PSYNAPSE

THE NEWSLETTER OF THE CPA'S PSYCHOPHARMACOLOGY SECTION

IN THIS ISSUE

Volume 5, Issue 1
Spring/Summer 2024

PSYCHOPHARMACOLOGY
SECTION OF THE CPA
CANADIAN PSYCHOLOGICAL ASSOCIATION
SOCIÉTÉ CANADIENNE DE PSYCHOLOGIE
PSYCHOPHARMACOLOGIE
SECTION DE LA SCP

A MESSAGE FROM THE EDITORS

Bryan Butler, Ph.D. Candidate, and Jérémie Richard, Ph.D.

Newsletter Editors

Dear members of the CPA Psychopharmacology Section,

It is our pleasure to present our Spring/Summer 2024 newsletter! In this issue, Dr. Robert K. Ax, discusses possible avenues to recruit young aspiring prescribing psychologists and the importance of highlighting prescribing psychology as a rewarding and viable career path prior to undergraduate studies. Dr. Jérémie Richard continues his ongoing series where he shares findings as well as reflects on his time conducting research into the use of psychedelic compounds in the treatment of mental health issues at Johns Hopkins University School of Medicine as part of the Center for Psychedelic & Consciousness Research. This issue of *PSYNAPSE* ends with RxP-related excerpts from Dr. Pat DeLeon's (former APA President) lyrically titled articles, "SITTIN' IN THE MORNIN' SUN" and "YO, BIG SHAQ, THE ONE AND ONLY".

Of interest to our membership, Dr. David Shearer shares his experience as a prescribing psychologist on the Ontario Psychological Association's podcast *ON Psych* (click on link below).

https://www.buzzsprout.com/1483819/episodes/15313507-s3e9-prescribing-psychologists-with-dr-david-shearer

Enjoy!

A CALL FOR CONTRIBUTIONS

We are always looking for contributions to the newsletter and welcome any ideas you may have. Here are some examples of what you might submit:

- Brief articles on psychopharmacology-related topics
- Short summaries of recently published research related to psychopharmacology
- Reviews of recently released books related to psychopharmacology
- Experiences of psychologists who have completed a post-doctoral M.Sc. in Clinical Psychopharmacology
- Advertisements for jobs—or anything else that might be of interest to section members!

Submissions will be reviewed by Bryan Butler and can be sent to: **bryan.butler@mail.mcgill.ca**

Previous newsletters can be accessed here: https://cpa.ca/sections/psychopharmacology/newsletters/

We hope that you are all keeping well.

Kind regards,

Bryan and Jérémie

AN ACADEMIC PIPELINE TO PRESCRIPTIVE AUTHORITY (RXP): IN SEARCH OF BEST FITS

Robert K. Ax, Ph.D.
Fellow of the American Psychological Association
Former president of APA's Division 18
Member of the Canadian Psychological Association

The MD Pipeline Starts Early

If you are fortunate, you learned at an early age what physicians and nurses do. You saw them regularly for routine healthcare. If that regimen didn't keep you healthy, trips to the school nurse, the emergency room or hospital were also educational experiences. For some young people, those encounters (supported by largely favorable media representations) were an entry point into the medical and nursing profession pipelines.

For medical schools, the active recruitment efforts start early. Targeting a finite prospect pool, outreach programs like "Mini-Medical School," such as the one offered by the University of Virginia School of Medicine (2023), and summer programs, for example, the Stanford University School of Medicine's (2023) curriculum, provide high school students the opportunity to learn about medical education and practice and perhaps enter the pipeline to a career in medicine.

To the most competitive undergraduates, many medical schools offer "early assurance" – by invitation only – during their freshman or sophomore year (Association of American Medical Colleges, 2023a). Early acceptance programs may take the form of a simultaneous admission to college and medical school BA/BS-MD programs (Association of American Medical Colleges, 2023b).

Of particular note is the program at Queen's University (n.d.) in Ontario, which is specifically geared to Black-identified and Indigenous students. It allows them to apply as high school students to Queen's University and then apply to the medical school there after two years.

An RxP Pipeline

No such pipelines exist for health service psychology, and particularly not for RxP. You were much less likely to gain an early, realistic understanding of what mental health professionals did unless you or a family member had a problem in living. Perhaps it wasn't until high school or university that you first entertained the idea of a career as a clinical, counseling or school psychologist.[1] There are no analogous

[1] Hoff et al. (2022) found that "doctor" always appeared among the top 10 preferred careers for adolescents at ages 13 through 18, except for males at age 15. "Nurse" was a preferred career choice for older females (2nd at age 17, 3rd at age 18). "Clinical psychologist" didn't appear on the list until age 18 (for females only, ranked 7th).

programs with the range and reach of those offered by the medical profession that might have attracted you to health service psychology.

How much more difficult, then, will it be to get the word out about RxP training, a specialty still seen as radical and adamantly opposed by many psychology department faculty members, the gatekeepers to graduate study? It's an important question for RxP advocates. According to one estimate, even in the states that have already authorized it, only an estimated 9% of psychologists will obtain RxP credentials (McGrath, 2010).

I hope those numbers will move somewhat higher, reflecting more students intending to practice in prisons, jails, Aboriginal health centres and other sites that serve marginalized patient populations. For that to occur, what are needed are "best fit" applicants to Master's of Science in Clinical Psychopharmacology (MSCP) programs. That means reaching out to talented students at early stages of their education, certainly before graduate school, whose qualifications and interests are highly compatible with an RxP education-practice track, offering them relevant didactic and experiential training and then letting these prospects self-select.

The Target Audience

RxP clearly isn't for everyone planning a career in health service psychology. Who are these "best fits" and what qualities do they possess? Given the creation of a Canadian RxP pipeline, whom should organized psychology seek to interest in entering it? Intelligent and highly ethical candidates, obviously. Beyond these prerequisites, I think prospects should demonstrate:

- A grounding in the natural sciences (including biology and chemistry) as well as in psychology courses.
- Personal congruence with a biopsychosocial model of practice, a holistic approach to patient care.
- Cognitive and emotional flexibility, an innovating spirit, rather than a dogmatic allegiance to any school of theory and practice.
- A thick skin. If the Canadian experience is anything like ours in the U.S., your first prescribing psychologists will be under a political microscope.
- A commitment to activism. Given where the initiative is, you'll need supporters to join their provincial or territorial psychological associations and work on behalf of scope of practice expansion. Too many here in the United States are content to wait for others to do the work and get authorizing laws passed before they enroll in MSCP programs. Those with a personal stake in seeing RxP authorized will be more motivated to work for the cause.

Action Steps for Current RxP Advocates

I'm optimistic that the Canadian Psychological Association and the academic establishment will eventually support a student outreach effort, but for now the heavy lifting must be done by a well-organized network of advocates in the provinces and territories. Once having implemented an MSCP program in Canada, it will be important to maintain a pool of potential applicants. This should be obvious, but needs stating because in the early 2000s several American RxP programs closed due to a lack of enrollees (Ax, Fagan, & Resnick, 2009). To establish and maintain the RxP pipeline:

- Access the prospect pool early and cast a wide net. Speak to high school students and university undergraduates, in addition to graduate students, in person and online. Seek ways to access non-psychology majors who might be looking for a different career path than the one they first considered. (Mid-career candidates are welcome, too, of course.)

- Build those advocacy networks. Seek out RxP advocates in academia who can speak to students starting at the introductory psychology level and can frame RxP as a viable, appropriate option for some health service psychologists.

- Create an RxP FAQ fact sheet. Nothing fancy here, just RxP facts, e.g., it's been authorized in seven U.S. states (with more on the way) and the U.S. military. Emphasize Canadian RxP activities. Normalize RxP: Note that scope of practice expansion is typical of evolving, viable health care professions. List MSCP-designated training programs (American Psychological Association, 2023). Hopefully, this will soon include one or more in Canada. Include a bibliography of published studies showing the benefits of the psychopharmacological option and combined treatments.

- Offer mentorship and role models. When students, whether undergraduate or graduate, gravitate toward RxP, offer guidance regarding the next steps in the education process. The "best-fit" prospects will have many questions. Invite prescribing psychologists to speak, in person or online, to classes or student events at conventions and conferences.

Last but not least is a bit of advice for those involved in creating and maintaining the pipeline and recruiting best-fit candidates: attend to self-care. This is a long slog and too often a thankless one. Keep your support systems close, especially your fellow RxP advocates. They know what you're going through.

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EXPERIENCES IN SCIENTIFIC PSYCHEDELIA – PART TWO

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A Moment of Reflection

One unexpected consequence of writing this recurring contribution to *Psynapse* is the opportunity for reflection. Six months ago, I was in the very early stages of my postdoctoral fellowship, and I now understand why very few people in this day and age of academia take one to two years to complete their fellowships. I am noticing so many opportunities for personal and professional development, for collaboration and mentorship, and potential "side projects", to the point that *prioritization* is easily becoming the most important skill for me to develop at this stage of my career. My experience and perception of time has never felt more accelerated. Despite this, I am beyond grateful to be feeling a sense of meaningfulness and purposefulness based on my work.

One piece of unsolicited advice I have to any doctoral student in psychology considering a postdoctoral fellowship: make no compromises in establishing a research program that is personally meaningful to you. Now is the time. I have heard endless stories over the years from graduate students stating that they do not feel intrinsically motivated to pursue their doctoral research. I can fully empathize and understand why this is if you see your doctorate as a means to an end (e.g., to become a licenced psychologist and work as a clinician). However, if you also have a passion for research, are considering a career in research, and you notice yourself making compromises in the topics you are researching, I strongly recommend *not* bringing this attitude into your academic life beyond the doctorate. It will make a world of difference and will have ramifications that transcend the boundaries of "work" and "personal life". If I have learned anything from my current mentors it is that in order to be a successful researcher, there has to be a sense that the boundaries between work and personal life are illusory. If you are deeply and intrinsically invested in the work you are doing, while it may remain effortful and demanding at times, it does not tend to feel like work *per se*.

Reflecting upon the past six months, the most substantial updates relevant to my experiences in scientific psychedelia are on **three** fronts.

First, I have been increasingly involved in ongoing clinical trials examining the therapeutic potential of the psychedelic and serotonin 2A receptor (5-HT2AR) agonist psilocybin. The opportunity and privilege to provide psychedelic-assisted psychotherapy is one of the most meaningful experiences of my postdoctoral fellowship to date. Furthermore, the experience of working with participants in the context of open-label versus double-blind randomized controlled trial has allowed me to put into context the hundreds of peer-reviewed articles I have read exploring the therapeutic potential of psychopharmacological agents from phase II to phase III clinical trials.

Second, I have been deeply immersed in and have completed a systematic synthesis of over 70 years of empirical literature investigating the therapeutic potential of psychedelics in the treatment of addictive behaviors. Ask me anything about the use of lysergic acid diethylamide (LSD), psilocybin, mescaline, dimethyltryptamine (DMT), 5-Methoxy-N,N-dimethyl-tryptamine (5-MeO-DMT), ibogaine, ketamine, and 3,4-methylenedioxy-methamphetamine (MDMA) in the treatment of addiction. I have an answer based on the available scientific literature.

Third, I attended my first two conferences examining the role of psychedelics in science, medicine, policy, and business. Specifically, I have had the opportunity to travel to the West Coast (Portland, Oregon) and Southern United States (New Orleans, Louisiana) to present emerging research findings in psychedelic science. The work I presented at both conferences focused predominantly on the role of psychedelics as a treatment for addictive behaviors. Beyond the research, I had the opportunity to meet with incredible scientists, directors of non-profit organizations, public policy analysts, and clinicians who are actively involved in providing psychedelic therapy services. For example, when I was in Portland for the *Horizons Northwest* conference, I had the chance to speak to those actively involved in providing psilocybin services at centers licenced by the Oregon Health Authority Public Health Division. In New Orleans, with the *International Society for Research on Psychedelics* (ISRP) conference being serendipitously held during the Mardi Gras festivities, I may have been unduly distracted outside of the main conference hours by southern dining and live jazz. This conference, being "by scientists, for scientists", I believe deserves a more detailed recounting and will be the focus of this issue. Specifically, I would like to present what I have learned from my colleagues with regards to clinical trial research findings that should be published within the next few years.

I am optimistic that by the next edition of *Psynapse* in Fall/Winter 2024, I will have some research findings of my own to share while providing a thoughtful perspective on the ongoing debate about the role of "psychological support" and "psychotherapy" in the context of clinical trial research utilizing psychedelics.

Emerging Findings in Psychedelic Science: Preliminary Findings from Ongoing and Recently Completed Clinical Trials

From February 16 to 18, 2024, the International Society for Research on Psychedelics (ISRP) held their most recent scientific meetings for the advancement of empirical science regarding classic psychedelics (ISRP, 2024). Over three days, over 50 talks and 20 posters were presented exploring pre-clinical, clinical, and observational findings from researchers in fields ranging from biochemistry to clinical psychology. Given that many of the presented findings have not yet been published in peer-reviewed journals, I thought it would be interesting to provide a review of some of the promising preliminary findings from five upcoming clinical trials utilizing psychedelics. The trials are presented in order based on nearest to furthest from completion.

Clinical trial comparing psilocybin to nicotine patch for Tobacco Addiction. Speaker: Matthew Johnson. Institution: Sheppard Pratt (previously Johns Hopkins University).

Matthew Johnson and colleagues have recently completed their clinical trial investigating the effects of a psilocybin as a treatment for tobacco use disorder (Clinical Trial ID: NCT01943994). Utilizing a double-blind, randomized, active-comparator study design, the effects of a single high dose of psilocybin (30 mg) were compared to nicotine replacement therapy (NRT) utilizing a transdermal nicotine patch based on recommended label usage. The psychotherapy component integrated in the trial features 13 weeks of cognitive behavioral intervention for smoking cessation, consistent across conditions. At the time of the

presentation, results for the expected 82 participants (42 psilocybin; 40 nicotine patch) were presented. At 6-month follow-up, 52% (*n* = 22) of the psilocybin group were biologically verified abstinent compared to 25% (*n* = 10) in the nicotine patch group. Binary logistic regression results indicated that those in the psilocybin treatment group were 3.30 times more likely to be abstinent (95% CI = 1.29 – 8.43, *p* = .013) compared to the nicotine patch group.

Pilot study of psilocybin for Post-Treatment Lyme Disease. Speaker: Albert Garcia-Romeu. Institution: Johns Hopkins University.

Albert Garcia-Romeu and colleagues have been working on a clinical trial investigating the effects of two open-label doses of psilocybin (15 mg and 15/25 mg) to address the overall symptom burden of individuals with post-treatment Lyme disease (PTLD) (Clinical Trial ID: NCT05305105). Common symptoms of PTLD include fatigue, sleep disturbance, musculoskeletal pain and/or cognitive difficulties. The psilocybin treatment was provided over an 8-week period, with dosing sessions spaced two weeks apart. No formal psychotherapy is provided, with treatment providers being present to provide "psychological support". At time of presentation, the study was nearing completion, with follow-up findings from 16 of the 20 needed participants to reach the recruitment goal. Overall, preliminary results were indicative of a reduction in total Lyme disease symptom burden scores, with specific reductions in pain, fatigue, and neuropsychiatric symptoms at the 1-month follow-up. General improvements in quality of life were also reported at 1- and 3-month follow-up.

Safety, tolerability, and clinical effects of single-dose psilocybin with non-directive support in the treatment of Obsessive-Compulsive Disorder: Results from a randomized, double-blind, placebo-controlled trial. Speaker: Terence Ching. Institution: Yale University.

Terrence Ching and colleagues have been working on a clinical trial investigating the effects of a single dose of psilocybin in the treatment of obsessive-compulsive disorder (OCD). The protocol for this trial was published in *Frontiers in Psychiatry* in 2023 (Ching et al., 2023). As part of the randomized, double-blind, placebo-controlled methodology, they compared the effectiveness of a single high-dose of psilocybin (25 mg) to the placebo condition, niacin (250 mg). No formal psychotherapy is provided for either condition, with treatment providers being present to provide "non-directive support". Participants were required to stay at the inpatient treatment centre for 5 days to go through the treatment phases of preparation, dosing and integration. At time of presentation, the study was nearing completion, discussing the findings from 22 of the 30 expected participants. Overall, preliminary results for safety, tolerability and efficacy are "highly encouraging" with "rapid and clinically significant reductions in OCD symptoms" being found at 12-weeks post-dosing with large effect sizes being reported based on Cohen's *d* calculations.

MDMA-Assisted Therapy for Social Anxiety Disorder: Treatment adaptation and mechanisms of action. Speaker: Jason Luoma. Institution: Portland Psychotherapy Clinic, Research, and Training Center.

Jason Luoma and colleagues have been working on a clinical trial investigating the effects of two doses of MDMA in the treatment of social anxiety disorder (SAD). The protocol for this trial was published in *Frontiers in Psychiatry* in 2023 (Lear et al., 2023). As part of the randomized, open-label delayed treatment study, they are comparing immediate treatment (3 preparation sessions, 2 dosing sessions [80 mg and 120 mg], 6 integration sessions) to delayed treatment 16-weeks later. The psychotherapy component integrated in the trial features approaches derived from acceptance and commitment therapy (ACT) and emotion-focused therapy (EFT). At time of presentation, 8 out of the expected 20 participants had completed the study. Reported preliminary findings were relevant to the mechanisms of change based on

participant accounts including the following: increased self-transcendent experiences and related emotions, reduced sensitivity to social-evaluative threat, increased self-compassion, reduced self-focused attention, an enhanced sense of interconnection with and similarity to others, and an increased attention to positive social events.

Preliminary effects of psilocybin in patients with Major Depressive Disorder and Co-occurring Alcohol Use Disorder. Speaker: Frederick Barrett. Institution: Johns Hopkins University.

Frederick Barett and colleagues have been working on a clinical trial investigating the effects of a psilocybin as a treatment for comorbid Major Depressive Disorder (MDD) and Alcohol Use Disorder (AUD) (Clinical Trial ID: NCT04620759). Utilizing a double-blind, randomized, placebo-controlled study design, the effects of a single high dose of psilocybin (25 mg) were compared to an inert placebo. The psychotherapy component integrated in the trial features brief motivational interviewing for alcohol use, consistent across both conditions. After the primary endpoint of the study, a second unblinded high dose of psilocybin (25 mg) was provided to all participants. At the time of the presentation, preliminary results were provided for 10 out of the 90 expected participants with data from baseline to the end of the open label dosing session. Overall, large effect sizes based on Cohen's *d* calculations were reported indicating decreases in depressive symptoms, decreases in the percentage of heavy drinking days and decreases in non-drinking days.

Concluding Remarks

From my perspective, these are fascinating findings. The breadth of health conditions and mental disorders indicating improvements in symptomatology as a result of psychedelic therapies is far reaching and raises questions about what exactly is happening at the level of underlying therapeutic mechanisms on a biological and psychological level. Although there are a number of theories and hypotheses in the field which attempt to explain these mechanisms, one area my mind is turning to as a researcher and clinician is to these categorical diagnostic entities and their utility in understanding the etiology of these disorders. Perhaps there is a need to apply alternative nosological systems that address these arbitrary boundaries between disorders and calling attention to higher-order factors underlying (psycho)pathology.

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"SITTIN' IN THE MORNIN' SUN" and "YO, BIG SHAQ, THE ONE AND ONLY"

Pat DeLeon, Ph.D., MPH, JD
Former APA President

"SITTIN' IN THE MORNIN' SUN"

RxP's Steady Maturation

Phil Hughes, UNC Eshelman School of Pharmacy and Cecil G. Sheps Center for Health Services Research: "With Colorado and Utah becoming the 6th and 7th state (respectively) to grant prescriptive authority (RxP) to psychologists over the past two years and several additional states working to pass similar laws, we appear to be firmly in the midst of a 'third wave' of RxP. As the number of RxP states continues to grow, I am excited to say that so too does the research on RxP. Most recently, my dissertation work examining RxP has resulted in two publications in the *American Psychologist*. Both studies were conducted with an intentionally interdisciplinary team of researchers, including myself (health services researcher), Joshua Niznik (pharmacoepidemiologist), Bob McGrath (psychologist), Casey Tak (health economist), Robert Christian (psychiatrist), Betsy Sleath (pharmacist), and Kathleen Thomas (health economist).

"The first study used a large private insurance claims database (n = 307,478) to examine the demographic (e.g., sex, age) and clinical (e.g., diagnosis, comorbidities) characteristics of patients who were prescribed a psychotropic medication by a prescribing psychologist, psychiatrist, or primary care physician. What we found was that prescribing psychologists are treating a patient population very similar to their psychiatrist peers rather than the less complex patients treated in primary care. More importantly, this included patients with a variety of physical comorbidities such as diabetes and cancer, providing evidence that prescribing psychologists are indeed capable of handling medically complex patients. Additionally, this study demonstrated that prescribing psychologists are less likely to prescribe antipsychotic medications than psychiatrists even after accounting for the patient's diagnosis. This finding suggests that the concerns about psychologists overprescribing antipsychotics expressed by RxP opponents may be unfounded."

"The second study used the same data as the first but looked at the year after their first psychotropic prescription to examine critical prescribing outcomes: adverse drug events, psychiatric emergency department utilization, medication adherence, and psychotropic polypharmacy. While far too technical to describe here, the methodology used in this study was designed to closely mimic a hypothetical Randomized Controlled Trial comparing prescribing psychologists (treatment) to psychiatrists (control 1) and primary care physicians (control 2). Among privately insured patients, we found evidence that prescribing psychologists produce lower rates of adverse drug events and polypharmacy than psychiatrists while having similar rates of psychiatric emergency department visits and medication adherence. The comparison with primary care physicians suggested a difference between primary and specialty mental health care, as both psychologists and psychiatrists had higher rates of psychiatric emergency department visits and polypharmacy than primary care physicians. In total, this highly robust study demonstrated that prescribing psychologists are no less safe than psychiatrists and, perhaps, may be safer in some regards."

"Much and more remains to be done to understand and document the impact of RxP on patients, mental health access, and the mental health workforce itself; however, the growing body of evidence repeatedly demonstrates that RxP is safe and effective. As this 'third wave' of RxP hopefully continues into the next legislative cycle, so too will the research showing that RxP is an evidence-based policy. As always, I am available by email [phughes1@email.unc.edu] and would be happy to discuss my research or further collaboration opportunities."

"YO, BIG SHAQ, THE ONE AND ONLY"

The Vibrant Public Policy Process

The public policy/legislative process is anything but static. It continues to evolve, reflecting subtle societal changes that many of our colleagues do not appreciate. Former APA President Ron Fox used to remind those of us interested in prescriptive authority (RxP) that visionary Ohio academic leaders were nursing's critical RxP catalyst. With significant foundation support, they successfully lobbied for RxP authority for their advanced graduate students, under faculty supervision. Upon graduation, those cohorts asked the Ohio legislature: "If I could provide needed clinical services as a student, why can't I continue to serve my patients now that I have graduated?" This past month I again had the pleasure of attending the AACN (American Association of Colleges of Nursing) Dean's Annual Conference where one of the invited speakers discussed her vision for the role of physicians. She was immediately met with considerable "push back" by the audience who spontaneously objected to AMA's systematic efforts to restrict nursing's clinical practice and called for the enactment of national scope of practice legislation, modeled after that adopted, again notwithstanding considerable medical opposition, by the Department of Veterans Affairs (VA). With the current leadership of academic nursing seemingly focusing upon what are essentially clinical practice issues, perhaps significant change is in the winds.

New Mexico: On March 6, 2002, New Mexico's landmark RxP legislation was signed by their Governor, becoming the first state (other than Indiana and Guam) to enact this authority. On February 29, 2024, their current Governor signed SB. 127 significantly updating New Mexico's precedent setting legislation. Leslie Dozzo, President of the State Psychologist Association (SPA) of New Mexico and a prescribing psychologist: "In over twenty years of practice in New Mexico, prescribing psychologists have been providing safe and effective services primary to rural and underserved communities and populations across the state. A recent survey of members found most responders provide roughly 95% of their services to Medicaid recipients or to the indigent. Our new legislation states: 'psychotropic medication' means a controlled substance or dangerous drug that may not be dispensed or administered without a prescription but is limited to only those agents related to the diagnosis and treatment or management of mental, nervous, emotional, behavioral, substance use or cognitive disorders, including the management of or protection from side effects that are a direct result from the use of those agents, whose use is consistent with the standards of practice for clinical psychopharmacology.' This is a significant improvement over the language that previously defined our practice. Instead of specifying which agents we can prescribe, this broadens the scope of our practice to that of 'clinical psychopharmacology' which more closely resembles the practice of other psychiatric providers. The legislation further broadens our scope of practice in that it now allows us to treat ADE's (side effects) of psychotropic medications, which is much closer to the standards of psychiatric practice, albeit in consultation with the patient's health care professional.

"The bill also adds prescribing psychologists with at least four years of experience as independent-level prescribers to the list of 'supervising clinicians' for a psychologist who is undergoing RxP training. The change of the supervisor terminology from 'prescribing physician' to 'prescribing clinician' opens the door

to prescribing psychologists (with 4 years' experience), who are now included in the term of 'prescribing clinician', to supervise psychologists during practica. This will need to be clarified in rule promulgation.

"Regarding the membership of the Board of Psychological Examiners, the bill now guarantees that of the five psychologist members, two shall be prescribing psychologists, an important change in the make-up of the board. It also recognizes our organization as eligible to nominate prescribing psychologists to fill those seats. Finally, the bill states: 'A psychologist with a conditional prescription certificate may prescribe and administer psychotropic medication injections under the supervision of a supervising clinician and upon completion of board-approved training. A prescribing psychologist may prescribe and administer psychotropic medication injections upon completion of board-approved training.' Prior to this, we have been able to prescribe injectable psychiatric medications, however we were unable to administer them."

Aloha,

Pat DeLeon, former APA President