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President's Column

Treating the Underserved— Comorbidity a Norm

Michael R. Tilus, PsyD

Commander, U.S. Public Health Service
President, Division 55

Prescribing psychologists have, or are, serving populations that are considered medically underserved, indigent, isolated, frontier, and marginalized. By virtue of where we serve, we treat very complicated co-morbid patients of every age, in various life stages, every day, all day, and all the time. While testifying recently for both North Dakota and Idaho legislative RxP bills, antagonists beat on us with the same drum beat alleging we are both “not trained and ignorant in treating these kinds of identified comorbid patients”. I found some Army adjectives swelling up within my chest, wondering where these antagonists practice, as I had not seen any of them in the fields and dirt roads around my duty station. Yet, the truth is, we are, have been, and remain, actively treating them in our many different clinical platforms. Within the public sector communities, we consult, collaborate, and get concurrence with our fellow medical providers for our rural primary and mental health care patients.

In my mind's eye, the prescribing psychology movement was born within the public service psychology womb. Following their inner heart and call, our RxP pioneers found an underserved population; fell in love

with the work and the people; committed themselves to the task; upgraded their skills, embedded themselves in the community, enlarged their capacities, and gave their life resources to serve. Many of these experience-rich pioneers are still serving in their communities while others have transitioned to academia, policy makers, and administration, but still serving.



Michael R. Tilus, PsyD

In my review of the rural mental health literature, ala ‘serving the underserved’, I found some good reads. Of note: Ax et al (2008) piece “Prescriptive Authority for Psychologists and the Public Sector: Serving Underserved Health Care Consumers” in Psychological Services could have been our Featured Piece as they update the prescriptive authority movement in multiple public sector domains, both in the USA and Canada. Morgan’s chapter (2003) “Nonphysician Prescribers in Rural Set-

tings: Unique Roles and Opportunities for Enhanced Mental Health Care” in B Hudnall Stamm’s (Ed. 2003) seminal work “Rural Behavioral Health Care An Interdisciplinary Guide” reads as if it was drafted this year. (For states with RxP legislation hopes, this may be a good reference work.)

Stamm et al (2003) documented the many challenges to providing psychological care in rural and frontier areas. But, much of the published data that I’ve read appears to be voices speaking from the colorless world of statistics or the inquiring researcher. The

Disclaimer: This does not represent the opinion of a federal agency or Native American Community.

personal voice of the practicing prescribing psychologist speaking from their lived experience in frontier America is missing. "Serving-the-underserved" for me translates into an applied prescribing practice that assumes a patient's comorbid baseline includes trauma, substance abuse, psychiatric disturbance, and accompanying uncontrolled general medical conditions. Any delivery of psychological services is therefore embedded within addiction medicine, traumatology, and primary care. But, often, this is the easy part.

One of the great disparities I see in the literature is the lack of viable and reliable informants and information given to these researchers, on the impact of working within "third-world-country agencies". This lack of collaborative data positions much of the reported data as suspect, in my rural mental health literature strikes me as being unusually culturally naïve and barren, especially in the face of what is claimed as a higher level of cultural competency.

Much of the rural mental health literature appeared to be a Pollyanna-spiced up version with a taste of Rural Heaven present and a bit of Eden hiding around the next bite. However, serving in Rural America did not satisfy my thirst for a divine drink after wading through a particularly harsh piece of practice life. In like manner, drinking the literature with hopes of receiving sturdy Shiraz tasted more like a Montana watering hole that held touches of the last nights' rain stirred with the natural earthy sulphuric ground.

This kind of watering hole, as a primary source of nourishment, is damaged and damaging- the paralyzing consequence to "Serving-the-Underserved". Sulphuric Shiraz-like Agencies that both titillate with opportunity while murderously poison.

Most prescribing medical psychologists serving in frontier America face this scenario every day.

Given an impossible mission with overwhelming mental and medical health needs, limited to no resources, insufficient licensed and qualified providers, limited to no supportive agency infrastructure, limited logistical planning with often no logistical agency, legal and ethical concerns, budgeted to fail, misidentified mission capacity, fatally flawed administrative intel, and toxic leadership, Frontier America health care and systems of care often meet "Third World" identifiers no matter whose definition.

Providing care to third-world populations through third-world-agencies provides a more transparent and congruent perspective to the medical psychologists practice realities and contextual environments. This third-world coupling of violence and nourishment cuts through and defines what we do in our clinical practice, and, what our clinical practice does to us.

I think this edition of the Tablet will gather some first-hand voices of prescribing medical psychologists who have been serving the underserved. It is within this context that prescribing psychologists continue to do what we do best. We consult, collaborate, and seek concurrence.

Honor to Serve!

References

- Ax, R. K., Harowski, K., Nussbaum, D., Bigelow, B. J., Meredith, J. M., & Taylor, R. R. (2008). Prescriptive authority for psychologists and the public sector: Serving underserved health care consumers. *Psychological Services, Vol. 5, No. 2.*, 184-197.
- Sammons, M.T. (2003). Nonphysician prescribers in rural settings: Unique roles and opportunities for enhanced mental health care. *Rural behavioral health care: An interdisciplinary guide*, Washington, DC: American Psychological Association, 121-131.
- Stamm, B. H. (Ed.). (2003). *Rural behavioral health care: An interdisciplinary guide*. Washington, DC: American Psychological Association.

Articles

Practicing in Rural South-Central New Mexico

T. Thompson, PhD

Living at the intersection of poverty, low education, poor self-care, chronic physical disease and the burdens of mental health: What a neighborhood to live and work in as a Medical/Prescribing Psychologist!

I am reflecting at this time on my last ten years as a Medical and Neuropsychologist with prescriptive authority in New Mexico. This reflection is sparked by many things including arriving at the age of sixty eight this summer, contemplating having been licensed as a psychologist for over forty one years, and acquiring postdoctoral training in neuropsychology and medical psychology over a course of years, as well as a request from Dr. Tillus for a submission. This is a natural time for reflection. The inquiry from Dr. Tillus came at an opportune time for me. I hope the following reflections will be of use to others.

I have practiced for the last ten years at a Rural Critical Care Hospital with an attached Community Mental Health Center in Sierra Vista Hospital located in Truth or Consequences, New Mexico. That's right, the town that changed its name to a game show back in the 50s. What the change explains I will not speculate upon at this juncture. This year, on June 24, I ended my tenure having moved from a position of contract consultation to full time Medical Director for Behavioral Health with full medical staff privileges.

I was privileged to help rebuild the CMHC. In the process, I learned enormously from the chief medical officer, James Malcolmson, MD, internists, and other members of the medical staff. Together we worked to build an integrated service. Not because it would become the new professional buzzword, but because survival in a poor, rural and underserved area depends on everyone covering everyone else's back. As a result of this need to survive, integration was a natural and worked well which is why I suspect it has become a "new goal" nationally. The influential and bidirectional interaction of rural health medical staff and behavioral health staff resulted in a tremendous amount of learning on the part of everyone involved. As part of the medical staff, I was fortunate to help the CMHC develop expanded consultation services to the emergency room, to the rural health clinic, and to the acute medical floor and even to the county detention center.



T. Thompson, PhD

Fortunately, my educational background as a Medical-Prescribing Psychologist included heavy exposure to family medicine. During training at New Mexico State University, I was able to spend almost two years with the Southern New Mexico Family Medicine Residency Program at Memorial Medical Center. Working side-by-side with residents and faculty I learned to assemble both a physical and medical picture of the patient. We learned to pay attention to the physical presenta-

tion of the patient, vital signs, our examination, the medical history, and findings over time.

I began to integrate an expanded level of understanding of physical medicine and pathophysiology with my years of experience in clinical and neuropsychology. As a result, the doors to a larger universe, the bidirectional universe of the comorbidities that exist between physical and mental disorders opened wide. The ability to conceptualize, understand and treat a patient population with enormous need began to take on an increased clarity. This was a patient population with exposure to multiple risk factors associated with family, social, educational, vocational and health hardships. I remember one faculty member saying if you go into community health programs these are the patients you will see. While many of us had experience with this population in our practices as psychologists, the words of this faculty member were exactly on target, in fact, on occasion, an understatement.

For me and one other postdoctoral prescribing psychology resident, Dr. Robert Mayfield, the exposure and training were further enhanced when we began working with mothers and children at La Casa, the domestic violence residential program in Las Cruces. Assisted by a caseworker and encouraged by a faculty member, we developed a weekly clinic for both these vulnerable mothers and children. We practiced what we had been trained to do performing basic physical assessment and screening with vital signs as well as developmental and mental health assessment. We would then refer the majority of these patients to the Residency Program Clinic or other community agencies where evaluations associated with developmental disabilities and assessment could be provided.

With faculty support, Dr. Mayfield and I moved beyond the "idea" that as Medical-Prescribing Psychologists in training we would see our patients for therapy and prescribe for them. Using the old cliché "being up close and personal" with this group of vulnerable mothers and children underscored the necessity we be prepared to assume the heavy lifting that much of psychiatry had been doing. Not that psychiatry wanted us to assume these responsibilities. It was the need of the underserved. It was reflective of the current Zeitgeist. For Dr. Mayfield and me as well as for some others, the tremendous unmet needs of the

underserved, poor, at risk, and vulnerable populations cried out for the Medical Prescribing Psychologist to step up and assume this role and carry our weight in collaboration with the other medical practitioners on this frontier.

As we emerged from training and initial licensing periods, our roles expanded. We encountered a much greater degree of involvement in the treatment of individuals for whom the spectrum of mental and physical disorders was highly complex. With the initial licensing of psychologists with prescriptive authority, at the conditional level and unconditional level, many of us became even more active in our new roles treating populations in which greater degrees of comorbidity, complexity and histories of multiple adversities were present. The training and supervision which we had received resulted in an increased skill sets, exponentially so. We emerged to work and participate with other medical professionals in those areas where there was a dire need, a need that surrounds us in southern New Mexico and New Mexico as a whole.

The Challenge

Most of New Mexico is categorized as an area of "persistent poverty" by the Federal Department of Agriculture (USDA). This designation means an area has a poverty rate higher than one out of every five people. This is an extreme degree of poverty which extends back many decades and is not unique to New Mexico. Across the nation, 82% of persistent poverty occurs in rural counties especially in isolated rural areas commonly designated as "Frontier" which is the classification for Sierra County. As a concrete reflection of the dire circumstances, the state of New Mexico refunds up to \$5000 on individual state taxes if you are a full time medical worker in one of these areas.

The national and state data are very clear. This population is complex secondary to many problems. These problems relate to physical health, personal care, and comorbid behavioral/mental disorders. In Sierra County, heart disease, cancer, chronic lower respiratory disease, cerebrovascular disease and diabetes are the leading causes of death, in that order. In the patients I began seeing, everyone had at least one if not more of these conditions. If they were younger, the health and personal care practices and risk factors

were such that if they did not then have these disorders, they certainly had the potential for developing these conditions which would soon complicate their lives even more so.

Recent 2012 Sierra County statistics noted heavy drinking rates for females (25%) and males (50%) was the worst for all counties in New Mexico. That rate had risen in females from 2005-2012. Similar findings were noted for binge drinking rates and for smoking with only obesity not significantly increasing. However, given obesity degree of occurrence in all comorbid disorders the latter result was not particularly outstanding.

Poverty, both males and females, was in the worst 10% of all counties in New Mexico and had increased over an approximate ten year time span. One of the last figures in 2006 showed the per capita income in Sierra County at slightly over \$22,000 and noted a poverty rate for children under eighteen of 44%. Data in 2012 also showed an increase to 59% of young children or almost 100,000 children in low income families which was defined as an income 200% below the federal poverty level. In sparsely populated (rural) New Mexico, at least 150,000 children live in poverty and nearly 80,000 in extreme poverty.

In 2007, the New Mexico Indicator Based Information System (NM-IBIS) reported poverty in the early years of a child's life, more than at any other time, has an especially harmful effect on continuing healthy development and well-being including both developmental delays and infant mortality. Quality of well-being complications in later childhood, such as teen pregnancies, substance abuse, and educational attainment are also influenced by the early experience of childhood poverty. Children born into poverty are less likely to have regular health care, proper nutrition, or opportunities for mental stimulation and enrichment.

I was able to capture my experiences and evolution of thinking in a presentation before the New Mexico Prescribing Psychologists in 2013. The presentation, "The intersection of poverty, low education, poor self-care, chronic physical disease and the burdens of mental health: the problem of patient complexity and the larger problem of preventing patient complexity" was a continuing attempt on my part to formulate what I

had encountered as well as what I knew others were encountering.

The presentation also reflected a recognition of how extremely fortunate I was to be able to provide care side-by-side with physicians, nurse practitioners and other providers. The opportunities for both learning and contributing to the learning of others were invaluable. As with all disorders in this population, and generalizing to other rural, urban, and Native peoples/Indian Country, these were disorders in which comorbidity was the "Norm" and in which the bi-directionality of that comorbidity was a defining feature. Certainly it was a defining feature in the training I received and is a defining feature for those Medical-Prescribing Psychologists who move to participate in care for these underserved and at risk populations.

One of the advantages of preparing the presentation was my ability to access the research and practice of others that supported my thinking. We are all part of the Zeitgeist. I found other articles in which individuals had done a very nice job of articulating their experience and thinking. In a slide presentation by Shim (2012) **Figure 1**, she articulated the high prevalence of mental disorders occurring among the chronic medical conditions seen in primary care. In that presentation, she emphasized the interaction and bi-directional nature of the relationship of these comorbidities. When an individual has a mental disorder they are at risk for developing a chronic physical condition and the opposite is equally true. Indeed, this was my experience.

A complex bidirectional risk pathway creates an enormous burden for the patients we treat. Not only does it create painful costs in the lives of these patients, it creates an enormous cost on the health care system itself. The failure to recognize this reality is now very obvious, even publicly so. Also exposed is the enormous failure at a national and state level to adequately fund Behavioral Health and the resulting failure to integrate factors which have been known for decades.

With the skill set that we bring to the table where are other medical colleagues were already working, Medical-Prescribing Psychologist, could work to help to treat the current need and try to participate in the reduction the long term comorbidities/risk factors. In

Chronic Medical Condition	% with depression/anxiety	% treated for depression/anxiety
Arthritis	32.3%	7.1%
Hypertension	30.5%	5.5%
Chronic Pain	61.2%	5.9%
Diabetes Mellitus	30.8%	5.2%
Asthma	60.5%	6.8%
Coronary Artery Disease	48.2%	5.7%
Cancer	39.8%	5.7%

Figure 1 . Comorbidity of Medical and Mental Disorders

concert with our medical colleagues we bring treatment of mental disorders and modification of life style behaviors to the table. As the old saying goes this is something that is biting us in the derriere. It has been, and will continue to do so until dealt with in a serious straightforward and realistic manner without the political one-liners, promises and doubletalk that characterize much if not most of what flows downhill from on high. There is still a wish at the level of state government in New Mexico that each pronounce of system change, new organization involvement, etc. will finally result in the “Fairy godmother appearing and turning the pumpkin into a coach and the mice into horses and footman”. I’m sure this is not unique to New Mexico.

The National Comorbidity Survey, 2001-2003, cited in the RWJF report, found 25% of adults had mental disorders. In this group with mental disorders, 68% had coexisting medical conditions. These facts are a small reflection of how long we have been aware of this data.

The disparity in quality and years of life are painfully obvious in rural southern New Mexico and in many other underserved rural, urban, and reservation areas. The tremendous burden of the impact on the quality of life as well as the “quantity” is reflected in multiple research and discussions. The knowledge is

so common it appeared in a USA Today article (2007). The author reported the data in the 1990’s reflected a ten to fifteen year decrease in lifespan among the mentally ill. The author goes on to note that at the time she was writing this article the disparity had increased to twenty five years. In addition, among individuals with the most serious of mental disorders almost half of the population has their daily functioning limited by at least one chronic illness. In addition, it is much more probable that those with mental disorders are having multiple physical illnesses and that these illnesses will become or are chronic.

The patient population, in Sierra County, is a population very much characterized by the above data. The patients are characterized by a large number of individuals who are exposed to many of the risk factors noted in **Figure 2**. A large number of these individuals present with low social economic status, poverty, low educational achievement, and low and insecure vocational achievement or status. The population in which these risk factors, Figure 2, operate are multigenerational and include poverty, unstable family leadership and patterns, poor health, poor models for self-care and family levels of dysfunction that continue to maintain and exacerbate this cycle. Comorbidity is the Norm and certainly this reality is what I encountered in Sierra County.

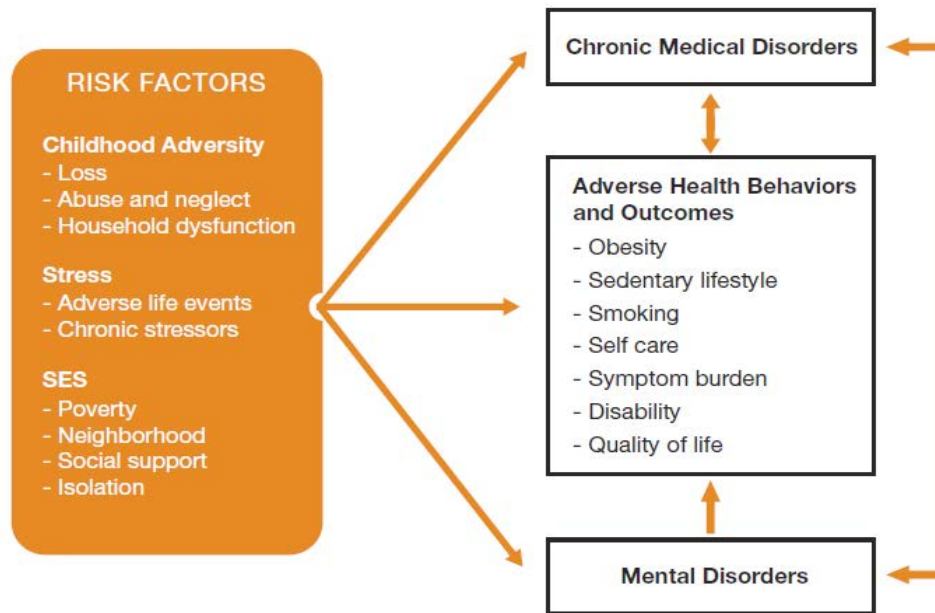


Figure 2. The bi-directionality of risk factors and comorbid medical and mental disorders. [Research Synthesis Report NO. 21-The Robert Wood Johnson Foundation-mental health disorders and medical comorbidity, page 6]

From the RWJF report, I note two of the conclusions which are pervasive in the patient population I have been treating.

Exposure to early traumas and chronic stress may be a risk factor for both mental and medical disorders:

- Results from the Adverse Childhood Experience study, a survey of approximately 10,000 adults in a Health maintenance Organization from 1995 to 1996, indicated a strong graded response between the level of exposure to childhood abuse or household dysfunction and poor health outcomes.
- People who experience more adverse exposures during childhood are more likely to report depression, suicide attempts and chronic medical conditions.
- Chronic stressors, such as lack of money for basic needs, care-giving responsibilities, conflict in relationships, or dealing with long-term medical conditions, are particularly strong predictors of depression.

Social economic factors, such as low income and poor educational attainment, are associated with mental disorders and medical conditions:

- Low social economic status reduces available resources, such as social support, and increases the chance of exposure to adverse environmental conditions.
- Individuals with low social support consistently report higher levels of depressive symptoms; this relationship can be found among the general population and among people with various chronic diseases.
- People of low social economic status are more likely to engage in adverse health behaviors such as eating a poor diet, smoking, and not exercising, which in turn contribute to the development of chronic medical conditions.

(Druss BG, and Walker ER Research Synthesis Report NO. 21, The Robert Wood Johnson Foundation, Mental disorders and medical comorbidity February, 2011)

Implementing Solutions

At the hospital and mental health clinic I encountered as I began work in Sierra County, the impact of these factors on patients was a constant and was related to treatment and the coordination of treatment with physicians, nurse practitioners, and other providers. It was a system where there were more patients than we, at the current level of staffing and funding, could ever hope to systematically and adequately treat either now or in the foreseeable future.

One of the fundamental tasks I had to address was the training and education of staff to a new model. The current staff possessed limited understanding of the impact of risk factors and stressors on the development of behavioral and physical disorders. Meaning no disrespect, I would describe the clinical view as one which would have been held much earlier, perhaps twenty or twenty five years ago. The staff had yet to be guided by current thinking regarding the patient as a whole system and the bidirectional nature of risk factors for behavioral and physical health. In addition they had not recognized the movement toward an integration of neuroscience. It was a staff in which counselors and therapists had never been trained and were not attuned to paying attention to the patient's physical presentation and functioning and really at some level continued to hold the old mind-body duality. I suspect this was not unusual for professionals of ten years ago who came to a clinic setting. Likely this situation continues to be present among clinical staff far more than we would like to believe. The situation is one where Evidenced Based Therapies were not common and still have not become common.

The term "Stress" in these settings is frequently used in notes, reports and communications when referring to patients. Stress is a ubiquitous term in the popular press and has been so overused that the real essence in the patient populations we treat has become fairly meaningless. This is true at some level for both mental health staff as well as medical staff. The significance of stress as it is experienced in these populations is something very different. It is the occurrence of an event, really a series of events, constant to the point it becomes background noise in the lives of these patients. Stress has been and continues to be

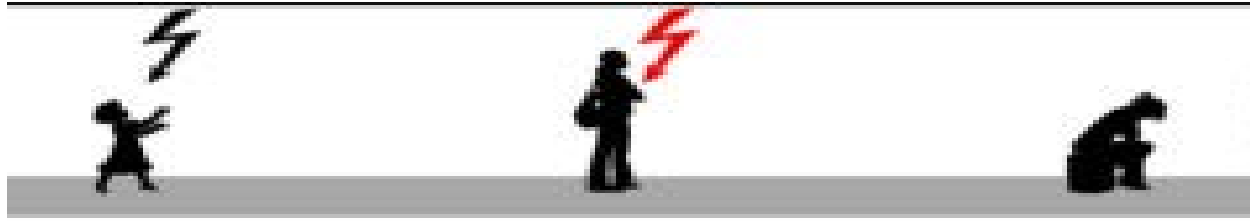
quite toxic to the body holding the physical and mental disorders.

For these individual patients, their stressful experiences frequently become inescapable and extend from the beginning to the end of life. Stress begins at critical times of development and is toxic to the long term functioning of the body. As this occurrence is multi-generational, it has a huge impact. Stress is toxic in the prenatal mom and negatively impacts the nature of in utero and later development. In the expectant mothers in this population it is frequently a toxic compound of circulating cortisol, nicotine, poor nutrition, and sadly other teratogenic substances that bathe the developing fetus.

The impact on child and adolescent development is critical. As adults, these individuals cannot adequately cope with many of the stressors they encounter because their entire system has never adequately developed in a manner allowing toleration and coping with a wide range of stressors. While we use the term and condition of PTSD, it is hard to know if the designation is accurate as most of these individuals have never really left the "battlefield". One might even say their PTSD is developmental and ongoing to a point no longer recognizable as such. At least, this is the challenge I encountered in this underserved population.

I also found the work of Raabe and Spengler (2013) adding insight to my understanding and teaching of what occurs in the lives of these patients. I have intertwined and cobbled these images together in my work in a manner that has been very useful. While presenting these concepts to therapists and other staff, I have found **Figure 3** to be useful in helping conceptualize the complexities of their patients. In addition, I have found it strikingly useful in teaching patients about what has happened to them and what will need to be done to help form the foundation of their treatment.

Figure 3 illustrates an enormous amount of what our patients are confronting from childhood through adulthood and on into older age. Along with Figure 2, the images visually explain the enormous impact occurring in the development of behavioral and physical disorders and the bidirectional manner in which both become chronic and magnified. These images



CHILD	TEEN-ADULT	MIDDLE-OLDER
(Toxic-CNS development combo)	(Toxic-long term ANS-Sympathetic)	(Toxic-long term ANS-Sympathetic)
Pre-perinatal risk	Low Ed/Voc/Poor\$\$	More of the same
failure of attachment	PTSD, Depression, Behavior	More of the same
Maternal depression	Drugs, EtOH, Nicotine	More of the same
maltreatment, neglect	Poor self care	More of the same
Domestic Violence	More of the same	<u>CAD,PAD,CVD,COPD</u>
Genetics and family environment	Violence (Perp-Vic)	<u>OSA,HTN,MI,DM-II</u>
	Legal-Jail-Prison	<u>Decreased life Span</u>

Figure 3. [Raabe & Spengler, *Frontiers in Psychiatry*]


are variations on the lives of many. As noted in Figure 3, the lightning of adversity, results in an over representation of Teen-Adult with educational disruption, increasing mental health disorders and representation in jail in the legal system. Thompson (2009) noted that this is an “Extremely vulnerable group with high-risk for early and ongoing failures of developmental adaptation. They are over represented as failing in the educational system, in the mental health system and juvenile justice referral systems” (page 2). Figures 1, 2 and 3 illustrate how we as Medical-Prescribing Psychologists are just one piece of the puzzle or mosaic if you will. These pieces desperately need a large, diverse and integrated team to move them in the direction of a clear and coherent image of treatment.

These images reflect the state in which the systems for our brain and our body are established. In the development of the brain, it is the laying down of systems for the regulation of stress, abstract thought, executive functioning, emotion and everything in between that will be characterized by dysfunctional interactions. The multi lightning strikes of adversity negatively impact the development and later capacity for learning, coping, and interpersonal relationships. This is not to say there is not a factor of resiliency or that all experiences are destructive. However, the transgenerational repetitive cycle takes its toll across a genetic, epigenetic, and experiential background

creating complexity and interactive comorbidity.

My experience, when teaching patients as well as staff, suggests that if used right, the images move the individual away from the idea of a duality of mind and body. A duality where the repetitive beliefs around “not being good enough” and all of the other “not enoughts” continually run the automatic programs of thoughts, feelings and behavior populating the lives and worldviews of patients. For me, this is a key piece to any psychopharmacological treatment of complex patients with multiple comorbidities or less complicated patients for that matter.

I continue to use these conceptualizations and images as a way of helping therapists understand the complexity they are encountering. They also argue for Evidenced Based Therapies (EBT) for patients. Without the latter, the success of medication treatment is an uphill battle that will never help as much as is possible. I have found that this conceptualization helps bring an understanding of the difficulties these patients have modifying cognition and behavior, something that staff must understand and which also informs the need for EBT. It also helps to further the understanding of how they as therapists and we as prescribers and teachers can become very frustrated in the bumpy road of therapy and medication compliance in these populations.



In addition, these figures provide a way of conceptualizing how patients with these developmental experiences and comorbidities can go rapidly from attempts at new problem-solving, new cognitions, and alternative behaviors into a repetitive pattern of old behaviors. Because the experience of risk factors (lightning strikes of adversity) occurs in interpersonal development, the potential for stimulus generalization of perceived threat with people and situations they encounter is not only enormous, it is ubiquitous. To use a term often associated with psychosis, there is a rapid “decompensation” into old repetitive patterns of faulty/inaccurate conceptualization and ways of coping that result in behaviors that continue to complicate the lives of the patients as they perceive the present through the eyes of the past. At its roots, all therapy is “response extinction”.

The skill sets which we as medical/prescribing psychologists bring to these settings are invaluable. They provide us with the ability to conceptualize complexity and guide psychopharmacological treatment as well as supervise and train therapists to conceptualize their patients in the complex context of treatment. The task of Medical-Prescribing Psychology in the integration of treatment and training includes working with behavioral health staff but also medical staff. Very frequently medical staffs tend to think of behavioral health issues in a non-brain based developmentally biological fashion. This requires us to bring our ability to provide integrated education to our staff and educate the other medical practitioners with whom we work. It is an approach that works to bridge the divisions in the way in which people conceptualize and communicate with each other about the issues and complexities of treatment in these populations where comorbidity is the norm.

As a Medical Prescribing Psychologist, one of the most troubling situations I encountered when I came to the CMHC clinic was the lack of vital signs with reference to medical problems in any of the behavioral health charts. This had occurred, for whatever reasons, even when the clinic had previously had earlier MD and CNP prescribers. In fact, for a brief period of time the clinic continued to have a part-time psychiatrist with whom I overlapped. Having come from a Family Practice Residency Program I was amazed there were no vital signs or references to medical problems. This was

something that could not and would not continue.

I was fortunate to have a very mature, talented and experienced rural health and mental health nurse join me. Together, we began to organize the treatment of our patients in a way that integrated the bidirectional complexities of medical and mental comorbidities. Between us, we established regular medical monitoring of patients. This included regularly scheduled labs, random blood sugars in certain patients, vital signs which always included height, weight, temperature, blood pressure, pulse, pulse ox and pain, with every consultation. I have been extremely fortunate to have had two such nurses over the last ten years. As a result, I was able to work with them to provide health related behavior education and interventions that were never available before.

We began to train a staff, primarily counselors of the “old school” where patient’s medical conditions had not been a focus, recognized or discussed. We moved to shift this view of the patient to one that integrated the multiple behavioral and medical factors present. The expectation we were teaching was one in which the discussion of patient’s problems must be predicated upon multiple aspects of medical and behavioral data that are equally important. In fact, if you do not have the medical data you have overlooked the first question. What is going on in the body and what is the early and later developmental context to which the brain was exposed? Without that, you have no idea where you are and what is occurring.

While I understood “old school” thinking it became mandatory during case staffing that the so-called psychological problems needed to be accompanied by information from medical and developmental history including vital signs, labs, communications with the PCP, and imaging if necessary. My question and my question to staff are always, “What do we know about the status of this individual brain developmentally and now?” In this context I always remember the quote from Greenough and Black, (1992) *“A basic assumption of this work is that the brain and the mind really are the same thing. Few readers would probably challenge this point, but there is a difference between believing this and actually thinking it all the time. When you really think this way, you recognize that studying what is going on in the brain can actually help to tell*

you what is going on in the mind.” (P. 156)

One of the first patients I saw during that early phase was a prime teaching example to the staff. The patient, a woman in her mid-fifties, was referred because of depression. When she entered I noticed the immediate smell of necrotic tissue. No one in behavioral health had paid any attention before to her diabetes. On the day I saw her, there was an old dirty bandage on her right leg and underneath that she had a full thickness diabetic/neuropathic ulcer. As a result, I pointed out to the behavioral health staff that had referred her that this was not “medication” consultation day. The patient needed to go to the emergency room and her PCP needed to be immediately notified. How could she be referred for medication when the essentials had been overlooked? How well could her brain function in “psychotherapy”? How could she not be depressed even if nothing else had happened to her? The stage was set from there on out.

The majority of patients I treated at the clinic ranged in age from latency to older adults. A large number of these were then followed by License Counselors and Licensed Social Workers for therapy and other staff for case and community management. The majority of these complex patients presented with comorbid disorders. The older the patient the more medical disorders and the more chronic they had typically become. Insulin and non-insulin-dependent type II diabetes, various stages of COPD-emphysema, obesity, hypertension and hyperlipidemia running the full spectrum of these disorders were present. In the older adult patients, cognitive changes secondary to vascular issues were present. In younger patients, those in their forties and moving into their fifties, we saw new patients who had never been evaluated for OSA when it is clearly a factor. Frequently, by asking for the ordering of an overnight oximetry, a relatively simple assessment, the need for later overnight sleep studies were confirmed as well as the need for nighttime oxygen.

The task is always one of working to appropriately educate the patients with regard to behavioral factors involved with both their chronic behavioral and medical disorders and to the effects, side effects and interactions of the medications. The success rate at this varies enormously. Some of the patients that we saw had been the recipients of the multi generational

lightning/adversity strikes and presented with long histories of nicotine addiction, poor self-care, poor healthcare, histories of alcohol abuse and difficulties regulating blood sugars, hypertension, etc. The behavioral pattern was long and complicated. In addition, the majority of these patients had not had the benefit of quality behavioral health treatment and medical/prescribing psychology consultation and intervention. Most had never had support in identifying problems such as OSA or support in dealing with these.

The second and equally important task was to encourage current staff in learning models related to EBT through workshops, my teaching, online classes, independent reading, etc. This was successful to varying degrees. It did not really become successful until we were able to hire a Licensed Independent Social Worker (LISW) with a very good background in Cognitive Behavioral Therapy. She was able to attract other younger staff that was eager to learn and train. As you can imagine, education in that setting had a steep learning curve and required people who were eager to learn and work hard. We were eventually successful. The process of transformation at the clinic took a while and some people were able to make the transition and transformation and many others were not. Those who did and those who came on board learned that a solid integration of important medical and pathophysiology concepts had to be integrated with EBT for proper treatment to occur. You needed to listen to and look at the patient for the comorbidities that presented. It became a working system where no staff member would watch a patient come down the hall ambulating themselves, using a walker, or in a wheelchair without people paying attention to the person’s physical presence, gait, balance and smell and no one would sit and only rehash and regurgitate the past with their patients.

Final Thoughts

As a Medical Prescribing Psychologist I do not think or suggest that my implementation of solutions was original. As always, I believe we are part of the Zeitgeist of our times. Part of that Zeitgeist for Medical-Prescribing Psychology has been in the evolving model. As we are increasingly working in rural and urban settings with the underserved and with Native Peoples in “Indian Country” we have been evolving that model.

That model has similarities to what we were initially exposed to and debated and it has enormous differences.

My sense of the emerging model in the Zeitgeist is one that has moved from a focus on the consultation room and prescribing for individual therapy patients to that of community health in areas where there is great need in which are greatly underserved. In this evolving model Medical-Prescribing Psychologists are moving in to settings as prescribers of medication, medical directors, and teachers/trainers for staffs that will provide EBT and case management. As Medical-Prescribing Psychologists the skill sets we have and the services we are able to provide and coordinate necessitate this shifting/evolving role.

Implicit in the discussion of my experience over the last 10 years is a model in which we as Medical-Prescribing Psychologists are able to make contribution, both short-term and long-term, to these very large problems of comorbid medical and mental disorders present throughout our healthcare systems. I encourage those of us who are Medical-Prescribing Psychologists, those who are in training and those who run training programs to listen to the Zeitgeist, understand this evolving model and the tremendous need of our fellow citizens, rural, urban, and native peoples.

References

- Druss, BG and Walker, ER. Research Synthesis Report NO, 21. The Robert Wood Johnson Foundation, Mental disorders and medical comorbidity. Princeton, NJ, (RWJF) February, 2011.
- Greenough, WT and Black, JE. Induction of brain structure by experience: Substrates for cognitive development. Pp. 155-200 in *Developmental Behavior Neuroscience*, Volume 24. M.R. Gunnar and C.A. Nelson, eds. Hillsdale, NJ: Erlbaum (1992).
- Miller, C. Child Poverty in New Mexico: Our communities need more than crumbs. Counter Punch 2013. Retrieved from: <http://www.counterpunch.org/archives>
- New Mexico's Indicator-Based Information System (NM-IBIS). Retrieved from: https://ibis.health.state.nm.us/Indicator/important_facts/NM
- Raabe, JB and Spengler, D. Epigenetic Risk Factors in PTSD and Depression. *Frontiers in Psychiatry*. 2013; 4:80. Published online 2013 Aug 7. Retrieved from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3736070>
- Shims, R. Co-Management of Chronic Physical Conditions and Chronic Behavioral Health Conditions. 2012 SAMSHA Primary and Behavioral Health Care. Power Point Slides. Retrieved from: http://www.integration.samhsa.gov/pbhci-learning-community/Primary_Care_Breakout.pptx
- Sierra County Community Health Profile. Community United for Quality Living Health Council. updated May 2009.
- Thompson, T. A Neuroscientifically Informed Approach to the Understanding and Conceptualization of Disorders of Affect, Violence, and Substance Abuse Among High-risk Preeteen, Early Adolescents and Young Adults with Histories of Neglect and Abuse. Unpublished manuscript 2009.
- United States Department of Agriculture Economic Research Service 2010 Frontier and Remote Area (FAR) Codes. Retrieved from: <http://www.ers.usda.gov/topics/rural-economy-population/rural-classifications>

Training Public Service Psychologists to Prescribe Psychoactive Medication: A Collaborative Effort by Division 18 and Alliant International University

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Past-President APA Div 18 (2000-01)

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In the late 1990's, APA Division 18 (Psychologists in Public Service) conducted an informal survey of Division members to identify ways that members would find greater value in the Division. The survey, which was coordinated by Dr. Randy Taylor, found that members desired that the Division sponsor high quality continuing education (CE), defined as CE that positively impacts clinical practice. Regarding desired educational content areas, highest rated were CE leading to better treatments for sequelae of traumatic events, and CE leading to the ability of psychologists to prescribe psychoactive medications.

Division 18 historically had noted that shortcomings of the mental health delivery systems were most blatant in public service settings: State and county facilities, correctional facilities, police and public safety work, veterans healthcare and evaluations settings. (Later, a new section of Division 18 was established to focus on services for Native Americans.) There was broad agreement within all Sections of Division 18 that prescribing psychologists would add significant quality in each of these areas.

Division 18 responded to the findings of this survey by establishing a Psychopharmacology Task Force that assisted in writing a report of the survey (a white paper-Taylor,

2000). These results were presented by Dr. Taylor at the 2000 convention of APA, in the "RxP Mini-convention" sanctioned by then APA President Pat DeLeon.



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Following the 2000 APA convention, Dr. Taylor adopted as his 2000-01 APA Division 18 presidential initiative (and Dr. Bob Ax continued in his 2001-02 term), to develop and implement a project with the goal of providing training for 100 Division 18 psychologists to be certified to prescribe psychoactive medications. The RxP Task Force developed a request for proposals (RFP) for the Division to seek an educational partner with an established RxP training program. The educational partnership was designed to be a collaboration that would provide training and practice opportunities in clinical psychopharmacology for Division 18 members, create incentives for psychopharmacology training for Division psychologists and establish an organization for prescribing psychologists in public service.

In 2003, the Division issued the request for proposals, "Preparing Public Service Psychologists for Prescribing Psychotropic Medications" and, in a competitive review process, California School of Professional Psychology-Alliant International University (AIU) was selected as the initial educational partner for this initiative.

The Division 18-AIU partnership was a unique opportunity that constituted a major step toward improvement of the delivery of mental health services to underserved populations by increasing the number of mental health professionals who work in public sector settings who are trained in both psychotherapy and psychopharmacology.

A priority objective of the project was to improve the health status of underserved populations by increasing the knowledge of psychopharmacology among psychologists practicing with patients in these populations who seek care in systems with limited treatment options. The project could also offer a career “pipeline” for minority psychologists, and for psychologists working with minority populations, in keeping with the Surgeon General’s (1999) recommendation to include more diversity in the mental health professions. Another objective of the project was to stimulate interest among psychologists practicing in the public sector to obtain advanced training in psychopharmacology, which would enable them to (1) practice collaboratively with prescribing professionals to enhance the quality of mental health care, and (2) qualify for prescribing authority as additional states pass authorizing legislation.

The specific goals for seeking funding and training included the following:

- Provide an incentive of free tuition for 100 public service licensed psychologists to complete an academic program leading to a Master of Science degree in Clinical Psychopharmacology.
- Provide guidance for these 100 psychologists to obtain supervised clinical residency experiences with at least 100 patients
- Provide a review course to prepare these psychologists to pass the APA Psychopharmacology Examination for Psychologists
- Document that these psychologists continue to work in public service employment for two years
- Conduct ongoing program evaluation of the outcome of this training program. (This evaluation was developed by Dr. Michael Neale,

whose untimely death prevented its completion).

Intended outcomes included:

1) For participating psychologists:

- Successful completion of the Master of Science in Psychopharmacology degree;
- supervised prescribing practicum with at least 100 patients;
- passing the Psychopharmacology Examination for Psychologists;
- improved mental health services to underserved clients.

2) For public service agencies employing the participating psychologists:

- Expanded access to mental health services for underserved clients;
- enhancement of the psychologists’ roles as biopsychosocial practitioners;
- increased consultation and collaboration with primary care physicians and other prescribing health care providers;
- improved health status for patients resulting from increased attention to, and successful treatment of, mental health concerns.

3) Generation of grant projects and research publications related to identification and treatment of psychological conditions in underserved populations.

Twenty Division 18 students began training in October 2006 and there were close to 80 students waiting admission, pending funding. Initial funding was obtained by a generous grant from the Laszlo N. Tauber Family Foundation, along with “matching funds” from individual psychologists, and organizations such as APA Division 55, the APA Practice Directorate, and the Virginia Academy of Clinical Psychologists. Considerable creativity and effort went into this process. For example, The Cherokee Nation paid for the tuition for two psychologists. Alliant International University hired professional fundraisers to investigate funding opportunities with foundations committed to ad-

vancements in delivery of health and mental health services, and members of the first cohort were asked for contributions. No additional institutional funding was found, and individual contributions came in very slowly. A decision was made that no further “full tuition scholarships” could be provided.

Division 18 leadership and Alliant Staff developed a “Plan B” to keep the Program going. Support from the Irving and Dorothy Rom Family Foundation provided half-tuition funding for additional Division 18 psychologists to be trained; Alliant scholarship funds were used to offer Division 18 members a 20% tuition scholarship, and four Division psychologists completed the program without funding support. Of the original 92 psychologists who were approved by Division 18 to participate in the Initiative, 44 actually entered training before the Initiative was officially terminated in June 2010.

Ripple Effects and Retrospect

The end of the official Alliant-Division 18 RxP initiative was not the end of efforts to train Public Service Psychologists in Psychopharmacology. The Initiative had highlighted a serious opportunity for improving mental health services in the Public Sector, and actually led to further opportunities. In 2009 a group of psychologists working in the Aberdeen Service Area of the Indian Health Service (IHS) initiated an effort that led to the IHS agreeing to partially fund six psychologists to be trained in psychopharmacology through the Alliant Program. Support from the Irving and Dorothy Rom Family Foundation provided the remainder of the tuition, allowing these psychologists to com-

plete training. Ongoing support from the Foundation has continued to the present time, and has provided half tuition RxP scholarships for 10 additional psychologists who work in Indian Country. In addition, Alliant has continued its own Public Service Psychology RxP scholarships that have supported psychologists working in the California Department of Corrections and Rehabilitation, the Federal Bureau of Prisons, and other public service settings. Additionally, the Psychopharmacology Program at Fairleigh Dickinson University introduced a small tuition discount for Division 18 members. Thus, although the goal of the original Division 18 Initiative to train 100 public service psychologists to prescribe medication was only a moderate success, the initiative began a process that continues to the present time to highlight the special needs of underserved populations for psychological services that integrate behavioral/mental health services and psychopharmacology. The spirit of that initiative is still with us!

References

1. Psychologists Prescribing Psycho-active Medications in Public Service Settings: A White Paper by a select task force of Division 18, Psychologists in Public Service, 2000 (by a select Division 18 task group below): Drs. Arthur Aaronson, Robert Ax, Patrick DeLeon, Alexander Kristevski, Ronald Levant, Steven Nisenbaum, Matthew Nissetti and Randy Taylor and presented by R. Taylor at the “RxP mini-convention” preceding the 2000 Convention of the American Psychological Association, Washington, DC
2. Government Accounting Office (GAO) draft report of evaluation following up initial 1997 report evaluating the Department of Defense Psychopharmacology Demonstration Project (PDP), 1998

The Rural RxP Scope of Practice of a Psychopharmacologist Without Prescriptive Authority

Yosef Geshuri, PhD, JD, MP

Diplomate, American Board of Medical Psychotherapists
Diplomate, American Board of Forensic Psychological Specialties
Diplomate, International Academy of Behavior Medicine
Diplomate, International College of Professional Psychologists—Master
Fellow, Prescribing Psychologists Register
Fellow, Advanced Practice Counseling/Psychotherapy
Fellow, Psychopharmacology and Serious Mental Illness
Board Certified Medical Investigator and Medical Psychologist

The interest and direct involvement in ‘*psychopharmacology*’ (a term not yet used in those days) goes back to the early 1970’ when I was teaching at the university in rural Northwest Missouri in the areas of my specialty, neuroanatomy/neurophysiology, conditioning and learning/behavior analysis. In addition to teaching, I started consulting at the Adolescent Program at a large state psychiatric hospital 40 miles south of us, St. Joseph State Hospital in Northwest Missouri, when the psychiatrist at this program, indeed a bright, open-minded and innovative British bred and trained psychiatrist, invited me to join his team at the Iowa State Psychiatric Hospital, 30 miles north of us, Clarinda Mental Health Institute, in Southwest Iowa, and consult at that facility’s Adolescent Program. He wanted, however, that as an academic, I should write a grant-proposal asking for Federal Funds, to help finance the Program of 150 Adolescents, all court-placed at this hospital, mostly from the Des Moines and the rest of Southwest Iowa catchment area. The grant application should go to the U.S. Department of Health, requesting the then known ‘Hospital Improvement Program’ (HIP) Grant, to design a comprehensive ‘Behaviorally Based’ (then known as ‘Behavior Modification’ or Beh-Mod) treatment and management program that would support

his treatment approach and would help reduce the use of psychoactive medications.

I immediately went to the task and worked on the grant-proposal, and in the meantime I also started studying, on my own, through various learning modalities, the wide range of the nature and applications of psychotropic medications, so that the comprehensive ‘behavioral treatment and management program’ would interact with and effectuate a reduction in the use of such medications. The grant-application of a comprehensive and detailed behavioral program was subsequently completed and submitted to the HIP Grant Program and the Grant was soon approved for \$250,000 per year with matching State funds for three years and I came on board as the co-director of the program with the program Psychiatrist. The program was so successful, that the Grant was renewed in 1975, with the details of the program and its level of success, in terms of behavioral intervention effectuating medical treatment approach, being presented at the Iowa Psychological Association (Geshuri, 1976). The Grant was renewed again three years later in 1978. Incidentally, the psychiatrist I worked with, who also had a private practice, was impressed with our work so that he invited



Yosef Geshuri, PhD, JD, MP

me to join his practice to bring the same behavioral intervention strategies to help individual patients and effectuate behavior/psychological interventions to reduce the use of medications.

In the meantime, I obtained psychology licenses to practice in Missouri in 1978 and in Iowa in 1979 and started my own practices. In addition to my teaching and consulting in various state psychiatric facilities in Iowa and Missouri, I was even invited to do some consultations in two facilities in Southeast Nebraska.

Living and working in Northwest Missouri 'Tornado Alley' and freezing weather, that we could no longer take, as we had moved to the Midwest from Southern California, first to go to graduate school (University of Iowa) and then getting an academic position in Northwest Missouri, we decided to move back to California at the end of 1979. I took a job as a staff psychologist at Porterville State Hospital in rural California (vineyards, walnut, orange and olive-groves, cotton-fields and hundreds of dairy-farms with their recognized 'aromas', with huge fields of growing feed for the cows), and after a few months, as I secured my license in California, I also opened a private practice in early 1981.

The involvement in psychopharmacology continued in a parallel fashion both in my private practice and at the State Hospital. As soon as I opened my private practice, the County Mental Health Psychiatrist, who also wanted to do some part-time private practice in addition to his regular County job, joined my part-time private practice, literally sharing my office. We started working collaboratively with patients invoking the same approach I worked with the psychiatrist in Iowa, again integrating effective cognitive-behavioral treatment programs with psychotropic medication.


While working at the 'State Hospital', which was later renamed 'Developmental Center' (PDC), as all of the patients/residents were developmentally disabled, I was appointed to the position of a Quality Assurance Consultant, and took on the task of heading the Behavior Management Committee, which had to review, approve and monitored all 'Restrictive-Behavior-Intervention Procedures' including overseeing and managing the use all the psychoactive medications in the facility of about 2000 patients, with about three forth

of all residents at the time were receiving such medications. The committee included three Physicians, one of whom was the Facility Psychiatrist, two other Psychologists, three Psychiatric Technicians an administrator, and whoever professional's case was presented. At about that time, psychologists also joined the Medical Staff of the Facility. During my tenure as a Committee Chair and Quality Assurance Consultant, I have developed written procedures for establishing medication treatments using the 'Minimum Effective Dose' requirements, as well as physicians' assessment procedures for 'Abnormal Involuntary Movements' for each patient receiving psychotropic medications, both of which had been adopted in other state facilities.

Again, here and for this purpose we also trained staff in conducting comprehensive 'Analyses of Behaviors' of patients who required restrictive-procedures, particularly the use of psychotropic medications, to develop effective behavior-intervention programs, again to effectuate the reduction of the use of medications, which was, and still is, required by Federal Regulation, as it is required in all such facilities.

Working with many physicians who also had practices in the community, I was soon asked by some of these physicians to see their patients who presented psychological problems which at the hospital, in the local community hospital, Sierra View District Hospital, now Medical Center (SVDH, now SVMC). Notably, for all the 35 years I have lived and practiced in this rural town, there has never been a regular full-time Psychiatrist here, with the closest practicing Psychiatrist 40 miles away, in a larger city. In 1990 I was also invited by the CEO of the Hospital to establish the Bioethics Committee at SVDH which was non-existent at that time, as I was involved in such an activity at PDC. I developed and chaired that Committee for five years.

As I had developed and expanded my private practice in the community, building my own clinic in 1986, and at the time I was involved with the Bioethics Committee and had met many physicians practicing at the hospital, I was invited to join the Medical Staff of the Hospital and consult on all cases involving psych. issues, in terms of psychotropic medications. Interestingly, at the time the Hospital did not have the information as to the Standards to have Privileges and how to involve/include a Psychologist on Medical Staff, so



that they asked me to write such Standards, which I happily did. I have been on Medical Staff of SVMC since the late 1990, providing consultations for inpatients when the attending doctor orders a Psych. Consult, with the doctor most often asking for such is the house Neurologist, with whom I work very closely.

My regular consults include, assessing the mental status of the hospitalized patient (many of whom are admitted for attempted suicide – many of whom I see at ER - or otherwise patients with Altered Mental Status), including recent history and current issues, providing Diagnoses and detailing a treatment approach, including pharmacological intervention plan. With my legal training, I also note and recommend follow-ups with legal/administrative issues, when the patient is, for example, found to be not-competent to care for self and his/her property. I also see patients for similar consultations at the Sub-Acute Department of the Hospital, with those patients who are placed there (from all over the State) for long-terms, all of whom are with some terminal organ-failure (such as Renal, Hepatic and/or Respiratory failure) and most of whom are intubated.

In the meantime, working with many physicians at the hospital and the community, providing similar consultations for patients who are referred to my office by community physicians, with many patients over the years who had been seeing psychiatrists in big cities 50-70 miles away, mind you for 10-minute visits, requesting to come to our office for therapy and medication management to be worked out between us and the primary care physicians.

Furthermore, several of these physicians, who place many of their older patients in nursing homes, invited me to provided similar consultations for their Geriatric Patients, most of whom are also with some form of Dementia (often 'With Behavioral Disturbances')

at the Nursing Homes. So in the past 20 years I have also been consulting, providing similar consultation as noted above, in several nursing homes.

Living and practicing in a rural area, I was contacted by a medical group from Los Angeles, who reviewed my credentials and subsequently contracted me to be a qualified medical examiner for the VA to conduct assessments of veterans for PTSD and TBI. Being a combat veteran myself, it has been very rewarding to work with many veterans, going all the way back to WWII, Korean, Viet Nam and the various in-between and Middle-Eastern Wars, who come to my office in Central California from 150+ mile radius catchment area.

Incidentally, noting my psychopharmacological education, which began in the early 1970' clear to the present time, also commencing PPR training in the early 1990' to today, I have amassed cumulatively way more than 1200 hours in didactic training. I have also taken the national written and oral exams, as well as fulfilling all the other requirements to be certified as a Psychopharmacologist. But unfortunately, in our State of California, we are still far from any prescriptive authority for any trained and certified Psychologist. So we have found fairly productive and effective ways to function in our role as Medical Psychologists and Psycho-pharmacologists, with expanded scope of practice, without the actual Prescriptive Authority.

Lastly, and somewhat related, wearing my Forensic Psychologist's 'hat', with my legal training, I do extensive work in both 'Criminal' and 'Civil' areas to assess individuals, in custody and out for various psych. disorders, most of whom take psychoactive medications, including issues of neurocognitive impairment, incapacity, insanity, diminished actuality, dementia and other disorders.

On Being Institutionalized With a New Prescription Pad

Christina Vento, PsyD, ABMP

In November 2008, I became the first prescribing psychologist to write a prescription within the NM Department of Health system at the New Mexico Behavioral Health Institute (NMBHI) at Las Vegas, NM (i.e., the NM State Hospital). It was for Abilify 20mg, daily for a patient diagnosed with schizoaffective disorder. My colleagues and family had a small betting pool running regarding which medication would be my first script but no one picked Abilify.

Finding my first prescribing job in 2008 had been difficult. There were only 16 others licensed in the state to prescribe at that time and hiring a psychologist to prescribe at the inpatient level was pretty far outside of the box. I was fortunate that several things converged to make a position at the State Hospital possible. First, in its 130 year history, the rural and isolated facility had always had a great deal of difficulty finding and retaining psychiatrists. Second, NMBHI has an enlightened psychologist, Dr. Troy Jones as its Executive Director. Third, Dr. Jones and I had been classmates during the first iteration of what would become the NMSU RxP program in 1999-2000, before he quit in order to focus primarily on administration. He was able to persuade two psychiatrists to supervise me for my Conditional license and overcame the objections of his Chief of Psychiatry to hire me. I had a house and family in Albuquerque, 130 miles away from NMBHI and relocating during the 2008 recession would have been very difficult. I arranged a 4 day-10 hour schedule and rented a room in a dusty trailer on the grounds of the hospital where I spent three nights a week for the next two and a half years.

At that time, NMBHI was intensely understaffed and its facilities in need of upgrading. The Chief of Psychiatry decided that I would split my time between the most understaffed (and coincidentally, much less desirable) inpatient units. 40% of my time would be allocated at the four long term care units which collectively housed 160 patients, who were a mixture of dementia, stroke and TBI patients with severe behavioral

disturbances and patients with severe mental illness whose physical health conditions required a skilled nursing facility. It was, in effect the nursing home of last resort, many patients having been expelled from other facilities around the state. Most patients were crowded into rooms with three other patients and the atmosphere was typically uncomfortably overheated, often smelly and generally chaotic with various shouts and cries heard at frequent intervals. For most of the first year I was the only mental health clinician working on these units, though I was later joined by a part time NP and a neuropsychologist which helped immensely. My patients there typically needed 10-15 physical health medications and were also on 4-8 mental health medications, most commonly antipsychotics. Some were grossly overmedicated when they came to us from other parts of the hospital. The distinction of “most overmedicated” went to a woman who was being concurrently prescribed a total of four antipsychotics (including both Geodon and Haldol), three mood stabilizers, two benzos and two antidepressants. Over a few months I was able to gradually reduce this by more than half after working with her on her anger at being involuntarily committed to the unit. There was an ongoing pressure from the nursing and tech staff to increase the sedating medications for vague complaints of “increased aggressive behavior”. Systemic inertia loomed large and I met with resistance to my attempts to modify the environment, analyze the details surrounding the behavior episodes or change nursing/tech staff procedures to improve the behavioral challenges non-pharmacologically.

Identity Confusion: “I’m from the Psychiatry Department”

On these units, explaining my actual title and licensure to patients with various cognitive impairments and severe mental illness was immediately problematic. I did not want to misrepresent my credentials and training but also not cause unnecessary confusion and distrust. My supervisors and I settled on “I’m Dr.

Vento from the Psychiatry Department” as the most honest without increasing confusion unduly. With so many acutely ill patients and so little of you to go around, the only thing you can really do is triage and focus on the most acute and at risk. Knowing what to do, exactly, was difficult as my practicum experiences had been in primary care with an entirely different level of complexity and intensity. My classroom training seemed far removed from the complex, acute and often elderly patients who were commonly on polypharmacological regimens I was taught to never to employ. Faced with numerous acute medical comorbidities, I often would sit and contemplate the least damaging thing I could change to try to make things better for the patient. These are not the sort of patients that are included in drug company studies, so relevant “evidence based medicine” data was essentially non-existent. They were far too complex, medically and psychiatrically and living in an environment that clearly exacerbated their symptoms. Due to the NMBHI psychiatrists’ initial doubts about my competency to be in my role, it was difficult to feel completely comfortable asking some questions in the beginning for fear of validating the psychiatrists’ misgivings. Fortunately, I was friendly with two outside psychiatrists who were able to answer my general questions about the nuts and bolts of running complex medication regimens in an informal consultative role. Their support, as well as frequent consultations with the team of NMBHI primary care physicians on the medical complexities made my work on these units both possible and ultimately successful.

The Rest of My Job


Another 40% of my position at NMBHI was as the clinical director for NMBHI’s 14 bed long term residential treatment center for adolescent males with sexually harmful behaviors known as the CARE Unit. My challenges there were less technical medical and more interpersonal and administrative. I did learn a memorable lesson on the behavioral disinhibition potential of benzodiazepines. A young man became extremely agitated and started severely and repeatedly harming himself. After several less restrictive verbal and physical interventions by different providers failed to help him de-escalate and stop self-harming, I made the decision to order an emergency injection of lorazepam as a last resort. This was successful in that he stopped harming himself but less than ideal in that he spent

the next 30 minutes openly masturbating in front of the staff observing him in the quiet room, an example of “Harm Reduction” in action. I also learned the value of frequent exercise on impulsive and volatile young men. We changed the unit schedule to start the day with a vigorous gym class instead of having a less vigorous one later in the schedule. We saw a modest but sustained reduction in interpersonal conflict and the education staff reported improvements in attention, classroom discipline and learning in the mornings following the vigorous exercise classes.

The last 20% of my time was to be on the admissions team for the hospital. I averaged two to four per week and triaging and treating whoever presented themselves stretched my clinical and diagnostic skills. Patients ranged from the woman who was not suicidal but felt she “just needed a break” from her conflicted family to the most acutely disturbed patients in my career. Although daunting at first, it was a rich learning experience and helped cement the clinical algorithms I use today. After about 18 months, I was tapped to share the on call rotation on nights and weekends with the handful of psychiatrists who were not locum tenums. While it felt validating to be trusted with the psychiatry call for the entire hospital, the expectation that one work the next day made it quite draining.

Afterwards

I worked at NMBHI until June 2011, spending half the week 130 miles away from my family and putting many thousands of miles on my vehicle. By the end of my two and a half years, there had been a number of positive changes at NMBHI. The first beds of a long delayed, state of the art replacement for the crowded and chaotic long term care units opened. Since then, almost all of the patients have been moved to a much more therapeutic physical environment. The final phase of the long term care replacement buildings was recently fully funded by the governor. A neuro-psychologist working on her RxP training and a psychiatric NP began working with me on the long term care units, greatly improving our ability to help those patients. Another RxP psychologist, Dr. Paul Bagwell began prescribing at the hospital’s Forensic section. Another RxP trained psychologist took my position on the adolescent unit and is completing his practicum hours.



Although the majority of the psychiatrists in 2008 were deeply skeptical about prescribing psychologists' global competency, their views gradually shifted after working alongside me and later also with Dr. Bagwell. In the beginning it was "It's a terrible idea, there's no way they can ever do the work competently" to "I think it's a terrible idea, but she at least seems to be

doing ok, for now" to later "Both of them seem to be doing ok for several years so maybe it's not always a bad idea". These one-by-one shifts in the attitudes of psychiatrists after they work with a medical/prescribing psychologist fuels the increasing acceptance of our profession and are critical to our long term success.

Psychopharmacology and Psychiatry; Both/And, Not Either/Or, in Better Serving the Underserved Community Needs

Manuel Fernandez, PsyD

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Contra Costa County is one of the largest counties in Northern California that is culturally rich and much diverse when it comes down to race, age, socioeconomic status (SES), sexual orientation, religion, and cultural beliefs. The density of the population is higher in some sectors of the County than others and communities continue to expand to remote areas (United States Census Bureau, 2013). As the communities expand, the need for services increases in areas where the medical demands are high and the resources are scarce (Community Health Needs Assessment, 2013, p.34). One of the major concerns in this County is providing services that are suited for the different needs of such diverse population. Just to mention a few, the Latino population usually complain of having difficulties in receiving medical and psychiatric services due to lack of providers, insurance coverage, financial difficulties, feeling that they are misunderstood, and believing that they are not treated with the best evidence based practice. Furthermore, when it comes down to psychiatric services the demand for bilingual and culturally sensitive clinicians is now a major problem in all sectors of this County. To mitigate for the need of vulnerable disadvantaged communities, other medically trained clinicians such as nurse practitioners, physician assistants, and medical psychologists or psychopharmacologists are, in many available ways, successfully providing these services due to the high need and unavailability of psychiatric services.

This article distills personal experiences in the medical field as a practicing psychopharmacologist in a suburban area of California. The underpinning premise of this recount is based on the first core general principle of the psychology Ethics Code -Beneficence


and Nonmaleficence. This principle emphasizes on the awareness to do no harm and includes providing better patient care. Throughout my years of practice as a psychopharmacologist, I encountered few psychiatrists that reminded me of this particular ethical tenet implying that my practice and services were in violation of such ethical standard. Mostly, these perceptions would subside after engaging in conversations about the medical aspect of psychopharmacology.



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My certification in psychopharmacology included the guidance and clinical supervision of John Echols, MD, Chair of Psychiatry at the County hospital where I completed my psychopharmacology rotations, cases, and clinical practice. While at the county hospital, I worked in the psychiatric consult liaison (CL) service. Dr. Echols is someone who strongly supports the idea that psychologists, after getting the necessary medical training to prescribe, can effectively do so because of the rigorous American Psychological Association (APA) accredited doctoral training programs to become psychologists and the clinical exposure to deal and treat severe psychiatric conditions. Dr. Echols was not only the person who motivated me to pursue training in psychopharmacology, he also heighten and broaden my knowledge in medicine with his lectures and practical exposure to severe medical cases that didn't necessarily required a psychiatric consult at the hospital. He is someone I can now call a mentor.

During my tenure working for the Contra Costa County Hospital, the value-added by the psychiatric consultation services I provided became eminent to attending physicians and medical residents, including the medical staff who were very appreciative of




my services. Precisely, earning my credibility from colleague physicians was the result of successful psychiatric case consultations and interventions that provided me with the practical experience to share the medical knowledge I gained through my training. Dr Echols played an influential role in the way I performed my duties as a psychopharmacologist and he demonstrated his complete trust in my decisions and recommendations. Collaboration with medical providers was supported with monthly psychiatry meetings attended by all the psychiatrists in the county and led by the psychiatric medical director. I had the opportunity to give lectures about the pharmaceutical management of chronic pain conditions and comorbid psychiatric conditions to them; these experiences led to greater collaboration and increased awareness of the role of psychologists who become psychopharmacologists in the medical field. However, my experience changed abruptly after I accepted a position as a therapist by an outpatient clinic in the same County and left the hospital.

The outpatient clinic that hired me served residents with demographic characteristics that had adverse implications for health and wellness. According to the Community Health Needs Assessment (2013), 13% of the residents in the Richmond area live in poverty and 16% lack health insurance coverage. I was enthusiastic about the opportunity to serve vulnerable communities, however, I had a rough experience integrating and leveraging my psychopharmacological training to meet the needs of the population due to deeply rooted mind-sets that prevailed within the clinic. Throughout my three-year endeavor at this clinic, there were times that I was blamed for working “out of my scope of practice.” The need for psychiatric services is immense in this part of the county; thus the notion of psychopharmacologists is still widely misunderstood by medical practitioners. Hierarchical, top-down institutions are still mainly governed by the belief that only psychiatrists are able and should be allowed to prescribe psychotropic medications. Seldom, senior management clinicians like Dr. Echols dare to step out of the box adopting and integrating new and more provocative theories that at the end of the day can shift the philosophical foundation of archaic institutions. Although there were several people who supported my knowledge and recognized the need for psychopharmacological interventions, in the process of advocating for these services, their efforts

came to a halt by the leadership in the County. For instance, a visiting psychiatrist, who came to the clinic while the other psychiatrist was on vacation, knew about my training based on previous encounters at the hospital. One day he was over booked and asked me to see a Latino girl and her family seeking psychiatric services after a hospital discharge. I saw the patient and did the medication recommendation to which the psychiatrist prescribed under his name and then he cosigned the psychiatric encounter. Months later the clinic’s psychiatrist found out what happened and complained to his superior. The visiting psychiatrist was told not to do it again. Even though the encounter was successful, and the needs of the patient were met which demonstrated a better patient care, none of it mattered; they would have preferred that the patient rescheduled.

In retrospect, many of these experiences make me ponder about what the real misunderstanding is about this profession. Is it about providing the services the patients need or is it about just not letting other clinicians help the cause because of a turf political battle? These roadblocks only impact the people we serve. At the end, the underserved become even more affected. The complaints I heard are that psychologists don’t get the medical training necessary to prescribe psychotropic medication. Well, that is true! That is why the APA has implemented the post-doctoral degree in psychopharmacology which includes clinical rotations. Psychologists go through a rigorous training and medical rotations that other clinicians are unaware of to become psychopharmacologists. Even when I explain that I am a psychopharmacologist and there is the acceptance from other clinicians, they still believe that my training didn’t include medicine or knowledge about the different areas in medicine and review of systems (ROS) until this is clarified several times.

Currently, my experiences with primary care physicians and attending physicians and residents at the hospital where I work as a psychopharmacologist is very rewarding. They continuously express their appreciation by the services psychopharmacologists provide. At first it requires explanation about the work we do as they always ask: “What is a psychopharmacologist?” to which my reply is: “We are the new breed in psychiatry.” At this hospital, I provide services to patients that are in dire need for psychiat-



ric services who come from different cultures and SES and my patients express feeling understood and leave with a clear understanding about the medications they are taking and about all the possible side effects; something that I hear in my practice from patients as not being the case when they visit other prescribing clinicians who spend less time with them.

Connecting with the underserved populations in ways that can directly make a positive impact in their well-being is paramount in clinical practice. It also involves accepting change; accepting new ways. Ultimately, what matters is that the patients get the care they need by providing better patient care and not by stop-

ping services because of the unavailability of psychiatrist when there are other medically trained clinicians that can do the job. Psychopharmacologists prove on a daily basis in California and in other states that they can do the job safely as well as any physician with this expertise.

References

- Community Health Needs Assessment. (2013). Retrieved July 1, 2015, from <http://share.kaiserpermanente.org/wp-content/uploads/2013/09/Vacaville-CHNA-2013.pdf>
- United States Census Bureau. (n.d.). Retrieved July 2, 2015, from <http://quickfacts.census.gov/qfd/states/06/06013.html>

Legislative Update With Aloha 2015

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2015 turned into an exciting year for advocates of prescriptive authority for psychologists in Hawai'i. The effort to move House Bill 1072 through both branches of the legislature saw several new faces from consumers, educators and private practitioners, who together contributed to increased awareness of the serious need for psychologists to gain prescribing privileges in our state.

The Hawai'i Psychological Association (HPA) has focused on advancing prescriptive authority for psychologists since 1984 when the first bill was introduced. In 2007 the prescriptive authority bill passed through the Hawai'i State Legislature only to be vetoed by Linda Lingle the Republican Governor at that time.

Since 2007 HPA faced various barriers but remained encouraged as efforts successfully continued to move the bill all the way through the Senate. From 2011 to 2014 attention was focused on building grass roots and community support for the bill. Relationships were cultivated with key legislators of rural, neighbor island areas as well as supportive physicians, community members and organizations and the UH Hilo Daniel K Inouye College of Pharmacy (DKICP) Master of Science in Clinical Psychopharmacology (MSCP) program. While this was a great start and we saw potential, we still needed more community support.

Things changed in the mental health services landscape in late 2014 following the closure of the only inpatient child and adolescent unit on the island of Maui. This created more awareness in the community regarding the scarcity of available psychiatric services

on island and the ongoing unmet behavioral needs on the island. Similarly, on Hawai'i Island, it was a critical


time with regard to growing community concerns regarding mental health needs in light of the advancing lava in a remote district on the island where schools and shopping centers were being evacuated and life as people in that district knew it was being turned upside down right before their eyes. Community members and leaders were feeling the pressure to come up with solutions to assist with the devastating effects of this natural phenomenon on multiple levels. This threatening situation highlighted the already dismal availability of qualified mental health care providers on Hawai'i Island, with extremely limited access to care for people with a dual substance and mental health diagnosis.

Through these changes the RxP initiative was able to be discussed once again as a viable, proven and cost-effective method to address the unmet behavioral needs across the state of Hawai'i, and particularly in certain rural areas. With the start of the 2015 Hawai'i Legislative session upon us, we were able to garner even more community support and advocates were able to request a meeting with key Legislators, such as, the Speaker of the House and the Chair of the House Consumer Protection Committee, who subsequently co-introduced the RxP Bill in the House.

The bill successfully passed through two hearings in the House (Health/Consumer Protection and Commerce; and Finance) and crossed over to the Senate only to be stalled in the Senate House Health Committee where, despite significant advocacy efforts on our



Judi Steinman, PhD



part, the bill eventually was not heard. There were some exciting moments such as when one legislator challenged a psychologist with a masters in clinical psychopharmacology to explain the differential diagnosis between neuroleptic malignant syndrome and serotonin syndrome, only to be shut down by the chair of the health committee.

Interestingly, legislators who had previously voted against RxP in Hawai'i felt more assured that the legislation would succeed because of the newly formed DKICP MSCP program. Most criticisms that prescribing psychologists "know nothing about the body" – as claimed by one local psychiatrist - were dispelled quickly when the legislators heard the extent and complexity of training in the medical model.

The success of the RxP Hawai'i group this year hinged on the involvement of community members who suffer from mental health disorders and their family members. One mother of an adult son with schizophrenia and comorbid drug addiction was very vocal about the lack of viable mental health care on Hawai'i Island. A young man from Maui who had difficulty getting medication for bipolar disorder became the community's voice. Organizations such as Mental Health America of Hawai'i were pivotal in distributing information to legislators, testifying and speaking with the press.

The growing coalition continues grass roots advocacy and is utilizing social media now more than ever to increase our audience and support. The RxP Hawai'i Facebook page grows steadily every day www.facebook.com/RxPHawaii. Dr. Kelly Harnick had the foresight to build a website where visitors learn that "Change is on the Horizon" for Hawai'i: <http://www.rxphawaii.com/>. There now are 760 signatures on a petition to support RxP in Hawai'i (<http://petitions.moveon.org/sign/rxp-hawaii-medical-psycholog>) and will look toward multiple ways to continue utilizing this support to advance RxP in Hawai'i in 2016.

This article would be incomplete without acknowledging some of the leaders of the RxP Hawai'i coalition. Dr. Kelly Harnick, Psy.D., ABPP, President of West Maui Counseling Center and Don Lane, of Mental Health Kokua and Director of the ARISE Benefit events engaged members of the House of Representatives early on in 2015. HPA continues to be well represented by President Marie Terry-Bivens, Psy.D. of Kauai, Executive Director Alex Santiago M.S.W. and HPA legislative committee member Julie Yurie Takishima Ph.D. Other essential participants include Marya Grambs, Executive Director of Mental Health America of Hawaii, Deborah Mich Fried, BSN, a registered nurse from Hawai'i Island and Cathy Hausman Klarin, a parent advocate from Hawai'i Island.

Forging an Alliance: Primary Care Physicians, Primary Care Psychologists, Prescribing Psychologists, Clinical Pharmacists, and Advance Practice Nurses

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Member—Division 55—American Psychological Association

Member—Society of Teachers of Family Medicine

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I. Fusion Reaction

The Institute of Medicine report (IOM, 1988) recommended that in the future behavioral care be integrated into primary care settings. This assertion was based on the reality that a shortage of psychiatrists was deferring psychiatric care to primary care providers in all but the large urban settings where persons seeking care could afford psychiatric care driven to more and more expensive levels by the shortage of providers.

At this same time accumulating evidence (Fraser & Shavlik, 2001) showed that the greatest health problems in the Western world and especially the United States were “lifestyle diseases” which resulted from the use of substances (tobacco, alcohol, recreational and illicit substances), poor dietary habits, lack of exercise, and the stress of an increasingly complex and competitive life. Many medical patients (more than 17% of Medicare Patients) have “mental disorders” which need to be treated in order to effectively prevent or treat many medical disorders. (Donohue, 2006). Many more patients have unhealthy lifestyles which constitute behavioral conditions which drive 70% of chronic disease. (Kung, H., et. al., 2008)

With these emerging realities as a background, the Family Medicine Center of the Southern New Mexico Family Medicine Residency added the training of primary care psychologists (known as behavioral health consultants) and prescribing psychology trainees to the training of medical residents, clinical pharmacists and advance practice nurses. This mix of professionals, bred of a similar purpose, began tentatively and then with increasing vigor to create collaborative re-

lationships focused on changing health related behaviors, physical, mental and social.

The introduction of prescribing psychology trainees to a medical residency was a first in the nation. Dr(s) Tommy Thompson and Robert Mayfield received training in physical assessment and medication management in the program. They were graduates of the Southwestern Institute for the Advancement of Pharmacotherapy, the training organization founded by Dr. Elaine Levine, the holder of the first prescribing psychology license in New Mexico. The medical faculty both welcomed the task of training psychologists in physical assessment and medication management, and took on the challenge of advancing their own knowledge and skills in providing behavioral services.

The task of training the medical residents in providing psychiatric services gave an entrée to the psychologists who were learning psychopharmacology and medication management but who could teach skills in psychological assessment and treatment to the residents. Under the leadership of Dr. Bert Garrett, and now Dr. John Andazola, Residency Director, and Dr. Bruce Sanfilippo, the Chief Medical Officer of Memorial Medical Center, the training of prescribing psychologists and primary care psychologists alongside the medical residents receives solid and enthusiastic support. The administration of Memorial Medical Center under the leadership of CEO John Harris continues to encourage inter-professional education and collaboration. The medical and pharmacy faculty are excellent teachers and collaborators.

The presence of New Mexico State University nearby which has a counseling psychology doctoral program

meant that there were doctoral students wanting training. Dr. Eve Adams of the Counseling and Education Psychology program had obtained a HRSA grant, the purpose of which was to fund the training of primary care psychologists who would work to change health related behaviors. Students participating under her leadership through the grant came to the Family Medicine Center to train, and their presence and availability to act as behavioral health consultants to the primary care providers meant that the clinic could provide integrated behavioral care focusing on both the changing of health related behaviors, and providing counseling for psychological disorders.

The fusion of these providers and their faculties has created a richer environment for all. Inter-professional training means that inter-professional and inter-professional faculty is required and with it inter-professional supervision of medical residents, prescribing psychologists, primary care psychologists, clinical pharmacists, and advance practice nurses. Patients are seen, at times together, by pairings of professionals in training from two of the three professional groups, often with consultation from a professional from the third. At times it is the primary care physician who takes the lead in organizing interventions, at others the prescribing psychologist and further, at others the initiative is led by the primary care psychologist. Preliminary research findings have shown that patient safety and outcomes are improved (Andazola, et. al., 2015).

II. Conclusions Drawn From Inter-Professional Training

What have we learned? The following conclusions have been drawn from discussions among the inter-professional faculty.

- a. The first difficulty in blending the cultures of other professional groups with the culture of medicine is one of language and communication. Inter-professional training permits participants to learn a common language which is a kind of medical standard terminology including common acronyms, length of communications, parsimonious use of non-instrumental social chat, and brief instrumental interactions. (Hoover & Andazola, 2012)
- b. Inter-professional training normalizes inter-professional collaboration.

- c. Inter-professional supervision broadens education and breaks stereotypes and artificial boundaries to cooperation and collaboration.
- d. Most behavioral patients have the need for the treatment of medical illness which at times exacerbate psychological distress making collaborative treatment in one setting efficient. Patients with serious mental illness have life spans shortened by as much as 25 years.
- e. Collaborative treatment reduces the likelihood of polypharmacy and iatrogenic harm to patients.
- f. Participating faculty and trainees report a preference for inter-professional collaboration and primary care settings in which communication and cooperation is enhanced and patient care seems more efficient, effective and rewarding.
- g. The participating professionals function and identity is changed and strengthened by the fusion of effort forged by inter-professional collaboration.

III. Legislation/Policy Implications

The education of health providers benefits from inter-professional training. Grant funding for medical, psychological, pharmacy and nursing education should be broadened to ensure that representatives of multiple-provider types be trained in the same settings. Since current findings across the professions suggests that integrated care is safer, more efficient and effective, financial support for students should be directed to those settings where such inter-professional collaborative training takes place.

IV. Conclusion

This experiment in inter-professional education and training is created by the need to train health care professionals who are prepared to serve the whole healthcare needs of underserved peoples in economically disadvantaged settings. The importance of meeting patient's needs coupled with the presence of professionals and students from several distinct professions creates an opportunity to fuse a new model of patient care that is highly effective in providing comprehensive and safe care and is rewarding, challenging and inspiring for the professionals involved.

References

- Andazola J , Benson S, Colmant S, Duarte M, Gomez D, Hales K, Hoover M, Leung P, Norris D, Pattison-Fitzsimmons D, Rose J, & Shumway B. *Enhanced Patient Safety Through Inter-professional Supervision of Resident's Patient Care*. Poster Presentation: Accreditation Council for Graduate Medical Education Annual Convention, 2015.
- Andazola, J., and Hoover, M. *Integrated Care in a Primary Care Setting: Opportunities and Challenges*. Presentation at the Annual Convention of the American Psychological Association, 2011.
- Collins,C., Hewson, D., Munger, R & Wade, T. *Evolving Models of Behavioral Care Integration in Primary Care*. Millbank Memorial Fund, 2010.
- Donohue, J. *Mental Health in the Medicare Part D Drug Benefit: A New Regulatory Model?* Health Affairs, 2006.
- Fraser, G. Shavlik, D. *Ten Years of Life: Is It a Matter of Choice?* Arch Intern Medicine, 2001.
- Hoover, M, Adams, E, Andazola, J, Billington, L, & Cox. Presentation at the Annual Spring Conference – Society of Teachers of Family Medicine. *Integrated Behavioral Care Education – Residency Based Co-Training of Medical and Behavioral Health Providers*, 2012
- Hoover, M & Andazola, J. *Integrated Behavioral Care Training in Family Practice Residency: Opportunities and Challenges*. J Clinical Psychology in Medical Settings, 2012.
- In Institute of Medicine (IOM). *Establishing transdisciplinary professionalism for improving health outcomes: Workshop summary*. Washington, DC: In Institute of Medicine (IOM), 2013.
- Katon, W., Lin, E., Von Korff, M., Ciechanowski, P., Ludman, E., Young, B., Peterson, D., Rutter, C', McGregor, M., & McCulloch, D. *Collaborative Care for Patients with Depression and Chronic Illnesses*. New England J. of Medicine, 2010.
- Kung, H. Hoyert, D., Xu, J., & Murphy, S. *Deaths: final data for 2005*. *National Vital Statistics Reports*, 2008.
- Wynia, M., McNellis, Okun, S., Webb, C., Rohrbach, V., & Von Kohn, I. *Core principles & values of effective team-based health care. Discussion Paper*. Institute of Medicine, Washington, DC., 2012.

The Treatment of Depression in Pregnant and Lactating Women

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Depression during pregnancy is relatively common. Approximately 20% of women experience depressive symptoms while pregnant. However, depression during pregnancy often goes unrecognized and untreated (Yonkers et al., 2009). Untreated maternal depression is associated with a number of adverse pregnancy outcomes, including premature birth, low infant birth weight, and postnatal complications. While many women choose to avoid pharmacological treatment for perinatal depression for fear of negative side-effects, evidence exists to suggest increased emotional instability and greater need for psychiatric care later in the lives of children whose depressed mothers did not receive adequate treatment (O'Keane & Marsh, 2009; Solomon, 2015).

Depression during the postpartum period, generally defined as beginning 3-6 months after child birth, is also common (Yawn, 2010). As many as 15% of postpartum women will develop a depressive disorder and up to 30% of adolescent mothers develop postpartum depression (Yawn, 2010).

Over the last several years, there have been a number of studies warning about in utero exposure to antidepressants (Nonacs, 2007). Cardiac defects, major malformations, and persistent pulmonary hypertension are three adverse outcomes most often discussed (Abel, 2010; American College of Obstetrics and Gynecology, 2008). In 2005, the Food and Drug Administration (FDA) warned that early exposure to paroxetine (Paxil) could increase the risk of congenital cardiac malformations in the unborn child, and classified the drug as pregnancy Category D (evidence

of human fetal risk, but benefits may warrant use) (United States Food and Drug Administration, 2005).

Depression during the perinatal period must not be ignored. As always, a "risk-benefit" analysis should be undertaken to determine the most prudent course of action for both the mother and child. The prescribing psychologist must determine whether to recommend psychotherapy, medication, or a combination of both, and the woman and her partner must be kept fully informed of the relative risks and benefits of all options.

Medication Risks

The prescribing psychologist must be aware of the possible fetal or neonatal risks associated with antidepressant medications. Psychotropic medications cross the placenta, can be found in amniotic fluid, and can enter human breast milk to a greater or lesser degree. The biggest risk of teratogenesis is during the first trimester of pregnancy, when the embryo is forming and developing (Louik & Lin, 2007). The prescribing professional should be familiar with the five FDA categories that indicate the potential for a drug to cause birth defects (United States Food and Drug Administration, 1979).

Studies regarding cardiac defects related to the use of selective serotonin reuptake inhibitors (SSRIs) and other antidepressants have yielded mixed results (Cooper, Willey, Pont, & Ray, 2007). Particular concern has often focused on the use of Paxil and right ventricular outflow tract obstruction as well as ventral septal defects with the use of sertraline (Zoloft) (Wichman et al., 2009). Huybrechts, Palmsten, and

Avorn (2014) published results from a study of nearly 950,000 pregnant women that examined the risk of cardiac defects with antidepressant use. The results from this large, population-based study suggested no substantial increase in cardiac malformations related to antidepressant use in the first trimester. And, specifically, no association was found between use of Paxil and right ventricular outflow tract obstruction or Zoloft and ventricular septal defects (Huybrechts, Palmsten, and Avorn, 2014). The baseline of major malformations in the general population of the United States is between 1% and approximately 4% (Cooper et al., 2007). A number of studies have found no significant increased prevalence of major noncardiac malformations in children exposed to SSRIs in utero versus those who were not so exposed (Malm, Artama, Gissler, & Rityanan, 2009; "Treatment of Depression in Pregnancy," 2009).

Persistent pulmonary hypertension (PPHN) of the newborn secondary to SSRI use in pregnancy has been noted as another potential risk. This condition can result in poor oxygenation to the tissues and organs. Three studies suggest an increased risk for PPHN with SSRI use in pregnancy (Chambers et al., 2006; Huybrechts et al, 2015; Källén and Olausson, 2008;). Three other studies do not support this association (Andrade, McPhillips, & Loren, 2009; Wilson, Zelig, & Harvey, 2011). The most recent of these, a very large study of women enrolled in Medicaid, found that the SSRIs may be consistent with a possible increase in PPHN risk, but the risk appeared to be more modest than noted in previous studies (Huybrechts et al, 2015).

In December 2011, the FDA reported that there is not sufficient evidence to conclude that SSRI use in pregnancy causes PPHN. The FDA recommends that prescribing professionals weigh the relatively small risk of PPHN against the known risks of untreated depression during pregnancy, and "treat depression during pregnancy as clinically appropriate" (United States Food and Drug Administration, 2011).

Treatment Recommendations

In 2009, the American Psychiatric Association (APA) and American College of Obstetrics and Gynecology (ACOG) generated recommendations for managing depression during pregnancy (2009). In those joint guidelines, the APA and ACOG recommended that

many patients with mild to moderate depression may be treated with psychotherapy as a first line. Treatment of depression was viewed against the backdrop of three common scenarios:

Considering Pregnancy

- If on medication for six months or longer and symptoms of depression are mild, consider tapering and discontinuing medications prior to pregnancy
- Discontinuation of medications may not be appropriate if there is a history of severe or recurrent depression

Pregnant and currently taking medication

- If a patient is stable and prefers to remain on medication, she should be able to do so after consultation with all appropriate healthcare providers and a clear understanding of the possible risks and benefits of medication
- Women who wish to discontinue medications may attempt tapering under the supervision of their prescribing professional. Note that those experiencing symptoms of major depression or have a history of severe depression will be at high risk for relapse. Again, it is incumbent upon the prescribing psychologist and treating physician to inform the patient of the possible risks and outcomes
- Consider replacing medication with psychotherapy for those women who wish to discontinue pharmacologic treatment
- Women with severe depression, e.g. who are suicidal, unable to function, experience significant weight loss, etc., should consider remaining on medication

Pregnant and not currently taking medication

- Psychotherapy must always be considered as a first-line treatment
- If a woman prefers medication, a full discussion of risks and benefits should be undertaken

The following general concepts regarding use of medication during pregnancy and lactation were published by ACOG in 2008 and reaffirmed in 2012 (Agency for

Healthcare Research and Quality, 2012; American College of Obstetrics and Gynecology, 2009).

- Multidisciplinary collaboration and management, whenever possible, is in the best interest of your patient. The prescribing psychologist should collaborate with the patient's obstetrician, primary care provider, pediatrician, etc.
- If feasible, try to avoid medications during the first trimester of pregnancy, in that the major organs of the fetus are developing at this time
- When medication is used a single medication at the lowest effective dose is preferable to the use of multiple medications
- Treatment should be individualized and a risk-benefit analysis should be undertaken in each case

Selecting an antidepressant in pregnancy

- Paxil should be avoided in pregnant women and those considering pregnancy as it carries a Category D rating from the FDA
- The most published data and clinical experience are noted with Prozac and Zoloft, and because of this one of these SSRIs is often a first choice in pregnancy when a medication is necessary (Wisner et al., 2000).
- Zoloft has a shorter half-life than Prozac, which may be advantageous to the newborn. And, Zoloft is one of 2 SSRIs generally thought to be most compatible with lactation. Prozac has the advantage of greater clinical experience, with more pregnant women having taken it than any other SSRI. Prozac, in addition to its long half-life, is typically not preferred in breastfeeding because it is more stimulating than some other SSRIs.

Selecting an antidepressant during lactation

- Generally, when less than 10% of an SSRI is excreted into breast milk, it is considered to be compatible with breast feeding.
- Excretion varies by agent. Zoloft is excreted into the breast milk at less than 2% and Paxil at less than 4% (The Carlat Psychiatry Report, 2010).

- Zoloft has the most published data in this regard and is often a first line SSRI when medications are necessary (Altshuler, Burt, McMullen, & Hendrick, 1995).

Interpersonal Psychotherapy in the Treatment of Perinatal Women with Depression

Prescribing psychologists should consider using psychotherapy to treat women with perinatal depression. Interpersonal psychotherapy (IPT) is a brief, empirically supported, and dynamically informed psychotherapy that is considered a first line response to the treatment of depression during pregnancy and the postpartum period (O'Hara, Stuart, Gorman, & Wenzel, 2000; Segre, Stuart, & O'Hara, 2004; Stuart & O'Hara, 1995; Stuart, 2012). IPT addresses the interpersonal relationships of patients and aims to both decrease the intensity of depressive symptoms and increase interpersonal functioning (Segre, Stuart, & O'Hara, 2004; Stuart & O'Hara 1995; Stuart, 2012). IPT interventions achieve these goals by modifying the nature of interpersonal relationships and/or one's expectations of those relationships (Stuart, 1995).

IPT is informed by both attachment theory and interpersonal theory; certain attachment styles and patterns of maladaptive communication lead to problems in interpersonal functioning, culminating in depression (Stuart & O'Hara 1995; Stuart, 2012). IPT conceptualizes perinatal depression as arising from disruptions to interpersonal relationships brought about by pregnancy and the birth of a child, resulting in an individual engaging in maladaptive communication or enacting an unhelpful attachment style (Segre, Stuart, & O'Hara, 2004; Stuart & O'Hara, 1995; Stuart, 2012). Specifically, IPT maintains that perinatal depression is engendered when women report discrepancies between the amount of social support they desire and that which they perceive they are receiving (Segre, Stuart, & O'Hara, 2004; Stuart & O'Hara, 1995; Stuart, 2012).

IPT delivers treatment for depression through a biopsychosocial paradigm, focusing intervention on three respective targets of depressive symptoms: psychiatric symptoms, Interpersonal Problem Areas, and social support (Stuart, 2012). IPT therapists utilize various tactics in working with patients. In the beginning of therapy, therapists use the interpersonal inventory tactic, a means of charting a woman's interpersonal

relationships and the degree of closeness between the patient and these individuals. Through the interpersonal formulation tactic, IPT therapists in the initial sessions conceptualize their patients as biopsychosocial-cultural-spiritual beings, in order to further inform the course of treatment. Finally, those clinicians practicing IPT determine which Interpersonal Problem Area represents the best focus of intervention. IPT recognizes three Interpersonal Problem Areas: role transitions, grief and loss, and interpersonal disputes. Determining which Interpersonal Problem Area best fits the patient's presenting problem informs the use of specific interventions for both conceptualization and treatment (Segre, Stuart, & O'Hara, 2004; Stuart & O'Hara, 1995; Stuart, 2012).

After conducting the assessments in the initial sessions of therapy and determining the Interpersonal Problem Area theme that matches the patient's presentation, IPT practitioners can use specific techniques (Stuart, 2012). Of the techniques utilized by IPT, Stuart (2012) outlines the most common: psychoeducation, communication analysis, interpersonal incidents, and role playing. IPT recommends that therapists utilize psychoeducation from the beginning of therapy, sharing information on the nature and course of depression, as well as knowledge on how this disorder may affect the development of the child. If a patient presents with an interpersonal dispute, IPT practitioners can have her discuss in detail a specific interpersonal incident, and then use communication analysis to help the patient process the incident and correct any unhelpful assumptions that may have instigated the incident. Finally, a clinician working through an IPT paradigm can use role play as a technique. Role play allows patients to develop insight into how they are communicating, how changes in communication could result in different outcomes, and how their partners might be experiencing certain communication patterns. IPT clinicians who use role play should have their patients first play the role of their partners, while the therapist acts as the patient. This role reversal allows the woman to appreciate the point-of-view of their partners, as well as observe the therapist demonstrating more effective means of communication. Specific intervention techniques during the middle phase of IPT therefore function to improve interpersonal functioning and decrease depressive symptoms through education and insight.

IPT, as a brief form of psychotherapy, ends when the client has successfully achieved her goals, as determined during the interpersonal formulation (Stuart, 2012). IPT clinicians should inform patients of the acute nature of this treatment and always discuss the possibility of relapse (Stuart, 2012). Maintenance therapy helps patients learn the interpersonal skills to directly address and mitigate on their own (Stuart, 2012).

Summary/Conclusion

Most recommendations found in the literature regarding use of medications in the treatment of depression for pregnant and lactating women are based primarily on consensus of expert opinion. Treatment of depression during the perinatal period should be individualized. The use of psychotherapy should always be considered as an option and utilized as a first line treatment when feasible. Medication in the treatment of depression of pregnant and lactating women should be used following a careful risk-benefit analysis and discussion with the woman and her partner. It is important for the prescribing psychologist to document the risk-benefit discussion along with whatever treatment decisions are made.

The empirical literature suggests specific recommendations for the efficacious treatment of peripartum depression in women. Available data and consensus of expert opinion point to the use of Zoloft and Prozac as reasonable selections in the treatment of major depression during pregnancy when a medication is indicated, and following a careful risk-benefit analysis and discussion with the mother and partner. Similarly, Zoloft and Paxil are noted as reasonable selections for breastfeeding women suffering from major depression when a medication is deemed necessary. Finally, clinical research has verified the efficacy of interpersonal psychotherapy for the treatment of perinatal depression in women. Prescribing psychologists can therefore consider these options for efficacious treatment of women diagnosed with peripartum depression.

References

- Abel, D. E. (2010). Medication safety during pregnancy. *Contemporary OB-GYN*, 2, 30-41.
- Agency for Healthcare Research and Quality. (2012). Use of psychiatric medications during pregnancy. Retrieved from

- <http://www.guideline.com/content.aspx?id=12490>.
- Altshuler, L. L., Burt, V. K., McMullen, M., & Hendrick, V. (1995). *Journal of Clinical Psychiatry*, *56*, 243-245.
- American College of Obstetrics and Gynecology. (2008). Use of psychiatric medication during pregnancy and lactation. *Obstetrics and Gynecology*, *112*, 1001 – 1020.
- American Psychiatric Association & American College of Obstetrics. (2009). The management of depression during pregnancy: A report from APA and ACOG. *American Journal of Obstetrics and Gynecology*, *114*, 703-713. doi:10.1097/AOG.0b013e3181ba0632.
- Andrade, S. E., McPhillips, H., & Loren, D. (2009). Antidepressant medication use and risk of persistent pulmonary hypertension of the newborn. *Pharmacoepidemiol Drug Safety*, *18*, 246-252.
- The Carlat Psychiatry Report Staff. (2010). Psychotropics in pregnancy and breastfeeding, *The Carlat Psychiatry Report*, *8*. Retrieved from <http://www.thecarlatreport.com/issue/vol8-no11>
- Chambers, C. D., Hernandez-Diaz, S., Van Marter, L. J., Werler, M. M., Louik, C., Jones, K. L., & Mitchell, A. A. (2006). SSRI and risk of persistent pulmonary hypertension of the newborn. *New England Journal of Medicine*, *354*, 579-587.
- Cooper, W. O., Willey, M.E., Pont, S. J., & Ray, W.A. (2007). Increasing use of antidepressants in pregnancy. *American Journal of Obstetrics and Gynecology*, *196*, 544.e1-544.e5.
- Huybrechts, K. F., Palmsten, K., & Avorn, J. (2014). Antidepressant use in pregnancy and the risk of cardiac defects. *New England Journal of Medicine*, *356*, 2397-2407.
- Huybrechts, K. F., Bateman, B. T., Palmsten, K., Desai, R. J., Patorno, E., Gopalakrishnan, C., Levin, R., Mogun, H., & Hernandez-Diaz, S. (2015). Antidepressant use late in pregnancy and risk of persistent pulmonary hypertension of the newborn. *JAMA*, *313*, 2142-2151. doi:10.1001/jama.2015.5605
- Källén, B. & Olausson, P. O. (2008). Maternal use of selective serotonin re-uptake inhibitors and persistent pulmonary hypertension of the newborn. *Pharmacoepidemiol Drug Safety*, *17*, 801-806.
- Louik, C. & Lin, A. E. (2007). First trimester use of SSRIs and the risk of birth defects. *New England Journal of Medicine*, *356*, 2684-2692.
- Malm, H., Artama, M., Gissler, M. & Ritvanan, A. (2009). Selective Serotonin reuptake inhibitors and risk for major congenital anomalies. *Obstetrics and Gynecology*. *118*, 111-120. doi: 10.1097/AOG.0b013e318220edc
- Nonacs, R. M. (2007). Postpartum depression. *eMedicine Obstetrics and Gynecology*. Retrieved from www.emedicine.com/med/topic.3408.htm.
- O'Hara, M. W., Stuart, S., Gorman, L. D., & Wenzel, A. (2000). Efficacy of interpersonal psychotherapy for postpartum depression. *The Archives of General Psychiatry*, *57*, 1039-1045.
- O'Keane, V., & Marsh, S.M. (2007). Depression during pregnancy. *BMJ*, *334*, 1003-1005.
- Segre, L. S., Stuart, S., & O'Hara, M. W. (2004). Interpersonal psychotherapy for antenatal and postpartum depression. *Primary Psychiatry*, *11*, 52-56, 66.
- Solomon, A. (2015, May 28). The secret sadness of pregnancy with depression. *The New York Times*. Retrieved from http://www.nytimes.com/2015/05/31/magazine/the-secret-sadness-of-pregnancy-with-depression.html?_r=0
- Stuart, S. & O'Hara, M. W. (1995). Interpersonal psychotherapy for postpartum depression: A treatment program. *The Journal of Psychotherapy Practice and Research*, *4*, 18-29.
- Stuart, S. (2012). Interpersonal psychotherapy for postpartum depression. *Clinical Psychology and Psychotherapy*, *19*, 134-140. doi: 10.1002/cpp.1778
- Treatment of depression in pregnancy. (2009). *Pharmacist's/Prescriber's Letter*, *25*, 251006.
- United States Food and Drug Administration. (1979). Labeling and prescription drug advertising: Content and format for labeling human prescription drugs. *Federal Register*, *44*, 37434-37467
- United States Food and Drug Administration (2005). Paroxetine HCl - Paxil and generic paroxetine. Retrieved from <http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm152062.htm>.
- United States Food and Drug Administration. (2011). FDA drug safety communication: Selective serotonin reuptake inhibitor (SSRI) antidepressant use during pregnancy and reports of a rare heart and lung condition in newborn babies. Retrieved from <http://www.fda.gov/Drugs/DrugSafety/ucm283375.htm>.
- Wichman, C. L., Morre, K. M., Lang, T. R., St. Sauver, J. L., Heise, R. H., & Watson, W. J. (2009). Congenital heart disease associated with selective serotonin reuptake inhibitor use during pregnancy. *Mayo Clin Proceedings*, *84*, 23-27.
- Wilson, K. L., Zelig, C. M., & Harvey, J. P. (2011). Persistent pulmonary hypertension of the newborn is associated with mode of delivery and not with maternal use of selective serotonin reuptake inhibitors. *American Journal of Perinatal Medicine*, *28*, 19-24.
- Wisner, K. L., Zarin, D. A., Holmboe, E. S., Applebaum, A. J., Gelenberg, H. L., & Leonard, E. F. (2000). Risk-benefit decision making for treatment of depression during pregnancy. *American Journal of Psychiatry*, *157*, 1933-1940.
- Yawn, B. (2010). Postpartum depression: Office interventions. *The Female Patient*, *35*, 48-54.
- Yonkers, K. A., Wisner, K. L., Stewart, D. E., Oberlander, T. F., Dell, D. L., Stotland, N., Ramin, S., Chaudron, L., & Lockwood, C. (2009). The management of depression during pregnancy: A report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. *General Hospital Psychiatry*, *31*, 403-413.

Heaven Across the River—A Follow-Up

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Writing a script in 2015



Preparing for the PEP in 2001

In the July 2010 issue of *The Tablet*, I penned a short article entitled “Heaven across the river: Frustrations and hopes of an Rx-trained psychologist in a ‘fat chance’ state next door to Louisiana”. This was in response to a request for articles from the editor, Laura Holcomb, about the personal experiences of psychologists who had become or were training to become medical psychologists. The section was entitled, “Tales from the Trenches.”

To put that article into context, a bill had been introduced in the Health and Welfare committee of the Mississippi House of Representatives and had received a public hearing. Notably, the physician-legislator on the committee had opined that psychologists weren’t educated enough to be prescribing dangerous antipsychotics like Effexor which could cause metabolic syndrome. I had retorted that most psychologists were educated enough to know Effexor was not an antipsychotic nor highly associated with metabolic syndrome; such fun! The bill never made it out of committee.

Therefore, in the article I stated:

“It’s personally extraordinarily FRUSTRATING, sometimes gut-wrenching, to be trapped in Mississippi

while, just 40 miles away across the Mississippi River, medical psychologists are writing scripts, giving nurses orders, ordering labs, practicing, well,...medical psychology.”

But then I said, “I still have dreams of awakening across the river in a practice there before I die. I’m running out of time—I’m 64, and have avoided the worse consequences of several medical pathologies that have been hot on my trail and don’t give a rip about my old age hopes and dreams. I envy Kelly Ray who graduated with me in the 2007 Alliant class. Kelly is doing all those things I mentioned and has a long career still ahead of her. Perhaps John Teal, a young Mississippi psychologist whose Alliant testing I’ve been proctoring, will go on to prescribe in my stead. However, for a pessimist such as myself, amazingly, I find I’m prepared to be surprised on the upside.”

Hey—I’m surprised! Most importantly I managed to stay above ground. Now John Teal and I both are practicing medical psychology in Louisiana. Time still is running out of me, so I share simply that some dreams *do come true, some pessimists are surprised on the upside and you can fully awaken in a practice among sleepy bayous across the river.*

Legislation & Advocacy

The Next Challenge Along the Way

Pat DeLeon, PhD

Former APA President—Division 55

Spending this segment of my career at the Uniformed Services University of the Health Sciences (USUHS) (DoD) as a distinguished professor of psychology and nursing, gives one an interesting perspective on Wounded Warriors and their families. Not surprisingly, this has led to reflecting upon those living APA Presidents who are themselves veterans. Joe Matarazzo was one of the original members of the USUHS Board of Regents and was absolutely critical to the establishment of the department of psychology. Bill McKeachie was a Navy destroyer radar officer. Current APA President Barry Anton and Don Bersoff have addressed our USUHS health policy seminar. Jack Wiggins and Nick Cummings, who were among the initial proponents of prescriptive authority (RxP) decades ago, have honorably served. In our judgment, the next major focus for those seriously interested in pursuing the RxP agenda should be the Department of Veterans Affairs (VA).

Quality Care: The DoD has admirably demonstrated the cost-effectiveness and clinical appropriateness of psychology obtaining prescriptive authority. Elaine Foster, one of the original DoD prescribing psychologists: "After graduating from the DoD Psychopharmacology Demonstration Project (PDP) I served as a prescribing psychologist in the Air Force for over 20 years. I continued to serve our active duty military after retiring, again as a prescribing psychologist under contract with the Air Force. During that time, I prescribed for our veterans when we had space available at our military clinic.... If I walked across the hospital parking lot to our annexed VA clinic, I could no longer

prescribe to that same patient I'd been prescribing to while he or she was active duty. The current VA restrictions are illogical.... Because New Mexico recognizes prescribing psychologists, I can now prescribe to our veterans, but only in New Mexico, and only through a third party contractor.... This just does not make sense." We would rhetorically ask: Where are the collective voices of those psychologists who are themselves veterans? They are the constituency who would most directly benefit from RxP. And, they are the interest group that APA's Heather O'Beirne Kelly is seeking to galvanize.



Pat DeLeon, PhD


Congressional Interest: The Senate Appropriations Committee report accompanying the Fiscal Year 2016 Appropriations bill for the Department of Veterans Affairs (Sen. Rpt. #114-57) notes that the VA's mission is to serve America's veterans and their families as their principal advocate in ensuring that they receive the care, support, and recognition they have earned in service to the Nation. As of September 30, 2014, there were an estimated 22 million living veterans and an estimated 25.7 million dependents of living veterans; as well as 566,000 survivors of deceased veterans who are receiving VA survivor benefits. Thus, there are approximately 48.3 million people, or 15% of the total estimated resident population, who are recipients or potential recipients of VA benefits. The Veterans Health Administration (VHA) is the nation's largest integrated healthcare system, consisting of 167 medical centers, 1,018 community-based outpatient clinics, 300 Vet centers, and 135 community-based living centers.

Under the Obama Administration a concerted effort has been made to expand the clinical responsibility of VA nursing personnel to the fullest extent of their training and education -- pursuant to Institute of Medicine (IOM) recommendations -- notwithstanding local state statute limitations. Although this would provide uniformity across the VA system, organized medicine has been less than supportive. The Senate Committee report: "Nursing Handbook. -- The Committee understands the VHA Nursing Handbook is currently under review. The Committee encourages VHA to seek input from internal VA program offices and external professional stakeholders prior to possible regulatory action and submission to the Under Secretary for Health for final approval. The Committee believes all possible outreach efforts should be used to communicate the proposed changes, to gather public comment, and to collaborate with Congress, stakeholders, VA nursing staff, and external organizations. The Committee requests VHA ensure changes to its handbooks do not conflict with other handbooks already in place within VHA." Admittedly, the Committee language is not as expressly supportive of nursing as we would prefer; however, it does reflect progress. Again, we would ask: Could not concerned psychologists, especially those who are themselves veterans, develop similar congressional interest for psychology's potential expansion of practice by obtaining prescriptive authority -- especially, given the impressive success within the sister federal agencies of DoD and the Indian Health Service?

The Senate report also included thoughtful language highlighting the unique needs of female veterans. "Women Veterans. -- The Committee believes VA must make better progress in addressing the needs of women veterans. Towards this end, the advance appropriation for fiscal year 2016 provided last year and the fiscal year 2017 advance appropriation included in the act fully fund gender-specific healthcare. Access to and utilization of VA benefits and services by women veterans remain low, with women often encountering cultural roadblocks in a system that was largely designed to meet the needs of male veterans. The Committee anticipates the results of an ongoing system-wide review intended to determine what type and number of healthcare workers the system should have to address current and future demand of gender-specific care. This review will help VA properly staff hospitals and clinics with healthcare profes-

sionals providing gender-specific care and lead to improved access for women veterans. Last year... VA was also encouraged, in consultation with the Department of Defense, to establish a women's working group within the VA/DoD Joint Executive Committee aimed at creating or strengthening transition programs which address female concerns and cultural roadblocks so more women veterans access VA benefits and services.... Furthermore, recent studies have shown servicewomen who experience sexual assault while serving in the military are far more likely to develop PTSD as compared to other female veterans. VA must be prepared to provide these veterans with mental health services designed to treat the effects of military sexual trauma." As Elaine and her DoD colleagues have demonstrated over a prolonged period of time, this is a population for which psychology has much to offer in assuring quality of care.

State Leadership Conference (SLC): At this year's inspirational APAPO state leadership conference, Katherine Nordal urged those attending to: "Shake off the negative attitudes some of our colleagues have about what's happening in health care. This world is changing. And health care is moving ahead -- with or without psychology." The Senate report makes clear that the VA will change: "Congress authorized the employment of licensed professional mental health counselors [LPMHC] and marriage and family therapists [MFT] by VA. However, the two professions comprise less than 1 percent of the VA behavioral health workforce despite representing 40 percent of the overall independent practice behavioral health workforce in the United States.... The Department is directed to report to the Committees on Appropriations of both Houses of Congress no later than 180 days after enactment of this act on the status of hiring additional LPMHC and MFT professionals and detailing how many are currently enrolled and planned to be enrolled in VA's mental health professional trainee program." Further, "The Committee encourages the Department to consider the expanded use of physician assistants [PAs] specializing in psychiatric care to address the mental health provider gap. PAs provide high quality, cost-effective medical care and are held to the same standard of healthcare delivery as their physician colleagues. Furthermore, the Department is directed to review and report to Congress a plan to improve recruitment and retention initiatives for PAs." Times are definitely changing.



Clinical Pharmacy: The American Pharmacists Association (APhA) recently highlighted for its membership the extent to which our nation's healthcare environment is undergoing unprecedented change. "Pharmacists are frequently referred to as the most underutilized health care professional. In part, this can be attributed to the sometimes antiquated pharmacy practice acts currently in use. As pharmacist education and training has evolved, the pharmacist scope of practice has not kept up with the pace of advancement. In order to align pharmacist education and training with scope of practice, states are incrementally making improvements to their pharmacy practice acts. Through efforts led by state pharmacy associations, there have been 32 bills introduced this year in 11 states addressing issues ranging from immunization authority to collaborative practice agreements and more.

"As Pharmacy Today goes to print, there are six states with active legislation addressing pharmacist collaborative practice authority. Several are seeking authority for nurse practitioners and in some cases physician assistants to be authorized to enter into a collaborative agreement with pharmacists. As primary care is evolving to a more team based approach and nurse practitioner and physician assistants playing a larger role in chronic disease management, it is important that they be able to access pharmacists' medication expertise. Under current law, there are 20 states where nurse practitioners and pharmacists can work together under a formal collaborative agreement." The future will require similar psychology-pharmacy collaborative practice agreements to be enacted by individual state legislatures, as well as developing a personal comfort level with interdisciplinary practice. Have any of our State Psychological Associations initiated joint meetings with pharmacy?

Keeping Promises

Glenn A. Ally, PhD, MP

In 1997, the first Louisiana RxP bill was put before the Louisiana legislature. There was only one small problem – there were no Louisiana psychologists formally trained in psychopharmacology. Dr. Jim Quillin and Dr. John Bolter subsequently set about not only developing a psychopharm program to provide such training to interested Louisiana psychologists, but also finding enough interested psychologists in the State to enroll in such a program. At that time, there was a promise that “someday” we will get prescriptive authority for specially trained psychologists in Louisiana. When Dr. Quillin contacted me to enroll in the first class that was to begin in 1998, it was a rather busy time in my life, and I felt I just did not have the time to devote to such an endeavor. So, I promised Dr. Quillin, though I could not be a member of the first class, I would definitely be a member of the second class. In 2000 when the second class began, I kept that promise.

On May 6, 2004, Louisiana Governor Kathleen Blanco signed HB1426 into law giving prescriptive authority to specially trained “medical psychologists.” Drs. Quillin and Bolter kept their promise. This was the culmination of many hours of dedication and hard work by proponents of RxP and many promises made by legislators and to legislators in Louisiana. In signing this bill into law, Governor Blanco read a statement. Obviously, the bill was quite controversial and the Governor wanted to assure the citizens of Louisiana that she had studied the issues and had studied the arguments on both sides of the issues. Part of her statement seemed to stand out for me, as it was something that many of us had discussed during our advocacy for her support of RxP. Her statement elicited a promise and included the following:




Glenn A. Ally, PhD, MP

“In many areas of the State there is a shortage of mental health care providers. I hope that this bill will encourage psychologists to extend care to underserved populations. I am committed to extending quality, affordable health care to as many of our citizens as possible.”
(Kathleen Blanco, 2004)

The Governor and many legislators kept their promises to us. It was now time for medical psychologists to keep our promises to them and the citizens of Louisiana.

Prior to that day in 2004, there were approximately 45 psychologists who had undergone training to become medical psychologists. Most of those who took that giant leap of faith that someday they would be able to prescribe, were psychologists who were already well established in their respective careers. There were few who were early career psychologists. With those already well-established in their careers, it seemed less likely that there would be a great deal of professional movement from existing job settings to fulfill the Governor’s request of extending care to the underserved – not that there were not a very few who were already providing psychological services to the poor. Keeping in mind that, generally, psychological services are not reimbursed by Medicaid in Louisiana, there were indeed few to provide psychological services for treatment of mental illnesses in the indigent. So, in my view, Governor Blanco’s challenge looked to be a difficult one.

For more than 30 years I had a practice that was what I would describe as both private and hospital based. In the early 1980s, I became affiliated with a non-profit, community owned, general hospital in Lafayette, Louisiana. As a non-profit and because of EMTALA



requiring hospitals to provide at least screening and stabilizing patients who showed up in emergency rooms, this hospital had a rather large indigent population. I had initially become a member of the medical staff as a neuropsychologist and provided services to the Physical Medicine and Rehabilitation Unit within the hospital. In addition, I provided consultation services throughout the entire hospital (“house” as it is called). So, it was really not a significant transition for me when I achieved prescriptive authority in 2005 and became a medical psychologist to continue to provide services throughout the “house” including to those patients who were indigent.

My introduction to prescribing psychotropic medications in my hospital practice actually came just before I was actually licensed to do so. In August of 2005, hurricane Katrina struck Louisiana causing the most natural destruction and devastation I had witnessed in my lifetime. When the city of New Orleans evacuated, Lafayette took on many of the patients that were evacuated from New Orleans hospitals. Patients from general hospitals, specialty hospitals, psychiatric hospitals, nursing homes and other facilities were flown into Lafayette, triaged and referred to local hospitals. Many of these patients had multiple medical problems and were transported without medical records. In addition to the obvious post traumatic stress, anxiety, and other reactions to the situation, there were many psychiatric patients who were without medications for several days. Though I had graduated from the psychopharm program, I had yet to take the PEP examination and had yet to receive the certificate of prescriptive authority from the licensing board. However, many of my physician colleagues had known that I had graduated from the psychopharm program and consulted me for assistance with those patients needing psychotropic medications. I would write the order for medications in patients’ charts and my physician colleagues would later come behind me and countersign my orders. This required not only an initial assessment of the patients’ psychological needs but also an assessment of the potential interaction of the psychotropic medications with other medications that had been prescribed for many patients’ presenting medical conditions. I could only describe those first few days following hurricane Katrina as “organized chaos” with respect to the influx of pa-

tients requiring medical and psychological attention in Lafayette.

After receiving prescriptive authority, I continued to provide consultation services to all units in the general hospital. In doing so, I was frequently consulted by my physician colleagues on patients with a variety of co-morbid conditions. For example, I saw patients on the Rehab Unit, on the dialysis unit, on the orthopedic unit, on the cardiac unit, on the oncology unit, on surgical units, and frequently in ICU. In addition to ordering psychotropic medications, I frequently ordered relevant lab work and imaging studies to assist with diagnosis and monitoring of my patients. When there were suspected medical issues, appropriate referrals were made to colleagues who specialized in treating those medical problems. Earlier in my second career (the post prescriptive authority career), our hospital had a psychiatric unit. Not only did I provide psychological services to that unit to include prescriptive authority, I also provided “on-call” coverage along with psychiatry.

One must also keep in mind that Louisiana is a fairly progressive State when it comes to the services provided by psychologists. Even before prescriptive authority became law, clinical psychologists had the statutory authority to be included on hospital medical staffs and write “orders” in hospital charts that were “within the scope of practice.” So the issue involving nursing and other hospital staff “taking orders” from psychologists was actually a non-issue. Additionally, psychologists already had the authority to execute emergency, involuntary commitment and to order restraints and seclusion.

Certainly, I was not the only medical psychologist in Louisiana to have such a hospital based practice. There were others in other cities in Louisiana including Children’s Hospital in New Orleans and a couple of Baton Rouge hospitals. So, in essence, my medical psychology colleagues and I were indeed keeping our promise to Governor Blanco and our legislators.

Many years before Governor Blanco’s challenge to medical psychology, there was another promise made to the American people. One of the last acts of President John F. Kennedy just weeks prior to his as-

sassination was his signing of the “Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.” Title II of this act was referred to as the “Community Mental Health Centers Act.” Kennedy had the vision of deinstitutionalizing the mentally ill and providing mental health care in local communities. He called for a “bold new approach” and pledged through this act to provide federal funding for the construction of public or non-profit community mental health centers (CMHCs) to provide inpatient care, outpatient care, partial hospitalization, emergency care, and consultation/education services. The promise was that of community based care rather than institutionalization.

Unfortunately, the promises of the CMHCs were only partially fulfilled. Only half of the proposed centers were ever built and none of them were fully funded. The law did not provide funding for long-term operation of the centers. In 1965, Medicaid was adopted and caused further acceleration of the deinstitutionalization. This pushed many more mental health consumers to the CMHCs than the centers were prepared to handle. Poor funding and poor reimbursement led many professionals to seek positions in a more lucrative private sector. Consequently, there were shortages seen in psychiatry to provide care for these patients.

With the above factors affecting CMHCs in Louisiana combined with fewer medical students choosing residencies in psychiatry, many positions for psychiatrists remained vacant for several years. The CMHCs began hiring physicians of varying specialties who were in the twilight of their careers to provide services, many of whom had little or no experience with significant mental illnesses. More social workers and other counselors were being hired in lieu of more expensive psychologists. Caseloads grew; wait times grew longer; times between appointments grew; and services dwindled.

So, with these factors in mind, the Governor’s urging of medical psychologists to provide services to the underserved, the need of the CMHCs for quality mental health practitioners with prescriptive authority, and our desire to have this new prescriber, the medical psychologist, accepted in the State system, I decided to apply for a position at our local CMHC in

Lafayette, Louisiana. I was able to convince my associate of more than 30 years, a medical psychologist, to also apply. We were the first medical psychologists in the State Community Mental Health Centers. Within a few weeks, another medical psychologist was contracted in another CMHC in Lake Charles, Louisiana.

The local CMHC in my area serves a seven parish (county) catchment area. We serve largely an indigent population, which also encompasses very rural areas of the State. There were several psychiatry positions vacant when I spoke to the director of the CMHC. Since my associate and I were both well established over the past 30 years in private practices, we would have to sacrifice time from our practices to take such positions. In 2007, we negotiated with the CMHC to split a full time psychiatry position such that we could maintain reduced private practices and contract to provide services for the State several hours a week. Although the hourly contract rate with the State was substantially less than the hourly rate charged in our private practices, we both felt that it was a very important step forward for RxP to have medical psychologists working in the State community mental health system, and I felt it was just another way to help keep a promise medical psychology made to the Governor and our lawmakers.

Dr. Joseph Henry Tyler Mental Health Center had a cadre of six psychiatrists, two physicians of other specialties, and a medical director who is a psychiatrist. While there was some initial caution regarding medical psychologists within the State bureaucracy at the Capitol, medical psychologists were welcomed with open arms by all staff from the very first day at the CMHC, and we have never felt anything but welcomed by our colleagues in medicine there. Our medical director allows for significant autonomy of the medical staff. We have had input as part of the medical staff and our opinions and consultations are sought just as we, medical psychologists, often seek consultation with our colleagues in psychiatry. Medical psychologists have now been providing treatment to include prescriptive authority in the CMHCs for more than seven years. Since the involvement of medical psychologists, the CMHC has continually requested to contract for more of our time and has offered higher hourly rates.

The patients we serve represent a largely indigent population – many having Medicaid or no insurance at all. Many utilize the large previously State run general hospital, commonly referred to as “Charity Hospital,” for their medical needs. Typically, this population tends to seek treatment when problems arise and get little in the way of “preventative care.” So, this large general hospital provides for medical care, and the CMHC provides for mental health care. Those patients who cannot afford medications may qualify to have their medications dispensed, free of charge, from the CMHC. Most often, the patients we serve have co-morbid conditions such as diabetes, heart disease, hypertension, kidney disease, liver disease, HIV, thyroid deficiencies, and neurological conditions to name a few. In fact, I cannot recall when I last saw a patient with **only** “textbook” depression and without some co-morbid condition. Quite often, the CMHC is the first line of medical screening that these patients may receive. We are frequently the source of the initial referral for other medical specialty care. With the addition of two more prescribers, our CMHC was able to reduce wait times for many patients and expand access to services.

So, when I hear opponents to RxP suggest that medical psychologists will not be safe providers once given prescriptive authority, I simply shake my head in disbelief. After 10 years of safe prescribing in Louisiana, I tend to ask those opponents to provide me data on any other prescribing profession in the State with a 10 period in their history of no problems in prescribing. Usually, that challenge is met with silence. When I hear opponents suggest that psychologists are in no greater numbers in rural areas than psychiatrists and that we will not serve the indigent or rural areas, I again tend to shake my head in disbelief. I point out that those of us who are serving in CMHCs are providing services to rural areas and to the poorest of the poor in our State. When I hear opponents assert that

psychologists with prescriptive authority will be unsafe in treating patients with co-morbid conditions, I again shake my head in disbelief as those opponents are either intentionally misleading to perhaps engender fear or are ignorant of what medical psychologists have been doing for the past 10 years (not to mention those prescribing psychologists in the military who have been safely prescribing for more than 20 years). When I hear opponents suggest that the pursuit of RxP is simply “a turf issue,” I again shake my head in disbelief. After a 10 year history of medical psychologists in Louisiana, I am not aware of medical psychologists putting one psychiatrist or one psychologist out of business. Unfortunately, there is too much mental health need requiring attention. It has simply not been the experience in Louisiana of medical psychologists putting anyone out of business. When I hear opponents indicate that having specially trained psychologists with prescriptive authority is “just bad” for people of a particular state, once again I shake my head in disbelief. Let me understand this, having an additional professional, already expert and proficient at diagnosing and treating mental illnesses, obtain and safely utilize prescriptive authority is somehow bad for the people of your state? I am amazed.

What I can also say at this time with confidence is that medical psychology in Louisiana continues keeping promises - to former Governor Kathleen Blanco, to the Speaker of the House, to the President of the Senate, to supportive legislators, and, most importantly, to the people of Louisiana...Promises to:

- Provide greater access—promise kept and on going.
- Continue providing quality mental health care—promise kept and on going.
- Safely prescribe appropriate psychotropic medications—promise kept and on going.



Update on the Idaho RxP Legislation

Susan Farber, PhD

Past President, Idaho Psychological Association

Idaho covers more land mass than all of New England but is one of the least densely populated states in the entire US. We span two time zones, have more wilderness than almost anywhere else and are designated “frontier” by some federal guidelines.

While there are over 300 psychologists in the state, only about 115-120 are practitioners who belong to the Idaho Psychological Association. In our state, we do extraordinary work simply because we have to. There are fewer mental health practitioners per capita here than anywhere else in the USA. We Idaho psychologists have become adaptable, learned to work with few resources, and are collegial and self-reliant. Even so, 30% of our citizens still live in counties with neither a psychologist or psychiatrist in them. Small wonder that we have one of the highest suicide rates in the nation.

Prescriptive authority for psychologists is a natural fit for this scenario. I am a former opponent who was won over by seeing competent work by nurse practitioners and PA’s and knowing that psychologists could be equally or more effective at providing the full range of mental health services. Since few of us had legislative experience (Our organization had not introduced a bill for over a decade) and many had no interest in RxP training (I’ve never had an interest in prescribing but want it for my fellow citizens and profession), we had to start from scratch. We hired a lobbyist and a former lieutenant governor/attorney general to write and guide our proposal through the legislature. More than once, I thought of us as the equivalent of a small, spontaneously arisen guerrilla group learning the terrain as we went.

Lesson learned: Hire the best lobbyist and advisors money can buy and from the dominant political

party in the state. They are worth every penny.

Early on, the generosity of leaders in the RxP movement coalesced into advisors we came to call our “brain trust”. Anthony Tranchita is a friend of one of our members and through him, we branched out to Michael Tilus, Robert McGrath, Glenn Ally, Morgan Sammons, Deb Baker, Marlin Hoover, and others. Every email was answered immediately. Information was shared, advice given and support offered unwaveringly. In the 40 plus years I have been a psychologist, I’ve never seen anything like it nor been more proud of my profession.

We also had to open our minds to the different political philosophies of our members and fellow citizens. This is an extremely conservative Republican state and some of our members adhere to that philosophy. Interestingly, I found it easier to talk about RxP to conservative Republicans than to any other group. Why? The issue of government overreach is deeply felt here. People resonate with the idea of getting services to our far-flung communities with safe training that does not cost the state anything. Basically, we are saying we will serve if the legislature removes false barriers and allows us to prove our worth.

I share this view of government overreach on this issue. The freedom we request is the epitome of taking responsibility for ourselves, being willing to be tested, and relishing the idea of demonstrating our competency.

Lesson learned: Get a “brain trust” and listen to them. Thank them often because without their mentoring, success could not happen.

Lesson learned: Listen to all sides. These are intelli-

gent people with different ideas.

We encountered little resistance and much support from our members. A former Idahoan, now a prescribing psychologist, Jennifer Darakjy, and our Executive Director, Deb Katz, were exceptional. As president, I held about a dozen “telephone town halls” where people could call in to discuss anything they wished.

I did receive private calls from colleagues who felt their jobs or livelihood threatened by the raging psychiatric/medical animus toward our proposal in some quarters. To them, we said stay silent and lie low. Let us be the public face. Because of age or position, those of us representing the public face of our movement would not be harmed.

Vigorous opposition came from the Idaho Medical Association. Early on, our lobbyist and advisor thought we could jointly propose legislation. As all of you reading this know, psychiatry can never fill the service deficits that exist now and into the future and, we are not a threat to anyone except to modify an outdated paradigm. We were met with an angry refusal to even meet. This continues to this day. IMA followed the line 100% of repeating the false statements published by their national organization. Late in the game, POPPP joined with them.

Lesson learned: Protect/shield your vulnerable members. Can't be repeated often enough.

We wrote, borrowed, revised and published many documents generously provided by our brain trust as vehicles to educate the public and legislators. We wheedled, cajoled and called in favors from family and friends. My daughter, Caitlin Farber, did graphics at no cost. All of our documents now are in the hands of Dr. Tilus and can be accessed at _____.

Support came from unexpected quarters. Interest was expressed in starting a psychopharmacology training program by one of the state universities. Organizations formerly aligned with medicine warmed to us. Spontaneous offers of help came from addiction centers who could not hire psychiatrists. Nursing home organizations and others were interested but wary of payment issues. Nurse practitioners individu-

ally were supportive but their organization was silent. Repeatedly we were told organizations were interested but did not want to spend “political capital”.

Lesson learned: Start earlier and work at garnering support. Many organizations might have backed us if they and we had a better understanding of payment options for prescribing psychologists.


So, how did it go? We had superb testimony to the Senate Health and Welfare committee, particularly from Drs. Hoover and Tilus. Our lawyer, David Leroy, former attorney general/lieutenant governor/Lincoln scholar/ defense attorney did a barnburner of a speech that was spectacular. We passed the senate Health and Welfare committee by a wide margin. We passed the Senate by an even larger margin.

The bill then went to the House Health and Welfare Committee which is led by one of the three MD's in the legislature. By our count, we had the votes to get out of committee and a solid chance to pass the house. Fred Wood MD, the chairman of the House committee, refused to allow the bill to be heard. Nothing swayed him. He claimed the issue was his mistrust of the education, but refused to allow discussion of even that. (Note: Consistently, education was one of the sound bites used effectively against us. We need to learn equally effective methods to satisfy non-MD's that our education is as comprehensive as it actually is.)

In the end, however, it was politics that stopped us. Where there is no substance left to opposition arguments, gamesmanship takes precedence. That's the way it works. Moral outcry gets us nowhere. We have to learn how to work our own game plan.

Lesson learned: Learn how to maneuver in the legislative process. We have to emerge from our protected comfort zone of scholarly debate and learn politically effective means of persuasion.

The legislature is over. The bill did not pass. Did we lose? No, not really. We now have a voice in the legislative process. Our advice now is sought on mental health legislation. Before, we weren't even noticed. We are forming a PAC to level the playing field with organizations who oppose us. We are suggesting



to our members that psychologists need to get on boards of insurance companies and businesses. Some of us have solicited people in our organization to run for the legislature and at least two are considering it.

Healthcare is changing. No one knows where it will end. We have wakened from our protected sleep and are beginning to realize that we need to be actively shaping our future. We are exploring how to do a better job this coming session.

Some final thoughts: Most of the people in our state leadership came of age professionally in the '70's-'80's. Clinical psychology was still early in development and the model of the MD at the top of the pyramid made sense in rural areas such as ours. The MD was the only one with the necessary breadth of knowledge in the community and there were few to no specialties. He/she did everything. My generation adhered to this paradigm. The community bought

into it. This is the paradigm I believe organized medicine still holds.

The real picture is very different now. Psychology and medicine are complex, multifaceted and mature disciplines. No one can have the necessary breadth of knowledge to do everything. Collaboration is essential. Competency in medication management has been demonstrated by NP's, PA, and the unblemished record of prescribing psychologists over the past decades. It used to be that one degree demonstrated competency. Now there are many roads to lead to the goal of safe, effective, comprehensive patient care. We are not asking to be junior MD's. We are stating that we are psychologists who can add exceptional services, our own point of view, and collaboration with this training.

Carpe diem.

New Mexico RxP and the State Psychologist Association—New Mexico

E. Mario Marquez, PhD, ABMP
Prescribing Psychologist

In light of the recent RxP success in Illinois you may be interested in the status of New Mexico RxP. You may recall the successful NM RxP legislative efforts back in 2001 and 2002. You may also recall the rules and regulations process which unfortunately became a repeat of the legislative battle. In 2003, the Psychology and Medical Boards appointed a “joint committee” to create rules and regulations to implement the law. Although the law was on our side at that point, it was not until 2005 that rules and regulations were finally agreed upon by both boards. The process to pass the bill was about two years, and it was almost three years before we were finally able to push through rules and regulations. We had to go back several times to our legislative Sponsors and register our concerns over the fact that (1) the “joint committee” was not doing its job, primarily because of intense pressure from our adversaries to derail the law, (2) a process that could have been completed in months actually was taking years, and (3) “they” refused to appoint Elaine LeVine or myself to the “joint committee.”

We felt like no one was more qualified at that time to serve on the “joint committee.” We had just completed a rigorous three year program in clinical psychopharmacology for psychologists and not only were we trained clinically, we also knew the law, inside and out. Another unfortunate, confounding factor in this story is that NMPA also chose not to appoint either one, or both of us as their representatives to the “joint committee.” Some felt a conflict of interest, but really, thinking back there was nothing “joint” about it. Many of the “joint committee” members were affiliated with the University of New Mexico Medical School, Psychiatry Department, or Psychology Department and were generally philosophically opposed to psychologists prescribing.

As a result, at one of the legislative subcommittee

hearings, members severely scolded the co-chairs of the “joint committee” (both from UNM). One worked at the medical school and was a member of the Medical Board, and the other worked in the psychology department and was President of the NM Board of Psychologist Examiners at the time. Luis Vargas did all he could do to weather the overwhelming storm upon him from UNM Psychiatry and Psychology Departments, for whom he worked, NM Psychiatric Society, NMPA, and us, the prescribing psychologists. One of our most stringent Representatives actually threatened UNM Medical School funding if they did not come up with rules and regulations.

After the chastising, we were still not appointed to the “joint committee,” but instead they appointed a psychologist professor from NM State University. In the end, three proposals were submitted through the “joint committee” to the Boards. Fortunately, in the eleventh hour before the dissolution of the “joint committee,” we were able to submit our rules and regulations proposal. The NM Psychiatric Society was allowed to submit their rules and regulations proposal, being that they disagreed with the “joint committee’s” recommendations and wanted much more training and supervision beyond the scope of the law. As a result, after all that mess, there were actually three proposals that went through for consideration by the Medical and Psychology Boards.

In 2004, in the midst of the fiasco, we had to petition the Governor in order to get final approval of the rules and regulations. One of our Bill Sponsors’ scheduled the meeting with the Governor and he was not pleased that a law passed and signed in 2002, was still not implemented. Relatively soon thereafter, under the leadership of the Regulation and Licensing Secretary, rules and regulations were finally approved, open to public comment, and registered. I digressed here some in an effort to warn our Illinois colleagues

and other states able to pass RxP legislation that the regulatory process can be another opportunity for our adversaries to derail RxP and for us not to forget that “the devil is in the details.”

In 2006, we resurrected the State Psychologist Association. This was actually Jim LeVine’s idea, Elaine’s husband. I mentioned that in the 1980’s there was an organization of which I was a member representing the state employed psychologists - State Psychologist Association. There were many battles fought at that level ,but in the end, thanks primarily to Richard Rodriguez , SPA was legislatively included as a nominating organization to the Governor for appointments to the the NM Board of Psychologist Examiners. Immediately in June 2006 we nominated four prescribing psychologists to the Governor for appointment to the NMBPE. Fortunately, Governor Richardson initially appointed Mike Cobb and later Robert Sherrill to the Board. Prior to that, Elaine earned an appointment to the NMBPE, through her contacts. At that point, Elaine was able to get the RxP ball rolling and made certain proper language was adhered to. Later, Elaine was objected to by an unknown source for her re-appointment, but nevertheless worked her magic during the time she served.

Fortunately, soon thereafter, Tommy Thompson was appointed to the Board following much discontent from NMPA. Tommy of course weathered it all, immediately was assigned to, and took control of the NMBPE RxP subcommittee and began the process of licensing appropriately trained and credentialed psychologists. To this day, Tommy continues to assist the Board in regulating RxP in New Mexico. Present Board members who are RxP licensed and nominated by SPA-NM are Terry Soter, Tony Kreuch, and Paul Bagwell. You will be pleased to know, since SPA-NM’s inception, under both republican and democrat administrations; we have successfully been able to maintain at least three prescribing psychologists of five psychologists on the Board of Examiners.


You may also be pleased to hear about some of the other advocacy efforts by prescribing psychologists in New Mexico. One of the biggest factors in our efforts has been our ability to fundraise politically. For about a decade, SPA-NM members have answered the call to support Governors, Legislators, Attorney Generals, and other state officials who have been willing to

push our movement forward. I can’t tell you how important this has been and how generous some of our members have been each and every time I’ve asked for their support. One example is when we decided to conduct a fund raiser for a Leadership Member of the House of Representatives last year. Elaine Foster, one of our most distinguished SPA-NM members, put out a challenge and committed to matching the highest donor. As a result, we were able to generate a substantial sum, qualifying us as a “Speaker’s Dinner Gold Sponsor.”

Recently, following the lead of our Louisiana colleagues, through our efforts and consultation with our attorney, prescribing psychologists in New Mexico can now bill E&M codes through the Medicaid Program. Of course there are stringent requirements and documentation required for billing E&M codes, as prescribing and medical psychologists can attest. It is dependent on a myriad of factors including, but not limited to, number of systems, number of assessments, number of diagnosis, number of treatments, type of interaction, number of prescriptions, and other criteria. Yet, even with the rigorous requirements of the 99 codes, there are prescribing psychologists who have attained to this level of assessment and treatment and many more are sure to follow.

SPA-NM is, and has been, actively involved with the NMBPE on other fronts, in addition to the nominations and appointments of Board members. In May 2013 we made a request to NMBPE confirming our opinion that prescribing psychologists are trained and qualified to perform single system psychiatric examinations as defined in federal regulations. In December 2013 the Board affirmed our position and expressed an opinion that we are indeed qualified to perform these examinations. Soon thereafter we were approved to bill the E&M codes. In May 2014, we asked that SPA-NM be included in the CE regulation listing several approved providers, some of which are no longer in existence. We were well received by Board members and the request appears as though it will be approved; however, we have not yet officially been informed.

Presently, SPA-NM has a new Board. I stepped down in the spring as president after five years, and three other board members also resigned, Elaine, Tommy and Blake White. I guess we all felt it was time for a



new generation of leaders to move RxP in New Mexico forward. We leave them with the highest bank account in the history of our organization and growing. There is an excellent CE Program in place. By the way, over the past five years we have been able to put on some excellent CE activities in collaboration with SIAP, Elaine's group, which is an APA approved CE Provider. SPA-NM now has a web page (a work in progress) and we are able to take fees and contributions through PayPal. Also, we updated our Articles of Incorporation

and IRS Forms, all thanks primarily to the efforts of Renee Wilkens who, as we like to say, brought us into the 21st Century. She will continue as Treasurer on the Board and will serve and act as the continuity link. New board members include Christina Vento, Marie Greenspan, Jo Velasquez and John Courtney, a formidable group, not to mention the many other distinguished SPA-NM members who continue to blaze the RxP trail. Please join me in wishing and supporting the new SPA-NM Board of Directors the very best.

Florida RxP Update

Anthony S. Ragusea, PsyD, ABPP

In Florida, RxP has progressed in fits and starts. When I first joined FPA in 2007 one of those starts was just about to sputter out. After beginning to organize effectively, a few psychologists convinced the legislature to study the issue. Unfortunately, the governmental committee only superficially analyzed the mental health needs in Florida and decided, perplexingly, that the number of psychiatrists was sufficient to meet demand and, therefore, there was no reason to expand the number of doctors providing psychopharmacology services. The resulting conclusion of the 2009 study effectively tabled the issue for the next few years. Later, Dr. Perry Buffington, a trained psychopharmacologist, was tasked with trying to revive the movement. His attempt to start a Florida Psychological Association psychopharm “academy” for psychologists that would be integrated with the training of med students was unfortunately met with some internal resistance, and was scrapped. We took another blow when Nova Southeastern University put its psychopharm program on hiatus for lack of demand. RxP in Florida was as dead as a doornail when our then-president, Dr. Steve Bloomfield, made it a goal to try again and in 2014 I was asked to chair the Prescriptive Authority Committee.


When we began, it became clear that we were essentially starting from zero. There was no committee, almost no funds, no organization, no records, and no direction. That’s a lot of inertia for one person to overcome, but fortunately FPA also saw the advantage of designating my father, Dr. Stephen Ragusea, as chair of the political fundraising committee for RxP. My father has decades of experience in advocating for psychology, and having two dedicated RxP supporters in charge has really been the catalyst to reignite

the movement. We began by slowly reintroducing the topic to our FPA leaders and membership, taking polls, writing articles, creating a database of information on supporters, and then adding open, monthly meetings conducted via videoconference (as Key West residents, in-person meetings on the mainland are just not practical, and it enables us to incorporate psychologists not only from all around our state but from others as well). We quickly created some structure within the Florida Psychological Association, including a mission statement and strategic plan. We identified a small group of committed supporters, developed a draft bill, and over the last year the committee has made more progress in organizing and mobilizing members than was ever achieved before. We benefit from having an FPA executive committee that supports RxP, reflecting the growing consensus among the membership that RxP is a worthy cause. We have met very little resistance to date, despite our efforts becoming increasingly organized and public.

At the time of this writing, our state psychology conference is about to begin, which we have succeeded in shaping to have a strong emphasis on RxP. FPA’s most recent newsletter was RxP-themed, and the conference will feature a psychopharmacology presentation (that will also help psychologists meet specific CE requirements in Medical Errors Prevention), a special guest appearance by Dr. Beth Rom-Rymer, and a keynote address by Dr. Pat DeLeon. We will have a special booth set up to accept donations on the spot (and donations can now be made at any time through FPA’s website). After the conference, we will likely focus on public outreach and education, conducting presentations, seeking letters of support, reviving Nova’s program, and developing relationships with



Anthony S. Ragusea,
PsyD, ABPP



outside organizations. And fundraising.

I view RxP as a grassroots political campaign. We do not have the luxury of turning to a few wealthy donors to quickly hire a lobbying group, nor do we live in a state with a political climate that is likely to be automatically friendly to our cause. To overcome these substantial obstacles, we are looking to build support from the ground up, from a wide range of constituent groups, and are considering non-traditional sources of fundraising such as crowdfunding.

We have no illusions; an RxP bill is a couple of years away from being introduced in Tallahassee. I may or may not still be chair of the RxP Committee when that happens. But my goal during my tenure is to shape conditions such that it becomes very difficult for Florida psychologists to ever put RxP on the back burner again. That means, in part, getting as many psychologists and non-psychologists as personally invested in our goal as possible. Many, but not all, of the existing trained prescribers and people who earned psychopharmacology degrees in our state are unable or unwilling to take leadership roles in our efforts. Many of our supporters have limited knowledge and experience with psychopharmacology themselves. And generally there is a lack of experience in advocacy and grassroots campaigning (including myself), so we can't overlook the importance of educating our own supporters about what it means to be a prescriber, and

how to talk about RxP to others to win their support. There is also still the ubiquitous challenge of inertia: convincing others to move beyond verbal support of RxP to actually doing the work and investing time and money to make it a reality. I believe that technology is our friend; we have tools at our disposal including videoconferencing, social media, email, online donations, smartphone apps, and others that make organizing, data gathering, and taking action easier than ever before, but these are tools that psychologists are not generally skilled in using for advocacy purposes. We need to study how other political organizations and nonprofits effectively leverage the Internet in particular to further their causes. Division 55 can help by functioning as a central repository for information about how to run a grassroots campaign, so that each state doesn't have to reinvent the wheel. APA could help immensely by just making funds available for state campaigns—it becomes very difficult to forget about RxP when there's money on the table to help pay for this advance in psychological practice.

So please stay tuned to what Florida is doing in coming months and years; we aim to be very open and public about our efforts. If you want to be involved or to share resources, please contact us at rxp@flapsych.com. Thanks for your support. <http://www.flapsych.com/?page=PrescribingPsychs>

Announcements

Division 55 Program for APA Convention

Thursday

8:00 AM - 9:50 AM

Symposium: The Illinois Prescriptive Authority Law—What Is Unique, Exciting, and Challenging?

Convention Centre Room 205B

Co-Listing Division: 12

Chair

Beth N. Rom-Rymer, PhD, Independent Practice, Chicago, IL

Participant/1st Author

Michelle Nealon-Woods, PsyD, Chicago School of Professional Psychology—Los Angeles

Title: Predoctoral Prescriptive Authority Training: The Joint Degree Model

Derek C. Philips, MA, Independent Practice, Lakeland, FL

Title: Prescriptive Authority: An Illinois Student Activist's Perspective

Danielle N. Harth, MA, Adler School of Professional Psychology, Chicago, IL

Title: Predoctoral RxP Training for Holistic Practice

Clayton Ciha, MBA, Alexian Brothers Behavioral Health Hospital, Hoffman Estates, IL

Title: Implementation of the Illinois Law's Requirement for the Series of Medical Rotations

Cendrine D. Robinson, MS, Uniformed Services University of the Health Services

Title: Action Through Advocacy: A Psychology Trainee's Perspective on RxP

Discussant

Lenore E. Walker, EdD, Nova Southeastern University

Patrick H. DeLeon, PhD, JD,

2:00 PM - 3:50 PM

Symposium: Disruptive Disorders—Integrating Pharmacotherapy and Psychotherapy

Convention Centre Room 205D

Co-Listing Division: 12

Chair

George M. Kapalka, PhD, Monmouth University

Participant/1stAuthor

Mary Y. Sa, PsyD, MS, Allina Health—Cambridge Medical Center, MN

Title: Integrated Treatment of Disruptive Behaviors in Mood and Personality Disorders

David F. Curtis, PhD, Texas Children's Hospital, Houston

Title: Best Practices for Treating Children and Adolescents With Oppositional Defiant Disorder

Edward F. Hudspeth, PhD, Henderson State University

Title: The Integrative Treatment of Intermittent Explosive Disorder

Tony C. Wu, PhD, MS, Walden University

Title: Integrated Treatments for Conduct Disorder

Friday

9:00 AM - 9:50 AM

Symposium: The Front Lines in Liberia—Advancing a Public Health Approach for Resilience in Ebola Medical Providers and Patients

Convention Centre Room 202B

Co-Listing Divisions: 18, 52

Chair

Michael R. Tilus, PsyD, MS, U.S. Public Health Service, Crow Agency, MT

Participant/1stAuthor

Anne C. Dobmeyer, PhD, U.S. Public Health Service, Dayton, OH

Title: Strategies and Challenges in Implementing a Public Health Response

Anthony Tranchita, PhD, U.S. Public Health Service, Grand Forks, ND

Title: Lessons Learned in Providing Predeployment, Mission Operations, and Postdeployment

Robin L. Toblin, PhD, MPH, Walter Reed Army Institute of Research, Silver Spring, MD

Title: Transitioning research finding into training material for Operation United Assistance

Jill Breitbach, PsyD, U.S. Department of Health and Human Services, Colorado Springs, CO

Title: Psychological applications: building interagency relationships for a whole of government response

10:00 AM - 11:50 AM

Symposium: The Psychopharmacological Basis of the Time Cure—A Novel Successful Treatment for PTSD

Convention Centre Room 104A

Co-Listing Division: 12

Chair

David Nussbaum, PhD, University of Toronto Scarborough, ON, Canada

Participant/1stAuthor

Philip Zimbardo, PhD, Stanford University

Title: Temporal Theory: A Basic Personality Dimension and Its Relation to Success in Life

Rosemary K.M. Sword, BA, Independent Practice, Makawao, HI

Title: The Time Cure: Application of Zimbardo's Temporal Theory for Successfully Addressing PTSD

Co-Author: Richard Sword (posthumous), PhD, Independent Practice, Makawao, HI
David Nussbaum, PhD,
Title: The ZTPI Meets Neuroscience: The Psychopharmacology of Future Hedonic Bias in Decision Making

Co-Author: Khadija Ibrahim, MS, Memorial University, St. John's, NL, Canada
Dhruti Bhandari, MS, University of Toronto Scarborough, ON, Canada
Title: Empirical Convergence of the ZTPI PH Scale With Decision Making and Personality Measures

Co-Author: Wade Deamond, MA, Fielding University
Co-Author: Diba Kaya, BS, University of Toronto, ON, Canada
Co-Author: Igor Mihajlovic, BS, University of Toronto, ON, Canada
Co-Author: Maryam Razi-Sherif, BS, Centre for Addiction and Mental Health, Toronto, ON, Canada
Co-Author: David Nussbaum, PhD,

4:00 PM - 4:50 PM

Business Meeting

Fairmont Royal York Hotel Manitoba Room

Chair

Michael R. Tilus, PsyD, MS, U.S. Public Health Service, Crow Agency, MT

5:00 PM - 5:50 PM

Social Hour

Fairmont Royal York Hotel Manitoba Room

Saturday

8:00 AM - 9:50 AM

Skill-Building Session (A): Interprofessional Communication and Integrated Behavioral Care

Convention Centre Room 104C

Co-Listing Divisions: 12, 22

Cochair

Marlin C. Hoover, PhD, MS, Memorial Medical Center, Las Cruces, NM
Stephen Colmant, PhD, Memorial Medical Center, Las Cruces, NM

Participant/1stAuthor

John Andazola, MD, Memorial Medical Center, Las Cruces, NM
Dolores Gomez, MD, Memorial Medical Center, Las Cruces, NM
Danielle Fitzsimmons-Pattison, MD, Memorial Medical Center, Las Cruces, NM
Sarah Gude, MD, Memorial Medical Center, Las Cruces, NM
Clayton Smith, MD, Memorial Medical Center, Las Cruces, NM
Tonya Oliver, PhD, Memorial Medical Center, Las Cruces, NM

Brett Shumway, MA, Memorial Medical Center, Las Cruces, NM
Annette Tardif, MA, Memorial Medical Center, Las Cruces, NM
Chu Hui Cha, MEd, Memorial Medical Center, Las Cruces, NM
Jamey L. Rislin, MSW, LCSW, New Mexico State University

8:00 AM - 9:50 AM

Symposium (A): Legislative Advocacy for Prescriptive Authority in the United States and Canada

Convention Centre Room 205D

Co-Listing Divisions: 12, 52, APAGS

Chair

James H. Bray, PhD, Baylor College of Medicine

Participant/1stAuthor

James H. Bray, PhD,

Title: Texas' Pursuit of Prescriptive Authority

Co-Author: Cheryl L. Hall, PhD, Independent Practice, Lubbock, TX

Heather Kelly, PhD, APA Office of Science Policy, Washington, DC

Title: Legislative Efforts for Prescriptive Authority in the U.S. Veterans Administration

Jane Storrie, PhD, Ontario Psychological Association, Toronto, ON, Canada

Title: Legislative Efforts in Canada

Beth N. Rom-Rymer, PhD, Independent Practice, Chicago, IL

Title: Implementing the Prescriptive Authority Bill in Illinois

Judi Steinman, PhD, University of Hawai'i - Hilo, Hilo, HI

Title: Hawai'i MSCP Training and Legislative efforts for Prescriptive Authority- 2015.

1:00 PM - 1:50 PM

Symposium (A): Expanding Psychology's Scope of Practice to Include Psychopharmacological Consultation and Prescriptive Practice

Convention Centre Room 201F

Co-Listing Division: 12

Participant/1stAuthor

Jane Storrie, PhD, Ontario Psychological Association, Toronto, ON, Canada

Title: Implementing Consultation Services for Psychologists With RxP Training in Ontario

Co-Author: Diana Velikonja, PhD, Ontario Psychological Association, Toronto, ON, Canada

Sunday

8:00 AM - 9:50 AM

Symposium (A): The Prescribing Clinical Health Psychologist—Raising the Value and Bar for Integrated Primary Care

Convention Centre Room 206F

Co-Listing Division: 12



Chair

Kevin M. McGuinness, PhD, MS, U.S. Public Health Service, Rockville, MD

Participant/1stAuthor

Michael R. Tilus, PsyD, MS, U.S. Public Health Service, Crow Agency, MT

Title: Improving Access to Health Promotion, Disease Prevention, and the Treatment of Chronic Illness

Marlin C. Hoover, PhD, MS, Memorial Medical Center, Las Cruces, NM

Title: The Prescribing Clinical Health Psychologist Shaping Interprofessional Education and Training

Antonio E. Puente, PhD, University of North Carolina at Wilmington

Title: Twenty-Five Years of Psychologically Based Pharmacological Intervention: Different Approaches to Expanding Psychology's Scope of Practice

Co-Author: Hana Kuwabara, BA, University of North Carolina at Wilmington

Co-Author: Andrea Mejia, BA, University of North Carolina at Wilmington

Co-Author: Margie Hernandez, MA, University of California--San Diego

Co-Author: Jacob Wisonowski, BA, University of North Carolina at Wilmington



Division 55 Award Winners for 2015

Dr. Cheryl Hall

Division 55 State Advocacy award for 2015
for your outstanding work in organizing and advocating
for prescription authority for psychologists in Texas.

Dr. Gerald Strauss

Division 55 State Advocacy award for 2015
for your outstanding work in organizing and advocating
for prescription authority for psychologists in Ohio.

Anthony Rinaldi

Division 55 Patrick DeLeon Prize for Young Psychologists award for 2015
for your outstanding publication on prescriptive
authority in the Counseling Psychologist.

Dr. Anthony Trancita

Division 55 Major Caraveo National Service Award for 2015
for your outstanding public service
work as a prescribing psychologist.

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Treasurer:

Kathleen M. McNamara, PhD

Member-at-large:

George M. Kapalka, PhD

APAGS representative:

Yolanda D. Perkins-Volk, MA

Save the Date: Mid-Winter Division 55 Conference

MARCH 5-6, 2016



DAY ONE THEME:

Severe Mental Illness:
Psychosis and Schizophrenia

SPEAKERS INCLUDE:

IRWIN ROSENFARB, PHD

who will discuss behavioral and environmental
interventions for schizophrenia

VERONICA PEREZ, PHD

who will present about biomarkers for schizophrenia

ALEX KAPELOWICZ, MD

who will discuss and review
psychopharmacology for psychosis



DAY TWO THEME:

RxP status across the United States,
strategies and current legislative efforts

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