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The Spring 2015 *Tablet* issue is broadly focused around the theme of “Advancing the RxP Initiative in the Federal Sector.” Clearly, my own prior Army and now US PUBLIC HEALTH SERVICE careers shape my perspective of the prescribing medical psychologist tradition. Host federal agencies have their own internal culture that providers must prescribe too if they are to advance in that agency’s ranks and maintain an agency loyalty. Over the past few years, I have had multiple friends who practice both psychology and medicine remark that they wished to resign from their psychological membership or their agency duties. They were unhappy with their state psychological association; the parent organizations of APA or APAPO were reportedly unfaithful to them as prescribers, or at least ambivalent. They complained that although they had medical colleagues’ support, they were still “outsiders.” And, I often found my own heart simmering with the same cultivating noxiousness.

Wishing to resign my membership, where do I send my letter? There appeared to be no headquarters or single standard-bearing agency to which to refer to see if one is being truly “evangelical” enough of a prescribing psychologist. And this appears to point to one of the RxP movement’s major characteristics today.

Enterprising RxP leaders, when they perceive a need or an opportunity, found new institutions with no need to consult other established bureaucracies. Often these agencies and their leaders thrive on competition with each other, sometimes in friendly competition among allies, other times in sharp rivalries that accentuate differences. Such institutions are to some degree dependent on the constituencies whom they cultivate. The institutions provide leadership and guidance for these RxP communities, but community opinion can also act as a constraint on what is to be taught, believed, practiced, or tolerated.

So what gives our bewilderingly complex RxP movement any coherence whatsoever? What keeps us from blowing apart into thousands of fragments moving further from each other as each develops peculiar RxP standards of practice with accompanying biblical-like beliefs?

Both my religious and psychological training share a common attraction for depth practice, so that while reflecting on the RxP movement as “advancing,” my contemplation immediately turned to people. For many years I have been nurtured by a band of persons within Div55 who I regard as “the holy resilient.” This band of outlaws when subjected to the fiercest pressures of change did not just endure or bounce back.
They appeared to become more focused in how they used their time and resources. They became more compassionate and endearing to their patients and populations they served. Their work took on a clear “depth” approach with a simpler desire—to serve.

Resilience for them was not a matter of getting back to normal. It was not about adjusting as well as they can. It wasn’t about reframing their schemas. They were all about moving beyond where they were at the start of their RxP change. They were all about becoming something new, something different, in response to their professional and personal longing. For me, it was an operational definition of my religious training of a “calling.” These holy resilient were all about becoming new providers, new persons, transforming.

This band remained as down-to-earth as ever. They still laughed some days; found reasons to weep on others; felt fear and anger; got cranky and bitter; expressed hopes and experienced burn out. More often than they wished, have to say, “I’m sorry.” Practicing psychology, while not. Practicing medicine, while not. The fiery change of RxP opened them up to something new, something other than, something holy ignorant. They exhibited a new kind of courage, a calmed patience, and a new freedom that was resilient in a holy way.

Whether they articulated my ascribed metaphorical reality or not, what I found in this motley crew was a kind of holy resilience that was taking hold of a transformative moment. Instead of collapsing or cooking up some new way to hang on for another decade, these resilient few were willing to enter and lead us into the dark uncertainty of RxP change with a sophisticated ignorance, a particular kind of emptiness, and an increasing ability to forget what you know and to give up the need to understand.

Remembering a cherished quote from Nicholas of Cusa, a brilliant fifteenth-century writer and ambassador for the Vatican, who said “we can never know as much as we want to know about the important things … but what is crucial is not what we know but that we know we don’t know.”

These holy resilient voiced loud and irreverent admissions about the RxP agenda; about who we were, about who we are, and about who we were becoming—and all of them to some degree rooted in uncertainty. Acting as if they were Zen masters, these holy resilient had an RxP awareness that sometimes rules and teachings are best observed when they are ignored.

As I contemplated again on the holy resilient within my RxP world, I found myself wondering how they do it. What helps them? How did they open themselves up for such growth and change? How did they manage their new relationship within their own agencies? How did their choices to follow an RxP path change them? Their personal identity? Their professional self? Their practice? I saw at least two gifts these resilient offered. First, there was a sacred rhythm that the resilient offered. Secondly, throughout the seasons of change they offered clustering questions.

A rhythm of “releasing and holding” appeared to be a “gifting” from the resilient. Sometimes with peacefulness and ease, and at other times, often with great struggle and pain, these pioneer prescribers let go. They abandoned long cherished dreams of psychological practice, set aside life patterns that had held them and sustained them before, and jettisoned clinical practices that once worked well for them but no longer do. Loyalties hard won, theoretical views, organizational commitments, valued relationships, even casual activities done as routinely as tying your shoes may be gone forever. Justifiably, those letting go may be angrily marked by the change that swept upon them. Grief, confusion, and naked fear often darkened those days.

And yet, these holy resilient “take hold.” With wisdom, cursing, and often much prayer, they take hold of fresh moments that they see growing both around them and within themselves. Gracelet moments were captured and marked by a lack of forced effort to appear optimistic or pretend everything is ok. A life-living experience by these resilient persons who broke through self-deception and know how much they don’t know. These resilient ones respect the edge of illusion where that part that remains unknown and unspoken gives us words and ideas the emptiness of our mind requires. There was room for mystery in both our lives and our practice. Where is the mystery in our RxP path?

How much has the study of medicine changed us? What will we become? What will our allegiances be based on? Are we still psychologists? Are we some-
thing else? If so, what are we? What am I “releasing” and “holding” in this change moment? How has this RxP learning changed my life work? And how has my life work taught me how to live? Who are the holy resilient that hover in my mind who instruct me in letting go and taking hold?

The clustering questions—this is the second area where the holy resilient offer help it seems. Whether or not they always asked these questions outright and with candor, I can’t remember. I think that on some level, they have dealt with them and somehow lived faithfully with the change that emerged from them. For me, these clustering questions hovered in the after-convention moments when I shared a cup of coffee or a beer with a colleague in some convention hideaway corner. The questions seem to have changed for me as the RxP path has changed. Clarity is a luxury. The cluster seems to apply equally to both my personal RxP adventure as well as the RxP Div55 communal-like change as well. I offer them to you as personally framed and flawed, but also in gratitude to the holy resilient who clustered them into potentially life-expanding measure.

These clustering questions are offered in a contemplative fashion:

1. What must I/Div55 “let go” of?
2. In the midst of my personal/professional change that is taking place, what abides?
3. What am I/Div55 invited to “put on”?
4. What fresh glimpses/gracelets of service to my patients do I see amid all that is going on?
5. What models of faithful change/“holy resilient” can I look to?
6. How might what I/Div55 am learning help our communities and patients?

Wishing to resign my membership, where do I send my letter? I still don’t know.

I want to resign from my old simplistic way of thinking about caring for people—medicine killed my old model.

I want to resign from my archaic allegiance to institutions that aren’t truly invested in caring for people, or me—disloyalty is dealt with harshly.

I want to resign from years of literalism and fundamentalism that had no room for spacious emptiness—we don’t know it all.

I want to resign from a personal or professional philosophy of life and practice that isn’t worth the risk of one’s life—am I crafting a life worth living?

I want to resign from celebrations of victory that are actually ways of defending against important and necessary losses—we don’t always win.

Wishing to resign my membership, where do I send my letter?

Honor to Serve!

2015 Division 55: 2015 February Presidential Musings

Michael R. Tilus, PsyD
Commander, U.S. Public Health Service
President, Division 55

It’s an honor to serve Division 55 this year. I respectfully submit these musings to you as reflective of my thinking for Div 55. They do not necessarily reflect the opinions of the American Psychological Association or Division 55 Board of Directors. I hope the nature of this reflection will give the Division a holding context for my perspectives on Division 55, Challenges, and 2015 Presidential Initiatives.
Division 55 has been my personal and professional “home” for more than 13 years now. When I began the didactic portion of the RxP path, I was thrilled to meet some of the brightest and most gifted psychologists in the field. These RxP psychologists were highly motivated; they were excited about the new path ahead; and they were willing to support other student learners in ways that were meaningful and vibrant.

RxP advocacy had already become extremely personal to me after serving my first duty station at an extremely isolated, frontier, medically underserved Indian Community. For the almost five years my wife and I served there, I was 100% unable to get a single Native American patient of mine in to see the part-time psychiatrist who visited our local community mental health outpatient department. Longstanding issues of limited access also had clear racist coloring that could not be ignored. Division 55’s primary life-blood was public health service psychology advocacy. It was a good fit!

After consulting with my wife, we committed personal and professional financial, emotional, and relational resources to meet the end-goal of our continued mission to serve medically underserved communities in Indian country with an increased capacity for practicing medicine, in addition to psychology. My wife and I would discover later on, that the path would strain all of our intentions and malign my heroic heart with a daily dose of unwanted reality. Reflecting back on the idealized goal and RxP workforce I so hoped to join helped me identify possible harmful effects that swang-and-swung my intra and inter pendulum.

As psychologists, we are trained to look honestly at the cases and concerns that our patients bring to our practice. And, yet, as I pondered our decision to follow this path now some years later, as I write this I can clearly identify where I have suffered significant psychological stress, and even points of trauma, while engaging in the rigorous pursuit of the RxP path. I remember the countless times I have encouraged, maneuvered, manipulated, and admonished patients to tolerate discomfort; to gain increased ability to confront the “demons” in their lives; to be patient as skills and knowledge grow in new ways after the passing of time. Appearing wise, I assumed the posture that I would be able to know how much this is healthy, albeit painful, and at what point it may become unhealthy for my patients. How did becoming a prescribing medical psychologist begin to mirror this same process?

Maybe there is something important, a distinction, between the means and ends. I remember reading constant commentaries from my warmly held and idealized RxP colleagues, that the RxP path is likened to all serious psychological transformation prescriptions, as it involves significant levels of discomfort, difficulty, and dis-ease. “Embrace the path” appeared to be the working motif that I surrendered myself to. This too sounded familiar to my therapy ears as another common parallel process I had verbalized to my patients. But now, my own personal RxP path had open potholes that were more than bumps on the road or random events that had disrupted my idealistic pilgrimage. Had our intensive RxP medicine become something other than painful, and was in fact harmful?

Was the problem in the practice, or in the approach? Was the RxP path I partook an unskillful pursuit, or was I inadequate? Did my practice, or I, hold unrealistic or uninformed expectations of the RxP way? Was the path ill-informed? Did I have unsuitable teachers? Or was this truly reflective of my own personal history of psychological fragility after returning from the first Gulf War? Was I more like my patients, minimizing and intellectualizing the prolonged effect within my soul that housed PTSD and Depressive thorny flow- ers?

These questions were now more than disturbing—they were adverse enough that I found myself unsuccessfully trying to manage their active fallout. The longer I stayed on this RxP path, the harder and harder it was to tell the difference between the life-sustaining emotional nourishment and the toxic poisons I ingested. The life-giving nourishment I needed to support life had become toxic. And now, I had learned to dig and extract what life-giving nourishment I could find from the abundant poisons that were richly at hand everywhere. The RxP path I was on appeared to be one that sought, maybe even required, nourishment from poisons, or in other ways, was poisoned by the redemptive nourishment I sought.

I see Division 55 mirroring my own RxP path. If Division 55 is to achieve its mission, support its member-
ship, increase professional recognition and stature, and advance the public health in both federal and state RxP legislation, I believe we need to know what our current condition is; what our strategic objectives might be; and how our refined vision and mission may ultimately protect and promote the overarching health and safety of our American communities, as we practice both medicine and psychology.

From these reflections, I respectfully submit my comments and observations about Division 55 with candor, honesty, and transparency. Again, these are my biased opinions that have previously been submitted to the Div 55 Board of Directors. Any errors are mine, and mine alone. And, my conclusions and observations may be 100% wrong.

Division 55 Challenges Today

1. **Reduced Div55 Membership**
   - Div55 membership has consistently dropped over the past five plus years to its all-time lowest number of approximately 440ish.
   - This number will vary over the next few months as other Div55 members renew, but I do not anticipate it will vary significantly.
   - This decrease appears generally consistent within the general declining membership of APA as well.
   - Senior Div55 members have worn out, retired, or are retiring, and subsequently, dropping from Div55 membership.
   - I believe evidence suggests a high number of Div55 members have left APA, or APA and Div55, for State associations that either license/monitor or directly support and advocate for the practicing RxP psychologist with meaning and value.

2. **Serious Morale Problem on Listserve**
   - Toxic nature of listserve has pushed many members away over the past few years.
   - Toxic nature of listserve currently inhibits many members from electing to post any response for fear of retaliation.

3. **Div 55 Balance Sheet**
   - Div55 has consistently run in the red over the past years.
   - Div55 cannot continue projecting a deficit every year.
   - Currently, Div55 has a strong balance sheet.

4. **Div 55 Has Little “Value-Added”**
   - No Journal.
   - Occasional Mid-Winter Conferences; expensive; reduced CEUs.
   - No ability to raise funds for state RxP advocacy.
   - Increased ambivalence about APA and Division loyalty.
   - Increased ambivalence about APAPAPO advocacy and RxP intent.

5. **The Tablet**
   - Recent publications have been thin with reduced attraction.
   - Limited generalizability to practitioners of medical psychology.

6. **Reduced Div55 Leadership**
   - Too few able and willing to “carry the water.”
   - Faithful and committed are worn out.

2015 Presidential Strategic Initiatives

1. Establish new listserve rules of behavior; monitor and enforce standards; encourage collegial conversations.
2. Balance the budget.
3. Increase the Membership with Value-Added Benefits to include The Tablet.
4. Support increased presence of prescribing psychologists in both the Federally Qualified Health Centers and VA; in the public health psychology spectrum (Division 18); and in grassroots state-initiative RxP legislation as appropriate.
5. Increase communication to Div55 listserve mem-
bers through regular accounts/reports in *The Tablet* and on the Web.


**Limitations**

- What can we realistically do this year?
- Who are the people that are committed to carrying some water?
- How can we support these people in their interests and shared missions?
- How can Div 55 best serve its membership?

**Summary**

I hope this document gives you a fuller sense of Div 55 standing and how I hope to discharge my duties this year. The Board of Directors and Committee Chairs stand ready to serve the Division in whatever way we can. Following this email announcement, I will be releasing other key documents that speak to the challenges and strategic initiatives I’ve highlighted above. On behalf of the Div55 Leadership, we remain engaged and active in supporting you and the prescribing medical psychology movement! Personal comments are welcomed: [mrtitus55@gmail.com](mailto:mrtitus55@gmail.com).

Honor to Serve!
From a single seed come the first shoots—and the first roots. So it is that the federal government has played a major role in the RxP movement from its earliest days. This volume of The Tablet provides something of a status update regarding federal activities vis-à-vis national RxP. I hope here to provide some perspective from which to consider the contributions of its various authors.

1994 to Late 2004: The Breakthrough Decade for State RxP

The landmark Department of Defense (DoD) Psychopharmacology Demonstration Project (PDP) graduated its first class in 1994 and was an unequivocal success. Although its graduates could only prescribe medication to military beneficiaries, the PDP proved to be a crucial steppingstone for every state RxP effort in the decade that followed. The PDP opened the door for New Mexico’s breakthrough legislation in 2002; and two years later the PDP remained the only source of objectively evaluated RxP safety data when Louisiana became the second state to enact RxP legislation. If the PDP was the seminal act from which the RxP movement sprouted, then New Mexico and Louisiana were the first fruits to emerge on that shoot at the end of the decade. It would be another decade before the root structure of the RxP movement would be sufficiently developed to support a third blossom, which we now know as Illinois.

A Fertile Federal Soil

The relationship between the federal government and the states is defined by the Constitution of the United States. Generally the states retain power over their own domestic issues and are only subject to federal authority under a finite set of circumstances. However, the states may request federal assistance when national interests are at stake. The national defense and the public health are crucial national interests served by the DoD and the Department of Health and Human Services (HHS), respectively. One of the things that these departments have in common is their authority to administer uniformed services.

The DoD is a federal department, which interfaces directly with states on issues limited to the national defense. It administers several uniformed services including the Army, Air Force, Navy and Marine Corps. The Navy provides all health services to Marine Corps beneficiaries. The DoD has a primary national defense mission and; therefore, has no independent national public health authority. For this reason the granting of prescriptive authority to PDP graduates impacted only uniformed service members/retirees and their dependent family members.

On the other hand, the HHS is a federal department that has a primary national public health mission, but no independent national defense authority. The uniformed service it administers is the Public Health Service (PHS) Commissioned Corps. The PHS is comprised of 13 HHS agencies including the Indian Health Service (IHS), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA) and its National Health Service Corps (NHSC) to name a just

Guest Column

On Roots, Shoots, Flowers, and Fruits:
Tilling the Federal Soil for RxP Growth

Kevin M. McGuinness, PhD, ABPP
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a few. The PHS Commissioned Corps also maintains interdepartmental agreements to provide health services to the departments of Defense, Homeland Security and Justice.

For the sake of this discussion the PHS Commissioned Corps may be understood as a network of more than 6,500 public health professionals, many of whom are clinical practitioners assigned to hospitals and clinics of the Indian Health Service; American Indian and Alaska native tribes; Army, Navy, Air Force and Coast Guard bases; federal prisons; state departments of health; universities; and federally qualified health centers (FQHC) spanning the nation. By now, we all know that what started out as a seed with the DoD PDP sprouted in New Mexico and Louisiana as law. What hasn’t been quite as clear is how the interface between state and federal authority has enabled an informational root system to grow across the nation in fertile federal soil expanding RxP awareness through the federal system over the decade from late 2004 to 2014. It comes down to a signature.

2005 to Late 2014: The Breakthrough Decade for Federal RxP

When New Mexico Governor Gary Johnson signed his state’s RxP bill into law in 2002, whether he knew it or not, he set the stage for improved access to mental health care in the state of New Mexico and every state in the nation as part of the public health mission of the Department of Health and Human Services through the U.S. Public Health Service Commissioned Corps. Before he put his pen to that paper, clinical psychology was already recognized as a health profession, by federal law; specifically, the Public Health Service Act. The Public Health Service Act states, in part that:

Notwithstanding any other law, any member of the [National Health Service] Corps licensed to practice medicine, osteopathic medicine, dentistry, or any other health profession in any State shall, while serving in the [National Health Service] Corps be allowed to practice such profession in any State. 42 U.S.C. § 254f (e).

So, the moment that RxP became part of clinical psychology’s scope of practice in New Mexico any New Mexico licensed prescribing psychologist was legally entitled to practice in any state in the nation; provided that said state had requested federal public health assistance and that said prescribing psychologist was sent to the requesting state by the federal government to meet that request.

New Mexico and Louisiana had created a wonderful opportunity to spread RxP awareness across the nation—to federal policy makers and state legislators alike. But, there were a number of obstacles that needed to be overcome. In 2002 there were no prescribing psychologists, anywhere; we had to make a few. And, there were no implementing regulations in New Mexico; a few of those were needed as well. And, even though the Public Health Service Act enabled the use of prescribing psychologists to fulfill its mission; it did not mandate their use by any federal agency. Each agency would have to decide whether it wanted to change its policy to include this upstart professional group. However, asking each agency to do so might have been tantamount to waking a hibernating bear to see if it was hungry. But, there was an alternative in the PHS Commissioned Corps, a uniformed service with a cross-cutting presence in many federal agencies.

It took until 2004 for New Mexico to install implementing regulations for its prescribing psychologist law. By then, Louisiana was well on its way to licensing its first medical psychologist. At about the same time I accepted a PHS Commissioned Corps assignment to the NHSC. I concluded that if I could obtain my license in Louisiana or New Mexico I might use the Public Health Service Act to set precedent within the federal government as its first licensed prescribing psychologist; and I might do so without waking up any hungry bears. In 2006 I was granted a medical psychology license by the state of Louisiana. That year I was transferred by the PHS Commissioned Corps to an FQHC in New Mexico where I wrote my first prescription under federal authority, with a Louisiana license. In 2008, while on a deployment in South Dakota I was granted prescription privileges by the IHS and became the first licensed medical psychologist to write prescriptions in that agency. Shortly thereafter, Dr. (Commander) Mike Tilus became the second PHS commissioned officer to be licensed as a prescribing psychologist. Since that time he has prescribed in North Dakota and Montana. But, prescription writing is just one of the fruits of RxP. What has been more important during this decade has taken place beneath the surface, at the root of RxP.
While RxP opponents have fought public legislative and media battles to retain the fruits of their labors, federal prescribers have been raising national awareness by installing the RxP message in the hearts, minds and political calculus of state and federal policymakers in the name of public health. Besides working in FQHCs and at IHS and tribal clinics and hospitals across the nation, federal prescribing psychologists have been influencing attitudes and making national policy that includes prescribing psychologists. In 2012 the PHS Commissioned Corps formally created commissioned officer billets for both prescribing and medical psychologists; the IHS began writing, advertising and filling similar positions for civilians in states with no RxP license laws; and the NHSC recognized the applicability of loan repayment to prescribing and medical psychologists. These are roots.

In 2015, when I brief a national policy maker or legislator on RxP, my introduction sites the thousands of prescriptions written and/or filled across the nation beginning in New Mexico and Louisiana and extending to Hawaii, Montana, North Dakota, South Dakota ... Illinois ... I mention the recognition of RxP by the U.S. Public Health Service Commissioned Corps, the Health Resources and Services Administration, the National Health Service Corps, the Army, Navy, and Air Force ... I offer an unblemished 20-year safety record of zero licensing board complaints and zero professional liability claims ... Then I wait for the inevitable question about the PDP, to which I respond in terms of all that has happened since.

2015-2024: The Harvest Decade for National RxP

I believe that the recent Illinois legislative victory signals a substantial harvest of successful RxP legislation in the coming decade; and I believe that all federal agencies will soon recognize and employ prescribing psychologists. The seed that was planted in 1994 by the PDP and sprouted in 2002 and 2004 in New Mexico and Louisiana is now supported by growing numbers of state licensed prescribing psychologists nationally; and it is firmly rooted in federal policy.
An Exciting Vision: Upon occasion, I have been “accused” of being overly optimistic about the future of psychology, especially by senior colleagues who might be emotionally invested in the past. Without question, the health care environment of the 21st century is rapidly changing. However, as long as the field continues to attract “the best and brightest,” I am confident that psychology and our colleagues in nursing and pharmacy will do very well. We must appreciate that the vision of our educational leadership is critical to the future.

I am currently serving on the nursing and psychology faculty of the Uniformed Services University of the Health Sciences (USUHS). Since we are located near our nation’s Capital, we are fortunate to be able to interact with psychology leaders from across the country, as well as senior APA staff. Former APA Presidents Ron Fox and Don Bersoff have addressed our interdisciplinary health policy class, as well as several Directorate Executive Directors. The students have been invited to a number of APA events, including the annual State Leadership conferences, the recent APA-ABA judicial conference, not to mention being included in ongoing convention activities. A typical initial response to a very last minute expression of interest in the APA Education Leadership Conference: “We would be happy to have some of your students participate. At this point in time we have space limitations or I would try to make this work” (Catherine Grus, Education Directorate). We fully expect that next time it will be possible. Throughout these experiences the palpable enthusiasm of the next generation has been very evident, as has been their interest in shaping their own destiny. USUHS recently announced that our current APA President Nadine Kaslow will be visiting with students and faculty. APA’s genuine responsiveness to the interests of our next generation is most impressive—Mahalo, Norman Anderson.

Postdoctoral Opportunities: One of the most exciting developments within the profession has been the establishment of psychology’s postdoctoral training initiatives. As we have evolved from being an exclusively mental health focused discipline into a bona fide health care profession, the breadth of clinical opportunities for psychological expertise to improve the quality of patients’ lives has been exponential. During his APA Presidency, World War II Army veteran Jack Wiggins visited with VA Secretary Tony Principi, a Vietnam veteran, and as a result of that discussion, the Secretary called for the VA to begin a psychology postdoctoral training program. Over the subsequent years, this initiative has steadily expanded, both in numbers and in its clinical focus. Visionary VA senior psychologist Bob Zeiss:

“Health professions education, across disciplines, is a core mission of the Department of Veterans Affairs (VA), with a general goal of providing high quality experiential learning opportunities to develop well educated and well trained health professionals for VA and for the nation. VA’s Office of Academic Affiliations (OAA) funds and oversees these training opportunities. During my tenure at OAA (2005-2013) and continuing today (under the leadership of Kenneth Jones, Director of Associated Health Education), the number of funded postdoctoral training positions increased from 52 to 402. Phase III of the five year Mental Health Expansion Initiative will increase those numbers even more for the 2015-2016 academic year.

“Working closely with Mental Health Services and supporting VA’s major initiatives to enhance both access to and quality of mental health care in VA, OAA
committed to increase the number of trainees in all mental health disciplines. Because of the strength of psychology staff across the nation, psychology as a discipline was particularly poised to develop new internship and postdoctoral programs and enhance existing ones. In recent years, we have increased the focus on developing training opportunities in smaller and rural VA health care settings. These programs provide the same kinds of opportunities as do larger, more traditional programs; they also are intended to generate a cadre of health care professionals eager to remain in and serve in those smaller and more rural settings.

“The focus on postdoctoral training is based on the premise that VA training provides a particularly highly qualified set of candidates from which to recruit future VA staff. Though graduating interns are generally experienced and skilled, the internship does not allow sufficient depth of training to become highly skilled in an emphasis or specialty area. Adding a postdoctoral year to training provides precisely that opportunity. Thus, not only does VA ensure that these new professionals have the skills relevant and necessary for quality care of Veterans, but we are also in a position to determine exactly which developing practitioners have the skills, attitudes, and dedication to VA care that we treasure in our employees.”

President Obama’s Patient Protection and Affordable Care Act (ACA) envisions the health care environment of tomorrow as providing interdisciplinary data-based care, with a priority on wellness, prevention, and services which are high quality and cost-effective (i.e., the “Triple Aim”—simultaneously improving population health, improving the patient experience of care, and reducing per capita cost). Combined with the Mental Health Parity legislation, the ACA represents the largest expansion of health insurance coverage, particularly for behavioral health, in the history of our nation. And, as Bob indicated, the Administration has demonstrated a concerted effort to engage all health care professions. Mary Dougherty, Director of Nursing Education OAA, reports that the VA supports academic partnerships with Schools of Nursing via the VA Nursing Academic Partnership (VANAP) which funds both baccalaureate and graduate students. The graduate programs are focused on Psychiatric Mental Health Nurse Practitioners (PMHNPs). Both programs require a residency—a post baccalaureate nurse residency or a PMHNP residency. The OAA provides funds for graduate and undergraduate faculty for both schools of nursing and VA, as well as stipends for graduate trainees, post baccalaureate nurse residents, and PMHNP residents. The development of a standard PMHNP competency, curriculum, and accreditation standards are expected outcomes of this program.

**Population Focused Health Care:** I have recently been appointed to the national advisory committee on Interdisciplinary Community-Based Linkages of the Health Resources and Services Administration (HRSA). The committee is charged with providing advice and recommendations on policy and program development to the Secretary of HHS concerning its various Title VII (Health Professions) training programs and is to submit an annual report to the Secretary and to Congress. Included within its jurisdiction is the Psychology Graduate Education program, as well as the Area Health Education Center, Geriatric Education Center, Quentin N. Burdick Program for Rural Interdisciplinary Training, Allied Health, Mental and Behavioral Health Education and Training initiatives, Education and Training in Pain Care, and the Integration of Quality Improvement and Patient Safety Training into Clinical Education of Health Professionals programs.

One of the challenges facing the nation is addressing the sequelae from possessing multiple chronic conditions (MCC). Currently 26% of adults have MCC; 67% of Medicaid beneficiaries with disabilities have three or more conditions. Not surprisingly, as conditions increase, so does the frequency of mortality, poor functional status, hospitalizations, readmissions, and adverse drug events. Sixty-six percent of US health care costs are for individuals with MCC and 93% of Medicare expenditures are for individuals with MCC. For those inpatients 18-44 years of age with more than two chronic conditions, depression is the most prevalent. The HHS Multiple Chronic Conditions Strategic Framework overarching goals include: Fostering health care and public health system changes, maximizing the use of proven self-care management, providing better tools and information to workers who deliver care to those with MCC, and facilitating research to fill knowledge gaps. The poor health outcomes of individuals with serious mental illnesses and other behavioral health problems warrants special attention because of the co-occurrences of these conditions with other chronic conditions. This
is a priority patient population for which psychology’s postdoctoral training would seem most appropriate; including those with specialized training in psychopharmacology.

Ron Rozensky, who served as a former chair of the committee: “It was a great experience representing psychology and having the opportunity to work with the chairs and vice chairs of other advisory committees representing the full range of health care disciplines. We collaborated on writing a letter to Congress during the drafting of the ACA underscoring the importance of the inclusion of interprofessional education, training, and service. Our 10th Report to Congress highlighted the importance of health behavior as a key component of a truly integrated health care system—what a great honor to chair that report!”

Reflections: I am intrigued by how our senior colleagues respond to retirement. Margy Heldring, former APA Congressional Fellow: “I am nearly full time with the group I founded, Grandmothers Against Gun Violence, after Sandy Hook. It is amazing to build a new organization of “Women of a Certain Age” and see everyone feel empowered and turn (return!) to activism. What an experience! Psychology seems farther and farther behind me, as I move out and back into policy and politics as a psychologist!” Why, Oh, Why Can’t I? Aloha.

I’m Sitting in the Railway Station

Pat DeLeon, PhD
Former APA President—Division 55—October 2014

The Institute of Medicine (IOM): As one of the “learned professions,” it is incumbent upon psychology and nursing to become aware of, and contribute meaningfully to, efforts by colleagues in other disciplines to address society’s most pressing needs. The Board on Children, Youth, and Families of the Institute of Medicine (IOM), directed by Kimber Bogard, released its most timely report Sports-Related Concussions in Youth: Improving the Science, Changing the Culture almost exactly one year ago. This visionary effort has received considerable attention in the popular media and the White House. With the intense focus currently on the health status of retired NFL players, and increasingly on those who played sports in college, the groundwork has perhaps been laid for fostering an important and scientifically based national discussion—one for which psychological expertise should be highly relevant. A major conclusion of the IOM report is that while some studies provide useful information, much remains unknown about the extent of concussions in youth; how to diagnose, manage, and prevent concussions; and the short- and long-term consequences of concussions, as well as repetitive head impacts that do not result in concussion symptoms.

Interestingly, among male athletes at the high school and collegiate levels, football, ice hockey, lacrosse, wrestling, and soccer consistently are associated with the highest rates of concussions. Among female athletes, soccer, lacrosse, basketball, and ice hockey are highest. There has been little research on the frequency of concussions among those playing intramural and club sports and in those younger than high school age. Accordingly, the IOM called upon the Centers for Disease Control and Prevention (CDC) to establish and oversee a national surveillance system to accurately determine the incidence of sports-related concussions among those aged 5 to 21. Although some research indicates that a series of molecular and functional changes take place in the brain following injury, little research has been conducted specifically focusing upon changes in the brain or on the differences between females and males. Diagnosis is currently based primarily on the symptoms reported by the individual rather than on objective diagnostic markers and there is little empirical evidence as to the optimal degree and duration of physical rest needed
to promote recovery.

The IOM specifically noted that today’s culture of sports negatively influences athletes’ self-reporting of concussion symptoms and their adherence to return-to-play guidance. Athletes, their teammates, as well as coaches and parents may not fully appreciate the health threats posed by concussions. Similarly for the nation’s military population, recruits are immersed in a culture that includes devotion to duty and service before self; thus, the critical nature of concussions may often go unheeded. It is postulated that if the youth sports community can adopt the belief that concussions are serious injuries and emphasize care for players with concussions until they are fully recovered, then the culture in which they compete will become much safer.

AARP: At the other end of the demographic continuum, around the same time, the AARP Public Policy Institute released its report exploring the probable availability (or lack thereof) of Family Caregivers in the foreseeable future. As Lynn Feinberg discussed at our interdisciplinary USUHS health policy class, today the majority of long-term services and supports are provided by family members. In 2010, the caregiver support ratio was more than 7 potential caregivers for every person in the high-risk years of 80-plus. By 2030, this ratio is projected to decline significantly to 4 to 1; and is expected to fall further to less than 3 to 1 by 2050, when all “boomers” will be in the high-risk years of late life.

Family caregivers—including family members, partners, or close friends—are a key factor in the ability to remain in one’s home and in the community when disability strikes. More than two-thirds (68%) of Americans believe that they will be able to rely on their families to meet their eventual long-term services and support needs when they require help. However, if fewer family members are available to provide everyday assistance to frail older people, more individuals are likely to need institutional care—at significantly greater cost both to themselves and to society. In recent years, the role of family caregivers has greatly expanded from coordinating and providing personal care and household chores to include medical and nursing tasks (such as wound care and administering injections). These nursing tasks used to be provided in hospitals and nursing homes and by home care providers, but increasingly are now being provided by family members. One of the major challenges facing the nation is addressing the sequela from possessing multiple chronic conditions (MCC). Currently 26% of adults have MCC; 67% of Medicaid beneficiaries with disabilities have three or more conditions. As conditions increase, so does the frequency of mortality, poor functional status, hospitalizations, readmissions, and adverse drug events. Today 66% of health care costs are for individuals with MCC, a vulnerable population which we would suggest could benefit significantly from the ready availability of behavioral health expertise.

AARP’s report notes that research has demonstrated the critical importance of family support in maintaining independence and reducing nursing home use among older people with disabilities. Between 1984 and 2004, institutional use declined by 37% among the older population, as the number of older people living in the community with two or more needs for assistance with activities of daily living (such as bathing, dressing, or using the toilet) rose by two-thirds. Medicaid costs for institutional care would have been an estimated $24 billion higher in 2004 had utilization rates remained unchanged after 1984. It is impossible to document the exact portion of these savings that is due to family caregiving; however, the high rates of family support among the growing number of older people with high levels of disabilities who live in the community strongly suggest that such support has been a critical factor in the dramatic decline of institutionalization and Medicaid use during the past couple of decades.

Notwithstanding, AARP projects that the caregiver support ratio is expected to plummet as boomers transition from caregivers into old age with the decades of the 2010s and 2020s being a period of transition. The population aged 45-64 is projected to increase by only 1% between 2010 and 2030; during the same period, the 80-plus population is projected to increase by 79%. The impact of these demographic changes will undoubtedly be further complicated by recent data indicating that the declines in disability rates may have stalled (and perhaps even reversed) among the young old and pre-retirees, largely because of the increases in obesity (which clearly has relevance to behavioral health). Accordingly, AARP has called for a national comprehensive person- and
family-centered Long-Term Services and Supports policy that would better serve the needs of older persons with disabilities, support family and friends in their caregiving roles, and promote greater efficiencies in public spending.

The Accountable Care Act (ACA): On March 23, 2010, President Obama signed into public law the Patient Protection and Affordable Care Act (ACA) [P.L. 111-148]. The ACA represents the largest expansion of health insurance coverage, particularly for behavioral health, in the history of our nation. The Commonwealth Fund recently issued a report card on its status. Four Defining Questions: (1) Are the marketplaces fully functional? Needs Improvement. (2) Did people enroll in the law’s new coverage options? Good To Excellent. (3) Are fewer people uninsured? Good To Excellent. (4) Is the quality of insurance improving? Is underinsurance declining and are people satisfied with their plans? Grade Pending. For Extra Credit: (1) Are people using their new insurance to get health care? Grade Extra Credit. (2) Is growth in health care costs moderating? Grade Pending. And finally, (3) Is the quality of care improving? Grade Pending. In summary: “It seems clear that where we have data, the ACA’s implementation has been associated with significant progress. Equally important, some of the potential problems it could have created such as much higher premiums in the individual market or a lack of insurer participation (which has actually increased for 2015) has not materialized. If the question is: Is the health care system better off in September 2014 than it was in 2010, the answer would seem to be yes.” Impressively, the Commonwealth Fund found that the percentage of adults ages 19-64 who are uninsured has declined from 20% just prior to open enrollment to 15%, which means there are an estimated 9.5 million fewer uninsured adults.

A critical component of the ACA’s commitment to improving access to quality health care throughout the nation is a significant investment in the Federally Qualified Community Health Centers (FQHC) program. Established during the Great Society Era of President Lyndon Johnson, when psychologist John Gardner was Secretary of the Department of Health, Education, and Welfare (HEW), these centers represent the true safety net for many Americans. Accordingly, we were very pleased to learn that prescribing psychologist Earl Sutherland was recently appointed medical director for the Big Horn County FQHC where he is actively implementing their integrated care program—another key element of the ACA. “Some people complain about getting older, but I prefer it to the alternative [Charles Brewer, APF benefactor extraordinaire].” Homeward Bound. Aloha.

Interprofessional Collaboration—The Future

Pat DeLeon, PhD
Former APA President—Division 19—February 2015

For our nation’s health care professionals, these are very “interesting” times. Change is always unsettling, especially when it is difficult to predict with any sense of certainty what the future will bring. Under the visionary leadership of APA President Nadine Kaslow, the Council of Representatives endorsed moving towards Competency-Based Education, an approach which has been adopted by nearly every other health care profession. At the end of last year, the Accreditation Council for Pharmacy Education, Commission on Collegiate Nursing Education, Commission on Dental Accreditation, Commission on Osteopathic College Accreditation, Council on Education for Public Health, and the Liaison Committee for Medical Education formed the Health Professions Accreditors Collaborative (HPAC). They are committed to discussing important developments in interprofessional education and exploring opportunities to engage in collaborative practice around the common goal of better preparing students to engage in interprofessional collaborative practice. They anticipate inviting other disciplines to join their effort later this year in response to inquiries.

If one reviews the training models of the other health professions, there is considerable interest (especially
within nursing and public health) in exposing their next generation of practitioners to the nuances and importance of appreciating health policy—and how, for example, over the past decade various health policy experts have increasingly urged the nation to emphasize developing systems of care, rather than continuing to rely upon individual practitioner expertise. Unfortunately, we have observed that such training is relatively rare within psychology’s training programs. Integrated and patient-centered, data-driven holistic primary care provided by interprofessional teams is one of the cornerstones of President Obama’s Patient Protection and Affordable Care Act (ACA). And, it has clearly been a high personal priority for U.S. Army Surgeon General Patty Horoho during her tenure.

Those colleagues trained in providing mental health and/or behavioral health care face significant challenges in effectively addressing our nation’s pressing needs. On a recent HRSA national advisory committee conference call it was noted: “Mental health disorders rank in the top five chronic illnesses in the U.S. An estimated 25 percent of U.S. adults currently suffer from mental illness and nearly half of all U.S. adults will develop at least one mental illness in their lifetime. In 2007, over 80 percent of individuals seen in the emergency room (ER) had mental disorders diagnosed as mood, anxiety and alcohol related disorders.”

At the Uniformed Services University of the Health Sciences (USUHS), nursing and psychology are pursuing ways to systematically share expertise. A number of courses are jointly taught and/or co-attended; e.g., Stress and Trauma in the Military Context, Introduction to Physiology, and Health Policy. Mental health students enrolled in both training programs (Doctor of Nursing Practice/Clinical and Medical Psychologist) regularly utilize the university’s simulation lab where live actors “play out” various symptomology for the trainees, while monitored on closed circuit television. Discussions are currently underway to facilitate cross-professional critiques of these experiences. An underlying question: Why should there be different training models?

A Very Far Reaching Vision: In January of this year, the Military Compensation and Retirement Modernization Commission, a blue ribbon panel established by Congress in 2013, submitted its 302-page Final Report to the Administration and Congress. Even a cursory review provides a sense of the unprecedented magnitude of their recommendations. “Our volunteer Service members are the strength of our military, and it is our continuous duty and obligation to ensure that the Services are properly resourced…. In considering the military health benefit, we focused on sustaining medical readiness by recommending a new readiness command, supporting elements, and framework for maintaining clinical skills....

“The critical nature of joint readiness, including the essential medical readiness ... make it clear that four-star leadership is needed to sustain dedicated focus on the joint readiness of the force. Ensuring that the hard-fought progress achieved during the past decade in the delivery of combat casualty care on the battlefield, the global capability for evacuating casualties and providing critical care while in transit, and the research that has led to advances in wound care and hemorrhage control, requires strong oversight at the highest level. The Commission thoroughly evaluated the merits of a four-star joint medical command.... (M)edicine is only one component of joint military readiness. The essential nature of military medicine by itself warrants four-star oversight, and the Commission concludes the best course of action is to create a four-star Joint Readiness Command to manage the readiness, as well as the interoperability, efficiency, and ‘jointness’ of the entire military force, including medical readiness....

“Health care is a constantly changing industry. The features of health care, including technology and the models for paying for and delivering care, rapidly evolve. Rather than attempting to replicate a private-sector health care system within DoD, and consequently following behind, the Commission believes beneficiaries would be better served by having direct access to the innovations found in private-sector health care. Furthermore, under commercial insurance, carriers have the tools, including the advancements in payment and delivery models... and the monetary and nonmonetary incentives... to increase value by operating more efficiently.” ‘Cause I’m leavin’ on a jet plane. Don’t know when I’ll be back again. Aloha.
The Apaches are famous for producing fierce warriors such as Geronimo. They are master survivalists; once I heard someone say that if there was a zombie apocalyptic event, the Apaches would still survive. Their valor was popularly noted as they were believed to be one of the last tribes to surrender to the U.S. government. Today, the Tribe has a number of successful enterprises including the Inn of the Mountain of Gods Resort and Casino and Ski Apache. Despite its financial ventures, many tribal members still live in poverty and experience significant problems related to being destitute. Chronic medical conditions such as metabolic dyscontrol, cardiovascular diseases and pain disorder are acutely prevalent and often times comorbid with psychological illnesses including an assortment of affective and anxiety disorders as well as substance use problems.

Mescalero Hospital is located approximately two hours northeast of Las Cruces, NM—home to New Mexico State University and their Clinical Psychopharmacology Post Doctorate program which graduated RxP leaders including Drs. Elaine Levine, Mario Vasquez and Tommy Thompson. The Hospital is located within the boundary lines of the Mescalero Apache reservation and nestled between the mountains and the desert. The surrounding two non-reservation towns are Alamogordo and Ruidoso (30 and 20 minutes, respectively). Alamogordo is a military town and home to Holloman AFB, and an hour and fifteen minutes to El Paso, TX where there is an international airport. Ruidoso is a touristic picturesque mountain town with lots of small shops, fine dining, skiing, and many outdoor sports activities; it is about 2½ to 3 hours from Albuquerque.

The hospital follows IHS Improving Patient Care model which is closely aligned with the national medical home movement. Mescalero Hospital provides urgent care as well as appointment-based outpatient services. Behavioral health, pharmacy, lab, optometry, x-ray, dietary, dental, and public health nursing are all on-site and all departments are linked through an electronic health record, perfect for gathering and analyzing information before making a treatment decision from a medication management perspective. Our inpatient is comprised of 13 beds; most common admissions are from diabetic crisis complications and alcohol withdrawals. There is a contract health service department that handles the financial arrangements to outside referrals. There are two larger hospitals nearby with emergency rooms that serve as referral sources to the patients if deemed necessary.

I had just finished my RxP practicum at another IHS site when my family and I decided to take a journey down to New Mexico. I was a bit apprehensive at first but now, I can honestly say that I am fortunate to have had the opportunity to work at Mescalero Hospital. The medical staffs are very supportive if one is willing to give a hand to help care for their patients. I think this is the essence of rural medicine—no egos, just patients.

I had no problems finding a medical doctor who was willing to supervise me for my conditional hours. Administration was equally welcoming; I was encouraged to take a leadership position and expand services as an active member of the medical staff. I had the opportunity to establish an ongoing chronic pain management committee to assist the medical team in their decision to prescribe opioids. Today, the behavioral health department is intimately integrated into primary care as we see patients in the examining rooms, often side by side with the patients’ primary care provider and nursing staff. We provide adjunct psychological treatments for hypertension, diabetes, obesity, assist with pain patients, order/review labs, screen and treat comorbid psychiatric problems with or without psychotropics, assist in differentiating between medical and psychiatric diagnosis, as well as co-manage mental health crises that present at
urgent care/medical floor. We also see patients who need behavioral health services in the inpatient unit. We actively participate in morning huddles; we are members of the discharge planning team, and we also provide services at the joint University of New Mexico/Mescalero Tribe’s school-based clinic and tribally run nursing home.

Unbeknownst to many, Mescalero Hospital served as a host to a number of RxPers. To my knowledge, I am the fourth prescribing psychologist (preceded by Drs. Mimi Sa, Carmen Diaz, and Bret Moore) to have had the chance to serve here. It is an ideal place to get started and learn how to manage psychotropics while blending in psychological service. Although it may be considered to be “off the grid,” I see this as an advantage. When you are practicing rural health care, you are often “it” and most clinicians learn to rely on one another and respect what everyone can bring to the table. We sure have our challenges, but the opportunity to work with the underserved and seeing the difference that you are making trumps it all.

We continue to expand as just this year, we welcomed Dr. Rafael Salas, a medical psychologist to our team. Following the hospital’s RxP friendly history, we formally established a relationship with NMSU through Dr. Levine and had our inaugural practicum last year. The well-respected Dr. Timothy Fjordbak was the first to complete the training. He should be succeeded by another post-doctoral trainee soon.

Hello From Crow Country

Marie Greenspan, PhD, MSCP

It’s calving season here on our huge reservation in southeastern Montana. Calving season begins the first week of March with raggedy little bundles appearing on the grass beside some of the cows and, eventually, most of the cows. The Mama cows seem to ignore the raggedy little bundles, munching the grass calmly, as they always do. In a day or two, the raggedy bundles struggle to their feet, some temporarily in a downward-dog position before they can make it to all fours. This week, they are tottering around, hundreds of brown, black, spotted, and cream-colored calves, trying to stay close to their mamas.

When I finished up the New Mexico RxP practicum requirements in my home state of Michigan and gathered the paperwork to apply for my provisional RxP license, I did not know what my two provisional years would look like, where I would serve them, or who would act as my physician supervisor. I had begun the Fairleigh Dickinson post-doc clinical psychopharmacology master’s program in 2007, but took a one year hiatus after that first semester, resuming in January 2009. Thankfully, Bob McGrath allowed me to rejoin my fabulous original cohort and our amazing teacher Marlin Hoover, looping back later to finish the two semesters I had missed, finishing the degree in April 2010. I took the PEP in October 2010, and passed.

It took until May 2011 to locate and begin two physician-supervised practica in my home state of Michigan. By August, 2012, I had completed all the requirements for the 80-hour physical assessment training and the 400-hour (100-case) clinical practicum required for New Mexico RxP conditional licensure. Some of my practicum experience was obtained in a remarkable Urban Indian Health Care setting, where traditional sweats were frequently conducted in the side yard of the old church in which the clinic was located, drumming and chanting were always in the background, and smudging was shared by all before every meeting and often throughout the day. My other practicum site, not nearly as ethnically interesting, was in a suburban primary care facility, distinguished by a huge population of Suboxone patients, which allowed me to learn more about opioid abuse than I ever wanted to know. My practicum supervisors, three of them between the two sites, were wonderful and supportive, as were a number of physicians who were not formally supervising me and several PAs and NPs. They always knew more medicine than I did and they were generous in their teaching, but often I was more knowledgeable about psych diagnoses, psych
meds, and about the art and science of combining psychoactive medications and non-pharmacological therapies.

Getting everything filed for the conditional RxP license was a little delayed, as my sister died during that interval, and I wanted time to do my own grieving and be supportive to my family. Application for the NM conditional RxP license requires a supervisory plan. In January 2013, I flew to Las Cruces, New Mexico to visit with Elaine Levine, John Courtney, Christina Vento and others who were then practicing RxPs in the area. They steered me to a psychiatrist who was willing to act as my supervisor and allow me to see patients in his practice. Based upon his agreement to supervise, I applied for the NM conditional RxP license, which was granted in March 2013.

Las Cruces is a gorgeous place, with lovely weather most of the year, and many wonderful and legendary RxP figures practicing there including Elaine Levine, Marlin Hoover and, at the time of my visit, Kevin Mc-Guinness. However, I couldn’t help but notice during my visit that there was no Costco in the area.

In mid-April, 2013, Earl Sutherland arranged for me to have a site visit to the Crow/Northern Cheyenne Indian Health Service Hospital. A full-service hospital, this site had (still has) a fully functioning electronic health record, inpatient medical and surgical services for adults; an emergency room; on-site lab; physical therapy department; x-ray services; a large primary care outpatient clinic with pediatricians, internal medicine and family practice physicians, OB-Gyn physicians and three Nurse practitioners; pediatric and adult dental services, an optometry clinic; a well-staffed and well-stocked pharmacy; and of course, an out-patient Behavioral Health department consisting at that time of Earl as a highly experienced child psychologist, prescribing psychologist, and the BH director; a social worker; and a clerical/reception staff. A psychiatrist came from Billings one or two days/month for medication management of some adult patients. The hospital served 16,000 Crow and Northern Cheyenne natives living on the reservation and closely surrounding areas.

I spent a day touring the hospital and the beautiful reservation with Earl, and we talked a lot. Earl told me I could expect a job offer. I then spent a few days in Billings, an hour away from the Rez, picturing life in the area. I did notice that there was a Costco.

I returned home to Michigan to think, talk to friends and family, and make a decision. After a week of thought, I chose to accept the IHS job offer, and I have never for a moment regretted that decision. The day I started work in June, 2013, I found that Mike Tilus had also joined us at Crow, so I was working with not one but two legendary figures in our RxP odyssey! Both men had been heroes to me since I began my RxP endeavor. Working with them, as well as the obvious advantages of an environment where everything was in place to support learning and collaborative, safe practice, constituted a situation which could not possibly have been more favorable for a newly licensed conditional RxP. I felt as if I had died and gone to RxP heaven! And a Costco only an hour away!

The psychiatrist who contracted with the hospital was unwilling to supervise me. Instead, an internal medicine doc, who is one of the brightest and most capable physicians I have ever worked with, agreed to do so. Between Earl, Mike, my great physician supervisor, and the support and friendship of the entire hospital professional staff, I believe I have enjoyed the ideal conditional experience.

My conditional time is almost finished now. It’s been a time of adventure and intense learning, and I feel as if I have traversed an entire personal and professional continent since June 2013, and in fact since September 2007 when I first began my psychopharmacology education and training. While I have pursued this at times arduous, scary and lonely path toward becoming a prescribing psychologist, I have found encouragement from many sources. Among them was the Indian Country-themed Tablet edition of November, 2010, in which Joanna Hartnell, Mike Tilus, Anthony Tranchita and other RxPs wrote inspiring articles about prescribing psychology practice in under-served settings. I most sincerely hope that hearing first-hand from some of us who today have the privilege of practicing in these areas will provide encouragement to the next wave of prescribing psychologists just finding their feet.
By way of introduction, I completed my psychopharmacology training at Fairleigh Dickenson University and following the passing of the PEP (second try), there were some concerns on the horizon in my private practice, and I thought: why not? My children were grown, so it was time for some new adventures!

At this same time, Dr. Michael Tilus was posting information on the listserv about jobs for prescribers within Indian Health Service (IHS). Unbeknownst to me, Dr. Tilus is an avid recruiter for IHS and he helped to usher me through the application process. Prior to this time, I knew really very little about Indian reservations, basically knowing only that they existed, somewhere. I downsized my possessions, and took off with the dog and two cats, and landed on a reservation in South Dakota first. There I competed the 80 hours under a family practice physician and started the first journey to earn my conditional prescribing license out of New Mexico.

In my early months I attended some pow-wows, ate Indian fry bread with wojapi (a fruit-like dipping sauce) and attending a small backyard sweat of one of my work colleagues. With that, I almost had a panic attack (the first ever), which meant it was an interesting experience … once! People were very nice to me there, and I felt welcomed into the fold.

Dr. Tilus, ever the recruiter, recommended me to a North Dakota-South Dakota reservation on TDY. They were without providers, and I drove the three hours every week for six weeks, going “home” on weekends. After that, I was offered the job as supervisor of the mental health department and the, by then, two dogs and same two cats and I moved north.

The journey with supervision was a longer one than I expected. But once the conditional license is earned, you are basically ordering everything yourself but you remain under weekly supervision. There was an abrupt departure of the pediatric physician at my location and suddenly I inherited about 60 ADHD kids along with a few other youth on medication. Other than my book learning, I had no real experience so it became a quick by the seat of my pants learning. Fortunately for me, there was a physician at my location who knew psychiatric medication management of a wide variety of conditions, and I leaned pretty heavily on him for the first year or so until I felt I had a pretty good handle on working with pediatrics.

The reservation here spans the two states and serves about 10,000 people. I live in government housing and my long commute to work consists of walking across the street to my office. It is a small town, and very rural, and on the weekend I am more than eager to head up to the city, a 55 mile trip each way, to grocery shop and run errands. People look at you funny when you tell them the closest Starbucks is 55 miles away.

I am the only one at my location to do psychiatric medication management, so most of my patient care is with medications. I have several therapists on staff who can do the therapy part, but not the medication part, so it’s just the best way for the division of labor at my location.

There is a fairly high suicide risk in Indian country for many reservations, which is true here. Many of our youth, and some adults, are sent to the hospitals at the nearest city for inpatient care. I have been able to build relationships with some of the psychiatrists there, and occasionally when I have a more challenging case, they have been willing to give me some guidance. For the most part, they have expressed being grateful that I am here as for such a long time there was no one to release people back to for follow up.

This April I will have been with IHS for five years. I am quite comfortable with most all the psychiatric medication patients that I have, but it remains challenging for me with some of the treatment resistant schizophrenic or depressed/bipolar patients which still gets my anxiety revved up. I make sure my
CEUs are all focused on psychopharmacology to further hone my skills once or twice a year when I attend CEUs. And of course my trusted physician colleague is still here to help me think things through on some of the more complex situations.

I have found the work in Indian country, and in a rural setting, to be very gratifying. At first many of the people were guarded as their experience is that people come and move on fairly rapidly so they must change providers often. Understandably this is difficult for them. Having been here for four years (this location), I have earned more respect and appreciation over time. I find it heartwarming to be out in my garden, or walking the dogs, and hearing “Hi Doc!” Many of the little neighborhood children like to come help in the garden, or come sit on the yard swing with me chatting away or help me walk the dogs.

Such a major change is not for everyone. Either it isn’t the right time in their life, or they are disinclined. But for those of you with an interest, I can tell you that you will find the work gratifying and you will really maximize your training. I know I have!

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**Ontario’s RxP Initiative**

Jane Storrie, PhD, CPsych, ABDA  
Diana Velikonja, PhD, CPsych  
Chairs, OPA Prescriptive Authority Committee

On 28 June 2007, former Ontario Minister of Health and Long-Term Care (MOHLTC), The Hon. George Smitherman, requested that the Health Professions Regulatory Advisory Council (HPRAC) provide advice on a number of issues to support the government’s commitment to ensure the health profession regulatory system keeps pace with the health care needs of Ontarians. One of the issues was the prescribing of drugs by non-physician health professionals.

In response, in January 2009, HPRAC released *Critical Links: Transforming and Supporting Patient Care*, a report which recommended a regulatory system that would enable Ontario’s health professionals to contribute to patient care to the fullest extent of their training and abilities, to collaborate with each other to produce the best possible results for patients, and to respond to the rising expectations of health care consumers.

HPRAC described the challenges facing the health care system, including the changing demographic make-up of the province. It was noted that Ontario is growing, aging, and become more urbanized and more diverse, creating new and more complex needs. HPRAC argued that rapid changes in population needs, coupled with advances in technology and clinical practice, place enormous demands on professionals to keep pace; demands that must be met not only by working the maximum extent of their capabilities, but also by developing new competencies.

With respect to prescribing, HPRAC noted that Ontario’s health care system faces challenges in the areas of access, efficiency, and sustainability. Allowing additional qualified health professionals to prescribe was considered integral to more efficient and effective patient-centred care.

**The Ontario Psychological Association’s RxP Initiative**

In 2007, OPA set up a Task Force to examine the issue of prescription privileges for psychologists, and explore the interest of the members in pursuing this expansion of practice. The development of the Task Force was announced through the listserv with significant support from members. The OPA membership was also surveyed with regard to their support of expanding their scope of practice to include prescriptive authority. The survey indicated that 83 percent of members were extremely supportive of this initiative. The remaining 17 percent of members requested more education on the initiative. Given this level of support, the OPA Prescriptive Authority Committee was struck to move forward on submitting the request to the MOHLTC.

It is the position of OPA that extending the scope of
practice of psychologists to include prescriptive authority would positively impact mental health care in Ontario. By substantially increasing health human resources in psychotropic prescribing and management, psychologists would fill gaps in professional services, improve access, and reduce wait times. Given that they are highly trained and qualified mental health professionals, psychologists with prescriptive authority would enhance the quality and efficiency of services and reduce risk of harm to patients.

With the ability of psychologists to integrate psychotherapeutic and psychopharmacologic modalities and standards of practice there would be improvement in patient outcomes, reduced system fragmentation, and better consistency of care. There would be benefits as well with respect to the economic burden of mental health care delivery through fewer hospitalizations and re-hospitalizations, and reduced visits to hospital emergency rooms and walk-in clinics.

The Process of Expansion of Scopes of Practice

Requesting changes to scopes of practice in Ontario first requires a letter of intent be sent to the MOHLTC, who would then charge HPRAC with providing direction to the Minister regarding the request.

HPRAC has criteria that it relies on in the consideration of advice to the MOHLTC concerning a potential change in the scope of practice of a health profession in Ontario. Where there is a sponsoring organization or profession, the proponent is asked to complete a questionnaire to describe its response to the criteria. HPRAC then sets out to determine relevant public interest concerns and questions, and attempts to understand all perspectives on an issue including those of key health care practitioners, other affected health care professionals, clients and patients, advocates and regulators.

Each issue proceeds through a multi-stage process where information and responses are requested from and shared with stakeholders. HPRAC will conduct literature, jurisdictional and jurisprudence reviews, and engage in key informant interviews. Its analysis of the issues will lead to a determination of additional information required, and the appropriate process to be used.

OPA decided to assist HPRAC with their duties by meeting with stakeholders to determine support and with the College of Psychologists of Ontario to secure their agreement to regulate prescribing psychologists prior to developing our submission.

The OPA Submission

On 9 November 2012, OPA forwarded a letter to Hon. Deborah Matthews, then the MOHLTC, requesting that the scope of practice of psychologists in Ontario be extended to include prescriptive authority. This was accompanied by a 165-page submission corresponding to HPRAC criteria, as well as supporting letters from the College of Psychologists of Ontario, and representatives of US jurisdictions who are pursuing or have been granted prescriptive authority.

We outlined necessary changes to legislation to allow psychologists to prescribe substances that fall within the definition of “drug” as set out in the Drug and Pharmacies Regulation Act, R.S.O. 1990 related to appropriate Schedule I drugs. This would include adding the following to the Psychology Act, 1991:

Treatment includes, for prescribing psychologists, the ability to prescribe psychotropic medications within the recognized scope of the profession, including the ordering and review of laboratory tests and other diagnostic tests in conjunction with the prescription, for the treatment of behavioural and mental conditions, the diagnosis of neuropsychological disorders and dysfunctions and psychologically based psychotic, neurotic and personality disorders and dysfunctions.

The response from the MOHLTC to our submission was overwhelmingly positive, but before Minister Matthews could refer it to HPRAC, Premier Dalton McGuinty prorogued the legislature, effectively bringing government to a standstill. Following his subsequent resignation, the Hon. Kathleen Wynne was appointed as the new Premier. Given that Ontario now had a non-elected Premier leading a minority government, no decisions were to be made that would require legislative change. Eventually, an election was held, and a new MOHLTC was appointed, Dr. Eric Hoskins. This was followed by a rather prolonged period to allow the new Minister to get up to speed.

Current Status of the OPA RxP Initiative

With the appointment of a new Minister, there were also staffing changes throughout the bureaucracy, and so we had to start again by meeting with new Ministe-
rial staffers, Parliamentary Assistants, Assistant Deputy Ministers and the Deputy Minister. We met with the Deputy Minister, Dr. Bob Bell, on 8 March 2015 and find ourselves once again in a holding pattern while the MOHLTC reviews the OPA submission.

During all of the delays, the OPA Prescriptive Authority Committee did not sit idle. We continued to meet with stakeholders and other healthcare associations to garner support. When we previously went through this process, we received incredible assistance from the Nurse Practitioners Association of Ontario, the Ontario Pharmacy Association, and the College of Family Physicians. The only exception was the Ontario Medical Association (OMA), who’s Psychiatry Section was adamantly opposed to RxP. After ongoing discussions, however, the OMA is considering supporting our submission, as is the Royal College of Physicians and Surgeons. This is, of course, very exciting.

We have also asked the MOHLTC to grant the right to execute Form 1s for involuntary psychiatric admissions and hospital admission and discharge privileges to psychologists. We have been meeting with other healthcare associations who are seeking expansion of practice, or pursuing initiatives that require legislative or regulatory change, so that we can move forward together.

We recently held a Reception at Queen’s Park, our legislature, where representatives of OPA met with elected officials from all three parties to discuss initiatives including RxP. We had a number of Ministers and MPPs (Members of Provincial Parliament) speak about the necessity of expanding our scope of practice. There does indeed seem to be good momentum on the government side.

OPA also started a public education campaign through our new website and social media platforms regarding the benefits to psychologist prescribing. We are meeting with patient and other advocacy groups who are already concerned with gaps in the mental health system in Ontario. These well-organized and media-savvy groups will help us to drum up public support for RxP.

We now have quite a number of Ontario psychologists enrolled in post-doctoral Master’s programs. The OPA Prescriptive Authority Committee is working with Dr. Bob McGrath of Fairleigh Dickinson University and the Ontario Pharmacy Association to develop a Canadian-content curriculum for FDU’s post-doctoral Master’s in Psychopharmacology.

We have also come to an agreement with the Nurse Practitioners Association of Ontario to establish prescribing Nurse Practitioners (who have been granted the same prescribing authority as physicians) as potential supervisors for the clinical supervised experience portion of RxP training. This will provide an alternative for our members should it prove difficult to find willing physicians.

In conclusion, we don’t know what the future holds for the RxP initiative in Ontario, but the OPA Submission has been well-received by the MOHLTC, and every other healthcare association that has pursued prescriptive authority has been granted it. The OPA Prescriptive Authority Committee remains optimistic that our request to expand our scope of practice will be successful.

The Advancement of RxP Initiative from an Early Career Psychologist Perspective

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As an Early Career Psychologist serving on Division 55 board it has allowed me to be in a position to support the advancement of prescriptive authority initiatives for psychologists. As an early career psychologist I hope to educate my successors of the need and the importance of the prescriptive movement for the viability of our profession. I see prescriptive privileges for psychologists as a necessary advancement in the
psychological profession. As the field of psychology moves towards the integration of care, the knowledge and need for prescriptive authority is imminent. I entered the field of psychology because I saw the need for mental health care and the integration of the mind and body connection. Having prescriptive authority is another tool that I may access for the betterment of patient care.

I am currently a second year student, near the completion of the Fairleigh Dickinson psychopharmacology program. The psychopharmacology program has equipped me with a broad knowledge base to address the psychopharmacology needs of my patients. As a result of my post-doctoral psychopharmacology training, I feel better equipped to have a prescriptive conversation with the prescribing doctors. The extensive psychopharmacology training that I received from my post-doctoral training dedicated to psychopharmacology was not offered in such depth during my doctoral training. My doctoral training in conjunction with my post-doctoral psychopharmacology training has prepared me for this pivotal time in the psychological profession in terms of integration of care.

As an early career psychologist I am invested in the future of the psychological profession. Psychopharmacology training and serving on the board of Division 55 have provided me a vehicle to advance the psychology field, not only from a profession standpoint but for improved patient care.

Rxp Advances: Update on State Advocacy

James H. Bray, PhD
Past President

Since the beginning of 2015, efforts to gain prescriptive authority for appropriately trained psychologists are on the rise. There had been a lull in activity in recent years (with the exception of the success in Illinois), but more states are once again advocating and submitting bills in state legislatures. The most active states are Hawaii, Idaho, and New Jersey. As of this writing, bills have passed at least one chamber and are awaiting passage in the second chamber. North Dakota submitted a bill, but it was not successful. The Texas Psychological Association is actively pursuing prescriptive authority, but we have not found a sponsor as of this writing. Florida, Michigan, and New York have active groups. At the 2015 APA State Leadership Conference there was a renewed buzz in the air about various state efforts. Division 55 leaders will be meeting soon with members of the APA and the APA Practice Organization to discuss better ways to increase collaborations between the groups.

At the national level, Congressman Beto O’Rourke (D-El Paso) is actively working to develop bi-partisan support for his bill to give appropriately trained psychologists the authority to prescribe in the Veterans Administration facilities. We will alert you when this progresses to the point that we need you to contact your Members of Congress to support Congressman O’Rourke’s bill.

There continue to be opponents within psychology to gaining prescriptive authority. However, at last year’s APA convention, Division 12 scheduled a debate between Bill Robiner and Bob McGrath. Bill presented a one-sided case against RxP that was filled with inaccuracies and old information. Bob McGrath presented the case for RxP in a reasonable and factual manner. At the beginning of the debate people were asked to vote whether they were for, against or undecided on the issue. After hearing the debate, people were asked to vote again to see if their opinions had changed. Remarkably, more people were in FAVOR of prescriptive authority after the debate. Bob did a fantastic job and his clear and factual approach swayed many undecided folks into a favorable position. Bravo to Bob!

At the APA State Leadership Conference over 400 psychologists visited their Congressional offices to advocate for a number of changes to advance the practice of psychology. First, we talked about the need to
repeal the Medicare Sustainable Growth Rate penalty. The SGR was an effort to rein in Medicare spending, but it was ineffective because it would cause up to 25% cuts in payments to service providers. The Congress has temporarily repealed the SGR over 20 times, and currently there is a bipartisan attempt to permanently repeal it. Second, we talked to our Members of Congress about ending unnecessary physician supervision for psychologists providing services in inpatient settings. Currently, it requires a physician order and approval to provide psychological services. We asked Congress to include us in the definition of physician for Medicare purposes to end this unnecessary supervision. Psychologists are the only doctorally trained health profession group who are not included in the physician definition for Medicare. Further, we asked Congress to include psychologists in the High Tech Act that would provide financial incentives for psychologists to transition to electronic health records. Behavioral health professionals were excluded from the original High Tech Act, but with the passage of the Affordable Care Act that emphasizes integrated healthcare, it makes better sense to include us so that we will be able to share our work in integrated healthcare systems.

Mark your calendars. Division 55 is once again co-sponsoring the University of Texas School of Pharmacy Psychiatric Psychopharmacology Update Conference in October 2015. The conference brings in experts to present the latest research and clinical information on psychopharm topics. Two psychologists are on the organizing committee and prescribing psychologists have given it very high ratings. See [http://www.utexas.edu/pharmacy/ce/conferences/psych/] for more information.

Feel free to contact me for feedback or more information: jbray@bcm.edu.

Hawaii FQHC Update

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Judi Steinman, PhD

In 1985, at the urging of the State’s senior Senator in Washington, Senator Daniel K. Inouye, Hawai’i introduced its first piece of legislation to authorize properly trained psychologists to prescribe. The medical and especially the psychiatric community of Hawai’i were on alert. The legislation did not pass and the legislation was again introduced in subsequent years, including the current year. It was early in these efforts, however, that the RxP movement in Hawai’i and the mission of Federally Qualified Health Centers (FQHCs) intersected.

For those unfamiliar with FQHCs, these are health care centers that receive funding under the federal legislation referred to as the Public Health Services Act. The Centers are to provide comprehensive health services, including both primary care and mental health services, either to federally designated medically underserved areas, or to a federally designated medically underserved population. Further definition of the medically underserved includes economic, cultural or linguistic barriers to accessing care. In Hawai’i, there are thirteen FQHCs, and while more recent data was not available at the time this article was drafted, a legislatively requested study in 2006 indicated that a psychiatrist was on staff at only two of these centers, while seven clinical psychologists were working at the FQHCs across the islands. More on the FQHCs in Hawai’i a little later. First here is more on the intersection.

At the January, 1989 convention of the Hawai’i Psychological Association, a well-attended workshop focused on the curriculum for prescribing psychologists that was being developed at Wright State University School of Professional Psychology as part of a grant from the APA Committee for the Advancement of Professional Psychology (CAPP). The curriculum addressed underserved populations and issues of diversity. Meanwhile, the latest version of the legislation at that time was being heard in the Hawai’i State House. The outcome of that legislative session was to have the bill referred to the Center for Alternative Dispute Resolution (ADR) at the University of Hawai’i.
For a year, an ADR process was led by two UH faculty, comprised of 15-20 representatives of various constituencies, including Psychology. In January 1990, the Center submitted the report, entitled *Underserved Mental Health Needs and Prescriptive Privileges for Psychologists in Hawaii: A Report on the Psychotropic Medications Roundtable*, back to the Legislature. The report included suggestions to improve mental health services for the “medically underserved mentally ill,” with the clearest consensus being that there were definitely underserved and unserved citizens across Hawai‘i, particularly on the neighbor islands (outside of Oahu).

A number of the recommendations incorporated some reference to teamwork or collaborative education, training or practice. These statements seemed intended to address the information that psychologists and psychiatrists would present in their testimony, which the legislators variously referred to as divergent, competing, or opposing! No statement of consensus was reached about the role for prescribing psychologists, but an addendum was included with the summary of the arguments for and against prescriptive authority for psychologists.

The 1989 legislation did not pass and was reintroduced several more times across the years, including this most recent legislative session. Two of the pieces of legislation crafted by the Hawai‘i Psychological Association, however, specifically addressed the needs of the underserved populations of the State. The HPA RxP Task Force, co-chaired by Dr. Robin Miyamoto and Dr. Jill Oliveira Gray, introduced legislation in 2005 that specifically and exclusively provided for psychologists in Federally Qualified Health Centers to prescribe medication for patients with mental health disorders and to do so in collaboration with the patient’s primary care physician. During this session the Legislature requested that the State Health Planning and Development Agency identify and evaluate barriers to specialty care, including mental health, and to make recommendations to improve access to that care. At the same time, the Legislature through a House Concurrent Resolution created an Interim Task Force on the accessibility of mental health care to consider the feasibility of authorizing psychologists to prescribe. Dr. Oliveira-Gray and Dr. Ray Folen represented Psychology on that six person group, which also included two psychiatrists and two legislators. One of the Representatives was a physician, who at the time was described by one of the co-chairs of the HPA RxP Task Force as “a new champion who demonstrated unwavering commitment to prescriptive authority” for psychologists. That same physician is now chairing the Committee in the Senate that (as of the writing of this article) has deferred sending the 2015 legislation forward to the full Senate.

In 2005 the recommendation from the Interim Task Force was for the Legislature to establish training requirements for prescribing psychologists with a professional affiliation with a Federally Qualified Health Center to prescribe psychoactive medications. The report from that group also included suggestions as to specific acceptable training and education requirements for psychologists.

Subsequently, in 2006, the legislation again focused on psychologists in FQHCs and on the underserved populations in the rural and remote areas of the State. The Hawaii Primary Care Association and the Medical Directors from several of the State’s FHQCs were ardent supporters of the legislation. For the first time, the legislation passed the full House and was moving well through the Senate; however, once again the bill failed to get to the full Senate for a vote when the Commerce and Consumer Affairs Committee Chair deferred the bill after a particularly argumentative hearing. This time the Senate adopted a Concurrent Resolution requesting its Legislative Reference Bureau to “study the issue” of appropriately trained psychologists prescribing “while practicing in Federally Qualified Health Centers or licensed health clinics located in federally designated medically underserved areas or in mental health professional shortage areas.”

The report, entitled *Prescriptive Authority for Psychologists: Issues and Considerations*, was issued in January 2007. This was prior to that year’s legislative session and consideration of HPA’s prescriptive authority bill, again tied to improving access to care through prescribing psychologists practicing in FQHCs. The report was a comprehensive summary of relevant information starting with the DoD Demonstration Project, and the evaluations of the graduates. It continued by looking at the laws granting prescriptive authority in Louisiana and New Mexico, and included the consideration of data on “patient safety issues.”

After proceeding through other topics (e.g., other
non-physician providers), the Report concluded with a review of the issues specific to Federally Qualified Health Centers. The legislation passed both the House and the Senate this time, affirming the value that prescribing psychologists would add to the health care services for underserved populations. Unfortunately, the affirmation was not going to reach the implementation stage. The Governor, known to have strong ties with organized medicine in Hawai`i, vetoed the bill, and there were not sufficient votes to override the veto.

The present 2015 prescriptive authority legislation is not tied to FQHCs, but continues the emphasis on serving the underserved populations of the State, with the introductory paragraph reading as follows:

**SECTION 1.** The legislature finds there is [sic] an insufficient number of prescribing mental health care providers available to serve the needs of Hawaii’s people. The delivery of quality, comprehensive, accessible, and affordable health care is enhanced by collaborative practice between licensed clinical psychologists and medical doctors. Providing advanced training in psychopharmacology to certain psychologists who wish to become medical psychologists would be beneficial to residents of Hawaii, particularly those who live in rural or medically underserved communities where mental health professionals with prescriptive authority are in short supply.

The Amended Report to the 2015 Legislature from the Hawai`i Physician Workforce Assessment Project verified that there are not enough psychiatrists across the state. Shortages range from 29 to 41 percent on the neighbor islands and 7.9 percent across the state. Resolutions were submitted in March by the one physician in the House of Representatives for yet one more taskforce to study the problem. The resolution, however, seeks to exclude psychologists even further by categorizing us with rabbis, Shinto priests and other non-pharmacological healers. Accordingly, despite full passage of House Bill 1072 through the House of Representatives, individual legislators continue to ignore the safety data from those states in which prescriptive authority exists and try to delay passage of this legislation for a thirty first year.

**Twenty-Five Years of Psychologically Based Pharmacological Intervention:**

**A Personal Journey**

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Though not very visible in some areas involved with expanding the scope of practice, one that I have worked on “behind the scenes” for almost 25 years has been prescription privilege for psychology.

I served on APA’s blue ribbon panel on psychopharmacology that endorsed prescription privileges for psychologists and was approved by Council in 1993. The focus was on a multi-level approach to pharmacological intervention—from basic knowledge to engagement to actual prescribing (see Smyer et. al, 1993). By 2004, nearly a decade after the task force reported its findings, two states (Louisiana, New Mexico) had passed legislation allowing psychologists to prescribe medication. Most recently, Illinois joined that small but growing group. However, the number of individuals who require psychopharmacological treatment continues to grow as prescription privilege legislation. Recently, Bray (2014) and DeLeon provided an update on the status of the robust and fluid situation. In that thoughtful article numerous viable alternatives were proposed. In the present article we provide additional review of now a 25-year effort as well as novel ideas for consideration.
My daughter, Krista, encouraged me to volunteer translating for Hispanic patients at our community’s multidisciplinary free clinic for indigents (www.capefearclinic.org). Over the last 15 years we developed its mental health component. The Cape Fear Clinic, of which I was President of the Board for the most recent 5 years, has grown to over 500 patients in the mental clinic alone but with limited support from the psychiatric community. As a consequence an alternative model had to be developed to address the growing number of individuals needing psychotropic medications. Using a collaborative practice model (CPM), I enlisted the support of the on-site pharmacist, Jennifer Buxton, PharmD (see Buxton, Altendorf, & Puente, 2012). Dr. Buxton and I work together every other Wednesday evening in this physician-supervised free clinic to diagnose and subsequently collaborate on what medicines might be appropriate for the individual client. We then refer them to the pharmacy clinic, also run by Dr. Buxton, in order to obtain free prescriptions. We have over 10 other mental health professionals, counselors, psychiatrist, psychologists and social workers who also participate in this program. This approach resulted in an exponential increase in the number of individuals that can receive prescriptions without direct physician involvement.

If there are individuals who are still not convinced that psychologists can be given prescriptive authority and manage these privileges responsibly, then one need only look at programs where these privileges have been enacted. The legislation in New Mexico, Louisiana and Illinois demonstrates that, from a political standpoint, prescriptive authority is feasible and provides accelerated treatments by psychologists. In fact, psychologists working in these states can now bill for these services using the “Pharmacological Management” add-on CPT code which I was involved with and was passed last year at the AMA Current Procedural Terminology meeting. (Note: I am one of 17 CPT voting panel members). This code, when used in conjunction with one of the psychotherapy codes, ensures these psychologists receive equal pay for equal work. For further information, see www.psychologycoding.com.

Perhaps the greatest obstacle in obtaining prescriptive authority now is not legislation but, in fact, ourselves as we need to have faith in our value and potential as leaders in healthcare. It has been 10 years since prescriptive authority for trained psychologists was first enacted and the need is growing. As the last 25 years has shown, there are numerous models in attempting to bridge the gap between what is needed and what we can do. Working together, we can make these changes happen in expanding psychology’s scope of practice, the service our clients are in need of and in helping increase the efficiency but reduce the cost of our expanding health care system.

References

Advancing the RxP Initiative in the Federal Sector: Department of Defense Update

Yaron G. Rabinowitz, PhD, ABPP, RxP

Although psychologists in the military have prescribed successfully since the inception of the Psychopharmacology Demonstration Project in the 1990s, the number of active duty prescribers remains relatively low, and formalized training opportunities are limited. Nevertheless, in recent years, there is growing grass roots support for increased training in clinical psychopharmacology across the services. Moreover, efforts
are underway to enhance coordination amongst the branches, to develop service-supported training programs, and to facilitate the credentialing of newly trained providers.

As is the case in the civilian sector, the significant unmet need for prescribing mental health providers in the military remains a major public health concern. This is especially true in deployed and isolated operational settings where psychologists often practice independently (e.g., infantry units, special operations units, carriers). Thus, prescribing psychologists can increase access to care and minimize the likelihood of patients being removed from theater for treatment. This, in turn, will have a positive impact on readiness, resource expenditure, and stigma reduction.

There are numerous other advantages to growing the number of prescribing psychologists in the military. With extensive training in both psychopharmacology and psychotherapy, prescribing psychologists can develop treatment plans that leverage combined modalities. This allows them to make medication decisions in the context of an integrated mental health care treatment strategy, resulting in more incisive decision-making and fewer failed medication trials. Moreover, by providing both psychotherapy and medication management, prescribing psychologists can offer patients a level of timeliness and responsiveness not otherwise possible. Not only do many patients prefer “one-stop shopping,” but reducing numbers of visits has important organizational implications. Overburdened mental health departments can reduce necessary patient contacts by using one provider (prescribing psychologist) for both psychotherapy and medication management, allowing psychiatrists to focus exclusively on patients who do not require psychotherapeutic intervention.

Recent developments in psychotropic medication policy have placed an increased premium on psychologists with psychopharmacology training. For example, in some military communities a service member can now remain on full active duty status while taking certain medications if the service member is closely monitored (e.g., Army aviation, Navy Submarine community). Psychologists are often the sole mental health providers assigned to units in these communities, and when trained in psychopharmacology, are ideally suited to provide such close monitoring.

Additionally, embedded providers with appropriate psychopharmacology training can make efficient and timely duty status decisions—within the unit—thereby minimizing the need to refer to external providers.

Unfortunately, despite organizational dynamics which have made RxP increasingly important, there has not been a formal, comprehensive military training program in clinical psychopharmacology since the end of the Psychopharmacology Demonstration Project. By contrast, virtually all other subspecialties offer formal postdoctoral training opportunities. Examples include neuropsychology, child psychology, and operational psychology. Military psychologists interested in pursuing RxP become credentialed to prescribe through either health psychology fellowships with a psychopharmacology component (e.g., at Tripler Army Medical Center) or, independently through distance based civilian programs.

Although beneficial, there are also challenges associated with these approaches for DoD providers. First, despite their inherent value, health psychology fellowships lack the psychopharmacology focus of dedicated programs. Moreover, many of the pure psychopharmacology programs lack military specific training, instruction, and clinical experience pertinent to the needs of active duty servicemen, women, and their families. Finally, in the case of civilian programs, the provider must shoulder the cost of tuition, making it an expensive proposition. Consequently, few active duty psychologists have availed themselves to the training.

Military RxP leaders have sought to address this by exploring different options for implementing formal training programs. One option includes a full-time active duty fellowship dedicated to RxP, with academic and clinical training conducted under one roof. The second involves clinical training at either a military or civilian medical center, with the academic component provided via distance learning from an accredited program, such as Farleigh Dickinson University’s Postdoctoral Master’s in Clinical Psychopharmacology.

Both approaches offer numerous advantages by providing increased uniformity and ensuring military focus and oversight. They would also provide each branch with a recognized post-doctoral training model, and would create a mechanism for training to be recognized for advancement. This is an extremely
important incentive to prospective RxP students. Finally, a formal postdoctoral training program would have the additional benefit of allowing the trainee to extend services under supervision to a military population.

DoD psychologists pursuing RxP often deal with a lack of consistency in support and considerable disparities in knowledge of requirements on the part of physicians, credentialing boards, and health care administrators. For example, some providers have been able to obtain the credential with relative ease whereas others, despite meeting all requirements, have faced extreme opposition or roadblocks borne out of lack of prior exposure to RxP. DoD requirements for military providers have existed for years and mirror APA guidelines. They include a Master’s degree in Psychopharmacology, passing the Psychopharmacology Exam for Psychologists (PEP), and completion of a supervised practicum (the Navy requires 100 patients, for example). Recently, a group of DoD prescribing psychologists has begun developing documentation to help aspiring prescribers. In the Navy, an effort is also underway to develop a mentoring program, mirroring that which has been so successful in the Public Health Service.

In summary, despite episodic stagnation over the years, DoD RxP is alive and well and appears to be gaining momentum. This parallels the superb growth and expansion occurring in the civilian sector. There appears to be renewed interest at multiple levels in the DoD, and the time is right for implementing broad changes to training and education. If successful, these efforts can have a dramatic impact not only across the services, but within psychology as a whole.

Combining Psychotropic Medications and Psychotherapy Generally Leads to Improved Outcomes and Therefore Reduces the Overall Cost of Care

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Kevin M. McGuinness, PhD, ABPP

In this brief research paper we provide recent findings answering two key points. We first ask if a combination of psychotherapy and pharmacotherapy are more effective than medication alone for most mental disorders. Then we ask if combinations of psychotherapy and pharmacotherapy reduce the cost of care.

To answer this, we queried PubMed, the National Library of Medicine’s online database. We only examined studies that included a cost component and a comparison between the addition of medicine or psychotherapy to treatment as usual, or to an existing regimen. We looked mainly at studies conducted in the US, but there is a large body of work from Europe and Great Britain that also supports the cost-efficacy of combined treatment (e.g., Wiles et al, 2010; Richards, et al., 2013) (1, 2, 3). Almost all the studies we examined were published in the past decade.

Please note that this is a brief research paper, not an in-depth review, so conclusions must be interpreted with caution. We believe, however, that this brief review is reflective of findings in the larger clinical literature. A summary of key points follows:

1. The number of Americans seeking treatment for depression and other mental health problems has increased dramatically in the past several decades.

Disclaimer: This article was prepared by the authors in their private capacities. The opinions expressed in this article are the authors’ own and do not necessarily reflect the opinions of the U.S. Public Health Service, the Health Resources and Services Administration, the Department of Health and Human Services, the United States government or any other.
Most patients, however, receive only medication, and the percentage of patients receiving psychotherapy instead of medication has declined, largely because patients are being treated in primary care settings where only medication is generally available. It is unclear if this results in overall improvement, but it has resulted in a dramatic rise in Medicare costs (4).

2. Most patients prefer psychotherapy to pharmacotherapy; however, a significant number of patients require both interventions in order to achieve clinical improvement in symptoms. Nonetheless, patient preference is a strong determinant of outcome, and most patients prefer either psychotherapy alone or psychotherapy with added medication. Patel and colleagues found that patients with obsessive-compulsive disorder preferred psychotherapy alone over medication by a wide margin (43% to 16%), followed by a combination of psychotherapy and medication (5).

3. A number of individuals do not respond to psychotropic medication alone. For these individuals, the combination of psychotherapy with medication can both improve outcomes and reduce costs. The opposite can also be true. For patients not responding to psychotherapy alone, the addition of pharmacotherapy to the treatment regimen can improve outcomes and lower overall costs. Cost-benefit is measured not only in the additional costs of providing another treatment, but in terms of the effectiveness of those treatments in reducing healthcare utilization and future treatment. In other words, patients who recover more completely are less like to use mental health resources in the future as opposed to those who do not experience significant improvement or only achieve partial remission. Van Aapeldorn and colleagues found that in patients with depression and panic disorder, patients preferred either psychotherapy or a combination of psychotherapy and medication. The cost of either of these was overall less than medication alone (6). Lynch et al. (2011) examined combination psychotherapy in depressed youth who had not responded to an antidepressant, and found that combination treatment, while having a higher initial cost, was significantly more cost-effective in the long run (7). Even in patients with serious and persistent mental illness, such as schizophrenia, the addition of psychotherapy to a medication regimen often reduces the need for subsequent inpatient admission and is highly cost-effective (8). Similarly, the addition of medication to psychotherapy for patients to 1 to 3 sessions of psychotherapy for depression (note that this number of sessions is generally lower than that thought needed for effective treatment) improved costs and outcomes (9). Other authors have recommended that cognitive behavioral therapy be offered to all patients who have not responded to a trial of antidepressants (10). More recent findings note that adding cognitive therapy to medication improves outcomes, largely among more depressed patients, for whom the cost of care is likely to be higher (11). In primary care settings, where use of medication is the predominant form of treatment, cost analyses have found that increasing primary care providers’ skill in offering behavioral interventions may serve as a significant cost reducer (12).

4. In patients with both physical and psychological illness, the addition of a psychotherapy treatment can reduce the cost of care and improve overall cost-effectiveness. A large study of Hispanic Americans with diabetes found very significant reductions in cost and improvements in cost-effectiveness by adding psychotherapy to a treatment regimen (13). In a very large study of patients with anxiety disorders, Joesch et al. (2012) found that while adding psychotherapy to a medication alone treatment resulted in a small initial cost increase, the cost-benefit equation was positive in the longer term (14). Another large study of enhanced treatment of panic disorder in emergency departments found significantly enhanced clinical outcomes as well as enhanced cost-benefit ratios (less expensive than medication alone) for providing behavioral management of panic in emergency departments. This is a particularly important study in that Emergency Department visits are not only extremely costly overall, but often result only in the patient receiving a prescription and a future referral to a mental health provider. Incremental cost-effectiveness ratios indicated that behavioral interventions were approximately one-half the cost of medication alone (15). Other large trials have found not only that patients prefer treatments with either psychotherapy alone or with medication added to psychotherapy, but also that patient preference is a strong determinant of outcome. In a study of 200 patients with Post-Traumatic Stress Disorder, Le et al. (2014) found highly sig-
significant improvements in quality of life and significant cost-efficacy of care for those receiving psychotherapy in addition to medication and for those who got the treatment they preferred (16). Another review, however, while reporting promising results, could not conclude that combination therapies for PTSD yielded better outcomes or cost-savings than individual interventions alone (17).

5. If a patient is receiving multiple prescriptions for the same problem (polypharmacy), adding psychotherapy can significantly reduce the number of prescriptions, with significant reductions in cost and improvement in outcome. One study found cost savings of over $250,000 annually by reducing the number of prescriptions given to troubled youth in a residential treatment center (18).

6. For patients with addictive disorders, such as alcoholism or nicotine dependence, which are among the most costly disorders in terms of expense and public health burden, or those who desire to stop smoking, combined treatments have repeatedly been demonstrated to be either more effective than medication alone (and, in the case of nicotine dependence, not only cost-effective but potentially life-saving) (19, 20). Sleep disorders are also extremely common and therefore costly. In the case of sleep disorders, either psychotherapy alone or a combination of psychotherapy with sleep medication clearly leads to better outcomes and reduced costs (21, 22).

7. Polypharmacy is an important risk factor for falls among middle-aged and older adults (23, 24). Psychotherapy and pharmacotherapy have been shown to be of equivalent efficacy (25, 26). The adverse side effects of antidepressant, antianxiety and antipsychotic medications, which may include increased risk of complicating illnesses, injuries, and death, are not associated with EB psychotherapies (27, 28). Therefore, the use of polypharmacy when evidence based (EB) psychotherapeutic alternatives exist, such as Cognitive Behavior Therapy (CBT), may not only be costlier, but also riskier.

The reduction of polypharmacy through the use of alternative EB psychotherapies is not only equally effective, but less costly in consideration of the prevention of avoidable morbidity and mortality.

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Establishing Uniform Requirements for Privileging Psychologists to Prescribe in Federal Service

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As those following the development of prescribing psychology (RxP) are aware, New Mexico, Louisiana, and most recently, Illinois, have passed legislation permitting appropriately trained psychologists to prescribe psychotropic medications. Some limited form of prescription authority is also permitted for psychologists in the state of Indiana and territory of Guam (McGrath, 2010). And currently, several states are in various stages of introducing RxP bills for a vote in their respective legislatures. As those who follow the RxP movement are also aware, the history of psychologists seeking prescription privileges goes back several decades. One of the most important historical RxP events involves the establishment of the Department of Defense Demonstration Project (e.g., Sammons and Brown, 1997) in the early 1990s in which a handful of psychologists underwent rigorous formal training to prescribe psychotropic medication. It is important to note that this was a federal endeavor rather than a state driven program. While individual states have continued to pursue prescription privileges for psychologists, similar efforts have continued in the federal sector with good results.

Currently, appropriately trained psychologists are prescribing psychotropic medication in the Departments of the Army, Navy and Air Force as well as in the Indian Health Service (IHS) and Public Health Service (PHS). The efforts at the state and federal levels have worked synergistically to move the RxP movement forward. In addition, legislative efforts are underway in an attempt to expand these privileges to the Department of Veterans Affairs (H. Kelly, personal communication, 17 MAR 2015). As a testament to the hard work and success of those who have made advances in the military, required criteria for each of the military services are specified in regulations specific to each service (Navy: BUMEDINST 6320.66E, 2013; Air Force: AFI44-119, 2011; Army: Department of the Army Memo, 2009). However, to date, neither the PHS nor the IHS have specific regulations. Rather the PHS psychologists adhere to service-specific criteria depending on the location of their duty station and the IHS psychologists obtain state licensure to prescribe in either New Mexico or Louisiana (M. Tilus, personal communication, 27 FEB 2015).

By far the most comprehensive criteria for prescriptive authority for psychologists are outlined by the Department of the Army (DoA, 2009). The Department of the Army permits psychologists to prescribe if they meet the following criteria: (1) is a graduate of the DoD demonstration project or have a master’s degree in psychopharmacology from a regionally accredited university; (2) obtain a passing score on the Psychopharmacology Examination for Psychologists (PEP); (3) document one year of supervision by a board certified psychiatrist or psychologist with prescribing privileges in a Military Treatment Facility (MTF); and (4) apply for prescription privileges within 24 months of passing the PEP. A suggested formulary is provided, but specific formularies are to be determined by the MTF granting prescription privileges.

The Department of the Navy delineates the following criteria (BUMEDINST 6320.66E, 2013): (1) completion of training in psychopharmacology from a program recommended by the American Psychological Associa-
tion and (2) passage of the PEP. There is no specific mention of graduates of the DoD program, but in practice those initial providers have been allowed to continue to prescribe. There is no delineation of required supervision and no specific mention of formulary.

The Department of the Air Force established the following criteria (AFI44-119, 2011): (1) graduates of the DoD Demonstration Project may continue to prescribe for the Air Force; (2) completion of a master’s degree in clinical psychopharmacology; (3) passage of the PEP; and (4) documentation of a minimum of one year of supervision by a psychiatrist or psychologist with prescriptive authority. There is no mention of formulary.

The important commonalities across military services include obtaining a master’s degree in psychopharmacology and passing the PEP. However, other important criteria vary between services including whether the master’s degree is from an approved or accredited school, if supervision is required, and if so, by whom and where, and if a formulary is recommended. Relatedly, there are several critical issues that need to be addressed. For example, since there are now three states that permit psychologists to prescribe, should the federal sector require state licensure as part of its requirements? Also, since many of the early trained psychologists in psychopharmacology completed certificate programs and not graduate degrees, should an exception be made for these individuals in which the degree requirement is waived?

We propose that as part of the maturing process of the field of RxP we should move toward identifying a uniform set of criteria that can be used across federal settings to privilege psychologists to prescribe psychotropic medication. Decisions to adopt privileging criteria rests with the individual federal entities and they each have an established process in place for recommending and adopting criteria for providers. However, those of us in the field of RxP can assist in this process by preparing a uniform set of recommendations. There are a variety of advantages in having a uniform set of criteria, but perhaps also some potential disadvantages.

Advantages of uniform criteria include further legitimizing the practice of RxP in the federal sector by identifying the highest standards and regulations for privileging. Shared criteria will reduce confusion between federal settings and likely facilitate smooth transfers of RxPs between federal agencies. By taking ownership of this process we can work to ensure that our federal criteria for privileging are neither too lenient nor too restrictive. Taking responsibility to set high, inclusive, attainable and uniform standards for the federal sector is a sign of a maturing field and can put us on par with other prescribing disciplines. Finally, uniform criteria would ensure quality across federal settings.

Some disadvantages might arise from setting uniform standards. New requirements might result in currently privileged RxPs no longer meeting criteria to prescribe in a specific federal agency. Poorly developed criteria could result in recommendations that are too lax and risk delegitimizing the field as a whole. Alternatively, criteria that are unnecessarily restrictive could reduce opportunity and growth for RxP in the federal sectors. Therefore, any recommended changes should be discussed thoroughly and vetted by the various stakeholders to avoid these pitfalls.

With this in mind, the current authors propose a minimum and uniform set of criteria to be used for the privileging of psychologists to prescribe psychotropic medications in federal agencies. The reader should consider this a starting point for further discussion with an eye toward the eventual adoption of a uniform set of criteria. This list is by no means exhaustive and the authors understand these criteria can have significant implications on current and future prescribing psychologists and the field as a whole.

**Proposed Uniform Criteria for Privileging Psychologists to Prescribe in Federal Agencies:**

1. A Post Doctorate Master’s Degree in Psychopharmacology from a regionally accredited and/or APA approved graduate program, or a Master’s Degree in Psychopharmacology earned during the pursuit and completion of a doctorate in psychology from an accredited graduate program, or a Post Doctorate certificate in psychopharmacology that meets APA recommendations prior to a specified year
(grandfather clause);

2. Passage of the PEP or other national certifying examination recommended by APA;

3. Documentation of one year of supervision by a licensed prescribing psychologist, board certified psychiatrist, or other board certified physician with specific knowledge of psychotropic medications in a community, state or federal setting;

4. Provide pharmacotherapy to a minimum of 100 patients during the supervisory period;

5. Current licensure from a state permitting psychologists to prescribe, or obtaining such a license within two years of being privileged in a federal agency to prescribe;

6. A statement indicating that medications typically used to treat psychiatric disorders are within the standard formulary of RxPs; and

7. A statement regarding the expectation of ongoing competence, continuing education in psychopharmacology and participation in quality management such as peer supervision.

References


“A Rising Tide Floats All Boats”

Earl Sutherland, PhD, ABMP

I retired last May from the Indian Health Service and am now the Medical Director of a Federally Qualified Health Center (FQHC). I believe that there is a great opportunity to dramatically increase access to comprehensive mental health services by granting FQHCs the same practice standards that the Veterans Affairs Department and the Indian Health Service have.

The DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services Rural Services fact sheet states that:

Federally qualified health centers (FQHCs) include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. Certain tribal organizations and FQHC Look-Alikes (an organization that meets PHS Section 330 eligibility requirements, but does not receive grant funding) also may receive special Medicare and Medicaid reimbursement.

For many rural areas FQHCs are the only source of health care. Like the Veterans Administration (VA) and the Indian Health Service (IHS), FQHCs were granted immunity from tort claims. Unlike those organizations FQHCs were not given the benefit of accepting any state license as sufficient for practice. A health care provider employed by a VA or IHS facility can practice with any valid state license and does not have to secure a license from the state in which the facility is located. The individual provider’s scope of practice is defined by their respective state license. For example, a New Mexico licensed prescribing psychologist can...
prescribe as an employee of an IHS facility in Montana.

The number of FQHCs has been increasing in rural states and Indian Country. Seventy percent of the patients seen at my FQHC are IHS eligible. FQHCs can also serve veterans through the new veteran’s choice program, providing greater access to rural veterans. Unfortunately, few health care providers want to live and work in small rural communities and the being able to have a health care provider start work immediately without the delay and expense of obtaining a local state license gives the VA and IHS a great advantage in recruitment. FQHCs in rural states are now asking their federal legislators to enact statutory changes so that they can have the same opportunity to have health care providers employed and practice with any valid state license. It is my hope that the American Psychological Association, as well as other national health care provider organizations can find common ground and support such a statutory change.

Public Health Service Prescriber Update

Anthony Tranchita, PhD

The Public Health Service currently has 10 officers actively writing prescriptions, and several more who are in training or supervision status. In my opinion, Prescribing Psychologists have in the past, and will continue into the future to play key roles in the Public Health Service by improving access to quality mental health care to the vulnerable and underserved in settings like in Indian Country and Military Medical Treatment Facilities, as well as standing ready to respond to public health emergencies. We are a small but mighty force, and one which I, along with others, hope to expand and grow.

In service to that goal, the Public Health Service prescribing/medical psychologist officers stood up a Special Interest Group for this practice last year. This was done to do what we can as officers to support others through what is often a difficult process to get supervision for licensure, study for licensure exam, walk through the process of licensure often from out of state, and face other challenges along the way. It furthermore allows us an opportunity to work together to bolster the science behind our practice, as well as gather data to show the positive impact prescribing psychologists can have in medically underserved communities. One of our members achieved full licensure this year, utilizing some of the materials from this group and we are looking to continue that trend.

In order to address some of the questions that arise regarding “what impact do you really have,” a number of us have been working together to develop a survey instrument for Prescribing Psychologists in the Federal service, not just Public Health Service Officers, but Active Duty Military, GS employees and contractors. So, if any of the above are you, please fill out that survey when it comes to you! We need good, updated data to advocate for ourselves in State and Federal Forums.
My name is Joseph C. Walloch and I’m honored to be serving as your APAGS Representative for Division 55 this 2015-2016 year. Professionally, I’m currently a 5th year student in clinical psychology (PsyD program) at the California School of Professional Psychology at Alliant International University, San Francisco and I’m a health service psychology intern, completing my residency at the University of Washington Counseling Center. There, my clinical emphases are in disordered eating, mindfulness, and Dialectical Behavior Therapy (DBT). In August 2015, I’ll be starting as an eating disorders health service psychology and DBT research fellow at the University of Nevada, Reno. As an eating disorders practitioner, I will have the opportunity to have an active part on the multidisciplinary treatment team.

I’ve been a member of APAGS since 2010 and have remained abreast of the new developments within Division 55 and in the field since that time, especially the new and exciting strides made for the advancement of psychopharmacotherapy among professional psychologists. The evolution of professional psychology is changing and doing so for the better. My interest in psychopharmacology and Division 55’s initiatives grew out of a desire to work more interactively with other medical practitioners, while being able to “speak the same language,” in order to provide the most effective and holistic treatment to the patient. Specifically, my desire is to work with and treat patients with complex presentations, such as eating disorders, those who struggle with non-suicidal self-injurious behaviors, and those who present as chronically suicidal. It’s evident to many that patients presenting with these various concerns, very often meet diagnostic criteria for myriad other comorbid disorders, such as major depressive disorder and generalized anxiety disorder, which at the present time benefit from not only psychosocial interventions, but also from psychopharmacological treatments.

At the current time, as I not only encounter and treat students on the university campus myself, but as I also speak with other colleagues working in comparable settings around the United States, I’m continuously amazed by the increase in the degree of severity and chronicity of their clinical presentations. Pistorello et al. (2013) assert that college counseling centers across our country are treating students with increasingly higher levels of psychopathology and other complex issues. This seems to be the new norm in this environment rather than a recent coincidence. Despite the fact that there still remain many university campuses which house both counseling services and clinical medicine in different facilities on-campus, increasingly more are becoming more combined entities as well, making comprehensive, integrative health more feasible and also expected. It therefore behooves us as mental health clinicians to develop new competencies, such as advanced knowledge in psychopharmacology, in order to work alongside other health practitioners.

Unfortunately, however, many of the psychotropic medications, such as antidepressants and various anxiolytics, being prescribed to the student patients are being done so by PCPs or nurse practitioners, due to the shortage of staff psychiatrists or other medical providers adequately trained or conversant in psychopharmacology and pharmacotherapy. Tulkin (2012) asserted that many PCPs have indicated that they need assistance in being able to differentially diagnosis and treat patients with psychiatric disorders, in addition to those who have medical and mental health conditions simultaneously. What remains interesting is that it is in the primary care setting where the majority of patients come to seek psychotropics and where many of those prescriptions are written. To me, this clinical knowledge gap is problematic and my hope for the future is that professional psycholo-
gists are awarded prescriptive authority in order to help bridge the gap between medical and psychological practitioners in order to provide the finest patient care.

As we move into the future where integrative health care will become more of the norm rather than the exception within increasingly more clinical settings, it is therefore imperative that student psychologists take a more proactive role in educating themselves about the advantages of learning more about the important role psychopharmacotherapy can play in patients’ treatment, and also about the benefits of becoming a prescribing medical psychologist, not only for the psychologist, but also for the patient’s well-being. This endeavor allows for the combination of the traditional skills of a professional psychologist with the new skills as a prescriber, which benefits the patient holistically.

I hope other student psychologists-in-training join me in the effort to help increase awareness of the importance that psychologists have as health service providers.

References

Legislation and Advocacy

Letter from Harold Kudler, MD

Department of Veterans Affairs
Veterans Health Administration
Washington DC 20420

FEB 09 2015

Jack G. Wiggins, Ph.D., Psy.D., ABPP
15817 E. Echo Hill Drive
Fountain Hills, AZ 85268

In Reply Refer To:

Dear Dr. Wiggins:

Thank you for contacting us regarding employment of psychologists with the Department of Veterans Affairs (VA). Specifically, you have voiced concern about the eligibility requirements for psychologists and have asked for information about the number of psychologists required by VA to meet the treatment needs of Veterans.

To ensure high quality care, VA has defined qualification standards for psychology positions based on a commitment to hire the most qualified professionals. These standards were established in negotiation with VA professional offices, the Unions that represent VA professional staff, and ultimately with Congress. These standards require that any psychologist hired in VA be a graduate of a doctoral program in professional psychology that is accredited by American Psychological Association (APA) and that he or she also has completed an APA-accredited internship. The requirement for an APA-accredited doctoral program as a condition for employment dates back to the 1940s. The requirement for an APA-accredited internship has been the Veterans Health Administration’s (VHA) standard since 1979, with the passage of Public Law 96-151, and it was reaffirmed with the conversion of Psychology staff to Hybrid Title 38 status in 2006. These standards have served VA and the nation’s Veterans well and have ensured access to high quality care. In recognition, however, that there are some highly-skilled psychologists who do not meet these standards, VHA is in the process of revising the Psychologist Qualification Standards. Once approved and published, these revised standards will allow those psychologists who completed an internship that was not accredited by APA to substitute board certification from the American Board of Professional Psychology for the accredited internship requirement.

VA has been eager to hire psychology staff who meet the necessary education standards. As of the end of December 2014, we have increased our staff by almost 3000 psychologists compared to staffing levels in September 2005, and we continue to hire successfully. The standards are, therefore, not preventing us from hiring psychology staff at the rate we have planned.

VA has made a major commitment to and investment in psychology training over the years. As part of VA’s current expansion initiative in mental health training programs, the Office of Academic Affiliations funded an additional 46 psychology interns and 96 new psychology fellows for fiscal year (FY) 2016.
Response to Harold Kudler, MD

February 28, 2015
To: Harold.Kudler@va.gov

By Jack G. Wiggins, Ph.D., A former President of the American Psychological Assn

Harold Kudler, M.D.
Chief Consultant, Mental Health Services
Office of Patient Care Services

Dear Dr. Kudler,

Thank you for your response to my letter to Secretary McDonald on November 5, 2014. I am pleased to learn that the VHA is continuing its review process for revising current VA Psychologist Qualification Standards. The Veterans Choice Act of 2014 was enacted to overcome chronic shortage of psychiatrists and other mental health services in the VHA. This Act authorizes eligible Veteran’s direct access to licensed psychologists when living in communities without ready access to VA facilities. Thus, it is time for the VHA to adopt new standards for licensed psychologists to provide necessary behavioral healthcare for treatment of mental disorders of Veterans!

1. The exposure of the mismanagement by the Phoenix VA Hospital clearly points out the major fault in the VHA system is the unmet needs of Veterans with PTSD and other mental disorders. This finding is cited by the Award winning investigative reporter Dennis Wagner in his series of reports on the VA in the Arizona Republic. Your letter mentioned that the

While the majority of these new trainees will be added to existing training programs, 15 new training programs are being created in FY 2016.

VA has developed a staffing model for outpatient mental health services that is population based related to the number of Veterans who are served, but it is not prescriptive regarding specific professional disciplines. Through the Veterans Choice Act, VA facilities have received funding that can be used to hire whatever professions are most needed and best suited to serve the needs of the Veterans in their locality.

Your concern for the well-being of our nation’s Veterans is appreciated. If you have further questions, please contact me at Harold.Kudler@va.gov or (202) 461-4154.

Sincerely,

Harold Kudler, M.D.
Chief Consultant, Mental Health Services
Office of Patient Care Services
VA has hired nearly 3000 psychologists during the 10 year period between 2005 and January 1, 2015. Hiring an average 300 psychologists per year for a decade suggests the planning by the Office of Patient Care Services fell woefully short in anticipating Veterans’ needs for services by licensed psychologists. The recent survey of Mental Health America reports there is a shortage of mental providers nationally with a ratio of 1 provider per 790 patients estimated to need mental health services. The Veterans Choice Act adds access and demand for mental treatment of Veterans and probably doubles the demand services by licensed psychologists over your population based staffing model for outpatient mental health services. You state, “The standards are, therefore, not preventing us from hiring psychology staff at the rate we had planned.” This may be true but the planning for Veterans’ needs for psychological treatments was grossly underestimated by the prior administration of the Office of Patient Care Services!

2. There are 10,000 licensed psychologists who are already trained and licensed to provide the services for mental conditions but who do not meet current VHA hiring policy requirements that could meet the added demands for mental healthcare authorized by the Veterans Choice Act. Veterans welcome the VHA initiating 15 new training programs for FY 2016. Veterans will benefit significantly from the expansion of funding for 46 psychological trainees and 96 new psychology fellows for fiscal year 2016. However, these numbers pall and become insignificant when the VA is facing existing mental care needs of 200,000 to 600,000 returning Veterans. An effective action plan is demanded by Congress to address mental healthcare needs of Veterans. Even the hiring of 500 psychiatrists that the VHA is recruiting for worldwide would fail to meet the existing mental health needs of Veterans.

3. Revision of VHA hiring policies for licensed psychologists must not be delayed any longer by the reorganization of the VA. The VHA has already had sufficient time to study the issue of hiring licensed psychologists from non-APA approved doctoral training programs. Yet, the VA has not produced evidence that there is any significant difference in quality of care of services between licensed psychologists graduating from APA-approved training and those licensed from non-APA approved doctoral psychology training programs. State boards licensing psychologists have faced these issues. They have concluded that standards for licensing the practice of psychology are those established by the State law rather than rules by a proprietary organization such as the APA. Without evidence to the contrary, the VA lacks justification for continuing requiring approval of the American Psychological Association (APA) for hiring psychologists licensed by the State in which they practice. It is time for the VA to rescind its current hiring policy regarding licensed psychologists and begin using State licensure as its standard for hiring.

4. VHA Standards for internship training of psychologists must also be those of State laws as the basis of hiring licensed psychologists rather than an APA-affiliate proprietary organization standards for specialty training. Your letter that the VHA is considering board certification from the Board of Professional Psychology for the accreditation. These ABPP specialty standards were not designed for the foundation of the practice of psychology for the diagnosis, treatment and rehabilitation of patients. APA’s refusal to oversee postdoctoral practice of psychology left the qualifications of and regulation of practice of psychology to States. APA Council assigned its Committee on Health Insurance implement State laws licensing psychologists to diagnosis, treat and rehabilitate people with mental conditions. All States have enacted psychological practice Acts and they have been enforce for the past 35 years!

5. The Veterans Access to Care through Choice, Accountability and Transparency Act of 2014 authorizes eligible Veterans care by practitioners in communities when 1.) VA facilities are not available or 2.) when the eligible Veteran chooses not to be evaluated or treated in VA facilities for health conditions including PTSD or other mental disorders. The Veterans Administration has not yet adopted State laws for the practice of psychology as the standard for hiring psychologists in the VHA. Archaic VA standards requiring APA approved doctoral training and experience for licensed psychologists psychology have been cited as the basis of VHA hiring of licensed psychologists. The Veterans Choice ACT authorizes eligible Veterans “freedom of choice” of licensed psychologists for PTSD and mental disorders among licensed providers that are available in their communities or locale. Requiring APA approved training of licensed psychologists effectively denies Veterans their freedom of
choice of providers. It places some licensed psychologists at an economic disadvantage with providers of other professions that do not have a VA proprietary restriction on their licensees (medicine, nursing and social work). The VHA must decide whether or not to enforce its hiring policies of licensed psychologists that would be antitrust violations in community practice. In view of the chronic shortage of psychiatric and high demand for behavioral health services mental disorders it is time for the VHA to amend its hiring protocol for licensed psychologists. New VA hiring policy should include psychologists licensed by States regardless where they trained or how they received their internship training experience!

6. The Clay Hunt SAV Act underscores the Congressional importance of Veterans’ public safety and access to mental health care for suicide prevention. The unanimity of passage of this Act also highlights national concerns about the excessive rate of suicides by Veterans and assigns corrective action to be done by the VA. Furthermore, Congress expects the VHA to carry out the intent of the Act and a pilot project without additional personnel or funding. The proposed 3 year pilot of recruiting and hiring psychiatrists through a student loan reduction plan has no direct connection to the reduction of Veterans suicide rate. At best, this “sweetheart” benefit for psychiatry may be tied to the collection and dissemination of data regarding Veterans’ suicides. Furthermore, this well intentioned legislation ties the benefits to Title 38 providers and excludes loan reduction benefits to doctoral level mental health professions of psychology and social work classified under the lesser Hybrid Title 38. This raises the question of whether there is a professional bias against mental health professions within the VA by not allowing doctoral level psychologists and social workers to be classified under Title 38. The chronic shortage of psychiatrists in the VHA has continued for 50 years and remains unabated. Yet, Veterans’ needs for behavioral treatment for PTSD and other mental conditions are often unfulfilled in VA Emergency Rooms. Reporter Dennis Wagner cites examples in the Phoenix VA Hospital ER where “potentially suicidal Veterans wait for hours for psychiatric evaluation, become anxious and agitated, then ‘elope’ from the hospital without evaluation or treatment.” This scenario of Veterans with mental conditions may occur several times a week at all times of day. This underscores the urgent need for the VHA to amend its current policies in order to use its existing doctoral level mental health specialists to deal with potential suicide risks among Veterans!

7. Recent research on military personnel demonstrate that suicidal behavior can be reduced successfully independently from psychiatric diagnoses and symptom severity! This study led by M. David Rudd, a psychologist, which will appear in the American Journal of Psychiatry, states:

“It is noteworthy that the observed reduction in suicide attempts occurred despite minimal differences in symptom severity between groups over time, a finding that mirrors previous outcomes from dialectical-behavior therapy (8, 9) and cognitive therapy (10). Given that the primary goal of brief CBT is emotion regulation and problem-solving skills development as opposed to symptom reduction, this finding is not surprising and supports the assertion that suicidal thoughts and behaviors should be targeted as a unique treatment goal separate from psychiatric diagnosis and symptom severity. In other words, effective treatment of risk for suicidal behavior does not require complete remission of a psychiatric diagnosis or symptom severity but rather the development of core skills in the areas of emotion regulation, interpersonal functioning, and cognitive restructuring.”

Thus, brief Cognitive Behavioral Therapy should be used to provide effective suicidal interventions to implement the intent of the Clay Hunt Suicide Prevention for American Veterans Act. This Act does not place any restrictions on the use of Hybrid Title 38 professionals. Therefore, the VHA has the opportunity to compare the results Hybrid Title 38 providers with those of Title 38 providers to diagnose and treat targeted suicidal behaviors. Such a VHA pilot project would be in keeping with the intent of this Suicide Prevention Act in a shorter time and on a broader scale than the language of the original legislation that requires 3 years for evaluation and reporting. This VHA targeted suicidal behavior project should use existing Title 38 and Hybrid 38 providers in all 150 VA Hospitals to demonstrate promptly VA reductions in suicides by Veterans.

The Suicide Prevention Project Proposal cited above is Veterans needs based and is not specific to any professional discipline and does promote more effective use of VHA doctoral providers. It is compatible and
consistent with the legislative intent of both the Veterans Choice and Clay Hunt Suicide Prevention Acts. I would appreciate your prompt review and comments to this Suicide Prevention Project and other substantive suggestions made in this letter.

Cordially,

Jack G. Wiggins, PhD
A former President of the American Psychological Association
15817 E. Echo Hill Drive
Fountain Hills, AZ 85268
480-816-4214

cc. Robert A. McDonald, Secretary of Veterans Affairs
Senator John McCain
Senator Jake Flake
Representative Jeff Miller, Chair Committee on Veterans Affairs
Representative Patty Murray, Committee on Veterans Affairs
Representative David Schweikert
Dennis Wagner, Reporter, The Arizona Republic

CANDIDATES

President
• Sean R. Evers, PhD, MSCP

Treasurer
• Kathleen M. McNamara, PhD, ABPP
• Brenda Payne, PhD, MSCP, ABPP

Member-at-Large
• LaSonia A. Barlow, PsyD, LLP, LPC, RAC
• George M. Kapalka, PhD, ABPP
• Anthony Tranchita, PhD

Student Representative
• Yolanda D. Perkins-Volk

CANDIDATE FOR PRESIDENT

Sean R. Evers, PhD, MSCP

I am excited to be considered as a candidate for the Presidency of the American Society for the Advancement of Pharmacotherapy (Division 55). The use of pharmacological interventions alone as the model for treatment of mental health problems has failed resulting in poor outcomes over time and an over-reliance on psychopharmacological medications. I feel that ASAP can be a pivotal force in shaping the future of the collaborative practice of psychological and psychopharmacological treatment asserting the primacy of psychological interventions with a knowledge, understanding and ability to use psychopharmacological interventions when needed to augment treatment.

The excitement of past ASAP meetings and conferences still echoes in my memory. Although there have been frustrating setbacks in the growth of prescribing psychology more states are working on passing enabling legislation each year to spread the prescriptive movement. The initial excitement we all experienced remains but has been hardened by experience. We need to grow our membership as we increase the number of states working on gaining prescriptive authority and reinvigorate our conferences.

Election Statements

I am asking for your vote to allow me to continue the important work of Division 55 and the expansion of the initiatives begun by our former executive boards and presidents. I will work to enhance the ongoing efforts of Division 55 to encourage collaborative practice, ensure high quality pharmacological training for psychologists training, and support states around the country as they work to pass legislation to grant appropriately trained psychologists prescriptive authority.

Thank you.

CANDIDATES FOR TREASURER

Kathleen M. McNamara, PhD, ABPP

I appreciate the opportunity to be considered for election as the Division’s Treasurer. The first part of my current term was spent with the Division transitioning from a management firm handling our finances to our own management. Having been Treasurer for another Division, I was aware of APA’s willingness to handle Division accounting, and recommended that the Board consider APA’s Financial Services. The Board subsequently contracted with APA, completing another transition, and allowing our financial accountability to be on firm footing.

My term as Treasurer has been one of overseeing change. The Division now is looking at a different kind of transition. The 2015 approved budget is a balanced one. With this stability in place, the Board can set priorities for our finances from a different vantage point. I have been pleased to accept the responsibility and be a good steward of our Division’s finances. We must remain financially healthy if we are to achieve what was defined as our purpose: enhancing psychological treatments combined with psychopharmacological medications, promoting the public interest by working for the establishment of high quality statutory and regulatory standards, encouraging collaborative practice with other health professions, seeking funding for training, and increasing access to improved mental health services.
I ask for your vote to serve again as Treasurer. I would like to continue to participate in the thoughtful deliberations which our Division must have if we are to accomplish what we were created to pursue.

Thank you and Aloha.

Brenda Payne, PhD, MSCP, ABPP

I would be pleased to work for Division 55 as Treasurer. I am a partner in a private practice clinic of seven psychologists in Iowa City, Iowa. I have been active at the state and federal level in advocacy in the Iowa Psychological Association for several years. I have been an active member of our state advocacy committee, and given testimony before legislative committees regarding psychologist prescriptive authority. I have a passion for promoting psychology and our ability to provide the full range of mental health treatment, including prescription medication.

I have been very involved in state psychological association leadership, and believe I have the skills to be an effective Treasurer. I was Treasurer of the Iowa Psychological Association from 2004-2005. I have been Federal Advocacy Coordinator for Iowa for six years. I have served on the Iowa Psychology Board (licensure) from 2008 to 2011, and was Chair of the Board for 2010-2011. I graduated from the FDU Psychopharmacology program in 2011, and am board certified in Child and Adolescent Clinical Psychology. I have experience working with others on executive boards, and have business experience as a small business owner since 2007.

Thank you,

Brenda Payne, PhD, MSCP, ABPP
Licensed Psychologist/HSP
MS Clinical Psychopharmacology
Board Certified, Clinical Child & Adolescent Psychology

CANDIDATES FOR MEMBER-AT-LARGE

LaSonja A. Barlow, PsyD, LLP, LPC, RAC

I am running for the office of Member at Large for Division 55. I was honored to serve as the past Division 55 Member at Large. I have been an active member of Division 55 for the past few years. I am very interested in pursuing the efforts for the advancement of prescribing privileges for psychologists. It is evident in my clinical practice that there is a need for prescribing privileges for psychologists in order to address the needs of patients. Serving in the position of Division 55, Member at Large I would be honored to promote Division 55’s initiatives in order to support their mission. As an early career psychologist I am passionate about grassroots initiatives of obtaining prescriptive privileges and eager to do my part to achieve that goal.

Professionally, I am a certified diplomate forensic psychologist, licensed professional counselor, registered addiction counselor, crisis care psychological first aid provider, and certified for the Disaster Assistance Response Team (DART). I am currently a second-year Clinical Psychopharmacology student at Fairleigh Dickinson University.

I have worked extensively with the substance abuse and mental health population in in-patient and outpatient settings. I am the Senior Outpatient Therapist at an inner city substance abuse outpatient program in Detroit, Michigan. I also have a private psychological and forensic consulta practice located in Farmington Hills, Michigan. At my private practice I treat children, teenagers, adults, as well as military veterans. My diverse clinical background provides me with insight of the mental health needs of patients, which is parallel with the mission of Division 55. Serving in the office of Member at Large would allow me the opportunity to be a strong advocate for Division 55 and promote better mental health care.

George M. Kapalka, PhD, ABPP

The RxP movement has had its ups and downs. Two states passed RxP about 10 years ago, and our profession’s enthusiasm about RxP was reflected in Division 55’s membership, reaching its height around that time. Since, however, Division 55 membership has dropped, as has support of RxP among some psychologists. Now, the RxP movement is again gaining speed, with the passage of RxP in Illinois, but support among psychologists remains inconsistent and Division 55 membership has not rebounded to the heights it once experienced.

Much of the opposition comes from academic psychologists, some of whom are also practicing clinicians. While divisions between clinicians and academics date back many decades and have
involved many different issues, it remains most prominent in views about RxP; most non-academic psychologist clinicians seem to support RxP (at least in principle), while most academic clinicians remain opposed.

As a practicing and board-certified clinical psychologist, and a graduate from PPR’s RxP training as well as FDU’s MS in Psychopharmacology, in my decades of practice I have seen my RxP training benefit many of my patients. However, I am also a full-time, tenured professor in an academic program, and so I simultaneously hold membership in the two groups which seem so much at odds at this time. Thus, I am in the position to attempt to bridge the gap. Indeed, as a Division 55 Board member, it would be my goal to increase the support for RxP among academic psychologists, and increase the ranks of Division 55 membership.

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Anthony Tranchita, PhD

My name is Anthony Tranchita, and I am running for Division 55 Member-at-Large. At the time of this writing I am about a year and a half into my conditional prescribing licensure, and am excited to continue this journey as a prescribing/medical psychologist. All of my prescribing to this point has been in a military setting, but the motivation to take this path was based upon working in a rural setting in Indian Country and seeing the issues with access to quality mental health care, particularly with psychotropic specialists. I do not think that prescriptive authority for psychologists is THE solution to those access to care issues in rural areas and for our Veterans, but I do believe it is one important aspect of the solution. I am running for Member-at-Large to be a part of Division 55’s efforts to grow and improve this aspect of psychology in future years to further the health of the Nation.

CANDIDATE FOR STUDENT REPRESENTATIVE

Yolanda D. Perkins-Volk

I am a third year doctoral student at the Minnesota School of Professional Psychology, at Argosy University studying clinical psychology with a focus on neuropsychology and clinical health psychology. I am in my second and final year as the Student Representative for Division 18 (Psychologists in Public Service). In this role I have initiated several social media sites for the division, advocated for and helped develop student-focused webinars, appointed students to committee and section leadership positions, spearheaded a student newsletter and mentorship program, all while maintaining weekly email communication with students, and most recently being a part of the division’s strategic planning.

I find importance and great personal meaning in working towards a common goal, as a part of a group. What I have learned while working as a part of a team or as an individual in either a group or leadership position is invaluable. Whether through my active duty service in the US Army, volunteering with an auxiliary military organization, giving time to a child advocacy organization, or my 11 years as a Federal Employee, I have learned how much can be accomplished when we work together using the talents of each person to the fullest, while maintaining a strong personal work ethic which best supports success.

I feel I am best suited for this position because of my specialized experience and because of my continued dedication to serve and represent the perspective of students in aspects of psychology and practice in which I have a personal stake.
Division 55 President Mike Tilus kindly asked me to put together a short piece summarizing my years working with a cause that has shaped in many ways my professional identity—the prescriptive authority movement. How prescriptive authority came to be a major force in the profession is, after all, a story worth telling, so here is my brief and highly biased version of history.

When did this all begin? A start date to the movement is frustratingly difficult to pin down, and anyone could legitimately pick any number of signal moments. Rather than try and nail one specific date down, here’s a bit of a notional timeline of major events that perhaps have led to where we are today.

1954—Lawrence Kubie publishes a treatise in the world renowned journal, surpassed in reputation only by *Lancet* and the *New England Journal* (not), *Texas Reports on Biology and Medicine*, in which he argued for the creation of a new mental health profession, neither medicine nor psychology, that would be free of the overly biological orientation of the former and the absence of same in the latter. This notion eventually resulted in the modestly successful Doctorate in Mental Health at Langley Porter in San Francisco that ran from the mid-70s to the early 80s. The DMH can’t really be counted as our history, though, like Kubie, aimed not to create psychologists with prescriptive authority but a new profession entirely.

Then followed a long pre-Cambrian period of relative silence, in which little of import occurred (except perhaps for the move by APA in the mid-1960s to refuse the government’s offer to have psychologists classified as a physician provider group for the purposes of Medicare billing—a decision that continues to hamper professional psychologists to this day).

But, if professional psychology was going through a long incubatory period in the 60s and 70s (we were doing—belatedly—lots of other things that established us as a health care profession, like establishing licensing boards, mandating the doctorate as a practice standard, and other trivial details), a true Cambrian explosion was occurring in other professions like nursing, which was busily expanding its training models and scope of practice, and physician’s assistants, where military medics who had learned the hard way to be essentially independent ER docs on the battlefields of Vietnam came home to find that the medical establishment had no place for their skills.

Some say that 1984 was the true start date of the movement, when the late Senator Dan Inouye gave a speech to the Hawai’i Psychological Association advocating that psychologists seek this authority. Others might argue that 1989, when the Congress, again at the urging of Senator Inouye, established the Psychopharmacology Demonstration Project at the Uniformed Services University/Walter Reed Army Medical Center—but footdragging by the services and determined resistance by organized medicine kept this program from starting until 1991, when this writer, along with three others, began a thinly disguised version of medical school in order to learn to prescribe. We would later be joined by a small cohort of others trained by the Department of Defense, and all three branches would write credentialing regulations ensuring that psychologists could utilize psychotropics in their practices, a move that has now been expanded to other federal agencies.

Others might rightfully say that the stalwart work of Elaine LeVine, Mario Marquez and colleagues in New Mexico, when the first state law allowing psychologists was enacted after a long and bitter struggle, was...
the true birth of the movement. But one might convincingly argue that not until Louisiana became the second state in 2006 did prescriptive authority become a movement and not an anomaly. Or, if you’re of an exceedingly conservative frame of mind, you might say we didn’t achieve movement status until 2014, when Illinois became the third state.

Let me propose two other dates that I think have been of signal importance in our movement. The first was contemporaneous with the good Dr. Kubie’s earthshattering report in 1954, and that was the introduction of the first effective antipsychotic, chlorpromazine, into clinical practice in North America. Prior to that time, severe mental illness had been managed with institutionalization combined with brutal somatic treatments like insulin coma therapy, lobotomy, crude electroconvulsive treatments, and a variety of often permanently disabling interventions (to say nothing of the horrifically inhumane practices that often marked involuntary commitment). The pharmacopoeia was pretty much limited to some old stalwarts like opiates, newer barbiturate sedatives, and, in rare institutional settings, the persistent ion lithium (which has a long and fascinating history in mental health dating to the mid-19th century, but that story is for another time).

Now Thorazine was no wonder drug, as we all know, no more than its successor antipsychotics, but it did something that earlier drugs had not, and that was to instill a peculiar sense of indifference to the symptoms of psychosis experienced by the sufferer. As has been famously noted, this led to the pandemonium of the asylum being largely replaced by silence. Subsequent manipulation of the phenothiazine nucleus then led to the introduction of the monoamine oxidase inhibitors, then the tricyclic antidepressants, then, via another tributary of the chemical stream, the benzodiazepines, and we were off to the (big-pharma funded) races.

During this time, professional psychology was largely doing nothing that pertained to drug treatments (our bench researcher colleagues were of course busy making important discoveries, and we cannot forget them), we were belatedly establishing our professional identity and trying (as we still are), to free ourselves of the arts and sciences legacy that hindered our transformation into a full-fledged health care profession.

But another tectonic shift occurred in 1987, one that meant that no matter how hard we tried, we couldn’t ignore the influence of pharmacological interventions on psychological practice. The next—and perhaps one of the last—“wonder” drugs hit the market, in the soon to be ubiquitous form of Prozac. As we all know, the comparatively benign side effect profile and toxicity index of fluoxetine compared to earlier antidepressants took psychopharmacology out of the hands of psychiatry and placed it firmly in the hands of primary care physicians. On the positive side, this increased the availability of pharmacological interventions to a much larger population of sufferers. Negatively, of course, the now-embarrassing rapturous reception of Prozac as a cure for all mental health ills led to well-deserved cynicism. But it also led to the incisive work of two psychologists, Drs. Kirsch and Greenberg, who in 1989 published a groundbreaking analysis indicating that the comparative efficacy of antidepressants like Prozac was, when stacked up against placebo, no great shakes. This formed the basis of a rational view of psychopharmacology that has informed many of our practices, but unfortunately has not moved the Prozac needle much away from the sorry reality that, at least in the United States, pharmacotherapy alone is the de facto treatment for patients with mental disorders.

However we decide to peg it, we’ve made a lot of progress in the last decades, but lots more remains to be done. Our first challenge is, I emphatically believe, a public health one. We are faced with the reality that many people seeking treatment for mental disorders cannot receive the comprehensive therapy they deserve. We know, as noted above, that the vast majority of people who do get treatment are offered one modality alone, medication, in spite of knowledge that is as close to certain as we can get in the social sciences that treatment with medication alone rarely does anything to improve long-term outcomes. We are faced with the withering opposition of organized psychiatry, a profession that seems intent on protecting market share rather than extending appropriate treatment to children, veterans, the elderly, and other groups in sore need of rational combinations of pharmacological and non-pharmacological treatments. And perhaps sadder than anything, we must frequently confront the often-vituperative objections of a faction...
of psychologists who adamantly refuse to acknowledge that prescriptive authority is a legitimate expansion of the scope of practice for appropriately trained psychologists.

But forward we must go, in spite of the decks being pretty much stacked against us. We know that legislative progress is being made, thanks to those like Beth Rom-Rymer in Illinois who abandon almost every other professional goal in order to achieve success, Judy Steinman in Hawai‘i who is currently engaged in a legislative struggle, and others like them. We understand that there are far more patients in need of treatment than any mental health profession can accommodate. We are confident in our knowledge that our patients deserve what many analyses indicate is the optimum treatment for mental illness—a combination of pharmacological and psychotherapeutic interventions. We content ourselves with the reality that it is for these patients, not for ourselves or our profession, that we pursue this cause.

Federal Advocacy Report

Gil Sanders, EdD
Division 55, FAC, and 2013-15 Member of the Committee of State Leaders

The 32nd annual State Leadership Conference was held in Washington, DC from March 14 to 17 at the Washington Grand Hyatt Hotel. The conference theme was Innovation and featured Jason Hwang, MD as the opening session’s keynote speaker. Dr. Hwang is the co-author of “The Innovator’s Prescription: A Disruptive Solution for Health Care.” His contention is that for health care reform to truly occur we need to use distinct business models that focus on various aspects of health care. Under a “solution-shop” model, health care would be organized around diagnostic activities and multidisciplinary cases. Following his keynote address he was joined by APAPO Executive Director, Katherine C. Nordal, PhD and APAPO Assistant Executive Director, Dan Abrahamson, PhD for a question and answer session on innovations in health care. During the evening of the first day the annual “Psychologically Healthy Workplace Awards were presented.

On Sunday morning the plenary session was presented by Ann Compton, former White House correspondent for ABC News. Compton addressed the attendees on the value of political giving in building relationships with elected officials and provided a review of how psychology’s legislative priorities in the US Congress are pursued through the profession’s use of direct lobbying, grassroots contacts and political giving to Congressional campaigns. The morning was completed with the presentation of six workshops on a wide variety of subjects with the general theme of changes in health care related to the Affordable Health Care Act to include the growth of Integrated Health Care. The noon luncheon honored the State Legislator of the Year, State Senator Creigh Deeds of Virginia. Sunday afternoon focused on the Governmental Relations Issue Briefings and Congressional Visit Rehearsals, which are the primary focus of the State Leadership Conference. At the issue briefings SLC attendees learned about the federal legislative process as well as effective techniques that can be applied to advocacy efforts designed to improve the health care system. All SLC attendees were expected to participate in visits to Capitol Hill on Tuesday where they meet directly with members of Congress and congressional staffers to present the primary concerns and recommendations that have been outlined by the APAPO Governmental Relations staff. The day’s activities concluded with a reception held to honor Senator Mike Crapo (R-Idaho). The senator is a long-time member of the US Senate’s Finance Committee which has jurisdiction over Medicare. Sen. Crapo was honored for his advocacy efforts for mental health legislation benefitting psychologists and their patients. This included his efforts in the most recently concluded session when he cosponsored the “Justice and Mental Health Collaboration Act of 2013.” This important legislation reauthorized the Mentally Ill Offender
and Treatment Crime Reduction Act’s grant program that supports collaborative programs that address the needs of justice system involved individuals with mental health conditions, mental health courts and in jail transition mental health services. Sen. Crapo also serves on the Senate Rural Health Caucus and is committed to advancing rural health care priorities. The reception was followed by an invitation only Black Tie dinner.

Monday, the 16th of March kicked off with a Plenary Session by Andy Goodman, Director, The Goodman Center and author of “Storytelling as Best Practice.” His presentation focus was that in order to have an impact you must have a story as data and well-ordered facts will not have the same lasting impact as a story relevant to your topic. The morning concluded with a series of workshops addressing State Association membership, dealing with micro aggressions, and the importance of political action committees. The afternoon again focused on the upcoming congressional visits by SLC members on Tuesday with special emphasis given to those making their first visit to Capitol Hill at SLC. The afternoon was also punctuated by the State Leadership Town Hall where new at large members and a Federal Advocacy Coordinator were elected to the Committee of State Leaders (CSL). The CSL is the committee that aids the APAPO Governmental Affairs staff in planning and organizing the SLC. Following the Town Hall there was a Plenary Session with Barry Anton, PhD, the current President of APA, and Norman B. Anderson, PhD, the Chief Executive Officer of APA. The day concluded with the State Leadership Banquet where Senator Heidi Heitkamp (D-North Dakota) was honored for her advocacy efforts on behalf of psychologists and their patients.

Tuesday the 17th was of course Saint Patrick’s Day but more important to SLC attendees it was the day when all the preparation for the visits to Capitol Hill was put into practice. Beginning in some cases as early as 8:00 AM, SLC attendees began descending on Capitol Hill to visit with congressional members and their respective staffs. Over 500 SLC members visited congressmen and senators with four primary asks.

1. Repeal Medicare’s Sustainable Growth Rate (SGR) formula
2. Co-Sponsor legislation (Medicare Mental Health Access Act) soon to be introduced that will permit psychologists to practice to the full extent of their current scope of practice without unnecessary physician supervision.
3. Add psychologists to the HITECH Act (Electronic Health Records Incentives) to make them eligible for Medicare electronic health records (HER) incentives.
4. Fix the Medicare payment formula to halt the declining psychologist reimbursement rates that have declined by more than 30 percent since 2001.

After the Hill visits, Federal Advocacy Coordinators summarized the effectiveness of their many visits during which they were accompanied by SLC attendees (generally from the home state of the FAC). Some FACs were able to visit with six congressional members and their staffs. After the briefings, everyone headed to the airports and home.

It was an extremely busy and jam-packed four days. Now in the next few weeks APAPO assessment payers will be receiving Action Alerts asking them to follow up with emails to their US Senators and Representatives with emails for an additional effort to bring the importance of four topics into clearer focus for the congressional members. I hope that when you see these Action Alerts that you respond promptly and then provide feedback directly to the Division FAC that forwarded the Alert (Bob McGrath or Gil Sanders). The software used by APAPO tracks the emails sent by APAPO assessment payers by zip code; therefore for the Division to be able report on the effectiveness of the Division in the planned lobbying effort each assessment payer must provide the names of those contacted (those to whom the emails were sent). In order to help every division member better understand each of the four topics that were discussed with members of Congress, summary information follows:

1. Repeal Medicare’s Sustainable Growth Rate

Medicare’s sustainable growth rate (SGR) is scheduled to cut reimbursement rates for psychologists and other providers by 21% on April 1st. Congress must prevent this cut and pass legislation this year to repeal the SGR.

Medicare payments to psychologists, physicians, and
other providers make up only 12% of the program’s spending. Despite this, and despite their being on the front line of patient care, Congress has left providers uncertain about their reimbursement rates by failing to repeal Medicare’s flawed sustainable growth rate (SGR). While Congress has prevented the SGR formula’s deep cuts from happening by repeatedly postponing its application, it is long past time to end this threat to provider payments by permanently repealing it. In so doing, providers can be more certain of their payment rates and are less likely to leave the program, better assuring Medicare beneficiaries’ access to needed care.

During the last two years, Congressional health committees developed legislation (H.R. 4015/S. 2000—which enjoyed bipartisan, bicameral support—to repeal the SGR and replace it with new Medicare payment and delivery models to more responsibly contain costs. This legislation, the “SGR Repeal and Medicare Provider Payment Modernization Act of 2014,” would have ended the continued uncertainty regarding Medicare payment rates for both beneficiaries and providers. Congress should work to reach bipartisan agreement on how to pay for the anticipated costs of this legislation, estimated at more than $140 billion over ten years, so that it can be enacted into law.

Repealing the SGR will help protect beneficiaries access to psychologists and other mental health providers. Psychologists are a cornerstone provider of mental and behavioral health services to Medicare beneficiaries, providing over 70% of hospital inpatient, partial hospital, and residential mental health care; nearly 50% of hospital outpatient mental health care; and nearly all psychological and neuropsychological testing.

But for psychologists, the SGR is only one part of the problem. Even without the SGR, Medicare reimbursement rates for psychologists’ services are roughly 17% below private sector reimbursement rates. The reimbursement rate for a 45-minute therapy session (the service most often billed by psychologists) has dropped 37% since 2001, adjusted for inflation, and rates for other services have had similar declines. Medicare’s low reimbursement rates are contributing to psychologists leaving the program. A 2013 study by the American Psychological Association Practice Organization found that 26% of respondents who had been Medicare participating providers had subsequently left the program.

Congress should also end the annual 2% Medicare cut occurring through 2021 due to budget sequestration, as required under the Budget Control Act of 2011. Although these cuts have received relatively little attention, they will ultimately reduce Medicare payments by nearly as much as the SGR itself. And unlike the SGR, the budget sequestration cuts are already being made.

Medicare’s payment rate reductions are happening at a time when the Institute of Medicine (IOM) has declared that older Americans’ access to mental health and substance abuse services “borders on a crisis.” Several statistics point to this conclusion:

- Each year, about 26% of all Medicare beneficiaries (more than 13 million Americans) experience some mental disorder, including cognitive disorders like Alzheimer’s disease. Serious mental illness, including bi-polar disorder or schizophrenia, is especially prevalent among beneficiaries who are under 65 and eligible for Medicare based on their disability.

- Studies show that roughly 70% of older adults who meet diagnostic criteria for major depressive disorder or for anxiety disorder do not receive mental health treatment.

- Medicare beneficiaries are at greater suicide risk than the general population: although adults over age 65 make up only 12% of the nation’s population, they account for 16% of all suicide deaths, according to the National Institute of Mental Health.

**APAPO believes that Congress should end the SGR once and for all, and restore Medicare payment rates for psychologists and other providers in order to protect beneficiaries access to care.**

### 2. Increase Medicare Beneficiaries’ Access to Mental Health Care by Allowing Psychologists to Practice Independently

*Congress should enact legislation—soon to be reintroduced—to allow psychologists to provide Medi-
care services to patients without unnecessary physician supervision. Medicare prohibits psychologists from practicing without physician referral or supervision in many treatment settings, even when they are authorized to do so under their state’s licensure law.

Psychologists are a major provider of mental and behavioral health services to Medicare beneficiaries, but are unable to provide their full range of services due to Medicare’s outdated and inappropriate physician oversight requirements. Psychologists provide over 70% of hospital inpatient, partial hospital, and residential mental health care; nearly 50% of hospital outpatient mental health care; and nearly all psychological and neuropsychological testing. Psychologists are licensed to practice without supervision in all states and the District of Columbia. Psychologists practice independently, without physician supervision, in all private sector health plans, Medicare Advantage plans, the Veterans Health Administration, and TRICARE.

Unlike other health insurance payers, Medicare requires physician supervision of psychologists’ services in many treatment settings, which means that when no physician is available, psychologists cannot treat beneficiaries. Medicare requires supervision of psychologists’ services provided in hospital outpatient departments, partial hospitalization programs, comprehensive outpatient rehabilitation facilities, rural health clinics, and federally qualified health centers. Supervision of psychologists’ services is frequently done by physicians who do not have significant training in psychological treatments.

I am the CEO and the primary person responsible for 3 clinics, 70 clinicians, 3,000 clients. Having a psychiatrist supervise me and everyone already supervised by me or someone else or working independently, is redundant clinically, time and cost wise....

We are licensed to practice independently. It makes the public mental health system much more expensive than it needs to be to maintain quality. It is VERY old school and no longer applies to a modern efficient clinic.

—K.S., psychologist in Maryland

Allowing psychologists to practice independently will improve Medicare beneficiaries’ access to mental health services, at a time when the need for psychologists’ services is growing:

- Studies show that roughly 70% of older adults who meet diagnostic criteria for major depressive disorder or for anxiety disorder do not receive mental health treatment.

Medicare beneficiaries are at greater suicide risk than the general population: although adults over age 65 make up only 12% of the nation’s population, they account for 16% of all suicide deaths, according to the National Institute of Mental Health.

There is a dire shortage of mental health professionals available to treat Medicare beneficiaries, and the shortage is getting worse. The Institute of Medicine has concluded that “if the nation is to confront the growing burden of Medicare costs, it must develop ways to maximize the productive capacity of the geriatric MH/SU [mental health and substance use] workforce.”

Medicare policy should be changed to let psychologists practice independently:

- Requiring physician supervision gets in the way of providing treatment. An estimated 77% of U.S. counties have a severe shortage of psychiatrists, the only physician specialty with significant training in the diagnosis and treatment of mental disorders. Psychiatrists have by far the lowest Medicare participation rates of any physicians.

- For years, Medicare has allowed dentists, podiatrists, chiropractors, and optometrists to practice without physician referral, with no adverse effect on beneficiaries’ treatment.

- The Medicare Mental Health Access Act would not expand psychologists’ scope of practice. Psychologists’ scope of practice is established solely by state—not federal—laws, and Medicare has strict guidelines for consultation and care coordination that remain in place under the legislation.

- Letting psychologists practice independently in Medicare will not increase program costs significantly. Medicare Advantage programs have not experienced cost increases by letting psychologists practice independently. Physi-
cian supervision requirements add unnecessary costs and can delay or prevent treatment.

Allowing psychologists to practice independently in all Medicare treatment settings will make it easier for beneficiaries to get the help they need—when they need it—regardless of where the service is provided. Legislation to do this is supported by a wide range of consumer and provider organizations, including:

- National Association for Rural Mental Health
- Brain Injury Association of America
- Paralyzed Veterans of America
- National Council for Behavioral Health
- American Foundation for Suicide Prevention
- Mental Health America
- TASH
- Association for Ambulatory Behavioral Health-care
- Center for Medicare Advocacy, Inc.
- American Association of Pastoral Counselors
- American Group Psychotherapy Association
- American Board of Professional Neuropsychology

3. Make Psychologists Eligible for HITECH Act Incentives

Congress should add psychologists to the HITECH Act to make them eligible for Medicare electronic health records incentives.

What is the HITECH Act? The Health Information Technology for Economic Clinical Health (HITECH) Act significantly expanded the U.S. government’s efforts to establish a national electronic health records (EHR) system. Such a system enables authorized health care professionals and hospitals to access centralized information such as lab test results and medication lists to provide coordinated, safer and efficient patient care. The Act includes significant mental health record confidentiality protection.

The Act authorizes the Centers for Medicare & Medicaid Services to provide a reimbursement incentive (Medicare and Medicaid) for physician and hospital providers who are successful in becoming “meaningful users” of EHR. Meaningful use eligible professionals—doctors, osteopaths, dentists, dental surgeons, podiatrists, optometrists and chiropractors—receive up to $44,000 in incentives over six years. These incentive payments began in January 2011, and will gradually phase down by 2016 for Medicare and 2025 for Medicaid. Starting in 2015, providers are expected to be actively utilizing EHRs in compliance with the meaningful use definition or be subject to financial penalties under Medicare.

Unfortunately, the HITECH Act excluded mental and behavioral health providers and treatment facilities from participating in the Medicare and Medicaid EHR incentive programs.

Why include psychologists? Including psychologists and other mental and behavioral health providers will help ensure that Medicare and Medicaid patients receive coordinated, high-quality care. More specifically, the inclusion of psychologists will generate savings for the programs. According to a recent Milliman actuarial study, people with serious mental disorders have medical costs 10 to 15 times higher than patients without psychiatric illnesses. The majority of these expenses reflect hospital emergency admissions resulting from psychiatric or medical emergencies. Recognizing mental health professionals as eligible “meaningful users” under the law will promote integration of psychology and mental health in primary care settings, reduce adverse drug to drug interactions, reduce duplicative tests, and provide necessary information to the emergency department at hospitals to triage patients more effectively.

Health information technology is the bedrock of any effort to coordinate and integrate care for patients across all modalities of care. Achieving healthcare integration (mental health into primary care) is hampered without EHR systems permitting mental health providers to communicate with medical/surgical providers already included in the HITECH Act.

What can Congress do? Congress can correct this exclusion by supporting and passing legislation to enable psychologists and other key behavioral health providers (psychiatric hospitals, community mental health centers, addiction treatment facilities) to qualify for much-needed EHR incentives to enhance quality of care. Congress is aware of the pressing need to advance Behavioral Health Information Technology as demonstrated by the bills that were introduced across the chambers in the 113th Congress through the leadership of Senators Rob Portman (R-OH) and
Sheldon Whitehouse (D-RI) and Representatives Tim Murphy (R-PA) and Ron Barber (D-AZ).

4. Medicare’s Shrinking Psychologist Reimbursement Rates

Medicare beneficiaries’ access to mental health services is being jeopardized by the steady erosion in psychologist reimbursement rates over more than a decade. This erosion in payment rates is due to a combination of factors within Medicare’s payment formula, which uniquely undervalue psychologists’ services.

Medicare reimbursement rates for psychologists have been falling steadily for years. In 2001, Medicare paid $102 for a 45 minute psychotherapy session (the most common mental health service). Today, the program pays just $84.74 for the same service, a more than 30% decline, adjusted for inflation. Rates for other psychologist services have dropped by similar amounts. Most of the decline in Medicare reimbursement rates for psychologists has happened since 2007, with the advent of new methodologies for calculating providers’ practice expenses.

These deep reimbursement declines are leading psychologists to leave the program, reduce their Medicare patient loads, and stop taking new Medicare patients. A 2013 American Psychological Association Practice Organization (APAPO) member survey revealed that 26% of responding psychologists were previously Medicare providers but left the program, primarily due to low reimbursement rates. Nearly half of those psychologists had left since 2008, coincident with the new practice expense methodology.

Medicare’s falling payment rates are endangering beneficiaries’ access to mental and behavioral health treatment, due to the fact that psychologists are a cornerstone provider of these services in the program. Psychologists are the predominant provider of behavioral health services to Medicare beneficiaries, providing nearly half of outpatient psychotherapy services and 70 percent of inpatient psychotherapy services. Psychologists provide almost all mental health diagnostic, testing, and assessment services under Medicare.

Beneficiaries are suffering because of this inadequate access. A recent report by the Institute of Medicine (IOM) states that the burden of mental illness and substance use disorders in older Americans “borders on a crisis,” and that there is a “serious workforce shortage” of mental health professionals available to meet the treatment needs of this population. Each year, about 26% of all Medicare beneficiaries experience some mental disorder, including cognitive disorders like Alzheimer’s disease. Studies show that roughly 70% of older adults who meet diagnostic criteria for major depressive disorder or for anxiety disorder do not receive mental health treatment.

The reduced access to psychologists caused by Medicare’s low reimbursement rates contributes to the dangerous trend toward inappropriate use of psychotropic medications. This issue is highlighted in a recent report from the Government Accountability Office (GAO), which found that while a large proportion of prescriptions for antipsychotic drugs for adults with dementia are used to treat behavioral symptoms, these drugs are not approved for this use, and carry significant health risks, including death. The link between inappropriate use of psychotropic medications and inadequate access to psychological services is demonstrated by the fact that in the U.S., nearly four out of every five antidepressant prescriptions are written by physicians who are not psychiatrists. Despite this trend, depressed primary care patients seeking treatment prefer psychotherapy to medication by a two-to-one margin.

APAPO has been discussing psychologists’ problems with the Medicare provider payment formula with the Centers for Medicare and Medicaid Services (CMS). Most recently, in October of 2014 APAPO met with CMS regarding the recent decline in Medicare reimbursement rates for psychologists’ services, and shared a letter describing the results of an analysis regarding the reasons for this decline, and options for reversing it. The analysis found that the erosion in psychologist reimbursement rates has been largely due to three factors:

- Psychologists have low, and steady, overhead costs. While other providers have increases in practice expenses year-to-year due to innovations in medical technology and equipment, psychologists’ primary practice expenses are low, and stay relatively steady from year to year. However, Medicare’s payment formula
indexes all providers practice expenses to each other, and as a result, psychologists’ practice expense-related reimbursements are repeatedly squeezed to make room for increases in practice expense payments to other providers.

- Psychologists are the predominant provider of the few procedures for which they bill Medicare. Under Medicare’s payment formula, a lower-paid specialty can have its payment rates lifted when higher practice expenses incurred by other specialties providing the same service are factored in. Since almost no other health care professionals provide the services that psychologists provide, there are seldom other specialties with higher practice expense payments to help raise payment rates for the service. The “rising tide” effect that occurs with practice expenses under Medicare’s formula works for some specialties, but not psychologists.

- Psychologists bill only a small number of different services; the average psychologist bills only two Current Procedural Terminology (CPT) codes. This means that reductions in payments for the few CPT codes they provide are not balanced out by increases in reimbursement rates for other services, as happens for many other providers.

APAPO has asked CMS to address this problem and is developing legislative recommendations to reverse the steady decline in Medicare reimbursement rates for psychologists, and looks forward to working with Congress on this issue.

APA Practice Organization March 2015

Obituaries

In Memory of Timothy Fjordbak, PsyD
February 23, 1951 - January 6, 2015

I know that the readers of this memorial, as members of Division 55, are aware that we lost a beautiful human being and devotee of our RxP cause. Timothy Fjordbak, PsyD, a brilliant and committed neuropsychologist, died from a senseless shooting at the Veterans Hospital in El Paso, Texas. The shooter was not one of Dr. Fjordbak’s patients or an acquaintance but was a very troubled veteran.

It would be easy to fill the pages of this Tablet with a discussion of his accomplishments. Instead, those of us who were graced to know him want to express some personal recollections so that you can share our feelings and help us honor him in remembrance:

I met Tim Fjordbak in 2011. I knew him mostly as a colleague.

He hired me to work with him at the El Paso VA. We worked close together over the course of about three years. My office was right next to his and our wall was paper thin so we could never help overhear each other’s conversations. “FJ” as he was affectionately called by his friends/colleagues at the VA was wise, kind, and had a great sense of humor. He was a Southern Gentleman and was always a trusted source of light at the VA; someone whose door was always open, and who could be depended upon for guidance in difficult situations.

I know that he inspired many through his work and friendships. FJ was a champion for prescription privileges and was instrumental in at least a half-dozen other psychologists entering the psychopharmacology program at NMSU. Many people routinely sought out his wisdom and guidance. He will always be missed.

—Stephen A. Colmant, PhD
Family Medicine
Las Cruces, New Mexico

During our years working closely together, Tim became my most trusted and loved friend and colleague. He
always had a kind word of encouragement and affirmation, consistently caring for and caring about others. So many came to depend upon the unique seasoning of which Tim brought to the life of our community. He had a genuine interest in people; a gentleness, warmth, and respect which were infectious. Tim did not put on airs, or consider himself to be better than others. He knew so well that all life is precious, and that each of us contributes in significant ways to the VA mission. Our VA community had truly become an extended family for him, as he touched the lives of Veteran’s and staff on a daily basis. Tim’s commitment and dedication to his profession were absolute. There was never any question about whether Tim would get something done, and whatever he did he accomplished with excellence.

In recent years, Tim had reached a stage in his life at which many decide to slow down, to put their career on “cruise control.” Tim didn’t know anything about slowing down, or about cruise control. Tim committed many hours, in concert with the VBA and the DOD, in establishing our embedded SEU (Special Exams Unit) presence in the IDES program located at Biggs. This is a vital service for those transitioning out of active duty who then are joining the ranks of our Veterans. Tim was committed to the mission of timely evaluations for those who have given of themselves in service to us all.

During recent years Tim also took head-on the significant challenge of gaining a postdoctoral Master’s Degree in Psychopharmacology at New Mexico State University. Following completion of his coursework at NMSU Tim passed with flying colors the extremely challenging Psychopharmacology Exam for Psychologists, and recently completed an internship at the Indian Health Service in Mescalero, New Mexico, making the roundtrip on weekends through much of the past year in addition to his normal work responsibilities at the El Paso VA. We will always miss Tim’s laugh, his willingness to punctuate the ever-present demands of work with a story, reminiscence, to provide the necessary relief of lightness and humor. He will always be remembered, and it my hope that we will all continue to grow in the virtues which he demonstrated so well.

—Paul Mostrom, PhD
Veterans Administration
El Paso, Texas

Tim was a great guy. The first time he came to Mescalero, he looked tired, somewhat nervous but very friendly. Although he was much senior and experienced than I, he had no qualms about dropping a goofy joke here and there that just made him much more approachable and down to earth. It was so funny to hear him poke fun at the El Paso Chihuahua baseball team! From the get go, it was apparent that he was an extremely hard worker. He literally worked seven days a week during the eight months that he spent with us in Mescalero as he worked full time at the VA, took off Fridays and would make the two hour drive to Mescalero from El Paso and continue to work Saturdays and Sundays. He never complained and always made the point of thanking us at the end of the day for being able to get his practicum hours. I will always have a picture of Tim walking around the hospital’s grounds with two briefcases one on each hand. I didn’t want to intrude and at first didn’t ask what in the world he was carrying in those briefcases. One day I asked and he showed me, he had been carrying a number of his personal collection of neuropsych tests with him to different departments to use with his patients. This really spoke to me about how genuine he was, he wanted to help his patients despite his long days, blending psychopharmacology with what he knew best, neuropsychology. He didn’t have to carry those heavy briefcases, he didn’t have to be so humble, but that was the kind of guy that he was, a great guy.”

—Robert Chang, PhD, MSCP
Mescalero Indian Reservation

Dr. Timothy Fjordbak started a volunteer position at Mescalero Hospital in April, 2014. Although he was with us for a relatively short period of time, he quickly gained the trust and respect of his colleagues at the hospital. His expertise in neuropsychology and knowledge of psychopharmacology was evident in his presentation of his patients. Not only was he respected for his intelligence, but he was warm, funny, friendly and a joy to be around. He was simply a nice guy to everyone. We all looked forward to the days that he came to the hospital. He made a big impact onto the community as he spent time at our affiliated nursing home, our inpatient unit, outpatient medical floor, our urgent care department and with our behavioral health patients.

Below are some of the memories expressed by the staff at Mescalero Hospital:

“A kind, gentle man who we are honored to have worked with. He treated all people he encountered with kindness and dignity. We will miss his gentle spirit”—Medical provider

“Whether it be just a greeting hello, or deep discussions with patients or about patients, Dr. Fjordbak’s kindness and compassion were above the norm, and truly a beacon of purity that made patients and providers at ease, making the best medicine he provided his voice and sweet nature.”—Medical provider

“Dr. Timothy Fjordbak was a dedicated provider who...
felt very passionate about helping his patients at Indian Health Services. I spoke with him on many occasions about his VA patients and how he felt the great need to help these individuals that sacrificed so much for our country. He was quick to smile and talk about music, football and any other issues that may have come up during our discussions throughout the days he volunteered for us here at Indian Health Services. His loss is felt greatly by everyone who was blessed to know him while he was here with us at Indian Health Services.” —Nursing

“...Dr. Timothy Fjordbak was a rare individual. His abilities were superior yet he carried on humbly...Tim truly cared as it was reflected in the successful outcomes of cases that many would call a lost cause...It was a pleasure and privilege knowing and being around Tim. We do miss him...” —Medical provider

—Dorlynn Simmons, CEO Mescalero Hospital

I knew Tim as a warm, bright-eyed student who came to every psychopharmacology class at New Mexico State University eager to learn and always appreciative of the knowledge and dedication of the professors. He asked thoughtful questions and seemed to know precise answers to all questions that the instructors asked. Recently, I had begun working with Tim and Representative Beto O’Rourke (who chairs the House of Representative’ Committee of Veterans Affairs) to assist in building the case for the Congressman to present to Congress the reasons that appropriately trained psychologists should prescribe in the Veterans administration. Dr. Fjordbak was weeks’ away from receiving his license to prescribe in New Mexico. What a ‘test case’ that would have been!—The Chief of Psychology at the El Paso VA who could prescribe psychotropics 20 miles North but not for his own patients.

I so enjoyed sharing thoughts and plans with Tim and was very much looking forward to knowing him better as a colleague and RxP advocate. I miss him, as well as the potential of our relationship that did not get to grow. From how everyone describes his winning ways, I am sure you can understand why it is so hard to fathom that anyone would want to snuff out his light. I can only hope that this tragedy brings better care for the confused and tormented veterans and more support and appreciation for the valued psychologists, such as Dr. Fjordbak, who dedicate themselves to the veterans’ care.

—Elaine S. LeVine, PhD, ABMP New Mexico State University

A scholarship has been set up in Dr. Fjordbak’s name at New Mexico State University for psychologists who participate in the psychopharmacology program (as a full time student or one participating in the pathophysiology sequence). At the present, we have received $11,000 in donations. With $25,000 the scholarship will be funded in perpetuity in his name. We would greatly appreciate your contribution. It can be mailed to College of Education, Office of the Dean—Timothy Fjordbak Fund, MSC 3AC, New Mexico State University, PO Box 30001, Las Cruces, NM 88003-9984.

Dr. Susan Patchin

Dr. Susan Patchin died unexpectedly on September 22, 2014, in Elko, Nevada of suspected cardiac complications. She was born in Astoria, Oregon April 11, 1959 and lived most of her life in the Portland, Oregon area. She is survived by her mother, Patricia, step-dad Gordon, sister Sherry and husband Dennis. Dr. Patchin had recently accepted a position in Elko, Nevada as a psychologist for IHS, Southern Bands Health Center. She had worked hard with both the Oregon Psychological Association and the American Psychological Association to secure prescriptive privileges for psychologists. Her hard work, deep concern for her clients, caring nature, sense of humor, and feisty disposition will be missed by friends and colleagues.

I am saddened to inform you that our friend and fellow Div 55 Board Member, Dr. Susan Patchin, recently passed this weekend. She had recently accepted a new assignment as the BH Director at Elko, Nevada Indian Health Service. Over the past few months, Susan was hospitalized in intensive care due to complications with longstanding general medical conditions. At this time, it is not clear where Susan will be memorialized. For some of us, it will be in our own private hearts. Susan was a close friend to many of us and was one of the original Oregon RxP pioneers. I will miss her. I will miss our talks. I will miss our praying together. “May Abba’s strength and loving kindness comfort you now, my friend, as your journey here among us is over.” —Michael Tilus
## 2015 ASAP Board of Directors

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