

PSYNAPSE

Spring 2011



Newsletter of the CPA Section on
Psychopharmacology

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NOTE FROM THE EDITOR

Dear Members of the CPA Section on Psychopharmacology,

Many thanks for your consistent support and advocacy. We have at last successfully completed this spring 2011 edition of Psynapse, the electronic newsletter of the CPA Section on Psychopharmacology. We are very fortunate to have contributions from our members. In this issue, we present few articles, and links to CPA convention that is going to be in Toronto, Canada. More, links to other groups from across the boarder are presented. In brief, here we have a contribution from one of our member, Dr. Ax, reflecting on the “Clinical Psychopharmacology Training”, and a short article by Amir A. Sepehry, PhD student, on “Practicing Clinical Psychopharmacology” in Canada. Both of these are in English.

On a different vein, for your information, several US states have legislation either pending or in proposal.

On a different note, I would like to express appreciation to the executive members of the CPA section of Psychopharmacology for diligently working with me on this newsletter.

Without further ado, I would like to thank you for your support and readership of the newsletter.

Cordially,

Amir A. Sepehry, BA, MSC, PhD student

Section Editor

**CLINICAL PSYCHOPHARMACOLOGY
TRAINING: COULD CANADA LEAD
THE WAY?**

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There is a great deal to admire in the recently released report of the Canadian Psychological Association (CPA) on Prescriptive Authority for Psychologists in Canada (2010). Its authors are to be congratulated for a job well done. While some of us would have wished that the task force had gone farther and proposed that CPA adopt Level 3 training for prescriptive authority as official policy, the report may prove over time to be one of the most meaningful and important documents yet produced concerning the training of psychologists, if the profession is willing to act on its

recommendations. To my mind, the core passage appears on p. 29:

As discussed above, the Task Force is recommending that basic psychopharmacological knowledge be an accreditation requirement. The Task Force is also asking the profession to consider going beyond basic biopsychopharmacological education, and adopt a fuller biopsychosocial education model to facilitate more active inter-professional contributions to the full range of psychologically relevant treatment decisions. This needs to be accomplished with a

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combination of undergraduate, pre-doctoral, and continuing education expectations. These steps provide an evolution of psychological practice towards a more comprehensive biopsychosocial model, which may or may not lead towards prescriptive practice at some future time.

This is a more coherent articulation of a biopsychosocial training model than appears in any American Psychological Association (APA) document I have seen. Consider, for example, that the three APA clinical psychopharmacology model training curricula, Levels 1 (basic; Kilbey et al., 1995), 2 (collaborative practice; Kilbey et al., 1997), and 3

(prescriptive authority; APA, 2007b), have never been coordinated, integrated or even published as a single volume. Completing the Level 1 or Level 2 curriculum has no explicit bearing on completing Level 3 training. Neither is there anything in the current APA pre-doctoral program accreditation criteria (APA, 2007a) requiring the study of clinical psychopharmacology (see below). The CPA Task Force Report (2010) is at least audacious and potentially transformative, holding out the promise of producing practitioners and scientists well prepared for a rapidly changing, competitive health care environment.

CLINICAL PSYCHOPHARMACOLOGY TRAINING: APA'S AMBIVALENCE

While APA has had some success in promoting Level 3 training for prescriptive authority, there is little in

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the existing predoctoral curriculum that would attract potential applicants who have a biopsychosocial perspective of human behavior to graduate programs. This state of affairs may explain the recent difficulties proponents have had in passing authorizing legislation. No state laws have been enacted since 2004, and even some of its most vocal proponents acknowledge that the RxP initiative appears to have “stalled” (Fox, DeLeon, Newman, Sammons, Dunivin, & Baker, 2009, p. 266). To date, American psychology has not created an education pipeline at the undergraduate and predoctoral levels which would produce sufficient numbers of individuals who are interested in Level 3 training and accordingly motivated to work on behalf of passing authorizing laws in their respective states. Published data, for example, shows that interest in postdoctoral Level 3 training decreases

as costs rise above \$10,000 (most of the degree-granting Level 3 programs cost considerably more), particularly among graduate students and early career practitioners (Fagan, Ax, Liss, Resnick, & Moody, 2007; Simpson & Kluck, 2007).

The most glaring inconsistency is the failure of APA, more than 15 years after the publication of the Level 1 model curriculum (Kilbey et al., 1995), to make basic clinical psychopharmacology course work an accreditation criterion.¹ Indeed, the authors of this APA document assert that “all psychologists need to have the basic knowledge in the area of clinical psychopharmacology represented by the entire knowledge base delineated in all

¹ Several years ago, my colleague, Dr. Robert J. Resnick, and I recommended in a “Monitor” editorial that Level 1 psychopharmacology training be made a criterion for accreditation of doctoral programs in psychology (Ax & Resnick, 2001).

the modules of the Level 1 curriculum” (Kilbey et al., 1995; p. 2). The relevant criterion in the current APA program accreditation manual merely refers to the “biological aspects of behavior” (APA, 2007a; p. 7).² This state of affairs suggests an enduring ambivalence within APA concerning the teaching of clinical psychopharmacology, and, by implication, related clinical practice, whether at the collaborative or prescribing level. The CPA task force report (2010), by contrast, offers the blueprint of a logically coherent, integrated, and progressive model of clinical psychopharmacology training.

BASIC TRAINING SOONER, RXP LATER?

² The corresponding CPA program accreditation requirement refers to the “biological bases of behavior (e.g. physiological psychology, comparative psychology, neuropsychology, psychopharmacology)” (CPA, 2002; p. 36).

Whether or not RxP ever becomes common practice in the United States or Canada, it is increasingly the case that psychologists seeing patients must have a working knowledge of psychotropic medications sufficient not only for direct interaction with their patients, but as well for collaborative practice on their behalf of their patients. Canadian RxP advocates who are disappointed in the task force recommendations (CPA, 2010) can console themselves by looking at the matter this way: Implementing a curriculum founded on the vision elaborated in the document could directly ensure that psychologists are prepared for practice (and research) in the evolving health care arena, *and could have the incidental benefit of creating a viable pipeline for Level 3 (RxP) training at a later date.* It could have more success over the long term than the

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current American clinical psychopharmacology training model, which, seen in terms of an undergraduate-to-postdoctoral continuum, appears caught in an approach-avoidance conflict.

CLINICAL PSYCHOPHARMACOLOGY'S RELEVANCE IN THE REAL WORLD TO PATIENTS AND PRACTITIONERS

While American psychologists have had only limited success in passing authorizing legislations (two states, New Mexico and Louisiana, to date), the more important impact, in terms of meeting the needs of underserved consumers, has been in the public sector, and this deserves further comment here. RxP has been an important presence in the United States military for nearly two decades, dating to the original Department of Defense Psychopharmacology Demonstration Project (Laskow & Grill,

2003). More recently, the Indian Health Service and Public Health Service have authorized properly credentialed psychologists to prescribe psychotropic medications. Both agencies provide services to marginalized patient populations, effectively countering the argument that RxP is only a guild issue. (See Hopewell [2008] and Younger [2010], for first-person accounts of practitioners' experiences in the Iraq combat theater. Also see McGuinness's [2010] report on his RxP practice with the Public Health Service at a rural community health center. All three articles are available online at <http://www.division55.org/TabletOnline.htm>).

There is something else for all psychologists to consider here: staying in "the loop." At least in the United States (and I suspect in Canada as well), the nature of outpatient mental health

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treatment is changing. The rate at which people are receiving it has been about the same for the past decade. However, the percentages of patients being seen for psychotherapy exclusively and psychotherapy-plus-psychotropic medication have been decreasing, while the rate for those receiving only psychotropic medication has been increasing (Olfson & Marcus, 2010).

This certainly means greater competition among “talk therapists” of all professions. Just as important, however, is the need for those who believe in the benefits of psychotherapy to have a voice – one that can be heard above the din of Big Pharma’s direct-to-consumer advertising -- in the health care system, to be in a position to educate patients about non-pharmacological treatment alternatives. It seems to me that those who have at least collaborative practice skills in clinical psychopharmacology

will have more access to patients. They will be more likely to be seen as full partners on interdisciplinary health care teams (and hence also to have the opportunity to educate other health care professionals) if they can speak the “language” of psychotropic medications. If so, their voices will be heard more clearly than those who willfully remain in traditional treatment silos.

WHO SEES THE BIG PICTURE?

How does the profession remain relevant to the needs of consumers of mental health services? A related question, from the standpoint of present and future students -- the consumers of *training* – is, What knowledge and skills must be imparted through the academic and experiential components of the professional psychology curriculum (at all levels) to ensure that program graduates will be viable in the health

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care marketplace in which they will practice? To the extent that knowledge of clinical psychopharmacology and related practice skills bear on these questions, it is incumbent on both CPA and APA to ensure that all students receive appropriate education and training in this domain, whether for collaborative or prescribing practice. Will that happen? At this point, I'm hopeful on behalf of American psychology, but right now I'd put my money on Canada.

References:

- American Psychological Association. (2007a; updated 2009, January). *Guidelines and principles for accreditation of programs in professional psychology*. Washington, DC: Author.
- American Psychological Association. (2007b). *Recommended postdoctoral education and training program in psychopharmacology for prescriptive authority* (Rev.). Washington, DC: Author.
- Ax, R. K., & Resnick, R. J. (2001, March). Prescription privileges: An immodest proposal. *The APA Monitor*, 53-54.
- Canadian Psychological Association. (2002). *Accreditation standards and*

procedures for doctoral programs and internships in professional psychology. Ottawa: Canadian Psychological Association.

- Canadian Psychological Association. (2010, November 10; revised 2011, January 17). *CPA Task Force on prescriptive authority for psychologists in Canada* (Report to the Canadian Psychological Association Board of Directors). Ottawa: Canadian Psychological Association.
- Fagan, T. J., Ax, R. K., Liss, M., Resnick, R. J., & Moody, W. (2007). Prescriptive authority and preferences for training. *Professional Psychology: Research and Practice*, 38, 104–111.
- Fox, R. E., DeLeon, P. H., Newman, R., Sammons, M. T., Dunivin, F. L. & Baker, D. C. (2009). Prescriptive authority and psychology: A status report. *American Psychologist*, 64, 257-268.
- Hopewell, A. (2008, June). First prescribing psychologists in combat theater. *The Tablet*, 9(2), 17-18.
- Kilbey, M. M., Bourg, E. F., Brown, R. T., Coursey, R. D., France, C., Johnson, D. L., et al. (1997, March). *Curriculum for Level 2 training in psychopharmacology: Curriculum for psychopharmacological training for particular populations using a collaborative practice model* (Final report of the APA Board of Educational Affairs on psychopharmacology education and training). Washington, DC: American Psychological Association.
- Kilbey, M. M., Brown, R. T., Coursey, R. D., Eisdorfer, C., France, C., Johnson, D. L., et al. (1995, December). *Report of the BEA*

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- Working Group to develop a Level 1 curriculum for psychopharmacology education and training.*
Washington, DC: American Psychological Association.
- Laskow, G. B., & Grill, D. J. (2003). The Department of Defense experiment: The Psychopharmacology Demonstration Project. In M. T. Sammons, R. E. Levant, & R. U. Paige (Eds.), *Prescriptive authority for psychologists: A history and guide* (pp. 77–101). Washington, DC: American Psychological Association.
- McGuinness, K. M. (2010, March). Prescribing in Chaparral, New Mexico. *The Tablet*, 11(1), 7-12.
- Olfson, M., & Marcus, S. (2010). National trends in outpatient psychotherapy [Abstract]. *The American Journal of Psychiatry*, 167, 1456-1463.
- Simpson, A. M., & Kluck, A. S. (2007). Prescription privileges: Graduate student knowledge and interest. *ASAP Tablet*, 8(3), 5–6.
- Younger, R. (2010, March). So now you can prescribe, what's next? *The Tablet*, 11(1), 6, 17.



PRACTICING CLINICAL PSYCHOPHARMACOLOGY

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In the United States, laws authorizing properly credentialed psychologists to prescribe psychotropic medications currently exist in Louisiana, New Mexico, and Guam. The American Psychological Association has created a model curriculum for prescriptive authority, known as Level 3 (American Psychological Association, 2007). To date, more than 1500 individuals have completed this program of study, either in postdoctoral masters degree or certification programs (Ax, Fagan & Resnick, 2009). However, the great majority of these individuals do not have prescriptive authority. Instead, those who are in clinical practice bring their knowledge and skills to bear on behalf of their patients in collaborative relationships with prescribing professionals. In this brief article, I would like to discuss practicing clinical psychopharmacology within this framework. This is a particularly timely subject pursuant to the release of the Canadian Psychological Association's (2010) *Report on Prescriptive Authority for Psychologists in Canada*, with its emphasis on pre-doctoral training and collaborative practice.

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Such practice requires maintaining current and comprehensive knowledge of the ever-evolving empirical evidence concerning psychotropic medications, e.g., their interactions with other medications and their impacts on bodily systems. Indeed, in today's health care environment, basic knowledge is essential to competent and ethical practice. As one physician (incidentally a prescriptive authority advocate) put it, "How can any psychologist practice optimally without knowledge of how psychoactive medicines behaviorally or cognitively affect their patients?" (Julien, 2011; p. 1). Familiarity with relevant medical and psychological literature enables psychologists to communicate with prescribers more effectively.

Beyond this, it is also desirable to evaluate the published data critically, and there exist several resources on assessing the evidence on their merits. Two recommended works in this regard are by Jadad, Moore, Carroll, Jenkinson, Reynolds, & Gavaghan (1996) and the *Cochrane Handbook*, developed by Higgins and Green (2005; also available online at www.cochrane-handbook.org). For geriatric populations, I would

suggest the recommendations provided by Kenneth Sakauye in *Geriatric Psychiatry Basics* (2008).

However, there are factors that need to be taken into consideration in addition to the empirical evidence, such as political and market questions. For instance, as our colleague Dr. Robert Ax (personal communication, 21 February, 2011) has suggested, we know that 1) the published evidence in the realm of disorders to which our profession attends may at times be inconclusive or contradictory; 2) the nature of these disorders often constitutes a moving target; our understanding of their causes and effects, and our beliefs about the most appropriate treatments for them may change, sometimes depending on what "voices" (e.g., the published evidence, the medical establishment, factions within organized psychology, Big Pharma) are heard loudest; 3) there are the patients' viewpoints and interests to consider, e.g., their preferences for a particular kind of treatment (or to decline treatment). In other words, psychologists evaluate their empirical knowledge of psychotropic medications critically and within a larger social

context, even as they remain sensitive to individual patients' concerns and needs.

Psychologists who wish to practice effectively and ethically must obtain adequate training in clinical psychopharmacology and update that knowledge regularly. In today's health care environment, these are necessary preconditions to remaining relevant to the needs of consumers of mental health treatment and to collaborating effectively with prescribing professionals.

References

American Psychological Association. (2007). *Recommended postdoctoral education and training program in psychopharmacology for prescriptive authority* (Rev.). Washington, DC: Author.

Ax, R. K., Fagan, T. J., & Resnick, R. J. (2009). Predoctoral training for prescriptive authority: The rationale and a combined model. *Psychological Services, 6*, 85-95.

Canadian Psychological Association. (2010, November 10; revised 2011, January 17). *CPA Task Force on prescriptive authority for*

psychologists in Canada (Report to the Canadian Psychological Association Board of Directors). Ottawa: Canadian Psychological Association.

Higgins J. P. T., & Green S. (Eds.). (2005). Assessment of study quality. Cochrane handbook for systematic reviews of interventions 4.2.5 [Updated May 2005]; Section 6. In: *The Cochrane Library, Issue 3*. Chichester: John Wiley & Sons, Ltd.

Jadad, A. R., Moore, R. A., Carroll, D., Jenkinson, C., Reynolds, D. J., & Gavaghan, D. J. (1996). Assessing the quality of reports of randomized clinical trials: Is blinding necessary? [Meta-Analysis]. *Controlled Clinical Trials, 17*(1), 1-12.

Julien, R. M. (2011). Psychopharmacology training in clinical psychology: a renewed call for action. *Journal of Clinical Psychology, 67*, 1-4. doi: 10.1002/jclp.20773



CPA-CONVENTION:

CPA's 72nd Annual convention is being held in Toronto, Ontario, June 2-4, 2011
<http://www.cpa.ca/convention/>

Our Business Meeting is on: Thursday, June 2, 2011 from 5:00 PM to 5:55 PM
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