

# THE MONTANA PSYCHOLOGIST

MONTANA PSYCHOLOGICAL ASSOCIATION

DECEMBER 2008

## PRESIDENT'S PERSPECTIVE WILLIAM PATENAUDE, PHD

MPA is faced with a very difficult task over the next several months. As the legislative session begins, there are a number of important issues that are being addressed, with few that are collectively agreed upon. While the outcome of these particular political agendas will affect the role of psychologists for some time to come, it is more important to recognize that these political agendas will also affect those that we treat. But it is easy to become seduced (maybe distracted?) into thinking the essential aspect of this work is defining the role of psychologists within the health care system and concomitant ability to make a living/establish personal identity. I do not want to suggest the role we play and our ability to garner value for this role is not an important element, but I want to encourage all of us to consider the principles upon which we base our actions, not only as individuals but as an organization as well.

The more substantive and meaningful implications of these efforts have to do with fulfilling our sense of duty/obligation as psychologists; in short, to reduce suffering and increase happiness. And by happiness, I do not mean the common language sense of that word where we are busy driving a particular make of car (I guess in Montana that would be "truck") or having great seats at the recent concert. Rather, by happiness I mean to capture the Aristotelian sense of the word "Eudaimonia," which is not an endpoint. Eudaimonia is a flourishing life, a life that has a certain character and deliberation. Eudaimonia is not fame or riches, it is more of committing ourselves to doing those things that are worth doing. As psychologists, we have chosen this profession (for those who are lucky, I suppose they have been called to this profession) not only because we aspire to help others but because we, too, strive to live a life of Eudaimonia. As in Phaedo, "That was the end of that man, who of all men of our day, was the best, the most just, the finest man who ever lived."

To understand what Eudaimonia means to an individual is to ask the question "What is the nature of man?" And to ask this question is to be a psychologist. It is to ask "What things do we think and do, the kinds of relationships we have, when we are fully expressing who we are and conducting ourselves in a way that is consistent with our character?" It is this question that is embedded in the Hippocratic corpus, where not only disease is taken out of the realm of purely mystic, religious, and magical explanations, a code of ethics is also developed.

I encourage you to consider these points as we strive to forward positions related to the various legislative efforts that will come this next session. It was not too long ago, when first considering a bill that would allow properly trained psychologist prescriptive privileges, Patrick Davis reminded us to make sure whatever we did was for the right reasons. I also encourage our parent organization, APA, to hear this reminder - to make decisions based on our character and on our obligations because of that character. MPA as an organization is committed to following-through with our duty and obligation to the people in Montana. But MPA needs your help. I am not sure what that help will look like as we continue to have discussions with APA and their ability (or lack there-of) to support our efforts. But one thing is clear: We will continue to do things because they are the right things to do.



### 2009 EVENTS

April 30-May 2  
**Tri-State  
Psychological  
Convention**  
Coeur d'Alene  
Resort  
Coeur d'Alene, ID

July  
**Summer CE**  
TBD

### INSIDE THIS ISSUE

President's 1  
Perspective

RxP Update 2

Report on APA 2-3  
Council of  
Representatives Meeting

Psychologist 4-5  
Collaboration with  
Medical Professionals  
Crucial for Optimal Care

Education Committee 6  
Report

Intervention with Insert  
A Capital "I"

MPA Membership 7  
Benefits

2009 MPA 8  
Dues Notice

Mental Health 9-10  
Parity Law

Classifieds 11-12

**RxP UPDATE**  
**EARL SUTHERLAND, PHD, RxP CHAIR**

We are in December and our hardest work is now beginning. In both Louisiana and New Mexico RxP passed because of the hard work and dedication of a small group of psychologists. MPA is small and now we need your dedication.

Your association has been working hard to provide education in RxP. In addition to MPA members, legislators were also invited to each of our three conferences and the RxP presentations were well received. As a result of those presentations we have received offers of sponsorship for our legislation. MPA members presented at the IHS National Behavioral Health conference in Billings and their participation was a significant force in moving the Billings Area (Montana and Wyoming) of IHS to formally support the training and hiring of prescribing psychologists. By this time next year there will be IHS psychologists prescribing in Montana. With your help they can do so with a Montana instead of a New Mexico license.

While we still have hope for some outside financial support, our CAPP grant application was rejected. It seems very probable that we will not be able to finance the additional lobbying efforts as we had hoped. I have prepared a power point presentation and a "Fact" sheet for your use in educating your legislators. Attachments tend not to go through on list serve broad cast so please email me – esuth1@msn.com and I will send them to you.

Your executives are formulating our final legislative strategy. Key legislative committee members and leaders have now been identified and we will need your help in contacting them and presenting our information. Whether you choose to pursue RxP training or not, you have a unique opportunity to determine the future and scope of practice for psychology in Montana. Please be willing to give of your time and knowledge when called upon.

**REPORT OF APA COUNCIL OF REPRESENTATIVES MEETING**  
**AUGUST 2008**  
**JANET P. WOLLERSHEIM, PHD**

Dr. Alan Kazdin, president of APA, conducted the meeting. The Society of Indian Psychologists' observer to Council provided an opening prayer and song.

Dr. Anderson, chief executive officer, (CEO), of the association gave some updates. In 2008, the budget will end with almost a million dollar deficit. Plans have been implemented to build a surplus in the budget each succeeding year. APA's strategic plan will focus on Mission (reason for being) and Vision (indices of what specifies success). The association received a number of awards, including one for the organization's building and another for the technological sophistication of the Psych Net team. APA's web site, (APA.org), has been revised, is much more comprehensive, and is very user friendly. It will be fine-tuned and available to all members in the first quarter of 2009.

Dr. Paul Craig, APA's Treasurer, gave an overview of the 2009 budget. While the 2008 budget will likely have a deficit of \$937,900, the preliminary 2009 budget projects a surplus of \$721,000. The new Chief Financial Officer, (CFO), Mr. Archie Turner, presented budget details. APA has three types of income: buildings, long term investments and operations. The majority of rent leases for APA's buildings are committed to 2019. The long term investments have lost value as have most investments in today's negative market. All of APA's long term investments through 6/30/08 have outperformed their respective benchmarks. Communications bring in 68% of the operating budget while dues and fees bring in 14%. In 2009 there will be a proposal to use the CPI to increase membership dues from \$279 to \$287. An increase of \$30 will also be proposed for convention registration. Council approved these budget projections and proposals in principle. Final acceptance will be discussed at the February 2009 Council meeting.

The American Psychological Foundation, (APF), announced that this year the Foundation awarded over \$800,000 in scholarships and grants. APF recognized Dr. Harry Levinson and his wife, Marion, for giving over \$100,000 to the foundation.

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**REPORT OF APA COUNCIL OF REPRESENTATIVES MEETING (CONTINUED)**  
**AUGUST 2008**  
**JANET P. WOLLERSHEIM, PHD**

Dr Kazdin updated members on the results of his presidential initiatives. One initiative addresses the issue of violence. One outcome of this venture will be a new APA journal devoted to violence issues. His second initiative focused on future challenges to the science of psychology. Work in this area is continuing and a number of pamphlets specifying these challenges are being printed. The third initiative studied post traumatic stress disorder and trauma in children and adolescents. This task force produced a number of documents delineating what we know and don't know and how to help those with these problems. Dr. Kazdin noted that we have much knowledge but that knowledge in itself does not change behavior. He strongly encouraged task forces and psychologist to have action plans to implement the knowledge we have gained.

The agenda for the meeting was a large one. There were many action items. Council also received a number of reports from working groups. One was from the Task Force on Mental Health and Abortion. This report does not support one political side or the other but specifies what science does and does not know about the issue. Research was not adequate to come to a conclusion for either side. Council also received a report from the Task Force on Strengthening the Teaching and Learning of Undergraduate Psychology. Council passed a resolution opposing prejudice and discrimination regarding transgender and gender variant individuals. Also passed were a number of items relating to continuing the work of various task forces. Council adopted recommended changes to the APA Convention that would appeal to scientists.

In 2009, APA will begin diversity training on aging to various governance groups. Council continued work on APA's strategic plan. This session focused on the issues of Mission and Vision. Mission is the fundamental reason for being. Vision encompasses what success looks like. Council approved the following as APA's Mission statement: "to advance the creation, communication, and application of psychological knowledge to benefit society and individuals." Work on the Vision component is continuing.

The association presented awards to two women journalists who have covered psychological topics. APA also recognized the contributions of Dr. Norman Abeles for his work in many areas including ethics, assessment, and aging. Dr. Annette La Greca was also recognized for her outstanding work in the fields of child clinical and pediatric psychology. Dr. David Baker, psychology historian, was applauded for his significant work in preserving the archives in psychology. All three received presidential citations. The Raymond D. Fowler Award was given to Dr. Charles L Brewer for exceptional teaching and contributions to education.

Council went into executive session to discuss the issue of the revision of the *International Classification of Disease* and psychology's involvement in this venture. The group voted to continue funding for a psychologist to work full time as part of the core revision team in the World Health Organization (WHO) through the anticipated completion of the ICD revision in 2012.

What follows are my impressions of this day and one-half meeting. Much business was conducted in a short period of time. Because of Council's large size, it has become increasingly important to have task forces to study and discuss details of issues and then bring their recommendations to Council. While a large body such as Council allows for much diversity and richness of ideas, it is very difficult to work efficiently in such a large group. We have to remind ourselves that APA's Council is really the board of directors of APA and that APA's Board of Directors is, in actuality, the executive committee of the board of directors, i.e., APA's Council of Representatives. It would be helpful if APA's naming of these two governing groups matched the names more commonly used by other organizations. An ever present challenge for Council is accommodating the diverse ideas of different psychologists without sacrificing high standards for the science and profession. Compromise is desirable when it can be gained without interfering with high standards or sound principles. Unfortunately, some important issues cannot be addressed by compromise.

In closing, I thank MPA members for giving me the opportunity to serve in this capacity. While there have been some frustrations, on the whole, the experience has been inspiring, educational and pleasurable. Each Council member can serve only two consecutive sessions. I have done that. I wish to congratulate Dr. Barton Evans as he begins his term on APA Council as MPA's representative in 2009. With his many talents and great capacity for work, I believe he will represent us very well.

## PSYCHOLOGIST COLLABORATION WITH MEDICAL PROFESSIONALS CRUCIAL FOR OPTIMAL CARE

NANCY BREEN RUDDY, PHD; DOROTHY BORRESEN, PHD, APN; BILL GUNN, PHD

As psychologists, we work collaboratively with patients, their social networks, and other helping professionals. However, many psychologists rarely collaborate with patients' primary care medical professionals. The lack of ongoing dialogue between mental health and medical professionals creates many missed opportunities to enhance patient care, build referral relationships, and reduce professional isolation. How can psychologists develop and maintain reciprocal, collaborative relationships with medical professionals? We recommend the following practice management and collaborative strategies.

*Make a commitment to collaboration with medical professionals:* Creating and maintaining collaborative relationships takes time and effort. While we believe the benefits far outweigh the challenges, psychologists must be willing to step outside of their comfort zone into the medical world.

*Make collaboration a routine part of your practice:* Routinely assess patients' current and past health issues and familial medical problems. Encourage patients who have not had regular medical care to seek consultation from a medical professional, to rule out physical causes of symptoms they believe to be stress-related. Ask the patient for a release of information to their primary care medical professional, and initiate communication. At a bare minimum, inform the medical professional when the patient initiates and terminates therapy with a *brief* letter.

*Reach out to medical professionals in your community:* While there is a continuum of practice styles, most primary care physicians recognize the importance of psychological and relational wellness on overall health. Many psychologists are unaware that approximately 30 – 50% of primary care visits address psychological and relational issues, and that most of the mental health care in the United States occurs in primary care (Lewis et al., 2004; Miranda et al., 1994; Kessler, Demler & Fran, 2005; Robins & Regier, 1991). The vast majority of people who need our services never darken the doorstep of a psychologist. Primary care medical professionals struggle to meet the needs of these patients, given their training and time constraints. They want to establish referral relationships with psychologists who will communicate with them about shared patients, and provide them with pre-referral consultation. Primary care professionals often spend many visits convincing a patient to seek therapy. An established relationship between the primary care professional and the psychologist facilitates referral, because the medical professional can recommend a specific psychologist based on a history of prior successful outcomes. Yet, this type of referral relationship is rare. To facilitate such a referral relationship, psychologists can contact medical professionals of current patients to discuss their care. Collaboration begets collaboration. Psychologists can also market their practice to medical professionals, highlighting their willingness to work collaboratively. Of course, one must then follow through on these promises.

*Cater communication and collaboration to the medical world:* Collaborative referral relationships are the norm in medicine. Medical specialists such as cardiologists routinely communicate their findings, impressions and treatment recommendations back to primary care professionals for implementation. The reality that mental health "specialists" don't communicate in this way is very frustrating to primary care professionals, and impedes optimal patient care.

To facilitate communication, develop form letters that briefly describe the patient's presenting concern, treatment plan (including anticipated length of care) and how these issues affect health. Ask primary care professionals the best way to establish contact, and provide them with the best means of contacting you. Recognize that phone conversations may be very difficult, given time constraints and schedule demands. Also recognize that primary care professionals may not communicate in return, as this is not the norm in their other referral relationships. This does not reflect a devaluation of psychologists' input.

*Respect the medical professional's relationship with the patient:* Ideally, primary care is ongoing comprehensive and preventative personal medical care which helps patients navigate the healthcare system and coordinates care among specialists and other healthcare providers. Many patients have a long term, close relationship with a medical professional.

It is important for psychologists to respect the relationship continuity in primary care for many reasons. This relationship preceded the psychotherapy referral, and will continue after the completion of the psychotherapy. It is almost disrespectful of the primary care professional when psychologists do not inform them about the initiation or discontinuation of psychotherapy.

Beyond the lack of professional courtesy, a lack of communication about the psychotherapy prevents the primary care professional from facilitating the psychotherapy process. Medical professionals can help psychologists gather contextual information. The medical professional's knowledge of the patient's "baseline" functioning can help assess treatment impact. Also, in many cases, the medical professional knows members of the extended family and knows the patient's social history. In short, a collaborative relationship allows the psychologist to use the primary care professional as a resource.

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**PSYCHOLOGIST COLLABORATION WITH MEDICAL PROFESSIONALS  
CRUCIAL FOR OPTIMAL CARE (CONTINUED)**

**NANCY BREEN RUDDY, PhD; DOROTHY BORRESEN, PhD, APN; BILL GUNN, PhD**

Primary care professionals can also serve a critical function when patients terminate psychotherapy prematurely. Patients who disengage from the therapeutic process don't cease to exist. If they are still in distress they are likely to return to a primary care medical professional for assistance. When the psychologist and medical professional have worked collaboratively, the medical professional can facilitate a return to therapy, when appropriate. When the premature termination reflected a poor patient/psychologist match, the psychologist can help the medical professional determine if a referral to another psychologist would be beneficial. However, without prior knowledge of the psychologist or the psychotherapy progress, the primary care professional is unable to serve these functions.

Finally, medical professionals and psychologists often struggle with professional isolation. The sense of shared care that results from productive collaborative relationships can reduce this sense of isolation. Psychologists who have shifted their practice style to become more collaborative often state they "wouldn't go back" to practicing without collaboration.

*Collaboration can be a critical feature of psychotherapy for patients whose primary care professional prescribes psychotropic medications, and for patients struggling with their own or a family member's medical condition:* Primary care professionals who are not informed about their patients' mental health care are "flying blind." In a similar vein, psychologists working with patients under the care of a medical professional who don't have access to information about their health "fly blind" as well. Illness is a common stressor resulting in psychotherapy referral. Approximately 50% of people with chronic illnesses such as diabetes suffer from depression (Kessler, Ormel, & Demler, 2003; Polsky, Doshi & Marcus, 2005; Russell & Hui, 2005). Also, many chronic illnesses require patients to make difficult lifestyle changes. The more that psychologists understand these issues, the more they can help patients cope with the emotional consequences of illness. In the United States, primary care medical professionals write most of the prescriptions for psychotropic medications. Clearly, it is in the best interest of the patient if the person prescribing psychotropic medication and the treating psychologist communicate and collaborate. This is all too often not the case.

While there are many advantages to collaboration between psychologists and medical professionals, it is not the norm in many practice communities. Psychologists have an opportunity to lead the mental health community towards greater collaboration. We believe that psychologists will find that collaboration can optimize patient care, strengthen and expand referral networks, and reduce professional isolation. It is more than worth the time and energy.

The interested reader is referred to our book, *The Collaborative Psychotherapist: Creating Reciprocal Relationships with Medical Professionals* for a more in depth discussion of practice management and therapeutic strategies to facilitate collaborative relationships with medical professionals.

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*Dr. Borresen is a clinical psychologist and psychiatric nurse practitioner who splits her time between teaching at RWJ/Plainsboro Family Practice Residency and her private practice in Lawrenceville, New Jersey.*

*Dr. Gunn is a psychologist on the faculty of the NH/Dartmouth Family Practice Residency. He has presented and published extensively about collaboration, and consults with health systems to improve the link between mental health and medical services.*

**EDUCATION COMMITTEE**  
**AUDREY MATTSON, PHD AND COLLEEN HOEBEN, PSYD CO-CHAIRS**

**FALL CONFERENCE 2008 A SUCCESS**

We just completed another great workshop! We had a good turn-out and attendees' feedback was generally quite positive. On November 6<sup>th</sup> John Preston, PsyD, ABPP from Alliant University presented on Psychopharmacology in the Treatment of Trauma. On November 7<sup>th</sup> Dr. Patrick Moran, Regional Training Consultant with Psychological Corporation presented an overview of changes contained in the new Wechsler Adult Intelligence Scale- Fourth Edition (WAIS-IV) released earlier this year and the Wechsler Memory Scale- Fourth Edition (WMS-IV) which will be published and available in early 2009. The second day of the Fall workshop Paul Arbisi, PhD, ABAP, ABPP, LP shared his extensive expertise on the new Minnesota Multiphasic Personality Inventory- 2 Restructured Form (MMPI-2RF), including an overview of its development, scales, scoring and interpretation. Dr. Arbisi is a professor at the University of Minnesota, Minneapolis campus and staff psychologist at the Minneapolis VA Medical Center. The workshop was excellent and the general opinion seemed to be that the new MMPI-2 RF was also impressive!

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**SPRING 2009**

Mark your calendars for the 2009 Tri-state Conference to be held this Spring with Washington and Idaho associations from April 30<sup>th</sup> to May 2<sup>nd</sup> in Couer'de Alene, Idaho. The keynote speaker will be James Bray, PhD who will speak on the Future of Psychology Practice. Dr. Bray is the incoming 2009 President of the American Psychological Association. He is also director, Family Counseling Clinic and associate professor, family and community medicine, Baylor College of Medicine, Houston, Texas. He received his PhD in clinical psychology from the University of Houston in 1980 and was on the faculty at Texas Woman's University, Houston Center for six years. He teaches psychology students, resident physicians and medical students and directs the faculty development program. He conducts research on divorce, remarriage, adolescent substance use, applied methodology and collaboration between physicians and psychologists. In addition to his internationally recognized research, he maintains an active clinical practice specializing in children and families, behavioral medicine, and child custody issues. He has been active in APA governance for over 15 years, involved in practice, science, education and state issues.

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**SUMMER 2009 AND BEYOND**

We have begun planning the 2009 Summer workshop. Tentative planning is in the works for two CE events in mid-July at Fairmont. First, a request was made to bring the APA Trust back for another Risk Management CE workshop. We are also in the preliminary stages of arranging a training workshop through the APA Violence Prevention Office related to the Adults and Children Together (ACT) Against Violence Program. The ACT Parents Raising Safe Kids is a national anti-violence research based program that mobilizes communities and educates families and caregivers to protect children and youth from violence before it occurs. The program achieves its goals by (a) establishing partnerships with organizations, coalitions, colleges, hospitals, and agencies; and (b) training professionals and other adults who work or are in regular contact with families. For additional information see [www.actagainstviolence.apa.org](http://www.actagainstviolence.apa.org) .

Future CE topics shared with us that are of interest to members include Health Psychology, Geropsychology, review of other test instruments (e.g., abbreviated IQ tests, executive function batteries, and the Personality Assessment Inventory) and motivational interviewing. If these topics, others, are also of interest to you please email us at: [CollenHoeben@cybernet1.com](mailto:CollenHoeben@cybernet1.com) and [amattson@rfwave.net](mailto:amattson@rfwave.net).

## INTERVENTION WITH A CAPITAL "I" MICHAEL BÜTZ, PHD

As many of you have heard from me before, we best serve the aims and goals of our profession by keeping the needs of our clients and our communities at the forefront of our thoughts and efforts.

At this point in time, there has been no greater need for our intervention than now! Montana has the #1 suicide rate in the nation per capita. Our clients, our communities, our state's citizens are desperately in need of the abilities and skills each of us possess. *But also, they need our knowledge and our voices as interventions in-and-of-themselves.*

The dawn of the 2009 Legislative Session lies before us, and we face challenges, perhaps arguably, greater than any other time in our state's history with regard to behavioral health services and preventative measures. The people of our state are dying in record numbers, and as professionals we have a duty to intervene in ways that are able to produce the greatest impact. While all of us have busy and demanding work with our individual clients, their families and possibly our communities as well as care systems; potentially, the best interventions that we can present are leading with our knowledge and voices to clarify, support and at times discourage legislative initiatives.

There has been no more momentous evidence of this possibility than the passage of parity legislation at the federal level. We have participated in, and witnessed a historic event. With one stroke this legislation opens up benefits to our clients that they otherwise would not enjoy. And now, it is incumbent on each of use to consider what lies beneath the unique distinction of having the #1 suicide rate in the nation; and, what we can do about it...

Though each one of us may contribute, and do their fair share – as coherent groups we can do more, and that influence can spread to other groups. And, with respect to the current crisis in this state, many of us can without a doubt provide a short list of why the crisis exists – our decision makers may, or may not know this even though we have said it before. We need to share these ideas, but also we need to update our knowledge of the current situation and initiatives under way here in Montana too. For example, two very important Interim Committees have been addressing first of all the status of behavioral healthcare services here in Montana, and secondly, gone to great efforts to filter behavioral health disorders and correction needs. See the work of the *Children's, Families, Health and Human Services Interim Committee* at the following link below and pay special attention to the report on Mental Health Services by the Consulting Group, DMA.

Link to CFHHS Committee:

[http://leg.mt.gov/css/Committees/interim/2007\\_2008/child\\_fam/default.asp](http://leg.mt.gov/css/Committees/interim/2007_2008/child_fam/default.asp)

Link to Executive Summary from Mental Health Study:

[http://leg.mt.gov/content/Committees/Interim/2007\\_2008/child\\_fam/assigned\\_studies/Montana%20MH%20Report%20Sec%20Exec%20%20and%20Rec%20Sum%20TOC.pdf](http://leg.mt.gov/content/Committees/Interim/2007_2008/child_fam/assigned_studies/Montana%20MH%20Report%20Sec%20Exec%20%20and%20Rec%20Sum%20TOC.pdf)

Also, the Law and Justice Interim Committee have produced a number of draft bills that should be of interest to each of us.

Link to L & J Committee:

[http://leg.mt.gov/css/Committees/interim/2007\\_2008/law\\_justice/default.asp](http://leg.mt.gov/css/Committees/interim/2007_2008/law_justice/default.asp)

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**INTERVENTION WITH A CAPITAL "I" (CONTINUED)**  
**MICHAEL BÜTZ, PHD**

We have a great deal that we can bring to the initiatives from these two committees as an association, and as individuals. There will be other legislative measures that come before us too, and there is little doubt about this.

As all of you know, we have steadily been working on following-through with Senator Weinberg's initiative to allow appropriately trained licensed psychologists to have prescription privileges. In the 2007 Legislative Session we participated in writing the bill, and the language is there. Legislators took notice, as did our colleagues, and in the end SB 522 fell short by six votes on the Senate Floor with very little lead time for educating these Senators – much to our amazement.

Since that time we have established that we have seven to eight licensed psychologists who have completed or who are in training to provide appropriate prescriptions. Since that time, we have partnered with Alliant International University/California School of Professional Psychology (AIU/CSPP) to help us champion quality education in this area, and we have supplied several psychopharmacology trainings for our members and state legislators. The legislators who have attended these trainings have all been impressed with how thoughtful the approach has been to educating our colleagues, and expressed their support. Several have stepped forward to offer to sponsor the bill for the 2009 session, both in the House and in the Senate. We also have reason to expect similar levels of support we received in the 2007 session from state agencies and other organizations. In short, we are well prepared to support this measure that will provide badly needed services in this time of crisis. And, each of you may recall, this was the fundamental reason we moved to support the Senator's initiative in the first place.

As Dr. Sutherland will share with you in his article on prescriptive authority, he promoted a series of presentations at the IHS/SAMSHA National Behavioral Health Conference in August in Billings. These presentations featured Dr. Marquez, President of Division 55, Dr. Tulkin who you have all come to know through AIU/CSPP, and others including several of us from Montana. The outcome, at this point in Montana the Chief Medical Officers of the Billings Area service units (six in Montana and one in Wyoming) have officially agreed to support a supervision/training protocol that will enable licensed psychologists to seek these privileges, and this level of discussion is also occurring at a national level as well. The panel that ultimately made the final points in this series of presentations was made up of those who have pledged their support to Montana's efforts, and MPA's own members.

We can make a difference, and have made significant advances on legislative matters in recent years through your advocacy, your knowledge, and most of all your caring for the well-being of Montana's citizens. Our Association and the citizens of Montana will need this same level of commitment from each of you in the coming 2009 Legislative Session. Speak to your legislators, ask them their concerns and ask them how we can help. Also when I, or another colleague, calls or emails to ask for your assistance please consider that lending your voice is an intervention that extends beyond your office and it will impact the lives of your clients, community and state for the foreseeable future.

That is an intervention with a capital "I".



## 2009 MEMBERSHIP *Benefits* Montana Psychological Association

To: Montana Psychologists

From: Marti L. Wangen, CAE, Executive Director  
Montana Psychological Association (MPA)

Re: *Membership in the Montana Psychological Association*

I'm writing to encourage you to renew your membership or to join the Montana Psychological Association for 2009. Membership in MPA provides multiple benefits, including:

1. Discounts on high quality, in-state Continuing Education offered several times yearly by MPA,
2. Access to discussion with your colleagues across the state via the MPA listserv and at MPA meetings,
3. Representation of your concerns to the legislature, Board of Psychologists, third party payors, APA and other entities nationwide that directly impact the practice of psychology and the lives of our clients,
4. Lobbying and testimony to the Montana Legislature regarding important issues that affect psychology and mental health,
5. Opportunities to serve in the leadership of Montana's most active psychological association,
6. Advocating for psychology and consultation available in multiple areas, including Ethics, Academic/Scientific, Insurance, Professional Practice, Psychopharmacology, Public Education, Continuing Education, Disaster Response, Early Career Psychologists, Rural Health, Federal Advocacy, and Diversity,

We have a busy year ahead of us in 2008. I hope we can count on you to join us in this and our other efforts in 2008.

7. Receipt of MPA's quarterly newsletter, *The Montana Psychologist*,  
8. That good feeling that comes from joining your colleagues in supporting the advancement of your profession in all its forms!

We greatly value your contribution.



# 2009 MEMBERSHIP DUES NOTICE

## Montana Psychological Association

New      Renewal      

**Membership type:**

- \_\_\_\_\_ Student \$ 25.00
- \_\_\_\_\_ Year 1: Calendar year of original licensure \$ 50.00
- \_\_\_\_\_ Year 2: 2<sup>nd</sup> calendar year of original licensure \$ 85.00
- \_\_\_\_\_ Year 3: 3<sup>rd</sup> calendar year of original licensure \$ 120.00
- \_\_\_\_\_ Year 4: 100% Membership dues \$ 150.00
- \_\_\_\_\_ Assessment added for members earning >\$35,000/year \$ 50 (Total dues \$200.00)
- \_\_\_\_\_ Affiliate (out of state or non-PhD/PsyD Montana resident) \$ 75.00
- \_\_\_\_\_ Special Circumstances \$ 75.00

**Donations:**

- \_\_\_\_\_ Charles Kelly Memorial Award
- \_\_\_\_\_ 2009 Legislative Funding

Would you prefer to receive your dues by mail or by check?  Mail  Check  Both

**TOTAL TO BE REMITTED WITH FORM TO ADDRESS BELOW**

**SPECIALTIES:** *(Please note - information will be used for the MPA Referral Program and printed in the membership roster for use by colleagues in referring clients)*

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Preferred Mailing Address: \_\_\_\_\_

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The tax deductibility of dues paid to MPA as an ordinary and necessary business expense is subject to restrictions imposed as a result of lobbying activities. MPA estimates that the nondeductible portion of your dues

**MENTAL HEALTH PARITY LAW**  
**GEORGE WATSON, PHD**

**QUESTION: What's one benefit of supporting MPA?**

**ANSWER: Passage of the new Mental Health Parity Law**

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MPA Members did their part in getting the Mental Health Parity Law passed. Many, many MPA members called and wrote persuasive arguments to their Montana Congressional representatives over past years as this bill slowly but surely worked its way through Congress. Not just once, not just twice, but many, many times. It does not go unnoticed at APA that Montana, even with a small population, has a percentage of its psychologists willing to contact their D.C. leaders that usually is in the top 10% of the fifty states and often in the top five (percent).

The impact of this Law upon Montanans will come to be significant in enhancing their access to mental health services. As that enhancement grows, so will the frequency of times psychologists can serve the public. This will help all psychologists. We suggest you take the time to thank your MPA colleagues for their efforts. If you are not yet a member, become one, become a member of the team. Everyone wins when you do.

Please find below a summary of the New Parity Law which comes from the Government Relations Staff of the American Psychological Association.

*Summary*

*“Purpose. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (The Wellstone-Domenici Parity Act), enacted into law on October 3, 2008, will end health insurance benefits inequity between mental health/substance use disorders and medical/surgical benefits for group health plans with more than 50 employees. The law becomes effective on January 1st, 2010. Under this new law, 113 million people across the country will have the right to non-discriminatory mental health coverage, including 82 million individuals enrolled in self-funded plans (regulated under ERISA), who cannot be assisted by State parity laws.”*

*Continued on next page*

**MENTAL HEALTH PARITY LAW (CONTINUED)**  
**GEORGE WATSON, PHD**

**“The Parity Requirement.** The new law amends the Mental Health Parity Act of 1996 to require that a group health plan of 50 or more employees (or coverage offered in connection with such a plan)-that provides both medical and surgical benefits and mental health or substance use benefits-to ensure that financial requirements and treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than those requirements and limitations placed on medical/surgical benefits.

- Equity coverage will apply to all financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses, and to all treatment limitations, including frequency of treatment, number of visits, days of coverage, or other similar limits.
- This new law builds on the current 1996 parity law, which already requires parity coverage for annual and lifetime dollar limits.
- Mental health and substance use disorder benefits are defined broadly to mean benefits with respect to services for mental health conditions and substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.
- A plan may not apply separate cost sharing requirements or treatment limitations to mental health and substance use disorder benefits.
- If a plan offers two or more benefit packages, the requirements of this Act will be applied separately to each package.
- As under the current federal parity law, mental health or substance use benefit coverage is not mandated. However, if a plan offers such coverage, it must be provided at parity in accordance with this Act.”

**“Out-Of-Network Benefits.** A group health plan (or coverage) that provides out-of-network coverage for medical/surgical benefits must also provide out-of-network coverage, at parity, for mental health/substance use disorder benefits. “

**“Preservation of State Law.** The current Health Insurance Portability and Accountability Act (HIPAA) preemption standard applies. This standard is extremely protective of State law. Only a State law that "prevents the application" of this Act will be preempted which means that stronger State parity and other consumer protection laws remain in place.”

**“Small Employer Exemption.** As with the current 1996 Federal parity law, small employers of 50 or fewer employees are exempt from the requirements of the Act. State parity laws will continue to apply to these employers, as well as to individual plans.”

**“Effective Date.** The Act will apply to plans beginning in the first plan coverage year that is one year after the date of enactment. **For most plans, this will mean the effective date begins on January 1, 2010.** Plans maintained under collective bargaining agreements ratified before the enactment date are not subject to the Act until they terminate (or until January 1, 2009, if this is a later date). The current 1996 parity act requirements for annual and lifetime dollar limits remain in effect for all plans, while the annual sunset in the 1996 parity act is eliminated, effective January 1, 2009.”

Source: *APA Practice Organization, Government Relations Office, October 2008*

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