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The Time for Change Has Arrived– Will We Do Our Part?

Pat DeLeon, Ph.D.

One of the most moving moments of my APA Presidency was asking Ruby Takanishi to present a Presidential citation to our colleague John Gardner, former Secretary of the Department of Health, Education, and Welfare (HEW) during the Great Society days of President Lyndon Johnson. The Secretary possessed an interesting perspective, especially relevant today – "What we have before us are some breathtaking opportunities disguised as insoluble problems (1965)."

At the end of last year, prior to taking office or releasing concrete policy proposals, Secretary-designate Tom Daschle participated in a public forum (expected to be one of 8,500 such forums that the Obama Administration will ultimately hold nationwide) designed to engage the American people about their thoughts and recommendations for how our nation's health care system could work better. Numerous health policy experts and business leaders would concur with the Wall Street Journal's view that: "The U.S. spends $2.3 trillion per year on health care – almost twice as much per person as other industrialized nations – but we aren't getting what we pay for. Studies show that fully a third of spending is wasted on treatments, drugs, and tests that don't improve Americans' health outcomes and that adults receive recommended treatments for many illnesses only 55% of the time. Economists warn that unless we can eliminate excess spending and put health-care dollars to better use, rising health-care costs will present a growing threat to our global...



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President's Column

The Sad Parable of the Second Generation Antipsychotics and the Clinical Practice of Psychopharmacology

Morgan Sammons, Ph.D., ABPP

As I write my first presidential column for Division 55, we are confronted yet again with increasing evidence that the practice of clinical psychopharmacology as we know it is undergoing tremendous upheaval. An article in the 15 January 2008 Wall Street Journal, in addition to one publicizing the latest findings of cardiovascular risk associated with antipsychotics, reported that Eli Lilly, the manufacturer of Zyprexa, had agreed on a 1.42B settlement to the federal government to resolve charges of improper marketing. These articles also reported what we have known for some time – that newer antipsychotic drugs, regardless of agent, are no more safe than the first generation of antipsychotics, but that they have captured a tremendous share of the market – over 90% of all...

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From the Editor– The Importance of Mentors to the RxP Movement

Laura Holcomb, Ph.D., MS lholcomb@hpmaine.com



I am excited about the opportunity to contribute to the RxP cause through becoming the new Division 55 Tablet editor. I look forward to learning from your submissions (please send to email address above). Thanks to Jeff Matranga, Ph.D., ABPP for his competent and dedicated service as the previous Tablet editor, and for taking on the role of APA 2009 Convention Program Chair for Division 55.

I have always believed in the importance of psychotropic medication as a tool for treating mental illness, especially for severe mental illness. In fact, I followed the pre-medical specialization track in my undergraduate psychology studies, considering going to medical school to become a psychiatrist. I had hoped to have the opportunity to utilize a combination of the relationship with the patient, psychotherapy, and psychotropic medications to help patients.

But after learning that the direction of psychiatry was becoming increasingly locked into the brief medication consult, without the luxury of time for the kind of therapeutic relationship I wanted to develop with patients, nor the amount of specific training in psychological diagnosis and treatment, I decided to pursue a doctorate in clinical psychology. I assumed that this decision would mean that I would not have the opportunity to develop expertise in the use of psychotropic medication, which was a sacrifice that seemed necessary, given my priorities. And given my focus in graduate school on developing skills in diagnostics and psychotherapy, I might have forgotten about my interest in psychopharmacology, if it were not for the impact of a few special psychologist mentors.

I was fortunate that **Gerald Strauss, Ph.D.**, first Chair of the RxP Task Force of the Ohio Psychological Association, was my supervisor in the Primary Care Psychology rotation during my pre-doctoral health psychology internship at the Veterans Affairs Medical Center in Cleveland, Ohio. Dr. Strauss has a unique background as a surgical Physician's Assistant, prior to becoming a psychologist and then completing training in clinical psychopharmacology. In the context of health psychology training in the Primary Care Clinic, he began to educate me about the appropriate use of psychotropic medications in combination with psychological treatments. I was surprised and excited to observe that Dr. Strauss was the "go to" person for the physicians related to information about prescribing psychotropic medications. He encouraged me to continue my education in psychopharmacology at the postdoctoral level, and to get involved with Division 55. He continues to mentor other health psychology pre-doctoral interns at the Cleveland VAMC. Please see his article on pg. 6 about the development of privileges for trained psychologists at the Cleveland VAMC to prescribe nicotine replacement therapy.

Robert Ferguson, Ph.D. continued the tutelage during my Behavioral Medicine Postdoctoral Internship at Dartmouth Medical School. He taught me to provide general guidance about classes of psychotropic medications (limited to the scope of my competence and training), in combination with education about psychological treatments, to physicians in the Internal Medicine department who were seeking consultation about patients' mental health needs. He also emphasized educating physicians about when to consider avoidance or discontinuation of psychotropic medication, such as with the potential for benzodiazepines, especially when taken PRN, to interfere with cognitive behavioral treatment of anxiety.

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Sammons, *President's Column*, continued



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antipsychotic sales are for second, rather than first generation agents. These facts present a very perplexing set of circumstances that directly affect the movement of psychologists to prescribe medication. How? Let me explain.

One of the chief paradoxes that has confronted clinical psychopharmacology since the modern era began with the introduction of the first effective antipsychotic, chlorpromazine, into clinical practice in the early 1950s. This paradox is that while subsequent generations of drugs, be they anxiolytics, mood stabilizers, antipsychotics, or antidepressants, are generally *safer*, they are no more effective than their forebears. Citalopram, or any of the SRIs, is of no greater efficacy than imipramine. Its benefits accrue through an enhanced safety profile, tolerability of side effects, and ease of administration. Diazepam is no more effective as an anxiolytic than phenobarbital, but risk of death in overdose is dramatically lower. You get the ...

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Sammons, *President's Column*, continued

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picture, safety and tolerability have improved, efficacy in general has stayed constant. In spite of the inability to improve efficacy, however, use of these agents has increased dramatically. Ease of administration (no blood tests, no cumbersome dosing regimens), the confidence that low lethality agents give providers, and treatment fads that affect both patients and providers have led to dramatic increases in use and a willingness to use them for non-indicated conditions and in populations (e.g., children) for whom safety and efficacy have not been established.

One would suppose, then, that this same scenario would apply to second generation antipsychotics: no more efficacious, but safer and more tolerable. This is unfortunately not the case. Newer antipsychotics, as evidence increasingly suggests, are neither safer than earlier drugs (we will put clozapine into a special safety category) nor do they possess a more tolerable side effect profile (weight gain and metabolic derangements are likely more problematic with the SGAs than with low-potency phenothiazines; the relative risk of severe cardiac problems is around the same for all antipsychotics). Yet they have captured over 90% of the antipsychotic market – a fact that utterly dismays state mental health budget managers, who end up paying dramatically higher prices for medications that are neither safer nor more effective than earlier antipsychotics. Think of the *opportunity cost* of all that money going to SGAs – how many patients could be afforded psychotherapy, or an effective community based treatment, if we weren't wasting all that money on SGAs?

It is very tempting to place all the blame for this on the unscrupulous marketing tactics of pharmaceutical firms, and certainly there is some culpability there. But this explanation, as appealing as it might be, doesn't tell the whole story and the rest of the story doesn't reflect very well on us, mental health professionals who prescribe, or recommend, the prescription of psychotropic drugs. Only by accepting our responsibility can we hope to improve the clinical practice of psychopharmacology.

Any new psychotropic has pretty remarkable seductive power over clinicians. This is because the agents we currently use aren't curative, and that most patients get some, but not a whole lot better, by using them. This reality frustrates both clinicians and patients who of course are looking for more substantive and lasting relief. So with only modestly potent medicines to choose from, we're always looking for the next better thing. I think we were especially vulnerable to the seduction of the SGAs because we had racked up such negative experiences with first generation agents. Not because they were inherently worse or more dangerous, as we have seen, but because we were using them as a blunt instrument in the treatment of psychosis. We started with the false premise that these were curative agents and then, frustrated when the cures did not occur, fell prey to the fallacy that befalls those who hold blunt instruments – we thought that if we swung them harder they'd work better. They didn't, but we dug ourselves into a therapeutic hole from which the SGAs promised rescue. Consequently, we were more than willing to be seduced by (and pay a premium price for), the supposed advantage of a new medication that could save us from our previous failings. Believers in cognitive dissonance would tell us that this investment of hope allowed us to disregard mounting evidence that we were paying for more than we got.

The tragedy is not that we fell prey to these false hopes but that we continue to ignore the reality around us. We are overusing the SGAs, just as we overused first generation agents, and we are using them inappropriately (at least until recently, the greatest proportional increase in the use of such agents was in adolescents without psychotic spectrum diagnoses). Fear of tardive dyskinesia, the brake that slowed the use of the first generation agents, is not an effective modulator when the SGAs are concerned. Only now are we becoming appropriately concerned about other risks they convey.

You may think that I have a pretty dismal attitude towards the use of antipsychotics or other psychotropics, but that's not the case. I don't argue for their abandonment, but for their rational use, and I'm particularly encouraged that we, as psychologists, can bring a new and better perspective to this field of clinical practice. It was, after all, a psychologist (Irving Kirsch) who was among the first to remind us of the large placebo effect associated with antidepressants. Likewise, another psychologist (Alan Bellack) was among the first to warn us that the SGAs didn't work to improve social functioning, or the negative symptoms, in schizophrenia.

So I do think we have the opportunity to set the example and lead the clinical field. We are taught to be more questioning of the clinical literature than perhaps our colleagues in medicine are. We are taught to be skeptical of easy solutions, (e.g., those that come in pill form). We understand that the complexities of our patient's problems cannot be reduced to a single line on a multiaxial diagnosis. We can use this wisdom to inform our practices, educate our patients, and reform the clinical use of SGAs and other commonly employed psychotropics. I look forward to working on this with you over the coming year.

Interview with David Barlow, Ph.D., ABPP

Laura Holcomb, Ph.D.



David Barlow, Ph.D., ABPP has published profusely in the area of emotional disorders and clinical research methodology. He is currently Professor of Psychology and Psychiatry, and Founder and Director Emeritus of the Center for Anxiety and Related Disorders at Boston University.

Dr. Barlow is the recipient of the 2000 American Psychological Association (APA) Distinguished Scientific Award for the Applications of Psychology. He is also the recipient of the First Annual Science Dissemination Award from the Society for a Science of Clinical Psychology of the APA; and recipient of the 2000 Distinguished Scientific Contribution Award from the Society of Clinical Psychology of the APA.

He is Past-President of the Society of Clinical Psychology of the American Psychological Association and the Association for Behavioral and Cognitive Therapies, past-Editor of the journals Behavior Therapy, Journal of Applied Behavior Analysis, and Clinical Psychology: Science and Practice, and currently Editor in Chief of the "Treatments that Work" series for Oxford University Press.

He was Chair of the American Psychological Association Task Force of Psychological Intervention Guidelines, was a member of the DSM-IV Task Force of the American Psychiatric Association, and was a Co-Chair of the Work Group for revising the anxiety disorder categories. He is also a Diplomat in Clinical Psychology of the American Board of Professional Psychology and maintains a private practice.

What is your view on prescribing privileges for Psychologists?

I spent the first ten years of my career in departments of psychiatry, first at the University of Mississippi Medical Center and then at Brown University, where I also had a joint appointment in the Department of Psychology. In each setting, I set up and ran Clinical Psychology Internship Programs but was also heavily involved in day-to-day inpatient and outpatient service delivery both as a direct provider and in a supervisory role. Since psychiatrists and psychiatric residents were always part of the team, I became immersed in psychotropic medication issues very early, both from a clinical and later from a research perspective.

I learned two things. First, medications can be very useful and, indeed, essential in some instances such as for the psychotic disorders. But these interventions are clearly enhanced when they are integrated with the new generation of powerful psychological treatments targeted to specific forms of psychopathology, even for psychotic disorders.

It also became clear that psychologists on staff and in training became quite proficient in their knowledge of medications. After leaving the training program many former trainees in practice became informal consultants to primary care providers on the most appropriate use of medications for both adults and children. Since many of our trainees went on to positions where this knowledge of medications came in handy, I concluded early on that psychologists, with appropriate additional training, could easily join the ranks of numerous other non-physician health professionals who now have (limited) prescription privileges in their areas of expertise. The individual most in the forefront of my mind is my daughter-in-law, who prescribes the full range of medications in her role as a very competent Nurse Practitioner in Tennessee working in Women's Health.

You are well known for your expertise in the area of anxiety disorders. What do you see as the appropriate role of psychotropic medication vs. therapy in the treatment of anxiety disorders?

As we learn more about the nature of psychopathology and the prognosis of various conditions, we understand better that medications play a very different role from disorder to disorder. In the anxiety disorders in particular, the latest medications most indicated are the SSRIs which have proven time and again in clinical trials to be about equally effective to powerful psychological treatments in the short term; that is, after approximately three months of treatment. But once all treatments are discontinued, evidence shows in study after study that the effects of psychological treatments are more lasting. In other words, there is less relapse (Craske & Barlow 2008). The one exception to this scenario is obsessive-compulsive disorder, where the most powerful psychological treatment, exposure and response prevention, is more effective than medication at all stages of the treatment process (Franklin & Foa, 2008).

There is also a myth that has been propagated, mostly by "Big Pharma," that concurrently combining drugs and psychological treatments for anxiety disorders is the best course of action. In fact, in study after study combining an SSRI with a psychological treatment confers no additional advantage and, of course, is more expensive than simply administering one treatment (monotherapy). Even with depression, results from administering both antidepressants and psychological treatments are ambiguous, although several large clinical trials do show an advantage to combination treatment, at least for the most severely depressed patients (Hollon, Stewart, & Strunk, 2006). Thus, for the anxiety disorders at least, most clinical practice guidelines from independent health agencies recommend monotherapy, with the psychological treatment administered first if the expertise is available, since psychological treatments are less intrusive than medications with fewer side effects, and are generally preferred as a first choice by consumers.

What is your opinion about the use of benzodiazepines for anxiety?

In the case of benzodiazepines, it is a well

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Holcomb, *Interview with David Barlow, Ph.D., ABPP*, continued

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known fact that these drugs interfere with the new learning that goes on in good psychological treatments for anxiety disorders. But it may be that the benzodiazepines developed a bad rap in the last decade because they were used inappropriately, and that psychologists might be in a better position to make use of them in an advantageous way.

Interestingly, some of my colleagues discovered over a decade ago a way to combine benzodiazepines and psychological treatments that can be highly effective in some patients, (Spiegel, Bruce, Gregg, & Nuzzarello. 1994; Spiegel, Wiegel, Baker & Greene, 2000). What we do is prescribe high potency benzodiazepines such as alprazolam (Xanax) at customary starting dosages and rates of titration for a two to three week period, with a firm contract with the patient to discontinue at that point, in order to give them time to start the psychological treatment. When we do it this way, we find that patients receive some immediate benefit, often within one day, but are then able to discontinue the benzodiazepines after two to three weeks while continuing on with the psychological treatment. With this particular "sequential" combination, patients remained largely better at an eight-year follow -up.

Are there certain patients who benefit most from this approach?

Patients who benefit most from this approach are those with a need to overcome phobic behavior quickly, such as the patient with agoraphobia in our clinic who desperately wanted to be at her daughter's wedding in the west coast in 2 weeks but had not flown or even been far from the house for years.

Any other thoughts about the use of psychotropics in the treatment of anxiety?

There is a new generation of drugs coming online that I refer to as "psychological drugs," since they are only effective in combination with psychological procedures. The best example of this is a drug called D-cycloserine (DCS), which is actually an old antibiotic. Neuroscientists have discovered that this drug, which is an N-methyl-D-aspartate (NMDA) partial agonist, actually works to enhance the creation of memories associated with the extinction of fear process during exposure therapies (Hofmann, 2007; Norberg, Krystal, & Tolin, 2008).

The drug is only administered acutely, meaning just before the psychological treatment sessions, and therefore, obviously, is best managed by a psychologist. Preliminary studies with DCS show some remarkable results across a wide range of anxiety disorders. It may be that other "psychological drugs" such as DCS, with strong theoretical and empirical underpinnings as to why they would integrate well with psychological treatments will be coming online, and psychologists would be in a good position to administer them.

Do you have a "take-home message" for psychologists seeking prescription privileges?

I believe that it is inevitable that prescription privileges will be available to psychologists in the coming years. The major policy players in our health care system are in favor of this development (with the exception of the medical profession) due to economic and health care availability reasons. In fact, I believe some very major changes under consideration at a national level (but still confidential) may well provide the "tipping point" for these privileges over the next several years.

In terms of a "take home message," I think all of us hope that as these privileges become available, psychologists will not fall into the trap that many physicians have of succumbing to the very real pressures to rely on medications as the principle therapeutic agent, at the expense of our newly developed arsenal of powerful psychological treatments for reasons of economics or convenience. If psychologists simply fall back on prescribing and then doing a bit of supportive psychotherapy every week or two, this would be a distinct disadvantage for the patient, particularly since physicians will always be the primary "go to" professional for medications.

But as psychologists assert their primacy in administering powerful psychological treatments, which will always be their principle expertise, then the judicious use or management of medications, including discontinuation, will be a very valuable skill indeed.

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Training VA Psychologists to Prescribe Nicotine Replacement Therapy Products: The Foot in the Door Technique

Gerald Strauss, Ph.D.



Gerald J Strauss, Ph.D. is the Section Chief of Clinical Health Psychology at the Louis Stokes, Cleveland, Department of Veterans Affairs Medical Center. He is a Past -President of the Ohio Psychological Association and was OPA's first Chair of the RxP Task Force.

A number of years ago, prior to nicotine replacement products (NRPs) becoming over-the-counter (OTC), psychologists at the Cleveland Department of Veterans Affairs Medical Center (DVAMC) had to hunt down physicians and request that a prescription be written for the nicotine patch or gum, to complement the behavioral treatment we were offering patients with smoking addictions. This method of practice was cumbersome and an inefficient use of time and effort. Through discussion with our medical and nursing colleagues, we developed a plan to gain limited, supervised prescriptive authority for nicotine replacement products.

This plan was based on what our nurse practitioners (NPs) continue to utilize today for their prescriptive authority at the VA. That is, the NPs complete a form which lists the limited formulary medications they will be prescribing in their clinical area, cite a physician overseer who will loosely supervise the prescribing practices, have their department chief and Chief of Staff (COS) sign the form, and file the form with the Medical Staff Office. The psychologists who were providing smoking cessation treatments at our DVAMC assumed the NP model of limited prescriptive authority for nicotine replacement products about 10 years ago. As with the NPs, the psychologists who were writing prescriptions for nicotine replacement products were required to resubmit newly signed forms to the Medical Staff Office on a yearly basis.

The above procedure continued until 2005. The procedure then changed at the recommendation of the COS. The process of change started when I visited his office to procure his yearly signature on my prescribing form. I was surprised when he said, "Why don't you psychologists add nicotine prescribing privileges to your credentialing package instead of having to go through this yearly process?" Well, I know an opportunity when I see one. The stage was set.

On returning to my office, a call was placed to the Chief of Psychology who was told of the conversation with the COS. I suggested that a training program be instituted for psychologists wishing nicotine replacement product prescribing privileges, and that those psychologists who were already prescribing under the NP model be grandfathered in with full privileges. We then brought in the Psychology Service, Director of Training for consultation.

We developed a plan for curriculum development for psychologist training to prescribe NRP's. Various articles and books were chosen to reflect both a behavioral and pharmacological approach to treatment of nicotine addiction. Once the literature was selected, an email went out to our health psychologists (HPs) to determine who might be interested in training. Three licensed HPs came forward.

The curriculum was designed as "self-management". That is, the HPs read chosen articles or book chapters and then we all convened to discuss what was read. We met for a 1-2 hour discussion, every week or two, for approximately 3 months. An oral examination of the reviewed literature was administered to the psychologists at this time.

After completing the didactic portion of the curriculum and successfully passing the oral exam, a supervision practicum began where the HPs worked up a number of patients and put forth a behavioral and pharmacological plan of treatment. I provided supervision of the cases, with a Beginning of Supervision form being signed by each of the HPs. After the HPs worked up a number of patients (approximately 10-20) and felt comfortable, a Completion of Supervision form was signed and sent to the medical center's Medical Executive Committee, where the nicotine prescriptive authority was granted. The VA pharmacy was then notified and the prescribing psychologist was given access to write prescription orders in the Computerized Patient Record System (CPRS).

Currently, the prescribing psychologists can write prescription orders for nicotine gum, patches, and lozenges. One might ask, "If NRPs are OTC, why are prescriptions needed?" Within the VA, such products are still prescription orders filled by the VA pharmacy. Nicotine replacement products are free for our veterans because we view tobacco abuse to be a nexus to many of the other medical co-morbidities we treat.

Since the initial training of the three HPs, I have trained another HP and four other VA psychologists who work in Community Based Outpatient Clinics (CBOC). The same articles and books were utilized as in the initial training; however, the discussion groups were held through video conferencing and the supervised

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Strauss, VA *Psychologists Prescribe Nicotine Replacement*, continued

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practica were completed through clinical notes, emails, and telephone conversations. The CBOC psychologists have now all completed their practica, and are awaiting approval from the Executive Committee.

Below is the Privileging Form we devised that our appropriately trained psychologists use in requesting prescriptive authority for NRPs (see Table 1 below).

The Next Hurdle:

In that this training was well organized and well received by the Medical Executive Committee and prescribing psychologists, the next logical step is to develop plans to expand the prescription authority to include other medications to treat nicotine addiction. Most notably in the pharmacology armamentarium to address smoking cessation are Bupropion (Zyban, Wellbutrin) and Varenicline (Chantix) as well as some older generation and less used medications. I suspect this plan will be met with significant resistance by some of our colleagues and, thus, the argument necessary for this strategy to succeed will need to be well thought out. Data necessary to convince the powers that be will most likely come from The Department of Defense Psychopharmacology Demonstration Project as well as the current knowledge that, with full prescriptive authority, medical psychologists in Louisiana and prescribing psychologists in New Mexico have not had any complaints filed against them.

Political realities will also play a role. While detractors will be obvious, we will need to garner VA medical and pharmacy supporters who are willing to be equally vocal. I plan to adapt our current curriculum to include additional literature needed to address the expanded formulary. Additionally, I believe it will be necessary to enlist PharmD and/or physician colleagues to act as supervisors during the practicum portion of the training. It may be that we will have to initiate the training first. That is, to have psychologists fully trained by completing the enhanced didactic and supervision curricula, then move toward privileging through the Medical Executive Committee. A number of strategies are currently under discussion.

Ultimate Plans:

It is well known that, for years, Pat DeLeon, Ph.D. has argued that the Veterans Health Administration (i.e., Department of Veterans Affairs Medical Centers) is an ideal setting to promulgate a psychopharmacology training program for psychologists. It is my hope that within the not-too-distant future we can expand upon the curriculum to educate interested psychologists in pharmacological treatment of smoking addiction, and have instituted a fully functioning psychopharmacology training program at the Cleveland DVAMC.

Table 1. Privilege Form

Prescriptive Authority for Nicotine Replacement Products: The prescribing psychologists must be familiar with the literature on nicotine addiction; the Transtheoretical model of behavior change; motivational interviewing techniques; evidence-based cognitive-behavioral methods of fostering tobacco cessation; the pharmacokinetics, pharmacodynamics, and drug interactions with nicotine replacement products; and the VA/DOD Clinical Practice Guidelines for Managing Tobacco Use-Update 2004. The prescribing psychologist will have read and be familiar with the Cleveland VA Medical Center Policy 11-25 *Physician's Orders*, Louis Stokes, Cleveland, DVA Medical Center By-laws, and VA Circular 10-91-117. The psychologist agrees to abide by the parameters of his/her scope of practice and all Medical Center polices and procedures.

Criteria for Privileging: *Prescribing authority for nicotine replacement products:* Psychologists currently with prescriptive authority for nicotine replacement products under a functional statement may be granted the full privilege. A senior prescribing psychologist will supervise a psychologist applying for his special privileged for a period of six months. Upon satisfactory completion the mentoring process, the psychologist may be granted prescriptive authority for nicotine replacement products.

Requested:

Full Privileges____ **Supervised Privileges____**

DeLeon, *Time for Change,* continued

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competitiveness and long-term fiscal security." Some experts would even put the level of inappropriate spending as high as 50%. Fortunately for psychology (and other non-physician disciplines), there is a growing consensus that greater priority must be given to prevention and wellness care.

Those interested in psychology's prescriptive authority (RxP) quest must appreciate that above all else, our prescribing colleagues are providing **Quality Care** that can be documented.

When those who oppose testify before their legislature, for example: "I am opposed to this measure because it advocates for a public policy that lowers the standard of quality medical care for Hawai'i's people suffering from behavioral and mental health illnesses that may require psychotropic medications," we should demand that they present the empirical evidence for their emotionally-based, outlandish statements. Glenn Ally reports: "No one is really keeping count of the number of Rx's written any longer…. including refills, orders in hospitals, patients on multiple medications; and orders to reduce, consolidate, and/or discontinue medications. I would venture to say that we have written more than 200,000. We have been writing prescriptions for a little over three years now, and we have been doing so in a variety of settings and, I might add, doing it safely…. (W)e have not had a single complaint against a medical psychologist in the three years since our statute was implemented."

Katherine Nordal reports that the Practice Directorate expects that as many as 12 states may introduce RxP legislation this year and for the first time ever, CAPP will not be able tosay "yes" to every state. Having worked on Capitol Hill for three and a half decades, I have learned that not only are politics always local, developing substantive policy agendas, such as RxP, truly requires local, as well as national, involvement. Accordingly, I would rhetorically ask: How many of us have actually met with members our own state legislature regarding RxP? And, what percentage of Division 55's membership actually contributes to Katherine's RxP Action Fund? Do we really do our part?

Undoubtedly, every one of us, from time to time, gets the feeling that the most recent generation of graduates knows so much more than we ever did, as we quietly wonder whether we would ever have been accepted into graduate school these days. The Institute of Medicine (IOM) report Genes, Behavior, and the Social Environment: Moving Beyond the Nature/ Nuture Debate (2006) definitely could give a number of us with clinical degrees pause, even if we minored in statistics. Former APA Science Directorate staff Christine Hartel, along with a number of her psychology colleagues, provides an exciting vision for the future, reviewing the state of the science on the interactions between the social environment and genetics that affect human health. Future research will often be **transdisciplinary** in nature.

During the 20th century, great strides were made in reducing disease and improving the health of individuals and populations. Public health measures such as sanitation, improved hygiene, and vaccines led to major reductions in mortality and morbidity. Increased attention to the hazards of the workplace resulted in reduced injuries and better health for workers. Advances in biomedical research helped expand knowledge of disease and spurred the development of new clinical and pharmaceutical interventions. The sequencing of the human genome has provided information that holds the promise for further improving human health. Congressional testimony by the various National Institutes of Health (NIH) Directors conveys their sense of excitement, while frequently referencing the NIH "roadmap."

As behavioral scientists, we appreciate that a large body of evidence has emerged indicating that social and behavioral factors such as socioeconomic status, smoking, diet, and alcohol use are important determinants of health. Recent studies also suggest that examining interactions among genetic and social-environmental factors could greatly enhance our understanding of health and illness. For example, there is evidence of a "gene-by-environment" interaction, in which the individual's response to environmental insults is moderated by his or her genetic makeup. And, that the socioeconomic status of communities can be associated with variations in central nervous system serotonergic responsivity, which may have implications for the prevalence of psychological disorders and behaviors such as depression, impulse aggression, and suicide.

Contributions from research conducted over the past few decades are pushing scientists to move beyond examining single agents of health and disease to a broader systems view which is based on the understanding that health outcomes are the result of multiple determinants and their interactions. Understanding the associations between health and interactions among social, behavioral, and genetic factors requires research that embraces the systems view and includes an examination of the interactive pathways through which these factors operate to affect health. This requires the participation of scientific investigators from a variety of different fields

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DeLeon, *Time for Change*, continued

(Continued from pt. 8)

and a shift from efforts that are dominated by single disciplines, to research that involves collaborative participation of scientists with various expertise at all stages of the research process.

While interdisciplinary research focuses on answering questions of mutual concern to those from various disciplines and multidisciplinary research involves research questions of both mutual and separate interest to participating investigators, **Transdisciplinary Research** implies the conceptualization of research questions that transcend the individual departments or specialized knowledge bases because they are intended to solve research questions that are, by definition, beyond the purview of the individual disciplines.

The context or culture within which individuals exist is known to exert influence on health outcomes. Relevant social and cultural environments include not only an individual's immediate personal environment (e.g., his or her family), but also the broader social contexts such as the community in which a person resides. Health psychologists are increasingly calling attention to the critical role of sociocultural context, a necessary factor to consider if efforts to modify risk behaviors are to be effective.

Many determinants of health are not static; That is, they influence health in a variety of ways throughout the life course. And yet, as Christine Hartel points out, currently most of the statistical software commonly used for epidemiologic analysis includes tests for interaction on a multiplicative scale but not on an additive scale. Thus, testing for interactions on an additive scale requires the development of new, accessible statistical software.

In recent years, attempts to determine why some people are healthy while others experience pain and illness most often have focused on the biological aspects of health. Again, however, a large body of evidence has emerged that indicates that, "almost half of all causes of mortality in the United States are linked to social and behavioral factors." Similarly, the totality of evidence suggests that education per se is a causal variable in improving health.

Health outcomes are multi-determined and result from complex interactions of many factors over time. Nevertheless, the study of health outcomes is still driven primarily by disciplines that focus upon their own unique areas of expertise and we would suggest, far too often, medical school dominated. If the study of health outcomes is to advance, investigators must break out of these disciplinary "silos" and attack the determinants of health in concert.

Those working closely with academic institutions have an appreciation for how difficult this necessary evolution will be to achieve. Those providing clinical services should appreciate that psychology obtaining RxP is absolutely critical for America's vision of a cost-effective, empirically-based, patient-centered 21st century healthcare environment. The time for change has arrived – Will we do our part?

Pat DeLeon, Ph.D., ABPP *is affectionately known as the Father of RxP. He was President of the American Psychological Association (APA) in 2000. He won the Division 55 award for National Contributions to Psychpharmacology in 2001 and the Division 55 Meritorious Service award in 2008.*

Holcomb, *From the Editor– The Importance of Mentors*, continued

(Continued from pg. 2)

Before moving to Maine, Dr. Ferguson was Co-Chair of the group of psychologists advocating RxP in New Hampshire.

My most recent mentor was **Jeff Matranga, Ph.D., ABPP**, former Tablet editor and current APA Convention program coordinator. I joined his practice of health psychologists in Waterville, Maine in 2002. At the time, he was entering his first year of the Postdoctoral Masters Program in Clinical Psychopharmacology at the Massachusetts School of Professional Psychology (MSPP). He was supportive of me entering the MSPP program in 2003, for which I was quite grateful. Being a year ahead of me in graduating from the program at MSPP, completing internship hours, and integrating psychopharmacology consultation to local physicians into the context of private practice, he provided me with valuable mentoring and encouragement as I followed in his footsteps. He is now co-chair of the Psychopharmacology Subcommittee of the Maine Psychological Association.

Because of my experiences with these wonderful mentors who have greatly influenced my career path, I believe that mentoring of graduate students, postdocs, and psychologist colleagues interested in RxP is a very important and powerful way to increase support for and/or involvement in psychopharmacology training and RxP. I would like to thank all of my mentors, as well as those of you who mentor in this area and are, thus, greatly contributing to the future of RxP and of psychology as a whole.

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