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Letter from the Editor

Richard Sylvester, PhD, MSCP

Take a moment and hug a loved one.
Take another moment to remember one you can no longer hug.

I think gratitude is an overlooked emotion. Maybe it is a bit hackneyed, but I also think there is always something to be thankful for in most situations or circumstances. In remembering the history of Division 55 and RxP, we have much for which we should be grateful. Sometimes displaying gratitude is misconstrued as a conclusion of sorts or otherwise associated with finality. Stopping our efforts to spread RxP or at least inform others of the potential good our movement offers would be as disrespectful to our founders as it would be a disservice to those RxP could potentially help in the future.

You, dear reader, hold more power in this movement than you may realize.

Often it seems people assume spreading the word about RxP involves political dealings or meetings with congress persons or representatives. Understand that this may sometimes be true, but volunteering to provide an hour long talk on RxP at a local conference or professional gathering can reach more people than one might think. By spreading knowledge to other professionals, we may also remove stigma or reduce apprehension about RxP. Underlying fear or misunderstanding regarding the nature of the training and practice of RxP serve only to hinder our movement.



Most readers of The Tablet are likely busy professionals or students. Being an active professional myself, I understand how precious time can be and one may not have the time to spare for much volunteer work. Lacking time to spare, perhaps consider a monetary donation to Division 55 or a local/state level organization to advance RxP. Every one of us was once a student and understands the rigors of academia. Students possess a unique opportunity to contribute to RxP by research and becoming the future of RxP (even a literature review can

be helpful and you could submit it to The Tablet for publication).

One may be grateful without being complacent. I would like to dedicate moments of gratitude to all our founders. I would especially like to thank

David Shearer and Judi Steinman for their help and encouragement on my own journey with RxP. I would like to send out an extra thanks to our current Division 55 President, Lynette Pujol, for her going well above and beyond in helping to make this issue of The Tablet possible.

President's Column

Lynette Pujol, Ph.D., MSCP



Dear colleagues,

Thank you for the honor and privilege of serving as your 25th President. The theme for our Silver Anniversary has been, "25 Years of Division 55: Celebrating the Past, Forging the Future." I believe we have done both this year. Here are a few highlights.

Celebrating the Past

- Dr. Amy Daley and Dr. Alyssa Cunningham and the Convention Committee organized a wonderful convention with an eye toward how we could serve the larger psychological community by including presentations geared toward a general audience in addition to those geared for us. This strategy was wildly successful. We had to turn people away from several standing room only presentations!
- We honored the history of Division 55 and Dr. Patrick DeLeon as an initial force that drove our movement. He continues to serve us today as Fellowship Chair.
- We celebrated (see the cake) together at a reception. How satisfying it was to see people linger, talk together, and make new friends.
- I was privileged to have conversations with several past Presidents of Division 55 and founders of RxP.

Forging the Future

- Our new APA guideline – *Psychologists' Involvement in Pharmacological Issues* was approved by APA Council and is published thanks to Dr. Dave Shearer and Dr. Bret Moore and their committee (see: <https://www.apa.org/about/policy/guidelines-pharmacological-issues.pdf>).
- A Specialty Renewal Committee was chosen. It will be chaired by Dr. Judi Steinman.
- Our ABRxP Board will be going through the process early next year and we will then open the door for all applicants for an ABPP in Psychopharmacological Psychology! You must have an MSCP and have passed the PEP, but you do not need to be licensed to prescribe. Get ready – it's coming soon!
- We have worked within a tight budget to maintain our financial stability. Thank you, Dr. Julie Price, Treasurer, for keeping us in line. Together, we did it!

Big CE Announcement

Dr. Daniel Lee and the CE Council Members are leading the way to assist you with your CEs. Division 55 has partnered with Trusted Provider Network (TPN.health) to bring you CE offerings related to psychopharmacology. This is an effort to boost our revenues since many of our members pay no dues. Stay tuned for the roll out soon. Please consider attending one of our events or gaining some (or all!) of your psychopharmacology CEs this way.

Many other things have happened in the background or are on the horizon. Thank you to Past-President Dr. Steven Curtis and President-Elect Bethe Lonning for your guidance and support as part of the Presidential Trio. Thank you to everyone who is working hard on the Board of Directors, as well as those in the legislative trenches moving our cause forward. Finally, my gratitude overflows for those who came before us who had a vision for psychology and faced even steeper odds than we do currently. May we all derive inspiration from them!

Finally, please join us on a committee or taskforce. Dr. Lonning is already preparing for a fantastic year.

Onward and upward!

Lynette



President Elect's Column

Elizabeth (Bethe) Lonning, Ph.D.

Greetings

will start by introducing myself, I am Dr. Elizabeth (Bethe) Lonning, and I will be your President of Division 55 beginning January 2026.

While I have only been a member of the Division for about 10 years, I have been involved with RxP since the early 2000s. I was President of my state association attending SLC (now called PSLC) when New Mexico became the first state to pass legislation allowing advanced trained psychologists prescriptive authority. As I listened to the rationale for this legislation, I remember thinking to myself, 'they could be talking about Iowa'. From that time forward, I have been involved. I led the effort in Iowa getting our legislation passed in 2016 and have continued to work on increasing RxP in my state. Along the way, I have served as a member and co-secretary of the Training Director Council of Division 55 and am completing my second 3-year term on APA's RxP Designation Committee with this past year serving in the role of Co-Chair.

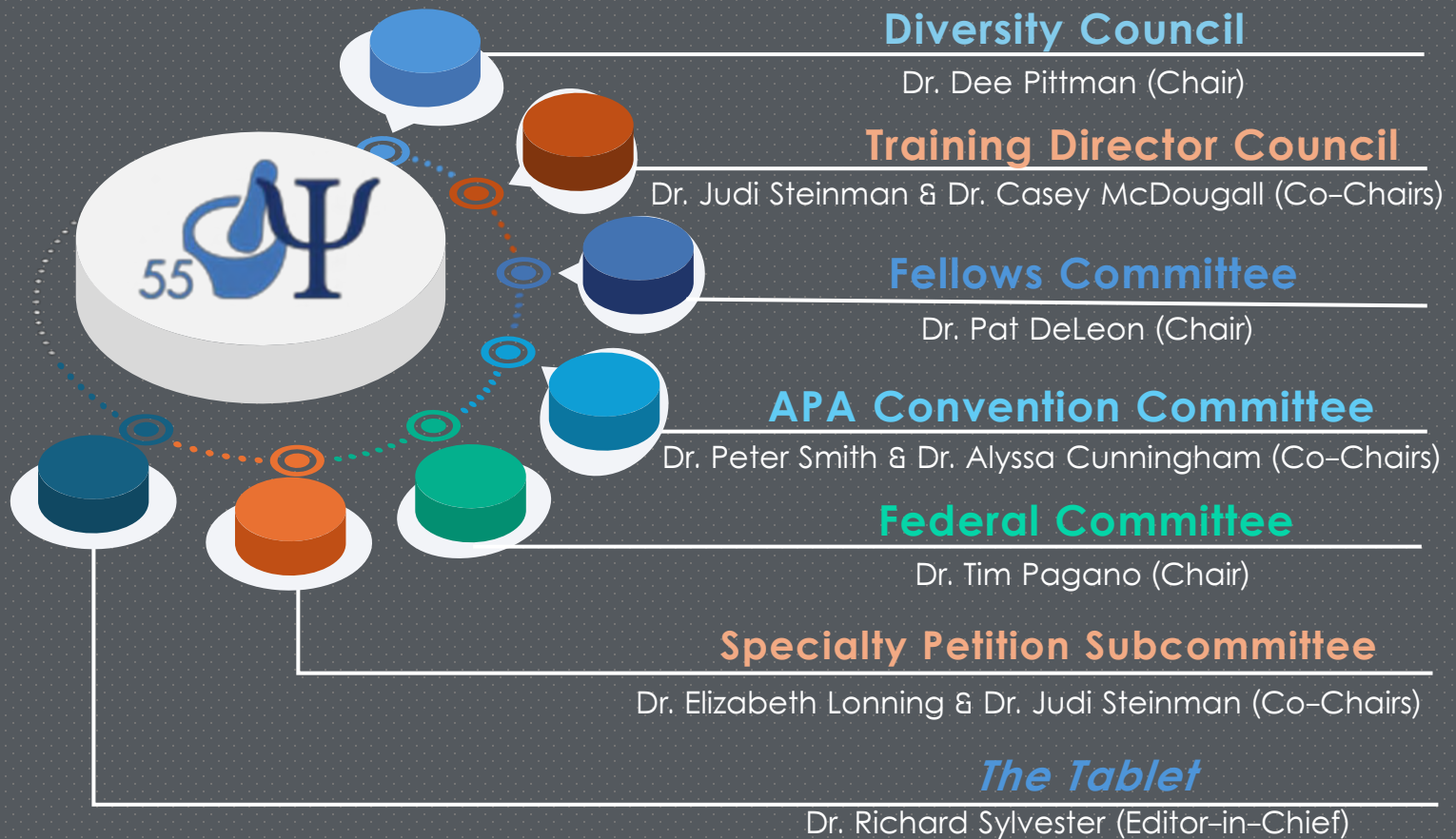
I am following many people who have done outstanding work for this Division. Most recently, Dr. Pujol committed to several goals for the Division which included completion of ABPP status, getting our CE committee revitalized and inviting people who have not previously been involved in leadership to become involved. I plan to continue working on these goals as well as beginning the process of renewing our specialty petition to retain our designation as a specialty within the profession. I have talked to existing committee chairs about the role of their committee and their willingness to continue to

serve as Chair and am pleased to say many have agreed to continue! There will also be some new faces in 2026 which I am excited about.

As mentioned above, our biggest project that will begin in 2026 is the renewal of our Specialty Petition. As you know, RxP was granted specialty status in 2019, and it is time for renewal. Due to the current administration's position on DEI issues, we have been granted an additional year for submission. However, this doesn't mean we will wait to begin the work. A committee has already been formed and has met on two occasions at the time of this writing, so we are moving ahead. Much of our work for the upcoming year will center around the needs of the renewal application and what the Division needs to do to ensure the specialty status gets renewed.

There are many ideas put forward on the listserv, and it is great to read about them. I encourage those with ideas about what the Division could do to reach out to myself or to one of the members at large on the Board with your thoughts and work toward developing a way to accomplish those ideas. This is a list of Committee Chairs for 2026 and you can connect with them as well with your ideas and willingness to serve.

2026 Committee Division 55 Chairs



..... *Connect & Share*
your ideas and willingness to serve

A Brief History of Division 55

The humble beginnings of Division 55 are recorded by Drs. Ruth Ullmann Paige and Elizabeth Robinson in *Prescriptive Authority for Psychologists: A History and Guide*, edited by Drs. Morgan Sammons, Ruth Paige, and Ronald Levant. It's a fascinating read of all the things that went on prior to establishing an APA Division.

1980

The APA Board of Professional Affairs taskforce proposed that psychology include physical interventions, such as biofeedback

1989

APA Board of Professional Affairs held a retreat solely devoted to prescriptive authority. At the end of the retreat Dr. Floyd Jennings, the only psychologist in the nation to have prescriptive authority as a member of the Public Health Service serving on an Indian Reservation spoke. It was recorded that there was a sense of "magic" at the retreat. The retreat ended with strong endorsement for research on feasibility and curricula development for prescriptive authority for psychologists.

1990

APA Council of Representatives was asked to create a special taskforce (Ad Hoc Taskforce on Psychopharmacology). Dr. Pat DeLeon was quoted as saying they had no idea how Council would react to this idea and the request for funding of \$16,275, but the proposal received overwhelming support (118-2). The report ultimately concluded that prescribing was feasible and desirable for psychologists.

1993

APA Council asked the Board of Educational Affairs and the Board of Scientific Affairs to develop training modules in psychopharmacology. Three levels of education were conceived: basic educational level needed by all psychologists, a second level needed for those who collaborate with physicians and other health care providers, and a third level for those who obtain prescriptive authority.

1995

CAPP



Dr. Jerry Clark, representative from CA "courageously" introduced a resolution to obtain APA-wide authorization for prescriptive authority. The resolution noted that the practice of psychology includes physical and psychological interventions when a) it was in the consumer's interest, and b) was within the scope of training, experience and competence of the attending psychologist.

The Committee for the Advancement of Professional Practice (CAPP) had primary responsibility for moving the prescriptive authority through APA. They created a report that included: 1) how to work with State Psychological Associations in rural states, 2) how to facilitate legislative efforts and education, and 3) they endorsed development of a model for post-doc fellowship.

APA Council of Representatives passed 2 resolutions: one endorsed model legislation and one contained recommendations for post-doc training.

1997



APA Council of Representatives authorized an examination for use by states, the Psychopharmacology Examination for Psychologists (PEP). Mini conventions on psychopharmacology were led by Dr. Pat DeLeon and Ron Levant.

Which brings us to an historic evening in 1997 at Morton's Steakhouse in Washington DC at the APA Convention. Dr. Pat DeLeon, psychology's foremost advocate for prescriptive authority, had decided to run for President of APA, and a group of friends and supporters gathered to celebrate the official announcement of his candidacy. (He won by the way!)

It was reported that the initial dinner table was 3, then 4 then more as Council members heard about this meeting. Those in attendance were largely comprised of members of Division 42 (Psychologists in Independent Practice), as well as those interested in rural issues where the demand for action was the greatest.



Washington D.C.
(Downtown)
PRIVATE DINING

1997

Dr. Elizabeth Robinson, then President of the APA Division 31 (now called State, Provincial and Territorial Psychological Association Affairs) offered the first organizational home to the people wanting to establish a division, since Division 31 shared the goals related to scope of practice and legislative issues. However, Div 31 bylaws did not provide a means for developing a new psychopharmacology section and the goals of Div 31 were broader than the prescriptive authority group wanted, so they explored creating a new division.

1999

Members got to work after 1999 APA convention with renewed energy:



The founding of Division 55 – Morton's Steakhouse, Washington, DC, February 1997, (From left to right) *Back row:* Morgan Sammons, Robert Resnick, Mike Enright, Jerry Morris; *Middle Row:* Paul Craig, Elizabeth Robinson, Kathy McNamara, Tommy Stigall, Alan Entin, Ron Rozensky, Margaret Heldring; *Front row:* Ruth Ullmann Paige, Pat DeLeon; *Not pictured:* Gil Hill.

“

The momentum generated from difficulties with Div 31, led to American Society for the Advancement of Pharmacotherapy (ASAP). No one was overjoyed with the new name, but everyone resonated well to its acronym of ASAP. There were 4 months to meet deadlines of getting 1% of APA members to sign a formal Petition for Division status. This was a Herculean task to be done by e-mail solicitation, but the members of ASAP responded asap! More than 1200 petitions were signed and more than 1000 were validated, which exceeded the 816 minimum membership requirements of APA. ASAP was given status as a provisional division under APA bylaws at the Feb 2001 APA Council of Representatives meeting and was granted full status the following year (2002). This robust growth of an idea into a division took place in only 3 years – a record for modern day APA. (Jack Wiggins, personal communication, p.73, 2001).

”

These are just a small sample of milestones the founders of prescriptive authority faced and achieved. A fuller explanation is found in Paige and Robinson's chapter in the book listed above. Division 55 has gone on to have 25 Presidents. Our beginning has been described as “humble.” They may have been, but they were also strategic and genius, requiring knowledge, fortitude, and political and relational skills.

Thank You Founders!

We stand on your shoulders as we forge the future

DIVISION 55

Presidential Timeline

2025 Lynette Pujol, PhD
 2024 Steven Curtis, PhD
 2023 David Shearer, PhD
 2022 Peter Smith, PsyD
 2021 Derek Phillips, PsyD

2015 Michael Tilus, PsyD
 2014 James Bray, PhD
 2013 Gilbert Sanders, EdD
 2012 Kevin McGuinness, PhD
 2011 Glenn Ally, PhD

2005 Matthew Nesselletti, PhD
 2004 Beth Rom-Rymer, PhD
 2003 Anita Brown, PhD
 2002 Ronald Fox, PhD
 2001 Jack Wiggins, Jr., PhD

This division was established as a candidate division at the Council of Representatives' February 2000 meeting. Officers will be elected later in 2000
(American Psychologist, 2000,)

2020 Richard Barnett, PsyD
 2019 Judith Steinman, PhD
 2018 Virginia Waters, PhD
 2017 Sean Evers, PhD
 2016 Neal Morris, EdD

2010 Owen Nichols, PsyD
 2009 Morgan Sammons, PhD
 2008 E. Mario Marquez, PhD
 2007 Elaine LeVine, PhD
 2006 Robert McGrath, PhD

2000 DIVISION 55 was Founded

2000 – 2021: known as "American Society for the Advancement of Pharmacotherapy (ASAP)"

2021 – NOW: known as "Society for Prescribing Psychology"

DIVISION 55

“ Past Presidents Experiences



The connections I've made through Div. 55 and my time on Board have been some of the most supportive and beneficial professional relationships I've ever made.

– Peter Smith, PsyD



In the words of Jim Quillin, if we don't quit, we win!!

– Bob McGrath, PhD



My memories are countless...but I distinctly remember endorsing the PDP at the Pennsylvania Psychological Association; support of the medical professionals along the way; encouragement of colleagues and family on this 'great adventure.'

– Anita Brown, PhD



I found everyone very welcoming to Div. 55 when the UH Hilo MSCP program began in 2011. Leadership was a natural progression as I got more involved with Div. 55.

– Judi Steinman, PhD



Motivation to raise more awareness around RxP for public and professionals inspired me to take on the leadership role at Div. 55.

– Rick Barnett, PsyD



The incredible progress we have made in our fight for prescriptive authority...they said it couldn't and shouldn't be done – but now we know different!

– James H. Bray, PhD



It's incumbent upon Div. 55, being the official voice of APA on prescribing psychology, to establish itself as the premier organization representing prescribing psychology on a national and international level.

– David Shearer, PhD



We were indeed proud to be able to stand head and shoulders with, even above, our medical colleagues in support of the integrated health care model we exposed.

– Elaine LeVine, PhD



At the 2023 Practice Leadership Conference, I had the honor of announcing to everyone in attendance that CO governor, Jared Polis, had just signed CO's RxP bill into law.

– Derek Phillips, PhD



QUIZ time

25th Anniversary

1 Which of the following artists sang a song about the year Guam first passed RxP legislation?

- | | |
|----------------------------|--|
| A Mandy Moore | C Bryan Adams |
| B Smashing Pumpkins | D (the artist formerly known as) Prince |

2 What's the full name of Division 55?

- | | |
|---|---|
| A Psychologists for Safe Prescribing | C Society for Psychological Pharmacology |
| B Society for Prescribing Psychology | D Division of Clinical Neuropsychopharmacology |

3 Which state was first to pass legislation granting psychologists prescriptive authority?

- | | |
|---------------------|-------------------|
| A Louisiana | C Illinois |
| B New Mexico | D Guam |

4 In what year did the U.S. Department of Defense begin training psychologists to prescribe medications?

- | | |
|---------------|---------------|
| A 1985 | C 1991 |
| B 1989 | D 1994 |

5 Roughly how many psychologists are board certified in prescriptive authority in the U.S. as of August 2025?

- | | |
|------------------------|--------------|
| A 200 | C 100 |
| B Fewer than 10 | D 50 |

6 Which medication name includes the name of a mythical Norse god?

- | | |
|-------------------|--------------------|
| A Vyvanse | C Thorazine |
| B Adderall | D Concerta |

7 The heart of which animal was used to discover neurotransmitters?

- | | |
|----------------|----------------|
| A Horse | C Frog |
| B Squid | D Mouse |

8 Division 55 is celebrating a big birthday this year! Which of the following is older than Div 55?

- | | |
|------------------------|------------------------|
| A The Sims game | C Hollister |
| B Harry Potter | D Camera phones |

9 Which medication made headlines when a sleep-deprived user bought a kayak on Amazon at 3am while under its influence—in a landlocked state?

- | | |
|------------------|--------------------|
| A Lunesta | C Trazodone |
| B Ambien | D Melatonin |

10 Who was the 1st President of Division 55?

- | | |
|---------------------------------|---------------------------|
| A E. Mario Marquez, PhD | C Ronald Fox, PhD |
| B Jack Wiggins, Jr., PhD | D Anita Brown, PhD |

Click
Here for
Answers

Legislative Updates

Pat DeLeon

Former APA President, October, 2025



“

WELL, I'M NOT BRAGGING, BABE, SO DON'T PUT ME DOWN

”

Exciting Times

One of this year's most exciting APA events is the *Psychologists in Politics* series heralding the contributions of members of our profession who are personally engaged in the political/public policy process at all levels of government. Alix Ginsberg, Deputy Chief of State Advocacy: “On September 29, I had the privilege of moderating a *Psychologists in Politics* conversation with Cheryl Stallings, Commissioner of Wake County, North Carolina, introduced by APA President Debra Kawahara. Sponsored by the Psychology PAC, this series highlights psychologists who have successfully transitioned into public office – offering insights into how psychology can inform leadership, policymaking, and community impact.

“Commissioner Stalling spoke with remarkable candor about her journey from school psychology to elected office and the deep sense of public service that drives her work. She reflected on how her background as a psychologist informs her leadership – emphasizing empathy, data-driven decision-making, and a commitment to listening deeply to the needs of her community. One of her

most striking points was that although federal politics often feels locked in constant partisanship, that isn't the case everywhere. At the state and local levels, she reminded us, there remains meaningful space for collaboration, common ground, and real progress on the issues that shape people's daily lives.

“Her story is a powerful reminder of the difference psychologists can make when they bring their expertise, values, and compassion into public service – and how psychology's voice is essential at every level of government.” Those interested in joining this inspiring series should contact Alix [aginsberg@apa.org].

A Pressing National Need

In October, Mental Health America released its annual report *State of Mental Health in America*. For the second time in a row, Nevada and Arizona were ranked the lowest; while this year New York, Hawaii and New Jersey ranked best in the nation for 2022 and 2023. Not surprisingly, citizens in the South and states with more rural populations

continue to face the greatest gaps in access to mental health care. “This report gives us a foundation to build better strategies, advocate for smarter policies, and target resources where they are needed most to address the ongoing mental health crisis in this country. By using these facts to fuel action, we can best support the individuals and communities the data represent, moving from awareness to lasting change.”

Key findings

In 2024, nearly 1 in 4 (23.4%) of adults experienced any mental illness; 17.7% had a substance use disorder; and 5.5% reported experiencing serious thoughts of suicide. Access remains a major barrier – in 2022 and 2023, 25% of adults with any mental illness reported an unmet need for mental health treatment in the past year and 77.09% of all adults with a substance use disorder did not receive treatment. Further, 9.2% of adults with any mental illness were uninsured, totaling over 5 million Americans.

Mental health among youth (ages 12–17) improved significantly from 2023 to 2024 with continued support needed to sustain these trends. 15.4% of youth experienced a major depressive episode in 2024, compared to 18.1% in 2023. Nevertheless, 11.3% of youth (2.8 million individuals) experienced a major depressive episode with severe impairment in 2024. 10.1% of youth reported serious thoughts of suicide in 2024, compared to 12.3% in 2023.

Nearly 3 million youth still reported serious thoughts of suicide in 2024, again

highlighting the need for sustained investment in both crisis care and upstream suicide prevention. For those who appreciate the clinical significance of integrated care, it is noteworthy that unfortunately 28.6% of our nation's youth (over 7 million young people) did not have a preventive health visit in 2022 and 2023, representing a missed opportunity for prevention and screening. “The data continue to show that the overall need for mental health care remains high, while access still falls short for too many. To make lasting progress, we must continue to invest in proven strategies that support people at every stage of life, and every step of their mental health journey.”

Innovative Training Models –The Importance of Interprofessional Collaboration and Training (IPE)

During the years that I was fortunate to serve on the U.S. Senate staff, I was constantly impressed by how the underlying policy issues facing the various health professions were extraordinarily similar, both the barriers and the opportunities to make a real sustained difference. And yet, it was also evident how infrequently they worked together, especially at the state level. With separate and isolated training programs, the notion of encouraging interprofessional collaboration simply does not seem to have been considered. And yet historically, those psychologists active in the early stages of developing state-based RxP training modules found clinical pharmacy quite supportive when asked for assistance;

at the national level, pharmacy provided exceptional assistance in establishing what ultimately became the Daniel K. Inouye College of Pharmacy at the University of Hawaii, Hilo.

Professor Mark Schneiderhan of the College of Pharmacy at the University of Minnesota has been developing the type of mental health-oriented training and clinical practice program which, in our judgment, would be what Mental Health America would seem to be calling for in their quest for investing in proven strategies and targeting resources where they are needed most. Over the past 15 years, Mark has trained 89 pharmacy students in patient care at the Human Development Center (HDC), a certified community behavioral health clinic serving northern Minnesota and Wisconsin based out of Duluth, Minnesota.

The HDC views itself as a “hub for everything that is rural” with their providers and trainees going out into the local and rural community and underserved clinics as part of assertive community treatment teams. Sometimes the demand is for mental health crisis care; other times it’s for substance-use programming. Last year HDC served well over 6,000 individuals while their crisis response team fielded 1,389 calls. They are especially involved with individuals diagnosed with Severe and Persistent Mental Illness (SPMI) who really have no place else to go.

Mark established a Comprehensive Medication Management (CMM) service, conducting a “deep dive” to create a

complete medication history of a patient, including over-the-counter medications and any other consumption (nutrients, caffeine, nicotine, etc.) that can affect biological systems. He also used laboratory testing to monitor side effects, analyze drug blood levels, and applied pharmacogenetic testing ascertaining how a patient’s system may be metabolizing medications. If approved by the patient, he coordinated care with the patient’s primary care provider and other HCD providers as needed. “With polypharmacy, you’ve got too many cooks in the kitchen... nobody’s really paying attention to how these medications are interacting with each other and how that can create this medication stew,” the psychiatric nurse medical director noted.

Currently, psychiatric pharmacists are not classified as “mental health providers” for reimbursement purposes within certified community behavioral health clinics, etc., thus preventing them from generating sufficient revenue to support operational costs. Mark: “A number of my students have gone on to do psych rotations and psych residencies. A lot of them choose my site because of their interest in mental health to begin with but I also get really excited when they actually want to go into the field of mental health because we do need to continue to grow this area.” [<https://aapp.org/psychpharm>].

In our judgment, Mark’s experience underscores the critical importance of for example, in the State of Georgia. Similarly psychiatric nurses and psychologists bringing

their personal experiences and expertise into the public policy/political process and especially focusing upon critical funding and reimbursement priorities. As Mark has proposed, eventually it may be necessary for: “All payers (CMS, commercial, and state Medicaid) to completely transition from a fee-for-service model to an outcome value-based collaborative care model for mental health that would include an interprofessional team (pharmacists, NPs, psychologists, social workers, psychiatrists, case management, peer support, etc.) with primary care.” Further, in order to develop an appreciation for a larger health policy perspective in the next generation, educators and clinicians must strive to expose their students (and themselves) to Interprofessional Integrated Practice. For, we would ask: How else will each mental health discipline come to appreciate the unique culture, language, and expertise of their professional colleagues?

Innovative Training Models – Crafted at the Local Level

Uniformed Services University (USU) colleague Alan Nordholm reports that San Diego County, where USU has a significant presence, will be investing \$75 million (in an initiative named Elevate) to grow local behavioral health staffing. This will fund a range of initiatives, from apprenticeship programs for entry-level positions to graduate-level training targeted at growing the number of professionals able to diagnose and treat mental illness. Designed with advice from a wide range of professionals,

the goal is to train 3,000 people over the next five years, some of whom will be working towards entry-level jobs and others will work towards greater levels of education that will allow them to earn higher levels of licensing. An involved County Supervisor noted: “Most importantly, we’re ensuring that when a child, a parent or a neighbor is in crisis, they can get the care they need, right here at home.”

At the base of the pyramid, 700 individuals are expected to be trained for entry-level positions as substance use counselors, case managers, and community health workers. This approach would assist trainees working as apprentices in existing organizations serving mental health clients, allowing them to learn on the job and eventually apply for state job certification. Another program undertaken with the National Association of Mental Illness of San Diego and Pacific Clinics, will seek to train 500 individuals to pass the state’s exam to work as peer support specialists. A third program will offer zero-interest forgivable loans to mental health care workers who wish to pursue master-level training to become licensed to work in roles such as clinical social workers, licensed professional clinical counselors, and marriage and family therapists. And, UC San Diego will be collaborating on a new doctorate-level program to train 135 registered nurses to become psychiatric mental health nurse practitioners. This designation allows the graduates to diagnose mental illness and prescribe psychiatric medications in collaboration with a

psychiatrist. The nursing program is structured so that those who enroll only have to come to campus eight times per semester, with the balance of their coursework available through remote learning. Given the historical difficulty in finding clinical practicum placements, Elevate is working with more than 90 mental health providers in the county to streamline the process of obtaining clinical practicum hours.

All of the programs envisioned will allow students to continue working at their existing jobs, or in their future jobs through apprenticeship, in acknowledgement that many individuals may not have pursued further education because they need to be able to keep paying their bills in the short term. The County Supervisor further cited the connection between education and clinical practice, and the ability to keep working while learning, as the key factors in making progress in the larger goal of significantly growing the local mental health care workforce.

Licensure Mobility

Alex Siegel, Director of Professional Affairs, Association of State and Provincial Psychology Boards (ASPPB): "Montana will become the 43rd jurisdiction to embrace Licensure Mobility as their PSYPACT legislation becomes effective October 1, 2025. There is active legislation in New York and Massachusetts. At the recent PSYPACT Commission meeting, the Commission voted to no longer require individuals to be from an APA/CPA accredited program to apply for and receive

an APIT or TAP which would authorize them to use PSYPACT for interjurisdictional practice. In other words, if one did not graduate from an APA/CPA accredited program it will no longer preclude one from obtaining an E. Passport or IPC from ASPPB, or APIT or TAP from the PSYPACT Commission." These are very creative and exciting times. "She's my little deuce coupe" (Brian Wilson & The Beach Boys, The Little Deuce Coupe).

Aloha,

Pat DeLeon

Ashley Norwood-Strickland, PhD, MSCP

Specializing in integrated care, rural mental health, and psychopharmacology, Dr. Ashley Norwood-Strickland serves in multiple clinical and academic roles across Alabama and is passionate about advancing access and equity in behavioral health. In addition to teaching at Auburn University, she travels 2.5 hours two days per week to serve as a core faculty member for the Jackson Hospital Family Medicine Residency Program in Montgomery, AL where she helped

establish and now runs the Behavioral Medicine rotation for the residency. Back at home the other three days of the week, she sees patients at the Whit Fitz-Gerald Family Medicine Clinic in Demopolis, AL and holds privileges at Whitfield Regional Hospital where she also serves as the sole provider for pediatric ED psychiatric evaluations. She holds active licenses in AL, MS, and IA and is excited to be applying for prescribing privileges in IA in the coming months.

Triage at Twilight: The Rural Pediatric Psychiatric Crisis and the Role of Behavioral Medicine and Prescribing Psychology

The emergency department is quiet at first glance. Someone's grandmother hasn't been dosing her insulin correctly. A middle-aged man is reporting vague chest pain and shortness of breath, but nothing that has the staff moving particularly quickly. Anyone who has spent time in a rural hospital knows that this kind of quiet can be misleading.

On this particular evening, a 10-year-old girl is sitting in a triage bay, repeating the same sentence over and over: "I don't want to be here anymore." Her mother is slumped in a chair nearby, and her grandmother waits outside in the lobby, both of them exhausted and scared. The child had tried to jump through her bedroom window, hoping it would "take her to another world." After stitching up her arm, the ED physician walks over to me and asks, "Can you help us figure out what needs to happen here?"

That moment captures what I have

come to think of as the twilight zone of rural psychiatric triage. It is the space between risk and intervention, between fear and stabilization, and between needing psychiatric expertise and having none available. It is the space where rural health systems live every night.

A year ago, this hospital had no pediatric behavioral health protocol at all. There was no behavioral-medicine provider to call, no structured assessment, and no clinician trained to offer crisis intervention. The staff had only one option when a child arrived expressing suicidal thoughts, engaging in self-injury, or showing escalating aggression. They would call every pediatric psychiatric unit in the state and hope someone had an open bed. While they waited, the child stayed in an ED bay for days. In a few cases, they waited nearly a full week. During that time, they received no therapy, no medication

evaluation, and no meaningful support.

That was the landscape when I started here in May. Since then, we have worked steadily to shift the tide.

The Broader Rural Pediatric Crisis

The experience in our hospital is not an outlier. Rural America faces a severe shortage of pediatric psychiatric resources. National data show that rural counties have far fewer child psychiatrists per capita than urban regions, and many rural counties have none at all (McBain et al., 2019). Even as the number of child psychiatrists has grown modestly, their distribution remains profoundly uneven. Families often travel long distances, frequently without reliable transportation, just to access basic specialty care. I cannot count the number of appointments that have had to be rescheduled or converted to telehealth because families simply could not get to the clinic.

Even when we do secure a psychiatric bed, the system itself is stacked against rural families. More than 90 percent of pediatric inpatient psychiatric beds in the United States are located in urban areas (Cushing et al., 2024). Rural EDs are left to manage these crises without the ability to transfer quickly, which leads to long waits, stalled progress, and prolonged emotional strain for the child and family. Parents often cannot visit because the drive is too far, gas money is scarce, or there is no vehicle at all. Even when rural children do receive inpatient care, studies show their hospital stays are shorter and their readmission

rates significantly higher (Bettenhausen et al., 2020). Their care tends to be fragmented, accelerated, and disconnected from consistent outpatient follow-up.

Another study found that although rural and urban caregivers reported similar “unmet needs,” rural parents had significantly lower rates of “met need,” meaning they had far less actual access to services. They also reported “no need” at higher rates (Pasli et al., 2022). This finding aligns with cultural patterns I see regularly: the belief that struggling children simply need to “work harder,” “be grateful,” or “keep their head down” instead of receiving mental health care. The CDC’s most recent rural child mental health brief highlights the same barriers: workforce shortages, geographic isolation, limited insurance coverage, and a lack of crisis services (CDC, 2024). For many rural families, the emergency department is the beginning and end of crisis care.

The Local Landscape: One Pediatric Psychiatrist for Hundreds of Miles

Our region relies on a single pediatric psychiatrist who covers up to ten counties. She sees patients at a different hospital, forty-five minutes away, and only on Thursdays which for some is almost 200 miles from them. She is overbooked, difficult to reach for real-time consultation, and her follow-up schedule stretches out for months.

At our hospital, we are fortunate to have a psychiatrist on staff, but his expertise is in adult and geriatric inpatient care. He manages two dedicated units (10 beds each)

and is highly skilled, but he does not feel comfortable evaluating pediatric psychiatric cases. The gap that remains is enormous. This is the same gap that exists in rural hospitals all across the country. Pediatric crisis cases get trapped between no outpatient support, no available inpatient beds, and no on-site clinician who feels equipped to assess them.

A 24 Hour Behavioral Medicine Lifeline

My role immediately changed the structure of the system. The hospital operates a rural health clinic across the street, staffed by a physician, nurse practitioners, and a physician assistant. That is where I am embedded. Most of my day is spent providing consultations, outpatient therapy, and psychological assessments to a predominantly Medicaid population, most of whom are children and adolescents. But I also provide behavioral health coverage to the ED around the clock. I am on call 24 hours a day, 365 days a year. In a larger hospital system this would never be sustainable, nor should one person be solely responsible for it. But this is the reality of rural care. When a child arrives in crisis, the ED calls me. I evaluate risk, determine whether the child can be safely discharged, facilitate inpatient transfers when needed, and, if discharge is appropriate, I schedule a follow-up appointment within the same week so care is immediately established. To be clear, becoming the only on-call provider was not part of my original plan. This is not about personal sacrifice or being a hero but speaks to the fragility of rural systems. Behavioral health in these settings

often rests on one or two clinicians (on many service lines); without them in this case, children wait in crisis with no support at all. Since May, I have assessed 23 children and adolescents who presented to our ED. Nineteen were able to return home safely and were seen in my clinic within the week. Four required inpatient care. Two of those cases stand out.

One was a painful example of how broken the system can be. A 12-year-old girl arrived with a legal history and an active relationship with juvenile probation. She told me she wanted to kill her mother and herself and that she wanted the event to be televised. After a thorough evaluation, I determined that inpatient hospitalization was necessary. However, the nearest psychiatric facility, located 100 miles away, denied her admission.

When I contacted them, the intake staff explained that they believed she should begin with outpatient treatment. They also said that because she had never been in psychiatric care before, outpatient therapy should come first. I remember feeling furious and deeply discouraged. How are children in our region supposed to “start outpatient care” when the nearest pediatric psychiatrist is only available once a week at a different hospital, and most families have no access to therapy? The very reason these children end up in crisis is because they have no access to services.

Not all cases feel this hopeless though, and some end in relief. A juxtaposition to her case was a 14-year-old boy with severe

autism who had not slept in more than 36 hours. By the time he reached the ED, he was irritable, combative, and overstimulated by the environment. The team administered propofol in an attempt to settle him, which only made him more agitated. His mother told me she was desperate and had exhausted every strategy she knew. In our region, primary care providers and general practitioners manage pediatric care because there are no pediatricians, so families often struggle to access specialized guidance for autism.

No one in the ED felt confident making medication recommendations. Our adult psychiatrist was on site and, and now through ongoing collaboration, feels comfortable participating in these consults when warranted. With the mother's permission, we discussed safe and developmentally appropriate options. We agreed to try trazodone for short-term stabilization. The next morning, his mother called, relieved and tearful. Her son had finally slept through the night. That brief intervention stabilized the crisis and allowed us to begin a longer-term plan.

The Work of Pediatric Psychiatric Triage

Pediatric crisis assessment is demanding and requires a layered approach. Clinicians must understand intent, access to means, developmental factors, environmental safety, and medical causes. Children express suicidal intent differently than adolescents and agitation can stem from medication effects, substance use, neurological issues, or metabolic factors. A child who appears safe cannot be discharged if their home

environment is unstable. We use tools such as the C-SSRS, ASQ, and SAFE-T, but tools alone are not enough. Triage requires integrating these findings with clinical judgment and a working understanding of the rural system's limitations. When a child can safely return home, I build a safety plan with the family, coordinate follow-up care, and work closely with the ED physician to address medication needs. This is where prescribing psychologists can significantly strengthen the system.

The Role of Psychopharmacology and the Case for RxP

Medication questions arise constantly. Families ask whether an SSRI should be restarted, whether a stimulant is worsening agitation, or whether symptoms could be caused by withdrawal. I have even had ED physician call me and ask about managing galactorrhea in a pediatric patient. Without pediatric psychiatry access, these questions often have no answer.

Prescribing psychologists can provide that missing link. At the risk of preaching to the choir, research shows that prescribing psychologists practice safely and effectively, particularly in underserved and rural areas. They bridge the gap between crisis stabilization and medication management by initiating or adjusting medications as appropriate and by coordinating follow-up care. So an RxP model improves continuity, reduces unnecessary admissions, and minimizes gaps in care. It just makes sense, right? Prescribing psychologists do not replace psychiatrists. They support systems that lack

reliable psychiatric access. In rural communities like mine, that support can be lifesaving.

Building a System That Works

Our triage model now includes 24-hour behavioral-medicine coverage, standardized assessments, close collaboration with medical staff, detailed safety planning, and structured follow-up. It ensures that no child sits untreated for days. It also gives the ED a consistent, dependable process for evaluating pediatric psychiatric emergencies.

This model can be replicated in other rural settings. Integrating behavioral medicine into emergency care and expanding prescribing psychology could dramatically improve outcomes for children across rural America. Rural pediatric psychiatric care exists in a fragile space. For years, that space was filled with waiting and uncertainty. Integrated behavioral medicine has shifted that trajectory for our hospital, and prescribing psychology has the potential to strengthen it further.

Crisis care cannot rely on a once-a-month visit from a pediatric psychiatrist. It must rely on clinicians who are present, trained, and embedded in the community. With expanded access to prescribing psychologists and continued integration of behavioral medicine, the twilight space that once held only waiting can become the first step toward safety, stabilization, and recovery. Rural children deserve nothing less.

References

- Bettenhausen, J. L., et al. (2020). Rural urban differences in hospitalization outcomes for children with mental health conditions. *JAMA Network Open*, 3(12), e2030885.
- CDC. (2024). *Child Mental Health in Rural America: Policy Brief*. Centers for Disease Control and Prevention.
- Cushing, A. M., et al. (2024). Pediatric inpatient psychiatric capacity in the United States, 2017 to 2022. *JAMA Pediatrics*, 178(1), 23–31.
- McBain, R. K., et al. (2019). Growth and distribution of child psychiatrists in the United States: 2010 to 2017. *Pediatrics*, 144(6), e20191576.
- Pasli, M., et al. (2022). Children's unmet need for mental health care across rural U.S. counties. *Children and Youth Services Review*, 139, 106564.

“

You've come a long way, Baby

”



Judith Steinman, PhD

It's not every day that an organization gets to celebrate its 25-year anniversary, but Division 55 gets to celebrate its creation every day throughout 2025. The phrase “You've come a long way, Baby” comes to mind when I think of all that has been accomplished by our members over two and a half decades, but I also think “We've only just begun.” As hard as everyone has worked to make prescriptive authority for psychologists a reality, we still have much to do.

Our listserv is often a place where our accomplishments as well as our hard-learned lessons are discussed. Earlier this year, Dr Robert Ax from Virginia lamented that we need a better pipeline for prescriptive authority training and practice. I could not agree with him more.

As our movement achieves successes – such as becoming an APA-recognized Specialty in 2020, achieving RxP status in seven states as of 2024, having over 1,000 members for several years in a row, beginning the process of board certification in 2025 and having six APA designated MSCP programs – we also need to expand the ways in which the division serves our students and graduates. We face numerous challenges such as establishing

experiential training sites and recruiting potential MSCP students at the doctoral and even the undergraduate level. Dr Ax observed that we have not moved the ball in terms of getting psychopharmacology into our psychology textbooks, let alone into required three credit doctoral level courses. I could not agree with him more.

I look to Division 55's next 25 years as the landscape upon which we can accomplish these goals. Being the perpetual optimist that I am, I hope that we can move the needle forward by inspiring our members to get involved, especially our students. Our current president, Dr Lynette Pujol recruited several early career psychologists and recent MSCP graduates to serve as committee chairs this year, a choice that I consider precisely on target for where the division needs to go. Fortunately, our incoming President, Dr Bethe Lonning, has adopted this same approach and we have new committee chairs and co-chairs getting involved with division activities.

We have regained our ability to offer CEs thanks to Dr Daniel Lee's leadership of the division's Continuing Education Council. Drs Amy Daley and Alyssa Cunningham (our 2025 convention co-chairs) have introduced

exciting activities such as the MSCP Fair and a "support group" for those seeking experiential training and PEP preparatory options. These events were designed specifically for those of you who are recent or soon-to-be MSCP graduates. These are opportunities created by our convention co-chairs, who have the unique insight of being students not that long ago.

Our Division 55 Training Director Council continues to seek ways to support our students. The council members are made up primarily of Program Directors George Kapalka (CSPP-Alliant International University), Geraldo Rodriguez-Menendez (Chicago School), Ryan Ernst (Drake University), Derek Phillips (Fairleigh Dickenson University, Co-Recording Secretary and Past President of Division 55), Eric Silk (Idaho State University and Membership Committee Chair of Division 55), Casey McDougall (New Mexico State University) as well as Bethe Lonning (Co-Recording Secretary and President-elect of Division 55) and me (Chair of the Training Director Council and Past President of Division 55). The new Colorado MSCP program (Amy Wachholtz) also has been invited to participate in council activities.

In this jubilee year, I hope that all of you who are educators may consider getting your school to create a psychopharmacology course, certificate or concentration/minor for doctoral students. Other ways to contribute to our RxP effort include offering to teach a course or ask your colleagues on the listserv if they would like to co-teach with you. Bring

topics to the CE Council if you would like to learn more about a specific class of drugs or a new medication that has come out. Consider mentoring or acting as a preceptor for a student who needs to complete experiential hours or who may otherwise need guidance. Pitch in when your state RxP committee needs new members. Join a committee, council or run for a board position. If you have graduated from an MSCP program, please take the PEP! It is the one thing that will make it clear to legislators that you continue to be committed to becoming a prescriber where you live.

I wish to recognize the people who have taken the mantel as president of division 55, each making their mark on our field in their own way. I do not know where I would be without the support of Drs Pat DeLeon and Beth Rom-Rymer. Did you know that our first two division presidents – Drs Jack Wiggins and Ronald Fox – were also presidents of APA? I will end my "look to the future" by looking at the list of those who have led the way as past presidents (see page 8). It is upon the shoulders of these giants in our field that today's leaders stand and extend the future of our profession.

Please find our infographic comparing the state RxP rules on page 29 and following. This tool will help those of you seeking RxP legislation in your state.

Malloy, J., Service, S., Smith, P., Steinman, J., Juarez, T. T., and APA Practice Office of Legal & State Advocacy. (2025, September 12). *Prescribing Psychology (RxP) Files 2025* [Infographic].

Division 55: 25 Years of Memories



Steve Curtis, PhD, NCSP, MSCP
Affiliate Faculty, PsyD Clinic
Psychology Program
Antioch University, San Diego
Presentation for
Division 55
25th Anniversary

Prescriptive Authority for
Psychotropic Medication in California
Vicki Vales Jones, MSc, RPharm
Clinical Practice, Therapies
Vicki Vales Jones, MSc, RPharm
Clinical Practice, Therapies
Vicki Vales Jones, MSc, RPharm
Clinical Practice, Therapies

2025-2026
PSYCHIATRIC PSYCHOLOGY
AWARD
For Richard, PhD, MEd, MEd, EdD
2025-2026
2025-2026

Happy 25th Anniversary
Div 55!

APA 2025





Inspiration and Dedications



(From left to right) Dr. Levine, Dr. Orabona-Foster, and Dr. Rom-Rymer

“

These are the shoulders of the giants upon which I have stood. Thank you for your past and continued courage and leadership.

– Massi Wyatt, PsyD

”

“

Sometimes it's a thankless task. But if anything is going to get done, you are usually the person who has to make it happen. I am grateful that we are continuing the charge.

– Morgan Sammons, Ph.D.
2009 President, Division 55

”



Quiz answers:

1. D – Prince (1999)
2. B – Society for Prescribing Psychology
3. B – New Mexico, 2002 – a tricky one. Guam was first but it's not a state, so the answer is NM
4. C – This one is another TRICKY one because it started the program in 91 but the first graduating class started prescribing in 1994
5. B – fewer than 10
6. C – Thorazine
7. C – Frog – Otto Lewis discovered neurotransmitters in 1921 using 2 frog hearts. He won a Nobel prize for this!
8. B – Harry Potter
9. B – Ambien
10. B – Jack G. Wiggins, Jr., PhD

Prescribing Psychology (RxP) Files 2025

Scope

Click Headings
to Jump to File

Coordinated Care

Patients & Supervisors

Formulary

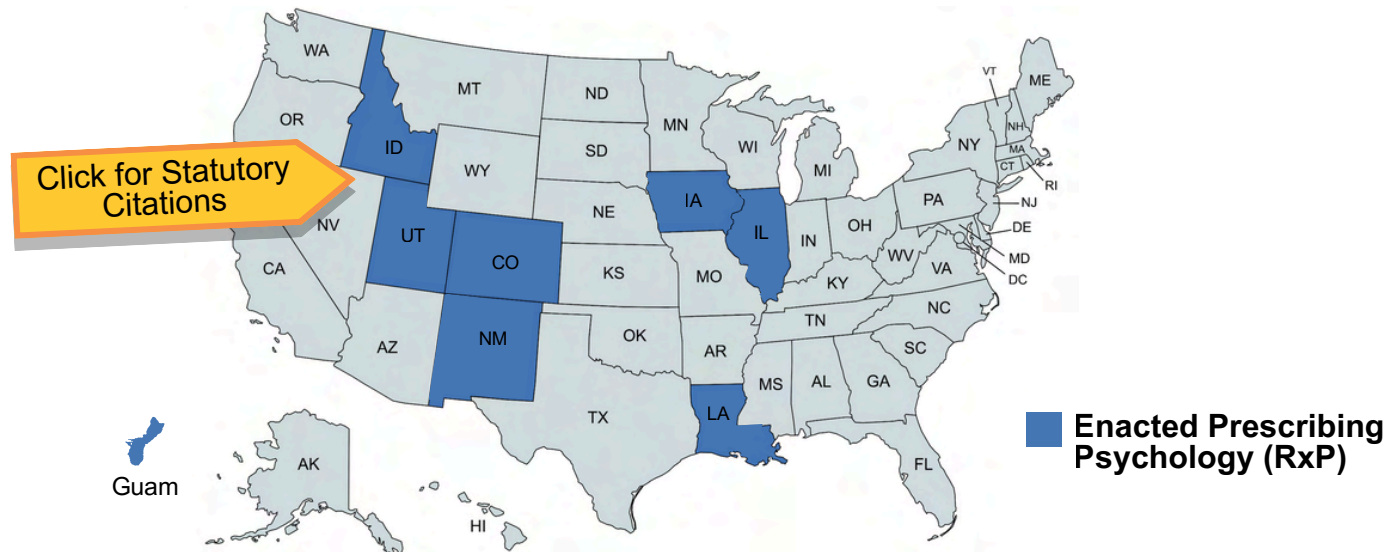
Oversight

RxP Exam Requirements

Other RxP Requirements

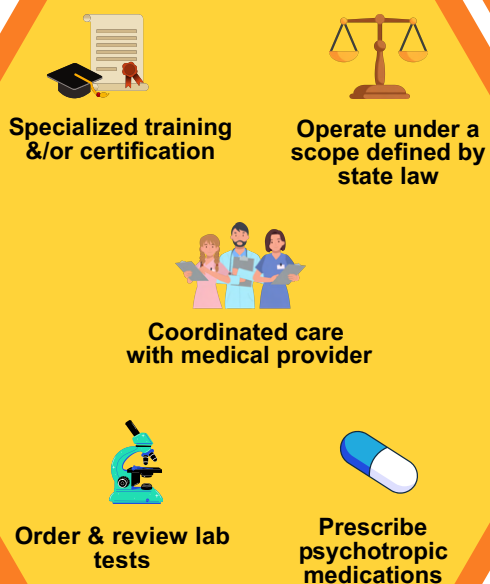
CE Requirements

STATE AND TERRITORY Prescribing Psychology Scope

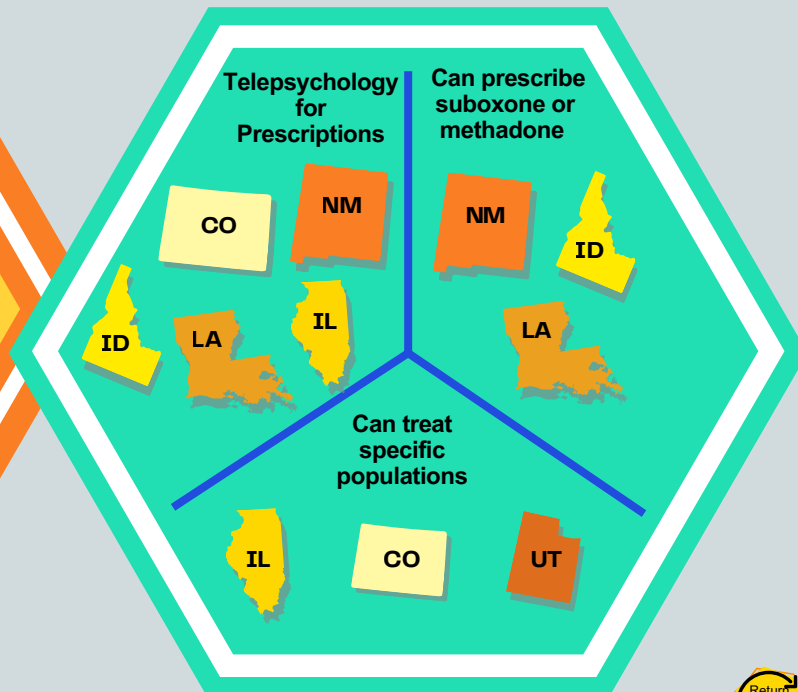


RxP is authorized in seven states and Guam, enabling the prescription and discontinuation of psychotropic medications pertinent to mental health treatment while adhering to state laws, professional training, and licensing requirements, including cooperative practice with medical professionals.

RxP Similarities Among States



RxP Differences Among States



PRESCRIBING PSYCHOLOGY Coordinated Care

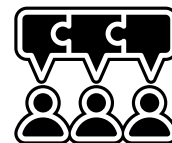
STANDARDS OF PRACTICE FOR RXP COLLABORATION WITH PCP BY STATE

Cooperative care is required by all states and legislations

	Maintains ongoing communication	Concurrence with PCP for prescriptions (or changes)	Reports changes in conditions to PCP	Reports adverse effects to PCP	Signed patient consent for PCP collaboration	Reports medical exam or lab results to PCP	Written description of collaborative dynamic
CO							
NM							
IL							
IA							
UT							
LA							
ID							
GUAM							



**RxP and Medical Providers:
Coordinating to Improve Holistic Health.**



CO: If a patient does not have a primary care physician, the prescribing psychologist shall refer the patient to a licensed physician prior to psychopharmacological treatment.

NM: Must report lab results.

ID: The prescribing psychologist must make every reasonable effort to encourage the patient to maintain or establish a relationship with a licensed medical provider (with documentation). Must document justification for the care provided (e.g., patient assessment information, the prescription record, provider notification, follow-up care plan). Must maintain documentation justifying provision of care.

UT: Must consult on medical examinations.

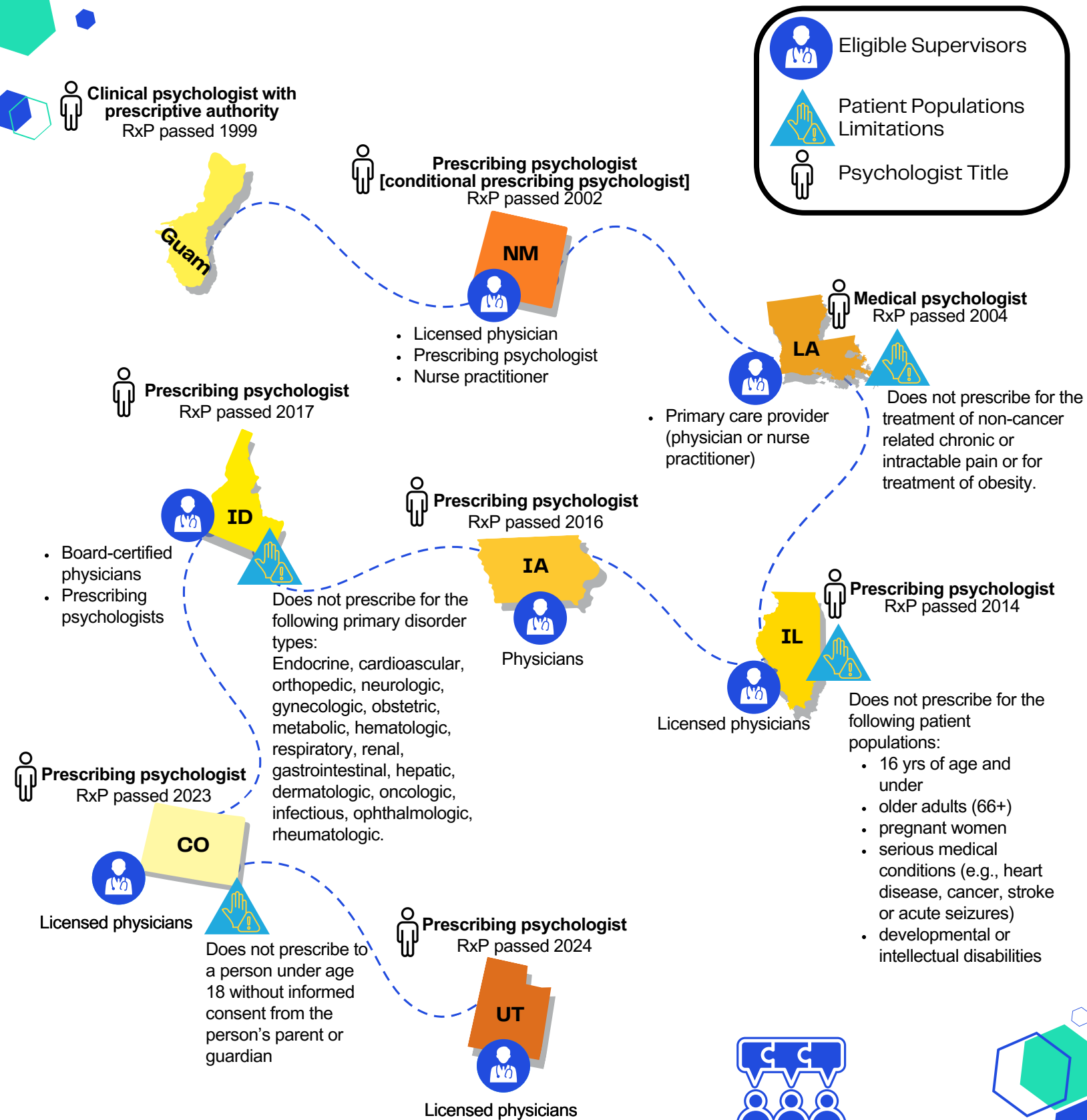
IL: Collaboration does not require an employment relationship, and an agreement may not restrict third-party payment sources accepted by the prescribing psychologist. The collaborative agreement shall contain provisions detailing notice for termination or change of status involving a written collaborative agreement, except when the notice is given for just cause. Must have monthly review of medication orders by RxP and specified notice of termination or change in collaborative agreement.

IA: Separate from mandatory CPA requirement, must contact patient's PCP (physician, NP or PA) at least on a quarterly basis or to convey the following information: (a) adding a new psychotropic medication; (b) discontinuing or changing the dosage; (c) patient experiencing adverse effects from any medication prescribed by the psychologist; (d) laboratory test results related to the medical care of a patient; or, (e) noted changes in patient's mental condition that may affect the patient's medical treatment. Limitations for working with vulnerable populations and physicians are limited to working with two RxPs at a time. Specified requirements for annual reviews. Permission or signature from PCP to prescribe is not needed; rather, prescribing psychologists are to alert the PCP to prescriptions and/or changes.

LA: See 46 LAC §6115(E) for physician consultation documentation requirements.

Supervisors and Patient Populations

Prescribing Psychology



RxP and Medical Providers:
Coordinating to Improve Holistic Health.



RxP Formulary

STATE AND REGIONAL FORMULARY AUTHORITY AND CONSTRAINTS
FOR PRESCRIBING (MEDICAL) PSYCHOLOGISTS

Iowa



Can prescribe psychotropic meds for mental disorders.



Cannot prescribe narcotics.

Colorado



Can prescribe psychotropic meds (including stimulants) for treatment of mental illness.

Cannot prescribe narcotics



Illinois



Can prescribe for treatment of mental health or illness.

Can prescribe benzodiazepines, Schedule III controlled substances except Flunitrazepam



Cannot prescribe injections.

Cannot prescribe Schedule II substances.

Cannot prescribe narcotics.

Utah



Can prescribe SSRIs and other medications approved under Subsection (1)(c), recognized in or customarily used in the diagnosis, treatment, and management of individuals with psychiatric, mental, cognitive, nervous, emotional, developmental, or behavioral disorders.

Cannot prescribe controlled substances (may be further defined in rulemaking).



Cannot prescribe narcotics.

Idaho



Can prescribe controlled substances for psychiatric, mental, cognitive, nervous, emotional, or behavioral disorders.



Must prescribe within scope of license and certification.



Can prescribe narcotics (i.e., buprenorphine and methadone for SUD tx)

Louisiana



Can prescribe controlled substances for mental, nervous, emotional, behavioral, substance use, or cognitive disorders.

Can prescribe narcotics (i.e., buprenorphine and methadone for SUD tx)

Guam



Can prescribe drugs or classes of drugs within competency as determined by the Board.

May not prescribe any drugs that are not routinely administered within the clinical psychologist's scope of practice.

New Mexico



Can prescribe psychotropic meds for mental, nervous, emotional, behavioral, substance use, or cognitive disorders.

Can prescribe and administer injections with board-approved training in consult with PCP.

Can order neuroimaging, x-rays, and other appropriate tests.

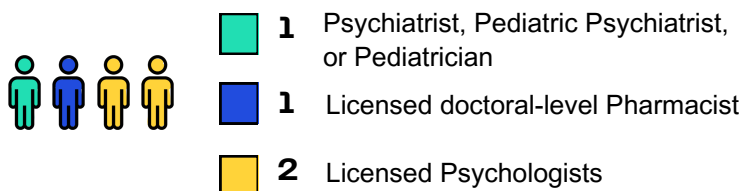




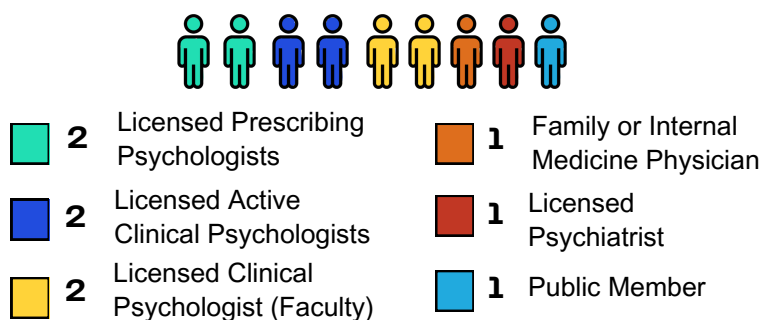
RxP Regulatory Oversight

Click on the title for each state to be directed to appropriate website

Idaho State Board of Psychologist Examiners & Advisory Committee

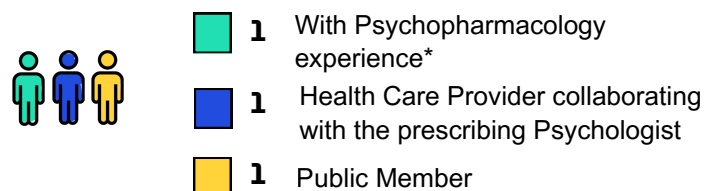


Illinois Clinical Psychologists Licensing & Disciplinary Board



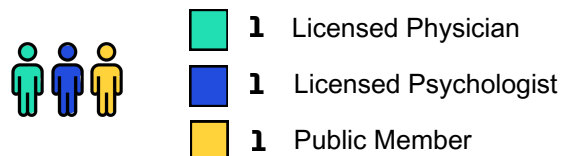
New Mexico State Board of Psychologist Examiners

For complaints involving collaboration, a joint board committee is involved consisting of the following appointed members:



* licensed physician, pharmacist, or psychologist; nurse practitioner or physician's assistant

Iowa Board of Psychology

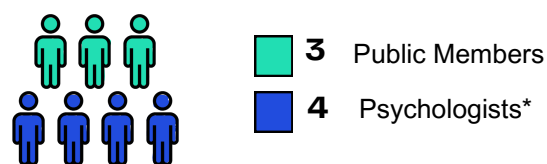


Guam Board of Allied Health Providers



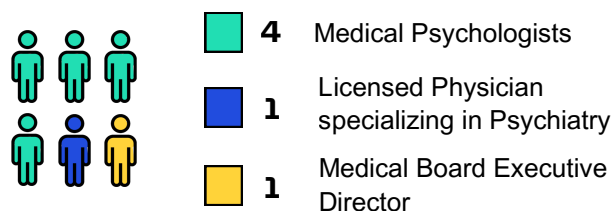
*1 rep. from each profession being examined for licensure

Colorado Board of Psychologist Examiners

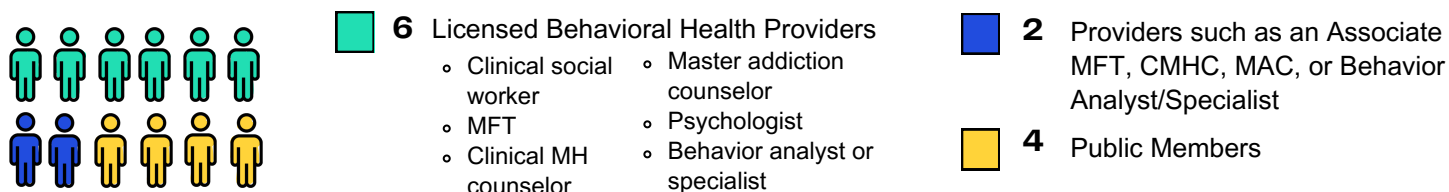


*at least 2 practicing psychologists & 1 prescribing psychologist

Louisiana Board of Medical Examiners & Medical Psychology Advisory Committee



Utah Behavioral Health Board



The division may consult with the medical board on issues involving the licensing of prescribing psychologists, provisional prescribing psychologists, and rulemaking related to prescribing psychology.



RxP REQUIREMENTS

Didactic Training Exam



State Psychology license*

An active non-prescribing psychology license is required in the state where they intend to apply for prescribing licensure

**click on title to be directed to the website*

Minimum Credit Hours

Minimum curriculum hours range from 30 credit hours or 450 curriculum (classroom) hours depending on the state requirements, which may include but not necessarily limited to Master of Science in Clinical Psychopharmacology (MSCP) program*

**see below for APA designated schools*



Course Curriculum*

includes (but not limited to)

- Anatomy and Physiology
- Microbiology
- Patient Evaluations
- Physical Assessment
- Biochemistry
- Clinical Pharmacotherapeutics
- Neuroscience
- Pharmacology
- Psychopharmacology
- Diagnostic Methods
- Pathophysiology

**click on title to be directed to the APA website*



Exam Requirement*

- National certification exam, such as the Psychopharmacology Exam for Psychologists (PEP)

**click on title to be directed to the website*



PRESCRIPTIVE AUTHORITY

ADDITIONAL REQUIREMENTS

RxP: ACTIVE STATE PSYCHOLOGY LICENSE



Sufficient Malpractice Insurance Coverage



DEA Controlled Substances Registration



State Issued Controlled Substances Permit

click on state for Statutory Citations

STATE: Idaho

TYPE: Clinical Experience determined by MSCP

TYPE: Provisional Certification Holder

EST: 2 yrs (2000 hrs)

QTY: 50 patients

Additional requirements for Pediatric* or Geriatric population

*at least 10 patients must be 12 yo or younger and at least 10 patients must be 13-17 yo

STATE: Utah

TYPE: Certified Prescribing Psychologist

EST: 2 yrs* (4000 hrs)

*at least 1 of the 2 years for Geriatric or Pediatric patients

STATE: New Mexico

EST: 80 hrs Clinical Assessment/Pathology

EST: 400 hrs

QTY: 100 patients

TYPE: Conditional Prescribing period

EST: 2 years

QTY: 50 patients

TYPE: Specialized training to administer long-acting injectable antipsychotics

STATE: Colorado

EST: 80 hrs Clinical Assessment

EST: 750 hrs

QTY: 150 patients

TYPE: Prescription Certificate

EST: 750 hrs*

*250 hrs must be spent specializing in children under 18 or persons older than 65 with comorbid medical conditions to work with the population

STATE: Iowa

EST: 40 hrs Clinical Assessment

EST: 400 hrs

QTY: 100 patients

TYPE: Conditional Prescribing

EST: 2 yrs*

QTY: 300 patients

*1 of the 2 years spent specializing in children, persons older than 65 with comorbid medical conditions

STATE: Illinois

Clinical training must meet accreditation standards for PAs, APNs, and MDs

TYPE: Pre-licensing

EST: 1620 hours

EST: 14 - 28 months

QTY: 9 medical specialty disciplines

Additional undergraduate level courses required

STATE: Louisiana

MP licensure supersedes psychology license

TYPE: Advanced Practice Certificate

EST: 3 years

QTY: 100 patients*

*25 must get antidepressants, 25 must be other medications

LEGEND

- States with Enacted RxP
- Practicum (Pre-licensure)
- Post-licensure (initial or conditional)
- Advanced/Specialized

**Guam is not included



Continuing Education (CE)

MINIMAL REQUIREMENTS EVERY 2 YEARS

GUAM

20 hrs CE in Pharmacology
+
40 hrs* CE psychology licensure renewal

**must include 6 hrs of Ethics training*

ILLINOIS

20 hrs CE in Pharmacology
+
24 hrs* CE psychology licensure renewal

**must include 3 hrs of Ethics training & 3 hrs of Diversity training*

LOUISIANA

15 hrs CE in Psychology

+

30 hrs* Continuing Medical Education (CME) every year ** related to Medical Psychology

**must include 2 hrs of Ethics training*

***25% CME hrs provided by Louisiana Academy of Medical Psychology*

UTAH

may be defined in rulemaking

COLORADO

40 hrs CE in Pharmacology and Psychopharmacology

IDAHO

30 hrs CE psychology licensure renewal

+

30 hrs* CE in Psychopharmacotherapy
**must include 4 hrs of Laws and Ethics*

IOWA

40 hrs CE in Psychopharmacology

+

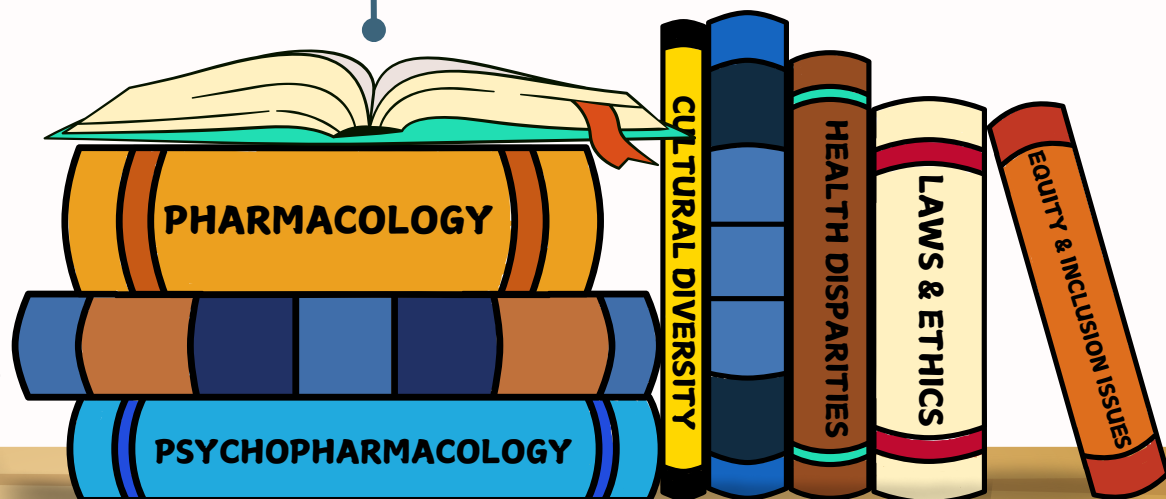
10 hrs* CE every year if treating children
**must be related to prescribing psychotropic medications to children*

NEW MEXICO

40 hrs CE in Psychopharmacotherapy and Psychopharmacology

+

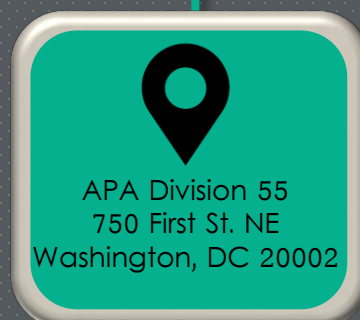
20 hrs* CE psychology licensure renewal
**must include 4 hrs of Ethics training, 4 hrs of Equity and Inclusion training, and 2 hrs of Cultural Diversity or Health Disparities training*



Connect with Division 55



CLICK ON LOGOS TO BE
DIRECTED TO WEBSITES



Donate Today!

Donations can be made directly to Division 55. Contact us today via phone or email, or send donations to the address listed.