As I write this column, the spring legislative cycle is winding down in a number of states. We had a great deal of activity with prescriptive authority legislation. Unfortunately, none of our bills succeeded (the bill in Oregon is still in play, and thanks to the stalwart efforts of Robin Henderson, Doug Marlow, and the Oregon Psychological Association, has passed out of committee and is headed for a full house vote the first week in May). Bills in North Dakota, Montana, Missouri, Hawaii and Tennessee stalled in committee or were not, for various reasons, brought to a vote. The incredible lobbying efforts of the Tennessee Psychological Association, led by Lance Laurence, Connie Paul, Keith Hulse and their extraordinary team pushed their bill the furthest it has been. They estimate that they were within one vote of passage but, feeling uncertain that they could capture that vote, wisely chose not to advance the bill. While some may argue with this strategy, I am in absolute support of their decision. It’s far better to withdraw a bill that you don’t think has a reasonable chance of success than to see a legislative defeat. The numerous psychologists who attended the Division 55 midwinter meeting in Nashville (at over 75 attendees, one of the most successful midwinter meetings we have had, again my kudos to Micki Levin and the superb organizing committee in Tennessee) provided direct support, fanning out across the Tennessee capitol on the first day of the legislative session and doing a superlative job of educating legislators. The reception hosted by the Tennessee Psychological Association held immediately after the Governor’s State of the State address attracted almost 2/3rds of Tennessee legislators and was an astonishing lobbying effort. Hosted by TPA president Mark Phillips along with APA President James Bray (whose fluency in drawl no doubt helped sway numerous legislators), it was one of the best organized events I’ve seen any psychology group put on. In spite of these extraordinarily dedicated psychologists and first rate lobbying initiatives, our bills haven’t had a lot of success. I think it’s useful to look at some of the reasons why – if we’re making mistakes, we should fix them. If we’re not effective in addressing the opposition’s arguments,...

(Continued on pg. 2)
From the Editor—RxP Legislative Efforts Issue
Laura Holcomb, Ph.D., MSCP  lholcomb@hpmaine.com

If you have been reading posts on the Division 55 Listserv lately, you know that members of Division 55 have been working very hard in 2009 on RxP legislative efforts. An impressive number of members joined forces during the well-attended (75+!) Division 55 Midwinter Conference to support the lobbying efforts of the Tennessee Psychological Association (Go Tennessee, my home state!). Many other states have also been working diligently to further the RxP cause, with a number of states introducing bills this legislative season (ND, MO, MT, IL, HI, OR, TN). As this edition goes to print, a bill has just been passed in the Oregon House, and we are all hoping for a good outcome in the Oregon Senate.

Morgan Sammons, Ph.D., ABPP, in his President’s Column, spearheads this issue in taking an honest look at where we are with RxP legislative efforts, giving deserved praise to those who have committed themselves to furthering RxP, while also encouraging us to “get smarter” in our approach. Division 55 members, Kathy Parker, Psy.D., MSCP from Illinois, LCDR Michael Tilus, Psy.D., MSCP from North Dakota, and Earl Sutherland, Ph.D., MSCP from Montana, have been gracious enough to represent their states in reporting and reflecting on their recent legislative efforts in pursuit of prescription privileges for qualified psychologists. I have also invited Brian Bigelow, Ph.D. to educate us about legislative efforts for RxP in Ontario, Canada.

Also related to legislative efforts,...

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Sammons, President’s Column, continued

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can we collectively devise more effective counterarguments?

Let’s face it. Every other non-physician health care profession has been much more successful in passing their prescriptive authority legislation than have we. Nurse practitioners can now prescribe medications in all 50 states and the District of Columbia. They have completely independent prescriptive authority for all medications, including controlled substances in 14 states, and prescriptive authority for all classes of medication with some physician involvement in another 33 states. There are now approximately 168,000 nurse practitioners in the United States. Physician Assistants are authorized to prescribe in 49 states. Although technically practicing under physician supervision, their scope of practice is continually expanding. Optometrists have expanded their scope of practice to include therapeutic as well as diagnostic agents in all US jurisdictions. Optometrists now treat glaucoma in 49 states plus the District of Columbia and Guam; prescribe systemic (oral) medications in 47 states, the District of Columbia and Guam; have the ability to prescribe controlled substances in 43 states and Guam; and utilize injectable agents in 32 states plus the District of Columbia. In the past 30 years, optometrists have been able to pass 173 laws expanding optometrists’ ability to prescribe or treat ocular disorders (even including surgical privileges); none have been repealed. There are now approximately 34,000 Certified Registered Nurse Anesthetists in the US, who administer 65% of all anesthetics delivered in this country.

Pharmacists continue to expand their scopes of practice. As of 1999, 24 states allowed some kind of collaborative practice agreement with physicians (the aforementioned data are abstracted from my contribution to...
Sammons, President’s Column, continued

Fox, DeLeon, Newman, Sammons, Dunivin, & Baker, Prescriptive Authority and Psychology: A status report, accepted for publication in the American Psychologist.

There is nothing to suggest that we will be less effective or safe as a group of practitioners than any of these other non-physician healthcare provider groups. The data from the Department of Defense’s Psychopharmacology Demonstration Project, and the absence of negative data from the now approximately 100 prescribing psychologists outside of the DOD, are strong testimonial to the fact that we do, like any other nonphysician group that has acquired prescriptive authority, practice both safely and effectively. As I argued some years ago, at the faintest hint of evidence that we might be prescribing unsafely, there would be an unimaginable hue and cry from organized medicine and patient safety groups (I called this the “dog in the nighttime” argument). The dog in the nighttime that guards patient safety simply hasn’t barked.

We also know that we are on absolutely solid ground when the access issue is addressed. Access to mental health services is getting worse, not better. Our colleague Mary Beth Kenkel, Dean of the College of Liberal Arts at Florida International University, reminded us of an article published in the April 2009 issue of Health Affairs (http://newsletters.commonwealthfund.org/rt/1840/17138/408/0/) reporting that two-thirds of US primary care physicians could not get outpatient mental health services for their patients. It was twice as difficult for these physicians to get mental health referrals, than to get referrals to any other specialty. A shortage of providers was one of the top reasons why referrals were impossible to obtain. Our opponents in organized medicine continue to try and blink this argument away. They propose a number of alternatives, such as better training for primary care providers, utilization of telehealth, or other means to better extend the supply of skilled providers of mental health services. But the bottom line is that these ideas never seem to make it past lobbying efforts, and we have yet to see truly original ideas, or follow through on any ideas, originate from medicine about how to fix this problem. By their fervid opposition to expanding the scope of practice of psychologists and other nonphysicians, they are endorsing the status quo — at costs to our patients that can be measured in very real terms, not lobbyist generated fears about patient outcome (In one state where I made a legislative appearance this year -to remain nameless- a lobbyist for our bill confessed that in years past he had been a lobbyist for the state medical association, and had gone before the legislature arguing that an epidemic of blindness would ensue if optometrists got authority to prescribe therapeutic drugs — an error to which he graciously owned up to in supporting our bill). By opposing appropriately trained psychologists the right to prescribe, it must be accepted that organized medicine is sacrificing patient well-being in favor of narrow professional interests. The issue is increasingly not a professional turf issue. It is a moral one.

We’ve made plenty of mistakes. We’ve introduced bills hastily without coordinating with our state and national associations (in one state, the state psychological association didn’t even know the bill was being introduced!). We’ve introduced bills without first doing the vital grassroots legwork that is essential to ensure passage. We’ve pretended that fund-raising doesn’t really matter (it does). We’ve turned down proposed legislation that advocates an incremental approach to prescriptive authority authority (i.e., first working under the authority of another prescriber) in spite of the fact that this is how our colleagues in nursing and other professions had their initial successes. We’ve relied on a few absolutely committed individuals in each state to do 99% of the work. We’ve been reluctant to reach out to...

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There are those who believe that Illinois may be the last state to gain prescriptive authority for psychologists, since the AMA is based here in Chicago. Our 2009 progress with IL HB527 would suggest otherwise.

Illinois is fortunate to have a strong RxP team in various regions of the state, and to be standing on the shoulders of RxP giants like Marlin Hoover, Pat Pimental, and Beth Rom-Rymer. Connie Natvig and I, co-chairs of the RxP subcommittee of IPA’s legislative committee (and relative newcomers to political activity), realize that the tremendous movement that we have seen with our current legislation would not have been possible without the many years of tireless effort and organization by Illinois RxP leaders like Marlin Hoover. Although Marlin is extremely busy with his practices in Illinois and New Mexico, as well as his teaching responsibilities with FDU, he continues to be available as a mentor, advisor and active RxP team member.

On 2/19/09, our HB 527 had a hearing in the House Health Care Licenses Committee, just one week after it was assigned to committee. What was different this year from previous legislative years was that our sponsor was from Danville, a small downstate town that typifies the lack of access to psychiatric care in rural communities. Representative William Black passionately testified that the one psychiatrist in Danville was leaving on 3/1/09 when the MHC closed due to funding cuts. What was also different this year at the hearing was the turnout of psychologists in support of the bill. There were 16 psychologists, wearing badges saying “SUPPORT ILLINOIS MEDICAL PSYCHOLOGISTS” sitting in the first two rows of the small hearing room, outnumbering the 6 representatives of the Illinois Medical Society. We were given more time to testify than in past years, and had representatives from the Center for Rural Psychology speak to the access issue and the availability of psychologists to meet rural mental health needs. Although we did not have enough votes to pass the bill out of committee at the time of the hearing, our sponsor managed to keep the bill in committee, giving us more time to gather grassroots support for a later hearing and vote.

Here are a few new things that we're doing this year that may be helpful with other states’ RxP efforts. Inspired by President Obama’s campaign success with the internet, we started a Facebook group called “Support Illinois Medical Psychologists.” Besides a description of HB 527 and the RxP movement in Illinois, it provides a link to our video and the capwiz link so group members can contact their legislator to support the bill. We also recently developed a website named ILFACT.org, designed to gain grassroots support. Our video is on You Tube and we have a Google campaign that links viewers to our IPA website page on Medical Psychologists and the capwiz link. Additionally, we have a Yahoo group for Illinois and another for the Midwest States where we can share information and organize our efforts.

We’ve been doing several RxP presentations to NAMI groups throughout the state, and committee members have joined their local NAMI chapter. Even though the NAMI organization has remained neutral on RxP, we have found that individual NAMI members have become quite vocal about access to mental health services and have been willing to support our bill and contact their legislators. We’re hoping that more consumers and family members will come forward and share their stories of struggles with access to psychiatric services.

We’ve also been making RxP...

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presentations at professional psychology schools in Illinois and have a large group of IPAGS students who have brought a great deal of energy to the RxP movement.

Our RxP brochures are in psychologists’ waiting rooms throughout the state and guide consumers about how to be supportive of our bill. We’re also working on strategies to mobilize support from medical and mental health providers, particularly those in underserved areas. In addition, the RxP committee is exploring ways to use various media to our advantage.

Recently, supporters of RxP have withstood attacks on the IPA Listserve from an IPA member who is also a member of POPPP. Maybe it’s because of the momentum that RxP is generating, but this person appeared very threatened by the recent RxP efforts and attempted to convince others that our bill was dead by making numerous inaccurate statements. This member’s statements resulted in a long discussion of RxP on the Listserve, which allowed us to educate and inform members as well as to sharpen our arguments and prepare us for future opposition to RxP.

While Illinois might not be the next state to gain prescriptive authority for psychologists, I am sure we will not be the last. Our lobbyist and IPA executive director have expressed encouragement about the progress and movement of this year’s bill. Despite my optimism, I am realistic enough to know that passing RxP legislation in Illinois will involve overcoming formidable opposition. But to paraphrase Randy Pausch from his Last Lecture, the brick walls exist to show how badly we want something. And we want it, not for ourselves or for our profession, but for those we have dedicated our lives to serving… those who aren’t always able to advocate for themselves.

Kathy Parker, Psy.D., MSCP is a Clinical Psychologist at Chicago-Read Mental Health Center, a state hospital in IL. She recently graduated from Alliant’s MSCP program as one of the Division 18 Public Sector psychologists. She serves as co-chair of the RxP legislation subcommittee of IPA’s Legislative Committee.

**Update on RxP Legislative Efforts in Montana**

Earl Sutherland, Ph.D., MSCP

The RxP bill submitted in the 2009 Montana Senate died in committee, yet the efforts and accomplishments that culminated in that bill continue on. Foremost among those accomplishments was obtaining the formal support for prescribing psychologists by the Billings Area Chief Medical Officers (CMOs) of the Indian Health Service (IHS). The Billings Area encompasses Montana and Wyoming and officially supports the training and recruitment of prescribing psychologists.

The Billings Area IHS facilities are the physical and mental health providers to the most underserved rural citizens of Montana and Wyoming. The quest for prescribing psychologists in Montana has, in large part, developed as a means to better serve the mental health needs of Native Americans. Currently there are four psychologists in Montana who have completed post-doctoral degrees in Clinical Psychopharmacology and all four are IHS employees.

RxP legislative efforts started in the 2007 legislative session with Senator Weinberg’s intent to file a bill for prescription privileging for psychologists.

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Sutherland, RxP Update In Montana, continued

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That bill passed out of committee but failed in the full senate. In support of RxP the Montana Psychological Association (MPA) marshaled efforts to support the bill and provide testimony. Over the next two years MPA sponsored RxP education at state association conferences and invited legislators to attend. MPA partnered with Alliant International University (AIU) to bring RxP training to the state. AIU generously provided logistical support and the expert training offered at the state conferences. During that time IHS psychologists completed RxP training and started a dialogue within IHS about obtaining formal support for prescribing psychologists. In late 2007 an IHS RxP trained psychologist was selected to chair the MPA RxP committee.

In 2008 the Bureau of Indian Affairs (BIA) and IHS agreed to jointly hold their annual conferences in Billings, Montana. IHS psychologists who were actively involved in RxP were offered the opportunity to help plan that conference. RxP presentations were offered at the joint conference that August and included psychologists from the Aberdeen and Billings Areas, Alliant University, Division 18 and Division 55 as well as MPA. Montana legislators were also invited to that conference. As a direct result of the information presented at that conference Billings Area psychologists were invited to make a presentation on RxP at the September Area CMOs meeting. That conference also resulted in an offer from a senior state senator to carry an RxP bill in the upcoming 2009 legislative session.

At the September meeting a Billings Area RxP trained psychologist presented the proposed prescribing psychologist training and credentialing model to the CMOs. Scope of practice for IHS psychologists is determined by their state licenses. There are currently two states in the nation that authorize psychologists to prescribe. Recommended training standards were modeled after the New Mexico requirements for prescribing psychologists. The model was embraced enthusiastically by participating CMOs. In fact, the CMO for the only service unit without an RxP trained psychologist requested information about how to recruit such a psychologist.

Although MPA did not qualify for a full CAPP grant, it did receive an emergency grant in December of 2008 and combined that money with other donations from MPA members and Division 55 members to secure additional lobbying support. Senator Jonathan Windy Boy was asked to carry the RxP bill and the entire Native American Caucus signed on in support. The bill was initially tabled in the senate health committee. A committee member who had signed on as a sponsor voted against the RxP bill. Senator Windy Boy cast the deciding vote that killed that senator’s seatbelt bill and that action seems to have been the explanation as to why he would vote against a bill he had agreed to support. The committee chairman had agreed to support RxP in the summer but seems to have changed his mind after losing his race for governor and seems to have consistently voted against any bill with a democrat as a primary sponsor. It was also discovered that the committee chair had physicians as his primary campaign contributors. In contrast to the 2007 session the governor refused to let any state agencies testify in support of any legislation.

An amended bill was later presented to the senate committee and for two minutes was voted out. The chairman voiced his opinion that there would not be enough time to have the amended bill written and submitted to the full senate before the mandatory transmittal deadline to the house. A committee member who had just voted to pass the amended RxP bill then moved to again table the bill. The bill was tabled by a one vote majority.

At the time three Billings area RxP...
psychologists are beginning their supervision and clinical training for New Mexico licensure. Their on site supervision will be provided by an IHS physician and the Area office is contracting for their specialty supervision. The Area office has also recently advertised for an RxP trained psychologist to fill the Behavioral Health Branch Chief position. When the Montana legislature meets again in 2011 there will be prescribing psychologists already working in the state who will be able to testify about their safety and competence.

Earl Sutherland, Ph.D., MS in Clinical Psychopharmacology, is the Director, Behavioral Health, Crow/N. Cheyenne Hospital, Indian Health Service. He is a Member at Large on the Board of Directors of Division 55.

Update on Legislative Efforts in RxP in North Dakota

LCDR Michael Tilus, Psy.D., MSCP

For the first time in North Dakota legislative history, North Dakota Representative Nancy Johnson from District 37 in Dickinson, North Dakota, and the Healthy 8 Communities Network, sponsored House Bill 1488 in January of 2009. HB 1488 authorizes appropriately trained, doctoral level psychologists authority to prescribe psychotropics in conjunction with their regular psychological duties.

Representative Johnson who serves as the Chair of Healthy 8 Communities Network and the Healthy 8 Coalition decided to present their need to the ND legislative session after the Dickinson community lost their only psychiatrist to retirement. Even though the physician gave the Dickinson hospital and community a two year advance notice of his impending retirement, they were unable to recruit a replacement. With the absence of a psychiatrist, the hospital was forced to close its inpatient psychiatric unit. Currently psychiatric patients from Dickinson must travel (one-way) 100 miles to Bismarck, ND, 131 miles to Williston, ND, 200 miles to Jamestown, ND, or 320 miles west to Billings, MT to receive psychiatric care. Consequently, this event has created much discussion on the issue of how prescribing psychologists can help fill the gaps of psychiatric services in rural ND.

A list of the ND licensed physicians by specialty, dated Jan 13, 2009, reveals that there are only 102 licensed psychiatrists in the state. This number includes four out-of-state psychiatrists and twenty psychiatric residents. Of the remaining 98 in-state psychiatrists, the four largest towns in ND boast 87 psychiatrists total, with Fargo showing 59 (60%), Bismarck with 13 (13%), Grand Forks with 8 (8%), and Minot with 7 (7%). The remaining 11 psychiatrists are listed as serving in Jamestown with 7 (7%), Devils Lake with 2 (2%), and Williston with 1 (1%) and Belcourt with 1 (1%). In essence, this leaves the vast majority of the state and many entire counties underserved with regard to psychiatric care.

A list of ND psychologists given to the writer by the ND Board of Psychology in January 2009 has a total of 201 licensed psychologists. Thirty-one psychologists serve out of state. The remaining 170 in-state psychologists reside in the four largest towns in ND respectively with Fargo hosting 50 (29%), Grand Forks with 50 (29%), Bismarck with 21 (12%), and Minot with 18 (11%). Dickinson and Jamestown list 6 psychologists each (4%). And the remaining 15 (9%) are in smaller towns throughout the state. In summary, the 8 counties that make...
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Tilus, RxP Update In North Dakota, continued

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up the Healthy 8 Coalition Network have 0 psychiatrists and just 6 psychologists. All eight counties have significant physical isolation from specialty health care providers. The extremely harsh winter climate impacts the ability of many ND residents to find and keep medical appointments. There are approximately 38,365 residents living in the Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark counties in the over 10,000 square mile area of southwestern North Dakota that the Healthy 8 Coalition Network and ND Representative Johnson are hoping to serve. In addition, there is a substantial American Indian population from the Mandan, Hidatsa, and Arikara Nations (the Three Affiliated Tribes) located on Fort Berthold Reservation that makes their home in the northern part of Dunn County.

As a better way to serve her constituents, in October 2008 Representative Johnson contacted me and requested a briefing and fact finding hearing for the Healthy 8 Committee on the requirements, training, scope of practice, and other legislative efforts of the psychologists who gained prescriptive authority in other states. Following this meeting, the coalition voted unanimously to request that Representative Johnson sponsor an RxP prescriptive authority bill.

That same month, I contacted the North Dakota Psychological Association leadership, inviting them to be a co-sponsor with Representative Johnson and the Healthy 8 Coalition. NDPA leadership believed the NDPA membership was generally ambivalent about the RxP issue, thought there was little energy for this issue, and did not wish to invest any “time, money, or energy into the RxP project.” The NDPA Board later formally chose a public position of neutrality.

In January 2009, ND Representative Johnson introduced HB 1488 into the Human Services Committee hearing and offered testimony. She was eloquent and persuasive—using key statements from Dr’s Morgan Sammons, Mario Marquez, Mark Muse, Robert McGrath, Howard Rubin, Bret Moore, Steven Tulkin, and Kevin McGuinness. Representative Johnson received, and presented to the House Committee, many supportive documents from national RxP psychology champions, APA President Dr. James Bray, Division 18 and 55 leadership, and local physicians, pharmacists, and psychologists. I offered testimony as a private, non-partisan, citizen who is currently practicing in the Indian Health Service on active duty with the US Public Health Service and a part-time private ND practitioner. I discussed the training requirements of an RxP psychologist, national APA standards and testing, and medical and supervisory practicum and preceptorship. Dr. Brenda King (former psychiatric nurse who went back to school for her doctorate in psychology and is now a clinical psychologist interested in RxP) offered profound personal and professional testimony given her past nursing history and current work as a psychologist.

The ND Medical Association and ND Psychiatric Association testified against the bill, arguing that there was (1) no problem with access to psychiatric care; (2) if psychologists want to prescribe they need to go to medical school; (3) the military experiment of prescribing psychologists was a “failure” and they had to close it; and (4) prescribing psychologists would be a public health hazard. At one point a psychiatrist testified that it would be “safer to have a veterinarian who prescribes medicine for your pet dog to prescribe for your child, than have a psychologist prescribe for your child.”

North Dakota Psychological Association President Dr. Paul Kolstoe testified last on behalf of NDPA, stating NDPA was “neutral concerning, HB 1488.”

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On February 11, 2009, Representative Johnson reported to me that HB 1488 got out of the committee with a “Do Pass” recommendation on a 7-6 vote. Five psychiatrists with two attorneys were present during this session, answering questions. In the end, the committee considered “access” as the critical point. HB 1488 was sent to the House for open floor debate.

On President’s Day of February 16, 2009, in open debate on the House floor, HB 1488 drew an animated response. ND Representative Porter threw the psychiatry party lines down, inspiring fear, public health hazard, and a special line about “psychologists have 400 hours of training, but even first graders in elementary school need 700 hours to graduate.”

Representative Johnson and two other House members spoke in support of the bill, while three spoke against it. Representative Weize, the Chairperson for the Human Services Committee, speaking as a member of the community, argued to fail the Committee’s prior “pass” vote. He summarized the committee’s concerns with two points: “Why didn’t the North Dakota Psychological Association support the bill? They are hoping to expand their scope of practice? This concerned us. Second, they only have 400 hours versus 1000’s of hours of medical doctors.”

HB 1488 was defeated with 38 yea votes, 54 nay votes, and 2 no votes.

Mark Muse, Ph.D. and Bob McGrath, Ph.D. have been working on specific ways to address the argument that RxP training is not adequate for sound prescribing practice when compared to medical school training. While those of us who have completed a Postdoctoral Masters in Clinical Psychopharmacology know that the training is extensive, legislators being influenced by the powerful physician community often do not understand this fact, and are swayed by turf-based arguments lacking basis in fact. The work by Drs. Muse and McGrath on quantifying RxP training compared to that received in medical school will undoubtedly be a valuable asset in RxP legislative efforts in the future. Please be sure to see Dr. Muse’s follow-up note on page 16 indicating that full results of their study are in press which will show that RxP trained psychologists receive greater than four times the formal instruction in pharmacology than do entry-level (MD/DO) physicians.

Finally, another important consideration to make relevant to further legislative efforts toward RxP, as well as to the future of psychology as a whole, is what the impact of impending health care reform, which is being promised by President Obama in the very near future, will be. Pat DeLeon, Ph.D., JD, ABPP, takes a look at the prospect of health care reform, and some things to consider as we look at the ways in which what psychologists have to offer are important to the discussion of the future of health care in the United States. As psychologists with RxP training, we are in a unique position to contribute to access and improved quality of mental health care. A climate of health care change will hopefully result in legislators being increasingly receptive to what we have to offer.

I welcome submissions of further state RxP updates. I am also hoping for submissions from prescribing psychologists in Louisiana and New Mexico, sharing your experiences to inform and further inspire those fighting for RxP in other states. Please send all submissions to lholcomb@hpmaine.com.
From all indications, we will see the enactment of Health Care Reform legislation this calendar year. President Obama has made it clear that this is a very high personal priority and one which directly relates to his vision of a vibrant and growing democracy. His February address before the Joint Session of Congress: “We will rebuild, we will recover, and the United States of America will emerge stronger than before…. The cost of health care eats up more and more of our savings each year, yet we keep delaying reform…. Now is the time to jumpstart job creation, re-start lending, and invest in areas like energy, health care, and education that will grow our economy, even as we make the hard choices to bring our deficit down…. [Health care] is a cost that now causes a bankruptcy in American every 30 seconds…. It is one of the major reasons why small businesses close their doors and corporations ship jobs overseas. And it’s one of the largest and fastest-growing parts of our budget. Given these facts, we can no longer afford to put health care reform on hold. Already we have done more to advance the cause of health care reform in the last thirty days than we have in the last decade…. I suffer no illusions that this will be an easy process. It will be hard. But I also know that nearly a century after Teddy Roosevelt first called for reform, the cost of our health care has weighed down our economy and the conscience of our Nation long enough. So let there be no doubt: health care reform cannot wait, it must not wait, and it will not wait another year.”

During her confirmation hearing to serve as Secretary of HHS, Governor Kathleen Sebelius echoed the President’s vision: “I know first-hand the challenge of standing up to the special interests to protect consumer interests…. Health care costs are crushing families, businesses, and government budgets. Since 2000, health insurance premiums have almost doubled and an additional 9 million Americans have become uninsured. Since 2004, the number of ‘under-insured’ families – those who pay for coverage but are unprotected against high costs – rose by 60 percent. The cost crisis in health care is worsening. The United States spent about $2.2 trillion on health care in 2007; $1 trillion more than what was spent in 1997, and half as much as is projected for 2018. High and rising health care costs have certainly contributed to the current economic crisis…."

From our Senate chief-of-staff meetings with the Administration and staff directors of the committees with health care jurisdiction, the same engaging message: controlling costs, improving quality and benefits, and taking advantage of new technology. One significant “inside the beltway” issue is whether those supportive of health care reform should use the budget reconciliation process as the legislative vehicle. Although not relevant in the House of Representatives where the majority party can almost always pass whatever legislation they wish, the consequence of such action would make a significant difference in the Senate where a unified minority can filibuster any other legislation by requiring 60 affirmative votes to proceed.

Senator Kent Conrad, Chairman of the Budget Committee: “The discretionary spending level in this conference report is $10 billion below the President’s proposal…. In addition, there are reconciliation instructions for health care and education. They require at least $2 billion in deficit reduction. I personally believe reconciliation, which is a special process here, a fast-track process, will not be used for health care because as people get into it, I think they will find it is a very difficult way to write major, substantive… (continued on pg. 11)
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legislation. My own prediction is that reconciliation will not be used for health care. The committees of jurisdiction have until October 15 to report legislation in the regular order of business using the regular procedure. I have talked with the chairman of the committee that has most of the responsibility for health care, and, of course, that is the Finance Committee. Senator Baucus says it is his full intention to proceed under the regular order, not using the reconciliation instruction. But it is there as an insurance policy….

“The third priority is fundamental health care reform, and that is accommodated in the conference report. We attempt to bend the health care cost curve to get costs under control, to improve health care outcomes for our nation’s people, to expand coverage because we have more than 40 million people now without any health care insurance. We increase research, especially devoted to those areas of highest opportunity to make meaningful progress, and we promote food and drug safety. Again, we do that in three ways with a reserve fund to accommodate the President’s initiative to reform the health care system; by funding for at least 2 years a reserve fund that further addresses Medicare physician payments; and continues investment in key health care programs, such as the NIH and the FDA…. While we have focused on these key priorities of the President – excellence in education, reducing our dependence on foreign energy, health care reform – we are doing it all in the context of dramatically reducing the deficit…..”

It is too early in the legislative process to ascertain whether health care reform legislation will specifically address the issue of adopting a “national scope of practice” for the various health professions. The wording of such an approach would be critical for psychology but probably not to those drafting the legislation. Historically, the federal government has deferred to state officials in this area. And yet, students of health policy will appreciate that the foundation is steadily being built for a comprehensive federal approach. In the Fall of 1998, the Pew Health Professions Commission, chaired by former Senate Majority Leader George Mitchell, released a series of reports proposing a new vision for our nation’s healthcare system. The Commission: “envisions a future regulatory system for the health professions that will undergo the following transformations to better serve the public interest: A move towards national standards…. Significant overlap of practice authority among the health professions…. New venues and participants for regulatory policy-making…. Integration of regulatory systems that protect health care consumers…. (And) Increased regulatory focus on quality of care and competence assurance.” Pew specifically recommended: “Congress should establish a national policy advisory body that will research, develop and publish national scopes of practice and continuing competency standards for state legislatures to implement.”

Psychology’s students of health policy should definitely recall that during her tenure as an APA Congressional Science Fellow on then-Senator Bill Bradley’s staff, Margy Heldring was instrumental in having the federal government (for the first time ever) set national health benefit standards for the private insurance market in preventing “drive through baby deliveries” on behalf of aggrieved consumers.

As a nation, we are rapidly moving into the 21st century with the unprecedented advances in the communications and technology fields having a dramatic impact upon our daily lives. It is clear that President Obama views this evolution as directly relevant to healthcare. His inaugural address: “Our capacity remains undiminished. But our time of standing pat, (continued on pg. 17)
Obtaining RxP legislation is first and foremost an education in how legal systems work and how to use them effectively. This is truly an education in its own right; my forays into the United States (e.g., Missouri) were very interesting and felt somehow strange compared to Ontario, Canada. It seems as if one form of democracy is perceived as caste in stone and that other forms simply don’t exist. I also recall being flabbergasted watching the California speaker of the house put her own two cents worth into the debate before the RxP vote was taken which resulted in a tabled decision. Up here in Canada, we have a common law parliamentary system, which behaves differently from an American state assembly. For example, the speaker of the house (in the legislative assembly) does not advocate for either side of the debate and makes an effort to stay out of the particulars, focusing on the process.

I was also intrigued by how very intensely political the American system is, with advocates for RxP button-holing senators and trying to get influence over the governor. Surprisingly, as well, unless the senate has enough votes for a bill, the governor can actually veto a decision, as in Hawaii. Our Governor is called the Premier and he would never have the power to veto a bill if the House of Commons was in favour of it. But then again, in Hawaii if the RxP bill is solidly supported then the governor cannot veto it.

So how do we move the RxP issue forward in Ontario? Firstly, we have to have our politicians in favour of the bill. In our case, this means that we have to persuade our Minister of Health. He listens to the public and to our Ontario Psychological Association. This is costing us a lot of lobbying money. (I have no idea what the equivalent to a minister is in the United States. We have ministers for health, education, municipal affairs, and so on. These ministers are in the Premier’s cabinet or his inner circle.) If the minister is in favour of the bill in question, then he has the Health Professions Regulatory Committee draft a working document for consideration by the Health Professions Regulatory Advisory Council (HPRAC). This is the regulatory committee that governs all health professions, from medicine and dentistry through to chiropractic medicine, as well as psychology.

Since the Minister of Health is in favour of expanding the scopes of practice of health disciplines, this position paper has to be deliberated by HPRAC which has the mandate of protecting the public firmly in mind. That is precisely where our paper sits until HPRAC is done with it. If HPRAC is in favour of the paper, then they will seek input from our College Council of the Psychologists of Ontario (CPO). Our CPO council is elected by our members. If the CPO is in favour of the paper, then it is, I believe, sent back to the Minister for further adjustments and then finally presented to the “floor” of the Ontario legislature. At this point the public debate begins. The “bill” at this point has to go through three stages or “readings”. If the final reading is approved, then it is sent to Senate and if approved again is proclaimed as law.

I hope this is all mostly correct. The ministerial system of government is relatively cumbersome, slow and heralds back to the days of colonial rule. Thus, it has a long history of checks and balances. But we have the RxP issue off the ground. Our Ontario government is keenly looking for ways to make efficiencies in health care, as health care currently accounts for about 53% of our Ontario tax budget and that clearly is unsustainable. We argue that psychologists can prescribe psychotropics cheaper and better. We all hope that they and our colleagues agree.

Any errors I own.

(continued on pg. 13)
Bigelow, Legislative Change in Ontario, continued

Dr. Brian J. Bigelow is a Registered Psychologist in the Province of Ontario with an ABPP in Child and Adolescent Clinical Psychology. He is a Full Professor and the Anglophone Director of the M.A. IM. Sc. in Human Development at Laurentian University. He also has a part-time independent practice, treating children and adolescents and performing related forensic assessments. Dr. Bigelow has completed the FICPP designation with the Prescribing Psychologists Register. He is currently on the RxP Task Force of the Ontario Psychological Association and is Secretary-Treasurer of the Psychopharmacology section of the Canadian Psychological Association.

Sammons, President’s Column, continued

our local legislators and establish the long term relationships we know are essential to passage of this type of legislation. We must continue to look at these processes and ensure we’re working shrewdly and effectively, and we will do this. But we must also accept that we’re dealing with a phenomenon that few if any other professions have had to deal with – vociferous opposition from within our own profession in the legislature.

I’m talking primarily, these days, about POPPP (Psychologists Opposed to Prescriptive Authority for Psychologists), a group of mostly academic psychologists whose arguments against prescriptive authority are remarkably similar to those of physicians. Here’s a snip from their website: “Rather than permitting psychologists to prescribe medications,” Sound familiar? It should. It’s the physician argument reproduced almost verbatim, argued in the face of a lack of evidence that the currently available models will ever be sufficient to meet the need. POPPP proponents also raise the patient safety argument, in spite of the absence of evidence that it has any validity. Now, I don’t think that the POPPP arguments turn the tide against us in any legislature. Lobbyists from organized medicine are much more daunting opponents. Yet by introducing this element of intraprofessional discord, POPPP likely can sway one or two wavering votes. And sometimes that’s all it takes.

I’m sure that our colleagues in POPPP believe in what they say, although there is clear evidence to refute many of the positions they put forward. But I’m also increasingly certain that they don’t represent the psychology of the future, which is a profession that needs far more than the counseling skills they advocate in order to survive in the healthcare marketplace. Instead, they hark back to a time when academic dispute was far more characteristic of the behavior of psychologists. What they fail to recognize is that as invigorating and intellectually appealing as such disputes were, they didn’t really matter to anyone outside the profession. As we’ve seen, expanding our scope of practice to include psycho-tropics matters quite a bit to large numbers of underserved patients. The outcome of this debate is far more important than any academic argument could ever be.

So carry on. We’re dealt a hard hand to compete against. Organized medicine is relentless in their turf-driven, heavily funded opposition. We need to get smarter about how we organize and ensure that our efforts are well-coordinated and strategically planned. To the extent that their arguments are more than reflexive opposition, we must find a mechanism for addressing the concerns of those within the profession who oppose prescriptive authority. Other professions have done it; we can do so as well. The stakes are too high to fail.
How does one compare medical school to RxP training in answering the assertion by those opposed to prescriptive authority for psychologists that anything short of medical school is deficient? The key to such an analysis is to demythify medical school. Medical school is, after all, so many hours spent in studying a particular curriculum. Yet, the problem lies in defining what goes into that curriculum, and how many hours are spent in each subject area. We all know that medical school lasts four years, but medical coursework is not divided into academic credits like the four-year doctorate in psychology, and there is no prescribed course of study, per se. While certain domains are suggested by national associations representing medical education (Liaison Committee on Medical Education, 2008; American Osteopathic Association 2009), individual medical schools draw up their own class list. And what is more, the classes are not of the standard 3 hour credits, but something more analogous to modules, workshops and practicum. A medical student passes a “year” not a class. There may be 10 content areas in a year, but they are not neatly divided into the equivalent of ten, three-hour courses leading to a standard 30 academic credit postgraduate year. So, how does one know if the amount of pharmacology, for example, in RxP training (approximately 20 graduate credit hours, or 300 contact hours) is equivalent to the amount of pharmacology that a medical student is exposed to? One way of doing this is to survey medical colleges and list the subject areas to which the student is exposed during any given year of study. If we assume an equal distribution of time across all subject areas, we could identify the number of subject areas formally identified as pertaining to pharmacology, and then assign the proportion of academic credit that the subject area represents in a year’s study (Muse & McGrath, in preparation). This is done for each year of study, and the sum of courses taken in pharmacology is assigned a total credit hour equivalent. This method would lead us to surmise, for example, that the first year of study at Yale Medical College (Yale, 2009) has no formal instruction in pharmacology, and that the second year requires one class in pharmacology out of nine subject areas. If we divide the relevant 2nd year’s 30 graduate academic credits by the number of subject areas, and extract the proportion that pharmacology comprises of that year, we arrive at approximately 3 credit hours for the first two years of medical school. Yale, as do many medical schools, divides its entry-level education into “preclinical years” (first two years), and “clinical years” (years 3 and 4). Year one, which spans 38 weeks, of Yale’s preclinical medical education contains the following content areas: Biochemistry, Cell Biology & Histology, Physiology, Immunobiology, Neurobiology, Pathology, Genetics, Human Anatomy, Professional Responsibility, Child & Adolescent Development, Clinical Epidemiology & Biostatistics, Biological Basis of Behavior, and Preclinical clerkship & Tutorial. If we were to assume that emphasis is equally distributed among the content areas, we would arrive at the following assignment of academic credit: 13 content areas divided into 1 year of full time studies (30 academic credits) = Approximately 2 credits per subject area. An alternative approach, which does not assume equal distribution of academic effort across all subject areas, would be to perform an item analysis of each content area. If we delve deeper into the Yale curriculum, for example, we find that all content areas are not equivalent in terms of time and effort spent. During the first year of medical studies at Yale, Biochemistry,...

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Cell Biology & Histology, Physiology, and Preclinical Clerkship & Tutorial span the entire 38 weeks of school, while Clinical Epidemiology & Biostatistics lasts 26 weeks, Human Anatomy lasts 21 weeks, Professional Responsibility 20 weeks, Neurobiology 12 weeks, Pathology eight weeks, Immunobiology, and Child & Adolescent Development both last seven weeks; Genetics, and Biological Basis of Behavior both four weeks. If we divide the 30 academic credits into the number of weeks spent per subject area, we come up with the following approximation: Biochemistry = 4 credits; Cell Biology & Histology = 4 credits; Physiology = 4 credits; Preclinical Internship and Tutorial = 4 credits; Clinical Epidemiology & Biostatistics = 3, Human Anatomy = 2 credits; Professional Responsibility = 2 credits; Neurobiology = 2 credits; Pathology = 2 credit; Child & Adolescent Development = 1 credit; Immunobiology = 1 credit; Genetic = ½ credit; Biological Basis of Behavior = ½ credit.

If we apply this second method of teasing out relative emphasis in the various content areas for calculating the number of credit hours spent formally studying pharmacology, we find that Yale’s second year is divided among different subjects, much like the first year, and that one such subject is Pharmacology. Pharmacology spans a 15 week period which, when its respective credit hours are calculated relative to other content areas of the second year (Microbiology, Epidemiology & Public Health, Pathology, Preclinical Clerkship & Tutorial, as well as two Modules dealing with the various specialty areas of medicine) yields approximately 3 graduate credits. The third and fourth year of entry-level medical instruction at Yale consists of practicum, without a formal rotation through pharmacy. Taking into consideration all four years of medical school, we arrive at the conclusion that about 3 graduate credit hours (or 45 contact hours) are dedicated to formal instruction in pharmacology.

There are problems with attempting to equate medical school training to RxP training not only because medical schools do not use standard graduate hours to designate the extent of instruction in any content area, nor because there is little standardization among the curriculum taught at different medical schools, nor solely because the majority of instruction in medical school is actually practicum and not equivalent to formal classroom didactics, but because there is little transparency as far as clearly publicized curriculum, let alone published class catalogues and schedules. Yale was used here as an example partly because it provides more detailed information about its curriculum than the majority of medical schools sampled.

So why make the comparison at all? The need to compare training between medical psychology and medical school was thrust upon psychologists by the accusations of the opposition to RxP that psychology’s training was not comparable. These claims have been made by physicians, quite a few of them psychiatrists; and so legislators supportive of RxP have asked for clarification. A second, and perhaps equally important, reason for making such a comparison is that it is a chance for RxP to shine. Any serious comparison between RxP prescribers’ professional training and the other prescribing professions, namely medicine and nursing, reveals unequivocally the splendid preparation that medical psychologists who have undergone specialty training in clinical psychopharmacology have (Muse & McGrath, in press). It is a preparation that far outstrips the competition. No matter how you do the math, RxP psychologists are eminently qualified to treat their patients within an integrative approach that incorporates pharmacotherapy among their other proven competencies; the opposition knows it, even as they attempt to obscure the fact.

(continued on pg. 16)
Tilus, RxP Update in North Dakota, continued

(continued from pg. 9)

ND Representative Nancy Johnson and the Healthy 8 Coalition Network put their community’s faith into action with HB 1488. The people in the “back 8 counties” of the southwestern corner of North Dakota have had their share of hard times. After talking to Representative Johnson, I shared her quiet sense of exhaustion from she and the Healthy 8 Coalition Network using all of their emotional and spiritual resources, resulting in their community’s continued psychiatric burden and a leader’s own personal lack of right to grieve. And yet in the spirit and resiliency of the North Dakota people, Representative Johnson and the Healthy 8 Coalition shine with new courage and new hope in their decision to present another RxP bill in the near future.

I wonder if psychology could learn something from their leadership role and lose the slothful ease of complacency and neutrality. HB 1488 was not about me or any state psychological association. It was about psychology’s inability, or unwillingness, to respond to a request for help and collaboration with the families and patients who live in the counties, most of which meet the designation for full time Health Professional Shortage Area or Medically Underserved Area, with average incomes below the North Dakota per capita person income of $17,769. The patients and families of these 8 counties pay the highest price, and lose the most, for psychology’s inability or unwillingness to step up to the plate.

LCDR Michael R. Tilus, Psy.D., MSCP serves as the Director of Social Services and Mental Health Programs at Spirit Lake Health Center in Fort Totten, North Dakota. He has chosen to serve in isolate, remote, medically underserved populations as the focus of his Public Health Service Career. Mike served in the U.S. Army for 12 years as a Chaplain and is a combat veteran of the first Gulf War of 1991. He has been an ordained minister with the International Church of the Foursquare Gospel for 30 years and is credentialed as a “Pastoral Psychologist and Chaplain.” Mike works hard to integrate cultural beliefs, positive spirituality, and family psychology into his psychology practice on the reservation. He is currently completing the final requirements for certification as a Conditional Prescribing Psychologist under New Mexico law.

Muse, Comparing Medical School Training to RxP Training, continued

(continued from pg. 15)

Mark Muse, Ed.D., MP, ABPP is licensed in Louisiana as a Medical Psychologist. He practices in a primary care setting.

Author’s Note
The above methodology has yielded an array of statistics on the similarities and differences between physicians’ and medical psychologists’ educational preparation to prescribe psychoactive medications. As follow up to the present article, the author has advanced the finding that RxP trained psychologists receive greater than four times the formal instruction in pharmacology than do entry-level (MD/DO) physicians. Full results of the study will soon be available in:


“RxP trained psychologists receive greater than four times the formal instruction in pharmacology than do entry-level (MD/DO) physicians.”

References
Liaison Committee on Medical Education (2008). Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree. Washington, DC: Association of American Medical Colleges.
DeLeon, Health Care Reform, continued

(continued from pg. 11)

of protecting narrow interests and putting off unpleasant decisions – that time has surely passed. Starting today, we must pick ourselves up, dust ourselves off and begin again the work of remaking America…. We will restore science to its rightful place and wield technology’s wonders to raise health care’s quality and lower its costs...."

The President’s Economic Stimulus legislation (P.L. 111-5) incorporated the Health Information Technology for Economic and Clinical Health (HITECH) Act, which is intended to promote the widespread adoption of health information technology (HIT) for the electronic sharing of clinical data among hospitals, health care providers, and other-health care stakeholders. Today, relatively few providers actually utilize HIT; the most recent estimate suggests that only about 5% of physicians have a fully functional electronic health records (EHR) system. The goal is to bring utilization up to 70% for hospitals and approximately 90% for physicians by 2019. The law raised the HIT National Coordinator’s budget from approximately $66 million in FY’09 to $2 billion, with numerous health policy experts suggesting that the federal government’s overall investment for HIT will reach $19+ billion under the stimulus legislation. What is the comparable utilization rate for psychology’s practitioners?

From a health policy perspective, it would be a natural evolution from possessing comprehensive HIT to ensuring that clinical care can be appropriately provided by taking advantage of the exciting developments in telehealth, the use of virtual realities, and expanding simulation modules. Stated slightly differently, the federal government must soon ensure that any parochial state-enacted scope of practice statute does not create an artificial barrier for patients to receive the most up-to-date quality of care. The various clinical disciplines must be allowed to effectively utilize their unique expertise, notwithstanding the “public hazard” allegations of competing disciplines. Has psychology enacted a sufficient number of RxP state statutes to gain legal standing to participate in this important forthcoming dialogue? We may learn the answer this Fall, shortly after our Toronto convention.

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 Psychopharmacology in 2001 and the Division 55 Meritorious Service Award in 2008.

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August 6-9, 2009
Division 55 Program
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Thursday 8-6-09

8:00 a.m. to 9:50 a.m.
Symposium (N): Advocacy Update- Status of Prescription Privileges at the State, Federal, and International Level
Chair
• Owen Nichols, Psy.D., MBA
Participant/1st Author
• Basil J. Pillay, Ph.D.
Discussants
• Deborah Baker, JD
• Huib Van Dis, MD, PhD
• Raymond A. Folen, PhD
• Elaine S. LeVine, PhD
• Kathy Parker, PsyD
• Gilbert O. Sanders, EdD
• Robert B. Rottschafer, PhD
• Beth N. Rom Rymer, PhD
• Earl Sutherland, Jr., PhD

10:00 a.m. to 11:50 a.m.
Symposium (S): Reshaping Clinical Practice– Prescriptive Authority and Beyond
Chair
• Robert E. McGrath, Ph.D.
Participants/1st Authors
• Trish Gallagher, PhD
• Robert H. Pietrzak, PhD
• Glenn A. Ally, PhD, MP
• Robert E. McGrath, PhD
Discussant
• Patrick H. DeLeon, PhD, JD
2009 APA Convention, August 6-9, Division 55 Program, continued

12:00 p.m. to 1:50 p.m.

Poster Session (F): Integrating Psychopharmacology Into Psychologists’ Expertise

Participants/1st Authors
- Terry Kohler, PsyD
- Ovett G. Chapman, BA
- William J. Burns, PhD, MS
- Thomas Kubiszyn, PhD
- Traci W. Olivier, BS
- Georae E. Letizia, MA
- Brandon C. Dennis, MA
- Joan M. Frye, MS
- Tara Samples, MS, MTS
- Channing Harris, MA
- Joy Welcker, EdS, MEd
- Dena Buchalter, MA
- Steven R. Tulkin, PhD

2:00 p.m. to 3:50 p.m.

Symposium (S): Prescriptive Authority for Indian Health Service Psychologists-Serving the Underserved

Co-Chairs
- Randy R. Taylor, PhD, MBA
- Steven R. Tulkin, PhD

Participants/1st Authors
- Kevin M. McGuinness, PhD, MS
- Connie Hunt, PhD
- Michael R. Tilus, PsyD
- Bret A. Moore, PsyD
- Vickie Claymore Lahammer, PhD
- Earl Sutherland, Jr., PhD

Discussants
- Patrick H. DeLeon, PhD, JD
- Beth N. Rom Rymer, PhD

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2009 APA Convention, August 6-9, Division 55 Program, continued
(continued from pg. 19)

Friday 8-7-09

8:00 a.m. to 9:50 a.m.
Symposium (S): RxP Training and Interdisciplinary Relationships - Building Successful Collaborations With Prescribers
Chair
- Steven R. Tulkin, PhD
Participants/1st Authors
- Alessandra Strada, PhD
- Marla M. Sanzone, PhD
- Michael Enright, PhD
- Jeff Matranga, PhD
Discussant
- Morgan T. Sammons, PhD

2:00 p.m. to 3:50 p.m.
Symposium (S): Biobehavioral Considerations in the Management of Chronic Headache Disorders
Chair
- Steven M. Baskin, PhD, MS
Participants/1st Authors
- Frank Andrasik, PhD
- Kenneth A. Holroyd, PhD
- Steven M. Baskin, PhD, MS
- Robert L. Ruff, MD, PhD
Discussant
- Jonathan M. Borkum, PhD

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2009 APA Convention, August 6-9, Division 55 Program, continued

4:00 p.m. to 5:50 p.m.
Symposium (S): Psychobiological Model for Motivational Decision Making-Pharmacotherapy Implications

Chair
- David Nussbaum, PhD

Participants/1st Authors
- Stephanie Bass, MA
- Martina Kalahani Bargis, BS
- Andrea Burden, MA
- Kristoffer Romero, MA

Discussant
- Beth N. Rom Rymer, PhD

Saturday 8-8-09

8:00 a.m. to 8:50 a.m.
Discussion (N): We Can and Shall Obtain Prescriptive Authority- A Conversation Hour

Co-Chairs
- Deborah Baker, JD
- Patrick H. DeLeon, PhD, JD

Participants/1st Authors
- Ronald E. Fox, PhD
- Elaine Orabona Foster, PhD
- Kathleen M. McNamara, PhD

9:00 a.m. to 10:50 a.m.
Symposium (S): Issues in Geriatric Psychopharmacology and Forensics

Chair
- Beth N. Rom Rymer, PhD

Participant/1st Author
- Dean Paret, PhD

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2009 APA Convention, August 6-9, Division 55 Program, continued
(continued from pg. 21)

(Saturday 8-8-09, continued)

11:00 a.m. to 12:50 p.m.
Symposium (S): CWC/Neuro- Brain Buffers and Brain Blows
Participants/1st Authors
• Joan B. Read, PhD
• John Bolter, PhD, MP

1:00 p.m. to 2:50 p.m.
Symposium (S): CWC/Evidence-Based Practice—Effective Treatment of Adult ADHD
Chair
• Robert J. Resnick, PhD
Participants/1st Authors
• Robert J. Resnick, PhD
• Kathleen G. Nadeau, PhD

4:00 p.m. to 4:50 p.m.
Business Meeting (N): Division 55 Business Meeting
Chair
• Morgan T. Sammons, PhD

5:00 p.m. to 5:50 p.m.
Presidential Address (N): Division 55 Presidential Address
By Morgan Sammons, Ph.D.

6:00 p.m. to 8:00 p.m.
• Division 55 Social Hour (see next page for announcement)
  This special event WILL NOT appear in APA Convention Program, so please add it to your calendar!

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You are cordially invited to the...

Division 55 Social Hour
Saturday, August 8, 6-8 PM
Aurora Room of the
Toronto Renaissance Hotel
Downtown (next to the Convention Center)

- Awards Ceremony
- Meet and Greet Friends from Division 55 and the Ontario Psychological Association
- Good food and good fun!

2009 APA Convention, August 6-9, Division 55 Program, continued

(continued from pg. 22)

Sunday 8-9-09

9:00 a.m. to 10:50 a.m.

Symposium (S): Bipolar Disorder-
Issues in Diagnosis and Treatment Implications

Chair
- Jeff Matranga, PhD

Participants/1st Authors
- Eric A. Youngstrom, PhD
- Camilo Ruggero, PhD
- Sagar Parikh, MD
- Christopher J. Miller, MS
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