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MESSAGE FROM THE CHAIR.

Sam Mikail

Several months ago I asked readers of The Canadian Clinical Psychologists to respond to a brief questionnaire regarding core curriculum in professional psychology. Results of the survey will be presented as part of a conversation session at the annual convention of CPA in P.E.I. What follows is a brief summary of selected results from the survey. My hope is that the results will stimulate discussion, and encourage you to share your views on core curriculum in future issues of the newsletter.

The sample consisted of 37 respondents characterized in the following manner:

- 14 directors of training of internship programs
- 25 hospital-based clinical psychologists
- 5 clinical psychology academics
- 3 private practitioners
- 1 was in a university counselling centre
- 1 non-clinical psychology academic

With regard to theoretical orientation *:

- 25 cognitive-behavioural,
- 12 psychodynamic,
- 7 interpersonal
- 7 systemic,
- 4 developmental,
- 3 client-centred,
- 2 experiential-humanistic,
- 2 eclectic

*(some picked more than one orientation, therefore the numbers exceed 37).

The number of respondents indicating that the following areas should comprise core curriculum were:

- Assessment: 37
- Treatment/Intervention: 36
- Research Methods: 32
- Consultation: 20
- Business Practice: 6
- Administration: 3
- Law-Public Policy-Knowledge of Health Care System: 21
- General Psychology: 32
- Ethics and Standards of Practice: 30
- Supervision Skills: 2
- Gender, Ethnicity, Individual Difference Issues: 2

A number of respondents provided greater detail in their responses. For example, 21 respondents indicated that assessment should include experience with personality, vocational, intelligence, and neuropsychological tests. Two respondents indicated that exposure to these instruments should involve at least 100 hours of practicum placement, while 5 respondents felt that 300 to 500 hours of practicum in assessment should be the minimum.

Although the survey is limited in its scope, and the sample is quite modest, it appears that the majority of respondents felt that the traditional areas of assessment, intervention, research, and ethics should continue to form the core of the curriculum in professional psychology. A significant number (57%) feel that expanding the core curriculum to include knowledge of public policy and the health care system would be appropriate. Very few respondents support one of the major recommendations of the Mississauga conference, i.e. that some emphasis be placed on aiding students in developing business, consultation, or administrative skills. It was surprising to find that few respondents felt that ethnicity, gender and individual difference variables should be included as a component of core curriculum.

The tone of the Mississauga conference certainly reflected the need to train our students in a different manner. In particular, the need to be aware of and responsive to market trends and

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consumer needs was emphasized. Also, there was considerable importance attached to having the profession as a whole, as well as individual psychologists, become more politically aware and astute. Results of the current survey do not seem to reflect this shift in thinking. The data suggest a more traditional view of professionalpsychologists as scientist—practitioners. Perhaps skills in business management, marketing of psychological services, and political action are important, but fall outside of what is considered to be core curriculum. It would appear that such skills may need to be developed informally, or at a later stage in one's career.

PRESCRIPTION PRIVILEGES

During recent years colleagues have argued that clinical psychologist should be extended the privilege of prescribing medication. The effort is intense in the United States currently but support in the profession is divided. I invited Lou Pagliaro to write a paper on the topic and am very pleased that he has made this contirbution. The contra position was gleaned through interaction on the internet. Your comments are invited. One way or another, you will hear and read more on this topic.

Pro: Drug Prescription Privileges for Canadian Psychologists: Attainable and Necessary

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Introduction

Drug prescription privileges for psychologists is probably one of the most critical and timely issues now facing the profession of psychology. This issue has been under active consideration in the United States for over a decade (Jones, 1984; Levine, 1984) and it also has been discussed for some time, although not as actively, in other countries, such as France (Singer, 1982). It is just beginning to be actively discussed in still other countries, including the United Kingdom (Wardle & Jackson, 1995) and Canada (e.g., Nussbaum, 1995; Pagliaro, 1989, 1994). The purpose of this brief article is to encourage active comment and discussion (and presumably action ?) in relation to this important issue. We will not attempt here a comprehensive review of the published arguments for and against drug prescription privileges for psychologists (see, for example, DeLeon, 1990; DeLeon, Fox, & Graham, 1991; Fox, 1988; Wardle & Jackson, 1995), but rather will present our views as they have developed over the past several years together with our rationale. As noted by Pagliaro (1989):
I strongly support the idea that psychologists should be granted prescribing privileges in order to be able to provide holistic and optimal care for their patients. I wouldrecommend that this prescription privilege be limited to the psychotropic medications (i.e., antidepressants, antipsychotic tranquilizers, sedative–hypnotics, stimulants). However, this does not mean that I endorse a carte blanche "enfranchisement" of the profession. Rather I would propose that doctoral prepared certified (chartered) psychologists be given the opportunity to obtain prescription certification. This certification could include, as a minimum: 1) University level courses on the clinical pharmacology of the psychotropics and related therapeutics; 2) a requirement for a specified number of hours of supervised prescribing; and 3) a comprehensive examination.
Our present discussion is organized around two general questions: 1. Are Drug Prescription Privileges Attainable? and 2. Are Drug Prescription Privileges Necessary?

Are Drug Prescription Privileges Attainable?

In 1989 we supported philosophically the granting of prescription privileges for clinical psychologists and now bolster our support given our experience in this area since that time. Having written over the past twenty years more specialized clinical pharmacology textbooks (e.g., Pagliaro & Pagliaro, 1983, 1986, 1995a) for health care professionals than any other living authors and having consulted with and taught clinical aspects of drug therapy to health care providers from virtually every discipline, we have come to understand the need for psychologists to have a better comprehension of the effects of psychotropics on cognition, learning, memory, and mental health. Thus, we began the development and teaching of a hierarchical integrated series of graduate courses reflecting the importance of pharmacopsychology to professional psychology practice (Pagliaro, 1993a). The term, pharmacopsychology, was selected and used to differentiate the focus and role of clinical psychologists from those of physicians while emphasizing the importance of pharmacotherapeutics to comprehensive psychology practice (Pagliaro & Pagliaro, 1992). As noted in our 1994 syllabus for this hierarchical integrated series of courses:
These graduate courses at the University of Alberta were developed to reflect: 1) the significant and increasing use of psychotropics across the lifespan, which is of relevance to educators, counsellors,

and clinical psychologists in primary, secondary, and post-secondary educational and health care settings; and 2) the propensity of these drugs to affect cognition, learning, memory, and psychological behaviour and health. In addition, the graduate courses have also been developed to reflect the growing interest among counselling psychologists, as part of the larger group of clinical psychologists, in obtaining prescription privileges in order to improve and to make more comprehensive their clinical practice and empirical study of relevant pharmacopsychologic phenomena.

The series of five courses includes lecture and seminar discussion of the following major areas of pharmacopsychology(approximately 35 hours each): the abusable psychotropics (i.e., those drugs and substances, such as alcohol and cocaine, the use of which is associated with physical or psychological dependence); the nonabusable psychotropics (e.g., antidepressants, antipsychotics, and other psychotropics, the use of which is not generally associated with physical or psychological dependence); modern theories purporting to explain why people come to use or not use the abusable psychotropics; and pharmacopsychologic research issues and methods. Following successful completion of these didactic courses, the students may enroll in a culminating one year practicum course (approximately 500 hours). This course focuses on the diagnosis and treatment of mental disorders, including the prescription of psychotherapy and pharmacotherapy, under the guidance and direction of ourselves and preceptors (i.e., physicians) who are licensed to prescribe drugs in the Province of Alberta. Attention also is given to monitoring and evaluating such therapies in regard to promoting optimal mental health among selected patients and clients. The series has attracted a number of graduate students from within the Department of Educational Psychology, who complete the courses in addition to their usual required degree requirements for Masters and Doctoral degrees. Increasingly, special graduate students (i.e., doctorally prepared chartered psychologists) have been accessing these courses. Approximately 30 students are currently in various phases of completion of the series with the first two students beginning the final practicum course, Fall 1995.

Feedback from the students who have completed various courses in the hierarchical series has been extremely positive. Obviously, if students did not highly value the courses in the series, they simply would not take them. Examples of anonymous course evaluation responses received from students enrolled in the nonabusable psychotropic course this past term reflecting the course evaluation comments received for other courses in the series, include:

"This course is one of the best, most useful courses I have had the pleasure of taking at the University of Alberta. I fully intend to take the entire series whether or not this exceeds the coursework necessary to complete my degree. This course was well-thought-out, well structured and run in a highly professional manner."

"I have learned more in this course than in any other I have taken . . ."

". . . I believe this course is essential for any person in the mental health profession."

"I found this to be an outstanding course . . . "

Obviously, the students have enjoyed the courses they have taken despite the required heavy academic requirements (e.g., required reading of a minimum of three textbooks; multiple written assignments; and a major paper for each course). We, too, have been impressed. These students (i.e., graduate students in Educational Psychology (Basic, Counselling, Special Education) and practicing chartered psychologists) are among the brightest and most capable students that we have had the opportunity to teach during our academic careers, which span some twenty-five years. We have absolutely no doubt that they can become paramount prescribers ofthe psychotropics without diminishing their skills and proficiency in psychotherapy. Further, because these students are representative of graduate psychology students and chartered psychologists who have met stringent academic and professional requirements for graduate education and licensure (e.g., clinical practice, research), we can generally expect the same results from their cohorts (i.e., other graduate psychology students and chartered psychologists).

As previously demonstrated in the United States (Sleek, 1994), and now here in Canada, psychologists can master the relevant aspects of clinical pharmacopsychology and learn to prescribe, not only as well as those in other disciplines, but, because of their clinical skills and academic abilities, perhaps better. Does this mean that psychologists will obtain drug prescription privileges? No, at least not just because they are capable. Another hurdle remains. Specifically, given the ability to meet the challenge, do psychologists have the professional and political will to obtain drug prescription privileges? In this regard we are reminded of a line from Shakespeare's, Julius Caesar:

"The fault, dear Brutus, is not in our stars,
But in ourselves, that we are underlings." (Act I, scene 2, line 140)

We do not mean here that psychologists are underlings if they do not prescribe drugs when compared to physicians or other psychologists

who do. However, we do mean that psychologists have it within their power to formulate their own professional identity and roles and should not leave these to chance or to the dictates of other professional or political groups. Psychologists who believe that drug prescription is valuable and desirable must take personal and professional responsibility for seeing that appropriate legal and professional practice changes are made (Pagliaro & Pagliaro, 1995b) or, by virtue of their own lack of "self-actualization", become underlings. Having identified this "hurdle", one question remains.

Are Drug Prescription Privileges Necessary?

Now that we have briefly addressed the question of whether psychologists can be prepared to competently prescribe the psychotropics, we turn to the related question of why should psychologists learn to prescribe the psychotropics.

We are in a time of significant economic, political, and social change. This period of change has the potential to impact professional psychology as traditional disciplinary lines are dissolving and new boundaries are being drawn. Issues, such as prescription and hospital admitting privileges for psychologists, as well as, for other health care professionals (e.g., nurse practitioners, clinical pharmacists, social workers) (Chi, 1991; Talley & Caverly, 1994), need to be expediently and adequately addressed. Naturally, it is to be expected that some psychologists and other health care professionals, perhaps being content in the status quo or fearful of change, may wish that things just be left alone and remain as they are. However, this is not possible, for as noted by Chesterton, "If you leave a thing alone you leave it to atorrent of change" (Orthodoxy, 1908). Thus, our only logical and rational alternative is to become involved with the changes, to view change not as a threat, but as an opportunity to broaden the profession of psychology in an effort to improve the health and well-being of our patients and clients, including individuals, families, and communities.

Those psychologists, who may wish to believe that these issues will remain south of the 49th parallel or "across the great ocean", might do well to consider the Ontario "Regulated Health Professions Act", which is being emulated in other Provinces, such as Alberta and Nova Scotia. This act provides a non-exclusive scope of practice for all the health professions. The psychology scope of practice provides that "The practice of Psychology is the assessment of behavioural and mental conditions, the diagnosis of neuropsychological disorders and dysfunctions, and the prevention and treatment of behavioural and mental disorders and dysfunctions, and the maintenance and enhancement of physical, intellectual, emotional, social, and interpersonal functioning" (Ontario passes . . ., 1992). By providing "non-exclusive" scopes of practice, this act appropriately and correctly recognizes that no one individual or group "owns" knowledge or a particular area of mental health practice. Certainly, the "prevention and treatment of behavioural and mental disorders and dysfunction" requires, if not prescription privileges for psychologists, then, at a minimum, a significant degree of specialized knowledge regarding the propensity of psychotropics to affect behavior, cognition, learning, memory, and mental health.

Therefore, even those psychologists who think that they do not need to prescribe psychotropics as part of their clinical services, including clinical, counselling, health, and school psychologists, require a working knowledge of the use and effects of the psychotropics. This knowledge is essential in order for them to be able to meet more comprehensively the needs of their clinical practices. For example, even a psychologist known to be the best psychotherapist in the world, would more than likely be unsuccessful in the treatment of clinical depression when that depression was a direct result of the use of a benzodiazepine (e.g., Ativan?, Halcion?, Valium?), the adverse reaction of which he or she was unaware. In another example, a school psychologist could be the best school psychologist in the world and would be unable to plan a successful intervention program for a learning disabled child in his or her school if he or she was unaware that the child's learning problem was directly related to anticonvulsant therapy for a seizure disorder. This argument becomes even more relevant when it is recognized that virtually every mental disorder, whether characterized by DSM-IV or other relevant criteria, can have its symptoms mimicked by the adverse drug reactions of the various psychotropics (Drugs that . . ., 1993; Pagliaro, 1995). As many psychologists have come to realize, appropriate pharmacotherapy is also a useful and necessary adjunct to appropriate psychotherapy and, as such, a welcome tool for use by appropriately prepared clinical psychologists.

Summary

A review of the issue of drug prescription privileges for psychologists appears to centre around two global questions: 1.) Is it attainable?; and 2.) Is it necessary? Because an overwhelming majority of patients and clients who access psychologic services use psychotropics (i.e., abusable psychotropics, such as alcohol, and nonabusable psychotropics, such as the antidepressants or antipsychotics) and have mental disorders amenable to treatment with the psychotropics (e.g., depression, schizophrenia), we strongly believe that all clinical psychologists require formal instruction in the area of pharmacopsychology in order to optimize the

services that they provide to their patients and clients. In addition, a certain number of clinical psychologists, who recognize the need for and desire to have prescription privileges, should be provided with the opportunity to obtain drug prescription privileges in order to provide more comprehensive services to their patients and clients who may require adjunct pharmacotherapy either independently or as active members of multidisciplinary treatment groups. University graduate and continuing professional education programs to prepare clinical psychologists to competently prescribe psychotropics have been developed in the United States and Canada that support the contention that drug prescription privileges are attainable for psychologists. The future is ours . . . let us not lose it.

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Contra: Arguments Against Prescription Privileges.

The following article identifies itself clearly. Permission to reprint it here ws obtained from Steven Haynes, Chair of the AAAPP.

AAAPP Committee Recommends a Fight on Prescription Privileges

The AAAPP Committee on Prescription Privileges (COPP) has recommended that AAAPP launch a major effort to resist to the movement toward prescription privileges for psychologists. COPP was formed in 1994 at the request of the President and Board. Based upon a survey of the membership (The Scientist Practitioner, December 1993), there seemed to be substantial opposition within the association to prescription authority for psychologists. The Committee was established to examine the issue.

The Committee was composed of a prestigious list of participants: Elaine Helby (Chair; University of Hawaii), Laura Carstensen (Stanford University), Ian Evans (State University of New York at Binghamton), Ray Corsini (Honolulu, HI), Leon Levy (University of Maryland, Baltimore County), Chris Piotrowski (University of West Florida), Lee Sechrest (University of Arizona), Michael Teich (University of Texas at Austin), Mervyn Wagner (University of South Carolina), Victor Sanua (St. John s University), and Tom Greene (Honolulu, HI). The report argued that were major negative implications for the science and profession of psychology if prescription authority continues to be pursued or legally granted.Their reasoning was lengthy and detailed. A segment of the actualtext of the report explaining their reasons for opposing prescription privileges is presented below.

Concluding the report, over a dozen action recommendations were made, most of which were adopted by the Board at its January meeting. Through a formal resolution (see related story) AAAPP has now become the first national

(USA) psychological society to oppose prescription privileges for psychologists.

Report of the AAAPP Committee on Prescription Privileges

Implications of Medicalizing Psychology Via Prescription Privileges

Prescription privileges proposals have been partly based upon concerns that there may be a shortage of psychiatrists in some regions of the country and that the majority of psychoactive medications are prescribed by non-psychiatric physicians. It is COPP's position that these societal concerns can be addressed within the medical profession and by encouraging collaboration between physicians and psychologists. The medicalizing of psychology in order to provide psychoactive drugs to underserved populations is neither warranted nor in the best interest of the discipline of psychology or the consumer of mental health services for at least the following general reasons:

(A) Societal needs for medical mental health services can be provided by those already trained in medical procedures. There is simply no reasonable precedent for applied psychologists to physically invade the human body.

There is a precedent for the practice of medicine by individuals who are not physicians under conditions of warfare. However, this possible transitory crisis should not set the standard for professional practice or licensure.

The expansion of the medical duties authorized for some allied physical health professionals (e.g. prescription authority for nurses and optometrists) does not set a precedent to medicalize psychology. It is faulty to equate the training and nature of these professions to psychology. The training of allied physical health professionals (e.g., nursing) is multidisciplinary and already medical in nature. In contrast, one distinguishing characteristic of the training of psychologists is that it is based upon psychological science. Doctoral training in the subspeciality of clinical psychology usually includes only one or two courses in the biological bases of behavior.

The precedent of psychologists adopting invasive psychological procedures with infrahumans or xxx procedures with humans does not provide a precedent for medicalizing psychology. Throughout the history of applied psychology, independently provided clinical interventions have been limited tononinvasive procedures. our research and training is designed for the licensed application of interventions that are either outside of, or on the skin (e.g., verbal therapies and biofeedback, respectively). Moreover, in those instances in which psychologists do employ invasive procedures in research with animals, both their training and their practices are narrowly focused. These researchers do not pretend to encompass the broad range of problems and practices that would be entailed in becoming proficient in conducting surgery on or prescribing drugs to humans. Even psychologists who have been working with animals for years do not argue to have become qualified for the practice of veterinary medicine.

(B) Applied psychology has a unique identity that serves legitimate societal needs. There is no convincing evidence that mental health consumers are clamoring for drugs to solve problems in living. A survey prepared for the American Psychological Association's Practice Directorate (Survey of General Population of the United States on Prescription Privileges for Psychologists, November, 1992) reports that 63% indicated that "helping a person understand" is the most important treatment for alleviating a mental health problem, while 15% indicated medication was most important (p. 7). This survey suggests psychology is promoting social welfare by concentrating on the development, evaluation, and application of psychotherapy as a treatment option. At leat one evaluation of consumer surveys concludes that psychological services are preferred over psychiatric services (V. Sanua, 1993, "Consumers' perceptions of psychologist and psychiatrists. psychologists do better", in M. Stern 7 P. Breggins (Eds.), The psychiatric patient, New York: Haworth press).

(C) In introducing empirically-supported psychological interventions in treatment and prevention settings, psychology as been authorized by licensing as an autonomous profession. These advances of the discipline have been science-driven and based upon the highest of ethical and professional standards. The current prescription privileges proposals did not develop from a reciprocal influence between practice and research. Instead of being an inherent outgrowth of our science, the current movement to medicalize psychology seemingly derives from precipitous guild concerns of practitioners.

For applied psychologists to adopt the prescription of psychoactive medication is not an evolutionary step but one that would cross disciplinary boundaries in such a way that psychologists would become responsible for the competent practice of medicine. The COPP acknowledges that crossing disciplinary boundaries under some circumstances can advance scientific knowledge and contribute to professional evolution. It is

feasible that cross-fertilization between psychological research and practice would over the decades lead to a profession that is some hybrid of applied psychology andmedicine. At present, however, doctoral training programs in applied psychology are already overloaded with curricular demands, precluding an inherent force to acquire a different domain in training.

The COPP concludes that prescription privileges would essentially redefine psychology as a specialty of medicine. The pro-prescription movement proposes a radical change in licensure laws that would legislatively overhaul the basic definition of psychology. The negative implications of such a sweeping change upon research, training, and practice of psychology seem to far outweigh any possible societal need for more medical mental health treatment. These changes would be destructive to the science and profession, as well as confuse public citizens, insurance companies, and lawmakers as to what constitutes psychology. The bases of these conclusions are listed more specifically below.

1. To adequately train psychologists to prescribe medication, and thus protect the consumer, would fundamentally change the curriculum in psychology at the undergraduate, graduate, internship, and post-doctoral levels. Basic training and continuing education requirements necessary to practice medicine are quite different from those that currently constitute psychology curricula.

It simply would not be feasible to include adequate medical training in a psychology department without a major increase in the time and resources necessary to train for the degree in clinical, or without shortchanging training in both medical procedures and psychological procedures. Many clinical programs already require over 6 years to complete. Many specialities, such as neuropsychology, are so complex that training must be pursued at the post-doctoral level in close collaboration with medicine. Psychology is a relatively young science and profession. Societal needs for effective psychological treatments are far from satisfied.

It is unlikely that training in medicalized psychology would involve the time and resources required for a Ph.D. – M.D. so that training in both specialities would meet current professional standards. Training in psychological science could be compromised because of the known serious toxic and poorly understood nature of many psychoactive medications. Prescription authority involves a wide domain of medical responsibility and liability for harm to the consumer. The appropriate use of psychoactive medication is controversial within psychiatry, and the serious nature of the side effects are well documented (e.g., V.D. Sanua, Psychotropic drugs: Prescription for disaster, paper presented at the 1992 convention of the American Psychological Association, Washington, D.C.). Regulatory standards for prescription authority would have immediate major effects upon trainingprograms and the priority of resources.

Thus, one concern is that medicalizing psychology through prescription authority could direct resources away from psychological science. A reduction of academic and applied resources dedicated to psychological treatments would fundamentally impair the growth of psychological science, as more faculty and resources become dedicated to medical training.

2. Another consequence of medicalizing psychology is that the discipline and profession will change by the very nature of the interests of the students drawn to training at the undergraduate, graduate and post-doctoral level. By the medical components of the licensing requirements alone, many students of psychology will have less interest in behavioral principles than those in the past. Consequently, there will be fewer resources for faculty, students, and practitioners dedicated to the promotion of the knowledge base of psychological science.

3. Medicalized psychologists would be conducting fewer psychological interventions and more medical ones, because the responsibilities associated with the latter are highly time-consuming. The time required for medical histories, physicals, consultations with physicians involved with the client, and continuing education would likely force the prescribing psychologist to dedicate most professional time to medical responsibilities. Consequently, the mental health consumer would have fewer opportunities to acquire psychotherapy derived from psychological science.

4. It is also the opinion of the COPP that it is unlikely that training in medical procedures as suggested by pro-prescription psychologists would meet the high standards historically adopted by applied psychology and medicine as distinct professions and expected by the mental health consumer. For example, the Hawaii Prescription Privilege Task Force proposals suggests 100 hours of training, a sharp reduction from the Task Forces' initial proposal of a two-year training model. A member of the Task Force justifies the proposal by saying "We initially started out with a two-year training model for political reasons, not because we believed it was clinically necessary. At that time, we hoped that two years of training would mollify even the harshest of critics (namely, psychiatrists). How naive we were! In retrospect, we now realize that we should have instead

focused on a training model that was both reasonable and appropriate." (Hawaii Psychologist, Fall 1994, p. 6).

The adoption of minimal and substandard medical procedures by applied psychologists might well erode the ethics and standards that have been distinguishing characteristics ofpsychology. This erosion of ethical standards also seems hypocritical. On the one had, pro-prescription psychologists argue that the field can easily acquire the expertise necessary to encroach heavily on the domain of medicine. On the other hand, organized psychology insists that other mental health professional (e.g., counselors, social workers) could not possibly perform functions that psychology has abrogated to itself.

5. The discipline of psychology has limited resources for lobbying efforts to promote our science and practice. The pursuit of prescription privileges would direct those resources to an expensive, lengthy and divisive agenda designed to redefine the discipline. The COPP believes our limited resources should be directed at maintaining our current status and promoting the development of psychological science and practice.

6. The adoption of prescription privileges by psychology could alienate psychiatrists and other physicians in individual and organizational relationships. Many research and applied psychologists depend upon collaborative efforts with physicians. No radical change in the nature of the practice of psychology, such as acquiring prescription privileges would be, should be contemplated without concern for collegiality with colleagues in other disciplines. It should be recognized that psychology cannot claim the privilege of prescribing drugs without risking the enmity not merely of psychiatry, but of the entire profession of medicine, with members of which many psychologists currently have close collaborative relationships reflecting collegiality of a high order.

7. The adoption of prescription privileges would introduce a whole new domain of legal liability for licensed psychologists that are already assumed by physicians. This duplication of services will result in greater societal costs. Financially costly implications include more complex regulation of ethical psychology by state agencies, establishing and monitoring continuing education requirements, treatment costs from malpractice, dealing with state boards of pharmacy, medicine, and nursing, and more expensive liability insurance (which, in turn, will raise the cost of mental health services).

8. It has taken decades for legislators and the public to appreciate the characteristics that distinguish the practice of psychology from other profession such as psychiatry and social work. This distinction has earned more university institutional support for psychology departments, more grant money for psychological research, and more licenses privileges to practice psychology. Medicalizing and essentially redefining psychology would obfuscate the field's unique resource needs and contributions the discipline has worked so hard for a century to establish. The COPP believes that psychology has made significant contributions to science andsociety and will continue to do so unless we as a profession abandon our discipline. One implicit message derived from the pro-prescription movement is that psychology cannot survive as a nonmedical science and profession. The COPP believes that psychology has earned itself a secure position in the sciences and applied professions.

That concludes the report.

Clinical Section Business

Membership in the Clinical Section as reported by CPA Office in March, 1995 is indicated below. We believe that many loyal members have neglected to renew their membership at the time of registration. You are being sent this issue of the Canadian Clinical Psychologist even if you are not a paid member for this year. However, our mailing list is usually the list of paid members obtained from the CPA Office. Please renew your membership immediately by writing to CPA and include your cheque for the 1995-96 membership ($20.00 for members, $5.00 for students). To make up for tardy renewal, persuade at least one colleague to join. Make the Clinical Section a strong effective voice for clinical psychology.

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