In This Issue

Clinicians’ Corner
Establishing a DoD Supervision Plan for Prescription Privileges
Laura Avila

Legislative Activities
Illinois RxP Bill
Beth N. Rom-Rymer

Perspectives
A Time of Change, Challenges, Opportunities
Patrick DeLeon

President’s Podium
The Historic Month of July
Gilbert O. Sanders

From the Editor
The Tablet is Now Indexed on PsycEXTRA
James D. Calvert
On Feb 13, 2009, Department of the Army, MEDCOM delineated Policy and Procedures for Credentialing and Privileging Clinical Psychologists to Prescribe Medications. The policy requires that psychologists complete a Masters degree in psychopharmacology from a regionally accredited university, a passing score on PEP, and the completion of one year of clinical supervision with a board-certified psychiatrist or prescribing psychologist within a DoD military treatment facility (MTF). Although military psychologists have been prescribing in the DoD since the 1990’s, this was the first officially recognized statement from the Department of the Army allowing properly trained civilian psychologists to prescribe in military treatment facilities.

Brooke Army Medical Center recently granted me and another RxP-trained psychologist prescription privileges with supervision for one year. BAMC is now one of three MTFs in the DoD with civilian prescribing psychologists. However, there are no established guidelines or plan for supervision under the current policy. In developing such a plan, I followed the guidelines set forth by AASPB and accepted by APA (2007) in completing a practicum experience. I also incorporated aspects of the psychopharmacology practicum experience delineated by both New Mexico and Fairleigh Dickinson postdoctoral psychopharmacology programs.

The plan is as follows:

Patient Population

The supervision plan requires that a minimum of 100 patients be seen over the course of one year. There should be an adequate number of intakes, follow-ups, and triage appointments to be determined by
the supervisor. The patient population should include a relatively balanced representation of age, gender, ethnicity, psychiatric diagnoses, and medical comorbidities. Experience in prescribing within each of the psychotropic medication classifications should aspire to be balanced. For example, at least 20 patients managed on antidepressants, 20 patients managed on atypical antipsychotics, 20 patients managed on mood stabilizers, and so forth. Understandably, there may be some overlap as well as some incongruence given the prevalence of prescribing medications from one class versus other classes.

The supervision experience will include the opportunity to refine minimum competence in each of the following areas: assessment of vital signs; mental status exam; review of systems; medical history interview/documentation; assessment of differential diagnoses (both physiological and psychological); psychopharmacology indications; and assessment of adverse effects with appropriate disposition; integrated treatment planning and management; and collaboration and consultation with medical providers.

**Supervision**

During the initial period, supervision is recommended during or immediately after each patient seen where medication management or labs/tests are indicated. As time progresses, supervision can become less immediate or frequent but should occur at least 1 hour weekly or after every 8 patients seen thereafter. Supervision can occur face-to-face, telephonically, or electronically. The supervisee can forward the medical note with orders to the supervisor for edits or comments. Once approved, the supervisee places the medical note with orders in the patient medical record system. The supervisor may choose to place an addendum to the note regarding his/her consensus to the plan; or the supervisee can document that consensus was obtained. The supervisor has the authority to change or cancel an order at his/her discretion.

It is imperative that the supervisee/supervisor professional relationship be based on mutual respect. The supervisee should choose a supervisor who is committed to the demands of the one year plan and is receptive of prescription privileges for RxP-trained psychologists.

The timeline for the frequency of scheduled supervision can be determined by the supervisor as he/she develops confidence in the supervisee’s judgment and competence. The supervisee will maintain a patient log and a supervision log over the year to document experience. Upon completion of the year, supervisor will provide a letter to the MTF’s Credentialing Office summarizing the outcome of the process to include his/her recommendations for the supervisee’s continued and independent practice in the area of psychopharmacology.

**Treatment Facility**

Treatment experience should occur in a medical clinic which will provide the widest range of patient diversity and psychiatric diagnoses. Experience will likely need to include inpatient admission intakes, as well
as C&L/Emergency Department consults to obtain training across the chronic and acute psychiatric spectrum. In these settings, the supervisee can obtain further experience in conducting physical exams, managing acute psychiatric symptoms, assessing for adverse effects, and providing appropriate disposition plans.

**Formulary**

The specific formulary is determined by the MTF granting the privileges. The BAMC formulary for prescribing psychologists includes the antidepressants (including MAOIs, TCAs), the typical and atypical antipsychotics, the anticonvulsants indicated for psychiatric conditions, the benzodiazepines, stimulants and cognitive enhancers (i.e., ADHD treatments and wake-promoting agents), and pregabalin.

**Collaboration with Other Prescribers**

The supervisee is encouraged and expected to participate in ongoing monthly case conferences and continuing education/didactics in psychopharmacology with prescribers from other disciplines (i.e. psychiatry, nursing) for collaboration and consultation.

In regard to my current experience, the credentialing committee at BAMC granted me privilege to prescribe with supervision in May, 2013. Given the importance of a good fit between supervisor and supervisee, I looked to identify someone who would be willing and available to commit to a year-long supervision experience. Prior to initializing supervision, my current supervisor and I met to discuss our clinical experience, conceptualization of patient care and psychopharmacology, and our individual expectations for a supervisory relationship. I have been following patients from an internal medicine clinic and a pulmonary clinic for medication management about 1.5 months. I entered my first medication order about 4 weeks ago, and so far have not had any patients complain of adverse effects. Initially it seemed incredulous that this plan was being realized, and later it felt daunting. Although I had felt very confident over the last few years consulting with primary care providers on medication with their patients, I admit I felt nervous when I met with the first patient that I would be assessing and following for medication. Supervision has been a very comprehensive and affirming experience, making this plan a great transition from consulting with providers to autonomous practice. I am fortunate to have a supervisor (psychiatrist) who is conservative in practice, expert in differential diagnoses, and also values the benefit of psychotherapy. Overall, I am excited to complete the remainder of the year and excited for the strides being made by RxP-trained psychologists across the DoD.

*The view(s) expressed herein are those of the author(s) and do not reflect the official policy or position of Brooke Army Medical Center, the U.S. Army Medical Department, the U.S. Army Office of the Surgeon General, the Department of the Army, Department of Defense or the U.S. Government.*
We have had a remarkable 14 months. On March 6th, 2012, the Illinois State Senate Public Health Committee passed our RxP Bill out of Committee by a vote of 6-4. With our lobbyists, we made the critical decision to spend the next 12 months educating our psychologists and legislators around the state on RxP issues; training Illinois psychologists in becoming effective advocates for RxP; and reaching out to mental health associations, social service organizations, law enforcement agencies, hospitals, mental health centers, physician groups, etc. to educate about, and advocate for, RxP.

Because of the strength and longevity of our lobbyists' relationships with our legislators and because of our Illinois psychologists' impressive advocacy and outreach efforts, we have been very fortunate to work with strongly committed and dedicated legislative chief sponsors: Senate President ProTem Don Harmon, Senator Dave Syverson, Representative John Bradley, and Representative Jim Sacia.

On March 12th, 2013, our RxP legislation passed out of the Senate Public Health Committee by the unanimous vote of 8-0 with one abstention. On April 25th, 2013, our RxP legislation overwhelmingly passed out of the Senate by a vote of 37-10 with 4 abstentions.

On May 7th, 2013, our Senate bill was placed in the House Executive Committee. Over the next several days, we were continually conferring with our lobbyists over the advisability of calling our bill. We made the strategic decision that we wanted to take more time to work with our Representatives so that the vote would reflect an informed understanding of the issues.

Since the end of our session on May 31st, we have been working and we will continue to work, very closely, with our legislators and all of our third party groups around the state. We are very fortunate that although this legislative session concluded on May 31st, we are in the first year of a two-year sequence. We are, therefore, able to build on all of our terrific accomplishments, to date, and focus on the House. We are also in productive discussions with the Governor’s Office. We are looking toward achieving passage during
our next legislative session in the spring of 2014 and winning the Governor’s approval.

Our Division 55 members have all been essential to our success and you will continue to be essential to our success as we move forward. We are in a very strong position and will get only stronger this year. Your personal letters, your physician letters, your financial contributions have all been an important part of the critical gains that we have made. Thank-you for your commitment, your energy, your valuable time. Together, we are forging a path in Illinois to make a significant change in the way healthcare is being delivered. We will not be deterred. There is no turning back.

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A good piece of legislation is like a good sentence; or a good piece of music. Everybody can recognize it. They say, 'Huh. It works. It makes sense.'

- Barack Obama, President of the United States

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Division 55 — 2013 Board of Directors

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<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
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As we excitedly observe from afar the evolving progress of our colleagues in New Jersey and Illinois, we should appreciate that historically where our profession has been able to have prescriptive authority (RxP) legislation enacted, it has been where a few have been sufficiently committed to make this their highest personal priority, demonstrated by never being “distracted” by other interesting events such as our annual APA conventions and state leadership conferences (SLCs). The public policy/political process is a very personal one where success only comes with vision, persistence, and commitment. As State Advocate Guru Mike Sullivan constantly reminds us, change is always the result of individual participation and that there are only a few who have been willing to become actively engaged. Those who succeed have focused on society’s real needs (i.e., envisioning a “higher agenda” beyond mere “turf issues”). Over the years we have also come to appreciate that substantive change always takes time; often far longer than one would initially predict, regardless of its ultimate benefit. And, that change is very unsettling for many.

State Leadership Conference (SLC): During this year’s extremely exciting APA State Leadership Conference (SLC), Practice Directorate Executive Director Katherine Nordal made clear to the over 500 attendees that unprecedented change is coming, particularly with the enactment of President Obama’s landmark Patient Protection and Affordable Care Act (ACA), and that it will be at the state and local level where the most critical implementation decisions will be made.

“The clock is ticking toward full implementation of the law and January 1, 2014 is coming quickly. But January 1st is really just a mile marker in this marathon we call health care reform. We’re facing unchartered territory with health care reform and there’s no universal roadmap to guide us. The details of ACA implementation vary from state to state, and so do the key players. There are challenges for the states. A princi-
Principal example is expansion of Medicaid. Millions of consumers are expected to move into the Medicaid system as ACA is fully implemented. We must pave the way for psychologists to provide services to the swelling ranks of Medicaid recipients. To do that, we need to confront barriers to our participation and reimbursement. Medicaid programs in 16 states do not recognize private sector psychologists as providers. For those that do, many place conditions and restrictions on psychologists’ participation. One restriction involves requiring physician referral for psychological services. And as of 2010, only 25 state Medicaid programs utilized health and behavior codes. APA created these codes more than 10 years ago to facilitate our involvement in integrated systems of care and allow reimbursement for interventions that target physical disorders — such as diabetes, chronic pain, and cardiac disease.

“One of the first steps in positioning for reform is for practitioners to recognize that they bring numerous professional skills and strengths to integrated care settings. These are factors that create ‘value-add’ for psychologists on health care teams and in integrated, interdisciplinary systems of care. And that’s what many of our practitioners increasingly will need to promote: the value and quality they can contribute to emerging models of care. We are a highly educated and talented discipline, and we need to identify and create opportunities to make others aware of the skills and strengths we can contribute to health care. I believe that if we are not valued as a health profession, it will detract from our value in other practice arenas as well. So regardless of how we feel about the current state of our health care system, psychology must take its seat at the table and contribute to the solutions needed to fix our ailing system. No one else is fighting the battles for psychology... and don’t expect them to. We need to look at our advocacy broadly as taking advantage of any opportunity to help others understand and appreciate the value of psychology and psychological services. It’s not enough to have a good message. We also need good messengers. Health care reform is a marathon – we’re in it for the long haul. New models of care and changes in health care financing won’t take shape overnight. For two years in a row at SLC our theme has been health care reform, and we’ve focused on the critical need for psychology to get engaged. We can’t hope to finish the marathon called health care reform if we’re not at the starting line. Fortunately, many psychology leaders have embraced our call to action.” - Katherine Nordal

Katherine has always been a staunch supporter of prescriptive authority. In our judgment, obtaining RxP is critical to psychology’s future as an independent health care provider.

Integrated Care: One of the defining features of the ACA is its emphasis upon increasing access to team-based, interdisciplinary, integrated patient-centered primary care. Accordingly, it will be interesting to see the extent to which visionary psychologists come to appreciate that the ongoing battles today between organized medicine and the Advanced Practice Registered Nurses (Doctors of Nursing Practice) are very much about psychology’s future, especially at the state level. It is estimated that the number of Nurse Practitioners will nearly double by 2025; from 128,000 in 2008 to 244,000. A similar trend exists for Physician
Assistants; where the number was 40,469 in 2000, increasing to 83,466 in 2010. A thought provoking article in the New England Journal of Medicine notes: “In Virginia, after prolonged negotiations that engaged the Medical Society of Virginia and the Virginia Council of Nurse Practitioners, the state legislature unanimously enacted a ‘compromise’ struck by the two organizations in March, 2012. The law stipulates that nurse practitioners must work as part of a patient-care team led and managed by a physician, and they must adhere to scope-of-practice limits as applied to them. The law expands from four to six the number of nurse practitioners who can be supervised by a physician, and it recognizes telemedicine as a legal form of oversight when nurse practitioners practice in different locations. The boards of medicine and nursing in Virginia jointly drafted regulations implementing the law. The AMA promotes the Virginia law as a model that other states should consider, but the American Association of Nurse Practitioners believes the law places Virginia out of step with national trends.”

Timely? We would remind the readership that on June 17, 2011 proposed regulations for Community Mental Health Centers (CMHCs) seeking federal support (i.e., Medicare and Medicaid reimbursement) were promulgated that would require “a psychiatric evaluation, completed by a psychiatrist or psychologist with physician counter signature, that includes the medical history and severity of symptoms.” As a condition of participation, the “CMHC must designate a physician-led interdisciplinary team that is responsible, with the client, for directing, coordinating, and managing the care and services furnished for each client. The interdisciplinary treatment team is composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and therapeutic needs of CMHC clients.”

The envisioned physician-led interdisciplinary team would provide the care and services, with the CMHC designating a psychiatric registered nurse, clinical psychologist, or clinical social worker, who is a member of the interdisciplinary team, to coordinate the care and treatment decisions with each client, in order to ensure that each client’s needs are assessed and that the active treatment plan is implemented as indicated.

Clearly the underlying policy issue being posed for psychology is: Whether our clinicians should be considered independent providers or allied health physician extenders?

Transformational Change is Necessary: The various reports issued by the Institute of Medicine (IOM) over the years should alert psychology, as Katherine Nordal has emphasized at SLCs, that what we as psychologists and data-oriented behavioral scientists believe should be a priority for our nation’s health care system is often unappreciated (or simply not understood) by those who establish clinical and programmatic priorities, and particularly the all-important reimbursement systems.

“Health care in America has experienced an explosion in knowledge, innovation, and capacity to manage previously fatal conditions. Yet, paradoxically, it falls short on such fundamentals as quality, outcomes, cost, and equity. Each action that could improve quality – developing knowledge, translating new
information into medical evidence, applying the new evidence to patient care – is marred by significant shortcomings and inefficiencies that result in missed opportunities, waste, and harm to patients.... In short, the country needs health care that learns by avoiding past mistakes and adopting newfound successes.... The entrenched challenges of the U.S. health care system demand a transformed approach. Left unchanged, health care will continue to underperform; cause unnecessary harm; and strain national, state, and family budgets. The actions required to reverse this trend will be notable, substantial, sometimes disruptive – and absolutely necessary. The imperatives are clear, but the changes are possible – and they offer the prospect for best care at lower cost for all Americans [IOM].” - Katherine Nordal

We would suggest that psychology’s maturing RxP quest and our active clinical participation in the evolving integrated models of care substantially reflect this underlying societal charge.

**Divisional Visionaries:** The RxP evolution is transformational and will make a substantial different in the lives of many individual patients, as well as our health care system’s definition of “quality care.” Psychology has a societal responsibility to address the critical psychosocial-cultural-economic gradient of care. As Katherine proffers: If not psychology, who? During the Illinois legislative hearings, former Division President Bob McGrath submitted testimony: “I am writing in support of awarding appropriately trained psychologists in Illinois the authority to prescribe. Any decision about scope of practice for a profession requires balancing the goal of maximizing freedom of choice/access to care with that of public safety. In this case, the empirical record clearly supports the proposed expansion in scope.

“First there is a clear shortage of specialty mental health prescribers. No one can argue with this assertion. Studies consistently demonstrate that 60-80% of all medications for mental disorders are prescribed by primary care physicians. These physicians are dedicated, conscientious, and caring, and they have valiantly filled the gap created by the lack of appropriate psychiatric services. However, they are diagnosing and treating mental disorders with little or no formal training in the diagnosis of mental disorders or in alternatives to medication. It is no surprise then to find they rely heavily on medications, even when such medications should not represent the first-line treatment. The result is over-medication and unnecessary medication. Allowing appropriately trained psychologists to prescribe would substantially increase the population of specialty mental health prescribers, increase the proportion of such prescribers who are familiar with circumstances in which alternatives to medication are superior, and reduce costs associated with using a physician as the primary prescriber.

“This argument only makes sense if prescribing psychologists are safe, and there the record is clear. Psychologists will only be allowed to prescribe after having completed at least five years of graduate training in psychology, becoming licensed as a psychologist, completing an additional three years of medical training,
and becoming licensed as a prescriber. Consider that in five years a physician becomes licensed to prescribe over 4000 medications and participate in any medical procedure from childbirth to surgery. In contrast, a psychologist who wants to prescribe spends three years learning approximately 100 medications (including their interactions with other drugs) and the small set of medical procedures relevant to their prescription (e.g., reading lab test results, performing and interpreting a physical examination).

“However, the case for psychologists as safe prescribers is not just logical; it is also data-based. Psychologists have prescribed for more than 20 years in the U.S. military; they have written hundreds of thousands of prescriptions in two U.S. states where psychologists can prescribe (Louisiana and New Mexico); they have served as prescribers in the U.S. Public Health Service and Indian Health Service. In all that time, not one complaint has ever been lodged against a prescribing psychologist. What is particularly telling is that not one physician has ever complained about the performance of a prescribing psychologist to a licensing board.

In more than 20 years of psychologists prescribing in the U.S. military, New Mexico, or Louisiana, there has not been one complaint filed against a prescribing psychologist.

“I am the Director of the M.S. Program in Clinical Psychopharmacology at Fairleigh Dickinson University. Fairleigh Dickinson is one of three institutions designated by the American Psychological Association as meeting the association’s guidelines for preparing psychologists to prescribe. So far, Fairleigh Dickinson has graduated over 100 psychologists with a master’s degree in clinical psychopharmacology. We have graduates who have prescribed in the military, in the Public Health Service, in the Indian Health Service, and in the states where psychologists are currently authorized to prescribe....

“Psychologists are a highly trained, ethically bound profession. We do not enter into the obligations of being a prescriber frivolously. The fact that we have designed a curriculum that requires three additional years of medical training after completion of the doctorate reflects a profession that perceives the role of the prescriber with great caution. Allowing psychologists to prescribe in Illinois will improve access to care without reducing public safety. I hope you will look beyond the emotional appeals of its opponents, and recognize it is the logical choice.”

Reflections: RxP: Jerry Strauss reported on the September, 2008 Louis Stokes VA Medical Center Psychology Service first annual all day conference open to VA and community psychologists titled “The RxP Movement in Psychology and Implications for Treating Patients with HIV and Tobacco Abuse.” Participants included former Division President Morgan Sammons and APA’s Randy Phelps. “The conference was well
attended by VA psychologists, psychology postdoctoral fellows and interns, and community psychologists; most of whom are very interested in the prescriptive authority movement for psychologists. This event may be the spring board for initiating a Psychopharmacology Training Program at the Cleveland VA. Stay tuned.”

A review of the feedback subsequently received from the trainees and postdocs was quite informative. A number felt that: “Many of the sessions focused on the diagnoses and situations where psychologists with prescription privileges could play a vital role. The speakers presented support for psychologists receiving prescription privileges and showed how prescription privileges for psychologists would lead to fully integrated care.” And also, “I felt the sessions that spoke about prescription privileges were one sided. I felt like I was at a sales pitch for prescription privileges in that only the pros were presented. It would have been nice to hear both the pros and cons. The cons seemed to arise from the audience, not the presenters.”

Retirement: Floyd Jennings is one of the first recognized prescribing psychologists, his expertise resulting in formal recognition in the Indian Health Service (IHS) Santa Fe hospital by-laws in the 1980s. “My hunch, albeit mere speculation, is that the quality of life post-retirement for psychologists is related to the degree to which investment in professional activities became the principal and deciding focus of personal identity for the person. That is, for persons – like myself – who invested far too much in professional activities to the detriment of development of personal areas of interest, retirement is a death sentence in the very near term; for one asks, either consciously or unconsciously, ‘Is this all there is?’ Thus, speaking solely for myself, therefore, I had decided to ‘work’ in some fashion until I infarct and expire. My mind continues to be active, even more so than in the past; and I write more, and think more about policy and long-range issues than short-term, tactical matters. To be sure, I am building in far more time for travel and those experiences for which I have longed; but nonetheless, continue to function in an employed fashion (the first such opportunity in decades) and the county appears in no hurry to discharge me. One wag said, ‘Why?’ You are now vested and we might as well continue to get some use from you...!” Aloha

Editor’s note: I am ever so grateful that Dr. DeLeon hasn’t retired from writing an article for every issue of The Tablet since I have been editor (and even before that). His insights, knowledge, and understanding about legislation and directions for healthcare are invaluable for all of us. We are indeed “in no hurry to discharge” you.

Have you written an article about psychopharmacology or would you like to write one? We are looking for articles and legislative updates. Contact Jim Calvert, Ph.D., Tablet editor, at jcalvert@calvertpartners.com to discuss your ideas or to submit an article.
Summer, especially July is full of historical dates. Perhaps most notable is the 4th of July which commemorates the signing of the Declaration of Independence. This 4th will be the 237th Anniversary of that truly historical date. The same date marks the end of another event that is likely to be over looked, the 150th Anniversary of the Battle of Gettysburg. Theoretically, Gettysburg is a battle that never should have occurred but one that changed history and basically insured the future of the United States of America.

The month of July has proven critical on multiple occasions in American history. On July 16, 1945 at the Trinity Test Site in New Mexico the atomic bomb was tested. On July 2, 1965 President Lyndon Johnson signed the Civil Rights Act. Neal Armstrong took his first steps on the moon in the early morning hours of the 20th of July 1969. Just a century before on the 28th of July 1868 the 14th Amendment was adopted.

Why the brief history lesson? Summer is well underway and in early August many of us will meet in Hawaii at the American Psychological Association Annual Convention. The Division has a great program with quality continuing education credits being offered. We will also honor several of our colleagues for accomplishments and contributions to the prescriptive authority movement. However, perhaps the most important aspect of July and the remaining months of this summer is work that is occurring out of sight and perhaps most unfortunately out of mind, it is the continuing efforts by our colleagues in in New Jersey and Illinois. This spring both accomplished hard fought victories but the war is far from over. The summer months are critical for the prescriptive authority battle, legislators still need to contacted, informed, and convinced that granting prescriptive authority to psychologists is not only safe (something that over 10 years of evidence has unquestionably shown), but can improve the quality of health care provided to the citizens of the states of Illinois and New Jersey.

Without an ongoing effort, the gains of this past spring cannot be sustained. While the legislative battles for this year are largely over, it is during the summer months that activities must continue in order that the victories made are pushed forward to the ultimate victory, that of enacted legislation enabling ap-
appropriately trained psychologists to prescribe. This effort not only takes the time and effort of those on the ground in these to battle ground states, but it takes significant financial contributions as legislative battles are not won on the facts or even the best arguments, or even what will improve health care and benefit the citizens of each respective state. Legislative battles need funding.

Prescriptive Authority is NOT a partisan issue, it is NOT a guild issue, it IS a service issue. The citizens of each state deserve the best health care available. Prescribing Psychologists help insure that the citizens of a state are provided with the best behavioral medical treatment available at one location by a single provider. I urge each of you to support the ongoing efforts in New Jersey and Illinois. Contact these states and provide not only words of support but letters that they can use from your experience and where your knowledge of psychopharmacology has been helpful to patients and physicians, and, of course, take a key and unlock you wallets and checkbooks as these continuing efforts requires contributions.

One last brief request—contact a colleague and ask him or her to join our effort. Ask them to join Division 55. Visit our website with them and have them fill out a membership application. We are making gains not only with progress in Illinois and New Jersey where we hope to obtain victory in 2014, but in the Department of Defense and the US Public Health Service. In the Department of Defense the Integrated Behavioral Health Consultant positions have provided opportunities for psychologists with knowledge of psychopharmacology to assist family practice providers in the management of patients. While psychologists in these settings may or may not be directly prescribing, the knowledge of psychopharmacology and appropriate behavioral diagnoses are proving to be of great benefit to patients and providers and adding many new physician and nurse allies for RxP.

Become a Member of the American Society for the Advancement of Pharmacotherapy (Division 55)

Available membership categories and associated dues are:
- Full Member/Fellow: $40/year
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For more information on Division 55 membership, please contact Amber Frausto, at afrausto.rw@gmail.com

Please submit an application available online at www.division55.org to:

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Cedar Park, TX 78630
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The Tablet Volume 14, Issue 2 July 2013 Page 14
The Tablet is Now Indexed on PsycEXTRA

James D. Calvert, Ph.D., MSCP  
Editor, The Tablet

Articles from The Tablet are now being indexed on PsycEXTRA. We have been working with APA for many months to begin indexing articles published in The Tablet. In late May, the last five years of articles were placed on PsycEXTRA. Since it can be a time-consuming exercise for APA to index each article, previous issues will be added over the coming months. Going forward, APA will continue to index new issues of The Tablet.

You can now go to PsycEXTRA and search for articles published in The Tablet. I have found that the easiest way to search for articles is to go to APA PsycNET and select the PsycEXTRA database. It is a much easier way to search than to go straight to PsycEXTRA. You can easily search by name, key word, topic, or any other parameter in the PsycNET search. I just typed the term “lurasidone” (Two graduate students and I wrote an article for The Tablet in 2011, so I knew it should be indexed) and the 25th entry was a reference to the whole issue of The Tablet where the article was published. The 26th entry was the following along with a full-text PDF:

Lurasidone for the treatment of schizophrenia: New advance or nothing new?  
doi: 10.1037/e625782012-003  
By Loehr, Valerie-Ruth; Trueba, Ana Francisca; Calvert, James D.  
The Tablet; Nov 2011; 12(3); 9-14 [APA Division 55, American Society for the Advancement of Pharmacotherapy].

By being indexed on PsycEXTRA people can more easily find our articles, and since most people using PsycNET simply select all of the databases (e.g., PsycINFO, PsycEXTRA), our articles will be included in most of those searches for psychopharmacology, pharmacotherapy, RxP, and related content. This gives us a great opportunity to disseminate information to more people and raises the visibility of Division 55. People no longer need to directly seek out information on our website. Instead of a few hundred people reading The Tablet, thousands can now access our work.
<table>
<thead>
<tr>
<th>Committee</th>
<th>Chairs/Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABPP</strong></td>
<td>Beth Rom-Rymer, Ph.D.</td>
</tr>
<tr>
<td><strong>CAPP Liaison</strong></td>
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<tr>
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</tr>
<tr>
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</tr>
<tr>
<td><strong>Gerontology Psychopharmacology Committee</strong></td>
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</tr>
<tr>
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</tr>
<tr>
<td><strong>Practice Guidelines Committee and Council Representative</strong></td>
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</tr>
<tr>
<td><strong>S.W.A.A.T. Committee</strong></td>
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</tr>
<tr>
<td><strong>Awards Committee</strong></td>
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