I got Luminal. I couldn't go on too long that way.... [And then] I was taken to see this man.

Sidney with mother Adella Roger in front of the Vienna Opera House, 1928. Adella Roger was engaged in a six-month advanced pediatrics course. During this time, she took Sidney to see Sigmund Freud for treatment of his tic.

Interviewer: I see. This Sigmund Freud.

Roger: I didn't know who he was. I was just taken to see this doctor who everybody said was world famous. Because my mother was an American studying there, she apparently had no problem in getting the doctor, as a courtesy to the other doctors, to see the son who has a tic.... I sat there and this man, who had a beard, was sitting in a big chair. Not a big office, certainly not his famous office. A small room in the hospital.[1] He never looked at me. He only talked to my mother in German, with some English thrown in. She would listen and he would talk to her. Soon he called a woman in – she looked fat and surly to me – and he said something to her in German. She led me out. My mother seemed excited. She said to me, "Do you realize that you've just seen the great Doctor Sigmund Freud?" I said no, I didn't realize it. I remember that distinctly. Then we went to a room and she put some metal strips on both sides of my head and turned up the electricity. The lady, who looked a little like my grandmother, attached these metal plates on both sides of my head and turned on the juice. I got a kind of a prickling sensation and as she turned it up, it got hotter and more painful. I started passing out and she turned it off.

The next day, I didn't twitch. My mother said, "You see, the treatment cured your twitch." And I said, with the instinct of a kid, "You know what, if you hit me on the head with a hammer, I wouldn't twitch for three days, I'm sure of that." Two or 3 days later I was twitching again. So much for Freud. I've had people ask me for years, "What was Freud like?" I would always say – and psychiatrists go crazy when I say – "I didn't even know who the old bastard was."

Interviewer: But he never looked directly at you?

Roger: He didn't really look at me. He didn't examine me. I felt ignored, as if he thought: This boy has a tic. Let's try some treatment for a tic. Oh, here's a story: There was a famous doctor, Doctor Romeo Greenspoon, who changed his name to Ralph Greenson.[2] He was treating me for my tic. I was one of his first American patients. Many years later he became Marilyn Monroe's psychiatrist. He told me this story.... He said Freud had written he was treating a patient with a tic. Freud wrote in his conclusion that the treatment was inconclusive because the patient committed suicide. I'd call that a successful treatment. He never twitched again. [laughter].... So, so much for Freud. So much for tics.

As noted above, Sidney Roger's account of his experience with electrotherapy seems to contradict the conventional wisdom that Freud had abandoned this form of treatment prior to 1900. Of course, it is at least conceivable that it was actually another doctor who prescribed the treatment, but Roger was apparently quite sure that he'd been taken to consult with Freud and it is hard to imagine why his mother would lie about this sort of thing. Roger also notes that his mother had a penchant for taking him to distinguished physicians and, as a member of the community of American physicians in Vienna, it is quite possible that she did have access to Freud (Affsprung, unpublished manuscript).

Exactly why Freud would have prescribed electrotherapy for Roger is another question. Perhaps he still hoped that electricity could be of some use to certain patients. Or perhaps, for whatever reason, he was not inclined to prescribe psychoanalysis for the boy and hoped that electrotherapy would at least provide some temporary relief, if only via the placebo effect. Perhaps Roger's mother, who was herself a physician, specifically requested this form of treatment, which was still being used in Europe during the 1920s. And why no follow-up appointments? Roger's family was in Vienna for some time so additional treatments would have been possible. Dr. Freud's greatness notwithstanding, perhaps Roger's mother was an incurable doctor-shopper (Roger certainly seems to suggest this) and simply moved on in search of other cures. Whatever the case, Roger's account of his meeting with Freud and his experience with electrotherapy provides an interesting and amusing glimpse into a bygone era of psychological science.

[1] Perhaps the Vienna Ambulatorium, a free clinic established by Freud (Danto, 1998), or the Viennese Children's Hospital.

[2] Ralph Greenson (1911-1979) was a prominent American psychoanalyst.

References

References available on the PPA Web site, www.PaPsy.org, or upon request from the author, eaffspru@bloomu.edu

Pennsylvania Retains Two APA Council Representatives

In the apportionment voting last fall to determine the number of seats each state/province/territory and APA division gets on APA's Council of Representatives for 2011, Pennsylvania was the only state to maintain two representatives. We barely held that distinction, with 3.73% of total votes. New York, the only other state with two seats for 2010, had 3.69% of the votes and lost one seat for 2011. California had 3.10% of the vote and maintains their one representative.

Some observers believe that the apportionment system is skewed in favor of divisions at the expense of the states. For example, three divisions received fewer votes than Pennsylvania but were allocated three or more seats. There were 9 states that had more than 1% of the vote and got 1 seat, whereas 10 divisions had 1% or less of the vote and got 2 seats. The Council of Representatives is APA's policymaking body and reflects the priorities of its 162 members. Pennsylvania's representatives are Drs. Steve Berk and Don McAleer.

The apportionment results are available on the APA Web site: http://www.apa.org/about/governance/council/2011-ballot-results.pdf

Dr. Samuel Knapp Comes to Pittsburgh

Shannon M. Wilson, M.S.

Shannon M. Wilson

On March 26, doctoral students were blessed with a rare opportunity in the Pittsburgh area. Dr. Sam Knapp came to Carlow University to speak with aspiring psychologists about the current status of the field of psychology and what to expect as we make the journey from students to early career psychologists. Students from Carlow, Chatham, Duquesne, and IUP came together to get their questions and concerns about the field addressed by Dr. Knapp.

Dr. Knapp began his presentation with a discussion about the value of meetings such as these and the importance of developing and maintaining a strong social network, especially with other graduate students who will become much needed sounding boards down the road. He argued that strong support systems have been found to predict success, quoting Carlow's very own Dr. Bob Reed.

Dr. Knapp provided a hand-out that outlined several FAQs, including satisfaction with a career in psychology, expected income as an early career psychologist, options for paying off student loans, the various career paths within the field, and the growing areas of the field. I have to say, this hand-out was all-encompassing and informative. If you see one lying around, grab it! (See "Psychology in Pennsylvania: Current Status and Future Directions" in this issue.)

So what were his answers? Well, satisfaction and optimism regarding psychology as a profession have rated fairly high for most of the last decade, with anywhere from 80 to 90% of psychologists reporting high to very high satisfaction and 60-70% of psychologists reporting high to very high optimism. The lowest ratings for both satisfaction and optimism occurred in 1999. Why? You guessed it – managed care. And I'm sorry to say, when it comes to income, only 40-50% of psychologists have reported high to very high satisfaction this past decade. Although psychologists are the highest paid "non-medical mental health" professionals, in comparison with other doctoral level professionals, psychologists earn less. In addition, the income for psychologists has decreased approximately 15% since 1993. Many psychologists have found ways to compensate for the loss of income by providing psychological services in such areas as forensics and I/O consultation.

Unfortunately, although income declines, the cost of education continues to rise. Eighty percent of early career psychologists report having significant debt.

Unfortunately, although income declines, the cost of education continues to rise. Eighty percent of early career psychologists report having significant debt. Dr. Knapp identified two areas in which psychologists could work and qualify for loan repayment: with underserved populations and within the prison system. In fact, 2 years of work in these areas could result in up to $50,000 in loan repayment! There is more money available for loan repayment now than in the past, and positions in these areas remain unfilled each year.

Where are today's psychologists working? The top three work settings for psychologists over the last decade are independent practice, group practice, and college/university. Dr. Knapp reported that the "Big Three" sources of interest in the field remain depression, anxiety, and relationships. A number of growing areas within the field were identified: psychological assessment, neuropsychology, psychopharmacology, behavioral health psychology, sports psychology, correctional psychology, and forensic psychology. Dr. Knapp referred to psychological testing, in particular, as "booming," especially in regard to potential organ recipients, bariatric surgery candidates, law enforcement, and employment. Behavioral health, or working to improve public health overall, especially in such areas as smoking cessation and nutrition, has seen increased professional interest as a result of an increase in people's desires to make necessary lifestyle changes. Other populations of growing interest include individuals with co-morbid substance abuse issues, children (especially in BHRS), and the aging population.

Dr. Knapp took another moment towards the end of his presentation to discuss the importance of social connectedness, and more specifically how social relationships correlate highly with individuals' reported happiness. Again, he made sure to emphasize the need for psychologists to be socially embedded with other psychologists, the need for psychologists to have colleagues with whom they can consult, both professionally and emotionally. One way to do this is to join PPA! This interconnectedness leads to increased professional satisfaction and decreased risk of facing disciplinary action.

Dr. Knapp opened up the discussion, addressing questions and concerns from the group. As for prescriptive privileges for psychologists, Dr. Knapp predicted that these privileges will first occur in states that have limited access to medical personnel. The first question asked by a student was about... well, internships, of course! Dr. Knapp stated that failing to get an internship at an APA-accredited site will not make or break your career.

As for health care reform, Dr. Knapp gave us a ton of worthwhile information. However, for the sake of brevity, I will mention only the main points. He highlighted three key pieces of legislation occurring in the last year that impact psychological practice: (1) mental health parity, (2) Medicare reimbursement, and (3) the health care reform plan. (See articles in this issue.) Most importantly, mental health parity will increase utilization of such services, though right now it only affects those who work for employers with 50+ employees. As of January 2011, psychologists will be included

under PCP, and not specialist, co-payments. Continued movement in Medicare reimbursement is going to require relentless work of psychologists in the political arena. The health care reform plan should even the playing field with insurance companies and also increase access to services via community health clinics.

Dr. Knapp doubts the trend towards evidence-based treatments will narrow the scope of the profession, except possibly in terms of insurance coverage. He did specify that "evidence-informed" therapy is preferential, and also emphasized the importance of flexibility, to ensure the unique needs of each individual client are being met.

The discussion ended with some good news for future early career psychologists: at some point psychologists may be able to gain licensure immediately following earning a degree, with all the work experience needed being done in two predoctoral years. Alas, this will not occur soon enough to benefit any of us currently in a doctoral program.

Having Dr. Knapp come and speak about issues pertinent to doctoral students was an awesome opportunity, and I'm pleased I was able to take advantage of it. We appreciate you making the trip to Pittsburgh, Dr. Knapp!

Member News

Dr. Frank Dattilio

Congratulations to **Dr. Frank Dattilio**, who has received the 2010 Marriage and Family Therapist of the Year Award by the Pennsylvania Association for Marriage and Family Therapy. This award is given annually to a member for outstanding contributions to the field of marriage and family therapy. Dr. Dattilio was honored for his seminal contributions to the development of cognitive-behavior therapy with couples and families. He is also one of the pioneers of cognitive-behavioral family therapy and has lectured in 80 countries. His works have been translated into 28 languages. Dr. Dattilio is featured in most of the marriage and family therapy training texts on cognitive and behavior therapy with couples and families.

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Check out PPA's Career Center

The Membership Benefits Committee would like to remind all PPA members that the new online Career Center is up and running! Simply click on the green box labeled "Career Opportunities" on the right hand side of the PPA home page (www.PaPsy.org). This is a resource for both job seekers and employers/recruiters.

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Bylaws Amendment Passes

The proposed amendment to the PPA bylaws that was printed in the May *Pennsylvania Psychologist* was approved unanimously by those who voted. The balloting ended June 1. The amendment completes the transition of the Pennsylvania Psychological Foundation to a more streamlined organization that is more closely aligned with the association. It provides for membership on the foundation board by five members of the association board, with four additional members who are not on the association board. The amendment is effective immediately.

2010 CE Calendar

The following programs are being offered either through co-sponsorship or solely by PPA.

September 24, 2010
APA Insurance Trust Risk Management Workshop
Harrisburg, PA
Marti Evans (717) 232-3817

November 4–5, 2010
Fall Continuing Education and Ethics Conference
Exton, PA
Marti Evans (717) 232-3817

For CE programs sponsored by one of the Regional Psychological Associations in Pennsylvania, visit http://www.PaPsy.org/resources/regional.html.

Registration materials and further conference information will be mailed to all members.

If you have additional questions, please contact Marti Evans at the PPA office.

also available at www.PaPsy.org – HOME STUDY CE COURSES

*Introduction to Ethical Decision Making** – NEW!
3 CE Credits

Staying Focused in the Age of Distraction: How Mindfulness, Prayer and Meditation Can Help You Pay Attention to What Really Matters – NEW!
5 CE Credits

*Competence, Advertising, Informed Consent and Other Professional Issues**
3 CE Credits

*Ethics and Professional Growth**
3 CE Credits

*Confidentiality, Record Keeping, Subpoenas, Mandated Reporting and Life Endangering Patients**
3 CE Credits

*Foundations of Ethical Practice**
6 CE Credits

*Ethics and Boundaries**
3 CE Credits

Readings in Multiculturalism
4 CE Credits

*Pennsylvania's Psychology Licensing Law, Regulations and Ethics**
6 CE Credits

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

For all Home Study CE Courses above contact: Katie Boyer (717) 232-3817, secretary@PaPsy.org.