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AMERICAN SOCIETY FOR THE ADVANCEMENT OF
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The Tablet

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A WORD FROM THE EDITORS

THE RETURN OF THE TABLET

After a several year hiatus, Division 55 is excited to resume the publication of our division newsletter. Our goal is to



publish the newsletter at least twice yearly with a longer-term

goal of quarterly publication. We are adding some new features and look forward to your feedback. For example, many Division 55 members and affiliates are actively engaged in research and education and we plan to recognize their work by listing their recent publications and projects.

This is a new section and undoubtedly we will have missed some of the great work our members are producing. Please send a citation of your work (in the past few years) that is not listed in this edition and we will make sure it gets in our next edition.

We are also adding a Review Section in which we will share information about articles, book chapters, books and other professional works related to psychopharmacology.

Finally, we have added a “Profiles in Prescribing Psychology” section. In this section we will highlight the work and experiences of a prescribing psychologist/medical psychologist in their

own words. It is our hope that this will acquaint all of us with some new faces and names as well as inspire us with a description of their journey to prescribe. We hope you enjoy this edition of the Tablet!

David S. Shearer, PhD and Judi Steinman, PhD

If you have questions or comments you can email davidshearer.rxp@yahoo.com

Have an article that you'd like published in The Tablet? Have a case vignette that you'd like to share with Division 55 members? Please contact David Shearer, Editor in Chief at davidshearer.rxp@yahoo.com

PAST PRESIDENT'S COLUMN

Rick Barnett, PsyD, MSCP, Division 55 President 2020

Editor's Note: This column was written in early 2020, but was never published. It is presented in it's original form here.

Welcome to the new Tablet. There are many important topics covered in this new issue so please read on!

I am delighted to serve as the 2020 division 55



creative and find new ways to thrive.

I believe that Division 55 members and our leaders are thriving. We have an amazing Board of Directors with whom I'm honored to serve and get to know more. I express my gratitude to this fantastic and committed group of people at each monthly meeting. We stand on the shoulders of our dedicated predecessors. I urge you to get to know our Board and our newly elected board members. We are so lucky to work together.

I completed the Master's Degree in Clinical Psychopharmacology from Fairleigh Dickinson University in 2007. I passed the PEP just before it transitioned to ASPPB in March 2017 (10 years later!). This galvanized me to re-commit myself to the prescriptive authority movement. Getting the degree and passing the PEP is a rewarding endeavor. If you are just beginning, in the middle of, or at the end of this education and training process, keep going! It's totally worth it.

president. We are in the middle of challenging times globally, nationally, for APA, and for the patients and students we serve. What we are collectively facing requires us to get

In my home state of Vermont we have had prescriptive authority bills in our legislature for the past 4 years. We will have new bills with new and former sponsors, in both the House and Senate, during the upcoming biennium. There are at least 12 other states that are very active in preparing for, or in the midst of, a push of their bills through the political process.

It is a fantastic time to be part of Division 55. This year, after at least three years of dedication, Clinical Psychopharmacology is on the cusp of becoming a specialty certification in the American Psychological Association (to be ratified by the APA Council of Representatives in August 2020).

States are more committed than ever to pass more laws and our membership is growing. We are active on social media (Twitter and Facebook) and we are becoming more and more attractive as a workforce. If you'd like to get more involved in any aspect of Division 55 from Diversity to Advocacy, from Research and Training to Governance and Networking, please reach out. We are a connected and active membership and together we bring strength and energy to this vital part of the field of psychology.

PRESIDENT'S COLUMN

Derek C. Phillips, PsyD, MSCP Division 55 President 2021

After the many twists and turns that 2020 provided, 2021 has finally arrived. I, for one, hope that at least in some ways, this year will be less eventful than last. Nevertheless, I am very excited and honored to serve as your 2021 President!



First, I want to deeply thank Dr. Judi Steinman for her stewardship of The Tablet over the past several years and Dr. Dave Shearer for agreeing to become its

new editor. Although The Tablet has been on a hiatus, I can assure you that the Division has not. You may have seen through other media some of the projects the Division 55 Board of Directors has been working on, but let me offer a summary.

1. First, our petition to recognize clinical psychopharmacology as an APA specialty was approved by the APA Council of Representatives in August 2020 for an initial recognition period of 7 years. This was the culmination of a multi-year effort with many, many individuals involved who deserve our most sincere thanks.
2. With the recognition of clinical psychopharmacology as an APA specialty, the Division 55 Board of Directors submitted an initial,

“brief proposal” to the American Board of Professional Psychology (ABPP) to create a new ABPP specialty board. This proposal was approved out of committee and will now go to the ABPP Board of Trustees for a vote at their mid-year meeting in June 2021. Various members of the Board will be present at this meeting to represent the Division and to give a presentation on the proposed ABPP specialty.

3. The Board has also been working to update and modernize the Division’s bylaws, which have not been amended since 2005. There are several proposed changes, including adding a Member-at-Large seat (making 4 total), increasing the length of the Student Representative’s term from 1 year to 2 years, and allowing for electronic voting for future bylaw amendment ballots.
4. The Board has been discussing for some time changing the name of the Division. In 2020, a survey was administered via the Division 55 Discuss listserv that asked about members’ thoughts about the current name, openness to changing the name, and potential options for a new name. After much discussion within our Board and with other related divisions, the Board voted in January 2021 to change the Division’s name from “American Society for the Advancement of Pharmacotherapy” to “Society for Prescribing Psychology.” At the time of writing, this proposed name change has been communicated to the APA Council of Representatives for a 60-day

commenting period and a bylaws amendment vote by the Division 55 membership is in progress. If the membership approves this change and there are no objections from APA Council, the new name will go into effect, likely by mid-2021.

I want to thank everyone who has worked tirelessly on these and other projects for our Division and invite other members to become involved as well to help further our movement. I look forward to reporting to you again soon and wish you all a very safe, healthy, and happy year!

Deprescribing in Outpatient Settings

James G. Underhill, PsyD, MP

Polypharmacy is associated with increased risks of adverse events, drug-drug interactions, falls, hospitalization, cognitive complaints, and mortality. Thus, optimizing



medication through careful deprescribing may represent a vital part of managing psychiatric disorders, avoiding adverse effects, and improving

outcomes.

Definition

Originating in the geriatric literature, the term “Deprescribing” refers to the process of intentionally reducing or discontinuing a medication to improve the patient’s health or reduce the risk of adverse side effects (e.g., Thompson, et al, 2013). The goal of deprescribing is to reduce medication interactions, medication harm, and improve care.

Since its advent in geriatrics, the term deprescribing has spread throughout the literature to such disciplines as internal medicine, infectious disease, psychiatry (e.g., Gupta & Cahill, 2016; Reeve, et al., 2014; Scott, et al., 2017). Medical and prescribing psychology have also adopted this term, citing the ability to deprescribe in prescription privilege efforts over the last decade.

Several different rationales for deprescribing have been described throughout the literature. In general, the rationales can be categorized in several general categories.

Pharmacodynamics: The human body remains a dynamic system throughout the course of a lifetime. The dynamic nature of this system is reflected in the age-based dosing recommendations and black box warnings. Within healthy human adults, brain volume is correlated with age (e.g., Terribilli, et al., 2011). Outside of healthy aging, the literature suggests that there is some correlation between age and chronic medical pathologies that are associated with dosing guidelines for psychiatric medications (e.g., Hayflick, 2004). Consequently, the risk of drug-disease interactions must be considered throughout the lifespan (Onder, 2010; Steinman, 2014). Careful deprescribing may represent a key method of reducing these interactions.

Pharmacokinetics: The number of medications being prescribed for an individual has been shown to correlate with adverse drug reactions (e.g., Nguyen, 2006). Individuals on more than 5 medications have been shown to have an approximate 13% rate of Adverse Drug Reactions or ADRs (Mangin, et al, 2018). ADRs, including falls, are a significant source of morbidity and mortality, with death rates exceeding that of some cancers (Malvezzi, et al., 2013; Just, et. al, 2017). There is some literature that indicates that deprescribing of psychotropics is associated with a reduced risk of ADRs (Campbell, 2014).

Adherence and “Pill Burden”: Originating in the HIV literature, the term “Pill Burden” refers to the number of pills that an individual takes, and the behavioral efforts associated with taking medication. Higher pill burden is associated with lower medication adherence (Farrell, 2013). While this may seem to be predicated upon the financial costs of taking medication, the literature indicates otherwise. In meta-analysis, HIV positive individuals who are prescribed combination antiretroviral medications in a single pill are more likely to adhere to the treatment regime despite higher costs (Nachega, et al., 2014). Likewise, there is significant evidence that pill burden is negatively correlated with an individual’s willingness to pay for medication (e.g., Hauber, 2017). It is therefore not surprising that deprescribing is associated with increased rates of treatment adherence (Reeve & Wiese, 2014).

Inappropriate medication: Inappropriate prescribing is often conceptualized by type of medication, total numbers of prescriptions or pills, and combinations of drugs concurrently prescribed. For medications that are not commonly abused, the patient may present already prescribed medications for diagnoses they do not have, or in dosages that are outside of guidelines. Controlled substances may represent a separate class of inappropriate medications. Individuals may present with long-standing prescriptions for controlled substances in dosing outside of guidelines, or in combination with other medications (e.g., coadministration of benzodiazepines with opioids). Such inappropriate medication regimes may call for deprescribing as a clinical intervention.

Legacy Medications: The term, “legacy medication” refers to a prescription that has been renewed beyond their initial appropriateness. For

psychotropics, several guidelines have been published that outline the length of usual treatment (e.g., zolpidem is FDA indicated for 2-6 weeks). Long term review of FDA data has shown that “antidepressants” should be prescribed for 15 months, or 6 months after symptom resolution (Borges, 2014). Despite these admonitions, studies have shown that legacy medications are common in outpatient populations with approximately 48% of patients being prescribed an antidepressant which was no longer useful or indicated (Mangin, D., et al., 2018).

Targets

Benzodiazepines and benzodiazepine receptor agonists: In general, benzodiazepines and receptor agonists are indicated for limited time use. Consequently, deprescribing should remain a key aspect as part of an informed treatment plan that includes these medications. Additional indications for benzodiazepine deprescribing include abuse of medication, opioid coadministration, age-related changes, and dependency (Schweizer & Rickels, 1998). Likewise, interactions with antihypertensives and glycemic control medications may result in falls and may warrant deprescribing of benzodiazepines as a clinical intervention.

Stimulants: The MTA (Multimodal Treatment Study of Children with ADHD) study and subsequent analyses have consistently demonstrated that stimulant medication is of limited long-term efficacy in ADHD populations (Molina, 2009). Likewise, longitudinal imaging data and clinical data indicates that ADHD may represent a developmental process which resolves with age (Shaw, 2006). Empirical evidence suggests that stimulants do not improve performance in individuals without ADHD; however, these same studies show that there is a

subjective sense of increased performance (e.g., Arria, et al., 2017). It is not surprising that stimulant use has more than doubled in the last 10 years without a public health crisis (Piper, 2018).

The potential risks of stimulants warrant the question of deprescribing. Stimulant use has been associated with mania, tics, hypertension, and cardiac events. These events or abuse may be indications for deprescribing.

Antipsychotics: Current literature suggests that most maintenance dosages of antipsychotics are too high (Harrington, 2018). While sub-therapeutic dosing of some antipsychotics has been associated with an increased risk of relapse, tolerability remains an additional factor in patient adherence. Both the CATIE and CUTLASS studies showed that dosage is associated with both tolerability and treatment nonadherence (Naber, 2009). Consequently, any decision to deprescribe should balance the dosage, risk of relapse, and tolerability to maximize adherence and outcome.

Cholinesterase inhibitors and memantine:

Appropriate use of acetylcholinesterase inhibitors and memantine involves both prescribing these medications to individuals who are likely to benefit, and deprescribing when the risks outweigh the benefits. Acetylcholinesterase inhibitors are generally indicated for mild to moderate dementia resulting from Alzheimer's disease, Parkinson's disease, vascular dementia, and Lewy body dementia. Memantine is indicated for the treatment of severe dementia of the Alzheimer's type (Reeve, 2019). While these medications are commonly used in neurocognitive disorders resulting from other pathologies including TBI, tumor, and CVA, there is limited data to support this use.

Acetylcholinesterase inhibitors can cause a variety

of adverse effects due to increased cholinergic stimulation, both centrally and peripherally. Commonly reported ADRs include gastrointestinal distress, urinary incontinence, tremor, and nightmares (Reeve, 2019). Current literature indicates a modest clinical improvement in individuals prescribed these medications (Knight, et al., 2018). Given the natural history of neurodegenerative disorders, deprescribing should be considered when weighing the risks and benefits of these medications.

Antidepressants: Current treatment guidelines indicate that antidepressant medication should be discontinued between 6 months and one year after symptom resolution. However, the most recent FDA data shows that the median length of antidepressant medication in the USA is approximately 5 years (e.g., Pratt, 2011). Indeed, the literature shows that prescription of antidepressants for longer than 15 months without reason is contraindicated. Despite clinicians' concerns, guidelines and meta-analyses seem to indicate that deprescribing is well tolerated in this class of medications (Maunde, 2019).

Methods

Deprescribing can be accomplished in several different ways. Professional guidelines have been developed to aid the treatment provider with clinical decision making in deprescribing. Conceptually, these guidelines can be categorized into two broad categories.

Stepwise Approach: Some literature has suggested that a stepwise approach to the practice of deprescribing is indicated (e.g., Scott, et al., 2017; Scott, et al., 2015). Several algorithms, guidelines, and flowcharts have been proposed to aid clinicians in determining which medications should be

deprescribed, and in which sequence. While an exhaustive review of this literature is outside the scope of this article, the general theme of these guidelines can be generally summarized as follows. First, the clinician should identify all medications prescribed. Second, the clinician should estimate the risk that each medication holds for the individual patient. Thirdly, the clinicians should determine how useful the specific medication is for the specific pathology. And finally, the clinician should prioritize deprescribing medications that cause harm or are no longer useful. (Gallagher, 2008). The methods used in deprescribing vary from planned abrupt discontinuation to a sequential process involving medication reduction in combination with nonpharmacological interventions.

In practice, stimulants likely represent the best example of a stepwise approach. "Drug holidays" remain a common practice in pediatric ADHD treatment. Such structured discontinuation has not been associated with adverse effects (Pierre, et al., 1999). Given the MTA's findings, combining behavioral therapy with a planned discontinuation should remain a key part of the stepwise approach to deprescribing stimulants. For acetylcholinesterase inhibitors and memantine, a stepwise approach to deprescribing has not been shown to differ in outcomes from a tapering approach (Reeve, 2019). Likewise, a structured approach for antidepressants, wherein CBT is started prior to deprescribing, has been shown to aid in relapse prevention (Maunde, 2019).

Tapering Approach: In some cases, a more nuanced approach to the rate of taper can be informed by the pharmacologic properties of the drug (including half-life) whether use of the medication causes up- or down-regulation of receptors that require time to

re-equilibrate, and even the likelihood of an adverse drug withdrawal (Bain, et al., 2008).

In practice, several of the targets mentioned in this article may warrant a tapering approach. In antipsychotics, the 6 month relapse rate after abrupt withdrawal of antipsychotics is double that of gradual deprescribing (Viguera, 1997). Likewise, cholinergic rebound and psychotic decompensation remain considerations in the deprescribing of antipsychotics that may warrant introduction of second generation antipsychotics and/or anticholinergic medications (Gilbert, et al. 1995). For benzodiazepines, guidelines indicate that a tapering approach is preferred when balancing the risks of harm from abuse with the risks of seizures (Ashton, 2005).

Summary

As medical psychologists, deprescribing remains an important tool in the care of patients. The manner in which deprescribing is accomplished can be informed by patient characteristics and the relative attributes of particular medications. Periodic evaluation of the continued risks, benefits, and usefulness of medications should remain a key aspect of treatment planning.

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The Case for the Efficacy of Prescribing Psychology: Utilizing Existing Research and Guidelines

David Shearer, PhD, MSCP

Supporters of prescribing psychology are often asked how we can determine if prescribing psychologists are effective prescribers of psychotropic medications. Those of us who have



been prescribing safely and effectively for several years or more can find this question surprising. However, legislators, medical providers, patients, and others can reasonably expect us to be able to answer this question with data. This article briefly discusses how current literature can be used to demonstrate the efficacy of the practice of prescribing psychology today.

In order to evaluate the efficacy of prescribing psychologists we must first define what the prescribing psychologist uniquely brings to the provision of services. While it may seem obvious that prescribing psychologists bring the ability to provide a combination of psychotherapy and psychopharmacological services to their clients, this is a remarkably unique skill set. While some psychiatrists or psychiatric nurse practitioners may have expertise in providing psychotherapy, many in those respective fields do not. Only prescribing psychologists are by definition and training both highly skilled psychotherapists and psychopharmacologists. Prescribing psychologists may provide therapy and/or psychopharmacological services to different populations in virtually any

multidisciplinary/integrative settings, individual practitioner roles, inpatient, consultation, emergent services and others.

With regards to specific psychological, biological or social problems the prescribing psychologist is prepared to provide services at a comprehensive level that meets both practice guidelines and the standard of practice. While non-prescribing psychologists are also very capable of meeting the research-based guidelines from a psychotherapeutic standpoint, only prescribing psychologists have the added benefit of also meeting the research-based guidelines for psychopharmacologic treatment as well. As the astute reader will note, the first-line treatment for some psychological problems (e.g., specific phobias) is some form of psychological treatment (e.g., CBT) with psychopharmacological intervention not generally recommended (e.g., Muse and Stahl, 2018; Shearer et al., 2014). In this case the prescribing psychologist can choose to utilize the recommended treatment. In contrast, the prescribing provider who is not also a psychologist, nor trained in psychotherapy, must either refer to an appropriate provider or use the only tool in their toolbox, medication. Conversely, in cases in which medication is clearly the first-line treatment of choice (e.g., acute mania in bipolar disorder; Welton & Roman, 2018) the prescribing psychologist has the ability and tools to choose the most effective treatment approach, psychopharmacologic intervention.

Using Clinical Practice Guidelines (CPGs) as an example, this section will briefly review how the unique skill-set of the prescribing psychologist is applied to two specific psychological problems; depressive disorders and posttraumatic stress disorder. There is agreement among experts that some psychological problems may respond well to combined psychological and psychopharmacological approach {e.g., Pffner & Haack, 2015 (ADHD), Dougherty, Rauch, & Jenike, 2015 (OCD); Cuijpers et al, 2014 (depression and anxiety)}. Other disorders are often treated with either medication or psychotherapy alone. In some cases the addition of medication to psychotherapy, or visa-versa, may improve outcomes (e.g., Cuijpers et al, 2014). The reader should keep in mind that patient preference is also a strong determining force in what treatment a patient receives. Even if the best current evidence suggests that a combined approach may be most successful, individual patients may strongly prefer medication only or psychotherapy only. Once again, the prescribing psychologist is able to meet the both the patient need and preferences in ways that most other psychotropic prescribers cannot.

Depressive Disorders

The American Psychological Association (APA) guidelines for the treatment of depressive disorders (APA, 2019) indicate that for a general adult population either medication, psychotherapy or both may be considered as first line treatment. For older adults, the APA guidelines recommend either a combined approach or group therapy. Similarly, the American Psychiatric Association (APA) has also published guidelines for the treatment of major depression (APA, 2010). These guidelines recommend either therapy or pharmacotherapy for mild to moderate depression in adults with optional combined treatment for patients with contributing

psychosocial factors. For adults with severe depression, with or without psychotic features, the American Psychiatric Association guidelines recommend either medication alone or a combined approach (APA, 2010).

Posttraumatic Stress Disorder

The American Psychological Association practice guidelines for the treatment of posttraumatic stress disorder (APA, 2017) also make specific recommendations for both therapy and psychopharmacologic treatment. The Veterans Affairs/Department of Defense guidelines for the treatment of posttraumatic stress disorder (PTSD) has specific recommendations for the use of therapy as first line treatment and medication as alternative or adjunctive treatment (US Department of Veterans Affairs, 2017).

The guidelines referenced above, as well as much of the research on behavioral health treatment for specific psychological disorders, do not differentiate between categories of providers. Rather the focus is on treatment outcomes for the services provided. The underlying assumption is that any provider licensed to provide these recommended interventions will improve patient outcomes by following these guidelines. The prescribing psychologist can provide every level of recommended treatment per these guidelines as described above.

Conclusion

From a historical perspective, McGrath (2019) has suggested that psychology could develop into a prescribing discipline for some psychologists similar to the way in which psychiatry evolved from

predominantly a therapy-focused to a medication-focused discipline. Indeed, with the addition of prescription privileges, the prescribing psychologist provides services comparable to psychiatrists, psychiatric nurse practitioners, and psychiatric physician assistants. However, it is the capacity to provide either medication management, therapy, or both that defines the current prescribing psychologist. The two primary ways in which psychopharmacological prescribing professions can be compared, other than annual salary, are training and efficacy. Muse and McGrath (2010) have published the only comparison of prescribing psychologists' training vs. physicians and nurse practitioners. They conclude that... "The results suggest that pharmacologically trained psychologists have as much or more education in psychopharmacology as do other entry-level prescribers, including physicians" (p 101). This conclusion has been challenged by some based on the fact that the physicians used as a comparison point were those who had graduated medical school, yet had not completed their four year psychiatry residency, in other words, entry level prescribers, as stated in the article. Nevertheless, the comparison shows comparable levels of didactic education in psychopharmacology. Another way to assess training is to compare psychotropic prescribers on a test of competence. This was undertaken by Cooper (2020) when he administered a 25 item exam on psychopharmacology to 66 providers: psychiatrists, general physicians, psychiatric nurse practitioners, general nurse practitioners, prescribing psychologists, and general

psychologists. The results revealed that the best performance was by psychiatrists, followed respectively by prescribing psychologists and then psychiatric nurse practitioners. However, there was no statistically significant difference in performance between the three groups. This suggests that the competence level, as measured by written exam, is comparable for psychiatrists, prescribing psychologists and psychiatric nurse practitioners.

Yes, as of this date, there is a limited amount of research specifically focusing on prescribing psychologists. This is in part due to the relatively recent origin of the field, but also because both psychotherapy and psychopharmacology are often independently researched. As discussed above Clinical Practice Guidelines (CPG), dosing regimens, and indications for psychotropic medication are same for all prescribers regardless of discipline. Therefore, the data evaluating the efficacy of psychopharmacology applies equally across specific prescribing disciplines. Support for basic comparability of disciplines is found in comparisons of training programs for different prescribing specialties (Muse and McGrath, 2010), an absence of serious adverse errors for prescribing psychologists over three decades, and the fact that prescribing psychologists are providing similar services in similar settings as other prescribing providers. Currently, the best data supporting psychologists who prescribe comes from research that either independently evaluates psychotherapy and pharmacotherapy or evaluates the combination

as provided by separate practitioners (prescribing and non-prescribing).

Psychopharmacology is a practice that has a long and well-documented record of efficacy. The specialty of prescribing psychology is in its essence applying an already existent base of evidence, established over many decades by psychiatry, as adjunctive skill for full-scope clinical psychology. As this specialty develops there will be more studies focusing specifically on prescribing psychology. However, we do not need to wait for those studies to demonstrate the basis of our efficacy as prescribers; our current psychopharmacological practice is informed by a vast database of research, clinical practice guidelines and medical reference materials.

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DIVISION 55 COUNCIL HIGHLIGHT

DIVISION 55 RESEARCH COUNCIL

Joseph E. Comaty, PhD, MP

The American Society for the Advancement of Pharmacotherapy (APA Division 55) has within it multiple Councils covering Training, Diversity, Continuing Education, and Research. This is a presentation of the Research Council and its mission and activities. The mission of the Research Council is to promote dissemination of high-quality, evidence-based research related to the causes of and treatments for mental illness and substance use disorders.

The main task of the council is to keep abreast of the clinical research relevant to the specialty and highlight articles and issues of interest. It encourages the critical reading of research and monitors ongoing trends in clinical psychopharmacology with an informed understanding of the needs of the populations served by psychologists specially trained in clinical psychopharmacology.

The Research Council posts relevant recent articles on this website, disseminates relevant information on clinical psychopharmacology to the membership via the Division 55 listserv, acts as consultant to Division 55 and other APA Divisions, and as a potential advisory resource to inform APA policy decisions on matters related to psychologists who have an interest in the application of psychopharmacological principles within their practice, or those specially trained psychologists who have or intend to pursue prescription privileges.

Finally, the Research Council offers its members' expertise and knowledge base as speakers on topics related to psychopharmacology and as a resource to SPTA committees in states that are in the process of or contemplating pursuing RxP legislation.

The Research Council is currently made up of the following members: **Chair:** Joseph E. Comaty, PhD, MP; **Members:** David M. Latini, PhD, MSW, MSCP; Alan Lincoln, PhD, MSCP, BCBA-D; David Shearer, PhD, MSCP; Andris Skuja, PhD; Judi Steinman, PhD, and Alan Dubro, PhD.

The Research Council meets regularly to plan activities and discuss how the Council can continue to support its stated mission. Some of the current activities include ongoing review of the literature to identify important articles of relevance to the membership of the Division and after review by the Research Council, they are posted on the Research Council's webpage on the Division's site. The Council is also discussing ways to support those members engaged in research and to promote more research activities by its members. The Council is exploring opportunities to develop a fellowship program to support students who have an interest in pursuing research in the area of psychopharmacology.

Recently, APA Council of Representatives approved the establishment of Clinical Psychopharmacology as a Specialty and is now listed on APA's webpage for *Recognized Specialties, Subspecialties and Proficiencies in Professional Psychology* at:

<https://www.apa.org/ed/graduate/specialize/recognized>.

Several members of the Research Council made substantial contributions to the specialty application submitted to APA's *Commission for the Recognition of Specialties and Subs specialties in Professional Psychology (CRSSPP)*. Based on this accomplishment, the Research Council hopes to move forward with an application to *The American Board of Professional Psychology* to establish Clinical Psychopharmacology as a certified specialty board.

Currently, there are five states that permit specially trained psychologists to prescribe medication for the treatment of mental health and substance use disorders including New Mexico, Louisiana, Illinois, Idaho, and Iowa. In addition, psychologists are able to prescribe in the military, within the U.S. Public Health Service, within the U.S. Indian Health Service, and in the territory of Guam. Several more states have active groups working on supporting legislation to allow psychologists to prescribe in their states. The Research Council actively supports these efforts.

We invite the reader to review the Research Council webpage at: <https://www.apadivisions.org/division-55/councils/research>. If you have an interest in the work of the Research Council or would like more information, please contact any of the current members or you can contact the Chair at: drscomatyadvokat@gmail.com.

LEGISLATION AND ADVOCACY

THE “ELBOW BUMP” GREETING – INTERESTING TIMES FOR SURE

Pat DeLeon, PhD, MPH, former APA

President, March 2020



Spring time brings the annual APA Practice Leadership Conference to our nation’s Capital, which is always the highlight of my professional year. The extraordinarily timely programmatic

theme for the 37th conference was “Maximizing the Impact of State and Federal Advocacy,” which fit very nicely into Sunday morning’s fascinating political prognostications by Charlie Cook. Approximately 350 colleagues attended, having the opportunity to attend exciting workshops on a wide range of critical issues including: Psychologists as change agents for immigration reform, chaired by Shirley Higuchi; Telepsychology, chaired by Deborah Baker; and So, you passed RxP in your state – What’s next? which was chaired by Doug Walter. During this last workshop, Beth Rom-Rymer, a former member of the APA Board of Directors, presented an update on developments in Illinois. Beth has also begun informing her colleagues that she will be a candidate for APA President next election cycle.

Over the years, I have especially appreciated the visionary support of Dan Abrahamson and Susan Lazaroff for actively involving our next generation, and particularly military psychology and mental health nursing graduate students from the Uniformed Services University (USU). “I want to thank the Practice Directorate once again for allowing me to attend the 2020 Conference. I got the opportunity to meet with so many incredible individuals who are passionate and devoted to public policy and leadership. This opportunity would not have been possible without the mentorship and devotion to the professional development of us by the USU psychology faculty, and I am very grateful for being allowed to take part in this important event.

“One of the workshops, which resonated with me most was led by Dr. Sandra Shullman (Current APA President). In this seminar, she shed light on the strengths and shortcomings of interactions between intergenerational leadership styles, and how groups and teams with members from diverse generations can begin to use each other’s strengths and interpersonal styles to successfully collaborate with one another, especially as it relates to evaluating program outcomes, developing new ideas and opportunities within our respective institutions, and overall valuing the strengths of different perspectives, experiences and overall communication styles of one another. One piece of advice she provided in her workshop was for

seasoned leaders from older generations to approach mentorship opportunities with an open, hands-on approach, by creating pathways and providing tangible lessons for their respective mentees who are in the early stages of developing their own ideas, perspectives, and goals within their own roles and institutions as Early Career Psychologists.

“After participating in this conference, I feel inspired and am motivated to share these lessons and ideas with my colleagues and mentors at USU. There were so many valuable moments from the PLC 2020 conference, and I am eager to begin implementing these new set of frameworks, ideas and perspectives to shape the future of Military Medicine” (Patricia Carreno. 2LT, MSC, USA).

Jared Skillings, APA Chief of Professional Practice, provided an insightful vision for the future during the Opening Reception. “PLC is one of the most important events of the year because it gives APA and SPTA leaders a chance to connect in person and encourage collaborative opportunities to work together. Last year APA was on the cusp of Transformation; we talked about what’s ahead for our profession and about how we could come together to broaden psychology’s impact. Since then, APA has taken several significant steps to turn that talk into action. Over the past year, we’ve done a lot of work to improve reimbursement rates. Psychology had a really big win for health behavior codes. CMS followed our recommendation and increased the values of those codes about 30 to 40 percent. They will now reimburse similarly to psychotherapy. Whether you see a patient with a medical diagnosis or with a mental health diagnosis, you’re going to be paid roughly the same. That is a really important indication that the medical system values the services we provide.

Moving onto innovation. Over the past year we witnessed a major milestone in the area of psychology and technology. Through the effective leadership of ASPPB, and especially CEO Mariann Burnetti-Atwell, PSYPACT has advanced. This is the Psychology Interjurisdictional Compact that allows psychologists to practice telehealth between states that passed the PSYPACT law without needing additional licensure. Currently, 12 states have adopted this law. And, I’m excited to say that 17 more states are strongly considering or have active legislation for PSYPACT this year. Think about that. It’s possible that in the near future, more than half of the states might have this law in place. This will help improve the accessibility of our services to the public, and especially to rural and underserved communities – communities that really need our care. It also provides a way for psychologists to deliver services to patients who may not be able to leave their homes – like people with transportation challenges, disabilities, or concerns about a contagious virus. PLC is the perfect place to hone your professional skills, leadership skills, and advocacy skills and start putting them to work.”

Reflections on the Journey: “I now want to hold office. I want to move my work onto a larger stage. I haven’t been president of anything since the ninth grade and no one has since asked me to run for anything. My friends are assuming high office: Judy Rodin has been elected President of the Eastern Psychological Association. I thought scientific honors and national office just came based on some organic acclamation for work accomplished. ‘Sandy,’ I ask in a moment of naïve and abashed candor, ‘Why am I never invited onto prestigious national committees?’ My friend, Sandra Scarr, is an all-around professional success and I am envious of her. She is chair of the

Department at the University of Virginia and a prominent researcher on race, poverty, and IQ. She is also politically astute, having evaded the wrath usually focused on researchers who find a genetic component of IQ. She is, moreover, the President of the breakaway American Psychological Society.

“These are not knighthoods, Marty. You probably think it beneath dignity, but scientific honors and national office are not bestowed because you happen to do good science. The dirty little secret is that you have to campaign for them. You have to make allies and then tell them you want it.’ (I am now informed that this is also true for knighthood.) I quietly and blushing all the while tell a few of my friends that I would like to be President of the Division of Clinical Psychology, Division 12, the largest unit of the APA. On my first try, David Barlow, the leading anxiety-therapy researcher, wins by a bit; but on my second try in 1993, I am easily elected.

“Being President is fun. I like the people – other clinical researchers for the most part. I like the venue – three meetings a year in Washington. And I like the work – moving the agenda of building good clinical science, an agenda foisted upon me at Penn, onto the national stage, where the petty politics of departmental infighting is not so obvious or so personal. My main issue is building support for evidence-based therapy.

Standing up for evidence-based therapy is dandy as far as the academic-based governing board of Division 12 is concerned. But as I begin to meet the therapists who are forced to labor under the insurance companies’ reimbursement guidelines derived from efficacy research, I learn that this work is not welcome in the trenches. Therapists told me that it is fodder for the managed care machine

which boxes them into overly simple diagnoses, stripped-down brief treatment, lower wages, invasion of privacy; and worst, ending therapy too early and without all the relief that longer therapy would produce.

“My December, 1995 American Psychologist article, on the significance of the Consumer Reports publication that November which highlighted the effectiveness of psychotherapy and which further noted that long-term treatment did considerably better than short-term treatment, was widely read and welcomed by these therapists. My sudden unpopularity with my research peers was outweighed by my new-founded popularity with therapists and they formed the largest voting bloc in APA. ‘I could be elected President of APA,’ I told my wife.

“‘I am going to run for President of APA, and I need Penn’s help,’ I told Judy Rodin, now President of the University of Pennsylvania. ‘I intend to take it seriously and I would like you to give me a five-year paid leave from Penn. One year to run and if elected, three years to serve and one year to recover and re-tool as a scientist.’ ‘OK,’ she tells me, ‘I will grant that in exchange for the copyrights on your Learned Optimism intellectual property. Penn will license these out to schools and corporations and that will pay for the cost of your leave.’

‘I’m thinking about running for President,’ I tell another colleague who is a member of the APA Board of Directors. ‘Impossible! The candidates line up years in advance and the order of succession is already designated.’ ‘Who chooses them? Isn’t this the only office in which all of the members of APA can vote?’ I ask naively. ‘The machine does and it is the one that has run APA ever since it was taken

over from the scientists fifteen years ago. It is a coalition of the leaders of the state associations, the activist practitioners from the Council of Representatives, and most importantly the Council for the Advancement of Private Practice, CAPPs.' I am appalled. How does sitting on committees in Washington for a decade and networking with the other committees qualify a person to lead all of American Psychology? The candidates campaign and so will I. Not with buttons, not with brochures, but with a speech. The main way to meet the therapists is at their state conventions. Starting in early 1996, I go to many conventions. I have one edge, name recognition. Unlike the other hopefuls, I am invited to give a standing-room only keynote speech in each of these states. My speech has a theme: psychotherapy needs better evidence for its effectiveness, evidence of the sort Consumer Reports began, and that science as the ally of practice can provide it. I get standing ovations.

"I venture into the lion's den. In the mid-1970s, a pugnacious no-nonsense psychotherapist named Rogers Wright led his 'dirty dozen' into a head-on collision with the science wing over who will run APA. The practitioners organize, a tactic that science regards as undignified and has never bothered to do, and Rogers demands proportional representation in governance. Science is blindsided and by 1980, the practitioners have won and science took a resentful back seat to practice. Rogers and I met at a deli in California and we were both surprised and delighted with what we found. He found a scientist sympathetic to practice and I found a street-fighter who wants to promote independent practice by bolstering it with good science. As our family drove through Yellowstone National Park in the late spring of 1996, I went to a pay phone and found out that I won the election by the largest vote

in modern history. I got almost 10,000 votes, three times as many as my nearest opponent.

"Talking with my daughter afterwards, I got the idea that powered the rest of my life. Psychology can be explicitly about building the good life. The practice and science of psychology has been half-baked. Psychology starts with the premise that getting it right equals not getting it wrong. It follows that if psychology can somehow eliminate all of the ills of the world – mental disorder, prejudice, ignorance, poverty, pessimism, loneliness and the like – human life would be worth living. But the absence of ill-being is not equal to the presence of well-being. Psychology can be about the presence of happiness not merely about the absence of unhappiness. Not getting it wrong does not equal getting it right.

"Visions of co-operation between science and practice danced in my head. The salvation of APA. The reunion of Practice and Science. I ask to be invited to a meeting of CAPPs to explain my vision. It did not go well. One question cut through the silence: 'What if the evidence does not come out in our favor?' I have only had one true mentor in my life – Ray Fowler. Ray was the CEO of APA and unlike the Presidents who come and go, he was its institutional memory. He defined his role as bringing out the best in its Presidents. Years later he confided in me that his best quality was that he suffered fools gladly and at that moment I knew whom he had in mind. 'There are two kinds leadership, Marty,' Ray told me after listening to the CAPPs fiasco, 'transactional and transformational. You cannot possibly out-transact these people. They sit on all the committees and they have great sitting power. They will out-sit you. If you are not going to fail, you need to be a transformational President. Your job is to transform

American Psychology” (Marty Seligman, 1998 APA President – adapted from The Hope Circuit, Public Affairs, 2018). “Tiny bubbles.... Make me feel fine” (Don Ho). Aloha.

Our Councils

Division 55 has various councils that serve an integral role in carrying out the division's mission of increasing access to quality psychopharmacotherapy through advocating nationwide for appropriately trained psychologists to prescribe psychotropic medications. Specifically, the mission of the **Diversity Council** is to promote inclusion of diversity-relevant issues in the administration of Division 55, to provide information and services relating to diversity to Division 55 membership, and to provide representation within APA on the intersection of diversity and psychopharmacotherapy within APA governance. The purpose of the Division 55 **Research Council** is to promote dissemination of high-quality, evidence-based research related to the causes of and treatments for mental illness and substance use disorders. The purpose of the **Training Council** is to monitor, coordinate and ensure that training in clinical psychopharmacology includes APA requirements, current clinical practice and relevant knowledge.

“I HAVE NOT LOST HOPE”

Pat DeLeon, PhD, MPH, former APA

President, March 2020

Although it is always impossible to predict the future with any sense of certainty, with today’s unprecedented public health restrictions upon our daily lives, it is perhaps rather common to attempt to “guestimate” what future psychological and behavioral health practice will be like. Reflecting upon those trends within the generic health care environment, which we have observed over the years at the federal level, one can make some educated estimates. Foremost, as reflected throughout President Obama’s landmark Patient Protection and Affordable Care Act (ACA), all of health care, including those psychological/behavioral health services provided by psychologists, psychiatric mental health nurse practitioners (DNP), social workers, clinical pharmacists, and psychiatrists, will become increasingly patient-centered.

In 2016, the National Academies of Sciences Engineering and Medicine (NASEM) noted that back in 2002, the Institute of Medicine (IOM) convened a summit of diverse stakeholders who made the case for reforming health professions education to improve the quality and safety of health care. And while many of their recommendations remain relevant today, it was felt that much had changed over the next decade, necessitating new thinking. Innovators at that time stressed the importance of “patient-centered care,” while today they think of patients as partners in health promotion and health care delivery. Patients have become integral members of the care team, not solely patients to be treated, and the team is recognized as comprising a variety of health professionals. It was further noted that

this fundamentally changed thinking was the culmination of many social, economic, and technological factors that were transforming the world and forcing the fields of both health care and education to rethink long-established organizational models.

Today’s pandemic should have impressed upon all of us the importance of actively engaging with technology in our clinical, research, and educational worlds. On April 27, 2004 President George W. Bush noted: “The way I like to kind of try to describe health care is, on the research side, we’re the best. We’re coming up with more innovative ways to save lives and to treat patients. Except when you think about the provider’s side, we’re kind of still in the buggy era.... (T)here’s a lot of talk about productivity gains in our society, and that’s because companies and industries have properly used information technology.... And yet the health care industry hasn’t touched it, except for certain areas. And one area that has is the Veterans Administration.”

Utilizing Webinar technology, Division 55 President-Elect Derek Phillips reports: “In April we sponsored a Webinar regarding our multi-year efforts to obtain formal recognition of clinical psychopharmacology as a specialty through the APA Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP). One hundred students and psychologists registered for this Webinar, with more than a dozen additional individuals requesting a link to the recording after maximum capacity had been reached. The Webinar was moderated by 2020 Division President Rick

Barnett. The presenters included Division leaders Sean Evers, Judi Steinman, and myself.

“During the Webinar, it was announced that, in early April, we were notified by APA that Clinical Psychopharmacology had received preliminary approval as an APA-recognized specialty for a period of seven years pending final approval by the APA Council of Representatives at its August 2020 meeting. Moving forward, the Division will be working with the American Board of Professional Psychology (ABPP) to create a clinical psychopharmacology specialty board and offer ABPP board certification in clinical psychopharmacology. Another goal for Division 55 is to join the Council of Chairs of Training Councils (CCTC) to represent the interests of clinical psychopharmacology alongside other psychology-related specialties and interest groups. Additional Webinars and other plans are in the works, so stay tuned!”

For those passionately committed to the RxP quest, a thoughtful communication we recently received from Gary VandenBos, now with the National Register, is most timely. Allen Frances, former chair of the Department of Psychiatry at Duke University and the American Psychiatric Association’s task force that produced the DSM-IV (1994) commented in The lure of “cool” brain research is stifling psychotherapy: “I can affirm confidently that there are no neat answers in psychiatry. The best we can do is embrace an ecumenical four-dimensional model that includes all possible contributors to human functioning: the biological, the psychological, the social, and the spiritual. Reducing people to just one element – their brain functioning, or their psychological tendencies, or their social context, or their struggle for meaning – results in a flat,

distorted image that leaves out more than it can capture....

“This misplaced reductionism [at NIMH] arose from the availability of spectacular research tools (e.g., the Human Genome Project, functional magnetic resonance imaging, molecular biology and machine learning) combined with the naïve belief that brain biology could eventually explain all aspects of mental functioning. The results have been a grand intellectual adventure, but a colossal clinical flop. We have acquired a fantastic window into gene and brain functioning, but little to help clinical practice. The more we learn about genetics and the brain, the more impossibly complicated both reveal themselves to be. In a rational world, NIMH would continue to fund a robust psychotherapy research budget and promote its use as a public-health initiative to reduce the current massive overprescription of psychiatric medication in the US. Brief psychotherapy would be the first-line treatment of most psychiatric problems that require intervention. Drug treatments would be reserved for severe psychiatric problems and for those people who haven’t responded sufficiently to watchful waiting or psychotherapy. Unfortunately, we don’t live in a rational world. Drug companies spend millions of dollars every year influencing politicians, marketing misleadingly to doctors, and pushing pharmaceutical treatments on the public.”

Personal Reflections: During the rather lengthy period that I had the opportunity to be involved within the APA governance, I had always been impressed by the dedication of James Jones in bringing pressing social issues to the attention of our governance colleagues for nearly three decades. For me, James was the APA Ethnic Minority Fellowship Program (MFP) and worked tirelessly to engage like-minded colleagues in the

other mental health professions and the Administration. A wonderful role model for generations to come, he constantly urged Council's leadership to keep addressing the importance of developing a profession of psychology that truly reflected the composition and pressing needs of the nation.

James, two questions: What Should APA Be Doing During These Critical Times: "In 1978, I, along with Dalmas Taylor, convened the Dulles Conference to determine what APA needed to do to elevate the participation of ethnic minority psychologists in all aspects of APA governance. We invited representation from the four main ethnic minority psychology groups – Association of Black Psychologists, Society of Indian Psychologists, Asian American Psychological Association, and Hispanic Psychological Association. After three days of intense discussion, debate, negotiation, and compromise, we invited APA leaders, headed by CEO Chuck Kiesler, to come and receive our report and recommendations. There was a lot of politicking that followed but the result was the establishment of the Office of Ethnic Minority Affairs, the Board of Ethnic Minority Affairs, and ultimately the Society for the Psychological Study of Culture, Ethnicity, and Race. So, my thought is APA should convene a Dulles Conference II. This is different from a Presidential Task Force as has been proposed, but a several days conference with broad representation from multiple stakeholder groups. The purpose of the conference is to answer the question you pose 'What should APA be doing in these critical times?' and to offer recommendations. It is not for me to say, or any one person to propose. It must be an organic and inclusive process that leads directly to decision making and policy and program action. APA should

fund the conference, and/or find partners in federal agencies and foundations. This is not a quick fix picking out 'low hanging fruit' or performative acts of sympathy or empathy. This is 'nuts and bolts' deliberation on how to address, attack and reduce systemic racism within psychology and within society."

And, What Are Your Aspirations For Our Next Generation of Psychologists? "When I directed the Minority Fellowship Program (MFP) we supported and nurtured a strong cadre of psychologists who have become leaders in the social justice effort in colleges and universities. Thomas Parham is President of California State University Dominguez Hills, Beverly Tatum is former President of Spelman College, Ana Mari Cauce is President of the University of Washington, Isiaah Crawford is President of the University of Puget Sound. All MFP recipients. Countless others are Provosts, Deans, Department Heads, Distinguished Scientists, and Jennifer Richeson is a recipient of the McArthur Genius Award. APA was and is the home of MFP.

"What I want from the next generation of psychologists is to continue the work of the last few generations. The network is larger and deeper, psychologists of color occupy a wide variety of leadership positions and possess enormous skill, dedication, and commitment to social justice. Of course, the problems they face are, in many ways more difficult to address because they have been shrouded in a variety of institutional, political, and cultural camouflages. The interweaving and interlocking of these problems, highlighted most recently by the symbolic and manifest exposure of systemic racism, require multidisciplinary and multidimensional approaches. The dedication, nimbleness, passion and compassion, coalition building, and collaboration is what I want future

psychologists to commit to. I am by nature optimistic and if our MFP cohorts, then and now, are any example, we will be on the right side of history!”

APA 2011 President Melba Vasquez appointed James to chair her Task Force on Reducing and Preventing Discrimination Against and Enhancing Benefits of Inclusion of People Whose Social Identities Are Marginalized in U.S. Society. Their mission was to identify and promote interventions to counteract and prevent those destructive processes of bias, prejudice, stereotypes, and discrimination. “When the potential, capacity, and talent of all members of society are optimally developed, this benefits all of society.”

The report’s principle recommendations reflected the Task Force’s judgment that APA can promote understanding of the psychological science that illuminates the mechanisms of discrimination and the promising pathways to beneficial diversity. According, its first recommendation was to: “Promote the significant role of psychological science to understanding and reducing discrimination and achieving benefits of diversity. The set of activities included here fall under the Strategic subgoals of decreasing health disparities and applying psychology to everyday living.” It further noted: “Psychologists agree that during the first 3 to 4 years of life, children are relatively naïve about racial/cultural differences. Although children do notice racial differences, conscious awareness of race and its social meanings are absent or minimal; young children are generally unable to articulate differences and are unaware of social norms about race.”

James has recently been sharing his thoughts with the media, including AAAS Science, on the divergent perceptions of the unrest surrounding the Black Lives Matter movement which have roots in unconscious biases and knowledge of historical contexts. “No doubt progress has been made, but what I think this event signals to me is that our efforts have been fundamentally incapable of redressing the negative feelings, perceptions, thoughts, beliefs that underlie this systematic, continued bias against black people. In one sense, I’m hopeful this is finally an inflection point, a watershed like the 1960s were, that fundamentally changes how we approach things. We’ve done a lot of research about how to reduce people’s adherence to stereotypes and help different groups recognize their commonalities. But at the same time, the academic enterprise does not inform policies as much as it should. Maybe this will galvanize policymakers to take the research more seriously.

“At national funding agencies, there is a hierarchy of value of what research is important, and funding for research into racial justice is slippery and grudgingly provided. One of the first things researchers can do is speak up to say, ‘This work is important, this work is valuable.’ Not only do we need more people of color involved in academia, but we need the questions they are asking to be viewed with greater positivity. If you want to have a professoriate that advances our understanding of these momentous issues in our society, it needs to be broader than just having more scientists of color. We must look at the problems we are facing and ask, ‘How do we get a scientific purchase on that?’” “These have been difficult days for every civil rights leader, for every lover of justice and peace” (Martin Luther King, Jr., APA, 1967). Aloha.

“ONCE UPON A TIME NOT SO LONG AGO”

Pat DeLeon, PhD, MPH, former APA

President, March 2020

Indian Health Service (IHS) -- Reflections: Floyd Jennings is one of the first federal psychologists (Indian Health Service) to pursue the prescriptive authority (RxP) agenda. His experience was prior to the graduation US Navy officers Morgan Sammons and John Sexton from the Department of Defense (DOD) psychopharmacology training program on June 17th, 1994. It would be an understatement to suggest that Floyd's efforts in the 1980's upset his physician colleagues at the national level. A copy of his Santa Fe hospital's by-laws is one of the vivid remembrances of the RxP quest that I still possess from my days on The Hill.

“It was the spring of 1987 when I arrived in Santa Fe, New Mexico as the Director of Mental Health Services for 12 tribal communities in Northern New Mexico. After presenting myself to the center director, I sought out the medical director, Benjamin Whitehill, MD, an internist, and O-6 in the Commissioned Corps of the US Public Health Service. He advised me on our first meeting that ‘we are developing a protocol by which you will exercise prescriptive privileges for psychotropic drugs under supervision of the area psychiatrist – under standing orders from me.’ He added ‘no scheduled drugs... and we’ll need to develop a formulary.’ Somewhat stunned, I inquired ‘Why?’, and was told that ‘Simply because there is need: We have been unsuccessful in securing psychiatric consultants to go to the tribal communities.’

“Having been involved with a psychiatric colleague in conducting investigational drug studies for over a decade, I was accustomed to evaluating a patient's response to a pharmacological agent,

documenting side effects and titrating doses. But this was a new arena. Nonetheless, I contacted the State Board of Psychology and was advised that no standards then existed for evaluating the qualifications or ethical issues involved, as I would be functioning under the auspices and direction of a physician.

“Over the next year or more, I had 392 patient contacts, some 97 of which involved prescribing a psychotropic agent (though at the time there the drugs available were the phenothiazines, thiothixene, and haloperidol; and antidepressants including amitriptyline, doxepin and MAO inhibitors). Lithium was prescribed by the area psychiatrist upon my recommendation. Subsequent review of all cases revealed no adverse effects or medication errors.

“In an era where prescriptive privileges are sought as part of the expansion of the scope of practice for psychologists, and often bitterly fought by psychiatric physicians, it may be important to note that: * In the beginning, prescriptive privileges were not sought, they were offered. * Caring physicians were not opposed to such expansion of the scope of practice, they sought it, were supportive and made it possible. * The area psychiatrist, in my circumstance, reviewed each and every case. We spoke on the telephone often; he was encouraging and helpful. * Such collaboration made possible expanding not a profession so much as the provision of services to a needy and grateful community. And, * When information of our efforts came to the attention of the U.S. Senate and I was asked to testify, there was much furor, the practice was halted – for a period – and the Chief Psychiatrist for

PHS/IHS came to Headquarters West from Maryland, reviewed every case, and found no errors.”

Significant Present-Day Progress: Beth Rom-Rymer: “I am thrilled to announce that our Illinois Psychology Licensing Board credentialed our fourth prescribing psychologist, Jessica Ransom, on Friday, October 9th! Although we have faced many obstacles in our quest to license prescribing psychologists in the State of Illinois, the most recent roadblock appears to have been set aside! We expect to have another four or five prescribing psychologists licensed by year’s end, to total nine, with more than another 10 prescribing psychologist trainees applying for licensure in 2021. With Illinois undergraduates and graduate students beginning their training to become prescribing psychologists in their earliest academic years, our expectation is that we will have 1,000 active, prescribing psychologists in the State of Illinois by 2040, just about doubling the number of licensed, doctoral level mental health prescribers in our state. You can be sure that, as APA President, advocacy for training and credentialing of prescribing psychologists, as well as conducting empirical research on the effectiveness of the prescribing psychologist, will be top priorities for me and our Association. The best is yet to come!”

Our Critical Public Health Infrastructure: For over two decades, Rhea Farberman was the key for APA’s media and strategic communications with the public. Under her watch, APA had a significant presence during times of national emergencies including hurricane Katrina, the Sandy Hook shooting, and 9/11. Today she plays a similar role for Trust for America’s Health, a national health policy forum. This fall, the Trust released its Blueprint for the 2021 Administration and Congress

entitled: The Promise of Good Health for All: Transforming Public Health in America. “Everyone in America should have the opportunity to lead a healthy life. Every community should be free from threats to health and all individuals and families should have access to services that support health and well-being regardless of who they are or where they live. A strong public health system is the foundation that allows the nation to fulfill this goal.” The COVID-19 pandemic should make the importance of this abundantly clear to all of us.

Those colleagues invested in the RxP quest should constantly reflect upon the importance of serving society and particularly, those who are unable to receive the quality of care they deserve in a timely fashion. Collectively we should appreciate that economist Jeffrey Bauer estimates that by fully empowering non-physician providers, our nation could reduce health care costs by 32%, which would result in an average annual savings of \$155 billion.

In their report, the Trust emphasized that investing in across-the-life span prevention, particularly tailored for those population groups most at risk, will not only result in a healthier population, doing so will reduce the need for spending on healthcare and disability programs. Today, only three percent of the nation’s annual \$3.5 trillion in healthcare spending is directed toward public health and prevention; instead most healthcare spending is necessitated by preventable illness and injury. At the time of this publication, the COVID-19 pandemic had already resulted in over 200,000 deaths in our nation; approximately 20% of the worldwide death total. Certain identifiable populations, such as ethnic minorities, LGBTQ+, and the elderly are especially at risk. People of color have a shorter life expectancy of 10 years or more than whites in neighboring areas. The infant mortality rates among

Black infants and American Indian/Alaska Native infants are respectively 2.3 times and 2.0 times that of non-Hispanic white infants. We are currently experiencing the first downward life expectancy in U.S. history which is a phenomenon not seen in most other economically developed nations. Many of our Health Disparities, spanning generations, are the result of poverty, discrimination, and disinvestment in communities of color – all rooted in structural racism. The National Academies of Sciences, Engineering, and Medicine (NAEM) has made it clear that “Health inequities are the result of more than individual choice or random occurrence.”

Reflections -- Prior To The Affordable Care Act (ACA): On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into public law (P.L. 111-148). In light of the ever-ongoing discussions considering its repeal, it is important to reflect upon the Institute of Medicine (IOM) 2000 report America’s Health Care Safety Net: Intact but Endangered. “At a time of unprecedented prosperity and budget surpluses it seems almost out of style to focus on groups in our nation who fall outside the economic and medical mainstreams. These people include not only the country’s 44 million uninsured individuals but also an almost equal number of low-income underinsured individuals. Vulnerable populations extend as well to poor and disadvantaged individuals living in inner cities and isolated rural communities, minority and immigrant families, people with special health care needs, and low-income groups who face a variety of other financial and nonfinancial barriers to stable health care coverage.”

The relationship between health insurance and access to health care and medical outcomes has

been well documented with uninsured individuals being less likely to have a regular source of care, more likely to report delay in seeking care, and more likely to report that they have not received needed care. The uninsured may be up to three times more likely to experience adverse outcomes and four times as likely to require both avoidable hospitalizations and emergency hospital care. The health care safety net has historically served as a default system for these individuals. Failure to support this system could have a devastating impact, not only on the populations who depend upon them for care but also on other providers that rely on the safety net to care for patients whom they are unable or unwilling to serve. The IOM Committee concluded that even within the context of insurance reform, segments of America’s most disadvantaged populations will continue to rely on traditional safety net providers, not only because these may be the only providers available and accessible, but also because many of these providers are uniquely organized and oriented to the special needs of low-income and uninsured populations. One example would be Federally Qualified Community Health Centers (FQHCs), which continue to have a significant shortage of behavioral health care providers. “Woah, livin’ on a prayer” (Bon Jovi). Aloha.

PROFILES IN PRESCRIBING PSYCHOLOGY

COMFORT IS THE ENEMY OF ACHIEVEMENT

Brian M. Seavey, PsyD, MSCP

It has been said that comfort is the enemy of achievement and my conviction of this simple axiom formed the starting line for the marathon



that would eventuate in attaining my prescriptive privileges. I had been working as a clinical psychologist for several years, and while I enjoyed the daily rigors of traditional psychotherapy, I desired to identify new

ways in which to enhance my professional development and increase the thoroughness of my therapeutic efficacy.

After a stint in private practice, I took a position as a behavioral health consultant in a primary care clinic at Madigan Army Medical Center. This assignment facilitated the opportunity to interact with numerous medical practitioners and I was routinely queried about which psychotropic medications would be appropriate for a variety of psychiatric symptoms. In an effort to increase my knowledge base and clinical competence and enhance the quality of care provided to my patients, I began a rudimentary study of the intended effects, risks, and potential side effects of various psychotropic medications. It was also at that time that I had the tremendous fortune to meet Dr. David Shearer, a prescribing psychologist, whose guidance, psychopharmacological mentorship, and

journey toward RxP. The number of patients within the medical clinic who were prescribed psychotropic medication by their PCMs, and concurrently seen for brief therapy, elucidated the delicate, yet potentially synergistic dance between psychotherapy and psychopharmacology. Given this first-hand exposure to the potential harmony of this union, I researched and enrolled in the MSCP program at Fairleigh Dickinson University. A few years and a couple of job changes later I ended up working with active duty soldiers at a military installation in Colorado. Truth be told, when I took this position in 2014, I did not know if, or when, the opportunity to prescribe would ever materialize. Nevertheless, my mild, self-diagnosed OCD would not allow me truncate the goal of passing the PEP.

I am immensely grateful to the leadership within the Department of Behavioral Health and the parent hospital, under which they fall, for their openness to and support in helping me to establish supervision. The outpatient clinic psychiatrist, under whom I worked, generously gave of his time and knowledge and helped me to develop a much more comprehensive understanding of the subtle nuances of psychotropic medication management, challenged me to consider numerous psychopharmacological options, and highlighted the ultimate importance of maintaining comprehensive medical records. Once the PEP was successfully in the rear-view mirror, I was allowed to work under his supervision to complete my 100 patient /400 hour practicum. Working in an outpatient clinic provided access to clients with a diverse array of clinical presentations, encompassing a broad spectrum of therapeutic and psychopharmacological

needs. Following completion of the practicum, I chose to apply for psychologist licensure in Louisiana, after which I submitted for credentialing as a medical psychologist. The latter is governed through the state Board of Medicine. Finally, once those steps had been completed, I was allowed to apply for my DEA license.

I will not say that the road to becoming a prescribing psychologist has been easy, but as Elon Musk once said, "When something is important enough, you do it even if the odds are not in your favor." I feel tremendously appreciative of all of the people involved in Division 55 and those who continue to tirelessly bear the torch for the RxP movement and improve those odds on a daily basis. I look forward to the opportunity to play a role in these ongoing efforts.

AWARDS AND HONORS

THE 2020 PATRICK H. DELEON PRIZE FOR OUTSTANDING STUDENT CONTRIBUTIONS TO THE ADVANCEMENT OF PHARMACOTHERAPY

Derek Phillips, PsyD, MSCP, Division

55 President, Letter of Acceptance

My journey with the RxP movement began in summer 2010 when, as a 1st year doctoral student at Adler

University in Chicago, I was placed at the Illinois



Psychological Association (IPA) for my 200-hour community service practicum. This practicum was required of all first-year students and was a way for students to give back to

the communities in the Chicagoland area by assisting various organizations with advocacy, program evaluation, program development, etc. before beginning clinical training. As I mentioned, I was placed at the IPA headquarters in Chicago's Loop, at the time around the block from Adler's campus, where I was assigned to grassroots advocacy work for IPA's ongoing legislative push to pass RxP legislation in Illinois, which included being a part of IPA's Legislative Committee and RxP Subcommittee. Not only did I thoroughly enjoy my practicum because of those with whom I worked, but I also found that prescriptive authority just "made sense" to me. From that point on, I knew it would be a large part of my professional future; however, I could have never anticipated the extent to which it would mold me as an advocate, leader, and professional psychologist. In fact, I was elected as the student representative to the

my first foray into RxP-related leadership.

Fast forward four years to summer 2014 when the Illinois General Assembly passed a bill that amended the Illinois Clinical Psychologist Licensing Act to establish a license for prescribing psychologists for those who complete additional education and training in clinical psychopharmacology at either the predoctoral or postdoctoral level. The bill was signed into law shortly thereafter by then-Governor Pat Quinn. At this exciting time in Illinois, I moved from Chicago to central Florida to complete my clinical psychology internship and clinical neuropsychology fellowship. During my 3 years in Florida, I was a member of the Florida Psychological Association's (FPA) RxP Committee, as Florida psychologists were beginning their journey toward making prescriptive authority for psychologists the law of the land. Although Florida has not yet passed an RxP bill, it has made major strides toward doing so with impressive victories in multiple committees. In 2015 and 2016, I served as a member of the APA Practice Organization's Committee for the Advancement of Professional Practice (CAPP), including as a member of the RxP Subcommittee that oversaw awarding grants to state psychological associations who were pursuing RxP.

In 2017, as my postdoctoral fellowship was coming to a close, I decided to apply to Fairleigh Dickinson University's M.S. in clinical psychopharmacology (MSCP) program based upon the recommendation of several colleagues who are FDU alumni. After being accepted into this program, I applied for and was ultimately a 2017 recipient of the Walter Katkovsky Scholarship for Psychopharmacology Training from the American Psychological

Foundation. Also in 2017, I was elected as a Member-at-Large on the Division 55 Board of Directors. I served in this capacity for 1 year before being appointed to serve as the Division's representative to the APA Council, which I did from 2018-2019.

As I began the FDU program in fall 2017, I returned to my native east central Illinois after accepting an offer to work as a clinical neuropsychologist in the Department of Neurology at Sarah Bush Lincoln Health Center (SBLHC), with the goal of becoming a licensed prescribing psychologist in the future. SBLHC is a 145-bed, non-profit, acute-care regional hospital serving 10 rural counties in east central Illinois, all of which are designated as mental health shortage areas. I completed FDU's MSCP program in fall 2019, at which time I was asked to become Director of the MSCP program, which I accepted, and then began in July 2020. Additionally, I passed the PEP and began my prescribing psychology residency in January 2020.

The specific requirements to become a prescribing psychologist in Illinois are reviewed next. I have completed them all, with the exception of the residency, which I am in now, and expect to complete in mid-2021.

Specifically, the required education includes undergraduate biomedical coursework (medical terminology, biology, microbiology, chemistry, and anatomy & physiology), as well as completion of a graduate program in clinical psychopharmacology, most commonly a Master of Science in clinical psychopharmacology (MSCP) degree. Additionally, individuals who wish to become a licensed prescribing psychologist in Illinois must pass the Psychopharmacology Examination for Psychologists (PEP), which is administered and maintained by the

Association for State and Provincial Psychology Boards (ASPPB). Finally, prospective prescribing psychologists must complete a prescribing psychology residency of 1,620 hours in which they complete rotations in 9 medical specialties (family medicine, psychiatry, pediatrics, obstetrics/gynecology, geriatrics, emergency medicine, surgery, internal medicine, and one elective) over the course of at least 14 months, and a research project.

In early 2020, I was elected as a member of the Illinois Association of Prescribing Psychologists Board of Directors, which has been a great honor as the Board works tirelessly to continue to implement Illinois' RxP statute. More generally, the prescribing/medical psychology movement enjoyed a major milestone in 2020! At its August 2020 meeting, the APA Council of Representatives voted to recognize "clinical psychopharmacology" as a specialty within psychology, as it has for other specialties like clinical neuropsychology, clinical health psychology, clinical psychology, etc. Future endeavors include applying to create a clinical psychopharmacology specialty board within the American Board of Professional Psychology (ABPP) and applying to become a member of the Council of Chairs of Training Councils (CCTC) to formally represent clinical psychopharmacology training programs among other psychology specialties.

On a more personal note, and the main reason I am writing to you, I was awarded the 2020 Patrick H. DeLeon Prize for Outstanding Student Contributions to the Advancement of Pharmacotherapy by Division 55 at its annual business meeting at the virtual APA Convention in August, just a couple of days after clinical psychopharmacology was formally approved as an APA-recognized specialty. Talk about an exciting few days! As if that were not enough, I

am also extremely proud to serve as your 2020 Division 55 President and very much look forward to representing you and leading the Division and the Division 55 of the American Psychological Association, was created to enhance psychological treatments combined with psychopharmacological medications.

OUR MISSION

Division 55 of the American Psychological Association, was created to enhance psychological treatments combined with psychopharmacological medications.

The division promotes the public interest by working for the establishment of high quality statutory and regulatory standards for psychological care. Division 55 encourages the collaborative practice of psychological and pharmacological treatments with other health professions. The division seeks funding for training in psycho-pharmacology and pharmacotherapy from private and public sources such as federal Graduate Medical Education programs. Division 55 facilitates increased access to improved mental health services in federal and state demonstration projects using psychologists trained in psychopharmacology.

TRIBUTES

John Preston, Psy.D., a huge contributor to the literature in psychopharmacology, a mentor to many, and a terrific teacher to countless psychologists, passed away in December 2020. He was the author or co-



author of twenty-two books on various topics including psychopharmacology, psychological assessment, neurobiology and psychotherapy. His books have been translated into 14 foreign languages. He was in clinical practice for 38 years and a workshop presenter for 27 years. He lectured in many locations throughout the North America, as well as in Africa, Europe and Russia. He will be greatly missed. The Division 55 Listserv was full of tributes to him after news of his passing was reported; a testament to his impact on so many. George Kapalka, PhD, MS, ABPP wrote the following remembrance.

I was privileged to be among the students in Prescribing Psychologists' Register's RxP training program in the mid to late 1990 and early 2000's. John Preston taught several of the courses. When I started, my medical background was limited, and I found some of the material quite intimidating. But John's teaching style was filled with clarity, organization and approachability that made complex concepts seem comprehensible. The more I attended the classes, the more I started to feel, "I can get this!" and that was largely because of John's teaching. Similarly, his writings are go-to references in the field, for their rare combination of comprehensiveness in

content and directness and lucidity in presentation. Indeed, John's style is one I since try to emulate (but, I am sure, never equaled) when I lecture about and teach psychopharmacology, and I often use his writings as resources and references. I'm not unique - he is a role model for many teachers. His impact on RxP, through his teachings and writings, is very significant, and will be felt for decades to come. On a personal level, I did not know John well, but I ran into him on a few occasions, and we chatted over coffee, lunch or dinner. I found him deep and thoughtful but always warm, approachable and collegial. On one occasion I had the opportunity to tell him how influential his teaching was over so many of his students. I could tell he was moved. He will greatly be missed by many of us fortunate enough to have been trained by him along our RxP journeys. George M. Kapalka, PhD, MS, ABPP

BOOK REVIEW: THE HANDBOOK OF CLINICAL PSYCHOPHARMACOLOGY FOR THERAPISTS

Review by Lynette A. Pujol, PhD, MSCP

Preston, J. D., O'Neal, J. H., Talaga, M. C., & Moore, B. A. (2021). *Handbook of clinical psychopharmacology for therapist (9th ed)*. New Harbinger Publications, Inc.

The American philosopher and psychologist William James said, "The great use of life is to spend it for something that will outlast it."

With the recently published *Handbook of Psychopharmacology for Therapists* (2021), now in



its 9th edition, the legacy of the late John D. Preston, Psy.D., ABPP endures. Familiar co-authors, John H. O'Neal, M.D. and Mary C. Talaga, RPh, Ph.D., are joined by Bret A. Moore, Ph.D., ABPP,

maintaining an impressive panel of expert authors.

The Handbook is marketed and widely used as a resource for mental health professionals and as a textbook for students in graduate training programs in psychology, social work, psychiatric nursing and counseling. It contains sufficient depth to be used as an introductory textbook for non-prescribers, to include sections on neuroanatomy, pharmacodynamics and pharmacokinetics, and proposed biologic bases of disorders. It also contains sufficient breadth to be

used as a resource for mental health practitioners who need to reference information on pharmacotherapy prescribed to their clientele. The authors obtain the lofty goal of creating a reference resource and text for a broad audience by clearly presenting complicated concepts. The book is organized into three sections with chapters covering the basics of psychopharmacology, the etiology, diagnosis and treatment of clinical syndromes (e.g., anxiety disorders, depressive disorders), and medications. New in this version are chapters on sleep-wake disorders and miscellaneous disorders (e.g., ADHD, cognitive disorders, and obesity to name a few), as well as updates in substance use disorders, child and adolescent psychopharmacology, and treating patients who are pregnant or breastfeeding.

Readers of previous versions will likely be pleased that the book retains its succinct writing style and practical approach. It is visually appealing with sidebars, diagrams, and boxed information. Coverage of a few topics may be pithier than a reader may desire (e.g., chronic pain has one short paragraph), but those topics are few, and even then, the most relevant psychopharmacologic treatments are included. Short case examples in each section bring treatment issues to life. Moreover, the book is replete with charts, which users will find helpful in day-to-day practice. Chapters on integrative models, medication nonadherence, medication discontinuation, and red flags to watch for are especially welcome information not usually covered in other resources.

Although the Handbook is likely not sufficient for prescribers as a sole reference, it is valuable as a quick resource for dosing, side-effects and common drug interactions. Additionally, it contains bottom-line recommendations based on clinical guidelines in areas where the practitioner may not be an expert, such as in a special population. Tables that synthesize material found in densely written textbooks will be beneficial for prescribers and MSCP students learning psychopharmacology for the PEP and for practice. I enjoyed to go when the right (research-based) answer is needed quickly. As the psychopharmacology community mourns the loss of Dr. John Preston, it can be confident that this book will a lasting tribute to his legacy.

RESEARCH REVIEW: COMPARING PSYCHOPHARMACOLOGICAL PRESCRIBER TRAINING MODELS VIA EXAMINATION OF CONTENT-BASED KNOWLEDGE

**Reported by David Shearer,
PhD, MSCP**

Ryan R. Coopers' Harvard University master's degree thesis, *Comparing Psychopharmacological Prescriber Training Models via Examination of Content-Based Knowledge*, was published online in November 2020. Cooper has



made a substantial contribution to the research literature on prescribing psychology with this work. The scholarship and attention to detail, both in how this study was conceived and conducted, are worthy of his alma mater. In his thesis, Cooper

describes the two main approaches that defenders of prescribing psychology have used to address opponents' criticism of RxP training; namely, curricular training comparisons and ratings/reviews by colleagues or other professionals. While these have been helpful approaches, Cooper points out that they "...do not provide data on the content knowledge of the prescribing psychologist compared to other prescribers" (pg 14).

The purpose of his study was to provide this comparison. Sixty-six participants took a test developed to assess psychopharmacologic knowledge. Cooper developed an online exam of content knowledge consisting of 25 questions. The questions were vetted by a practicing psychiatrist and efforts were made to avoid developing a test that did not give unfair advantage to one group over

medication were used" (pg 21). The author assessed each prescriber's basic competence using this test of content-based knowledge. The participants included in the study were non-psychiatric physicians, psychiatric physicians, non-psychiatric family nurse practitioners, psychiatric nurse practitioners, non-prescribing (or general) psychologists, and prescribing psychologist.

Prescribing psychologists' scores fell in between those of psychiatrists and psychiatric nurse practitioners with the psychiatrists performing best. However, there were no statistical differences in performance amongst these three groups. Cooper reveals that those who prescribe the greatest number of psychiatric medications, namely non-psychiatric physicians and non-psychiatric nurse practitioners, did significantly more poorly on the exam than the three psychiatric prescribers (psychiatrists, psychiatric nurse practitioners, and prescribing psychologists). Finally, general psychologists did significantly worse than prescribing psychologists on the test.

This study provides strong evidence that prescribing psychologists' competency in psychopharmacologic knowledge is a result of their postdoctoral training in psychopharmacology. In sum, Cooper's study provides compelling evidence of prescribing psychologists' competence and established a new line of research to measure that competence. (Follow this link for the original article: <https://nrs.harvard.edu/URN-3:HUL.INSTREPOS:37365636>)

Citation: Cooper, Ryan R. 2020. Comparing Psychopharmacological Prescriber Training Models via Examination of Content-Based Knowledge. Master's thesis, Harvard Extension School.

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FLUVOXAMINE MAY PREVENT SERIOUS ILLNESS IN COVID-19 PATIENTS

Review by Alan Dubro, PhD,

MSCP

Coronavirus disease 2019 (COVID-19), caused by infection with the novel severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), can result in serious illness leading to hospitalization, intensive care unit admission, and death. Further evidence suggested that lung damage from COVID-19 was related to an excessive inflammatory response. A potential mechanism for immune modulation is σ -1 receptor (S1R) agonism. Fluvoxamine (Luvox), a selective serotonin reuptake inhibitor (SSRI) has a high affinity for S1R. Potentially, fluvoxamine, given as early treatment in individuals with mild COVID-19 illness, may prevent clinical deterioration.

This hypothesis was initially assessed in a randomized clinical trial (fluvoxamine vs. placebo) E. Lenze et al. 2020). This was a double-blind, placebo-controlled, randomized clinical trial that compared fluvoxamine with placebo in adult outpatients with confirmed SARS-CoV-2 infection. Participants were recruited via electronic health records, physician and other health professional referrals, study advertisements near COVID-19 testing centers and in emergency departments, referrals by colleagues, a study website, and communication in local television and newspapers. Study supplies were delivered to self-quarantined study patients as a package left at their door and the study materials consisted of the study medication, an oxygen saturation monitor, an automated blood pressure monitor, and a thermometer. All data collection was done by twice-daily surveys sent to patients via email, with phone-based data collection as backup to

ensure that individuals without internet access were able to participate. The surveys recorded oxygen saturation, vital signs, medication adherence, and COVID-19 symptoms. Exclusion criteria included having COVID-19 that required hospitalization or evidence of the primary end point with oxygen saturation less than 92% on room air at the time of randomization. Randomization schedules were generated that stratified by age (18-44, 45-54, 55-64, and ≥ 65 years) and sex. All outcome assessors, investigators, and research staff who were in contact with participants were blinded to participant treatment assignment.

Participants received a dose of 50 mg of fluvoxamine (or matching placebo) in the evening immediately after the baseline assessment and confirmation of eligibility, then for 2 days at a dose of 100 mg twice daily as tolerated, and then increasing to a dose of 100 mg 3 times daily as tolerated through day 15 then stopped. Of 1337 patients screened, 834 (62%) were excluded, 322 (24%) were contacted and declined participation, and 181 (14%) were randomized and provided with study materials. One hundred fifty-two participants completed the study.

Clinical deterioration occurred in 0 of 80 patients in the fluvoxamine group and in 6 of 72 (8.3%) patients in the placebo group. In the placebo group, cases of clinical deterioration ranged from 1 to 7 days after randomization and from 3 to 12 days after the onset of COVID-19 symptoms. Four of 6 patients were hospitalized for COVID-19 illness, with the length of stay ranging from 4 to 21 days. One patient required mechanical ventilation for 10 days.

Based on the results of this study Seftel et al. (2021), reported a real-world experience using fluvoxamine for coronavirus disease 19 (COVID-19) in a prospective cohort in the setting of a mass outbreak. Overall, 65 persons opted to receive fluvoxamine 50mg twice daily and 48 declined. Incidence of hospitalization was 0% (0/65) with fluvoxamine and 12.5% (6/48) with observation alone. At 14 days, residual symptoms persisted in 0% (0/65) with fluvoxamine and 60% (29/48) with observation.

The potential advantages of fluvoxamine for outpatient treatment of COVID-19 include its safety, widespread availability, low cost, and oral administration.

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DIVISION 55 NEWS

A NAME CHANGE FOR DIVISION 55

In accordance with Association Rule 100-3 DIVISION NAME CHANGE, divisions and members of the Council of Representatives are hereby notified that the Executive Committee of APA Division 55, American Society for the Advancement of Pharmacotherapy, has proposed a change of name to its membership. If adopted by the membership, the new name will be Society for Prescribing Psychology.

APA SPECIALTY DESIGNATION FOR CLINICAL PSYCHOPHARMACOLOGY APPROVED

Division 55's petition to recognize Clinical Psychopharmacology as an APA specialty was approved by the APA Council of Representatives in August 2020 for an initial recognition period of 7 years.

BLUE CROSS OF ILLINOIS RECOGNIZES PRESCRIBING PSYCHOLOGISTS

Dr. Beth Rom-Rymer reports: Along with my wonderful colleague and Division 55 President, Dr. Derek Phillips, I am happy to announce that our colleagues in the Illinois Psychological Association and the Illinois Association of Prescribing Psychologists worked together to achieve recognition of Prescribing Psychologists by our largest state commercial insurer, Blue Cross Blue Shield of Illinois. In particular, Dr. Patricia Farrell, Chair of the Health Care Reimbursement Committee, of the IPA, spent endless hours persuading BCBS executives to add the prescribing psychologist code (094) to the BCBS list of clinicians who can be providers for BCBS. The Illinois Association of Prescribing Psychologists is now working to increase reimbursement rates for prescribing psychologists, reflective of our hard-earned expertise.

ILLINOIS ADDS MORE ACTIVE PRESCRIBING PSYCHOLOGISTS TO THEIR WORKFORCE

According to the latest report the state of Illinois now has 8 credentialed prescribing psychologists.

MANY STATES CONTINUE TO ADVOCATE FOR PRESCRIPTIVE AUTHORITY including Arizona, Colorado, Florida, Hawaii, Nebraska, Pennsylvania, Texas, Vermont, and Washington.

DIV 55 LAUNCHES A CURBSIDE CONSULTATION SERIES

In an attempt to increase the value and benefits of membership in Division 55, leadership (Board of Directors) decided to develop a case conference that taps into the wide range of expertise and various practice specialties of our members. Selected experts were approached based on their current practice in prescribing psychology to see if they would be willing to volunteer for a case conference in a format of their choosing. Options included presenting in a Grand Rounds format, a didactic with Q&A, or an opportunity for participants to bring specific questions about cases they are working on. The goal is to have these up to 10 times per year, monthly with July/August off. The past and upcoming presenters and topics can be seen below. Don't forget to put future dates on your calendar...you won't want to miss this opportunity!

Past Case Conferences

- September 2020: Dr. Alan Ostby
- October 2020: Christina Vento, PsyD, ABMP, MACP
- November 2020: Sam Dutton Ph.D. MSCP
- December 2020: Marlin C Hoover, PhD, MSCP, ABPP-CL
- January 2021: Bret A. Moore, Psy.D., ABPP

- February 2021: Anthony P. Tranchita, PhD, MSCP Treatment of Methamphetamine Users
- March 2021 David Shearer, PhD, MSCP Treatment of the Psychiatric Symptoms of Huntington’s Disease

authority within the Department of Veterans Affairs, which we have recently advocated for in testimony for the record to Congress as well as regulatory comments to VA.” Sophie can be reached at sfriedl@apa.org.

Upcoming Case Conferences:

- April 18, 2021 3pm PCT/6pm EST; Julie Myers, PsyD, MSCP & Alexander Papp, MD ABPN
- May 16, 2021 3pm PCT/6pm EST; Julie Myers, PsyD, MSCP & Alexander Papp, MD ABPN
- TBD Ruth Roa-Navarrete, PsyD MSCP

SOPHIE FRIEDL, MPH, IS THE NEW DIRECTOR OF MILITARY AND VETERAN’S HEALTH POLICY AT APA



Sophie Friedl started the position at APA on August 3rd, 2020, after working as a Professional Staff Member on the Senate Committee on Veterans’ Affairs for Sen. Jon Tester (D-Mont.). She describes her work as follows: “I handle APA’s Advocacy work in the military and veteran health space. I handle all VA issues – psychologist practice in VA, VA research, and VA’s psychologist training program – as well as DoD issues relating to health – TRICARE network adequacy, health research and training. In that capacity, I work with members of Congress and VA staff to advocate on issues of importance to APA and psychologists. One of those issues is prescribing

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RECENT PUBLICATIONS BY DIVISION 55 MEMBERS

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McGrath, R. E. (2020). What is the right amount of training? Response to Robiner et al. *Clinical Psychology: Science and Practice*, 27(1), e12315. <https://doi.org/10.1111/cpsp.12315>

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Preston, J.D., O'Neal, J.H., Talaga, M.C., and Moore, B.A. (2021). *Child and Adolescent Clinical Psychopharmacology Made Simple, 4th Edition*: New Harbinger's Publications, Inc., Oakland, CA.

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Shearer, D.S., Pujol, L., & Moore, B.A. (expected 2021). Prescribing psychologists in the Army: Primary care integration and tele-psychopharmacology. In B. Rom-Rymer (Ed). *Prescribing psychologists in the military: History, regulations, and cutting-edge practice*.

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Kothadia, R.J., Krause, M., and Atezaz Saeed, S. (2021) *Current Psychiatry*, 20 (01):33-38. doi:10.12788/cp.0078.

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