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On March 6, 2002, then-Gov. Gary Johnson signed New Mexico’s HB170 into public law, authorizing appropriately trained psychologists to prescribe. On Jan. 7, 2005, Mario Marquez applied for his “conditional certification.” In May 2004, Louisiana followed suit and medical psychologist John Bolter wrote his first script on Jan. 20, 2005. Both the New Mexico and Louisiana State Psychological Associations had been working on their ultimately successful legislation for over five years. When did psychology’s prescriptive authority quest actually begin?

In 1984, U.S. Sen. Daniel K. Inouye, D-Hawaii, urged the Hawaii Psychological Association to seek this authority. In 1972, visionary APA President Nick Cummings, Ph.D., raised this possibility with the board of directors. In August 1995, the APA Council of Representatives formally endorsed prescriptive authority.

By the end of 2008, Glenn Ally, Ph.D. estimated that 200,000 psychotropic medication orders had been written by his Louisiana colleagues. Today, Morgan Sammons, Ph.D., who is now dean of the California School of Professional Psychology, postulates that between 800 and 1,000 colleagues have completed their formal psychopharmacological training. The numbers are indeed impressive.

With the passage of President Obama’s landmark Patient Protection and Affordable Care Act more than 32 million Americans will soon have access to high quality, patient-centered primary care for the first time in their lives. The president’s vision calls for the utilization of the most up-to-date advances in communications and computer technology, an emphasis upon prevention and wellness care and the steady development of comprehensive systems of care (Accountable Care Organizations (ACOs)) throughout the land.
Under previous administrations, these would probably have been considered Health Maintenance Organizations (HMOs – President Nixon) and/or Managed Care (President Clinton). Interdisciplinary care, comparison across diagnoses and patient populations and reliance upon objective gold standards will increasingly become the norm.

The administration is providing the states with sufficient flexibility to craft the health care environment which best fits their unique situations. Within this broader policy frame of reference, I would suggest that psychology’s prescriptive authority quest fundamentally represents an important evolution of the field into primary care health psychology. And, I would also suggest that over the next decade there will be an increasing number of psychologists providing integrated care as employees in organized systems, such as federally qualified community health centers (FQCHCs) and ACOs, rather than working in traditional independent small practices or community mental health centers. Times are changing.

As I reflect upon the professional literature over the past 25 years, there have been consistent and increasing calls for the integration of mental health (now frequently called “behavioral health”) services within primary care. Whether one considers “Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention” (1979) or the Institute of Medicine report “Health and Behavior: Frontiers of Research in the Biobehavioral Sciences” (1982), the underlying message is very clear. Primary care providers, with considerably less mental health training than psychologists, have been providing care for 60 percent to 80 percent of those with discernible mental health disorders.

Most practicing psychologists have been trained in a traditional mental health setting, pursuant to the community mental health center movement of President Kennedy’s era, the psychological services organization of the VA, and/or university-based mental health clinics. Collectively we have not been aware of the far reaching community health center initiatives of President Johnson’s Great Society era, which provide the federal safety net for millions of Americans.

Those federal (and increasingly civilian) psychologists who do possess prescriptive authority have emphasized that their clinical skills are in definite demand and that their integrated skills have allowed them to clinically modify prescribed regimens of psychotropic medications more appropriately for their patients’ benefit.

Within the Indian Health Service, pioneers such as Floyd Jennings, Ph.D., prescribed with standing or-
ders at the Santa Fe Indian hospital in New Mexico during the mid-1980s, where quality assurance reviews of cases were quite positive. In June 1994, APA President Bob Resnick, Ph.D., attended the graduation ceremony for the first two Department of Defense psychopharmacology training graduates, Cmdr. John Sexton, Ph.D., and Cmdr. Morgan Sammons, Ph.D.

When one studies the literature for various subpopulations, such as the elderly, children, ethnic minorities, etc., the picture is again quite clear: psychologists with prescriptive authority provide the highest quality of care.

Although I have been involved in this movement over the years, it is impossible to predict with any sense of certainty which will be the next state to enact prescriptive authority legislation. Will, for example, Hawaii and Oregon be successful in reviving their vetoed bills?

The numbers of psychologists completing their advanced training continues to grow. As of the fall of 2010, 276 graduates had been admitted to take the APA PEP (Psychopharmacology Examination for Psychologists) developed by the APA Practice Organization’s College of Professional Psychology. With the advances occurring in educational technology, I would expect that those on their clinical internships will soon have ready access to medication decision protocols. Over the years, slightly more than one third of our state associations have established task forces to coordinate prescriptive authority activities, with nearly a quarter having introduced relevant legislation.

Fundamental change always takes time; oftentimes, longer than one might initially expect. Today, several of the states pursuing prescriptive authority, such as Arizona and New Jersey, were initially considered to be among those that their leaders felt would be the “last in the nation” to undertake such action.

Leadership changes, as does the nation’s health care environment. Looking over the Congressional landscape, it is evident that we will continue to see an increasing number of non-physician primary care providers adopting the doctoral level of training as their standard and expanding their scopes of practice to fully utilize their clinical expertise. The right to prescribe medications by nurse practitioners and doctors of nursing practice, as well as by clinical pharmacists, for example, continues to mature exponentially across the nation and to be appropriate for their training. They are calling for patients to have the freedom to be treated by the practitioners of their choice. Sound familiar?

I am confident that psychology’s leadership will appreciate the growing importance of proactive vi-
sion and action. As Harvey V. Fineberg, M.D., president of the Institute of Medicine, has stated: “Dealing equally with health care for mental, substance-use and general health conditions requires a fundamental change in how we as a society and health care systems think about and respond to these problems and illnesses. Mental and substance-use problems and illnesses should not be viewed as separate from, and unrelated to, overall health and general health care (2006).”

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The American Psychological Association (APA) and the American Society for the Advancement of Pharmacotherapy (ASAP), APA Division 55, have advocated for prescriptive authority for psychologists (RxP) to provide greater access to service and higher quality of care for society’s mental health needs. Over the past 20 years of advocacy by APA and ASAP there has also been an increase of prescribing psychotropic medications to children. Pediatric psychologists regularly find themselves confronted by issues specific to children and psychopharmacology. The extent to which psychologists should be involved in psychopharmacology is hotly debated. There are major rifts among various factions in the field regarding psychologists’ identity as medication prescribers, but psychologists need to expand their skill-sets and competencies to take on increased roles in integrated healthcare systems (Eby, Chin, Rollock, Schwartz, and Worrell, 2011). Recognizing the need to develop a model training program for psychologists to develop skill-sets that reach beyond traditional practice realms and into larger integrated healthcare systems, specifically primary-care settings, the APA developed a psychopharmacology training model. The purpose of this article is to critically examine prescriptive authority issues and consider pediatric psychopharmacology training implications that are unique to each child-focused subfield (clinical, counseling, and school) in professional psychology. Implications for training programs in clinical, counseling, and school psychology are discussed and needs are identified with respect to training and curricular requirements.

APA recommends three levels of psychopharmacology training for psychologists with no distinction between those being trained to work with children versus those trained to work with adult populations: Level 1: Psychotropic Information Provider (psychopharmacology course with biopsychology or biological bases

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of behavior as a prerequisite) includes involvement in treatment collaboration and decision-making through psychotropic research; Level 2: Collaborative Practice (multiple courses plus supervised practice/research) includes for monitoring/evaluation of dose-response for medication titration, effectiveness, and side-effects, and enhancement of pharmacotherapy integration into a comprehensive treatment plan; Level 3: Prescriptive Authority allows psychologists prescription privileges limited to the scope of their practice (Smyer et al., 1993).

With APA’s push for greater healthcare system integration, it is increasingly difficult not only to distinguish the roles of psychologists from other mental healthcare professionals but also the subfields within professional psychology, most notably clinical, counseling, and school psychology. Although historically and fundamentally different, practitioners in each subfield recognize the need for more psychopharmacology training (Ax, Forbes, & Thompson, 1997; Tatman et al., 1997; Evans & Murphy, 1997; Ponterotto, 1985; Kubiszyn & Carlson, 1995).

Distinguishing the Fields

Clinical Psychology

APA’s Council of Specialties in Professional Psychology (CoS) (2011) defines clinical psychology as: “a general practice and health service provider specialty...Clinical psychologists assess, diagnose, predict, prevent and treat psychopathology, mental disorders, and other individual or group problems to improve behavior adjustment, adaptation, personal effectiveness and satisfaction.” Practitioners traditionally work in hospitals, mental health clinics, and counseling and treatment centers. While clinical psychologists typically address the mental health needs of adults (Roberts, 2005), clinical child psychologists work with children.

APA’s CoS defines clinical child psychology as: “a specialty in professional psychology bringing together the basic tenets of clinical psychology with a thorough background in child, adolescent and family development and developmental psychopathology. Clinical child psychologists focus on understanding, preventing, diagnosing, and treating psychological, cognitive, emotional, developmental, behavioral, and family problems of children.” Practitioners typically work in hospitals, clinics, counseling centers, and more recently in school settings.

Counseling Psychology

APA’s CoS defines counseling psychology as: “a health service provider specialty focusing on helping people with physical, emotional, and mental disorders improve their well-being, prevent and alleviate distress and maladjustment...In addition, practitioners provide assessment, diagnosis, and treatment of psychopathology.” Practitioners usually work within hospitals, community health and university counseling centers,
and other schools settings. Though a need exists for more mental health service delivery to children, most counseling psychologists end up working with adult populations. Counseling psychology, in particular, has been slow to keep up with current pharmacological trends in service delivery to children in terms of both training and education. Counseling psychologists are in a unique position in that while many realize pharmacotherapy’s relevance as a treatment option, overly relying on its use goes against many core values of the field (Murray, 2006). Nevertheless, over the past several decades, due to increased push for evidence-based treatments, DSM training in counseling curriculums (Fong, 1993), and legislative efforts for counselors to be defined as “healthcare providers,” there has been a “medicalization of the profession” (Hansen, 2005). This shift towards the more objective “medical model” places more emphasis from counseling training programs on the biological bases of behavior and pharmacotherapy as a treatment option.

School Psychology

APA’s CoS defines school psychology as: “a general practice and health service provider specialty... concerned with the science and practice of psychology with children, youth, families, learners of all ages, and the schooling process. The basic training of school psychologists prepares them to provide a range of psychological diagnoses, assessment, intervention, prevention, health promotion, and program development and evaluation services with special focus on the developmental processes of children and youth within the context of schools, families and other systems.” While a defining feature of school psychology is its work with children in school settings, practitioners also practice in primary-care settings such as community-based mental health centers and medical facilities. School psychologists tend to play crucial roles working across systems of care to promote children’s well-being and address barriers to learning and development. Additionally, the profession focuses on empirical evidence for treatments, including school-based psychosocial approaches (Kratochwill & Stoiber, 2002) and psychopharmacological treatments within pediatric populations (APA, 2006).

Meeting Pediatric Psychopharmacology Needs

Meeting Needs within Primary-Care Settings

Among subfields, clinical psychology has considerable training overlap with primary-care clientele and practice settings. Traditionally working in a variety of healthcare facilities, practitioners have already created a niche by working with patients suffering a wide-range of both chronic and acute mental illness.

Acknowledging the expanded roles in primary-care settings that counseling psychologists will inevitably take on, Ponterotto (1985) posits that by having a basic knowledge and understanding of medical interventions, counselors will be better prepared to handle diverse clientele and make appropriate medication referrals. Levels 1 and 2 training for counseling psychologists provide practitioners not only an awareness of what drugs are prescribed and for what reasons, but also an ability to establish collaborative relationships...
with primary care physicians (PCPs). While intervention practices of PCPs tend to focus on treatment of clinical symptoms rather than the disorder, counseling psychologists focus on understanding and treating the underlying etiological and phenomenological processes of the symptoms. Counseling psychologists’ use of the psychological treatment model combined with the PCPs use of the medical treatment model ensures greater comprehensive service to children and adolescents.

School psychologists can take on greater roles in medication consultation, evaluation, monitoring, and treatment decision-making, not only in school settings, but also primary-care settings. Working with physicians and other mental health professionals outside of school settings is common for those school psychologists that are well trained in intervention development, implementation, and evaluation (Carlson, 2008; HaileMariam, Bradley-Johnson & Johnson, 2002). While school psychologists do not appear to be interested in prescriptive authority as a whole (Kubiszyn & Carlson, 1995), the ability to collaborate and communicate with others regarding data-based decision-making and specifically the appropriateness of change resulting from medication treatment remains essential to the profession (Carlson, Demaray & Hunter-Oehmke, 2006).

Collaborating with PCPs on medication treatment is necessary for more effective outcomes

Trained in psychological assessment, child-focused psychologists from each subfield are able to contribute valid and reliable information facilitating a comprehensive understanding of the child (Rozensky, Sweet, & Tovian, 1997). Considering the “whole child” and the rapid physical, cognitive, and social-emotional developments which children and adolescents undergo, psychologists and PCPs can collaborate on medication treatment plans for more effective outcomes. Other duties of child-focused psychologists include providing therapy, addressing psychosocial issues affecting treatment compliance, and monitoring potential side-effects and contraindications. Students, interns, postdoctoral trainees and practitioners from each subfield seek more training and practice opportunities in primary-care settings (Rozensky et al., 1997).

Meeting Needs within School Settings

Psychotropic medications are often prescribed to address behaviors in the school context. Given the extent of time that children spend in schools, where they often present with the widest range of mental, emotional, and behavior difficulties, great pressure is put on these settings to provide comprehensive mental health service (Jackson, Alberts, & Roberts, 2010). As data-based problem-solvers, an empirical approach to investigate the costs and benefits of treatments that are intended to impact school-related behavior is a priority. Monitoring those target behaviors as well as the development of replacement behaviors and/or side-effects is an essential component of any progress-monitoring approach.
While school psychologists have traditionally been mainstays in the schools, clinical and counseling psychologists are now also working within these settings to fulfill psychopharmacology needs (Cobb et al., 2004; Jackson et al., 2010). Psychologists participate in referral teams in determining whether an evaluation is needed from a physician. They are relied on for teacher and staff consultation regarding medication issues, including explaining how medication will lead to improved cognitive and academic outcomes in the classroom and possible side-effects. They determine the extent in which cognitive, academic, emotional, or behavioral deficits are displayed across various times and settings. Also, psychologists work with teachers in establishing accommodations or modifications to accompany medication treatments within an individualized education plan, as well as acquiring student information and classroom data for referrals and progress-monitoring.

**Training to Meet Pediatric Psychopharmacology Needs**

**Providing Level 3 Training**

Although the consensus in professional psychology towards prescriptive authority remains positive (DeLeon, Fox, & Graham, 1991; Gutierrez & Silk, 1998), many in the field continue to argue against RxP; espousing insufficient training and education standards that professional psychologists currently receive in psychopharmacology as a crux in their dissention (e.g., DeNelsky, 1996; Heiby, 2010; Moyer, 1995; Robiner et al. 2002). However, a 1997 U.S. Government Accountability Office (GAO) audit of the Department of Defenses' Psychopharmacology Demonstration Project found that the project was successful in training psychologists to safely and effectively prescribe medication (GAO, 1997). While this audit demonstrates that psychologists can be trained to prescribe medication, many considerations exist in determining how this training should be carried out.

A debate regarding Level 3 training remains whether it should be offered at the predoctoral or postdoctoral level. Given current barriers to students deciding to attain postdoctoral RxP training (e.g., cost, training and education commitment for licensure compared to other professions, slow passing pace of prescriptive authority legislation in states other than NM & LA), Ax, Fagan, and Resnick (2009) advocate for allowing the Level 3 training option entirely at the predoctoral level. Offering a predoctoral training option may provide long-term advantages for training programs such as lower costs, increased enrollment, and an expanded training market. However, training director opinions remain divided on whether providing predoctoral RxP training is feasible (Evans & Murphy, 1997).
Other evidence suggests a specialty track for RxP may be more appropriate than incorporating psychopharmacology training into generic graduate school curriculums (Grandin & Blackmore, 2006). APA’s Council of Representatives developed and adopted a Level 3 training curriculum at the postdoctoral level, whereby competence-based assessment and a capstone competency is required along with psychopharmacology didactic coursework and a supervised “residency” (APA, 2009). The proposed Level 3 training for the RxP requirement of 400 contact hours (minimum) of relevant psychopharmacology didactic instruction as well as a supervised postdoctoral residency (APA, 2009) currently expands beyond the scope of most university-based programs. For Level 3 training, some programs will have the resources and student interest, while most will not.

The few existing RxP training programs in either university or professional school based programs utilize distance learning, web-based instruction, and executive track modules (weekend offerings) to facilitate accessibility (Fox et al., 2009). To provide the necessary array of training and coursework required, psychology programs can integrate with other training programs (e.g., health science, dental, nursing, medical, or pharmacy) (Smyer et al., 1993). This integration would likely increase the scope of relevant course offerings and facilitate access to trained faculty to serve in supervisory roles in practica and internship settings.

The need for and feasibility of providing Level 3 training will continue to spark debate not only within the medical field, but also within the field of psychology. Robiner et al. (2002) recognize barriers facing training programs (e.g., funding, time constraints, and availability of appropriately-trained faculty) which constrain curriculum, practicum, supervision, and evaluation opportunities. As Level 3 training is done at the postdoctoral level with conferral of a master’s degree or certificate in psychopharmacology through specialized training programs (e.g., Alliant International University, Nova Southeastern University, Fairleigh Dickinson University), one could argue that training and education implications within the three subfields remain less important. Of greater relevance may be ensuring a smooth transition into a prescriptive authority training program for practitioners coming out of clinical, counseling, or school psychology programs electing to do so. APA’s (2009) recommendation of allowing up to 20% of previous coursework in basic science and neuroscience (Domains I & II) to transfer into postdoctoral training may entice some licensed practitioners to pursue Level 3 training that otherwise would not have.

While most RxP training programs are still in their infancy, there are already programs graduating practitioners with Level 3 training, allowing limited prescriptive authority. However, for most programs, offering this training may be unrealistic as only a minority of students, practitioners, and training directors in each subfield report a willingness to obtain RxP personally (Ax et al., 1997; Ax et al., 2009; deMayo, 2002; Kubiszyn & Carlson, 1995; Lusher et al., 2002). Although few child-focused psychologists are interested in
prescribing medication themselves, the vast majority will, inevitably, be needed for important roles in collaboration, evaluation and monitoring (Kubiszyn & Carlson, 1995). Therefore, the need for psychopharmacology training at Levels 1 and 2 may be less debatable as the training is more feasible and the professional roles more defined.

Providing Level 1 and 2 Training

Compared to Level 3 training for RxP, less debate exists as to the need for child-focused psychologists to obtain Level 1 and 2 training for roles as psychotropic information providers and collaborative monitors and evaluators. The importance of Level 1 and 2 training is highlighted as the majority of practitioners report involvement in making medication recommendations, discussing medication-related issues with patients, and consulting with physicians about medication (VandenBos & Williams, 2000). However, the feasibility of implementing these types of training programs will continue to elicit dissention among the fields. Many training programs may reasonably be able to provide Level 1 training by offering a comprehensive predoctoral psychopharmacology course. Clinical, counseling, and school psychology programs meeting APA-accreditation requirements will likely already offer a Biological Bases of Behavior (prerequisite) course as part of the general psychology coursework core (if a program does not require or offer either class, then students would ideally be encouraged to take them as continuing education credits as many community colleges offer courses in psychopharmacology and/or biopsychology). Carlson (2001) profiles a program which examined its Biological Bases of Behavior APA-breadth requirement and made modifications and adjustments by focusing more closely on a practice-focused psychopharmacology curriculum for Level 1 training. However, a paucity of specific examples of feasibly engaging in this type of training is found within the literature. Examples within other professional training programs focusing on child mental health issues were not found. The difficulty of providing training for Level 2 psychopharmacology roles is apparent as no specific examples of training in Level 2 curriculum and practica were found. Overall, such training efforts do not appear to be taking place to any great extent. Rather, McGrath (2011) postulates “the de facto path to preparation for Level 2 has become completion of the Level 3 didactic coursework through one of the available programs without participation in a supervised clinical experience” (p. 19).

Because of the already extended training for most doctoral programs, many training directors feel incorporating Level 2 coursework is too difficult at the predoctoral level

While providing Level 2 training is conceivable, incorporating relevant coursework (e.g., developmental psychopharmacology, pathophysiology, and psychodiagnosis) and training experiences proves difficult for most pro-
grams; especially as many program directors feel the training period to licensure and practice is overly long already (Roberts, 2005). The dilemma arises of removing a course from the curriculum, if another is added. Course curriculum amendments will likely not be feasible, especially if all current courses are accreditation requirements. Even without curriculum change, exposure to basic psychopharmacology can be incorporated into existing curriculums through supplemental psychopharmacology readings, seminars, lectures, grand rounds, research, and practica in schools and primary-care settings (Tulkin & Stock, 2004). Though curriculum among the three practice areas is similar, clinical programs typically include more psychopharmacology coursework than do counseling or school (Cobb et al., 2004). However, clinical and counseling programs often receive less preparation in working with children than do school programs (Snyder & Elliot, 2005), and training in consultation with parents, teachers, and school staff can aid in consultation with PCPs. Still, training programs in all three fields lack coursework in consultation and collaboration with psychiatrists or PCPs (Pisani, Berry, & Goldfarb, 2005). With increased multidisciplinary integration, a clearly defined set of consultation and collaboration guidelines is vital for adhering to proper roles, ethics, and standards of collaboration (Kapalka, 2011).

Due to school playing a central role in children’s lives, all psychologists’ training should incorporate relevant legal and ethical issues inherent in medication dispensation in children within school settings. Training should provide a basic understanding of the Individuals with Disabilities Education Act (IDEA 2004, Pub. L. No. 108-446) and it’s relation to Response to Intervention initiatives. Also, case law regarding medication issues in school-settings (e.g., Benskin v. Taft, 1980; Valerie J. v. Derry CO-OP School District, 1991) should be studied perhaps as part of professional issues and ethics coursework, or supervised practica or internship seminars.

Likewise, school psychology training programs, which typically provide the most school-based training experience, would be wise to establish partnerships and coordinate practica experiences in primary-care settings. These provide a cost-effective method of providing training in primary-care psychopharmacology and preparing psychologists for medication collaboration in integrated healthcare systems. However, providing proper supervision in these settings is a major obstacle for most programs (McGrath & Sammons, 2011), as psychology program faculty will likely not have the necessary psychopharmacology training or education background to serve as supervisors. For this reason, it may be difficult to arrange for specialized practicum or internship in psychopharmacology where trainees can engage in collaborative care with PCPs.
Conclusion

Child-focused psychologists are needed to provide greater accessibility-to and quality-of care for children and adolescents as pediatric prescribing rates increase. Competent in both psychotherapy and pharmacotheraphy, the prescribing psychologists’ ability to incorporate a “psychobiosocial” model of care to children and adolescents ensures more efficacious treatment (Levine & Foster, 2010) than the more narrow biological paradigm used by PCPs. As child-focused psychologists create a niche in integrated healthcare systems, the training provided by graduate programs within professional psychology must continue to be critically evaluated. The following are considerations for training programs:

1 Training programs, along with APA, would ideally evaluate current training and education offerings by conducting periodic “need-assessments” to determine needs and trends in the field. After determining training and education needs, programs may address these needs by incorporating them into the program training sequence, philosophy, and mission statement.

2 Training programs must recognize the implications of managed-care and its increased reliance on evidence-based medicine (e.g., psychopharmacology). To address the training needs of psychologists working within primary-care settings with medical treatments, programs would ideally incorporate psychopharmacology training initiatives and other evidence-based approaches to treatment into the program training sequence, philosophy, and mission statement.

3 Training programs must recognize the significant overlap among clinical, counseling, and school psychology. As roles, settings and training-needs blend among the child-focused fields, there is need for more integration and collaboration among them.

4 Training programs would ideally recognize the need for more interdisciplinary integration. To provide needed psychopharmacology training, especially at Level 3, programs will need to consider options for providing coursework and supervised clinical experience through other university-based disciplines providing training and education in pediatric psychopharmacology and primary-care practice.

5 The field of professional psychology may benefit from establishing a consensus psychopharmacology training standard. A lacking standard and formal designation requirement for APA guidelines will likely cause child-focused fields to grow more disparate in their training.

References


logical Association.


Neuropsychopharmacology of Parkinson’s Disease Psychosis

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Parkinson’s disease (PD) is a neurodegenerative disease common in aging populations, second only to Alzheimer’s disease (McDonald, Richard, & DeLong, 2003). The onset of PD often occurs in the mid-fifties to mid-sixties with individuals first experiencing primary PD symptoms, with secondary psychological and cognitive symptoms often presenting later (Schrag, Jahanshahi, & Quinn, 2000). Primary symptoms of PD are largely motor-related and are caused by the death of dopaminergic neurons in the brain, particularly within the substantia nigra (Dauer & Przedborski, 2003), and include unstable and rigid posture, tremor while at rest, and slow movement or bradykinesia (Slaughter, Slaughter, Nichols, Holmes, & Martens, 2001; Dauer & Przedborski, 2003). While inherent in PD, parkinsonian motor symptoms can occur in other parkinsonian disorders such as those induced by head traumas, infections, medications, tumors, or other disorders. Such non-PD parkinsonian disorders are designated as secondary parkinsonism, while a diagnosis of...
PD is considered primary parkinsonism (Dauer & Przedborski, 2003).

**Etiology of PD**

Research suggests there are multiple etiologies of PD. Among these are environmental causes and inherited genetic factors. Although specific toxins have yet to be proven to cause PD, various chemicals and toxins have been implicated the development of PD. Support for the role of environmental factors has come from evidence that exposure to methylphenyl-tetrahydrodipryidine (MPTP), a toxic manufacturing byproduct of meperidine, causes parkinsonian symptoms upon reaching dopamine receptor sites (Olanow & Tatton, 1999; Dauer & Przedborski, 2003). Approximately 90-95% of PD cases are designated as sporadic PD and are likely due to environmental causes, while the remaining cases (5-10%) are likely the result of genetic factors and are designated as familial PD (Dauer & Przedborski, 2003). The heritability of PD, specifically of early onset PD (before age 50) has been established through twin studies, as well as in studies investigating common alleles for specific genes implicated in PD which show that the presence of specific polymorphisms may result in an inherited vulnerability toward early onset PD (Olanow & Tatton, 1999). Whether familial or sporadic, untreated PD leads to increased mortality and exacerbation of motor-related parkinsonian symptoms. With nearly one million individuals suffering from familial or sporadic PD in the United States, the need for advances in treatment is evident (Olanow & Tatton, 1999).

**Neuropsychiatric Symptoms of PD**

Complicating the treatment of PD are neuropsychiatric symptoms that often occur along with PD and cause further discomfort and distress, sometimes eclipsing the suffering caused by motor symptoms and greatly diminishing quality of life (Schrag et al., 2000; Burn, 2010). Such symptoms include trouble sleeping, cognitive impairment, dementia, depression, anxiety, and psychosis (McDonald, Richard, & DeLong, 2003). Neuropsychiatric issues are common in the PD population, with the incidence rate of neuropsychiatric symptoms in the PD population (27%) far surpassing that of the population of age-matched individuals without PD (Burn, 2010). Further study is necessary regarding how the development, progression, and treatment of PD may instigate comorbid neuropsychiatric symptoms.

**Pharmacotherapy of PD**

The treatment of PD is complex, and even the most effective treatments do not give full relief from parkinsonian symptoms nor stop the death of dopaminergic neurons. Thus, the most popular and supported treatments work mainly through their ability to address motor related symptoms (Dauer & Przedborski, 2003).

**Levodopa / Carbidopa** – The most popular pharmacotherapy currently on the market is levodopa, a central nervous system agent which is converted to dopamine. Levodopa is often combined with carbidopa,
a peripheral dopa decarboxylase inhibitor, in order to inhibit levodopa from converting to dopamine until it has reached the brain. Drugs combining levodopa and carbidopa (e.g., Atamet®, Parcopa®, Sinemet®, Stalevo®, Lodosyn®) allow lower doses to be effective and decrease nausea, which may occur at higher doses. This combination drug is prescribed to be administered two to four times per day depending on dose and rate of release (American Society of Health-System Pharmacists, 2012).

While arguably the most potent and effective pharmacological treatment currently available for PD, treatment with levodopa has many downfalls (Jankovic & Aguilar, 2008). Mood swings and involuntary movements (dyskinesias) are commonly seen in patients when the drug is beginning to wear off. After prolonged (five to ten years) levodopa use, and as the course of the disorder progresses, levodopa becomes less effective at controlling motor symptoms (Jankovic & Aguilar, 2008; McDonald et al., 2003). Due to the detrimental effects of prolonged levodopa use, patients are often first prescribed dopamine agonists, such as pramipexole and ropinirole, to increase dopaminergic activity through activation of dopamine receptors (D1, D2, and D3) without undergoing the process of synthesis in the presynaptic cleft. Dopamine agonists are used to control symptoms until the need for stronger medication such as levodopa is warranted. This progression of treatment allows the disease to be treated in accordance with symptom severity, saving the strongest medication for when it is needed the most. Once the severity of motor symptoms warrants the introduction of levodopa into the treatment regimen, a drug combining levodopa and carbidopa is often prescribed (Jankovic & Aguilar, 2008).

**Parkinson’s Disease Psychosis (PDP)**

Nearly one half of all PD patients using dopaminergic treatments (e.g., levodopa) experience Parkinson’s Disease Psychosis (PDP), a condition characterized by hallucinations and/or delusions due to increased synaptic activity at the dopamine D₂ receptors located within the limbic system (Meltzer, Mills, Revell, Williams, Johnson, Bahr, & Friedman, 2010; Fox, Brotchie, & Lang, 2008). The hallucinations and delusions inherent in PDP are currently treated with atypical antipsychotics (e.g., quetiapine, clozapine) commonly used in the treatment of schizophrenia. Even when prescribed at low doses, atypical antipsychotics often cause an array of side effects such as sedation, sensitive skin, tachycardia, dizziness, and changes in blood lipid profile (e.g., cholesterol and glucose levels) and weight, which can limit their tolerability in PDP populations (Meltzer et al., 2010; American Society of Health-System Pharmacists, 2012).
Atypical Antipsychotics and PDP

Quetiapine has been used for treatment of PDP but there are still questions of clinical efficacy. Preliminary studies suggest that quetiapine alleviates PDP symptoms seemingly without the threat of agranulocytosis or detrimentally affecting motor symptoms; however, it is subject to many of the same adverse reactions and side effects as other atypical antipsychotics, limiting its tolerability in the PDP population (Meltzer et al., 2010). Other atypical antipsychotics are also regularly used to treat hallucinations and delusions in PDP, but they differ in tolerability and efficacy, with some drugs such as risperidone and olanzapine worsening parkinsonian motor symptoms (Meltzer et al., 2010; Weintraub & Stern, 2005).

Among the most effective treatments currently available for PDP is clozapine. Clozapine is effective in treating PDP at doses much lower than used for schizophrenia – 6.25-75mg daily to treat PDP compared to 100-900mg daily to treat schizophrenia (Meltzer et al., 2010; Teva Pharmaceutical, 2011). Given the numerous potentially problematic side effects of clozapine, such as excessive saliva production (48%), drowsiness (46%), weight gain (31%), dizziness (27%), rapid heartbeat (25%), and agranulocytosis (1%), lower dosing may help reduce the incidence of side effects (Alvir, Lieberman, Safferman, Schwimmer, & Schaaf, 1993; Teva Pharmaceuticals, 2011). Interestingly, research suggests that clozapine’s influence on blocking serotonin activity at 5-HT$_{2A}$ receptor sites is responsible for its efficacy in treating PDP, whereas its influence on blocking dopamine activity at dopamine D$_2$ receptor sites is responsible for its efficacy in treating positive symptoms of schizophrenia (Meltzer et al., 2010).

Clozapine’s antipsychotic effect on PDP through the blocking of 5-HT$_{2A}$ receptors implicates the role of serotonin in PDP, thus suggesting that treatment advances focus on 5-HT$_{2A}$ blocking agents. Thus, investigation of drugs possessing similar antipsychotic effects through the blocking of 5-HT$_{2A}$ receptors (antagonists or inverse agonists) that don’t exert influence on H$_1$ or D$_2$ receptors has commenced, giving hope to the treatment of PDP without atypical antipsychotics (Meltzer et al., 2010; Wendling, 2008).

Pimavanserin

Pimavanserin, an experimental treatment for PDP that acts as a 5-HT$_{2A}$ serotonin inverse agonist with little or no activity at 5-HT$_{2C}$ or dopamine receptors, offers the possibility of treating PDP with fewer side effects (Ballard & Corbett, 2010). McFarland, Price, and Bonhaus (2011) reported the efficacy of pimavanserin in alleviating PDP-like symptoms in an animal model. Studying the antipsychotic effects of pimavanserin on rats with neural lesions in the substantia nigra to simulate motor impairment and symptoms similar to those of psychosis (e.g., psychomotor agitation), McFarland and colleagues found support for the alleviation of psychotic symptoms without affecting motor function. This animal model supports the use of serotonin...
inverse agonists and/or antagonists for PDP.

Further support lies in the results of a randomized control trial conducted by Meltzer, Peters, Elkis, Ruschel, Rosenthal, and Mills (2008) in which 412 individuals with schizophrenia exhibiting psychotic symptoms were randomized to treatments consisting of an antipsychotic (2mg or 6mg, atypical or typical) with either placebo or 20mg pimavanserin. Results indicate that adding 20mg pimavanserin to a 2mg dose of risperidone was safer than and as efficacious as a larger (6mg) dose of risperidone (Meltzer et al., 2008). Though this study was conducted with individuals suffering from schizophrenia, it supports the importance of serotonin in the treatment of psychoses, as well as the safety of pimavanserin.

Initial study of the efficacy, tolerability, and safety of pimavanserin for the treatment of PDP was conducted in the drug’s Phase II clinical trial, consisting of a randomized control trial over eight weeks (four week intervention and four week follow-up) at two sites (n=60), using a titrated dosing schedule (20mg, 40mg, 60mg). Results indicated that pimavanserin is a tolerable, efficacious treatment for PDP, producing improvement in psychotic symptoms (i.e., delusions, hallucinations) trending toward significance. Specifically, patients receiving pimavanserin experienced a 40% improvement of psychotic symptoms compared to those receiving placebo. Long term study (14 months) regarding the safety of pimavanserin indicates it is safe at doses equal to or less than 60mg daily. Side effects commonly seen with atypical antipsychotic use were uncommon in the treatment group and no different from the placebo group (Meltzer et al., 2010; Revel, Friedman, Johnson, Williams, Mills, 2008; Wendling, 2008).

Initial Phase III studies of pimavanserin found that while it was tolerable and safe, it was not significantly better than placebo at treating PDP

While pimavanserin has shown promise in prior efficacy studies, it is currently undergoing Phase III clinical trials in which the efficacy of 20mg and 40mg pimavanserin daily, in addition to dopaminergic treatment (e.g., levodopa) for motor symptoms, shows some encouragement in the development of improved PDP treatment. The initial Phase III study in 2009 established that the drug is tolerable and safe, yet the drug’s efficacy was not found to be significantly better than placebo (Fiske, 2012; ACADIA Pharmaceuticals, 2010). While a trend toward an antipsychotic effect was found for doses of 40mg daily, this trend was non-significant. Because of a very large placebo response from patients outside of the United States, the data from this initial Phase III study was reanalyzed using only United States’ patients. The results indicated that 40 mg pimavanserin was significantly better than placebo for PDP (Securities & Exchange Commission, 2011).

Due to a large placebo response by patients outside the US during early Phase III trials, the data was reanalyzed using only US patients, and pimavanserin was found to be significantly better than placebo at treating PDP
Results of a second Phase III trial were published in 2010, further indicating the tolerability and safety of pimavanserin, as well as its lack of an effect of motor symptoms. Here, administration of 20mg daily of pimavanserin trended toward significance, further indicating the potential efficacy of this novel drug. Phase III trials (020 study) continue, with results of the latest trial expected in late 2012 (Mills, 2011). Roger Mills (2012), Executive Vice President for Acadia Pharmaceuticals, indicated that initial results for the 020 study look promising.

Conclusion

The treatment of PD and subsequent PDP is extremely complicated, with drugs efficacious in treating motor symptoms of PD often leading to adverse effects such as sedation and psychosis. Though treatment combinations currently exist to counteract some side effects of dopamine replacement therapies (e.g., levodopa with carbidopa), these treatments do not address the psychotic symptoms that almost half of all PD patients experience as a result of dopaminergic treatments. Atypical antipsychotics are currently relied upon to treat hallucinations and delusions inherent in PDP, yet are associated with many side effects and can worsen PD motor symptoms due to their effect of dopamine receptors. Among the most promising advances in PDP treatment is pimavanserin, a serotonin 5-HT$_2A$ inverse agonist, which has been shown to help alleviate psychotic symptoms without many of the side effects or motor effects associated with atypical antipsychotics. While results regarding pimavanserin’s efficacy have been mixed thus far in its Phase III clinical trials, pimavanserin has shown to be tolerable and safe, exhibiting strong trends in effectiveness on PDP symptoms (Rodnitzky, 2012). Whether or not pimavanserin is evidenced as efficacious and becomes a mainstream treatment for PDP, it has initiated conversation in the field regarding new non-dopaminergic treatments for PDP that instills hope in the future of PD and PDP treatment.

References


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Perspectives

The Era of Transformation

Patrick Deleon, Ph.D., J.D., M.P.H., ABPP
former APA President – Division 55

When The Moon Is In The Seventh House. And Jupiter Aligns With Mars. As our nation’s health care costs continue to rise faster than almost any other segment of our economy -- expenditures of $2.6 trillion in 2010, or over 10 times the $256 billion in 1980 -- the health care environment is undergoing unprecedented transformation. In many ways, “bending the cost curve” has become the rationale for instituting substantive changes which health policy experts, particularly those at the Institute of Medicine (IOM), have recommended for decades. A key element of President Obama’s landmark Patient Protection and Affordable Care Act (PPACA) is dramatically increasing the availability of quality primary care, with an emphasis upon patient-centered (definitely not provider-centric) services. It is estimated that chronic disease treatment currently accounts for over 75% of expenditures, with obesity being a major contributor. Chronic pain, for example, affects at least 116 million American adults – more than the total for heart disease, cancer, and diabetes combined. Pain costs the nation $635 billion each year in treatment and lost productivity. Accordingly, prevention, public health strategies, effective utilization of technology (e.g., telehealth, informatics, and virtual treatment modalities), as well as behavioral expertise will become of increasing clinical and policy importance. Change is always unsettling. This movement away from traditional fee-for-service, small (often solo) practice models towards accountability, reimbursing for demonstrated outcomes, and large systems of care (e.g., Accountable Care Organizations (ACOs)) is definitely difficult for our senior practitioners and educators. Interdisciplinary collaboration and integrated care are the future. To achieve this laudatory goal, practice and education must increasingly work together.

Health care costs have increased over tenfold since 1980

There is a movement away from solo practice to large systems of care
This past summer, six major professional educational organizations released the report Core Competencies for Interprofessional Collaborative Practice. This visionary effort by the American Association of Colleges of Nursing, the American Association of Colleges of Osteopathic Medicine, the American Association of Colleges of Pharmacy, the American Dental Education Association, the Association of American Medical Colleges (AAMC), and the Association of Schools of Public Health lays out a strategic plan for implementing a number of recommendations made by the IOM over the past 40 years. The underlying objective is to ensure safe, high quality, accessible, patient-centered care. It will not be easy to establish a culture of interprofessional learning and genuine respect for the competence of others. There is a long history of “turf wars” under the banner of “patient safety.” Nevertheless, it is important to appreciate that How care is delivered is steadily becoming appreciated as being as important as What care is delivered. Developing effective teams and redesigned systems is critical. These underlying concepts are reflected in PPACA’s ACO and medical home provisions. On a personal level, having retired from the U.S. Senate staff after 38+ years, I look forward to working on these intriguing issues from a university perspective.

The underlying purpose of interprofessional learning is to prepare health professional students for deliberately working together with the common goal of building a safer and better health care system. To be successful, one must appreciate that educational institutions have a responsibility to both produce a health care workforce that is responsive to the nation’s evolving health care needs and also to ensure that their graduates are able to practice to the full extent of their expertise. Practice and education can no long be viewed as separate entities. The optimal use of the workforce requires a cooperative effort in the form of teams sharing common goals and incorporating the patient, family, and/or community as active members. This is particularly important for addressing the complex needs of chronic conditions where the psychosocial-economic-cultural gradient of care is so significant. Examples of exciting interprofessional education exist but are rare. For example, the Accreditation Council on Graduate Medical Education multispecialty resident survey data showed that formal team training experiences with non-physicians was significantly related to greater resident satisfaction with learning and overall training experiences, as well as to less depression, anxiety, and sleepiness, and to fewer reports by residents of having made a serious medical error.

Educational competencies need to fit practice needs and demands

Core competencies are needed to: * Create a coordinated effort across the health professions to embed essential content in all health professions education curricula. * Guide professional and institutional curricular development of learning approaches and assessment strategies to achieve productive outcomes. * Provide the foundation for a learning continuum in interprofessional competency development across the
professions and the lifelong learning trajectory. * Acknowledge that evaluation and research will strengthen the scholarship in this area. * Prompt dialogue to evaluate the “fit” between educationally identified core competencies and practice needs/demands. And, * Actively involve accreditation agencies and licensing and credentialing bodies in the process.

The report notes: “It may be more helpful to think in terms of competencies that are common or overlapping more than one health profession but not necessarily all health professions. This can be the source of interprofessional tensions, such as in the debate about overlapping competencies between primary care physicians and nurse practitioners. The overlap may be a strategy to extend the reach of a health profession whose practitioners are inaccessible for various reasons.... ‘Complementary’ competencies enhance the qualities of other professions in providing care.... “Collaborative’ competencies are those that each profession needs to work together with others, such as other specialties within a profession, between professions, with patients and families, with non-professionals and volunteers, within and between organizations, within communities, and at a broader policy level.”

Perhaps the heart of this transformation: “Provision of patient-centered care is the goal of interprofessional teamwork. The nature of the relationship between the patient and the team of health professionals is central to competency development for interprofessional collaborative practice. Without this kind of centeredness, interprofessional teamwork has little rationale.” Mutual respect and trust are foundational to effective interprofessional relationships. Collaborative care honors the diversity that is reflected in the individual expertise each profession brings. All team members must place the interests of patients and populations at the center of health care delivery. Today, too many health professions students have little knowledge about or experience with interprofessional communication. Working in teams involves sharing one’s expertise and being willing to relinquish some professional autonomy to work closely with others, including the patient and his/her family. “The challenges to bringing about transformational change in health professions education, which includes much stronger emphasis on ‘learning together to work together,’ are real and will require creativity and commitment to overcome. However, positive changes... indicate that many of the elements requiring change are ‘unfreezing’.... Every indication is that the time is now indeed right for transformational changes and, collectively, we are ready for action.” We would rhetorically ask: Should not those pursuing psychology’s psychopharmacology (RxP) agenda rightfully see themselves as being on the forefront of their profession’s evolution into the 21st century?

A Refreshing Vision: Reflecting upon the experiences of retired colleagues, Vickie Mays has insightfully proposed intergenerational collaboration: “I have seen some wonderful transformations in retirement. What I love is the executive group that sends retired executives to work free with community organi-
izations. I wish there was a community service mandate at all high schools and universities as that is the time to have those executives get a sense of community. What would make psychology a transformed profession is if, like our law colleagues, we had to do pro bono work. I have thought on a couple of occasions of trying to move this through APA by having people indicate their willingness and then having APA put it on a website as a start. We at UCLA now have a volunteer center and it has made a big difference in the tackling of community needs. We bus the students into a school and in one day we renovate a school, rehab a facility, any number of things! If such an approach were systematically implemented in federally qualified community health centers, we would expect that our senior and new career colleagues would work together to develop that necessary comfort level to effectively integrate psychological expertise with primary care needs.

“What would make psychology a transformed profession is if, like our law colleagues, we had to do pro bono work.”

**Changing Times:** * The Substance Abuse and Mental Health Services Administration (SAMHSA) recently announced the availability of $35.7 million for up to 32 Primary and Behavioral Health Care Integration grants for community behavioral health organizations to establish coordinated and integrated services through the collocation of primary and specialty care medical services. The goal is to improve the physical health status of adults with serious mental illnesses who have, or are at risk for, co-occurring physical health conditions and chronic diseases, with the objective of supporting the “triple aim” of improving their health, enhancing consumers’ experience of care, and reducing the cost of care. * Pharmacy students are now eligible for the National Health Service Corps State Loan Repayment Program. Through program guidance, the Health Resources and Services Administration has provided states with the flexibility to include additional healthcare professionals, including pharmacists, in the state loan repayment program. Thirty-one states currently participate in this initiative. Only states that are seeking new or continued funding are eligible to include the expanded health professionals during this funding cycle. A state agency must be responsible for the grant management – health care reform is, indeed, local.

**SAMHSA recently announced $35.7 million in grants to establish integrated services**

**Federal Trade Commission (FTC):** Under the Carter Administration, the FTC aggressively addressed the issue of competition in health care. Recently, under the Chairmanship of Jon Leibowitz, the FTC has again focused upon health care and particularly the findings of the IOM report *The Future of Nursing: Leading Change, Advancing Health.* In response to a request by a Kentucky State legislator regarding pending legislation: “Recent reports by the Institute of Medicine (IOM) have identified a key role for advanced practice nurses in improving the delivery of health care.... Among other things, the IOM found that advanced practice nurses play a key role in improving access to health care and ‘restrictions on scope of practice... have undermined [nurses’] ability to provide and improve both general and advanced care.’ You have advised that the
Currently required collaborative prescribing agreement provides no physician supervision and can be costly to APRNs. As a result, the requirement is likely to limit the availability of APRN care. Given the potential benefits of eliminating unwarranted impediments to APRN practice, we recommend that the Kentucky legislature seek to ensure that statutory limits on APRNs are no stricter than patient protection requires. Absent a finding there are countervailing safety concerns regarding APRN prescribing practices for nonscheduled substances, SB187 appears to be a precompetitive improvement in the law that would benefit Kentucky health care consumers.

“The FTC is charged under the FTC Act with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce. Competition is at the core of America’s economy, and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, more choices, and greater innovation. Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key target of FTC law enforcement, research, and advocacy. Recently, FTC staff have analyzed the likely competitive effects of proposed APRN regulations in other states.” This Is The Dawning Of The Age Of Aquarius. Aloha

President’s Podium

Veterans Administration and RxP

Kevin M. McGuinness, Ph.D., MP, JD, ABPP
President, Division 55

In March of this year I had the privilege and pleasure of writing my first Presidential column for the Tablet. On that occasion I chose to write to our members of my optimism regarding the RxP movement. I spoke of the many states and state leaders who continue to advocate for RxP legislation across our nation. I reminded our readership that state legislation not only permits states to address mental health care inequities at the state level, but also at the national level, through federal policies impacting federal beneficiaries across the nation.
I am aware of specific federal policies that have enabled federal health care practitioners, including medical-prescribing psychologists, to provide their services to federal beneficiaries in any state to which they may be assigned. While positions for prescribing psychologists are being written and vacancy announcements for such positions are being posted quite regularly by virtually every government agency with a principal healthcare mission; the Veterans Administration has yet to privilege properly credentialed medical-prescribing psychologist to provide services to our nation’s veterans; this, despite a severe shortage of mental health professionals within the Veterans Administration that has triggered hearings in both houses of Congress.

In April members of our Board took advantage of an invitation to provide testimony for inclusion in the official hearing record of the Senate Committee on Veterans’ Affairs regarding and entitled VA Mental Health Care: Evaluating Access and Assessing Care. The text of that testimony is incorporated into this column.

As you read the testimony keep in mind that the Board of Directors is your board. Our ability to advocate for our patients depends upon our membership. Our ability to lead and to attract talented leaders depends upon our membership. We will continue to advocate for our shared interests. Toward that end, however, I ask that each member of Division 55 recruit a new member to the Division so that our voice can be more readily heard above the crowd of competing voices and competing policy interests at the local, state, and national level.

I want to thank Dr. Kathleen McNamara for her outstanding support as we prepared testimony for the Senate Committee on Veterans’ Affairs.

Finally, I want to express my heartfelt thanks to each of our Division 55 candidates who supported our Division by running for elected office this year; and I congratulate each of our newly elected officers for 2013: President-Elect Dr. James Bray (Former President of the APA); Secretary Dr. Christina Vento; and Member-at-Large Dr. Susan Patchin.

A copy of the testimony to the Senate Committee on Veterans’ Affairs is published in its entirety on the following pages.
April 25, 2012

Chairman Patty Murray
Senate Committee on Veterans’ Affairs
142 Russell Senate Office Building
Washington, DC 20510

Ranking Member Richard Burr
Senate Committee on Veterans’ Affairs
825A Hart Senate Office Building
Washington, DC 20510

Dear Chairman Murray and Ranking Member Burr:

Thank you for the opportunity to comment on the mental health services workforce shortage in the Veterans Administration. The American Society for the Advancement of Pharmacotherapy is deeply concerned that all available resources are not being effectively utilized to improve timely access to safe and effective mental health services for our nation’s veterans.

The American Psychological Association (APA) was founded in July 1892 and is deeply rooted in the uniformed services of the United States and the Veteran’s Administration. Following the end of World II the science and practice of psychology boomed, and the APA experienced its greatest membership growth between 1945 and 1970. Several factors fueled this growth (“APA History,” 2012):

- Many returning servicemen saw the great need for better psychological services firsthand during the war and there was special interest in the domains of clinical and applied psychology.
- The GI Bill, the Veterans Administration Clinical Psychology training program, and the creation of the National Institute of Mental Health contributed to the increased interest in psychology.
- The Veteran’s Administration accelerated the growth of professional psychology by collaborating to meet the needs of returning veterans.

APA’s Center for Workforce Studies estimates that there are now upwards of 93,000 practicing psychologists in the United States. Today APA has approximately 150,000 members and 56 divisions representing subfields of psychology (“How Many Practicing Psychologists,” 2012). The American Society for Advancement of Pharmacotherapy (ASAP) is Division 55 of the American Psychological Association.
ASAP was created to enhance psychological treatments combined with psychopharmacological medications. The Division promotes the public interest by working for the establishment of high quality statutory and regulatory standards for psychological care. Division 55 encourages the collaborative and interprofessional practice of psychological and pharmacological treatments as it endeavors to facilitate increased access to improved mental health services for all Americans (American Society, 2012). ASAP recognizes that the VHA is again striving to develop action plans and staffing models that better meet the mental and behavioral health demands of its growing veteran patient population (Review of Veterans’ Access, 2012); and we applaud these efforts.

In anticipation of the return of our service men and women from the wars in Iraq and Afghanistan, members of ASAP encouraged VA psychologists to educate the leadership of the Veteran’s Health Administration (VHA) regarding professional psychology’s readiness to support its mission in the 21st Century as it did in the 20th Century following World War II: when psychology expanded its scope of practice with the support of the VA.

Like ASAP, the VHA is aware that there is a national shortage of psychiatrists and an over-abundance of veterans in need of mental health services. Due to the efforts of professional psychologists in 2008, the VHA is also aware of the availability of licensed medical/prescribing psychologists, who are licensed to prescribe medications as well as psychotherapy and other mental health services required by the VHA to improve mental health care access for returning veterans. In fact, for many years VHA physicians have been referring veterans to medical/prescribing psychologists for outpatient pharmacotherapy and psychotherapy (K.M. McGuinness, personal communication, April 24, 2012) (G. Ally, personal communication, April 24, 2012).

In 2008, however, the VHA considered and rejected a proposal to utilize medical/prescribing psychologists within the VA system, even though they were utilized by the VA as independent health care providers in local communities. Unfortunately, the question asked was not “How can the VHA benefit from the use of this resource?” Rather, the VHA restricted its consideration to the idea of a limited demonstration project and utilized outdated information from the DOD Psychopharmacology Demonstration Project of the 1990’s to make its decision (Veterans Health Administration, Executive Decision Memo, April 28, 2008).

Based upon outdated information, unsupported assumptions and apparently flawed staffing predictions, the VA decided in 2008 not to utilize this resource, stating in an Executive Decision Memo that,

“psychologists may not prescribe in VA at this time. VA may wish to reconsider this position once the education and training issues have been resolved, once there is a demonstrated need for psychologists to prescribe in VA, and once there is a
demonstrated interest among psychologists to engage in such training, provided that costs are reasonable (See Attachment 1, Executive Decision Memo).”

VA’s focus on a demonstration project, rather than inviting medical/prescribing psychologists to apply for VHA jobs, is expressed in the Executive Decision Memo in the form of unfounded concerns and speculation about the cost to the VHA of educating and training such practitioners and whether psychologists would be interested in such training. Not surprisingly though, the question whether psychologists would pursue such training and the concern about education costs asserted in 2008 become moot when one looks at the facts. For example:

- Medical/prescribing psychologists, like other practitioners, have been paying for their own educations since the end of the DOD Psychopharmacology Demonstration Project in the 1990’s;
- An estimated 2000 medical/prescribing psychologists have completed training since prescriptive authority for psychologists was first enacted (R.E. McGrath, personal communication, April, 2012);
- Since prescriptive authority for psychologists was enacted in New Mexico, medical/prescribing psychologists have increased the number of psychotropic prescribers by 25%, substantially improving the access to care problem in that state (E.S. Levine, personal correspondence, January, 2012);
- Since prescriptive authority for psychologists was enacted in New Mexico and Louisiana more than one hundred psychologists have become licensed to prescribe medications (Sammons, 2010);
- At present there are licensed medical/prescribing psychologists employed in federal agencies across the nation (McGuinness, K.M. & Titus, M.R., 2010).

Even though the cost of education and training of medical/prescribing psychologists is borne by the individual practitioner, federal agencies do provide student loan forgiveness, student loan repayment and other incentives for medical/prescribing psychologists, as provided for by law and policy. Assumptions aside, and with the notable exception of the Veteran’s Administration, all current evidence demonstrates that medical psychologists are recognized, independent, doctoral level health care providers in federal health care agencies and uniformed services with designated health care components (McGuinness, K.M. & Titus, M.R., 2010).

Interestingly, the VA’s Executive Decision Memo denying prescription privileges to medical/prescribing psychologists also called into question whether there was a “demonstrated need for psychologists to prescribe in VA.” If there was no “demonstrated” need in 2008, the current report of the VA’s Inspector General, Review of Veterans’ Access to Mental Health Care, has clearly documented that there is a demonstrated need at this time for professionals who can both prescribe medication and provide the full range of diagnostic and evidence based treatment services. The fact that there is a growing pool of medical/prescribing psychologists in
federal agencies across the nation, while the VHA maintains prolonged wait times for its veterans in need of timely mental health care, begs a few questions:

- With regard to our veterans returning from Iraq and Afghanistan, has the VA abandoned its visionary and proactive problem-solving approach that proved so instrumental in meeting the needs of post-WWII veterans?
- Why does it seem that the VA is restricting its staffing pool to particular types of mental health practitioners, rather than utilizing all available resources?
- What does the evidence say?

It is without dispute that the VHA and all federal agencies have a responsibility to ensure safety for their constituents. While, the VA’s Executive Decision Memo expressed concern about how to train psychologists to address co-morbidity, its authors seemed unaware that psychologists train themselves to address such issues, just as do psychiatrists. In fact, psychologists, particularly medical/prescribing psychologists, have well-established multidisciplinary and interprofessional practice models. (McGuinness, Tlius, McGuinness, & Sa, 2012; Cosgrove & Moore, 2012; Tlius, McGuinness, Sa, Sutherland, Moore, Barnes, Hartnell, & Tranchuta, 2010). Safety, though, was never questioned in the 2008 Executive Decision Memo. Instead the memo emphasized and discussed at length, training issues, variations in state license laws, and whether other psychologists approve of prescriptive authority.

More to the point would have been a discussion of the following facts:

- Medical/prescribing psychologists can now be licensed in two states and one US territory;
- Under a variety of circumstances medical/prescribing psychologists in federal service can prescribe in any state or territory of the U.S. if they are licensed in just one state or territory (See 42 U.S.C. § 254d(j) (4));
- The American Psychological Association has a formal process in place for the designation of postdoctoral education and training programs in psychopharmacology for prescriptive authority; (APA Designation Committee, 2012);
- Since medical/prescribing psychologists began prescribing medications 7 years ago, not one adverse event has ever been reported against a licensed medical/prescribing psychologist to any state licensing board or the APA Insurance Trust. (See Attachment 2, R. Sherrill, personal correspondence, January, 2012) (G. Ally, personal communication, April, 2012) (B. Rom Rymer, personal communication, April 2012);
- Medical/prescribing psychologists are actively prescribing in the Army, Navy, Air Force, and agencies of the U.S. Public Health Service (including the Indian Health Service and the Health Resources and Services Administration/National Health Service Corps (McGuinness, K.M. & Tlius, M.R., 2010)
• Medical/prescribing psychologists are currently active in North Dakota, New Mexico, Louisiana, Montana and other states in Federally Qualified Health Centers and American Indian reservations. (K.M. McGuinness, personal correspondence, April 25, 2011)

• The U.S. Coast Guard, part of the U.S. Department of Homeland Security, is actively recruiting medical/prescribing psychologists for service at multiple locations on the east coast and at the same pay grade as their psychiatric colleagues. (See Attachment 3, Recent Coast Guard Positions for Medical-Prescribing Psychologist.)

A particularly embarrassing reality is that licensed medical/prescribing psychologists who have served our nation’s military on the battlefield or at sea as Army, Navy, Air Force, Coast Guard or Public Health Service commissioned officers cannot serve them in the VHA. Yet, we continue to have an access to care issue within the VA.

The American Society for the Advancement of Pharmacotherapy is grateful for this opportunity to provide testimony and looks forward to supporting the Senate Committee on Veterans Affairs and the Veteran’s Administration as our nation seeks to serve those who have served us in uniform.

Kevin M. McGuinness, PhD, MP

President
Board of Directors
Reading Shahidullah and Carlson’s article on RxP training (this issue) and Pat Deleon’s instruction that education and practice can no longer be viewed as separate entities got me to thinking about doctoral level training in psychology, especially the practice areas of clinical, counseling and school psychology. As both a lecturer at a university with a clinical psychology program and an APA internship site visitor, I see the that there is often a disconnect between doctoral programs and clinical internships. Indeed, the rise of Psy.D. programs came about, in part, because of this disconnect. Traditional Ph.D. programs often focused extensively on research, sometimes to the detriment of clinical training.

Of course, understanding the science of human behavior is the cornerstone of psychology training. Being born out of traditional academia, psychology’s underpinnings come from an experimental approach, which differs from professional degrees such as law and medicine, which were designed more specifically for practice. And many people see the division between academic and professional degrees as a divide that should not be crossed. I remember a colleague of mine once stated, after finding out that the new university president was an attorney, that the new president wasn’t a real academic since he “only” had a professional degree.

Since the majority of students getting their doctorates in clinical, counseling and school psychology are interested in practice, we must heed Pat Deleon’s cautionary advice that educational competencies must fit practice needs and demands. We can’t afford to see a divide between academic and professional degrees, although I often see it in the divide between what universities offer and what internship programs need. With the changing world of healthcare, those who understand other disciplines and learn how to collaborate and work together will be the most successful.
Training our students in therapy and assessment is no longer enough. We must educate them about other disciplines, train them to collaborate and appreciate the expertise of others (including clients and families), and help them work in teams. The skills of working collaboratively don’t come easily and must be taught and practiced.

Training in RxP offers psychologists a unique opportunity in collaboration and cross-discipline training. As Pat Deleon points out, training in multiple specialties can be beneficial to both professionals and clients. Though RxP is viewed by some within psychology and many outside of it as an attempt to take over someone else’s turf, gaining knowledge and skill in a variety of health care approaches enriches understanding of other professionals and allows for more professional collaboration—as long as people don’t hole-up in their respective bunkers. Learning from other disciplines and working together is the basis for good RxP training. In my own training I took classes and received training from pharmacists, psychiatrists, physician’s assistants, and nurse practitioners.

There is no reason we have to limit learning from other disciplines to postdoctoral RxP training. Learning from and collaborating with other disciplines at the predoctoral level will help our students enter practice with the collaborative, team-building skills they need for 21st century healthcare.

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American Psychological Foundation
GOLD MEDAL AWARDS

About the American Psychological Foundation
APF provides financial support for innovative research and programs that enhance the power of psychology to elevate the human condition and advance human potential both now and in generations to come.

Since 1953, APF has supported a broad range of scholarships and grants for students and early career psychologists as well as research and program grants that use psychology to improve people’s lives.

APF encourages applications from individuals who represent diversity in race, ethnicity, gender, age, disability, and sexual orientation.

About the Gold Medal Awards
The Gold Medal Awards recognize life achievement in and enduring contributions to psychology. Awards are conferred in four categories:

Gold Medal Award for Life Achievement in the Science of Psychology recognizes a distinguished career and enduring contribution to advancing psychological science.

Gold Medal Award for Life Achievement in the Application of Psychology recognizes a distinguished career and enduring contribution to advancing the application of psychology through methods, research, and/or application of psychological techniques to important practical problems.

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Gold Medal Award for Life Achievement in the Practice of Psychology recognizes a distinguished career and enduring contribution to advancing the professional practice of psychology through a demonstrable effect on patterns of service delivery in the profession.

Eligibility Requirements
Eligibility is limited to psychologists 65 years or older residing in North America.

Nomination Requirements
Nominations letters should indicate the specific Gold Medal Award for which the individual is being nominated and should include the following:

Nomination statement that traces the nominee’s cumulative record of enduring contribution to the purpose of the award;
Nominee’s current vita and bibliography;
Letters in support of the nomination are also welcome, but please refrain from sending supplementary materials such as videos, books, brochures, or magazines;
All nomination materials should be coordinated and collected by a chief nominator and forwarded to APF in one package.

Submission Process and Deadline
The deadline for receipt of nomination materials is December 1, 2012. Please e-mail materials to pkadir@apa.org or mail to: American Psychological Foundation, Gold Medal Awards, 750 First Street, NE, Washington, DC 20002-4242.

Please be advised that APF does not provide feedback to grant applicants or award nominees on their proposals or nominations.

Questions about this program should be directed to Parie Kadir, Program Officer, at pkadir@apa.org.
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