

THE TABLET

2026 SPRING EDITION

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TO JUMP TO SECTIONS

Table of Contents

Letter from Editor: <i>Richard Sylvester</i>	1
Legislative and Social Action Committee (LASAC) report: <i>Judi Steinman</i>	2
President's Column: <i>Elizabeth Lonning</i>	4
Legislative Update: <i>Pat DeLeon</i>	7
"A Day in the Life" of <i>Dr. Anna Wegierek</i>	12
Behavioral Strategies for Apathy and Late Life Depression by <i>Jaime Wilson</i>	14
The Unsurprising Connection Between Clinical Psychology* and Prescriptive Authority by <i>Sheldon Lewkis</i>	19
Division 55 Makes History: The ABRxP Story	23
And then there were 8!: <i>Rick Barnett</i>	29
"Shining a Spotlight on RxP" featuring <i>Dr. Jax Gallios</i>	30
Celebration of Life for Dr. Joseph Hirsch: <i>Thomas Kozak</i>	41
Important Calander Events	44
Board Member Elections	47
Contact Information	50

Letter from the Editor in Chief



RICHARD SYLVESTER, PHD, MS CP

I hope you enjoy history, because if you're reading this, you are part of it. One more state has enacted legislation granting prescriptive authority to psychologists. Another is on the cusp of doing so. That is remarkable, and I extend my most heartfelt thanks to the many hardworking individuals who have worked tirelessly to make it happen. That said, there is still much work to be done.

In this issue, I'd like to highlight a couple of individuals who are on the front lines of practice and research. We are introducing two new columns that I hope will become popular enough to return in future issues.



"A DAY IN THE LIFE"

features Dr. Anna Maria Wegierek. This column aims to capture both personal and practical experiences in applied clinical work. Dr. Wegierek shares valuable insight and wisdom on communicating with patients and removing barriers to treatment progress.



"SHINING A SPOTLIGHT ON RXP"

features Dr. Jacqueline Marie Gallios. Dr. Gallios is a highly active advocate for RxP, having published four articles on the topic within the past year, with a book forthcoming. Her hard work and dedication to advancing awareness of RxP are greatly appreciated.

If you would like to submit your own *"A Day in the Life"* or *"Shining a Spotlight on RxP"* column for a future issue of The Tablet, please email me at RSylvesterJr@gmail.com.

“What an exciting year 2026 has turned into for RxP!”

Judi Steinman, PhD



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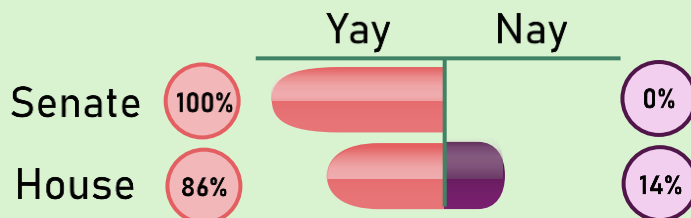
everal states began with RxP bills and many Division 55 members helped support them in seeking Prescriptive Authority for Psychologists. Maryland and Tennessee had hearings in 2026, a significant step towards building relationships with legislators that will lead to RxP in the future.

Vermont’s Rick Barnett has certainly paid his dues over the last decade to make VT the eighth state to pass RxP legislation. Kudos to Rick, a past president of Division 55, for his perseverance and fortitude throughout the process. As Pat DeLeon has said many times, paraphrasing Jim Quinlan, a past RxP pioneer of blessed memory, “If we don’t quit, we win.” You can read more about VT’s success later in this issue.

As I write, Hawai`i is on the cusp of passing a unique RxP bill, a three-year pilot study which allows psychologists to practice under the supervision of a physician or psychiatrist at Federally Qualified Health Centers on the islands of

Kaua`i and Hawai`i. The only restriction to the formulary is that opioids cannot be prescribed. There is an age limit for patients (18-65 years of age).

The bill was heard by four committees – health and consumer protection for both House and Senate – and had been whittled down to being able to prescribe SSRIs and SNRIs only. Fortunately, House Health Chair Joy SanBuenaventura worked out the final version of the bill in conference committee, and it passed with the final floor votes:



The bill awaits Governor Josh Green’s signature. He has until June 30th to provide a list of all bills that he plans to veto and until July 15th to sign the bill into law. Any non-vetoed bill becomes law on July 16th whether or not he signs it.

Our success in Hawai'i this round has as much to do with the team of people who rallied together to make calls, write letters, create educational materials, testify live, and attend meetings. Alex Lichton, chair of the Hawai'i Psychological Association's Legislative Action Committee provided stability, continued outreach and stewardship throughout the year. The HPA lobbyist made major contributions to our strategy and outreach endeavors. Members of our RxP team who are also part of Division 55 include Sarah Emma Thompson, Andrew May, Sam Dutton, Nancy Sidun and Larry James. Daniel Baon (the division's incoming student representative), Teresa Jaurez (our current student representative), Rachel Domgaard and Charlotte Savage were all new to the legislative process and helped with infographics, reaching out to members for support and submitting testimony. Last, but definitely not least, is Kathleen McNamara, who returned to advocating for RxP in Hawai'i and was pivotal in making connections with local residents and

legislators alike. Kathleen had been involved in RxP efforts when they started in the 1980s and I am so proud to have been able to collaborate with her on our most current (and hopefully last) effort to successfully bring RxP to the islands.

We hope that you consider joining the Division's Legislative and Social Action Committee (LASAC) as individual states forge ahead to bring RxP to your state. Some of the many ways that we can help you are to provide materials for educating your state association members as well as legislators. We can provide resources for webinars or presentations at your state convention. We can help you avoid reinventing the wheel when it comes to addressing longstanding yet unsubstantiated criticisms against RxP. This committee was created specifically so that we can work together to make RxP a possibility for the future.

Mahalo,

Judi



President's Column

Elizabeth (Bethe) Lonning, Ph.D.



I want to provide you with an update on what has been happening in the Division and with RxP.

*L*et's start with legislation. Many states including Vermont, Maryland, Hawaii, Tennessee and Pennsylvania put forth legislation this year. At the time of this writing, Hawaii, Vermont and Pennsylvania are still active. Maryland had a bill introduced that did not move during the session---this is the first attempt in the state and having a bill introduced is absolute progress! Tennessee also had legislation that did not move through the process but made significant strides in their efforts. Although there is certainly disappointment when legislation doesn't end in passage of a law allowing prescriptive authority for psychologists, any movement is positive and I hope

A decorative floral border surrounds the central text box. It features various colorful flowers including tulips, daisies, and smaller blossoms in shades of purple, blue, yellow, and pink, with green leaves and stems.

HELLO
&
Welcome
to the 2nd
quarter of
2026

those leading the charge in Maryland and Tennessee will decide to continue the effort. I am sure all of you have seen emails on the listserv to assist states in their efforts and I hope when/if Vermont, Hawaii or Pennsylvania need anything from us, that we will again respond to their call. It would be great to get states 8, 9, and 10 this year!

An update on the Board and committee chairs---as I mentioned in my December writing, we have new people involved in co-chair positions which is fantastic. We also have a new Federal Committee Chair. Dr. Tim Pagano needed to resign his position and Dr. Sydney Hoover was very willing to take on the responsibility when asked. In addition, I am continuing to work with the Members-At-Large to increase their role and have them be the connection between membership and the Board. Of course, members may contact any Board member at any time about concerns or issues they would like to call to the Board's attention.



Our Membership Chair, Dr. Eric Silk presents us with information about membership at each Board meeting. Currently, there are many folks who have not renewed their membership--if you know of someone, please encourage them to renew.



Our Continuing Education (CE) Chair, Dr. Daniel Lee is working hard to bring CE to our Division in the near future. We have formed a partnership with TPN to provide a platform for the CE presentations and Dr. Lee is in the process of connecting with folks who have offered to provide CE so sessions can be scheduled. If you have a subject matter you would like to present, please contact Dr. Lee.

We continue to work on the Specialty Petition Renewal. We have met with our consultant and have a timeline to provide us guidance. We hope to make significant progress

with writing the petition sections by the end of this year. If you are interested in assisting with this process, please contact me as! there is room for you!

APA is in Washington DC this year and registration opens April 22, 2026. Our convention chairs, Drs. Alyssa Cunningham and Peter Smith, have done excellent work getting our Division ready for August! All presentations have been reviewed, presenters have been notified of their acceptance, and the proposed schedule has been submitted to APA for approval. In addition, a site for our social has been reserved. I hope to see many of you at our session presentations and at the social!

As usual, there are many good ideas presented and discussed on the listerv regarding what the Division should be doing or projects to take on. To act on these ideas, the Division needs resources--both financial and 'people'. Please consider donating to the Division (it is easy to do via our website) and donating your time to a project for the Division.

We need *all of us* to make progress to meet

our
MISSION



Thank You
for being
part of
Division 55

Click here to
Join Today



“

BACK IN 1958 WE DROVE AN OLD V8. AND
WHEN IT'D GONE A HUNDRED THOU' WE
GOT OUT AND PUSHED IT A MILE

”

Pat DeLeon

Former APA President

Addressing the Unique Challenges and Opportunities of Rural America:

I had the distinct pleasure of serving on the APA Board of Directors when then-President Jack Wiggins established his 1992 Presidential Task Force on Rural Health, which in 1996 officially became the APA Committee on Rural Health. Council Representative Ron Brown reports that in February the Council of Representatives, by a vote of 166-0, with one abstention, approved a policy to acknowledge the unique challenges faced by rural communities and increase support for policies and adequate funding for programs to increase access to mental health care in rural communities. The new policy also advocates for expanding services to increase safe housing, food access, support for youth in juvenile justice and child protective systems, resources on

domestic and intimate partner violence, maternal mental health care, elder abuse prevention and response, and suicide prevention, to help rural communities contend with unique structural and economic disadvantages.

Ron further reported that APA President Wendi Williams presented a Presidential Citation to members of the APA Rural Health Caucus, the Committee on Rural Health, the Division 31 Rural Health Section, and all psychologists leading in advocacy for rural communities, for strengthening rural behavioral health systems by addressing the challenges created by workforce shortages, geographic isolation, and limited infrastructure.

Interestingly, in enacting the Consolidate Appropriations Act, 2026 [P.L.119-75] the U.S. Senate echoed psychology's efforts: "Graduate Psychology Education [GPE] – the Committee includes \$25,000,000 for the inter-professional GPE program to increase the number of health

service psychologists trained to provide integrated services to high-need, high-demand populations in rural and urban communities. The Committee recognizes the growing need for highly trained mental and behavioral health professionals to deliver evidence-based behavioral interventions for pain management in addressing the opioid epidemic. The Committee also notes continued mental health needs among youth and adolescents and urges HRSA to strengthen investments in the training of health service psychologists to help meet these demands.”

At the 2026 Practice and SPTA Leadership Conference, rural advocate Diana Prescott opined that as a psychologist from a farming background, these annual gatherings in particular provided a comfortable APA home with so many rural-related efforts. “Whereas Maine is often regarded as a state with little diversity, we do host an amazing amount of diversity that may not be readily apparent. For example, there is a large native population indigenous to the state and it is not unusual to encounter French-speaking Mainers with Canadian roots. Many years ago, I started a breakfast meeting with our women psychologist members, many of whom said they felt isolated. I am pleased that these have continued and

have been one important source of support for women practicing in Maine.

“Our rural psychologists often drive long distances to reach meetings and obtain continuing education. Attending these can help rural psychologists feel more connected in their work life. Simple e-mail relationships and consultation with other colleagues helps with professional isolation. Dual roles are often encountered by the rural psychologist. Dual roles are not always bad and can sometime enhance the therapeutic relationship. However, it is important to have colleagues with whom these issues can be discussed (e.g., consultation group). For example, a staff member who has a client deliver her baby or the parent of a client buying her home. For those persons from rural communities, it is important not to assume understanding. I believe it is important to respectfully try to learn about the particular rural community, as they vary greatly, even within regions. State psychological associations can assist practicing psychologists by helping connect those who want to work in rural communities with others who are experienced working in rural settings for mentorship.”

Increasing Categories of Behavioral Health Providers – Potentially a National Trend?

Brad Potts has been carefully monitoring the development of a new category of behavioral health care provider in Ohio,

primarily sponsored by the medical establishment. "The Ohio legislature formally established a new type of mental health professional: the Certified Mental Health Assistant (CMHA). CMHAs will provide mental health care under the supervision, control, and direction of a physician with whom they have a supervision agreement."

The Services they may perform include:

-  Ordering diagnostic, therapeutic, & other medical services as appropriate, based on the patient's diagnosis made by the supervising physician
-  Ordering, prescribing, furnishing/administering drugs & authorized medical devices
-  Ordering or referring patients to occupational therapy, if related to their diagnosis
-  Referring patients to emergency medical services for acute safety concerns, with prompt consultation with the supervising physician
-  Providing telehealth services in accordance with applicable law

"The CMHA may delegate tasks to implement a patient's care plan as long as he/she is physically present and possesses physician-delegated prescriptive authority for any drugs. The new statute prohibits CMHAs from Making initial diagnoses; Treating patients for diagnoses not found in the DSM or designated by the Medical Board; and Engaging in

electroconvulsive therapy, transcranial magnetic stimulation, or other invasive interventions as defined by Medical Board rules. CMHA applicants must hold a bachelor's degree and a CMHA diploma from an accredited medical or osteopathic medical school. Licenses are valid for two years and require CE in pharmacology. The detailed CMHA education program includes basic behavioral health counseling and can be completed with 30 credit hours of graduate coursework, the majority of which do not differ significantly from psychology's MSCP program requirements."

Unanticipated Support for Mental Health:

The National Academies of Sciences, Engineering and Medicine (NASEM) recently released Mental Health, Suicide Prevention, and Addiction Mitigation in Construction and Maintenance (2026). This report was sponsored by the American Association of State Highway and Transportation Officials in cooperation with the Federal Highway Administration. Both of these are definitely outside of our traditional expectations for support of mental health care. Highlights of their 50 state and D.C. Department of Transportation (DOT) survey confirmed that our nation is facing a behavioral health/mental health crisis and one that is rarely, if ever, considered by healthcare systems: "Mental health challenges, suicide risk, and substance use disorders continue to affect workers in the transportation

construction, and maintenance sectors at disproportionate rates. With the construction industry consistently reporting higher than average rates of suicide and drug use, state departments of transportation (DOTs) are increasingly being called on to implement programs that promote psychological wellbeing and address behavioral health challenges. However, these efforts remain inconsistent across agencies, and guidance tailored to the unique needs of the DOT workforce is limited.”

From their literature review, it was evident that although awareness of mental health concerns in the construction and transportation sectors is growing, DOT specific documentation and research remain sparse. Most efforts are part of larger state-run Employee Assistance Programs (EAPs) or workforce wellbeing initiatives, with few tailored interventions focusing on suicide prevention or substance misuse among field staff. The majority of state DOTs (about 87%) provide at least some mental health or wellbeing support, most commonly through EAPs, health and wellness communications, or general employee training. However, dedicated initiatives for suicide prevention or addiction mitigation are less common. Agencies reported challenges in reaching field-based employees,

securing leadership buy-in, and addressing the stigma of mental health. Most DOTs (about 92%) also lack performance tracking mechanisms or formal evaluation frameworks for mental health initiatives.

Few agencies have programs tailored specifically to field crews or construction workers, where mental health risks are often the highest. Suicide prevention was less commonly addressed as a stand-alone topic, and substance use interventions tended to focus on compliance with federal requirements for substance abuse programs rather than holistic support. Approximately 16.5% of construction workers report heavy drinking; 11.6% report illicit drug use; and 14.3% experience substance-related problems. The opioid crisis particularly affected this sector, accounting for 26% of nationwide overdose fatalities in 2017.

The report's literature review identified four main categories of mental health indicators:

- Individual lifestyle [exercise & weight management]
- Psychosocial [stress & depression]
- Physiological [cardiovascular conditions & general health]
- Work attitudes [job satisfaction & commitment]

With growing technological integration across industries, digital tools perhaps now offer new avenues for addressing mental health in construction. It was recommended that research is needed to design interventions that consider the mobility, work hours, and culture of field-based teams, particularly construction and maintenance crews. Finding that mental health is often siloed from occupational safety, it was asked: How can wellbeing initiatives be integrated into core safety programs and training? Not surprisingly, many employees fear judgment or repercussions when seeking support. The growing awareness and emerging practices within state DOTs clearly underscore the need for more targeted guidance, research, and interagency collaboration to effectively support the mental health and wellbeing of transportation construction and maintenance personnel of state DOTs.

AMSUS:

The Society of Federal Health Professionals (AMSUS) is a member-based organization providing education and professional development to support federal health professionals and their missions at the Departments of Defense, Veterans Affairs, Health and Human Services, and Homeland

Security. The membership represents all healthcare disciplines including civilians and individuals of the military medical services of coalition and partner nations. This year AMSUS recognized Jack Tsai of the Department of Veterans Affairs with their Research & Development Award. This award recognizes his decade-long research on addressing Veteran homelessness.

"I'm grateful to be recognized by the award but the award really represents the work of the VA Homeless Programs Office. Substantial progress has been made in addressing Veteran homelessness in the past decade and a half. Since 2020 there has been an over 50% reduction in homelessness. I've been lucky enough to be part of the ride and injecting and supporting research to inform practice and policy. Veteran homelessness remains a problem and a VA priority, and so our work continues." – Jack Tsai



♪ We didn't know who we were....
We were just a ridin' on the road. ♪

–(John Denver, On The Road)

Aloha,

Pat DeLeon

Dr. Anna Maria Wegierek



Dr. Anna Maria Wegierek is a Licensed Prescribing Psychologist, born and educated in Poland. After completing her master's degree, she immigrated to the United States and rebuilt her professional career from the ground up. She earned her Doctorate in Clinical Psychology and completed a Postdoctoral Master of Science in Clinical Psychopharmacology, as well as a Postdoctoral Neuropsychology Certificate. She also holds a Master of Arts in Professional Counseling and a Master of Arts in Psychology and Special Education.

Board certified as a Forensic Mental Health Evaluator, Dr. Wegierek specializes in neuropsychological assessment and medication management. Since opening her clinic in 1998, she has dedicated her career to serving the Polish-speaking community, with a particular focus on individuals navigating immigration-related stressors alongside everyday mental health challenges. Her practice provides comprehensive psychological and psychiatric care under one roof, supported by a dedicated clinical team and grounded in culturally responsive, evidence-based treatment.



When You Do Not Tell the Doctor Everything: Medication, Communication, and Medication Decisions

Having a strong relationship with your doctor is crucial, especially when it comes to discussing mental health and treatment options. Communication can already be challenging, as there is often limited time or insufficient clarification during appointments. Despite these barriers, it is essential for patients to do as much as possible to convey accurate information.

Prescribing psychologists, who are well-trained and spend 45 to 60 minutes with their patients, are particularly well-positioned to provide thorough care. These longer visits allow enough time for diagnostic clarification and help avoid misunderstandings, while also providing space for detailed discussion.

Even with this time, patients may still face several obstacles. Many patients do not fully understand their own diagnostic criteria, which can lead them to expect a different treatment plan than what is actually appropriate. Often, patients come in after discussing their mental health concerns with friends or family members, who are not trained in diagnosing mental health conditions. This can result in disappointment and, in some cases, a less effective treatment plan. Therefore, it is important for patients to remain flexible and open during the appointment, listening carefully to the provider and asking questions to clarify the diagnosis.

It is also essential for patients to remember that they have the right to choose their provider, and that the initial visit does not obligate them to continue care with a particular doctor. Nowadays, patients have choices and can see different prescribers. Traditional prescribers are psychiatrists who completed a medical degree. Other prescribers may include nurse practitioners, physician assistants, and many others.

Prescribing psychologists, however, have both the training and education to provide medication management as well as psychotherapy. This combination offers patients an excellent option, especially for those who need time to discuss life issues alongside their medication management.

Other factors that interfere with clear communication include:

- ➡ Lack of trust toward a new provider
- ➡ Reluctance to make changes
- ➡ Not being ready to take medication
- ➡ Hesitation to share personal mental health issues with family members who may accompany them
- ➡ Concerns about documentation going to insurance companies, lawyers, or workplaces
- ➡ Cultural issues, as many cultures do not view medication management as a first option
- ➡ Attending the visit due to family pressure, even when not wanting treatment

What can patients do?

Patients can take steps to improve the effectiveness of their appointments. Preparing notes ahead of time, bringing complete medical documentation, bringing all current medications, and having a clear plan for the visit can make a substantial difference. A well-prepared plan helps the doctor provide accurate explanations, make better-informed decisions, and arrive at a diagnosis that truly reflects the patient's experiences. For instance, failing to disclose alcohol use or other behaviors may lead to incorrect assumptions and less effective treatment.

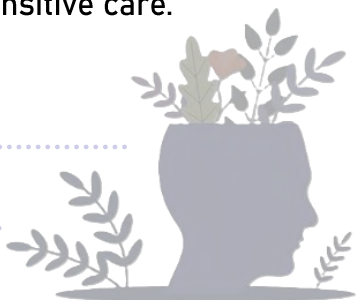
One particularly important issue is that shame and embarrassment often prevent patients from sharing essential details about their symptoms. Open and honest communication, even when difficult, is the cornerstone of effective care.



Despite these and many other obstacles, prescribing psychologists are highly trained. After earning their doctoral degree, they pursue additional training in psychopharmacology through master's programs, extensive supervision, internships, fellowships, and residencies. They are well-prepared to build trust, address reluctance to make changes, ease hesitation to share personal and often difficult or shameful issues and provide culturally sensitive care.

When patients feel heard and understood, this fosters trust, clarity, and ultimately more accurate diagnoses and treatment decisions. Prescribing psychologists are trained not only in medication management but also in the psychological aspects of care. They know how to work with patients struggling with shame, guilt, or emotional outbursts, and they are skilled at understanding human behavior with sensitivity and compassion.

In conclusion, while no doctor is infallible, patients play a key role in ensuring that care especially regarding medication and mental health treatment is appropriate and effective. Preparing in advance, being open, and working collaboratively with a prescribing psychologist can help overcome many of the initial barriers to successful care.





Dr. Jaime Wilson is a Deaf prescribing medical psychologist and board-certified neuropsychologist practicing across Washington State and beyond. With hospital privileges and collaborations with physicians, forensic experts, and allied professionals, he provides extensive neuropsychological insights for global care.

He's a recognized leader in inclusive practice, having served as Past President of the Association of Medical Professionals with Hearing Loss (AMPHL). He currently serves on the Diversity Council of the Society of Prescribing Psychology and previously served as chair of the Diversity Committee at the American Board of Professional Neuropsychology.

Born with a profound hearing loss, Dr. Wilson grew up using bilateral hearing aids and primarily communicated using spoken language, although he is also fluent in American Sign Language. He resides in Olympia, WA, with his equally Deaf wife (an RN), their three children, and their spirited King Charles Spaniel, Pepper Jack.

Dr. Jaime A. B. Wilson

Ph.D., ABN, ABPP

Postdoctoral M.S. in Clinical Psychopharmacology

I've always enjoyed writing and creating educational content for clinicians. Recently I had the opportunity to publish an article in The Carlat Geriatric Psychiatry Report titled "Behavioral Strategies for Apathy and Late-Life Depression."

Part of my motivation for writing the piece was simply the joy of teaching and sharing practical tools with other clinicians. At the same time, opportunities like this also help increase visibility for our field. Seeing the title "Prescribing Medical Psychologist" attached to discussions of medications, behavioral interventions, and geriatric mental health within a psychiatry-focused publication felt meaningful.

Moments like this help normalize the presence of prescribing psychologists in broader medical and psychiatric conversations and highlight the contributions our field can bring to patient care.

The article explores practical strategies clinicians can use when older adults present with reduced motivation or emotional "flatness." A key message is that apathy is often distinct from depression and may respond particularly well to behavioral activation and small, achievable "microgoals" that help restore daily engagement and quality of life. (*see page 16 for article*)

Dr. Wilson is the author of two heartfelt, empowering books:

- Preserving the Etchings of the Mind offers an easy-to-read, hopeful guide to protecting the aging brain and safeguarding memory, especially in the context of hearing loss. With over 50 five-star reviews, it's become a trusted resource for families and clinicians alike:
<https://amzn.to/3LHl8su>
- His newly released Bridge of Time: Caregivers & Care Receivers with Hearing Loss in Alzheimer's & Dementia is a tender roadmap for navigating memory loss and hearing loss with compassion—available now:
<https://amzn.to/414duQO>



Discover more about his work, connect online, or explore his books at www.WilsonClinical.com or via your favorite social media channels:
https://linktr.ee/dr_wilson

Jaime A.B. Wilson, PhD, ABN, ABPP, MSCP. Prescribing medical psychologist and board-certified neuropsychologist in private practice, Tacoma, WA. Dr. Wilson has no financial relationships with companies related to this material

Margaret, 74, is a retired librarian. Once active and socially engaged, she now skips breakfast, naps frequently, and goes to bed by 7 pm. She has gained 18 pounds, wakes several times at night, and avoids walking due to knee pain. Her PHQ-9 score is 7 (mild depression), but her Apathy Evaluation Scale (AES) score is 42, which indicates clinically significant apathy. She says she doesn't feel particularly sad—just “blah”—and asks you, “Is feeling flat just part of aging?”

Apathy ≠ depression

Apathy is a motivation disorder with low initiative, reduced interest, and blunted emotions. Unlike depression, it lacks guilt and sadness. It's also the most common neuropsychiatric symptom in dementia and often precedes cognitive decline (van Dalen JW et al, JAMA Psychiatry 2018;75(10):1012–1021).

Clinical considerations

- To distinguish apathy from depression, ask:
- “Does anything interest you today?” (apathy)
- “Do you feel sad or down?” (depression)

If you suspect apathy, use the AES (www.tinyurl.com/5fa2t58e); a score of ≥ 42 indicates at least mild apathy in older adults. For more, see “How to Identify and Treat Apathy and Late-Life Depression” in CGPR Oct/Nov/Dec 2022.

SSRIs may worsen apathy. Instead, try behavioral activation or low-dose dopaminergic agents like methylphenidate to help restore drive.

Why behavioral change matters

Lifestyle interventions are often overlooked in psychiatric care, yet they are foundational for treating apathy, preventing cognitive decline, and improving overall well-being. Behavioral activation can even match the efficacy of medications for late-life depression. A 2022 National Institute on Aging report called sustained behavior change “foundational” to healthy aging (Hughes JM et al, Gerontologist 2023;63(8):1268–1278). Small steps like consistent walking or joining a community class can significantly improve well-being. But change isn't easy. To help make it more realistic, here's a set of microgoals to improve mood, sleep, cognition, and overall quality of life in older adults.

You ask Margaret to name one thing she might enjoy this week, like watering plants or calling a friend.

Behavior change works best when it's personal. Habits tied to values last longer, and small, specific actions build confidence. A "microgoal" is a goal so small that it feels doable right away, like walking for five minutes after lunch instead of pledging to "exercise more." At each visit, use the OARS mnemonic from motivational interviewing to turn intentions into action:

Open-ended question:

What's one thing you'd like to try before our next appointment?"

- Too big: "I want to exercise more."
- Microgoal: "I'll walk to the mailbox after lunch each day."

Affirmation:

"You already took the hardest step, which is starting the conversation."

Reflective listening:

"You want to feel more energetic so you can keep up with your grandkids, and walking feels like a good place to start."

Summary:

"So you're planning a short daily walk and recognize why it matters. What could make it easier to remember?"

At the next visit, ask about the results directly: "How did it go trying that

new thing we discussed?" Most patients will follow through because the goal is their own, not yours. Celebrate progress, however small, and build on it. Over time, these microgoals add up to meaningful, lasting change.

Lifestyle pillars

Start with a Circle of Health wheel, a visual framework of well-being domains like movement, rest, relationships, and spirituality (www.tinyurl.com/4pzp5afj (<http://www.tinyurl.com/4pzp5afj>)). Ask, "Which domain matters most to you?" That answer guides where to begin (Bokhour BG et al, *Altern Complement Med* 2020;26(s1):S116–S122).

1. Exercise

Older adults should aim for 150 minutes of moderate aerobic activity weekly, plus strength training twice a week. Group activities like walking or tai chi outperform solo activities because they add structure, accountability, and social support (McMahon SK et al, *JAMA Netw Open* 2024;7:e240298)

 **Clinical considerations:** Prescribe exercise like a medication. Suggest a step tracker. If pain limits mobility, try water aerobics or recumbent bikes.

🔧 *Microgoal:* Walk 10 minutes after breakfast 3 times a week, bonus if with a friend.

2. Nutrition

Malnutrition and poor diet contribute to fatigue and cognitive decline. The MIND diet— leafy greens, berries, nuts, whole grains, fish, olive oil—may reduce AD risk, though trial data are mixed (Barnes LL et al, *N Engl J Med* 2023;389(7):602–611).

🔧 *Clinical considerations:* Monitor weight, appetite, and food access. Suggest Meals on Wheels if needed. For chewing/swallowing issues, smoothies and soups can help maintain fiber intake. For tech-savvy patients, photo-based apps like SnapCalorie offer quick feedback.

🔧 *Microgoal:* Swap one snack this week from cookies to nuts.

3. Social connection

Loneliness raises mortality risk just as much as smoking 15 cigarettes daily. It also worsens depression and speeds cognitive decline.

🔧 *Clinical considerations:* Ask how many meaningful contacts patients had in the past week. Encourage new interactions via phone, library

classes, or virtual groups. Ask family members to help with tech setup if needed. Reassess and celebrate at each step.

🔧 *Microgoal:* Add one social interaction this week: calling a friend, joining a class, or visiting the library.

4. Novelty

Real-world learning (eg, photography, language, crafts) beats brain games for cognition (Leanos S et al, *J Gerontol B* 2023;78(8):1305–1317). Choirs, art groups, and classes improve mood and social connection.

🔧 *Clinical considerations:* Encourage spending 20–30 minutes daily on a mentally engaging task. Activities that combine novelty with socializing offer extra benefits.

🔧 *Microgoal:* Spend 20 minutes this week learning something new like a language, a song, or a craft.

5. Sleep

Sleep issues are often early signs of aging-related decline. Older adults still need seven to eight hours nightly. Fragmented sleep increases dementia and depression risk.

🔧 *Clinical considerations:* Set consistent sleep-wake times and add morning

sunlight exposure. Bright light therapy (10,000 lux for 30 minutes) can improve circadian rhythm and mood. Apply CBT-Insomnia principles like sleep restriction. Avoid evening caffeine and review meds that may impair sleep (eg, steroids, decongestants, painkillers).

 **Microgoal:** Wake at the same time daily and get 10 minutes of morning sunlight

Margaret starts with two microgoals:

- *twice-weekly senior center yoga*
- *one healthy lunch swap per week.*

At first, she misses a few classes, but she keeps at it. By her two-month follow-up, she's lost a few pounds, feels steadier on her feet, and notices she's sleeping better. She even surprised her grandson with a phrase she learned in her beginner Spanish class.



Carlat Verdict:

In late life, behavioral change often works better than medication for apathy, depression, and early cognitive decline. Start with what matters most, set microgoals, and build from there.

For those interested, the full article can be found here:

<https://www.thecarlatreport.com/articles/5875-behavioral-strategies-for-apathy-and-late-life-depression>

Note:

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Dr. Sheldon Lewkis works as neuropsychologist with a practice based in Vancouver, British Columbia. He is also licensed in Washington State. In his treatment work he utilizes a range of leading-edge neuromodulation techniques integrated with talking therapy and guided in part by EEG assessment with quantitative analysis. He has a long history of working as a medical-legal expert witness in Canada and Washington state with focus on mild traumatic brain injury. He spends time in Japan, where at times he teaches graduate students quantitative EEG and EEG neurofeedback at the Institute of Applied Brain Sciences at Waseda University, Tokyo. He strongly supports efforts to expand the scope of practice of psychologists who have acquired suitable learning backgrounds; this expansion of scope including prescriptive authority as well as a focus on the uses of nootropics/neutraceuticals.

The Unsurprising Connection Between Clinical Psychology* and Prescriptive Authority

Psychology is not a field centrally focused on such matters of talking therapies and assessment of emotional and cognitive function, although these are not unimportant areas within the field. Psychology as it is taught at undergraduate and graduate levels and in the work that doctoral graduates engage in, is to varying degrees (and seemingly even more so in recent years) inclusive of what is usually referred to as: **“cognitive neuroscience”** or **“behavioral neuroscience”** or **“applied brain science.”** When studies are more exclusively focused consistent with these terms, the program may exist within the psychology department or may stand independent but closely related to the psychology department. This area of study implies a direct or contextual focus on brain function as it pertains to thinking, emotions, perception, and clinical matters.

Undergraduate psychology students

emerge with some degree of foundation in neuroscience, and masters and doctoral psychology (or psychology department joint-programs) graduates with a research focus in neuroscience, emerge with highly specialized leading-edge expertise relating to aspects of brain function. Doctoral psychology students in clinical programs will have an enhanced education in relevant matters of neuroscience building on their undergraduate courses, and much more so if their clinical stream is more exclusively focused in the area referred to as “neuropsychology” or otherwise individually tailored to include a more substantial neuroscience focus.

The strength of the association between psychology and neuroscience is perhaps most clearly evidenced by the contributions of individuals with psychology department (or joint program) graduate study as authors of published

peer reviewed research papers focused on neuroscience. Another indicator of such expertise are the many such graduates who hold appointments in medical faculties lecturing in areas of brain science with clinical relevance and including psychopharmacology. This is not a very uncommon career trajectory through psychology training.

Pubmed.com is the website that is the major means by which health science researchers and clinicians locate references to peer-reviewed published papers in relevant journals. If one searches for recently published and more remotely published papers in major areas of applied neuroscience relevant to mental health, it is highly common to find authors whose doctoral degree was completed in psychology departments or in a joint program involving a psychology department. These papers are focused on leading-edge developments and clinical implications in a wide range of areas and including:

- Psychopharmacology (e.g., drugs for emotional disorders and dementia).
- Neuromodulation treatment (e.g., transcranial magnetic stimulation-rTMS and photobiomodulation).
- Use of functional MRI (fMRI) to characterize brain networks (i.e., brain structures and circuits serving as the infrastructure for mental functioning and clinical conditions).
- Brain dynamics in concussions (mild traumatic brain injury), PTSD, and ADHD and their relation to symptomatology and treatment approaches.

- 
- 20
- Refinements in EEG and closely related magnetoencephalographic (MEG) assessment as well as EEG neurofeedback treatment.
 - Brain mechanisms involved in Parkinson's, Alzheimer's and other dementing diseases.
 - Vagal nerve and autonomic nervous system dynamics and more generally in mental dysregulation and treatment.
 - Brain dynamics of thinking, emotions, perception, and language.

As a personal example, I cite below a few recent papers that have come to my attention (in relation to my own clinical work) that fall within the areas listed above, where at least one author's doctorate was earned in a psychology department.

- Marvi, A.I., Hutchinson, S., Fedorenko, E., Saxe, R.R., Kamps, F.S., Regev, T.I., Chen, E.M., & Kanwisher, N.G. (2025). An Efficient Multifunction fMRI Localizer for High-Level Visual, Auditory, and Cognitive Regions in Humans. *Imaging Neuroscience*, Advance Publication. <https://doi.org/10.1162/IMAG.a.905>
- Iverson GL, Dams-O'Connor K, Panenka WJ, Stephens JA, Lockman SD, Lawati ZA, Lequerica AH, McPherson JI, Kamins J, Silverberg ND. New Diagnostic Criteria for Mild Traumatic Brain Injury: Medical-Legal Considerations. *Arch Phys Med Rehabil*. 2025 Jul 5:S0003-9993(25)00774-9. doi: 10.1016/j.apmr.2025.06.015. Epub ahead of print. PMID: 40623617.

- Marbil MG, Galarneau JM, Yeates KO, Minich NM, Hershey AD, Orr SL, Defta DM, Taylor HG, Bigler ED, Cohen DM, Bacevice A, Bangert BA, Ware AL. Posttraumatic headache and clinical recovery after pediatric concussion. *J Int Neuropsychol Soc.* 2025 May 21:1-13. doi: 10.1017/S1355617725000128. Epub ahead of print. PMID: 40394964.
- Porges SW. Disorders of gut-brain interaction through the lens of polyvagal theory. *Neurogastroenterol Motil.* 2025 Mar;37(3):e14926. doi: 10.1111/nmo.14926. Epub 2024 Sep 30. PMID: 39344751; PMCID: PMC11911287.
- Naeser MA, Martin PI, Ho MD, Krengel MH, Bogdanova Y, Knight JA, Hamblin MR, Fedoruk AE, Poole LG, Cheng C, Koo B. Transcranial Photobiomodulation Treatment: Significant Improvements in Four Ex-Football Players with Possible Chronic Traumatic Encephalopathy. *J Alzheimers Dis Rep.* 2023 Jan 31;7(1):77-105. doi: 10.3233/ADR-220022. PMID: 36777329; PMCID: PMC9912826.

Not only have these authors' academic background in psychology programs prepared them for this type of leading-edge research, many are also involved in supervising clinical psychology graduate students or teaching courses that clinical psychology graduate students take either as a core curriculum inclusion or choose independently to enhance their expertise in accordance with a desired focus in their dissertation research and future clinical work. Even clinical psychology graduates

not in a stream of study heavily weighted towards brain science possess an integrated multi-dimensional understanding of mental functioning typically inclusive of central nervous system anatomy and physiology and relevant concepts relating to brain dysregulation. All will also have a very substantial understanding of diagnosis, causes, and treatments pertaining to mental health. And all clinical psychology doctoral graduates will complete their programs as exceptionally motivated and bright clinicians possessing training in the scientific method of inquiry. These individuals are typically life-long learners predisposed to expand and refine their knowledge base and clinical methods.

As clinical psychologists engage in further learning following completion of their degree, some are drawn to expand the comprehensiveness of their clinical treatment alternatives to include prescription drugs utilized for mental health challenges. Their background training, experience, and licensing as doctoral level clinicians in mental health can readily be integrated with and synergize with new learning focused in the essential knowledgebase of clinical psychopharmacology. This is now achieved through very well-designed postdoctoral Masters of Science psychopharmacology programs (of which there are now several in the United States) and an associated examination and practicum designed for this purpose. These mental health clinicians do indeed successfully acquire the expertise to safely prescribe and monitor the drug class

relevant to mental functioning. This has been proven to be a very successful trajectory of expansion of clinical scope for many years now and is presently legislatively authorized in seven states as well as in military service. Ultimately this expansion of skill-set flows to those in need at a time when our society is unprecedentedly pressurized.

***This paper pertains to clinical psychology training as it is the educational pathway the author of this paper is most familiar with.**

Dr. Sheldon Lewkis, R.Psych

Practice in Neuropsychology

Diplomate, International qEEG Certification Board

BCN Board Certified in Neurofeedback, Fellow

Affiliate, Institute of Applied Brain Sciences, Waseda University, Tokyo

Student: Postdoctoral M.S., Program in Psychopharmacology, New Mexico State University



Lynette Pujol
PhD, MSCP, ABRxP



Derek Phillips
PsyD, MSCP, ABRxP

The process for establishing the American Board of Psychopharmacological Psychology (ABRxP) was led by the American Psychological Association (APA) Division 55 (Society for Prescribing Psychology). This article highlights the history of the creation of the ABRxP and includes a status update.

Division 55 Makes History: The ABRxP Story

The Importance of Specialty Status

The APA identifies and recognizes specialties in psychology beyond clinical, counseling, school, and industrial/organizational psychology. The process involves completion of a specialty petition that details how a particular specialty (e.g., clinical neuropsychology, clinical health psychology) is distinguished from these general practice specialties. The application is quite extensive and involves identification of an administrative organization with infrastructure and regular meetings, the public need for such a specialty, recognition of the importance of cultural and individual differences and diversity in training of specialists, and proof of distinctiveness in several areas, including populations served, problems specific to the specialty, and different procedures and techniques. Petitions also document how scientific and theoretical knowledge is acquired and extended, didactic and experiential preparation needed for practice, structures and models of education and training in the specialty, and opportunities for professional development and education. Plans for how the specialty will further the quality and utility of its knowledge, skills, and services, how guidelines for the practice will be developed and disseminated, and how the public will recognize specialists and understand their competency, as well as a brief description of the specialty for the public are required. In short, it is no small feat to become a new specialty in psychology.

The specialty petition for recognition of clinical psychopharmacology as a specialty in psychology was completed by a committee from the Society for Prescribing Psychology (APA Division 55). Drs. Sean Evers, Derek Phillips, and Judi Steinman, and their committee submitted a 268-page document with the required information in December 2019. The specialty petition was ultimately approved by the APA Council of Representatives in 2020, formally recognizing clinical psychopharmacology as a psychological specialty.

The Why and How of Establishing a New ABPP Board

The American Board of Professional Psychology (ABPP) certification has long been a respected credential to both psychologists and the public. To the public and patients, board certification is an extra step in the assurance of the competent delivery of specialty treatment. Psychologists with board certification complete a rigorous, peer-reviewed process in which their professionalism, knowledge, and skills in evidence-based practice are examined. The process of being boarded, which is required for physician specialization, has a different meaning for psychologists, but the shared process of extensive review is generally meaningful in healthcare delivery. Hospitals and other healthcare settings look favorably when a psychologist is board certified and some systems pay a higher differential for having earned the certification.

For psychologists with prescriptive authority and/or consultants, the recency with which the specialty was formally recognized, and the small numbers overall enhances the importance of ABPP certification. Board certification informs the public that the psychologist can be trusted to deliver professional and competent

evidence-based specialty care.

Once the specialty of clinical psychopharmacology was formally acknowledged by

APA in 2020, the process of establishing an ABPP began through Division 55's ABPP Committee, led by Dr. Derek Phillips. The ABPP Board of Trustees (BoT) process for establishing a new ABPP specialty is as follows:

1. The brief proposal

A brief proposal was presented twice. The initial proposal was written by Dr. Derek Phillips and Dr. Judi Steinman and was presented to the BoT initially in June 2021 by Dr. Derek Phillips and Dr. Marlin Hoover. The vote from the BoT was a tie, which equated to the motion failing, which essentially tabled the discussion. Feedback concerned the viability and sustainability of a new board, since there are still small numbers of individuals with training in clinical psychopharmacology. Surveying those who might want to pursue board certification was suggested, to include other divisions of APA. The second presentation to the BoT was in June 2023 when the suggested survey of members had been created, distributed, and analyzed, and letters of support had been solicited from psychologists interested in the credential. The second proposal was written and presented by Dr. Derek Phillips and Dr. Lynette Pujol. This time, the BoT approved the proposal and the proposal advanced to the formal application stage.

2. The formal application

The formal application consisted of detailing the process of board certification. The formal application answered questions such as, “How do we know you are a specialty?” The historical development of the specialty, organizational and financial stability shown by Division 55 minutes and treasury reports, demographic estimates of specialists now and in the future, information on specific practice procedures, parameters of practices, problems addressed by the specialist, populations served, skills and procedures utilized, primary settings in which practice occurs, and a comprehensive rationale for the specialty were included in this application. In addition, educational training standards and practice guidelines used, how the specialty addresses individual differences and diversity, evidence-based practice research, and credentialing procedures were also discussed. A review of the proposed procedures for being boarded were included, among other required elements. The formal application was a total of 179 pages, complete with appendices. Division 55 paid a \$2500 fee to submit the formal application. The BoT voted affirmatively on the formal application in December 2024, and we moved to the next step, the implementation plan.

3. The implementation plan

The implementation plan phase of the process consisted of creating a candidate manual and examiner manual for the specialty. To create these manuals, the processes of multiple existing specialty boards were reviewed. The result was the creation of the requirements for standard and senior submissions. These manuals totaled 115 pages and another \$2500 fee were submitted to ABPP from Division 55. The ABPP BoT approved the manuals in May 2025. Review and revisions from the ABPP Standards Committee followed.

The need to align to the ABPP naming convention to be recognized as a psychologist (versus the proposed name of clinical psychopharmacology) was communicated by ABPP. All ABPP specialties end in the word “psychology” (e.g., clinical neuropsychology, clinical health psychology, serious mental illness psychology). Various iterations of the name were discussed to include why neither “medical psychology”, nor “prescribing psychology” adequately covered all people who might be eligible for board certification and/or might connote something that was not true (i.e., not all individuals who will be board certified will have prescriptive authority). The name “psychopharmacological psychology” was adopted, which is the name of the new board. With the implementation plan approved, the next and final step of the process is the monitoring phase, during which ABRxP has earned provisional affiliation with ABPP.

Specialty Requirements for ABRxP

In addition to meeting the generic requirements for ABPP, applicants for standard option ABRxP must have:

1. A Master of Science in clinical psychopharmacology (MSCP) degree or equivalent [e.g., Master of Arts in clinical psychopharmacology, (MACP)]. Most readers will be familiar with APA-designated MSCP programs: Alliant University, Drake University, Fairleigh Dickinson University, Idaho State University, New Mexico State University, and The Chicago School. The University of Colorado at Denver has a new program that is not yet designated by APA.
2. Supervision of clinical and/or consultative psychopharmacological services to at least 100 patients supervised by a physician, nurse practitioner, physician assistant, or prescribing/medical psychologist.

Applicants for the senior option ABRxP must have:

1. An MSCP or equivalent degree (e.g., MACP)
2. 15-years post-licensure experience as a psychologist
3. At least five (5) years of professional experience prescribing, consulting, or engaged in professional work in the field of psychopharmacological psychology (e.g., clinical research in psychopharmacology, teaching, writing). One year should equal approximately 2,000 hours of professional work.

Founding board members were chosen from the ABPP committee as well as from those who demonstrated needed expertise (e.g., treatment of pediatric patients and serious mental illness). Other than the authors, founding board members are Drs. Joseph Comaty, George Kapalka, Melody Moore, Rebecca Richey, and David Shearer.

4. The monitoring phase and provisional affiliation

Four of the founding board members began the process of examinations in December 2025. To date, three of the seven founding board members have completed the process and have earned board certification in psychopharmacological psychology. Once all the founding board members are certified and trained as examiners, the process will be open to everyone, likely by mid-summer 2026. As a part of monitoring a new board, a member of the ABPP Standards Committee observes each of the first 30 evaluations and provides feedback to the examiners after the oral exam. The feedback has already resulted in rearranging the order of the examination, which required minor modifications of both the candidate and examiner manuals.

Written Examination

Both standard and senior option candidates must submit proof they passed the Psychopharmacology Examination for Psychologists (PEP). Candidates do not need to be licensed to prescribe to obtain an ABRxP, but they must have passed the PEP.

Practice Samples & Oral Examination

The oral examination focuses on the examination of the functional competencies of assessment, consultation, and intervention, as well as all the other foundational ABPP competencies through practice samples. Foundational competencies include scientific knowledge/methods, evidence-based practice, ethical/legal standards & policy, individual and cultural diversity, professionalism, interdisciplinary systems, relationships, and reflective practice, self-assessment, & self-care. For the standard option, practice samples consist of two de-identified notes of patients the psychologist treated or for whom they have provided consultation over the past two years. A statement addressing how assessment, consultation, intervention, diversity, and ethics were considered in these samples is required, along with a current curriculum vitae (CV). For the senior option, candidates are expected to submit a professional practice statement discussing their

career and how their work furthered psychopharmacological psychology and/or prescriptive authority for psychologists, as well as four samples of their work and a CV. Examples of practice sample activities for seniors are authorship of journal articles, books, or scholarly presentations; grant funding in psychopharmacology; program development; significant leadership roles; research, and/or design of MSCP programs or curricula. When practice samples are approved, the oral examination can be scheduled.

The initial portion of the oral examination consists of a professional identity query and examination of the practice samples. The second part of the oral examination contains a fact-finding session in which the candidate is given a few details about a patient. They may ask any questions they would like for 20 minutes to obtain more information. After that time, they will be expected to discuss their conceptualization and treatment plan, to include prescribing or deprescribing medication. The final portion of the oral examination is presentation of an ethical case scenario in which the candidate is expected to address all potential ethical issues. Those who achieve board certification will be designated by the initials "ABRxP", since the board is currently provisionally affiliated with ABPP. When 30 psychologists have earned certification, the board will move from provisional to full affiliation and the designation becomes "ABPP."

Summary

The creation of the APA-recognized specialty of clinical psychopharmacology rested on the work of many visionaries of the past and volunteers from the Society for Prescribing Psychology (APA Division 55) who wrote the extensive specialty petition and achieved specialty status. Division 55 quickly followed by leading the charge to engage in the multi-year, multi-step process for creation of the ABRxP board. Division 55 members paid the \$5000 fee to become a new specialty board. For those in the camp of "What has APA done for me lately?" this is part of it. You practice in a recognized specialty in psychology and can now be board certified

in that specialty.

Although we were asked to write about the history of how ABRxP came about, we are much more excited about the future. The ABPP is a marker of professionalism of the highest caliber. We know that individuals who seek further training in psychopharmacology are a special breed of life-long learners. Our specialty is the only one that requires a degree above the doctoral degree. Board certification is a fitting marker of achievement for psychopharmacological psychologists. The process of board certification in psychopharmacological psychology is a collegial and enriching experience that will enhance your practice credentials. We invite you to begin preparation for this exciting journey.





RICK BARNETT,
PSYD, LADC

VERMONT MAKES HISTORY

RxP Comes to the East Coast

RxP
Prescription for
Psychologists
RxP in the US

And then there were 8!

*Celebrating
VERMONT!*

RxP STATES

- ✓ Vermont
- ✓ Utah
- ✓ New Mexico
- ✓ Louisiana
- ✓ Illinois
- ✓ Iowa
- ✓ Idaho
- ✓ Colorado

More Access. Better Care. Stronger Communities. ♥

The movement continues. And we're just getting started.

**TODAY,
APRIL 27, 2026**

Governor Phil Scott
signed H.237 into law,
making Vermont the
eighth state to grant
prescriptive authority
to psychologists.

INFOGRAPHIC CREATED BY CHAT GPT

On April 27, 2026, Governor Philip Scott signed H.237 into law, making Vermont the 8th state — and the first on the East Coast — to grant prescriptive authority to doctoral-level psychologists with extensive advanced education and training. For those of us who have been in this fight since the Vermont Psychological Association board voted to pursue RxP back in 2016, it felt a little like watching a slow-motion near car crash turned miracle finally happen.

The road was anything but straight. Five consecutive biennia. Bills in the House, the Senate, and most often both. Plenty of “not this year.” What kept us going was the knowledge that Vermonters — particularly in rural and underserved communities — were waiting. Inspiration from other states like Idaho in 2017, and Colorado and Utah in 2023 and 2024 was vital in keeping our energy alive. Division 55 support was crucial the whole way through.

Many discouragements but also strokes of luck proved decisive in the final stretch. In 2020 Vermont had just passed a Sunrise Review law, and our RxP scope expansion became its inaugural test case in 2021. The Office of Professional Regulation had a vested interest in making the new process work, and work it did though painstakingly slow!

Second — and this is the part that belongs in a legislative thriller — we hired a lobbyist who had previously worked for the opposition. She knew every argument, every tactic, every pressure point. Let's just say the playbook looked familiar.

None of this happens without the tireless leadership of Rep. Topper McFaun of Barre, the final version of the bill's chief House sponsor, who stepped away due to a family illness before the signing. His fingerprints are all over this victory.

Governor Scott's signing letter raised a concern that the Department of Mental Health was not consulted prior to passage. The record, however, tells a different story. The VPA engaged extensively with DMH beginning in 2017, along with the Green Mountain Care Board, the Secretary of the Agency of Human Services, and virtually every major stakeholder in Vermont's behavioral health landscape. The decade-long process was anything but opaque.

Vermont's model is intentionally collaborative — requiring a written agreement with a psychiatrist, rigorous postdoctoral training, 14 months of 5 clinical rotations. and a national certifying exam (PEP). This is integrated care, not a turf grab. The communities that need us most have been waiting long enough.



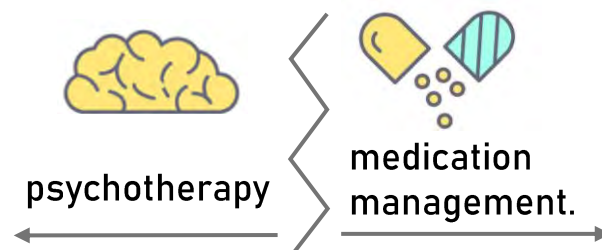
Dr. Jax Gallios

My path to becoming a psychologist—and eventually pursuing prescriptive authority—was shaped long before I entered graduate school. I grew up in a bilingual Hispanic household, where I witnessed firsthand how language, culture, and systemic barriers influenced access to mental health care. Many of the people around me—friends, neighbors, and members of my community—struggled to navigate health systems that were not designed with them in mind. For those who did not speak English fluently, even basic access to care could become an exhausting and discouraging process—something I saw play out again and again while growing up.

At the same time, I became aware of how certain privileges influenced how individuals were received in academic and professional spaces. My lighter skin tone, cultural fluency, and native English proficiency often made it easier for me to move through systems that others found difficult to access. Recognizing this difference created a deep sense of responsibility in me. From early on, I

understood that pursuing a career in psychology meant more than providing services—it meant working toward a system in which people from all cultural and linguistic backgrounds could receive appropriate, respectful, and effective care without having to fight so hard simply to be heard.

That commitment led me to clinical psychology, where I found a profession uniquely dedicated to understanding human behavior within the broader context of culture, environment, and lived experience. Over the course of my training and clinical work, however, I repeatedly encountered a structural challenge within the mental health system: the separation between psychotherapy and medication management



Many patients would receive psychotherapy from one provider while medications were managed by another clinician—often with little

to no coordination between them. For patients already facing language barriers, financial constraints, or transportation challenges, this fragmentation created additional obstacles to receiving consistent care—often dangerous ones when critical pieces of a patient's story were spread across multiple providers who rarely communicated with one another.

These experiences gradually led me to explore clinical psychopharmacology and the movement toward prescriptive authority for psychologists (RxP). The idea that psychologists could integrate medication management into the same therapeutic relationship where psychotherapy and assessment already occur resonated with me immediately! Rather than replacing psychiatrists or altering the identity of psychology, RxP represents an expansion of the tools psychologists can use to address complex mental health conditions within a holistic, psychobiosocial framework. For the kind of integrated, patient-centered practice I envisioned, it felt like a natural and powerful extension of psychology's core mission.



In 2022, after having more free time than I knew what to do with (and wow did that quickly change!), I decided the time was right to formally begin

pursuing this path by enrolling in the Master of Science in Clinical Psychopharmacology program at Fairleigh Dickinson University (FDU). The program provides the advanced medical and pharmacological training designed specifically for psychologists who wish to

Integrate medication management into their clinical practice. For me, the decision was driven by the same values that first drew me to psychology: improving access to care, reducing disparities, and ensuring that treatment decisions consider the full context of a patient's life rather than focusing on only one piece of the puzzle

Throughout my work as a clinician, I have continued to see how barriers to psychiatric care disproportionately affect underserved communities. Long waitlists, shortages of psychiatric prescribers, and fragmented treatment systems often leave individuals without timely intervention when they need it most. These challenges are particularly pronounced in communities where language and cultural differences already complicate access to care. Expanding the number of clinicians who can provide integrated, culturally responsive treatment is therefore not simply a professional goal—it is a matter of equity and public health and, ultimately, about ensuring that people receive the care they deserve when they need it most. In many ways, this reality is also what motivated me to take up authorship as actively as I have (which ironically, I actually really dislike writing—hysterical given how much I write!).

Through my writing and research, I hope to advocate for prescriptive authority for psychologists and, more importantly, for the many patients whose access to timely and comprehensive mental health care depends on expanding the workforce capable of providing it. The four articles summarized below (pages 34 – 41) reflect different dimensions of this work.

Together, they explore the training pathway that prepares psychologists for prescriptive authority, the empirical evidence supporting the safety and effectiveness of prescribing psychologists, and the broader implications of RxP for advancing equity and access in mental health care. In addition to these articles, I am currently under contract to author what will be the first comprehensive book devoted to prescriptive authority for psychologists, which will examine the access-to-care crisis RxP

seeks to address, the training pathway for prescribing psychologists, the evidence supporting safety and efficacy, cost-effectiveness considerations, common criticisms and misconceptions about the model, and policy directions for the future of integrated mental health care. The book is expected to be published later this year and aims to provide a comprehensive overview of the evidence and policy considerations shaping the future of prescribing psychologists.



THE GALLIOS FAMILY





“The Rigorous Path to Prescriptive Authority for Psychologists (RxP): Building on Psychological Expertise for Safe, Effective, and Holistic Mental Health Care”

The first article examines the educational and clinical training pathway that prepares psychologists to obtain prescriptive authority, commonly referred to as RxP. As demand for mental health services continues to increase across the United States, the article explores how specially trained psychologists can help address provider shortages while maintaining high standards of patient safety and clinical competence within an integrated model of care.

The article begins by describing the current mental health workforce challenges and the growing need for accessible, comprehensive care. In response to these challenges, several states have enacted legislation granting prescriptive authority to psychologists who complete specialized training in clinical psychopharmacology. The article outlines how this model allows psychologists to integrate medication management with psychotherapy and psychological assessment within a single provider relationship while promoting continuity and coordination of care. The central focus of the article is the rigorous training required to obtain prescriptive authority. Psychologists pursuing RxP must first complete a doctoral degree in psychology and obtain licensure

and obtain licensure before beginning specialized training in clinical psychopharmacology. This additional training typically includes a Master of Science in Clinical Psychopharmacology (MSCP) degree, which provides foundational education in medical sciences such as anatomy, physiology, pharmacology, and pathophysiology, alongside advanced instruction in psychopharmacology and clinical decision-making related to the treatment of mental and behavioral health conditions. The role of supervised clinical experience in developing prescribing competence is also described. During this phase of training, psychologists work under medical supervision in diverse clinical settings while gaining practical experience in physical assessment, medication management, and differential diagnosis. This supervised training ensures that prescribing psychologists develop the clinical judgment necessary to safely integrate pharmacological and psychological interventions within real-world clinical environments. The Psychopharmacology Examination for Psychologists (PEP), a national licensing examination administered by the Association of State and Provincial Psychology Boards, is also reviewed.



“ these safeguards ensure that prescribing psychologists maintain the knowledge and skills necessary to provide safe and effective medication management ”

The PEP evaluates a psychologist's mastery of clinical psychopharmacology, including pharmacology, medical differential diagnosis, treatment planning, and ethical decision-making. Successfully passing this examination represents a critical milestone in demonstrating competency for prescriptive practice and readiness for independent prescribing within authorized jurisdictions.

Beyond outlining the training pathway, the article reviews the broader framework that supports patient safety within the RxP model. This framework includes competency-based education, extensive supervised training, standardized national examination requirements, and ongoing continuing education in psychopharmacology after licensure. Together, these safeguards ensure that prescribing psychologists maintain the knowledge and skills necessary to provide safe and effective medication management throughout their professional careers.

The article concludes by situating RxP within the broader context of mental health care delivery. By combining psychological expertise with specialized training in clinical psychopharmacology, prescribing psychologists contribute to an integrated model of care that addresses the biological, psychological, and social dimensions of mental health. As more states consider expanding prescriptive authority for psychologists, the article emphasizes the importance of understanding the rigor of the training model that supports this evolving area of professional practice and its potential role in improving access to comprehensive mental health services—which is critical given how often RxP opposition narratives try to trivialize RxP training.

"The Proven Safety and Efficacy of Prescribing Psychologists (RxP): A Policy Initiative for Mental Health Care Access in New Jersey"

The second article, which I co-wrote with Dr. Leah Kaylor, PhD, MSCP, takes a policy-focused approach and was intentionally written in the style of a white paper. Rather than focusing on the training pathway itself, this piece examines the empirical evidence supporting prescriptive authority for psychologists and evaluates its implications for improving mental health care access in New Jersey and informing state-level policy discussions about workforce expansion.

The article begins by outlining the severity of the mental health care access crisis. Despite significant demand for services, large numbers of individuals in New Jersey are unable to obtain timely psychiatric care due to provider shortages, long wait times, and insurance barriers. Against this backdrop, the article explores whether granting prescriptive authority to specially trained psychologists could serve as a practical and evidence-based policy response to address gaps in psychiatric service availability.

Because the article is structured as a white paper, its primary purpose is to synthesize and present research findings in a way that can inform policy discussions. It reviews more than three decades of data from

states and federal systems in which psychologists already have prescriptive authority. Across these jurisdictions, the evidence consistently demonstrates that prescribing psychologists provide safe and effective psychopharmacological care. Studies examining malpractice history, regulatory oversight, and clinical outcomes show no increase in adverse events associated with prescribing psychologists, reinforcing the safety of the model and the reliability of its regulatory safeguards.

A significant portion of the article addresses prescribing patterns and clinical practice. Research indicates that prescribing psychologists tend to follow conservative prescribing strategies, often emphasizing careful medication monitoring and deprescribing when appropriate. Large-scale analyses of insurance claims data suggest lower rates of psychotropic polypharmacy and adverse drug events compared to some other prescribers. These findings support the view that prescribing psychologists approach medication management within a broader framework of comprehensive mental health care rather than relying on medication as a standalone intervention or default treatment



“ RxP policies may reduce long-term health care expenditures while improving clinical outcomes ”

strategy.

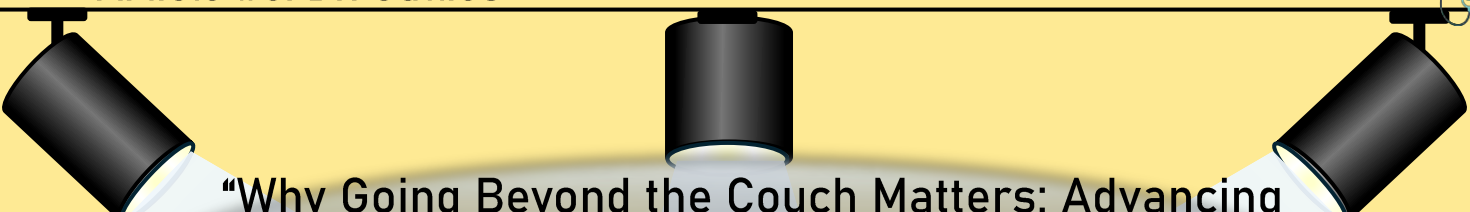
The article also examines the broader public health impact of RxP policies. Evidence from states that have implemented prescriptive authority suggests that expanding the number of trained psychiatric prescribers can significantly improve access to care, particularly in underserved and rural communities where psychiatric providers are scarce. Some studies have also identified reductions in suicide rates and other mental illness-related mortality following the implementation of RxP legislation, highlighting its potential role in strengthening mental health systems and improving population-level mental health outcomes.

Another key section of the article focuses on disparities in mental health care access. Psychologists frequently serve individuals who rely on Medicaid, Medicare, or other publicly funded health programs, as well as communities facing socioeconomic barriers to care. By enabling specially trained psychologists to provide both psychotherapy and medication management, RxP policies help reduce fragmentation in treatment and improve continuity of care for vulnerable populations

who might otherwise experience significant barriers to receiving coordinated services.

Finally, the article considers the economic implications of RxP as a public health policy. Untreated mental illness carries substantial financial and societal costs, and several economic analyses suggest that expanding the mental health workforce through prescribing psychologists could be a cost-effective strategy. By increasing provider availability and facilitating earlier intervention, RxP policies may reduce long-term health care expenditures while improving clinical outcomes across both public and private health systems.

Overall, the article presents a comprehensive, research-based policy analysis intended to inform discussions about prescriptive authority in New Jersey. By synthesizing decades of empirical research and examining the issue through both clinical and public health lenses, the piece argues that prescribing psychologists represent a safe, evidence-supported, and potentially transformative addition to the mental health care workforce within the state and potentially beyond.



“Why Going Beyond the Couch Matters: Advancing Mental Health Equity and Access Through Prescriptive Authority for Psychologists (RxP)”

The third article approaches prescriptive authority from a more personal and equity-focused perspective, examining how cultural competence, language access, and systemic barriers influence the delivery of mental health care. While the previous articles focus on training pathways and policy evidence, this piece centers on the lived realities of underserved communities and the role prescribing psychologists can play in addressing persistent disparities in access to care and promoting more equitable mental health outcomes.

The article begins by discussing how cultural and linguistic barriers often shape people's ability to receive appropriate mental health treatment. In many communities, particularly among individuals who do not speak English fluently, navigating the health care system can be extraordinarily difficult. Language differences, cultural misunderstandings, and provider shortages frequently lead to delayed diagnoses, inappropriate treatment, or an inability to access care at all. These challenges contribute to longstanding disparities in mental health outcomes among Hispanic and other underserved populations across the United States.

Against this backdrop, the article explores how the integrated care model offered by prescribing psychologists can help address these systemic barriers. Psychologists already play a central role in delivering psychotherapy and psychological assessment, often serving as the primary point of contact for individuals seeking mental health services. When psychologists receive specialized training in clinical psychopharmacology, they gain the ability to integrate medication management with psychological treatment within a single therapeutic relationship. This integrated approach reduces fragmentation of care, eliminates unnecessary referrals, and allows treatment decisions to be informed simultaneously by psychological, biological, and social factors within a unified treatment framework.

The article also highlights the ways in which RxP policies may expand access to culturally responsive mental health care. Psychologists are more likely than many other prescribers to accept both public and private insurance and to practice in underserved communities. By increasing the number of clinicians who can provide both psychotherapy and medication management, RxP legislation can help reduce wait times for psychiatric care

“cultural and linguistic barriers often shape people's ability to receive appropriate mental health treatment”



and improve continuity of treatment. This is particularly important in areas where patients currently face months-long waitlists for medication appointments or must travel significant distances to see psychiatric providers in order to receive pharmacological treatment.

A significant portion of the article examines how integrated psychological and pharmacological care may contribute to improved public health outcomes. Research from jurisdictions where RxP has been implemented suggests that expanding access to trained prescribers can reduce treatment delays and improve early intervention for serious mental health conditions. Some studies have also linked these expanded care models to reductions in suicide rates and mental illness-related mortality, underscoring the broader societal benefits of improving access to timely treatment and comprehensive mental health services.

The article further explores how prescribing psychologists can play a role in addressing diagnostic and treatment inequities. Cultural and linguistic differences can sometimes lead to misinterpretation of

symptoms, particularly when evaluations are conducted in a language that is not the patient's primary one. The integrated training model for prescribing psychologists emphasizes culturally informed assessment and individualized treatment planning, ensuring that psychopharmacological decisions take into account biological variability as well as sociocultural context when determining the most appropriate course of care.

Ultimately, the article frames prescriptive authority as more than a scope-of-practice expansion. Instead, it presents RxP as part of a broader effort to create a more equitable mental health care system—one that reduces fragmentation, expands the workforce, and improves access for communities historically underserved by traditional models of care. By combining psychological expertise with specialized training in clinical psychopharmacology, prescribing psychologists are positioned to deliver comprehensive, culturally responsive treatment that addresses both the psychological and biological dimensions of mental health while strengthening continuity of care for diverse patient populations.

“Prescriptive Authority for Psychologists (RxP) Is a Public Health Imperative: Policymakers Must Dismantle Regulatory Barriers That Restrict Access to Needed Care”

The fourth article affirms that expanding prescriptive authority for psychologists (RxP) is a necessary public health response to the growing shortage of psychiatric providers in the United States. It situates RxP within the broader context of the mental health workforce crisis, noting that psychiatrists are increasingly scarce in many regions and that most psychiatric medications are already prescribed outside psychiatry, primarily by primary care clinicians. As demand for mental health services continues to rise—particularly following the COVID-19 pandemic—the article presents RxP as a practical and evidence-based strategy to expand access to timely care and strengthen the nation’s mental health workforce.

The article begins by describing the scale of the current workforce shortage. A large proportion of U.S. counties lack a practicing psychiatrist, wait times for psychiatric appointments have increased substantially, and many psychiatrists are approaching retirement age. These factors contribute to significant barriers for patients seeking psychiatric evaluation and medication management, particularly in rural and underserved communities. In response, the article highlights jurisdictions where psychologists with

specialized training are already authorized to prescribe medications, as well as federal systems such as the United States Department of Defense and the Indian Health Service that have implemented prescribing psychologists’ services.

A central theme of the article is the rigorous education and clinical training required for psychologists to obtain prescriptive authority. Before pursuing RxP, psychologists must complete a doctoral degree, obtain independent licensure, and accumulate extensive supervised clinical experience. Additional training includes a Master of Science in Clinical Psychopharmacology (MSCP), advanced coursework in biomedical sciences such as anatomy, physiology, pharmacology, and pathophysiology, and supervised clinical experience integrating medication management with psychological treatment. Psychologists must also pass the PEP before practicing independently as prescribers demonstrating competency in clinical psychopharmacology and medical decision-making.

The article also addresses several common criticisms raised by opponents of RxP. It examines claims that prescribing psychologists lack sufficient medical training and argue that these claims often rely on



selective or misleading comparisons of training hours across professions. The article explains that psychologists accumulate extensive supervised clinical experience during doctoral education, internship, postdoctoral training, and independent practice prior to pursuing prescribing privileges. It also clarifies misunderstandings about the structure of MSCP programs, including the frequently cited “400 contact hours,” which refers specifically to supervised prescribing practice rather than the entirety of pharmacological training required within accredited psychopharmacology programs.

Another section reviews empirical research examining the safety and effectiveness of prescribing psychologists. Studies from jurisdictions where RxP has been implemented—including federal programs and several states—have found that prescribing psychologists provide safe and effective psychopharmacological care. Some research suggests that their prescribing practices are associated with lower rates of adverse drug events and reduced polypharmacy compared to other prescribers, reflecting a treatment approach that emphasizes conservative medication use alongside behavioral and psychotherapeutic interventions grounded in comprehensive psychological assessment.

The article also discusses the broader implications of RxP for improving access to care. Psychologists are more widely distributed

across geographic regions than psychiatrists and frequently practice in community mental health centers, integrated primary care clinics, and rural settings. As a result, expanding prescriptive authority has the potential to increase the number of qualified mental health prescribers in areas where psychiatric services are limited or unavailable. Research cited in the article suggests that expanding RxP could significantly reduce provider shortages and improve access to timely mental health treatment for individuals who might otherwise face prolonged delays in care.

Finally, the article emphasizes the importance of interdisciplinary collaboration in modern mental health care. Prescribing psychologists are described not as replacements for psychiatrists but as complementary members of integrated care teams who bring specialized expertise in psychological assessment, psychotherapy, and behavioral interventions alongside advanced training in psychopharmacology. The article concludes that, given the scale of the mental health workforce shortage and the existing evidence supporting the safety and effectiveness of prescribing psychologists, expanding RxP represents a practical and evidence-based strategy for strengthening the nation's mental health care system while maintaining high standards of patient safety and professional accountability.

A celebration of life



Dr. Joseph A. Hirsch

◆ 1951 - 2026 ◆

Dear Division 55 members:

It is with great sadness to inform you that on February 4, 2026, Joseph A. Hirsch, Ph.D., Psy.D. passed away at age 75 years. As many of you may recall, Dr. Hirsch was an instructor for several national courses the Prescribing Psychologists' Register offered during the late 1990's and early 2000's. Our class featured Doctoral Level Psychologists from Texas, Oklahoma, Arkansas and Colorado who attended classes conducted at Concordia University in Austin, Texas and Texas Woman's University Health Science Campus in Dallas, Texas.

We delighted in the fact that Dr. Hirsch first trained as a Ph.D. in Pharmacology and worked as a pharmacist for many years. Later, he returned to school and obtained a Psy.D. Degree specializing in neuropsychology and went on to conduct many in-depth neuropsychological evaluations. His presentations offered students a well-developed grasp of both the pharmacological and psychological components involved in effective patient care.

**Joseph A. Hirsch is survived by his wife Karen along with a son and grandson.
(And us too)**

**His wife Karen, asked that we relate a story he
told to friends and colleagues with great delight.**



Written by Dr. Thomas Michael Kozak, a long-time friend and colleague.



HIRSCH & THE HAT TRICK

At the last class he taught in our sequence of RxP training courses, we felt it only fitting to buy this New York City born and raised person something to

remember us "Southerners" by. What better than a genuine Stetson "Cowboy" hat. But it needed to be a surprise..... and the hat he wore that day didn't have a size label. So, what to do?!! Several of us decided we "wanted to have our pictures taken with him" and held our heads next to him for a series of photos. Later we scurried off, viewed the pictures, compared head sizes of Joe next to us and made our best estimate of Dr. Hirsch's head size.



A celebration of Life

Dr. Joseph A. Hirsch

1951 - 2026

REVEALING THE HAT TRICK

After the Saturday class, Drs. Tim Branaman, Fernando Obledo and Carol Pierce Davis and I went on a search mission to Cavender's Boot City to rescue our prize. At the end of Sunday's class, we presented the gift on behalf of the Prescribing Psychologist's Register as a token of our appreciation. Only then did we tell him the shenanigans we engaged..... to get the correct hat size. He thought there was something strange about our furtive attempts to get just the right pictures with him and "Now it all made sense!"



ON DISPLAY



Visiting Joe in his Greenwich Village, NYC apartment revealed he kept it on prominent display, for all to see. He recalled his encounters with us as much as we did him.



WHAT HAPPENED TO THE PPR PIONEERS?

Tim Branaman went on to become Chair of the Texas State Board of Examiners of Psychologists and promised to add his official approval to any bill that would have permitted trained psychologists (in RxP) to prescribe.



"WHO BETTER TO HAVE TEACH US, HUH"

According to Dr. Comaty, who was a long-time friend to Dr. Hirsch, Joe was a great contributor to the PEP qualifying examination for Psychopharmacology. Who better to have teach us, huh!?!?

A celebration of Life



Dr. Joseph A. Hirsch

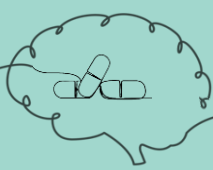
1951 - 2026

WHAT HAPPENED TO THE PPR PIONEERS?

Tom Kozak was the administrator for this PPR program. Later Tom was awarded a plaque for his Texas group's support of the New Mexico's Psychopharmacology program which became the first state to permit psychologists to prescribe.

Tom Kozak and his daughter, also a psychologist, authored a chapter in *Pediatricians and Pharmacologically Trained Psychologists*, George M. Kapalka (editor), Springer ISBN 978-1-4419-7779-3. Title: *The Clinical Experience of RxP-Trained Psychologists Working in Non-RxP States*. by Thomas M. Kozak and Andrea Kozak Miller. Some of the data and vignettes from our psychopharmacology program were incorporated into that Chapter.

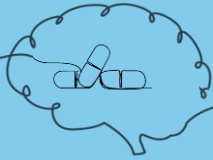




JUNE

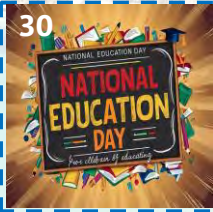
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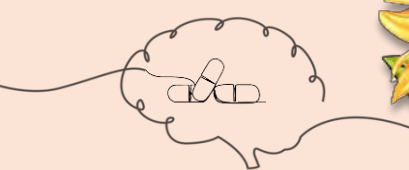
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	1	2 Div. 55 Federal Advocacy Mtg @ 8:30pm ET	3	4	5	6 NATIONAL HIGHER EDUCATION DAY
7	8	9	10 Div. 55 Research Council Mtg @ 7pm ET	11 CALL YOUR DOCTOR DAY	12	13
14 U.S. ARMY BIRTHDAY - JUNE 14	15	16	17	18 Div. 55 Board of Directors Mtg @ 8:15pm ET	19 JUNETEENTH FREEDOM DAY	20 SUMMER SOLSTICE
21 Happy FATHER'S DAY	22	23	24	25	26	27 NATIONAL PTSD AWARENESS DAY
28	29	30				



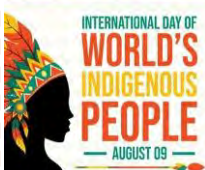
JULY

2026

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
			1	2	3	
5	6	7 Div. 55 Federal Advocacy Mtg @ 8:30pm ET	8	9	10	11  WORLD BENZO DIAZEPINE AWARENESS
12 NEW CONVERSATIONS DAY 	13	14	15	16 Div. 55 Board of Directors Mtg @ 8:15pm ET	17	18
19	20	21	22 Training Director Council Mtg @ 8-9pm ET	23	24 International SELF CARE DAY 	25
26 National DISABILITY INDEPENDENCE DAY 	27	28	29	30 	31	



2026

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
						1  WORLD LUNG CANCER DAY
2	3	4 Div. 55 Federal Advocacy Mtg @ 8:30pm ET	5	6 APA Convention	7 APA Convention Div. 55 Social	8 APA Convention
 INTERNATIONAL DAY OF WORLD'S INDIGENOUS PEOPLE AUGUST 09	10	11	12 Div. 55 Research Council Mtg @ 7pm ET	13	14	15 NATIONAL RELAXATION DAY 
16	17	18  WORLD NEVER GIVE UP DAY AUGUST 18	19	20	21	22
23  INTERNATIONAL DAY FOR ABOLISHED SLAVERY	24	25  WORLD DAY OF SOCIAL JUSTICE	26	27	28	29 
30 National GRIEF Awareness Day	31  INTERNATIONAL OVERDOSE AWARENESS DAY					



BOARD MEMBER CANDIDATES



VOTING CLOSED 5/15/26
STAY TUNED FOR RESULTS



DR. DEMIETRICE PITTMAN, PHD, MSCP

I am deeply honored to be nominated for the position of President-Elect of Division 55 - Society for Prescribing Psychology.

My journey to this point has been influenced by over two decades as a military psychologist, where I have served individuals and families in environments that demand resilience, access to care, and sound clinical judgment. In these settings, I have witnessed firsthand the gaps in behavioral healthcare and the significant impact when providers are equipped with a broader range of tools to address patient needs. This experience has inspired my commitment to the mission of prescribing psychology.

For me, this work is not just professional; it is profoundly personal. As a mother, I comprehend the responsibility of caring for others while striving to grow, lead, and contribute meaningfully. Balancing these roles has reinforced my belief that our field must promote not only excellence but also support, mentorship, and community throughout all stages of career and life.

I see prescribing psychology as both an opportunity and a responsibility: to broaden access to high-quality care, to maintain rigorous training standards, and to lead with integrity as our role in healthcare continues to evolve.

If elected, I will strive to ensure that Division 55 continues to grow thoughtfully, supporting its members, mentoring future leaders, and advancing a vision of care that is comprehensive, ethical, and rooted in the core values of psychology.

DANIEL BOAN, BA

I am honored to submit my candidacy for the Student Representative position for Division 55, the Society for Prescribing Psychology. As a doctoral student in clinical psychology living in the state of Hawaii, I am passionate about expanding access to mental health care and advancing the role of psychologists in integrated healthcare settings. Division 55's mission strongly aligns with my professional goals of improving access to care through advocacy, education, and interdisciplinary collaboration.

Through my clinical training experiences, I have observed significant barriers to psychiatric care, including long wait times and limited access to prescribers, particularly in underserved and rural communities. These experiences have reinforced my belief that appropriately trained prescribing psychologists can help improve continuity of care and increase access to mental health services for many individuals who might otherwise go without treatment.

If elected, I hope to increase student engagement within Division 55, promote awareness of training pathways in psychopharmacology, and help connect students with mentorship, training opportunities, and professional development resources. I would also work to ensure that student perspectives are represented within the division and help facilitate communication between student members and Division leadership.

PRESIDENT

STUDENT REPRESENTATIVE

VOTING CLOSED 5/15/26
STAY TUNED FOR RESULTS



DR. JOCELYN MARKOWICZ, PHD, MSCP

I am honored to submit my candidacy for Secretary of Division 55. As a Licensed Psychologist with over 15 years of experience, I have practiced across correctional, medical, academic, government, and private practice settings. These diverse roles have shaped my commitment to ethical service, interdisciplinary collaboration, and the thoughtful strengthening of systems that support both clinicians and the communities we serve. I strive to contribute with professionalism, steadiness, and respect for the collective mission of our field.

My decision to pursue advanced training in clinical psychopharmacology through the MSCP program at New Mexico State University marked a natural extension of my dedication to expanding access to comprehensive, evidence-based care. I joined Division 55 during my first year of training and later founded a Prescribing Psychologist Network to encourage and support colleagues seeking advanced education. I have also supported RxP initiatives in Michigan and remain committed to promoting safe, responsible prescribing practices that enhance patient outcomes and broaden access to services.

I am currently finalizing my application materials to begin the required two-year supervised practice under a conditional prescription certificate in New Mexico. I am grateful to pursue this next phase of practice. I look forward to learning alongside leaders in our field while supporting psychologists who are strengthening their clinical expertise and broadening access to integrated care. Board service represents an opportunity to contribute in return for the training, legislative insight, and mentorship I have received through Division 55.

If elected Secretary, I would serve with humility, consistency, and strong organizational discipline. I am committed to clear communication, operational integrity, and supporting Division 55's sustained growth and responsible advancement nationwide.



DR. DIEM PHAN, PHD, MSCP

I am well qualified to serve as Secretary of APA Division 55 (Society for Prescribing Psychology) given my clinical, academic, and leadership experience within the evolving field of psychology and psychopharmacology. As a Licensed Psychologist with nearly 15 years of experience in integrated behavioral health, I have built a career grounded in collaboration, organization, and a deep commitment to advancing high-quality, evidence-based care. I have passed the Psychopharmacology Examination for Psychologists (PEP) and am currently completing my 750-hour Psychopharmacology Fellowship and anticipate obtaining prescriptive authority this summer in Colorado, positioning me to actively contribute to the growth and visibility of Prescribing Psychology.

My work spans psychotherapy, psychological assessment, and medication management, and I am actively involved in developing training pathways for future Prescribing Psychologists with collaborations with local clinics and psychiatrists. This experience serves to further strengthen my ability to coordinate across disciplines, manage complex initiatives, and communicate effectively with diverse stakeholders—skills that are essential for the Secretary role.

I am highly organized, detail-oriented, and committed to clear, timely communication. I value transparency, collaboration, and the dissemination of information that supports member engagement and professional development. Serving as Secretary would allow me to contribute meaningfully to Division 55's mission by supporting its operations, strengthening connections among members, and helping advance the role of Prescribing Psychologists across the country.



VOTING CLOSED 5/15/26
STAY TUNED FOR RESULTS



DR. TERRI LUCERO, PHD, MSCP

I am honored to be considered for the Member at Large position on Division 55's board. Although I have over 26 years of experience as a licensed clinical psychologist and neuropsychologist, I am a newcomer to RxP, and I am thrilled to be a part of this supportive community. I would bring to this role my newfound passion and steadfast commitment to advancing prescriptive authority for psychologists.

Licensed in Colorado and New Mexico and PSYPACT-authorized, I recently completed my MSCP at NMSU and am currently fulfilling RxP fellowship requirements while preparing for the PEP exam. During my MSCP training, I served as the student representative to the New Mexico SPA Board (NM's RxP organization), gaining a valuable perspective on state-level advocacy. I continue this work as a member of the Colorado Psychological Association's RxP Legislative Committee, where we are working to refine Colorado's 2023 prescriptive authority law and address implementation challenges. Recent meetings with lobbyists and legislators have deepened my understanding of the policy landscape, regulatory barriers, and advocacy strategies essential to advancing our field.

As Member at Large for the Division, I would prioritize: (1) supporting legislative advocacy and policy development to expand prescriptive authority nationwide, (2) strengthening training pathways and sustainable fellowship opportunities, and (3) amplifying the voices of emerging prescribing psychologists navigating early implementation challenges.

I am eager to serve Division 55, bridging perspectives between pioneering RxP practitioners and newcomers to represent our field's full breadth of experience.

DR. GAIL MARTIN, PSYD, NCSP, ABSNP

MEMBER AT LARGE

MEMBER AT LARGE

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