Increase In Plasma Levels of Clozapine after Addition of Isoniazid

Michael C. Angelini, M.A., Pharm.D.
Jacqueline MacCormack-Gagnon, Pharm.D.

Editor’s note: Dr. Angelini is an educator and supervisor in the M.S. in Clinical Psychopharmacology program at Massachusetts School of Professional Psychology (MSPP). He will be presenting at APA in Boston this August.

Drug to drug interactions occur under two main headings: pharmacokinetic and pharmacodynamic. Pharmacokinetic interactions occur when one drug changes the absorption, distribution, metabolism and/or excretion of another drug. Pharmacodynamic interactions are those when two drugs interact in such a way as to work against each other (antagonistic), add to each other (agonistic) or exponentially increase the effect of each other (synergistic). When dealing with patients requiring multiple drug therapy it is prudent to try to predict the likely interactions that can occur and how they will manifest. The next step is to monitor the patient to catch the interaction in its early phase so that the patient is not harmed. Following is a report of how we predicted a possible pharmacokinetic drug interaction between clozapine (Clozaril) and isoniazid and a pharmacodynamic interaction between venlafaxine (Effexor) and isoniazid. The appropriate oversight resulted in a non-harmful event despite the fact that the pharmacokinetic interaction actually did occur, and had we not predicted it, monitored for it, and adjusted therapy, could have been fatal.

Clozapine was the first atypical antipsychotic, a class of drugs with activity against both the positive and negative symptoms of schizophrenia and a lower incidence of extrapyramidal adverse effects compared to the typical antipsychotics. Clozapine’s potential to cause agranulocytosis has limited its use, but it is still commonly used for treatment-resistant schizophrenia due to its superior efficacy for this indication compared to other antipsychotic agents. The Cytochrome P450 (CYP) enzyme system plays a major role in clozapine’s clearance. Clozapine goes through extensive biotransformation with oxidative metabolism and forms 2 major metabolites, desmethyliclozapine (norclozapine), an active metabolite (a substrate of CYP1A2 and CYP3A4) and clozapine N-oxide, an inactive metabolite (a substrate of CYP3A4). In vitro and clinical data have demonstrated that CYP1A2 is the major substrate of clozapine and that the formation of norclozapine correlates with CYP1A2 activity. The administration of concomitant drugs that are known to induce or inhibit CYP450 1A2 have demonstrated fluctuations in clozapine plasma levels. Cigarette smoke, an inducer of the CYP1A2 enzyme has been associated with a 20-40% lower mean serum clozapine concentration. Fluvoxamine, a potent inhibitor of CYP1A2 has been associated with a 5-12 fold increase in the serum clozapine concentration. A small study conducted by Raaska and Neuvonen reported that concomitant use of ciprofloxacin, an inhibitor of CYP1A2 was associated with a 29% and 31% increase in the mean serum concentration of clozapine and N-desmethylclozapine (nortclozapine). Isoniazid (INH) is commonly used in combination with other drugs for the treatment of tuberculosis or as monotherapy for treatment of latent tuberculosis. INH inhibits the CYP
Public service is a big part of the prescription privileges movement. As many of you know from the listserv announcement in April, prescribing psychologist Dr. Alan Hopewell has been awarded the Bronze Star Medal for meritorious service in Iraq. Please see the full announcement on page 5.

APA will have its annual convention August 14-17 in Boston. There will be many superb offerings sponsored by Division 55. Please see the program summary that is included in this issue. Many thanks to Stan Berman, Steve Tulkin, and others who are working very hard to put this program together.

Michael Angelini, Pharm.D., M.A., is a prescriber in the V.A. system who has a master’s degree in psychology and is a favorite teacher and supervisor at the M.S. in Clinical Psychopharmacology program at the Massachusetts School of Professional Psychology (MSPP). In this issue, Dr. Angelini and Dr. Jacqueline MacCormack-Gagnon present a case study which is the first published report of a pharmacokinetic drug interaction between clozapine (Clozaril) and isoniazid, the anti-tubercular agent.

See Dr. Michael Brunner’s fascinating results of the RxP survey conducted in Minnesota recently. A prior survey had used a...um...very creative interpretation of data to assert that psychologists did not support RxP. Dr. Brunner and colleagues labored to conduct a very fair survey and came up with quite supportive results, which are included in this issue.

Sincerely,

jeff@hpmaine.com

The Neuroscience Education Institute (NEI) is extending a wonderful offer to all members of Division 55.


Members of Division 55 have been invited to receive this discount even if not yet a member of NEI!
The Fourth Annual American Society for the Advancement of Pharmacotherapy Mid-Winter Conference was an event to remember. The highlight of the gathering had to be the advocacy effort at the State Capitol in Jefferson City on January 8, 2008. A small, but tenacious nucleus of Division 55 leaders united with members of the Missouri Psychological Association (MOPA) to accomplish what is unprecedented up to this point in time in our efforts to obtain prescriptive authority for appropriately trained psychologists. On the very first day of the Missouri Legislative session, following an exhilarating press conference in the House Lounge organized by MOPA in collaboration with APA and ASAP, this small band of psychologists led by Representative Dannie Moore, Dr. Roy Holland, Dr. Marci Manna, and Dr. Mark Skrade, proceeded to obtain 60 co-sponsors for House Bill 1739. Later that evening, no fewer than 40 Missouri State Legislators attended a reception at the Old Opera House in downtown Jefferson City. The festivity provided a wonderful opportunity for RxP psychologists and proponents to lobby the Senators and Representatives and their staff — and oh did we lobby! By the time the conference was over in Kansas City, 85 co-sponsors in the House of Representatives had signed onto the Bill. Of course, this does not guarantee passage; however, as of this writing the legislation has been voted out of the respective committees in the House and Senate, and is on the calendar of the Senate Floor.

Did I mention the Conference itself was also quite motivating? My heartfelt appreciation goes out to everyone, particularly Dr. Beth Rom-Rymer, and the others too many to mention here, who gave of themselves to organize and pull off the historical successes achieved in Missouri. I also want to thank all the participants who attended the conference. Please go to the website for more details, pictures, and links.

Under the skilled direction of Drs. Steve Tulkin and Stanley Berman, the D55 Program for the 116th American Psychological Association Convention in Boston, August 14-17, 2008 is complete. I may be a bit biased, but in my opinion, our program in Boston has to be one of the best assembled since the inception of our Division only seven years ago. Convention details are available online and in The Tablet. Please plan to attend all the Division’s events and join with me in thanking Steve and Stan for a job well done, up to this point. There is more work to be done in Boston, and a lot of fun to be had.

Thanks to Drs. Jack Wiggins and Morgan Sammons who have been busy identifying candidates for the division’s annual awards to be presented at our awards ceremony at Convention. Please stay tuned. I think you are going to be quite satisfied with this year’s recipients.

Hats off to Dr. Bob McGrath who chaired D55’s nominations committee for our election of officers and APA Boards and Committees. The work has been completed, the nominations have been sent forward, and the individuals have been contacted. Hopefully the Council of Representatives will vote D55 members onto APA Committees and Boards. You will be receiving ballots from APA in the near future for the division elections. Please vote. We have some outstanding candidates running for division officers.

The D55 National Strategy Task Force continues to work on a national strategy to license more psychologists trained in psychopharmacology. I am very happy to report that Dr. Kevin McGuiness, a Public Health Service psychologist licensed as a Medical Psychologist in Louisiana and working in Southern New Mexico has been credentialed to prescribe in Indian Health Services. I am also delighted to tell you that under the leadership of Dr. Michael Tilus, seven Native American psychologists from Aberdeen Area Indian Health Services have begun psychopharmacology training in an effort to become licensed and credentialed to prescribe.

On a different note, Senate Bill 1427 in California did not make it out of committee. I appreciate that there was disagreement between members of the division with regard to some of the language in the bill. Nonetheless, it was very disheartening to me, personally, that we were unable to unite on behalf of our patients. The outcome may have been different had we been able to speak with one voice. In the future, I pray we learn from our mistakes. There is much work to be done with regard to the California RxP effort, and the board is discussing ways in which to address these types of situations in the future. Division 55 is always ready, willing, and able to assist organizations work out differences regarding proposed legislation, but the work should be done prior to dropping a bill. The efforts of D55 members, Drs. Howard Rubin, John Reeves, John Caccavale, and their colleagues, who spearheaded SB-1427, are very much appreciated.

Dr. Elaine Orabona-Foster, our well-known DOD prescribing psychologist, has decided to step down from the board. I wish to thank her for her years of service to D55 and all of her accomplishments and efforts on behalf of RxP. We are

CONTINUED ON PAGE 19
ISONIAZID CONTINUED FROM PAGE 1

P450 system, including CYP1A2. Increased theophylline (a substrate of CYP1A2) plasma concentrations have been reported with the co-administration of INH.

Currently, no reports of drug-drug interactions with the co-administration of clozapine and isoniazid have been published. In view of the fact that clozapine is a substrate of CYP1A2 and isoniazid is an inhibitor of this isoenzyme, it could be predicted that coadministration of these two drugs would result in an increase in the clozapine serum concentration.

Case Report

JD is a 65 year old Caucasian male group home resident with diagnoses of paranoid schizophrenia, generalized anxiety disorder, social anxiety disorder, hypertension, frequent constipation and mild anemia. His medication list was clozapine 200mg BID, venlafaxine XR 150mg BID, metoprolol 25mg BID, docusate 100 mg BID, and milk of magnesia 30 cc prn. After a diagnosis of tuberculosis (TB), JD was prescribed INH 300mg QD for a 9 month course of therapy. Prior to the initiation of the INH, clozapine and norclozapine levels were drawn due to the anticipation that INH could possibly increase clozapine levels. The results were 397 ng/mL and 384 ng/mL for clozapine and norclozapine respectively. Three days post INH initiation another clozapine/norclozapine level was drawn. The results were 569 ng/mL and 520 ng/mL, respectively. Six days later (9 days post INH initiation) another clozapine/norclozapine level was drawn and the results were 756 ng/mL and 725 ng/mL. The patient was not displaying any significant toxicities except for excess sedation. The clozapine dose was reduced to 150mg BID at this time and another level was drawn 11 days later. The clozapine/norclozapine levels lowered to 527 ng/mL and 614 ng/mL, respectively. The dose was reduced again to 100mg BID. Twenty-one days later another clozapine/norclozapine level was drawn and the results were 385 ng/mL and 379 ng/mL, respectively. This clozapine dose was maintained for the duration of the patients INH therapy with 5 more levels being drawn during that time. These ranged from 337-482 ng/mL for clozapine and 277-412 ng/mL for norclozapine. JD was psychiatrically stable during this time. His WBC ranged from 5-10/mm$^3$ and his ANC ranged from 3-7.6/mm$^3$. After 9 months of treatment, the INH was discontinued and JD was continued on clozapine 100 mg BID. Fifty four days after INH discontinuation a clozapine/norclozapine level was drawn and the results were 239 ng/mL and 221 ng/mL, respectively. We did not increase the clozapine dose at this time but followed the patient carefully within the residential care setting for any signs of psychiatric relapse. A month later the patient started to become psychiatrically symptomatic and the clozapine dose was titrated back up to 100 mg QAM and 300 mg QHS, resulting in stability.

This case clearly shows the impact that INH can have on serum clozapine and norclozapine levels. Within 9 days of INH initiation, the clozapine serum level rose 90%. A subsequent 50% clozapine dose reduction resulted in serum levels similar to pre-INH levels. The serum level then remained consistent throughout the rest of the course of INH therapy in addition to the patient remaining psychiatrically stable. Upon discontinuation of the INH, clozapine serum levels reduced by 37%. After 3 months of reduced clozapine levels the patient became psychiatrically unstable and required a dose increase to pre-INH levels. The patient has returned to pre-INH stability status since.

One other interesting drug interaction that we followed was between INH and venlafaxine. INH has been reported as having monoamine oxidase inhibition$^7,8$. This, when combined with a serotonin reuptake inhibitor could cause serotonin syndrome and when combined with a norepinephrine reuptake inhibitor could result in a hypertensive crisis. Despite the continued use of venlafaxine XR (a serotonin and norepinephrine reuptake inhibitor) at 150 mg BID the patient displayed neither serotonin syndrome symptoms nor increases in blood pressure. In fact, JD had a reduction in blood pressure which resulted in discontinuation of his metoprolol.

This case provides the first published report of a pharmacokinetic drug interaction between the anti-tubercular agent isoniazid (INH) and the atypical antipsychotic clozapine. Patients stabilized on clozapine that require the addition of INH should be monitored for potential clozapine toxicity and, upon INH discontinuation, should be monitored for subtherapeutic clozapine levels possibly resulting in relapse.

References

Prescribing Psychologist in Iraq
Awarded a Bronze Star Medal

Dr. Alan Hopewell, prescribing psychologist in Iraq, has been awarded the Bronze Star Medal for meritorious service in Operation Iraqi Freedom. Dr. Hopewell is the first Prescribing Psychologist ever to serve in a combat theater. He provides services to over 50,000 troops assigned to Victory Base Complex, which includes Camps Liberty, Victory, Riva Ridge, Stryker, Sather Air force Base, Baghdad International Airport, and Greater Baghdad. Larger units served include the 1st Cavalry Division, 3rd Infantry Division, 4th Infantry Division, 2nd Stryker Regiment, Multi-National Division, and the 101st Airborne Division.

In his service, Dr. Hopewell has written over 2000 prescriptions. He served as Theater Consultant for Traumatic Brain Injury and is the Senior Neuropsychologist on active duty in the Department of Defense. Dr. Hopewell has written policies for and has overseen psychological testing for incarcerated terrorists as well as local Iraqi citizens traumatized by the war, with testing done in Arabic. He has provided theater-wide training for Traumatic Brain Injury with in vivo research in association with the 38th Explosive Ordinance Company, involving explosives detonations “outside the wire.”

Please see Dr. Hopewell’s commentary about being a prescribing psychologist in a combat theater beginning on page 17.

Division 55 Members Gain New Benefit From NEI

BECOME A MEMBER OF THE NEUROSCIENCE EDUCATION INSTITUTE

~RECEIVE A 33% DISCOUNT ON NEI MEMBERSHIP~
~$250 VALUE FOR ONLY $169 ~

3 EASY WAYS TO JOIN NEI:

-At the NEI Website, http://www.neiglobal.com/go/div55, use the promo code DIV55TODAY at checkout to get the special rate.
-Call NEI at +1 888-535-5600 and mention promo code DIV55TODAY to get the special rate.
-Send an email to NEI, membership@neiglobal.com, and mention promo code DIV55TODAY to get the special rate.

Division 55 is a sponsor of NEI continuing education for psychologists approved by the American Psychological Association.
Challenges and Consequences of a Survey Assessing Prescription Privileges for Psychologists: 2007 Survey Results in Minnesota

By Michael Brunner, Ph.D., LP

Editor’s Note: Michael Brunner, Ph.D., LP practices at the Albert Lea Medical Center in Albert Lea, MN. He is President of the Minnesota Psychological Association and a member of the legislative committee and is the MN Chapter Chair of Division 55, the American Society for the Advancement of Pharmacotherapy. His e-mail is mbrunnerphd@msn.com.

Surveys of psychologists’ attitudes have been used to gauge support for prescription privileges for psychologists (RxP). Sammons, Gorny, Zinner, & Allen (2000), examined two decades of surveys regarding RxP and found that “on average, 65% (SD = 12%) of the psychologists surveyed . . . were in favor or strongly in favor of prescriptive authority . . . .” In 2004, Kapalka, McGrath, & Zielinski (2004) found similar support with 66% of New Jersey psychologists in favor of RxP. In a survey of Minnesota Psychological Association (MPA) members, Ritchie (1996) found that 66% supported RxP. In a survey of doctoral-level licensed psychologists in Minnesota (MN), using multivariate statistical analyses, Adix (dissertation, 2006) concluded, “There is little support by Minnesota’s psychologists for prescription privileges.” However, the question in his survey that directly assessed support for RxP was confounded, i.e., “I support pursuing prescription privileges for psychologists, but do not want them for myself,” and this precluded comparison with other surveys that directly assess psychologists’ support of RxP.

State associations utilize results from surveys to establish policy and make decisions regarding their stance on issues, and RxP is no different. In Minnesota, the issue of RxP has stagnated, and MPA has chosen to remain neutral at this time. Although there do not currently appear to be very many vocal opponents to RxP; in 1998 the MPA governance took a position in support of states pursuing prescriptive authority for appropriately trained psychologists. One particularly vocal member published an articulate and scathing commentary on this “risky policy shift,” and threatened to end his membership with the organization (Robiner, 1998). This reactionary response appears to have been one factor that contributed to the MPA’s decision to refrain from moving forward with support for RxP in Minnesota. In 2002, Barrett reported that in an informal request for “member feedback” the majority of MPA respondents opposed RxP. Barrett’s summary of feedback lacked the methodological rigor to be considered a formal survey and also had a very low response rate (N = 39). Thus, opponents to RxP claimed to have “data” that MN psychologists do not support RxP, and frequently made claims to this effect whenever proponents made attempts to advance the issue within MPA.

Although active in MN, including the establishment of a Division 55 state chapter, RxP proponents have not been visible or active in the MPA in recent years. In 2006, after attending a state leadership conference and being aware of MPA member interest in RxP, a MPA Governing Council (GC) member proposed that an RxP task force be established within the organization.

In March 2006, the MPA GC agreed to establish an ad hoc task force in order to examine the opinions of MN practicing psychologists with respect to RxP. The task force was composed of several proponents and opponents of RxP and convened several meetings in 2006. The task force identified parameters for further study, deadlocked in the discussions due to the composition of the task force, but ultimately offered a recommendation that the issue be studied further. Arguments were again advanced by opponents to RxP that few psychologists support the issue in Minnesota (Sethre, 1996a, 1996b), utilizing Adix’s (2006) dissertation findings to bolster this claim. The executive committee of the MPA decided that a survey of psychologist opinions regarding RxP would provide useful information to the organization and would be the best place to begin. An APA Committee for the Advancement of Professional Psychology (CAPP) RxP seed grant was obtained. This funding along with $500.00 from the MPA was used to fund the survey.

Method

Participants. The Minnesota Board of Psychology mailing list was used to identify licensed psychologists. All licensed psychologists in Minnesota on the mailing list were sent the survey. Undeliverable surveys were not returned to MPA, and therefore, the number of undeliverable surveys was unable to be calculated. Based on a recent mailing using the same mailing list, it is estimated that approximately three-and-one-half percent of the surveys could not be delivered.

Continued on page 13
Divison 55 Program Summary

2008

APA Annual Convention

8/14 Thu: 8:00 AM 8:50 AM
Boston Convention and Exhibition Center
Meeting Room 152

Conversation Hour (N): Which Psychopharmacology Program to Choose Meet the Training Program Directors

Chair
Steven R. Tulkin, PhD, MS, Alliant International University, San Francisco

Participant/1stAuthor
Suzanne Anthony, PhD, Argosy University/Hawaii
Stanley J. Berman, PhD, Massachusetts School of Professional Psychology
Elaine S. LeVine, PhD, Independent Practice, Las Cruces, NM
Robert McGrath, PhD, Fairleigh Dickinson University
Matthew Nessetti, PhD, MD, Nebraska Mental Health Centers, Lincoln
Steven R. Tulkin, PhD, MS, Alliant International University, San Francisco
Lenore E. Walker, EdD, Nova Southeastern University

8/14 Thu: 9:00 AM 10:50 AM
Boston Convention and Exhibition Center
Meeting Room 205B

Symposium (S): Psychotherapy and Psychopharmacology With Children and Adolescents What’s the Evidence?

Chair
Stanley J. Berman, PhD, Massachusetts School of Professional Psychology

Participant/1stAuthor
Ronald T. Brown, PhD, Temple University
John Courtney, MP, PsyD, Children’s Hospital, New Orleans, LA
Title: Psychopharmacology Consultation in a Children's Hospital
CoAuthor: George M. Kapalka, PhD, Monmouth University
George J. DuPaul, PhD, Lehigh University
Title: Children and Adolescents with ADHD: Integrated Psychopharmacology and Psychosocial Interventions
Gretchen B. LeFever, PhD, Regent University
Title: Questioning Common ADHD Treatment Assumptions with Buried Scientific Data
CoAuthor: David O. Antonuccio, PhD, University of Nevada School of Medicine

Discussant
Ronald T. Brown, PhD

Continued on page 8
Symposium (S): Evolution of Psychopharmacology Practice for Psychologists Where We Are

Chair
Mario Marquez, PhD, Independent Practice, Albuquerque, NM

Participant/1st Author
Elaine S. LeVine, PhD, Center Through the Looking Glass, Las Cruces, NM
Title: Evolving Practice for StateLicensed Prescribing Medical Psychologists
Patrick H. DeLeon, PhD, JD, Office of Senator Daniel K. Inouye, Washington, DC
Title: Evolving RxP Practice in Public Service Psychology
Beth N. RomRymer, PhD, Independent Practice, Chicago, IL
Title: Evolution and Challenges of RxP Advocacy: Creating a National Strategy
Robert McGrath, PhD, Fairleigh Dickinson University
Title: Evolution of Clinical Practice Guidelines and RxP Ethics
Morgan T. Sammons, PhD, Alliant International University San Francisco
Title: What We Need for RxP Success and Growth

Discussant
Russ Newman, PhD, JD, Alliant International University San Diego

Symposium (S): Models of Psychopharmacology Services in Primary Care

Chair
Alan R. Gruber, PhD, MD, NeuroBehavioral Associates, Weymouth, MA

Participant/1st Author
Theresa A. Faulkner, PhD, LifeQuest Behavioral Health, Sheridan, WY
Title: Wyoming Psychologist's Experience Collaborating With Medical Professionals
James Bray, PhD, Baylor College of Medicine
Title: Primary Care Psychology: Issues in Collaboration and Marketing
Alan R. Gruber, PhD, MD,
Title: Psychopharmacology in LongTerm Care: Legal Mandates and Clinical Practice
Andris Skuja, PhD, MS, Kaiser Permanente Medical Center, Oakland, CA
Title: Impact of RxP Training on Professional Relationships in Psychiatry and Emergency Departments
Matthew Nessetti, PhD, MD, Nebraska Mental Health Centers, Lincoln
Title: Seamless Integrated Primary Care: A Model for Medical Psychology

Discussant
Christine A. Gray, PsyD, MS, Independent Practice, Auburn, ME

Conversation Hour (N): Should Prescribing Psychologists and RxP Programs Accept Corporate Gifts?

Chair
Robert McGrath, PhD, Fairleigh Dickinson University

Participant/1st Author
David O. Antonuccio, PhD, University of Nevada School of Medicine
Philip G. Zimbardo, PhD, Stanford University
Glenn A. Ally, MP, PhD, Independent Practice, Lafayette, LA
Beth N. RomRymer, PhD, Independent Practice, Chicago, IL
Symposium (S): Integrating Psychological and Pharmacological Treatments: Pain, Eating Disorders, Geropsych/LTC, and Hospice

Chair
Margaret Heldring, PhD, University of Washington

Participant/1st Author
Dean K. Paret, PhD, Senior Connections of Texas, PLLC, Fort Worth
Title: Role of the Pharmacologically Trained Geropsychologist in LongTerm Care
Marla M. Sanzone, PhD, MS, Independent Practice, Annapolis, MD
Title: Current Understandings in the Pharmacological Treatment of Eating Disorders
Dennis P. Girard, EdD, New England Baptist Hospital, Boston, MA
Title: Psychotropic Medications to Reduce Opiate Use in Postoperative Pain Patients
Alessandra StradaRusso, PhD, Beth Israel Medical Center, New York, NY
Title: Psychopharmacology Consultations With Hospice Patients

Discussant
Steven R. Tulkin, PhD, MS, Alliant International University San Francisco

---

Symposium (S): Integrating Psychological and Psychopharmacological Treatments for Returning Military Personnel

Chair
Morgan T. Sammons, PhD, Alliant International UniversitySan Francisco

Participant/1st Author
Heidi SqueirKraft, PhD, Naval Health Research Center, San Diego, CA
Title: Providing Psychological Services in the Deployed Environment
Blake Chaffee, PhD, Behavioral Health Triwest Healthcare Alliance, Phoenix, AZ
Title: Preparing Civilian Providers to Work with Military Members and Families
Bret A. Moore, PsyD, U.S. Army, Fort Hood, TX
Title: Psychological and Psychopharmacological Services in Iraq: EvidenceBased and CommonSense Approaches

Discussant
Morgan T. Sammons, PhD
Social Hour (N): and Awards Presentation

8/16 Sat: 8:00 AM - 9:50 AM
Boston Convention and Exhibition Center
Meeting Rooms 102A and B

Symposium (S): Integrating Psychological and Pharmacological Treatments in Rehabilitation Settings

Chair
Robert McGrath, PhD, Fairleigh Dickinson University

Participant/1stAuthor
Glenn A. Ally, MP, PhD, Independent Practice, Lafayette, LA
Title: Role of the Medical Psychologist in a Rehabilitation Facility
Terry L. Braciszewski, PhD, Ann Arbor Rehabilitation Centers, Inc., MI
Title: Integrating Psychopharmacology Into Community-Based Interdisciplinary Rehabilitation
Kathleen S. Brown, PhD, Tripler Army Medical Center, Honolulu, HI
Title: Psychology’s Role in Impacting Prescribing Behaviors in Multidisciplinary Pain Teams
Robert C. Mayfield, PhD, Memorial Medical Center, Las Cruces, NM
Title: Integrating Behavioral and Pharmacological Treatments for Rehabilitation of Developmental Disabilities

Discussant
Jay Umoto, PhD, VA Puget Sound Health Care System, Seattle, WA

8/16 Sat: 9:00 AM - 9:50 AM
Boston Convention and Exhibition Center
Meeting Room 254A

Invited Address (S): [Giordano]
Chair
Owen T. Nichols, PsyD, Western State Hospital, Hopkinsville, KY

Participant/1stAuthor
Arlene S. Giordano, PhD, Independent Practice, Sonora, CA
Title: Resistant Depression: Psychopharmacological Strategies

8/16 Sat: 10:00 AM - 11:50 AM
Boston Convention and Exhibition Center
Meeting Rooms 102A and B

Invited Address (S): [Angelini]
Chair
Stanley J. Berman, PhD, Massachusetts School of Professional Psychology

Participant/1stAuthor
Michael Angelini, MA, Massachusetts College of Pharmacy and Health Science
Title: Drug Drug Interaction: Keeping Up to Date
**8/16 Sat: 12:00 PM – 1:50 PM**

**Symposium (S): Impact of Prescription Privileges on Psychological Practice Louisiana’s Story**

**Cochairs**
Darlyne G. Nemeth, MP, PhD, Neuropsychology Center of Louisiana, Baton Rouge
Kelly P. Ray, PhD, Independent Practice, Baton Rouge, LA

**Participant/1stAuthor**
Darlyne G. Nemeth, MP, PhD,
Title: *Integrating Prescription Privileges into a Clinical and Neuropsychological Evaluation and Intervention Practice*
Kelly P. Ray, PhD
Title: *Preparing to be a Medical Psychologist*
Traci E. Wimberly, BS, Neuropsychology Center of Louisiana, Baton Rouge
Title: *Choosing a Graduate Program That Integrates Psychology and Psychopharmacology*
Joseph Tramontana, PhD, Bluebonnet Psychological Services, Baton Rouge, LA
Title: *Using a Medical Psychologist as a Psychopharmacological Consultant*
Glenn A. Ally, MP, PhD, Independent Practice, Lafayette, LA
Title: *State Licensing Board Issues in the Medical Psychologist Process*

**Discussant**
Michael Berard, MP, PhD, Independent Practice, Lafayette, LA

---

**8/16 Sat: 2:00 PM – 3:50 PM**

**Symposium (N): Advocacy for Prescription Authority National Unity Conference and State Updates**

**Chair**
Mario Marquez, PhD, Independent Practice, Albuquerque, NM

**Participant/1stAuthor**
Beth N. RomRymer, PhD, Independent Practice, Chicago, IL
Title: *Missouri Midwinter Conference: A Template for RxP National Advocacy*
Marci M. Manna, PhD, MS, Independent Practice, Branson, MO
Title: *RxP Legislation in Missouri: What Did We Learn*
Earl B.H. Sutherland, Jr., PhD, Indian Health Service, Crow Agency, MT
Title: *RxP Advocacy in Montana*
Robin E.S. Miyamoto, PsyD, Tripler Army Medical Center, Honolulu, HI
Title: *Hawaii Update: If We Don’t Quit, We Will Win*
Deborah Baker, JD, APA Office of Legal and Regulatory Affairs, Washington, DC
Title: *State by State Update on RxP Advocacy and Legislation*
E. Breese Anderson, MA, Chicago School of Professional Psychology
Title: *Model for Student Participation in Prescriptive Authority*
CoAuthor: Erin O. Zerth, MA, Southern Illinois University Carbondale

**Discussant**
Katherine Nordal, PhD, APA Office of Education for Professional Practice, Washington, DC

---

**8/16 Sat: 4:00 PM – 4:50 PM**

**Presidential Address (N): [Marquez]**

**Chair**
Elaine S. LeVine, PhD, Independent Practice, Las Cruces, NM

**Participant/1stAuthor**
Mario Marquez, PhD, Independent Practice, Albuquerque, NM
Title: *Planning State RxP Legislation in 2009*

---

**8/16 Sat: 5:00 PM – 5:50 PM**

**Business Meeting (N): [r]and General Membership Meeting**

**Chair**
Mario Marquez, PhD, Independent Practice, Albuquerque, NM
APA Annual Convention

Everything You Want to Know About RxP Training Programs

A conversation hour about RxP training and a chance to meet the Directors of RxP Training Programs

Thursday August 14, 2008
8:00A.M

Boston Convention Center
Room 152

It’ll be worth it!

Division 55’s Social Hour and Awards Ceremony

Friday August 15, 2008
6:00 P.M to 7:50 P.M.

Boston Marriot Copley Place Hotel
Third Floor Atrium

Don’t miss it!
The majority of respondents were not members of the MPA (60% nonmembers vs. 40% members). Most respondents reported that their highest degree for the practice of psychology was a doctorate (64%) rather than a master’s degree (36%). Respondents identified themselves as working mostly in clinical settings (85%) compared to academic (7%) or other settings (9%). The mean age of respondents was 53.5 years (median = 55, mode = 60).

Surveys were mailed directly to 3,583 licensed psychologists. Completed surveys were received from 1,185 respondents (33.07%). No information was available about those who did not return the surveys; thus it is not known if this is a representative sample of Minnesota psychologists’ opinions about RxP.

**Material.** A 2004 RxP survey completed in New Jersey (Kapalka et al., 1994) was used as a guide when developing the current survey. The MPA executive committee drafted and then revised three survey questions from the New Jersey survey based on input from several MPA members. The three questions were: 1. I support prescriptive authority in Minnesota for psychologists who receive training that would be defined in state law if and when legislation is passed. 2. The MPA should support prescriptive authority for properly trained psychologists. 3. I would pursue training to prescribe if and when such legislation is enacted. Respondent choices were strongly agree, agree, disagree, and strongly disagree. Demographic information including membership in the MPA, highest degree for the practice of psychology, primary work responsibility, and age was also collected.

**Procedure.** A tear-off postcard survey was developed. Return postage on the surveys was pre-paid, resulting in no cost to survey recipients. Surveys were mailed to all licensed psychologists in MN in November 2007. Survey results were tabulated by association staff in January 2008 and results were distributed and reviewed by the MPA GC on January 19, 2008.

**Results**

Of the MPA survey respondents, 76% percent reported having a doctorate while 24% reported having a Master’s degree. Within MPA, 68% of members report having a doctorate and 28% a master’s degree. (See Table 1). Overall, respondents to the survey as well as those who indicated being members of MPA reported having a doctoral degree more frequently than a master’s degree (64% vs. 36%), while psychology licensees in Minnesota are about equally divided between the two degrees (2003 Survey of Minnesota Psychologists).

Seven hundred and eleven (approximately 27%) of all non-MPA member psychologists returned the survey. Four hundred and sixty-five MPA members responded to the survey (49% of membership).

Most respondents identified themselves as working in clinical settings (84.60%) compared to academic (6.48%) and other settings (8.92%). Demographic data are listed in Table 1. The average age of survey respondents is 53.5 (standard deviation = 9.38). The average age of MPA members who provide their age is 55.6 years. The average age of MPA members who completed the survey is 54.9 years (standard deviation = 9.44). In a survey (Kohout, Li, & Wicherski, 2007) of APA members, the mean age is 50.4 years.

**Table 1. Demographic Data**

<table>
<thead>
<tr>
<th>Highest degree for psychology practice</th>
<th>All responses</th>
<th>MPA members</th>
<th>All responses</th>
<th>MPA members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctorate</td>
<td>756</td>
<td>354</td>
<td>64.01</td>
<td>76.46</td>
</tr>
<tr>
<td>Master’s</td>
<td>425</td>
<td>109</td>
<td>35.99</td>
<td>23.54</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member of MPA</th>
<th>All responses</th>
<th>MPA members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>465</td>
<td>39.54</td>
</tr>
<tr>
<td>No</td>
<td>711</td>
<td>60.46</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary work setting</th>
<th>All responses</th>
<th>MPA members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academic</td>
<td>77</td>
<td>27</td>
</tr>
<tr>
<td>Clinical</td>
<td>1005</td>
<td>405</td>
</tr>
<tr>
<td>Other</td>
<td>106</td>
<td>33</td>
</tr>
</tbody>
</table>

Sixty-four percent of all respondents support RxP for properly trained psychologists (see Table 2). MPA members and non-MPA members support RxP in approximately equal measure (65% vs. 64%). Psychologists whose highest degree is a doctorate support RxP slightly less frequently than those whose highest degree is a master’s (63% vs. 67%). Sixty-four percent of those who work both in academic and clinical settings along with 67% of those who identified themselves as working in other settings support RxP. Those between the ages of 40-49 were most likely to support RxP (70%), followed by those 60 and older (65%), 50-59 (64%), and younger than 40 (64%).

**CONTINUED ON PAGE 14**
Table 2. Survey Question #1: I support prescriptive authority in Minnesota for psychologists who receive training that would be defined in state law if and when legislation is passed.

<table>
<thead>
<tr>
<th></th>
<th>Percent Strongly Support or Support</th>
<th>Percent Do Not Support or Strongly Do Not Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Psychologists</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>MPA Members</td>
<td>65</td>
<td>35</td>
</tr>
<tr>
<td>Non-MPA Members</td>
<td>64</td>
<td>35</td>
</tr>
<tr>
<td>Doctorate</td>
<td>63</td>
<td>37</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>67</td>
<td>33</td>
</tr>
<tr>
<td>Academic Work Setting</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>Clinical Work Setting</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>Other Work Setting</td>
<td>67</td>
<td>33</td>
</tr>
<tr>
<td>&lt; 40 Years Old</td>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>40-49 Years Old</td>
<td>70</td>
<td>30</td>
</tr>
<tr>
<td>50-59 Years Old</td>
<td>64</td>
<td>35</td>
</tr>
<tr>
<td>&gt; 60 Years Old</td>
<td>65</td>
<td>34</td>
</tr>
</tbody>
</table>

Sixty-three percent of the respondents think the MPA should support RxP (see Table 3). Both MPA members and non-members believe that the MPA should support RxP (62% and 63%). Sixty-one percent of psychologists whose highest degree is a doctorate compared to 66% of those whose highest degree is a master’s think that the MPA should support RxP. Those who work in academic settings were least likely to believe that the MPA should support RxP (60%), compared to 63% in clinical settings, and 67% in other settings. Age group did not differentiate beliefs about whether the MPA should support RxP (<40 = 62%, 40-49 = 62%, 50-59 = 63%, >60 = 64%).

Table 3. Survey Question #2: The MPA should support prescriptive authority for properly trained psychologists.
Thirty-three percent of those who completed the survey said that they would pursue training to prescribe if and when legislation is enacted (see Table 4). Twenty-eight percent of MPA members would pursue training compared to 35% of non-members. Those psychologists whose highest degree is a master’s expressed slightly greater interest in RxP training than those whose highest degree is a doctorate (35% compared to 31%). Those who work in clinical and “other” work settings expressed more interest in pursuing training than those who work in academic settings (33%, 35%, and 22% respectively). Younger psychologists expressed a greater interest in pursuing training than older psychologists (<40 = 37%, 40-49 = 41%, 50-59 = 31%, >60 = 28%).

Table 4. Survey Question #3: I would pursue training to prescribe if and when legislation is enacted.

<table>
<thead>
<tr>
<th></th>
<th>Percent Strongly Support or Support</th>
<th>Percent Do Not Support or Strongly Do Not Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Psychologists</td>
<td>33</td>
<td>67</td>
</tr>
<tr>
<td>MPA Members</td>
<td>28</td>
<td>72</td>
</tr>
<tr>
<td>Non-MPA Members</td>
<td>35</td>
<td>65</td>
</tr>
<tr>
<td>Doctorate</td>
<td>31</td>
<td>69</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>35</td>
<td>65</td>
</tr>
<tr>
<td>Academic Work Setting</td>
<td>22</td>
<td>76</td>
</tr>
<tr>
<td>Clinical Work Setting</td>
<td>33</td>
<td>67</td>
</tr>
<tr>
<td>Other Work Setting</td>
<td>35</td>
<td>65</td>
</tr>
<tr>
<td>&lt;40 Years Old</td>
<td>37</td>
<td>53</td>
</tr>
<tr>
<td>40-49 Years Old</td>
<td>41</td>
<td>59</td>
</tr>
<tr>
<td>50-59 Years Old</td>
<td>31</td>
<td>69</td>
</tr>
<tr>
<td>&gt;60 Years Old</td>
<td>28</td>
<td>72</td>
</tr>
</tbody>
</table>

Discussion

More Minnesota psychologists support RxP and believe that the MPA should support RxP than those who do not. Psychologists’ support of RxP is consistent with results found nationally (Sammons et al., 2000) and in a previous survey in Minnesota (Ritchie, 1996). This finding did not vary noticeably regardless of membership in the MPA, level of training (i.e., doctoral vs. master’s), work setting, or age. Fewer psychologists in Minnesota said that they would pursue RxP training if and when legislation is enacted than what Sammons (2000) reported (53%), but it is close to that reported in a more recent survey of New Jersey psychologists (Kapalka et al., 2004; 31%). This survey revealed that those in academic settings are less likely to pursue RxP training than those in clinical or other work settings, and younger psychologists are more likely to pursue training than older psychologists. MPA members reported that they would be less likely to pursue RxP training than non-members.

The primary rationale for this survey was to provide a clearer picture of Minnesota psychologists’ support of RxP in order to help the MPA determine a course of action regarding this issue. Prior to the survey, there was a lack of clarity regarding current support for RxP in Minnesota, and this handicapped those in governance in the organization from determining a course of action. Although one could argue that survey results from other states almost universally reveal psychologists’ support for RxP, it could (and was) argued that Minnesota psychologists are different. Further, due to the threats made by those few vocal members who oppose RxP, most governing council members had not been willing to take a stand on the issue, particularly when they were unable to cite solid data to support their position. These survey results provided one source of information necessary for those in governance in the organization to support RxP.

Among those who support RxP, there are those who question the need and even the wisdom of engaging the State Psychological Association (SPA) in deliberations about RxP. As I have discussed in this paper, the simple act of getting the SPA to agree to a survey took almost one year and completing the survey another year. Engaging most bureaucr...
cies in a process of decision making, commitment, and change is a time-consuming process. It is certainly less time consuming for several committed individuals to proceed in attempt to obtain RxP than to engage the SPA. Additionally, there are risks that by engaging the SPA in deliberations about RxP, the process will be further slowed and any legislation will not reflect the intentions of RxP proponents. However, there are also risks and drawbacks of not involving the SPA in deliberations about the advancement of the RxP initiative.

In Minnesota, as is probably the case in most states, psychologists who strongly support RxP and are willing to actively participate in the process of advancing legislation are few in number. This is true even though the majority of psychologists support RxP. A survey not only defuses the argument that psychologists in MN do not support RxP, but it also draws out supporters who are otherwise not connected with those who are seeking legislative authority for RxP in the state. This is important as it provides a base of psychologists who will seek training, lobby legislators, and contribute financially to RxP. More immediately, the survey provides a reason for continued discussion of RxP in the state. At the level of governance, supportive results provide SPA leaders with “cover” to support RxP and makes leadership opposition to RxP more difficult as it would be a stand that is contrary to the opinions of the majority of the membership. Thus, these results can be used as justification to support RxP as a response to the negative commentary that these results generate from opponents. Legislatively, it is important that the SPA supports RxP. It would be very difficult to pass RxP legislation if the SPA is not supportive. It is very helpful to have the SPA in support of RxP for financial purposes as APA only provides grants to SPAs to pursue RxP legislation. The APA does not provide grants to individuals or non-affiliated groups.

However, noninvolvement on the part of SPAs does not preclude pursuit of RxP legislation by committed individuals. The MPA sponsored this survey, but the results will be used by those of us who are also pursuing RxP outside of the association. By being involved in the SPA and generating organizational support for the RxP survey, this allowed those of us who are supporters to capitalize on the established infrastructure and resources of the SPA. For those of us who support RxP in Minnesota, this continues to be an appropriate strategy and, at this time, it also benefits the state association. As these survey results reveal, the majority of MN psychologists support RxP, and the SPA benefits by knowing this and, perhaps, acting on it.

To those who support RxP, the greatest risk in doing this type of survey was that psychologists in the state would not support RxP. For us in MN, the potential benefits of favorable results outweighed the risks of negative findings. If those opposed to RxP had outnumbered those in favor of it, it would have been difficult to make a case that the MPA should support this issue. However, in Minnesota this was not the case. Now, the stated association has data that can guide policy and RxP proponents have information that will help advance RxP regardless of the stand that the SPA ultimately takes.

References
Sethre, R. (1996a). MPA should have a civil, but also objective dialogue about whether to pursue RxP. Minnesota Psychologist, 55(6), 6-7.
The planning and implementation of the Department of Defense (DOD) Psychopharmacology Training Program for Psychologists in the 1990s ignited controversy among medical and psychological communities which debated issues from the philosophy of training Prescribing Psychologists to patient safety considerations. The termination of the initial DOD program when the ten authorized trainees had been graduated and the eventual separation from active duty or retirement of the majority of these trained Psychologists also served to maintain these debates and to raise the question of the viability of such training and service models.

That debate exists no more.

Even as some academic Psychologists themselves continue to position themselves against legislative prescriptive authority initiatives such as has been the recent case in Missouri, the pseudo-arguments against prescriptive authority have fallen prey to the reality of such authority. This reality has been accelerated by what few anticipated at the time, but what is always ultimately unavoidable as wars never “go away” but just change form: military conflict which requires a revision of military power and the inevitable revision of medical services within the Armed Forces. The increased recognition of and demand for mental health services within the Armed Forces has already led to an amplified need for Psychologists with a variety of skills, and the numbers of Soldiers with PTSD as well as concussion and more serious traumatic brain injuries (TBI) has also led to an enhanced emphasis upon the neurophysiological substrates of such disorders.

As military operations continued in Afghanistan in Operation Enduring Freedom (OEF) and in Iraq in Operation Iraqi Freedom (OIF), both Naval Captain Robert Younger and I were given assignments to the 785th Medical Company (Combat Stress Control) as part of the Surge associated with OIF 2007-2008. Captain Younger had been activated from his reserve unit and the Veteran’s Administration Hospital in Shreveport, Louisiana, and I had volunteered to be commissioned as a Regular Army Officer for my fourth tour of duty after having had a prior Cold War career. Since both of us have licenses in Louisiana as Prescribing Medical Psychologists and I have a license in New Mexico as a Conditional Prescribing Psychologist, we became the first Psychologists to enter active military service with State prescriptive authority.

After serving as the Officer-in-Charge of the largest outpatient mental health facility in the world at Carl R. Darnall Army Medical Center, Ft. Hood, Texas, I joined Capt. Younger as part of the 785th in Iraq, although we were stationed at opposite ends of the catchment area of the 785th. Working with over 400 Soldiers at Ft. Hood exposed to explosions with possible concussions at Ft. Hood gave me a good preparation for my OIF duties and helped me significantly with my prescriptive practice. This preparation was to be needed with the 785th, as this unit has proven to be one of the busiest, if not the single busiest CSC unit in the entire Global War on Terror. Comprised of about 85 mental health personnel and staff, the 785th had been activated from its Reserve status and sent to its second OIF deployment. Although headquartered at Victory Base Complex just northwest of Baghdad proper and completely surrounding the Baghdad International Airport, the 785th supported a number of detached operations at smaller Forward Operating Bases (FOBs) from Mahmudiyah in the South to Anaconda and Balad Air Force Base in the North. One of the identified challenges of the 785th, along with all other CSC units, was the challenge of providing adequate mental health services to Soldiers at remote outposts and who had difficulty coming to larger fixed bases for treatment.

During deployment, my duties involved writing over 2000 prescriptions and “circuit riding” between the Restoration Center at Camp Liberty (where Soldiers could receive an average of 3-4 days respite) to Camp Stryker, home of the 2nd Stryker Regiment and the 101st Airborne Division. Prescriptive authority allowed me to serve as a potent “force multiplier” in terms of services rendered, especially at Camp Stryker, where I was often the sole medication provider for psychotropics. My credentials were accepted at five different pharmacies with an unrestricted formulary, giving me great latitude in being able to provide services to troops being seen by the 785th, the associated Troop Medical Clinics, and at one of the major detention
centers for incarcerated terrorists. Having state licenses translated into ready acceptance by my colleagues, most of whom are used to a number of medical personnel having dual or multiple degrees and licenses. Without exception, a short explanation that I was dually degreed and held a prescriptive license was quite sufficient for those who had never heard of a Prescribing Medical Psychologist. Prescriptive authority also allowed me to develop quick and close relationships with other medical personnel such as the Physicians’ Assistants and medics who had much more interaction with the troops and who were more often “outside the wire” and able to visit the smaller FOBs and the even smaller community patrol bases.

One of the issues raised is that military Psychologists supposedly work with a young, healthy population, and that experience with some psychotropic agents or complicated cases is thus restricted. On the contrary, I found practice in a Combat Theater to be quite challenging, and the morbidity and complexity of some cases was often demanding. The harsh environment of Iraq and levels of hazard as well as work requirements place substantial physiological demand upon most Soldiers, and medication management must be accordingly adjusted. Since numbers of troops have been activated from Reserve and National Guard units, since some Soldiers are now older, and since services were also provided to some civilian contractors, medical conditions not usually expected were encountered. Brain abscess, cardiac conditions, diabetes, seizure activity, hypothyroidism, and remote developmental conditions proved to be among some of the complex cases handled. The necessity of insuring that troops were functioning adequately cognitively and not, for example, sedated while manning extremely dangerous equipment ranging from small arms to Paladin and Hellfire weapons platforms presented a constant skill demand for the prescribers. Added to this challenge was that some medications or doses were not always available and serum levels for mood stabilizers such as lithium and depakote could not be obtained. Soldiers requiring such management were generally deemed nondeployable. Some interesting cases were seen in which I specially ordered modafinil, using this agent successfully in cases of Circadian Rhythm Disorder and in one case of concussion from a suicide attacker with a hidden vest.

The challenge of reaching troops at the smaller posts remained, but was at least partially addressed by good relations with the Prevention Teams of the 785th, these teams constantly “jumping” via Blackhawk helicopters to visit forward troops. Knowing the capabilities of the Prescribing Psychologist as well as our other mental health professionals, our Prevention Teams were able to identify Soldiers at these forward posts and get them the help they needed. I was able to undertake one “Mission to Mahmudiyah” in which I met with the 785th team stationed there as well as the medics for this area. This mission enabled me to provide consultation, a lecture, and educational materials which aided their skill in using psychotropic medications considerably. Telemedicine was also frequently helpful, as when these outlying providers were educated as to the resources the 785th was able to provide. Clinicians were able to call in by phone or communicate via email for consultation on medication use. As a number of physicians tasked for TMC duties had specialties other than Psychiatry, Internal Medicine, or Neurology, such consultation seemed to be especially appreciated.

And finally, the acceptance and working relationship of both Capt. Younger and myself with our Psychiatric colleagues can be described as nothing short of excellent. As the sole Psychologist at Camp Liberty, I was often called upon to don my “other hats” and provide psychological assessment, research, and brain injury expertise to our Psychiatric and other mental health colleagues which would otherwise be unavailable. Prescriptive authority proved to be a substantial help in terms of flexibility, knowledge basis, and clinical services which were provided in a critical and efficient timeframe to serving troops. Even with a specialty in Neuropsychology, a better fundamental understanding of pharmacological functions of the nervous system also proved quite valuable with those troops experiencing TBI, PTSD, and often the combination of both. Judicious and skilled use of psychotropics additionally reduced the number and severity of side effects, as no serious side effects were ever seen with my cohort of patients, and the few side effects which occurred were minor, such as transient headache, stomach ache, or sweating. Many times, the ability to “unprescribe” was helpful as I could reduce or stop medications started previously which were no longer helpful or even problematic.

During World War II, four out of every five Psychologists was either directly or indirectly involved in the war effort and thus served the nation. In many respects, American Clinical Psychology owes its very existence to wartime demands and the support and experience of military service. As increasing numbers of Psychologists are trained and licensed in Clinical Psychopharmacology, the hope is that the ranks of those who are willing and able to serve the nation will multiply in order to see our troops to a successful conclusion in the War on Terror and to aid in the readjustment of all to our families and communities—the ultimate goal of all Soldiers.
certainly going to miss Elaine on the board, but thankfully she remains a member of the division.

Dr. Lenore Walker, RxP Training Director at Nova Southeastern University in Florida has graciously accepted appointment to Chair the Education and Training Committee. I am certain Lenore will perform admirably in this position.

I wish to acknowledge and publicly thank several other individuals whose hard work, mostly behind the scenes, helps to keep our division stable: Dr. Gordon Herz, who manages our listserv and website; Dr. Anton Tolman, who Chairs the Chapter Chairs; Dr. Warren Rice, Continuing Education Director; and Dr. Jeff Matranga, Editor of the Tablet, who soon will be handing the reigns over to a successor.

Finally, I would be remiss not to mention the recent outstanding accomplishments of several other D55 members. Remarkably, Dr. Alan Hopewell has been awarded the Bronze Star Medal for meritorious service in Operation Iraqi Freedom. Alan is the only Army Prescribing Psychologist ever to be assigned to a combat theater. We owe Alan a great debt of gratitude. As we all know, Dr. James Bray, former D55 Treasurer, was elected APA President. D55 member and RxP advocate, Dr. Katherine Nordal, is our new Executive Director of the APA Practice Directorate. We look forward to a fruitful and long standing working relationship with Katherine. Last, but certainly not least, congratulations to Dr. Elaine LeVine who was appointed to the Committee for the Advancement of Professional Practice.

Hope to see you in Boston!
<table>
<thead>
<tr>
<th>Committee</th>
<th>Chair</th>
<th>Co-Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-Based Research Committee</td>
<td>Beth Rom-Rymer, Ph.D.</td>
<td></td>
</tr>
<tr>
<td>Federal Advocacy Coordinator</td>
<td>Gilbert Sanders, Ph.D.</td>
<td></td>
</tr>
<tr>
<td>Pediatric Population Committee</td>
<td>George Kapalka, Ph.D.</td>
<td></td>
</tr>
<tr>
<td>Gerontology Psychopharmacology Committee</td>
<td>Merla Arnold, Ph.D.</td>
<td>Beth Rom-Rymer, Ph.D.</td>
</tr>
<tr>
<td>International Psychology Committee</td>
<td>Martin Gittelman, Ph.D.</td>
<td></td>
</tr>
<tr>
<td>Membership Committee</td>
<td>Beth Rom-Rymer, Ph.D.</td>
<td></td>
</tr>
<tr>
<td>Web Page</td>
<td>Gordon Herz, Ph.D.</td>
<td></td>
</tr>
<tr>
<td>ABPP</td>
<td>Beth Rom-Rymer, Ph.D.</td>
<td></td>
</tr>
<tr>
<td>Fellows Committee</td>
<td>Alan Gruber, D.S.W., Ph.D., M.D.</td>
<td></td>
</tr>
<tr>
<td>Practice Guidelines Committee</td>
<td>Bob McGrath, Ph.D.</td>
<td></td>
</tr>
<tr>
<td>Special Populations Committee</td>
<td>Victor De La Cancela, Ph.D., MPH,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ABPP, FICPP (ethnic);</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Susan Patchin, Psy.D. (rural),</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elaine Mantell, Ph.D. (women)</td>
<td></td>
</tr>
<tr>
<td>S.W.A.A.T. Committee</td>
<td>Owen Nichols, Ph.D.</td>
<td></td>
</tr>
<tr>
<td>Tablet</td>
<td>Jeff Matranga, Ph.D., ABPP</td>
<td>Lauren Holleb, M.A.</td>
</tr>
<tr>
<td>RxP National Task Force</td>
<td>Mario Marquez, Ph.D., ABMP</td>
<td></td>
</tr>
<tr>
<td>Early Career Psychologist</td>
<td>John Fitzgerald, Ph.D.</td>
<td></td>
</tr>
<tr>
<td>Media</td>
<td>Nina Tocci, Ph. D.</td>
<td></td>
</tr>
</tbody>
</table>

The American Psychological Association
Division Services Office/Div 55
750 First Street NE
Washington DC 20002-4242