



New Mexico Psychologist

Newsletter of the New Mexico Psychological Association

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Spring 2011

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NMPA Initiates Early Career Psychologist Mentorship Program

Dear colleagues and fellow NMPA members,

The NMPA Board of Directors is proud to announce the development of a Professional Mentoring Program. The program is aimed at serving the needs of early career psychologists, students and other members who are seeking mentors to assist them in developing their professional careers, expanding their knowledge base, and handling diverse issues.

Mentoring is important in the development of every psychologist. The mentoring relationship between a more experienced psychologist and an early career psychologist or student helps facilitate the professional growth of the mentee by placing them in contact with mentors who may have specialized expertise and who act as supportive role models and guides. The experience gives mentors an opportunity to help future and new psychologists in their professional development. Mentors also gain the intrinsic satisfaction of contributing to the professional growth of the mentee. It is

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Am I There Yet?

*Reflections on my first SLC from an
Early-Career Psychologist by Nicole Duranceaux, PhD*

Rare is the parent who, even on the shortest of trips, hasn't heard the phrase: *are we there yet?* My skin usually crawls upon its utterance, particularly after what seems like the 80th time it's asked. However, that phrase keeps creeping into mind in reference to myself: specifically, my career and my overall identity as a new psychologist. Do I know what the heck I'm doing, and should I really be turned loose on society? Why I am strangely thrilled and terrified at the same time? *Am I there yet?* Questions such as these were looming large in my thoughts during my first trip to the APA's State Leadership Conference (SLC) where I represented NMPA as the Early-Career Psychologist (ECP) Delegate.

I was excited to attend the SLC, and it was one of the most informative conferences I have attended. Both the breadth and depth of the information provided were incredible, and I learned a tremendous amount. Going to the House and Senate, advocating with my colleagues (my colleagues!), seemed almost as ordinary as it did surreal. I spent much of my time with ECPs from all over the US and Canada, as well as with more seasoned psychologists who were focused on ECP issues. They were gracious, open, and willing to share their challenges and successes, and their ideas on increasing the contributions of ECPs to local associations. I must say, though, upon considerable reflection, the "rubber met the road" for me around the dinner table.

Identity is a funny thing. Sitting there at the formal dinner (where Nancy Pelosi was the keynote speaker), I actually *felt* like a psychologist. We shared a table with a delegation from another state,

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NMPA State Leadership Conference Delegation: Mellie Myer, Deborah Okon, Tony Kreuch, Ken Gilman, Nicole Duranceaux

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The New Mexico Psychologist

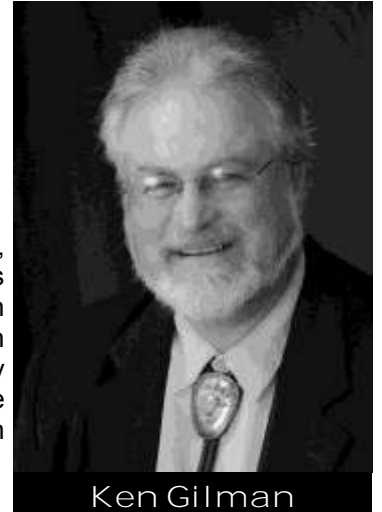
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President's

COLUMN

By Ken Gilman, PhD



What is it about the SLC that makes it worth enduring four grueling days of activities, chasing legislators around Capitol Hill, and losing lots of sleep? For me, it's the cross fertilization opportunities. Talking engagement strategies for early career people with Pennsylvanians & Kansans, mentoring strategies with lowans, continuing ed with Arkansans, prescription initiatives with Montanans and Oregonians, banjo technology with West Virginians, . . . Just a few of the opportunities for interactions where we got to share ways in which we show some creative leadership as well as to hear from folks who have tried some things that might benefit us.

Then throw in some top notch speakers and panels on issues critical for us to be thinking creatively about: leadership opportunities in this era of healthcare reform; how our national organization is coping with the economic realities of our times; political eddies and flows in healthcare reform; developing leadership; perspectives from leaders in industry and business about behavioral healthcare, and on and on. It's a chance to see the breadth of our profession in action. It's also interesting to see how strongly New Mexico is represented in both the number/depth of our delegation and in the strength of our organization in numbers, ideas and impact for our size.



NMPA Board Retreat at home of Ken Gilman, March 26, 2011



A PSYCHOLOGIST'S RURAL HEALTH RESOURCE GUIDE - Working in a Medical Home Practice with Medicaid Clients and/or in a Primary Care Health Setting in Rural Areas of New Mexico

By Ricardo Gonzales, NMPA Diversity Delegate

The State's intention about Medicaid behavioral health care has evolved over the years moving towards a greater integration and coordination of services (both behavioral and medical) for those who are Seriously Emotionally Disturbed (adults and children), and those with substance abuse problems (adults and children). This movement has led to the development of Core Service Agencies (CSAs) and the greater use of Federally Qualified Health Centers (FQHCs)/Rural Health Centers (RHCs). The development of CSAs (modeled after the concept of a Medical Home), and the focus on behavioral health care in FQHC/RHC (Primary Care settings) is also in response to the Federal Government's Health Care Reform Plans and the expansion of Medicaid services.

Over the years NMPA has pushed for greater numbers of psychologists to work with the Medicaid population. This push has focused on Psychologists seeing Medicaid clients in a private practice setting. This resource guide, however, describes work in a CSA and in an FQHC/RHC where Medicaid clients are also served.

We have set up a link at our NMPA website of "A Psychologist's Rural Health Resource Guide" (click on to find at – www.nmpa.com). These materials have been developed for Psychologists interested in work in rural areas of New Mexico, who also want to know how best to sell themselves when seeking out employment in these settings. Below is a quick overview of this Resource Guide.

- New Mexico injury and violence mortality death rates (e.g., alcohol, drug, suicide, and homicide) continue to exceed U.S. injury and violence mortality death rates (as well as in most State counties), despite State Public Behavioral Health Care Reform efforts to rectify these problems over the last 10 years.
- The State's current move towards improving quality and accessibility of Medicaid behavioral health services (to include reducing the above noted death rates), seeks to integrate behavioral health services with medical services. The net effect of this strategy opens the door for Psychologists to work in Medicaid environments such as in Core Service Agencies, Federally Qualified Health Centers and Rural Health Centers.
- However, only 24% of all Psychologists in the state see Medicaid clients, and most of these Psychologists (e.g., 80%) are located in major urbanized areas of the state (primarily in five of 32 counties).
- The State has approved the development of Core Service Agencies which are modeled after the concept of a "Medical Home". The development of these agencies is in line with Federal Health Care reform plans for Medicaid expansion.
- A hallmark of a Core Service Agency involves the use of enhanced assessments and comprehensive service planning for the seriously emotionally disturbed through the entire age spectrum. However, only those with advanced education and training are to provide these coordination services.
- A hallmark of a Federally Qualified Health Center (FQHC)/Rural Health Center (RHC) include the provision of medical and behavioral health services under one roof.
- FQHC/RHC service provision and payment encumbrances (both Medicaid and Medicare) are held to a minimum when compared with other service provision environments in independent practice.
- The \$5000 Rural Health Care Tax Credit applies to Psychologist work in CSAs, FQHCs, and RHCs if care is provided in underserved designated areas.
- Providers with specialty Medicare designations (which include Psychologists) must have advanced degrees to work in FQHC/RHC environments and to be able to bill for services.
- Non-physician specialty practitioner groups that include Psychologists are considered a "Core Service" in an FQHC/RHC.

Psychological expertise working in rural environments includes knowing about Evidence-Based practices and about cultural competence. Another facet of this expertise includes knowing about the State's history involving behavioral health service provision and service limitations.

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APAIT Legal and
Ethical Risks
Conference with
Eric Harris, JD, PhD
April 8, 2011

A Psychologist's Rural Health Resource Guide *continued*

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Below is a listing of resources that we have set up for easy access either via a website link or PDF file (at www.nmpa.com) to help any Psychologist interested in knowing further about the above points, and to facilitate plans they may have for finding work in these clinical environments in rural areas here in New Mexico.

RESOURCES:

- 1) This Resource Guide (see website links, PDF files/attachments) include the following reading materials - APA's Stance on Evidence-Based Practice for Psychologists, a description of a Core Service Agency, comparisons of a Federally Qualified Health Center and a Rural Health Center including a report on the practice of psychology in these environments, reports/website links to Federal Medicaid/Medicare programs to help understand payment (Medicaid/Medicare) issues in these environments, Rural Health Care Tax Credit area designations/rules, current data on New Mexico injury and violence mortality, a summary of the history of New Mexico Medicaid Behavioral Health Care Reform, and a report on how Evidence Based Treatment (EBT) "intersects" with cultural competence in rural environments.
- 2) Included among the materials of this Resource Guide are maps of the state of New Mexico showing State Collaboratives and of State towns and cities, a website link to a map of the 117 Primary Care (FQHC/RHC) clinics in the State to include the locations of Core Service Agencies and phone numbers to contact FQHC/RHC/Core Service Agency programs.
- 3) There is a link to a six hour workshop by Dr. William Miller on Motivational Interviewing (MI) that includes a discussion of the use of MI in Primary Care settings, an understanding of how empathy fits in as a core ingredient of MI, detailed discussions of the use of EBTs/and about their use in Primary Care Settings to improve quality and reduce drop-out rates.
- 4) There is a Psychologist's Position Description for working in a Primary Care rural setting here in New Mexico to give some perspective on a Psychologist's skill level for working in these settings.
- 5) Finally, there is a brief Road Map of how to utilize the above materials to locate where you practice in the State to help you consider where there are Psychologist service limitations and or limitations in behavioral health services offered in these rural area Primary Care clinics (i.e., keep in mind that approximately 56% of these 117 clinics do not have BH services), and to know where Core Service Agencies are located.

REFERENCES:

New Mexico Substance Abuse Epidemiology Profile, Santa Fe, NM: Substance Abuse Epidemiology Program, Injury and Behavior Epidemiology Bureau, 2010.

Racial and Ethnic Health Disparities Report Card, Santa Fe, NM: New Mexico Department of Health, Division of Policy and Performance, 2009.

Mental Health Parity Implementation:

The Good, the Bad and the Ugly

By Tony Kreuch, PsyD President-Elect

I attended the APA Annual State Leadership Conference for the first time this year and it was truly a rewarding experience for me personally. In addition to getting to know fellow psychologists in various leadership positions from across the United States and Canada and enjoying the camaraderie of our “fine and fun-loving” New Mexico Delegation, I was able to attend several workshops and meetings of importance to our profession. One workshop in particular that I wanted to summarize for our membership was an interesting and informative presentation on the current status of mental health parity that I attended along with Nicole Duranceaux, Ph.D., our Early Career Psychologist Representative.



Tony Kreuch, PsyD

The workshop “*Parity In Practice: Health Plan Compliance With the Mental Health Parity Law and Challenges Ahead*” was chaired by Doug Walter, J.D., the Counsel for Legislative and Regulatory Affairs, Government Relations, APA Practice Directorate, with presentations by Ron Bachman, President and CEO of Healthcare Visions, Inc., Terrence Koller, Ph.D., Executive Director of the Illinois Psychological Association and Alan Nessman, J.D., Senior Special Counsel, Legal & Regulatory Affairs. The presenters did an excellent job of exploring current health insurance plan compliance with the law along with providing an overview of the challenges ahead related to ending discrimination against those in need of mental health treatment and improving access to care.

The “Good”. There are many good things happening as a result of this law. As you no doubt are aware, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was signed into law on October 3, 2008 by then President George Bush with the Interim Final Rule (IFR) published in the Federal Register in February 2010. The Act officially went into effect for most health plans on January 1 of this year. Basically, MHPAEA requires that a group health plan that provides both medical/surgical and mental health/substance use benefits must ensure that both the financial requirements and treatment limitations on mental health/substance use treatment are no more restrictive than the requirements and limitations placed on medical/surgical benefits (parity!). The Parity requirement is applicable to all group health plans that have at least 51 enrollees, providing that the plan offers both mental health and medical/surgical benefits. The American Psychological Association Practice Organization (APAPO) has been tracking health plan compliance since January 1. Some good news: thus far, the vast majority of health plans and employers have kept mental health/substance use coverage with only minor changes and APAPO has found that the transition to parity has in most cases been relatively seamless with the primary concerns being related to the need for the two separate information systems – Behavioral and Medical - learning how to communicate and transfer information. The law is also very clear about an insurer not discriminating against a participant or provider on the basis of “medical necessity” arguments (no more or less stringent with MH/SUD benefits than medical/surgical benefits); and it also protects against a mental health practitioner, such as a psychologist, from being identified as a “specialist” for purposes of garnering a higher co-pay from the participant.

Most employers surveyed thus far have indicated that the parity requirement is only making up a small portion of the overall trends in health care cost increases and are in agreement with the addition of a more equitable mental health benefit. Why? Well, one reason is that we have made a compelling case for the connection between chronic health conditions and mental and emotional illness. Illnesses such as hypertension, diabetes and asthma are frequently intertwined with stress, anxiety, depression or substance use disorders. Many employers are on board with this, often for perhaps less than altruistic reasons, as they are coming to see the impact on the financial bottom line when mental and emotional disorders are effectively addressed in a more integrated fashion. In fact, the presenters pointed out that several recent ROI analyses have shown that the number one overlooked health condition impacting corporate health and productivity is depression, with on average 4.3% of workers requiring treatment annually at a total cost of more than \$25,000/worker (more than double the corporate costs of a worker with diabetes!). Businesses are recognizing that providing better access to care for mental and emotional conditions improves productivity, absenteeism, turnover rate, morale, error frequency and reduces the number of disability claims. Psychologists have contributed greatly to this understanding (and ultimately to the congressional support needed for parity) through our research efforts, demonstrating (as examples) that depression is a treatable condition and not a “character flaw,” a recognition of the need to equally treat mental and emotional co-morbidities, and of the corporate bottom-line bene-

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Mental Health Parity Implementation: *The Good, the Bad and the Ugly*

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fits associated with maintaining and improving group mental health and substance use benefits.

The “Bad”. Unfortunately, as you might have guessed, not all is good with the current status of MHPAEA. For one thing, the law is not applicable to individual markets, to employers who have fewer than 50 enrollees on their group health plan and, *big* players such as Medicare and Medicaid. Additionally, the law includes a provision that allows state and local government agencies to “opt out” of the parity requirement, potentially having a detrimental influence on large numbers of workers and their dependents. For example, the state of New Mexico employs approximately 20,000 workers, so an “opt out” here would potentially have a significant impact on access to mental health care for many individuals. Regarding Medicare and Medicaid, there are both claims processing changes and proposed federal legislation efforts that supposedly aim to bring parity into these systems. However, the phase-in guidance for this is, as pointed out by our presenters, very unclear and especially fuzzy when it comes to equity within the practice of psychologists who do not as of yet fall under the auspices of the Medicare “physician” definition (which hopefully will change soon). In preparation for this article I took a look at the proposed Medicare phase-in equity formula for mental health services and I will admit that I did not take enough math in college to understand it very well.

The “Ugly”. Of course, when it comes to patients and providers attempting to obtain necessary care and reimbursement from insurance companies we would expect at least some degree of “ugly”. One of our presenters, Terrence Koller, Ph.D., Executive Director of the Illinois Psychological Association (IPA), summarized the problems they have experienced with Blue Cross Blue Shield of Illinois over what he termed the “shifting battleground” of denial of services due to “medical necessity” and the potentially problematic and discriminatory use of pre-authorization requirements for mental health benefits.

In summary, coinciding with the anticipated implementation of MHPAEA, BCBS of Illinois began requiring all of its members to obtain preauthorization for all outpatient visits for behavioral health services. The IPA became quite concerned about the potential that this practice was in violation of parity and would limit care. In response to an IPA inquiry about this new practice, BCBS of Illinois sent an email response to the IPA indicating in a general way that this was being implemented similarly to how they review “thresholds for medical-surgical care”. In a letter response to BCBS of Illinois, IPA pointed out that no pre-authorization was required by the company for any form of outpatient care with a primary care physician or with other medical specialists. Additionally, BCBS of Illinois stated that “the initial pre-authorization would not be subject to medical necessity review”, a statement that was challenged by IPA since there was no specifically identified purpose to this initial step. IPA also referenced the “huge disaster” caused by BCBS of Florida when that company attempted to introduce a similar no-review pre-authorization requirement with its members. In Florida the computer system was inadequate for the handling of the flood of additional authorization requests and basically failed, causing enormous billing problems for months. As the time for implementation of this pre-authorization requirement drew nearer late last year, IPA became increasingly concerned when it became aware that the BCBS Ill system (like in Florida) was not up and running, would not be operational until the first quarter of 2011 and that members were experiencing long waits while attempting to obtain pre-authorizations by telephone and also finding that BCBS Ill staff members were unaware of the new requirement. IPA again contacted BCBS Ill about this without resolution and finally reached out to Illinois Senator Richard Durbin for assistance. Senator Durbin’s staff contacted BCBS Ill directly and pointedly raised concerns that “any attempt to circumvent the parity rules would have a grave impact on access to care and would not be tolerated”. Senator Durbin’s staff reminded BCBS Ill that their requirement to preauthorize behavioral health visits was NOT required of medical/surgical conditions and as such was a violation of the parity law. Following this, BCBS Ill backed off of their position and have since removed the preauthorization requirement for outpatient behavioral health services and updated their brochures and website member information accordingly.

Kudo’s to IPA for their advocacy efforts. Dr. Keller encouraged all state psychological associations and all psychologists to be aware and diligent as insurance companies look for new and creative ways to circumvent parity. He suggested that we keep the following checklist handy if/when we become concerned about potentially discriminatory practices by a health plan:

- Is the plan exempt from parity?
- Does the management of mental health care appear to be more restrictive/intrusive than the management of

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Mental Health Parity Implementation: *The Good, the Bad and the Ugly*

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medical/surgical care?

- Is the coverage and benefit package comparable?
- What is the company's explanation for the disparity?

Should you have concerns that an insurance company might be in violation of parity, contact NMPA or Alan Nessman, J.D., with APA @ (202) 336-5886 for advocacy follow-up.

In summary, proper implementation of mental health parity is so crucial to the important work that we do as psychologists. While there are many bright spots thus far, in particular with the numbers of employers who are on board in recognizing the value of parity, there have been and will continue to be challenges ahead. However, the mere fact that parity is now *law* is in my view wonderful but long, long overdue. Stay tuned, time will tell.

Mentoring Program Matches Early Career and Seasoned Psychologists

(Continued from page 1)

an opportunity to share experiences and knowledge with new psychologists, and also learn about new developments and treatments in the field from recently trained mentees.

The mentoring program will "match" mentor volunteers with mentees based on shared areas of interest and location. These topic areas may include, but are not limited to: private practice, diversity, developing a career in academics, prescribing psychology, neuropsychology, establishing a career trajectory, work-life balance issues, getting involved in state or national psychology organizations, leadership positions, forensics, organizational consultation, and research.

One aspect of this program's vision is to provide mentorship on becoming and being a psychologist, which includes, but is not limited to, logistics of a particular specialization. In keeping with this, NMPA will make the best effort to match mentors and mentees based on several factors (e.g., interests, location, time commitment). However, matches based primarily on professional pursuits cannot be guaranteed, and it may be the case that pairs with diverse professional interests result in a good match that is fulfilling to both parties

The mentees meet one-on-one with their mentors or by phone if location is an issue. An NMPA mentor provides guidance in professional development, expertise in their areas of interest, and collegial support to mentees. Mentoring is not supervision and does not take the place of supervision. Feedback from mentees in other programs found that the best mentors listened to their needs, were supportive, reduced anxiety, increased knowledge, gave strategies, gave specific advice, discussed specific tasks, and gave honest and direct answers.

Mentor requirements: must be licensed, no active restriction or requirements on their license and a NMPA member in good standing. Mentee requirements: NMPA member in good standing (student or full member). The mentoring relationship can be terminated by either mentor or mentee if deemed unsatisfactory by either party. NMPA will help coordinate a new "match" if the original is deemed not to be a good fit.

Currently, we are in the process of recruiting experienced psychologists to serve as mentors, and we need your help. If you are interested in becoming a mentor, please download the mentor application form from NMPA's website at www.nmpa.com, and return it to the address on the form or email it to newmexpa@aol.com. Thank you for your help and if you have questions or would like additional information about the program, please call the NMPA office at (505) 883-7376.

If you would like to sign up as a mentor or mentee, please fill out and send in to NMPA, an application on pages 16 and 17.

Ken Gilman, PhD
NMPA President

Nicole Duranceaux, PhD
NMPA Early Career Psychologist

“Am I there Yet? By NMPA Early Career Psychologist Nicole Duranceaux, continued

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chatted about life and mental health issues, and enjoyed good food and good company. At that moment, I fully embraced the early-career identity, and more importantly the psychologist identity. It was clear I was an accepted, meaningful member of the delegation, and not in an eyes-open-mouth-shut kind of way. What an experience!

“Hey, aren’t you supposed to be out there for the *minority* photo?”

You know that sound of nails on a chalkboard? That’s the screeching I heard in my head along with the sound of my heart now thumping fast and loud. Of the eight who sat at this table, this woman, a fellow psychologist, was addressing me.

Identity really *is* a funny thing. It was clear that my ethnicity, and not my ECP status, was presently most salient, which was galaxies apart from how I self identified at that moment. Heart thumping and face flushing, I sat there for what felt like an eternity wondering how I should respond.



Nicole Duranceaux, PhD

“Why would you say that,” I inquired, in a tone that wasn’t completely devoid of pleasantness. The lady looked like the proverbial deer in the headlights, saying nothing. So, I asked again, smiling. Her eyes now as large as saucers, she mumbled something like, “well, I don’t know...I just thought...ummm...maybe you’re Italian?”

In fairness, someone had made an announcement about all “Diversity Delegates” and “minorities” meeting in the lobby for a photo. Also, of those at our table, I was certainly the “brownest.” Further, I’m sure she’s a really nice person with the purest of intentions, and insert-a-dozen-other-reasons-for-me-to-second-guess-myself here. All that may be true, *and* my reaction was just that: my reaction. I smiled again (a real smile, not an evil one, I promise) and said, “I am teasing you a bit, so I will let you off the hook. No, I’m not going out there for the *minority* photo. I’m an early-career delegate and I’m not going to be a mascot. Thanks for checking in, though.” I don’t recall hearing anything else from that lady the rest of the evening.

Judge, I mean evaluate, my response as you will. Believe me, I’ve replayed it over and over in my head at least 100 times and speculated endlessly about what this woman’s post-dinner reaction entailed. I’ve also written and abandoned this article at least five times, feeling at moments like I’m on very shaky ground. Well, here it is because the point, for myself anyway, is not necessarily what I said at that charged instant, but that I said *something*. It now seems like the most natural thing in the world to respectfully engage a colleague who has (however innocently or ignorantly) commented on *my* identity. I appreciate your tolerance as I stumble here and there in trying to figure this out.

Am I a psychologist? Yes. Am I an early-career psychologist? Unequivocally yes. Am I a *minority* psychologist? I don’t know. What I do know is that I should, and do, have a say in that, even if I don’t have every answer or even one answer. Is there a magic moment during which one transforms from a trainee to a full-fledged, walking, talking psychology machine with the poise and acumen to hold one’s own in any given situation while leaping tall buildings in a single bound? Probably not. I can only speak for myself, but it certainly isn’t the conferral of the doctorate or even the moment of licensure that marks this transition. When it does happen (and I won’t be an ECP forever!), it will be through a process made up of many, many moments in which decisions are made, points-of-view are asserted, and a place is carved for me within the psychologist guild.

So, *am I there yet?* Well, yes, and no. I’m as sure that I am *there* as I am certain that I will forever have a ways to go. I am so grateful to have attended the SLC, growing pains and all, and to have been part of such an amazing NM delegation.

I am enthusiastically moving forward as the current NMPA ECP Board Member and it is a treat to work with so many gifted, talented, and knowledgeable psychologists. We have some interesting ideas to share, and so many of you have already responded to the call to provide much-needed mentorship. Please look for me and say hello at the next NMPA event. You’ll recognize me. I’ll be the one heading the opposite way from any photos.

APA Practice Assessment Dollars Hard at Work!

By Deborah Okon, PhD, Federal Advocacy Coordinator

Imagine the scene: You are completing your annual APA membership form and then get to the "Practice Assessment." Groan! Why do I have to pay this??? I never really knew the answer to that question until I agreed to become your APAPO Federal Advocacy Coordinator for New Mexico. In this newsletter, you will find a series of articles that share what happened at the APAPO-sponsored State Leadership Conference. In this article, I'll describe some ways the APAPO has used your money to advocate for psychology.

First of all, here is some of the bang for your buck. Look at some of the things that our \$140 assessment accomplished:

Psychologists did not lose 27% of their payments per session!

Patient copays are going down! (For example, Medicare coinsurance for mental health dropped from 37.5% to 31.25% since 2010; next year it will be down to 25%. Similar things started happening this year with some private insurance companies.)

Our own Senator Bingaman joined with Senator Olympia Snowe (R-Maine) to cosponsor a bill that includes psychologists under the Medicare physician definition. (See below for details.)

Here's how that happened: The APA has always helped clinicians, but it wasn't until 2001 that they started the practice organization. This non-profit entity focuses on the influence of legislators. Apparently, congress only looks after the needs of professionals if they know why it is important. Think about it: If congress doesn't know what a psychologist does, why would they ever generate or vote for legislation that supports our practice? How will those congress members know what we do unless they know us? Thus, the APA created the practice organization with a major purpose of introducing congress to the practice of psychology.

The APAPO (in conjunction with the Association for the Advancement of Psychology) hired a small group of bright, highly motivated people who work full time to build and maintain strong relationships with congress. That group coordinates a large network of volunteers (including me) to activate psychologists across the nation.

They train us to most effectively (and efficiently) influence our congress members, and they carefully select goals that are most likely to be accepted by the current congress. Those government relations folks use the SLC to motivate us (the practicing psychologist volunteers) to motivate you (the practicing psychologist constituents) to motivate congress members (those who want to get re-elected) to support psychologists!! And, every March, they bring in hundreds of psychologists for the SLC, where we go en-masse to meet with the staff of almost every representative and senator.

This year's focus is all about Medicare. Bear in mind that Medicare rules directly influence all insurance companies. We are asking Congress to address the impending SGR cut (29% this year) and the impending psychotherapy fee cut (5%), both of which will occur if Congress doesn't act by the end of 2011. We are asking Congress to include psychologists under the Medicare physician definition. This inclusion would make us eligible for Medicare incentive payments (such as funding to establish electronic records), billing for E&M codes, and would allow psychologists to

(Continued on page 11)



From left: Ken Gilman, Nicole Duranceaux, Tony Kreuch, Mellie Myer and Deborah Okon after speech by Keynote Speaker Rep. Nancy Pelosi

The Psychologically Healthy Workplace Award Committee NEEDS YOU!!!

By Bobby Holstead, PhD

The PHWA Committee needs input from you, the members of NMPA! This committee, consisting of Bobby Holstead, PhD, Bob Ericson, PhD, and Howard Ottenheimer, PhD, is continuing our 2011 work by soliciting referrals of companies that you the members have run across that seem to do a good job of taking care of their employees. Past state-wide and national winners from New Mexico (Sandia Prep and Sysco Food Services) have been referred to the committee from NMPA members, and we would like that trend to continue. We currently have one organization in the process of applying, and we recently received another possible referral from a NMPA member of a local company which we will be contacting soon.

As you may know, this program is administered at both the national/APA and state levels. It is designed to recognize those companies, whether large, medium, or small, which meet several or all of 5 criteria. These criteria include the following: employee recognition, employee involvement, health and safety, work-life balance, and employee growth and development. On the state level, a company or organization does not have to meet all 5 criteria, but it would have to meet all criteria to be referred to APA for consideration of a national award.

What's in it for the company or organization to apply? If an organization applies, then it can get feedback from an on-line employee survey, feedback from those committee members who do a site visit, and there can be media or PR attention if a company wins an award.

If you have a company that you would like to send to the PHWA committee, feel free to give your contact person my name and number (505-344-9500) or you can call me yourself. An alternative approach could be to direct the contact person to APA's web-site for this program at www.phwa.org. Help us keep the trend going of NMPA receiving some attention at the APA level by sending us another potential national award winner!



Psychologically Healthy Workplace Awards



Psychologically Healthy Workplace Awards



Psychologically Healthy Workplace Awards

APA Practice Assessment Dollars at Work continued

(Continued from page 10)

not only run partial hospitalization programs (as we already do), but get paid by Medicare without having to get a medical doctor to sign off. It also would allow us to automatically be included whenever Medicare establishes new programs for "physicians."

Lest you worry that we are trying to become medical doctors... no, we are not! Medicare already includes dentists, podiatrists, and optometrists in the physician definition. In fact, we are the only doctoral-trained healthcare providers who are not included under the physician definition. There are bills already introduced in the House and Senate (even a psychiatrist representative said he planned to support it!), so we just need to push our members to VOTE! (I'll tell you when.)

I've committed to continue my role as your Federal Advocacy Coordinator, and I maintain my stamina through your responses. So, thank you for reading my alerts and doing the quick follow up contacts with your members. Thanks for getting to know your representatives, if you happen to live in their neighborhoods or know their friends and families or work on their campaigns, and thanks for telling people why psychologists are important. That's how we all make a difference!!

Disaster Response Update

On April 12, Robert Tanner, NMPA Disaster Response Coordinator, taught a class called "Psychological First Aid", a course for the American Red Cross. This course is a requirement for all disaster volunteers.

On April 10 Dr. Tanner taught "Coping with Deployment", also offered by the American Red Cross and sponsored by the Department of Defense. This course was available to military families and this particular course was offered to blue star mothers.

Trainings com up on regular basis. If anyone is interested in a class or in disaster mental health, please call 828-3270 for upcoming training information and dates.

NMPA Offers Live Webinars

NMPA is partnering with the Kentucky Psychological Association (KPA) to bring you **Religion, Spirituality, and Clinical Practice**, one hour webinars that provide psychologists and other mental health providers with a series of presentations designed to consider ethical and culturally sensitive clinical practice with a diverse spectrum of spiritual and religious clients. Theoretical, cultural, and empirical considerations will be addressed in relation to practice issues. Because these presentations are only an hour in length, books and articles will be suggested for further review of the specific areas of discussion. **Register at www.nmpa.com**



You can sign up for one, a few or all and each provides cultural diversity credit. KPA is an APA-approved sponsor of continuing education and will provide your CE certificate for one credit for each hour seminar. These workshops are live, and you must be able to access the Internet during the webinar and must phone in for the audio. A valid email address is required at registration in order to receive instructions and access codes. Each webinar is \$35 for NMPA members and \$40 for nonmembers, with discounts if you register for 5 or more. You will receive your log-in code and instructions a week prior to each event.

May 11, 2011, (Wed), 10-11 AM: Working with American Roman Catholics. Presented by Dr. Edward Shafranske (Pepperdine University.) Workshop Objectives: Develop awareness of a world-view characteristic of many Roman Catholic clients. Learn how to engage this world-view competently in the context of clinical practice.

Jun 15, 2011, (Wed), 10-11 AM: Working with American Muslims. Presented by Dr. Saba Rasheed Ali (University of Iowa). Workshop Objectives: Develop awareness of a world-view characteristic of many Muslim clients. Learn how to engage this world-view competently in the context of clinical practice

Jul 13, 2011, (Wed), 10-11 AM: Affirmative Therapy for American Jews. Presented by Dr. Lewis Schlosser (Seton Hall University). Workshop Objectives: Reduce reliance on stereotypes and assumptions about American Jews. Identify Jews as an American ethnic minority. Provide information regarding Jews and Jewish culture. Discuss tenets of culturally appropriate and affirmative psychotherapy with American Jews.

Aug 24, 2011, 10-11 AM: American Buddhists in Counseling: World View Considerations.+ Presented by Eleanor Rosch, Ph.D. (University of California - Berkeley). Workshop Objectives: Understand the background of Buddhist thought and practices, particularly relevant to American Buddhists. Discuss how current research on effects of mindfulness and other meditations is markedly different from Buddhism as a path of psychological and spiritual discovery.

Sept 14, 2011, (Wed) 10-11 AM: Evidence-Based Religious and Spiritual Therapies. Presented by Dr. Jamie Aten (University of Southern Mississippi). Workshop Objectives: Consider the next step in the evolution of clinical services related to religious and spiritual issues – evidenced-based religious and spiritual practices. Learn about empirically supported treatments for mental health problems that are explicitly based in religious and spiritual systems.

Know about PsycLINK?

By Deborah Okon

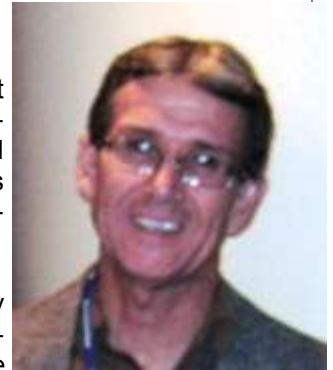
It's a Wiki search engine, information resource and discussion venue created by psychologists for psychologists. If you are an APA member, go to <http://psyclink.apa.org> and sign up. You can look up anything from recommended bibliotherapy ideas, resources for setting up your practice (renting, professional wills), or useful approaches to therapy. Members can ask questions, blog about psychological issues, post useful information, or readily search the database and know that it is posted by psychologists and has been vetted by the organization. You even can look at the poster's profile to see their background. Much better than a Google Search! Once you've posted a question, you can receive automatic notification when there is a response.

Please bookmark this today, as it is an APA pilot project and will disappear if not adequately used by August 2012.

Two Cultural Competence Home Study Courses Become Ethics Coursework

By Ricardo Gonzales, Diversity Delegate

Home-study Courses #3 and #4 have now become Ethics Courses!! The manuscripts that are used for these courses (“APA’s Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists”, and “The Psychological Treatment of Ethnic Minority Populations”) are public policy statements made by Divisions 15 and 45 of the American Psychological Association, and the Councils of the National Latino, Asian, Black and Indian Associations of the American Psychological Association.



Ricardo Gonzales, PhD

These public policy statements are considered Guidelines involving culturally and ethnically appropriate standards for working with ethnic minorities. Most State Psychological Associations use these manuscripts as Ethics Study Guides because these materials reference Guidelines to Ethics Standards and the treatment of these minority populations.

Cultural competence is an ethical responsibility. Ethical Principals A, D, and E (of the American Psychological Association) and Ethical Standards 1.08 and 1.09 require that psychologists be knowledgeable and aware of cultural, individual and role differences and accord appropriate respect to the fundamental rights, dignity and worth of all people respecting the diverse opinions, values and attitudes of clients, while being concerned not to harm them, obtaining the necessary knowledge and training to maintain competence and high standards in working with individuals of diverse backgrounds, and to contribute to social justice. The above manuscripts review Guidelines that address the above Ethical Principals and Standards by describing what it means and what is required to be competent to work with racially/ethnically different populations.

The Continuing Education Committee of the New Mexico Psychological Association sponsors Home-study Courses #3 and #4 as Ethics continuing education credit for the New Mexico Board of Psychologist Examiners. The course exam questions have been altered to address the course Guidelines and Ethical Standards. These Home-study Courses will no longer be accepted as Cultural Diversity CEs. However, you can retake these courses if you have not taken them during the most recent Continuing Education reporting period.

To recap the Licensing Regulations as they pertain to the above Home-study Course changes – during each reporting period :

- 1) Newly licensed psychologists must complete 8 CPE credit hours of “Cultural Competence” coursework promulgated by the Board of Psychologist Examiners specific to New Mexico Cultural Diversity
- 2) Already licensed psychologists must complete 4 CPE credit hours of “Clinical Diversity” course work related to the populations the Psychologist serves (e.g., if these are ethnic minorities or those who are poor any of the 54 hours of our Cultural Competence Home-study Courses at the website can be used as “Clinical Diversity” coursework), and finally
- 3) Category V of the Licensing Regulations specifies the completion of 5 CPE credit hours of “Ethics practice of psychology” coursework specifically with attention to topics/coursework involving ethics. Home-study Courses #3 and #4 can now be used to fulfill this Ethics licensing requirement. You can access the revamped Home-study Courses #3 and #4 at (<http://nmpa.com/displaycommon.cfm?an=1&subarticlenbr=33>). If you have further questions about any changes to the Cultural Competence website please contact Mellie at the NMPA office or me at rgonzales@dishmail.net.

NMPA’s Chapter II/Northern New Mexico has recently reorganized and now has a listserv and meets in Santa Fe. If you would like to participate in the Chapter II meetings or join their listserv, email newmexpa@aol.com with your request.

Do you want to be added to the NMPA listserv?
Email Mellie at newmexpa@aol.com if you are not currently receiving listserv messages and we will add your email address.



Legislative Report 2011

By Dan Matthews, PhD



Governor Susana Martinez has signed NMPA-backed SB 377 into law. Sponsored by Sen. Gerald Ortiz y Pino and carried to the House floor by Rep. Gail Chasey, this NMPA initiated bill facilitates licensure of well-trained candidates. It gives credit toward licensure for practicum experiences in graduate school. New Mexico becomes the tenth state to move in this direction for post-doctoral hours (Alabama never required them, hurting mobility to other states). Two years of supervised experience are still required for licensure, but these can now be:

- high quality pre-doctoral supervised hours (meeting guidelines set out by the Association of State and Provincial Psychology Boards),
- predoctoral internships, with more credit being given for APA-approved internships
- the remainder of two-years in supervised post-doctoral hours.

Historically (e.g., after WW II), prospective psychologists got a doctorate in any area of psychology then became clinicians by getting postdoctoral supervised experience. The standard length of the experience requirement became and remains two years. As training programs became more structured, pre-doctoral internships counted for up to one of these years.

More recently, as APA and the Association of State and Provincial Psychology Boards (ASPPB) became more demanding in their expectations for supervised practica in doctoral programs, many think it is appropriate to credit these toward licensure as well. APA supports this direction and ASPPB has established guidelines: where the experience fits in the sequence of training, how much supervision is provided, by whom, etc.

ASPPB has already established forms for documenting pre-doctoral practicum hours as part of their system of universal application for licensure. In the near future, this universal application system will be piloted in New Mexico and Oklahoma to be expanded to all states who want to use it in the future. The application process will be online and will be usable later to receive ASPPB's Certificate of Professional Qualification (CPQ). The CPQ facilitates mobility of licenses to other states and is accepted in New Mexico. Thus, the timing of the passage of SB 377 is fortuitous in coinciding with a system of documenting licensure requirements in a more up-to-date fashion. Cheri Koinis, Ph.D. initiated the change incorporated in SB 377, researched other states, helped develop the language for it, served as expert in legislative hearings and served in all ways as an active legislative committee member. I refer to this as "Cheri's law" for these reasons. Cheri feels thanked enough by the experience and the success of the bill, but thanks anyway.

NMPA as an organization also supported prohibiting corporal punishment in the schools (HB 172, Rep. Rick Miera and Sen. Cynthia Nava) and we spoke in favor of it in its first committee hearing. Our support for this bill is based on recent meta-analysis of the research and on APA's long history of opposition to corporal punishment in the schools and other public institutions. The APA Council's resolution was passed in 1975 and contains these highlights:

"WHEREAS: The resort to corporal punishment tends to reduce the likelihood of employing more effective, humane, and creative ways of interacting with children;. . .

"WHEREAS: Research has shown that the effective use of punishment in eliminating undesirable behavior requires precision in timing, duration, intensity, and specificity, as well as considerable sophistication in controlling a variety of relevant environmental and cognitive factors, such that punishment administered in institutional settings, without attention to all these factors, is likely to instill hostility, rage, and a sense of powerlessness without reducing the undesirable behavior;

"THEREFORE, BE IT RESOLVED: That the American Psychological Association opposes the use of corporal punishment in schools, juvenile facilities, child care nurseries, and all other institutions, public or private, where children are cared for or educated (Conger, 1975)."



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New Mexico Psychological Association - Mentoring Program
MENTEE APPLICATION FORM (Must be an NMPA Member to participate)

PLEASE PRINT CLEARLY

Name _____ Degree _____

First Name

Last Name

Address _____

City _____ State _____ Zip _____

Primary Phone _____ Other Phone _____

E-Mail _____

Graduate School: Please Check One - Attended Attending

Are you currently licensed in NM? Yes No

Current Work Location _____

Primary Interest Areas: Please indicate your level of interest in the areas below by ranking them from 1-4; 1 = most interested & 4 = least interested. You do NOT need to number your interest level for each individual category (Treatment, Setting, etc.); simply indicate what most interests you across all four areas.

- | <u>Treatment</u> | <u>Setting</u> | <u>Focus</u> | <u>Interests</u> |
|--|---|---|--|
| <input type="checkbox"/> Adult Therapy | <input type="checkbox"/> Private Practice | <input type="checkbox"/> Cognitive-Behavioral | <input type="checkbox"/> Diversity |
| <input type="checkbox"/> Child Therapy | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Psychodynamic | <input type="checkbox"/> NMPA Leadership |
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Academia | <input type="checkbox"/> Assessment | <input type="checkbox"/> Early Career Issues |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Research | <input type="checkbox"/> Neuropsychology | <input type="checkbox"/> Career Transitions |
| <input type="checkbox"/> Couples Therapy | <input type="checkbox"/> Community MH | <input type="checkbox"/> RxP | <input type="checkbox"/> Balancing Work and Family |
| | | <input type="checkbox"/> Forensic | |

If you are interested in areas aside from those above, please describe them:

If you are seeking mentoring regarding a specific area of diversity (i.e. race, sexuality, etc.) please describe:

Please save, complete and email this form to newmexpa@aol.com
or return by mail to

NMPA
8205 Spain NE, Suite 202
Albuquerque, NM 87109

**New Mexico Psychological Association - Mentoring Program
MENTOR APPLICATION FORM (Must be an NMPA Member to participate)**

PLEASE PRINT CLEARLY

Name _____ Degree _____

First Name Last Name

Address _____

City _____ State _____ Zip _____

Office Phone _____ Fax _____

E-Mail _____

Are you currently licensed in NM? Yes No

Current Work Location _____

Primary Interest Areas (place an X in all areas in which you are comfortable mentoring. Leave all others blank):

<u>Treatment</u>	<u>Setting</u>	<u>Focus</u>	<u>Interests</u>
<input type="checkbox"/> Adult Therapy	<input type="checkbox"/> Private Practice	<input type="checkbox"/> Cognitive-Behavioral	<input type="checkbox"/> Diversity
<input type="checkbox"/> Child Therapy	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Psychodynamic	<input type="checkbox"/> NMPA Leadership
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Academia	<input type="checkbox"/> Assessment	<input type="checkbox"/> Early Career Issues
<input type="checkbox"/> Divorce	<input type="checkbox"/> Research	<input type="checkbox"/> Neuropsychology	<input type="checkbox"/> Career Transitions
<input type="checkbox"/> Couples Therapy	<input type="checkbox"/> Community MH	<input type="checkbox"/> RxP	<input type="checkbox"/> Balancing Work and Family
		<input type="checkbox"/> Forensic	

If you are interested in mentoring in areas aside from those above, please describe them:

Early Career Psychologists often have questions/concerns in such areas as balancing work and family life, diversity issues as they relate to new work environments and/or roles as supervisor versus supervisee, etc. Are you willing to provide explicit mentorship in these areas?

Research interests and/or additional comments:

Would you be willing to take on a second mentee? Yes No

Please return this form to
NMPA
8205 Spain NE, Suite 202
Albuquerque, NM 87109
or save, complete and email to newmexpa@aol.com

A New, Evidence-based Moderate Drinking Web Application for Non-dependent Problem Drinkers

by Reid K. Hester, PhD

The *Journal of Consulting and Clinical Psychology* just published our paper titled, ModerateDrinking.com and Moderation Management: Outcomes of a randomized clinical trial with non-dependent problem drinkers (citation below).

This is the second of two papers reporting the outcomes of our study. The first, published in the *Journal of Substance Abuse Treatment* in late 2009 reported the early, 3 month outcomes. In that paper we found that the MD + MM group had better outcomes on percent days abstinent and on peak BAC per drinking day. From 3 to 12 months though the MM only group continued to reduce its drinking while the MD + MM group maintained their early gains. The result was that while there continued to be a difference in percent days abstinent favoring the MD + MM group, the drinking outcomes were not as significantly different.

Here's the abstract of the *JCCP* paper.

Objective: To evaluate the effectiveness of a web-based protocol, ModerateDrinking.com (MD; www.moderatedrinking.com) combined with use of the online resources of Moderation Management (MM; www.moderation.org) as opposed to the use of the online resources of MM alone.

Method: We randomly assigned 80 problem drinkers to either the experimental or control group with follow-ups at 3, 6, and 12 months. Results: Seventy-five participants (94%) had outcome data at 1 or more follow-up points, and 59 participants (73%) were assessed at all 3 follow-ups. Comparing baseline measures to the average outcomes at follow-ups indicated a significant overall reduction in both groups in alcohol-related problems and consumption variables. Compared with the control group, the experimental group had better outcomes on percent days abstinent. There was an interaction between intensity of drinking at baseline and treatment in determining outcomes assessing

drinking. Less heavy drinkers in the experimental group had better outcomes on log mean blood alcohol content (BAC) per drinking day compared with the control group. Heavier drinkers did not differentially benefit from the MD program on this measure. Mixed model analyses in general corroborated these outcomes. Conclusion: The outcome data provide partial evidence for the effectiveness of the MD web application combined with MM, compared with the effectiveness of the resources available online at MM by themselves.

Citation: ModerateDrinking.com and moderation management: Outcomes of a randomized clinical trial with non-dependent problem drinkers. Hester, Reid K.; Delaney, Harold D.; Campbell, William. *Journal of Consulting and Clinical Psychology*, 79, Apr 2011, 215-224.

NMPA members who would like a copy of these two papers can email me at reidhester@behaviortherapy.com. If you're interested in reviewing the program for use with your clients, I can provide you with a reviewer's access code. The site is subscription based and net profits are donated to Moderation Management.



Reid Hester, PhD

SAVE THE DATE!

NMPA Fall Conference Psychological Practice in Primary Care: An Integrated Model

October 14, 2011
Indian Pueblo Cultural Center, Albuquerque
All day, lunch included

Keynote address:
"Psychological Practice in Primary Care:
Towards a Collaborative Model"

**presented by James Bray, PhD,
Past APA President**

Registration begins in June, www.nmpa.com

Upcoming 2011 NMPA Events

Please email
newmexpa@aol.com to check on
times and dates as times may
change

May 18

Executive Committee meeting,
5:30 pm

June 18

Board and Executive
Committee meetings
9-Noon

July 20

Executive Committee meeting,
5:30 pm

August 17

Executive Committee meeting,
5:30 pm

September 24

Board and Executive
Committee meetings
9-Noon

October 14

NMPA Fall Conference
"Psychological Practice in
Primary Care: An
Integrated Model"

Indian Pueblo Cultural Center,
Albuquerque
All day

November 16

Executive Committee meeting,
5:30 pm

December 14

Executive Committee meeting,
5:30 pm

February 2011 APA Council of Representatives Feb. 18-20 Meeting Report

Michael Rodriguez, PhD, NMPA Council Representative

Doctoral-level members of APA will see their dues reduced next year as a result of action taken by the Council of Representatives at its February meeting. In addition to passing a \$40 reduction to the annual full members' dues, the Council adopted six new or revised guidelines, including a set to guide evaluations in child protection matters, and accepted several presidential task force reports. The Council also established a new task force to create guidelines for psychologists' use of telepsychology.

The reduction in full members' dues, from the current \$287 to \$247 beginning in 2012, is part of an overall redesign of the association's dues schedule as proposed by the Membership Board. The revised schedule moves the association from a dues schedule based on discounts for specific constituency groups to reduced costs for all full members. Early career members will still enjoy reduced dues for their first eight years of membership. This action rescinds a 2011 Council decision to grant a \$25 dues discount to APA members who are also members of the Federation for the Advancement of Behavioral and Brain Sciences, the Association for Psychological Science, the Society for Neuroscience, the state, provincial and territorial psychological associations and the four national ethnic minority psychological associations.

The Council voted to:

- Adopt guidelines in the areas of parenting coordination; practice in health care delivery systems; psychological evaluations in child protection matters; assessment of and intervention with people with disabilities; evaluation of dementia and age-related cognitive change; and psychological practice with lesbian, gay and bisexual clients. (I have a copy of these in my agenda; please contact me if you would like to see them – mrrunner@comcast.net)
- Approve the report of the 2010 Presidential Task Force on Advancing Practice. The work of the task force included the launch of PsycLINK, the APA practice wiki, an online resource for information sharing and collaboration amongst psychologists. Visit the wiki at <http://psyclink.apa.org/display/ITS/PsycLINK+-+The+Practice+Wiki>
- Approve the report of the 2010 Presidential Task Force on Caregiving. The work of the task force included the creation of a Web-based resources "briefcase" for psychologists and members of the public on care-giving issues. See the web-based brief-case at <http://www.apa.org/pi/about/publications/caregivers/index.aspx>
- Approve the 2011 association budget, including operating expenses of \$106,857,300 and forecasted revenue of \$106,877,300.

"I'm very proud of the work of the association as reflected in the actions taken by Council at this meeting," APA President Melba J. T. Vasquez, PhD, said at the close of the 2 ½-day meeting. "The guidelines and task force reports are now a part of the official APA record and will help psychologists do their jobs and continue to serve the public."