Report to the General Assembly

An Act Concerning the Department of Public Health's Oversight Responsibilities relating to Scope of Practice Determinations:

Scope of Practice Review Committee Report on Psychologists

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State of Connecticut
Department of Public Health
Report to the General Assembly

Scope of Practice Review Committee Report on Psychology

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Executive Summary

In accordance with Connecticut General Statutes (CGS) Sections 19ad through 19a-16f, the Connecticut Psychological Association (CPA) submitted a scope of practice request to the Department of Public Health to provide prescriptive authority to doctoral level psychologists who obtain a Master of Science degree in psychopharmacology. A scope of practice review committee was established to review and evaluate the request as well as subsequent written responses to the request and additional information that was gathered through the review process.

The scope of practice review committee included medical and nursing organizations, the Connecticut Hospital Association, and the CPA. In reviewing and evaluating the information presented, the scope of practice committee primarily focused on assessing public health and safety risks associated with the request, whether the request could enhance the access to quality and affordable health care, and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training.

The CPA described its request for prescriptive authority as one mechanism to address the shortage of psychopharmacologic prescribers amidst the growing number of people in need of mental health care and psychopharmacologic medication. The CPA cited frequent challenges for patients trying to find a prescriber, including long wait lists when a provider is identified. Other challenges in access to mental health care cited by CPA include the aging physician population, and declining participation of psychiatrists in public and private insurance plans. The CPA sees allowing appropriately credentialed psychologists to prescribe improve access to both integrated and comprehensive mental health services, including for disadvantaged populations.

The CPA presented information to the review committee on topics including the proposed psychopharmacology curriculum, regional and national trends on psychologists prescribing, and the lack of documented patient safety issues related to psychologist prescribing. The CPA also emphasized the importance of a psychologist experiencing a supervised practicum with a licensed physician or APRN prior to being certified to prescribe.

The Connecticut Hospital Association was open to the concept as a mechanism to help improve the current mental health system, as long as quality and safety are not compromised. However, the rest of the organizations that participated on the committee felt that a profession without formal medical or nursing training does not possess the knowledge and skills to appropriately and safely prescribe.

The review committee was unable to reach a consensus on a pathway to prescribing for psychologists.

Background

Connecticut General Statutes (CGS) Sections 19ad through 19a-16f establish a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under the provisions of this act, persons or entities acting on behalf of a health care profession that may be directly impacted by a scope of practice request may submit a written impact statement to the Department of Public Health. The Commissioner of Public Health shall, within available appropriations, establish and appoint members to a scope of practice review committee for each timely scope of practice request received by the Department. Committees shall consist of the following members:

1. Two members recommended by the requestor to represent the health care profession making the scope of practice request;
2. Two members recommended by each person or entity that has submitted a written impact statement, to represent the health care profession(s) directly impacted by the scope of practice request; and
3. The Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, non-voting member of the committee.

Scope of practice review committees shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an assessment of any public health and safety risks that may be associated with the request, whether the request my enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. Upon concluding its review and evaluation of the scope of practice request, the committee shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The Department of Public Health (DPH) is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

Scope of Practice Request

The Connecticut Psychological Association (CPA) submitted a scope of practice request to expand the practice of psychology in Connecticut to include prescriptive authority. The expansion would apply to doctoral level licensed psychologists who:

- obtain a Master of Science degree in psychopharmacology;
- participate in a supervised clinical experience in prescribing under a Connecticut licensed prescriber; and
- successfully complete a national board examination (i.e. the American Psychological Association Psychopharmacology Examination for Psychologists).

Impact Statements and Responses to Impact Statements

Written impact statements in response to the scope of practice request submitted by the CPA were received from the Connecticut Chapter of the Academy of Pediatrics, the Connecticut Academy of Family Physicians, the Connecticut Council of Child and Adolescent Psychiatry, the Connecticut Hospital Association, the Connecticut Nurses Association, the Connecticut Psychiatric Society, the Connecticut State Medical Society, and the Connecticut APRN Society. Almost all of the impact statements expressed concerns or opposition regarding the requested scope expansion. The concerns were primarily related to perceptions that the education and training of psychologists, even with an additional degree in pharmacology, is not sufficient to safely prescribe medicine.

The Department and CPA also received approximately 70 emails in opposition to the proposal from individuals, primarily physicians, throughout the country. These emails were all in opposition to the proposal, but did not request to be part of the review committee or claim to represent any particular profession. Nor did they necessarily describe how the proposal would impact their profession. However, CPA did acknowledge many of these emails.

CPA provided written responses to the various associations and societies that provided impact statements, and to individual practitioners identified as licensed and working in Connecticut who submitted statements. The responses by CPA acknowledged the concerns of each association or society and offered the following points:

1. The data clearly shows, in the states and in the federal government where prescriptive authority is allowed, that psychologists have been prescribing safely. In addition, there is no data that shows that psychologists over prescribe. Finally, psychologists view medication as one piece of a comprehensive treatment plan and if anything, tend to prescribe less than other medical professionals.
2. The state of Connecticut, like all states is facing an opioid crisis. As we all agree that the crisis is undeniable, it is clear that the state needs more expertly trained addiction and mental health professionals with the ability to use all available treatment tools.
3. Psychologists have been safely prescribing since 1997. In the states and federal agencies where prescriptive authority is allowed, there is no data to suggest that there was any issue with respect to patient safety.
4. It appears that your concern on education and training seems to be focused solely on the undergraduate and doctoral training programs of the psychologist, and not on the Masters in Science post-doctoral training that is required with prescriptive authority for psychologists. After a four – six year post-bachelor's degree doctorate, including two years of internship and in residency, if a psychologist chooses to pursue prescriptive authority, the psychologist must:
    a. Complete a two year Masters of Science Degree in Clinical Psychopharmacology, including, but not limited, to courses in pathophysiology, clinical medicine and physical examination, laboratory studies, neuropathology, neuropharmacology, clinical pharmacology, and clinical psychopharmacology, ethics and professional issues.

b. Upon completion of the coursework, there is a national board exam, developed by physicians, pharmacologists, and medical psychologists.
c. There is a requirement to complete a clinical practicum that includes prescribing for 100 patients (or 400 contact hours) under the supervision of a physician with a requirement that patients with a variety of psychiatric and addiction diagnoses are seen.
d. Before a psychologist can prescribe independently, he/she must be supervised for a period of not less than one year.

5. The CPA has been at the forefront of collaborative healthcare between all practitioners of the healing arts.

Scope of Practice Review Committee Membership

In accordance with CGS Sections 19ad through 19a-16f, a scope of practice review committee was established to review and evaluate the scope of practice request submitted by the Connecticut Psychological Association. Membership on the scope of practice review committee included:

1. Connecticut APRN Society
2. Connecticut Association of Family Physicians
3. Connecticut Chapter of the American Academy of Pediatrics
4. Connecticut Council of Child and Adolescent Psychiatry
5. Connecticut Hospital Association
6. Connecticut Nurses Association
7. Connecticut Psychiatric Society
8. Connecticut Psychological Association
9. Connecticut State Medical Society
10. The Commissioner's designee (chairperson and ex-officio, non-voting member).

Scope of Practice Review Committee Evaluation of Request

The Connecticut Psychological Association's scope of practice request included all of the required elements identified in PA 11-209 as outlined below.

Health & Safety Benefits

The CPA identified a number of health and safety benefits they believe can result from psychologists having prescribing authority in Connecticut. These benefits include addressing the increasing need for comprehensive mental health treatment, mitigating a "mental health prescriber shortage," an aging physician population, and a decline in psychiatrists accepting any or certain types of insurance.

The CPA also referenced an increase in the use of psychotropic medications and an increase in the number of mental health patients prescribed multiple medications (polypharmacy). The CPA request describes data from a study indicating that many who prescribe psychotropic medications are general practitioners. The study suggests that non-psychiatrists prescribing psychotropic medications may

improve access to treatment for many patients. However, the study cited concerns that treatment by non-psychiatrists is not necessarily coupled with other services such as psychotherapy, medication monitoring, the appropriate intensity of treatment, and treatment consistent with evidence-based guidelines. The CPA proposal describes how research shows that psychotherapy plus medication is most effective for many mental health disorders, but many patients currently must visit two providers for mental health issues – the prescriber and a therapist. The CPA states that appropriately trained prescribing psychologists could safely provide all of these services and remove the need for some patients to visit two providers.

Access to Healthcare

The CPA states that expanding the current scope of practice to include prescribing psychologists would have a significant and positive impact on access to mental health prescribers. The CPA compared data from the E-license system on physicians with a specialty in psychiatry and psychologists. Both professions have a higher presence in urban areas compared to more rural areas. The CPA believes that prescribing authority could improve access to mental health prescribers in rural areas, and improve access for disadvantaged populations in general. The data analysis provided by CPA did not take into account advanced practice registered nurses and physician assistants who are capable of prescribing.

Laws Governing the Profession

The statutes governing the profession of psychology are found in Connecticut General Statutes Section 20-186 through Section 20-195. The regulations governing psychology are found in the Regulations of Connecticut State Agencies Sections 20-188.1 through 20-188.3. The CPA included these statutes and regulations as Appendix B and Appendix C in the CPA scope of practice request included in the appendices of this document.

Current Requirements for Education and Training and Applicable Certification Requirements

The current general requirements for licensure as a psychologist in Connecticut are:

- A doctoral degree from an approved program in psychology. Programs fully accredited by the American Psychological Association (APA) are approved. Programs without this accreditation are subject to an individual review to ensure the program meets the requirements in Connecticut's regulations (Section 20-188-2)
- Completion of at least one year of supervised work experience at the pre or post-doctoral level
- Completion of the Examination for Professional Practice in Psychology (EPPP) administered by the Association of State and Provincial Psychology Boards
- Completion of the Connecticut jurisprudence examination for psychologists.

Summary of Known Scope of Practice Changes

None

Impact on Existing Relationships within the Health Care Delivery System

The CPA suggests that the request will further enhance the relationship between psychologists and physicians in Connecticut. The CPA referenced 2013 Connecticut legislation that allowed physicians and psychologists to incorporate together as business partners. The CPA described how this legislation facilitated integrated care between the two professions and improved access to mental health care. The CPA described that prescription rights for psychologists will facilitate integrating behavioral and physical health care that will result in fewer doctor visits.

Economic Impact

The CPA proposal suggests that allowing psychologists to prescribe will have a positive impact on the healthcare delivery system. The CPA claims that healthcare utilization cost savings will be realized because patients will obtain equivalent care seeing only a prescribing psychologist and not be required to see a psychologists and a separate practitioner (e.g. physician or APRN), thereby reducing the overall number of office visits. The CPA also claims that there may be a reduction in emergency department visits for mental health intervention due to an increase in access to medication prescribers that would result from psychologists being able to prescribe. Lastly, the CPA suggests that prescribing psychologists will lead to reduced polypharmacy and lower medical costs for patients.

Regional and National Trends

Currently, psychologists also have prescriptive authority in New Mexico (as of 2002), Louisiana (as of 2004), Illinois (as of 2014), Iowa (as of 2016), Idaho (as of 2017), and the U.S. territory of Guam (as of 1999). Also, the Defense Department, the U.S. Public Health Service and the Indian Health Service permit appropriately trained psychologists to prescribe.

Each of the states and Guam require additional education in pharmacology, beyond the requirements for licensure, for a psychologist to prescribe. In general, the additional education in pharmacology seems to align with the Master of Science degree in psychopharmacology requirement proposed by CPA.

The Department reviewed the psychology prescribing laws in each state listed above. Each of the states that allow psychologists to prescribe require some sort of collaborative relationship with a licensed physician or other prescriber and/or collaboration with a patient's primary or attending physician. It appears that the only state that currently has a pathway to true independent prescribing is New Mexico. Independent prescribing in New Mexico may be allowed after the two years under physician supervision and upon the recommendation of the supervising physician and peer review. All other jurisdictions require an ongoing relationship or communication with a supervising physician or other prescriber, and/or collaboration with the patient's primary caregiver.

Other Health Care Professions that may be impacted by the Scope of Practice Request as Identified by the Requestor

The CPA correctly anticipated that individuals from the psychiatry field would oppose the CPA's request to allow psychologists to prescribe. However, there is also opposition from others in medical and nursing fields as evidenced by the broad participation of organizations representing these groups. The CPA also correctly identified that the primary concerns of those in opposition would be that public safety would be compromised and that psychologists training and education is inadequate to prescribe medications.

Description of How the Request Relates to the Profession's Ability to Practice to the Full Extent of the Profession's Education and Training

The CPA argues that allowing psychologists to prescribe after completing a post-doctoral Master of Science degree in psychopharmacology is a natural and appropriate extension of the education and training of psychologists.

Findings/Conclusions

The Connecticut Psychological Association (CPA) submitted a scope of practice request for the practice of psychology to allow certain psychologists to prescribe medications. This expansion of a psychologist's scope would require that a licensed PhD-level psychologist obtain a Master of Science Degree in psychopharmacology, successfully complete a national board examination, and receive clinical supervision from a physician or APRN for a period of time.

The scope of practice review committee reviewed all of the information provided in the Connecticut Psychological Association's scope of practice request and had ongoing discussions during the three scope of practice review committee meetings. The CPA invited Dr. David Greenfield, licensed psychologist and Assistant Clinical Professor of Psychiatry at the University Of Connecticut School Of Medicine, to discuss his experience earning a Master of Science Degree in Clinical Psychopharmacology equivalent to the proposed post-doctoral education requirement for psychologists to prescribe. In reviewing and evaluating the information presented, the scope of practice committee focused on assessing any public health and safety benefits associated with the request, whether the request may enhance access to quality and affordable health care, and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training.

All committee participants agreed that there is an increase in the use of psychotropic drugs and patients receiving multiple medications. They also acknowledged that many patients have a prescriber and a therapist. However, most of the organizations represented on the committee expressed that they did not feel that allowing psychologists to prescribe was in the best interest of patients. The overarching concern is that these groups generally believe that the proposed training and qualifications do not

provide a medical foundation necessary for psychologists to effectively or safely prescribe. They strongly believe that the extensive medical training and experience that physicians and advanced practice registered nurses receive prior to independently prescribing is essential to safely and effectively prescribe medications.

The medical and nursing organizations were particularly concerned with the risks associated with prescribing to pediatric, geriatric, and patients with other existing medical conditions. According to these organizations, the value of a residency or long term supervised experience in different settings provide physicians and APRNs the experience to understand all the things that can go wrong with prescribed medications. For example, there are concerns that non-medically trained individuals will not understand differential medical diagnoses that could appear as a mental health condition, the need to monitor drug interactions, and importance of monitoring the liver functions and other physiological responses while patients are prescribed medications.

Regarding access to mental health care, the CPA estimated that 182 currently licensed psychologists in Connecticut would become prescribers. The CPA feels that prescribing psychologists would have a positive impact on the public's ability to readily access a mental health prescriber and streamline care.

Opponents of psychologist prescribing privileges felt that efforts to improve reimbursement and assure reimbursement parity for mental health treatment through insurance providers would be a more effective mechanism to improve access to quality mental health care. Opponents also argued that expanding access to less qualified prescribers is not in the best interest of patients with mental health conditions requiring medication. They also argued that people with mental health issues are often stigmatized as second class citizens and that allowing their medical treatment to be guided by prescribers that lack a strong medical or nursing background could contribute to that stigma.

The CPA described that psychologists have been prescribing safely since 1997. The CPA referenced that there is no data to suggest that there was any issue with respect to patient safety in the states and federal agencies where psychologists are allowed to prescribe. However, it was argued that the lack of documented patient safety issues from a small number of states and agencies on a relatively small number of prescribing psychologists is not sufficient to demonstrate a strong safety record or that there is no risk to patients.

The Connecticut Hospital Association was the only organization at the table that did not necessarily oppose the concept of psychologists prescribing. The CHA expressed that it is open to the concept, and the issues of most concern are quality, safety, and access. CHA emphasized that there are major issues related to mental health care access and that the current system is not working for any age group, but particularly for children.

The CPA asserted that the opioid crisis highlights the need for more expertly trained addiction and mental health professionals with the ability to use all available treatment tools (e.g. medication assisted

treatment). There was no disagreement that there is a need for qualified addiction and mental health professionals using all appropriate treatment tools. Those opposed to psychologists prescribing expressed high respect for the clinical expertise and quality services that psychologists provide to individuals with substance use and mental health issues. However, those opposed also expressed concerns that adding a non-medically trained category of prescribers into Connecticut's health care landscape could potentially contribute to inappropriate prescribing.

A member of one of the organizations opposed to psychologists prescribing provided data they entitled Psychologists Prescribing: Concerning Findings within CMS Medicare Part D Prescriber Data in Louisiana and New Mexico from 2014 and 2015 (see appendices). The author of the analysis implies that psychologists in Louisiana and New Mexico are prescribing outside of the scope of medications used for mental health treatment. Factors to consider when looking at this data are 1) the overall number of these types of prescriptions is not included in the analysis, and 2) based on the prescribing laws and requirements in these two states, it is not known if these prescriptions were ordered under the supervision or in collaboration with a prescribing physician. Knowledge of these factors may contribute to a better understanding of the information provided.

The CPA asserts that the proposed additional post graduate requirements for psychologist prescribing rights, including a period of supervision under another licensed prescriber, are sufficient for a psychologist to safely prescribe medications for their patients. The Connecticut Hospital Association remained open to the concept of psychologists prescribing as a mechanism to expand access to mental health prescribers as long as safety and quality could be maintained. The other professional groups that participated on the committee maintained their objection to the concept of psychologists prescribing.

While the majority of those on the committee objected to the concept of psychologists prescribing, there was unanimous appreciation and high respect for the clinical treatment provided by psychologists. Many members expressed a desire for more quality clinical mental health services that could lead to less prescribing. The professions expressed the importance of continuing to foster a collaborative team approach to treating mental health and substance use issues that effectively utilizes the skills and expertise of various professions.

The review committee was unable to reach a consensus on a pathway to prescribing for psychologists.

Appendix A

Scope of Practice Law

Scope of Practice Law

Connecticut General Statutes
19a-16d - 19a-6f

Sec. 19a-16d. Submission of scope of practice requests and written impact statements to Department of Public Health. Requests for exemption. Notification and publication of requests. (a) Any person or entity, acting on behalf of a health care profession that seeks to establish a new scope of practice or change a profession's scope of practice, may submit a written scope of practice request to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(b) (1) Any written scope of practice request submitted to the Department of Public Health pursuant to subsection (a) of this section shall include the following information:

(A) A plain language description of the request;

(B) Public health and safety benefits that the requestor believes will be achieved should the request be implemented and, if applicable, a description of any harm to public health and safety should the request not be implemented;

(C) The impact that the request will have on public access to health care;

(D) A brief summary of state or federal laws that govern the health care profession making the request;

(E) The state's current regulatory oversight of the health care profession making the request;

(F) All current education, training and examination requirements and any relevant certification requirements applicable to the health care profession making the request;

(G) A summary of known scope of practice changes either requested or enacted concerning the health care profession in the five-year period preceding the date of the request;

(H) The extent to which the request directly impacts existing relationships within the health care delivery system;

(I) The anticipated economic impact of the request on the health care delivery system;

(J) Regional and national trends concerning licensure of the health care profession making the request and a summary of relevant scope of practice provisions enacted in other states;

(K) Identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact and efforts made by the requestor to discuss the request with such health care professions; and

(L) A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training.

(2) In lieu of submitting a scope of practice request as described in subdivision (1) of this subsection, any person or entity acting on behalf of a health care profession may submit a request for an exemption from the processes described in this section and section 19a-16e. A request for exemption shall include a plain language description of the request and the reasons for the request for exemption, including, but not limited to: (A) Exigent circumstances which necessitate an immediate response to the scope of practice request, (B) the lack of any dispute concerning the scope of practice request, or (C) any outstanding issues among health care professions concerning the scope of practice request can easily be resolved. Such request for exemption shall be submitted to the Department of Public Health not later than August fifteenth of the year preceding the commencement of the next regular session of the General Assembly.

(c) In any year in which a scope of practice request is received pursuant to this section, not later than September fifteenth of the year preceding the commencement of the next regular session of the General Assembly, the Department of Public Health, within available appropriations, shall: (1) Provide written notification to the joint standing committee of the General Assembly having cognizance of matters relating to public health of any health care profession that has submitted a scope of practice request, including any request for exemption, to the department pursuant to this section; and (2) post any such request, including any request for exemption, and the name and address of the requestor on the department's web site.

(d) Any person or entity, acting on behalf of a health care profession that may be directly impacted by a scope of practice request submitted pursuant to this section, may submit to the

department a written statement identifying the nature of the impact not later than October first of the year preceding the next regular session of the General Assembly. Any such person or entity directly impacted by a scope of practice request shall indicate the nature of the impact taking into consideration the criteria set forth in subsection (b) of this section and shall provide a copy of the written impact statement to the requestor. Not later than October fifteenth of such year, the requestor shall submit a written response to the department and any person or entity that has provided a written impact statement. The requestor's written response shall include, but not be limited to, a description of areas of agreement and disagreement between the respective health care professions.

Sec. 19a-16e. Scope of practice review committees. Membership. Duties. (a) On or before November first of the year preceding the commencement of the next regular session of the General Assembly, the Commissioner of Public Health shall, within available appropriations allocated to the department, establish and appoint members to a scope of practice review committee for each timely scope of practice request submitted to the department pursuant to section 19a-16d. Committees established pursuant to this section shall consist of the following members: (1) Two members recommended by the requestor to represent the health care profession making the scope of practice request; (2) two members recommended by each person or entity that has submitted a written impact statement pursuant to subsection (d) of section 19a-16d to represent the health care professions directly impacted by the scope of practice request; and (3) the Commissioner of Public Health or the commissioner's designee, who shall serve as an ex-officio, nonvoting member of the committee. The Commissioner of Public Health or the commissioner's designee shall serve as the chairperson of any such committee. The Commissioner of Public Health may appoint additional members to any committee established pursuant to this section to include representatives from health care professions having a proximate relationship to the underlying request if the commissioner or the commissioner's designee determines that such expansion would be beneficial to a resolution of the issues presented. Any member of such committee shall serve without compensation.

(b) Any committee established pursuant to this section shall review and evaluate the scope of practice request, subsequent written responses to the request and any other information the committee deems relevant to the scope of practice request. Such review and evaluation shall include, but not be limited to, an

assessment of any public health and safety risks that may be associated with the request, whether the request may enhance access to quality and affordable health care and whether the request enhances the ability of the profession to practice to the full extent of the profession's education and training. The committee, when carrying out the duties prescribed in this section, may seek input on the scope of practice request from the Department of Public Health and such other entities as the committee determines necessary in order to provide its written findings as described in subsection (c) of this section.

(c) The committee, upon concluding its review and evaluation of the scope of practice request, shall provide its findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The committee shall provide the written findings to said joint standing committee not later than the February first following the date of the committee's establishment. The committee shall include with its written findings all materials that were presented to the committee for review and consideration during the review process. The committee shall terminate on the date that it submits its written findings to said joint standing committee.

Sec. 19a-16f. Report to General Assembly on scope of practice review processes. On or before January 1, 2013, the Commissioner of Public Health shall evaluate the processes implemented pursuant to sections 19a-16d and 19a-16e and report to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a, on the effectiveness of such processes in addressing scope of practice requests. Such report may also include recommendations from the committee concerning measures that could be implemented to improve the scope of practice review process.

Appendix B

Committee Membership

Psychologists

Committee Membership

All participating organizations are reflected; however substituted individual committee members may not be listed

Name of Organization	Committee Members
CT Department of Public Health (DPH)	Chris Andresen Meghan Bennett Steve Carragher Wendy Furniss
CT APRN Society	Laura Bracale Danielle Morgan
CT Association of Family Physicians	Drew Edwards Stacy Taylor
CT Council of Child & Adolescent Psychiatry / CT American Academy of Pediatrics	Judy Blei Sheena Joychan Dorothy Stubbe Jillian Wood
CT Hospital Association (CHA)	Karen Buckley Marielle Daniels
CT Nurses Association (CNA)	Mary Jane Williams
CT Psychiatric Society (CPS)	Elizabeth Burch Jacquelyn Coleman Reena Kapoor
CT Psychological Association (CPA)	Barbara Bunk David Greenfield Mary Kane Sharif Okasha
CT State Medical Society (CSMS)	Ken Ferrucci Falisha Gilman Bo Subbarao

Appendix C

Original Scope of Practice Request

CONNECTICUT PSYCHOLOGICAL ASSOCIATION

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12APP
P.O. Box 340308
Hartford, CT 06124-0308

August 14, 2017

Re: Request for Review of Scope of Practice for Psychologists

Via Email: karen.wilson@ct.gov and Hand Delivery

Ms. Wilson,

The Connecticut Psychological Association (CPA) is herein submitting documentation to request a review of the scope of practice of psychology to allow appropriately trained psychologists to prescribe psychotropic medications. This expansion would require that the licensed psychologist obtain an additional Master of Science degree in psychopharmacology, over and above the doctoral level training he or she has already obtained; clinical supervision from physicians or advanced practice nurse practitioners who have experience with the psychiatric population and formulary is also proposed. The proposed training is projected to require 2 – 3 years.

The Connecticut Psychological Association (CPA) is the major professional society that represents psychologists and psychology graduate students in the State of Connecticut. We have served psychologists in Connecticut for the past 54 years. Our mission is to further the development and usefulness of psychology as a science, as a profession, and as a means of promoting human welfare; to establish and maintain high standards of professional competence, of training, of service, and of professional and ethical conduct for its membership; to provide opportunities for students pursuing training in psychology to become more fully engaged in the standards, interests, and collegiality of the profession; and to provide opportunities for professional growth and the increase and diffusion of psychological knowledge through the exchange of ideas and information. The CPA is an affiliate of the American Psychological Association, the leading organization representing psychology in the country.

We believe that recent changes in our healthcare environment support this enhancement for appropriately medically trained psychologists. Specifically, Connecticut's citizens are experiencing limited access to mental health prescribers while the need for such services is dramatically increasing.

We respectfully submit the attached request for selection for a scope of practice review under Public Act 11-209.

Please contact the undersigned at (860) 989-7612 with questions.

Barbara S. Bunk, Ph.D.
Co-chair, CPA Task Force on Prescriptive Authority

PO Box 915, North Haven, CT 06473-0915 | Phone: (860) 404-0333 | Fax: (860) 673-0819 | www.connpsych.org

Request for Review of Scope of Practice
Connecticut Psychological Association

1. A plain language description of the request:

The present request is to expand the scope of practice of psychology for appropriately medically trained psychologists to include prescriptive authority in their scope of practice. Specifically, the expanded scope would apply to doctoral level psychologists who obtained a Master of Science degree in psychopharmacology.

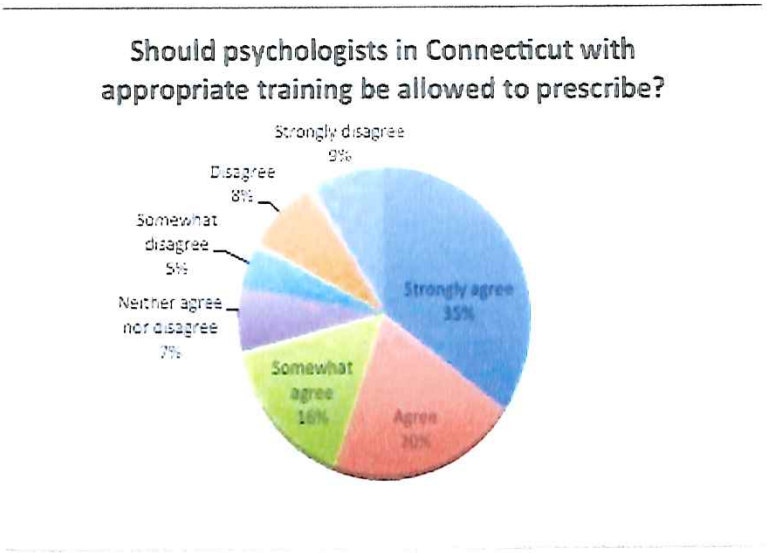
Currently, there is a shortage of psychopharmacologic prescribers for Connecticut residents and throughout the country. The shortage, which increases each year, keeps more patients waiting longer for comprehensive treatment. At the same time, there are a growing number of people who are in need of mental health care and psychopharmacologic intervention; one recent study indicated that nearly 1 in 6 adults are now taking at least 1 psychotropic medication. [1] As a result clients, family members, and communities at large, suffer unnecessarily with the impact of inadequately treated mental health symptoms.

Psychologists licensed in Connecticut are doctoral providers of mental health and psychiatric services and are fully qualified to diagnose and treat a full range of mental health, psychiatric, and substance use disorders. Currently Psychologists licensed in Connecticut also have the legal ability to write an emergency psychiatric commitment certification and well as maintain medical staff hospital privileges in hospitals and other healthcare facilities. Licensure as a psychologist requires a doctoral degree in psychology from an educational program that has been accredited by the American Psychological Association (APA) [or an educational program of equivalence] which generally requires years 4 - 6 years of full-time study; at least a 1-year (2000 hour) Internship; successful completion of the National Board Examination for Professional Practice in Psychology (EPPP); and successful completion of the Connecticut Jurisprudence Exam. In addition a 1-year (2000 hour) post-doctoral Residency/Fellowship is also required for licensure as a practicing psychologist. (Please see Appendix A for description as posted on the Connecticut Department of Public Health website regarding Psychology Licensure.)

The APA supports prescriptive authority for psychologists who are appropriately trained beyond the doctoral degree. APA has established a comprehensive curriculum for *Prescribing Psychologists* as well as a Designation Committee for Postdoctoral Education and Training for Prescriptive Authority. Significantly, the APA College of Professional Psychology has also developed the *Psychopharmacology Examination for Psychologists (PEP)*, specifically as a national board examination for credentialing psychologists with advanced training in clinical psychopharmacology.

Early this year the *CPA Task Force Regarding Prescriptive Authority for Psychologists* conducted a survey of licensed psychologists and psychology graduate students across the state

to learn about their thoughts and perspectives on prescriptive authority for properly trained psychologists (i.e., *Prescribing Psychologists*). The results of the survey in Connecticut are in line with the national trend. Psychologists responded to the question *'Clinical psychologists in CT with appropriate training should have the authority to prescribe psychotropic medications in CT'* in the following manner:



Graduate students responded similarly to psychologists; more than 70% of graduate students and licensed psychologists endorsed agreement.

The current request to expand psychologists' scope of practice would allow appropriately medically trained psychologists to be prescribers of psychotropic medications. This advanced training would entail obtaining a postdoctoral Master of Science degree in clinical psychopharmacology, including courses in basic biological sciences, neurosciences, pharmacology, clinical medicine, supervised clinical experience, and eventual certification as an independent prescriber of psychopharmacologic medications.

2. Public health and safety benefits that the requestor believes will occur if the request is implemented and, if applicable, a description of any harm to public health and safety if it is not implemented:

Prescriptive authority for appropriately trained psychologists will benefit the public health and safety of Connecticut's citizens most notably by increasing access to care. Integrating healthcare services is one nationwide healthcare trend intended to address the access issue. Towards that aim in 2013, the Connecticut General Assembly passed legislation allowing physicians and psychologists to practice out of the same office creating seamless access to care for behavioral health services.

Several trends that negatively affect access to care are also evident nationally and statewide. This includes: dramatically increased need for effective comprehensive mental health treatment; an aging physician population, with declining numbers of psychiatrists and fewer who accept insurance; and a reported increase in polypharmacy. Authorizing appropriately trained psychologists to prescribe will help address these issues in Connecticut.

Increasing Need

The need for comprehensive mental health treatment is increasing. According to the National Association on Mental Illness (NAMI), 1 in 5 adults in America experience mental illness. In addition, 21.4% of youth (ages 13-18) and 13% of children (ages 5-12) experience severe mental disorder. It is also important to note that nearly 50% of lifetime mental illness begins to show symptoms before age 14 years (75% by age 24 years). More startling is the statistic from the National Institute of Mental Health that 50% of children age 8-15 received mental health services within the past year. At the same time, nearly 60% of adults and 50% of youth do not receive treatment for their mental illnesses.[2] Access to comprehensive mental and psychiatric care is even more critical for economically disadvantaged and underserved populations. A venue of increasing importance for psychologists to practice in is community health centers, which are comprehensive clinics serving low income and underserved communities funded by the Health Resources and Services Administration, the primary Federal agency for improving access to health care. Another organized health care setting that has shown dramatic increases in psychologist employment is the Department of Veterans Affairs healthcare system.

Prescriber Shortage

There is currently a mental health prescriber shortage, sometimes called a 'recruitment crisis' in the psychiatric literature. For this and other reasons, there are a dwindling numbers of psychiatrists. According to Association of American Medical Colleges (AAMC) *2016 Physician Workforce Study*, psychiatry had a minus (-) 1.4 percentage change between 2010 and 2015 nationally. In addition, data suggests that new medical school graduates are not choosing psychiatry. [3,4]

Anecdotal evidence abounds that new patients have a difficult time finding a prescriber, and wait lists are long. In the 2017 survey of psychologists in Connecticut, 70% disagreed with the statement, *'There are currently an adequate number of qualified prescribers in my area to prescribe psychotropic medications.'* Many patients who are referred for medication evaluation to psychiatrists report very long wait times for initial appointments, and many psychiatrists report not taking new patients and/or insurance. Although no specific data on Connecticut is reported on these issues, we can extrapolate from available data that wait times to see a prescriber are long. Overall, there are 1585 psychiatrists listed on the DPH Elicense Downloadable Roster, 1265 of who listed a Connecticut address as primary (data pulled on 4/4/17). This seems like a large number, however, the great majority list addresses in Fairfield County, Hartford County, and New Haven County, which are places with major research

hospitals and universities, so those psychiatrists are not necessarily in clinical practice. On the other hand, Connecticut's rural counties list very few psychiatrists: 9 psychiatrists in Litchfield County, 13 psychiatrists in New London County, 12 in Tolland County, and 7 in Windham County. (Please see Table 1 and Figure 1 below for additional information.)

Special populations such as children and adolescents in the state are likely suffering greatly as well. In 2016, it was reported that people under the age of 18 years comprised 21.1% of Connecticut's population, and though it is unknown from the DPH Roster how many child psychiatrists there are in the state, it is likely far fewer than the demand.

	Psychologists	Psychiatrists	Total
Fairfield	476	273	749
Hartford	488	307	795
Litchfield	55	23	78
Middlesex	110	53	163
New Haven	473	502	975
New London	65	40	105
Tolland	80	19	99
Windham	27	10	37

Table 1. Number of licensed psychologists and psychiatrists in each Connecticut county. Numbers include providers who filed a Connecticut address with the Department of Public Health.

A study by the Mental Health Association of Maryland reported that only 14% of the 1154 psychiatrists listed in-network for plans sold on the ACA insurance exchange had an appointment available within 45 days; in Connecticut, the situation is likely similar.[5]

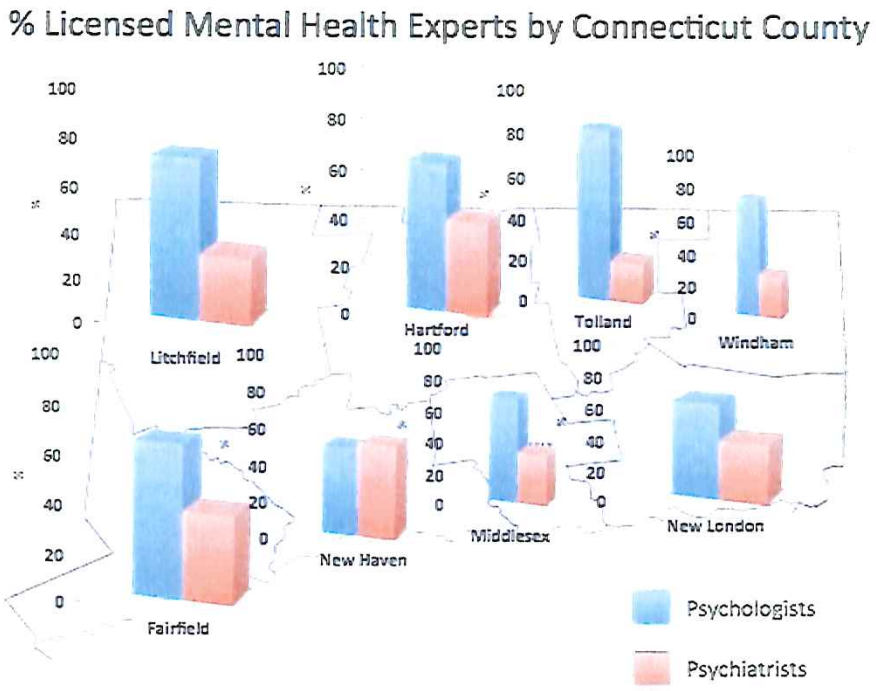


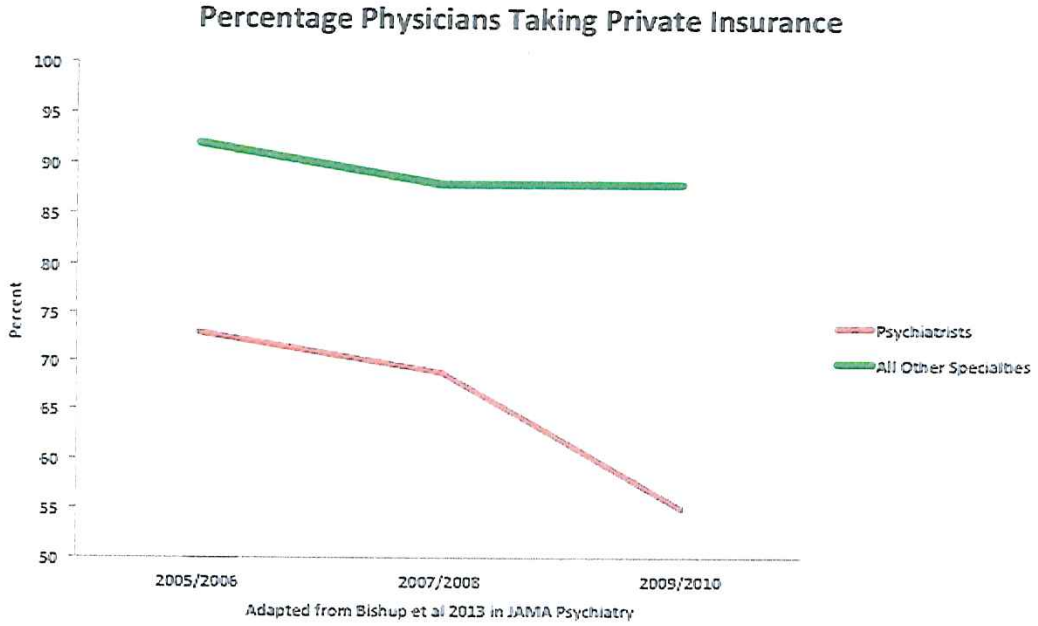
Figure 1. Percent of licensed psychologists and psychiatrists by Connecticut county. Numbers include providers who filed a Connecticut address with the Department of Public Health.

MDs are Getting Older

According to a study by the Association of American Medical Colleges in 2013, psychiatrists were the fourth oldest of 41 specialty groups, with 59% age 55 or older. In the *AAMC 2017 Update* of that same report, there is a large projected shortfall for primary care physicians, as well as in non-primary care specialties including psychiatry. In addition, the report states "for all specialty categories physician-retirement decisions are projected to have great impact on supply, as more than 1/3 of all currently active physicians will be 65 or older." And if indeed access continues to be improved via the *Affordable Care Act* for the currently underserved populations, "demand for physicians could rise substantially." These data are important, as they will certainly contribute to the rise in societal stressors, and further impact access to appropriate care for mental health and substance abuse disorders. [6,7]

Declining Participation in Public and Private Insurance

Another aspect of the concern is that many prescribers no longer take private insurance or Medicare, which further complicates the patient access disparity. A 2010 study in the Journal of American Medical Association indicated that 55% of psychiatrists took insurance at that time, which was a 20% decline from 5 years prior. This compares with all other specialties, wherein 93% took private insurance and 86% took Medicare (at the time surveyed). [8]



Increase in Use of Psychotropic Medications

Simultaneously with the decline in the number of psychiatrists who take insurance, there is a rapid increase in psychotropic medication use. The use of psychotropic drugs by adult Americans increased 22% from 2001 to 2010 with one in five adults now taking at least one psychotropic medication. [9] These psychotropic drugs, while useful, are powerful; and while they are valuable tools in treating mental illness, it is in the public's best to interest to have a greater number of appropriately trained mental/psychiatric prescribers. *Prescribing Psychologists* would be an asset toward this end.

Compounding the increased use issue is the rapid increase in mental health clients prescribed a polypharmacological regimen of multiple medications. From 1980 to 1990, monotherapy treatment decreased from 48% to 31%, and in 2000 it was 20%. Despite extensive research and recommendations on optimal dosing of psychotropic medication, polypharmacy and excessive dosing are still prevalent in clinical practice. In one study in 2008, up to one-third of patients visiting outpatient psychiatry departments have been found to be on more than three or more psychotropic drugs. [10,11,12,13]

Research has consistently shown that psychotherapy plus medication is most effective for many mental health disorders; most patients consequently see two separate providers for their mental health issues. Demand for psychiatric medication continues to dramatically increase and has, in part, led to office visits with psychiatrists lasting less than 10 minutes as well as psychiatrists declining the use of more time-consuming psychosocial interventions. These practices might also

affect some aspects of diagnostic clarity, along with the fact that many psychiatric medications are prescribed by non-psychiatric providers. (See section below.) For example, a recent article indicated that 67% of primary care physicians and 62% of psychiatrists treat normal sadness as a medical illness and consequently treated with an antidepressant. [14,15]

Most Frequent Mental Health/Psychiatric Prescribers are Not Psychiatrists

The most common treatment setting for individuals with psychological disorders is a general medical practice without concomitant specialty services. A 2006-2007 Study by The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) reported in 2009 found that 59 percent of all prescriptions for psychotropic medications are written by general practitioners. "The important role of general practitioners in prescribing antidepressant medications and treating depression has been documented," the study authors wrote. "However, the extent to which general practitioners are prescribing other types of psychotropic medications has received less emphasis." The study, conducted by researchers from Thomson Reuters and the federal Substance Abuse and Mental Health Services Administration (SAMHSA), analyzed prescribing patterns for psychotropic drugs from August 2006 through July 2007. Of the 472 million prescriptions written for psychotropic medications during the study period, the researchers found that general practitioners prescribed 62 percent of antidepressants, 52 percent of stimulants (mainly drugs to treat attention deficit hyperactivity disorder), 37 percent of antipsychotics, and 22 percent of anti-mania medications. Pediatricians were included as general practitioners and wrote 25 percent of all stimulant prescriptions. [16, 17]

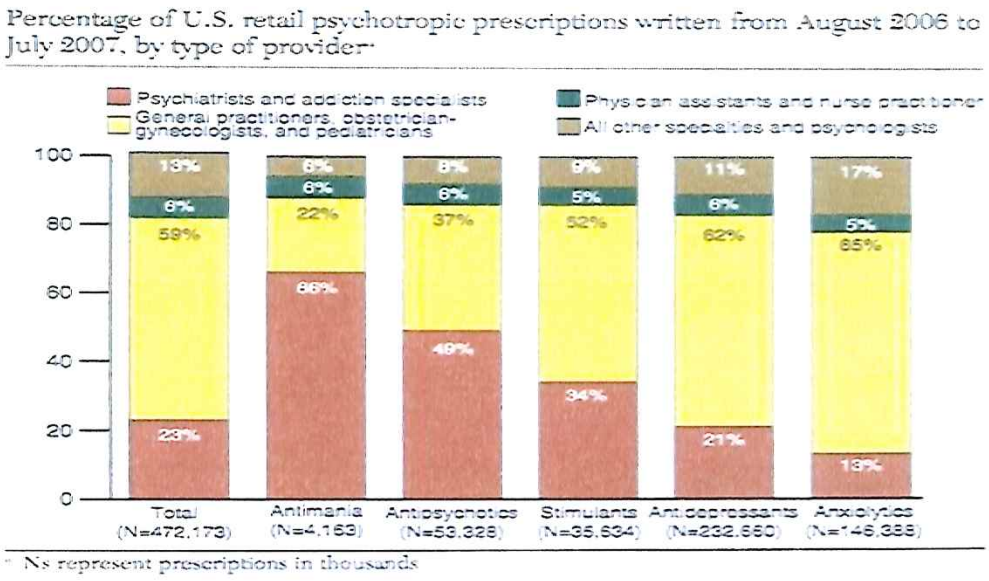


Figure 2. Percentage U.S. retail prescriptions of psychotropic medications by provider type.

Prescribing of psychotropic medications by non-psychiatrists may improve access to treatment for many patients, the study notes. However, the authors cite evidence that primary care physicians often are unable to find outpatient mental health services for their patients. In

addition, they cite concerns about whether patients treated by non-specialists receive psychotherapy, medication monitoring, appropriate intensity of treatment, and treatment consistent with evidence-based guidelines; all of which *Prescribing Psychologists* could provide.

In addition, research from the Society of Teachers of Family Medicine Group on Pharmacotherapy, a group that offers recommendations for family practice residents in pharmacotherapy, indicates that more than 60% of those in family medicine programs had no formal psychopharmacotherapy curriculum at all.[18] Similarly, other psychiatric provider's preparation is less extensive than that of the appropriately trained psychologist. *Prescribing Psychologists* can help alleviate these concerns, as the training in psychotropic medications will be extensive.

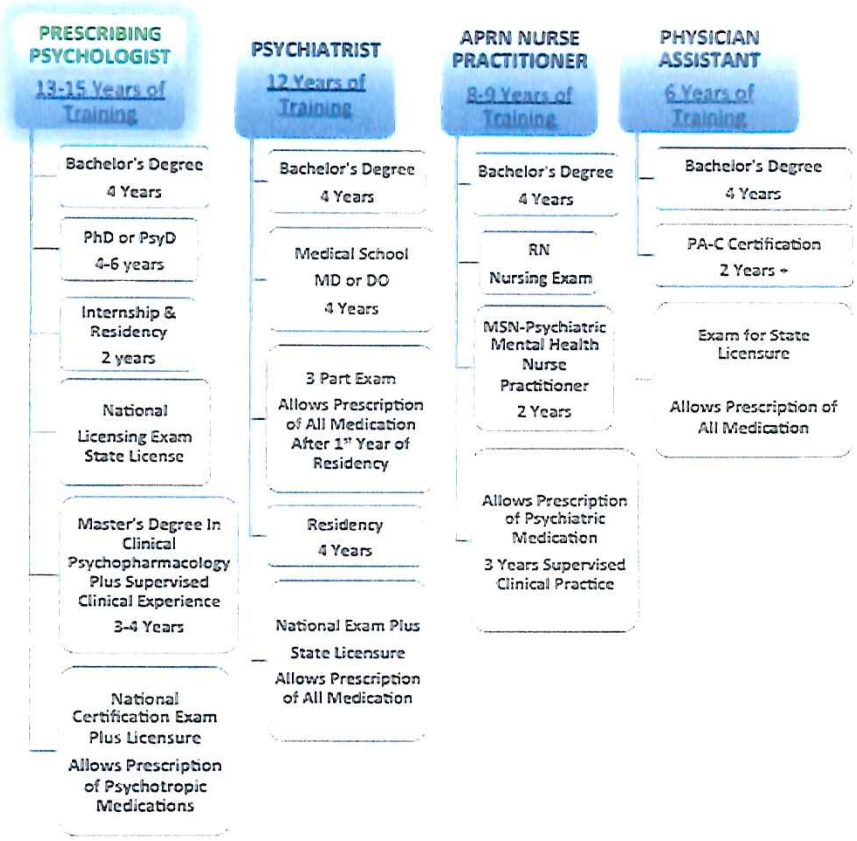


Figure 3. Training comparison of providers who are eligible or seeking eligibility to prescribe psychotropic medications.

3. The impact of the request on public access to health care:

Expanding the current scope to include *Prescribing Psychologists* would have a significantly positive impact on the public's ability to readily access a mental health prescriber. Psychologists

are specially trained in evaluation and diagnosis of mental illnesses, whereas non-psychiatric physicians are not. Having access to a provider with this specialized training who can also prescribe medication is an asset for streamlined care. Data from the DPH Elicense Downloadable Roster regarding psychologists (downloaded on 5/4/17) stated that there are a total of 1787 with primary Connecticut addresses. Similar to psychiatrists, a great majority of psychologists are in urban counties, though the numbers with addresses in rural counties are as follows: 49 in Litchfield County; 33 in New London County; 62 in Tolland County; and 23 in Windham County. (See Table 1 for comparison by county of psychologists and psychiatrists.) In Louisiana a study identified approximately 9% of all licensed healthcare psychologists have been certified as prescribers and are currently prescribing medication. If this statistic approximates the number who would become certified in Connecticut, prescriptive authority for all qualified psychologists would result in an increase of 182 available prescribers, or 161 of those with Connecticut addresses.

In addition, this expansion would also improve access for the disadvantaged population. A recent survey of 26 *Prescribing Psychologists* indicated that the majority of their caseload was economically, socially, linguistically, or otherwise disadvantaged. Further, this group reported that they increased access for clients from disadvantaged backgrounds by 20 percent.[19] This makes good sense when considering the background of psychology. Psychologists' training is rooted in behavioral and psychotherapeutic interventions. Psychologists began their career as undergraduates and pursued a career in psychology based on their attraction to those traditions. Prescriptive authority training for psychologists is an exclusively post-doctoral specialty, but the distinction in what drew practitioners to the field in the first place will encourage continued preference for psychological along with biological case formulation and treatment. The postdoctoral model solidifies the practitioner's identity with traditional values of a psychologist.

Also, a cornerstone of the prescribing psychologist movement is recognizing that, 'The power to prescribe is the power not to prescribe.' Burgeoning rates of polypharmacy, growing appreciation of long-term adverse effects, and a focus on patient-centered practice also present specific indications for de-prescribing in psychiatry. Current literature indicates that *Prescribing Psychologists* are likely to use less medication than a physician prescriber, potentially reducing instances of over-medication and polypharmacy.[20, 21, 22]

For example, American Biodyne, Inc. offered mental health carve out services and employed psychologists who had received a 130 hour hybridized course in psychotherapy and pharmacology as behavioral health managers. Over four years a study was conducted with 1.64 million treatment episodes. It was reported that of the 68% of patients that were taking medication at the start of treatment, only 13% were taking medication at the end of treatment.[23] Also in 1989 congress funded a pilot project to train psychologists in the Department of Defense to prescribe. This proved to be a controversial undertaking, and as a result, the first cohort did not begin their training in the Psychopharmacology Demonstration Project (PDP) until 1991. PDP remained controversial due to opposition from psychiatrists and was terminated in 1997.

However, all graduates of the project filled critical needs as prescribers and uniformly performed with excellence. The report noted the absence of a single significant adverse event among patients treated by the PDP graduates. Despite their additional training, the PDP graduates' values and practices still identified them as psychologists. They continued to rely heavily on psychotherapy and assessment instruments as tools in treatment.[24]

4. A brief summary of state or federal laws governing the profession:

Federal Law

Currently, appropriately trained psychologists are prescribing psychotropic medication in the Departments of the Army, Navy and Air Force as well as in the Indian Health Service (IHS) and Public Health Service (PHS). There is also federal movement to allow the prescriptive privileges the Department of Veterans Affairs. Each branch of the of the military appear to have regulations or guidance specific to each service:

- **Navy:** BUMEDINST 6320.66E, 2013;
- **Air Force:** AFI44-119, 2011;
- **Army:** Department of the Army Memo, 2009

The PHS and the IHS do not have specific regulations. The PHS psychologists are required to adhere to service-specific criteria at the location where they are stationed. The IHS psychologists obtain state licensure to prescribe in either New Mexico or Louisiana.[25]

Army

The Army permits psychologists to prescribe if they:

1. Are a graduate of the Department of Defense (DoD) Demonstration Project or have a master's degree in psychopharmacology from a regionally accredited university;
2. Obtain a passing score on the Psychopharmacology Examination for Psychologists (PEP);
3. Document one year of supervision by a board certified psychiatrist or psychologist with prescribing privileges in a Military Treatment Facility (MTF); and
4. Apply for prescription privileges within 24 months of passing the PEP. A suggested formulary is provided, but specific formularies are to be determined by the MTF granting prescription privileges.

Navy

The Navy has the following criteria:

1. Completion of training in psychopharmacology from a program recommended by the American Psychological Association; and
2. Passage of the PEP. There is no specific mention of graduates of the DoD program, but in practice those initial providers have been allowed to continue to prescribe. There is no delineation of required supervision and no specific mention of formulary.

Air Force

The Air Force has the following criteria:

1. Graduates of the DoD Demonstration Project may continue to prescribe for the Air Force;
2. Completion of a master's degree in clinical psychopharmacology;
3. Passage of the PEP; and
4. Documentation of a minimum of one year of supervision by a psychiatrist or psychologist with prescriptive authority. There is no mention of formulary.

All branches of the service require obtaining a master's degree in psychopharmacology and passing the PEP.

There has been some discussion of making the federal criteria uniform.

State Law

In Connecticut a psychologist must be hold a doctoral level degree to be licensed. The state of Connecticut regulates, oversees and disciplines psychologists through the Board Of Examiners and statutes and regulations. The statutes are found at C.G.S. **Sec. 20-186** through **Sec. 20-195.** Regulations are found at the Regulations of Connecticut State Agencies Psychologist Educational and Work Experience Requirements, **Sections 20-188.1** through **20-188.3** . These statutes and regulations are included in their entirety as Appendix B and Appendix C at the end of this document.

5. The state's current regulatory oversight of the profession:

Psychologists in Connecticut are licensed and regulated by the Connecticut Department of Public Health.

The Board of Examiners (BOE) for Psychologists resides in the Department of Health and is responsible for overseeing the licensing and discipline of psychologists. In addition, in conjunction with the Department, the BOE reviews statutory and regulatory proposals and meets quarterly. Information on the BOE is found at ct.gov/dph/cwp/view.asp?a=3143&q=388938.

6. All current education, training, and examination requirements and any relevant certification requirements applicable to the profession:

Current Statutes and Regulations

Statutes: *Connecticut General Statutes Chapter 383 Psychologists* identifies the statutes governing psychologists in Connecticut (Appendix B). They are listed as follows, and can also be found at https://www.cga.ct.gov/2015/pub/Chap_383.htm.

Sec. 20-186. Board of examiners.
Sec. 20-186a. Duties of board of examiners.
Sec. 20-187. Report. Secretary. Conduct of investigations.
Sec. 20-187a. License required. Practice defined.
Sec. 20-188. Examination; qualifications.
Sec. 20-189. Graduation from approved education program required.
Sec. 20-190. Licensure by endorsement. Waiver of examination. Fee.
Sec. 20-191. Certification without examination of applicants with three years' experience.
Sec. 20-191a. Renewal of license.
Sec. 20-191b. Fees for lost license and verifying licensure.
Sec. 20-191c. Continuing education.
Sec. 20-192. Disciplinary action; grounds; appeals.
Sec. 20-193. False representation. Penalties.
Sec. 20-194. Right to practice medicine not granted.
Sec. 20-194a. Hospital or health care facility staff privileges allowed.
Sec. 20-195. Exempted activities and employment.

Regulations: Current regulations for psychologists, including requirements for educational and work experience for licensure are listed in *Regulations of Connecticut State Agencies: Psychologist Educational and Work Experience* (Appendix C) as follows and can be found at ct.gov/dph/lib/dph/practitioner_licensing_and_investigations/plis/psychology/psych_regs.pdf.

20-188-1. Definitions
20-8-2. Doctoral Educational Standards for Connecticut Psychology Licensure
20-188-3. Work experience standards for Connecticut Psychology Licensure

CPA Proposal

The present proposal to expand the scope of practice for appropriately medically trained psychologists to include prescriptive authority in accordance with applicable state and federal laws includes:

- Proposed Statutory Language to Allow Appropriately Trained Psychologists to Prescribe, which is based on the American Psychological Association (APA) Model Act; and
- Proposed Post-doctoral Education and Training Curriculum, based in a Master of Science degree in psychopharmacology.

Proposed Statutory Language to Allow Appropriately Trained Psychologists to Prescribe

A. Definitions

(1) "Department" means the Connecticut Department of Public Health (DPH).

(2) "Controlled substance" means any drug substance or immediate precursor enumerated in schedules 1-5 of the U.S. Drug Enforcement Administration Controlled Substance Act (www.usdoj.gov/dea/agency/csa.htm) and as adopted by Food Drug and Cosmetic Act of 1938.

(3) "Drug" shall have the same meaning as that term is given in Food Drug and Cosmetic Act of 1938).

(4) "Prescribing Psychologist" means a licensed, doctoral-level psychologist who has undergone specialized education and training in preparation for prescriptive practice and has passed an examination accepted by the Department relevant to establishing competence for prescribing, and has received from the Department a current certificate granting prescriptive authority, which has not been revoked or suspended.

(5) "Clinical experience" means a period of supervised clinical training and practice in which psychiatric and medical diagnoses and clinical interventions are learned and which are conducted and supervised as part of the training program.

(6) "Prescription" is an order for a drug, laboratory or imaging test{s} or any medicine{s}, device{s} or treatment{s}, including {a} controlled substance{s}, as defined by state law.

(7) "Prescriptive authority" means the authority to prescribe, administer, discontinue, and/or distribute without charge, drugs or controlled substances recognized in or customarily used in the diagnosis, treatment, and management of individuals with psychiatric, psychological, addiction/substance disorders, mental, cognitive, nervous, emotional or behavioral disorders, or other procedures directly related thereto within the scope of practice of psychology in accordance with rules and regulations adopted by the Department.

B. Certification

(1) The Department shall certify licensed, doctoral-level psychologists to exercise prescriptive authority in accordance with applicable state and federal laws.

(2) The Department shall develop and implement procedures for reviewing education and training credentials for that certification process, in accordance with current standards of professional practice.

C. Initial Application Requirements for Prescriptive Authority

A psychologist who applies for prescriptive authority shall demonstrate all of the following by official transcript or other official evidence satisfactory to the Department:

(1) The psychologist must hold a current license at the doctoral level to provide health care services as a psychologist in Connecticut;

(2) As defined by the Department, and consistent with established policies of the American Psychological Association for educating and training psychologists in preparation for prescriptive authority:

> a. The psychologist must have completed a master's degree in clinical psychopharmacology, i.e., an organized sequence of study in an organized program offering intensive didactic education, and including the following core areas of instruction: basic biological sciences, neurosciences, clinical and research pharmacology, neuropharmacology, and psychopharmacology, clinical medicine and pathophysiology, physical assessment and laboratory exams, clinical pharmacotherapeutics, research, professional, ethical and legal issues. The didactic portion of the education shall consist of an appropriate number of didactic hours to ensure acquisition of the necessary knowledge and skills to prescribe in a safe and effective manner.
>
> b. The psychologist must have obtained relevant clinical experience sufficient to attain competency in the psychopharmacological treatment of a diverse patient population under the supervision of qualified practitioners as determined by the Department.

(3) Continuing medical education required: Specific ongoing continuing medical/psychopharmacological education of not less than 40 hours per year with a specialized focus on clinical pharmacology, neuropharmacology, clinical psychopharmacology, and medically-assisted substance abuse treatment. This does not substitute the standard required continuing education requirement for licensed psychologists already in place. An approved sponsor of continuing medical/psychiatric or addiction medicine education shall provide such continuing medical education.

D. Maintenance of Prescriptive Authority Certification

(1) The Department shall prescribe by rule a method for the maintenance of prescriptive authority at the time of or in conjunction with the renewal of general psychologist license.

(2) Each provider shall present satisfactory evidence to the Department demonstrating the completion of no less than 40 contact hours of continuing medical education instruction relevant to prescriptive authority during the previous year or licensure renewal period.

E. Prescribing Practices

(1) *Prescribing Psychologists* shall be authorized to prescribe, administer, discontinue, and/or distribute without charge, drugs or controlled substances recognized in or customarily used in the diagnosis, treatment, and management of individuals with psychiatric, psychological, mental, cognitive, nervous, emotional or behavioral disorders and relevant to the practice of psychology, or other procedures directly related thereto within the scope of practice of psychology in accordance with rules and regulations adopted by the Department.

(2) No psychologist shall issue a prescription unless the psychologist holds a valid certificate of prescriptive authority.

(3) Each prescription issued by the *Prescribing Psychologist* shall:

a. Comply with all applicable state and federal laws and regulations.

b. Be identified as written by the *Prescribing Psychologist* in such manner as determined by the Department.

(4) A record of all prescriptions shall be maintained in the patient's record.

(5) A psychologist shall not delegate the authority to prescribe drugs to any other person.

(6) If the Prescribing Psychologist performs acts of diagnosis and treatment that involves alterations in health status, as described in subsection (1) of this section, they shall collaborate with a physician licensed to practice medicine in this state.

F. Controlled Substance Prescriptive Authority

(1) When authorized to prescribe controlled substances, psychologists authorized to prescribe shall file in a timely manner their Drug Enforcement Agency (DEA) registration and the state controlled and dangerous substances license number, if applicable with the Department.

(2) Psychologists are active doctoral providers in the treatment and management of substance use and addictions disorders, and recognize the current opiate epidemic. *Prescribing Psychologists* will be eligible for a SAMHSA buprenorphine waiver for opiate addiction treatment if federal regulations so permit. Currently Physicians, Nurse Practitioners and Physician Assistants are eligible for such a waiver; all healthcare professionals must undergo an online training to be eligible for Medication Assisted Treatment (MAT) for opiate addiction using buprenorphine.[26]

(3) The Department shall maintain current records of every *Prescribing Psychologist* authorized to prescribe, including DEA registration and number.

G. Interaction with the Commission of Pharmacy, Department of Consumer Protection.

(1) The Department shall transmit to the Commission of Pharmacy an initial list of psychologists authorized to prescribe containing the following information:

a. The name and practice address of the Prescribing Psychologist;

b. The psychologist's identification number assigned by the Department; and

c. The effective date of prescriptive authority.

(2) The Department shall promptly forward to the Commission of Pharmacy any additions to the initial list as new certificates are issued.

(3) The Department shall notify the Commission of Pharmacy in a timely manner upon termination, suspension, or reinstatement of a psychologist's prescriptive authority.

H. Powers and Duties of the Department

The Department shall promulgate rules and regulations for denying, modifying, suspending, or revoking the prescriptive authority certification of a psychologist authorized to prescribe. The Department shall also have the power to require remediation of any deficiencies in the training or practice pattern of the *Prescribing Psychologist* when, in the judgment of the Department, such deficiencies could reasonably be expected to jeopardize the health, safety, or welfare of the public.

I. Amendments to Existing State Laws

Amendments will be made to current statutes and regulations so that *Prescribing Psychologists* may write appropriate medication and diagnostic orders. These will include but not be limited to controlled substances, advanced practice registered nurse practice, pharmacy, and hospital/other licensed health care facilities.

CPA Proposed Curriculum for *Prescribing Psychologists*: Overview
(Please see Appendix D for details of proposed curriculum.)

The proposed curriculum for *Prescribing Psychologists* includes completion of comprehensive didactic medical training, supervised clinical experience and a National Board Examination and Certification. The total post-doctoral, master's degree program shall not be less 30 graduate credit hours or its equivalent of approximately total 270 academic credit hours of biological sciences and clinical instruction (total completion time 2-3 years). The proposed detailed curriculum in its entirety can be found in Appendix D.

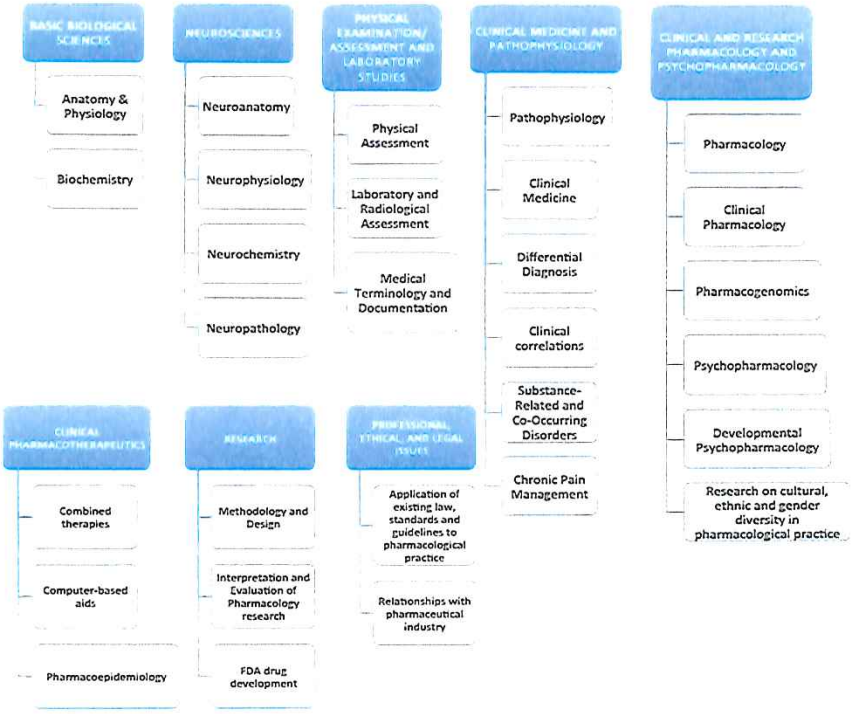


Figure 4. Academic medical training for *Prescribing Psychologists* who are eligible or seeking eligibility to prescribe psychotropic medications.

Overall training should be an organized sequence of education and clinical experience that provides an integrative approach to learning as well as the opportunity to assess competencies in skills and applied knowledge. After completion of the 10-course/topic sequence, psychologists are eligible to sit for a comprehensive board examination, which was developed by the APA College of Professional Psychology specifically as a credentialing examination for psychologists with advanced training in clinical psychopharmacology.

Prior to being certified to prescribe, the psychologist must complete a supervised 400-hour practicum with a minimum of 100 patients consisting of psychopharmacological treatment reflecting a variety of mental health, psychiatric, and substance use disorders. This practica will

be under the supervision of either a licensed physician (MD or DO) or an advanced practice registered nurse (APRN) who has full prescriptive authority at the independent practice level.

Supervised Practice Prior to Independent Practice:

The *Prescribing Psychologist* will be supervised for 1 year (1000 hours) by a licensed physician (MD or DO) or an advanced practice registered nurse (APRN) who has full prescriptive authority in Connecticut. Supervision must address (1) a reasonable and appropriate level of medical consultation and referral if needed, (2) patient care coverage in the *Prescribing Psychologist* absence, and (3) methods to review patient outcomes and disclose the supervisory relationship to the patient.

7. A summary of known scope of practice changes requested or enacted concerning the profession in the five years preceding the request:

- None

8. The extent to which the request directly affects existing relationships within the health care delivery system:

Most significantly, this request has the potential to further enhance the relationship between psychologists and physicians in the state. In 2013, Connecticut lawmakers passed a bill that allows physicians and psychologists to incorporate together as business partners, which facilitated integrated care between physicians and psychologists and improved access to mental health care. Such collaboration provided one avenue for patients to see their primary care doctor and psychologist in one visit and thereby provide a continuity of care that was inaccessible previously. *Prescribing Psychologists* will additionally facilitate integration of behavioral and physical health care. Patients will have enhanced access to integrated behavioral healthcare that will result in fewer doctor visits and will lead to better care for patients.

9. The anticipated economic impact of the request on the health care delivery system:

Allowing *Prescribing Psychologists* in Connecticut will have a net positive economic impact on healthcare delivery system. The impacts will occur across several levels. Most importantly, improved access to efficient and adequate mental health care will lower costs for both the State and the patient. That is, with greater access to a prescriptive provider, some patients are more likely to obtain timely treatment. In addition for patients who are already being seen by a *Prescribing Psychologist*, it will eliminate the need to visit an additional provider or Emergency Department (ED) at a hospital. We anticipate that there will be utilization cost savings, reduced

ED visits, and greater efficiency for patients there will be fewer doctor's visits and decreased polypharmacology.[a]

Healthcare Utilization Cost Savings

Patients who choose to obtain care from *Prescribing Psychologists* will reduce overall medical system utilization. This will be achieved by obtaining psychosocial treatment and pharmacological intervention from the same provider and will reduce system redundancy and inefficiency. In essence, patients will not have to see as many providers to obtain equivalent care.

As an example, a typical outpatient will see a psychologist once per week and will see their medication manager once per month for a total of 5 visits per month. For the patients of estimated 160 *Prescribing Psychologists* who will be licensed to prescribe, patient care will be streamlined with one fewer office visit per month since the same provider will now deliver both the pharmacological and psychotherapeutic services. By reducing overall visits, the state could therein recoup millions of dollars annually in Medicaid savings. [b]

Reduced Emergency Department Visits

An estimated one in eight emergency room visits involves a mental and/or substance use condition, and there are also anticipated savings due to reduced ED visits. Financial concerns represent important barriers to care, especially among those with unmet need for mental health services and many individuals and families are not engaging in preventative or early mental health treatment due to financial distress. Consequently many people present for intervention at hospital Emergency Departments instead of at outpatient facilities. The total cost per patient in the ED is nearly $750[c] excluding general medical care. Adding 160 *Prescribing Psychologists* as mental health prescribers will reduce barriers to treatment, and these providers will likely be in underserved areas taking insurance. By increasing access through the introduction of *Prescribing Psychologists*, the state of Connecticut could save approximately $3.6 million annually in avoidable ED charges. [27]

Reduced Polypharmacy and Lower Medical Costs for Patients

One certain benefit for patients (as mentioned above) will be that patients of *Prescribing Psychologists* will have fewer doctors' visits, which will decrease their out of pocket costs.

In addition, there will be a savings resulting from more streamlined pharmacy. Though the origin of what is driving polypharmacy in mental health during the past 20 years is unclear, the trends themselves are undeniable. Patients are being prescribed more medications. They are also being

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[a] Estimates of costs and savings reported here are based on references noted below.

[b] Savings of 1 session per patient per month, estimate billable insurance rate at $60; 160 *Prescribing Psychologists* see 40 patients per month; 10.5 months treatment. There could be up to $4 million in annual Medicaid savings.

[c] Conservative estimate derived from 2014 ED Final Report p. 6 (cga.ct.gov) by averaging Husky B and Husky C ED visits.

seen for less time. Psychiatric prescribers are very busy; prescribing and managing medications requires far less time than assessment and behavioral intervention. The financial impact of this 'medication creep' has led to unnecessary medical costs such side effects and drug/drug interactions. While the full cost of medication misuse and polypharmacy in mental health is not entirely known, it can be estimated to be close to $10 million[d] in Connecticut alone. Adding *Prescribing Psychologists* who will inevitably utilize concurrent psychosocial interventions in longer visits will decrease costs considerably. If the resulting savings were 25 - 50%, this would save the state $2 - 5 million in medical expenditures annually. [28,29,30]

It should also be noted that these references and data likely produce underestimates, as it is reported for time periods that do not include the effects of the current opioid crisis in Connecticut and the entire nation.

10. Regional and national trends in licensing of the health profession making the request and a summary of relevant scope of practice provisions enacted in other states:

The prescriptive authority movement for psychologists in the United States began early in the 1980s to address the ever-increasing shortfall in the availability of appropriately trained prescribers. At that time there were concerns expressed by the medical community that allowing non-physicians to prescribe would compromise that patient safety. Advocates for *Prescribing Psychologists*, however, countered that the doctoral level psychological training combined with specific psychopharmacologic instruction would provide a solid basis for patients' safety. During the next decade, the Department of Defense designed and implemented a training program in part to determine the feasibility of training *Prescribing Psychologists*. The project was independently evaluated in 1996, and successfully demonstrated that psychologists can be taught to prescribe safely. The early experiences of *Prescribing Psychologists* indicated that primary care physicians, patients and most other stakeholders thought prescriptive authority for psychologists to be a favorable idea; psychiatrists were an exception. In recent years more states have passed prescriptive authority as a direct result to address an increasing access shortage as more prescribers retire from practice or refuse to take patient insurance. Appropriately trained psychologists may now be credentialed to prescribe in the Defense Department, the U.S. Public Health Service and the Indian Health Service. Currently, psychologists also have prescriptive authority in New Mexico, Louisiana, Illinois, Iowa, Idaho, and the U.S. territory of Guam.

GUAM

In 1999, the U.S. territory of Guam was the first jurisdiction to change their scope to allow *Prescribing Psychologists* to prescribe (Guam Public Law 24-329). The specific legislation utilized a model similar to physician assistant, mandating that *Prescribing Psychologists* collaborate with physicians practicing in the same specialty area. The impetus for the Guam

[d] Total cost of polypharmacy estimated nationally $177 billion; CT estimated 1% of U.S. population; mental health dollars in CT = 5.6% of all healthcare dollars.

legislation was the fact that only five psychiatrists served the island, which consists of 160,000 residents and a million tourists a year. For Guam's legislation, please see:

http://www.guamlegislature.com/Bills_Introduced_28th/Bill%20No.%20333(EC).pdf

NEW MEXICO

In 2002, New Mexico followed Guam (New Mexico Administrative Code 16.22.20-16.22.29) in establishing psychologist prescriptive authority. To quality for a prescribing certificate in New Mexico, psychologists complete at least 450 hours of coursework, an 80-hour practicum in clinical assessment and pathophysiology, and a 400-hour, 100-patient practicum under physician supervision. The academic component includes psychopharmacology, neuroanatomy, neurophysiology, clinical pharmacology, pathophysiology, pharmacotherapeutics, pharmacoepidemiology and physical and lab assessments. Additionally those seeking prescriptive authority must pass a national certification examination, the Psychopharmacology Examination for Psychologists. After completing these requirements, psychologists licensed to practice in New Mexico are eligible for a two-year conditional prescription certificate allowing them to prescribe under supervision of a physician. At the end of two years, if the supervisor approves and the psychologist's prescribing records pass an independent peer review, the psychologist can apply to prescribe independently. Only at that point will *Prescribing Psychologists* work independently, albeit in close collaboration with the patient's physician. For New Mexico's legislation, please see:

http://www.rld.state.nm.us/uploads/files/Rule%20Book%20For%20Web2016.pdf

LOUISIANA

In 2004, Louisiana established prescriptive authority through establishing a medical psychology program. This program was developed as a unique healthcare profession and moved the regulation of their practice of medical psychology to the Louisiana State Board of Medical Examiners. Currently, regulation of *Prescribing Psychologists* (defined as medical psychologists) and psychologists who practice psychotherapy and psychological testing have shifted to the Louisiana Board of Medical Examiners. This makes Louisiana the only state in the U.S. where a medical board has authority over the regulation of the entire practice of psychology. The rationale for creation of the measure was that front-line treatments of psychological disorders are currently managed by non-psychiatric physicians who generally embrace the role of psychologists in assisting in the management of these conditions. For Louisiana's legislation, please see:

http://www.lsbme.la.gov/sites/default/files/documents/Rules/Individual%20Rules/Medical%20Psychologists.pdf

ILLINOIS

In 2014, Illinois became the third state in the nation to allow psychologists prescriptive authority. Licensed clinical psychologists in Illinois who want to prescribe successfully complete advanced education and training in psychopharmacology as well as supervised clinical training in various settings, such as hospitals, outpatient clinics, community mental health clinics and correctional facilities. The new legislation occurred as a result of a tremendous access shortage, with few inpatient psychiatric services in many counties. Access was most difficult among people who need help the most: low-income, rural and minority populations whose needs are often underserved. For Illinois's legislation, please see:

http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1294&ChapterID=24

IOWA

In 2016, Iowa became the 4th state in the nation of allow psychologist prescriptive authority. The law permits licensed psychologists to obtain prescriptive authority once they have successfully completed a post-doctoral Master of Science degree in clinical psychopharmacology, a supervised practicum in clinical assessment and pathophysiology, and passed a national examination. These components are in addition to the mandatory education and training required to become a licensed psychologist. *Prescribing Psychologists* in Iowa also need to complete a two-year conditional prescribing period under a licensed physician's supervision to be eligible for independent prescriptive authority. For psychologists who treat special populations such as children, the elderly or people with comorbid physical conditions, this will include completion of a year of supervised conditional prescribing. In addition, *Prescribing Psychologists* must maintain a collaborative relationship with the patient's physician. Additionally the law mandates collaboration between the state boards of psychology and medicine in drafting the implementation rules. For Iowa's legislation, please see:

https://www.legis.iowa.gov/legislation/BillBook?ga=86&ba=HF2334

IDAHO

Most recently in 2017, Idaho granted prescriptive authority to Idaho licensed psychologists. Similar to other state requirements Idaho requires licensed psychologists to successfully complete a postdoctoral master's degree in clinical psychopharmacology, a supervised practicum in clinical assessment and pathophysiology, and to pass a national examination. Psychologists who meet these requirements will have a two-year provisional certificate to prescribe under the mandatory supervision of an MD. The rationale for this new law was to expand the role of psychologists in managing the care of mental health patients. This change will lead to shorter wait times for mental health services and will translate into stronger integrated care teams. For Idaho's legislation, please see:

https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2017/legislation/H0212.pdf

FEDERAL TRENDS

For Federal trends, please see Question 4, above.

11. Identification of any health care professions that can reasonably be anticipated to be directly affected by the request, the nature of the impact, and efforts made by the requestor to discuss it with such health care professions:

The psychological community reasonably anticipates that psychiatry's professional organization will object to this current request. The field of psychiatry has historically opposed such legislation; their primary stated concerns have been (A) public safety will be compromised, and (B) psychologist's education is inadequate.

Regarding (A), there is no evidence that *Prescribing Psychologists* have created a risk to patient safety; in fact, the literature clearly dispels those arguments.[31, 32, 33]

Regarding (B), the proposal for *Prescribing Psychologists* requires that the doctoral level psychologist obtain a post-doctoral master's degree in psychopharmacology. Doctoral programs in psychology involve at least 4 years of rigorous academic and theoretical training in the social, emotional and biological development of normative and pathological behaviors across the life-span; practicum experiences that involve close supervision of clinical experiences during 2-4 years of academic training; and investigation and understanding of scientific and research methods. In addition, before graduation a psychology doctoral student must do an internship that typically entails 1 year of full-time (closely supervised) clinical experience. Psychology licensure also requires no less than 1800 additional hours of supervised work. The educational program for the doctorate (Appendix A) indicates the rigor and thoroughness of the training. In addition, the current proposal (Appendix D) adds a post-doctoral master's degree in psychopharmacology, i.e., a program consisting of 270 hours of science and clinical instruction, with a total completion time of 2 - 3 years and 400 additional hours of supervised clinical experience. This training more than adequately addresses the unsubstantiated concern.

We will make extensive efforts to collaborate with Connecticut Medical Society, Connecticut Psychiatric Society, and all health and mental health organizations.

12. A description of how the request relates to the health care profession's ability to practice to the full extent of the profession's education and training:

Allowing psychologists to prescribe after completing a rigorous post-doctoral Master of Science degree with advanced training in psychopharmacology is a natural and appropriate extension of the education and training of psychologists. Psychologists have been trained in evaluation and diagnosis, and additional training in psychopharmacology provides a natural extension and

option for treatment following diagnosis. In addition, *Prescribing Psychologists* will become skilled at intervention with psychopharmacological medications, an integral part of contemporary mental health practice. Instead of the care of a patient being solely psychological or solely pharmacological as it is in Connecticut now, this would allow appropriately trained psychologists to provide full access to mental health care.

Appendix A

Current Psychologist Licensure Requirements

An applicant for licensure shall meet the eligibility requirements outlined below:

A. Successful completion of a doctoral degree from an approved program in psychology. (1) Programs holding full accreditation by the American Psychological Association during the applicant's attendance meet the requirements for an approved program in psychology. (2) Programs not so accredited are subject to an individual review to ensure that the applicant's psychology program meets the requirements outlined in Section 20-188-2 of the Regulations of Connecticut State Agencies; an applicant who has received a doctoral degree in psychology that does not meet the requirements outlined in the Regulations may remediate the required coursework post-doctorally in a program accredited by the APA. (3) An applicant who has received a doctoral degree in a non-applied or non-clinical area of psychology shall meet the educational requirements provided the applicant has completed a respecialization program in an applied psychology program accredited by the APA.

B. Successful completion of at least 1 year of supervised work experience at the pre or post-doctoral level. (1) Work experience as part of an internship required to complete the doctoral degree cannot be counted toward meeting this requirement. (2) The work experience must be either no less than 35 hours per week for a minimum of 46 weeks within 12 consecutive months ***or*** be no less than 1,800 hours within 24 consecutive months. No more than 40 hours per week may be credited toward the required experience. (4) Supervision is defined as direct, face-to-face supervision provided by a doctoral-level psychologist who is licensed in the state where the experience was conducted. (5) The experience must be appropriate to the applicant's graduate coursework and intended area of practice. (6) For each 40 hours of work experience, the supervision shall consist of at least 3 hours of which no less than 1 hour shall be individual, direct, face-to-face supervision. (7) The supervisor shall not concurrently supervise more than a total of 3 individuals completing the work experience. (8) An applicant may substitute two (2) years of licensed work experience in lieu of this requirement. (9) Additional requirements pertaining to work experience for individuals commencing such experience on and after April 1, 1988, are specified in Section 20-188-3 of the Regulations of Connecticut State Agencies.

C. Successful completion of the following examinations:
   a. The Examination for Professional Practice in Psychology (EPPP) administered by the Association of State and Provincial Psychology Boards. Prior to April 2001, the cut score for the EPPP is 70%. On or after April 2001, the passing score is 500. If taking the EPPP as a Connecticut candidate, once all application material has been submitted and reviewed by this office, the applicant will be notified in writing as to the applicant's eligibility for the EPPP examination. Once notified, the applicant will be provided with instructions as to how to register on-line for the examination. Once the applicant has registered for the examination on-line, the applicant will receive

via email, instructions as to scheduling an examination within a 60-day testing window with Prometric Testing Center. Failure to take the examination in the 60-day window will result in a penalty by PES.

b. The Connecticut jurisprudence examination. This examination consists of twenty-five (25) multiple-choice items; at least eighteen (18) questions must be answered correctly in order to pass. This examination is scheduled six (6) times per year.

Appendix B
Connecticut General Statutes
Chapter 383 - Psychologists

Table of Contents

Sec. 20-186. Board of examiners. (a) The Board of Examiners of Psychologists shall consist of five members appointed by the Governor, three of whom shall be practicing psychologists in good professional standing and licensed according to the provisions of this chapter and two of whom shall be public members. Each such member shall be a resident of this state. No member of said board shall be an elected or appointed officer of any professional association of psychologists or have been such an officer during the year immediately preceding his appointment. The Governor shall designate one member as chairman of said board and shall fill any vacancy therein by appointment for the unexpired portion of the term. No member shall serve for more than two full consecutive terms commencing after July 1, 1980. Members shall not be compensated for their services.

(b) Said board shall meet at least once during each calendar quarter and at such other times as the chairman deems necessary. Special meetings shall be held on the request of a majority of the board after notice in accordance with the provisions of section 1-225. A majority of the members of the board shall constitute a quorum. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from office. Minutes of all meetings shall be recorded by the board.

No member shall participate in the affairs of the board during the pendency of any disciplinary proceedings by the board against such member.

(1949 Rev., S. 4632; 1957, P.A. 269, S. 2; 1969, P.A. 597, S. 1; P.A. 77-614, S. 427, 610; P.A. 80-484, S. 68, 176; P.A. 81-471, S. 39, 71; June Sp. Sess. P.A. 91-12, S. 23, 55; P.A. 98-143, S. 12, 24.)

History: 1969 act substituted "licensed" for "certified"; P.A. 77-614 clarified appointment provisions generally, deleted provision setting terms at five years beginning on July first and reduced psychologist members from five to three, adding two public members, effective January 1, 1979; P.A. 80-484 replaced requirement that psychologist members have practiced for five years with requirement that they be currently practicing and in good professional standing, prohibited professional members from being elected officials of professional associations within one year of their appointment, required all members to be state residents rather than "electors", deleted provisions re removal for incompetence etc. and re three-member quorum, limited terms of service to two after July 1, 1984, provided for reimbursement for expenses and added Subsec. (b) re meetings, members' attendance, etc.; P.A. 81-471 changed "elected official" to "elected or appointed officer" as of July 1, 1981; June Sp. Sess. P.A. 91-12 eliminated expense reimbursement for board members; P.A. 98-143 added quorum provision in Subsec. (b), effective July 1, 1998.

See Sec. 4-9a for definition of "public member".

See Sec. 4-40a re compensation and expenses of licensing boards and commissions.

See Secs. 19a-8 to 19a-12, inclusive, re powers and duties of boards and commissions within Department of Public Health.

Sec. 20-186a. Duties of board of examiners. The Board of Examiners of Psychologists shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints filed against practitioners licensed under this chapter and (3) impose sanctions where appropriate.

(P.A. 80-484, S. 69, 176.)

Sec. 20-187. Report. Secretary. Conduct of investigations. Section 20-187 is repealed.

(1949 Rev., S. 4633; 1957, P.A. 269, S. 3; September, 1957, P.A. 11, S. 13; 1969, P.A. 597, S. 2; P.A. 77-614, S. 609, 610.)

Sec. 20-187a. License required. Practice defined. No person shall practice psychology unless he has obtained a license as provided in section 20-188. The practice of psychology means the rendering of professional services under any title or description of services incorporating the words psychologist, psychological or psychology, to the public or to any public or private

organization for a fee or other remuneration. Professional psychological services means the application, by persons trained in psychology, of established principles of learning, motivation, perception, thinking and emotional relationships to the assessment, diagnosis, prevention, treatment and amelioration of psychological problems or emotional or mental disorders of individuals or groups, including but not limited to counseling, guidance, psychotherapy, behavior modification and personnel evaluation, with persons or groups in the areas of work, family, school, marriage and personal relationships; measuring and testing of personality, intelligence, aptitudes, emotions, public opinion, attitudes and skills; and research relating to human behavior.

(1969, P.A. 597, S. 3; P.A. 86-42.)

History: P.A. 86-42 changed the definition of professional psychological services to include "the assessment, diagnosis, prevention, treatment and amelioration of psychological problems or emotional or mental disorders of individuals or groups".

Sec. 20-188. Examination; qualifications. Before granting a license to a psychologist, the department shall, except as provided in section 20-190, require any applicant therefor to pass an examination in psychology prescribed by the department with the advice and consent of the board. Each applicant shall pay a fee of five hundred sixty-five dollars, and shall satisfy the department that such applicant: (1) Has received the doctoral degree based on a program of studies whose content was primarily psychological from an educational institution approved in accordance with section 20-189; and (2) has had at least one year's experience that meets the requirements established in regulations adopted by the department, in consultation with the board, in accordance with the provisions of chapter 54. The department shall establish a passing score with the consent of the board. Any certificate granted by the board of examiners prior to June 24, 1969, shall be deemed a valid license permitting continuance of profession subject to the provisions of this chapter. An applicant who is licensed or certified as a psychologist in another state, territory or commonwealth of the United States may substitute two years of licensed or certified work experience in the practice of psychology, as defined in section 20-187a, in lieu of the requirements of subdivision (2) of this section.

(1949 Rev., S. 4635; 1957, P.A. 269, S. 4; 1959, P.A. 616, S. 57; 1969, P.A. 597, S. 4; June, 1971, P.A. 8, S. 64; 1972, P.A. 127, S. 42; P.A. 77-614, S. 428, 610; P.A. 80-484, S. 70, 174, 176; P.A. 81-471, S. 40, 71; P.A. 89-251, S. 101, 203; P.A. 93-381, S. 9, 39; P.A. 95-125, S. 1, 6; 95-257, S. 12, 21, 58; P.A. 08-184, S. 41; June Sp. Sess. P.A. 09-3, S. 210; P.A. 14-231, S. 34.)

History: 1959 act increased application fee from $15 to $50, deleting stipulation that fee be nonreturnable and eliminated $10 examination fee; 1969 act substituted "license" for "certificate", deleted reference to repealed Sec. 20-191, required in Subdiv. (c) that doctoral degree be in area of psychology in which applicant intends to practice and in Subdiv. (d) that experience be postdoctoral and in the area in which applicant intends to practice, rephrased

provision re verification of residency, added requirement for verification of area of psychology and revised validation of previously issued licenses, changing date from May 15, 1957, to June 24, 1969, and adding "permitting continuance of profession subject to the provisions of this chapter"; 1971 act raised application fee from $50 to $150; 1972 act required applicant to be at least 18 rather than 21, reflecting changed age of majority; P.A. 77-614 required consent of health services commissioner for examinations and specified that actual administering and grading of examinations be by health services department rather than by board, effective January 1, 1979; P.A. 80-484 essentially transferred remaining duties of board to health services department, retaining board in an advisory capacity, added provision for establishment of passing scores and revised applicant's qualifications provisions to delete minimum age and residency requirement and requirements that applicant be of good moral character and not have failed examination within previous six months; P.A. 81-471 reduced fee for applicants for licensure without examination to $100 from former level of $150 and eliminated requirement that doctoral degree and/or postdoctoral experience be in the area of psychology which applicant intends to practice; P.A. 89-251 increased the application fee from $150 to $450, except applicants' fee for licensure under Sec. 20-190 increased from $100 to $120; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-125 deleted reference to the fee for a license under Sec. 20-190, effective June 7, 1995; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 08-184 deleted requirement that examination be given at time and place prescribed by department, deleted provision re examination being administered to applicants by department under supervision of board and provision requiring "postdoctoral" experience, replaced provision re good faith intent to practice psychology with provision re experience meeting requirements established by department in consultation with board, deleted provisions that required department to grade examinations and provide graded papers to unsuccessful candidates and made technical changes; June Sp. Sess. P.A. 09-3 increased fee from $450 to $565; P.A. 14-231 added provision re applicant licensed or certified as a psychologist in another state, territory or commonwealth may substitute work experience and made a technical change.

Sec. 20-189. Graduation from approved education program required. Applicants shall graduate from an education program approved by the board with the consent of the Commissioner of Public Health.

(1949 Rev., S. 4634; 1969, P.A. 597, S. 5; P.A. 77-614, S. 302, 610; P.A. 81-471, S. 41, 71; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58.)

History: 1969 act substituted "license" for "certificate"; P.A. 77-614 replaced secretary of the state board of education with commissioner of education, effective January 1, 1979; P.A. 81-471 eliminated registration of educational institutions and added new provision requiring that applicants graduate from approved education programs; P.A. 93-381 replaced commissioner of

health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995.

Sec. 20-190. Licensure by endorsement. Waiver of examination. Fee. An applicant for licensure by endorsement shall present evidence satisfactory to the Department of Public Health that the applicant is a currently practicing, competent practitioner and who at the time of application is licensed or certified by a similar board of another state whose standards, in the opinion of the department, are substantially similar to, or higher than, those of this state, or that the applicant holds a current certificate of professional qualification in psychology from the Association of State and Provincial Psychology Boards. The department may waive the examination for any person holding a diploma from a nationally recognized board or agency approved by the department, with the consent of the board of examiners. The department may require such applicant to provide satisfactory evidence that the applicant understands Connecticut laws and regulations relating to the practice of psychology. The fee for such license shall be five hundred sixty-five dollars. No license shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint. The department shall inform the board annually of the number of applications it receives for licensure by endorsement under this section.

(1949 Rev., S. 4636; 1957, P.A. 269, S. 5; 1969, P.A. 597, S. 6; June, 1971, P.A. 8, S. 65; P.A. 80-484, S. 71, 176; P.A. 81-471, S. 42, 71; P.A. 88-357, S. 9; P.A. 89-91, S. 1, 3; 89-251, S. 102, 203; P.A. 93-381, S. 9, 39; P.A. 95-125, S. 2, 6; 95-257, S. 12, 21, 58; P.A. 01-86; June Sp. Sess. P.A. 09-3, S. 211.)

History: 1969 act substituted "license" for "certificate", deleted provision allowing waiver of examination for person who has been practicing in another state for at least three years and who convinces board that granting him a license would be in the public interest and added proviso re verification of area of psychology in which applicant intends to practice; 1971 act imposed license fee of $100; P.A. 80-484 transferred licensing power from board to health services department, allowed waiver of examination only for "currently practicing competent" practitioners, rephrased provision re standards of other states and added provisions prohibiting licensure of person involved in disciplinary action or unresolved complaint and requiring notification of board of number of applications received; P.A. 81-471 eliminated requirement that applicants verify the area of psychology in which they intend to practice; P.A. 88-357 added requirement that the department be satisfied that the applicant or person understands Connecticut laws and regulations relating to the practice of psychology; P.A. 89-91 changed "shall" to "may" regarding the waiving of the examination for persons holding a diploma from a nationally recognized board or agency and changed approved by the "board of examiners" to "department, with the consent of the board of examiners"; P.A. 89-251 raised license fee from $100 to $300; P.A. 93-381 replaced department of health services with department of public health and

addiction services, effective July 1, 1993; P.A. 95-125 changed the license fee from $300 to $450, effective June 7, 1995; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 01-86 replaced provision re granting a license without examination with provisions re licensure by endorsement, deleted provisions re satisfaction of department, added provision re holding certificate of professional qualification from the Association of State and Provincial Psychology Boards and added provision authorizing department to require satisfactory evidence of the applicant's understanding of state law re the practice of psychology; June Sp. Sess. P.A. 09-3 increased fee from $450 to $565.

Sec. 20-191. Certification without examination of applicants with three years' experience. Section 20-191 is repealed.

(1957, P.A. 269, S. 10; 1969, P.A. 597, S. 14.)

Sec. 20-191a. Renewal of license. Each license issued under this chapter shall be renewed annually in accordance with the provisions of section 19a-88. Thirty days prior to the expiration date of each license under said section 19a-88, the department shall mail to the last-known address of each licensed psychologist an application for renewal in such form as said department determines. Each such application, on or before such expiration date, shall be returned to said department, together with a fee of the professional services fee for class I, as defined in section 33-182*l*, and the department shall thereupon issue a renewal license. In the event of failure of a psychologist to apply for such renewal license by such expiration date, he may so apply subject to the provisions of subsection (b) of said section 19a-88.

(1959, P.A. 654, S. 1; 1969, P.A. 597, S. 7; June, 1971, P.A. 8, S. 66; 1972, P.A. 223, S. 10; P.A. 80-484, S. 72, 176; P.A. 81-471, S. 43, 71; P.A. 89-251, S. 103, 203; May Sp. Sess. P.A. 92-16, S. 47, 89.)

History: 1969 act replaced "certificate" and "certified" with "license" and "licensed", required that applications for renewal contain provision for verification of psychologists' areas of practice and required that published roster contain indication of psychologists' areas of practice; 1971 act increased renewal fee from $5 to $50, increased additional charge for late renewals up to December first from $1 to $5 per month and increased penalty charged for renewals after December first from $1 to $10 for each month of delay, deleting obsolete maximum penalty charge of $5; 1972 act revised provisions to reflect change from biennial to annual renewal and halved the renewal fee; P.A. 80-484 required that renewals accord with provisions of Sec. 19-45 as of January 1, 1981, deleting references to October first renewal dates, to penalties and charges for late renewals and to publication of roster of psychologists and transferred license renewal powers from board to department of health services; P.A. 81-471 eliminated requirement that application include provision for verification of area of psychology in which applicant is practicing and deleted reference to July first as date by which department is to send out

applications for renewal; P.A. 89-251 increased the application fee from $25 to $75; May Sp. Sess. 92-16 replaced license renewal fee of $75 with fee equaling professional service fee class I established pursuant to Sec. 33-182*l*.

Sec. 20-191b. Fees for lost license and verifying licensure. Section 20-191b is repealed, effective June 7, 1995.

(1959, P.A. 654, S. 2; 1969, P.A. 597, S. 8; P.A. 95-125, S. 5, 6.)

Sec. 20-191c. Continuing education. (a) Except as provided in subsection (e) of this section, for registration periods beginning on and after October 1, 2014, each psychologist licensed in accordance with this chapter shall complete a minimum of ten hours of continuing education during each registration period. For purposes of this section, "registration period" means the twelve-month period for which a license has been renewed in accordance with the provisions of section 19a-88 and is current and valid.

(b) Qualifying continuing education activities shall be related to the practice of psychology and shall include courses, seminars, workshops, conferences and postdoctoral institutes offered or approved by: (1) The American Psychological Association; (2) a regionally accredited institution of higher education graduate program; (3) a nationally recognized provider of continuing education seminars; (4) the Department of Mental Health and Addiction Services; or (5) a behavioral science organization that is professionally or scientifically recognized. Not more than five continuing education units during each registration period shall be completed via the Internet, distance learning or home study. Qualifying continuing education activities may include a licensee's research-based presentation at a professional conference, provided not more than five continuing education units during each registration period shall be completed by such activities. A licensee who has earned a diploma from the American Board of Professional Psychology during the registration period may substitute the diploma for continuing education requirements for such registration period. For purposes of this section, "continuing education unit" means fifty to sixty minutes of participation in accredited continuing professional education.

(c) Each licensee shall obtain a certificate of completion from a provider of continuing education for all continuing education activities that are successfully completed and shall retain such certificate for not less than three years after the license renewal date for which the continuing education activity was completed. Upon the request of the Commissioner of Public Health a licensee shall submit such certificate to the Department of Public Health. A licensee who fails to comply with the continuing education requirements prescribed in this section may be subject to disciplinary action pursuant to section 20-192.

(d) A licensee applying for license renewal for the first time shall be exempt from the continuing education requirements under subsection (a) of this section. In individual cases

involving medical disability or illness, the Commissioner of Public Health may grant a waiver of the continuing education requirements or an extension of time within which to fulfill the continuing education requirements of this section to any licensee, provided the licensee submits to the department an application for waiver or extension of time on a form prescribed by the commissioner, along with a certification by a licensed physician of the disability or illness and such other documentation as may be required by the commissioner. The commissioner may grant a waiver or extension for a period not to exceed one registration period, except the commissioner may grant additional waivers or extensions if the medical disability or illness upon which a waiver or extension is granted continues beyond the period of the waiver or extension and the licensee applies for an additional waiver or extension. The commissioner may grant a waiver of the continuing education requirements to a licensee who is not engaged in active professional practice, in any form, during a registration period, provided the licensee submits a notarized application on a form prescribed by the commissioner prior to the end of the registration period. A licensee who is granted a waiver under the provisions of this subsection may not engage in professional practice until the licensee has met the continuing education requirements of this section.

(e) Any licensee granted a waiver of the continuing education requirements pursuant to the provisions of subsection (d) of this section shall be required to complete five hours of continuing education not later than six months after the date on which such licensee returns to active practice. In addition, such licensee shall comply with the certificate of completion requirements prescribed in subsection (c) of this section.

(f) Any licensee whose license has become void pursuant to section 19a-88 for one year or more and who applies to the department for reinstatement of such license pursuant to section 19a-14 shall submit with such application evidence documenting that such applicant has successfully completed ten hours of continuing education within the one-year period immediately preceding the date of application for reinstatement.

(g) The commissioner may accept continuing education activities completed by a licensee in another state or country to meet the requirements of this section.

(P.A. 14-231, S. 56.)

Sec. 20-192. Disciplinary action; grounds; appeals. The board may take any action set forth in section 19a-17, if the license holder: Has been convicted of a felony; has been found by the board to have employed fraud or deceit in obtaining his license or in the course of any professional activity, to have violated any provision of this chapter or any regulation adopted hereunder or to have acted negligently, incompetently or wrongfully in the conduct of his profession; practiced in an area of psychology for which he is not qualified; is suffering from physical or mental illness, emotional disorder or loss of motor skill, including but not limited to, deterioration through the aging process or is suffering from the abuse or excessive use of drugs,

including alcohol, narcotics or chemicals. The Commissioner of Public Health may order a license holder to submit to a reasonable physical or mental examination if his physical or mental capacity to practice safely is the subject of an investigation. Said commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17. Notice of any contemplated action under said section, of the cause therefor and the date of hearing thereon shall be given and an opportunity for hearing afforded as provided in the regulations adopted by the Commissioner of Public Health. The Attorney General shall, upon request, furnish legal assistance to the board. Any person aggrieved by any action of the board may appeal therefrom as provided in section 4-183, except such appeal shall be made returnable to the judicial district where he resides. Such appeal shall have precedence over nonprivileged cases in respect to order of trial.

(1949 Rev., S. 4637; 1957, P.A. 269, S. 6; 1969, P.A. 597, S. 9; 1971, P.A. 870, S. 62; P.A. 76-436, S. 426, 681; P.A. 77-603, S. 72, 125; 77-614, S. 429, 610; P.A. 78-280, S. 43, 44, 127; P.A. 80-484, S. 73, 176; P.A. 88-230, S. 1, 12; P.A. 90-98, S. 1, 2; P.A. 93-142, S. 4, 7, 8; 93-381, S. 9, 39; P.A. 95-220, S. 4–6; 95-257, S. 12, 21, 58; P.A. 96-47, S. 9.)

History: 1969 act substituted "license" for "certificate", raised maximum suspension period from one to three years and allowed suspension or revocation of license of psychologist for practice in an area of psychology for which he is not qualified; 1971 act replaced superior court with court of common pleas, effective September 1, 1971, except that courts with cases pending retain jurisdiction unless pending matters deemed transferable; P.A. 76-436 replaced court of common pleas with superior court and added reference to judicial districts, effective July 1, 1978; P.A. 77-603 replaced previous appeal provisions with statement that appeals shall be in accordance with Sec. 4-183, retaining provision granting appeals precedence in order of trial and specifying venue in county of residence; P.A. 77-614 allowed suspension or revocation of license for violation of chapter or related regulations, replaced detailed provisions re hearing procedure with reference to hearing procedure in regulations adopted by health services commissioner and deleted provisions concerning venue and precedence in order of trial for appeals, effective January 1, 1979; P.A. 78-280 restored venue and precedence in order of trial provisions; P.A. 80-484 expanded disciplinary actions to include those in Sec. 19-4s, revised grounds to include fraud or deceit "in the course of any professional activity" and acting "incompetently", added grounds re physical or mental illness, emotional disorder etc. and drug or alcohol abuse etc., added provisions re mental or physical examination and re petitions to court for enforcement of orders or actions and deleted provision re procedure for reinstatement of license following three-year revocation; P.A. 88-230 replaced "judicial district of Hartford-New Britain" with "judicial district of Hartford", effective September 1, 1991; P.A. 90-98 changed the effective date of P.A. 88-230 from September 1, 1991, to September 1, 1993; P.A. 93-142 changed the effective date of P.A. 88-230 from September 1, 1993, to September 1, 1996, effective June 14, 1993; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 95-220

changed the effective date of P.A. 88-230 from September 1, 1996, to September 1, 1998, effective July 1, 1995; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 96-47 made no substantive change (Revisor's note: The word "or" was added editorially by the Revisors after "hereunder" in the phrase "... or any regulation adopted hereunder or to have acted negligently, ...").

Sec. 20-193. False representation. Penalties. Any person not licensed as provided in this chapter who, except as provided in section 20-195, represents himself as a psychologist or, having had his license suspended or revoked continues to represent himself as a psychologist, or carries on the practice of psychology as defined in sections 20-187a and 20-188, shall be guilty of a class D felony. Each instance of patient contact or consultation which is in violation of this section shall be deemed a separate offense. Failure to renew a license in a timely manner shall not constitute a violation for the purposes of this section. Any such person shall be enjoined from such practice by the Superior Court upon application by the board. The Department of Public Health may, on its own initiative or at the request of the board, investigate any alleged violation of the provisions of this chapter or any regulations adopted hereunder.

(1949 Rev., S. 4638; 1957, P.A. 269, S. 1, 8; 624, S. 1; 1969, P.A. 597, S. 10; P.A. 77-614, S. 430, 610; P.A. 84-526, S. 13; P.A. 93-381, S. 9, 39; P.A. 95-257, S. 12, 21, 58; P.A. 13-258, S. 82.)

History: 1969 act substituted "licensed" and "license" for "certified" and "certificate", made provisions applicable on or after January 1, 1970, forbade carrying on the practice of psychology rather than rendering "service for remuneration ... under any title or description of services incorporating the words 'psychologist', 'psychological' or 'psychology'" and added provision re enjoining psychologist from practice by superior court on board's application; P.A. 77-614 transferred investigation power from board to health services department acting on its initiative or at board's request and added reference to violation of regulations, effective January 1, 1979; P.A. 84-526 amended section by changing penalty for violation of any provision of chapter to a fine of not more than $500 or imprisonment of not more than five years, and added provisions that each instance of patient contact or consultation shall constitute a separate offense and failure to renew license in timely manner is not a violation for purposes of section; P.A. 93-381 replaced department of health services with department of public health and addiction services, effective July 1, 1993; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 13-258 changed penalty from fine of not more than $500 or imprisonment of not more than 5 years to a class D felony and made a technical change.

Sec. 20-194. Right to practice medicine not granted. Nothing in this chapter shall be construed to grant to licensed psychologists the right to practice medicine as defined in section 20-9.

(1957, P.A. 269, S. 7; 1969, P.A. 597, S. 11.)

History: 1969 act substituted "licensed" for "certified".

Sec. 20-194a. Hospital or health care facility staff privileges allowed. Any hospital or health care facility may allow a psychologist, licensed pursuant to this chapter, full staff privileges in accordance with the standards of the Joint Commission on Accreditation of Health Care Organizations if the criteria that has been set forth by the hospital or health care facility is met.

(P.A. 95-271, S. 36.)

Sec. 20-195. Exempted activities and employment. (a) Nothing in this chapter shall be construed to limit the activities and services of a graduate student, intern or resident in psychology, pursuing a course of study in an educational institution under the provisions of section 20-189, if such activities constitute a part of a supervised course of study. No license as a psychologist shall be required of a person holding a doctoral degree based on a program of studies whose content was primarily psychological from an educational institution approved under the provisions of section 20-189, provided such activities and services are necessary to satisfy the work experience as required by section 20-188. The provisions of this chapter shall not apply to any person in the salaried employ of any person, firm, corporation, educational institution or governmental agency when acting within the person's own organization. Nothing in this chapter shall be construed to prevent the giving of accurate information concerning education and experience by any person in any application for employment. Nothing in this chapter shall be construed to prevent physicians, optometrists, chiropractors, members of the clergy, attorneys-at-law or social workers from doing work of a psychological nature consistent with accepted standards in their respective professions.

(b) Nothing in this chapter shall prevent any person holding a certificate as school psychologist or school psychological examiner, granted by the State Board of Education, from using such title to describe his activities within an elementary or secondary school. Nothing in this chapter shall prevent any person who holds a standard or professional educator certificate, granted by said board, as school psychologist or school psychological examiner from using such title to describe his activities within the private sector. Such activities within the private sector shall be limited to: (1) Evaluation, diagnosis, or test interpretation limited to assessment of intellectual ability, learning patterns, achievement, motivation, or personality factors directly related to learning problems in an educational setting; (2) short-term professional advisement and interpretive services with children or adults for amelioration or prevention of educationally-related problems; (3) educational or vocational consultation or direct educational services to schools, agencies, organizations or individuals, said consultation being directly related to learning problems; and (4) development of educational programs such as designing more efficient and psychologically sound classroom situations and acting as a catalyst for teacher

involvement in adaptations and innovations. Section 10-145b and regulations adopted by the State Board of Education concerning revocation of a standard or professional educator certificate shall apply to a school psychologist or school psychological examiner who uses such title to describe activities within the private sector.

(c) Nothing in this chapter shall prevent any person employed by the state prior to July 1, 1985, with a title in the psychology series of the classified service from using a title in such series to describe his or her duties in the course of his or her employment with the state. The provisions of section 20-187a shall not apply to any person employed in such psychology series prior to July 1, 1985.

(1957, P.A. 269, S. 1, 9; 624, S. 1; 1969, P.A. 597, S. 12; P.A. 81-198; P.A. 85-613, S. 138, 154; P.A. 98-252, S. 36, 80; P.A. 99-102, S. 30; P.A. 04-221, S. 11; P.A. 08-184, S. 42.)

History: 1969 act deleted exemption to chapter's provisions previously allowed to nonresident psychologists temporarily employed in state under certain conditions, extended exemption to include persons employed by educational institutions, referred to "elementary or secondary" schools rather than "public" schools, deleted provision protecting firm's or corporation's right to use titles in Sec. 20-193 if certified by nationally recognized board or agency approved by board of examiners and added provision protecting right of physicians, osteopaths, etc. from "doing work of a psychological nature" consistent with accepted standards in their respective professions; P.A. 81-198 placed provisions re use of titles by school psychologists and school psychological examiners in new Subsec. (b) and added provisions re use of titles in connection with activities in the private sector; P.A. 85-613 added Subsec. (c) re employment by state prior to July 1, 1985, of persons in psychology series of classified service and nonapplicability of Sec. 20-187a to such persons; P.A. 98-252 amended Subsec. (b) to add references to professional educator certificates and to make a technical change, effective July 1, 1998; P.A. 99-102 amended Subsec. (a) by deleting obsolete reference to osteopaths and making technical changes; P.A. 04-221 amended Subsec. (a) by allowing postdoctoral candidate to perform certain activities without a license; P.A. 08-184 amended Subsec. (a) by deleting "registered" re educational institutions and by eliminating "postdoctoral" re required work experience.

Appendix C
Current Regulations for Psychologist

Regulations of Connecticut State Agencies. Psychologist Educational and Work Experience Requirements.

Sec. 20-188-1. Definitions

(a) "Accreditation by the American Psychological Association" shall mean that: (1) the program held provisional accreditation status or full accreditation status throughout the period of the applicant's enrollment, provided said provisional status subsequently progressed without interruption to full accreditation; or (2) the program held probationary accreditation status during the applicant's enrollment and, upon termination of said probationary
status, subsequently achieved full accreditation.

(b) "Recognized regional accrediting body" shall mean one of the following accrediting bodies: New England Association of Schools and Colleges; Middle States Commission on Higher Education; North Central Association of Colleges and Schools; Northwest Association of Colleges and Universities; Southern Association of Colleges and Schools; and Western Association of Schools and Colleges.

(c) "Accreditation by a recognized regional accrediting body" shall mean that: (1) the institution held accreditation status or candidacy for accreditation throughout the period of the applicant's enrollment, provided said candidacy status subsequently progressed without interruption to full accreditation; or (2) the institution held accreditation status under probation or show-cause order during the applicant's enrollment and, upon termination of said probation or show-cause order, accreditation status was maintained without interruption.

(d) "Acceptable documentation" shall mean published institutional documents contemporaneous with the applicant's enrollment. In the absence of such published documents, "acceptable documentation" may be satisfied by appropriate certifications, based on institutional records, by the institution's Chief Academic officer.

(e) "Acceptable evidence of professional identification" shall mean: member or fellow status in the American Psychological Association; or Diplomate status with the American Board of Professional Psychology; or state psychology licensure or certification; or receipt of the doctoral degree based in part upon a psychological dissertation, or the doctoral degree based on other evidence of proficiency in psychological scholarship from a program primarily psychological in content and conferred by a graduate or professional school that is regionally accredited, or that has achieved such accreditation within five years of the year the doctoral degree was granted, or one of equivalent standing outside the United States.

(f) "Acceptable evidence of applicant coursework" shall mean official transcript records of coursework completed with a passing grade, such records to be supplemented, where necessary to validate course content, with course catalogue descriptions, course outlines or syllabi, and/or student plans of study from official institutional files contemporaneous with the applicant's enrollment.

(g) "Closely related" shall mean related as a spouse, child, grandchild, child's or grandchild's spouse, parent, grandparent, brother, or sister.

(h) "Department" shall mean the Department of Public Health.

(i) "Board" shall mean the Board of Examiners for Psychologists, as established by Connecticut
General Statutes, Section 20-186.
(j) "Employ on a full-time basis" shall mean to employ an individual for a minimum of thirty (30) hours per
week.

Sec. 20-188-2. Doctoral Educational Standards for Connecticut Psychology Licensure

(a) A program holding accreditation by the American Psychological Association shall constitute an approved doctoral educational program in psychology for Connecticut psychology licensure, pursuant to Connecticut General Statutes, Sections 20-188 and 20-189.

(b) A program, in which the applicant completed the doctoral degree prior to July 1, 1989, and which does not hold accreditation by the American Psychological Association shall be an approved doctoral educational program in psychology for Connecticut psychology licensure, pursuant to Connecticut General Statutes, Section 20-188 and 20-189, when the Department has determined, with the advice and assistance of the Board, that the program was in compliance with recognized written national standards for the preparation of psychologists which were in effect at the time of the applicant's matriculation in such program. These standards shall include, but not necessarily be limited to, those contained within the following publications: The American Psychological Association's "accreditation procedures and criteria" in effect at the time of the applicant's matriculation in the program; and for an applicant matriculating in such program in and after 1977, the national register of health service providers in psychology's "guidelines for defining doctoral degrees in psychology."

(c) A program located within the United States or its territories, in which the applicant completed the doctoral degree on or after July 1, 1989, which does not hold accreditation by the American Psychological Association shall be an approved doctoral educational program in psychology for Connecticut psychology licensure, pursuant to Connecticut General Statutes Sections 20-188 and 20-189, when all of the criteria specified below are satisfied:

(1) The program shall be offered in an institution of higher education holding accreditation by a recognized regional accrediting body. The institution which granted the applicant's doctoral degree shall hold accreditation by a recognized regional accrediting body to grant degrees at the doctoral level. Any other institution at which the applicant completed graduate-level coursework in psychology shall have held accreditation by a recognized regional accrediting body to grant degrees at the graduate level.

(2) The program, wherever it may be administratively housed, shall be clearly identified and labeled as a psychology program. Acceptable documentation shall clearly identify the program as a psychology program with the intent to educate and train professional psychologists.

(3) The program shall stand as a recognizable, coherent organizational entity within the institution. Acceptable documentation shall clearly demonstrate that the institution has recognized and established an organizational structure, curriculum, administration, and faculty for the psychology program.

(4) Psychologists shall have clear authority and primary responsibility for the core and specialty areas within the program. Acceptable documentation shall clearly identify a psychologist or psychologists responsible for core and specialty areas within the program. When the professional identification of the responsible individual(s) is in question, acceptable evidence of professional identification shall be required.
(5) The program shall be an organized, integrated sequence of required study designed and predominantly taught by the psychology faculty responsible for the doctoral program. Acceptable documentation shall clearly identify specific educational objectives and an organized, sequenced plan for meeting these objectives through required coursework, elective study, and related training experiences. Said objectives and plan must be designed and predominantly taught by faculty of the program. The requirements of this subsection shall not be satisfied when a program permits educational objectives to be met solely by the completion of a specified number of course credits, examinations, independent study experiences, and/or hours of work experience.
(6) The program shall have an identifiable core of full-time psychology faculty. Acceptable documentation shall clearly identify a core of psychologists serving as full-time faculty for the program. When the professional identification of the responsible individual(s) is in question, acceptable evidence of professional identification shall be required.
(7) The program shall have an identifiable body of students who are matriculated in that program for a doctoral degree. Acceptable documentation shall clearly demonstrate that the program has an identifiable body of doctoral students matriculated in that program.
(8) The applicant shall complete a course of studies which encompasses a minimum of three academic years, or its equivalent, of full-time graduate study, of which a minimum of one academic year, or its equivalent, of full-time academic graduate study in psychology must be completed in residence at the institution granting the doctoral degree. Acceptable evidence of applicant coursework shall document completion of the specified minimum lengths of full-time graduate study and study in residence. The requirement for study in residence shall be satisfied by full-time registration, attendance at, and participation in didactic coursework at the physical site of the institution granting the doctoral degree.

Such requirement shall not be satisfied solely by the accumulation of contact hours with faculty or supervisors remote from the physical site of the institution granting the doctoral degree, nor solely by the completion of a specified number of course credits, independent study experiences, examinations, and/or hours of work experience.
(9) The applicant shall complete a course of studies which encompasses instruction in scientific methods in psychology and which shall include instruction in research design and methodology, statistics, and psychometrics. Acceptable evidence of applicant coursework shall document satisfactory completion of a minimum of six graduate semester hours, or ten graduate trimester hours, of study in scientific methods of psychology, including the study of research design and methodology, statistics, and psychometrics. Not less than three graduate

semester hours, or five graduate trimester hours, of the applicant's study in scientific methods of psychology shall be in research design, methodology, and statistics.
(10) The applicant shall demonstrate that the content of his doctoral program was primarily psychological by completion of classroom instruction in the following four substantive basic science areas: (A) Biological bases of behavior, for example, physiological psychology, comparative psychology, neuropsychology, sensation-and perception, psychopharmacology. (B) Cognitive–affective bases of behavior, for example, learning, thinking, motivation, emotion. (C) Social bases of behavior, for example, social psychology, group processes, organizational and systems theory. (D) Individual differences, for example, personality theory, human development, abnormal psychology. Acceptable evidence of applicant coursework shall document satisfactory completion of a total of at least twenty one graduate semester hours, or thirty-five graduate trimester hours, of classroom instruction encompassing the four substantive content areas specified in this subsection. The requirements of this subsection shall not be satisfied by any course which had a predominantly applied or clinical focus.

(11) The applicant shall complete a course of studies which includes a formal practicum, internship, or field training which is supervised by program faculty, which is appropriate to the practice of psychology, and which is a minimum of one academic year in duration. Acceptable evidence of applicant coursework shall document satisfactory completion of a formal supervised practicum, internship, or field in psychology. The requirements of this section shall not be satisfied by dissertation work alone.
(12) An applicant who has received a doctoral degree in psychology that does not meet the requirements of subdivisions (a) or (b) of this section may remediate the required coursework post-doctorally. Such supplemental course work shall consist of formal doctoral level course work meeting the requirements of subdivisions (9), (10) and (11) of this section and must be completed in a program that meets the requirements of subsection (a) of this section.
(13) An applicant who has received a doctoral degree in a non applied or non clinical area of psychology shall meet the requirements of this subsection provided the applicant has completed a respecialization program in an applied psychology program accredited by the American Psychological Association. (d) A program located outside the United States or its territories which does not hold accreditation by the American Psychological Association shall be an approved doctoral educational program in psychology for Connecticut licensure, pursuant to Connecticut General Statutes, Sections 20-188 and 20-189, when all of the criteria specified below are satisfied:

(1) The program shall be offered by an institution of higher education approved to grant degrees at the doctoral level by the appropriate governmental or government-recognized body of the jurisdiction in which it is located. The applicant shall be required to demonstrate that the degree granted is equivalent in level and content to a doctoral degree in psychology as granted by an approved United States program, as defined by these regulations. The applicant shall be responsible for providing official documentation of educational program, translations of any non-

English language documentation, and professional evaluations of educational credentials by a credentials evaluation service designated by the Department.
(2) The program and applicant shall be required to meet the criteria of subsections (c)(2) through (c)(11) of this Section.

Sec. 20-188-3. Work Experience Standards for Connecticut Psychology Licensure

Work experience initiated on or after April 1, 1988, shall be satisfactory for Connecticut Psychology Licensure, pursuant to Connecticut General Statutes, Section 20-188, when all of the criteria specified below are satisfied.

(a) The work experience shall consist of at least one year at the pre or post-doctoral level and does not include an internship completed as part of the requirements of completing a doctoral degree.

(1) The work experience shall consist of either: (A) no less than thirty-five hours per week for no less than forty-six weeks within twelve consecutive months, or (B) no less than 1800 hours within twenty-four consecutive months. No more than forty hours per week shall be credited toward the required experience.

(2) The completion date of such experience shall be no later than eight weeks prior to the scheduled date of administration of the licensure examination to which the applicant is seeking admission.

(b) The work experience shall be supervised in accordance with this subsection and subsection (d) of this section by one or more doctoral-level psychologist(s) licensed in the state where the experience was completed and supervised. A doctoral-level licensed psychologist shall have either directly supervised the applicant, or consulted with the applicant under contract to the employment setting. For each 40 hours of work experience, such supervision or consultation shall consist of at least three hours of which no less than one hour shall be individual, direct, face-to-face supervision or consultation.

The supervisor shall not be closely related to the supervisee nor have such other relationship to the supervisee that may reasonably be seen to compromise the objectivity of the supervisor. The supervisor shall not concurrently supervise more than a total of three individuals completing the
work experience.

(c) The work experience shall be within an area for which the applicant is qualified by the applicant's doctoral education and shall be appropriate to the applicant's intended area of practice. The duties the applicant shall be performing, as documented by the supervisor, shall be within an area for which the applicant has completed a directly related sequence of graduate coursework and a supervised pre-doctoral internship, practicum, field training or laboratory training. Acceptable evidence of applicant coursework shall be required.

(d) The work experience shall be within an acceptable employment setting as defined in this subsection.

(1) Documentation from the employment setting shall establish that the setting provides supervision for the applicant and that the employment setting shall:

(A) employ on a full-time basis or contract or otherwise provide for the services of a doctoral-level licensed psychologist engaged in work in an

area for which the applicant is qualified by the applicant's doctoral education in accordance with subsection (c) of this section;
(B) provide the applicant an opportunity for regularly occurring professional interaction and collaboration with other disciplines, an opportunity to utilize a variety of techniques and interventions, and an opportunity to work with a broad range of populations and conditions and
(C) The licensed doctoral-level psychologist shall have direct and continuing
administrative control of, as well as full professional responsibility and accountability for the activities performed and services provided by the applicant; the doctoral level licensed psychologist shall certify to the applicant's satisfactory completion of the work experience in accordance with subsection (e) of this section.

(2) The requirements of this subsection shall not be satisfied when the experience is completed within an applicant's independent practice setting, or when the applicant receives direct client fees or variable compensation based upon client fees generated.

(e) The experience shall be certified as satisfactorily completed by the licensed doctoral level psychologist who directly supervised the applicant. (f) When such experience is to be completed in Connecticut, the applicant may file a supervised work experience plan with the Department on forms prescribed by the Department. Written approval of the plan of supervised experience may be obtained from the Department prior to the applicant's beginning such experience, based upon compliance of the plan with the requirements of this section.

(1) In order to obtain such approval, the applicant shall: (A) satisfy the Department that the applicant has completed or is enrolled in a doctoral education program in psychology approved for Connecticut psychology licensure; and (B) submit an acceptable plan for supervised work experience to the Department.
(2) Prior to licensure and during the period of time devoted to completing the work experience in Connecticut under the terms of an approved plan, the applicant shall be permitted to use the description "psychology resident" solely in the conduct of such applicant's approved work experience plan. Outside of an applicant's employment under the terms of a plan approved pursuant to subsection (f)(1) of this section, in accordance with Connecticut General Statutes, Section 20-187(a), applicants shall refrain from using any title employing the terms "psychologist", "psychology", or "psychological" to describe their services offered to the public, or to any public or private organization for a fee or other remuneration. Activities exempt from this provision are set forth in Connecticut General Statutes.

Appendix D

Proposed: Post-doctoral Education and Training in Clinical Psychopharmacology

These standards are intended to describe a postdoctoral, master's degree experience. This program involves advanced training in a specific content area of psychology representing a significant expansion of scope of practice. The prerequisites for admission to a program continue to be (1) a doctoral degree in psychology; (2) current licensure as a psychologist, and (3) practice as a health services provider as defined by state or federal law, where applicable, or as defined by APA.

Training programs in psychopharmacology for prescriptive authority can award transfer credit for no more than twenty percent (20%) of the total curriculum hours. This twenty percent shall be limited to the basic science and neuroscience domains of the curriculum.

Academic Medical Training. The total post-doctoral, master's degree program shall not be less 30 graduate credit hours or its equivalent of approximately 270 credit hours of sciences, clinical medicine, plus a supervised practicum instruction. Total completion time 2-3 years.

I. Basic Biological Sciences:
- A. Anatomy & Physiology
- B. Biochemistry

II. Neurosciences:
- A. Neuroanatomy
- B. Neurophysiology
- C. Neurochemistry
- D. Neuropathology

III. Physical Examination/Assessment and Laboratory Studies:
- A. Physical Assessment
- B. Laboratory and Radiological Assessment
- C. Medical Terminology and Documentation
- D. Integration of A-C through supervised clinical experience or lab experience in conducting physical exams, ordering psychometric, laboratory, or diagnostic tests, understanding results and interpretation, and referral to patient's primary or specialty medical provider.

IV. Clinical Medicine and Pathophysiology:
- A. Pathophysiology with particular emphasis on cardiac, renal, hepatic, neurologic, gastrointestinal, hematologic, dermatologic and endocrine systems.
- B. Clinical Medicine, with particular emphasis on signs, symptoms and treatment of disease states with behavioral, cognitive and emotional manifestations or comorbidities.
- C. Differential Diagnosis.

D. Clinical correlations-the illustration of the content of this domain through case study.
E. Substance-Related and Co-Occurring Disorders.
F. Chronic Pain Management.
G. Integration of A-F through supervised clinical experience or lab experience in taking medical history, assessment for differential diagnosis, and review of systems.
H. Sleep Medicine.

V. Clinical and Research Pharmacology and Psychopharmacology
A. Pharmacology
B. Clinical Pharmacology
C. Pharmacogenomics
D. Psychopharmacology
E. Developmental Psychopharmacology
F. Research on cultural, ethnic and gender diversity in pharmacological practice; and lifespan/developmental factors related to drug metabolism, compliance, and adherence.
G. Integration of A-F through supervised clinical experience or lab experience in Clinical Medicine and ongoing treatment monitoring and evaluation.

VI. Clinical Pharmacotherapeutics
A. Combined therapies - Psychotherapy/pharmacotherapy interactions.
B. Computer-based aids to practice.
C. Pharmacoepidemiology.
D. Integration of A-C through supervised clinical experience or lab experience in integrated treatment planning. Topics include: Cultural, age, gender, and ethnic factors in pharmacotherapeutics; psychogenomics and genetic factors in medication prescribing; adverse drug effects, drug/drug interaction; psychiatric symptoms and co-morbidity secondary to medical illness.

VII. Research
A. Methodology and Design of psychopharmacological research.
B. Interpretation and Evaluation of Pharmacology research.
C. FDA drug development and other regulatory processes (DEA, etc.).

VIII. Professional, Ethical, and Legal Issues
A. Application of existing law, standards and guidelines to pharmacological practice.
B. Relationships with pharmaceutical industry.
1. Conflict of interest.
2. Evaluation of pharmaceutical marketing practices.
3. Critical consumer and patient welfare issues [economic issues in prescribing medication].

Supervised Clinical Experience. The supervised clinical experience should be an organized sequence of education and training that provides an integrative approach to learning as well as the opportunity to assess competencies in skills and applied knowledge. The intent of the supervised clinical experience (practicum) is two-fold:

1. To provide ongoing integration of didactic and applied clinical knowledge throughout the learning sequence, including ample opportunities for practical learning and clinical application of skills.

2. To provide opportunity for programs to assess formative and summative clinical competency in skills and applied knowledge. In addition to the didactic hours, the number of hours needed to achieve mastery of clinical competencies is expected to be substantial and will vary across individuals. The supervised clinical experience is intended to be an intensive and closely supervised experience.

The APA recommends 100 patients under supervision of a Connecticut licensed prescriber. One hundred patients is equivalent of approximately 400 clock hours of direct medication treatment services. It is recommended that the prescribing psychologist obtain experience across a diverse formulary with a variety of mental health and substance abuse disorders.

The range of diagnostic categories, settings and characteristics such as development across the lifespan, gender, health status, and ethnicity reflected in the patients seen in connection with the supervised clinical experience should be appropriate to the current and anticipated practice of the *Prescribing Psychologist* candidate. It should allow the practitioner to gain exposure to acute, short-term, and maintenance medication strategies. The *Prescribing Psychologist* candidate gains supervised clinical experience with a sufficient range and number of patients in order to demonstrate threshold performance levels for each of the competency areas. In order to achieve the complex clinical competency skills required for independent prescribing, a sufficient number of supervised patient contact hours must be completed.

The supervised clinical training experiences must be approved by the training director of the academic program prior to commencing that placement. The program must document the total number of supervised clinical experience hours of each student's experience. These must be broken out by face-to-face patient contacts versus other clinical experiences, and the clinical competencies employed. In addition, the method and appropriate benchmarks for assuring each clinical competency must be described. These methods may include, for example, performing physical examinations and presenting cases based on actual and simulated

patients. The *Prescribing Psychologist* candidate recommends/prescribes in consultation with or under a designated supervisor(s) with demonstrated skills and experience in clinical psychopharmacology and in accordance with the prevailing jurisdictional law. The program is responsible for the approval and oversight of each supervised clinical experience. Final approval of the supervised clinical experience must be provided by the program prior to initiation.

National Board Examination and Certification.

After completion of the 10-course/topic sequence, participants are eligible to sit for a comprehensive examination. One option for this exam is the *Psychopharmacology Examination for Psychologists* (PEP), which was developed by the APA College of Professional Psychology specifically as a credentialing examination for psychologists with advanced training in clinical psychopharmacology.

The psychologist must pass an examination developed by a nationally recognized body and approved by Department.

The examination evaluates success in relation to 10 learning objectives:

1. Integrating clinical psychopharmacology in practice.
2. Understanding the implications of neuroscience for the action of pharmacological agents.
3. Developing Nervous System Pathology.
4. Learning elements of physiology and pathophysiology relevant to prescribing.
5. Developing an understanding of a biopsychosocial perspective on assessment.
6. Enhancing skills in differential diagnosis as they relate to psychopharmacological practice.
7. Developing knowledge of pharmacology.
8. Developing an extensive understanding of clinical psychopharmacology.
9. Understanding research issues in psychopharmacological practice.
10. Understanding professional issues specific to involvement in psychopharmacology.

References

1. Moore, T.J. and Mattison, D.R. (2017) Adult Utilization of Psychiatric Drugs and Differences by Sex, Age, and Race. *JAMA Intern Med. 2017; 177(2):* 274-275. (Additionally, https://www.scientificamerican.com/article/1-in-6-americans-takes-a-psychiatric-drug/ and http://www.cnn.com/2016/12/12/health/psychiatric-drug-use/index.html; and https://www.livescience.com/57170-americans-psychiatrics-drug-use.html.)
2. Retrieved from www.nimh.nih.gov and www.nami.org. Also see #3, #5, and #6 below.
3. *2016 Physician Specialty Data Report. Association of American Medical Colleges.* Retrieved from www.aamc.org.
4. Retrieved from http://health.usnews.com/health-news/news/articles/2012/03/30/fewer-us-med-students-choose-psychiatry-report
5. Retrieved from Mental Health Association of Maryland website https://www.mhamd.org/network-adequacy-series-part-fuss/
6. Retrieved from www.aamc.org. *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025.* (2015): Association of American Medical Colleges.
7. Retrieved from www.aamc.org. *2017 Update – The Complexities of Physician Supply and Demand: Projections from 2015 – 2030.* Association of American Medical Colleges.
8. Bishop, T.F., Press, M.J., Keyhani, S. and Pincus, H.A. (2014) Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care. *JAMA Psychiatry. 2014;71(2):*176-181. Doi:10.1001/jamapsychiatry.2013.2862
9. Rittmannsberger, H. (2002). The use of drug monotherapy in psychiatric inpatient treatment. *Prog Neuropsychopharmacol Biol Psychiatry, 26*(3), 547-551.
10. Bitter, I., Chou, J. C., Ungvari, G. S., Tang, W. K., Xiang, Z., Iwanami, A., & Gaszner, P. (2003). Prescribing for inpatients with schizophrenia: an international multi-center comparative study. *Pharmacopsychiatry, 36*(4), 143-149. Doi: 10.1055/s-2003-41199
11. Smith, B. (2012). Inappropriate prescribing. *Monitor on Psychology, 43*(6), 36.
12. Sohler, N. L., Walkup, J., McAlpine, D., Boyer, C., & Olfson, M. (2003). Antipsychotic dosage at hospital discharge and outcomes among persons with schizophrenia. *Psychiatr Serv, 54*(9), 1258-1263. Doi: 10.1176/appi.ps.54.9.1258.
13. Diaz, F. J., & De Leon, J. (2002). Excessive antipsychotic dosing in 2 U.S. State hospitals. *J Clin Psychiatry, 63*(11), 998-1003.
14. Mojtabai, R., & Olfson, M. (2008). National trends in psychotherapy by office-based psychiatrists. *Arch Gen Psychiatry, 65*(8), 962-970. Doi: 10.1001/archpsyc.65.8.962
15. Lawrence, R.E, Rasinski, K. A., Yoon, J. D., & Curlin, F. A. (2015). Psychiatrists' and primary care physicians' beliefs about overtreatment of depression and anxiety. *J Nerv Ment Dis, 203*(2), 120-125.
16. Olfson, M., Marcus, S. C., & Pincus, H. A. (1999). Trends in office-based psychiatric practice. *Am J Psychiatry, 156*(3), 451-457. Doi: 10.1176/ajp.156.3.451
17. Wang, P. S., Demler, O., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2006). Changing profiles of service sectors used for mental health care in the United States. *Am J Psychiatry, 163*(7), 1187-1198. Doi: 10.1176/appi.ajp.163.7.1187

18. Bazaldua, O., Ables, A. Z., Dickerson, L. M., Hansen, L., Harris, I., Hoehns, J.P. (2005). Suggested guidelines for pharmacotherapy curricula in family medicine residency training: recommendations from the Society of Teachers of Family Medicine Group on Pharmacotherapy. *Fam Med, 37*(2), 99-104.
19. Muse M. and McGrath R. (2009). Training comparison among three professions prescribing psychoactive medications: psychiatric nurse practitioners, physicians, and pharmacologically-trained psychologists. J. Clin.Psychol.
20. McGrath, R. E. (2010). Prescriptive authority for psychologists. *Annu Rev Clin Psychol, 6*, 21-47. Doi: 10.1146/annurev-clinpsy-090209-151448
21. LeVine, E. S., & Foster, E. O. (2010). *Integration of psychotherapy and pharmacotherapy by prescribing–medical psychologists: A psychobiosocial model of care.* In McGrath R. E., Moore B. A. (Eds.), Pharmacotherapy for psychologists: Prescribing and collaborative roles (pp. 105-131). Washington, DC: American Psychological Association
22. McGrath, R. E. (2004). Saving our psychosocial souls. *Am Psychol, 59*(7), 644-645. Doi: 10.1037/0003-066X.59.7.644
23. Wiggins, J. & Cummings, N. (1998) National study of the experience of psychologists with psychotropic medication and psychotherapy. *Professional Psychology: Research and Practice, 29,* 549-552.
24. Sammons, M.T., & Brown, A.B. (1997). The Department of Defense Psychopharmacology Demonstration Project: An evolving program for postdoctoral education in psychology. *Professional Psychology: Research and Practice*, 28 (2), 107-112. http://dx.doi.org/10.1037/0735-7028.28.2.107
25. Shearer, D.S., Moore, B.A. & Park, A., (2015), *Establishing uniform requirements for privileging of psychologists to prescribe psychotropic medications in federal agencies.* http://www.apadivisions.org/division-55/publications/tablet/2015/04/requirements.aspx
26. Information available at Substance Abuse and Mental Health Administration website www.samhsa.gov.
27. Hospital Emergency Department Use and Its Impact on the State Medicaid Budget January 31, 2014 Legislative Program Review and Investigations Committee Connecticut General Assembly (found at www.cga.ct.gov)
28. Retrieved from http://www.psychiatry.org/news-room/apa-blogs/apa-blog/2016/11/emergency-room-visits-for-mental-health-conditions-expect-long-waits
29. Ernst, F. R., & Grizzle, A. J. (2001). Drug-related morbidity and mortality: updating the cost-of-illness model. *Journal of the American Pharmaceutical Association (Washington, D.C.: 1996), 41*(2), 192-199.
30. Stuart, R. B., & Heiby, E. M. (2007). To prescribe or not to prescribe: Eleven exploratory questions *Sci. Rev. Ment. Health Pract., 5*, 4-32.
31. Carlat, D.J. (2010) The case for prescribing psychologists. *National Psychologist*, 19, 13.
32. Newman, R., Phelps, R., Sammons, M. T., Dunivin, D. L., & Cullen, E. A. (2000). Evaluation of the Psychopharmacology Demonstration Project: A retrospective analysis. *Professional Psychology: Research and Practice, 31*(6), 598-603. http://dx.doi.org/10.1037/0735-7028.31.6.598

33. McGrath, R. E., & Muse, M. (2010). Room for a new standard? Response to comments by Heiby. Journal of Clinical Psychol- ogy, 66, 112–115. doi:10.1002/jclp.20658.

Appendix D

Impact Statements

Connecticut Council of Child and Adolescent Psychiatry, Inc.

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Hartford, CT 06106
fx-860-727-9863

Officers

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President

Mirela Loftus, MD
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Laine Taylor, DO
Secretary-Treasurer

Brian Keyes, MD
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Jillian Wood
Executive Director

Impact Statement

September, 2017

Policy Statement on Psychologists Prescribing

The American Academy of Child and Adolescent Psychiatry (our parent national organization representing nearly 9,200 physician members) opposes any legislation or regulation at the state or federal level that would grant psychologists prescribing privileges.

Mental illness and psychotropic medications affect not only the developing brain but all organ systems. Child and adolescent psychiatrists obtain a four-year medical education with a focus on anatomy, physiology and pharmacology. During the subsequent five years of residency training, child and adolescent psychiatrists receive extensive clinical supervision in evidence-based treatments and management of medications and side effects. We oppose psychologists prescribing medication because psychologists do not have a medical education that is essential for the appropriate and safe prescription of medications.

The CT Council on Child and Adolescent Psychiatry represents nearly 300 child and adolescent psychiatrists in the state of Connecticut. Our mission is to promote the healthy development of children, adolescents, and families through advocacy, education, and research, and to meet the professional needs of child and adolescent psychiatrists throughout their careers.

We feel that the children and adolescents of Connecticut will be directly negatively impacted by allowing **prescribing rights to the scope of practice for psychologists.**

A Dangerous Practice:
We write in strong opposition to increasing the scope of practice for psychologists, specifically allowing them to prescribe medications, including psychotropic medications. This is dangerous and risks patient safety, and exposes patients, particularly special patient populations, including children, adolescents, and transitional-aged youth, to substandard care.

This would allow a new class of prescribers who have no medical education to treat vulnerable children, many of whom have serious emotional disturbances, at a critical time in their physical and mental development. Connecticut should not be leading the country in allowing children and adolescents to receive care from someone other than the best-qualified medical professional.

Shortage of Physicians:
While Connecticut has a shortage of medical professionals in a variety of clinical specialties, it in no way should allow any of our residents to receive psychiatric medication from anyone lacking the requisite medical background in physical

disorders, ordering and interpreting laboratory tests, and recognizing side effect and drug interactions necessary to create the best targeted treatment plan. The judgment of a psychiatrist, primary care physician, or psychiatric nurse practitioner who can safely prescribe medication, titrate, and monitor psychiatric medication is necessary.

No Adverse Effects?
It is inaccurate for proponents of psychologists prescribing to state that no adverse effects have been recorded from prescribing psychologists in New Mexico and Louisiana, the only two states that currently grant prescriptive authority to psychologists. No formal studies of the impact on access to care, patients' safety, nor a formal review of the wide-variety of drugs reportedly prescribed by psychologists have been conducted with respect to such laws.

Access isn't Simple Geography:
Evidence shows that allowing psychologists to prescribe medications will not improve access to quality mental health care, especially in rural areas. Psychiatrists and psychologists practice in the exact same communities; as such, mental health care delivery in underserved communities would not improve by granting psychologists prescriptive authority.

See Exhibit A (Hartford Map)
See Exhibit B (Connecticut Map)

What is the Difference between Adults and Children or Adolescents:
An accurate treatment plan is essential for young people due to the possible serious setbacks to a child's emotional and physical development from an untreated or misdiagnosed mental health disorder. Adolescents differ from adults in the way they behave, solve problems, and make decisions. Research has demonstrated that the brain continues to develop throughout adolescence and into early adulthood. Even adult psychiatrists, with their own extensive medical training gained in medical school and through a four-year accredited residency in psychiatry, prefer a child and adolescent psychiatrist to treat the complex needs of a pediatric patient, and many consider it malpractice to do otherwise. Psychotropic medication impacts all parts of the body, not just the brain, and if inappropriately prescribed can cause potentially dangerous consequences such as convulsions, seizures, heart arrhythmias, blood disease, or even death. Children's bodies metabolize medications differently than adults, and formulations and dosages must be individually adjusted to their needs.

Medical training and exposure to a variety of medical conditions is necessary to accurately distinguish between mental illnesses, such as schizophrenia, and conditions which may mimic a mental illness, such as brain tumors and thyroid disease.

Qualifications of Medical Providers:
A board-eligible child and adolescent psychiatrist is a MD/DO physician with at least five, although often six years of additional training beyond medical school, including two to three years of additional subspecialty clinical training in psychiatry and neuroscience specific to the medical needs of children. As such, they have the unique skills to appropriately treat medically ill patients, including those that present in an emergency department. A psychologist cannot safely nor realistically replicate the extensive medical and clinical training of a physician, let alone a child and adolescent psychiatrist, or even a psychiatric nurse practitioner.

Over the course of the 7 to 9 years of clinical training child and adolescent psychiatric trainees experience the longitudinal course of illness of many children both in inpatient and outpatient settings with many different psychiatric and medical problems that are often intertwined. The trainees get to learn how to manage--in supervised settings--not only the illnesses, but also the many subtle and not-so-subtle medical and emotional side effects and other problems that go along with short and long term psychotropic medication use.

See Exhibit C-– Biomedical Training Chart
See Exhibit D – Key Differences Between Psychiatrists and Psychologists

Qualifications of a Psychologist:
A PsyD or PhD in psychology demonstrates knowledge in certain social behaviors and research, but not the years of necessary medical training or clinical experience to safely and effectively prescribe and monitor medications. A physician graduate of an accredited medical school cannot practice medicine without physician supervision before completing his or her established four-year residency program.

Psychologists are an Integral Part of Mental Health Care:
What is not in question is that licensed psychologists, along with psychiatrists, may provide psychotherapy (talk or play therapy) to patients seen by a psychiatrist. Some form of psychotherapy is typically ordered with medication. Expanding a psychologist's scope to prescribe medications risks limiting the availability of an important treatment option for patients seeking mental health care through necessary psychotherapy.

Where Does Increasing the Scope of Practice for Psychologists Get Us?
Programs that train psychologists to prescribe medication are not cost effective. For example, a Department of Defense demonstration program cost more than $6 million to train only 10 psychologists to prescribe – roughly $610,000 per psychologist. These 10 psychologists were closely overseen by a psychiatrist, yet the program was deemed a failure by the U.S. Government Accountability Office, and ended abruptly in 1997. [1]

What are the solutions?:

- **Inadequate funding** for the mental health system is the real public health issue. A law granting psychologists prescription authority will not address this greater public health issue.
- Rather than granting psychologists prescription privileges, which risks patient safety and has not been shown to increase access to care, policymakers **should invest in other solutions that improve access to specialized mental health care**.

[1] 1. Department of Defense, GAO/HEHS-99-98 DOD Prescribing Psychologists, 1.

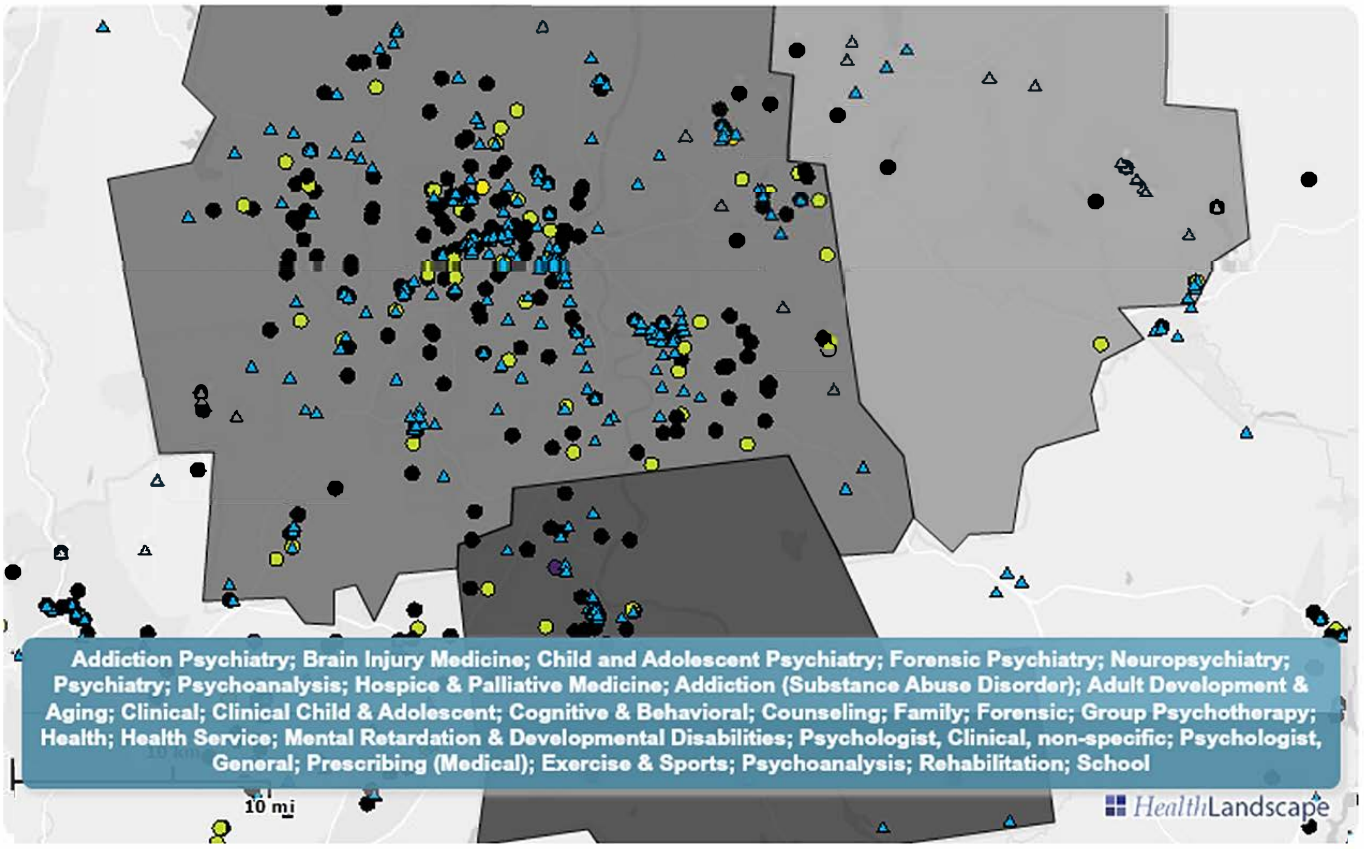
- **CT has improved access** to mental health care by implementing collaborative programs between child and adolescent psychiatrists and primary care physicians (ACCESS MH).
- **Expand ACCESS MH** to include schools, young adults and young women suffering from maternal depression.
- **Connecticut's collaborative care programs** Access Mental Health has increased primary care physicians' capacity to serve children with mental health problems, helping to alleviate the shortage of child and adolescent psychiatrists.
- Supporting **appropriately reimbursed psychiatry services** through telepsychiatry can close the gap between the need for mental health services and available psychiatric care. An evolving evidence base has established that telepsychiatry is feasible, acceptable, and as effective as care delivered in person, and superior to mental healthcare provided in primary care.
- Initiatives to **support medical students in their training as child and adolescent psychiatrists,** such as loan repayments and scholarships, encourage more physicians to pursue the specialty and strengthen the mental health workforce.
- Initiatives to **support child and adolescent psychiatry training programs** such as the one at Solnit Center in Middletown, enabling the Center to fund and enroll additional residents.

As medical professionals who will be impacted by this change in scope of practice, the CT Council on Child and Adolescent Psychiatry respectfully requests that two of our members be selected to serve on the scope of practice committee if one is formed.

Exhibit A (Hartford Map)

Hartford, CT

HealthLandscape



Population per Provider

- 905
- 1108
- 2828

Providers

- Addiction Psychiatry
- Brain Injury Medicine
- Child and Adolescent Psychiatry
- Forensic Psychiatry
- Neuropsychiatry
- Other Physicians
- Psychologist, Clinical

County	FIPS	Total Providers	Population per Provider	Population (2010)	Change since 2000	Population Density (per sq mi)	Percent Population over 65	Percent Population under 18
Hartford County, Connecticut	09003	807	1,108 : 1	894014	36831	1191.2	0.15	0.23
Middlesex County, Connecticut	09007	183	905 : 1	165676	10605	433.7	0.15	0.21
Tolland County, Connecticut	09013	54	2,828 : 1	152691	16327	366.1	0.12	0.2

About the AMA Health Workforce Mapper:

The AMA Health Workforce Mapper is interactive tool that illustrates the geographic locations of the health care workforce in each stat

About the AMA Health Workforce Mapper Project Team:

The American Medical Association: The American Medical Association (AMA) is a tireless advocate for physicians and patients in stat

Robert Graham Center: The AAFP's Robert Graham Center for Policy Studies in Family Medicine and Primary Care is a research cent

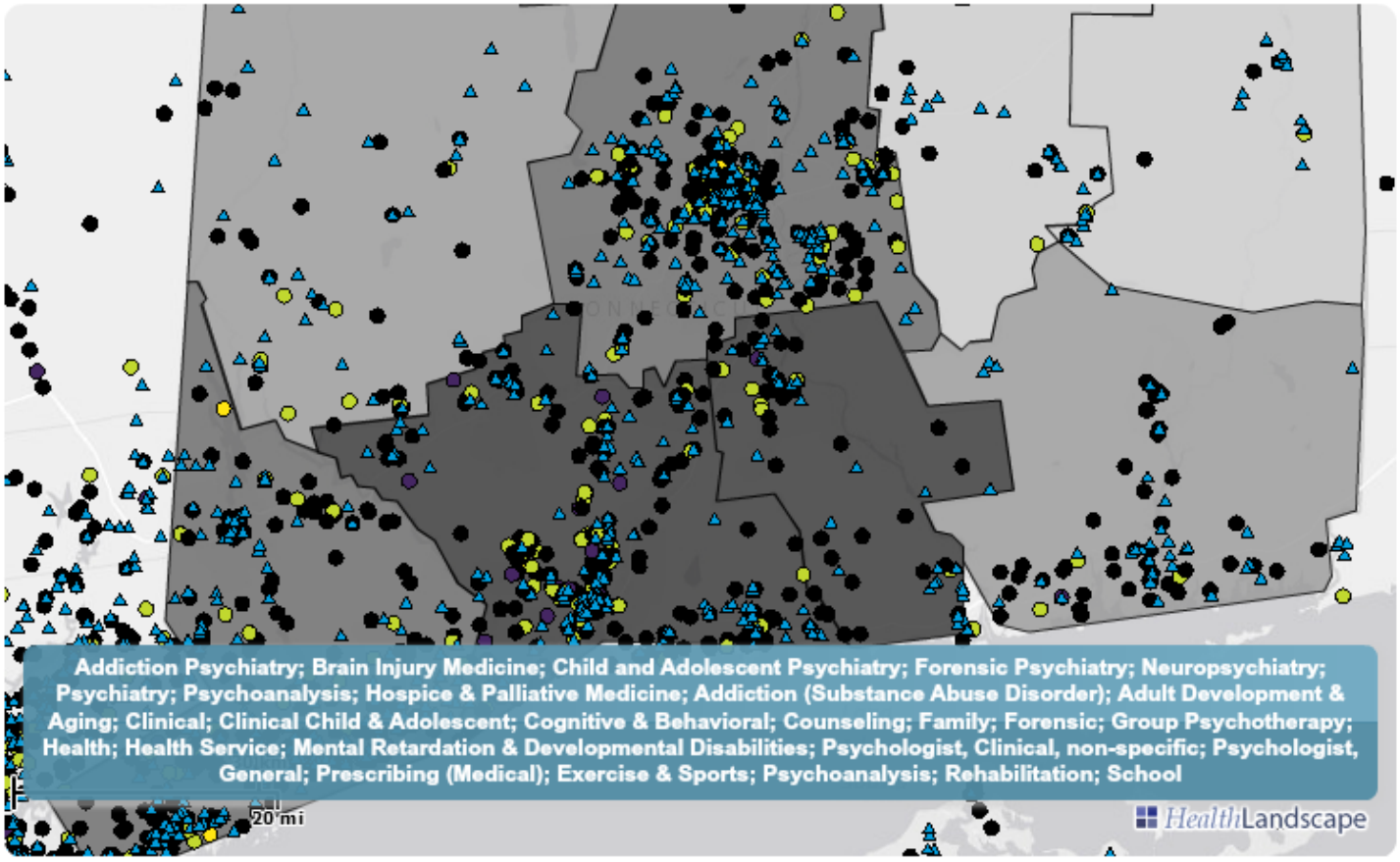
HealthLandscape: HealthLandscape develops, administers, and markets geospatial analysis software tools and professional servi

AAFP: The American Academy of Family Physicians (AAFP) is the national association of family doctors. It is one of the largest nationa

Exhibit B (Connecticut Map)

CT mapper

HealthLandscape



Population per Provider

- 880 to 905
- 1,108 to 1,385
- 2,092 to 2,753
- 2,828 to 4,935

Providers

- Addiction Psychiatry
- Brain Injury Medicine
- Child and Adolescent Psychiatry
- Forensic Psychiatry
- Neuropsychiatry
- Other Physicians
- Psychologist, Clinical

County	FIPS	Total Providers	Population per Provider	Population (2010)	Change since 2000	Population Density (per sq mi)	Percent Population over 65	Percent Population under 18
Fairfield County, Connecticut	09001	662	1,385 : 1	916829	34262	1420.8	0.14	0.25
Hartford County, Connecticut	09003	807	1,108 : 1	894014	36831	1191.2	0.15	0.23
Litchfield County, Connecticut	09005	69	2,753 : 1	189927	7734	201	0.16	0.22
Middlesex County, Connecticut	09007	183	905 : 1	165676	10605	433.7	0.15	0.21
New Haven County, Connecticut	09009	980	880 : 1	862477	38469	1392.9	0.14	0.22
New London County, Connecticut	09011	131	2,092 : 1	274055	14967	401.6	0.14	0.22
Tolland County, Connecticut	09013	54	2,828 : 1	152691	16327	366.1	0.12	0.2
Windham County, Connecticut	09015	24	4,935 : 1	118428	9337	227.1	0.13	0.22

About the AMA Health Workforce Mapper:

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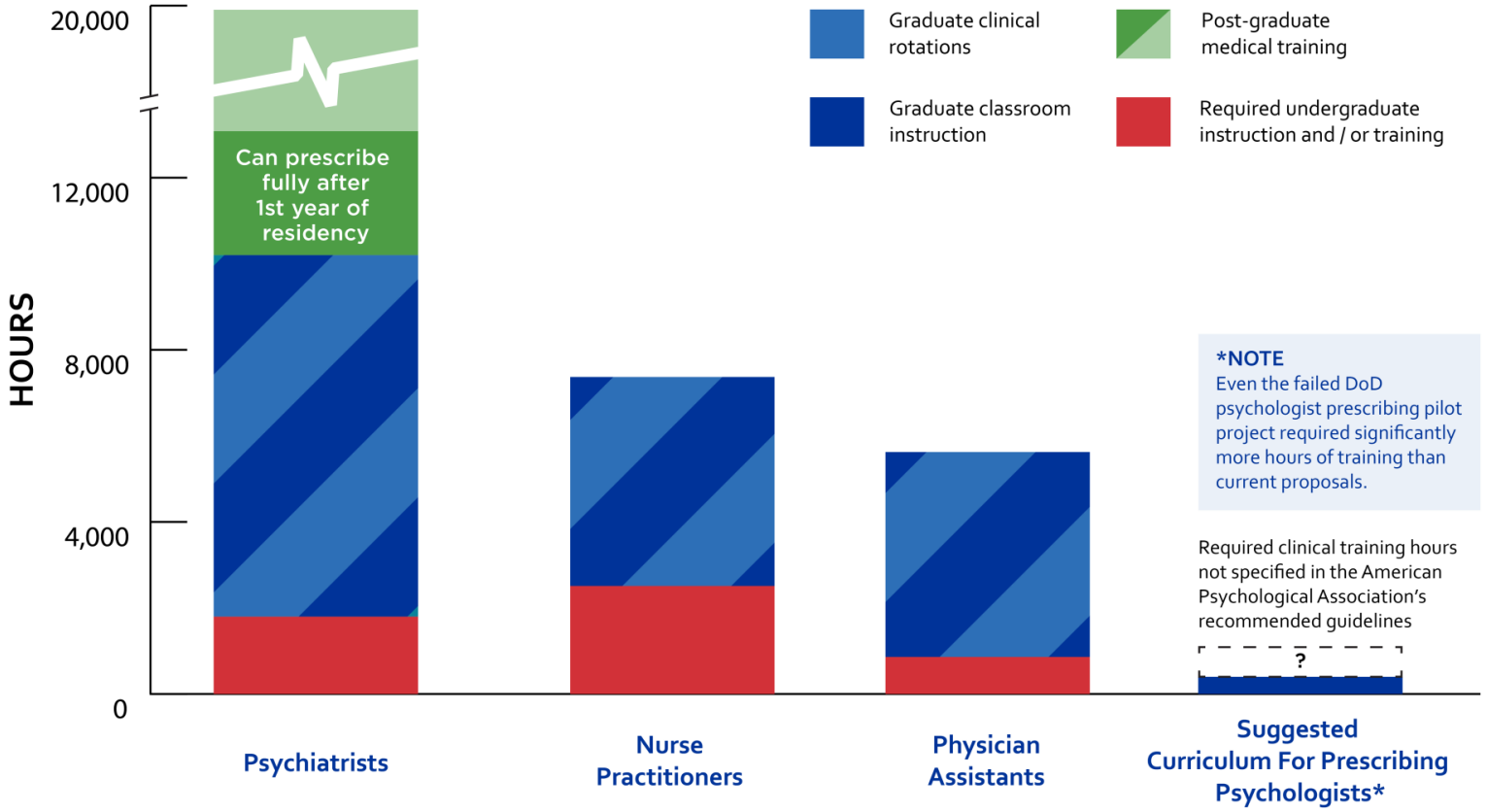
AAFP: The American Academy of Family Physicians (AAFP) is the national association of family doctors. It is one of the largest nationa

Exhibit C– Biomedical Training Chart

Biomedical Training is Necessary to Prescribe Safely



Prescribing Can't Be Taught In Just Ten Weeks

Oppose the Unsafe Psychologist-Prescribing BILL ####

Key Differences Between Psychiatrists and Psychologists

Differences That Matter

Psychologists are not medical doctors and under legislative proposals to allow certain psychologists to prescribe medications, would not be required to get the training necessary to safely prescribe powerful medications.

- Psychiatrists are medical doctors (MDs) with up to 12 years of medical training in biology, anatomy, microbiology, pharmacology, chemistry and the other biomedical coursework. Also included are clinical rotations and training, medical internship and four years of residency learning to diagnose mental and physical disease and prescribe medications to treat illnesses.
- Psychologists have an academic degree (Psy.D. or Ph.D.) in the study of psychology and human behavior. They do not have the underpinnings of any medical coursework. They may do an internship that is generally performed at counseling centers or schools.
- Psychiatrists are trained to review medical records, examine patients, order and analyze appropriate lab reports and determine if an illness is actually the manifestation of an underlying medical-mental illness.
- Psychologists are trained to test for deficits in psychological functions and human behavior. They focus on behavioral change through talk therapy, not underlying biological causes and problems.

Requirements for the Practice of Medicine are Increasing

- A crash course in prescribing cannot substitute for the comprehensive knowledge and skills physicians achieve through medical education and rigorous clinical experience.
- Non-physician professionals who do prescribe (e.g., nurse practitioners, physician assistants) have significantly more medical training than what the psychologists propose for themselves. These non-physician providers also generally require strong supervision and have limits on the types of drugs that can be prescribed.
- Lowering standards to prescribe is a dangerous and costly venture. These proposals often place licensure regulation of proposed "medical psychologists" or "prescribing psychologists" under state psychology boards that lack the necessary medical expertise to oversee and ensure safe practice and standards of care.

CONNECTICUT ACADEMY OF
FAMILY PHYSICIANS
CARING FOR CONNECTICUT'S FAMILIES

September 22, 2017

Meghan Bennett
Connecticut Department of Public Health
Practitioner Licensing and Investigation Section
410 Capitol Avenue MS #12APP
Hartford, CT 06134

On behalf of over 450 Family Physicians who are members of the Connecticut Academy of Family Physicians (CAFP) we are submitting comments regarding whether psychologists can or should be granted certain prescriptive authority.

The CAFP opposes the expansion for services because of the impact it would have on providing quality of care to the people of Connecticut. Psychologist do not receive any medical training during their education. A Master's Degree online course on psychopharmacology will not compare with the medical contact hours obtained by Physicians, APRNS and Physician Assistants. Medications affect the whole body and a knowledge of medicine is necessary to prescribe medications correctly.

Adding more prescribers will not improve quality of access to care.

If a scope of practice review committee is created, we request that a representative of the CAFP be allowed to participate.

Very Truly Yours,

Stacy Taylor

Stacy Taylor, MD
Legislative Chair

One Regency Drive • P.O. Box 30 • Bloomfield, CT 06002
Telephone (860) 243-3977 • (800) 600-CAFP in CT only • *FAX* (860) 286-0787 • *Web Page* www.ctafp.org

September 27, 2017

Dear Karen Wilson;

I am a psychiatrist licensed in Connecticut and am writing in opposition to the proposal submitted by the Connecticut Psychological Association for the granting of prescribing authority to psychologists.

Psychologists play a vital role in our health system, but they have neither the education nor the clinical experience to safely prescribe medication. Psychiatric medications have effects throughout the body- they don't just work on the brain. Psychiatric medications can have complex interactions with medications prescribed to treat other medical conditions and have the potential for life-threatening complications particularly if the medical complication is not recognized quickly.

In medical school and in residency we are exposed to different specialties and learn a great amount of medicine in addition to psychiatry. At first pass, one might say "why does a psychiatrist need to study surgery? Or "How does learning how to treat hypertension make you a better psychiatrist?". Due to this very medical training, I have been able to recognize and get help for patients who present with psychiatric symptoms but instead have an unrecognized non-psychiatric medical condition. My medical background has been essential in both properly diagnosing and treating psychiatric illness and safely managing side effects and interactions between medications.

Patients with psychiatric illnesses are entitled to competent and safe care just like patients with any other medical illness. I would not want an aesthetician deciding if my moles are cancerous just because they are used to looking at skin. I would not want a surgical technician performing my surgery, or a dietician prescribing my diabetes medications while they advise me about healthy eating. There are other avenues to address the shortage of psychiatrists that do not put our patient's safety in jeopardy.

1. Increasing psychiatric residency spots would be one great way to increase access to psychiatrists. In 2017, psychiatry had a 99.7% match rate for residency. It is as competitive of a specialty as ER. Psychiatry is a sought-after specialty with 6% of medical school seniors choosing psychiatry as their specialty.
2. Starting loan forgiveness programs for psychiatrists practicing in rural communities may draw more into underserved areas.
3. Collaborative care programs between psychiatrists and primary care can effectively screen and treat populations of psychiatric patients. These patients are then managed by primary care but with psychiatrist backup.
4. Tele psychiatry is becoming more readily available. I have practiced tele psychiatry in Connecticut for the last year. I am able to see patients throughout the state regardless of their proximity to my office. Tele psychiatry eliminates many of the barriers patients have finding providers in certain parts of the state.

Please oppose this bill. Do not put our patient's safety at risk by allowing psychologists to prescribe medication.

Sincerely,

Melissa Welby, MD
Board Certified Psychiatrist
President, Connecticut Psychiatric Association
99 Cherry Street Unit D Milford, CT 06460
1088 Black Rock Turnpike Fairfield, CT 06825

Child, Adolescent,
& Adult Psychiatrist
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Lisa Karabelnik, M.D.

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September 27, 2017

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS #12APP
P.O. Box 340308
Hartford, CT 06124-0308

Via e-mail

Dear Ms. Wilson;

I am writing to you regarding the proposal by the Connecticut Psychological Society to allow "appropriately trained psychologists" to begin prescribing psychotropic medications after 2-3 years of training and earning a Masters of Science. According to the proposal, the Society believes that allowing this to happen would increase access to psychiatric care for those in rural settings. I am writing to correct their fallacies.

I am a physician who has been practicing psychiatry for almost 20 years. I completed a triple board residency program in Pediatrics, Adult Psychiatry and Child and Adolescent Psychiatry. I am boarded in both Adult Psychiatry and Child and Adolescent Psychiatry. Prior to being allowed to write the board exams in my specialties, I completed almost 50,000 hours of training. I took care of adults and children who were medically and psychiatrically ill. I learned about psychiatric illnesses and the physical illnesses that masquerade as psychiatric and are potentially deadly unless they are caught by an astute clinician. I learned about developmental theory, different types of therapy and spend many hours mastering different schools of therapeutic thought. I learned about the medications which are prescribed for

various illnesses including Ulcerative Colitis, hypertension, cancer, Hashimoto's thyroiditis, hypothyroidism, parathyroid syndrome, and diabetes to name a few. I also learned how to differentiate between medical conditions which commonly present with psychiatric symptoms and actual psychiatric disorders. On top of rigorous courses which lasted 6 months to a year in human physiology, pathophysiology, microbiology, pharmacology, and anatomy during medical school, I spent many hours during my residency learning about psychiatric drugs, their method of action and the ways in which they interact with medicines used for physical illnesses. I had first-hand experience watching what happened when different medication cocktails were created out of necessity and dosages had to be adjusted. I wrote one nationally standardized test (USMLE 3) after my first year of internship (10,000 clinical hours of training beyond 4 years of medical school two of which were on the hospital floors) to allow me to begin to prescribe medications independently and prior to that had to pass two nationally standardized tests (USMLE 1 and 2) to allow me to progress past my second year of medical school and then to graduate. All of this training was on top of an undergraduate degree that was full of basic science courses like chemistry, organic chemistry, biology, and biochemistry which prepared me for the basic coursework of medical school.

Psychologists do have 4-6 years of schooling but their coursework is in the social sciences not in the physical/biological sciences. Though they learn about development and about the psychiatric diagnoses as per the Diagnostic and Statistical Manual, they do not learn to differentiate between medical and psychiatric causes of illness. Many psychologists spend most of their time in school focused on how to administer standardized tests in a non-biased and effective manner and how to differentiate diagnoses based on the results of said testing. (Though I see the results of their testing and have a basic ability to interpret the results, I would never presume myself to be competent to administer the test and interpret the raw data as it is simply not part of my training.) Other psychologists spend time mastering multiple schools of therapeutic thought in order to become competent providers of therapy. Even with a 2-3 year course in psychopharmacology, their training would not begin to approach that of those with a DO or an MD. Additionally, their coursework would be narrowly focused and they would be more likely than a well-trained MDs to miss important medical crossover diagnoses. (This is already an issue with many of the APRNs and PAs who also have significantly less training and are already allowed to practice. In case report after case report and in many studies there are patients who have barely survived after a midlevel provider has told them a symptom is "nothing to worry about."

The argument that giving psychologists the right to prescribe would increase the access of people living in rural areas to a certified psychiatric provider as there are not enough psychiatrists to provide said care is a complicated issue. Firstly, there are multiple medical school graduates, tens of thousands a year, who do not match to a residency program as there is not enough government funding put into residencies in family medicine, internal medicine, pediatrics, and psychiatry. This proposal would exacerbate this discrepancy as it would require that psychologists take up additional training time that could and should go to people who have graduated from medical school. Additionally, the reimbursement that insurance companies deem acceptable for psychiatrists is significantly lower than the reimbursement awarded to many other subspecialties such as surgery, radiology, and dermatology. For that matter, the risk of a malpractice lawsuit is as high for psychiatrists as it is for surgeons as we are constantly caring for patients who are suicidal and at risk for harming themselves. Perhaps most importantly, if one looks at where the practices of psychologists are located, most are centered in the same areas as the psychiatrists—around the big medical centers. In fact, many of my patients travel almost as far to see their therapist on a weekly basis as they do to see me on a less frequent basis.

Psychologists are valuable partners for my colleagues and I. We work together as part of a treatment team, each providing the other with valuable pieces of information. There is a reason why we focus on different areas. There are times that psychologists tell their patients to not take medications that I prescribe and suggest that they ask for highly addictive medications such as benzodiazepines or suggest that they take a medication which is contraindicated due to another medication the patient is taking. Giving them the right to cross over and make medical decisions places a very vulnerable, psychiatrically ill population at incredible risk, especially when one looks at the geriatric and pediatric group who are more sensitive to the side effects of medications. Midlevel providers, due to their lack of comprehensive training also tend to over order a significant number of expensive laboratory tests which increase the cost to the patients and insurance companies but do no help with the medical decision-making in a productive way.

Finally, allowing psychologists to prescribe would result in a two-tiered system with those uneducated about the training process ending up with a psychologist or midlevel provider who has inadequate training and those who are educated, insisting on a fully qualified psychiatrist. A perfect recipe for a two-tiered system with the winners being those who are more educated and live at a higher socio-economic level and the losers being those enrolled in assistance programs like Medicaid. If the psychologists want to be considered equivalent to a medical prescriber, then they would have to write the board examination in

Psychiatry and Neurology just like the Psychiatrists (entitling them to treat adults) and a separate examination for certification in Geriatric Psychiatry, Addiction Psychiatry, Child and Adolescent Psychiatry, etc. if they want to practice in any specialized area.

In light of the above, I urge you to protect the vulnerable populations of our state by carefully reviewing the proposal by the psychologists and voting against it. Your positive consideration of my request would be appreciated.

Sincerely,

Lisa Karabelnik

CONNECTICUT HOSPITAL ASSOCIATION

MEMORANDUM

TO: Meghan Bennett, Practitioner Licensing and Investigations Section
Connecticut Department of Public Health

FROM: Karen Buckley, Vice President, Advocacy

DATE: September 28, 2017

SUBJECT: Impact Statement – Scope of Practice Request – Connecticut Psychological Association

The Connecticut Hospital Association (CHA), a trade association representing 27 acute care hospitals in Connecticut, submits this impact statement, in accordance with Chapter 368a of the Connecticut General Statutes, in response to the scope of practice change requested by the Connecticut Psychological Association. The change requested would modify the current scope to permit certain trained psychologists to prescribe psychotropic medications.

The requested modification would change the healthcare delivery system in Connecticut. Patient access to the full spectrum of mental health services is an area of focus for CHA and its members. Connecticut hospitals employ or utilize a significant number of licensed healthcare professionals including physicians, advanced practice registered nurses, physician assistants, and other allied health professionals. The request will impact the delivery of care to hospital patients and may require hospital policies and procedures to be changed.

If the Department appoints a Scope of Practice Review Committee, CHA respectfully requests an appointment to the Committee.

KMB:ljs
By E-mail
cc: Barbara S. Bunk, Ph.D.

Connecticut Psychiatric Society

September 29, 2017

Ms. Karen Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue
Hartford, CT 06134

By email: Karen.Wilson@CT.gov

By email: CC: info@connpsych.org

Dear Ms. Wilson:

The Connecticut Psychological Association seeks to expand its scope of practice authority to include the ability to prescribe medications.

Impact on public health and safety:

If this change in scope is authorized, patients will receive medications from practitioners that have not received any training in medical treatment of patients. The proposed Master's degree cannot substitute for the comprehensive knowledge and skills physicians, including psychiatrists, achieve through pre-med instruction in biology and chemistry, 2,700 hours of classroom training in medical school and another four years of residency during which they work full-time in a clinical setting.

It is not clear whether the ability of psychologists to prescribe is limited to psychotropic medications. It is not stated how "psychotropic" medications would be defined. Many medications that are not used to treat mental illness can have psychotropic effects. Conversely, medicines used to treat mental illness can have profound physical effects on the body, especially if the patient is suffering from underlying physical conditions such as diabetes, heart problems, and asthma. Medical training is required to identify and treat these conditions.

The impact of the request on public access to health care:

Factors limiting access to mental healthcare have nothing to do with the number of "prescribers." Workforce issues in all of the mental health professions are being carefully studied. Lack of reasonable reimbursements and authorizations for care at all levels are serious concerns that will not be helped by this proposal. Further, with the current opioid crisis the idea to bring more prescribers to the health care field does not seem sound.

The CPA cites a survey of psychologists and graduate student that reports their belief that psychologists should have the authority to prescribe psychotropic medications in Connecticut, but they cite no statistics or opinions by professionals or the public that public health or safety will be improved by this proposal. It is implied that more psychologists will make themselves available to increase access to mental health services in currently underserved areas. Today's economics make

this highly unlikely. Between the inability to obtain prior authorizations and poor reimbursement, it is unlikely that psychologist will be any more successful than psychiatrists in covering their practice costs.

All current education, training, and examination requirements and any relevant certification requirements applicable to the profession;

As mentioned above, the current training of psychologists involves no contact with medical patients. The chart on page 8 of their proposal seeks to equate the time spent acquiring a Ph.D. and the "internship" with four years of medical school. As noted above the training of any medical doctor far exceeds the training of psychologists. Although not stated, it is highly unlikely that psychologists will attain the required hours for the degree by sitting in classrooms, so we assume they will take classes online. Supervision for their clinical experience is proposed to be by other psychologists who themselves, of course, have no medical training.

The extent to which the request directly affects existing relationships within the health care delivery system;

Psychologists perform a necessary service to Connecticut's citizens. They practice individually, in collaboration with physicians and on multidisciplinary teams. Prescribing will directly affect all of those practice setting. Although their participation at the hospital level is implied, they do not have the authority to commit patients, nor do they have admitting privileges. Nor should they.

The anticipated economic impact of the request on the health care delivery system:

It can be expected that additional expenses will be incurred. Data from various studies show that when the number of prescribers is increased, the number of prescriptions goes up also. It is most cost effective when the practitioner with the most medical experience evaluates the patient. Otherwise the practitioner who has no medical knowledge will be forced to pass the patient on to a second appointment with a medical doctor if there are pre-existing medical conditions or medical complications occur.

Regional and national trends in licensing of the health profession making the request and a summary of relevant scope of practice provisions enacted in other states:

Two states, New Mexico and Louisiana have allowed prescribing by psychologists since 2002 and 2004 respectively. Four states have enacted the laws in the recent past, but there are no data available yet. If the scope committee is authorized, Connecticut Psychiatric Society is prepared to show the data that it has gathered on the extent of psychologists prescribing as well as the status of recently passed legislation.

The Connecticut Psychiatric Society hereby requests that if a Scope of Practice Committee on this matter is convened, we may appoint two representatives to that Committee.

Thank you.

Jacquelyn T. Coleman, Executive Director

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Email: cps@ssmgt.com Website: www.ctpsych.org

Connecticut State Medical Society
FOUNDED IN 1792

127 Washington Avenue, East Building, 3rd Floor, North Haven, CT 06473
Phone (203) 865-0587 Fax (203) 865-4997 www.csms.org

September 29, 2017

Meghan Bennett
Connecticut Department of Public Health
Practitioner Licensing and Investigations Section
410 Capitol Avenue MS #12APP
Hartford, CT 06134

Dear Ms. Bennett:

On behalf of the membership of the Connecticut State Medical Society (CSMS), please accept this statement, consistent with the requirements of Public Act 11-209, regarding the recent submission for an expansion in scope of practice by the Connecticut Psychological Association (CPS).

CPS has submitted a request which represents a significant alteration to the scope and practice parameters for psychologists by providing prescriptive authority. The request for this change raises significant concern over its potential to impact the amount of controlled substance prescriptions provided to patients. No one should need reminding that we already struggle with an epidemic of addiction to prescription drugs. The CPS scope proposal makes no provision for the experiential training that is essential for the safe and effective prescribing of potentially dangerous pharmacologic agents. Any action that expands the practice of psychology into the realm of prescription must undergo a care review of its appropriateness with regard to both intended and unintended consequences that would impact safety and the effective delivery of health care.

Psychologists are a valuable member of the healthcare team, often partnering with psychiatrists and other medical doctors. They are well trained to deliver the services they provide. However, CSMS is concerned about the significant impact this proposal could have on the healthcare delivery system. Therefore, we fully request that prior to any proposed policy or legislation that a scope of practice review committee be established, and that CSMS be provided representation on the committee.

Sincerely,

Ken Ferrucci
Senior Vice President of Government Affairs

cc: Barbara S. Bunk, Ph.D.
Co-Chair, CPA Task Force on Prescriptive Authority

October 1,2017

Meghan Bennett
Connecticut Department of Public Health
Practitioner Licensing and Investigations Section
410 Capitol Avenue MS #12APP
Hartford, CT 06134

Meghan.bennett@ct.gov

Dear Ms. Wilson:

On behalf of the Connecticut Nurses' Association we are submitting an impact statement regarding the scope of practice request submitted by the Connecticut Psychological Association. We have concerns and questions, based on their request.

The Connecticut Psychological Association (CPA) is looking to expand their scope of practice to allow psychologists who are "appropriately trained" to prescribe psychotropic medications. As nurses represent the largest profession in the health care team they will be impacted by a change in scope of practice and relationship to orders and patient care. Additionally, in their request, they seek to be granted prescriptive authority around medically assisted therapy (MAT). We need to understand the relationship between the proposed education, their client population and the formulary for prescribing.

Nurses have an ethical obligation to share their professional experience and expertise to inform decision making as they are on the front lines of health care and act as a bridge between consumers and health care providers, thus understanding needs, barriers, challenges and successes to consider in decision making. Further exploration of the formulary, the psychopharmacology training and appropriate restrictions in prescribing. In addition, careful consideration for ongoing education requirements and the CARA law will need to be explored.

The Connecticut practice of psychologists has not included medicine thus the proposed expansion is a large step forward, and it is not clear if the proposed required training truly meets the need while their Master's training is insufficient to support safe prescription and management in complex patients.

The Connecticut Nurses' Association is acutely aware of the mental health and opioid crisis in our states and is deeply concerned about patient access to mental health services. But it is imperative that we ensure patients have access to providers who can safely meet their needs.

Our nurses who are trained as APRNs all over CT, approximately 1400 of us, provide psychotherapy and/or medication management in a variety of mental health settings and work with members of the health care team to coordinate and facilitate timely and safe care.

The Connecticut Nurses' Association welcomes a seat at the table if this scope of practice request is selected to move forward.

Respectfully Submitted,

Kimberly Sandor
Executive Director
Connecticut Nurses' Association

Mary Jane Williams
Chair of the Government Relations Committee
Connecticut Nurses' Association

Karen G. Wilson, HPA
Practitioner Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, MS#12APP
P.O. Box 340308
Hartford, CT 06134
Phone: (860)509-7590
Fax: (860)707-1983
e-mail: Karen.Wilson@ct.gov

October 1, 2017

Dear Ms Wilson:

As Chair of The Psychiatric Nurse Practitioner Subcommittee, a specialty section of the CT APRN Society, I am submitting an impact statement on behalf of Psychiatric Advanced Practice Registered Nurses (APRNs) in Connecticut regarding the scope of practice request submitted by the Connecticut Psychological Association. We have concerns and questions, based on their request.

1. A plain language description of the request:

The Connecticut Psychological Association (CPA) is looking to expand their scope of practice to allow psychologists who are "appropriately trained" to prescribe psychotropic medications. Additionally, in their request, they seek to be granted prescriptive authority around medically assisted therapy (MAT). They are calling these folks "medically trained psychologists" and propose the following changes to their training and scope:

a. Currently doctoral level psychologists would obtain a Master of Science degree in psychopharmacology (2-3 year training).
b. Psychologists in Connecticut would then seek clinical supervision from physicians or APRNs.
c. There is mention of: "a formulary is also proposed", but this is not specific.
d. They report that the American Psychological Association (APA) has an established curriculum for *Prescribing Psychologists* and a national board certification exam.
e. Psychologists have asked to prescribe Schedule 1-5 controlled substances.
f. Psychologists have asked to prescribe: "orders for drugs, labs, imaging tests, devices, treatments, and controlled substances".

g. The "prescriptive authority" they seek has no restrictions – there is no period of supervision and no clarity around a formulary.
h. The ongoing certification process is vague. Psychologists currently need only 10 CEUs per registration period and they are proposing 40 per year for the "medical psychologist".
i. They discuss, upon findings of "alterations in health status", that they will "collaborate with a licensed physician". This is vague and non-directive, and excludes the APRNs and PAs that manage patients daily as PCPs.
j. Psychologists believe they will be eligible by SAMHSA to apply for a waiver to prescribe buprenorphine. That is not language readily apparent in the CARA law.

The current scope of practice of psychologists here in Connecticut is defined in CGS Chapter 383. Sec. 20-194: "Right to practice medicine not granted" clearly addresses, that while the psychologists' training is widely encompassing of the assessment, diagnoses, and treatment of mental health and substance use disorders with other modalities, medicine is not within their bounds. They are currently seeking a rather large expansion of practice with a relatively small amount of education and training.

The Psychiatric APRNs in Connecticut are concerned about patient safety, most urgently. We agree that there is a paucity of specialty providers trained to manage psychiatric illness and addictions here in Connecticut.

The SOP request quotes dropping numbers of psychiatrists available for future care. I am happy to report that admissions to APRN programs continue to increase exponentially every year and our colleagues in medicine are problem solving daily on how to alter the course of medical school (cost; length) to attract more attendees. Having practiced psychopharmacology for the last 17 years here in Connecticut, I am reassured that the statistics my colleagues site around access are fed by more robust variables in a complicated health care system currently in even more flux. This multifaceted systemic problem will not be fixed by simply adding more prescribers, certainly those who will not be well trained.

Having reviewed the curriculum offered by the psychologists that outlines their Masters training, we are even more convicted that this didactic is insufficient to produce medication managers capable of providing safe and comprehensive care to this ever tri-morbid population.

The CPA discuss the common use of "office visits with psychiatrists lasting less than 10 minutes". There have been many changes in the rigors of psychiatric practice over the last several years (DSM V, E&M coding, ICD-10) that have ensured this an almost impossible way to practice any longer. Some practitioners do still do the "medication management visit", but we are all held to the federally regulated billing and coding standards that the rest of the practices of medicine function within, so this has not been the standard of care of any medicating practitioner since 2013.

Psychiatric APRNs all over CT, approximately 1400 of us, provide psychotherapy and/or medication management in a variety of mental health settings. We provide medical back up for our colleagues in psychology readily.

The psychologists have quoted millions of dollars saved in their huge expansion of practice. Our concerns mount as we review an insufficient curriculum, coupled with requests for an exceedingly unrestricted and independent/unsupervised practice post-Master's training that lead us back to consider the safety of Connecticut's most vulnerable population.

The Psychiatric Nurse Practitioners welcomes a seat at this table if this scope of practice is selected for review.

Respectfully Submitted,

Danielle Morgan, MSN, CNS, Family PMHNP, APRN-BC

I am a board certified psychiatrist and I have been doing private practice of psychiatry in Connecticut for many years. I did my residency in psychiatry at Johns Hopkins where I also graduated with the degree of Doctor of Science in Mental Health. I am a former President of the Connecticut Psychiatric Society and Clinical Professor of Psychiatry at Yale University School of Medicine. This statement reflects my personal opinions and not the opinions of the Connecticut Psychiatric Society, Yale University or any of the associations or academic institutions to which I belong.

Psychologists are our indispensable partners in the diagnosis and treatment of mental disorders. For several years I was the leader of multidisciplinary teams that included psychiatrists, psychologists, nurses, and social workers. We worked as a team to provide the best possible care to our patients, many of whom came with complex medical and psychosocial problems. I have valued and appreciated the unique expertise of psychologists in psychological testing, development of behavioral interventions, psychotherapy, outcome assessment, and staff education.

I am, however, concerned about the attempt of psychologists to prescribe medications. The following are my concerns:

1. Patients do not come in nice, clean folders marked as "easy" (to be treated by psychologists) or "complicated" (to be treated by psychiatrists). They come with combinations and permutations of physical illnesses, mental disorders, deviant behaviors, personality disturbances, intellectual deficits, and disruptions in their life stories. They often present themselves to us with non-psychiatric medical illnesses, at times obscure or not easily recognized, as well as symptoms and behaviors that could be, for example, manifestations of non-psychiatric diseases, psychiatric side-effects of non-psychiatric medications, non-psychiatric side-effects of psychiatric medications, peculiar interactions among medications, or simply culturally sanctioned or prohibited behaviors. To be able to rapidly sort out the different possibilities (what in medicine we call "differentials"), training in psychopharmacology, even at the level of a Master's degree, is not sufficient. Truly, 400 hours of training in psychopharmacology may be OK to do research in that field but they are not OK to treat patients and certainly no substitute for the 20,000 hours of training that psychiatrists receive during their medical school, residency, and fellowship training.

2. According to the website of the American Psychological Association, most antidepressants and other psychiatric medications are prescribed by primary care physicians. **Primary care physicians are far better qualified to prescribe those medications than psychologists, even with the additional training proposed by the Connecticut Psychological Association. If psychologists are allowed to prescribe, primary care physicians will transfer the medication management of mental disorders to psychologists, and as a result, the standard for the care of psychiatric patients will be significantly reduced.**

3. **The assumption that psychologists will establish practices in rural areas has never been proven. Even if true, prescribing authority to psychologists will have an adverse and discriminatory impact on populations from rural areas, particularly those from low income groups and minorities.** Just because they are poor and minority members, they should not be relegated to hurriedly prepared "prescribers".

No other specialty in medicine has non-medically trained people prescribe medications. Imagine this: would the legislators approve prescription of medications by a pharmacist with a Ph.D.in Psychology or a PsyD and no other training? Certainly a pharmacist would know a lot more about medications than a person with 400 hours of training leading to a Master's degree in psychopharmacology.

So what is the answer to the problem of access to psychiatric services? Certainly we, psychiatrists, cannot multiply ourselves like the psychologists did when they lowered the standards of their profession by establishing a PsyD degree in addition to the highly respected Ph.D. in Clinical Psychology. **The answer, seems to me, is to rapidly promote, facilitate, and stimulate telepsychiatry and establish a reimbursement system that will encourage team work, allow patients to receive psychotherapy and medication management on the same day, and reward the practice of psychotherapy.**

Sincerely,
John M. de Figueiredo

John M. de Figueiredo, MD, ScD, DLFAPA
Clinical Professor of Psychiatry
Yale University School of Medicine
Past President
Connecticut Psychiatric Society

American Academy of Pediatrics
Hezekiah Beardsley Connecticut Chapter

HEZEKIAH BEARDSLEY CONNECTICUT CHAPTER

101 OAK STREET • HARTFORD, CT 06106 • TEL. (860) 525-9738 • FAX (860) 727-9863

October 2, 2017

TO: Karen Wilson and Meghan Bennett
Practitioner Licensing and Investigation Section

FROM: Jillian Wood, Executive Director
Anton Alerte, MD, President

Re: Impact of Increasing the Scope of Practice of Psychologists

The Connecticut Chapter of the American Academy of Pediatrics is the professional society represents nearly 1000 primary care and specialty pediatricians in the state of Connecticut. We are concerned with the potential change of scope of practice for psychologists, including allowing them to prescribe medications. We feel that allowing psychologists to prescribe medications including psychotropic medications will be detrimental to the children whom we care for, and to we physicians, who work to manage, understand and treat children and adolescents who may be experiencing very difficult mental and physical illnesses.

A key point in this discussion is the vast education and training that physicians must undergo. Generally, a pediatrician undergoes between 12,000-14,000 hours of patient care during training (attached AAP State Advocacy Infographic–Pediatric Education and Training). Included in this training is coursework in biochemistry, physiology, pharmacology, neurobiology, and neuroscience.

There is a significant difference between a psychologist and a medical doctor. Each profession is an expert in their own field, but it is clear when understanding the level of training that physicians have much more instruction in pharmacology and the human body than psychologists have.

With respect to psychologist education, the AMA Scope of Practice Data Series–Psychologists [1], notes that "Doctoral program curriculum Requirements vary greatly by program. As mentioned above, there are no standard curriculum requirements for doctoral psychology program accreditation. A survey of the top four Ph.D. psychology programs as ranked by U.S. News & World Report, showed that none of these doctoral programs require coursework in the biological sciences or pharmacy sciences, except for the "breadth requirement" or core-course components that require students to take a course or two on the biological aspects of behavior. Most of the programs do offer students a neurobiology/neuropharmacology course, but the course is not a required one."

The American Academy of Pediatrics (AAP) believes that optimal pediatric care is best rendered by using a team-based approach led by a pediatrician. As the clinician most extensively educated in pediatric health care, the pediatrician has the depth and breadth of knowledge, skills, and

[1] AMA Scope of Practice Data Series–Psychologists, 17

experience to assume this role and should be held to the highest standards. Collaboration with family physicians or child psychiatrists is an important component of pediatric health care delivery, as are partnerships with non-physician clinicians in an effort to provide safe and effective quality health care for all infants, children, adolescents, and young adults. The AAP recognizes the importance of team-based education and training. Furthermore, the AAP maintains that to ensure safe and effective care, all members of the health care team must be required to demonstrate adequate education, training, skills, and competencies in pediatric health within their scope of practice, and all members of the health care team must provide care that is consistent with their education, training, and licensure. Patient safety and public protection must be the primary benchmarks in making any decision on changes involving the scope of practice of those who care for children.

In *Pediatrics June 2013,* Scope of Practice Issues in the Delivery of Pediatric Health Care the Committee on Pediatric Workforce agreed with Connecticut that the scope of practice legislation falls under the jurisdiction of individual states. State legislatures are therefore the loci of deliberations on these issues. The competing political agendas and perspectives expressed during these deliberations often generate highly charged debates. To bring a uniformity of approach and an essential level of civility to this discourse, the AAP endorses the 2005 recommendations of the Federation of State Medical Boards regarding the approach to scope of practice legislation. A portion of the Federation of State Medical Boards statement follows: "Changing or creating a new scope of practice for a health profession necessitates establishment of a legitimate need for the change, along with a systematic review of the impact of the proposed change on public health, safety, and welfare. Patient safety and public protection must be the primary objectives in making decisions on scope of practice. It is important for boards and legislatures to recognize that there are often significant differences in the prerequisites, the scope, and the duration of education provided to other health care practitioners when compared with that provided to physicians. Policy makers must ensure that all practitioners are prepared, by virtue of education and training, to provide the services authorized in their scope of practice in a safe, effective, and economical manner."

We appreciate the Department of Public Health recognizing that this issue is difficult and that it must be looked at with the view that safety is of utmost importance.

The CT Chapter of the American Academy of Pediatrics requests two seats on the Scope of Practice Committee, should one be formed.

AMA Scope of Practice Data Series

demographics

education and training

licensure and regulation

professional organization

current literature

A resource compendium for state medical associations and national medical specialty societies

Psychologists

American Medical Association
May 2008

AMA AMERICAN MEDICAL ASSOCIATION

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Appendix 31

Figures

Acknowledgments

Many people have contributed to the compilation of the information contained within this module. The American Medical Association gratefully acknowledges the contributions of the American Psychiatric Association, the Tennessee Medical Association, and the South Dakota State Medical Association for their significant input into this module.

I. Overview

The American Medical Association's (AMA) Advocacy Resource Center (ARC) has created this information module on psychologists to serve as a resource for state medical associations, national medical specialty societies, and policymakers. This guide is one of ten separate modules, collectively comprising the Scope of Practice Data Series, each covering a specific nonphysician health care profession.

Without a doubt, limited licensure health care providers play an integral role in the delivery of health care in this country. Efficient delivery of care, by all accounts, requires a team-based approach, which cannot exist without inter-professional collaboration between physicians, nurses, and other limited licensure health care providers. With the appropriate education, training, and licensing, these providers can and do provide safe and essential health care to patients. The health and safety of patients are threatened, however, when limited licensure providers are permitted to perform services that are not commensurate with their education or training.

Each year, in nearly every state and at times on the federal level, limited licensure health care providers lobby state legislatures, their own state regulatory boards, or federal regulators for expansions of their scope(s) of practice. While some scope expansions may be appropriate, others definitely are not. It is important, therefore, to be able to explain to legislators and regulators limitations in the education and/or training of limited licensure health care providers that may result in the substandard or harmful care of patients. Those limitations are brought clearly into focus when compared with the comprehensiveness and depth of the medical education and training of physicians.

Issues of access to qualified physicians in rural or underserved areas provide limited licensure providers with what, at first glance, seems to be a legitimate rationale for lobbying for expanded scope of practice. However, solutions to actual or perceived workforce shortages simply cannot justify practice expansions that expose patients to unnecessary health risks.

In November 2005, the AMA House of Delegates approved Resolution 814, which called for the study of the qualifications, education, academic requirements, licensure, certification, independent governance, ethical standards, disciplinary processes, and peer review of limited licensure health care providers. By surveying the type and frequency of bills introduced in state legislatures, and in consultation with state medical associations and national medical specialty societies, the AMA identified ten distinct limited licensure professions that are currently seeking scope of practice expansions that may be potentially harmful to the public.

Each module in this Scope of Practice Data Series is intended to assist in educating policymakers and others on the qualifications of a particular limited licensure health care profession, as well as the qualifications physicians possess that prepare them to accept the responsibility for full, unrestricted licensure to practice medicine in all its branches. It is within the framework of education and training that health care professionals are best prepared to deliver safe, quality care under legislatively authorized state scopes of practice.

It is the AMA's intention that the information contained within these Scope of Practice Data Series modules provide background information for state and federal-based advocacy campaigns where the health and safety of patients may be threatened as a result of unwarranted scope of practice expansions sought by limited licensure providers.

Michael D. Maves, MD, MBA
Executive Vice President, Chief Executive Officer
American Medical Association

Disclaimer: This module is intended for informational purposes only, may not be used in credentialing decisions of individual practitioners, and does not constitute a limitation or expansion of the lawful scope of practice applicable to practitioners in any state. The only content that the AMA endorses within this module is its policies. All information gathered from outside sources does not reflect the official policy of the AMA.

II. Introduction

The American Medical Association (AMA) is pleased to offer this informative module on psychologists with the intention that it assist in countering the claims made by psychologists in their advocacy efforts to obtain prescription privileges in the states. The information contained within all ten Scope of Practice Data Series modules will complement existing state medical association and national medical specialty society resources on scope of practice expansions by nonphysician practitioners.

This module examines the education, training, and other qualifications psychologists possess, as well as licensure requirements and current scope of practice privileges in all the 50 states. Additional resources, such as regulatory board operating procedures, national medical association policies, and a bibliography of medical journal, psychological, and other articles, will equip states with information needed to refute psychologists' arguments in favor of granting them the right to prescribe psychotropic medications.

It is critical to note here that the professional organization of the psychologists, the American Psychological Association (ApA), is the driving force behind the push to obtain prescribing authority for doctoral-level psychologists. There has been significant disagreement, however, within the ApA membership not only on whether psychology as a profession should embrace the pursuit of prescription privileges, but also on whether current post-doctoral psychopharmacology program curricula adequately equip psychologists for the weighty responsibilities attendant to prescribing psychotropic medicines. Please note that there are many types of practicing psychologists, and this module focuses mostly upon the qualifications of clinical psychologists, and, to a lesser extent, counseling and school psychologists. These three types of psychologists are most likely to pursue prescribing authority.

The ApA instituted its "Pursuit of Prescription Privileges for Psychologists" ("RxP") in the mid-to-late 1980s. The RxP movement began with an ApA Board of Professional Affairs endorsement of immediate study on the feasibility of RxP and appropriate corresponding curricula in psychopharmacology. In 1988, Congressional conferees directed the U.S. Department of Defense (DoD) to establish a pilot project to train psychologists in issuing psychotropic medications "under certain circumstances."

The DoD Psychopharmacology Demonstration Project (PDP) has become a rallying point for psychologists hoping to secure prescribing authority. The PDP is consistently hailed by psychologists as a "victory"—proof that psychologists can indeed be trained to safely prescribe psychotropic drugs to patients. However, ApA psychologists and their proponents fail to mention the significant limitations of this study and wholly disregard the lack of generalizability of the PDP results to a wide age-spectrum, civilian patient population.

Briefly, enrollees of the DoD's PDP were the most highly scrutinized prescribers in history. Not only were the participants carefully screened and selected, but the didactic and clinical psychopharmacology training they received far exceeds the curriculum of any post-graduate psychopharmacology training course in existence today. In addition to one full year of didactic classroom lectures, PDP participants spent a second year training full time under the direct supervision of military psychiatrists, evaluating and treating military patients and family members for possible psychopharmacological intervention.

Current ApA-approved post-doctoral psychopharmacology training programs require a minimum of only 300 contact hours of didactic instruction, which may occur in nontraditional methods such as correspondence course or video lecture. ApA-approved courses must similarly offer a clinical practicum with 100 patients seen for psychopharmacology evaluation; no requirement of physician supervision for the enrollees is required. In fact, the ApA only requires that supervision "should be provided by qualified practitioners with demonstrated skills and experience in clinical psychopharmacology." *(www.apa.org/ed/rx_pmodcurri.pdf)*

These current ApA standards were adopted in 1996 despite the more substantial recommendations of an ApA-sponsored and funded 1995 Blue Ribbon Panel comprised of members of the California Psychological Association and the California School of Professional Psychology–Los Angeles. Though less rigorous than the PDP curriculum, the Blue Ribbon Panel nonetheless called for 395-570 didactic hours in biomedical lecture curriculum, as well as an 18-month clinical practicum.

Despite successive decreased standards for psychopharmacology training programs, and despite vocal internal

disharmony among ApA members over the capability of psychologists to provide safe care to patients with such minimal psychopharmacology training, ApA leadership has, at various times, implied that prescribing psychotropic medications is "no big deal":

> "To proclaim that one needs to go to medical school and take all of their courses to perform this clinical function (to prescribe medications) is to be absurd, to put it mildly."
> —Patrick DeLeon, PhD, MPH, JD
> Past President, ApA (May 1, 1989)

> "The key seems to be hand-on experience. You sit down with a physician and you say what you would do; and the physician tells you whether that's good or bad. Very quickly you learn to model what the physician would have done."
> —Patrick DeLeon, PhD, MPH, JD
> Past President, ApA (May 1, 1989)

> "…85% of all prescriptions for psychotropic medications are written by nonpsychiatric physicians who got 4 to 6 weeks of training. I'm sure we could do a better job."
> —Robert Resnick, PhD
> Past President, ApA (October 1992)

> "It's always going to be a public-health argument; that we should not have prescription privileges because we did not go to medical school. But prescription privileges is no big deal. It's like learning how to use a desk-top computer."
> —Patrick DeLeon, PhD, MPH, JD
> Past President, ApA (September 7, 1993)

Worthy of note in this initiative to secure prescription privileges is the adamant opposition, as a profession, to modifying the current doctoral psychology curriculum to include substantial biomedical coursework. The major reason for this is that psychologists do not want to depart from their primary identity as psychosocial service providers; even for those who are eager to obtain prescribing authority, the goal is to retain a psychotherapeutic focus in treatment. This reluctance to include a "biomedical" focus in either the doctoral education of psychologists or in the treatment of their patients does not deter the ApA from pushing forward with its advocacy agenda of 50-state recognition of prescribing privileges for psychologists. The hesitance to modify current doctoral level curriculum to include biomedical-centric coursework at the possible expense of psychosocial and behavioral courses conveniently allows the ApA to endorse post-doctoral psychopharmacology training programs of a mere 350 contact lecture hours as the preferred method for psychologists to acquire the knowledge the ApA considers necessary to prescribe.

In fact, established educational programs which include medical curriculum and training (such as Nurse Practitioner or Physician Assistant programs), and are potential avenues for psychologists to obtain an appropriate medical knowledge base, are not considered by the ApA to be feasible routes for psychologists to pursue. The rationale behind this thinking is that the ApA wants psychologists to obtain their psychopharmacology education part-time in order to prevent the interruption of practice necessary to attend a full-time training program.

Department directors of graduate academic psychology programs have consistently and forcefully indicated their unwillingness to modify their behavioral, statistical, and testing/methodology doctoral program curriculum to include biomedical coursework. There is near universal agreement within the profession to maintain a psychosocial focus in graduate psychology education. Recent evidence published in psychology journals indicates that while an overall majority of ApA members approve of the pursuit of prescribing privileges for psychologists, there are widespread differences of opinion regarding the current psychopharmacology training models: their curriculum, contact hours, qualifications for admission, and post-graduate status (some psychologists believe prescribing should be a "track" or course of study pursued during doctoral school with formal courses in the biological and medical sciences).

The National Alliance for the Mentally Ill (NAMI), a consumer group advocating for mental health parity, does not support psychologist prescribing, stating on their Web site:

"The only research conducted on psychologists' prescribing privileges, the PDP was conducted under circumstances very different from those experienced by mental health practitioners in the public sector. DoD psychologists practice under controlled circumstances, with specific formularies and close collegial relationships with psychiatrists. Moreover, with some exceptions,

they tend to treat patients with less serious mental illnesses. By contrast, psychologists in the public sector would more likely treat patients with more serious mental illnesses and other medical conditions. They would also have less access to consultation and supervision by psychiatrist colleagues, due to severe workforce shortages in the public sector." *(www.nami.org)*

We hope that the information contained in this module, along with the bibliography and other resources will provide the tools necessary to combat psychologists' overreaching claims of proficiency in prescribing. The AMA has adopted formal policy opposing prescribing authority for psychologists. The American Psychiatric Association (APA) stands ready to assist states in their defense of the practice of medicine, and welcomes queries for information and assistance on this initiative. By focusing the resources of organized medicine, we can protect patient safety and preserve the highest quality care for patients. Together we are indeed truly stronger.

Advocacy Resource Center
American Medical Association

AMA Scope of Practice Data Series Module Distribution Policy

The modules are advocacy tools used to educate legislators, regulatory bodies and other governmental decision-makers on the education and training of physician and nonphysician health care providers. As such, the AMA will distribute the modules to the following parties:

(1) State Medical Associations
(2) State Medical Boards
(3) National Medical Specialty Societies
(4) National Medical Organizations

In line with the express purpose of the modules being governmentally-directed advocacy, it will not be the policy of the AMA to provide the modules to individual physicians.

Organizations supplied with the module shall mirror the intent, purpose and standards of the AMA distribution guidelines.

III. Psychology as a profession

Definition(s)

According to Stedman's medical dictionary, a psychologist is a "specialist in psychology licensed to practice professional psychology (a clinical psychologist), or qualified to teach psychology as a scholarly discipline, or whose scientific specialty is a subfield of psychology."[1] Psychologists study the human mind and behavior. Clinical psychologists—who constitute the largest specialty—most often work in counseling centers, independent or group practices, hospitals, or clinics. They help mentally and emotionally disturbed individuals adjust to life and may assist medical and surgical patients in dealing with illnesses or injuries. Clinical psychologists often interview patients and give diagnostic tests.[2]

The American Psychological Association (ApA) definition states: "Psychologists have a doctoral degree in psychology from an organized, sequential program in a regionally accredited university or professional school."[3]

The American Psychiatric Association (APA) defines a psychologist as someone who "applies psychological principles to the treatment of mental, emotional, and behavioral disorders and developmental disabilities through a broad range of psychotherapies. A psychologist is commonly trained in advanced psychology, abnormal psychology, statistics, testing theory, psychological testing, psychological theory, research methods, psychotherapeutic techniques, and psychosocial evaluation."[4]

Specialization

The ApA recognizes several subfields within their profession (see below). Although psychologists may "specialize" in a subfield through their education and/or practice, **there are no state or national requirements for specialty board certification.**[5] The ApA recognized subfields are:

- **Clinical psychologists:** assess and treat mental, emotional, and behavioral disorders. These range from short-term crises, such as difficulties resulting from adolescent rebellion, to more severe, chronic conditions such as schizophrenia.
- **Cognitive and perceptual psychologists:** study human perception, thinking, and memory.
- **Counseling psychologists:** help people recognize their strengths and resources to cope with their problems. Counseling psychologists are responsible for psychotherapy/counseling, teaching, and scientific research with individuals of all ages, families, and organizations (e.g., schools, hospitals, and businesses).
- **Developmental psychologists:** study the psychological development of the human being that takes place throughout life.
- **Educational psychologists:** concentrate on how effective teaching and learning take place.
- **Engineering psychologists:** conduct research on how people work best with machines.
- **Evolutionary psychologists:** study how evolutionary principles such as mutation, adaptation, and selective fitness influence human thought, feeling, and behavior.
- **Experimental psychologists:** are interested in a wide range of psychological phenomena, including cognitive processes, comparative psychology (cross-species comparisons), learning and conditioning, and psychophysics.
- **Forensic psychologists:** apply psychological principles to legal issues.
- **Health psychologists:** specialize in how biological, psychological, and social factors affect health and illness.

1. Web. Stedman's Medical Dictionary. Retrieved June 11, 2006. Search term "psychologist." *www.stedmans.com*
2. Web. Bureau of Labor Statistics (BLS), U.S. Department of Labor. "Occupational Outlook Handbook 2006-2007 Edition" Retrieved June 9 & 28, 2006. Search term "psychologist." *www.bls.gov/oco/ocos056.htm*
3. Web. American Psychological Association. Retrieved June 9, 11, 27 & 28, 2006. *www.apa.org*
4. Web. American Psychiatric Association. Retrieved August 26, 2006. *www.healthyminds.org/differences.cfm*
5. Web. American Psychological Association. Retrieved June 9, 11, 27 & 28, 2006. *www.apa.org*

- **Industrial/organizational psychologists:** apply psychological principles and research methods to the work place in the interest of improving productivity and the quality of work life.
- **Neuropsychologists/behavioral neuropsychologists:** explore the relationship between brain systems and behavior.
- **Quantitative and measurement psychologists:** focus on methods and techniques for designing experiments and analyzing psychological data.
- **Rehabilitation psychologists:** work with stroke and accident victims, people with mental retardation, and those with developmental disabilities caused by such conditions as cerebral palsy, epilepsy, and autism.
- **School psychologists:** work directly with public and private schools.
- **Social psychologists:** study how a person's mental life and behavior are shaped by interactions with other people.
- **Sports psychologists:** help athletes refine their focus on competition goals, become more motivated, and learn to deal with the anxiety and fear of failure that often accompany competition.

General duties and responsibilities

Psychologists' jobs and duties vary greatly. Psychologists can be employed by hospitals, nursing homes, and other health care facilities, as well as in schools, universities, corporate industry, or in private practice.[6]

Historically, clinical psychologists have practiced psychotherapy or "talk therapy," which is a general term for a way of treating mental and emotional disorders by having the patient talk about his or her condition and its related issues with a mental health professional.[7] The goals of psychotherapy are for the patient to learn about the cause(s) of his or her conditions in order to better understand them. The individual will also learn to identify and make changes in troubling behavior or thoughts, explore relationships and experiences, find better ways to emotionally cope and solve problems, and set realistic goals for his or her life.[8] Talk therapy is still practiced by many psychologists, and is recognized as an important part of treatment for depression and bipolar disorder by the Depression and Bipolar Support Alliance.[9]

Clinical psychologists may also assist medical and surgical patients in dealing with illnesses or injuries. Some clinical psychologists work in physical rehabilitation settings, treating patients with spinal cord injuries, chronic pain or illness, stroke, arthritis, or neurological conditions. Others help people deal with times of personal emotional crisis, such as divorce or the death of a loved one. They may provide individual, family, or group psychotherapy and may design and implement behavior modification programs. Some clinical psychologists collaborate with physicians and other specialists to develop and implement treatment and intervention programs for patients. Other clinical psychologists work in universities and medical schools, where they train graduate students in the delivery of mental health and behavioral medicine services. Some administer community mental health programs.[10]

6. Web. Bureau of Labor Statistics (BLS), U.S. Department of Labor. "Occupational Outlook Handbook 2006-2007 Edition" Retrieved June 9, 2006. Search term "psychologist." *www.bls.gov/oco/ocos056.htm*
7. Web. Mayo Clinic. "Psychotherapy: Improve Your Mental Health Through Talk Therapy." Retrieved August 27, 2006. *www.mayoclinic.com/health/psychotherapy/MH00009*
8. *Id.*
9. Web. Depression & Bipolar Support Alliance. Retrieved August 28, 2006. *www.dbsalliance.org/info/Psychotherapy.html*
10. Web. Bureau of Labor Statistics (BLS), U.S. Department of Labor. "Occupational Outlook Handbook 2006-2007 Edition" Retrieved August 28, 2006. Search term "psychologist." *www.bls.gov/oco/ocos056.htm*

Brief history of the profession

Psychology is generally believed to have originated with the Greek philosophers Plato, Socrates, and Aristotle between 427-322 B.C. However, psychology as an academic discipline did not evolve until 1879 when Wilhelm Wundt opened the first formal psychological laboratory at the University of Leipzig in Germany. The first American laboratory was founded at Johns Hopkins University in 1883. Since that time, schools in the United States have rapidly developed psychology programs.[11]

Clinical psychology, in particular, grew rapidly in the 1950s due to the demands from World War II veterans. With this, psychology became a profession as well as a science.[12]

Demographics

Number of psychologists in workforce

According to the U.S. Bureau of Labor Statistics, psychologists held approximately 179,000 jobs in 2004.[13] (See **Figure 1**, "State licensure requirements for psychologists," for details.)

Employment types/locales

Clinical psychologists, in particular, work in a variety of settings including individual private practice, mental health service units, managed health care organizations, hospitals, schools, universities, industries, legal systems, medical systems, counseling centers, governmental agencies, and military services.[14]

In a 2001 ApA survey, a majority of self-professed "clinical psychologists" were employed in independent practices (65%), comprising 46% in individual private practices and 19% in group private practices. Approximately 14% and 5% of these licensed, doctoral-level respondents reported that they worked in hospitals and clinics (e.g., Community Mental Health Centers, HMOs, outpatient clinics), respectively. Three percent of the respondents reported elementary/secondary schools, while 2% or less of the remaining respondents claimed other settings such as university student counseling centers, criminal justice systems, rehabilitation facilities, or other human service settings.[15]

Salary data

Median annual earnings of wage and salary clinical counseling, and school psychologists in May 2004 were $54,950. The middle 50% earned between $41,850 and $71,880. The lowest 10% earned less than $32,280, and the highest 10% earned more than $92,250.[16] The 2001 ApA salary survey also found that the overall 12-month median salary for licensed doctoral-level clinical psychologists was $72,000 in 2001.[17]

The U.S. Bureau of Labor Statistics forecasts that employment of psychologists will grow faster than the average for all occupations through 2014.[18]

11. Web. Psycholpedia. Retrieved June 11, 2006. Search term "psychology timeline." *http://library.thinkquest.org/C005870/history/index.php?id=timeline*
12. "Non-Physician Clinician: Monograph Series." Published by the American Osteopathic Association Division of State Government Affairs. September, 2005. Pg.37
13. Web. Bureau of Labor Statistics (BLS), U.S. Department of Labor. "Occupational Outlook Handbook 2006-2007 Edition" Retrieved June 9 & 28, 2006. Search term "psychologist." *www.bls.gov/oco/ocos056.htm*
14. Web. American Psychological Association. Retrieved June 9, 11, 27 & 28, 2006. *www.apa.org*
15. Web. American Psychological Association. "Report of the 2001 Salary Survey" Retrieved June 29, 2006. *http://research.apa.org/01salary/index.html*
16. Web. Bureau of Labor Statistics (BLS), U.S. Department of Labor. "Occupational Outlook Handbook 2006-2007 Edition" Retrieved June 9, 2006. Search term "psychologist." *www.bls.gov/oco/ocos056.htm*
17. Web. American Psychological Association. "Report of the 2001 Salary Survey" Retrieved June 29, 2006. *http://research.apa.org/01salary/index.html*
18. *Id.*

IV. Billing for services

Medicare

Clinical psychologists: Medicare reimburses qualified "clinical psychologists" for both therapeutic and diagnostic services in both inpatient and outpatient settings. Qualified "clinical psychologists" are required by law to "accept assignment." In other words, "clinical psychologists" who are Medicare providers must accept Medicare's "approved" reimbursement rate as payment in full for the services they provide to Medicare beneficiaries. This does not mean, however, that a "clinical psychologist" must treat every individual that comes to the office. "Clinical psychologists" can choose to refer a person to another "clinical psychologist" if they are unable to treat the patient.[19]

Independently-practicing psychologists: Medicare will cover only diagnostic services provided by "independently-practicing psychologists." Therapeutic services provided by "independently-practicing psychologists" are not covered by Medicare, nor are independently-practicing psychologists required to accept assignment. When providing diagnostic services, however, non-participating 'independently-practicing psychologists' who do not choose to accept assignment are subjected to a limiting charge.[20]

Psychologists can not choose to be an "independently-practicing psychologist" for some situations and a "clinical psychologist" on other occasions. Each provider receives only one specialty designation.[21]

Outpatient mental health treatment limitation: By law, Medicare must reduce its payment for outpatient mental health therapy services to 62.5% of the 80% that Medicare customarily pays. This is known as the outpatient mental health treatment limitation. This outpatient mental health treatment limitation does not reduce reimbursement. In effect, it shifts payment responsibility from Medicare to the beneficiary. The beneficiary portion of the payment is called the "co-payment." The simple explanation is that, for outpatient therapy services, Medicare will pay 50% of the approved amount and the beneficiary must pay the remaining 50% of the approved amount.[22]

Inpatient therapy services and all diagnostic services (which include the initial diagnostic interview examination - CPT code 90801) fall under the regular 80%-20% Medicare co-pay. The mental health treatment limitation does not apply to these services. However, testing services performed to evaluate a patient's progress during treatment are considered part of treatment and are subject to the limitation.[23]

Diagnostic services: Diagnostic services fall under Medicare's normal 80%-20% co-payment scenario. This means that the beneficiary is required to pay 20% of the approved charges under most circumstances. For diagnostic services, "clinical psychologists," because they must accept assignment, may not collect above the approved amount. "Independently-practicing psychologists" collect the 20% co-payment and may also collect additional payment from the patient to bring them to their actual fee or to the limiting charge, whichever is less. Independently-practicing psychologists who sign an agreement of participation with Medicare have opted to accept Medicare's approved amount as payment in full. Therefore, they may collect only the 20% co-payment from the Medicare beneficiary.[24]

Medicaid

State Medicaid agencies administer their own plans but must meet federal guidelines set by the Centers for Medicare & Medicaid Services (CMS). States are not required to include psychological services in their Medicaid plans. As seen in the chart below, about half of the states offer services by a psychologist in independent practice as a benefit for adults. Some of the other

19. Web. American Psychological Association. "Medicare Handbook: A Guide for Psychologists" Retrieved June 29, 2006. *www.apa.org/practice/medtoc.html*
20. *Id.*
21. *Id.*
22. *Id.*
23. *Id.*
24. *Id.*

states choose to cover psychological services only offered through a clinic, hospital, or community health center. In these states, a psychologist is not allowed to bill Medicaid directly. Even in the states that offer psychological services, the coverage limitations vary. For example, Massachusetts and Washington cover psychological evaluations but not treatment. Other restrictions that states have placed on psychological services include: Kansas (4 hours of psychological testing over two years); New Hampshire (psychotherapy limited to 12 sessions per year); and Vermont (psychotherapy capped at $500 per year).[25]

Children covered by Medicaid have access to psychological services as part of the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits. EPSDT mandates coverage and screening of mental conditions. States must offer EPSDT to all Medicaid-eligible children under age 21.[26]

State Medicaid mental health care coverage for adults[27]

State	Coverage
Alabama	• $1 per visit co-payment • Limited to specified set of procedures billable, with varying frequency limits • Fee for service reimbursement
Alaska	• None
Arizona	• Fee for service reimbursement
Arkansas	• None
California	• $1 per visit co-payment • Limited to 2 service sessions per month with other specified providers in any setting • Fee for service reimbursement
Colorado	• None
Connecticut	• None
Delaware	• None
D.C.	• None
Florida	• None
Georgia	• None
Hawaii	• Prior psychotherapy approval required • Limited to 4 hours of psychological testing per year • Fee for service reimbursement
Idaho	• None
Illinois	• None
Indiana	• Prior approval required for specified services, including psychological testing • Limited to 20 service time units per year • Fee for service reimbursement
Iowa	• $2 per day co-payment • Fee for service reimbursement

25. Web. American Psychological Association. "Medicaid and Psychology" Retrieved June 29, 2006. *www.apahelpcenter.org/articles/article.php?id=65*

26. *Id.*

27. Web. The Kaiser Commission on Medicaid and the Uninsured. Retrieved 7/27/2006. The Kaiser Commission gathered its information from "Medicaid State Plans and State Plan amendments submitted to and approved by the Department of Health and Human Services' Center for Medicare & Medicaid Services (CMS). Additional information was obtained from state Web sites. From this information, state-specific summaries were prepared by Health Management Associates and sent to Medicaid officials in the respective jurisdictions for validation. *www.kff.org/medicaid/benefits/service.jsp.* Phone call to Kaiser Commission. 8/10/2006. Information verified through Lexis-Nexis searches 8/10/2006.

State	Coverage
Kansas	• $3 per visit co-payment • Limited to 4 hours of psychological testing and evaluation every 2 years • Limited to 32 hours of psychotherapy per year • Fee for service reimbursement
Kentucky	• None
Louisiana	• None
Maine	• $0.50-$2 per day, depending on payment, up to $20 per month • Fee for service reimbursement
Maryland	• Prior approval required • Limits for service and visits vary based on medical need
	• Fee for service reimbursement
Massachusetts	• Limited to psychological testing and 1 testing session every 6 months
	• Fee for service reimbursement
Michigan	• None
Minnesota	• Fee for service reimbursement
Mississippi	• None
Missouri	• Prior approval required • Fee for service reimbursement
Montana	• $3 per visit co-payment • Limited to 16 service sessions per year for adults and 24 for children • Fee for service reimbursement
Nebraska	• Fee for service reimbursement
Nevada	• None
New Hampshire	• Limited to 12 service sessions per year with other specified practitioners; must be by independent psychologist • Fee for service reimbursement
New Jersey	• Limits include psychotherapy services up to $900 per year or $400 for nursing facility residents • Fee for service reimbursement
New Mexico	• $7 per visit co-payment with annual maximum across all services based on income • Prior approval required for any services other than psychological evaluation • Fee for service reimbursement
New York	• Fee for service reimbursement
North Carolina[28]	• Prior approval required • Fee for service reimbursement
North Dakota	• $2 per visit co-payment • Limited to 1 speech evaluation per year • Limited to 40 psychotherapy visits per year • Fee for service reimbursement
Ohio	• None
Oklahoma	• None

28. Web. North Carolina Division of Medical Assistance. "Mental Health Reform" documents. Retrieved 8/10/2006. *www.dhhs.state.nc.us/dma*

State	Coverage
Oregon	• None
Pennsylvania[29]	• Fee for service reimbursement
Rhode Island	• None
South Carolina	• None
South Dakota	• Limited to 40 hours therapy per year • Fee for service reimbursement
Tennessee	• Fee for service reimbursement
Texas	• None
Utah	• Services limited by type and by beneficiary age and condition • Fee for service reimbursement
Vermont	• Limited to $500 per year on psychotherapy, with some exceptions • Fee for service reimbursement
Virginia	• Prior approval required after initial 5 visits
	• Fee for service reimbursement
Washington	• Prior approval required • Limited to psychological evaluations only, treatment is not covered • Fee for service reimbursement
West Virginia	• Prior approval required • Fee for service reimbursement
Wisconsin	• None
Wyoming	• $1 per therapy service co-payment • Fee for service reimbursement

29. Web. PA Department of Public Welfare. Retrieved 8/10/2006. *www.dpw.state.pa.us/LowInc/BehaveMentalHealth*

V. Education and training of psychologists

Doctoral and master's degree programs (overview)

Both Master's and Doctoral level psychologists are commonly referred to as "psychologists." Master's level psychologists are typically "counseling psychologists" or school psychologists.[30] In about half of the states, however, master's level psychologists may be licensed and perform under the supervision of a doctoral level psychologist. Several states allow for some independence of master's level psychologists.[31] Master's degree programs generally require one to two years of graduate study.[32] Master's level psychologists can receive either an MA or MS degree. School psychologists can also receive a Master's of Education degree.[33]

A doctoral degree generally requires five to seven years of graduate study. Both the PsyD and the PhD degree programs lead to the doctoral degree in psychology. Psychologists with a PhD qualify for a wide range of teaching, clinical, and counseling positions. Psychologists with a PsyD degree usually work in clinical positions or in private practices.[34] Psychologists may also hold an EdD degree, in which a terminal degree in education is awarded, with a possibility for graduate-level concentration in child development, educational psychology, or other areas. Typically, a practitioner with an EdD works as a school psychologist or as an administrator.

U.S. and Canadian schools granting these degrees

There are approximately 200 master's level programs in the United States and approximately 185 ApA-accredited doctoral programs in the United States[35] and 56 in Canada.[36] Approximately 20,000 students are currently enrolled in doctoral level programs.[37] Two online programs profess to offer PhDs in psychology: Walden University (*www.waldenu.edu*), and Capella University (*www.capella.edu*). Both online programs offer a "clinical psychology" specialization; however, neither school is accredited by the ApA or the Association of State and Provincial Psychology Boards/National Register accreditation project.[38]

Graduates per year

A year 2000 article states that clinical psychology programs produce approximately 2,000 doctoral degrees per year (1,300 PhD and 600 to 700 PsyD degrees).[39]

Accrediting bodies and program accreditation

There are two bodies that accredit doctoral level psychology programs.

The American Psychological Association (ApA)
Through its **Committee on Accreditation (CoA),** the ApA accredits doctoral training programs in clinical, counseling, and school psychology, as well as institutions that provide internships for doctoral students in school, clinical, and counseling psychology.[40] The ApA's CoA accredits programs to inform the educational community and the general public that an institution or a program has clearly defined and appropriate objectives and maintains conditions under which their achievement can reasonably be expected.

30. Web. Psyc Web. "Masters and Doctoral Level Careers in Psychology and Related Areas." Retrieved August 7, 2006. *www.psywww.com/careers/masters.htm*
31. Web. North American Association of Masters in Psychology. Retrieved August 7, 2006. *www.enamp.org/index.php*
32. Web. Psyc Web. "Masters and Doctoral Level Careers in Psychology and Related Areas." Retrieved August 7, 2006. *www.psywww.com/careers/masters.htm*
33. *Id.*
34. Web. Bureau of Labor Statistics (BLS), U.S. Department of Labor. "Occupational Outlook Handbook 2006-2007 Edition" Retrieved June 9, 2006. Search term "psychologist." *www.bls.gov/oco/ocos056.htm*
35. Web. Psychology Schools. Retrieved August 7, 2006. *www.psychologyschools.com*
36. *Id.*
37. Web. American Psychological Association. Retrieved June 9, 11, 27 & 28, 2006. *www.apa.org*
38. Web search "psychology doctoral program." *www.waldenu.edu* and *www.capella.edu*
39. Web. PsiChi: The National Honor Society in Psychology. "Clinical versus Counseling Psychology: What's the Diff?" Retrieved June 19, 2006. *www.psichi.org/pubs/articles/article_73.asp*
40. Web. American Psychological Association. Retrieved June 9 & 11, 2006. *www.apa.org*

Core competencies for accreditation by the ApA's CoA include:

- Broad and general preparation for entry level practice;
- Broad and in-depth post-doctoral preparation for professional practice at the advanced level in substantive traditional practice areas; focused and in-depth post-doctoral preparation for practice in substantive specialty practice areas;
- Science and practice; and
- Program philosophies, training models and missions.

The CoA's standards for doctoral level psychology education require that a program has and implements a clear and coherent curriculum plan that provides the means whereby all students can acquire and demonstrate substantial understanding of and competence in the following areas:

- Biological aspects of behavior;
- Cognitive and affective aspects of behavior;
- Social aspects of behavior;
- History and systems of psychology;
- Psychological measurement;
- Research methodology; and
- Techniques of data analysis.[41]

The ApA's CoA does not require any **standard core course requirements.** The ApA CoA's "Guidelines and Principals for Accreditation of Programs in Professional Psychology" can be found at *www.ApA.org/ed/G&P052.pdf*.[42]

ASPPB/National Register

The second body that accredits doctoral level psychology programs is a joint effort of the Association of State and Provincial Psychology Boards and the National Register of Health Service Providers in Psychology and (referred to as ASPPB/National Register project). The ASPPB/National Register accredits the following: 1) programs that are accredited by the ApA or the Canadian Psychological Association (CPA), or (2) doctoral degree programs that are not currently accredited by the ApA or the CPA.

Like the CoA, the ASPPB/National Register similarly requires no standard core courses for accreditation. For accreditation, a program shall require every student to demonstrate *competence*, which is defined as at least *three credit hours*, in the following:

- Scientific and professional ethics and standards;
- Research design and methodology;
- Statistics;
- Psychometric theory;
- Biological bases of behavior: physiological psychology, comparative psychology;
- Neuropsychology, sensation and perception, and psychopharmacology;
- Cognitive-affective bases of behavior: learning, thinking, motivation, and emotion;
- Social bases of behavior: social psychology, group processes, organizational and systems theory; and
- Individual differences: personality theory, human development, and abnormal psychology.[43]

Master's level degree programs are neither accredited by the ApA's CoA nor the ASPPB-NR. The North American Association of Masters in Psychology accredits Master's degree programs through its "Master's in Psychology Accreditation Council." As of December 31, 2005, the Council has accredited seventeen master's level programs.[44]

Autonomy and accreditation of the accrediting body

The CoA is recognized as a specialized accreditor by the U.S. Secretary of Education (see *www.ed.gov/admins/finaid/accred/index.html*), as well as by the Council for Higher Education Accreditation (see *www.chea.org/Directories/special.asp*). The CoA also is a member of the Association of Specialized and Professional Accreditors (see *www.aspa-usa.org*).[45] The CoA is composed of 21 members: 4 persons who are involved in academic leadership for graduate education in psychology at the department level or higher; 10

41. Web. American Psychological Association. Retrieved October 13, 2006. *www.apa.org/ed/G&P052.pdf*
42. Web. American Psychological Association. Retrieved June 9 & 11, 2006. *www.apa.org*
43. Web. Association of State and Provincial Psychology Boards (ASPPB). Retrieved June 28, 2006. *www.asppb.org/licensure/license/designation.aspx*
44. Web. Northamerican Association of Masters in Psychology. Retrieved August 7, 2006. *www.enamp.org/modules.php?name=Content&pa=showpage&pid=75*
45. Web. American Psychological Association. Retrieved June 9, 11, 27 & 28, 2006. *www.apa.org*

members who are involved in academic educational or training programs; 4 members who are involved in the professional practice of psychology; 2 members of the public; and 1 graduate student of psychology.

The ApA's Office of Program Consultation "supports the CoA in carrying out its responsibilities as the nationally recognized accrediting body for professional education and training in psychology. The office publishes lists of accredited programs, consults with programs considering application as well as those already accredited, prepares special reports on program quality, conducts research on accreditation outcomes, and assists the CoA in formulating policy guidance documents to support the accreditation process."[46]

The Association of State and Provincial Psychology Boards and the National Register of Health Service Providers in Psychology

The ASPPB/National Register accreditation project was established in 1980. The project serves as a resource for state licensure bodies.[47] The ASPPB/National Register accreditation project is independent of the ApA.

The Master's in Psychology Accreditation Council was established in 1995. The Council is not currently recognized by any national programs, but is currently pursuing recognition.[48]

Psychology program admission requirements

There are over 1,900 United States colleges and universities that offer a psychology major. There are no standard curriculum requirements for a Bachelor's degree in psychology. Furthermore, admission to a doctoral program in psychology does not require an undergraduate degree in psychology.[49]

As ranked by the *U.S. News & World Report*,[50] the top four ranked doctoral programs in clinical psychology were reviewed: the University of Wisconsin–Madison; the University of California–Los Angeles; the University of California–Berkeley; and the University of Pennsylvania. General requirements for admission into these doctoral programs in psychology were: GRE (Graduate Record Examination) scores of at least 1200, a GPA of at least 3.0, and several introductory-level psychology courses. The GRE measures verbal reasoning, quantitative reasoning, critical thinking, and analytical writing skills.[51] The programs also recommended that students have the following college-level coursework: course(s) in the natural sciences; course(s) in mathematics; and course(s) in the physical sciences. Letters of recommendation and written statements of purpose are also required.[52]

Doctoral program curriculum

Requirements vary greatly by program. As mentioned above, there are no standard curriculum requirements for doctoral psychology program accreditation. A survey of the top four Ph.D. psychology programs (see above), as ranked by *U.S. News & World Report*, showed that **none of these doctoral programs require coursework in the biological sciences or pharmacy sciences,** except for the "breadth requirement" or core-course components that require students to take a course or two on the *biological aspects of behavior.** Most of the programs do offer students a neurobiology/neuropharmacology course, but the course is *not* a required one.[53]

46. *Id.*
47. Web. Association of State and Provincial Psychology Boards (ASPPB). Retrieved June 28, 2006. *www.asppb.org/licensure/license/designation.aspx*
48. Web. Northamerican Association of Masters in Psychology. Retrieved August 7, 2006. *www.enamp.org/modules.php?name=Content&pa=showpage&pid=75*
49. Web. *U.S. News & World Report*. "America's Best Colleges 2006." Retrieved June 11, 2006. Search term "psychology." *www.usnews.com/usnews/edu/college/rankings/rankindex_brief.php*
50. *Id.*
51. Web. Educational Testing Service. Retrieved October 17, 2006. *www.ets.org/portal/site/ets/menuitem.fab*
52. Web. University of Wisconsin-Madison Department of Psychology *http://psych.wisc.edu*. UCLA Department of Psychology *www.psych.ucla.edu*. University of California-Berkeley Psychology Department *http://psychology.berkeley.edu*. University of Pennsylvania Psychology Department *www.psych.upenn.edu*.
53. *Id.*

Summary of doctoral level coursework requirements in sample psychology programs[54]

Course	Lecture	Practicum
Introduction/review	8-15 credit units	
Professional development	2-6 credit units	
Statistics	1-6 credit units	
Research methods	6-9 credit units	
Research		11 credit units—requirement varies by student
Clinical assessment	3-6 credit units	
Clinical intervention/theory	6 credit units	
Practicum		20 credit units—400 hours
Diversity/ethnic issues	0-3 credit units	
Colloquia	0-6 credit units	
*Biological aspects of behavior	0-6 credit units	
Cognitive aspects of behavior	0-6 credit units	
Social aspects of behavior	0-6 credit units	
Individual differences in behavior	0-3 credit units	
Internship		1 year
Electives	1-10 credit units	

Requirements for graduation

A psychology doctoral degree generally requires four to six years of graduate study. The PhD degree culminates in the presentation and defense of a dissertation based on original research. Courses in quantitative research methods, which include the application of statistics and computer-based analysis, are an integral part of graduate study and are necessary to complete the dissertation. The PsyD degree may be based on practical work and examinations rather than a dissertation. PhD psychologists have a greater emphasis on research, whereas PsyD psychologists often focus on application. Depending upon the training institution, PsyD candidates may also complete the program earlier than PhD candidates due to less rigorous publication, teaching, and research demands. "For practical purposes, both degrees are recognized…and psychologists with either degree can be licensed and have identical professional privileges."[55] The EdD, a doctoral degree awarded from a school of education, generally also requires original research and a dissertation for graduation. Graduates specializing in clinical or counseling psychology are required to partake in at least a one-year internship *during* their years of study in order to graduate with the doctoral degree.[56]

Post-doctoral clinical practicum/residency

All ApA-accredited psychology PhD programs in clinical, school, or counseling psychology additionally require candidates for graduation to participate in a 1-year residency program.[57]

54. *Id.* Phone conversations with the University of California–Berkeley and the University of Pennsylvania psychology departments (8/29/2006).
55. Web. Nonverbal Learning Disorder on the Web. Retrieved on October 20, 2006. *www.nldontheweb.org/concepts.htm*
56. Web. Bureau of Labor Statistics (BLS), U.S. Department of Labor. "Occupational Outlook Handbook 2006-2007 Edition" Retrieved June 9, 2006. Search term "psychologist." *www.bls.gov/oco/ocos056.htm*
57. Web. American Psychological Association. "Guidelines and Principals for Accreditation of Professional Programs in Psychology." Retrieve June 28, 2006. *www.apa.org/ed/G&P052.pdf*

Through the CoA, the ApA also accredits post-doctoral psychology residency programs. Requirements for accreditation include broad philosophical objectives in these six core areas:

(1) institutional/program eligibility; (2) program philosophy, training plan, and objectives; (3) program resources; (4) cultural and individual differences and diversity; (5) resident-supervisor relations; and (6) program self-assessment and quality enhancement.[58]

The program must offer post-doctoral education and training in psychology, one goal of which is to provide residents with education and training in preparation for practice at an advanced level in a substantive traditional or specialty practice area in professional psychology. The program must require of each resident a minimum of one year (twelve months) of full-time training, or two years of half time training to be completed within 24 months, where the primary training method is supervised service delivery in direct contact with service recipients.[59]

The program must require that all PhD residents demonstrate an advanced level of professional psychological competencies, skills, proficiencies, abilities, and knowledge in the following:

- Theories and effective methods of psychological assessment, diagnosis, and intervention;
- Consultation, program evaluation, supervision, and/or teaching;
- Strategies of scholarly inquiry;
- Organization, management, and administration issues pertinent to psychological service delivery and practice, training, and research;
- Professional conduct, ethics and law, and other standards for providers of psychological services;
- Issues of cultural and individual diversity relevant to all of the above.[60]

Supervision requirements for the post-doctoral psychology residency require that, at a minimum, the full-time resident will receive four hours of structured learning activities per week, at least two hours of which will include individual face-to-face supervision. This supervision must be consistent with PhD residents' training activities, and the methods of supervision must be appropriate for advanced practice training and must reflect the knowledge base for the traditional or specialty practice area in supervision. Each PhD resident will have at least two supervisors, only one of whom must be a psychologist who serves as the primary supervisor. Finally, PhD residents must have access to supervisor consultation or intervention in cases of emergency.[61]

It is interesting to note that the CoA requirements for post-doctoral training programs require that the programs "encourage their residents to participate in state, provincial, regional, national, and international professional and scientific organizations."[62]

58. *Id.*
59. *Id.*
60. *Id.*
61. *Id.*
62. *Id.*

VI. National Board Examination

The Association of State and Provincial Psychology Boards (ASPPB) develops and administers the **Examination for Professional Practice in Psychology (EPPP).** The EPPP is typically taken once candidates graduate with their doctoral degree. The exam contains 225 questions (of which 200 are scored and 25 are test items), and candidates are allowed four hours and fifteen minutes to complete the test.[63] The EPPP is weighted in the following manner:

- **Biological bases of behavior (11%): biological and neural bases of behavior; psychopharmacology; methodologies supporting this body of knowledge** *(the subtopics tested which pertain to psychopharmacology are noted below):*
  - *Correlates and determinants of biological and neural bases of behavior* pertaining to perception, action, attention, memory, temperament, and mood in normal, acute, and chronic disordered states (e.g., drug or carbon monoxide intoxication, stroke and focal lesions); and/or acute and chronic disease (e.g., insulin shock, diabetes, mood disorders, dementia, schizophrenia, and Alzheimer's).
  - *Drug classification* (e.g., anti-anxiety, anti-depressant, anti-psychotic, anti-convulsant, cognitive enhancing, hallucinogenic, depressant, stimulant); pharmacokinetics (administration, distribution, metabolism, elimination), and pharmacodynamics (receptor actions, second and third messenger system actions, neural plasticity) as they relate to the desired and non-desired acute and chronic effects of therapeutic drugs, abused drugs, and drug interactions.
  - *Guidelines for pharmacological treatment* of mental disorders (e.g., disorders for which they are available, recognized pharmacological treatments, efficacy and outcome information, and combination with non-pharmacological treatments).
- **Cognitive-affective bases of behavior (13%):** cognition and its neural bases; theories and empirical bases of learning, memory, motivation, affect, emotion, and executive function; factors that influence cognitive performance and/or emotional experience and their interaction.
- **Social and multicultural bases of behavior (12%):** intrapersonal, interpersonal, intragroup, and intergroup processes and dynamics; theories of personality; issues in diversity.
- **Growth and lifespan development (13%):** age-appropriate development across the lifespan; atypical patterns of development; protective and risk factors that influence developmental outcomes for individuals.
- **Assessment and diagnosis (14%):** psychometrics; assessment models and instruments; assessment methods for initial status of and change by individuals, couples, families, groups, and organizations/systems; diagnostic classification systems and their limitations.
- **Treatment, intervention, and prevention (15%):** individual, couple, family, group, organizational, or community interventions for specific concerns/disorders in diverse populations; intervention and prevention theories; best practices; consultation models and processes.
- **Research methods and statistics (7%):** research design, methodology, and program evaluation; instrument selection and validation; statistical models, assumptions, and procedures.
- **Ethical, legal, and professional issues (15%):** codes of ethics; professional standards for practice; legal mandates and restrictions; guidelines for ethical decision-making; professional training and supervision.[64]

63. Web. Association of State and Provincial Psychology Boards (ASPPB). Retrieved June 28, 2006 and August 28, 2006. *www.asppb.org/students/default.aspx*

64. *Id.*

EPPP content, as described above, was first implemented in June 2005. A modified version of the above content was administered between 1997 and 2005; this version also included exam questions on biological bases of behavior and psychopharmacology.

Content weight of the EPPP administered **prior to 1997** is as follows:

- **Problem definition/diagnosis (26%):** techniques of behavioral assessment; theories and principles relevant to identifying a patient's needs; factors affecting behavior; symptoms of common physical diseases and psychophysiologic reactions and syndromes; effects of major psychotropic drugs and common prescription drugs on behavior, affect, and cognition.
- **Design, implementation and assessment of intervention (26%):** intervention techniques (e.g., stress management, counseling, and guidance, group therapy, marital and family therapy, cognitive and behavioral oriented approaches, etc.)
- **Research (17.5%):** methods of inquiry and measurement; research design; experimental artifacts; statistics; techniques of communicating findings and implications.
- **Professional, legal, and ethical issues (16.5%):** legal issues, rights of patients, professional guidelines for supervision, and legal liabilities.
- **Applications to social systems (14%):** factors affecting the quality of work and life; performance evaluation; consultation models and techniques, performance tests; decision-making strategies; factors affecting morale of social systems; organization structure and processes group dynamics; evaluation of environments and human resources systems.[65]

Most states require candidates to receive a minimum passing score on the EPPP to obtain a license to practice as a psychologist. States' passing scores vary from their own fixed score (as determined by the Board of Psychology) to adoption of the EPPP recommended passing score of 500 for independent practice.[66] (See **Figure 1**, "State licensure requirements for psychologists," for details.)

The **American Board of Professional Psychology (ABPP)** recognizes professional achievement by awarding *specialty certification*, primarily in clinical psychology, clinical neuropsychology, and counseling, forensic, industrial-organizational, and school psychology. Candidates for ABPP certification must demonstrate a doctorate in psychology, post-doctoral training in their specialty, five years of experience, professional endorsements, and a passing grade on an examination.[67] **Specialty certification is not required for state licensure or reimbursement.**

65. *Id.*

66. *Id.*

67. Web. Bureau of Labor Statistics (BLS), U.S. Department of Labor. "Occupational Outlook Handbook 2006-2007 Edition" Retrieved June 9, 2006. Search term "psychologist." *www.bls.gov/oco/ocos056.htm*

VII. Post-doctoral psychopharmacology training programs

Psychopharmacology training for psychologists includes post-doctoral coursework taken by psychologists who are interested in either learning more about psychotropic medicine or in pursuing prescribing authority. The existing training programs are currently offered as either certificate programs or master's degrees. These programs typically consist of both a lecture component and a clinical practicum. In many cases the clinical practicum is not mandatory, but is available as an elective for those students who intend to pursue prescribing authority. However, in the two states that currently license psychologists to prescribe (Louisiana and New Mexico), only one, New Mexico, requires clinical practicum experience.

Applicants to these training programs need not reside in either of the states that presently license psychologists to prescribe. Many of these programs in fact offer their lecture components in weekend, correspondence, or internet formats. One interesting side note regarding these training programs is that several of them reduce the tuition if the student is a member of a state psychology association chapter.

Curriculum recommendations

ApA Blue Ribbon Panel curriculum

In 1995, the ApA's Blue Ribbon Panel of the Professional Task Force of the California Psychological Association and the California School of Professional Psychology–Los Angeles, developed its recommendations for a bio-behavioral curriculum that would, in their words, "effectively prepare psychologists to prescribe medicine."[68] The Blue Ribbon Panel consisted of professionals in the fields of psychology, nursing, behavioral sciences research, and medicine; four MDs (one neurologist, and three whose specialties were not readily discernible) representing the UCLA School of Medicine, Duke University, the Yale University School of Medicine, and the Charles R. Drew University of Medicine and Sciences in Los Angeles, served on the Panel.[69]

A primary goal of the Panel was to develop recommendations for a bio-behavioral curriculum that would prepare doctorally trained psychologists to prescribe medication relevant to their practice. The curriculum recommendations would be made generally available to educational institutions and public policy makers concerned with health reform.[70]

The Panel's recommendations are noted below. For the didactic component, the Panel recommended 260-435 contact hours over a six-month period of academic instruction. Additionally, the Panel recommends up to 135 contact hours of didactic laboratory training combined with the practicum, which was recommended to span 18 months with a minimum of 100 patients seen, and at least 2 hours a week of supervision by a qualified practitioner.[71]

Blue Ribbon Panel's recommended psychopharmacology curriculum requirements[72]

Course	Hours
Neuroanatomy	25-45
Neurophysiology	25-45
Neurobiochemistry	20-30
Pharmacology	30
Clinical pharmacology	30-45
Psychopharmacology	45-60
Developmental psychopharmacology	10-15
Chemical dependency, pain management	15-45
Pathophysiology	90-120
Physical assessment and laboratory intro	30-45
Professional/ethical/legal	15
Psychotherapy/pharmacology interactions	15
Interactive computer technology	15
Pharmacoepidemiology	30-45
Recommended practicum	18 months/ 100 patients

68. Web. American Psychological Association Division 40 (Clinical Neuropsychology Records). Blue Ribbon Panel Report. Retrieved August 29, 2006. *www.lib.lsu.edu/special/apa/report167.htm*

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

Blue Ribbon Panel recommendations:

- **395-570 contact hours of didactic instruction (over 6-9 months)**
- **18 months of clinical practicum with at least 100 patients seen and 2 hours per week supervision**

The Blue Ribbon Panel was supported and funded by the ApA. It is significant to note that although the ApA's pursuit of prescribing authority ("RxP") initiative was founded upon perceived "successes" in the DoD's Psychopharmacology Demonstration Project (PDP), the training requirements for the PDP far exceeded the Blue Ribbon, and subsequent ApA, recommendations.

Department of Defense Psychopharmacology Demonstration Project (PDP) curriculum

Training requirements for the PDP participants varied, depending on when the participants entered the program. The first PDP training class of four psychologists (1991) received two years of didactic instruction, totaling about 1,400 hours.[73] The subsequent three classes (of 2, 5, and 2 psychologists respectively) each received 712 hours of didactic instruction. Topical content curriculum for the subsequent 712-hour classes included:

Course	Hours
Pharmacology	102
Clinical pharmacology	21
Clinical medicine	121
Clinical concepts	100
Anatomy/cell biology	48
Neuroscience I, II	91
Biochemistry	57
Physiology	39
Pathophysiology	60
Health assessment	39
Clinical psychopharmacology	34

DoD PDP program curriculum (years 2-4):

- **712 contact hours of didactic instruction (over one year)**
- **12 months of clinical practicum with six months of Psychiatry inpatient service, and 6 months of Psychiatry outpatient service (see below)**

The PDP Clinical Practicum component was also much more inpatient extensive for the entering class of the PDP than for the subsequent three classes, although all classes spent one year total in their clinical practica. The entering class rotated through nine months of full-time inpatient observation at the Walter Reed Army Medical Center (WRAMC), and spent one month on call for the WRAMC Psychiatry Admission Service, one month on Psychiatry consults, and one month of chart review/lecture series on psychopharmacologically treated patients from a chronic care outpatient clinic. All participants were supervised by psychiatrists.[74] The subsequent PDP classes spent six months on WRAMC inpatient rotations, and spent the other six months dividing time between the Psychiatry clinic and Psychiatry consult service.[75] (More in-depth information about PDP, including official reports and conclusions, can be accessed through the DoD-related links in the "Literature and resources" section of the Appendix.)

ApA Level 3 Psychopharmacology Program curriculum recommendations

The ApA has identified and endorsed three separate levels of preparation in psychopharmacology training for psychologists. The three levels are differentiated based on factors such as depth and breadth of training, inclusion of a supervised practical component, and the ultimate use for which the psychologist would put the training. Level 1 consists of basic psychopharmacology education. Level 2 psychopharmacology education is intended for a consultation liaison model of collaborative practice between psychologists and professionals licensed to prescribe. It is suggested that Levels 1 and 2 education could be obtained either as part of a doctoral program or through continuing education at the post-doctoral level. Level 3 education is for prescription privileges for doctoral level psychologists.[76]

The ApA's *current* Level 3 recommendations (promulgated in 1996) for post-doctoral training programs in psychopharmacology have decreased even further from

73. Web. Final Report of the DoD Prescribing Psychologists Program, May 1998. *www.dod.mil/pubs/foi/PrescribePsychologists.pdf*

74. *Id.*

75. *Id.*

76. Web. American Psychological Association. Retrieved October 30, 2006. *www.apa.org/ed/Level1Curriculumnew.pdf (Introduction).*

the PDP program training, and are also significantly less than what was recommended by the Blue Ribbon Panel. **The ApA's recommendations for Level 3 post-doctoral psychopharmacology training include:**

- **A minimum of 300 contact hours of didactic instruction:**

Course	Hours
Neuroanatomy	25
Neurophysiology	25
Neurochemistry	25
Pharmacology	30
Clinical pharmacology	30
Psychopharmacology	45
Developmental psychopharmacology	10
Clinical dependency/pain management	15
Pathophysiology	60
Physical assessment/laboratory exams	45
Professional, legal, ethical issues	15
Psychotherapy-pharmacotherapy interactions	10
Computer based aids to practice	5
Pharmacoepidemiology	10

- **A clinical practicum with at least 100 patients seen,** and 2 hours per supervision by qualified practitioners with demonstrated skills and experience in clinical psychopharmacology.[77]

ApA Level 3 Psychopharmacology Training Curriculum recommendations:

- **300 contact hours of didactic instruction**
- **Clinical practicum consisting of 100 patients**

*Note that although the ApA recommends a minimum of 300 contact hours of didactic instruction, their topic area recommendations listed above nonetheless add up to 350 hours of didactic instruction. A telephone call to the ApA revealed no acknowledgment or explanation of the seeming discrepancy posted on their Web site.[78]

Other psychopharmacology program curriculum recommendations

In October 2005, the National Register of Health Service Providers in Psychology and the Association of State and Provincial Psychology Board jointly adopted the **"Criteria for Approval of a Designated Postdoctoral Program in Clinical Psychopharmacology."** These criteria, although **not yet implemented,** are meant to establish standards for accreditation for post-doctoral psychopharmacology training programs *(note the increase in recommended minimum didactic contact hours (350) as compared to current ApA recommendations (300)*.

The criteria recommended by the National Register/ ASPPB include:

- Program trainees must hold a doctoral degree (PhD, PsyD, or EdD), and be licensed in the state where services are provided.
- Program curriculum must include a minimum of **350** contact hours of didactic instruction followed by a demonstration of competence in the following areas: neurosciences, pharmacology and psychopharmacology, pathophysiology, physical and laboratory assessment, pharmacotherapeutics, professional, legal, ethical, and interprofessional issues.
- Program trainees must complete a clinical practicum with a minimum of 100 patients seen for pharmacotherapy evaluation.
- Program graduates are required to take the Psychopharmacology Examination for Psychologists (PEP) or equivalent national program.[79] *(See further below for information on the PEP.)*

Figures comparing the various models for psychopharmacology training are included. See **Figure 5**, "Length of training for various psychologist psychopharmacology programs as opposed to U.S. Virgin Islands bill 26-0318" and **Figure 6**, "Equivalent years of biomedical education and training for prescribing practitioners."

77. Web. American Psychological Association. Retrieved October 25, 2006. *www.apa.org/ed/rx_pmodcurri.pdf*

78. Telephone conversation with ApA's College of Professional Psychology, October 27, 2006.

79. Web. Association of State and Provincial Psychology Boards (ASPPB). Retrieved June 29, 2006. *www.nationalregister.org/RXPCriteria_Oct3_Final.pdf*

Existing psychopharmacology training programs

Current information shows that there are nine programs in existence for the post-doctoral psychopharmacology education of psychologists.[80] Only four of them award Master's degrees; the rest are certificate programs or course-level instruction. Several other organizations offer workshops, courses, or seminars in psychopharmacology, but only these nine claim to meet Level 3 ApA requirements for post-doctoral training in psychopharmacology. Licensure regulations in Louisiana require the completion of a Master's degree in clinical pharmacology, while New Mexico requires completion of an approved training program.

There is, however, a wide variety of learning formats within which the program curriculum is offered: traditional classroom learning, weekend instruction, Web-based course lecture videos or coursework, or self-directed study with online supplementation and testing.

A list of existing psychopharmacology training programs is provided below. Information on the curriculum and learning formats are available on each program's Web site; some are quite detailed, while others offer only vague information about their programs. Still others have no Web site. The information below notes Web site address and learning formats used by the programs. A quick program comparison is available through the ApA's Division 55 Web site (the section related to RxP privileges for psychologists), although substantive information about the programs is not available on this site.[81]

The Master's degree programs are:

- **The California School of Professional Psychology/ Alliant International University** (*www.alliant.edu*)
  - Most students participate in on-campus learning, but students living over 100 miles from a teaching site can attend through audio conference call and videotapes of classes. Weekend campus learning takes place approximately every third weekend for 22 months.
- **Farleigh Dickinson University** (*www.rxpsychology.com*)
  - Though the bulk of the curriculum is delivered through a distance format, students meet five weekends during the course of training (20 months).
  - Approximately 7-8% tuition discount for ApA members or members of state psychological associations.
- **The Massachusetts School of Professional Psychology** (*http://psychopharm.mspp.edu)*
  - The program is offered in Boston. Classes are held on Fridays from 9 a.m. to 5 p.m. and Saturdays from 8 a.m. to 4 p.m. Classes are scheduled approximately every two to five weekends from September through June for two years.
- **Nova Southeastern University Center for Psychological Studies** (*http://cps.nova.edu/*)
  - 10 6-day sessions (9 a.m.–5 p.m.) held on campus over two years.

The certificate programs and course-level instruction are:

- **Prescribing Psychologists' Register** (*www.pprpsych.com)*
  - Live seminars, distance learning via university affiliated training programs, and/or video taped presentations.
- **Southwestern Institute for the Advancement of Psychotherapy/New Mexico State University** (*www.zianet.com/jamesthomp/siap.html)*
  - On-site weekend instruction.
- **The Psychopharmacology Institute/Infinity University** (*www.nmhc-clinics.com/pages/TPI/ppp.html)*
  - Distance learning/correspondence.
- **Argosy University/American School of Professional Psychology**
  - Learning format is not indicated.
- **Texas A&M College of Education and Human Development, Center for Distance Learning**
  - Mostly Web-based instruction; some on-campus instruction is required.

Programs that satisfy New Mexico's licensing criteria of 450 contact hours of didactic instruction also appear to satisfy the minimum number of didactic hours (395) recommended by the Blue Ribbon Panel. An August 6, 2004 *Psychiatric News* article states that seven programs

80. Web. ApA Monitor, March 2000. "Training in Psychopharmacology Gathers Steam." Retrieved October 30, 2006. *www.apa.org/monitor/mar00/psychopharm.html*

81. Web. ApA. Retrieved October 30, 2006. *www.division55.org/Pages/PostdoctoralEducation.htm*

meet New Mexico's requirements for psychopharmacology training: the California School of Professional Psychology/Alliant International University; Farleigh Dickinson University; the Massachusetts School of Professional Psychology; Nova Southeastern University; the Prescribing Psychologists' Register; the Southwestern Institute/New Mexico State University; and the Psychopharmacology Institute/Infinity University.[82]

Certification examination: PEP

Psychologists pursuing prescribing authority in either New Mexico or Louisiana must pass a national certification exam to meet state licensure requirements. **To date, the only exam available is the Psychopharmacology Examination for Psychologists (PEP), which has been developed by the American Psychological Association.**

Requirements to sit for the PEP include: a doctoral degree in psychology; the provision of health services in psychology; a current psychology license in good standing; and successful completion of a post-doctoral program of psychopharmacology education which contains at least 300 contact hours in the following areas: neurosciences, pharmacology, psychopharmacology, physiology, pathophysiology, physical and laboratory assessment, and clinical pharmacotherapeutics.[83]

The exam consists of 150 questions in the following ten content areas, with questions weighted as noted:

- Integrating clinical psychopharmacology with the practice of psychology (15%);
- Neuroscience (8%);
- Nervous system pathology (9%);
- Physiology and pathophysiology (9%);
- Biopsychosocial and pharmacologic assessment and monitoring (10%);
- Differential diagnosis (13%);
- Pharmacology (12%);
- Clinical psychopharmacology (13%);
- Research (4%); and
- Professional, legal, ethical, and interprofessional issues (7%).[84]

82. Web. Psychiatry Online. Retrieved November 1, 2006. *http://pn.psychiatryonline.org/cgi/content/full/39/15/1*

83. Web. ApApractice. Retrieved October 27, 2006. *www.apapractice.org/apo/pracorg/pep.html#*

84. *Id.*

VIII. State licensure and regulation

State licensure

Psychologists in independent practice or those who offer any type of patient care—including clinical, counseling, and school psychologists—must meet certification or licensing requirements in the state in which they practice (including the District of Columbia). Licensing laws vary by state and by type of psychologist position, and require licensed psychologists to limit their practice to areas in which they have developed professional competence through training and experience. Clinical and counseling psychologists usually require a doctorate in psychology, the completion of an approved internship, and one to two years of professional experience. In addition, all states require that applicants pass an examination. Most state licensing boards administer a standardized test, and many supplement that with additional oral or written examinations. Some, but not all, states require continuing education for renewal of the license.[85] Furthermore, some states license Master's level professionals in limited scope capacities. See **Figure 2**, "State licensure requirements for master's degree level psychologists."

State requirements for psychologist licensure in the 50 states

Licensure and continuing education requirements for both doctoral degree and master's degree psychologists are included in **Figure 1**, "State licensure requirements for psychologists" and **Figure 2**, "State licensure requirements for master's degree level psychologists."

State boards of psychology

Information on the authority, procedures of operation, composition, and appointment procedures of state boards of psychology can be found in **Figure 4**, "State boards of psychology operating information." Additionally, contact information for state boards of psychology is included in the Appendix.

State scope of practice regulations for psychologists

Psychologist scope of practice varies by state. One of the major initiatives of the ApA is the "Pursuit of Prescription Privileges for Psychologists (RxP)". This initiative seeks prescribing authority for "well trained" psychologists.[86] Currently, the only states to grant prescribing authority to psychologists are New Mexico and Louisiana.[87] ApA Division 55 is the working group established for the advancement of pharmacotherapy for psychologists.[88]

Information on psychologists' state scope of practice regulations can be found in **Figure 3**, "State scope of practice for psychologists."

Licensure requirements for prescribing psychologists

Statutory authority: New Mexico (N.M.A.C. 61-9-17)

As of November 1, 2006, there are 4 psychologists licensed to prescribe in New Mexico.[89]

New Mexico utilizes a two-step process to license psychologists who wish to prescribe. Psychologists who meet certain requirements are eligible for "conditional prescribing certificates." After a two-year period of physician supervision, the psychologist with a "conditional certificate" is eligible to pursue a "general certificate." Psychologists must have malpractice insurance to obtain either certificate. Additionally, both the psychopharmacology training course and the proficiency exam taken by the psychologist applicant must be approved by both the New Mexico Board of Psychologist Examiners as well as the state's Board of Medical Examiners (implying at least some medical oversight of the process).

85. Web. Bureau of Labor Statistics (BLS), U.S. Department of Labor. "Occupational Outlook Handbook 2006-2007 Edition" Retrieved June 9, 2006. Search term "psychologist." *www.bls.gov/oco/ocos056.htm*
86. Web. National Register of Health Service Providers in Psychology. *www.nationalregister.org/designate_psychopharmacology.html*. Retrieved on October 18, 2006. "Psychologists will be trained by programs meeting credible standards, and the public will benefit from the services of well trained psychologists."
87. Lexis-Nexis legislative search.
88. Web. American Psychological Association Division 55. Retrieved June 29, 2006. *www.division55.org/Pages/News.htm*
89. Phone call to New Mexico Board of Psychology Examiners (Cynthia), November 1, 2006.

Requirements for the Conditional Certificate include:

- Must be a doctorally prepared psychologist;
- Must have been in practice for at least a 5-year period;
- Must complete 450 didactic hours in the core areas of neuroscience, pharmacology, psychopharmacology, pathophysiology, appropriate laboratory and physical assessment, and clinical pharmacotherapeutics;
- Must complete a 400-hour practicum with at least 100 patients with mental disorders, supervised by a psychiatrist; and
- Must pass a national certification examination.

Requirements for the General Certificate to Prescribe include:

- Must hold a Conditional Certificate; and
- Must complete two years of experience prescribing psychotropic medicine under the supervision of a licensed physician.
- Holds a current Louisiana license to practice psychology with an applied clinical specialty as defined by the board.
- Has successfully graduated with a post-doctoral master's degree in clinical psychopharmacology from a regionally accredited institution or equivalent to the post-doctoral master's degree as approved by the board. The curriculum shall include instruction in anatomy and physiology, biochemistry, neurosciences, pharmacology, psychopharmacology, clinical medicine/pathophysiology and health assessment, including relevant physical and laboratory assessment.
- Must pass a national proficiency exam in psychopharmacology.

The Louisiana regulations merely require that applicants for prescribing privileges hold a current state license to practice psychology with an applied clinical specialty. The psychology board does not specify the amount of time (contact or credit hours) required to obtain a Master's degree in clinical psychopharmacology, and no clinical practicum (supervised or unsupervised) is required.

However, slight safeguards are in place in Louisiana. A medical psychologist holding a valid certificate to prescribe shall prescribe only in consultation and collaboration with the patient's primary or attending physician, and with the concurrence of that physician. The medical psychologist shall also re-consult with the patient's physician prior to making changes in the patient's medication regimen, including dosage adjustments, and adding or discontinuing a medication. The medical psychologist and the physician shall document the consultation in the patient's medical record. And in the event a patient does not have a primary or attending physician, the medical psychologist shall not prescribe for that patient. Furthermore, a medical psychologist shall not delegate the prescribing of a drug to any other individual.

Statutory authority: Louisiana (L.R.S. 37, Ch. 28 § 2373)

As of November 1, 2006, there are 33 "Medical Psychologists" licensed to prescribe in Louisiana.[90]

Under Louisiana regulations, psychologists who are licensed to prescribe medications for mental and emotional disorders are called "medical psychologists" and can include the credential "MP" after their degree. The Louisiana Board of Examiners in Psychology shall issue a certificate of prescribing authority to any psychologist who files an application upon a form and in such a manner as the board prescribes, and who furnishes satisfactory evidence to the board that the psychologist meets each of the following requirements:

90. Phone call to Louisiana State Board of Examiners of Psychologists (Jamie), November 1, 2006.

IX. Professional organizations in psychology

American Psychological Association (ApA) is a scientific and professional organization that represents psychology in the United States. ApA is the largest association of psychologists worldwide.[91]

American Psychological Association
750 First St. N.E.
Washington, DC 20002-4242
(202) 336-5500[92]

Membership requirements

There are over 150,000 members in all categories of the ApA. Interested individuals can join at several different "membership levels": member, associate, student affiliate, teacher affiliate, and international affiliate.[93] It is unknown how many "members" are doctoral-level psychologists; the ApA would not divulge the number of its doctoral-level members.[94]

- **Member:** an applicant must possess a doctoral degree in psychology or a related field from a regionally accredited graduate or professional school or a school that achieved such accreditation within 5 years of the doctoral degree (or a school of similar standing outside of the United States). This degree must be based, in part, upon a psychological dissertation or other evidence of proficiency in psychological scholarship. Degrees from foreign institutions must show U.S. equivalency. ApA may require additional information to evaluate qualifications for membership.[95]
- **Associate member:** an individual may join as an "associate member" of the ApA if they possess a master's degree or 2 years of graduate study in psychology or a related field at a regionally accredited institution. Initially, associate members are not allowed to vote or hold office. However, after five consecutive years of membership, associate members may vote.[96]
- **Student member:** an individual may join the ApA as a "student member" if they are currently taking psychology courses at the graduate or undergraduate level. High school students may also join as "high school student affiliates" if they are currently enrolled in high school and interested in the field of psychology.[97]
- **Affiliate:** an individual who teaches psychology may join the ApA as a "teacher affiliate." There are two designations of "teacher affiliates," the "community college teacher affiliate" and the "high school teacher affiliate."[98] Any psychologists living outside the United States or Canada can join the ApA as an "international affiliate."[99]

ApA Model Legislation on Psychologist Prescribing Privileges
www.rxpsychology.com/RxPMODLAW.pdf

The American Board of Professional Psychology (ABPP)
ABPP is an organization that certifies specialists in the field of psychology. (*www.abpp.org*)

300 Drayton Street, 3rd Floor
Savannah, GA 31401
(800) 255-7792

The journal of ABPP is the "The Specialist" and it can be found on this Web site:
www.abpp.org/Newsletter/newsletter_link_page.htm

91. Web. American Psychological Association. Retrieved June 9, 11, 27 & 28, 2006. *www.apa.org*
92. *Id.*
93. *Id.*
94. Phone conversation with the American Psychological Association (800) 374-2721 (August 28, 2006).
95. *Id.*
96. *Id.*
97. *Id.*
98. *Id.*
99. *Id.*

The Society for Personality and Social Psychology (SPSP)
The SPSP has defined goals of furthering the generation and dissemination of research in personality and social psychology. (*www.spsp.org*)

SPSP Office Manager
Department of Psychology
Cornell University
Ithaca, NY 14853

The journals of SPSP are the "Personality and Social Psychology Bulletin" (PSPB) and the "Personality and Social Psychology Review" (PSPR). The PSPB is published monthly and can be found online at: *www.spsp.org/pspb.htm*. The PSPR is published quarterly and can be found online at: *www.spsp.org/pspr.htm*.

American Association of Applied and Preventive Psychology (AAAPP)
This professional society has publicly testified and offered written letters—from a psychologist's view—opposing prescribing privileges for psychologists. The last known address for this group is:

P.O. Box 3822
Tucson, AZ 85722
Phone: (520) 621-9182

See the following Web sites for information on the AAAPP's position:
http://nationalpsychologist.com/articles/art7984.htm (1998)
www.narpa.org/prescribe.htm (1998)

Society for Scientific Clinical Psychology (SSSC)
[also known as the Society of Clinical Psychology]
The SSSC is a section of the ApA (section III, Division 12). Disagreement amongst members of this section concerning prescribing privileges for psychologists is particularly high, and their debates have not been shielded from the public view. See the SSSC newsletter, "The Clinical Psychologist" for the following articles:

- Volume 57, Issue 3, Summer 2004: ApA's Prescription Privileges Project: Time for a Radical Overhaul, available at *www.apa.org/divisions/div12/tcp_journals/tcp_su04.pdf*
- Volume 58, Issue 4, Fall 2005: Why are Graduate Students not Talking about Prescriptive Authority? A Discussion of Prescription Training for Psychologists, available at *www.apa.org/divisions/div12/tcp_journals/TCP_fa05.pdf*

The late John Winston Bush, Ph.D., a psychologist and member of the SSSC, was a particularly vocal opponent to prescribing privileges for psychologists who were trained under the current model curriculum adopted by psychopharmacology training programs. He considered the current training model to put "ease of acquiring prescriptive authority unconscionably far ahead of patients' safety." (Summer 2004, "The Clinical Psychologist" newsletter)

State psychology chapter associations
Contact information on state psychology chapter associations is included in the Appendix.

Appendix

State psychology boards

Alabama Board of Examiners in Psychology
660 Adams Ave., Suite 360
Montgomery, AL 36104
(334) 242-4127
www.psychology.state.al.us/index.htm

Alaska Board of Psychologist and Psychological Associate Examiners
333 Willoughby Ave., 9th Floor, SOB
P.O. Box 110806
Juneau, AK 99811-0806
(907) 465-3811
www.dced.state.ak.us/occ/ppsy.htm

Arizona Board of Psychologist Examiners
1400 W. Washington, Room 235
Phoenix, AZ 85007
(602) 542-8162
www.psychboard.az.gov

Arkansas Board of Psychology
101 E. Capitol, Suite 415
Little Rock, AR 72201
(501) 682-6168
www.state.ar.us/abep

California Board of Psychology
1422 Howe Ave., Suite 22
Sacramento, CA 95825-3200
(916) 263-2696
www.psychboard.ca.gov

Colorado Board of Psychologist Examiners
1560 Broadway, Suite 880
Denver, CO 80202
(303) 894-7768
www.dora.state.co.us/mental-health/psy/psyboard.htm

Connecticut Board of Examiners of Psychologists
Department of Public Health
P.O. Box 340308
410 Capitol Ave., MS# 12APP
Hartford, CT 06134
(860) 509-7603
www.dph.state.ct.us/Public_Health_Hearing_Office/hearing_office/Psychologists/Psychologists.htm

Delaware Board of Examiners of Psychology
861 Silver Lake Blvd., Cannon Building, Suite 203
Dover, DE 19904
(302) 739-4522, ext. 220
http://dpr.delaware.gov/boards/psychology/index.shtml

District of Columbia Board of Psychology
825 N. Capitol St. N.E., Suite 2224
Washington, DC 20002
(202) 442-4766
http://dchealth.dc.gov/doh/cwp/view,a,1371,q,600757,dohNav_GID,1891,dohNav,%7C34592%7C34594%7C,.asp

Florida Board of Psychology
4052 Bald Cypress Way, Bin #C05
Tallahassee, FL 32399-3255
(850) 245-4373
www.doh.state.fl.us/mqa/psychology/psy_home.html

Georgia State Board of Examiners of Psychologists
237 Coliseum Drive
Macon, GA 31217-3858
(478) 207-1670
www.sos.state.ga.us/plb/psych

Hawaii Board of Psychology
Department of Commerce and Consumer Affairs–PVL
Attn: PSY
P.O. Box 3469
Honolulu, HI 96801
(808) 586-2693
www.hawaii.gov/dcca/areas/pvl/boards/psychology

Idaho State Board of Psychologist Examiners
Bureau of Occupational Licenses
1109 Main St., Suite 220
Boise, ID 83702
(208) 334-3233
http://ibol.idaho.gov/psy.htm

Illinois Clinical Psychologists Licensing & Disciplinary Committee
Division of Professional Regulation
320 W. Washington St., 3rd Floor
Springfield, IL 62786
(217) 782-0458
www.idfpr.com/dpr/WHO/psych.asp

Indiana State Psychology Board
(Attn: Indiana State Board of Dentistry)
402 W. Washington St., Suite W066
Indianapolis, IN 46204
(317) 234-2057
www.in.gov/pla/bandc/ispb

Iowa Board of Psychology Examiners
Department of Public Health
321 E. 12th St., Lucas State Office Bldg., 5th Floor
Des Moines, IA 50319-0075
(515) 281-4401
www.idph.state.ia.us/licensure/board_home.asp?board=psy

Kansas Behavioral Sciences Regulatory Board
712 S. Kansas Ave.
Topeka, KS 66603-3817
(785) 296-3240
www.ksbsrb.org/psychologists.html

Kentucky State Board of Examiners of Psychology
P.O. Box 1360
Frankfort, KY 40602-0456
(502) 564-3296, ext. 225
http://finance.ky.gov/ourcabinet/caboff/OAS/op/psychbd

Louisiana State Board of Examiners of Psychologists
8280 YMCA Plaza Drive
One Oak Square, Building 8-B
Baton Rouge, LA 70810
(225) 763-3935
www.lsbep.org

Maine Board of Examiners of Psychologists
35 State House Station
Augusta, ME 04333-0035
(207) 624-8600
www.maine.gov/pfr/olr/categories/cat35.htm

Maryland Board of Examiners of Psychologists
4201 Patterson Ave.
Baltimore, MD 21215-2299
(410) 764-4787
www.dhmh.state.md.us/psych/index.html

Massachusetts Board of Registration of Psychologists
239 Causeway St., Suite 500
Boston, MA 02114
(617) 727-9925
www.mass.gov/dpl/boards/py/index.htm

Michigan Board of Psychology
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/mdch/0,1607,7-132-27417_27529_27552---,00.html

Minnesota Board of Psychology
2829 University Ave. S.E., Suite 320
St. Paul, MN 55414-3237
(612) 617-2230
www.psychologyboard.state.mn.us

Mississippi Board of Psychology
419 E. Broadway
Yazoo City, MS 13769
(662) 716-3934
www.psychologyboard.state.ms.us/msbp/msbp.nsf

Missouri State Committee of Psychologists
3605 Missouri Blvd.
Jefferson City, MO 65109
(573) 751-0099
http://pr.mo.gov/psychologists.asp

Montana Board of Psychologists
301 S. Park Ave., Room 430
Helena, MT 59620-0513
(406) 841-2394
http://mt.gov/dli/bsd/license/bsd_boards/psy_board/board_page.asp

Nebraska Board of Psychologists
301 Centennial Mall South, 3rd Floor
P.O. Box 94986
Lincoln, NE 68509-4986
(402) 471-2117
www.hhs.state.ne.us/crl/mhcs/psych/psych.htm

State of Nevada Board of Psychological Examiners
P.O. Box 2286
Reno, NV 89505-2286
(775) 688-1268
http://psyexam.state.nv.us

New Hampshire Board of Mental Health Practice
49 Donovan St.
Concord, NH 03301
(603) 271-6762
www.state.nh.us/mhpb

New Jersey State Board of Psychological Examiners
P.O. Box 45017
Newark, NJ 07101
(973) 504-6470
www.state.nj.us/lps/ca/medical/psycho.htm

New Mexico Board of Psychologist Examiners
2550 Cerrillos Road
Santa Fe, NM 87505
(505) 476-4607
www.rld.state.nm.us/b&c/psychology

New York State Board for Psychology
New York State Education Department,
Office of the Professions
89 Washington Ave., 2nd Floor, East Wing
Albany, NY 12234-1000
(518) 474-3817, ext. 150
www.op.nysed.gov/psych.htm

North Carolina Psychology Board
895 State Farm Road, Suite 101
Boone, NC 28607
(828) 262-2258
www.ncpsychologyboard.org

North Dakota State Board of Psychologist Examiners
P.O. Box 7458
Bismarck, ND 58507-7458
(701) 250-8691
http://governor.nd.gov/boards/boards-query.asp?Board_ID=88

Ohio State Board of Psychology
77 S. High St., Suite 1830
Columbus, OH 43215-6108
(614)466-8808
http://psychology.ohio.gov

Oklahoma State Board of Examiners of Psychologists
201 N.E. 38th Terrace, Suite 3
Oklahoma City, OK 73105
(405) 524-9094
www.ok.gov/agencies/contact.php?page=135

Oregon State Board of Psychologist Examiners
3218 Pringle Road S.E., Suite 130
Salem, OR 97302-6309
(503) 378-4154
www.obpe.state.or.us

Pennsylvania State Board of Psychology
2601 N. Third St.
Harrisburg, PA 17110
(717) 783-7155, ext. 3
www.dos.state.pa.us/bpoa/cwp/view.asp?a=1104&q=433051

Rhode Island Board of Psychology
Office of Health Professionals Regulations
Cannon Building
3 Capitol Hill, Room 104
Providence, RI 02908-5097
(401) 222-2827
www.health.ri.gov/hsr/professions/psych.php

South Carolina Board of Examiners in Psychology
P.O. Box 11329
Columbia, SC 29211-1329
(803) 896-4664
www.llr.state.sc.us/POL/Psychology

South Dakota Board of Examiners of Psychologists
135 E. Illinois, Suite 214
Spearfish, SD 57783
(605) 642-1600
www.state.sd.us/dhs/boards/psychologists/psych-ho.htm

Tennessee Board of Examiners in Psychology
425 Fifth Ave. N., First Floor, Cordell Hull Building
Nashville, TN 37243
(615) 532-5127
www2.state.tn.us/health/Boards/Psychology

Texas State Board of Examiners of Psychologists
333 Guadalupe, Tower 2, Room 450
Austin, TX 78701
(512) 305-7700
www.tsbep.state.tx.us

Utah Psychologist Licensing Board
Division of Occupational & Professional Licensing
160 E. 300 S, Box 146741
Salt Lake City, UT 84114-6741
(801) 530-6628
www.dopl.utah.gov/licensing/psychologist.html

Vermont Board of Psychological Examiners
Office of Professional Regulation
26 Terrace St.
Montpelier, VT 05609-1106
(802) 828-2373
www.vtprofessionals.org/opr1/psychologists

Virginia Board of Psychology
6603 W. Broad St., 5th Floor
Richmond, VA 23230-1717
(804) 662-9913
www.dhp.state.va.us/psychology/default.htm

Washington State Examining Board of Psychology
Department of Health
P.O. Box 47869
Olympia, WA 98504-7869
(360) 236-4912
https://fortress.wa.gov/doh/hpqa1/hps7/psychology/default.htm

West Virginia Board of Examiners of Psychologists
P.O. Box 3955
Charleston, WV 25339-3955
(304) 558-3040
www.wvpsychbd.org

Wisconsin Psychology Examining Board
Department of Regulation & Licensing
Bureau of Health Service Professions
P.O. Box 8935
Madison, WI 53708-8935
(608) 266-2112
http://drl.wi.gov/boards/psy/index.htm

Wyoming State Board of Psychology
2020 Carey Ave., Suite 201
Cheyenne, WV 82002
(307) 777-6529
http://plboards.state.wy.us/Psychology/index.asp

State psychology chapter associations

Alabama Psychological Association
660 Adams Ave., Suite 394
Montgomery, AL 36104
(334) 262-8245
www.alapsych.org

Alaska Psychological Association
P.O. Box 241292
Anchorage, AK 99524-1292
(907) 344-8878
www.ak-pa.org

Arizona Psychological Association
6210 E. Thomas Road, Suite 209
Scottsdale, AZ 85251
(480) 675-9477
www.azpa.org

Arkansas Psychological Association
302 Stewart Road
Scott, AR 72142
(501) 614-6500
www.arpapsych.org

California Psychological Association
3835 N. Freeway Blvd., Suite 240
Sacramento, CA 95834
(916) 286-7979
www.calpsychlink.org

Colorado Psychological Association
7995 E. Prentice Ave., Suite 100
Greenwood Village, CO 80111
(303) 692-9303
www.coloradopsych.org

Connecticut Psychological Association
342 N. Main St.
West Hartford, CT 06117-2507
(860) 586-7522
www.connpsych.org

Delaware Psychological Association
P.O. Box 718
Claymont, DE 19703
(302) 379-0528
www.depsych.org

District of Columbia Psychological Association
750 First St. N.E., Suite 7306
Washington, DC 20002-4241
(202) 336-5559
www.dcpsychology.org

Florida Psychological Association
408 Office Plaza
Tallahassee, FL 32301-2757
(850) 656-2222
www.flapsych.com

Georgia Psychological Association
1750 Century Circle, Suite 10
Atlanta, GA 30345
(404) 634-6272
www.gapsychology.org

Hawaii Psychological Association
1188 Bishop St., Suite 912
Honolulu, HI 96813
(808)521-8995
www.hawaiipsych.org

Idaho Psychological Association
P.O. Box 352
Boise, ID 83701-0352
(208) 375-0125
www.idahopsych.org

Illinois Psychological Association
203 N. Wabash Ave., Suite 1404
Chicago, Il 60601-2413
(312) 372-7610
www.illinoispsychology.org

Indiana Psychological Association
1431 N. Delaware St.
Indianapolis, IN 46202
(317) 638-3501, ext. 222
www.indianapsychologist.org

Iowa Psychological Association
48428 290th Ave.
Rolfe, IA 50581
(712) 848-3595
www.iowapsychology.org

Kansas Psychological Association
P.O. Box 3326
Lawrence, KS 66046
(785) 856-9572
www.kspsych.org

Kentucky Psychological Association
120 Sears Ave., Suite 202
Louisville, KY 40207
(502) 894-0777
www.kpa.org

Louisiana Psychological Association
1003 Leycester Drive
Baton Rouge, LA 70808
(225) 766-0185
www.louisianapsychologist.org

Maine Psychological Association
P.O. Box 5435
Augusta, ME 04332
(207) 621-0732
www.mepa.org

Maryland Psychological Association
10025 Gov. Warfield Parkway, Suite 102
Columbia, MD 21044
(410) 992-4258
www.marylandpsychology.org/

Massachusetts Psychological Association
195 Worcester St., Suite 303
Wellesley, MA 02481
(781) 263-0080
www.masspsych.org

Michigan Psychological Association
2105 University Park Drive, Suite C-1
Okemos, MI 48864
(517) 347-1885
www.michpsych.org

Minnesota Psychological Association
1000 Westgate Drive, Suite # 252
St. Paul, Minnesota 55114-1067
(651) 203-7249
www.mnpsych.org

Mississippi Psychological Association
P.O. Box 16826
Jackson, MS 39236
(601) 366-3105
www.mpassoc.org

Missouri Psychological Association
3340 American Ave.
P.O. Box 104900
Jefferson City, MO 65110-4900
(573) 634-8852
www.mopsych.org

Montana Psychological Association
P.O. Box 81334
Billings, MT 59108
(406) 252-2559
http://wtp.net/mpa

Nebraska Psychological Association
1044 H St.
Lincoln, NE 68508-3169
(402) 475-0709
www.nebpsych.org

Nevada State Psychological Association
75 Hunt Valley Trail
Henderson, NV 89052
(702) 454-0050
www.nevadapsychologists.org

New Hampshire Psychological Association
P.O. Box 1205
Concord, NH 03302-1205
(603) 225-9925
www.nhpaonline.org

New Jersey Psychological Association
414 Eagle Rock Ave., Suite 211
West Orange, NJ 07052
(973) 243-9800
www.psychologynj.org

New Mexico Psychological Association
2501 San Pedro, N.E., Suite 110
Albuquerque, NM 87110
(505) 883-7376
www.nmpa.com

New York State Psychological Association
Six Executive Park Drive
Albany, NY 12203
(518) 437-1040
www.nyspa.org

North Carolina Psychological Association
1004 Dresser Court, Suite 106
Raleigh, NC 27609-7353
(919) 872-1005
www.ncpsychology.com

North Dakota Psychological Association
P.O. Box 7370
Bismarck, ND 58507-7370
(701) 223-9045
www.psychologyinfo.com/directory/ND/association.html

Ohio Psychological Association
400 E. Town St., Suite 200
Columbus, OH 43215-1599
(614) 224-0034
www.ohpsych.org

Oklahoma Psychological Association
6412 N. Santa Fe Ave., Suite C
Oklahoma City, OK 73116-9111
(405) 879-0069
http://okpsych.org

Oregon Psychological Association
147 S.E. 102nd Ave.
Portland, OR 97216
(503) 253-9155
www.opa.org

Pennsylvania Psychological Association
416 Forster St.
Harrisburg, PA 17102-1748
(717) 232-3817
www.papsy.org

Rhode Island Psychological Association
1643 Warwick Ave., PMB 103
Warwick, RI 02889
(401) 736-2900
www.ripsych.org

South Carolina Psychological Association
P.O. Box 2450
Beaufort, SC 29901
(843) 838-6050
www.scpa.affiniscape.com

South Dakota Psychological Association
Sumption & Wyland
818 S. Hawthorne Ave.
Sioux Falls, SD 57104-4537
(605) 336-0244
www.psysd.org

Tennessee Psychological Association
P.O. Box 281296
Memphis, TN 38168
(901) 372-9133
www.tpaonline.org

Texas Psychological Association
1005 Congress, Suite 410
Austin, TX 78701
(512) 280-4099
www.texaspsyc.org

Utah Psychological Association
275 E. South Temple, Suite 112
Salt Lake City, UT 84111
(801) 359-5646
https://cfd45.cfdynamics.com/nexuscomputer/upa/index.cfm

Vermont Psychological Association
P.O. Box 1017
100 State St., Suite 330
Montpelier, VT 05601-1017
(802) 229-5447
www.vermontpsych.org

Virginia Psychological Association
118 N. 8th St.
Richmond, VA 23219-2305
(804) 643-7300 or (888) 275-8227
www.vapsych.org

Washington State Psychological Association
711 N. 35th St., Suite 206
Seattle, WA 98103
(206) 547-4220
www.wapsych.org

West Virginia Psychological Association
P. O. Box 58058
Charleston, WV 25358
(304) 345-5805
www.wvpsychology.org

Wisconsin Psychological Association
121 S. Hancock St.
Madison, WI 53703-3461
(608) 251-1450
www.wipsychology.org

Wyoming Psychological Association
P.O. Box 1191
Laramie, WY 82073-1191
(307) 745-3167
www.wypsych.org

National association policy concerning psychologist prescribing

National medical associations

American Medical Association
Please use the following link to access AMA policies:
www.ama-assn.org/ama/noindex/category/11760.html

H-345.989 Psychologist Prescribing
The AMA: (1) opposes the prescribing of medication by psychologists; (2) strongly urges through mail and electronic communications technology that all state medical societies work closely with local psychiatric societies to oppose legislative or ballot initiatives authorizing the prescribing of medications by psychologists; and (3) supports and will work in concert with the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, and with state and other appropriate medical societies in order to defeat initiatives that authorize psychologist prescribing prescription medication. (Sub. Res. 214, A-89; Res. 204, A-97; Reaffirmation A-99)

H-35.974 Prescribing by Allied Health Practitioners
Our AMA will work with national specialty societies to monitor the status of any initiatives to introduce legislation that would permit prescribing by psychologists and other allied health practitioners, and develop in concert with state medical associations specific strategies aimed at successfully opposing the passage of any such future legislation. (Sub. Res. 203, A-02)

H-120.959 DVA Non-Physician Prescribing Authority
Our AMA will continue to pursue appropriate regulatory, legislative, and legal means to oppose any efforts to permit non-physician health care professionals to prescribe medications. (Sub. Res. 220, A-99; Reaffirmed: CMS Rep. 11, I-99)

H-120.955 Non-Physician Prescribing
(1) Our AMA advocates that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication. This responsibility includes the liability for such actions. (2) AMA supports the development of methodologically valid research on the relative impact of non-physician prescribing on the quality of health care. (CMS Rep. 11, I-99)

H-160.949 Practicing Medicine by Non-Physicians
Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given; (2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers; (3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; (4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision; and (5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine. (Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00)

G-620.021 Prescribing by Allied Health Practitioners
Our AMA: (1) when confronted with attempts by non-physicians to expand scope of practice via state legislation, shall work at the invitation of its component societies to develop strategies to most effectively promote and protect the best interest of our patients; (2) shall continue to work with national medical specialty societies to assist them in working with and coordinating activities with state medical associations and that the AMA, when requested by either a state medical association or a national specialty society, provide a mechanism to attempt to resolve any dispute between such organizations; and (3) shall become actively involved in lobbying and/or communicating with state officials at the request of the state medical associations. (Sub. Res. 203, A-02)

D-35.998 New Mexico Psychologist Prescribing Law
Our AMA: (1) in concert with the New Mexico Medical Society and American Psychiatric Association (APA) shall review the circumstances which led to the passage of the clinical psychologist prescribing bill in New Mexico, with the aim of providing the best possible assistance to other states facing similar circumstances; and (2) shall work with the APA to analyze the implications of the clinical psychologist prescribing bill passed in New Mexico on similar initiatives in other states. (Sub. Res. 203, A-02)

D-120.996 Non-Physician Prescribing
Our AMA: (1) in collaboration with specialty societies, will immediately develop programs to educate the public about the difference in education and professional standards between physicians and non-physician health care providers; and (2) will encourage state medical associations and other interested physician organizations to proactively use the advocacy campaign materials on scope of practice developed by the Advocacy Resource Center. (CMS Rep. 11, I-99)

American Osteopathic Association
Non-physician clinicians
Whereas, non-physician clinicians can be categorized into one of the three following groups: midlevel professionals who are meant to work under the supervision of or in collaboration with physicians, non-physician independent traditional professionals who practice independently within specialty areas, and alternative medicine providers who follow and independently practice alternative therapies; and
Whereas, non-physician clinicians are gaining increased licensure and practice privileges in areas that were once only held by physicians including, but not limited to, prescribing drugs and medical or surgical treatments, practicing autonomously, performing surgery, and being reimbursed by all types of third-party payors; and

Whereas, non-physician clinicians are gaining even more expansive privileges that they already possess; and Whereas, patient safety is the foremost concern when addressing issues of expanding scopes of practice for any health care profession; and
Whereas, patient safety and state laws mandate that physicians meet a minimum threshold of education, post-graduate training, examination, and regulation for an unlimited license to practice medicine; and
Whereas, many of these non-physician clinician professions are undertaking tasks that overlap with physician practice without being required to meet the equivalent threshold of education, post-graduate training, examination, and regulation established for physicians by state licensing boards; now, therefore, be it
Resolved, that the American Osteopathic Association adopt the attached policy paper as its position on non-physician clinicians including appropriate on-site supervision (2000, revised 2005).
www.osteopathic.org/pdf/aoa_postiong-n.pdf (See pages 98-104)

American Academy of Family Physicians
Prescribing
The American Academy of Family Physicians opposes any action that limits patients' access to physician-prescribed pharmaceuticals, and opposes any actions by pharmaceutical companies, public or private health insurers, legislation, the FDA, or any other agency, which may have the effect of limiting by specialty the use of any pharmaceutical product.

The AAFP believes that only licensed doctors of medicine, osteopathy, dentistry, and podiatry should have the statutory authority to prescribe drugs for human consumption.

Under physician supervision, physician assistants and advanced practice nurses may have the statutory authority to prescribe drugs for human consumption.

Pharmacists should not alter a prescription written by a physician, except in an integrated practice supervised by a physician or when permitted by state law.

In order to preserve patient confidentiality the Academy opposes any requirement that a diagnosis be placed on a prescription form. (1995) (2006)
www.aafp.org/online/en/home/policy/policies/d/drugs.html#Parsys0009

Guidelines on the supervision of certified nurse midwives, nurse practitioners and physician assistants
Family physicians have utilized certified nurse midwives, nurse practitioners, and physician assistants in extending the availability of health care more than any other medical specialty. Approximately thirty percent of family physicians report utilizing at least one of these non-physician providers (NPPs) in their practices. Moreover, family physicians have been at the forefront of innovation in the utilization of NPPs, especially in underserved communities. The Academy has supported a wide variety of efforts by policy makers to improve access to health care services in underserved communities including the innovative utilization of NPPs.

The increasing variety of situations in which NPPs are utilized and the growing tendency of health policy makers to identify NPPs as a means of improving the availability of health care services raises important issues regarding the appropriate relationship between NPPs and their supervising physicians. Current Academy policy on NPPs stipulates that these providers always function under the "direction and responsible supervision of a practicing, licensed physician. The Academy, however, believes that practicing physicians and health policy makers will benefit from a more detailed set of guidelines on the supervision of NPPs.

These guidelines are intended to serve as a set of general principles with which physicians and policy makers can assess the role of NPPs in improving access to health care services.

It is important to note that an extremely varied set of laws and regulations defining the legal relationship between physicians and NPPs has been adopted by the federal government and all 50 states. While these guidelines will provide general direction, physicians and NPPs are urged to fully comply with all federal, state and local laws and regulations regarding health care delivery.

Health plans and physician practices which utilize non-physician care providers should provide information to members/patients regarding the possibility of being seen by a non-physician provider. Such information should be stated in clear terms in plan/practice advertisements and communications, the information should be made known to the patient at the time their appointment is made, and should be clearly stated by the non-physician provider at the time the patient is seen.

Physician responsibility

The central principle underlying physician supervision of NPPs is that the physician retains ultimate responsibility of the patient care rendered. Physician supervision means that the NPP only performs medical acts and procedures that have been specifically authorized and directed by the supervising physician.

It is useful to conceptualize state NPP laws as providing physicians with the authority to delegate the performance of certain medical acts to NPPs who meet specified criteria and who function under certain requirements for supervision. The supervising physician bears both the authority and the responsibility for the delegated acts. Accordingly, the tasks delegated to the NPP should be within the scope of practice of the supervising physician. The physician remains responsible for assuring that all delegated activities are within the scope of the NPP's training and experience.

The physician must afford supervision adequate to ensure that the NPP provides care in accordance with accepted medical standards. It is the Academy's position that those services that are delegated to and provided by NPPs are traditional physician services that must be provided with equal quality. To provide services that are substandard quality would establish a second-class system of health care.

Supervision defined

Supervision means to coordinate, direct, and inspect on an ongoing basis the accomplishments of another, or to oversee, with the power to direct, the implementation of one's own or another's intentions. The supervising physician must have the opportunity and the ability to exercise oversight, control, and direction of the services of a NPP. Accordingly, it is the responsibility of the supervising physician to direct and review the work, records, and practice of the NPP on a continuous basis to ensure that appropriate directions are given and understood and that appropriate treatment is rendered.

Supervision includes, but is not limited to: (1) the continuous availability of direct communication either in person or by electronic communications between the NPP and supervising physician; (2) the active overview of NPP activities including direct observation of the NPP's ability to take a history and perform a physical examination; (3) the personal review of the NPP's practice at regular intervals including an assessment of referrals made or consultations requested by the NPP with other health professionals; (4) regular chart review; (5) the delineation of a plan for emergencies; and (6) the designation of an alternate physician in the absence of the supervisor. The circumstance of each practice determines the exact means by which responsible supervision is accomplished.

Direction

It is the responsibility of the physician to ensure that appropriate directions are given, understood, and executed. The physician must provide direction to NPPs in order to specify what medical services should be provided for all types of cases that the NPP is expected to see. These directions may take the form of written protocols, in person, over the phone, or by some other means of electronic communication.

Protocols developed by the supervising physician and NPP should include guidelines describing and delineating NPP functions and responsibilities. From these guidelines, the NPP may provide medical care as an extension of the supervising physician. Protocols should be as specific in their guidance as the physician and NPP require for their particular practice. Many states require that the physician and NPP develop detailed written protocols, and, in some instances, these protocols must be submitted to and approved by the state medical board. As a practical matter, it is not possible to cover all clinical situations in written protocols. Nonetheless, there must be a clear understanding between the physician and NPP regarding the actions that may be undertaken by the NPP in all commonly encountered clinical situations and, especially, under what circumstances physician consultation is to be immediately obtained.

The development of adequate protocols, whether written or oral, requires an initial period during which the NPP works under the close supervision of the physician. The degree of supervision should lessen only when the physician can ensure that the NPP will provide care in accordance with directions and accepted medical standards. Furthermore, the physician and NPP must regularly review protocols to ensure their currency in regard to the physician's scope of practice, the range of tasks that have been delegated by the physician and the evolving standards of medical practice.

Immediate physician consultation will be indicated for specified clinical situations and in situations falling outside those specified in written and oral protocols. The goal is to err on the side of the NPP seeking physician involvement more often than proves to be necessary.

Review

Supervision is intended to ensure that directions are implemented properly. The supervising physician must develop and carry out a plan to ensure NPP quality of care. This plan must be in compliance with all applicable laws and regulations. Generally, state laws limit the number of NPPs that a physician may supervise. The plan for supervision should consider: (1) the training and experience of both the supervising physician and NPP; (2) the duties the NPP will or will not perform without first receiving the physician's guidance and permission; (3) the duties of the NPP is not expected to perform except in emergency; (4) communication arrangements in various situations or practice settings; and (5) the availability of back-up supervisors.

The supervising physician must regularly review the quality of medical services rendered by the NPP by reviewing medical records to ensure compliance with directions and standard of care, and to protect patient welfare. The minimum frequency with which such review takes place is, in some instances, specified in federal and state law. In establishing the frequency and extent of record review, the physician may consider the scope of duties that have been delegated to the experience of, and the patient load of the NPP.

An NPP should not provide health care services during periods of time when the supervising physician is unavailable unless an alternate supervisor has been designated. Explicit alternate supervising physician requirements are usually set forth in state law.

Remote supervision

In principle, supervision should recognize the diversity of practice settings in which NPPs are utilized. As a practical matter, the efficient utilization of a NPP, especially in rural areas, will from time-to-time result in off-site physician supervision. It is generally presumed that the supervising physician will routinely be present at the location where the NPP practices. However, few states require the supervising physician to be physically present at all times when a NPP is providing care or the supervising physician to be specifically consulted before a delegated task is performed. Several states make explicit provision for NPP practice at sites remote from the supervising physician's primary office, and the federal Medicare statute provides for remote NPP practice in rural health clinics.

Where on-site supervision is not provided, the burden is on the physician and the NPP to establish that lack of on-site supervision is reasonable under the circumstances. Some states require explicit approval to utilize a NPP in a remote site. If the NPP is providing services at a remote site, the physician and NPP must ensure that distance does not become an impediment to the regular and adequate review of the NPP's work. No decrement in oversight or quality should result from remote supervision.

Generally, the utilization of a NPP at a remote site involves a physician-NPP team that has had sufficient opportunity to establish a close working relationship before the NPP is deployed to the remote site. The super vising physician must be available in person or by electronic communication at all times when the NPP is caring for patients. There should be established clear transportation and backup procedures for the immediate care of patients needing emergency care and care beyond NPP's scope of practice. As with on-site supervision, the appropriate degree of remote supervision includes an overview of NPP's activities to determine that directions are being followed; immediate availability for necessary consultations; personal and regular review of patient records; and periodic discussion of conditions, protocols, procedures, and patients. (1992) (2002)
www.aafp.org/online/en/home/policy/policies/n/nonphysicianproviders.html

Consumer groups opposing psychologist prescribing

National Alliance on Mental Illness (NAMI)
Position on prescribing privileges for psychologists
"Based on the information and evidence obtained at the Task Force meeting and in preparing this report, staff believe that it would not be appropriate at this time for NAMI to adopt a position in support of state legislation allowing prescribing privileges for psychologists."
www.nami.org/Template.cfm?Section=Issue_Spotlights&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=5&ContentID=15953

Depression and Bipolar Support Alliance
Position on prescribing authority
"To safely prescribe psychotropic medication, extensive education of the physiology of the entire body is necessary. Safe and effective use of medications to treat brain disorders requires medical training to ensure a thorough understanding of physiology, chemistry, drug interactions and medical problems that mask symptoms of mental illness. Diagnosing and medication treatment for mental illnesses such as clinical depression and bipolar disorder (also known as manic-depression) requires the same level of medical skill and knowledge as diagnosing and treating all serious, life-threatening illnesses, such as heart disease and hypertension."
www.dbsalliance.org/Media/DBSA_Positions.html#Prescriptions

Related health associations opposing psychologist prescribing

International Society of Psychiatric-Mental Health Nurses
Response to clinical psychologists prescribing psychotropic medications
www.ispn-psych.org/docs/11-01prescriptive-authority.pdf

American Psychiatric Association fact sheet

April 1999

Department of Defense Psychopharmacology Demonstration Project

Issue

Should Congress accept the U.S. Government Accounting Office's (GAO) congressionally requested report on the DoD Psychopharmacology Demonstration Project (PDP) to train psychologists to prescribe medication? GAO stated, "given PDP's substantial costs and questionable benefits . . . we see no reason to reinstate this demonstration project."

Background

In August 1991, at Senator Daniel Inouye's (D-HI) behest, the Department of Defense began a controversial program to increase the scope of practice of clinical psychologists in the military so they could independently treat patients with psychotropic medication. Recruitment has been difficult, and only 13 psychologists have participated in the program since 1991 (the goal was 6 psychologists per yearly PDP class, making a target of 30 psychologists from each of the program years 1991-1995). Of the 13 participants in the PDP, 7 completed it and 3 dropped out. Of the drop-outs, one left to go to medical school, one left because of dissatisfaction with the program itself, and the other left the military altogether. The other three—two of which were recruited from the civilian population because of a lack of interest among military clinical psychologists—will finish the program in June 1997. According to the GAO, the costs associated with the program have exceeded $6 million, or about $610,000 per psychologist. Public Law 104-106 terminated program effective June 30, 1997. The law, the National Defense Authorization Act for FY 1996, also required the GAO, the federal government's independent watchdog agency, to submit a report evaluating the success of the PDP program and recommending whether or not the program should be reinstated.

APA position

The GAO Report rightly states, "because medical training is not required to practice clinical psychology, psychologists are not qualified to prescribe medication," rightly points out that "clinical psychologists practice psychology, not medicine," and rightly asserts that "psychologists cannot be substituted for psychiatrists." Further, GAO states that "the MHSS (military health services system) needs no prescribing psychologists or any other additional mental health providers authorized to prescribe psychotropic medication."

The GAO concludes that "given DoD's readiness require ments, the PDP's substantial cost and questionable benefits, and the project's persistent implementation difficulties, we see no reason to reinstate this demonstration project."

Congress should not provide any funding source to continue any program to train clinical psychologists to prescribe medications.

Testimony of the American Psychiatric Association presented to the Maine Health and Human Services Committee

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Presented by
Edward B.K. Pontius, MD
February 10, 2004

Dear Senator Brennan, Representative Kane and Members of the Health and Human Services Committee,

This afternoon I'm providing testimony in opposition to LD 1713 as currently drafted. I propose to you that this bill be revised to eliminate reference to prescriptive authority and that it be expanded in scope to address some of the very real access problems we see in Maine.

I am a physician specializing in psychiatry and currently Medical Director for Sweetser as well as Medical Director for the new Maine Telepsychiatry Initiative. I have more than 20 years experience in clinical research, training, and the design and implementation of successful multidisciplinary mental health teams.

All of us in Maine should appreciate the leadership shown by you, Senator Brennan, and this committee in addressing serious on-going issues of access to effective mental health care in Maine. This is an important issue and there is much to be done. Establishing a study commission is a good first step.

Unfortunately, the bill as currently drafted includes a significant misstep. The current language provides that this study should include "whether prescriptive authority for psychotropic drugs should be extended to other health care professionals". This particular direction is in error and would lead to serious negative consequences for those in need of mental health care in Maine. I'd like to tell you the reasons why.

First, the issue of extending prescriptive authority rests on the false premise that there is a shortage of licensed health providers with prescriptive authority in Maine. In fact, in Maine there are currently physicians (both MD's and DO's), nurse practitioners, and physician assistants, practicing under physician supervision, and all of these individuals are currently licensed by the state of Maine to prescribe psychotropic medications. In Maine as in all other states, the majority of psychotropic medications are prescribed by doctors who are not psychiatrists, just as the bulk of cardiac medications prescriptions are written by primary care doctors rather than cardiologists. Lack of sufficient individuals with prescriptive authority is not the issue we need to address. In fact, in Maine we have 29% more prescribing practitioners per capita than in the US as a whole.

Second, it has been suggested that there is no need for concern about individuals without medical training being able to prescribe—that it would be sufficient for them to have some limited training, something less than the training required of physicians, nurse practitioners or physician assistants. This is false. First, without adequate medical training the many medical conditions that can present as psychiatric conditions—important treatable conditions including endocrine, immune disorders, and even infectious diseases—could very likely not be considered and appropriately treated. This would be a very unfortunate situation for patients in Maine.

Third, although many psychotropic medications are better tolerated than drugs that were available just a few years ago, all the medications that we use have side-effects and are dangerous in the hands of those with inadequate training. None of the medications that we use are limited in their impact to the brain or nervous system—these medications are distributed throughout every organ system in the body and interact with both medical conditions and medications prescribed for other conditions. To effectively use psychotropics a practitioner must know about the body as a whole, in health and in illness, and about how psychotropic medications interact with the person's whole body and other treatments. The training to do this safely and effectively cannot be abbreviated.

Finally, although the first line of care for most Mainers with mental illness will be primary care practitioners, it is important that we be able to continue to bring to Maine the psychiatrists and the child psychiatrists that can support primary care in the stabilization and treatment of those with the most difficult mental health problems. I have personally helped to recruit

a number of psychiatrists and child psychiatrists to come to Maine, including three new child psychiatrists who we have brought to Maine from out-of-state in the past 18 months.

Maine does need to pay attention to the real issues of access to appropriate mental health care. It is important that we not entangle this effort with a mistaken focus on extending prescriptive authority. Real progress can be made by strengthening our efforts to provide more effective support for psychiatric consultation to primary care practitioners. One such opportunity is the Maine Telepsychiatry Initiative, a new program that is using technology to bring psychiatric expertise within reach of patients in need at more than 208 existing telemedicine sites across the state. Let's please work together for telepsychiatry and other opportunities to improve access to mental health care in Maine.

Thank you for this opportunity to contribute to your consideration of this important issue.

Sincerely,
Ed Pontius, MD

Statement of the American Psychiatric Association on an application to increase the scope of practice for psychologists Before the House of Representatives and Senate Health Committees of Reference State of Arizona

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(202) 682-6000

Presented by
Maurice Rappaport, MD, PhD
December 5, 2001

Good afternoon. My name is Maurice Rappaport. I am a psychiatric physician with a private practice in San Jose, California. I am also a member of the Board of Trustees of the American Psychiatric Association (APA). I will be speaking today on behalf of the APA, a national medical specialty society that represents more than 38,000 psychiatric physicians, and the 650 psychiatric physicians in Arizona, on a proposal for legislation that would authorize psychologists to prescribe and administer psychotropic medications.

The APA joins the Arizona Psychiatric Society in strongly opposing this concept. Our opposition is a proud history of seeking to assure that patients with mental illnesses (including substance abuse disorders) are protected by a dual safety net of appropriate medical education and medically supervised residency clinical training.

Having a PhD in psychology and an MD with board certification in psychiatry and neurology, I believe psychologists should not prescribe. It boils down to three critical issues: need, quality of care, and economics.

In Arizona, as in the other 49 states, under current law, psychologists are prohibited from prescribing drugs. In addition to psychiatrists and other physicians, only dentists, and, to a limited degree, optometrists, advanced nurse practitioners, and other practitioners, who have a medical educational and training, may write prescriptions. This proposal would eliminate current restrictions in the law that prohibit psychologists from prescribing medication. Psychologists would be permitted to write prescriptions not only for psychotropic and other brain medications, but also for coronary disease, cancer, or any other medical condition. To do this they need only take some courses that meet the training requirements to be set by the state Board of Psychology, not the state Board of Medicine.

Mental illnesses—schizophrenia, major depression, bipolar disorder, childhood autism, Tourette's disorder, and post-traumatic disorders, to name some of the most prevalent—are serious disorders. They are illnesses involving abnormalities in brain chemistry, many with strong genetic components, affecting the very essence of being human: our capacity to think, to reason, to judge reality, and to control our emotions and behavior. The drugs used to treat them are among the most powerful and potentially dangerous medications available in modern medicine.

Mental illnesses have come out of the Dark Ages of stigma, mystery, avoidance and myth to be diagnosed, studied and treated like all other illnesses that physicians are licensed to do by virtue of four years of medical school, followed by four years of supervised residency. This means a person spends four years in a full time training program attempting to gain experience and knowledge of disease states, and the use of a wide array of psychoactive and many non-psychoactive medications, plus requirements for constantly updated education.

This legislative proposal, if enacted, could put people with serious mental illnesses at risk. The idea that a psychologist, who has no medical background, can be trained in a couple of years to use these medications well, trivializes patients with mental illnesses. Yes, one can learn how to prescribe Prozac safely in two years, but what if it doesn't work? Or what if the patient has a bad reaction, or has compounding medical conditions?

This proposal has a number of serious flaws and limitations:

There is no demonstrable health care need to grant psychologists prescribing authority. The claim that individuals in rural areas would be better served is erroneous on several counts. In most sparsely populated areas where psychiatric physicians are not nearby, neither are there properly qualified clinical psychologists. Moreover, in most instances, psychiatrists are within reasonable geographic distances. And, it should be remembered that family physicians are generally better represented throughout the state than are psychologists. There is no evidence to support the claim that psychologists, if given prescribing authority, will relocate to underserved rural or impoverished areas in Arizona.

In California, where I practice, a survey revealed that there is adequate coverage by psychiatrists and other physicians when prescriptions need to be written—even in underpopulated areas that cannot support psychiatrists, psychologists, or other mental health workers. In those areas, psychiatrists are willing to "ride circuit" and provide services just like the judges of yesteryear. The problem is not the scarcity of physicians for prescribing, but the absence of mental health insurance coverage for more in-depth therapy. The same holds true for inner cities and other areas populated largely by underserved minorities and the poor.

If psychologists were authorized to prescribe, the quality of care would decrease. There would be an artificial sundering of the mind from the body—a philosophically unhealthy approach that undermines a holistic consideration of an indivisible biopsychosocial condition.

The medications psychologists would like to prescribe are powerful and potentially dangerous. Psychologists want prescriptive authority for drugs that have a biochemical basis in the treatment of major mental illnesses. The current generation medications used to treat mental illnesses are potent, powerful modifiers of brain chemistry. They also affect other organ systems and interact with other medications. Indeed, 50 percent of patients with mental illness are on such additional medications to treat other medical illnesses. Similarly, approximately 90 percent of developmentally disabled persons requiring psychotropic medications also have to be treated with other medications because they have concomitant serious medical problems. All of these medications must be used together by a physician who is trained and understands the organ systems, their functions, and the various interactions of medications.

There were many things I learned in medical school that, as a psychologist, I could not have appreciated. I learned about the life-threatening consequences of erroneous decisions about medications, and about the interactions of psychotropic drugs with medications given to help other body systems. The sudden emergence of significant signs and symptoms (such as hypotension or hypertension, a life-threatening neuroleptic malignant syndrome, an anaphylactic reaction from an unanticipated critical drug response, or induced cardiac irregularities) is not the type of hands-on physical evaluation situation that a psychologist trained in the social and behavioral sciences would be prepared for.

Psychologists do not have the medical model training of non-physician providers who have limited prescribing authority. When I completed my PhD in psychology within a university setting, I was most appreciative of what I had learned. I learned how to recognize good and bad research, about the usefulness and limitations of psychometric testing, and the limitations of talk services in dealing with seriously ill patients. Unfortunately, I also learned that some of the very bright people entering psychology denigrated the medical model, chaffed at society's placement of physicians in the health treatment system, and—in an understandable wish to be independent—did not want to be under a medical structure.

The 24-hour-a-day experience in dealing with serious people problems—with ready access to the experience and counsel of supervising physicians—builds a store of knowledge that is critical for good treatment of future patients and cannot be obtained in a non-medical context.

Psychologist training, in contrast, occurs largely outside a medical context and sometimes outside a university setting. In schools without walls, questions arise about the quality of training. Furthermore, the claim by psychologists that they have more mental health training than most others falls down when one looks at two things: the substance of some of the material used in their training, and its lack of translation into treatment outcomes that are significantly more successful than those of other nonphysician mental health practitioners. This type of training does not prepare the trainee to detect and treat concomitant physical problems that do not require referral to medical specialists.

Psychologists argue that, just as other non-physician health providers (e.g., nurses, physicians' assistants, and optometrists) prescribe, psychologists can easily and readily prescribe medication. This argument fails because these other providers have substantial training in the medical model, which psychologists do not have. As Russ Newman, PhD, American Psychological Association Executive Director for Practice Directorate, said about prescription privileges, (published in the March 2000 issue of) on a "psychological model for prescribing", he anticipates prescribing psychologists as applying, true to their profession, a "psychological model of treatment" which he sees as "qualitatively" different from medical care. Is this what the legislature envisions for constituents by allowing psychologists to

prescribe medications, "just" an expansion of psychological treatment? Even Medicare requires an attestation by a medical doctor for a psychologist to treat a Medicare patient in the clinical psychologists' present scope of practice. Moreover, medical authorities or medical colleges do not approve continuing education courses on pharmacology taken by psychologists. Such courses, which may be taken as part-time or even "at home" courses, are not substitute for medical education.

Psychiatrists are the only physicians trained to deal in an integrated fashion with physical and mental health problems associated with brain disorders. Psychiatrists and other physicians are trained to assess whether the mental symptoms exhibited by a patient are the consequence of some underlying physical illness. Many patients, whose brain disorders are treated with brain medications, have other serious medical conditions requiring medications. Psychiatrists are knowledgeable about the systemic effects of brain medications and their interaction with patients' other physical conditions and the medicine they may be taking, including both prescribed and illicit drugs. Modern psychiatry takes an integrated mind-body approach to treating mental illnesses.

Congress terminated the U.S. Department of Defense Psychopharmacology Demonstration Program (PDP) in 1996. The prescribing proposal states that psychologists want to join "fellow psychologists who have the authority to prescribe medications." No state grants psychologists the legal authority to prescribe medications—such authority comes only from having earned a medical or nursing degree. Only a handful of psychologists, trained in the discontinued Department of Defense Psychopharmacology Demonstration Program (PDP), prescribe in a controlled military setting. Terminated by Congress in 1996, the PDP resulted in 10 prescribing psychologists in the military health service at a cost of more than $6 million.

The Congressional "watchdog" agency, the General Accounting Office, strongly criticized the PDP as "not adequately justified because the [military health system] has no demonstrated need for them [the prescribing psychologists], the cost is substantial, and the benefits uncertain."

Reflecting their limited training, these psychologists needed to rely on supervision and backup of physicians to ensure they weren't missing underlying serious medical problems in the PDP. Also, for patient safety reasons, these psychologists were not permitted to treat certain categories of patients (e.g., children, or elderly patients).

No state in the nation gives prescribing authority to psychologists. In fact, since 1990, 14 states, some repeatedly, have rejected legislation to grant psychologists prescription privileges. Legislation to give psychologists prescribing authority would be a high-risk experiment in which one of the state's most vulnerable populations—persons with mental illnesses—would be subjected to second-class health care by a group of inadequately trained providers who want to be physicians without the requisite medical training and education.

Psychologists are social scientists. A psychologist possesses an academic degree, such as a PhD, not a medical degree. Psychologists are trained to assess behavioral and cognitive changes. Their education as social scientist provides them with no training in chemistry, physiology, pharmacology, biochemistry or other fields related to medicine.

The modest training required of certified psychologists under this proposal in no way provides an adequate substitute for the extensive training required of licensed psychiatrists and other physicians. Substantial medical training is a prerequisite to prescribing brain medications which do not just work on the brain, but interact with the whole human physical structure. To be licensed as a physician, a person must have more than 4,000 classroom hours of medical school, and a one-year internship within a medical setting. In addition, psychiatrists and other specialist physicians must have at least three years of residency. The training that would be required for certification—by the Board of Psychology, not the Board of Medicine—involves only a fraction of the medical school classroom hours.

Further, psychologists prescribing would drive up the cost of health care with no apparent benefit to the State. As prescribing psychologists would have only limited and inadequate training to detect and treat most non-mental medical conditions, physician services—at additional costs—would be required. Once allowed to prescribe, psychologists would demand the same reimbursement as fully trained physicians. There would be increased costs associated with extra medical referrals and, at times, errors of non-referral when the seriousness of a patient's medical condition was not recognized.

Also granting psychologists prescribing authority would entail increases in, for example, state regulatory costs and liability insurance rates. Ultimately, these costs are borne by all taxpayers.

Psychologists, like all of us, deserve to make a decent living, but not at the expense of decreased quality if care and increased health costs. They are being squeezed economically by competing mental health workers such as licensed clinical social workers, marriage, family, and child counselors; other types of counselors; psychiatric nurses; physician assistants and others. To gain a competitive edge in the psychotherapy marketplace, it is quite understandable why psychologists would want to strive for economic and prestige enhancements associated with authorization to prescribe.

A far better approach to patient care is to improve the mental health training of primary care physicians, who are more widely distributed than are psychologists. If greater specialization is needed, psychiatrists can be made available through circuit riding and modern technology such as video conferencing, which can provide psychiatric services to residents of rural areas. A number of sparsely populated states have been using this technology for years.

It is clearly not in the best interest of patients to have psychologists prescribe. Their wish to operate independently in a medical arena is a potentially dangerous proposition. Their greatest contributions are made by valuing and practicing the basics on which their discipline is founded.

For these reasons—but most importantly, for the protection of Arizona's residents with mental illness—we urge you to reject this proposal.

Literature and resources

Medical literature

CNS Drugs. **2006;20(1):51-66.**
Prescription privileges for psychologists: a comprehensive review and critical analysis of current issues and controversies.
Lavoie KL,
Barone S.
Division of Chest Medicine, Research Center, Hopital du Sacre-Coeur de Montreal, Quebec, Canada.

The debate over whether clinical psychologists should be granted the right to prescribe psychoactive medications has received considerable attention over the past 2 decades in North America and, more recently, in the UK. Proponents of granting prescription privileges to clinical psychologists argue that mental health care services are in crisis and that the mental health needs of society are not being met. They attribute this crisis primarily to the inappropriate prescribing practices of general practitioners and a persistent shortage of psychiatrists. It is believed that, as they would increase the scope of the practice of psychology, prescription privileges for psychologists would enhance mental health services by increasing public access to qualified professionals who are able to prescribe. The profession of psychology remains divided on the issue, and opponents have been equally outspoken in their arguments. The purpose of the present article is to place the pursuit of prescription privileges for psychologists in context by discussing the historical antecedents and major forces driving the debate. The major arguments put forth for and against prescription privileges for psychologists are presented, followed by a critical analysis of the validity and coherence of those arguments. Through this analysis, the following question is addressed. Is there currently sufficient empirical support for the desirability, feasibility, safety and cost effectiveness of granting prescription privileges to psychologists? Although proponents of granting prescription privileges to psychologists present several compelling arguments in favour of this practice, there remains a consistent lack of empirical evidence for the desirability, feasibility, safety and cost effectiveness of this proposal. More research is needed before we can conclude that prescription privileges for psychologists are a safe and logical solution to the problems facing the mental health care system.
PMID: 16396524 [PubMed - indexed for MEDLINE]

Can J Psychiatry. **2002 Jun;47(5):443-9.**
Should psychologists be granted prescription privileges? A review of the prescription privilege debate for psychiatrists.
Lavoie KL,
Fleet RP.
Montreal Heart Institute, Sacre-Coeur Hospital, Research Center, Montreal, QC.
kiml_lavoie@yahoo.ca

Background: The debate over whether clinical psychologists should be granted the right to prescribe psychoactive medication has received considerable attention over the last 2 decades in the US, but there has been relatively little discussion of this controversial topic among Canadian mental health professionals, namely psychologists and psychiatrists. Proponents of prescription privileges (PPs), including the American Psychological Association (ApA), argue that psychologists do not and cannot function as independent professionals because the medical profession places many restrictions on their practice. It is believed that PPs would help circumvent professional psychology's impending marginalization by increasing psychology's scope of practice. Proponents also argue that PPs would enhance mental health services by increasing public access to professionals who can prescribe.

Objective: The purpose of this article is to inform psychiatrists about the major arguments presented for and against PPs for psychologists and to discuss the major implications of PPs for both professional psychology and psychiatry.

Methods: We conducted a literature search of relevant articles published from 1980 to the present appearing on Psychlit and Medline databases, using "prescription privileges" and "psychologists" as search titles.

Conclusion: Although proponents present several compelling arguments in favour of PPs for psychologists, pilot projects relating to feasibility and efficacy are either sparse or incomplete. Thus, it is too soon to tell whether PPs could or should be pursued. Clearly, more research is needed before we conclude that PPs for psychologists are a safe and necessary solution to psychology's alleged impending marginalization.
PMID: 12085679 [PubMed - indexed for MEDLINE]

J Clin Psychiatry. **1991 Jan;52(1):4-8.**
Comment in:
The "deep structure" of clinical medicine and prescribing privileges for psychologists.
Pies RW.
Department of Psychiatry, Tufts University School of Medicine, Boston, Mass.

Clinical medicine in general and psychiatry in particular have their roots in the Hippocratic tradition. It is this tradition that defines the "deep structure" of the medical profession. Although the field of clinical psychology has a similar "surface structure" to that of psychiatry and general medicine, it has evolved from a wholly different set of deep structural antecedents. These issues relate directly to the question of "prescribing privileges" for psychologists. The addition of coursework in psychopharmacology to the psychology curriculum would not alter the deep structure of the profession nor would it equip psychologists to prescribe psychotropic medication. There are, however, ways in which the disciplines of medicine and psychology can cooperate in the education of clinicians.
PMID: 1958242 [PubMed - indexed for MEDLINE]

Gen Hosp Psychiatry. **2006 May-Jun;28(3):249-254.**
Access of behavioral health patients to prescribing professionals.
Greenberg GA, Myer J, Sernyak M, Rosenheck RA.

Advanced practice nurses (APNs), including clinical nurse specialists and nurse practitioners, now have prescribing privileges in all states. This study examined the proportion of Department of Veteran Affairs (VA) mental health patients who were seen by any prescribing professional and specifically the proportion and characteristics of patients who were treated exclusively by APNs. Method: Logistic regression models were used to examine data on all patients who received care in VA specialty mental health clinics in 2002 (n=767,920). We first identified patient characteristics independently associated with prescriber contact and, secondly, among those with prescriber contact, exclusive contact with an APN. We also compared characteristics of patients seen exclusively by an APN with those who saw both a physician and an APN. Results: The strongest predictors of both whether a veteran saw a prescriber (66.6%) and whether that prescriber was exclusively an APN (6.7%) were indicators of severity. Specifically, more severe diagnoses, such as schizophrenia or bipolar disorder, receipt of VA disability payments and greater service use increased the odds that a veteran would have had a prescriber contact, decreased the odds that they would see an APN exclusively and, among those who saw an APN, increased the odds that they would also see a physician. Conclusions: Patients who see physician prescribers have more severe mental health problems than those who see APNs. Our results indicate that APNs and physicians treat distinguishable patient populations, suggesting that APNs may not be substitutes for physicians.

Md Med. **2002 Fall;3(4):21-3, 45.**
The 2002 psychologist prescribing law in New Mexico: the psychiatrists' perspective.
Yager J.
Department of Psychiatry, University of New Mexico School of Medicine.

In March 2002 New Mexico passed the first state statute permitting the development of a process leading to prescriptive authority for doctoral level psychologists who obtain requisite training and certification. This article reviews the background of these events, the political processes by which this expanded scope of practice for psychologists evolved, the current state of regulatory discussions regarding this statute, forecasts of the practical impact of this legislation on practitioner patterns, and prospects for the future.
PMID: 12481742 [PubMed - indexed for MEDLINE]

Psychology literature

Am Psychol. **1996 Mar;51(3):230-4.**
Basic science training in psychopharmacology. How much is enough?
Sammons MT,
Sexton JL,
Meredith JM.
National Naval Medical Center, Bethesda, Maryland, USA.

Training psychologists to administer psychotropic medication will require acquisition of a unique knowledge base and set of skills that are generally not components of graduate education in psychology. Nevertheless, the current level of basic science training in graduate education in psychology is substantial and should, with minor modification, allow adequate preparation for students to enter into specialized training to prescribe. The direct provision of psychopharmacology requires psychologists to demonstrate competencies in addition to those

required in the general provision of psychological services. Such competencies are perhaps best taught at the post-doctoral level. The authors argue that all curricula training professional psychologists should be able to train psychologists capable of practicing as independent, full-fledged health care providers.
PMID: 8881532 [PubMed - indexed for MEDLINE]

***J Clin Psychol.* 2002 Jun;58(6):681-96.**
Prescribing privileges: grail for some practitioners, potential calamity for interprofessional collaboration in mental health.
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The focus of this article is the probable consequences, in the event psychologists aggressively pursue prescription privileges (RxP), upon collaboration between psychologists and physicians. The case for RxP is briefly and critically summarized and the current state of collaboration between psychologists and medical professionals is reviewed. Data are presented from a recent small survey of clinical psychologists that support the following hypotheses: (1) psychiatrists and other medical professional receive a consequential volume of referrals from psychologists which would be diminished by RxP; (2) psychologists receive referrals for psychosocial services from medical professionals which would be diminished by RxP; (3) psychologists anticipate an adverse effect upon collaboration from RxP; and (4) contrary to some claims, psychologists are at best divided over RxP. Implications of these findings upon interprofessional collaboration are discussed. Copyright 2002 Wiley Periodicals, Inc. *J Clin Psychol* 58: 681-696, 2002.
PMID: 12007159 [PubMed - indexed for MEDLINE]

***J Clin Psychol.* 2002 Jun;58(6):659-76.**
Training for prescriptions vs. prescriptions for training: where are we now? Where should we be? How do we get there?
McFall RM.
Department of Psychology, Indiana University-Bloomington, 47405, USA. *mcfall@indiana.edu*

The proposal that state legislatures should grant prescription privileges to psychologists is examined critically, with particular attention to the proposal's implications for the future education and training of clinical psychologists. First, the current status of clinical psychology is described. Then, an alternative to the prescription privilege proposal is presented; this alternative prescribes a scientific approach to clinical psychology. Finally, a plan for achieving this alternative is outlined. Copyright 2002 Wiley Periodicals, Inc. *J Clin Psycho*l 58: 659-676, 2002.
PMID: 12007157 [PubMed - indexed for MEDLINE]

***J Clin Psychol.* 2002 Jun;58(6):709-22.**
Concluding remarks on the debate about prescription privileges for psychologists.
Heiby EM.
Department of Psychology, University of Hawaii, Honolulu, 96822, USA. *heiby@hawaii.edu*

This article summarizes the six primary arguments for and against prescription privileges for psychologists (PPP or RxP) that were presented in this special issue. Four articles addressed points made in the testimony in favor of PPP by the American Psychological Association. Six articles addressed points in the testimony against PPP by the American Association of Applied and Preventive Psychology. It is concluded that the PPP debate reflects a deep schism in clinical psychology that represents a serious disunity in the field. The disunity is seen as a divide between those trained to be psychotherapists and those trained to be scientist-practitioners. It is argued that the former support PPP and are interested in the survival of professional schools, while the latter oppose PPP and are interested in the survival of university departments of psychology. For the discipline to survive there must be a rapprochement between these factions and alternatives to PPP for the retraining of psychotherapy practitioners. Copyright 2002 Wiley Periodicals, Inc. *J Clin Psychol* 58: 709-722, 2002.
PMID: 12007161 [PubMed - indexed for MEDLINE]

***J Clin Psychol.* 2002 Jun;58(6):635-48.**
Just say no to psychotropic drugs!
Albee GW.
University of Vermont, USA.

Prescribing drugs for mental disorders by psychologists means accepting an invalid model—the brain disease, biological-defect explanation of psychopathology—that is advanced by political conservatives and accepted by some naive, well-intentioned, but misinformed moderates who have not thought critically about the issue. Conservative psychiatry serves the ruling class by rejecting or ignoring the fact that most mental disorders are learned in the context of social and economic injustice, and familiar dysfunction. If we accept the fallacy of brain disease and genetic defect as the major causes of mental disorder and succeed in getting prescription privileges we will have sold our soul to the devil!
PMID: 12007155 [PubMed - indexed for MEDLINE]

***J Clin Psychol.* 2002 Jun;58(6):677-80.**
The high cost of prescription privileges.
Wagner MK.
University of South Carolina, USA.

This article presents some data regarding the costs in the augmentation of programs aimed at equipping psychologist to prescribe medications. Data are presented relative to the financial burden it will place on students, universities, internship sites, and the consumers of psychological services. Copyright 2002 Wiley Periodicals, Inc. *J Clin Psychol* 58: 677-680, 2002.
PMID: 12007158 [PubMed - indexed for MEDLINE]

***Professional Psychol Res Pract.* 2004;35(4):336-344.**
A debate on prescription privileges for psychologists.
Heiby EM,
DeLeon PH,
Anderson T.

This article presents the comments of Elaine M. Heiby and Patrick H. DeLeon during a debate on prescription privileges for psychologists held at the August 2002 convention of the American Psychological Association (ApA). The debate began with DeLeon presenting arguments in favor of the ApA policy on this issue, followed by Heiby presenting argument against the policy. The presenters discussed the justification for the ApA model of training for prescription privileges and the impact of training for prescription privileges on university-based departments of psychology.

***J Clin Psychol.* 2002 Jun;58(6):649-58.**
Preparing psychologists to prescribe.
Sechrest L,
Coan JA.
Department of Psychology, University of Arizona, Tucson, 85721, USA. *sechrest@u.arizona.edu*

In this report, an investigation of the training received by professionals currently authorized to prescribe medications is considered as a step toward understanding what might be involved in preparing psychologists appropriately if prescription privileges for psychology were to be obtained. Information about admission and curriculum requirements was collected from medical schools, dental schools, physician assistant programs, nurse practitioner programs, and schools of optometry. Results suggest a high level of pharmacologically relevant coursework is required for admission to, and the completion of, programs that currently prepare their professionals to prescribe. It is argued that preparing psychologists to prescribe would likely entail similar training requirements in addition to, or instead of, those already in place, leaving clinical psychology dramatically and permanently altered. Copyright 2002 Wiley Periodicals, Inc. *J Clin Psychol* 58: 649-658, 2002.
PMID: 12007156 [PubMed - indexed for MEDLINE]

***J Clin Psychol in Med Settings.* 2003 Sep;10(3).**
Prescriptive authority for psychologists: despite deficits in education and knowledge?
Robiner WN, Beraman DL, Berman M, Grove WM, Colon E, Armstrong J, Mareck S, Tanenbaum RL.

As some psychologists advocate for prescription privileges, the need for closer analysis of the differences between psychologists and psychiatrists grows. Our data reveal key gaps in psychologists' training and significant limitations in their knowledge of pertaining to prescribing relative to psychiatrists. Attitudes toward prescribing and estimates of psychologists' competence in prescribing are presented. The authors believe that psychologists' deficits in training and pertinent knowledge constitute major hurdles to competent prescribing. Caution is warranted about expanding psychologists' scope of practice to include prescribing.

***Clin Psychol Sci Pract.* 2002;9:264-69.**
Invasion of the body snatchers: prescription privileges, professional schools, and the drive to create a new behavioral health profession.
Hayes SC,
Chang G.

The effect and perhaps the purpose of the prescription privilege movement in psychology will be to create a new behavioral health profession under the name "psychology," initially controlled by practice interests and by professional schools of psychology. It is a logical extension not of psychology per se but of certain trends within professional practice. A new behavioral health profession might be worthwhile, considered on its own terms, but ironically the very forces giving rise to it within psychology are pushing the movement down a path that could create a public health hazard and problems for both empirical clinical psychology and for the existing practice base.

Clin Psychol Sci Pract. **2002;9:256-258.**
It is time for a moratorium on legislation enabling prescription privileges for psychologists.
Heiby EM.

The prescription privileges proposal may be one of the most widely debated and divisive issues organized psychology has ever faced. I argue that the concerns raised and evidence presented by Robiner et al. in this issue's article opposing prescription privileges justify an immediate review of American Psychological Association (ApA) policy on prescription privileges and an accompanying moratorium on enabling legislation. It is critical that both basic and applied psychologists appreciate that the proposal is not just a professional and consumer protection issue, but fundamentally a training issue that would overhaul the nature of the entire discipline. Concerns raised include the viability of university-based departments of psychology and thereby the maintenance of psychological science and its evidence-based applications.

Can Psychol-Psychol Can. **2001 May;42(2):119-125**
A meta-analysis of opinion data on the prescription privilege debate.
Walters GD.

A meta-analysis of opinion survey data examined the attitudes of practicing psychologists, psychologists in training, and directors of clinical and internship training towards prescription privileges for psychologists. Three prescription-relevant statements were reviewed: (1) properly trained psychologists should be allowed to prescribe psychotropic medication; (2) ApA should advocate in favour of prescription privileges for psychologists; (3) I would personally seek prescription privileges should such privileges be made available to psychologists. The results, based on 17 samples, showed minimal consensus and a general split of opinion on the advisability of pursuing the prescription privilege agenda. These findings suggest that prescription privileges have the potential to confuse issues of training and identity for future generations of psychologists.

Other journals or literature

Am J Law Med. **2003;29(4):489-524.**
American Society of Law, Medicine, and Ethics. Boston University School of Law.
Fool's gold: psychologists using disingenuous reasoning to mislead legislature into granting psychologists prescriptive authority.
Pollitt B.

Mental illness is a serious problem in the United States. The American Psychological Association offers five main reasons why legislatures should grant psychologists the privilege to prescribe medication: 1) psychologists' education and clinical training better qualify them to diagnose and treat mental illness in comparison with primary care physicians; 2) the Department of Defense Psychopharmacology Demonstration Project ("PDP") demonstrated non-physician psychologists can prescribe psychotropic medications safely; 3) the recommended post-doctoral training requirements adequately prepare psychologists to prescribe safely psychotropic medications; 4) this privilege will increase availability of mental health care services, especially in rural areas; and 5) this privilege will result in an overall reduction in medical expenses, because patients will visit only one health care provider instead of two—one for psychotherapy and one for medication. The psychologists' contention that granting them prescriptive authority would significantly allay un-met mental health needs in rural areas is also highly questionable. Psychologists seeking prescriptive authority conclude that granting them this privilege will increase patient access to psychotropic medication, especially in rural areas. Instead of working on collaborative models in which physicians prescribe medication and psychologists provide therapy, they seek to supplant psychiatry and non-prescribing psychologists by creating a "new breed" of psychologist (a.k.a. pseudo-psychiatrist).

Law Psychol Rev. **2005;29:243-260.**
Power to prescribe: the debate over prescription privileges for psychologists and the legal issues implicated.
Long JE Jr.

The debate over prescription privileges has persisted for the past two decades within the field of psychology between clinical and academic psychologists, and also by concerned outsiders such as psychiatrists, physicians, and government officials. While variance does exist in the survey data, it appears that a slight majority of psychologists are in favor of the initiative by the American Psychological Association (ApA) to obtain prescription privileges, with anywhere from 9 to 62 percent of psychologists who would actually pursue the training. Essentially, the increased availability of psychotropic treatments to the public—especially in rural areas—and the proposition that prescription authority is the next logical step in the professional development of clinical psychology are the two prevailing arguments advanced by proponents of the ApA's initiative. According to some opponents of prescription privileges

for psychologists, there have never been objections to psychologists obtaining such authority under certain conditions—for example going to medical school or training in certain nursing programs. Thus, the main concern for opponents of laws granting prescription privileges—like the statutes enacted by New Mexico and Louisiana—is the risk to patients' safety and well-being resulting from inadequate training of psychologists to prescribe medication.

Documents pertaining to the Department of Defense (DoD) Psychopharmacology Demonstration Project

Defense health care: need for more prescribing psychologists is not adequately justified.
HEHS-97-83, April 1, 1997.
www.gao.gov/archive/1997/he97083.pdf

Prescribing psychologists: DoD demonstration participants perform well but have little effect on readiness or costs.
HEHS-99-98, May 25, 1999.
www.gao.gov/archive/1999/he99098.pdf

Reports, testimony, and correspondence.
Reports, testimony, correspondence, and other publications GAO/OPA-99-9 United States General Accounting Office GAO Office of Public Affairs month in review: May 1999.
Visit the Web site below for a pdf version of the testimony of May 25, 1999 GAO report.
www.gao.gov/archive/1999/pa99009.pdf

Final report: DoD prescribing psychologists: external analysis, monitoring, and evaluation of the program and its participants.
May 1998.
www.dod.mil/pubs/foi/PrescribePsychologists.pdf

The ACNP evaluation report and final summary.
American College Of Neuropsychopharmacology Newsletter
ACNP Bulletin, Vol. 6, No. 3, Summer 2000.
www.acnp.org/Default.aspx?Page=Bulletin

Figure 1. State licensure requirements for psychologists

State	Psychologists Currently Licensed in State	Doctoral degree required?	Master's level licensure?	Post-doctoral clinical/practicum experience required?	Examination required for licensure?	ASPPB agreement of reciprocity?	"Senior" Psychologist Waive-In for Licensure?	Continuing education requirements
Alabama	819 (as of 8/1/2006)	Yes. (Code of Ala. § 34-26-41)	AL licenses "Psychological Technicians" at the Masters Degree level. (Ala. Admin. Code r. 750-X-2A-.04)	None. APA or Canadian Psychological Association accredited internship lasting one to two years pre-doctoral degree. 2 hours/week individual supervision; 2 hours/week group supervision. (Ala. Admin. Code r. 750-X-2-.06)	EPPP Passing Score=ASPPB Reccomm-ended Score; Local exam also required Passing Score=80% (Ala. Admin. Code r. 750-X-3-.01)	No	No	Required. 20 hours per year. (Ala. Admin. Code r. 750-X-3A-.03)
Alaska	161 (as of 4/10/2006)**	Yes. (Alaska Stat. § 08.86.130)	AK licenses "Psychological Associates" at the Masters Degree level. (Alaska Stat. § 08.86.160)	Two years post doctoral supervised experience required. 1500 total hours/1 hour per-week individual supervision. (12 Alaska Admin. Code 60.080)	EPPP Passing Score= 500 Local written Examinat-ion also required, Passing Score =70% (12 Alaska Admin. Code 60.110, 12 Alaska Admin. Code 60.140)	No	No	Required.40 hours over two years. Courses include: Ethics, jurisprudence and law. (12 Alaska Admin. Code 60.260)
Arizona	1239 (as of 8/1/2006)	Yes. (A.R.S. § 32-2071)	No.	Post-doctoral experience required. 1500 hours to be completed within three years. 2 hours per week individual supervision, 2 hours per week group supervision. (A.R.S. § 32-2071)	EPPP Passing Score=70% on written or 500 on computer based. (AZ S.B. 1080 (Enacted 2006, not yet incorporated into statutes))	No	Yes. 20 or more years of licensure, no discipline, other verification of training, waive documentation (AZ S.B. 1080 (Enacted 2006, not yet incorporated into statutes))	Required. *60 hours over two years. Courses include: Ethics, jurisprudence and law. (A.R.S. § 32-2074)*
Arkansas	473 (as of 4/11/2006)**	Yes. (A.C.A. § 17-53-106)	AR licenses "Psychological Examiners" at the Masters Degree level. (A.C.A. § 17-97-303)	Post-doctoral experience required. 2000 hours to be completed within two years. One hour per week individual supervision. (074 00 CARR 001)	EPPP Passing Score=ASPPB Reccomm-ended; Oral examination required (074 00 CARR 001)	Yes. (074 00 CARR 001)	Yes. If applicant has 20 or more years of licensure, no discipline then Senior psychologists license may be issued. (074 00 CARR 001)	Required. 40 hours over two years. (074 00 CARR 001)

Figure 1. State licensure requirements for psychologists

State	Psychologists Currently Licensed in State	Doctoral degree required?	Master's level licensure?	Post-doctoral clinical/practicum experience required?	Examination required for licensure?	ASPPB agreement of reciprocity?	"Senior" Psychologist Waive-In for Licensure?	Continuing education requirements
California	17500 (as of 8/2005)**	Yes. (Cal Bus & Prof Code § 2914)	CA licenses "Psychological Assistants" at the Masters Degree level. (Cal Bus & Prof Code § 2913)	One year required training. 1500 hours. (16 CCR 1387)	EPPP Passing Score=ASPPB Reccomm-ended; computer-assisted examination also required (Cal Bus & Prof Code § 2942, 16 CCR 1388)	No	No	Required. 36 hours over two years. Courses to include: ethics, jurisprudence, law and domestic violence. (16 CCR 1397.61)
Colorado	2235 (as of 8/1/2006)*	Yes. (C.R.S. 12-43-304)	No.	1500 hours in 12 months; supervision required. (C.R.S. 12-43-304)	Passed a single, written examination in psychology as prescribed by the board and jurisprudence examination. (C.R.S. 12-43-304) *EPPP Passing Score=500; Written examination also required, passing grade =80%*	No	No	Not required.
Connecticut	1626 (as of 8/1/2006)	Yes. (Regs., Conn. State Agencies § 20-188-2)	No.	One year supervised experience. (Regs., Conn. State Agencies § 20-188-3)	All applicants must pass an examination in psychology to be given at such time and place as the department prescribes. (Conn. Gen. Stat. § 20-188) *EPPP Passing Score= 500; Local written exam also required.*	No	No	Not required.
Delaware	386 (as of 8/1/2006)**	Yes. (24 Del. C. § 3508)	DE licenses "Psychological Assistants" at the Master's degree level. (24 Del. C. § 3508)	One year supervised experience. 1500 hours. One hour/week individual supervision. (CDR 10-527-001(7.2))	EPPP Passing Score=ASPPB Recommended Score (24 Del. C. § 3506)	Yes. (24 Del. C. § 3511)	No	Required.40 hours over two years. (CDR 10-527-001)
D.C.	1200 (as of 9/2005)**	Yes. (CDCR 17-6902)	No.	4000 hours supervised experience within 2 to 3 years.(CDCR 17-6902)	Passage of national exam. (CDCR 17-6904) *EPPP Passing Score= 500;* Local written exam also required (CDCR 17-6905).	No	No	Required.30 hours over two years. (CDCR 17-6906)

Figure 1. State licensure requirements for psychologists

State	Psychologists Currently Licensed in State	Doctoral degree required?	Master's level licensure?	Post-doctoral clinical/practicum experience required?	Examination required for licensure?	ASPPB agreement of reciprocity?	"Senior" Psychologist Waive-In for Licensure?	Continuing education requirements
Florida	3767 (as of 8/1/2006)	Yes. (Fla. Stat. § 490.005)	No.	2000 hours supervised experience required in 2 years. 1 hour/week individual supervision & 1 hour/week group supervision. (64B19-11.005, F.A.C.)	EPPP=ASPPB recommended score; Local written exam required. (Fla. Stat. § 490.005)	No	No	Required.40 hours over two years. Courses include: Ethics, jurisprudence and law, domestic violence and the prevention of medical errors. (64B19-13.003, F.A.C.)
Georgia	1963 (as of 8/1/2006)*	Yes. (O.C.G.A. § 43-39-8)	No.	1500 hours of individually supervised experience. (Ga. Comp. R. & Regs. r. 510-2-.05)	EPPP=500; Local written exam also required. (Ga. Comp. R. & Regs. r. 510-2-.01)	No.	Yes. If applicant has current licensure for 10+ yrs., info./verification form from jurisdiction of licensure, in good standing, oral + written GA exams, then licensure by endorsement may be granted. (Ga. Comp. R. & Regs. r. 510-3-.02)	Required. 40 hours over two years. Required courses include: ethics, jurisprudence, law, cultural diversity and psychopharmacology.(Ga. Comp. R. & Regs. r. 510-8-.01)
Hawaii	784 (as of 6/15/2006)	Yes. (HRS § 465-7)	No.	One year of post doctoral supervised experience and an internship OR one year of supervised experience in an internship or residency program in an organized health service training program. (HRS § 465-7)	EPPP Passing Score= not less than 70% and local state exam passage score not less than 75%. (WCHR § 16-98-30)	No	Yes. If applicant has 20 years experience, current license accepted as meeting requirements of licensure, no disciplinary sanctions the HI license may be granted. (HRS § 465-7)	Not required.

Figure 1. State licensure requirements for psychologists

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Idaho	354 (as of 8/1/2006)	Yes. (Idaho Code § 54-2307)	No.	One year supervised experience. One hour/week individual supervision. (IDAPA 24.12.01.550)	EPPP Passing Score=500 (IDAPA 24.12.01.200)	No	Yes. If applicant has valid license for 20+ years, no disciplinary sanctions, has met cont. ed. requirements for last 5 yrs, the license may be granted. (Idaho Code § 54-2312A)	Required. 20 hours per year. (IDAPA 24.12.01.401)
Illinois	5602 (as of 8/3/2006)	Yes. (225 ILCS 15/10)	No.	One year supervised experience. One hour/week individual supervision. (225 ILCS 15/10)	Board shall authorize examinations to ascertain the qualifications and fitness of applicants. (225 ILCS 15/6) *EPPP Passing Score=500*	No	Yes. If applicant has licensure 20+ years no disciplinary sanctions, then license may be granted (225 ILCS 15/11)	Not required.
Indiana	1627 (as of 8/1/2006)	Yes. (Burns Ind. Code Ann. § 25-33-1-5.1)	No.	Pre-doctoral internship required: minimum one year. (868 IAC 1.1-4-1)	EPPP Passing Score=500; Local written exam also required. (Burns Ind. Code Ann. § 25-33-1-9)	No	No	Required. 40 hours over two years. (Burns Ind. Code Ann. § 25-33-2-2)
Iowa	475 (as of 2/21/2006)**	Yes. (Iowa Code § 154B.6)	No.	One year supervised experience. 1 hr/week, face-to-face supervision. (645 IAC 240.6(154B))	EPPP Passing Score=500; Local written exam also required. (645 IAC 240.4(154B))	No	No	Required. 40 hours over two years. (645 IAC 241.2(272C))
Kansas	731 (as of 8/3/2006)	No. (K.S.A. § 74-5361)	KS licenses "Masters Level Psychologists." These psychologists may only practice under the direction of a licensed clinical psychologist. (K.S.A. § 74-5361)	At least one year supervised experience. (K.A.R. § 102-1-5a)	EPPP Passing Score=70% (K.A.R. § 102-1-4)	No	No	Required. 50 hours over two years. (K.A.R. § 102-1-15)

Figure 1. State licensure requirements for psychologists

State	Psychologists Currently Licensed in State	Doctoral degree required?	Master's level licensure?	Post-doctoral clinical/practicum experience required?	Examination required for licensure?	ASPPB agreement of reciprocity?	"Senior" Psychologist Waive-In for Licensure?	Continuing education requirements
Kentucky	805 (as of 8/1/2006)	Yes. (KRS § 319.050)	KY licenses "Psychological Associates" and "Licensed Psychological Practitioners" at the Masters Degree level. (KRS § 319.053, KRS § 319.064)	2000 hours supervised experience. (201 KAR 26:171)	EPPP Passing Score=500; Local oral exam also required. (201 KAR 26:230)	Yes. (201 KAR 26:180)	No	Required. 30 hours over three years. Courses include, ethics, jurisprudence, law. (201 KAR 26:175)
Louisiana	617 (as of 8/1/2006)	Yes. LA also licenses "Medical psychologists" are those who have undergone specialized training in clinical psychopharmacology and have passed a national proficiency examination in psychopharmacology. (La. R.S. 37:2356, La. R.S. 37:2373)	No.	Minimum of 2 years experience, one year of which may be a pre-doctoral internship. (La. R.S. 37:2356)	EPPP Passing Score=500; Local oral and written exams also required. Passing Score=70%. (La. R.S. 37:2356, LAC 46:LXIII.503)	Yes. Licensure requirements must be substantially equivalent and other jurisdiction must allow reciprocity for LA licensed individuals. (LAC 46:LXIII.201)	No	Required. 30 hours over two years. (LAC 46:LXIII.801)
Maine	540 (as of 8/1/2006)	Yes. (CMR 02-415-003)	ME licenses "Psychological Examiner" at the Master's degree level. (CMR 02-415-003)	1500 hours supervision within 2 years. 1 hour/week individual supervision, 2 hours/week group. (CMR 02-415-003)	EPPP Passing Score=70%' Local oral exam also required. (CMR 02-415-003)	No	No	Required. 40 hours over two years. (CMR 02-415-005)
Maryland	2400 (as of 8/3/2006)	Yes. (COMAR 10.36.01.03)	MD licenses "Psychology Associates" at the Master's degree level. (COMAR 10.36.01.03)	One year supervision required. 1 hour/week individual supervision. (COMAR 10.36.01.04)	EPPP Passing Score=ASPPB recommended; Local exam also required. (COMAR 10.36.01.06)	No	No	Required. 40 hours over two years. (COMAR 10.36.02.03)
Massachusetts	4919 (as of 8/1/2006)	Yes. (ALM GL ch. 112, § 119)	No.	1600 hours supervision required within three years. (251 CMR 3.04)	EPPP Passing Score=500; Local written exam also required. (251 CMR 3.07)	No.	No	Required. 20 hours over two years. (251 CMR 4.03)

Figure 1. State licensure requirements for psychologists

State	Psychologists Currently Licensed in State	Doctoral degree required?	Master's level licensure?	Post-doctoral clinical/practicum experience required?	Examination required for licensure?	ASPPB agreement of reciprocity?	"Senior" Psychologist Waive-In for Licensure?	Continuing education requirements
Michigan	2594 (as of 7/21/2005)**	No. (MCL § 333.18223)	MI grants limited licenses to those who hold Master's degrees. These psychologists may only practice under the direction of a licensed clinical psychologist. (MCL § 333.18223)	Two years supervised experience. (MCL § 333.18223)	Board shall establish examination requirements. (MICH. ADMIN. CODE R 338.2504) *EPPP Passing Score=ASPPB recommended; Local exam also required.*	No	No	Not required. (MCL § 333.18233)
Minnesota	2000 (as of 7/27/2005)**	Yes. (Minn. Stat. § 148.907)	MN licenses "Licensed Psychological Practitioners" at the Master's degree level. (Minn. Stat. § 148.908) **There is grandfather clause for Master's level psychologist licensed prior to 1991.**	Minimum one full year or the equivalent in part-time supervision. (Minn. Stat. § 148.907)	Must pass EPP. *(EPPP Passing Score=500)* Local written and oral exams also required. (Minn. R. 7200.3000, Minn. R. 7200.3000)	No.	No	Required. 40 hours over two years. (Minn. R. 7200.3820)
Mississippi	365 (as of 8/2/2/006)	Yes. (Miss. Code Ann. § 73-31-13)	No.	2000 hours supervision must be completed within two years. 2 hours/week individual supervision. (CMSR 50-021-001)	EPPP Passing Score=500, ASPPB recommended. (CMSR 50-021-001)	Yes. (Miss. Code Ann. § 73-31-15)	Yes. If applicant has valid license 20+ years; in good standing, Board may waive written exam. (Miss. Code Ann. § 73-31-15)	Required. 20 hours over two years. Courses include ethics, jurisprudence and law. (CMSR 50-021-001)
Missouri	1720 (as of 8/2/2/006)	Yes. (§ 337.021 R.S.Mo. & Confirmed with Board)	**There is grandfather clause for Master's level psychologist licensed prior to 1996.** (§ 337.021 R.S.Mo. & Confirmed with Board)	1500 hours within 24 months. One hour/week individual supervision. (§ 337.025 R.S.Mo. & Confirmed with Board)	EPPP Passing Score=ASPPB recommended; Local exam also required. (4 CSR 235-2.060)	Yes. (§ 337.020 R.S.Mo.)	No.	Required. 40 hours over two years. (4 CSR 235-7.010)

Figure 1. State licensure requirements for psychologists

State	Psychologists Currently Licensed in State	Doctoral degree required?	Master's level licensure?	Post-doctoral clinical/practicum experience required?	Examination required for licensure?	ASPPB agreement of reciprocity?	"Senior" Psychologist Waive-In for Licensure?	Continuing education requirements
Montana	232 (as of 7/27/2005)**	Yes. (Mont. Code Anno., § 37-17-302)	No.	One year supervision required. (Mont. Code Anno., § 37-17-302) *1 hour/week individual supervision.*	Board shall prescribe examinations. (Mont. Code Anno., § 37-17-302) *EPPP Passing Score=500; Local oral exam also required.*	No.	Yes. If applicant has had licensure 20+ years, no disciplinary sanctions, MT oral exam. Board may issue license. (Mont. Code Anno., § 37-17-310)	Required. 40 hours over two years. (MONT. ADMIN. R. 24.189.2107)
Nebraska	395 (as of 8/3/2006)	Yes. (R.R.S. Neb. § 71-1,206.15)	NE licenses "Psychological Assistants" and "Psychological Associates" at the Master's degree level. (Nebraska Admin. Code Title 172, Ch. 155)	At least one year supervision required, 1,500 or more hours in total duration, including 1,000 or more hours of direct service hours earned in not more than 24 months. (R.R.S. Neb. § 71-1,206.15, Nebraska Admin. Code Title 172, Ch. 155)	EPPP Passing Score=ASPPB recommended; Local exam also required. (Nebraska Admin. Code Title 172, Ch. 155)	No	Yes. If applicant has 20+ years licensure, Board may issue license. (Nebraska Admin. Code Title 172, Ch. 155 Section 155-003.03)	Required.(R.R.S. Neb. § 71-1,206.31) *24 hours in two years.*
Nevada	322 (as of 1/27/2006)**	Yes. (Nev. Rev. Stat. Ann. § 641.170)	No.	One year supervision required. (NAC 641.080)	EPPP Passing Score=ASPPB recommended; Local oral exam also required. (Nev. Rev. Stat. Ann. § 641.180)	No.	No.	Required. 30 hours over two years. (NAC 641.136)
New Hampshire	617 (as of 8/2/2006)	Yes. (RSA 330-A:16)	No.	1500 hours over 24 months. One hour per week individual supervision. (N.H. Admin. Rules, Mhp 302.04)	EPPP Passing Score=ASPPB recommended; Local oral exam also required. (N.H. Admin. Rules, Mhp 302.05)	No.	No.	Required. (RSA 330-A:10) *40 hours over two years. Required courses include: ethics, jurisprudence and law.*
New Jersey	2883 (as of 8/2/2/006)**	Yes. (N.J. Stat. § 45:14B-17)	No.	One year supervision. (N.J. Stat. § 45:14B-17)	EPPP Passing Score= ASPPB recommended score; Local oral exam also required.(N.J.A.C. 13:42-5.1)	No	No.	Not required.

Figure 1. State licensure requirements for psychologists

State	Psychologists Currently Licensed in State	Doctoral degree required?	Master's level licensure?	Post-doctoral clinical/practicum experience required?	Examination required for licensure?	ASPPB agreement of reciprocity?	"Senior" Psychologist Waive-In for Licensure?	Continuing education requirements
New Mexico	560 (as of 8/2/2006)	Yes.NM also grants "Prescription Certificates" to candidates who meet certain requirements. (16.22.4.8 NMAC, N.M. Stat. Ann. § 61-9-17.1)	NM licenses "Psychologist Associates" at the Masters Level. (16.22.12.9 NMAC)	1500 hours over three years. One hour per week individual supervision. (16.22.6.8 NMAC, 16.22.6.9 NMAC)	EPPP Passing Score=500; Local oral exam also required. (16.22.7.8 NMAC)	No.	Yes. If applicant has current licensure 20+ years, no disciplinary sanctions, Board may issue license (16.22.5.11 NMAC)	Required. 60 hours over three years. Required courses include cultural diversity. Additional requirements to maintain "prescription certificate." (16.22.9.8 NMAC, N.M. Stat. Ann. § 61-9-17.1)
New York	11087 (as of 7/21/2006)*	Yes. (§ 72.1)	No.	One year supervision required. One hour per week individual supervision. (§ 72.2)	EPPP Passing Score=ASPPB recommended score. (§ 72.3)	No	No	Not required.
North Carolina	1500 (as of 8/2/2006)	Yes. (N.C. Gen. Stat. § 90-270.11)	NC licenses "Psychologist Associate" at the Master's level. (N.C. Gen. Stat. § 90-270.11)	1500 hours supervision required. One hour per week individual supervision. (21 N.C.A.C. 54.2009)	EPPP Passing Score=500; Local written exam also required. (21 N.C.A.C. 54.1901)	No.	Yes. Applicant who has 15+ years licensure, no disciplinary sanctions, NC written exam. May be issued license at "senior psychologist" level. (21 N.C.A.C. 54.1707)	Required. 18 hours over two years. (21 N.C.A.C. 54.2104) *Required courses include ethics, jurisprudence, law.*
North Dakota	185 (as of 9/28/2005)**	Yes. (N.D. Cent. Code, § 43-32-20)	No.	2000 hours supervised experience. (N.D. Admin. Code 66-02-01-11.1)	EPPP Passing Score=500; Local oral exam also required. (N.D. Admin. Code 66-02-01-09.1, N.D. Admin. Code 66-02-01-10)	No	No	Required. 40 hours over two years. (N.D. Admin. Code 66-03-01-02)
Ohio	3200 (as of 11/23/2005)**	Yes. (ORC Ann. 4732.10)	OH licenses "Psychology Assistant" at the Master's Level. (OAC Ann. 4732-13-03)	1,800 hours supervised experience to be completed within three years. (OAC Ann. 4732-9-01, 4732-9-03)	EPPP Passing Score=ASPPB recommended score; Local oral exam also required. (OAC Ann. 4732-11-01)	No	No	Required. 23 hours over two years. *Courses include ethics, jurisprudence and law.* (ORC Ann. 4732.141)

Figure 1. State licensure requirements for psychologists

State	Psychologists Currently Licensed in State	Doctoral degree required?	Master's level licensure?	Post-doctoral clinical/practicum experience required?	Examination required for licensure?	ASPPB agreement of reciprocity?	"Senior" Psychologist Waive-In for Licensure?	Continuing education requirements
Oklahoma	560 (as of 8/3/2006)	Yes. (59 Okl. St. § 1362)	OK licenses "Licensed Behavioral Practitioners" at the Master's Level. (59 Okl. St. § 1935)	2000 hours over three years. (O.A.C. § 575:10-1-2)	EPPP Passing Score=ASPPB recommended score, Oral and written examinations also required. (O.A.C. § 575:10-1-2)	Yes. (59 Okl. St. § 1366)	No	Required. 20 hours per year. (O.A.C. § 575:10-1-8)
Oregon	1250 (as of 8/9/2006)	Yes. (ORS § 675.030)	OR licenses "Psychologist Associate" at the Master's level. (ORS § 675.065)	At least 2 years supervised experience required, one year may be a pre-doctoral internship. (Or. Admin. R. 858-010-0036)	EPPP Passing Score=500, oral examination also required. (Or. Admin. R. 858-010-0025)	No	Yes. If applicant has 15+ years experience, national exam may be waived. (ORS § 675.050)	Required. 50 hours over two years. *Courses include ethics, jurisprudence and law.* (Or. Admin. R. 858-040-0015)
Pennsylvania	5751 (as of 7/22/2005)**	Yes. (49 Pa. Code § 41.31)	No.	1500 hours supervised experience. (49 Pa. Code § 41.31)	*EPPP Passing Score= 500*, local exam also required. (49 Pa. Code § 41.41)	No	No	Required. 30 hours over two years. (49 Pa. Code § 41.59)
Rhode Island	650 (as of 8/9/2006)	Yes. (CRIR 14-140-036)	No.	One year supervised experience. *One hour/week individual supervision*. (CRIR 14-140-036)	EPPP Passing Score= 500, *oral exam also required*. (CRIR 14-140-036)	No	No	Required. 40 hours over two years. (CRIR 14-140-036)
South Carolina	441 (as of 7/28/2005)	Yes. (S.C. Code Ann. § 40-55-80)	No.	Two years supervised experience, one of which may be pre-doctoral. One hour per week individual supervision. (S.C. Code Regs. 100-1)	*EPPP Passing Score= 500*, oral exam also required. (S.C. Code Ann. § 40-55-80)	Yes. (S.C. Code Ann. § 40-55-80)	No	Required. 12 hours over 12 months. (S.C. Code Regs. 100-10)
South Dakota	196 (as of 8/2/2006)	Yes.	**Doctoral degrees were not required for licensure prior to 1982.** (S.D. Codified Laws § 36-27A-13)	One year supervised experience. (S.D. Codified Laws § 36-27A-12)	EPPP Passing Score= 500, oral and written exam required. (ARSD 20:60:05:06, ARSD 20:60:05:07)	No	No	Required. (S.D. Codified Laws § 36-27A-26)

Figure 1. State licensure requirements for psychologists

State	Psychologists Currently Licensed in State	Doctoral degree required?	Master's level licensure?	Post-doctoral clinical/practicum experience required?	Examination required for licensure?	ASPPB agreement of reciprocity?	"Senior" Psychologist Waive-In for Licensure?	Continuing education requirements
Tennessee	1225 (as of 1/26/2006)**	Yes. (Tenn. Comp. R. & Regs. R. 1180-2-.02)	TN licensed "Psychological Examiners" at the Master's level. (Tenn. Comp. R. & Regs. R. 1180-3-.02)	1900 hours supervised experience, at least one hour per week individual supervision. (Tenn. Comp. R. & Regs. R. 1180-2-.02)	EPPP Passing Score= 500, oral exam also required. (Tenn. Comp. R. & Regs. R. 1180-2-.04)	No	Yes. Applicants who received their doctoral degree prior to January 1, 1982 have no supervision requirements. (Tenn. Comp. R. & Regs. R. 1180-2-.02)	Required. 40 hours over two years. (Tenn. Comp. R. & Regs. R. 1180-1-.08)
Texas	3653 (as of 10/2005)*	Yes. (Tex. Occ. Code § 501.255, 501.252, 501.259)	TX licenses "Licensed Psychological Associates" at the Master's level. (Tex. Occ. Code §501.259)	Two years of supervised experience in the field: one year of which may be as part of the doctoral program and at least one year of which began after the date the person's doctoral degree was conferred. (Tex. Occ. Code § 501.252)	*EPPP Passing Score= 500*, oral and written examinations required. (Tex. Occ. Code § 501.252)	Yes. (Tex. Occ. Code § 501.262)	No	Required. *12 hours per year. Courses required include: ethics, jurisprudence & law.* (Tex. Occ. Code § 501.252)
Utah	725 (as of 7/28/2005)**	Yes. (Utah Code Ann. § 58-61-304)	No.	2000 hours supervised experience over 24 months. (Utah Code Ann. § 58-61-304)	EPPP Passing Score= ASPPB recommended score, written examination also required. (U.A.C. R156-61-302a)	No	No	Required. 48 hours over two years. (U.A.C. R156-61-302h)
Vermont	548 (as of 8/2/2006	No. (CVR 04-030-270)	Applicants may be licensed as "Psychologist-Masters". (CVR 04-030-270)	4000 hours supervised experience, 2,000 of which must occur after the completion of the highest degree. At least one hour per week individual supervision. (CVR 04-030-270)	EPPP Passing Score= 500, local exam also required. (CVR 04-030-270)	No	No	Required. 60 hours over two years. Courses include: Ethics, jurisprudence and law. (CVR 04-030-270)
Virginia	2325 (as of 8/2/2006)	Yes. (18 VAC 125-20-54, 18 VAC 125-20-55)	No.	One year full-time residency required. Minimum two hours individual supervision per week. (18 VAC 125-20-65.)	*EPPP Passing score= ASPPB recommended score*, national/local written exam required. (18 VAC 125-20-80.)	No	Yes. If applicant has 20+ years experience, Board may issue license. (18 VAC 125-20-42)	Required. 14 hours per year. (18 VAC 125-20-121.)

Figure 1. State licensure requirements for psychologists

State	Psychologists Currently Licensed in State	Doctoral degree required?	Master's level licensure?	Post-doctoral clinical/practicum experience required?	Examination required for licensure?	ASPPB agreement of reciprocity?	"Senior" Psychologist Waive-In for Licensure?	Continuing education requirements
Washington	1709 (as of 1/26/2006)**	Yes. (Rev. Code Wash. (ARCW) § 18.83.070)	No.	One year supervised experience (minimum 1500 clock hours). Minimum one hour face-to-face supervision per every 20 hours of work. (WAC § 246-924-060)	EPPP Passing Score= 70%, local written and oral exam also required. (WAC § 240-924-070, WAC § 246-924-090)	No	No	Required. 60 hours over three years. *Required courses include ethics, jurisprudence and law.* (WAC § 246-924-230)
West Virginia	594 (as of 8/2/2006)	No. (W. Va. Code § 30-21-7)	Masters Degree applicants with five years experience are also allowed to apply for license. (W. Va. Code § 30-21-7)	Doctoral degree applicants must have one year supervised experience or 2000 hours within 24 months. Master's degree applicants must have five year's experience. (W. Va. Code § 30-21-7)	EPPP Passing Score= 70% Local oral exam also required (W. Va. CSR § 17-2-6)	No	No	Required. 20 hours over two years. *Board approves courses which typically include ethics, jurisprudence and law. 3 credit hours must be in ethics. (W. Va. CSR § 17-2-9)*
Wisconsin	1450 (as of 8/2/2006)	Yes. (Wis. Stat. § 455.04)	No.	1500 hours supervision required. One hour per week individual supervision. (Wis. Adm. Code Psy 2.09)	EPPP Passing Score= ASPPB recommended score Written exam on elements of practice essential to the public health, safety or welfare also required. (Wis. Adm. Code Psy 3.07)	Yes (Wis. Adm. Code Psy 2.12)	Yes. Applicants with 20+ years licensure may waive some document requirements and the national exam requirement. (Wis. Adm. Code Psy 2.12)	Required. 40 hours over two years. (Wis. Adm. Code Psy 4.02)
Wyoming	212 (as of 8/9/2006)	Yes. (WCWR 024-068-005, WCWR 024-068-006)	WY licenses "Psychological Practitioners" at the Masters Degree level. (WCWR 024-068-006)	1500 hours supervision required. Two hours per week individual supervision. (WCWR 024-068-005)	EPPP Passing Score= ASPPB recommended score (WCWR 024-068-005)	No	No.	Required. 30 hours over two years. (WCWR 024-068-008)

EPPP=Examination for Professional Practice in Psychology

ASPPB= Association of State and Provincial Psychology Boards

All information compiled from state statutes and administrative code.

italicized information was obtained from state Board websites and/or phone calls with Boards

Workforce numbers gathered from phone conversations with the Board unless indicated as:

*Workforce number gathered from Board website.

Figure 2. State licensure requirements for master's degree level psychologists

State	Code Citation	Master's Level Designation	Supervisory Requirements
Alabama	Code of Ala. § 34-26-1	Psychological Technician	Mandated supervision. May provide the following services after adequate training without supervision: administering and interpreting tests, interviewing and screening, and psychoeducational interventions.
Alaska	Alaska Stat. § 08.86.166	Psychological Associate	Supervision requirements not outlined in statutes or regulations.
Arizona		NONE	
Arkansas	A.C.A. § 17-97-102	Psychological Examiner	Required to be supervised with the exception of psychoeducational testing and diagnosis.
California	16 CCR 1391.5	Psychological Assistant	Supervision required.
Colorado		NONE	
Connecticut		NONE	
Delaware	24 Del. C. § 3502	Psychological Assistant	Supervision required.
D.C.		NONE	
Florida		NONE	
Georgia		NONE	
Hawaii		NONE	
Idaho		NONE	
Illinois		NONE	
Indiana		NONE	
Iowa		NONE	
Kansas	K.A.R. § 102-4-1a & State Board website	Master's Level Psychologist	Supervision required.
Kentucky	KRS § 319.064, KRS § 319.053	Psychological Associate, Licensed Psychological Practitioner	Psychological Associate--Supervision required. Licensed Psychological Practitioner may perform certain functions without supervision.
Louisiana		NONE	
Maine	32 M.R.S. § 3811	Psychological Examiner	Provides services involving the application of recognized principles, methods and procedures of the science and profession of psychology, but limited to interviewing or administering and interpreting tests of mental abilities, aptitudes, interests and personality characteristics, for such purposes as psychological evaluation or for educational or vocational selection, guidance or placement. A psychological examiner may provide intervention, such as consultation, behavior management or social skills training under the supervision of a licensed psychologist or as otherwise provided in law or rules issued in accordance with this chapter. A psychological examiner may not provide psychotherapy services under any circumstances.
Maryland	Md. HEALTH OCCUPATIONS Code Ann. § 18-301	Psychology Associate	Supervision required.
Massachusetts		NONE	
Michigan	MCL § 333.18212	Limited License	Supervision required.

Figure 2. State licensure requirements for master's degree level psychologists

State	Code Citation	Master's Level Designation	Supervisory Requirements
Minnesota	Minn. Stat. § 148.908, Minn. Stat. § 148.925	Licensed Psychological Practitioner, Psychologist*	Supervision required. *Grandfather clause for master's level individuals licensed prior to 1991. Supervision is not required for these individuals.
Mississippi		NONE	
Missouri	4 CSR 235-2.020	*Psychologist	*Psychologists were licensed at the master's degree level until 1996. Supervision is not required for these individuals.
Montana		NONE	
Nebraska	Nebraska Admin. Code Title 172, Ch. 155	Psychological Assistant or Psychologist Associate	A person who administers and scores and may develop interpretations of psychological testing under the supervision of a psychologist.
Nevada		NONE	
New Hampshire		NONE	
New Jersey		NONE	
New Mexico	16.22.12.8 NMAC	Psychologist Associate	Supervision required.
New York		NONE	
North Carolina	N.C. Gen. Stat. § 90-270.5	Psychological Associate	May provide certain services without supervision.
North Dakota		NONE	
Ohio	OAC Ann. 4732-13-03	Psychology Assistant	Supervision required.
Oklahoma	59 Okl. St. § 1931, 59 Okl. St. § 1935	Licensed Behavioral Practitioner	Allows for independent practice.
Oregon	ORS § 675.065	Psychologist Associate	Supervision required. Functions may include, but are not restricted to administering tests of mental abilities, and conducting personality assessments and counseling, including educational and vocational planning. Individual may petition board to function without supervision.
Pennsylvania		NONE	
Rhode Island		NONE	
South Carolina		NONE	
South Dakota	S.D. Codified Laws § 36-27A-13	*Psychologist	*Doctoral degrees were not required for licensure prior to 1982. Supervision is not required for these individuals.
Tennessee	Tenn. Code Ann. § 63-11-202	Psychological Examiner	Supervision typically required. Supervision required for the following activities or services: overall personality appraisal or classification, personality counseling, psychotherapy, behavior analysis or personality readjustment techniques. Supervision not required for the administration and interpretation of tests and psychological research services to organizations.
Texas	State Board Website "How to Become Licensed"	Licensed Psychological Associate	Supervision required.
Utah		NONE	
Vermont	26 V.S.A. § 3011a	Psychologist-Masters	Independent practice allowed.
Virginia		NONE	
Washington		NONE	

Figure 2. State licensure requirements for master's degree level psychologists

State	Code Citation	Master's Level Designation	Supervisory Requirements
West Virginia	W. Va. Code § 30-21-7	Psychologist	Master's level degree holders are not distinguished from doctoral level candidates for purposes of licensure as psychologists.
Wisconsin		NONE	
Wyoming	WCWR 024-068-006	Psychological practitioner	Supervision required.
All information complied from State Statutes and Regulations, State Board Websites & Phone Calls with Boards			

Figure 3. State scope of practice of psychologists

State	Statutory Authority	Observation	Evaluation	Psychological Testing	Hypnosis	Substance Abuse Treatment	Rx Privileges
Alabama	(Code of Ala. § 34-26-1, Ala. Admin. Code r. 750-X, Appendix III)	✓	✓	✓	✓	✓	Psychologists specifically prohibited. "Nothing in this definition shall be construed as permitting the use of those forms of psychotherapy which involve the administration or prescription of drugs or electro-shock or in any way infringing upon the practice of medicine..." (Code of Ala. § 34-26-1)
Alaska	(Alaska Stat. § 08.86.230)	✓	✓	✓	✓	Not specific	Only allowed by certain practitioners. Psychologists not included. (Alaska Stat. § 08.80.480)
Arizona	(A.R.S. § 32-2061)	✓	✓	✓	Not specific	Not specific	Psychologists specifically prohibited from "practicing medicine." (A.R.S. § 32-2076)
Arkansas	(A.C.A. § 17-97-102)	✓	✓	✓	✓	✓	"Practice of psychology shall not infringe on the practice of medicine." (A.C.A. § 17-97-101)
California	(Cal Bus & Prof Code § 2903)	✓	✓	✓	✓	✓	Psychologists specifically prohibited. "The practice of psychology shall not include prescribing drugs, performing surgery or administering electroconvulsive therapy." (Cal Bus & Prof Code § 2904)
Colorado	(C.R.S. 12-43-303)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (C.R.S. 12-22-102)
Connecticut	(Conn. Gen. Stat. § 20-187a)	✓	✓	✓	Not specific	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (Conn. Gen. Stat. § 20-571)
Delaware	(24 Del. C. § 3502)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists not included. (16 Del. C. § 4701)

Figure 3. State scope of practice of psychologists

State	Statutory Authority	Observation	Evaluation	Psychological Testing	Hypnosis	Substance Abuse Treatment	Rx Privileges
D.C.	(D.C. Code § 3-1201.02)	✓	✓	✓	✓	Not specific	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (D.C. Code § 3-1201.02)
Florida	(Fla. Stat. § 490.003)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (Fla. Stat. § 465.003)
Georgia	(O.C.G.A. § 43-39-1)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (O.C.G.A. § 26-4-5)
Hawaii	(HRS § 465-1)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists not included. (HRS § 329-1)
Idaho	(Idaho Code § 54-2302)	✓	✓	✓	Not specific	Not specific	Only allowed by certain practitioners. Psychologists not included. (Idaho Code § 54-1705)
Illinois	(225 ILCS 15/2)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists not included. (410 ILCS 620/2.36)

Figure 3. State scope of practice of psychologists

State	Statutory Authority	Observation	Evaluation	Psychological Testing	Hypnosis	Substance Abuse Treatment	Rx Privileges
Indiana	(Burns Ind. Code Ann. § 25-33-1-2)	✓	✓	✓	Not specific	Not specific	Psychologists specifically prohibited. "An individual licensed as a psychologist may not prescribe medication unless the individual is a practitioner…" (Burns Ind. Code Ann. § 25-33-1-2)
Iowa	(Iowa Code § 154B.1)	✓	✓	✓	Not specific	Not specific	Only allowed by certain practitioners. Psychologists not included. (Iowa Code § 155A.3)
Kansas	(K.S.A. § 74-5302)	✓	✓	✓	Not specific	Not specific	Only allowed by certain practitioners. Psychologists not included. (K.S.A. § 65-1626)
Kentucky	(KRS § 319.010)	✓	✓	✓	Not specific	✓	Only allowed by certain practitioners. Psychologists not included. (KRS § 217.015)
Louisiana AS OF NOVEMBER 1, 2006, THERE ARE 33 PSYCHOLOGISTS LICENSED TO PRESCRIBE	(La. R.S. 37:2352)	✓	✓	✓	✓	✓	**Yes. Prescribing allowed by "medical psychologists." (La. R.S. 37:2371-37:2378)** A medical psychologist holding a valid certificate to prescribe shall prescribe only in consultation and collaboration with the patient's primary or attending physician, and with the concurrence of that physician. The medical psychologist shall also re-consult with the patient's physician prior to making changes in the patient's medication regimen, including dosage adjustments, adding or discontinuing a medication. The medical psychologist and the physician shall document the consultation in the patient's medical record. In the event a patient does not have a primary or attending physician, the medical psychologist shall not prescribe for that patient. A medical psychologist shall not delegate the prescribing of a drug to any other individual. Medical psychologists are not allowed to prescribe narcotics. (La. R.S. 37:2371 & La. R.S. 37:2375)
Maine	(32 M.R.S. § 3811)	✓	✓	✓	✓	Not specific	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (32 M.R.S. § 13702)
Maryland	(Md. HEALTH OCCUPATIONS Code Ann. § 18-101)	✓	✓	✓	✓	Not specific	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (Md. HEALTH-GENERAL Code Ann. § 21-201)
Massachusetts	(ALM GL ch. 112, § 118)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (ALM GL ch. 94C, § 1)

Figure 3. State scope of practice of psychologists

State	Statutory Authority	Observation	Evaluation	Psychological Testing	Hypnosis	Substance Abuse Treatment	Rx Privileges
Michigan	(MCLS § 333.18201)	✓	✓	✓	✓	Not specific	Only allowed by certain practitioners. Psychologists not included. (MCLS § 333.17708)
Minnesota	(Minn. Stat. § 148.89)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists not included. (Minn. Stat. § 151.01)
Mississippi	(Miss. Code Ann. § 73-31-3)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists not included. (CMSR 50-018-001)
Missouri	(§ 337.015 R.S.Mo.)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (§ 338.095 R.S.Mo.)
Montana	(Mont. Code Anno., § 37-17-102)	✓	✓	✓	✓	✓	Psychologists specifically prohibited. "Nothing in this chapter shall be construed as permitting psychologists to prescribe drugs, perform surgery, or administer electroconvulsive therapy." (Mont. Code Anno., § 37-17-103)
Nebraska	(Nebraska Admin. Code Title 172, Ch. 155)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists not included. (R.R.S. Neb. § 71-1,142)

Figure 3. State scope of practice of psychologists

State	Statutory Authority	Observation	Evaluation	Psychological Testing	Hypnosis	Substance Abuse Treatment	Rx Privileges
Nevada	(Nev. Rev. Stat. Ann. § 641.025)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists not included. (Nev. Rev. Stat. Ann. § 453.128)
New Hampshire	(RSA 330-A:2)	✓	✓	✓	Not specific	Not specific	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (RSA 318:1)
New Jersey	(N.J.A.C. 13:42-1.1)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (N.J. Stat. § 24:6E-4)
New Mexico AS OF NOVEMBER 1, 2006, THERE ARE 4 PSYCHOLOGISTS LICENSED TO PRESCRIBE	(16.22.1.7 NMAC)	✓	✓	✓	✓	✓	**Yes. Prescribing allowed by "prescribing psychologists." (16.22.21.8 NMAC)** A conditional prescribing or prescribing psychologist shall not prescribe a drug, substance or controlled substance that is not contained in the formulary described in 16.22.27 NMAC. Unless specifically agreed to by the primary treating health care practitioner, a conditional prescribing or prescribing psychologist shall not prescribe medications for patients with the following conditions: 1) patients with a serious co-morbid disease of the central nervous system; (2) patients with cardiac arrhythmia; (3) patients who are being pharmacologically treated for coronary vascular disease; (4) patients with blood dyscrasia;(5) patients who are hospitalized for an acute medical condition; or (6) women who are pregnant or breast feeding. A conditional prescribing or prescribing psychologist may order and review laboratory tests that are necessary to maximize the psychopharmacological effectiveness and to minimize the potential untoward effects of medications that are prescribed.
New Mexico (Con't)							The psychologist shall not: (1) perform medical procedures such as spinal taps, intramuscular or intravenous administration of medication, or phlebotomy; (2) order or interpret neurovascular imaging procedures that use contrast media; (3) order or interpret neuro-imagining that require the use of radioactive material;(4) order or interpret roentgenological procedures (x-rays); or (5) perform amytal interviews.
New York	(New York Education Law, Article 153)	✓	✓	✓	✓	Not specific	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (10 NYCRR § 910.1)

Figure 3. State scope of practice of psychologists

State	Statutory Authority	Observation	Evaluation	Psychological Testing	Hypnosis	Substance Abuse Treatment	Rx Privileges
North Carolina	(N.C. Gen. Stat. § 90-270.2)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (N.C. Gen. Stat. § 90-87)
North Dakota	(N.D. Cent. Code, § 43-32-01)	✓	✓	✓	Not specific	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (N.D. Cent. Code, § 43-15-01)
Ohio	(ORC Ann. 4732.01)	✓	✓	✓	✓	Not specific	Only allowed by certain practitioners. Psychologists not included. (ORC Ann. 4729.01)
Oklahoma	(59 Okl. St. § 1352)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists not included. (59 Okl. St. § 353.1)
Oregon	(ORS § 675.010)	✓	✓	✓	Not specific	Not specific	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (ORS § 475.005)
Pennsylvania	(63 P.S. § 1202)	✓	✓	✓	Not specific	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (63 P.S. § 390-2)
Rhode Island	(R.I. Gen. Laws § 5-44-1)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (R.I. Gen. Laws § 5-19.1-2)
South Carolina	(S.C. Code Ann. § 40-55-50)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (S.C. Code Ann. § 40-43-30)

Figure 3. State scope of practice of psychologists

State	Statutory Authority	Observation	Evaluation	Psychological Testing	Hypnosis	Substance Abuse Treatment	Rx Privileges
South Dakota	(S.D. Codified Laws § 36-27A-1)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists not included. (S.D. Codified Laws § 39-15-8)
Tennessee	(Tenn. Code Ann. § 63-11-203)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists not included. (Tenn. Code Ann. § 53-10-101)
Texas	(Tex. Occ. Code § 501.003)	✓	✓	✓	✓	Not specific	Only allowed by certain practitioners. Psychologists not included. (Tex. Health & Safety Code § 481.002)
Utah	(Utah Code Ann. § 58-61-102)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (Utah Code Ann. § 58-17b-102)
Vermont	(26 V.S.A. § 3001)	✓	✓	✓	Not specific	✓	Only allowed by certain practitioners. Psychologists not included. (18 V.S.A. § 4201)
Virginia	(Va. Code Ann. § 54.1-3600)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (Va. Code Ann. § 54.1-3401)
Washington	(Rev. Code Wash. (ARCW) § 18.83.010)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (Rev. Code Wash. (ARCW) § 18.64.011)
West Virginia	(W. Va. Code § 30-21-2)	✓	✓	✓	Not specific	Not specific	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (W. Va. Code § 30-5-1b)

Figure 3. State scope of practice of psychologists

State	Statutory Authority	Observation	Evaluation	Psychological Testing	Hypnosis	Substance Abuse Treatment	Rx Privileges
Wisconsin	(Wis. Stat. § 455.01)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists are not licensed to prescribe. (Wis. Stat. § 450.01)
Wyoming	(Wyo. Stat. § 33-27-113)	✓	✓	✓	✓	✓	Only allowed by certain practitioners. Psychologists not included. (Wyo. Stat. § 33-24-136)

Scope information usually contained in definition of "psychology" or "psychologist" or within specific scope provisions.

Prescriptive authority information is typically found in the state pharmacy code, and often within the the definition of "prescription," "legend drug," "prescriber" or "practitioner." In the chart there are four designations: 1. Yes, 2. "Psychologists Specifically Prohibited"--This means there is a provision in the psychology code/regs that specifically prohibits psychologists prescribing, 3. "Only allowed by certain practitioners. Psychologists not included"--This means that in code there is a specific list of persons who can prescribe and psychologists are not included in the list., and 4."Only allowed by certain practitioners. Psychologists are not licensed to prescribe"--This means that in the code there is a list of people who can prescribe followed by a provision that says any others who are authorized by code OR sometimes the code says that anyone authorized by code can prescribe. In these cases, psychologists are not authorized in their scope of practice, but also not specifically excluded.

Figure 4. State boards of psychology operating information

State	Regulatory Board	Statutory Authority	Board Composition	Appointment Procedure	Special Procedures/ Other
Alabama	Alabama Board of Examiners in Psychology	Code of Ala. §34-26-20	7 members: 2 licensed/academic, 3 licensed/practicing, 1 psychological technician and 1 public member who must be black.	Governor appoints all members to 5-year terms.	Not Applicable.
Alaska	Board of Psychologist and Psychological Associate Examiners	Alaska Stat § 08.86.010	5 members: 3 licensed, 1 licensed psychological associate, and 1 public member.	Governor appoints all members to 4-year staggered terms.	Not applicable.
Arizona	Board of Psychologist Examiners	A.R.S. §32-2062	9 members: 6 licensed (2 academic and 3 practicing) and 3 public members.	Governor appoints all members to 5-year terms.	"Engage in a full exchange of information with other regulatory boards and psychological associations, national psychology organizations and the Arizona psychological association and its components."
Arkansas	Arkansas Psychology Board	A.C.A. §17-97-201	9 members: 1 academic, 4 practicing, 2 psychological examiners; 2 retired/or not actively engaged in practice psychologists (1 aged 60 or older).	Governor appoints all members to 5-year terms.	Not Applicable.
California	Board of Psychology	Cal Bus & Prof. Code §2920	9 members: 5 licensed, 4 public members.	Governor appoints the 5 licensed members and 2 members of the public. The Senate Rules Committee and the Speaker of the House each appoint one public members. All serve 4-year terms.	Not Applicable.
Colorado	State Board of Psychologist Examiners	C.R.S. 12-43-302	7 members: 3 licensed, 4 public members.	Governor appoints all members to 4-year terms.	Not Applicable.
Connecticut	Board of Examiners of Psychologists	Conn. Gen. Stat. §20-186	5 members: 3 licensed, 2 public members	Governor appoints all members. Terms not defined.	Not Applicable.
Delaware	Board of Examiners of Psychologists	24 Del. C. §3503	9 members: 5 licensed, 4 public members.	Governor appoints all members to 3-year terms.	Not Applicable.

Figure 4. State boards of psychology operating information

State	Regulatory Board	Statutory Authority	Board Composition	Appointment Procedure	Special Procedures/ Other
D.C.	Board of Psychology	D.C. Code § 3-1202.11	5 members: 4 licensed, 1 consumer.	Mayor appoints all members with the advice of Council to 3-year terms. Terms are as follows: 1 member serves for 1 year, 2 members serve for 2 years, 2 members serve for 3 years.	Not Applicable.
Florida	Board of Psychology	Fla. Stat. § 490.004	7 members: 5 licensed, 2 public members. One member must be 60+ years old.	Governor appoints, and the Senate confirms, all members to 4-year terms.	Not Applicable.
Georgia	State Board of Examiners of Psychologists	O.C.G.A. §43-39-2	6 members: 5 licensed and 1 consumer.	Governor appoints all members to 5-year terms.	Not Applicable.
Hawaii	Board of Psychology	HRS § 465-4	7 members: 5 licensed with 5+ years experience and 2 public members.	*Governor appoints all members.* Terms not defined.	Not Applicable.
Idaho	Idaho State Board of Psychologist Examiners	Idaho Code § 54-2304	5 members: 4 licensed (at least one practicing and one research), 1 public member.	Governor appoints all members to 4-year staggered terms.	Not Applicable.
Illinois	Clinical Psychologists Licensing and Disciplinary Board	225 ILCS 15/7, 225 ILCS 15/2	7 members: 4 licensed clinical, 2 licensed academic, and 1 public member.	Members are appointed by Secretary of Financial and Professional Regulation. Terms not defined.	Not Applicable.
Indiana	State Psychology Board	Burns Ind. Code Ann. §25-33-1-3	7 members: 6 licensed (with 5+ years experience), 1 public member.	Governor appoints all members to 3-year terms.	Bd. shall provide to interested parties (for comment) the names of restricted psychological tests and instruments proposed for rule-making.
Iowa	Board of Psychology Examiners	645 IAC 239.3(17A, 147, 272C)	7 members: 5 licensed (1 academic, 2 provide services, 1 practices in areas of applied psychology and 1 research), 2 public members.	Governor appoints all members and the Senate confirms. Terms not defined.	Not Applicable.
Kansas	Behavioral Sciences Regulatory Board	K.S.A. § 74-7501	11 members: 2 licensed, 2 licensed social workers, 1 professional counselor, 1 marriage and family therapist, 1 licensed masters level psychologist, and 4 public members.	Governor appoints all members to 4-year terms.	Not Applicable.

Figure 4. State boards of psychology operating information

State	Regulatory Board	Statutory Authority	Board Composition	Appointment Procedure	Special Procedures/ Other
Kentucky	Board of Examiners of Psychology	KRS §319.020	9 members: 6 licensed, 2 certified psychologists or licensed psychological practitioners or licensed psychological associates and 1 public member.	Governor appoints all members to 4-year terms.	Not Applicable.
Louisiana	Louisiana State Board of Examiners of Psychologists	La. R.S. 37:2353	5 members: all licensed psychologists with 5+ years experience.	Governor appoints all members to 5-year terms. The Senate confirms the appointments.	Not Applicable.
Maine	State Board of Examiners of Psychologists	32 MRS § 3821, 3821-A	9 members: 7 licensed (at least one psychological examiner), 2 public members.	Governor appoints all members to 3-year terms.	Board may contract with consultant for advice and assistance.
Maryland	State Board of Examiners of Psychologists	Md. HEALTH OCCUPATIONS Code Ann. § 18-201, 18-202	9 members: 7 licensed all with 5+ years experience (at least 2 service and 2 academic) and 2 consumers.	Governor appoints all members with the advice of the Secretary and the advice and consent of the Senate to 4-year terms.	Not Applicable.
Massachusetts	Board of Registration of Psychologists	ALM GL ch.13, § 76, 77	9 members: 7 licensed all with 5+ years experience (4 certified health service providers), and 2 public members.	Governor appoints all members to 5-year terms.	Not Applicable.
Michigan	Michigan Board of Psychology	MCLS § 333.18221	9 members: 5 psychologists (including one non-doctoral) and 4 public members.	*Members have staggered terms.* Terms and length of terms not defined.	Not Applicable.
Minnesota	Board of Psychology	Minn Stat. § 148.90	11 members: 3 licensed doctoral, 2 licensed masters, 2 psychologists (not necessarily licensed, and each representing a doctoral or master's training program), 1 psychological practitioner, and 3 public members.	Governor appoints all members. Terms not defined.	Not Applicable.
Mississippi	Mississippi Board of Psychology	Miss. Code Ann. § 73-31-5	7 members: 1 public and 6 licensed (3 academic and 3 practicing).	Governor appoints all members to 5-year terms.	Not Applicable.
Missouri	State Committee of Psychologists	§ 337.050 R.S.Mo.	8 members: 7 licensed with 3+ years experience (2 practicing and 2 engaged in doctoral teaching and training) and 1 public member.	Governor appoints all members upon recommendation of the director of the Division of Professional Registration and upon the advice and consent of the Senate to 5-year staggered terms.	Not Applicable.

Figure 4. State boards of psychology operating information

State	Regulatory Board	Statutory Authority	Board Composition	Appointment Procedure	Special Procedures/ Other
Montana	Board of Psychologists	Mont. Code Anno. § 2-15-1741	6 members: 2 licensed practicing, 1 licensed and working in public health, 1 licensed academic, and 2 general public.	Governor appoints all members, the Senate approves, to 5-year staggered terms.	Not Applicable.
Nebraska	Board of Psychologists	R.R.S. Neb. § 71-111 through R.R.S. Neb. § 71-114, R.R.S. Neb. § 116	7 members: 5 psychologists all with 5+ years experience (2 of 5 years may have been in research), 2 public members.	State Board of Health appoints all members to 5-year terms.	Not Applicable.
Nevada	Board of Psychological Examiners	Nev. Rev. Stat. Ann. § 641.030, 641.035	5 members: 4 licensed with 5+ years experience, 1 public member.	Governor appoints all members to 4-year terms.	Not Applicable.
New Hampshire	Board of Mental Health Practice	RSA 330-A:3	7 members: 1 licensed, 1 licensed pastoral psychotherapist, 1 licensed clinical social worker, 1 licensed marriage and family therapist, 1 licensed clinical mental health counselor, and 2 public members.	Governor appoints all members, *Executive* Council approves, to 3-year terms.	Not Applicable.
New Jersey	State Board of Psychological Examiners	NJ Stat. §45:14B-9, 14B-10, 14B-11	7 members: all licensed psychologists for 5+ years, actively practicing, or doing research or doctoral training.	Governor appoints all members to 3-year terms.	Not Applicable.
New Mexico	NM State Board of Psychologist Examiners	NM Stat. Ann. § 61-9-5	8 members: 4 licensed, 1 licensed psychologist associate, and 3 members of the public.	Governor appoints all members to 3-year staggered terms.	Not Applicable.
New York	State Board of Psychology	Education Law Article 153 § 7602	Not less than 11 psychologists and *1 member of the public.*	Appointed by the Board of Regents, recommended by the Commissioner of Education to *5-year terms.*	Not Applicable.
North Carolina	NC Psychology Board	N.C. Gen. Stat. § 90-270.6, 90-270.7	7 members: 3 licensed with 5+ years experience, 2 licensed psychological associates, and 2 members of the public. Each Bd. member must reside in a different congressional district at the time of the appointment.	Governor appoints all members to 3-year staggered terms.	Not Applicable.
North Dakota	State Board of Psychologist Examiners	ND Century Code §43-32-02, 43-32-03	5 members: all licensed psychologists with 5+ years experience and 5 years holding a doctoral degree (at least 1 must be engaged primarily in providing service in psychology and 1 academic)	Governor appoints all members to 3-year terms.	Not Applicable.

Figure 4. State boards of psychology operating information

State	Regulatory Board	Statutory Authority	Board Composition	Appointment Procedure	Special Procedures/ Other
Ohio	State Board of Psychology	ORC Ann. 4732.02	9 members: 6 licensed psychologists or licensed school psychologists and 3 patient advocates. Patient advocates are either parents or other relatives of a person who has received or is receiving mental health services or representatives of organizations that represent persons who have received or are receiving mental health services.	Governor appoints all members with the advice and consent of the Senate to 5-year terms.	Board members are paid a salary for their service as established in ORC Ann. 124.15 and ORC Ann. 124.152
Oklahoma	State Board of Examiners of Psychologists	59 Okl. St. § 1352.1, 1354, 1355	7 members: 5 licensed, 2 public members.	Governor appoints all members to 4-year terms.	Not Applicable.
Oregon	State Board of Psychologist Examiners	ORS §675.100	7 members: 5 licensed and 2 public members.	Governor appoints all members to 3-year terms and the Senate confirms the appointments.	Not Applicable.
Pennsylvania	State Board of Psychology	63 P.S. §1203.1	9 members: 6 licensed, 2 public members and the Commissioner of Professional and Occupational Affairs.	Appointed by the Governor to 4-year terms with the advice and consent of the Senate.	Not Applicable.
Rhode Island	Board of Psychology	R.I. Gen. Laws § 5-44-3, 5-44-4	5 members: 4 psychologists with 5+ years experience (at least 1 academic and 1 licensed) and 1 public member.	Appointed by the Director of the Department of Health with Governor approved appointments to 3-year terms.	Not Applicable.
South Carolina	State Board of Examiners in Psychology	SC Code Ann. § 40-55-20, 40-55-30	8 members: 3 clinical, 2 counseling, 1 school psychologist, 1 experimental, social, indus./organizational, or community psychologist, 1 public member.	Governor appoints all members to 5-year terms.	Not Applicable.
South Dakota	Board of Examiners of Psychologists	S.D. Codified Laws § 36-27A-3	7 members: 5 licensed with 2+ years experience, and 2 public members.	Governor appoints all members to 3-year terms.	Not Applicable.
Tennessee	Board of Examiners in Psychology	Tenn. Code § 63-11-101, 63-11-102	9 members: 2 academic, 4 licensed, 2 psychological examiners, and 1 public member. Governor shall strive to ensure that at least 1 Bd. member is aged 60 or older and that at least 1 member is of a racial minority.	Governor appoints all members to 5-year terms.	Not Applicable.

Figure 4. State boards of psychology operating information

State	Regulatory Board	Statutory Authority	Board Composition	Appointment Procedure	Special Procedures/ Other
Texas	Texas State Board of Examiners of Psychologists	Tex. Occ. Code § 501.051, 501.054, 501.059	9 members: 4 psychologists with 5+ years experience; 2 psychological associates with 5+ years experience, and 3 public members. A Bd. appointee must complete a training program prior to active participation on the Bd.	Governor appoints all members with the advice and consent of the Senate to 6-year staggered terms.	Not Applicable.
Utah	Psychologist Board	Utah Code Ann. § 58-61-201, Utah Code Ann. § 58-1-201	5 members: 4 licensed, 1 public member.	Appointed by the Executive Director of the Department of Commerce to 4-year terms. Governor will confirm or reject.	Not Applicable.
Vermont	Board of Psychological Examiners	26 V.S.A. § 3006, 3007	5 members: 3 licensed and 2 public members.	Governor appoints all members.	Not Applicable.
Virginia	Virginia Board of Psychology	18 VAC 125-20-10, Va. Code Ann. § 54.1-3603, 54.1-3604	9 members: 7 psychologists: 5 clinical, 1 school psychologist, 1 applied (1 of the 7 must be an academic psychologist) and 2 public members.	Governor appoints all members to 4-year terms.	Not Applicable.
Washington	Examining Board of Psychology	Rev. Code Wash. § 18-83.035	9 members: 7 psychologists with 3+ years experience, 2 public members.	Governor appoints all members to 5-year staggered terms.	Not Applicable.
West Virginia	Board of Examiners of Psychologists	W.Va. Code §30-21-5	5 members: all licensed with 2+ years experience, at least one must be a school psychologist.	Governor appoints all members, and the Senate confirms, to 3-year staggered terms.	Members may be paid such reasonable compensation as the board may from time to time determine.
Wisconsin	Psychology Examining Board	Wis. Stat. § 15.405, Wis. Stat. § 15.08	6 members: 4 psychologists (each to represent a different specialty area), 2 public members.	Governor nominates all members, Senate approves, to 4-year staggered terms.	Not Applicable.
Wyoming	WY State Board of Psychology Rules and Regulations	WCWR 024-068-001, 024-068-002	7 members: 5 licensed, 1 school psychologist, 1 psychological practitioner, and 2 public members.	Governor appoints all members to 5-year staggered terms.	Not Applicable.
All information compiled from state statutes and administrative code.					
Italicized information was obtained from state Board websites and/or phone calls with Boards					

Figure 5. Length of training for various psychologist psychopharmacology programs as opposed to U.S. Virgin Island bill 26-0318 training proposal

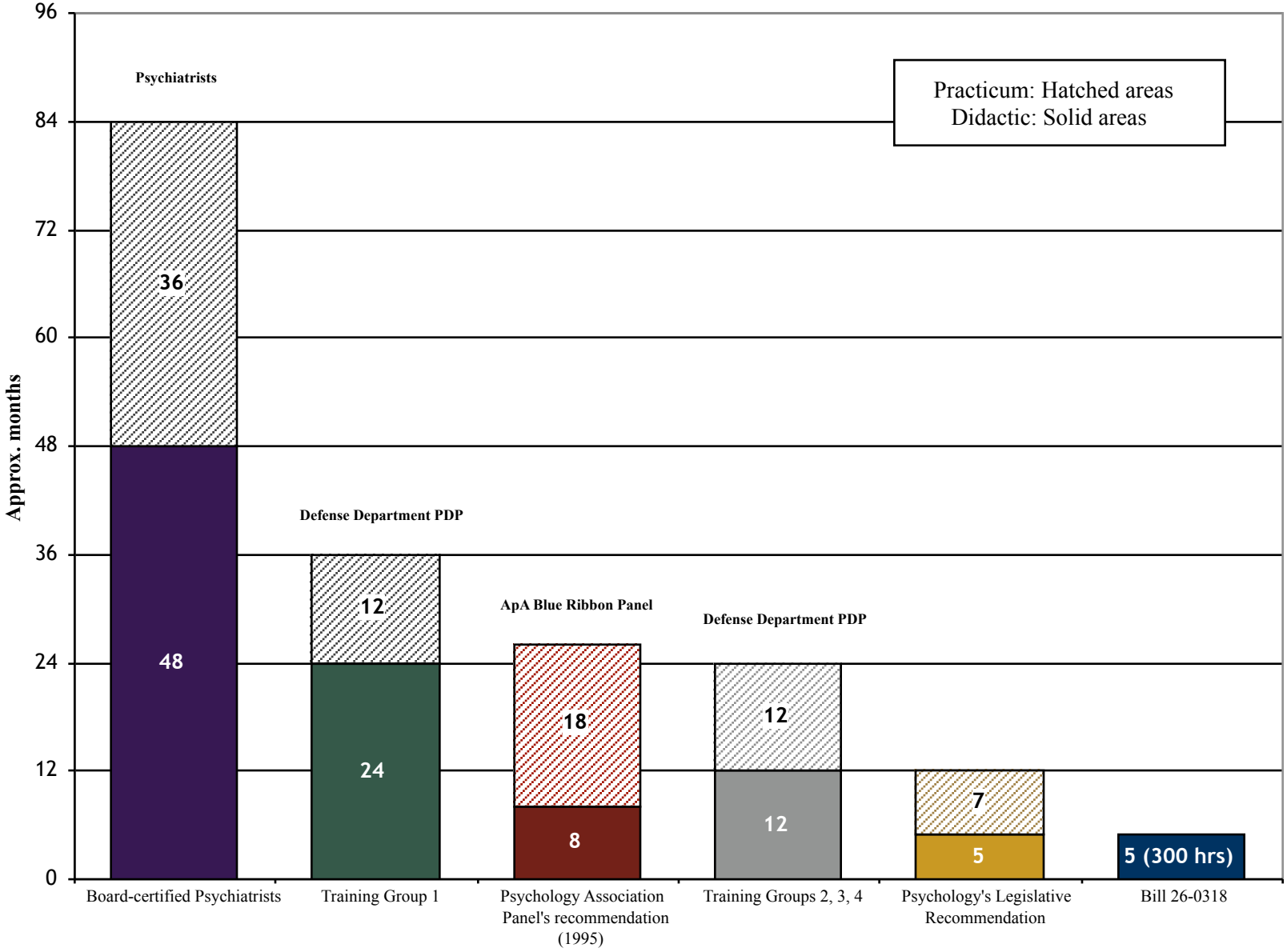
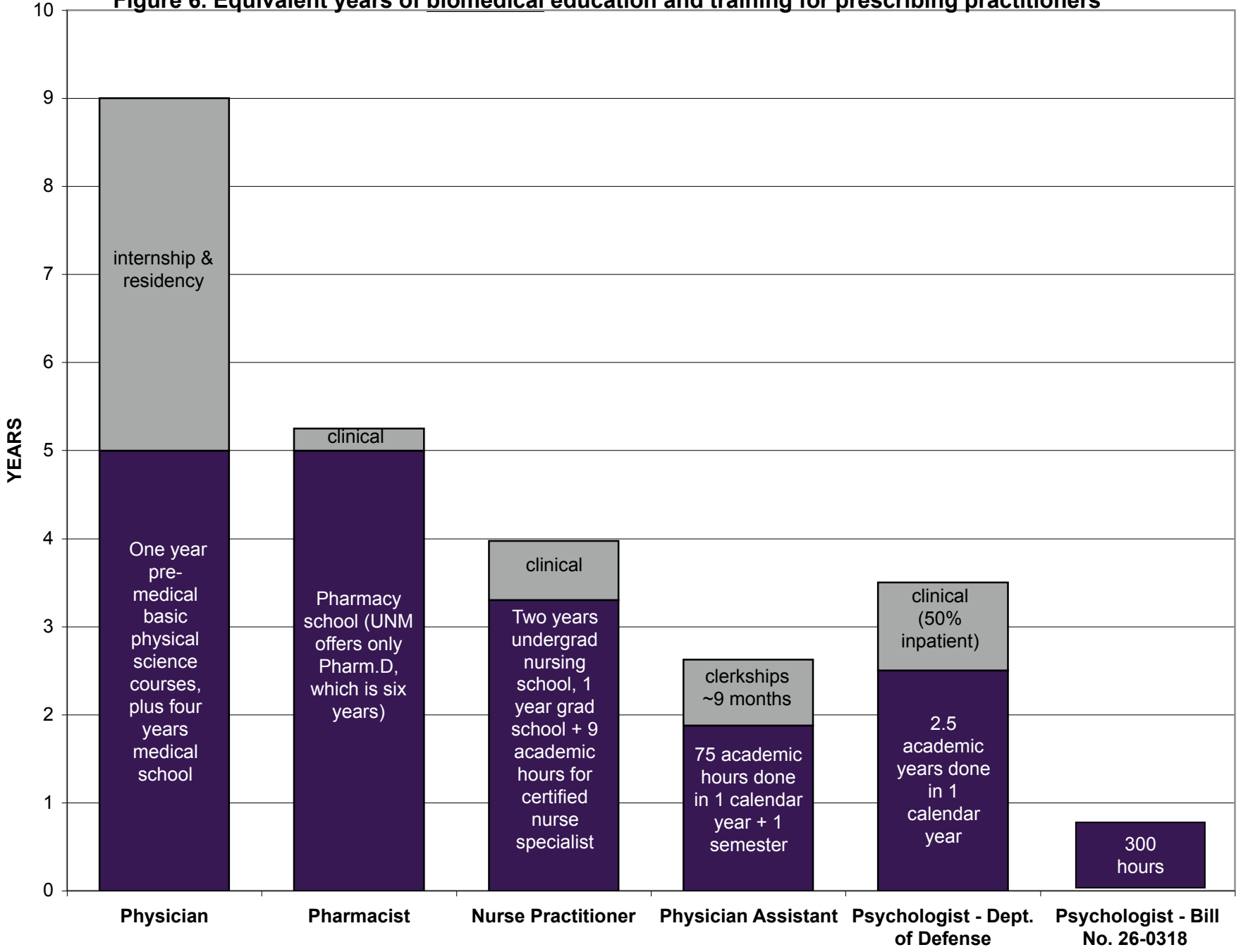


Figure 6. Equivalent years of biomedical education and training for prescribing practitioners



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Appendix E

Response to Impact Statements

CONNECTICUT
PSYCHOLOGICAL ASSOCIATION

October 6, 2017

Jillian Wood
Executive Director
Connecticut Council of Child and Adolescent Psychiatry, Inc.
101 Oak Street
Hartford CT 06106

Dear Jillian:

The Connecticut Psychological Association (CPA) thanks the Connecticut Council of Child and Adolescent Psychiatry, Inc. (CCCAP) for its statement dated September, 2017.

CPA is most concerned about access to comprehensive mental health and addiction services for all Connecticut residents.

While we appreciate the concerns raised by CCACP in its statement, we would point to the following:

1. The data clearly shows, in the states and in the federal government where prescriptive authority is allowed, that psychologists have been prescribing safely. In addition, there is no data that shows that psychologists over prescribe. Finally, psychologists view medication as one piece of a comprehensive treatment plan and if anything, tend to prescribe less than other medical professionals.

2. Similar to other professions, the treatment of children is a specialty area for psychologists. Our 57-page document on prescriptive authority makes it clear that psychologists would only practice within the scope of their training.

3. The state of Connecticut, like all states is facing an opioid crisis. As we all agree that the crisis is undeniable, it is clear that the state needs more expertly trained addiction and mental health professionals with the ability to use all available treatment tools.

4. Psychologists have been safely prescribing since 1997. In the states and federal agencies where prescriptive authority is allowed, there is no data to suggest that there was any issue with respect to patient safety.

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5. It appears that your concern on education and training seems to be focused solely on the undergraduate and doctoral training programs of the psychologist, and not on the Masters in Science post-doctoral training that is required with prescriptive authority for psychologists. After a four – six year post-bachelor's degree doctorate, including two years of internship and in residency, if a psychologist chooses to pursue prescriptive authority, the psychologist must:

    a. Complete a two year Masters of Science Degree in Clinical Psychopharmacology, including, but not limited, to courses in pathophysiology, clinical medicine and physical examination, laboratory studies, neuropathology, neuropharmacology, clinical pharmacology, and clinical psychopharmacology, ethics and professional issues.
    b. Upon completion of the coursework, there is a national board exam, developed by physicians, pharmacologists, and medical psychologists.
    c. There is a requirement to complete a clinical practicum that includes prescribing for 100 patients (or 400 contact hours) under the supervision of a physician with a requirement that patients with a variety psychiatric and addiction diagnoses are seen.
    d. Before a psychologist can prescribe independently, he/she must be supervised for a period of not less than one year.

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CPA welcomes the opportunity to discuss our proposal in a committee established by the Department of Public Health and where we would request two seats to address our mutual interests concerning the health of Connecticut citizens.

Respectfully,

Barbara S. Bunk, PhD.
Co-Chair, CPA Task Force on Prescriptive Authority

From: Barbara Bunk
To: contact@drmelissawelby.com
Cc: Andresen, Chris; Anita Schepker
Subject: Thank You from Connecticut Psychological Association
Date: Friday, October 06, 2017 12:28:27 PM

Dear Dr. Welby :

The Connecticut Psychological Association thanks you for your submission of an impact statement regarding our Request for Review of Scope of Practice for Psychologists in Connecticut.

CPA is most concerned about access to comprehensive mental health and addiction services for all Connecticut residents.

While we appreciate the concerns raised in your statement, we would point to the following:

1. The data clearly shows, in the states and in the federal government where prescriptive authority is allowed, that psychologists have been prescribing safely. In addition, there is no data that shows that psychologists over prescribe. Finally, psychologists view medication as one piece of a comprehensive treatment plan and if anything, tend to prescribe less than other medical professionals.

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Again, the CPA thanks you for your contribution.

Barbara S. Bunk, Ph.D.

Co-chair, CPA Task Force on Prescriptive Authority

From: Barbara Bunk
To: drkarabelnik@gmail.com
Cc: Andresen, Chris; Anita Schepker
Subject: Thank You from Connecticut Psychological Association
Date: Friday, October 06, 2017 12:28:20 PM

Dear Dr. Karabelnik:

The Connecticut Psychological Association thanks you for your submission of an impact statement regarding our Request for Review of Scope of Practice for Psychologists in Connecticut.

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While we appreciate the concerns raised in your statement, we would point to the following:

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Again, the CPA thanks you for your contribution.

Barbara S. Bunk, Ph.D.

Co-chair, CPA Task Force on Prescriptive Authority

CONNECTICUT PSYCHOLOGICAL ASSOCIATION

October 6, 2017

Ms. Karen Buckley
The Connecticut Hospital Association

Dear Ms. Buckley:

The Connecticut Psychological Association (CPA) thanks the Connecticut Hospital Association (CHA) for its statement dated September 28, 2017.

CPA is most concerned about access to comprehensive mental health and addiction services for all Connecticut residents.

We appreciate the fact that CHA pointed out the necessity of patients having access to a full spectrum of mental health services. As noted, CHA has many allied health professionals who have privileges in the state's hospitals, including psychologists.

We look forward to a discussion with CHA and would note:

1. The data clearly shows, in the states and in the federal government where prescriptive authority is allowed, that psychologists have been prescribing safely. In addition, there is no data that shows that psychologists over prescribe. Finally, psychologists view medication as one piece of a comprehensive treatment plan and if anything, tend to prescribe less than other medical professionals.

2. The opioid crisis is undeniable; this is precisely the reason why we need more expertly trained addiction and mental health professionals with the ability to use all available treatment tools.

3. Psychologists have been safely prescribing since 1997. In the states and federal agencies where prescriptive authority is allowed, there is no data to suggest that there was any issue with respect to patient safety.

4. After a four – six year post-bachelor's degree doctorate, including two years of internship and residency, if a psychologist chooses to pursue prescriptive authority, the psychologist must:

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pathophysiology, clinical medicine and physical examination, laboratory studies, neuropathology, neuropharmacology, clinical pharmacology, and clinical psychopharmacology, ethics and professional issues.

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c. There is a requirement to complete a clinical practicum that includes prescribing for 100 patients (or 400 contact hours) under the supervision of a physician with a requirement that patients with a variety psychiatric and addiction diagnoses are seen.
d. Before a psychologist can prescribe independently, he/she must be supervised for a period of not less than one year.

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Respectfully,

Barbara S. Bunk, PhD.
Co-Chair, CPA Task Force on Prescriptive Authority

CONNECTICUT
PSYCHOLOGICAL ASSOCIATION

October 6, 2017

Mr. Ken Ferrucci
Senior Vice President of Government Affairs
Connecticut State Medical Society
127 Washington Avenue
East Building, 3rd Floor
North Haven, CT 06473

Dear Mr. Ferrucci:

The Connecticut Psychological Association (CPA) thanks the Connecticut State Medical (CSMS) Society for its statement dated September 29, 2017.

CPA is most concerned about access to comprehensive mental health and addiction services for all Connecticut residents.

While we appreciate the concerns raised by CSMS in its statement, we would point to the following:

1. The data clearly shows, in the states and in the federal government where prescriptive authority is allowed, that psychologists have been prescribing safely. In addition, there is no data that shows that psychologists over prescribe. Finally, psychologists view medication as one piece of a comprehensive treatment plan and if anything, tend to prescribe less than other medical professionals.

2. The opioid crisis is undeniable; this is precisely the reason why we need more expertly trained addiction and mental health professionals with the ability to use all available treatment tools.

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4. After a four – six year post-bachelor's degree doctorate, including two years of internship and residency, if a psychologist chooses to pursue prescriptive authority, the psychologist must:

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a. Complete a two year Masters of Science Degree in Clinical Psychopharmacology, including, but not limited, to courses in pathophysiology, clinical medicine and physical examination, laboratory studies, neuropathology, neuropharmacology, clinical pharmacology, and clinical psychopharmacology, ethics and professional issues.
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c. There is a requirement to complete a clinical practicum that includes prescribing for 100 patients (or 400 contact hours) under the supervision of a physician with a requirement that patients with a variety psychiatric and addiction diagnoses are seen.
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Respectfully,

Barbara S. Bunk, PhD.
Co-Chair, CPA Task Force on Prescriptive Authority

CONNECTICUT PSYCHOLOGICAL ASSOCIATION

October 6, 2017

Danielle Morgan MSN, CNS, APRN_BC

The Connecticut Advanced Practice Registered Nurse Society
PO Box 330357
West Hartford, CT 06133-0357

Dear Ms. Morgan:

The Connecticut Psychological Association (CPA) thanks the Connecticut Advanced Practice Registered Nurses Society (CTAPRNS) for its statement dated October 1, 2017.

CPA is most concerned about access to comprehensive mental health and addiction services for all Connecticut residents.

While we appreciate the concerns raised by CTAPRNS in its statement, we would point to the following:

1. The data clearly shows, in the states and in the federal government where prescriptive authority is allowed, that psychologists have been prescribing safely. In addition, there is no data that shows that psychologists over prescribe. Finally, psychologists view medication as one piece of a comprehensive treatment plan and if anything, tend to prescribe less than other medical professionals.

2. The state of Connecticut, like all states is facing an opioid crisis. As we all agree that the crisis is undeniable, it is clear that the state needs more expertly trained addiction and mental health professionals with the ability to use all available treatment tools.

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4. It appears that your concern on education and training seems to be focused solely on the undergraduate and doctoral training programs of the psychologist, and not on the Masters in Science post-doctoral training that is required with

prescriptive authority for psychologists. After a four – six year post-bachelor's degree doctorate, including two years of internship and in residency, if a psychologist chooses to pursue prescriptive authority, the psychologist must:

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Respectfully,

Barbara S. Bunk, PhD.
Co-Chair, CPA Task Force on Prescriptive Authority

CONNECTICUT PSYCHOLOGICAL ASSOCIATION

October 6, 2017

Kimberly Sander, Executive Director
Mary Jane Williams, Chair of the Government Relations Committee
Connecticut Nurses' Association
1224 Mill St, BLDG B
East Berlin, CT 06023

Dear Ms. Sander and Ms. Williams:

The Connecticut Psychological Association (CPA) thanks the Connecticut Nurses Association (CAN) for its statement dated October 1, 2017.

CPA is most concerned about access to comprehensive mental health and addiction services for all Connecticut residents.

While we appreciate the concerns raised by CNA in its statement, we would point to the following:

1. The data clearly shows, in the states and in the federal government where prescriptive authority is allowed, that psychologists have been prescribing safely. In addition, there is no data that shows that psychologists over prescribe. Finally, psychologists view medication as one piece of a comprehensive treatment plan and if anything, tend to prescribe less than other medical professionals.

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From: Barbara Bunk
To: johndefig@sbcglobal.net
Cc: Andresen, Chris; Anita Schepker
Subject: Thank You from Connecticut Psychological Association
Date: Friday, October 06, 2017 12:28:13 PM

Dear Dr. de Figueiredo:

The Connecticut Psychological Association thanks you for your submission of an impact statement regarding our Request for Review of Scope of Practice for Psychologists in Connecticut.

CPA is most concerned about access to comprehensive mental health and addiction services for all Connecticut residents.

While we appreciate the concerns raised in your statement, we would point to the following:

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Again, the CPA thanks you for your contribution.

Barbara S. Bunk, Ph.D.

Co-chair, CPA Task Force on Prescriptive Authority

CONNECTICUT PSYCHOLOGICAL ASSOCIATION

October 6, 2017

Jillian Wood
Executive Director
American Academy of Pediatrics
Hezekiah Beardsley Connecticut Chapter
101 Oak Street
Hartford CT 06106

Dear Jillian:

The Connecticut Psychological Association (CPA) thanks the Connecticut Chapter of the American Academy of Pediatrics, Inc. (CCAAP) for its statement dated October 2, 2017.

CPA is most concerned about access to comprehensive mental health and addiction services for all Connecticut residents.

While we appreciate the concerns raised by CCAAP in its statement, we would point to the following:

1. The data clearly shows, in the states and in the federal government where prescriptive authority is allowed, that psychologists have been prescribing safely. In addition, there is no data that shows that psychologists over prescribe. Finally, psychologists view medication as one piece of a comprehensive treatment plan and if anything, tend to prescribe less than other medical professionals.

2. Similar to other professions, the treatment of children is a specialty area for psychologists. Our 57-page document on prescriptive authority makes it clear that psychologists would only practice within the scope of their training.

3. The state of Connecticut, like all states is facing an opioid crisis. As we all agree that the crisis is undeniable, it is clear that the state needs more expertly trained addiction and mental health professionals with the ability to use all available treatment tools.

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Respectfully,

Barbara S. Bunk, PhD.
Co-Chair, CPA Task Force on Prescriptive Authority

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Respectfully,

Barbara S. Bunk, PhD.
Co-Chair, CPA Task Force on Prescriptive Authority

Appendix D

American Psychological Association's

Recommended Postdoctoral Education & Training Program in

Psychopharmacology for Prescriptive Authority

APPROVED BY APA COUNCIL OF REPRESENTATIVES
AUGUST 9, 2009

Recommended Postdoctoral Education and Training Program In Psychopharmacology for Prescriptive Authority

INTRODUCTION

Education and training in psychopharmacology for prescriptive authority has evolved rapidly over the past two decades. As of the writing of this document, there were approximately 10 programs in a range of educational contexts offering this training on a postdoctoral basis. As more states pass laws authorizing properly trained psychologists to prescribe it will continue to be necessary to define what is meant by "properly trained psychologists." Psychology's ethical responsibility to the public requires that the profession be able to define the training needs and minimum competencies required for prescriptive authority. This document reflects the most current thinking in the field as to the nature of such education and training. It incorporates knowledge and experience derived since the 1996 version of this document, *Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges*, became APA policy.

In accordance with Association Rule 30-8.3 requiring that all APA standards and guidelines be reviewed at least every 10 years, and in light of the advances that have been made in prescriptive authority education and training and legislation enacted since the document *APA Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges* (1996 Recommended Training) was approved in 1996,[1] the Council of Representatives authorized a joint BEA-CAPP Task Force in February 2006 to review the current program requirements and recommend any necessary updates and revisions.

When the original model program standards were developed over a decade ago, few programs existed and no state legislation, enabling psychologists to prescribe, had been enacted. Since then, a number of new programs have developed operating under varying education and training models, and enabling legislation has been passed in two states and one U.S. territory (with legislation pending or planned in several others). These developments clearly called for revisions of the existing policy.

Contextual Framework

The program described in this document is a postdoctoral experience, which is intended to be an extension of doctoral education and training in psychological practice. Accordingly, the scientific basis of pharmacology and its application to clinical practices of prescribing must be viewed in the context of the total complex of factors influencing human psychology. Education

[1] The 1996 Recommended Training was based on several earlier documents, including the Department of Defense Psychopharmacology Demonstration Project curriculum, the report of the Blue Ribbon Panel of the Professional Education Task Force of the California Psychological Association, and an initial document prepared by the CAPP Task Force on Prescription Privileges. The final draft of the document was developed by the APA Presidential Working Group and submitted to the APA Council of Representatives.

and training should reflect the integration of research literature and practice experience on the relationship between psychopharmacological and psychological interventions.

Psychopharmacology education and training for psychologists, while building on training traditions in medicine, pharmacy, and nursing, should be conducted in a manner consistent with the education and training of psychologists. These standards are also designed specifically to meet the needs of practicing psychologists and their patients and are intended, in part, as a service to the public by describing the minimum requirements for this training.

Application for Psychologists Matriculating through the 1996 Recommended Training

A number of programs have emerged that included many, if not most, of the key elements of the 1996 Recommended Training, and many psychologists have completed significant portions of the 1996 Recommended Training through those programs. The revisions found in the present document reflect subsequent advances in learning models and methods of pedagogy, as well as feedback from psychologists who have completed a postdoctoral program in psychopharmacology. Inasmuch as the current document builds on the earlier model, those psychologists who completed programs based on that earlier model can be recognized as meeting the curriculum requirements relevant at the time of their matriculation. To address the needs of those psychologists who completed postdoctoral programs that did not meet all requirements of the 1996 Recommended Training, programs are encouraged to develop policies that would permit, on an individual case basis, the demonstration of competence to meet current program requirements.

Essential Elements

Postdoctoral Education and Training

These standards are intended to describe a postdoctoral experience. This program involves advanced training in a specific content area of psychology representing a significant expansion of scope of practice. The prerequisites for admission to a program continue to be (1) a doctoral degree in psychology; (2) current licensure as a psychologist, and (3) practice as a health services provider as defined by state law, where applicable, or as defined by APA. The 1996 Recommended Postdoctoral Training Program includes didactic coursework prerequisites that are included now in these standards in the basic sciences and neurosciences domains of instruction. Training programs in psychopharmacology for prescriptive authority can award transfer credit for no more than twenty percent (20%) of the total curriculum hours. This twenty percent shall be limited to the basic science and neuroscience domains of the curriculum.

These standards include three components that reflect an evolution in instruction and assessment from the 1996 Recommended Training. These include integration of didactic instruction and supervised experience, the incorporation of competence based assessment, and incorporation of a capstone competency.

Integrated Didactic Instruction and Supervised Clinical Experience

Relevant supervised clinical experiences are now integrated into the sequence of courses. These standards allow psychologists to assimilate new knowledge as it is learned through its application.

The revised curriculum integrates supervised clinical experiences with coursework so that as each content area is addressed in the curriculum, supervised clinical experiences relating to the course content are provided to the participant. Supervised clinical experience remains an important aspect of training. By building such experiences into the sequence of didactic coursework, participants will be able to apply the concepts acquired through coursework at the time that is optimal for cementing learning.

The term "supervised clinical experience" is substituted for the term "practicum" used in the 1996 Recommended Training.

Addition of Elements of a Competency Model

The curriculum promotes the integration of knowledge, skills and attitudes fundamental to professional practice with psychopharmacologic interventions. In this context, movement to competency-based models to measure education and training outcomes is occurring across the health professions. These models include both formative (ongoing) and summative (end point) assessment approaches. Various entities within psychology (e.g., the APA Benchmark Competencies Initiative, the APA Policy on Education and Training Leading to Licensure, and the Practicum Working Group on Competencies) are focusing on the identification and assessment of competencies in education and training that have resulted in important changes in how educational outcomes are defined and evaluated. The APA Task Force on the Assessment of Competence in Professional Psychology articulated 15 principles that are a useful resource in this process. By focusing on necessary competencies, these standards are intended to allow maximum flexibility in program design within the parameters of ensuring an optimal educational experience.

Capstone Competency Evaluation

To be consistent with a model that emphasizes the mastery of essential competencies, training programs developed under these standards provide a capstone competency evaluation that requires integration of the knowledge, skills, and attitudes the psychologist is expected to master during their matriculation in the program. Two recommended components of this could be a review of a portfolio of cumulative supervised clinical experiences and the application of the knowledge, skills, and attitudes to unrehearsed clinical situations ranging from routine, uncomplicated cases to those of a more complex nature involving multiple medical comorbidities. This evaluation is distinct from any evaluation that focuses exclusively on mastery of information, such as the Psychopharmacology Examination for Psychologists. The capstone competency evaluation is summative and follows demonstration of mastery of multiple, foundational competencies throughout the training program.

Education and Training in Issues of Diversity

Programs developed under these standards will continue their commitment to providing training courses and experiences that encourage sensitivity to the interactions between pharmacological interventions with development across the lifespan, gender, health status, and ethnicity of patients. This focus is reflected in both the didactic and experiential components of the program so that psychologists will develop the appropriate skill-based competencies to address diversity in the population being served.

Designation Process Requirement

Both the 1996 Recommended Training and these standards are exclusively relevant to the evaluation of programs, not individuals; they are not intended to be used for the evaluation of individuals' qualifications to engage in any activities related to psychopharmacology. The policies do, however, have important implications for determining whether or not individual psychologists have completed an acceptable course of education and training. The shift to an emphasis on skills-based competencies and away from requirements presumed to be suggestive of the mastery of skills (such as the institutional location of the training, the number of hours allotted to each topic, or the type of credential awarded upon the completion of training) implies that it is the development of critical competencies that should decide whether or not the training is adequate. Experiences to date do not provide a convincing rationale for choosing any given training model over others. Furthermore, it seems prudent to encourage the development of viable alternative routes to training competent practitioners at this still early stage in the development of this area of practice.

The shift to include more of a competency-based model, the breadth of formats in which programs may operate, the integration of didactic coursework and supervised clinical experience, and other significant changes in demonstration of competency and methods of assessment of competencies require a mechanism to ensure that programs are providing the recommended education and training outlined in these standards. Therefore, APA will establish a formal designation body that represents psychopharmacology education and training programs, educators, relevant basic scientists, relevant public interests and practitioners to establish processes and procedures to evaluate consistency with these standards that will provide a system for assuring that programs are providing education and training presumed necessary for responsible psychopharmacological practices. Although detailed recommendations for establishing an appropriate designation process were beyond the scope of the task force that developed these standards, such a system is important and the establishment of a designation body is critical to establishing and maintaining minimal standards of program quality.

Maintenance of Competencies through Lifelong Learning

Postdoctoral training programs in psychopharmacology for prescriptive authority are rigorous and comprehensive in didactic content, clinical experiences, and the integration of psychological and pharmacological principles. Programs developed under these standards place a special emphasis on preparing psychologists to evaluate future advances in psychopharmacological knowledge and on the critical importance of lifelong learning in psychopharmacological practice.

Summary

These policies and procedures represent changes inherent in a shift toward a competency-based model of learning and assessment in preparation for prescriptive authority, and are intended to set the context for the understanding of the curriculum as further described in this document. Given the rapid evolution of the field, these standards should be reviewed in five years. This review should include a review of the quality assurance systems.

PREREQUISITES FOR ADMISSION TO EDUCATION AND TRAINING PROGRAMS IN PSYCHOPHARMACOLOGY

To participate in postdoctoral education and training in psychopharmacology, programs must require that psychologists meet the following prerequisites:
1. be a graduate of a doctoral program in psychology;
2. hold a current state license as a psychologist; and
3. practice as a "health services provider" psychologist as defined by state law, where applicable, or as defined by APA.[2]

PROGRAM CHARACTERISTICS

The entire program of education and training should be an organized and sequenced program of instruction at the postdoctoral level.

The program is responsible for determining and disseminating admissions standards. The program could develop policies for allowing credit from a previous graduate or postdoctoral education and training program(s). To ensure that the training experience is up-to-date, sequential, and cumulative, transfer of a limited number of credits as appropriate for previous coursework is not to exceed twenty percent (20%) of the postdoctoral curriculum and is to be limited to the basic science and neuroscience domains (Domains I & II). This does not preclude the development of program policies that would permit, on an individual case basis, the meeting of program requirements through a current demonstration of competence obtained through prior postdoctoral education and training. In such unusual cases, program policies should explicitly state the criteria for such decisions, and there should be an accompanying record of the specific competencies demonstrated by the psychologist and those yet to be acquired through the program.

The program is accountable for establishing and demonstrating evidence of appropriate quality assurance mechanisms. As such, the program will demonstrate the following characteristics:

[2] In 1995, the APA Council of Representatives approved the following definition of "health service provider" psychologists: Psychologists are recognized as Health Service Providers if they are duly trained and experienced in the delivery of preventive, assessment, diagnostic and therapeutic intervention services relative to the psychological and physical health of consumers based on: 1) having completed scientific and professional training resulting in a doctoral degree in psychology; 2) having completed an internship and supervised experience in health care settings; and 3) having been licensed as psychologists at the independent practice level.

Ethical Standards

The program administrators and faculty will abide by the current Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association.

Mission

The program has a clear and comprehensive mission statement that guides it, is approved by the governing body, and is publicly communicated.

Governance & Administration

The program has sufficient financial resources and access to appropriate physical resources to support its mission.

The program has qualified and competent administrators, including a director, with appropriate administrative authority.

The legal authority and operating control of the program are clearly described.

Program Characteristics

The program is an integrated and organized program of study.

The program has an identifiable body of students.

The program is clearly identified and labeled as a postdoctoral education and training program in psychopharmacology for prescriptive authority.

The program ensures the quality of education and training, including any consortial relationships or contractual agreements.

The program protects the security, confidentiality, integrity, and availability of student records.

The program has due process and grievance procedures.

The program regularly engages in a process of self-evaluation.

The program ensures that students maintain licensure throughout the program.

Faculty

Faculty and supervisors are qualified and sufficient in number to accomplish the program's education and training goals.

In addition to psychology, the program faculty and supervisors may come from a variety of appropriate disciplines. Faculty will participate in the program's planning, implementation and evaluation.

Learning Resources

The program provides access to facilities, services, and learning/information resources that are appropriate to support its didactic and experiential teaching, research, and service mission. This may include access to facilities, library materials, and an appropriate array of learning resources.

Further, the program will offer an integrated and sequential program of instruction as evidenced through the following:

1. An organized sequence of courses with relevant syllabi;
2. Frequent evaluation of students' knowledge and application of that knowledge and feedback to students of outcomes;
3. Periodic program evaluation;
4. Certification of program completion upon demonstration of appropriate level of competence

DIDACTIC INSTRUCTION AND SUPERVISED CLINICAL EXPERIENCE

A competency-based approach entails educational objectives or defined competencies at each level of learning. Competences facilitate demonstration of the ability to perform defined tasks along a continuum with a wide range of possible outcomes. Competencies are conceived as holistic and represent:

- **knowledge** of subject matter concepts and procedures
- **performance** of behaviors that demonstrate specific skills and abilities
- **problem solving** strategies and capabilities that involve elements of critical thinking and ethical responsibility
- **self reflection** that focuses on knowing the limits of one's knowledge; clarification of attitudes, beliefs, and values; and identification of self perceptions and motivations in the context of prescriptive authority.

Assessment of the delineated competencies for prescriptive authority includes approaches that integrate evaluation that is both formative (i.e., ongoing corrective feedback that advises for further development) and summative (i.e., determines attainment of a specific competency). Assessment is developmentally informed and conducted using multiple reliable and valid methods and varied sources of information. This approach shifts the focus from exclusively documenting what is taught to one based on demonstrating what students have learned and how they effectively apply didactic instruction in integrated practice. Throughout the curriculum, students will demonstrate threshold performance levels at identified benchmarks of competence across the delineated competencies.

The topics that should be addressed by the psychopharmacology curriculum must cover a broad range of both basic science and clinical content areas with sufficient specificity such that the

learner is adequately prepared for the practical application of the knowledge and skills attained. All areas should also address cultural context, including variability due to development across the lifespan, gender, health status, and ethnicity. A foundation of knowledge should be laid so that the learner can continually develop an understanding of and ability to use emerging treatments. This foundation should include instruction in the core principles regarding the implementation and evaluation of research on psychoactive substances.

Didactic Content Areas

The approaches taken to the didactic instruction of content should make use of multiple pedagogical methods. In addition to the provision of knowledge via more traditional means such as readings, lecture and discussion, participants may make use of various means for applying, integrating and thereby broadening their knowledge via the analysis of clinical cases, problem based learning, computerized patients and simulations using layered decision models, and skills-based demonstrations throughout the curriculum.

Recognizing that this is a dynamic field and that subsequent revision may become necessary over time, 400 contact hours, at a minimum, of didactic instruction is expected in the following core content areas (I-VIII).

As programs may develop specific courses using different content integration approaches, these are not meant as specific courses and the contact hours are not broken down into each area. The program must demonstrate that all content is covered and that the students achieve clinical competency in all content areas. Italicized content represents examples of some of the clinical competencies that may be associated with the domain of instruction.

I. Basic Science
- A. Anatomy & Physiology
- B. Biochemistry

II. Neurosciences
- A. Neuroanatomy
- B. Neurophysiology
- C. Neurochemistry

III. Physical Assessment and Laboratory Exams
- A. Physical Assessment
- B. Laboratory and Radiological Assessment
- C. Medical Terminology and Documentation
- *Integration of A-C through supervised clinical experience or lab experience in conducting physical exam, ordering psychometric and laboratory tests, understanding results and interpretation*

IV. Clinical Medicine and Pathophysiology
- A. Pathophysiology with particular emphasis on cardiac, renal, hepatic, neurologic, gastrointestinal, hematologic, dermatologic and endocrine systems.

B. Clinical Medicine, with particular emphasis on signs, symptoms and treatment of disease states with behavioral, cognitive and emotional manifestations or comorbidities
C. Differential Diagnosis
D. Clinical correlations-the illustration of the content of this domain through case study
E. Substance-Related and Co-Occuring Disorders
F. Chronic Pain Management
Integration of A-F through supervised clinical experience or lab experience in taking medical history, assessment for differential diagnosis, and review of systems

V. Clinical and Research Pharmacology and Psychopharmacology
A. Pharmacology
B. Clinical Pharmacology
C. Pharmacogenetics
D. Psychopharmacology
E. Developmental Psychopharmacology
F. Issues of diversity in pharmacological practice (e.g., sex/gender, racial/ethnic, and lifespan factors related to drug metabolism access, acceptance, and adherence)
Integration of A-F through supervised clinical experience or lab experience in Clinical Medicine and ongoing treatment monitoring and evaluation

VI. Clinical Pharmacotherapeutics
A. Combined therapies - Psychotherapy/pharmacotherapy interactions
B. Computer-based aids to practice
C. Pharmacoepidemiology
Integration of A-C through supervised clinical experience or lab experience in integrated treatment planning and consultation and implications of treatment

VII. Research
A. Methodology and Design of psychopharmacological research
B. Interpretation and Evaluation of research
C. FDA drug development and other regulatory processes

VIII. Professional, Ethical, and Legal Issues
A. Application of existing law, standards and guidelines to pharmacological practice
B. Relationships with pharmaceutical industry
1. Conflict of interest
2. Evaluation of pharmaceutical marketing practices
3. Critical consumer

Supervised Clinical Experience

The supervised clinical experience should be an organized sequence of education and training that provides an integrative approach to learning as well as the opportunity to assess competencies in skills and applied knowledge. The intent of the supervised clinical experience is two-fold:

1. To provide ongoing integration of didactic and applied clinical knowledge throughout the learning sequence, including ample opportunities for practical learning and clinical application of skills.

2. To provide opportunity for programs to assess formative and summative clinical competency in skills and applied knowledge.

In addition to the didactic hours, the number of hours needed to achieve mastery of clinical competencies is expected to be substantial and will vary across individuals.

The supervised clinical experience is intended to be an intensive, closely supervised experience. The range of diagnostic categories, settings and characteristics such as development across the lifespan, gender, health status, and ethnicity reflected in the patients seen in connection with the supervised clinical experience should be appropriate to the current and anticipated practice of the trainee. It should allow the practitioner to gain exposure to acute, short-term, and maintenance medication strategies.

The trainee gains supervised clinical experience with a sufficient range and number of patients in order to demonstrate threshold performance levels for each of the competency areas. In order to achieve the complex clinical competency skills required for independent prescribing, a sufficient number of supervised patient contact hours must be completed. The supervised clinical training experiences must be approved by the training director prior to commencing that placement. The program must document the total number of supervised clinical experience hours that students experience. These must be broken out by face-to-face patient contacts versus other clinical experiences, and the clinical competencies employed.

In addition, the method and appropriate benchmarks for assuring each clinical competency must be described. These methods may include, for example, performing physical examinations and presenting cases based on actual and simulated patients. The trainee recommends/prescribes in consultation with or under a designated supervisor(s) with demonstrated skills and experience in clinical psychopharmacology and in accordance with the prevailing jurisdictional law.

The program is responsible for the approval and oversight of each supervised clinical experience. Final approval of the supervised clinical experience must be provided by the program prior to initiation.

The supervised clinical experience may be integrated into each level of education and training, provided in a final summative practical experience or a combination of both according to the design of the program. The last item in *Domains of Instruction, Sections III-VI*, encompasses areas where clinical experience can be integrated with didactic instruction.

In either event, the trainee must demonstrate competency in his or her ability to integrate didactic learning and applied clinical skill in a capstone competency evaluation.

There is also a responsibility to maintain competency through continuing education over the lifespan of maintaining and practicing in prescriptive authority or collaborative activities with prescribing professionals.

The clinical competencies targeted by this experience include the following:

1. PHYSICAL EXAM AND MENTAL STATUS

Knowledge and execution of elements and sequence of both comprehensive and focused physical examination and mental status evaluation, proper use of instruments used in physical examination (e.g., stethoscope, blood pressure measurement devices, etc.), and scope of knowledge gained from physical examination and mental status examination recognizing variation associated with developmental stage and diversity

2. REVIEW OF SYSTEMS

Knowledge and ability to systematically describe the process of integrating information learned from patient reports, signs, symptoms, and a review of each of the major body systems recognizing normal developmental variations

3. MEDICAL HISTORY INTERVIEW AND DOCUMENTATION

Ability to systematically conduct a patient or parent/caregiver clinical interview producing a patient's medical, surgical, and psychiatric (if any) history and medication history in cultural context as well as a family medical and psychiatric history, and to communicate the findings in written and verbal form

4. ASSESSMENT: INDICATIONS AND INTERPRETATION

Ability to order and interpret appropriate tests (e.g., psychometric, laboratory and radiological) for the purpose of making a differential diagnosis and for monitoring therapeutic and adverse effects of treatment

5. DIFFERENTIAL DIAGNOSIS

Use of appropriate processes, including established diagnostic criteria (e.g., ICD-9, DSM-IV), to determine primary and alternate diagnoses

6. INTEGRATED TREATMENT PLANNING

Ability to identify and select, using all available data, the most appropriate treatment alternatives, including medication, psychosocial and combined treatments and to sequence treatment within the larger biopsychosocial context

7. CONSULTATION AND COLLABORATION

Understanding of the parameters of the role of the prescribing psychologist or medical psychologist and working with other professionals in an advisory or collaborative manner to effect treatment of a patient

8. TREATMENT MANAGEMENT

Application, monitoring and modification, as needed, of treatments and the writing of valid and complete prescriptions

Fairleigh Dickinson
UNIVERSITY

COURSE SYLLABUS

M.S. Program in Clinical Psychopharmacology

PSYC7910: BIOLOGICAL FOUNDATIONS OF PSYCHOPHARMACOLOGICAL PRACTICE I

September 2 – October 22, 2014

PSYC7915: BIOLOGICAL FOUNDATIONS OF PSYCHOPHARMACOLOGICAL PRACTICE II

October 23 – December 14, 2014

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Appendix 5: Module 5: Hematology and Immunology

Appendix 6: Module 6: Gastrointestinal and Hepatic Systems

Appendix 7: Module 7: Endocrine System

Appendix 8: Module 8: Musculoskeletal and Dermatologic Systems

Appendix 9: Module 9: Reproductive System

COURSE SYLLABUS

Information provided here is in addition to information available in your Student Manual.

COURSE DESCRIPTION

The Biological Foundations of Psychopharmacological Practice I and II courses provide an integrated approach to the study of primary body systems: respiratory, cardiovascular, renal, hematologic/immunologic, gastrointestinal, endocrine, reproductive, musculoskeletal, and dermatologic. The approach correlates fundamental knowledge of the anatomy, physiology, and pathophysiology of a specific body system with the clinical applications of health assessment, physical examination, and laboratory and diagnostic assessment pertaining to each body system. Clinical medicine concepts will be explored utilizing a problem-solving approach. The goals of these two courses are to enhance the student's recognition of signs and symptoms of medical conditions requiring collaboration with and referral to other health professionals, and to provide knowledge about the psychological, biological, and medical correlates of disease. Knowledge of the medical sequelae of psychotropic agents and familiarity with standard medical treatment of common disease states are addressed.

For each body system, specific diseases or disorders have been selected because of their frequency of occurrence, their heuristic value in illustrating important underlying principles of physiology and pathophysiology, and their effect on the bio-availability and bio-disposition of drugs. These diseases and disorders will be addressed in course materials in terms of the following nine concepts.

1. Epidemiology
2. Anatomical review of involved organ systems
3. Signs and symptoms, including diagnostics
4. Etiology
5. Genetic predisposition
6. Related disease states and differentiation
7. Sequelae and prognosis of pathophysiology
8. Common therapies
9. Effect of disease state and therapies on psychotherapeutic intervention

PLACEMENT

Biological Foundations I and II are completed in a single semester. They represent two of the four foundation courses for the program; Neuroscience and Neuropharmacology complete the set. Completion of all four foundation courses is required before students may progress to the third semester courses, Clinical Pharmacology and Professional Issues & Practice Management. Students subsequently enroll in the four treatment-focused courses: Affective Disorders, Psychotic Disorders, Anxiety Disorders, and Other Disorders. Successful completion of the ten-course didactic sequence of the Psychopharmacology Postdoctoral Training Program makes the candidate eligible to enroll in the Clinical Practicum Elective.

COURSE OBJECTIVES

Upon completion of these courses the student will be able to:
1. Analyze the relationship between normal physiology and pathophysiology of each body system.
2. Integrate pathophysiological concepts and clinical manifestations related to selected diseases in body systems.
3. Demonstrate fundamental knowledge of underlying principles of physiology and pathophysiology in preparation for understanding the bio-availability and bio-disposition of drugs.
4. Differentiate normal variations in health status from pathological findings across the life span.
5. Demonstrate skill in performing basic health assessment across the life span, including head to toe physical examination.
6. Collect, organize, record, and present health assessment data.
7. Differentiate normal from abnormal laboratory and diagnostic clinical data.

In achieving each of these objectives, issues of lifespan development, gender, and ethnic diversity will be discussed.

FACULTY AND STAFF

Instructor

Laura G. Leahy, MSN, APRN, PMH-CNS/FNP, BC
Family Psychiatric Nurse Practitioner
NEI Global Master Psychopharmacologist
Editor/Author, *Manual of Clinical Psychopharmacology for Nurses*
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Ms. Leahy received her B.S. in Psychology & Human Development from Duke University in 1987 and her B.S.N. (1989) and M.S.N. (1991) in Child and Family Psychiatric Mental Health Nursing from the University of Pennsylvania. She is presently working on her DrNP at Drexel University and has completed all but her dissertation. Ms. Leahy has also been certified as a Master Psychopharmacologist through Stephen Stahl's Neuroscience Educational Institute. Laura has taught Advanced Psychopharmacology across the Lifespan at the University of Pennsylvania's School of Nursing for the past ten years. She was also involved as a clinical instructor for the inaugural Post-Doctoral Psychopharmacology Program at Fairleigh Dickinson University. Presently, Ms. Leahy maintains a private outpatient practice, specializing in Treatment Resistance symptoms and Psychopharmacology. She has been prescribing and providing psychotherapy services as a Family Psychiatric Nurse Practitioner for over 23 years. She was the co-founder of Center for Family Guidance, the largest privately held psychiatric mental health organization in New Jersey.

Ms. Leahy has recently (May 2013) published *The Manual of Clinical Psychopharmacology for Nurses* through the American Psychiatric Association and had previously published *Pocket Psych Drugs* (2010) through F.A. Davis. She presents extensively on the local, state and national levels on various topics

related to psychopharmacology, pharmacogenetics, child & adolescent psychiatric disorders & pharmacological treatments as well as women's mental health, among other areas of psychiatry and mental health.

Video Expert Presenters

Biological Foundations I

Appendix 1: Basic Cellular Concepts **– John P. McDonough, CRNA, ARNP, Ed.D.**
Appendix 2: Cardiovascular System **– John P. McDonough, CRNA, ARNP, Ed.D.**
Appendix 3: Respiratory System **– John P. McDonough, CRNA, ARNP, Ed.D.**
Appendix 4a: Renal/Genitourinary System **– Randall L. Tackett, Ph.D.**
Appendix 4b: Acid/Base Balance – **Randall L. Tackett, Ph.D.**

Biological Foundations II

Appendix 5: Hematology and Immunology – **W. Patrick Monaghan, CLS, SBB, Ph.D.**
Appendix 6: Gastrointestinal and Hepatic Systems – **Randall L. Tackett, Ph.D.**
Appendix 7: Endocrine System – **John T. Johnson, Pharm.D., CDE**
Appendix 8: Musculoskeletal and Dermatologic Systems – **Randall L. Tackett, Ph.D.**
Appendix 9: Reproductive System – **Laura Street, RNC, M.S.N.**

24/7 Technical Support

FDU Technical Assistance Center (FDUTAC)
Phone: 973-443-8822 (973-443-UTAC)
E-mail: fdutac@fdu.edu

STUDENT EVALUATION

40%: Two online objective exams (prorated depending on number of DSQs completed)
15%: Participation in weekly discussion forums (prorated depending on number of DSQs completed)
30%: Completion of Directed Study Questions (prorated depending on number completed)
15%: Written Case Presentation (prorated depending on number of DSQs completed)

PASSING GRADE

To be assured of satisfactory completion of this course applicable to progression to the next term, **the student must achieve a score of 80% or better of the total points available. A grade of less than 75% represents failure of the course.**

CONTINUING PROFESSIONAL EDUCATION CREDITS

Fairleigh Dickinson University School of Psychology is approved by the American Psychological Association to sponsor continuing education for psychologists. Fairleigh Dickinson University School of Psychology maintains responsibility for this program and its contents. With a student participation rate of at least 80%, PSYC7910 and PSYC7915 are each approved for 45 continuing professional

education credits for psychologists. One case presentation is required each semester, for 14 credits. Half is allotted to each of the courses for the semester.

# Hours	Activity
25	Readings/videos
5	Chats
8	Exams
7	Case presentation

TEXTBOOKS

Required

- McCance, K. L., & Huether, S. E. (2014). *Pathophysiology: The biologic basis for disease in adults and children* (7th ed.). Elsevier Health Sciences. ISBN 13-9780323187350
- Jarvis, C. (2011). *Physical examination and health assessment* (6th ed.). Elsevier Health Sciences. ISBN 1437701515.

Recommended

- Leahy, L. G., & Kohler, C. G. (2013). *Manual of clinical psychopharmacology for nurses.* Washington, DC: American Psychiatric Publishing. ISBN 1585624349
- Jarvis, C. (2011). *Pocket companion for Physical Examination and Health Assessment* (6th ed.). Elsevier Health Sciences. ISBN 1437714420.
- Dipiro, J. T., Talbert, R. L., Yee, G. C., Wells, B. G., & Posey, L. M. (Eds.). (2014). *Pharmacotherapy: A pathophysiologic approach* (9th ed.). New York: McGraw-Hill. ISBN 0071800530.
- Gomella, L. G., Haist, S. A., & Adams, A. G. (Eds.). (2014). *Clinician's Pocket Drug Reference 2014*. New York: McGraw-Hill. ISBN13-9780071824965.
- Van Putte, C., Regan, J., & Russo, A. (2010). *Seeley's Anatomy and Physiology* (9th ed.). New York: McGraw-Hill. ISBN 0077350030.
- Venes, D. (2013). *Taber's cyclopedic medical dictionary* (22nd ed.). New York: F.A. Davis. ISBN 13-9780803629806.

DIRECTED STUDY QUESTIONS

Directed Study Questions are optional for this course. To receive credit, you must submit responses to your instructor by the date listed in the Course Schedule.

Please remember the DSQs are intended to be SHORT answer questions. When you are asked to generate a list, you do not need more than 1-2 sentences for each item in the list. When the question is open-ended, you never need to provide more than 1-2 paragraphs of information. In fact, many questions can be answered using bullet points and charts or tables.

If you're not sure what the question is looking for, rather than spending hours trying to produce every piece of information you can, feel free to discuss it with your instructor.

PLEASE don’t let obsessional tendencies get in the way of completing the DSQs in a timely manner. The goal of the DSQs is to demonstrate a basic understanding of processes, and to help consolidate the key information, not to demonstrate you know everything about everything. Educational research demonstrates that what you will take away from any learning experience is the most central information, and in practice you will need to rely on resource materials for many of the details.

CHATS

The weekly chats are intended to reinforce your weekly readings and video assignments. Each week, one or two students will develop and lead a discussion on the module's topic listed in the weekly course outline. The presentation is typically done in a powerpoint format highlighting the system's biological aspects, physiological aspects, major disorders seen in clinical practice, medications used to treat those disorders and potential psychiatric symptom "mimics" as well as psychotropic drug impact on the system. Typically 30 slides is sufficient, as the idea of the chats is to stimulate discussion and reinforce the concepts previously reviewed. The Chat leader(s) may also include peer reviewed articles relevant to the topic at hand. Please include questions to pose to your peers in the cohort, as this tends to make the chats more dynamic. The Chat leader(s) will post the presentation to WebCampus and then lead the audio discussion during the chat hour.

COURSE SCHEDULE

Biological Foundations I PSYC 7910

WEEK	MODULE	ACTIVITY
1: 9/2-9/7 **CHATS** **9/2 at 9:30pm** **Leahy** **ALL GROUPS** Course Intro	1: Basic Cellular Concepts	**Video:** Appendix 1 **Reading:** McCance & Huether Chap 1-3
2: 9/8-9/14 **9/8, 9/9: Leahy** Basic Concepts	1: Basic Cellular Concepts	**Reading:** Jarvis, Units I-II **Directed Study Questions:** Module 1 due 9/13 (optional)
3: 9/15-9/21 **9/15:** **9/16a:** **9/16b:** Hypertension	2: Cardiovascular System	**Video:** Appendix 2 **Reading:** McCance & Huether, Chap 31-33
4: 9/22-9/28 **9/22:** **9/23a:** **9/23b:** Cardiovascular Disease	2: Cardiovascular System	**Reading:** Jarvis, Unit III: 19-20 **Directed Study Questions:** Module 2 due 9/27 (optional) **Midterm Exam 7910 (Weeks 1-4):** Posted 9/26, Due 10/1
5: 9/29-10/5 **9/29:** **9/30a:** **9/30b:** Asthma	3: Respiratory System	**Video:** Appendix 3 **Reading:** McCance & Huether, Chap. 34-36
6: 10/6-10/12 **10/6:** **10/7a:** **10/7b:** COPD	3: Respiratory System	**Reading:** Jarvis, Unit III: 18 **Directed Study Questions:** Module 3 due 10/11 (optional)
7: 10/13-10/19 **10/13:** **10/14a:** **10/14b** Kidney Disease	4: Renal/Genitourinary System	**Video:** Appendix 4a **Reading:** McCance & Huether, Chap. 37-39 Jarvis, Unit III: 24 & 26
8: 10/20-10/22* **10/20:** **10/21a:** **10/21b:** UTI's & Prostrate	4: Renal/Genitourinary System	**Video:** Appendix 4b **Directed Study Questions:** Module 4 due 10/25 (optional) **Final Exam 7910 (Weeks 5-8):** Posted 10/24, due 10/29

Biological Foundations II PSYC 7915

WEEK	MODULE	ACTIVITY
9: 10/23-10/29 **10/27:** **10/28a:** **10/28b:** Epstein Barr Virus & Lyme's	5: Hematology and Immunology	**Video:** Appendix 5 **Reading:** McCance & Huether, Chap. 27-30
10: 10/30-11/2*	6: Digestive & Hepatic Systems	**Video:** Appendix 6 **Reading:** McCance & Huether, Chap. 40-42 Jarvis Unit III: 16, 21 & 25 **Directed Study Questions:** Module 5 due 11/8 (optional)
11: 11/3-11/9 **11/3:** **11/4a:** **11/4b:** Hepatotoxicity	6: Digestive & Hepatic Systems	**Directed Study Questions:** Module 6 due 11/15 (optional)
12: 11/10-11/16 **11/10:** **11/11a:** **11/11b:** Diabetes	7: Endocrine System	**Video:** Appendix 7 **Reading:** McCance & Huether, Chap.21-22 Jarvis, Unit III: 13 **Midterm Exam 7915 (Weeks 9-12):** Posted 11/21, Due 11/26
13: 11/17-11/23 **11/17:** **11/18a:** **11/18b:** Thyroid Disease	7: Endocrine System	**Directed Study Questions:** Module 7 due 11/29 (optional) **Review for Case Study:** Jarvis Unit IV
14: 11/24-11/30 **11/24:** **11/25a:** **11/25b:** Fibromyalgia & Psoriasis	8: Musculoskeletal and Dermatologic Systems	**Video:** Appendix 8 **Reading:** McCance & Huether, Chap. 43-47 Jarvis, Unit III: 12 & 22
15: 12/1-12/7 **12/1:** **12/2a:** **12/2b:** Menopause & ↓ Testosterone	9: Reproductive System	**Video:** Appendix 9 **Case Presentation DUE: 12/03** **Reading:** McCance & Huether, Chap. 23-26 Jarvis, Unit III: 17 & 24-26 **Directed Study Questions:** Module 8 due 12/6 (optional)

WEEK	MODULE	ACTIVITY
	9: Reproductive System	**Directed Study Questions:** Module 9 due 12/13 (optional) **Final Exam 7915 (Weeks 13-16):** Posted 12/12, due 12/17 **Complete the Satisfaction Survey**

*Note these cells represent deviations from the standard week format.

HISTORY AND PHYSICAL FORMAT

Identification Data:
Chief Complaint (CC):
History of Present Illness (PMI):
Past Psychiatric History
Past Medical History (PMH):
Past Surgical History (PSH):
Family History (FH):
Social History: Include drug, ETOH and tobacco use here
Medications:
Allergies: list reaction

Review of Systems (ROS):

- General
- Skin
- Head
- Ears
- Eyes
- Nose, Sinuses
- Mouth, Throat, Neck
- Breasts
- Respiratory
- Cardiac
- Gastrointestinal
- Urinary
- Genital
- Peripheral Vascular
- Musculoskeletal
- Neurologic
- Hematologic
- Endocrine
- Psychiatric

Physical Exam (PE):

- Vital Signs
- General Survey
- Skin
- Head, Ears, Eyes, Nose, Throat (HEENT)
- Neck
- Breasts
- Heart
- Lungs
- Abdomen
- Genitourinary
- Rectal

Musculoskeletal
Vascular
Lymphatic
Neurologic

Labs:
Assessment:
Plan:

HISTORY AND PHYSICAL EVALUATION

Criterion	Points
Identification Data	**5**
Chief Complaint	**5**
History of Present Illness	**5**
Past Psychiatric History	**5**
Past Medical History	**5**
Past Surgical History	**5**
Family History	**5**
Social History	**5**
Medications	**5**
Allergies	**5**
Review of Systems	**20**
Physical Exam	**15**
Labs	**5**
Assessment	**5**
Plan	**5**
TOTAL	**100**

It is expected that the subject of your Case Presentation will demonstrate some sort of medical disorder involving one or more of the body systems reviewed in this semester, or at least demonstrate significant risk for the development of such a disorder. It is preferred that the case also involve complications of a psychiatric nature (e.g., drug-drug interaction problems). You need not administer the examinations involved in this report, just have access to the results. If need be, you can generate mock test data appropriate to the case to complete sections of the report, but the inclusion of actual data is considered desirable. Given the requirements, ***it is strongly recommended you start looking for an appropriate case early in the semester.***

Given your current progress in the program, an important part of this exercise is to stay focused extensively if not exclusively on the medical issues presented by the case. It is your assignment to consider this case from the perspective of a traditional provider of medical care rather than as a psychology. In later courses the case assignment will call for a more integrated biopsychosocial approach.

If you have additional questions about the structure of the Case Presentation, please raise them as early as possible with your instructor.

MODULE 1: Basic Cellular Concepts

EXPERT PRESENTER

John P. McDonough, CRNA, ARNP, Ed.D.

TIME FRAME

Weeks 1-2

LEARNING OBJECTIVES

1. Describe the normal anatomy and physiology of the human cell and tissue, identifying the major structures and their function.
2. Describe the mechanisms of homeostasis, adaptation, and active and passive transport.
3. Relate the role of genetics to diagnosis and treatment of disease.
4. Describe the normal aging process.
5. Relate cellular neoplasia to metastasis.

READING ASSIGNMENTS

1. McCance & Huether, Chap. 1-3.
2. Jarvis, Units I-II.

VIDEO LECTURE OUTLINE

See Appendix 1

DIRECTED STUDY QUESTIONS

1. Compare and contrast endocrine, paracrine and synaptic signaling.
2. Compare and contrast endocytosis, exocytosis and active and passive transport giving examples of each.
3. Describe the cellular adaptations, and the reasons for each adaptation made by each of the following processes: atrophy, hypertrophy, hyperplasia, and metaplasia.
4. List the various accumulations that may occur as manifestations of cellular injury.
5. Discuss the cellular mechanism of normal aging. Identify the clinical manifestations of somatic death.

MODULE 2: Cardiovascular System

EXPERT PRESENTER

John P. McDonough, CRNA, ARNP, Ed.D.

TIME FRAME

Weeks 3-4

LEARNING OBJECTIVES

1. Describe the normal anatomy and physiology of the cardiovascular system, identifying the major organ structures and their function.
2. Identify the routine diagnostic studies and physical assessment used to differentiate normal from pathological structure and function of the cardiovascular system.
3. Apply knowledge of the etiology, signs and symptoms, pathophysiology, diagnostics, genetic predisposition, prognosis, and common therapies to treat patients/clients with hypertension, congestive heart failure, coronary artery disease, myocardial infarction, angina, and arrhythmia.
4. Describe the mechanisms of central and local blood pressure control, rennin-angiotensin, baroreceptor reflex, and cardiac performance.
5. Correlate the mechanical and electrical activity of the heart.
6. Demonstrate basic knowledge of the pathophysiology and treatment modalities for congenital cardiovascular disorders.

READING ASSIGNMENTS

1. McCance & Huether, Chap 31-33
2. Relevant portions of Jarvis, Unit III, 19 & 20

VIDEO LECTURE OUTLINE

See Appendix 2

DIRECTED STUDY QUESTIONS

1. Discuss the factors influencing systemic blood pressure.
2. Discuss hypertension with attention to causation, treatment and complications.
3. Identify the risk factors for arteriosclerosis.
4. Compare and contrast the cardiomyopathies.
5. Define an arrhythmia and state its significance.

MODULE 3: Respiratory System

EXPERT PRESENTER

John P. McDonough, CRNA, ARNP, Ed.D.

TIME FRAME

Weeks 5-6

LEARNING OBJECTIVES

1. Describe the normal anatomy and physiology of the respiratory system, identifying the major organ structures and their function.
2. Identify the routine diagnostic studies and physical assessment used to differentiate normal from pathological structure and function of the respiratory system.
3. Apply knowledge of the etiology, signs and symptoms, pathophysiology, diagnostics, genetic predisposition, prognosis, and common therapies to treat patients/clients with chronic obstructive pulmonary disease (i.e., bronchitis and emphysema) and asthma.
4. Describe the mechanisms of ventilation - perfusion, regulation of ventilation, hypoxemia, and oxygen – carbon dioxide exchange.
5. Describe the role of the respiratory system for maintaining acid-base balance.
6. Demonstrate basic knowledge of the pathophysiology and treatment modalities for pneumonia, upper respiratory infections, tuberculosis, adult respiratory distress syndrome, atalectasis, pulmonary hypertension, lung cancer, and cystic fibrosis.

READING ASSIGNMENTS

1. McCance & Huether, Chap. 34-36
2. Relevant portions of Jarvis, Unit III, 18

VIDEO LECTURE OUTLINE

See Appendix 3

DIRECTED STUDY QUESTIONS

1. Describe the neurochemical control of ventilation.
2. Describe the pulmonary changes that occur with normal aging.
3. Define hyperventilation and hypoventilation.
4. List conditions outside the pulmonary system that directly affect pulmonary function.
5. Differentiate between hypoxia and hypoxemia.
6. Describe common consequences of obstructive pulmonary disease.

MODULE 4: Renal/Genitourinary System

EXPERT PRESENTER

Randall L. Tackett, Ph.D.

TIME FRAME

Weeks 7-8

LEARNING OBJECTIVES

1. Describe the normal anatomy and physiology of the genitourinary system, identifying the major organ structures and their function.
2. Identify the routine diagnostic studies and physical assessment used to differentiate normal from pathological structure and function of the genitourinary system.
3. Apply knowledge of the etiology, signs and symptoms, pathophysiology, diagnostics, genetic predisposition, prognosis, and common therapies to treat patients/clients with acute and chronic renal failure, urinary tract infections, and acute and chronic pyelonephritis.
4. Describe the role of the kidneys for promoting homeostasis, acid-base balance, and fluid and electrolyte balance.
5. Describe glomerular filtration rate, including control and assessment.
6. Define serum sodium osmolarity and related controls.
7. Predict expected changes in homeostasis produced by renal pathology.
8. Correlate age related changes in renal function with the patient's response to drugs.
9. Demonstrate basic knowledge of the pathophysiology and treatment modalities for glomerulonephritis and kidney stones.

READING ASSIGNMENTS

1. McCance & Huether, Chap. 37-39
2. Relevant portions of Jarvis, Unit III, 24 & 26

VIDEO LECTURE OUTLINE

See Appendix 4a, 4b

DIRECTED STUDY QUESTIONS

1. Explain how the kidney contributes to the acid-base balance.
2. Outline the mechanisms responsible for glomerular injury.
3. Describe the pathophysiology and clinical manifestations of acute and chronic glomerulonephritis.
4. Describe the development of the nephrotic syndrome and identify the clinical manifestations associated with this condition.
5. Define enuresis and discuss the theories concerning its etiology.

MODULE 5: Hematology and Immunology

EXPERT PRESENTER

W. Patrick Monaghan, CLS, SBB, Ph.D.

TIME FRAME

Week 9

LEARNING OBJECTIVES

1. Describe the major constituents of human blood.
2. Identify each test and normal value of a complete blood count.
3. Describe the classification of anemias.
4. Relate the role of blood group incompatibility and hemolytic disease of the newborn.
5. Describe the most frequently used blood tests.
6. List the major components of the lymphatic system.
7. Describe the role of the B-cell in humoral immunity and the role of the T-cell in cell mediated immunity.
8. Identify each class and function of immunoglobulins.
9. Distinguish between antigens of the HLA complex, the ABO and the Rh of blood.
10. Describe “antigen processing and presentation” by the macrophage group systems.

READING ASSIGNMENTS

1. McCance & Huether, Chap 27-30

VIDEO LECTURE OUTLINE

See Appendix 5

DIRECTED STUDY QUESTIONS

1. List the major morphologic classification of anemias.
2. Define antigen, antibody, natural and acquired immunity.
3. Describe the primary and secondary immune response.
4. List each major class of immunoglobulin and describe a major function of each class.
5. List the four major elements that an antigen must fulfill to elicit an immune response.
6. Describe the three major physiologic functions of antibodies.
7. Describe several immunologic observations that have been described in the aging population.

MODULE 6: Gastrointestinal and Hepatic Systems

EXPERT PRESENTER

Randall L. Tackett, Ph.D.

TIME FRAME

Weeks 10-11

LEARNING OBJECTIVES

1. Describe the normal anatomy and physiology of the gastrointestinal system, identifying the major organ structures and their function.
2. Identify the routine diagnostic studies and physical assessment used to differentiate normal from pathological structure and function of the gastrointestinal system.
3 Apply knowledge of the etiology, signs and symptoms, pathophysiology, diagnostics, genetic predisposition, prognosis, and common therapies to treat patients/clients with gastroesophageal reflux disease, peptic ulcer disease, and liver failure and cirrhosis.
4. Describe stimulants and inhibitors of gastric secretion.
5. Describe digestion of carbohydrates, proteins, and fats.
6. Describe the formation, secretion, and reabsorption of bile.
7. Identify the characteristics of gastric and duodenal ulcers.
8. Correlate changes in liver function with a patient's response to drugs.
9. Demonstrate basic knowledge of the pathophysiology of liver failure and cirrhosis.

READING ASSIGNMENT

1. McCance & Huether, Chap. 40-42
2. Relevant portions of Jarvis, Unit III, 16, 21 & 25

VIDEO LECTURE OUTLINE

See Appendix 6

DIRECTED STUDY QUESTIONS

1. Describe the process of enterohepatic circulation.
2. Identify the disorders of gastrointestinal motility and their clinical manifestations.
3. Explain the pathophysiology of gastroesophageal reflux disease, its clinical manifestation and treatment.
4. Compare and contrast the pathophysiology and clinical manifestations of gastric and duodenal ulcers.
5. Describe the pathophysiology, clinical manifestations and sequelae of cirrhosis.

MODULE 7: Endocrine System

EXPERT PRESENTER

John T. Johnson Pharm.D., C.D.E.

TIME FRAME

Weeks 12-13

LEARNING OBJECTIVES

1. Describe the normal anatomy and physiology of the endocrine system, identifying the major organ structures and their function.
2. Identify the routine diagnostic studies and physical assessment used to differentiate normal from pathological structure and function of the endocrine system.
3. Apply knowledge of the etiology, signs and symptoms, pathophysiology, diagnostics, genetic predisposition, prognosis, and common therapies to treat patients/clients with type 1 and type 2 diabetes and hyper- and hypo-thyroidism.
4. Differentiate positive and negative feedback systems, and up and down regulation specific to the endocrine system.
5. Demonstrate basic knowledge of the pathophysiology and treatment of common pituitary diseases.
6. List the effects of aging on the thyroid gland.

READING ASSIGNMENT

Required

1. McCance & Huether, Chap. 21 & 22
2. Relevant portions of Jarvis, Unit III, 13
3. Review for Case Study: Jarvis, Unit IV

Recommended

1. DiPiro et al., Chap. 70-71.

VIDEO LECTURE OUTLINE

See Appendix 7

DIRECTED STUDY QUESTIONS

1. List the factors that control hormone release.
2. Describe the difference in positive and negative feedback mechanisms.

3. Explain the interaction that different hormones of the anterior pituitary have on thyroid function and diabetes.
4. Describe the relationship of TH, TSH, TRH, T3, and T4.
5. List the effects of aging on the thyroid gland.
6. Explain the differences in Type 1 and Type 2 diabetes.

MODULE 8: Musculoskeletal and Dermatologic Systems

EXPERT PRESENTER

Randall L. Tackett, Ph.D.

TIME FRAME

Week 14

LEARNING OBJECTIVES

1. Describe the normal anatomy and physiology of the musculoskeletal and dermatologic systems, identifying the major cell types and their function.
2. Identify the routine diagnostic studies and physical assessment used to differentiate normal from pathological structure and function of the musculoskeletal system.
3. Apply knowledge of the etiology, signs and symptoms, pathophysiology, diagnostics, genetic predisposition, prognosis, and common therapies to treat patients/clients with osteoporosis, rheumatoid arthritis, and myasthenia gravis.
4. Describe how bone integrity is maintained.
5. Describe the motor unit of the muscle.
6. Explain the process of muscle contraction.
7. Identify the age-related changes in bone and skeletal muscle.
8. Demonstrate basic knowledge of the pathophysiology and treatment modalities for multiple sclerosis, ankylosing spondylitis, osteomyelitis, and fibromyalgia.

READING ASSIGNMENTS

1. McCance & Huether, Chap. 43-47.
2. Relevant portions of Jarvis, Unit III, 12 & 22

VIDEO LECTURE OUTLINE

See Appendix 8

DIRECTED STUDY QUESTIONS

1. Describe the motor unit of the muscle and its function.
2. Explain the pathophysiology, clinical manifestations and treatment of osteoporosis.
3. Identify the types of osteoarthritis and differentiate between each type.
4. Describe the pathogenesis of rheumatoid arthritis.
5. Describe the pathophysiology of fibromyalgia, its clinical manifestation and treatment.
6. Describe the pathophysiology, clinical manifestation and treatment of myasthenia gravis.
7. Describe the types of skin reactions that are drug-induced.

MODULE 9: Reproductive System

EXPERT PRESENTER

Laura Street, R.N.C., M.S.N.

TIME FRAME

Week 15

LEARNING OBJECTIVES

1. Describe the normal anatomy and physiology of the male and female reproductive system, identifying the major organ structures and their function.
2. Identify the routine diagnostic studies and physical assessment used to differentiate normal from pathological structure and function of the reproductive system.
3. Apply knowledge of the etiology, signs and symptoms, pathophysiology, diagnostics, genetic predisposition, prognosis, and common therapies to treat patients/clients with sexual dysfunction, sexually transmitted infections, and breast cancer.
4. Describe the physiology of the menstrual cycle.
5. Describe the relationship of the male and female hormones including the positive and negative feedback mechanisms.
6. Demonstrate basic knowledge of the pathophysiology and treatment modalities for pre-eclampsia and eclampsia of pregnancy, ectopic pregnancy, endometrial cancer, benign prostatic hypertrophy, prostatic and testicular cancer, premenstrual syndrome, dysmenorrhea, and endometriosis.

READING ASSIGNMENTS

1. McCance & Huether, Chap. 23-26.
2. Relevant portions of Jarvis, Unit III, 17 & 24-26

VIDEO LECTURE OUTLINE

See Appendix 9

DIRECTED STUDY QUESTIONS

1. Describe the past and present theories of premenstrual syndrome.
2. Identify the evaluation criteria for premenstrual dysphoric disorder.
3. Explain the treatment options for premenstrual dysphoric disorder.
4. Describe the theoretical cause of endometriosis.
5. Differentiate between primary and secondary dysmenorrhea.
6. Explain the pathophysiology of dysmenorrhea.
7. Describe the pathophysiology and clinical manifestations for prostatic cancer.
8. Describe the clinical manifestations and evaluation options for testicular cancer.

Fairleigh Dickinson
UNIVERSITY

COURSE SYLLABUS

M.S. Program in Clinical Psychopharmacology

PSYC7930: CLINICAL PHARMACOLOGY

September 1 – October 21, 2015

TABLE OF CONTENTS

Appendix 4: Module 4: Drugs Affecting the Central Nervous System

Appendix 5: Module 5: Anti-Infectives, Antibiotics, and Antivirals

Appendix 6: Module 6: Drugs Affecting the Endocrine System

Appendix 7: Module 7: Lifestyle Drugs

Appendix 8: Module 8: Chronic Pain

COURSE SYLLABUS

COURSE DESCRIPTION

Clinical Pharmacology focuses on the basic principles of pharmacology, including epidemiology and pharmacogenomics. The course also provides an overview to all the major drug classes, including mechanism of action, side effects, indications, and contraindications for each. A review of major classes of drugs is preparatory for the intensive focus on psychopharmacological agents in the coming semesters.

PLACEMENT

Clinical Pharmacology is offered during the same semester as the Professional Issues & Practice Management course. Students may enroll in this semester any time after completion of the foundations core, which includes Biological Foundations of Clinical Psychopharmacology I and II, and Neuroscience/Neuropharmacology. Following completion of the foundations core, they may progress through the remaining courses in any sequence. Successful completion of the ten didactic courses of Psychopharmacology Postdoctoral Training Program, makes the candidate eligible to enroll in the Clinical Practicum Elective.

COURSE OBJECTIVES

Upon completion of these courses, the student will:

1. Understand the basic principles of pharmacology, pharmacokinetics and pharmacodynamics as they relate to drug action
2. State the principle indications for the major drug classes
3. Explain the mechanism of action of the major drug categories
4. Identify adverse drug actions of the major drug classes
5. Recognize potential drug interactions
6. Identify precautions and contraindications in the use of drugs

In achieving each of these objectives, issues of lifespan development, gender, and ethnic diversity will be integrated.

FACULTY AND STAFF

Instructor

Merrill Norton Pharm.D., D.Ph.,ICCDP-D (Doctorate of Pharmacy Practice with specialty areas in Addiction Medicine, Psychiatric Medicine, and Chronic Pain Management, University of Georgia, 2008)
University of Georgia
Athens, GA
706-542-5371

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Dr. Merrill Norton is a clinical associate professor at the University of Georgia College of Pharmacy. His area of specialty is addiction pharmacy, which includes psychotropic medications, addiction medicine, and pain management medications. Dr. Norton has an internationally recognized reputation in addiction pharmacology and treatment with his former position being program director for the Atlanta Recovering Professionals Program at the Metro Atlanta Recovery Residences, Inc. of Atlanta, Georgia, an internationally recognized treatment facility for health care professionals. Dr. Norton has worked with impaired pharmacists and other health care professionals for over 25 years and is the former Director of the Recovering Pharmacists Program at the Talbott Recovery Campus.

Video Expert Presenters

Module 1: General Principles of Pharmacology **- Randall Tackett, Ph.D.**
Module 1: Drug Metabolism and Pharmacogenomics - **Randall Tackett, Ph.D.**
Module 2: Drugs Affecting the Autonomic Nervous System **- Randall Tackett, Ph.D.**
Module 3: Drugs Affecting the Cardiovascular and Respiratory Systems **– Randall Tackett, PhD**
Module 4: Drugs Affecting the Central Nervous System **- Randall Tackett, PhD**
Module 5: Anti-Infectives, Antibiotics, and Antivirals **- Randall Tackett, Ph.D.**
Module 6: Drugs Affecting the Endocrine System **- Randall Tackett, Ph.D.**
Module 7: Lifestyle Drugs – **Randall Tackett, Ph.D.**
Module 8: Chronic Pain – **Merrill Norton, Pharm.D.**

24/7 Technical Support

FDU Technical Assistance Center (FDUTAC)
Phone: 973-443-8822 (973-443-UTAC)
E-mail: fdutac@fdu.edu

STUDENT EVALUATION

50%: Two online objective exams
25%: Participation in weekly chats
25%: Written Semester Project

PASSING GRADE

To be assured of satisfactory completion of this course applicable to progression to the next term, **the student must achieve a score of 80% or better of the total points available. A grade of less than 75% represents failure of the course.**

CONTINUING PROFESSIONAL EDUCATION CREDITS

Fairleigh Dickinson University School of Psychology is approved by the American Psychological Association to offer continuing education for psychologists. The School of Psychology maintains responsibility for the program. With a student participation rate of at least 80%, PSYC7930 is approved for 45 continuing professional education credits for psychologists.

# Hours	Activity
25	Readings/videos
5	Chats
8	Exams
7	Semester Project

TEXTBOOKS

Required

1. Brunton, L., Chabner, B., & Knollman, B. (Eds). (2010). *Goodman & Gilman's The Pharmacological Basis of Therapeutics* (12th ed.). New York: McGraw-Hill. ISBN 0071624422.
2. See Semester Project (p. 8)

DIRECTED STUDY QUESTIONS (DSQs)

In this course, DSQs are used as the basis for chat discussions of course material. You should familiarize yourself with the material before the chat session, but you should not prepare a formal response. Your instructor will expect the student to be prepared to answer the DSQs during each chat session and your participation will be a major consideration in grading for the chat section (25%) of this course.

COURSE SCHEDULE

WEEK	MODULE	ACTIVITY
1: 9/1-9/6	1: General Principles of Pharmacology	**Video:** Appendix 1a **Readings:** Goodman & Gilman pp 17-70; 73-86, 1879-1889
2: 9/7-9/13	1: General Principles of Pharmacology	**Video:** Appendix 1b & 1c **Readings:** Goodman & Gilman pp 123-142; 145-165
3: 9/14-9/20	2: Drugs Affecting the Autonomic Nervous System	**Video:** Appendix 2 **Readings:** Goodman & Gilman pp 171-330
4: 9/21-9/27	3: Drugs Affecting the Cardiovascular and Respiratory Systems	**Video:** Appendix 3 **Readings:** Goodman & Gilman pp 671-701; 721-741; 747-783; 790-810; 820-845; 860-874; 892-904; 1031-1061 **Exam 1 (Weeks 1-4):** Posted 9/25, due 9/30
5: 9/28-10/4	4: Drugs Affecting the Central Nervous System	**Video:** Appendix 4 **Readings:** Goodman & Gilman pp 397-477; 583-606
6: 10/5-10/11	5: Anti-Infectives, Antibiotics, and Antivirals	**Video:** Appendix 5 **Readings:** Goodman & Gilman pp 1365-1378; 1463-1660
7: 10/12-10/15*	6: Drugs Affecting the Endocrine System	**Video:** Appendix 6 **Readings:** Goodman & Gilman pp 1129-1271; 1833-1851
8: 10/16-10/21*	7: Lifestyle Drugs 8: Chronic Pain	**Video:** Appendices 7 & 8 **Readings:** Goodman & Gilman pp 481-521; 959-1000 **Exam 2 (Weeks 5-8):** Posted 10/16, due 10/21 **Complete the Satisfaction Survey**

*Note these cells represent deviations from the standard week format.

SEMESTER PROJECT

"The power to prescribe is the power not to prescribe" – Russ Newman

The "case presentation" for this semester is different than that used in other semesters. It was designed in light of the theme for this semester, which is the creation of your personal identity as a critical user of pharmacotherapy in clinical practice. Your case presentation is more of a book report. Begin by choosing one of the following sources opposing the use of psychotropic medications:

1. Carlat, D. (2010). *Unhinged: The trouble with psychiatry—A doctor's revelations about a profession in crisis*. New York: Free Press. ISBN: 141659079X.
2. Kirsch, I. (2011). *The emperor's new drugs: Exploding the antidepressant myth.* New York: Basic Books.
3. Healy, D. (2006). *Let them eat Prozac: The unhealthy relationship between the pharmaceutical industry and depression*. New York: New York University Press. ISBN 0814736971.
4. Dubovsky, A. N., & Dubovsky, S. L. (2007). *Psychotropic drug prescriber's survival guide: Ethical mental health treatment in the age of big pharma*. New York: Norton. ISBN: 0393705102.
5. Whitaker, R. (2010). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Crown. ISBN: 0307452417.

Read the book you choose, and critically evaluate the case made by the author. This should include the following:

1. A critical analysis of the central arguments. This may involve:
   a. Reviewing some of the research cited by the author and evaluating whether the author has accurately interpreted the results.
   b. Reviewing subsequent research to determine whether the arguments raised are consistent with more recent findings.
   c. Evaluating the logic of the central argument based on the evidence provided.
2. Some sort of statement about your intended use of medication in your own practice. This should include:
   a. Common errors you see in the practice of pharmacotherapy (both idiosyncratic and systemic), and how you would avoid them in your own practice.
   b. How you would integrate pharmacotherapy and psychotherapy in your own practice, including procedures you would use to make decisions concerning the use of psychotherapy, pharmacotherapy, or their combination.
   c. Ways in which you expect the practice of pharmacotherapy to change the nature of your practice.

A good resource to help you with this project is the Library Resources available through library.fdu.edu. From these portals you can search PsycINFO, get electronic access to all journals to which our libraries subscribe that offer this option, and check our holdings. At any point where you are asked for a username and password, just use the same ones you use to access webcampus.

This project is meant to be fun! Don't be too concerned about grading. The intent here is to get you thinking about how you think pharmacotherapy should be integrated into psychology, where standard

practice needs to be fixed, and what it means to be a prescribing psychologist. **Your project should be submitted to the course instructor for PSYC7935 by the date that will be listed in the schedule for that course**. Length is open, but brevity is the soul of wit.

MODULE 1: General Principles of Pharmacology

EXPERT PRESENTER

Randall Tackett, Ph.D.

TIME FRAME

Weeks 1-2

LEARNING OBJECTIVES

1. Describe potential mechanisms by which drugs elicit their therapeutic and toxic effects.
2. Describe the metabolism and excretion of drugs.
3. Differentiate between pharmacodynamic and pharmacokinetic mediated drug responses.
4. Describe the process of drug discovery, approval, and surveillance of adverse drug actions.
5. Identify mechanisms associated with drug interactions.
6. Identify alterations in drug responses in special populations (ethnic, gender, age).

READING ASSIGNMENT

Week 1

Goodman & Gilman, pp. 17-70; 73-86, 1879-1889

Week 2

Goodman & Gilman, pp. 123-142; 145-165

DIRECTED STUDY QUESTIONS

1. Describe the most common routes of drug metabolism and excretion.
2. Describe the role of protein binding in drug distribution.
3. Describe the various phases of clinical investigation and the process of adverse reaction surveillance.
4. What parameters are identified as pharmacodynamic parameters and which are considered pharmacokinetic parameters?
5. Identify common mechanisms of drug interactions.
6. Describe the general mechanisms associated with therapeutic and toxic drug effects.
7. Discuss how drug effects may be affected by pharmacogenomics.

VIDEO LECTURE OUTLINES

Appendices 1a, 1b, & 1c

MODULE 2: Drugs Affecting the Autonomic Nervous System

EXPERT PRESENTER

Randall Tackett, Ph.D.

TIME FRAME

Week 3

LEARNING OBJECTIVES

1. Review the autonomic receptors and the effect of agonists and antagonists on these receptors.
2. Describe the effects of drugs that act as direct or indirect agonists of autonomic nervous system receptors (muscarinic, ACHase inhibitors, alpha agonists, OTC drugs, stimulants, appetite suppressants).
3. Describe the effects of drugs which act as antagonists of autonomic nervous system receptors. (anticholinergics, alpha and beta blockers).
4. Identify drugs that act therapeutically by acting on non-autonomic nervous system receptors (e.g., antihistamines, prostaglandins).

READING ASSIGNMENT

Goodman & Gilman, pp. 171-330

DIRECTED STUDY QUESTIONS

1. Develop an outline of the major body systems depicting the autonomic nervous system receptors and the result of stimulation of these receptors.
2. Identify the therapeutic use and potential side effects of each of the following classes of drugs:
   a. Antimuscarinics
   b. Cholinergic agonists
   c. Anticholinesterases
   d. Sympathomimetic agents
   e. Adrenoceptor antagonists
3. Identify the drugs used as antihistamines and their potential side effects.
4. Identify potential drug interactions between autonomic nervous system drugs and antihistamines with psychotropic agents.

VIDEO LECTURE OUTLINE

Appendix 2

MODULE 3: Drugs Affecting the Cardiovascular and Respiratory System

EXPERT PRESENTER

Randall L Tackett, PhD

TIME FRAME

Week 4

LEARNING OBJECTIVES

1. Define the mechanism of action of prototypical drugs used to treat hypertension, hypercholesterolemia, angina, arrhythmias, and congestive heart failure.
2. Define the mechanism of action of drugs that are used to treat asthma and other related respiratory diseases.
3. Understand the indications/contraindications for use of specific drugs within a drug class.
4. List the major toxicities associated with the use of these drugs.
5. Identify side effects associated with these drugs with specific emphasis on neurological or cognitive effects.

READING ASSIGNMENTS

Goodman & Gilman, pp. 671-701; 721-741; 747-783; 790-810; 820-845; 860-874; 892-904; 1031-1061

DIRECTED STUDY QUESTIONS

1. Define the potential mechanism of actions and major side effects for each of the following classes of drugs:
   a. Antihypertensive agents
   b. Hypocholesterolemic agents
   c. Congestive heart failure agents
   d. Anti-anginal agents
   e. Antiarrhythmic drugs
2. Describe the mechanisms of action of drugs used in the treatment of asthma and respiratory disorders.
3. Identify potential drug interactions between cardiovascular or respiratory drugs with psychotropic agents.
4. Identify potential problems with the use of cardiovascular or respiratory drugs in patients with co-morbid psychiatric conditions.

VIDEO LECTURE OUTLINE

Appendix 3

MODULE 4: Drugs Affecting the Central Nervous System

EXPERT PRESENTER

Randall L Tackett, PhD

TIME FRAME

Week 5

LEARNING OBJECTIVES

1. Identify the mechanism of action of prototypical drugs used to treat depression, anxiety, psychosis, epilepsy and parkinsonism.
2. Understand the indications/contraindications for use of specific drugs within a drug class.
3. List the major side effects associated with the use of these drugs.
4. Identify side effects associated with alterations in the hepatic, hematological, and other body systems.
5. Recognize potential drug interactions associated with the use of these drugs.

READING ASSIGNMENT

Goodman & Gilman, pp. 397-477; 583-606

DIRECTED STUDY QUESTIONS

1. Identify the major mechanism of action and side effects associated with the prototypical drugs in the following classes:
   a. Anti-anxiety agents
   b. Anti-psychotic agents
   c. Antidepressants
   d. Anti-parkinson agents
   e. Anti-convulsant agents
2. Identify side effects associated with alterations in the hepatic, hematological, and other body systems.

VIDEO LECTURE OUTLINE

Appendix 4

MODULE 5: Anti-Infectives, Antibiotics, and Antivirals

EXPERT PRESENTER

Randall Tackett, Ph.D.

TIME FRAME

Week 6

LEARNING OBJECTIVES

1. Describe the process of inflammation and identify potential sites of drug interaction.
2. List the major side effects associated with the acute and chronic use of anti-inflammatory drugs.
3. Identify the major classes of antiviral and antibiotic drugs and describe their mechanism of action.
4. List the indications for each of the major classes of antibiotics and antiviral drugs (specifically, for the treatment of AIDS).
5. Identify the major side effects associated with the use of antibiotics and antiviral drugs.
6. Describe potential drug interactions.

READING ASSIGNMENT

Goodman & Gilman, pp. 1365-1378; 1463-1660

DIRECTED STUDY QUESTIONS

1. Describe the process of inflammation and identify potential sites of drug interaction.
2. List the major side effects associated with the acute and chronic use of anti-inflammatory drugs.
3. Identify the major classes of antiviral and antibiotic drugs and describe their mechanism of action.
4. Identify the major side effects associated with the use of antibiotics and antiviral drugs.

VIDEO LECTURE OUTLINE

Appendix 5

MODULE 6: Drugs Affecting the Endocrine System

EXPERT PRESENTER

Randall L. Tackett, Ph.D.

TIME FRAME

Week 7

LEARNING OBJECTIVES

1. Define the mechanism of action of reproductive system (estrogens, progestins, androgens, antiestrogens) and thyroid hormones.
2. Identify indications and contraindications associated with their use.
3. List the major side effects with special emphasis on affect and cognition.
4. Identify major drug interactions associated with their use.

READING ASSIGNMENT

Goodman & Gilman, pp. 1129-1271; 1833-1851

DIRECTED STUDY QUESTIONS

1. Define the mechanism of action of reproductive system (estrogens, progestins, androgens, antiestrogens) and thyroid hormones.
2. Identify indications and contraindications associated with their use.
3. List the major side effects with special emphasis on affect and cognition.

VIDEO LECTURE OUTLINE

Appendix 6

MODULE 7: Lifestyle Drugs

EXPERT PRESENTER

Randall L. Tackett, Ph.D.

TIME FRAME

Week 8

LEARNING OBJECTIVES

At the conclusion of this session, participants should be able to:

1. Contrast the regulation of herbs to that of prescription medications.
2. Describe the mechanism of action, suggested use and side effects of Kava, Valerian, DHEA, echinacea, ma huang, St John's wort and SAMe.
3. Understand etiological models of obesity.
4. Discuss binge eating.
5. Understand the treatment options for obese patients.
6. Describe drug therapy for obesity.
7. Understand the pharmacological treatment for anorexia and bulimia.

READING ASSIGNMENT

Goodman & Gilman, pp. 481-521

DIRECTED STUDY QUESTIONS

1. Discuss complications associated with obesity.
2. Discuss medications that may increase appetite.
3. Differentiate between anorexia and bulimia.
4. List and discuss medications used to treat obesity.
5. List and discuss medications used to treat anorexia and bulimia.
6. Describe the cautions that should be provided to a patient who is using an herb.
7. Contrast the regulation of herbs to that of prescription medications.

VIDEO LECTURE OUTLINE

Appendix 7

MODULE 8: Chronic Pain

EXPERT PRESENTER

Merrill Norton, Pharm.D.

TIME FRAME

Week 8

LEARNING OBJECTIVES

1. To understand the difference between chronic and acute pain.
2. To learn about the pharmacological treatment for chronic pain.

READING ASSIGNMENTS

Goodman & Gilman, pp. 959-1000

DIRECTED STUDY QUESTIONS

1. Differentiate between chronic and acute pain.
2. List the classes of medications that may be used to treat chronic pain.
3. Discuss the uses of antidepressants and anticonvulsants in the treatment of pain.

VIDEO LECTURE OUTLINE

Appendix 8

Fairleigh Dickinson
UNIVERSITY

COURSE SYLLABUS

M.S. Program in Clinical Psychopharmacology

PSYC7935: PROFESSIONAL ISSUES AND PRACTICE MANAGEMENT

October 22 – December 13, 2015

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COURSE SYLLABUS

COURSE DESCRIPTION

The Professional Issues and Practice Management course focuses on various issues associated with the professional conduct of a psychological practice in pharmacotherapy. These include more empirical topics such as epidemiology, genetic factors in psychopathology, and the critical consumption of research. It also includes professional issues such as the requirements for a legal prescription, electronic tools for pharmacotherapy, working in primary care, and communications with other professionals.

PLACEMENT

The Professional Issues and Practice Management course is offered during the same semester as the Clinical Psychopharmacology course. Students may enroll in this semester any time after completion of the foundations core, which includes Biological Foundations of Clinical Psychopharmacology I and II, Neuroscience, and Neuropharmacology. Following completion of the foundations core, they may progress through the remaining courses in any sequence. Successful completion of the ten didactic courses of M.S. Program in Clinical Psychopharmacology makes the candidate eligible to enroll in the Clinical Practicum Elective.

COURSE OBJECTIVES

Upon completion of this course, the student will have developed an understanding of:
1. Guidelines for writing prescriptions, documentation, and ordering medical tests.
2. Current knowledge of and controversies surrounding the epidemiology of psychological disorders.
3. The management of professional relations as a collaborating or prescribing psychologist.
4. Legal, professional, ethical, and liability-related issues associated with prescriptive practice.
5. Issues in professional development associated with prescriptive authority, including legislative advocacy and important resources for the prescribing professional.
6. How to be an effective consumer of drug research.

In achieving these objectives, issues of lifespan development, gender, and ethnic diversity will be integrated.

FACULTY AND STAFF

Course Instructor

Anne R. Farrar-Anton, Ph.D.
130 West Pleasant Avenue, #190
Maywood, NJ, 07607
Telephone: 201-315-7652
Primary Email: farraran@fdu.edu

Dr. Anne Farrar-Anton is a licensed psychologist in New Jersey and New York. She has been employed at Hackensack University Medical Center for the past 15.5 years and is on Medical Staff within the Department of Pediatrics. She began working at the Institute for Child Development and was there for 5.5 years prior to transitioning to the Institute for Pediatric Cancer and Blood Disorders, where she has worked for the past 10 years; she primarily works with children and their families who have been diagnosed with cancer, blood disorders, or require a bone marrow transplant. She currently serves as the Supervisor of the Psychological and Educational services. She conducts comprehensive neuropsychological evaluations, psychotherapy and crisis counseling with children and families, supervises and trains doctoral students, and has an active research agenda. Her primary goal is to assist the children and families suffering from various life-threatening medical illnesses to find adaptive ways to cope with the stressors that are presented to them and utilizes a biopsychosocial orientation. The focus can be anywhere on the spectrum from adjusting to diagnosis, survivorship issues and late effects of treatment, palliation, to end-of-life issues.

Dr. Farrar-Anton earned her master's in Counseling and her doctorate degree in Counseling Psychology from Seton Hall University in South Orange, NJ. Dr. Farrar-Anton completed a two-year post-doctoral fellowship in pediatric neuropsychology at the Institute for Child Development at Hackensack University Medical Center. Most recently Dr. Farrar-Anton completed a Post-Doctoral Master's of Science in Clinical Psychopharmacology (MSCP, 2009) from Fairleigh Dickinson University along with the Certificate Program in Integrated Primary Care (2011) in order to better understand psychotropic medications as well as how to collaborate/integrate psychology within a medical setting. Dr. Farrar-Anton served in the role of Associate Director of the MSCP program in 2009-2011 and was appointed to serve as Director in July 2015. Dr. Farrar-Anton is able to utilize her knowledge on psychotropic medications to better understand her patient's symptoms and be able to collaborate with the physicians prescribing these various medications.

Dr. Farrar-Anton also established her private practice in 2010 in Bergen County and provides both psychological and neuropsychological services. She is an adjunct professor for the School of Psychology and the School of Education at Fairleigh Dickinson University as well as a testing/therapy supervisor at the Center for Psychological Services. She is also an adjunct professor at William Paterson University. Her current classes include Introduction to School Testing, Biopsychology, and Clinical Psychopharmacology at the Master's and Doctoral level.

Dr. Farrar-Anton has been involved in numerous leadership positions at the county, state, and national level as well as is involved with national psychological and neuropsychological organizations. Governor Christopher Christie also appointed her in 2015 for a 3-year appointment to the NJ Board of Psychological Examiners. She has served twice as President of the New Jersey Neuropsychological Society (NJNS) and is currently in the role of Secretary. She has also served in numerous leadership positions including past Chair of the Membership Committee of the New Jersey Psychological Association (NJPA). She is also an author of several journal publications and a book chapter. In her free time, she enjoys spending time learning ballroom dancing and also spending time with her therapy dog who competes in agility.

Video Expert Presenters

Appendix 1: Practical Issues in Prescriptive Practice - **Bret A. Moore, Psy.D., ABPP**
Appendix 3: Professional Relationships and Communications – **Bret A. Moore, Psy.D., ABPP** and colleagues
Appendix 4a: Professional Issues and Bioethics – **Morgan Sammons, Ph.D.**
Appendix 4b: Issues in Prescriptive Practice **– Robert E. McGrath, Ph.D.**
Appendix 5: Being an Informed Consumer of Drug Research **– Robert E. McGrath, Ph.D.**
Appendix 6: Integrating Psychotherapy with Pharmacotherapy **– Bret A. Moore, Psy.D., ABPP** and colleagues

24/7 University Technical Assistance Center

Phone: 973-443-8822 (973-443-UTAC)
E-mail: fdutac@fdu.edu

STUDENT EVALUATION

66%: Two online objective exams
33%: Written Semester Project

PASSING GRADE

To be assured of satisfactory completion of this course applicable to progression to the next term, **the student must achieve a score of 80% or better of the total points available. A grade of less than 75% represents failure of the course.**

CONTINUING PROFESSIONAL EDUCATION CREDITS

Fairleigh Dickinson University School of Psychology is approved by the American Psychological Association to offer continuing education for psychologists. The School of Psychology maintains responsibility for the program. With a student participation rate of at least 80%, PSYC7955 is approved for 48 continuing professional education credits for psychologists. One weekend Regional Interaction Session occurs each semester; 10.5 hours for this experience is credited to each 7.5-week course completed during the semester: 3.5 for preparation of a clinical case study and 7 for the session.

# Hours	Activity
25	Readings/videos
5	Chats
8	Exams
7	Semester Project

TEXTBOOKS

Required

1. McGrath, R. E., & Moore, B. A. (Eds.). (2010). *Pharmacotherapy for psychologists: Prescribing and collaborative roles*. Washington DC: APA Books. ISBN: 9781433808005
2. Muse, M. & Moore, B. A. (Eds.). (2012). Handbook of Clinical Psychopharmacology for Psychologists. New York, NY: John Wiley & Sons. ISBN: 9780470907573

Recommended

1. *The Carlat Psychiatry Report*. Published monthly. To order: http://thecarlatreport.com.
2. *Journal of Clinical Psychiatry*. Published monthly. To order: https://www.psychiatrist.com/newuser.
3. *Psychiatry Drug Alerts*. A six page monthly newsletter – great for side effect reports. To order: http://www.alertpubs.com

DIRECTED STUDY QUESTIONS

The Directed Study Questions for this course are designed primarily as practice-enhancing activities and opinion pieces. Although it is strongly recommended that students complete the DSQs, completion of the DSQs is **not required** for this course. Feedback on DSQs will be provided if turned in and requested by the student.

Please remember the DSQs are intended to be SHORT answer questions. When you are asked to generate a list, you do not need more than 1-2 sentences for each item in the list. When the question is open-ended, you never need to provide more than 1-2 paragraphs of information.

If you're not sure what the question is looking for, rather than spending hours trying to produce every piece of information you can, feel free to discuss it with your facilitator, and if you're not comfortable with the feedback you receive, your instructor.

PLEASE don't let obsessional tendencies get in the way of completing the DSQs in a timely manner. The goal of the DSQs is to demonstrate a basic understanding of processes, and to help consolidate the key information, not to demonstrate you know everything about everything. Educational research demonstrates that what you will take away from any learning experience is the most central information, and in practice you will need to rely on resource materials for many of the details.

COURSE SCHEDULE

WEEK	MODULE	ACTIVITY
1: 10/22-10/28	1: Practical Issues in Prescriptive Practice	**Video:** Appendix 1 **Readings:** Fugh-Berman& Ahari, 2007; Jenkins & Vaida, 2007; Mark et al., 2009; Moore & Muse, 2012; Phillips, 2004; JCAHO Do Not Use List; Dangerous Abbreviations List **Directed Study Questions (optional):** Module 1 due 10/28
2: 10/29-11/4	2: Epidemiology	**Readings:** Addington & Rapoport, 2012; Austin, 2013; Konrad et al., 2009; Ellis et al., 2009; Thomas et al., 2009; Reeves et al., 2011 **Directed Study Questions (optional):** Module 1 due 11/4 **Identify book for Semester Project, if not done already**
3: 11/5-11/11	3: Professional Relationships	**Video:** Appendix 3 **Readings:** Ally, 2010; Gruber, 2010; Mantell et al., 2004; McGrath & Sammons, 2011 **Directed Study Questions (optional):** Module 3 due 11/11
4: 11/12-11/15*	4: Legal and Professional Issues	**Video:** Appendix 4a **Readings:** APA, 2011; McGrath, 2010; McGrath & Rom-Rymer, 2010 **Exam 1 (Weeks 1-4):** Posted 11/13, due 11/18
5: 11/16-11/22	4: Legal and Professional Issues	**Video:** Appendix 4b **Readings:** Cosgrove & Moore, 2012; Dörken, 1990 **Directed Study Questions (optional):** Module 4 due 11/22

WEEK	MODULE	ACTIVITY
6: 11/23-11/29	5: Using Research	**Video:** Appendix 5 **Reading:** Gigerenzer et al., 2008; McGrath, 2012 **Semester Project:** Submit to Instructor by 11/29
7: 11/30-12/6	5: Using Research	**Readings:** McGrath, 2010; Fournier et al., 2010; Roshanaei-Moghaddam et al., 2010; Goldacre, 2012 **Directed Study Questions (optional):** Module 5 due 12/6
8: 12/7-12/13	6: Integrating Psychotherapy with Pharmacotherapy	**Video:** Appendix 6 **Reading:** LeVine & Foster, 2010; Muse & Moore, 2012; Smith, 2012; Winston et al., 2005 **Directed Study Questions (optional):** Module 6 due 12/13 **Exam 2 (Weeks 5-8):** Posted 12/11 due 12/16 **Complete the Satisfaction Survey**

*Deviations from the standard week format.

SEMESTER PROJECT

"The power to prescribe is the power not to prescribe" – Russ Newman

The "case presentation" for this semester is different than that used in other semesters. It was designed in light of the theme for this semester, which is the creation of your personal identity as a critical user of pharmacotherapy in clinical practice. Your case presentation is more of a book report. Begin by choosing one of the following sources opposing the use of psychotropic medications:

1. Carlat, D. (2010). *Unhinged: The trouble with psychiatry—A doctor's revelations about a profession in crisis*. New York: Free Press. ISBN: 141659079X.
2. Conrad, P. (2007). *The medicalization of society: On the transformation of human conditions into treatable disorders.* Baltimore, MD: Johns Hopkins University Press.
3. Moynihan, R., & Cassels, A. (2006). *Selling sickness: How the world's biggest pharmaceutical companies are turning us all into patients*. New York: Nation Books.
4. Healy, D. (2006). *Let them eat Prozac: The unhealthy relationship between the pharmaceutical industry and depression*. New York: New York University Press. ISBN 0814736971.
5. Dubovsky, A. N., & Dubovsky, S. L. (2007). *Psychotropic drug prescriber's survival guide: Ethical mental health treatment in the age of big pharma*. New York: Norton. ISBN: 0393705102.
6. Whitaker, R. (2010). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Crown. ISBN: 0307452417.

Read the book you choose, and critically evaluate the case made by the author. This should include the following:

1. A critical analysis of the central arguments. This may involve:
   a. Reviewing some of the research cited by the author and evaluating whether the author has accurately interpreted the results.
   b. Reviewing subsequent research to determine whether the arguments raised are consistent with more recent findings.
   c. Evaluating the logic of the central argument based on the evidence provided.
2. Some sort of statement about your intended use of medication in your own practice. This should include:
   a. Common errors you see in the practice of pharmacotherapy (both idiosyncratic and systemic), and how you would avoid them in your own practice.
   b. How you would integrate pharmacotherapy and psychotherapy in your own practice, including procedures you would use to make decisions concerning the use of psychotherapy, pharmacotherapy, or their combination.
   c. Ways in which you expect the practice of pharmacotherapy to change the nature of your practice.

A good resource to help you with this project is the Library Resources available through library.fdu.edu. From these portals you can search PsycINFO, get electronic access to all journals to which our libraries subscribe that offer this option, and check our holdings. At any point where you are asked for a username and password, just use the same ones you use to access webcampus.

This project is meant to be both and thought provoking. The intent here is to get you thinking about how you think pharmacotherapy should be integrated into psychology, where standard practice needs to be fixed, and what it means to be a prescribing psychologist. **Your project should be submitted to the course instructor for PSYC7935**. Length is open, but brevity is the soul of wit.

Criterion	**Points**
Summary of the book	20%
Critical review of sampled literature	30%
Review of more recent research	30%
Statement of intended use of medications	20%

MODULE 1: Practical Issues in Prescriptive Practice

EXPERT PRESENTER

Bret A. Moore, Psy.D., ABPP

TIME FRAME

Week 1

LEARNING OBJECTIVES

1. Discuss the issue of professional identity as a prescriber
2. Identify the differences between licensing, credentialing, and registration
3. Describe the decision making process with regard to prescribing psychotropic medications
4. Identify the most salient issues when consulting with other providers
5. Identify core components of effective documentation
6. Understand common medical terms
7. Identify common medication errors
8. Identify common reasons for adverse drug reactions
9. Identify the components of a hand written prescription
10. Discuss the benefits of electronic medication and laboratory orders
11. Identify issues that affect medication compliance

READING ASSIGNMENT

1. Fugh-Berman, A., & Ahari, S. (2007). Following the script: How drug reps make friends and influence doctors. *PLOS Medicine, 4*, 621-625.
2. Jenkins, R. H., & Vaida, A. J. (2007). Simple strategies to avoid medication errors: Safe medication use is achievable and affordable if you follow these recommendations. *Family Practice Management, 14*, 41-47.
3. Mark, T. L., Levit, K. R., & Buck, J. A. (2009). Psychotropic drug prescriptions by medical specialty. *Psychiatric Services, 60,* 1167.
4. Moore, B. A. & Muse, M. (2012). Medical psychology: definitions, controversies, and new directions. In M. Muse & B. A. Moore (Eds.), *Handbook of Clinical Psychopharmacology for Psychologists* (pp. 1-16). New York, NY: John Wiley & Sons.
5. Phillips, M. W., Jr. (2004). Avoiding medical errors: JCAHO documentation requirements. *Journal of the American Dietetic Association, 104*, 171-173.
6. Do not use list: http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf
7. Dangerous abbreviations list: http://www.nccmerp.org/dangerousAbbrev.html
8. Error-prone abbreviations list: http://www.ismp.org/tools/errorproneabbreviations.pdf

DIRECTED STUDY QUESTIONS

1. Provide evidence that you have joined the MedWatch e-list via http://www.fda.gov/medwatch. If you're not currently enrolled, you'll receive an email confirming your registration once it is completed.

MODULE 2: Epidemiology

TIME FRAME

Week 2

LEARNING OBJECTIVES

1. Know current information about the epidemiology of psychological disorders.
2. Understand the relationship between epidemiology and genetic research in psychopathology.
3. Learn the relevance of epidemiological research to the prescriptive authority movement.

READING ASSIGNMENT

1. Addington, A. M., & Rapoport, J. L. (2012). Annual research review: Impact of advances in genetics in understanding developmental psychopathology. *Journal of Child Psychology and Psychiatry, 53,* 510-518.
2. Austin, J. (2013). Genetic testing for psychiatric disorders: Its current role in clinical psychiatric practice. *Psychiatric Times*.
3. Konrad, T. R., Ellis, A. R., Thomas, K. C., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of need for mental health professionals in the United States. *Psychiatric Services, 60,* 1307-1314.
4. Ellis, A. R., Konrad, T. R., Thomas, K. C., & Morrissey, J. P. (2009). County-level estimates of mental health professional supply in the United States. *Psychiatric Services, 60,* 1315-1322.
5. Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. *Psychiatric Services, 60,* 1323-1328.
6. Reeves et al. (2011). *Mental illness surveillance among adults in the United States*. Atlanta: Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm?s_cid=su6003a1_w

DIRECTED STUDY QUESTIONS

1. Preparation to integrate future research into the genetics of mental disorders requires learning a new lingo. Provide definitions for the following. Some are not defined in your articles and for others you may find definitions online that are easier to follow than those in the articles:
   a. Epigenetics
   b. Proteome
   c. Genome-wide association study (GWAS)
   d. Single nucleotide polymorphism (SNP)
   e. Copy number variation (CNV)
   f. Linkage study

MODULE 3: Professional Relationships

EXPERT PRESENTER

Bret A. Moore, Psy.D. (Moderator)
David Shearer, Ph.D.
Robert Younger, Ph.D.
Earl Sutherland, Ph.D.

TIME FRAME

Week 3

LEARNING OBJECTIVES

1. Understand the effective use of collaboration with other health care professionals in the care of patients (e.g., establishing boundaries, communicating about patient care, proper and timely follow-up, split treatment, consultation and liaison).
2. Know when and how to make and receive patient referrals.
3. Effectively educate patients and their families about treatment modalities.
4. Accurately assess patient compliance and overcome barriers to optimize therapy.

READING ASSIGNMENT

1. Ally, G. A. (2010). Nuts and bolts of prescriptive practice. In R. E. McGrath & B. A. Moore (Eds.), *Pharmacotherapy for psychologists: Prescribing and collaborative roles.* Washington DC: APA Books.
2. Gruber, A. R. (2010). Psychologists in primary care. In R. E. McGrath & B. A. Moore (Eds.), *Pharmacotherapy for psychologists: Prescribing and collaborative roles* (pp. 173-187). Washington, DC: American Psychological Association.
3. Mantell, E. O., Ortiz, S. O. & Planthara, P. M. (2004). What price prescribing? A commentary on the effect of prescription authority on psychological practice. *Professional Psychology: Research and Practice, 35,* 164-169.
4. McGrath, R. E., & Sammons, M. T. (2011). Prescribing and primary care psychology: Complementary paths for professional psychology. *Professional Psychology: Research and Practice, 42,* 113-120.

DIRECTED STUDY QUESTIONS

1. Think about what you should keep in mind when collaborating with primary care physicians. What concepts will help that collaboration proceed more effectively?
2. You do not have the authority to prescribe. Even so, as a graduate of the M.S. Program, you may find yourself collaborating with medical professionals (physicians, APNs) who will want your input on medications. What do you see as the issues you must address in such collaborations?

3. It is our hope that eventually at least some of you will become prescribing/medical psychologists in the future, which will at times involve collaborating with other mental health professionals who will refer people to you for medication. What do you see as the issues you must address in such collaborations?
4. As a prescribing/medical psychologist, you will also at times collaborate with other medical professionals who will refer people to you for medication. What do you see as the issues you must address in such collaborations?

MODULE 4: Legal and Professional Issues

EXPERT PRESENTER

Week 4

Morgan Sammons, Ph.D.

Week 5

Robert E. McGrath, Ph.D.

TIME FRAME

Weeks 4-5

LEARNING OBJECTIVES

1. Identify the legal elements associated with the practice of psychopharmacological interventions.
2. Know the legal basis and levels of drug scheduling.
3. Know and utilize the standards of care and practice guidelines for the treatment of major mental disorders.
4. Identify the benefits and limitations (risk/benefit ratio) of integrating psychotherapy and pharmacotherapy in various circumstances (e.g., pregnancy, lactation, drug treatment).
5. Recognize liability issues associated with pharmacological practice.
6. Identify the ethical issues in the integration of psychotherapy and pharmacotherapy (whether economic, cultural, gender- or age-related)
7. Identify and avoid sources of potential conflict of interest.
8. Recognize and avoid scientific misconduct.
9. Know and appreciate the ethical issues of psychopharmacological research involving humans and animals (i.e., IRB approval, confidentiality, and informed consent).
10. Identify issues involved in the integration of pharmacotherapy and psychotherapy.
11. Recognize the importance of advocacy for comprehensive patient care (e.g., increasing patient access, prescription privilege advocacy, and legislative status).

READING ASSIGNMENTS

Week 4

1. American Psychological Association. (2011). Practice guidelines regarding psychologists' involvement in pharmacological issues. *American Psychologist, 66*, 835-849.
2. McGrath, R. E. (2010). Prescriptive authority for psychologists. *Annual Review of Clinical Psychology*.

3. McGrath, R. E. & Rom-Rymer, B. N. (2010). Ethical considerations in pharmacotherapy for psychologists. In R. E. McGrath & B. A. Moore (Eds.), *Pharmacotherapy for psychologists: Prescribing and collaborative roles*. Washington DC: APA Books.

Week 5

1. Cosgrove, L. & Moore, B. A. (2012). Professional, legal, ethical, and interprofessional issues in clinical psychopharmacology. In M. Muse & B. A. Moore (Eds.), *Handbook of Clinical Psychopharmacology for Psychologists* (pp. 457-482). New York, NY: John Wiley & Sons.
2. Dörken, H. (1990). Malpractice claims experiences of psychologists: Policy issues, cost comparisons with psychiatrists, and prescription privilege implications. *Professional Psychology: Research and Practice, 21*, 150-152.

Recommended

APA model licensing law for prescriptive authority. This is available in the course website at webcampus

DIRECTED STUDY QUESTIONS

1. Discuss the fundamental elements of informed consent in the provision of psychotropic agents.
2. Do you see any evidence that issues of gender or ethnicity impact on diagnostic or prescribing practices in your area?
3. Prepare and submit a written report on the current status of efforts by your State Psychological Association to develop a prescriptive authority agenda.

MODULE 5: Using Research

EXPERT PRESENTER

Robert E. McGrath, Ph.D.

TIME FRAME

Weeks 6-7

LEARNING OBJECTIVES

1. Address issues of diversity as they impact on our knowledge and practice of pharmacotherapy.
2. Review controversies in the effectiveness of psychotropic medications.
3. Discuss controversies concerning relationships with the pharmaceutical industry.
4. Identify useful sources of on-going education and support as a prescribing professional.
5. Enhance the ability to be an effective consumer of research on the use of psychotropic medications.

READING ASSIGNMENT

Week 6

1. Gigerenzer, G., Gaissmaier, W., Kurz-Milcke, E., Schwartz, L. M., & Woloshin, S. (2007). Helping doctors and patients make sense of health statistics. *Psychological Science in the Public Interest, 8,* 53-96.
2. McGrath, R. E. (2012). Research in clinical psychopharmacology. In M. Muse & B. A. Moore (Eds.), *Handbook of Clinical Psychopharmacology for Psychologists* (pp. 431-456). New York, NY: John Wiley & Sons.

Week 7

1. McGrath, R. E. (2010). Evaluating drug research. In R. E. McGrath & B. A. Moore (Eds.), *Pharmacotherapy for psychologists: Prescribing and collaborative roles*. Washington DC: APA Books.
2. Fournier, J. C., DeRubeis, R. J., Hollon, S. D., Dimidjian, S., Amsterdam, J. D. Shelton, R. C., & Fawcett, J. (2010). Antidepressant drug effects and depression severity: A patient-level meta-analysis. *JAMA, 303,* 47-53.
3. Roshanaei-Moghaddam, B., Pauly, M. C., Atkins, D. C., Baldwin, S. A., Stein, M. B., & Roy-Byrne, P. (2011). Relative effects of CBT and pharmacotherapy in depression versus anxiety: Is medication somewhat better for depression, and CBT somewhat better for anxiety? *Depression and Anxiety, 28,* 560-567.
4. Ben Goldacre. (2012). What doctors don't know about the drugs they prescribe. Available at http://www.ted.com/talks/ben_goldacre_what_doctors_don_t_know_about_the_drugs_they_prescribe.html

DIRECTED STUDY QUESTIONS

1. What percent of your current caseload is presently taking psychopharmacological agents? Of these, what percent do you believe derive a clear benefit from the medication not attributable to placebo effects? Do you find efficacy rates vary across medications or diagnostic groups? What percent of those receiving medication report bothersome or serious side effects?
2. Provide evidence you have downloaded the free version of Epocrates (epocrates.com) to your phone, tablet, or computer (e.g., a screen shot). FYI: Division 55 offers discounts on both of these products.
3. Visit Cochrane Reviews at http://www.cochrane.org. Search for a disorder or treatment that interests you (be creative). Choose from the list of search results. You will see a brief description of the review and a link to the Cochrane Library. Click on the link, and the next page will give you an opportunity to read the entire review. If you're not able to access the review that way, as an FDU student you have access to the entire library through your webmail account. Just go to http://librarydb.fdu.edu/onlinelibrary.html, scroll down to the Cochrane Library link, and access the library that way. Read, summarize, and analyze the review. This need only be a couple of paragraphs. Just summarize the conclusions, and indicate any concerns, questions, or disagreements you have with the findings.

MODULE 6: Integrating Psychotherapy with Pharmacotherapy

EXPERT PRESENTERS

Bret A. Moore, Psy.D. (Moderator)
David Shearer, Ph.D.
Earl Sutherland, Ph.D.
Robert Younger, Ph.D.

TIME FRAME

Week 8

LEARNING OBJECTIVES

1. Develop an understanding of how and when psychotherapy and pharmacotherapy can work synergistically.
2. Identify those disease states more likely to respond to psychotherapy.
3. Identify those disease states more likely to respond to pharmacotherapy.
4. Learn about methods of individualizing and optimizing treatment using all therapeutic options in concert.

READING ASSIGNMENT

1. LeVine, E. S., & Foster, E. O. (2010). Integration of psychotherapy and pharmacotherapy by prescribing/medical psychologists: A psychobiosocial model of care. In R. E. McGrath & B. A. Moore (Eds.), *Pharmacotherapy for psychologists: Prescribing and collaborative roles*. Washington DC: APA Books.
2. Muse, M. & Moore, B. A. (2012). Integrating clinical psychopharmacology within the practice of medical psychology. In M. Muse & B. A. Moore (Eds.)., *Handbook of Clinical Psychopharmacology for Psychologists*. New York, NY: John Wiley & Sons.
3. Smith, B. L. (2012, June). Inappropriate prescribing: Research shows that all too often, Americans are taking medications that may not work or may be inappropriate for their mental health problems. *APA Monitor, 43,* 36-40.
4. Winston, A., Been, H., & Serby, M. (2005). Psychotherapy and psychopharmacology: Different universes or an integrated future? *Journal of Psychotherapy Integration, 15,* 213-223.

DIRECTED STUDY QUESTIONS

1. Detail the risks and limitations involved in combining psychotherapy and pharmacotherapy.

Fairleigh Dickinson
UNIVERSITY

COURSE SYLLABUS

M.S. Program in Clinical Psychopharmacology

PSYC7920: NEUROSCIENCE

January 5 – February 25, 2015

PSYC7925: NEUROPHARMACOLOGY

February 26 – April 19, 2015

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Module 7: Appendix 7b: Neuroendocrinology

COURSE SYLLABUS

Information provided here is in addition to information available in your Student Manual.

COURSE DESCRIPTION

Neuroscience focuses on the anatomy and physiology of the nervous system, beginning at the cellular level. Knowledge of principles of neuroanatomy, neurophysiology, neurochemistry, and neuropathology will serve as the foundation for the understanding of neurotransmitter systems and their role in the etiology and treatment of mental and neurodegenerative disorders.

Neuropharmacology continues the study of neurotransmitter systems and other factors in the pharmacological treatment of mental disorders. It includes the knowledge base pertaining to pharmacology and psychopharmacology, and an introduction to the major classes of psychotropic medications.

PLACEMENT

Neuroscience and Neuropharmacology are completed in a single semester. They represent two of the four science foundation courses for the program; Biological Foundations I and II complete the set. Each course is 7.5 weeks in length. Neuroscience and Neuropharmacology rotate with Biological Foundations I and II, so students will complete the Neuroscience and Neuropharmacology courses either in their first or second semester in the program. Students begin the program with either the two-course Biological Foundations core or the two-course Neurosciences core, but completion of all four foundation courses is required before students may progress to the third semester courses, Clinical Pharmacology and Professional Issues & Practice Management. Students subsequently enroll in the four treatment-focused courses: Affective Disorders, Psychotic Disorders, Anxiety Disorders, and Other Disorders. Successful completion of the ten-course didactic sequence of the Psychopharmacology Postdoctoral Training Program makes the candidate eligible to enroll in the elective Clinical Practicum.

COURSE OBJECTIVES

Upon completion of these courses, the student will be able to:

1. Understand cellular composition of the nervous system, its structure, electrical and chemical function. Relate synaptic transmission to neurotransmitter and drug action.
2. Identify gross anatomical structures of the central and autonomic nervous systems and surrounding structures. For each structure, identify associated function, major dysfunction, and associated pathology.
3. Apply pertinent neurological examination, and radiological and laboratory investigative techniques.
4. Relate physiological function of cortical areas, subcortical structures and tracts implicated in the etiology of mental and neurodegenerative disorders. For each system identify major types of dysfunction and associated pathophysiology.
5. Describe and correlate the major neurochemical systems associated with mental disorders, and psychotropic medications.

6. Correlate the basic principles of pharmacology to psychotropic drug action.

In achieving each of these objectives, issues of lifespan development, gender, and ethnic diversity will be discussed.

FACULTY AND STAFF

Course Instructor

Michael A. Ansonoff, Ph.D. (Albert Einstein College of Medicine, 2000)
Department of Neuroscience and Cell Biology
University of Medicine and Dentistry of New Jersey
675 Hoes Lane
Piscataway, NJ 08540
Cell: 609-213-8736
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Dr. Ansonoff received his Ph.D. from the Sue Golding Graduate program at Albert Einstein Medical School of Yeshiva University (Neuroscience Program) following training in the laboratory of Dr. Anne Etgen on cellular and behavioral mechanisms by which ovarian steroids regulate brain function. His research involved investigating the regulatory mechanisms by which ovarian steroids desensitize adrenergic receptors in the female rodent. He then completed a 5-year post-doctoral fellowship at the University of Medicine and Dentistry of New Jersey studying the behavioral and pharmacological consequences of opioid receptor gene ablation in mice. Presently, he is still at the University of Medicine and Dentistry of New Jersey, however, his research interests have shifted towards examining the consequences of the knockout of the nociceptin receptor and its endogenous ligand on food consumption and obesity. In addition, he has developed a keen interest in science education leading him to complete a M.A. in education at Fairleigh Dickenson University.

Video Expert Presenters

Neuroscience

Module 1: Appendix 1: Neuroanatomy **– Katie Sokolowski, Ph.D.**
Module 2: Appendix 2: Neuron and Electrical Transmission **– James Gordon, Ph.D.**
Module 3: Appendix 3a: Synaptic Transmission **– Randall Tackett, Ph.D.**
Module 3: Appendix 3b: Classical Neurotransmitters in Synaptic Transmission **– Gordon Barr, Ph.D.**
Module 4: Appendix 4a: Neurological Examination and Assessment **– Alvin Terry, Jr., Ph.D.**
Module 4: Appendix 4b: Nervous System Pathology: Sensory **– Alvin Terry, Jr., Ph.D.**

Neuropharmacology

Module 4: Appendix 4c: Nervous System Pathology: Motor & Memory **– Alvin Terry, Jr., Ph.D.**
Module 5: Appendix 5a: Basic Pharmacology **– Christopher Capuano, Ph.D.**
Module 5: Appendix 5b: Introduction to Psychotropics**– Michael Ansonoff, Ph.D.**

Module 6: Appendix 6: Neurotransmitters **– Michael Ansonoff, Ph.D.**
Module 7: Appendix 7a: Peptide Transmission **– Jesus Angulo, Ph.D**.
Module 7: Appendix 7b: Neuroendocrinology**– Tara Cominski, Ph.D.**

Gordon A. Barr, Ph.D., did his graduate work at Carnegie-Mellon University, where he earned his Ph.D. degree in Psychology from the Graduate School of Industrial Administration. He completed a postdoctoral fellowship in Neuropharmacology with Wagner Bridger, M.D., at Albert Einstein College of Medicine, and after a number of years on the faculty at Albert Einstein he joined the Psychology Department at Hunter College. There he has taught courses in psychology, statistics, neuroscience, and psychopharmacology to undergraduate and graduate students and postdoctoral fellows. At Hunter, he was Coordinator/Director of the NIMH Minority Access to Research Careers program (MARC) for 10 years at Hunter and is currently Program Director for the Minority Institution Drug Abuse Research Development Program (MIDARP) in Psychology and Biology. For the past 14 years, he has maintained a laboratory at New York State Psychiatric Institute and Columbia University College of Medicine. His research interests include differences in the biological processes that mediate pain in infants versus adults, the action of analgesic drugs in the young, the mechanisms of tolerance of and dependence on opiate drugs in infants, and the long-term consequences of early experiences on gene expression and behavior. He has served on several NIH study sections, is a Career Development Awardee from the National Institute on Drug Abuse (NIDA), and has been awarded a number of research and research training grants from NIH.

Dr. Richard Bodnar is Professor and Chairman of the Department of Psychology and former Head of the Neuropsychology Doctoral Subprogram of the City University of New York. He earned his Ph.D. degree from City University of New York in 1976. Dr. Bodnar has appeared as a principal or co-author on over 200 peer-reviewed publications that focus mainly on the roles of opioid systems in mediating analgesia, stress, and ingestive behaviors using pharmacological and molecular techniques.

Dr. Christopher Capuano holds a Ph.D. in Biopsychology with specializations and research interests in behavioral neuroscience, neuropsychopharmacology, and health psychology. He is presently an Associate Professor and Director of the School of Psychology on the Metropolitan Campus of Fairleigh Dickinson University in New Jersey, where he also serves as University Director of Animal Research Facilities. As Director of the School of Psychology, he has responsibility for administrative oversight of the Psychopharmacology Postdoctoral Training Program, as well as an APA-accredited Ph.D. Program in Clinical Psychology, Psy.D. and M.A. Plus Certificate Programs in School Psychology, and a number of other graduate and undergraduate programs in psychology, both domestic and overseas. Over the past ten years or more, Dr. Capuano has taught doctoral level courses in Physiological Psychology, Biological Bases of Behavior, Psychopharmacology, and Child and Adolescent Psychopharmacology. He has conducted research and has published and reviewed abstracts and articles in refereed journals such as *Developmental Brain Research*; *Neuropharmacology*; *Neuropeptides*; *Pharmacology, Biochemistry and Behavior*; *Psychopharmacology Bulletin*; A*nnals of Behavioral Medicine*; and *Obesity Research.* In addition to holding memberships in several professional organizations, he is a Fellow of the North American Association for the Study of Obesity. Dr. Capuano has also provided professional consultation to the pharmaceutical industry as a research scientist, and to physicians and other health care professionals on the pharmacokinetics and pharmacodynamics of newly approved psychotropic medications.

Dr. James Gordon is a psychophysiologist who has been studying the functioning of the visual system for more than 30 years. He has used a wide variety of techniques to explore the neural mechanisms underlying color vision and its development. These have included psychophysical and electrophysiological studies on humans, as well as electrophysiological studies on a number of other species including monkeys. His current studies are focused on examining the parallel pathways which convey information from eye to brain in humans and in the creation of techniques to explore these pathways developmentally as well as in several neural pathologies including dyslexia, multiple sclerosis, and Alzheimer's disease. He has taught Advanced Neuroscience to doctoral students in Biopsychology and Neuroscience at the City University of New York for 20 years.

Katie Sokolowski is a postdoctoral fellow at the Center for Neuroscience Research at Children's National Medical Center, Washington DC. She obtained her PhD in Neurodevelopmental Toxicology from the Joint Graduate Program in Toxicology at Rutgers-UMDNJ. Her doctoral thesis work concentrated on the effects of low levels of the environmental toxicant, methylmercury, on hippocampus development and function. Her current work is geared towards understanding how the limbic system circuits develop and function.

Dr. Randall L. Tackett received his Ph.D in Pharmacology and Toxicology from the University of Georgia in 1979. Following a two year postdoctoral fellowship at the Medical College of South Carolina, he joined the University of Georgia College of Pharmacy as an Assistant Professor of Pharmacology and Toxicology in 1981. He has served as the Director of Research and Graduate Studies of the College and as Department Head for the Department of Pharmacology and Toxicology. In 1995, he was promoted to Professor and joined the Department of Clinical and Administrative Sciences in 1997. He received the Georgia Psychological Association's Outstanding Faculty Award in 1999 for his development of the Postgraduate Psychopharmacology Curriculum in the State of Georgia. The American Psychological Association (APA) recognized Dr. Tackett for his work with the Postgraduate Psychopharmacology Program with an APA Presidential Citation in 2000.

Dr. Alvin Terry earned his Ph.D. in Pharmacology from the University of South Carolina in1991. He completed a Post Doctoral Fellowship at the Medical College of Georgia in 1992. He has served in various teaching and research faculty positions at the University of South Carolina, the Medical College of Georgia, and the University of Georgia since 1987. Dr. Terry's research interests focus on the role of central cholinergic receptors in the neurodegeneration and cognitive decline associated with age-related disorders of memory including Alzheimer's Disease, Parkinson's Disease, and Dementia with Lewy Bodies. He currently uses rodent and non-human primate models to investigate the role of high affinity nicotinic acetylcholinergic receptors (i.e., the heteromeric $\alpha_4\beta_2$ subtype) in age-related neurodegeneration and as a potential target for neurotrophic, neuroprotective, and cognitive enhancing compounds.

24/7 Technical Support

FDU Technical Assistance Center (UTAC)
Phone: 973-443-8822
E-mail: fdutac@fdu.edu

STUDENT EVALUATION

40%: Two online objective exams (prorated depending on number of DSQs completed)
15%: Participation in weekly chats (prorated depending on number of DSQs completed)
30%: Completion of Directed Study Questions (prorated depending on number completed)
15%: Written Case Presentation (prorated depending on number of DSQs completed)

PASSING GRADE

To be assured of satisfactory completion of this course applicable to progression to the next term, **the student must achieve a score of 80% or better of the total points available. A grade of less than 75% represents failure of the course.**

CONTINUING PROFESSIONAL EDUCATION CREDITS

Fairleigh Dickinson University School of Psychology is approved by the American Psychological Association to sponsor continuing education for psychologists. Fairleigh Dickinson University School of Psychology maintains responsibility for this program and its contents. With a student participation rate of at least 80%, PSYC7920 and PSYC7925 are each approved for 45 continuing professional education credits for psychologists. One case presentation is required each semester, for 14 credits. Half is allotted to each of the courses for the semester.

# Hours	Activity
25	Readings/videos
5	Chats
8	Exams
7	Case presentation

TEXTBOOKS

Required

1. Julien, R. M., Advokat, C. D., & Comaty, J. E. (2010). *A primer of drug action: A comprehensive guide to the actions, uses, and side effects of psychoactive drugs* (12th ed.). New York: Worth. ISBN: 9781429233439.
2. Purves, D., Augustine, G. J., Fitzpatrick, D. Hall, W. C., LaMantia, A.-S. White, L. E. (Eds.). (2012). *Neuroscience* (5th ed.). Sunderland MA: Sinauer Associates. ISBN: 9780878936472.

Highly Recommended

1. Stahl, S. M. (2008). *Stahl's essential psychopharmacology: Neuroscientific basis and practical applications* (3rd ed). New York: Cambridge University Press. ISBN: 9780521673761.
2. Hendelman, W. J. (2005). *Atlas of functional neuroanatomy* (2nd ed.). Boca Raton, FL: CRC Press. ISBN: 084933084X.

Recommended

1. Blumenfeld, H. (2010). *Neuroanatomy through clinical cases* (2nd ed.). Sunderland MA: Sinauer Associates. ISBN: 9780878930586.
2. Virani, A. S., Bezchlibnyk-Butler, K. Z., Jeffries, J. J., & Procyshyn, R. M. (Ed.) (2011). *Clinical handbook of psychotropic drugs* (19th ed.). Seattle: Hogrefe & Huber. ISBN: 9780889373952.

DIRECTED STUDY QUESTIONS

Directed Study Questions are optional for this course. To receive credit, you must submit responses to your instructor by the date listed in the Course Schedule.

Please remember the DSQs are intended to be SHORT answer questions. When you are asked to generate a list, you do not need more than 1-2 sentences for each item in the list. When the question is open-ended, you never need to provide more than 1-2 paragraphs of information.

If you're not sure what the question is looking for, rather than spending hours trying to produce every piece of information you can, feel free to discuss it with your instructor.

PLEASE don't let obsessional tendencies get in the way of completing the DSQs in a timely manner. The goal of the DSQs is to demonstrate a basic understanding of processes, and to help consolidate the key information, not to demonstrate you know everything about everything. Educational research demonstrates that what you will take away from any learning experience is the most central information, and in practice you will need to rely on resource materials for many of the details.

COURSE SCHEDULE

Neuroscience: Note the course starts intensely to get the basics. Try to start early.

WEEK	MODULE	ACTIVITY
1: 1/5-1/11	1: Macrostructure of the Nervous System	**Video:** Appendix 1 File 1 **Readings:** Purves, Purves 1-21, 717-735
2: 1/12-1/18	1: Macrostructure of the Nervous System	**Video:** Appendix 1 File 2 **Readings:** Purves, 735-759 **Directed Study Questions:** Module 1 due 1/18 (optional)
3: 1/19-1/25	2: Microstructure of the Brain/Electrical Signaling	**Video:** Appendix 2 (start this week) **Readings:** Purves, 25-76
4: 1/26-2/1	2: Electrical Signaling	**Video:** Appendix 2 (finish this week) **Directed Study Questions:** Module 2 due 2/1 (optional) **Exam 1 (Weeks 1-4):** Posted 1/30, due 2/4
5: 2/2-2/8	3: Chemical Processes: Synaptic Transmission	**Video:** Appendix 3a **Readings:** Purves, 77-108 **Directed Study Questions:** Module 3 part 1 due 2/8 (optional)
6: 2/9-2/15	3: Chemical Processes: Classical Transmitters in Synaptic Transmission	**Video:** Appendix 3b **Readings:** Julien, Chap. 3; Purves, 109-140 **Directed Study Questions:** Module 3 part 2 due 2/15 (optional)
7: 2/16-2/22	4: Neurobiology and Pathophysiology: Neurological Examination and Assessment	**Video:** Appendix 4a **Readings:** Purves, 721-728 **Exam 2 (Weeks 5-8):** Posted 2/20, due 2/25

WEEK	MODULE	ACTIVITY
8: 2/23-2/25*	4: Neurobiology and Pathophysiology: Sensory	**Video:** Appendix 4b **Readings:** Purves, 182-183, 379-380, 735-741

Neuropharmacology

WEEK	MODULE	ACTIVITY
1: 2/26-3/4	4: Neurobiology and Pathophysiology: Motor and Memory	**Video:** Appendix 4c **Readings:** Julien, Chap. 20; Purves Chap. 17, pp 712-715
2: 3/5-3/11	5: Basics of Pharmacology	**Video:** Start Appendix 5a **Readings:** Start Julien, Chap. 1-2 **Directed Study Questions:** Module 4 due 3/8 (optional)
3: 3/12-3/18	5: Basics of Pharmacology:	**Video:** Finish Appendix 5a **Readings:** Finish reading Julian Chap. 1-2
4: 3/19-3/22*	5: Basics of Pharmacology: Introduction to Psychotropics	**Video:** Start Appendix 5b **Readings:** Start Julien, Chap. 4-8, 18-19 **Directed Study Questions:** Module 5 due 3/22 (optional) **Exam 1 (Weeks 1-4):** Posted 3/20, due 3/25
5: 3/23-3/29	5: Basics of Pharmacology Introduction to Psychotropics	**Video:** Finish Appendix 5b **Readings:** Finish Julien, Chap. 4-8, 18-19
6: 3/30-4/5	6: Neurotransmitters as Mechanisms of Drug Action	**Video:** Appendix 6 **Readings:** Julien, Chap. 3; Purves, Chap. 5-6 (some rereading) **Directed Study Questions:** Module 6 due 4/5 (optional) **Case Presentation:** Submit by 3/30

WEEK	MODULE	ACTIVITY
7: 4/6-4/12	7: Neuroendocrinology: Molecular and Cell Physiology of Neuropeptides	**Video:** Appendix 7a **Readings:** Start Purves, Chap. 7
8: 4/13-4/19	7: Neuroendocrinology: HPA Axis	**Video:** Appendix 7b **Readings:** Finish Purves, Chap. 7, Chap. 21 **Directed Study Questions:** Module 7 due 4/19 (optional) **Exam 2 (weeks 5-8):** Posted 4/17, due 4/22 **Complete the Student Satisfaction Survey**

*Not a full week

HISTORY AND PHYSICAL FORMAT

Identification Data:
Chief Complaint (CC):
History of Present Illness (PMI):
Past Psychiatric History
Past Medical History (PMH):
Past Surgical History (PSH):
Family History (FH):
Social History: Include drug, ETOH and tobacco use here
Medications:
Allergies: list reaction

Review of Systems (ROS):

General
Skin
Head
Ears
Eyes
Nose, Sinuses
Mouth, Throat, Neck
Breasts
Respiratory
Cardiac
Gastrointestinal
Urinary
Genital
Peripheral Vascular
Musculoskeletal
Neurologic
Hematologic
Endocrine
Psychiatric
Neurologic

Physical Exam (PE):

Vital Signs
General Survey
Skin
Head, Ears, Eyes, Nose, Throat (HEENT)
Neck
Breasts
Heart
Lungs
Abdomen
Genitourinary
Rectal
Musculoskeletal
Vascular
Lymphatic

Labs:
Assessment:
Plan:

HISTORY AND PHYSICAL EVALUATION

Criterion	Points
Identification Data	**5**
Chief Complaint	**5**
History of Present Illness	**5**
Past Psychiatric History	**5**
Past Medical History	**5**
Past Surgical History	**5**
Family History	**5**
Social History	**5**
Medications	**5**
Allergies	**5**
Review of Systems	**20**
Physical Exam	**15**
Labs	**5**
Assessment	**5**
Plan	**5**
TOTAL	**100**

It is expected that the subject of your Case Presentation will demonstrate some sort of diminution of neurological abilities, or at least be a member of a population that tends to demonstrate such diminution. This could be a patient who has suffered brain trauma of any severity, a resident of a geriatric facility, or even a personal acquaintance who is elderly. It is preferred that the case also involve complications of a psychiatric nature (e.g., drug-drug interaction problems). You need not administer the examinations involved in this report, just have access to the results. If need be, you can generate mock test data appropriate to the case to complete sections of the report, but the inclusion of actual data is considered desirable. Given the requirements, ***it is strongly recommended you start looking for an appropriate case early in the semester.***

Given your current progress in the program, an important part of this exercise is to stay focused extensively if not exclusively on the medical and neurological issues presented by the case. It is your assignment to consider this case from the perspective of a traditional provider of medical care rather than as a psychology. In later courses the case assignment will call for a more integrated biopsychosocial approach.

If you have additional questions about the structure of the Case Presentation, please raise them as early as possible with your Facilitator.

MODULE 1: Macrostructure of the Nervous System

EXPERT PRESENTER

Katie Sokolowski, Ph.D.

TIME FRAME

PSYC7920 Weeks 1-2

LEARNING OBJECTIVES

1. Describe the organizational structure and function of the human brain, including orientation of axes and planes, types of brain sections, gross neuroanatomy including superior, lateral, ventral and medial views of the brain, organization of the frontal, parietal, temporal and occipital lobes, cerebral vasculature, organization of the ventricular system, and the cranial and spinal nerves.
2. Identify the organization of the limbic system, basal ganglia, hypothalamus, and thalamus.

READING ASSIGNMENTS

Required
Week 1: Purves 1-21, 717-735
Week 2: Purves, 735-759

Recommended
Hendelman: This entire soft-cover book is helpful. It has functional and clinical anatomy in it.

DIRECTED STUDY QUESTIONS

1. Indicate how the central sulcus and the lateral sulcus separate the frontal, temporal and parietal lobes of the cortex in general, and how they separate specific gyri in the brain responsible for motor function, somatosensory function, audition and speech in particular. What arterial branch uses these sulci for vascularization of these sulci, and what behavioral dysfunctions can occur with occlusion or hemorrhage of this artery?
2. List the 12 cranial nerves, describing where in the neuraxis they are found; whether they are afferent (sensory), efferent (motor) or mixed (sensory-motor); and a brief description of their function.
3. Describe the three major descending motor tracts from the brain to the spinal cord.
4. How are the laminae of the spinal cord organized in terms of somatosensory, visceral and motor components?
5. Both Parkinson's disease and Huntington's disease involve dysfunctional interactions between the substantia nigra and the basal ganglia. Indicate anatomical and neurochemical similarities and differences between these two diseases.

VIDEO LECTURE OUTLINE

See Appendix 1

MODULE 2: Microstructure of the Brain/ Electrical Signaling

EXPERT PRESENTER

James Gordon, Ph.D.

TIME FRAME

PSYC7920 Weeks 3-4

LEARNING OBJECTIVES

1. Identify the fundamental properties of the neuron as the basic element of the nervous system.
2. Identify the overall structure of the neuron.
3. Describe the characteristics of the membrane.
4. Describe the role of ion channels in the resting and action potential.
5. Identify the transmission of information by passive local current and by action potentials.

READING ASSIGNMENTS

Required
Week 3&4: Purves, 25-76

DIRECTED STUDY QUESTIONS

1. Discuss the origin of the resting potential. Consider both the passive properties of the membrane and the active properties of the sodium-potassium pump.
2. Describe voltage gated ion channels and their role in generation of the action potential.
3. How does the action potential move along the axon? Consider the role of passive current spread of and sodium channel inactivation in this process.

VIDEO LECTURE OUTLINE

See Appendix 2

MODULE 3: Chemical Processes

EXPERT PRESENTERS

Randall Tackett, Ph.D.
Gordon Barr, Ph.D.

TIME FRAME

PSYC7920 Weeks 5-6

LEARNING OBJECTIVES

1. Describe the synapse and the structures that are important in synaptic transmission.
2. Differentiate between synaptic and secretory vesicles.
3. Compare and contrast exocytotic and non-exocytotic release.
4. Identify the characteristics of a true neurotransmitter.
5. Compare and contrast the two major types of postsynaptic receptors.
6. Describe mechanisms of termination of a neurotransmitter's response.
7. Identify the recognized second messengers and describe their role in postsynaptic signal transduction.
8. Identify potential sites of drug interaction at the synapse.
9. To identify sites of possible drug action
10. To understand the concepts of transmitter synthesis, storage, release, degradation and reuptake, including associated issues such as rate limiting steps
11. To understand different types of receptors and their signaling mechanisms
12. To identify the functions of acetylcholine and epinephrine in the autonomic nervous system.

READING ASSIGNMENTS

Required
Week 5: Purves, 77-109
Week 6: Julien, Chap. 3; Purves, 110-140

DIRECTED STUDY QUESTIONS (Part 1)

1. Identify five characteristics of a true neurotransmitter.
2. Compare and contrast the two major types of postsynaptic receptors.
3. Identify the recognized second messengers and describe their role in postsynaptic signal transduction.
4. Identify potential sites of drug interaction at the synapse.

DIRECTED STUDY QUESTIONS (Part 2)

5. Describe the fundamental differences between metabotropic and ionotropic receptors. Give examples of each.
6. The sympathetic and parasympathetic nervous systems use different transmitters to maintain or disturb homeostasis. What are they and how do they interact with the target organs to change levels of arousal.
7. Describe the ways by which neurotransmitter action is terminated at the synapse.
8. For dopamine, describe its synthesis and degradation and specify where drugs could act to alter dopaminergic transmission.

VIDEO LECTURE OUTLINE

See Appendix 3a and 3b

MODULE 4: Neurobiology and Pathophysiology

EXPERT PRESENTER

Alvin V. Terry, Ph.D.

TIME FRAME

PSYC7920 Weeks 7-8
PSYC7925 Week 1

LEARNING OBJECTIVES

1. Recognize, describe and understand the importance and significance of each of the major domains of the neurologic exam.
2. Interpret key findings that are associated with each domain.
3. List the cranial nerves, briefly overview the physiologic role and importance of each nerve, and identify how each nerve (or group of nerves) is tested during the neurologic exam.
4. Describe the major imaging techniques and other technical methods used for neurologic assessment and generally understand the important types of information that may be derived from each technique.
5. Develop an understanding of key issues in Parkinson's Disease and Alzheimer's disease: major clinical signs, symptoms, prevalence, epidemiology, etiological theories, pertinent pathophysiological processes and anatomical changes, and major drug classes (with representative examples) and other therapeutic modalities utilized for each condition.
6. Develop an understanding of key issues associated with the most common types of cerebrovascular disease and seizure disorders: major clinical signs, symptoms, prevalence, epidemiology, etiological theories, pertinent pathophysiological processes and anatomical changes, and major drug classes (with representative examples) and other therapeutic modalities utilized for each condition.

READING ASSIGNMENTS

Required: PSYC7920
Week 7: Purves, 721-728
Week 8: Purves, 182-183, 379-380, 735-741
Required: PSYC7925
Week 1: Julien, Chap. 20; Purves Chpt 17, pp 712-715

DIRECTED STUDY QUESTIONS

1. Ms. Windsong suffered a head injury from a motor vehicle accident. She injured her right ear, her right occipital lobe, her right temporal lobe, and parts of her diencephalon. She has the following

sensory deficits: hyposmia, inability to hear high-frequency sounds, and bilateral left hemianopia. Explain what these sensory deficits are and why they occurred.
2. Ms. Spinosa has increased intracranial pressure of 30 mm hg caused by a massive closed head injury. Explain the process of increasing intracranial pressure and discuss possible complications if the pressure is not decreased.
3. Sally Simmons' husband has recently been diagnosed with late-onset familial Alzheimer disease (FAD). She wants to know what caused it and what the disease course will be.
4. Ms. Evans has a flexion injury with resultant incomplete spinal cord transection at level C4-5. What symptoms would you expect Ms. Evans to have 1 month after her injury?
5. Explain the difference between brain tumors found in children and brain tumors found in adults.
6. Differentiate between the tremor that is generally associated with Parkinson's Disease versus that generally associated with benign essential (familial) tremor.

VIDEO LECTURE OUTLINES

See Appendices 4a, 4b and 4c

MODULE 5: Basics of Pharmacology

EXPERT PRESENTER

Michael Ansonoff, Ph.D.
Christopher Capuano, Ph.D.

TIME FRAME

PSYC7925 Weeks 2-5

LEARNING OBJECTIVES

After completing this unit, the student should fully understand and be able to discuss each of the following:

1. The properties of biological (plasma and other) membranes that influence passive (osmotic) diffusion of drugs, and other transport mechanisms.
2. The absorption of drugs from sites along the alimentary canal—especially from areas within the GI tract (stomach and upper intestines), and factors that influence the rate of absorption following oral administration of drugs.
3. The absorption of drugs from sites other than the GI tract following administration of drugs via routes of administration other than oral.
4. The factors influencing drug distribution—especially distribution to the CNS and to the brain specifically.
5. The role of hepatic enzyme systems in drug metabolism—specifically cytochrome P450 enzyme systems, and the various reactions that alter molecular structures of drugs and their solubility(ies) and readiness for excretion.
6. Other factors influencing drug metabolism such as diet, enzyme induction, co-administration of drugs, hormonal factors, and other nonspecific factors.
7. The role of the kidney in excretion of drugs including glomerular filtration, passive (osmotic) diffusion, and other transport mechanisms associated with renal secretion and reabsorption.
8. Other routes of drug excretion.
9. Pharmacokinetic (and pharmacodynamic) differences in pediatric and geriatric populations.
10. Time course (rates) of drug absorption, distribution and elimination; concept of drug half-life; drug half-life, accumulation and steady state concentration; therapeutic drug monitoring; and different types of drug tolerance and dependence.
11. Single vs. multi-compartment models and the concept of drug half-life.
12. Basic principles of toxicology including types of toxicity, exposure to different toxins, and the field of genetic toxicology.
13. Different types of receptors, both structurally and functionally.
14. Sites, specific mechanisms, and specific examples of drug action—specifically psychotropic drug action.
15. Classification of receptors; drug-receptor binding, affinity and specificity.

16. Functional classification of psychotropic drugs: agonists, antagonists; physiological (functional), chemical, and pharmacological antagonism; competitive vs. noncompetitive pharmacological antagonism.
17. Dose-response relationships: graded vs. quantal dose-response curves; dose, potency, intensification of effect, minimal and maximal effects; effective vs. lethal doses, and indices of drug safety.
18. Ethics in pharmacology and pharmacotherapy.
19. Process of drug discovery, drug development and investigation; drug naming; and drug legislation.
20. Major categories of psychotropic or psychotherapeutic medications including structural and/or chemical as well as functional classifications within each category, and generic and trade names of prototypic drugs in each classification.
21. Primary and secondary action(s) of drugs in each classification (i.e., pharmacology or specific mechanism(s) by which the primary and secondary therapeutic effect(s) are produced; e.g., SSRIs exert their antidepressant effect by selectively inhibiting the reuptake of serotonin).
22. Approved and non-approved (off-label) indications for medications in each classification.
23. Range and degree of side (or adverse) effects associated with medications in each classification including any serious physical as well as psychological contraindications.

READING ASSIGNMENT

Required
Week 2: Julien, Chap. 1-2
Weeks 3-4: Julien, Chap. 4-8, 18-19

Recommended
Stahl

DIRECTED STUDY QUESTIONS

1. Compare and contrast the absorption and redistribution (to the brain specifically) of the following psychotropic drugs following oral administration as a tablet or capsule: a weak acid with a pKa of 5.5; a weak acid with a pKa of 9.5; and a weak base with a pKa of 2.5.
2. Discuss the role the liver plays in the elimination and excretion of drugs and why the action of hepatic enzyme systems is crucial to the effectiveness of the kidney in the excretion of drugs and their metabolites.
3. Distinguish between physiological (functional), chemical, and pharmacological antagonism. What accounts for the difference between competitive and noncompetitive pharmacological antagonism?
4. Distinguish between SSRIs, SARIs, and NaSSAs. How does each group produce its antidepressant effect, and what therapeutic benefit(s) does each group have over the others, if any?
5. Distinguish between conventional (typical) and novel (atypical) antipsychotic drugs. Why is it that some of the novel antipsychotics are thought to be better medications?
6. How is it that the side-effect profile of a drug often determines whether it is selected for a specific patient? Explain.

VIDEO LECTURE OUTLINES

See Appendices 5a and 5b

MODULE 6: Neurotransmitters as Mechanisms of Drug Action

EXPERT PRESENTER

Michael Anosnoff. Ph.D.

TIME FRAME

PSYC7925 Weeks 6

LEARNING OBJECTIVES

After completing this unit, the student should fully understand and be able to discuss each of the following:

1. The three major classes of neurotransmitters.
2. The synthesis, release, metabolism and roles of each of the following transmitters.
   Serotonin
   Histamine
   Glutamate
   GABA
   Glycine
   ATP
   NO

READING ASSIGNMENTS

Required
1. Julien, Chap. 3; Purves, Chap. 5-6
(some of this material already appears in the readings)

Highly Recommended
Stahl

Recommended
B-B&J: *There are no specific page recommendations, as this is recommended as a general reference work, but it would inform the student substantially to review the drug information in that book at appropriate weeks in this course.*

DIRECTED STUDY QUESTIONS

1. Identify the three major classes of neurotransmitters.
2. Describe the synthesis, release, metabolism, and roles of each of the following transmitters:
   a. Serotonin
   b. Histamine
   c. Glutamate
   d. GABA
   e. Glycine
   f. ATP
   g. NO

VIDEO LECTURE OUTLINE

See Appendix 6

MODULE 7: Neuroendocrinology

EXPERT PRESENTER

Jesus Angulo, Ph.D.
Tara Cominski, Ph.D.

TIME FRAME

PSYC7925 Weeks 7-8

LEARNING OBJECTIVES

1. Comprehension of hormone receptor signaling mechanisms operating throughout the hypothalamic-pituitary-adrenal axis.
2. Contrast between peptide hormones and steroid hormones.
3. Comparison of the slow and fast mechanisms induced by the hormone in the target cell.
4. Molecular mechanism accounting for symptomatology of hormone dysfunction in the hypothalamic-pituitary-adrenal axis
5. Understanding of the pathway of neuropeptide synthesis from the soma to the axon terminal of the neuron.
6. Comparison of release of neuropeptides with classical neurotransmitters.
7. Familiarity with the various signaling pathways utilized by neuropeptides.
8. Neuropeptides as neurotransmitters and/or neuromodulators.

READING ASSIGNMENTS

Week 7: Purves, Chap. 7
Week 8: Purves, Chap. 21

DIRECTED STUDY QUESTIONS

1. Contrast the mechanism by which ACTH and cortisol affect the target cell. Draw diagrams for the signaling pathways.
2. Explain the differences between neurocrine, endocrine, and neuroendocrine secretions.
3. What are the components of the HPA axis? What is negative feedback?

4. How do the anterior and posterior lobes of the pituitary gland differ in the nature of their connection with the hypothalamus? Briefly describe which homeostatic processes are associated with each of the lobes.
5. Contrast the synthesis of a classical neurotransmitter with a peptide in the axon terminal.
6. Two peptides (A & B) bind to different receptors on the cell surface. Peptide A increases while peptide B decreases the concentration of intracellular cAMP, respectively. Describe the mechanism by which they regulate the levels of intracellular cAMP.

VIDEO LECTURE OUTLINES

See Appendices 7a and 7b

COURSE SYLLABUS

M.S. Program in Clinical Psychopharmacology

PSYC7940: TREATMENT ISSUES IN PSYCHOPHARMACOLOGY: AFFECTIVE DISORDERS

January 11 - March 2, 2016

TABLE OF CONTENTS

COURSE SYLLABUS

Information provided here is in addition to information available in your Student Manual. Please pay particularly close attention to the discussion of Directed Study Questions, as the information differs from that presented in the manual.

COURSE DESCRIPTION

Treatment Issues in Psychopharmacology: Affective Disorders provides a broad overview of the pharmacological treatment of affective disorders. This includes both the management of unipolar depression and the various spectrums of bipolar disorder. The course assumes a working knowledge of the *Diagnostic and Statistical Manual* criteria for affective disorders, as well as presentation, manifestations, and differential diagnosis of these categories.

The course begins with the application of material from the foundation courses (Biological Foundations, Neuroscience, and Neuropharmacology) to the affective disorders. Biological models of the disorders are reviewed, as are classes of medications appropriate to the treatment of mood dysfunction. These topics will be covered through a variety of means to include readings, videos, and case studies. Other topics to be covered include management of side effects and the neuropharmacology associated with commonly used medications for affective disorders. Issues of culture, gender, ethnicity, and lifespan development as they impact on the medication management of affective disorders will be explored.

As with other Treatment Issues courses, a portion of the integration of material will be accomplished through the use of a case-based problem-solving approach. The student is expected to develop a flexible approach to the implementation of evidence-based strategies as warranted for individual cases.

PLACEMENT

Affective Disorders can only be completed after the four foundation courses (Biological Foundations I and II, Neuroscience, and Neuropharmacology). It builds on those courses by applying prior learning to the management of cases of affective disorders. Affective Disorders and Psychotic Disorders rotate with Anxiety Disorders and Other Disorders, so students will usually complete the Affective and Psychotic Disorders courses either in their fourth or fifth semester in the program. None of the courses in this rotation may be waived. Successful completion of this rotation completes the didactic sequence of the Psychopharmacology Postdoctoral Training Program, making the candidate eligible to enroll in the Clinical Practicum Elective.

COURSE OBJECTIVES

Upon completion of these courses the student will be able to:

1. Describe both current and recently popular models used to explain the etiology of affective disorders from a biological perspective.
2. Identify the classes of drugs commonly used for the treatment of affective disorders, and neurobiological models for understanding their palliative effects.

3. Apply evidenced-based strategies for prescribing medications for affective disorders.
4. Identify and apply evidence-based standards for the integration of psychotherapy and pharmacotherapy in the treatment of affective disorders.

In achieving each of these objectives, issues of lifespan development, gender, and ethnic diversity will be discussed.

FACULTY AND STAFF

Course Instructor

Bret A. Moore, Psy.D., ABPP
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Bret A. Moore is a board certified clinical psychologist and prescribing psychologist in San Antonio, Texas, Adjoint Associate Professor of Psychiatry at the University of Texas Health Science Center at San Antonio, and Adjunct Faculty at Adler University in Chicago, Illinois. He is the author or editor of 13 books including *Pharmacotherapy for Psychologists: Prescribing and Collaborative Roles*, *Handbook of Clinical Psychopharmacology for Psychologists* and *Anxiety Disorders: A Guide for Integrating Psychopharmacology and Psychotherapy*, which he co-edited with Stephen Stahl. He is a freelance popular press writer and has published pieces in *Scientific American Mind, The New Republic*, and *Military Times* and on *Psych Central, Psychology Today*, and *Lifezette*. He is a CME Reviewer for the Neuroscience Education Institute, Series Editor of Clinical Topics in Psychology and Psychiatry for Routledge/Taylor & Francis Press, and member of the Wellness Committee at Boulder Crest Retreat, Bluemont, Virginia.

Dr. Moore is a former active-duty Army psychologist and two-tour veteran of Iraq. He is a recipient of the Arthur W. Melton Award for Early Career Achievement in Military Psychology from Division 19 of the American Psychological Association and the Early Career Achievement Award from Division 18, and is a Fellow of the American Psychological Association. His views and opinions on clinical psychology, military psychology, and psychopharmacology have been quoted in *USA Today*, the *New York Times*, *Boston Globe*, *National Geographic, TV Guide* and on NPR, the BBC, CNN, CBS News, Fox News and the CBC.

Video Expert Presenters

Module 1: Neurobiology of Affective Disorders **– Thomas Schwartz, M. D.**
Module 2: Neuropharmacology of Antidepressants and Mood Stabilizers **– Mark Muse, Ph.D.**
Module 3: Pharmacotherapy of Depression **– Bret A. Moore, Psy.D., ABPP**
Module 4: Pharmacotherapy of Bipolar Disorders **– Bret A. Moore, Psy.D., ABPP**
Module 5: Combined Treatment of Affective Disorders **– David Shearer, Ph. D.**

Thomas L. Schwartz is a Professor of Psychiatry at the SUNY Upstate Medical University in Syracuse, NY, USA. He is the director of medical student education for his department and is a pivotal member of his institution's new direction curriculum task force. Administratively and clinically, he is the director of all adult psychiatry clinical services (outpatient, inpatient, consultation) for his department. He has been awarded state and national teaching awards, is published in peer reviewed journals, and has a web presence (webMD, MEDSCAPE, NEIglobal) where he actively writes and teaches. Finally, he is an editor of four textbooks (Depression: Treatment Strategies and Management (with Timothy Petersen, 1st and 2nd Eds) by Informa, Antipsychotic Drugs: Pharmacology, Side Effects and Abuse (with James Megna and Michael Topel) by Nova, and Integrating Psychotherapy and Psychopharmacology (with Irismar Reis de Oliveira, and Stephen Stahl in Press) by Routledge.

Mark Muse is licensed as a medical psychologist by the Louisiana State Board of Medical Examiners and is licensed by the Maryland Board of Examiners of Psychologists, with competency to consult with patients and providers on psychopharmacotherapy. He is the senior editor of the psychopharmacology textbook *Handbook of Clinical Psychopharmacology for Psychologists*.

David Shearer earned his PhD in psychology from Utah State University in 2001 and during that time he also completed a master's degree in school psychology. Dr. Shearer moved to New Mexico in 2004 to work on the Navajo reservation as a clinical psychologist for the Bureau of Indian Affairs. During that time he completed a master's degree in clinical psychopharmacology from New Mexico State. He is licensed as a prescribing and clinical psychologist in the State of New Mexico. He currently works as a full time prescribing psychologist in the Department of Family Medicine at Madigan Hospital in Tacoma, Washington. Madigan is one of the busiest hospitals in the Pacific Northwest with 160,000 soldiers, family members and retirees living within the 40-mile catchment area. He is on the faculty of the Department of Behavioral Health and is the Director of Behavioral Sciences for the Family Medicine Residency. Dr. Shearers' research and clinical interests include combined psychopharmacological and psychological treatments for behavioral health disorders, prescribing psychology in primary care settings, military psychology and anxiety disorders.

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STUDENT EVALUATION

Two online objective exams = 200 points
Written Case Presentation = 100 points
Participation in weekly chats = 30 points
Total Possible Points = 330

PASSING GRADE

To be assured of satisfactory completion of this course applicable to progression to the next term, **the student must achieve a score of 80% or better of the total points available. A grade of less than 75% represents failure of the course.**

CONTINUING PROFESSIONAL EDUCATION CREDITS

Fairleigh Dickinson University is approved by the American Psychological Association to offer continuing professional education for psychologists. Fairleigh Dickinson University School of Psychology maintains responsibility for the program. With a student participation rate of at least 80%, PSYC7940 is approved for 48 continuing professional education credits for psychologists.

# Hours	Activity
25	Readings/Videos/Directed Study Questions
5	Chats
8	Exams
7	Case Presentation

TEXTBOOKS

Required

1. Stahl, S. M. (2013). *Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications* (4th ed). New York: Cambridge University Press. ISBN: 978-1107686465.
2. Stein, D., Lerer, B. & Stahl, S. M. (2012). *Essential Evidence-Based Psychopharmacology* (2nd ed). New York: Cambridge University Press. ISBN: 978-1107400108.
3. Reis de Oliveira, Schwartz, T. & Stahl, S. M. (2013). *Integrating Psychotherapy and Psychopharmacology: A Handbook for Clinicians.* New York: Roultedge Press. ISBN: 978-0415838573.
4. Stahl, S. M. (2011). Case Studies: Stahl's Essential Psychopharmacology. New York: Cambridge University Press. ISBN: 0521182085.

DIRECTED STUDY QUESTIONS

The instructor for this course has decided to make completion of the Directed Study Questions voluntary and not required to be submitted to the instructor. Although these questions will be voluntary, **exam questions may be developed from these questions and should be used as a study guide for the exams**.

If you choose to complete the DSQs, please remember they are intended to be SHORT answer questions. When you are asked to generate a list, you do not need more than 1-2 sentences for each item in the list. When the question is open-ended, you never need to provide more than 1-2 paragraphs of information.

COURSE SCHEDULE

WEEK	MODULE	ACTIVITY
1: 1/11-1/17	1: Neurobiology of Affective Disorders	**Video:** Appendix 1

WEEK	MODULE	ACTIVITY
		Readings: Essential Psychopharmacology-Chapter 6 **Directed Study Questions:** Module 1 due 1/17
2: 1/18-1/24	2: Neruopharmacology of Antidepressants and Mood Stablizers	**Video:** Appendix 2 **Readings:** Ciraulo et al. (2011) Keck et al. (2002)
3: 1/25-1/31	3: Pharmacotherapy of Depression	**Video:** Appendix 3 **Readings:** Essential Psychopharmacology-Chapter 7 **Directed Study Questions:** Module 2 due 1/31
4: 2/1-2/7	3: Pharmacotherapy of Depression	**Readings:** Essential Evidence-Based Psychopharmacology-Chapter 4 Rush et al. (2006) Serotonin Syndrome article MAOI article Warfarin article **Exam 1:** Posted 2/4 Due 2/7 (Modules 1-3)
5: 2/8-2/14	4: Pharmacotherapy of Bipolar Disorder	**Video:** Appendix 4 **Readings:** Essential Psychopharmacology-Chapter 8 **Directed Study Questions:** Module 3 due 2/14
6: 2/15-2/21	4: Pharmacotherapy of Bipolar Disorder	**Readings:** Essential Evidence-Based Psychopharmacology-Chapter 3 NEJM lab values article
7: 2/22-2/28	5: Combined Treatment for Affective Disorders	**Video:** Appendx 5 **Readings:** Integrating Psychotherapy and Psychopharmacology-Chapters 3 & 4 Culjpers et al. (2013) **Directed Study Questions:** Module 4 due 2/28 **Exam 2:** Posted 2/26, Due 3/1 (Modules 4 and 5)
8: 2/29-3/2*	5: Combined Treatment for Affective Disorders	**Complete Student Satisfaction Survey** Module 5, Due 3/2

*Not a full week

CASE PRESENTATION FORMAT (MOOD DISORDER)

Date of Birth:

Date of Evaluation:

Patient Demographics:

Informants:

Reason for Evaluation:

Symptom presentation (to include, at a minimum, symptom type, frequency, duration, and impact on functioning):

Patient's Medical History:
- **Hospitalizations:**
- **Surgeries:**
- **Cardiac:**
- **Pulmonary:**
- **Gastrointestinal:**
- **Neurological:**
- **Genitourinary:**
- **Muscular/Dermatologic:**
- **Eyes/Ears/Nose/Throat:**
- **Endocrine:**
- **Hepatic:**
- **Skeletal:**
- **Psychiatric:**
- **Developmental:**
- **Lifestyle (smoking, D & A, sexuality, legal, weight, etc.):**

Patient's Medication History:
- **Current Medications (including over the counter and herbals):**
- **Past Medications (including response/lack of response):**
- **Medication Allergies:**
- **Other Allergies:**

Patient's Social History:

Family Medical/Psychiatric History:
Maternal side:
Paternal side:

Family Social History:

Physical Assessment Findings:
Physical/Neurological Evaluation:
Laboratory Findings:
Diagnostic Tests:

Conclusions (with rationale):

DSM Diagnosis (Including Rule-Outs):

Recommendations (with rationale): IT IS TO YOUR BENEFIT TO BE AS DETAILED AS POSSIBLE. THE GOAL IS TO ASSESS WHETHER OR NOT YOU UNDERSTAND WHY YOU ARE CHOOSING YOUR STATED TREATMENT PLAN AND HOW TO MANAGE THE PATIENT.
Additional LaboratoryTests:
Medication Plan: include initial recommendation (med, dosage, frequency), monitoring plan, labs/procedures required, reasonable obstacles to treatment and plan for addressing those obstacles, potential side effects to be concerned about, etc.
Additional Recommendations: e.g., OT, other medical or psychosocial interventions, case management

CASE PRESENTATION EVALUATION

Criterion	Points
Symptom presentation and history	**20**
Medical and medication history	**20**
Physical assessment and findings	**20**
Recommendations and rationales	**40**
TOTAL	**100**

It is expected that the subject of your Case Presentation will demonstrate a mood disorder or psychotic disorder. You need not administer the examinations involved in this report, just have access to the results. If need be, you can generate mock test data appropriate to the case to complete sections of the report, but the inclusion of actual data is considered desirable. Given this requirement, ***it is strongly recommended you start looking for an appropriate case early in the semester. Also, this is not a psychological evaluation. Please do not submit a psychological testing report.***

Given your current progress in the program, this report is intended to demonstrate your competence at adopting an integrated biopsychosocial approach to understanding the patient. This requires not only a complete review of each of the domains potentially contributing to this individual's pathology, as well as a treatment plan that demonstrates sensitivity to each of those domains.

It is important to be detailed regarding your medication recommendations. Stating "start fluoxetine 20mg qd" or "initiate zyprexa 5mg qhs" are not sufficient. Ensure that you discuss issues surrounding potential side effects, treatment course, medication interactions, etc. Provide the same detail as if you were explaining to your patient why you were prescribing a particular medication(s).

If you have additional questions about the structure of the Case Presentation, please raise them as early as possible with your Facilitator.

MODULE 1: Neruobiology of Affective Disorders

EXPERT PRESENTER

Thomas Schwartz, M. D.

TIME FRAME

Week 1

LEARNING OBJECTIVE

I. DESCRIBE THE VARIOUS BIOLOGICAL MODELS USED TO EXPLAIN THE ETIOLOGY OF AFFECTIVE DISORDERS
II. DESCRIBE THE BIOCHEMICAL BASIS OF DEPRESSION AND BIPOLAR DISORDER
III. DESCRIBE THE PROPOSED NEURALCIRCUITRY ASSOCIATED WITH DEPRESSION AND MANIA

READING ASSIGNMENT

Stahl's Essential Psychopharmacology-Chapter 6

VIDEO LECTURE OUTLINE

See Appendix 1

DIRECTED STUDY QUESTIONS

1. Compare and contrast the two biological models for studying the etiology of affective disorders.
2. Describe the role of norepinephrine and serotonin in depression and mania.

MODULE 2: Neuropharmacology of Antidepressants and Mood Stabilizers

EXPERT PRESENTER

Mark Muse, Ph.D.

TIME FRAME

Week 2

LEARNING OBJECTIVES

I. DESCRIBE THE NEUROPHARMACOLOGICAL PROPERTIES OF THE MAJOR CLASSES OF ANTIDEPRESSANTS
II. DESCRIBE THE NEUROPHARMACOLOGICAL PROPERTIES OF COMMONLY PRESCRIBED MOOD STABILIERS
III. DESCRIBE THE NEUROPHARMACOLOGICAL PROPERTIES OF OTHER MEDICATIONS USED TO TREAT AFFECTIVE DISORDERS (ATYPICAL APs, PSYCHOSTIMULANTS, ETC)
IV. DESCRIBE THE NEUROPHARMACOLOGICAL AND BIOLOGICAL CORRELATES OF ADVERSE EFFECTS ASSOCIATED WITH ANTIDEPRESSANT MEDICATIONS AND MOOD STABILIZERS

READING ASSIGNMENT

Ciraulo et al. (2011)
Keck et al. (2002)

VIDEO LECTURE OUTLINE

See Appendix 2

DIRECTED STUDY QUESTIONS

1. List the mechanism of action of the SSRIs, SNRIs, TCAs, and MAOIs.
2. Discuss the theory behind using non-antidepressants in the treatment of depression.

MODULE 3: Pharmacotherapy of Depression

EXPERT PRESENTER

Bret A. Moore, Psy.D., ABPP

TIME FRAME

Weeks 3-4

LEARNING OBJECTIVES

I. DESCRIBE THE DIFFERENT CLASSES OF MEDICATIONS USED TO TREAT DEPRESSION
II. DESCRIBE THE RESEARCH RELATED TO EVIDENCE-BASED AND SYMPTOM-BASED DRUG SELECTION FOR DEPRESSION
III. IDENTIFY STRATEGIES FOR MANAGING DRUG-DRUG AND DRUG-FOOD INTERACTIONS, ADVERSE REACTIONS, AND COMPLICATING MEDICAL ISSUES ASSOCIATED WITH MEDICATIONS COMMONLY USED TO TREAT DEPRESSION

READING ASSIGNMENT

Essential Psychopharmacology-Chapter 7
Essential Evidence-Based Psychopharmacology-Chapter 4
Rush et al. (2006)
Serotonin Syndrome article
MAOI article
Warfarin article

VIDEO LECTURE OUTLINE

See Appendix 3

DIRECTED STUDY QUESTIONS

1. A patient has been taking fluoxetine for several months. The patient begins complaining of loss of libido and impotency that has emerged since he has been on fluoxetine. This has become an issue which is now affecting compliance. What therapeutic alternatives do you have regarding treating the sexual dysfunction?

2. A patient has been receiving venlafaxine for treatment of depression and appears to be doing well. Compliance with the medication appears to be good but her spouse has complained that since being

on venlafaxine, she has begun to exhibit hyperactivity. This could be explained by what pharmacological actions of the drug?

3. List the most common side effects associated with each of the classes of antidepressant drugs.

MODULE 4: Pharmacotherapy of Bipolar Disorder

EXPERT PRESENTER

Bret A. Moore, Psy.D., ABPP

TIME FRAME

Weeks 5-6

LEARNING OBJECTIVES

I. DESCRIBE THE DIFFERENT CLASSES OF MEDICATIONS USED TO TREAT BIPOLAR DISORDER
II. DESCRIBE THE RESEARCH RELATED TO EVIDENCE-BASED AND SYMPTOM-BASED DRUG SELECTION FOR BIPOLAR DISORDERS
III. IDENTIFY STRATEGIES FOR MANAGING DRUG-DRUG AND DRUG-FOOD INTERACTIONS, ADVERSE REACTIONS, AND COMPLICATING MEDICAL ISSUES ASSOCIATED WITH MEDICATIONS COMMONLY USED TO TREAT BIPOLAR DISORDER

READING ASSIGNMENT

Essential Psychopharmacology-Chapter 8
Essential Evidence-Based Psychopharmacology-Chapter 3
NEJM lab values article

VIDEO LECTURE OUTLINE

See Appendix 4

DIRECTED STUDY QUESTIONS

1. Discuss the role in therapy for the various available mood stabilizers and atypical antipsychotics; compare and contrast.
2. List some components of an initial work-up to rule out or identify physical health problems that might influence your treatment of a patients bipolar disorder.
3. What is the current role of the various newer anticonvulsants in the treatment of bipolar disorder and what is the quality of the literature supporting or rejecting their efficacy?

MODULE 5: Combined Treatment for Affective Disorders

EXPERT PRESENTER

David Shearer, Ph.D.

TIME FRAME

Weeks 7-8

LEARNING OBJECTIVES

I. DESCRIBE THE RESEARCH ASSOCIATED WITH COMBINED TREATMENT OF AFFECTIVE DISORDERS
II. IDENTIFY EVIDENCE-BASED STRATEGIES FOR COMBINING PSYCHOTHERAPY AND PHARMACOTHERAPY IN THE TREATMENT OF AFFECTIVE DISORDERS

READING ASSIGNMENT

Integrating Psychotherapy and Psychopharmacology-Chapters 3 & 4
Culjpers et al. (2013)

VIDEO LECTURE OUTLINE

See Appendix 5

DIRECTED STUDY QUESTIONS

1. Discuss the supporting research for combining psychotherapy and medication in the treatment of affective disorders.

2. Discuss gaps in the research regarding the combination of psychotherapy and medication in the treatment of affective disorders.

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COURSE SYLLABUS

M.S. Program in Clinical Psychopharmacology

PSYC7945: TREATMENT ISSUES IN PSYCHOPHARMACOLOGY: PSYCHOTIC DISORDERS

March 3 – April 25, 2016

TABLE OF CONTENTS

COURSE SYLLABUS

COURSE DESCRIPTION

Treatment Issues in Psychopharmacology: Psychotic Disorders provides a case study approach to the pharmacological treatment of psychotic disorders. The course assumes a working knowledge of the *Diagnostic and Statistical Manual* criteria for psychotic disorders, as well as presentation, manifestations, and differential diagnosis of this category.

The course begins with the application of material from the foundation courses (Biological Foundations, Neuroscience, and Neuropharmacology) to the psychotic disorders. Biological models of the disorders are reviewed, as are classes of medications appropriate to the treatment of psychosis. In addition, the student will be exposed to current evidence based guidelines for the pharmacological management of psychotic disorders. This is followed by a review of important issues in treatment, such as the management of side effects and treatment of refractory patients. Issues of culture, ethnicity, and lifespan development as they impact on the medication management of psychotic disorders will be explored.

As with other Treatment Issues courses, a portion of the material will consist of a case-based problem-solving approach. The student is expected to develop a flexible approach to the implementation of treatment guidelines as warranted for individual cases.

PLACEMENT

Psychotic Disorders can only be completed after the four foundation courses (Biological Foundations I and II, Neuroscience, and Neuropharmacology), as well as the Clinical Pharmacology/Professional Issues & Practice Management sequence. It builds on those courses by applying prior learning to the management of cases of psychotic disorders. It is offered in the same semester as the course in the treatment of Affective Disorders. Affective Disorders and Psychotic Disorders rotate with Anxiety Disorders and Other Disorders, so students will complete the Affective and Psychotic Disorders courses either in their fourth or fifth semester in the program. None of the courses in this rotation may be waived. Successful completion of this rotation completes the didactic sequence of the Psychopharmacology Postdoctoral Training Program, making the candidate eligible to enroll in the Clinical Practicum Elective.

COURSE OBJECTIVES

Upon completion of this course the student will be able to:

1. Describe both current and recently popular models used to explain the etiology of psychotic disorders from a biological perspective.
2. Identify the classes of drugs commonly used for the treatment of psychotic disorders, and neurobiological models for understanding their palliative effects.
3. Apply evidenced-based strategies for prescribing medications for psychotic disorders, aggression, in emergency settings, and with child and nursing patients.

4. Identify and apply evidence-based standards for the integration of psychotherapy and pharmacotherapy in the treatment of psychotic disorders.

FACULTY AND STAFF

Course Instructor

Bret A. Moore, Psy.D., ABPP
25822 Coronado Ridge
San Antonio, TX 78260
Telephone: 713-823-2869
Primary Email: bamoore@student.fdu.edu

Bret A. Moore is a board certified clinical psychologist and prescribing psychologist in San Antonio, Texas, Adjoint Associate Professor of Psychiatry at the University of Texas Health Science Center at San Antonio, and Adjunct Faculty at Adler University in Chicago, Illinois. He is the author or editor of 13 books including *Pharmacotherapy for Psychologists: Prescribing and Collaborative Roles, Handbook of Clinical Psychopharmacology for Psychologists* and *Anxiety Disorders: A Guide for Integrating Psychopharmacology and Psychotherapy*, which he co-edited with Stephen Stahl. He is a freelance popular press writer and has published pieces in *Scientific American Mind, The New Republic*, and *Military Times* and on *Psych Central*, *Psychology Today*, and *Lifezette*. He is a CME Reviewer for the Neuroscience Education Institute, Series Editor of Clinical Topics in Psychology and Psychiatry for Routledge/Taylor & Francis Press, and member of the Wellness Committee at Boulder Crest Retreat, Bluemont, Virginia.

Dr. Moore is a former active-duty Army psychologist and two-tour veteran of Iraq. He is a recipient of the Arthur W. Melton Award for Early Career Achievement in Military Psychology from Division 19 of the American Psychological Association and the Early Career Achievement Award from Division 18, and is a Fellow of the American Psychological Association. His views and opinions on clinical psychology, military psychology, and psychopharmacology have been quoted in *USA Today*, the *New York Times*, *Boston Globe*, *National Geographic, TV Guide* and on NPR, the BBC, CNN, CBS News, Fox News and the CBC.

Video Expert Presenters

Module 1: Neurobiology of Schizophrenia and Other Psychotic Disorders **– Thomas Schwartz, M. D.**
Module 2: Neuropharmacology of Antipsychotic Medications **– Samuel Dutton, Ph.D.**
Module 3: Pharmacotherapy of Psychotic Disorders **– Bret A. Moore, Psy.D., ABPP**
Module 4: Utilization of Antipsychotic Medications in Managing Aggressive, Emergent, Child, Pregnant, and Nursing Patients **– Bret A. Moore, Psy.D., ABPP**
Module 5: Combined Treatment of Psychotic Disorders **- David Shearer, Ph.D.**

Thomas L. Schwartz is a Professor of Psychiatry at the SUNY Upstate Medical University in Syracuse, NY, USA. He is the director of medical student education for his department and is a pivotal member of his institution's new direction curriculum task force. Administratively and clinically, he is the director of all adult psychiatry clinical services (outpatient, inpatient,

consultation) for his department. He has been awarded state and national teaching awards, is published in peer reviewed journals, and has a web presence (webMD, MEDSCAPE, NEIglobal) where he actively writes and teaches. Finally, he is an editor of four textbooks (Depression: Treatment Strategies and Management (with Timothy Petersen, 1st and 2nd Eds) by Informa, Antipsychotic Drugs: Pharmacology, Side Effects and Abuse (with James Megna and Michael Topel) by Nova, and Integrating Psychotherapy and Psychopharmacology (with Irismar Reis de Oliveira, and Stephen Stahl in Press) by Routledge.

CDR Sameul Dutton completed his Ph.D. at the University of Maryland, College Park, his Air Force residency at Andrews Air Force Base, MD, and a 500-hour externship at the Baltimore V.A. Inpatient PTSD Unit. He completed eight years active duty with the U.S. Air Force, finishing with an overseas long tour at Yokota Air Base, Japan. He then traded his active duty Air Force commission for a commission in the U.S. Public Health Service under the U.S. Surgeon General. He worked for five years in the Dep't of Homeland Security, U.S. Immigration, at a 1,000-bed detention facility. During this time, he received his Postdoctoral Master of Science in Psychopharmacology from Alliant International University. Since late 2011 he has been detailed to the U.S. Naval Academy as a prescribing psychologist, Naval Health Clinic Annapolis (NHCA). He currently oversees the Mental Health Department, NHCA as well as behavioral health services in primary care. He is also an adjunct faculty member at the Uniformed Services University of Health Sciences.

David Shearer earned his PhD in psychology from Utah State University in 2001 and during that time he also completed a master's degree in school psychology. Dr. Shearer moved to New Mexico in 2004 to work on the Navajo reservation as a clinical psychologist for the Bureau of Indian Affairs. During that time he completed a master's degree in clinical psychopharmacology from New Mexico State. He is licensed as a prescribing and clinical psychologist in the State of New Mexico. He currently works as a full time prescribing psychologist in the Department of Family Medicine at Madigan Hospital in Tacoma, Washington. Madigan is one of the busiest hospitals in the Pacific Northwest with 160,000 soldiers, family members and retirees living within the 40-mile catchment area. He is on the faculty of the Department of Behavioral Health and is the Director of Behavioral Sciences for the Family Medicine Residency. Dr. Shearers' research and clinical interests include combined psychopharmacological and psychological treatments for behavioral health disorders, prescribing psychology in primary care settings, military psychology and anxiety disorders.

24/7 Technical Support

FDU Technical Assistance Center (FDUTAC)
Phone: 973-443-8822 (973-443-UTAC)
E-mail: fdutac@fdu.edu

STUDENT EVALUATION

Two online objective exams = 200 points
Written Case Presentation = 100 points
Participation in weekly chats = 30 points
Total Possible Points = 330

PASSING GRADE

To be assured of satisfactory completion of this course applicable to progression to the next term, **the student must achieve a score of 80% or better of the total points available. A grade of less than 75% represents failure of the course.**

CONTINUING PROFESSIONAL EDUCATION CREDITS

Fairleigh Dickinson University is approved by the American Psychological Association to offer continuing professional education for psychologists. Fairleigh Dickinson University School of Psychology maintains responsibility for the program. With a student participation rate of at least 80%, PSYC7940 is approved for 48 continuing professional education credits for psychologists.

# Hours	Activity
25	Readings/Videos/Directed Study Questions
5	Chats
7.5	Exams
3.5	Case presentation

TEXTBOOKS

Required

1. Stahl, S. M. (2013). *Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications* (4th ed). New York: Cambridge University Press. ISBN: 978-1107686465.
2. Stein, D., Lerer, B. & Stahl, S. M. (2012). *Essential Evidence-Based Psychopharmacology* (2nd ed). New York: Cambridge University Press. ISBN: 978-1107400108.
3. Reis de Oliveira, Schwartz, T. & Stahl, S. M. (2013). *Integrating Psychotherapy and Psychopharmacology: A Handbook for Clinicians.* New York: Roultedge Press. ISBN: 978-0415838573.
4. Stahl, S. M. (2011). Case Studies: Stahl's Essential Psychopharmacology. New York: Cambridge University Press. ISBN: 0521182085.

DIRECTED STUDY QUESTIONS

The instructor for this course has decided to make completion of the Directed Study Questions voluntary. Althugh these questions will be voluntary, exam questions will be developed from these questions and should be used as a study guide for the exams. Deadlines for each set of Directed Study Questions are provided in the Course Schedule.

Please remember the DSQs are intended to be SHORT answer questions. When you are asked to generate a list, you do not need more than 1-2 sentences for each item in the list. When the question is open-ended, you never need to provide more than 1-2 paragraphs of information.

If you're not sure what the question is looking for, rather than spending hours trying to produce every piece of information you can, feel free to discuss it with your facilitator, and if you're not comfortable with the feedback you receive, your instructor.

PLEASE don't let obsessional tendencies get in the way of completing the DSQs in a timely manner. The goal of the DSQs is to demonstrate a basic understanding of processes, and to help consolidate the key information, not to demonstrate you know everything about everything. Educational research demonstrates that what you will take away from any learning experience is the most central information, and in practice you will need to rely on resource materials for many of the details.

COURSE SCHEDULE

WEEK	MODULE	ACTIVITY
1: 3/3-3/9	1: Neurobiology of Schizophrenia	**Video:** Appendix 1 **Readings:** Stahl's Essential Psychopharmacology-Chapter 4
2: 3/10-3/16	2: Neuropharmacology of Antipsychotics	**Video:** Appendix 2 **Readings:** Stahl's Essential Psychopharmacology-Chapter 5 **Directed Study Questions:** Module 1 due 3/17
3: 3/17-3/23	3: Pharmacotherapy of Psychotic Disorders	**Video:** Appendix 3 Stahl's Essential Psychopharmacology-Chapter 5 (continued) Essential Evidence-Based Psychopharmacology-Chapter 2
4: 3/24-3/28*	3: Pharmacothearpy of Psychotic Disorders	**Readings:** Moore, Morrissette, & Stahl (in press) Freedman (2005) Lieberman et al. (2005) Leucht et al. (2013) **Exam (Modules 1-3):** Posted 3/25, Due 3/30
5: 3/29-4/4	4: Aggressive and Emergency Patients	**Video:** Appendix 4 **Readings:** Mohr et al. (2005) Sonnier and Barzman (2011) **Directed Study Questions:** Module 2 due 4/4 **Case Presentation:** Due 4/5
6: 4/5-4/11	4: Child, Pregnant, and Nursing Patients	**Video:** Appendix 4 **Directed Study Questions:** Module 3 due 4/5 **Readings:** AACAP Practice Paramaters National Guideline Clearinghouse
7: 4/12-4/18	5. Combined Treatment of Psychotic Disorders	**Video:** Appendix 5 **Readings:**

WEEK	MODULE	ACTIVITY
		Integrating Psychotherapy and Psychopharmacology-Chapter 5 **Directed Study Questions:** Module 4 due 4/18
8: 4/19-4/25	5: Combined Treatment of Psychotic Disorders	**Directed Study Questions:** Module 5 due 4/25 **Exam (Modules 4-5):** Posted 4/21, due 4/25

*Not a full week

CASE PRESENTATION FORMAT (Psychosis)

Date of Birth:

Date of Evaluation:

Patient Demographics:

Informants:

Reason for Evaluation:

Symptom presentation (to include, at a minimum, symptom type, frequency, duration, and impact on functioning):

Patient's Medical History:
- **Hospitalizations:**
- **Surgeries:**
- **Cardiac:**
- **Pulmonary:**
- **Gastrointestinal:**
- **Neurological:**
- **Genitourinary:**
- **Muscular/Dermatologic:**
- **Eyes/Ears/Nose/Throat:**
- **Endocrine:**
- **Hepatic:**
- **Skeletal:**
- **Psychiatric:**
- **Developmental:**
- **Lifestyle (smoking, D & A, sexuality, legal, weight, etc.):**

Patient's Medication History:
- **Current Medications (including over the counter and herbals):**
- **Past Medications (including response/lack of response):**
- **Medication Allergies:**
- **Other Allergies:**

Patient's Social History:

Family Medical/Psychiatric History:
Maternal side:
Paternal side:

Family Social History:

Physical Assessment Findings:
Physical/Neurological Evaluation:
Laboratory Findings:
Diagnostic Tests:

Conclusions (with rationale):

DSM Diagnosis:
Axis I:
Axis II:
Axis III:

Recommendations (with rationale): IT IS TO YOUR BENEFIT TO BE AS DETAILED AS POSSIBLE. THE GOAL IS TO ASSESS WHETHER OR NOT YOU UNDERSTAND WHY YOU ARE CHOOSING YOUR STATED TREATMENT PLAN AND HOW TO MANAGE THE PATIENT.
Additional LaboratoryTests:
Medication Plan: include initial recommendation (med, dosage, frequency), monitoring plan, labs/procedures required, reasonable obstacles to treatment and plan for addressing those obstacles, potential side effects to be concerned about, etc.
Additional Recommendations: e.g., OT, other medical or psychosocial interventions, case management

CASE PRESENTATION EVALUATION

Criterion	Points
Symptom presenation and history	**20**
Medical and medication history	**20**
Physical assessment and findings	**20**
Recommendations and rationales	**40**
TOTAL	**100**

It is expected that the subject of your Case Presentation will demonstrate a mood disorder or psychotic disorder. You need not administer the examinations involved in this report, just have access to the results. If need be, you can generate mock test data appropriate to the case to complete sections of the report, but the inclusion of actual data is considered desirable. Given this requirement, ***it is strongly recommended you start looking for an appropriate case early in the semester. Also, this is not a psychological evaluation. Please do not submit a psychological testing report.***

Given your current progress in the program, this report is intended to demonstrate your competence at adopting an integrated biopsychosocial approach to understanding the patient. This requires not only a complete review of each of the domains potentially contributing to this individual's pathology, as well as a treatment plan that demonstrates sensitivity to each of those domains.

It is important to be detailed regarding your medication recommendations. Stating "start risperdal 1mg bid" is not sufficient. Ensure that you discuss issues surrounding potential side effects, treatment course, medication interactions, etc. Provide the same detail as if you were explaining to your patient why you were prescribing a particular medication(s).

If you have additional questions about the structure of the Case Presentation, please raise them as early as possible with your Facilitator.

MODULE 1: Neurobiology of Schizophrenia

EXPERT PRESENTERS

Thomas Schwartz, M. D.

TIME FRAME

Week 1

LEARNING OBJECTIVES

I. DESCRIBE THE VARIOUS BIOLOGICAL MODELS USED TO EXPLAIN THE ETIOLOGY OF SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS
II. DESCRIBE THE BIOCHEMICAL BASIS OF SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS
III. DESCRIBE THE PROPOSED NEURALCIRCUITRY ASSOCIATED WITH SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

READING ASSIGNMENT

Stahl's Essential Psychopharmacology-Chapter 4

DIRECTED STUDY QUESTIONS

None

VIDEO LECTURE OUTLINE

See Appendix 1

MODULE 2: Neuropharmacology of Antipsychotics

EXPERT PRESENTER

Samuel Dutton, Ph.D.

TIME FRAME

Week 2

LEARNING OBJECTIVES

I. DESCRIBE THE NEUROPHARMACOLOGICAL PROPERTIES OF FIRST GENERATION ANTIPSYCHOTIC MEDICATIONS
II. DESCRIBE THE NEUROPHARMACOLOGICAL PROPERTIES OF SECOND GENERATION ANTIPSYCHOTIC MEDICATIONS
III. DESCRIBE THE NEUROPHARMACOLOGICAL AND BIOLOGICAL CORRELATES OF ADVERSE EFFECTS ASSOCIATED WITH ANTIPSYCHOTIC MEDICATIONS

READING ASSIGNMENT

Stahl's Essential Psychopharmacology-Chapter 5

DIRECTED STUDY QUESTIONS

1. Describe three (3) different ways you can mitigate or minimize extrapyramidal effects.
2. What are two differences between typical and atypical antipsychotic medications?

VIDEO LECTURE OUTLINE

See Appendix 2

MODULE 3: Pharmacotherapy of Schizophrenia and Other Psychotic Disorders

EXPERT PRESENTERS

Bret A. Moore, Psy.D., ABPP

TIME FRAME

Weeks 3-4

LEARNING OBJECTIVES

I. LIST THE DIFFERENT CLASSES OF MEDICATIONS USED TO TREAT SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS
II. DESCRIBE THE RESEARCH RELATED TO EVIDENCE-BASED AND SYMPTOM-BASED DRUG SELECTION FOR SCHIZOPHRENIA
III. IDENTIFY STRATEGIES FOR MANAGING DRUG-DRUG AND DRUG-FOOD INTERACTIONS, ADVERSE REACTIONS AND COMPLICATING MEDICAL ISSUES ASSOCIATED WITH MEDICATIONS COMMONLY USED TO TREAT SCHIZOPHRENIA

READING ASSIGNMENT

1. Freedman, R. (2005). The choice of antipsychotic drugs for schizophrenia. *New England Journal of Medicine, 353*, 1286-1288.
2. Lieberman, J. A., Stroup, T. S., McEvoy, J. P., Swartz, M. S., Rosenheck, R. A. Perkins, D. O., Keefe, R. S. E., Davis, S. M., Davis, C. E., Lebowitz, B. D., Severe, J., & Hsiao, J. K., for the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) investigators. (2005). Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *New England Journal of Medicine, 353*, 1209-1223. Also see the accompanying editorial.
3. Leucht et al. (2013)
4. Moore, B. A., Morrisette, D., & Stahl, S. M. (in press). Unconventional" Treatment Strategies for Schizophrenia: Polypharmacy and Heroic Dosing. *British Journal of Psychiatry Bulletin.*
5. Stahl's Essential Psychopharmacology-Chapter 5
6. Essential Evidence-Based Psychopharmacology-Chapter 2

DIRECTED STUDY QUESTIONS

1. Discuss the pros and cons of olanzapine, quetiapine, risperidone, ziprasidone, aripiprazole, and clozapine relative to each other in the treatment of schizophrenia. I recommend a table format.

VIDEO LECTURE OUTLINE

See Appendix 3

MODULE 4: Management of Aggressive, Emergency, Child, Nursing, and Pregnant Patients

EXPERT PRESENTER

Bret A. Moore, Psy.D., ABPP

TIME FRAME

Weeks 5-6

LEARNING OBJECTIVES

I. IDENTIFY EVIDENCE-BASED STRATEGIES FOR TREATING AGGRESSIIVE BEHAVIOR
II. IDENTIFY EVIDENCE-BASED STRATEGIES FOR USING ANTIPSYCHOTIC MEDICATIONS IN EMERGENCY SETTINGS
III. IDENTIFY EVIDENCE-BASED STRATEGIES FOR TREATING CHILD, PREGNANT AND NURSING PATIENTS WITH ANTIPSYCHOTIC MEDICATIONS
IV. LIST THE VARIOUS CONTRAINDICATIONS AND RISKS ASSOCIATED WITH USING ANTIPSYCHOTIC MEDICATIONS WITH CHILD, PREGNANT, AND NURSING PATIENTS

READING ASSIGNMENT

Mohr et al. (2005)
Sonnier and Barzman (2011)
AACAP Practice Paramaters
National Guideline Clearinghouse

DIRECTED STUDY QUESTIONS

1. What is the evidence that atypical antipsychotic medications are superior to haloperidol and/or lorazepam in the treatment of acute agitation of unknown etiology?

2. List the various pharmacodynamic and pharmacokinetic issues related to using antipsychotic issues with child, nursing, and pregnant patients.

VIDEO LECTURE OUTLINE

See Appendix 4

MODULE 5: Combined Treatment of Schizophrenia and Other Psychotic Disorders

EXPERT PRESENTER

David Shearer, Ph. D.

TIME FRAME

Weeks 7-8

LEARNING OBJECTIVES

I. DESCRIBE THE RESEARCH ASSOCIATED WITH COMBINED TREATMENT OF SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS
II. IDENTIFY EVIDENCE-BASED STRATEGIES FOR COMBINING PSYCHOTHERAPY AND PHARMACOTHERAPY IN THE TREATMENT OF SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

READING ASSIGNMENT

Integrating Psychotherapy and Psychopharmacology-Chapter 5

DIRECTED STUDY QUESTIONS

1. Describe the strengths and limitations associated with combined treatment of schizophrenia and other psychotic disorders.

2. Discuss the gaps in research related to combined treatment of schizophrenia and other psychotic disorders.

VIDEO LECTURE OUTLINE

See Appendix 5

Fairleigh Dickinson
UNIVERSITY

COURSE SYLLABUS

Psychopharmacology Postdoctoral Training Program

PSYC7950: ANXIETY DISORDERS

May 2, 2016 – June 22, 2016

TABLE OF CONTENTS

COURSE SYLLABUS

COURSE DESCRIPTION

Treatment Issues in Clinical Psychopharmacology: Anxiety Disorders provides a case study approach to the pharmacological treatment of anxiety disorders. The course assumes a working knowledge of the *Diagnostic and Statistical Manual* criteria for anxiety disorders, as well as presentation, manifestations, and differential diagnosis of this category.

The course begins with the application of material from the foundation courses (Biological Foundations, Neuroscience, and Neuropharmacology) to the anxiety disorders. Biological models (neuropathological and neuroendocrinological) of the disorders are reviewed, as are classes of medications appropriate to the treatment of anxiety. In addition, the student will be exposed to current treatment guidelines for the pharmacological management of anxiety disorders. This is followed by a review of important issues in treatment, such as the management of side effects and treatment of refractory patients. Issues of culture, ethnicity, and lifespan development as they impact on the medication management of anxiety disorders will be explored.

As with other Treatment Issues courses, much of the integration of material will be accomplished through the use of a case-based problem-solving approach. The student is expected to develop a flexible approach to the implementation of treatment guidelines as warranted for individual cases.

PLACEMENT

Anxiety Disorders can only be completed after the four foundation courses (Biological Foundations I and II, Neuroscience, and Neuropharmacology), as well as the Clinical Pharmacology/Professional Issues & Practice Management sequence. It builds on those courses by applying prior learning to the management of cases of psychotic disorders. It is offered in the same semester as the course in the treatment of Other Disorders. Anxiety Disorders and Other Disorders rotate with the Affective Disorders and Psychotic Disorders courses, so students will complete the Anxiety and Other Disorders courses either in their fourth or fifth semester in the program. None of the courses in this rotation may be waived. Successful completion of this rotation completes the didactic sequence of the Psychopharmacology Postdoctoral Training Program, making the candidate eligible to enroll in the Clinical Practicum Elective.

COURSE OBJECTIVES

Upon completion of these courses, the student will be able to:

1. Describe the clinical presentation, signs and symptoms, diagnostic criteria, and pathophysiology for anxiety disorders.
2. Discuss the efficacy of pharmacologic treatment options in the acute and long-term management of anxiety disorders.

3. Outline the mechanisms of action, pharmacokinetic, pharmacodynamic, adverse events, significant drug interactions, and warnings/precautions (including medical comorbidities and black box warnings) for drugs used in anxiety disorders.
4. Describe treatment guidelines and select clinical trials, including study design, strengths and weaknesses, and implications for practical management of anxiety disorders.
5. Select an evidenced-based drug therapy regimen (drug, dose, schedule, time to response, and duration of therapy) for stabilizing symptoms and preventing relapse given the clinical presentation of a pecific patient.
6. Outline a plan for monitoring and managing the safety and efficacy of drug therapy.
7. Describe the management of anxiety disorders in special populations (e.g., pregnancy/lactation, the elderly).
8. Discuss the integration of behavioral and pharmacological treatment for anxiety disorders.

In achieving each of these objectives, issues of lifespan development, gender, and ethnic diversity will be integrated.

FACULTY AND STAFF

Course Instructor

Bret A. Moore, Psy.D., ABPP
25822 Coronado Ridge
San Antonio, TX 78260
Telephone: 713-823-2869
Primary Email: bamoore@student.fdu.edu

Bret A. Moore is a board certified clinical psychologist and prescribing psychologist in San Antonio, Texas, Adjoint Associate Professor of Psychiatry at the University of Texas Health Science Center at San Antonio, and Adjunct Faculty at Adler University in Chicago, Illinois. He is the author or editor of 13 books including *Pharmacotherapy for Psychologists: Prescribing and Collaborative Roles*, *Handbook of Clinical Psychopharmacology for Psychologists* and *Anxiety Disorders: A Guide for Integrating Psychopharmacology and Psychotherapy*, which he co-edited with Stephen Stahl. He is a freelance popular press writer and has published pieces in *Scientific American Mind, The New Republic*, and *Military Times* and on *Psych Central, Psychology Today*, and *Lifezette*. He is a CME Reviewer for the Neuroscience Education Institute, Series Editor of Clinical Topics in Psychology and Psychiatry for Routledge/Taylor & Francis Press, and member of the Wellness Committee at Boulder Crest Retreat, Bluemont, Virginia.

Dr. Moore is a former active-duty Army psychologist and two-tour veteran of Iraq. He is a recipient of the Arthur W. Melton Award for Early Career Achievement in Military Psychology from Division 19 of the American Psychological Association and the Early Career Achievement Award from Division 18, and is a Fellow of the American Psychological Association. His views and opinions on clinical psychology, military psychology, and psychopharmacology have been quoted in *USA Today*, the *New York Times*, *Boston Globe*, *National Geographic*, *TV Guide* and on NPR, the BBC, CNN, CBS News, Fox News and the CBC.

Video Expert Presenters

All Modules–**Klugh Kennedy, PharmD**

24/7 Technical Support

FDU Technical Assistance Center (UTAC)
Phone: 973-443-8822
E-mail: fdutac@fdu.edu

STUDENT EVALUATION

Two online exams = 200 points
Written Case Presentation = 100 points
Participation in weekly chats = 30 points
Total Possible Points = 330

PASSING GRADE

To be assured of satisfactory completion of this course applicable to progression to the next term, **the student must achieve a score of 80% or better of the total points available. A grade of less than 75% represents failure of the course.**

CONTINUING PROFESSIONAL EDUCATION CREDITS

Fairleigh Dickinson University School of Psychology is approved by the American Psychological Association to offer continuing education for psychologists. The School of Psychology maintains responsibility for the program. With a student participation rate of at least 80%, PSYC7950 is approved for 48 continuing professional education credits for psychologists. One weekend Regional Interaction Session occurs each semester; 10.5 hours for this experience is credited to each 7.5-week course completed during the semester: 3.5 for preparation of a clinical case study and 7 for the session.

# Hours	Activity
25	Readings/videos
5	Chats
8	Exams
7	Case presentation

TEXTBOOKS

Required

1. Stahl, S. M. (2013). *Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications* (4th ed). New York: Cambridge University Press. ISBN: 978-1107686465.
2. Stein, D., Lerer, B. & Stahl, S. M. (2012). *Essential Evidence-Based Psychopharmacology* (2nd ed). New York: Cambridge University Press. ISBN: 978-1107400108.

3. Reis de Oliveira, Schwartz, T. & Stahl, S. M. (2013). *Integrating Psychotherapy and Psychopharmacology: A Handbook for Clinicians.* New York: Roultedge Press. ISBN: 978-0415838573.
4. Stahl, S. M. (2011). Case Studies: Stahl's Essential Psychopharmacology. New York: Cambridge University Press. ISBN: 0521182085.

DIRECTED STUDY QUESTIONS

The instructor for this course has decided to make completion of the Directed Study Questions voluntary and not required to be submitted to the instructor. Although these questions will be voluntary, exam questions may be developed from these questions and should be used as a study guide for the exams.

If you choose to complete the DSQs, please remember they are intended to be SHORT answer questions. When you are asked to generate a list, you do not need more than 1-2 sentences for each item in the list. When the question is open-ended, you never need to provide more than 1-2 paragraphs of information.

COURSE SCHEDULE

WEEK	MODULE	ACTIVITY
1: 5/2-5/8	1: Overview of Anxiety Disorders	**Video:** Watch Module 1 **Readings:** Essential Psychopharmacology-Chapter 9
2: 5/9 – 5/15 3: 5/16 – 5/20*	2: Generalized Anxiety Disorder	**Video:** Watch Module 2 **Readings:** Baldwin et al., 2014 Essential Evidence-Based Psychopharmacology-Chapter 7
4: 5/21-5/25	3: Panic Disorder	**Video:** Watch Module 3 **Readings:** Essential Evidence-Based Psychopharmacology-Chapter 5
5: 5/26-6/1	4: OCD	**Video:** Watch Module 4 **Readings:** Essential Evidence-Based Psychopharmacology-Chapter 8 **Exam 1 (Weeks 1-4):** Posted 5/27, due 6/1
6: 6/2-6/8	5: Post Traumatic Stress Disorder	**Video:** Watch Module 5 **Readings:** Essential Evidence-Based Psychopharmacology-Chapter 9
7: 6/9-6/15	6: Social Anxiety Disorder	**Video:** Watch Module 6 **Readings:** Essential Evidence-Based Psychopharmacology-Chapter 6
8: 6/16-6/22	7: Combined Treatment and Review	**Readings:** Integrating Psychotherapy and Psychopharmacology-Chapter 6 **Exam 2 (Weeks 5-8):** Posted 6/17, due 6/24

*Note this cell represents a deviation from the standard week format.

CASE PRESENTATION FORMAT (Anxiety Disorder/Other Disorder)

Date of Birth:

Date of Evaluation:

Patient Demographics:

Informants:

Reason for Evaluation:

Symptom presentation (to include, at a minimum, symptom type, frequency, duration, and impact on functioning):

Patient's Medical History:

- **Hospitalizations:**
- **Surgeries:**
- **Cardiac:**
- **Pulmonary:**
- **Gastrointestinal:**
- **Neurological:**
- **Genitourinary:**
- **Muscular/Dermatologic:**
- **Eyes/Ears/Nose/Throat:**
- **Endocrine:**
- **Hepatic:**
- **Skeletal:**
- **Psychiatric:**
- **Developmental:**
- **Lifestyle (smoking, D & A, sexuality, legal, weight, etc.):**

Patient's Medication History:

- **Current Medications (including over the counter and herbals):**
- **Past Medications (including response/lack of response):**
- **Medication Allergies:**
- **Other Allergies:**

Patient's Social History:

Family Medical/Psychiatric History:
Maternal side:
Paternal side:

Family Social History:

Physical Assessment Findings:
Physical/Neurological Evaluation:
Laboratory Findings:
Diagnostic Tests:

Conclusions (with rationale):

DSM Diagnosis (Including Rule-Outs):

Recommendations (with rationale): IT IS TO YOUR BENEFIT TO BE AS DETAILED AS POSSIBLE. THE GOAL IS TO ASSESS WHETHER OR NOT YOU UNDERSTAND WHY YOU ARE CHOOSING YOUR STATED TREATMENT PLAN AND HOW TO MANAGE THE PATIENT.
Additional LaboratoryTests:
Medication Plan: include initial recommendation (med, dosage, frequency), monitoring plan, labs/procedures required, reasonable obstacles to treatment and plan for addressing those obstacles, potential side effects to be concerned about, etc.
Additional Recommendations: e.g., OT, other medical or psychosocial interventions, case management

CASE PRESENTATION EVALUATION

Criterion	Points
Symptom presentation and history	**20**
Medical and medication history	**20**
Physical assessment and findings	**20**
Recommendations and rationales	**40**
TOTAL	**100**

It is expected that the subject of your Case Presentation will demonstrate an anxiety disorder or other disorder covered in 7955. You need not administer the examinations involved in this report, just have access to the results. If need be, you can generate mock test data appropriate to the case to complete sections of the report, but the inclusion of actual data is considered desirable. Given this requirement, ***it is strongly recommended you start looking for an appropriate case early in the semester. Also, this is not a psychological evaluation. Please do not submit a psychological testing report.***

Given your current progress in the program, this report is intended to demonstrate your competence at adopting an integrated biopsychosocial approach to understanding the patient. This requires not only a complete review of each of the domains potentially contributing to this individual's pathology, as well as a treatment plan that demonstrates sensitivity to each of those domains.

It is important to be detailed regarding your medication recommendations. Stating "start fluoxetine 20mg qd" or "initiate zyprexa 5mg qhs" are not sufficient. Ensure that you discuss issues surrounding potential side effects, treatment course, medication interactions, etc. Provide the same detail as if you were explaining to your patient why you were prescribing a particular medication(s).

If you have additional questions about the structure of the Case Presentation, please raise them as early as possible with your Facilitator.

MODULE 1: Overview

EXPERT PRESENTER

Klugh Kennedy, PharmD, BCPP

TIME FRAME

Week 1

LEARNING OBJECTIVES

After completing this unit, the student should fully understand and be able to discuss each of the following:

- Review of Evidence Based Practice
- Discuss Anxiety Disorders with focus on characteristics useful in managing drug therapy
- Illustrate why anxiety disorders are so important in a program focused on pharmacotherapy and medical illness
- Diagnostic classification and prevalence of anxiety disorders: Evolution of standardized classification systems (i.e., ICD and/or DSM) and implications for neurobiology.
- Sources of fear and anxiety in the brain—neural circuits and the role of the amygdala, hippocampus and other brain structures in the generation and inhibition of fear and anxiety (afferent and efferent systems of the amygdala; behavioral, autonomic and endocrine responses associated with the "expression" of fear and anxiety including the stress response; efferent projections of the amygdala associated with the "experience" of fear and anxiety and emotional coloring; and the role of CRH, excitatory amino acids, NE, ACH and other neurochemicals).
- The role of successful pharmacotherapies in the derivation of neurobiological hypotheses and models of anxiety.

READING ASSIGNMENTS

Essential Psychopharmacology-Chapter 9

VIDEO LECTURE OUTLINE

See Module 1

MODULE 2: Generalized Anxiety Disorder

EXPERT PRESENTER

Klugh Kennedy, PharmD, BCPP

TIME FRAME

Weeks 2-3

LEARNING OBJECTIVES

1. Describe the essential target features of GAD for pharmacotherapeutic treatment.
2. Understand the pharmacotherapy and the evidence in GAD
3. Discuss the evidence based role of pharmacotherapy in the management of GAD

READING ASSIGNMENTS

Baldwin et al., 2014
Essential Evidence-Based Psychopharmacology-Chapter 7

DIRECTED STUDY QUESTIONS

Discuss the risk benefits ratio for using antipsychotics to treat GAD

VIDEO LECTURE OUTLINES

See Module 2

MODULE 3: Panic Disorder

EXPERT PRESENTER

Klugh Kennedy, PharmD, BCPP

TIME FRAME

Week 4

LEARNING OBJECTIVES

1. Describe the essential target features of Panic Disorder for pharmacotherapeutic treatment.
2. Understand the pharmacotherapy and the evidence in Panic Disorder

READING ASSIGNMENTS

Essential Evidence-Based Psychopharmacology-Chapter 5

DIRECTED STUDY QUESTIONS

How is panic disorder different than generalized anxiety disorder in pathophysiology?

VIDEO LECTURE OUTLINES

See Module 3

MODULE 4: Obsessive Compulsive Disorder

EXPERT PRESENTER

Klugh Kennedy, PharmD, BCPP

TIME FRAME

Week 5

LEARNING OBJECTIVES

1. Discuss the role of pharmacotherapy in the management of core OCD symptoms
2. Discuss the role of pharmacotherapy in the management of residual OCD symptomatology

READING ASSIGNMENTS

Essential Evidence-Based Psychopharmacology-Chapter 8

DIRECTED STUDY QUESTIONS

Describe pharmacological treatment strategies for obsessive-compulsive disorder, including severe OCD that is refractory to treatment with antidepressants.

VIDEO LECTURE OUTLINE

See Module 4

MODULE 5: Post Traumatic Stress Disorder

EXPERT PRESENTER

Klugh Kennedy, PharmD, BCPP

TIME FRAME

Week 6

LEARNING OBJECTIVES

1. Understand the current pharmacotherapeutic management of the core symptomatology of PTSD
2. Understand the role of pharmacotherapy and the options for residual symptoms.

READING ASSIGNMENTS

Essential Evidence-Based Psychopharmacology-Chapter 9

DIRECTED STUDY QUESTIONS

What are the relative merits of pharmacological and non-pharmacological treatment for Post Traumatic Stress Disorder? When, or if, should pharmacological treatment be used as the mainstay of therapy?

VIDEO LECTURE OUTLINES

See Module 5

MODULE 6: Social Anxiety Disorder

EXPERT PRESENTER

Klugh Kennedy, PharmD, BCPP

TIME FRAME

Week 7/8

LEARNING OBJECTIVES

1. Describe the essential target features of SAD for pharmacotherapeutic treatment.
2. Understand the pharmacotherapy and the evidence in SAD
3. Understand effective combined treatments for anxiety disorders.

READING ASSIGNMENTS

Essential Evidence-Based Psychopharmacology-Chapter 6
Integrating Psychotherapy and Psychopharmacology-Chapter 6

VIDEO LECTURE OUTLINES

See Module 6

COURSE SYLLABUS

Psychopharmacology Postdoctoral Training Program

PSYC 7955: OTHER DISORDERS

June 23 – August 14, 2016

TABLE OF CONTENTS

COURSE SYLLABUS

COURSE DESCRIPTION

Treatment Issues in Psychopharmacology: Other Disorders provides a case study approach to a variety of disorder classes not covered previously. The course assumes a working knowledge of the *Diagnostic and Statistical Manual* criteria for disorders covered in the course, as well as presentation, manifestations, and differential diagnosis of this category.

Each module of the course is self-contained and geared to the specific issues associated with the disorder. Biological models of the disorders are reviewed as appropriate, as are classes of medications currently considered appropriate to the treatment of each. In addition, the student will be exposed to current treatment guidelines for pharmacological management.

As with other Treatment Issues courses, much of the integration of material will be accomplished through the use of a case-based problem-solving approach. The student is expected to develop a flexible approach to the implementation of treatment guidelines as warranted for individual cases.

PLACEMENT

In general, Other Disorders can only be completed after the four foundation courses (Biological Foundations I and II, Neuroscience, and Neuropharmacology), as well as the Clinical Pharmacology/Professional Issues & Practice Management sequence. It builds on those courses by applying prior learning to the management of cases of psychotic disorders. It is offered in the same semester as the course in the treatment of Anxiety Disorders. Students will generally complete the Anxiety and Other Disorders courses either in their fourth or fifth semester in the program, after completion of courses in Affective and Psychotic Disorders. None of the courses in this rotation may be waived. Successful completion of this rotation completes the didactic sequence of the Psychopharmacology Postdoctoral Training Program, making the candidate eligible to participate in the qualifying examination and enroll in the Clinical Practicum Elective.

COURSE OBJECTIVES

Upon completion of these courses, the student will:

1. Understand the biological bases and pharmacological treatment of eating disorders.
2. Be able to describe the various forms of dementia and their medication management.
3. Have a basic knowledge of the pharmacological treatment of chronic pain.
4. Develop a basic understanding of drug therapy for several sleep disorders.
5. Know the most common forms of treatment with medication for childhood disorders.
6. Understand general issues in the medication management of childhood disorders.
7. Have a better sense of drug therapy for various substance-related disorders.
8. Develop a basic understanding of how medication is used for the treatment of various personality disorders.

In achieving each of these objectives, issues of lifespan development, gender, and ethnic diversity will be integrated.

FACULTY AND STAFF

Course Instructor

Bret A. Moore, Psy.D., ABPP
25822 Coronado Ridge
San Antonio, TX 78260
Telephone: 713-823-2869
Primary Email: bamoore@student.fdu.edu

Bret A. Moore is a board certified clinical psychologist and prescribing psychologist in San Antonio, Texas, Adjoint Associate Professor of Psychiatry at the University of Texas Health Science Center at San Antonio, and Adjunct Faculty at Adler University in Chicago, Illinois. He is the author or editor of 13 books including *Pharmacotherapy for Psychologists: Prescribing and Collaborative Roles, Handbook of Clinical Psychopharmacology for Psychologists* and *Anxiety Disorders: A Guide for Integrating Psychopharmacology and Psychotherapy*, which he co-edited with Stephen Stahl. He is a freelance popular press writer and has published pieces in *Scientific American Mind, The New Republic*, and *Military Times* and on *Psych Central, Psychology Today*, and *Lifezette*. He is a CME Reviewer for the Neuroscience Education Institute, Series Editor of Clinical Topics in Psychology and Psychiatry for Routledge/Taylor & Francis Press, and member of the Wellness Committee at Boulder Crest Retreat, Bluemont, Virginia.

Dr. Moore is a former active-duty Army psychologist and two-tour veteran of Iraq. He is a recipient of the Arthur W. Melton Award for Early Career Achievement in Military Psychology from Division 19 of the American Psychological Association and the Early Career Achievement Award from Division 18, and is a Fellow of the American Psychological Association. His views and opinions on clinical psychology, military psychology, and psychopharmacology have been quoted in *USA Today*, the *New York Times*, *Boston Globe*, *National Geographic, TV Guide* and on NPR, the BBC, CNN, CBS News, Fox News and the CBC.

Presenters

Module 1: Substance-Related Disorders **– W. Klugh Kennedy, Pharm.D.**
Module 2: Personality Disorders **– W. Klugh Kennedy, Pharm.D.**
Module 3: Sleep Disorders **–W. Klugh Kennedy, Pharm.D.**
Module 4: Cognitive Disorders **–W. Klugh Kennedy, Pharm.D.**
Module 5: Childhood/Adolescent Disorders**–Laura G Leahy, RN, APN**
Module 6 & 7: Eating Disorders and Pain Disorders-**Instructor**

Ms. Leahy received her B.S. in Psychology & Human Development from Duke University in 1987 and her B.S.N. (1989) and M.S.N. (1991) in Child and Family Psychiatric Mental Health Nursing from the University of Pennsylvania. She is presently working on her DrNP at Drexel University and has

completed all but her dissertation. Ms. Leahy has also been certified as a Master Psychopharmacologist through Stephen Stahl's Neuroscience Educational Institute. Laura has taught Advanced Psychopharmacology across the Lifespan at the University of Pennsylvania's School of Nursing for the past ten years. She was also involved as a clinical instructor for the inaugural Post-Doctoral Psychopharmacology Program at Fairleigh Dickinson University. Presently, Ms. Leahy maintains a private outpatient practice, specializing in Treatment Resistance symptoms and Psychopharmacology. She has been prescribing and providing psychotherapy services as a Family Psychiatric Nurse Practitioner for over 23 years. She was the co-founder of Center for Family Guidance, the largest privately held psychiatric mental health organization in New Jersey.

Ms. Leahy has (May 2013) published *The Manual of Clinical Psychopharmacology for Nurses* through the American Psychiatric Association and had previously published *Pocket Psych Drugs* (2010) through F.A. Davis. She presents extensively on the local, state and national levels on various topics related to psychopharmacology, pharmacogenetics, child & adolescent psychiatric disorders & pharmacological treatments as well as women's mental health, among other areas of psychiatry and mental health.

24/7 Technical Support

FDUTechnicalAssistanceCenter (UTAC)
Phone: 973-443-8822
E-mail: fdutac@fdu.edu

STUDENT EVALUATION

Two online exams = 200 points
Written Case Presentation = 100 points
Participation in weekly chats = 30 points
Total Possible Points = 330

PASSING GRADE

To be assured of satisfactory completion of this course applicable to progression to the next term, **the student must achieve a score of 70% or better of the total points available. A grade of less than 69% represents failure of the course.**

CONTINUING PROFESSIONAL EDUCATION CREDITS

Fairleigh Dickinson University School of Psychology is approved by the American Psychological Association to offer continuing education for psychologists. The School of Psychology maintains responsibility for the program. With a student participation rate of at least 80%, PSYC7955 is approved for 48 continuing professional education credits for psychologists. One weekend Regional Interaction Session occurs each semester; 10.5 hours for this experience is credited to each 7.5-week course completed during the semester: 3.5 for preparation of a clinical case study and 7 for the session.

# Hours	Activity
25	Readings/videos

5	Chats
8	Exams
7	Case presentation

TEXTBOOKS

Required

1. Stahl, S. M. (2013). *Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications* (4th ed). New York: Cambridge University Press. ISBN: 978-1107686465.
2. Stein, D., Lerer, B. & Stahl, S. M. (2012). *Essential Evidence-Based Psychopharmacology* (2nd ed). New York: Cambridge University Press. ISBN: 978-1107400108.
3. Reis de Oliveira, Schwartz, T. & Stahl, S. M. (2013). *Integrating Psychotherapy and Psychopharmacology: A Handbook for Clinicians.* New York: Roultedge Press. ISBN: 978-0415838573.
4. Stahl, S. M. (2011). Case Studies: Stahl's Essential Psychopharmacology. New York: Cambridge University Press. ISBN: 0521182085.

DIRECTED STUDY QUESTIONS

The instructor for this course has decided to make completion of the Directed Study Questions voluntary and not required to be submitted to the instructor. Although these questions will be voluntary, exam questions may be developed from these questions and should be used as a study guide for the exams.

If you choose to complete the DSQs, please remember they are intended to be SHORT answer questions. When you are asked to generate a list, you do not need more than 1-2 sentences for each item in the list. When the question is open-ended, you never need to provide more than 1-2 paragraphs of information.

COURSE SCHEDULE

WEEK	MODULE	ACTIVITY
1: 6/24 - 6/29	1: Substance-Related Disorders	**Video:1** Module 1 **Readings:** Essential Evidence-Based Psychopharmacology-Chapters 11 & 12
2: 6/30 -7/6	2: Personality Disorders	**Video:** Module 2 **Readings:** Essential Evidence-Based Psychopharmacology-Chapter 14
3: 7/7-7/13	3: Sleep Disorders	**Video:** Module 3 **Readings:** Essential Psychopharmacology-Chapter 11 Integrating Psychotherapy and Psychopharmacology-Chapter 9
4: 7/14-7/20	4: Cognitive Disorders	**Video:** Module 4 **Readings:** Essential Psychopharmacology-Chapter 13 Essential Evidence-Based Psychopharmacology-Chapter 13 **Exam 1 (Weeks 1-4):** Posted 7/15, due 7/20
5: 7/21-7/27	5a: Childhood/Adolescent Disorders	**Video:** Module 5a **Readings:** Magellan Health AACAP Practice Parameters
6: 7/28-8/3	5b: Childhood/Adolescent Disorders	**Video:** Module 5b **Readings** Essential Evidence-Based Psychopharmacology-Chapter 1 AACAP Schizophrenia

WEEK	MODULE	ACTIVITY
7: 8/4-8/10	6: Eating Disorders	**Readings:** Essential Evidence-Based Psychopharmacology-Chapter 10 Integrating Psychotherapy and Psychopharmacology-Chapter 7 **Case Presentation:** Submit to instructor by 8/9 **Exam 2 (Weeks 5-8):** Posted 8/5, due 8/12
8: 8/11-8/14*	7: Pain Disorders	**Readings:** Essential Psychopharmacology-Chapter 10

*Note this cell represent deviations from the standard week format.

CASE PRESENTATION FORMAT

Identification Data:
Chief Complaint (CC):
History of Present Illness (PMI):
Past Psychiatric History
Past Medical History (PMH):
Past Surgical History (PSH):
Family History (FH):
Social History:
Medications:
Allergies:list reaction

Review of Systems (ROS):

General
Skin
Head
Ears
Eyes
Nose, Sinuses
Mouth, Throat, Neck
Breasts
Respiratory
Cardiac
Gastrointestinal
Urinary
Genital
Peripheral Vascular
Musculoskeletal
Neurologic
Hematologic
Endocrine
Psychiatric

Physical Exam (PE):

Vital Signs
General Survey
Skin
Head, Ears, Eyes, Nose, Throat (HEENT)
Neck
Breasts
Heart
Lungs
Abdomen
Genitourinary

Rectal
Musculoskeletal
Vascular
Lymphatic
Neurologic

Psychological Assessment Findings:
Intellectual/Cognitive Evaluation:
Psychological/Psychosocial Evaluation:

Labs:
Assessment:
DSM Diagnosis:
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

Plan:
Additional Tests:
Medication Plan (include initial recommendation, monitoring plan, reasonable obstacles to treatment and plan for addressing those obstacles)
Psychotherapy Plan (include modality, monitoring plan, expected course of treatment)
Additional Recommendations (e.g., OT, other medical interventions, case management)

CASE PRESENTATION EVALUATION

Criterion	Points
Written Report	**40**
Formulation and documentation of history, symptoms, review of systems, etc.	**20**
Impressions and rationales	**20**
Recommendations and rationales	**20**
TOTAL	**100**

It is expected that the subject of your Case Presentation will demonstrate one of the disorders to be discussed during the course of this semester (an Anxiety Disorder or Other). You need not administer the examinations involved in this report, just have access to the results. If need be, you can generate mock test data appropriate to the case to complete sections of the report, but the inclusion of actual data is considered desirable. Given this requirement, ***it is strongly recommended you start looking for an appropriate case early in the semester.***

Given your current progress in the program, this report is intended to demonstrate your competence at adopting an integrated biopsychosocial approach to understanding the patient. This requires not only a complete review of each of the domains potentially contributing to this individual's pathology, as well as a treatment plan that demonstrates sensitivity to each of those domains.

You are welcome and even encouraged to present your case during the weekly chats for group discussion. Most students enjoy this experience far more that a pure paper exercise.

If you have additional questions about the structure of the Case Presentation, please raise them as early as possible with your instructor.

MODULE 1: Substance-Related Disorders

EXPERT PRESENTER

W. Klugh Kennedy, PharmD., BCPP

TIME FRAME

Week 1

LEARNING OBJECTIVES

1. To provide an understanding of the role of drug therapy in the treatment of substance, addiction, withdrawal, and recovery.

READING ASSIGNMENTS

Essential Evidence-Based Psychopharmacology-Chapters 11 & 12

DIRECTED STUDY QUESTIONS

1. Compare and contrast the withdrawal symptoms of opiate withdrawal, cocaine withdrawal, and alcohol withdrawal.
2. Compare and contrast the symptoms of opiate intoxication, cocaine intoxication and alcohol intoxication, synthetic cannabinoid intoxication vs marijuana intoxication, stimulant hallucinogens (LSD, DMT, Nbom, 2cb, MDMA, etc), Ketamine, Cathinones,ibogaine, etc.
3. List the drugs useful in withdrawal and continued abstinence for opiates vs. alcohol.
4. Compare and contrastMethadone and Suboxone and the existence of maintenance programs vs detoxification.

VIDEO LECTURE OUTLINES

See Appendix 1

MODULE 2: Personality Disorders

EXPERT PRESENTER

W. Klugh Kennedy, PharmD., BCPP

TIME FRAME

Week 3

LEARNING OBJECTIVES

To discuss the role of drug therapy in the treatment of the various personality disorders.

READING ASSIGNMENTS

Essential Evidence-Based Psychopharmacology-Chapter 14

DIRECTED STUDY QUESTIONS

None

VIDEO LECTURE OUTLINE

See Appendix 2

MODULE 3: Sleep Disorders

EXPERT PRESENTER

W. Klugh Kennedy, PharmD.

TIME FRAME

Week 3

LEARNING OBJECTIVES

1. To understand the sleep cycle.
2. To understand insomnia.
3. To understand the treatment of insomnia.
4. To discuss drug therapy for sleep disorders.

READING ASSIGNMENT

Essential Psychopharmacology-Chapter 11
Integrating Psychotherapy and Psychopharmacology-Chapter 9

DIRECTED STUDY QUESTIONS

1. Discuss the etiologies for sleep disorders.
2. Compare and contrast acute and chronic sleep disorders.
3. List medications that may cause insomnia.
4. Discuss sleep hygiene.
5. List agents used to treat insomnia. List reasons for using or not using different medications.
6. Compare and contrast the various benzodiazepines used for insomnia.
7. List treatments for narcolepsy.

VIDEO LECTURE OUTLINE

See Appendix 3

MODULE 4: Cognitive Disorders

EXPERT PRESENTER

W. Klugh Kennedy, PharmD., BCPP

TIME FRAME

Week 4

LEARNING OBJECTIVES

1. Review types and causes of dementia.
2. Understand consequences of dementia.
3. Understand drug therapy for dementia.

READING ASSIGNMENT

Required
Essential Psychopharmacology-Chapter 13
Essential Evidence-Based Psychopharmacology-Chapter 13

DIRECTED STUDY QUESTIONS

1. List the drugs and their mechanisms of action used to slow the progression of Alzheimer's type dementia.
2. Compare and contrast types of dementia and discuss the role of drug therapy in the management of the primary disease and the psychiatric complications such as agitation

VIDEO LECTURE OUTLINE

See Appendix 4

MODULE 5: Childhood/Adolescent Disorders

EXPERT PRESENTER

Laura Leahy, RN, APN

TIME FRAME

Weeks 5-6

LEARNING OBJECTIVES

1. Identify concerns associated with the use of psychotropic medications in children.
2. Describe the mechanism of action and side effects of drugs used in the treatment of ADHD.
3. Describe the drugs and their mechanisms and side effects used in the treatment of OCD in children.
4. Describe the use of psychotropic employed in the treatment of general anxiety disorder in children.
5. Describe the pharmacological treatment of other child psychiatric disorders.

READING ASSIGNMENT

Magellan Health
AACAP Practice Parameters
Essential Evidence-Based Psychopharmacology-Chapter 1
AACAP Schizophrenia

DIRECTED STUDY QUESTIONS

1. Compare and contrast the drugs used to treat ADHD
2. Describe the concerns related to the adverse effects of psychotropic drugs in children.

VIDEO LECTURE OUTLINE

See Appendix 5

MODULE 6: Eating Disorders

EXPERT PRESENTER

Instructor

TIME FRAME

Weeks 7

LEARNING OBJECTIVES

1. Describe the various eating disorders and associated physical and psychological effects.
2. Describe the psychopharmacological and combined treatments for eating disorders.

READING ASSIGNMENT

Required
Essential Psychopharmacology-Chapter 13
Essential Evidence-Based Psychopharmacology-Chapter 13

DIRECTED STUDY QUESTIONS

None

VIDEO LECTURE OUTLINE

Not applicable

MODULE 7: Pain Disorders

EXPERT PRESENTER

Instructor

TIME FRAME

Week 8

LEARNING OBJECTIVES

1. Describe the various chronic pain disorders and associated physical and psychological effects.
2. Describe the psychopharmacological treatments for pain disorders.

READING ASSIGNMENT

Required
Essential Psychopharmacology-Chapter 13
Essential Evidence-Based Psychopharmacology-Chapter 13

DIRECTED STUDY QUESTIONS

None

VIDEO LECTURE OUTLINE

Not applicable

Appendix G

State of Louisiana

Medical Psychology Practice Act

Medical Psychology Practice Act

§1360.51. Short title

This Part may be cited as the "Medical Psychology Practice Act".

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.52. Definitions

As used in this Part the following words, terms, and phrases have the meaning ascribed to them in this Section, unless the context clearly indicates a different meaning:

(1) "Board" means the Louisiana State Board of Medical Examiners as established in R.S. 37:1263.

(2) "Drug" means the same as the term "drug" as defined in R.S. 40:961(16), including controlled substances except narcotics, but shall be limited only to those agents related to the diagnosis and treatment or management of mental, nervous, emotional, behavioral, substance abuse, or cognitive disorders. Nothing in this Part shall be construed to permit a medical psychologist to administer or prescribe a narcotic.

(3) "LAMP" means the Louisiana Academy of Medical Psychologists.

(4) "LSBEP" means the Louisiana State Board of Examiners of Psychologists.

(5) "Medical psychologist" or "MP" means a psychological practitioner who has undergone specialized training in clinical psychopharmacology and has passed a national proficiency examination in psychopharmacology approved by the board. Such practice specifically includes the authority to administer, prescribe, and distribute without charge, drugs as defined in this Part.

(6) "Medical Psychology Advisory Committee" means a committee, established by the board for purposes as defined in this Part.

(7) "Medical psychology" means that profession of the health sciences which deals with the examination, diagnosis, psychological, pharmacologic and other somatic treatment and/or management of mental, nervous, emotional, behavioral, substance abuse, or cognitive disorders, and specifically includes the authority to administer, distribute without charge and/or prescribe drugs as defined in this Part. In addition, the practice of medical psychology includes those practices defined in R.S. 37:2352(5).

(8) "Mental, nervous, emotional, behavioral, substance abuse and cognitive disorders" means those disorders, illnesses, or diseases listed in either the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or the mental, nervous, emotional, behavioral, substance abuse, and cognitive disorders listed in the International Classification of Diseases published by the World Health Organization.

(9) "Narcotics" means those natural or synthetic opioid analgesics, and their derivatives used to relieve pain.

(10) "Nurse" for the purpose of this Part means a licensed practical nurse or a registered nurse.

(11) "Physician" means an individual licensed by the board to engage in the practice of medicine in the state of Louisiana.

Acts 2009, No. 251, §11, eff. July 1 2009.

§1360.53. Powers and duties of the board

The board shall have and exercise with respect to medical psychologists, all powers and duties granted to it by R.S. 37:1261 et seq., relative to physicians. In addition, the board shall have the authority to:

(1) Establish and publish standards of medical psychology practice in accordance with those developed and accepted by the profession.

(2) Approve, deny, revoke, suspend, renew and reinstate licensure or certification of duly qualified applicants.

(3) Adopt, promulgate, revise, and enforce orders, rules, and regulations for initial licensure, renewal and certificates of advanced practice as the board may deem necessary to ensure the competency of applicants, the protection of the public and proper administration of this Part in accordance with the Administrative Procedure Act.

(4) Conduct hearings on charges calling for the denial, suspension, revocation, or refusal to renew a license or certificate.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.54. License required

No one shall engage in the practice of medical psychology, or hold himself out as a medical psychologist in this state unless licensed in accordance with the provisions of this Part.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.55. Qualifications of applicants

A. Notwithstanding any other provision of this Part or other law, on or before January 1, 2010, any medical psychologist shall be issued a medical psychology license by the board upon satisfaction of all of the following criteria:

(1) Holds a current and unrestricted license in good standing to practice psychology issued by the Louisiana State Board of Examiners of Psychologists.

(2) Holds a current and unrestricted certificate of prescriptive authority issued by the Louisiana State Board of Examiners of Psychologists.

(3) Holds a controlled and dangerous substance permit issued by the Louisiana Board of Pharmacy.

(4) Holds a controlled substance registration issued by the United States Drug Enforcement Administration.

B. After January 1, 2010, the board shall issue a medical psychology license to applicants who submit an application upon a form and in such a manner as the board prescribes and who furnish evidence to the board which meets all of the following criteria:

(1) Holds a current and unrestricted license in good standing to practice psychology issued by the Louisiana State Board of Examiners of Psychologists.

(2) Has successfully graduated with a post-doctoral master's degree in clinical psychopharmacology from a regionally accredited institution or has completed equivalent training to the post-doctoral master's degree approved by the board. The curriculum shall include instruction in anatomy and physiology, biochemistry, neurosciences, pharmacology, psychopharmacology, clinical medicine/pathophysiology, and health assessment, including relevant physical and laboratory assessment.

(3) Has passed a national exam in psychopharmacology approved by the board.

C. Medical psychologists licensed by the board shall be eligible for a controlled and dangerous substance permit and registration issued by the state and the United States Drug Enforcement Agency.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.56. Consultation and collaboration for medical psychologists without a certificate of advanced practice

A. Medical psychologists shall prescribe only in consultation and collaboration with the patient's primary or attending physician, and with the concurrence of that physician.

B. The medical psychologist shall also re-consult with the patient's physician prior to making changes in the patient's medication treatment protocol, as established with the physician, or as otherwise directed by the physician. The medical psychologist and the physician shall document the consultation in the patient's medical record.

C. In the event a patient does not have a primary or attending physician, the medical psychologist shall not prescribe for that patient.

D. The board shall promulgate rules relating to how the consultation and collaboration shall be affected in consultation with the Medical Psychology Advisory Committee.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.57. Certificate of advanced practice

Medical psychologists who satisfy the requirements specified by R.S. 37:1360.55(A) of this Part and who possess all of the following additional qualifications to the satisfaction of the board shall be issued a certificate of advanced practice:

(1) Three years of experience practicing as a medical psychologist. For those individuals licensed under R.S. 37:1360.55(A), such experience shall be deemed to have commenced with the issuance of the original certificate of prescriptive authority issued by the Louisiana State Board of Examiners of Psychologists.

(2) Treatment of a minimum of one hundred patients including twenty-five or more involving the use of major psychotropics and twenty-five or more involving the use of major antidepressants which demonstrate the competence of the medical psychologist.

(3) The recommendation of two collaborating physicians, each of whom holds an unconditional license to practice medicine in Louisiana, and who are each familiar with the applicant's competence to practice medical psychology.

(4) The recommendation of the Medical Psychology Advisory Committee.

(5) The completion of a minimum of one hundred hours of continuing medical education relating to the use of medications in the management of patients with psychiatric illness commencing with the issuance of a certificate of prescriptive authority by the Louisiana State Board of Examiners of Psychologists prior to January 1, 2010, or by the board after this date.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.58. Issuance and renewal of license

A. The board shall issue a license or certificate to any person who meets the qualifications provided for in this Part and the rules and regulations of the board, and who pays the respective fees fixed by the board.

B. A license or certificate issued under the provisions of this Part shall be subject to annual renewal and shall expire and become null and void unless renewed in the manner prescribed by the board.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.59. Designation of license

A. A license or certificate issued under this Part shall designate the licensee's status with respect to advanced practice.

B. Any individual who is issued a license as a medical psychologist under the provisions of this Part may use the words "medical psychologist" or "psychologist" or may use the letters "MP" in connection with his name to denote licensure.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.60. Reinstatement of license

A. Any license or certificate suspended, revoked, or otherwise restricted by the board may be reinstated by the board.

B. A license or certificate that has expired without renewal may be reinstated by the board for a period of two years from the date of expiration, provided the applicant is otherwise eligible under the provisions of this Part, pays the applicable fees, and satisfies the continuing education and such other requirements as may be established by the board.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.61. Standards of practice for medical psychologists

A. Medical psychologists shall be authorized to administer and prescribe only drugs recognized and customarily used for the management of mental, nervous, emotional, behavioral, substance abuse, and cognitive diseases or disorders.

B. Standards for the treatment or management of common complications of the drug therapy provided by medical psychologists will be set forth in rules and regulations which shall be promulgated and adopted by the board, in consultation with the Medical Psychology Advisory Committee, in accordance with the Administrative Procedure Act.

C. Medical psychologists may not order, administer, prescribe, or distribute narcotics, as defined in this Part.

D. Nothing in this Part shall be interpreted or construed as permitting a medical psychologist to pharmacologically treat patients for other primary medical conditions, unless specifically defined in and authorized by the board in such rules and regulations as might be necessary.

E. Practitioners licensed under this Part may order and interpret laboratory studies and other medical diagnostic procedures, as necessary for adequate pretreatment health screening, diagnosis of mental, nervous, emotional, behavioral, substance abuse, and cognitive disorders and treatment maintenance, including those necessary for the monitoring of potential side-effects associated with medications prescribed by the medical psychologist.

F. Medical psychologists shall maintain Basic Life Support certification.

G. Notwithstanding any law to the contrary, nothing in this Part shall prohibit or restrict medical psychologists, licensed under the provisions of this Part, from employing or otherwise utilizing psychological technicians or psychometricians to assist in the provision of non-medical psychological services.

(1) Psychological technicians or psychometricians shall be authorized to administer psychological tests and provide other technical, ancillary non-medical psychological services as specifically ordered by the medical psychologist.

(2) Psychological technicians or psychometricians shall minimally hold a bachelor's degree in psychology from an accredited college or university.

(3) Psychological technicians or psychometricians shall administer psychological tests or provide other technical,

ancillary non-medical psychological services only under the general supervision of the medical psychologist.

(4) The medical psychologist employing or otherwise utilizing the services of a psychological technician or psychometrician assumes the professional responsibility and liability for all services and actions undertaken by the psychological technician or psychometrician acting on behalf of the medical psychologist.

(5) The medical psychologist shall provide the board, in such manner and form as directed by the board, with the name and credentials of any psychological technician or psychometrician under his or her supervision.

(6) Psychological technicians or psychometrician in the employ or otherwise utilized by a medical psychologist under the provisions of this Part may provide other technical, ancillary non-medical psychological services as might be approved by the board.

(7) The board, in consultation with the Medical Psychology Advisory Committee, shall have the authority to promulgate such rules and regulations necessary to otherwise govern the activities of psychological technicians or psychometricians.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.62. Standards of practice for medical psychologists holding certificates of advanced practice

A. Patients receiving care from a medical psychologist who holds a certificate of advanced practice issued under this Part shall have an established primary, attending, or referring physician licensed by the board who shall be responsible for the patient's overall medical care.

B. The primary, attending, or referring physician shall evaluate the patient for medical conditions in accordance with customary practice standards, and as might be indicated based on the medications that the patient is receiving and/or risk factors that may be present. If the patient has been referred to a medical psychologist holding a certificate of advanced practice for the express purpose of evaluation and treatment to include drug management by the primary, attending, or referring physician, this condition shall be considered met.

C. The medical psychologist shall provide the primary, attending, or referring physician with a summary of the treatment planned at the initiation of treatment.

D. The medical psychologist shall provide the primary, attending, or referring physician with follow up reports as may be dictated by the patient's condition.

E. The medical psychologist shall provide the patient's primary, attending, or referring physician with a summary of the patient's condition and treatment no less than annually.

F. The requirements for Subsections C, D, and E of this Section shall be considered satisfied if the medical psychologist provides the physician with a copy of the initial examination and follow up visit records.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.63. Medical Psychology Advisory Committee

A. A Medical Psychology Advisory Committee shall be established by the board for the purpose of reviewing and recommending action on application for licensure, recommending educational requirements for other medical activities that may be provided by medical psychologists, recommending changes in related statutes and rules, as well as other activities as might be requested by the board.

B. The Medical Psychology Advisory Committee shall consist of the following five members selected by the board:

(1) One member shall be a physician who is certified by the American Board of Medical Specialties or the American Osteopathic Association equivalent in the specialty of psychiatry and who is licensed to practice medicine in this state selected from a list of names submitted by the Louisiana State Medical Society and who is recommended by the Louisiana Psychiatric Medical Association and the Louisiana Academy of Medical Psychologists.

(2) Four members shall be medical psychologists selected from a list of names recommended by the Louisiana Academy of Medical Psychologists.

C. The executive director of the board shall serve as an ex officio, non-voting member of the committee.

D. Members shall serve at the pleasure of the board. A vacancy in an unexpired term shall be filled in the manner of the original appointment.

E. The committee may meet as needed but shall meet at least twice a year. A majority of the members of the committee shall constitute a quorum for the transaction of all business.

F. Members of the committee shall serve without compensation but shall be reimbursed for travel expenses incurred in attendance at meetings and other official business on behalf of the committee or the board.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.64. Privileged communications

A. In judicial proceedings, whether civil, criminal, or juvenile, legislative and administrative proceedings, and proceedings preliminary and ancillary thereto, a patient or his legal representative, may refuse to disclose or prevent the disclosure of confidential information, including information contained in administrative records, communicated to a medical psychologist licensed under this Part, or persons reasonably believed by the patient to be so licensed, or to their employees or other persons under their supervision, for the purpose of diagnosis, evaluation, or treatment of any mental or emotional condition or disorder.

B. In the absence of evidence to the contrary, the medical psychologist is presumed to be authorized to claim the privilege on behalf of the patient.

C. This privilege may not be claimed by or on behalf of the patient in the following circumstances:

(1) Where child abuse, elder abuse, or the abuse of individuals with disabilities or incompetent individuals is known or reasonably suspected.

(2) Where the validity of a will of a deceased former patient is contested or his mental or emotional condition is at issue otherwise on judicial or administrative proceedings.

(3) Where the information is necessary for the defense of the medical psychologist in a malpractice action brought by the patient.

(4) Where an immediate threat of physical violence against a clearly identified victim or victims is disclosed to the medical psychologist.

(5) In the context of civil commitment proceedings, where an immediate threat of self-inflicted damage is disclosed to the medical psychologist.

(6) Where the patient puts his mental state in issue by alleging mental or emotional damages or condition in any judicial or administrative proceedings.

(7) Where the patient is examined pursuant to court order.

(8) Where the board is conducting an investigation or hearing.

Acts 2009, No. 251, §11, eff. July 1, 2009; Acts 2014, No. 811, §19, eff. June 23, 2014.

§1360.65. Continuing medical education

A. Medical psychologists shall annually complete a minimum of twenty hours of approved continuing medical education relevant to the practice of medical psychology.

B. Approved sponsors of continuing medical education for practitioners licensed under this Part shall include, the Louisiana Academy of Medical Psychologists, the Louisiana State Medical Society, sponsors accredited by the Accreditation Council for Continuing Medical Education approved to offer Category 1 educational activities, and other sponsors as may be approved by the board.

C. A minimum of twenty-five percent of a medical psychologist's continuing medical education shall be provided by the Louisiana Academy of Medical Psychology.

D. In addition to meeting the requirements for continuing medical education, as required in Subsection A of this Section, medical psychologists shall annually complete a minimum of fifteen hours of continuing education in psychology. Approved sponsors for this additional requirement shall include the Louisiana Psychological Association, the American Psychological Association, and other sponsors as may be approved by the board.

E. A minimum of two of the required hours of continuing medical education or additional continuing education, as set forth in this Section, shall specifically involve ethics, as relevant to the practice of medical psychology.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.66. Fees

The board, under its authority established in R.S. 37:1281, shall fix fees for the purpose of administering the provisions of this Part.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.67. Causes for refusal to issue, suspension or revocation of licenses, permits, and certificates

A. The board may refuse to issue, or may suspend or revoke any license or certificate, or impose probationary or other

restrictions on any license or certificate issued under this Part for the following causes:

(1) Conviction of a felony.

(2) Conviction of any crime or offense arising out of or relating to the practice of medical psychology.

(3) Fraud, deceit, or perjury in obtaining a diploma or certificate.

(4) Fraud or deception in applying for or procuring a license to practice psychology or medical psychology.

(5) Making any fraudulent or untrue statement to the board.

(6) Refusal to appear before the board after having been ordered to do so in writing by a duly authorized agent of the board.

(7) Habitual or recurring abuse of drugs, including alcohol, which affect the central nervous system and which are capable of inducing physiological or psychological dependence.

(8) Refusing to submit to the examinations and inquiry of an examining committee of physicians appointed or designated by the board to inquire into an applicant or licensee's physical and mental fitness and ability to practice medical psychology with reasonable skill and safety to patients.

(9) Prescribing, dispensing, or administering legally controlled substances or any dependency-inducing medication without legitimate medical justification therefore or in other than a legal or legitimate manner.

(10) Impersonation of another licensed practitioner.

(11) Incompetence.

(12) Voluntary or involuntary commitment or interdiction by due process of law.

(13) Failure to self-report in writing to the board any personal action which constitutes a violation of this Part within thirty days of the occurrence.

(14) Solicitation of patients or self-promotion through advertising or communication, public or private, which is fraudulent, false, deceptive, or misleading.

(15) Making or submitting false, deceptive, or unfounded claims, reports, or opinions to any patient, insurance company or indemnity association, company, individual, or governmental authority for the purpose of obtaining any thing of economic value.

(16) Soliciting, accepting, or receiving any thing of economic value in return for and based on the referral of patients to another person, firm, or corporation or in return for the prescription of medications.

(17) Unprofessional conduct.

(18) Continuing or recurring practice which fails to satisfy the prevailing and usually accepted standards of medical psychology practice in this state.

(19) Gross, willful, and continued overcharging for professional services.

(20) Abandonment of a patient.

(21) Knowingly performing any act which, in any way, assists an unqualified person to practice medical psychology, or having professional connection with or lending one's name to an illegal practitioner.

(22) Inability to practice medical psychology with reasonable skill or safety to patients because of mental illness or deficiency; physical illness, including but not limited to deterioration through the aging process or loss of motor skills; or excessive use or abuse of drugs, including alcohol.

(23) Violation of ethical principles and codes of conduct as promulgated by the American Psychological Association or violation of any code of ethics adopted in the rules and regulations of the board or other immoral, unprofessional, or dishonorable conduct as defined in the rules and regulations of the board.

(24) Practicing medical psychology in such a manner as to endanger the welfare of patients, including but not limited to:

(a) Harassment, intimidation, or abuse, sexual or otherwise, of a patient.

(b) Engaging in sexual intercourse or other sexual contact with a patient.

(c) Gross malpractice, repeated malpractice, or gross negligence in the practice of medical psychology.

(25) Use of repeated untruthful, deceptive, or improbable statements concerning the licensee's qualifications or the effects or results of proposed treatment, including functioning

outside of one's professional competence established by education, training, and experience.

(26) Exercising undue influence in such a manner as to exploit the patient for financial or other personal advantage to the practitioner or a third party.

(27) Refusal of a licensing authority of another state to issue or renew a license, permit, or certificate to practice psychology or medical psychology in that state or the revocation, suspension, or other restriction imposed on a license, permit, or certificate issued by such licensing authority which prevents or restricts practice in that state, or the surrender of a license, permit, or certificate issued by another state when criminal or administrative charges are pending or threatened against the holder of such license, permit, or certificate.

(28) Violation of any rules and regulations of the board, or any provisions of this Part.

B. The board may, as a probationary condition, or as a condition of the reinstatement of any license or certificate suspended or revoked hereunder, require the license or certificate holder to pay all costs of the board proceedings, including investigator, stenographer, and attorney fees, and to pay a fine not to exceed five thousand dollars.

C. Any license or certificate suspended, revoked, or otherwise restricted by the board may be reinstated by the board.

D. The board's final decision in an adjudication proceeding conducted pursuant to this Section, other than by consent order, agreement, or other informal disposition, shall constitute a public record, and the board may disclose and provide such final decision to any person, firm, or corporation, or to the public generally. The board's disposition of an adjudication proceeding by consent order shall not constitute a public record, but the board shall have authority and discretion to disclose such disposition.

E. No judicial order staying or enjoining the effectiveness or enforcement of a final decision or order of the board in an adjudication proceeding, whether issued pursuant to R.S. 49:964(C) or otherwise, shall be effective, or be issued to be effective, beyond the earlier of either:

(1) One hundred twenty days from the date on which the board's decision or order was rendered.

(2) The date on which a court of competent jurisdiction enters judgment in a proceeding for judicial review of the board's decision or order issued pursuant to R.S. 49:964.

F. Notwithstanding any other law to the contrary, no judicial order staying, enjoining, or continuing an adjudication proceeding before, or a preliminary, procedural, or intermediate decision, ruling, order, or action of, the board shall be effective or issued to be effective, whether pursuant to R.S. 49:964 or otherwise, prior to the exhaustion of all administrative remedies and issuance of a final decision or order by the board.

G. No order staying or enjoining a final decision or order of the board shall be issued unless the district court finds that the applicant or petitioner has established that the issuance of the stay does neither of the following:

(1) Threaten harm to other interested parties, including individuals for whom the applicant or petitioner may render medical psychology services.

(2) Constitute a threat to the health, safety, and welfare of the citizens of this state.

H. No stay of a final decision or order of the board shall be granted ex parte. The court shall schedule a hearing on a request for a stay order within ten days from filing of the request. The court's decision to either grant or deny the stay order shall be rendered within five days after the conclusion of the hearing.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.68. Persons and practices not affected

Nothing in this Part shall be construed as preventing or restricting the practice, services, or activities of any individual:

(1) Licensed in this state by any other law from engaging in the profession or occupation for which he is licensed.

(2) Employed as a medical psychologist by the United States government in the event the individual practices solely under the direction or control of a United States governmental agency by which he is employed.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.69. Orders to nurses

Notwithstanding any law or rule or regulation to the contrary, including but not limited to Chapter 11 of this Title, it shall be considered to be within the scope of the practice of nursing as defined in Chapter 11 of this Title for a registered nurse, licensed practical nurse, and any other health care provider licensed under Chapter 11 of this Title to execute and

effectuate any order or direction otherwise within the scope of the practice of said health care provider when that order is within the scope of practice of medical psychology and given to him by a medical psychologist licensed under Part VI of Chapter 15 of this Title, and, when given in an institutional setting, the order is within the scope of the privileges granted to the medical psychologist by that institution.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.70. Injunction; penalty; attorney fees; costs

A. The board, through its president or the president's designee, may cause to issue in any competent court, a writ of injunction enjoining any person from practicing medical psychology in this state as defined herein until such person obtains a license under the provisions of this Part. This injunction shall not be subject to being released upon bond.

B. In the suit for an injunction, the board, through its president or designee, may demand of the defendant a penalty of not more than five hundred dollars, and attorney fees, in addition to court costs. This judgment for penalty, attorney fees, and court costs may be rendered in the same judgment in which the injunction is made absolute.

C. The trial of the proceeding by injunction shall be summary and by the judge without a jury.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.71. Penalties

A. It shall be a misdemeanor for any individual:

(1) Not licensed under this Part to represent himself as a medical psychologist.

(2) Not licensed under this Part to engage in the practice of medical psychology.

(3) To represent himself as a medical psychologist during the time that his license as a medical psychologist shall be suspended or revoked or lapsed.

(4) To otherwise violate the provisions of this Part.

B. Such misdemeanor shall be punishable upon conviction by imprisonment for not more than six months, or by a fine of not less than one hundred dollars nor more than five hundred dollars, or both. Each violation shall be deemed a separate offense.

C. Such misdemeanor shall be prosecuted by the district attorney of the judicial district in which the offense was committed in the name of the people of the state of Louisiana.

Acts 2009, No. 251, §11, eff. July 1, 2009.

§1360.72. Transfer of files

The Louisiana State Board of Examiners of Psychologists shall provide the board with copies of all files relating to medical psychologists.

Acts 2009, No. 251, §11, eff. July 1, 2009.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XLV. Medical Professions

Subpart 1. General

Subchapter M. Medical Psychologists Fees

§231. Scope of Subchapter

A. The rules of this Subchapter prescribe the fees and costs applicable to licensing and certification of medical psychologists.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270 and 37:1281; 37:1360.66.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:888 (March 2011).

§233. Licenses, Certificates, Permits

A. For processing an application for licensure as a medical psychologist, a fee of $250 shall be payable to the board.

B. For processing an application for certification of the advanced practice of medical psychology, a fee of $150 shall be payable to the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1281, 37:1360.66.

HISTORICAL NOTE: Promulgated by the Department of Health Hospitals, Board of Medical Examiners, LR 37:888 (March 2011).

§235. Annual Renewal

A. For processing a medical psychologist's annual renewal of license, a fee of $200 shall be payable to the board.

B. For processing a medical psychologist's annual renewal of a certificate of advanced practice, a fee of $100 shall be payable to the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1281, 37:1360.66.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:888 (March 2011).

TITLE 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XLV. Medical Professions

Subpart 2. Licensure and Certification

Chapter 39. Medical Psychologists

Subchapter A. General Provisions

§3901. Scope of Chapter and Definitions

A. The rules of this Chapter govern the licensing and certification of medical psychologists in the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:888 (March 2011).

§3903. Definitions

A. As used in this Chapter, the following terms and phrases shall have the meanings specified.

Applicant—an individual who has applied to the board for a license as a medical psychologist or a certificate of advanced practice.

Approved—as applied to an examination, school, college, university, institution, organization, program, curriculum, course of study or continuing professional education, shall mean affirmatively recognized and sanctioned by the board in accordance with this Chapter.

Board—the Louisiana State Board of Medical Examiners, as constituted in R.S. 37:1263.

Bona-Fide Medication Sample—a medication, other than a controlled substance, packaged by the original manufacturer thereof in such quantity as does not exceed a reasonable therapeutic dosage and provided at no cost to a medical psychologist for administration or distribution to a patient at no cost to the patient.

Certificate of Advanced Practice or *Certificate* or *Certification*—the board's official recognition of a medical psychologist's lawful authority to engage in advanced practice of medical psychology as provided by R.S. 37:1360.57 and Subpart 3 of these rules.

Collaborating Physician—a physician who consults and/or collaborates with a medical psychologist.

Concurrence or Concur—a physician's agreement to a plan for psychopharmacological management of a patient based on prior discussion with a medical psychologist.

Consultation and Collaboration with a MP or *Consult* and/or *Collaborate*—that practice in which a physician discusses and, if deemed appropriate, concurs in a medical psychologist's plan for psychopharmacologic management of a patient for whom the physician is the primary or attending physician.

Controlled Substance—any substance defined, enumerated, or included in federal or state statute or regulations 21 C.F.R. 1308.11-.15 or R.S. 40:964, or any substance which may hereafter be designated as a controlled substance by amendment or supplementation of such regulations or statute.

Discussion—a communication between a physician and a medical psychologist conducted in person, by telephone, in writing or by some other appropriate means.

Drug—shall mean the same as the term "drug" as defined in R.S. 40:961(16), including controlled substances except narcotics, but shall be limited to only those agents related to the diagnosis and treatment or management of mental, nervous, emotional, behavioral, substance abuse or cognitive disorders.

Good Moral Character—as applied to an applicant, means that:

a. the applicant has not, prior to or during the pendency of an application to the board, been guilty of any act, omission, condition, or circumstance which would provide legal cause under R.S. 37:1360.67 for the suspension or revocation of a license or certificate;

b. the applicant has not, prior to or in connection with the application, made any representation to the board, knowingly or unknowingly, which is in fact false or misleading as to a material fact or omits to state any fact or matter that is material to the application; or

c. the applicant has not made any representation or failed to make a representation or engaged in any act or omission which is false, deceptive, fraudulent, or misleading in achieving or obtaining any of the qualifications for a license or certificate required by this Chapter.

LAMP—the Louisiana Academy of Medical Psychologists.

LSBEP—the Louisiana State Board of Examiners of Psychologists, as constituted in R.S. 37:2353.

Medication—is synonymous with *drug*, as defined herein.

Medical Psychologist or *MP*—a psychological practitioner who has undergone specialized training in clinical psychopharmacology and has passed a national proficiency examination in psychopharmacology approved by the board. Such practice includes the authority to administer and prescribe drugs and distribute *bona-fide* medication samples, as defined in this Section.

Medical Psychology—that profession of the health sciences which deals with the examination, diagnosis, psychological, pharmacologic and other somatic treatment and/or management of mental, nervous, emotional, behavioral, substance abuse or cognitive disorders, and specifically includes the authority to administer, and prescribe drugs and distribute *bona-fide* medication samples as defined in this Section. In addition, the practice of medical psychology includes those practices as defined in R.S. 37:2352(5).

Medical Psychology Advisory Committee or *Committee*—a committee to the board constituted under R.S. 37:1360.63.

Medical Psychology Practice Act or MP Act—Acts 2009, No. 251, R.S. 37:1360.51-1360.72.

Mental, Nervous, Emotional, Behavorial, Substance Abuse and Cognitive Disorders—those disorders, illnesses or diseases listed in either the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or the mental, nervous, emotional, behavioral, substance abuse and cognitive disorders listed in the International Classification of Diseases published by the World Health Organization.

Narcotics—natural and synthetic opioid analgesics and their derivatives used to relieve pain.

Physician—an individual licensed by the board to engage in the practice of medicine in the state of Louisiana as evidenced by a current license duly issued by the board.

Primary or Attending Physician—a physician who has an active clinical relationship with a patient and is principally responsible for the health care needs of the patient, or currently attending to the

health care needs of the patient, or considered by the patient to be his or her primary or attending physician.

Psychopharmacologic Management—the treatment and/or management of the mental, nervous, emotional, behavioral, substance abuse and cognitive disorders with medication.

State—any state of the United States, the District of Columbia, and Puerto Rico.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:888 (March 2011), repromulgated LR 37:1151 (April 2011).

Subchapter B. Requirements and Qualifications for License

§3905. Scope of Subchapter

A. The rules of this Subchapter prescribe the requirements, qualifications and conditions for licensure as a medical psychologist in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:889 (March 2011).

§3907. Qualifications for License

A. To be eligible for a license to practice as a medical psychologist an applicant shall:

1. possess a current, unrestricted license in good standing to practice psychology duly issued by the LSBEP;

2. be a citizen of the Unites States or possess valid and current legal authority to reside and work in the United States duly issued by the Commissioner of the Immigration and Naturalization Service of the United States under and pursuant to the Immigration and Nationality Act (66 Stat. 163) and the Commissioner's regulations thereunder (8 CFR);

3. be of good moral character as defined by Section 3903A of these rules;

4. possess approved certification in Basic Life Support (BLS);

5. possess:

a. a post-doctoral master's degree in clinical psychopharmacology conferred by a regionally accredited institution approved by the board; or

b. equivalent training to a post-doctoral master's degree in clinical psychopharmacology approved by the board;

6. have within the past 3 years, in conformity with the restrictions and limitations prescribed by this Chapter, taken and passed a national examination in psychopharmacology approved by the board; and

7. not be otherwise disqualified by any ground for denying a license provided by the MP Act or these rules.

B. The burden of satisfying the board as to the qualifications and eligibility of an applicant for licensure shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by and to the satisfaction of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:889 (March 2011).

§3909. Alternative Qualifications for License

A. Provided application is made within 12 months of the effective date of these rules, an individual who desires to be licensed as a MP may qualify for licensure pursuant to R.S. 37:1360.55A without compliance with the requirements prescribed by Section 3907, upon submission of evidence satisfactory to the board that the applicant possessed all of the following as of January 1, 2010:

1. an unrestricted license in good standing to practice psychology issued by the LSBEP;

2. an unrestricted certificate of prescriptive authority issued by the LSBEP;

3. a controlled substance permit duly issued by the Louisiana State Board of Pharmacy;

4. a controlled substance registration duly issued by the United States Drug Enforcement Administration; and

5. as of the date of application, not be otherwise disqualified by any ground for denying a license provided by the MP Act or these rules.

B. The alternative qualification provided by this Section shall expire and become null, void and to no effect 12 months and 1 day following the effective date of these rules.

C. The burden of satisfying the board as to the qualifications and eligibility of an applicant for licensure shall be upon the applicant. An applicant

shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by and to the satisfaction of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:890 (March 2011).

§3911. Qualifications for Certificate of Advanced Practice

A. To be eligible for a certificate of advanced practice an applicant shall, as of the date of application to the board, have:

1. a current, unrestricted license as a MP duly issued by the board and not be the subject of an investigation or pending disciplinary proceeding by the board;

2. practiced as a MP for at least three of the past four years. With respect to individuals licensed under the alternative qualification provided in Section 3909 of this Chapter, such experience shall be deemed to have commenced on the date that the applicant's initial certificate of prescriptive authority was issued by the LSBPE;

3. as a MP, treated at least one hundred patients which demonstrate the competence of the medical psychologist. Of this number at least 25 shall have involved the use of major psychotropics and at least 25 shall have involved the use of major antidepressants;

4. received the written recommendation of two collaborating physicians who hold a current, unrestricted license to practice medicine in this state duly issued by the board, who are familiar with the applicant's competence to practice medical psychology;

5. received a favorable recommendation from the committee; and

6. completed a minimum of one hundred hours of continuing medical education relating to the use of medications in the management of patients with psychiatric illnesses, commencing with:

a. initial issuance of a certificate of prescriptive authority by the LSBPE if prior to January 1, 2010; or

b. the date the MP is licensed by the board after January 1, 2010.

B. The burden of satisfying the board as to the qualifications and eligibility of an applicant for certification shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by and to the satisfaction of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:890 (March 2011).

Subchapter C. Application

§3913. Scope of Subchapter

A. The rules of this Subchapter govern the procedures and requirements for application to the board for a license to practice medical psychology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:890 (March 2011).

§3915. Application Procedure

A. Application must be made and submitted in a format approved by the board and shall include:

1. proof, documented in a form satisfactory to the board, that the applicant possesses the qualifications set forth in this Chapter, along with a recent photograph;

2. certification of the truthfulness and authenticity of all information, representations and documents contained in or submitted with the completed application;

3. criminal history record information;

4. payment of the fee provided in Chapter 1 of these rules; and

5. such other information and documentation as the board may require.

B. Upon submission of a completed application a personal interview with a member of the board or a designee may be required as a condition of licensure when:

1. discrepancies exist in an initial application;

2. an applicant has been the subject of prior adverse action in any jurisdiction; or

3. the board has questions respecting an application response.

C. The recommendation of the board member or designee as to the applicant's fitness for licensure shall be made a part of the applicant's file.

D. The board may reject or refuse to consider an application which is not complete in every detail. The board may in its discretion require a more detailed or complete response to any request for information set forth in the application as a condition to application consideration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:890 (March 2011).

§3917. Effect of Application

A. The submission of an application for licensure to the board shall constitute and operate as an authorization by the applicant to each educational institution at which the applicant has matriculated, each state or federal agency to which the applicant has applied for any license, permit, certificate, or registration, each person, firm, corporation, clinic, office, or institution by whom or with whom the applicant has been employed in the practice of psychology or medical psychology, each physician or other health care practitioner whom the applicant has consulted or seen for diagnosis or treatment and each professional organization or specialty board to which the applicant has applied for membership, to disclose and release to the board any and all information and documentation concerning the applicant which the board deems material to consideration of the application. With respect to any such information or documentation, the submission of an application for licensing to the board shall equally constitute and operate as a consent by the applicant to disclosure and release of such information and documentation and as a waiver by the applicant of any privilege or right of confidentiality which the applicant would otherwise possess with respect thereto.

B. By submission of an application for licensure to the board an applicant shall be deemed to have given his consent to submit to physical or mental examinations if, when, and in the manner so directed by the board and to waive all objections as to the admissibility or disclosure of findings, reports, or recommendations pertaining thereto on the grounds of privileges provided by law. The expense of any such examination shall be borne by the applicant.

C. The submission of an application for licensure to the board shall constitute and operate as an authorization and consent by the applicant to the board to disclose and release any information or documentation set forth in or submitted with the applicant's application or obtained by the board from other persons, firms, corporations, associations, or governmental entities pursuant to this Section to any person, firm, corporation, association, or governmental entity having a lawful, legitimate, and reasonable need therefore including, without limitation, the psychology or medical psychology licensing authority of any state; the Federal Drug Enforcement Administration; the Louisiana Board of Pharmacy; the Department of Health and Hospitals; federal, state, county, parish and municipal health and law enforcement agencies; and the Armed Services.

D. The board, acting through its president or a member designated by the president, may approve the issuance of any directive or order to carry out the provisions of Subsection B of this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:891 (March 2011).

Subchapter D. Board Approval of Schools, Colleges, Universities, or Institutions

§3919. Scope of Subchapter

A. The rules of this Subchapter prescribe the requirements for board approval of a school, college, university or institution for the purpose of assessing qualifications for medical psychology licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:891.

§3921. Applicability of Approval

A. Successful completion of a post-doctoral master's degree in clinical psychopharmacology from a regional accredited institution approved by the board is among the educational qualifications required for MP licensure.

B. The completion of training approved by the board that is equivalent to a post-doctoral master's degree in clinical psychopharmacology is an alternative educational qualification for MP licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:891 (March 2011).

§3923. Approval of Schools and Colleges

A. A school, college, university or institution shall be concurrently considered approved by the board for purposes of qualification under this Chapter provided it:

1. is accredited by one of the six regional bodies recognized by the United States Department of Educations' Council on Postsecondary Accreditation;

2. has achieved the highest level of accreditation or approval awarded by statutory authorities of the state in which the school or college is located;

3. offers a full-time post-doctoral master's program in clinical psychopharmacology that:

a. includes curriculum instruction in each of the following areas:

i. anatomy and physiology;

ii. biochemistry;

iii. neurosciences to include neuroanatomy, neuropathology, neurophysiology, neurochemistry and neuroimaging;

iv. pharmacology;

v. psychopharmacology;

vi. clinical medicine/pathophysiology; and

vii. health assessment, including relevant physical and laboratory assessment; and

b. provides opportunity to review, present and discuss each of the following:

i. case examples representing a broad range of clinical psychopathologies;

ii. medical conditions presenting as psychiatric illness;

iii. treatment complexities, including complicating medical conditions, diagnostic questions, choice of medications, and untoward side effects;

iv. compliance problems; and

v. alternative treatments and treatment failures.

B. Board approval of a school, college, university or institution shall be deemed to be effective as to an applicant if such school, college, university or institution was approved as of the date on which the applicant's post-doctoral master's degree in clinical psychopharmacology was awarded.

C. Subject to Section 3925 of these rules, a school, college, university or institution accepted by the LSBPE for MP prescriptive authority on or before January 1, 2010, shall be considered approved by the board for purposes of qualification under this Chapter.

D. For the purposes of this Chapter, equivalent training to the post-doctoral master's degree provided in R.S. 37:1360.55B.(2) is defined as the successful completion of the Department of Defense Psychopharmacology Demonstration Project (DOD-PDP), or a similar program developed and operated under the auspices of any branch of the United States armed services and approved by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:891 (March 2011).

§3925. Withdrawal of Approval

A. Notwithstanding current or prior approval pursuant to this Subchapter or by individual determination, the board's approval of any school, college, university or institution may be withdrawn at any time upon its affirmative finding that such school, college, university or institution does not possess the qualifications for approval specified by this Subchapter or by the MP Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:892 (March 2011).

Subchapter E. Examination

§3927. Scope of Subchapter

A. The rules of this Subchapter designate the examination, passing score, restrictions, limitations and exceptions applicable to medical psychologist licensure in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:892 (March 2011).

§3929. Designation of Examination

A. The MP licensing examination approved and accepted by the board, pursuant to R.S. 37:1360.55B(3), is the Psychopharmacology Examination for Psychologists (PEP), developed by the American Psychological Association practice organization's College of Professional Psychology and its contractor, the Professional Examination Service, or their successor(s) organizations.

B. The PEP or such other examination as the board may approve shall:

1. be taken after the successful completion of the post-doctoral master's program in clinical psychopharmacology; and

2. not less than three years prior to the date of MP application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:892 (March 2011).

§3931. Passing Score

A. An applicant will be deemed to have successfully passed the examination upon attaining a score equivalent to the passing score required by the PEP and its contractor, the Professional Examination Service, or their successor(s) organizations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:892 (March 2011).

§3933. Restriction, Limitations on Examinations

A. Applicants shall be required to authorize the PEP and the Professional Examination Service to release their testing scores to the board each time the applicant-examinee attempts the examination according to the procedures for such notification established by the PEP.

B. An applicant having failed to attain a passing score upon taking the examination four times shall not thereafter be considered for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:892 (March 2011).

Subchapter F. Licensure Issuance, Termination, Renewal, Reinstatement

§3935. Scope of Subchapter

A. The rules of this Subchapter prescribe the requirements applicable to issuance, termination, renewal and reinstatement of a license to practice medical psychology in this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:892 (March 2011).

§3937. Issuance of Licensure; Certificate of Advanced Practice

A. If the qualifications, requirements, and procedures set forth in this Chapter are met to its satisfaction the board shall issue a license to the applicant to engage in the practice of medical psychology in this state.

B. If the qualifications, requirements, and procedures set forth in this Chapter are met to its satisfaction the board shall issue a certificate of advanced practice to the applicant to engage in the advanced practice of medical psychology in this state.

C. A license or certificate issued under this Chapter shall designate the applicant's status with respect to advanced practice.

D. Every MP is responsible for updating the board within 15 days should any of the required contact information submitted with an application change after license or certificate issuance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:892 (March 2011).

§3939. Expiration of License, Certificate

A. Every license or certificate issued under this Chapter shall expire and thereby become null, void and to no effect the following year on the last day of June.

B. The timely submission of a properly completed application for renewal of a license shall operate to continue an expiring license, and if applicable a certificate of advanced practice, in full force and effect pending renewal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:893 (March 2011).

§3941. Renewal of License, Certificate

A. Every license or certificate issued by the board shall be renewed annually on or before the last day of June by submitting to the board a properly completed renewal application, in a format specified by the board, together with the renewal fee prescribed by Chapter 1 of these rules and documentation of:

1. satisfaction of the continuing professional education requirement prescribed by this Chapter; and

2. maintenance of basic life support.

B. Possession of a current, unrestricted license to practice psychology duly issued by the LSBPE is a requirement for initial licensure as a medical psychologist under this Chapter but shall not be required by the board for license renewal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:893 (March 2011).

§3943. Reinstatement of Expired License or Certificate

A. A license or certificate that has expired without renewal may be reinstated by the board provided that application is made within two years of the date of expiration.

B. A MP whose license and/or certificate has expired for a period in excess of two years or who is otherwise ineligible for reinstatement under this Section may apply to the board for an initial original license or certificate pursuant to these rules.

C. An applicant seeking reinstatement more than one but less than two years from the date on which his or her license or certificate expired shall demonstrate, as a condition of reinstatement, satisfaction of the continuing professional education required by these rules for each year since the date of the license expiration. As additional conditions of reinstatement the board may require that the applicant:

1. complete a statistical affidavit and provide a recent photograph;

2. take and successfully pass:

a. all or a designated portion of the national examination required for licensure under this Chapter;

b. a written certification or recertification examination acceptable to the board; and/or

c. demonstrate clinical competency by successfully completing a program designated by the board, following consultation with the committee, and any recommended remediation.

D. An applicant whose license to practice psychology or medical psychology has been revoked, suspended or placed on probation by the licensing authority of any state or who has voluntarily or involuntarily surrendered his or her license to practice psychology or medical psychology in consideration of the dismissal or discontinuance of pending or threatened administrative or criminal charges following the date on which his or her license to practice as a MP in Louisiana expired, shall be deemed ineligible for license reinstatement.

E. An application for reinstatement of a license or certificate meeting the requirements and conditions of this Chapter may nonetheless be denied for any of the causes for which an application for original licensure or certification may be refused by the board pursuant to R.S. 37:1360.67 or for violation of these rules.

F. An application for reinstatement shall be made in a format supplied by the board together with the applicable fees and costs for license and/or certificate renewal under Chapter 1 of these rules, plus a penalty computed as follows.

1. If the application is made less than one year from the date of expiration, the penalty shall be equal to the renewal fee of the license and, if applicable, the certificate.

2. If the application is made more than one but less than two years from the date of expiration, the penalty shall be equal to twice the renewal fee of the license and, if applicable, the certificate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:893 (March 2011).

Subchapter G. Medical Psychology Advisory Committee

§3945. Scope of Subchapter

A. The rules of this Subchapter identify the constitution, functions and responsibilities of the medical psychology advisory committee to the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:893 (March 2011).

§3947. Constitution, Function and Responsibilities of Advisory Committee

A. The board shall constitute and appoint a Medical Psychology Advisory Committee which shall be organized and function in accordance with the MP Act and these rules.

B. Composition. The committee shall be comprised of five members, consisting of:

1. one physician selected from a list of names submitted by the Louisiana State Medical Society,

and recommended by Louisiana Psychiatric Medical Association and LAMP, who is certified in the specialty of psychiatry by a member board of the American Board of Medical Specialties or the American Osteopathic Association; and

2. four medical psychologists selected by the board from a list of names recommended by LAMP.

C. Appointment. Each member, to be eligible for and prior to appointment to the committee, shall have maintained residency and a current and unrestricted license or certificate to practice their respective professions in the state of Louisiana for not less than two years.

D. Term of Service. Each member of the committee shall serve for a term of four years, or until a successor is appointed and shall be eligible for reappointment. Committee members serve at the pleasure of the board. Committee members may be reappointed to two additional terms of four years with the length of the terms to be staggered after the first term.

E. Functions of the Committee. The Committee will provide the Board with recommendations relating to the following matters:

1. applications for licensure and for certificates of advanced practice (initial and renewal);

2. educational requirements for licensure and for certificates of advanced practice (initial and renewal);

3. changes in related statutes and rules; and

4. other activities as might be requested by the board.

F. Committee Meetings, Officers. The committee shall meet at least twice each calendar year, or more frequently as may be deemed necessary by a quorum of the committee or by the board. Three members of the committee constitute a quorum. The committee shall elect from among its members a chair, a vice-chair, and a secretary. The chair, or in the absence or unavailability of the chair, the vice-chair, shall call, designate the date, time, and place of, and preside at all meetings of the committee. The secretary shall record or cause to be recorded accurate and complete written minutes of all meetings of the committee and shall cause copies of the same to be provided to the board.

G. Confidentiality. In discharging the functions authorized under this Section, the committee and the individual members thereof shall, when acting within the scope of such authority, be deemed agents of the board. Committee members are prohibited from communicating, disclosing, or in any way releasing to anyone other than the board, any confidential information or documents obtained when acting as the agents of the board without first obtaining the written authorization of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:893 (March 2011).

Subchapter H. Continuing Education

§3949. Scope of Subchapter

A. The rules of this Subchapter provide standards for the continuing professional education required for annual renewal of a license to practice as a medical psychologist, and prescribe procedures applicable to satisfaction and documentation thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:894 (March 2011).

§3951. Continuing Education Requirement

A. To be eligible for license renewal a MP shall evidence and document in a format specified by the board the successful completion of 35 hours of approved continuing professional education that includes:

1. not less than 20 hours of continuing medical education relevant to the practice of medical psychology; and

2. not less than fift15een hours of continuing education in psychology.

B. A minimum of 25 percent of the continuing medical education required by this Section shall be provided by LAMP.

C. At least two hours required by this Section shall be devoted to ethics relevant to the practice of medical psychology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:894 (March 2011).

§3953. Qualifying Programs and Activities

A. To be acceptable as qualified continuing professional education under these rules, an activity or program must have significant intellectual or practical content, dealing primarily with matters

related to medical psychology or psychology, and its primary objective must be to maintain or increase the participant's competence as a MP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:894 (March 2011).

§3955. Approval of Program Sponsors

A. Any category 1 education program, course, seminar or activity offered or sponsored by the organizations set forth in this Section shall presumptively be deemed approved by the board for purposes of qualifying as an approved continuing professional education.

B. Approved sponsors of continuing medical education for practitioners licensed under this Part shall include the Louisiana Academy of Medical Psychologists, the Louisiana State Medical Society, the Louisiana Psychiatric Medical Association, the State of Louisiana Department of Health and Hospitals Office of Behavioral Health or its successor, sponsors accredited by the Accreditation Council for Continuing Medical Education approved to offer category 1 educational activities, and other sponsors as may be approved by the board.

C. Approved sponsors for continuing education in psychology shall include the Louisiana Psychological Association, the American Psychological Association, the Louisiana Academy of Medical Psychologists, the state of Louisiana Department of Health and Hospitals, Office of Behavioral Health or its successor, and other sponsors as may be approved by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:894 (March 2011).

§3957. Documentation Procedure

A. A format or method specified by the board for documenting and certifying completion of continuing professional education shall be completed by licensees and returned with an annual renewal application.

B. Any certification of continuing professional education activities not presumptively approved or preapproved in writing by the board pursuant to these rules shall be referred to the committee for its evaluation and recommendations. If the committee determines that an activity certified by an applicant for renewal in satisfaction of continuing education requirements does not qualify for recognition by the board or does not qualify for the number of continuing education units claimed by the applicant, the board shall give notice of such determination to the applicant for renewal. The board's decision with respect to approval and recognition of any such activity shall be final.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:895 (March 2011).

§3959. Failure to Satisfy Continuing Education Requirements

A. An applicant for license renewal who fails to evidence satisfaction of the continuing professional education requirements shall be given written notice of such failure by the board. The license of the applicant shall remain in full force and effect for a period of 60 days following the mailing of such notice, following which it shall be deemed expired, unrenewed, and subject to revocation without further notice, unless the applicant shall have, within such 60 days, furnished the board satisfactory evidence, by affidavit, that:

1. applicant has satisfied the applicable continuing professional education requirements; or

2. applicant's failure to satisfy the continuing professional education requirements was occasioned by disability, illness, or other good cause as may be determined by the board.

B. The license of a MP whose license has expired by nonrenewal or been revoked for failure to satisfy the continuing education requirements of these rules may be reinstated by the board within the time and in accordance with the procedures for reinstatement provided by these rules.

AUTHOITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:895 (March 2011).

§3961. Waiver of Requirements

A. The board may, in its discretion, waive all or part of the continuing professional education required by these rules in favor of a MP who makes written request for such waiver and evidences to the satisfaction of the board a permanent physical disability, illness, financial hardship, or other similar extenuating circumstances precluding the MP's satisfaction of the continuing professional education requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:895 (March 2011).

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XLV. Medical Professions

Subpart 3. Practice

Chapter 61. Medical Psychologists

Subchapter A. General Provisions

§6101. Scope of Chapter

A. The rules of this Chapter govern the practice of medical psychologists in the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:895 (March 2011).

Subchapter B. Necessity for License, Exemptions

§6103. Necessity for License

A. No person shall engage in the practice of medical psychology in the state of Louisiana, or identify or hold himself or herself out as such, nor use in connection with his or her name the words "medical psychologists" or the letters "MP" or any other words, letters, abbreviations, insignia, or signs tending to indicate or imply that the person is a medical psychologist, unless he or she is currently licensed by the board as a medical psychologist.

B. No person shall engage in the advanced practice of medical psychology as defined in the MP Act or these rules in this state in the absence of a current certificate of advanced practice issued by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:895 (March 2011).

§6105. Exemptions

A. The provisions of this Chapter shall not prevent, restrict the practice, services, or activities of any individual:

1. licensed by other laws in this state from engaging in the profession or occupation for which he or she is licensed; or

2. employed as a medical psychologist by the United States government when practicing solely under the direction or control of the United States government agency by which he or she is employed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:895 (March 2011).

Subchapter C. Ethical Guidelines, Authority, Limitations and Standards of Practice

§6107. Scope of Subchapter

A. This Subchapter provides the ethical guidelines, authority, limitations and standards of practice of individuals licensed to practice medical psychology in the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:895 (March 2011).

§6109. Ethical Guidelines

A. A medical psychologist shall, in the practice of medical psychology, observe and abide by the code of ethics of the American Medical Association and American Psychological Association.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:896 (March 2011).

§6111. Authority of Practice

A. An individual currently licensed by the board as a medical psychologist is authorized to:

1. order, administer, and prescribe or distribute without charge drugs recognized as customarily used for the management of mental, nervous, emotional, behavioral, substance abuse and cognitive diseases or disorders; and

2. order and interpret routine laboratory studies and other medical diagnostic procedures, as necessary for adequate pretreatment health screening, diagnosis of mental, nervous, emotional, behavioral, substance abuse and cognitive disorders and treatment maintenance, including those necessary for the monitoring of potential side effects associated with medications prescribed by the MP.

B. An individual currently certified for advanced practice by the board is authorized to engage in the advanced practice of medical psychology as defined by the MP Act and these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:896 (March 2011).

§6113. Limitations of Practice

A. A medical psychologist shall not:

1. order, administer, prescribe or distribute drugs that are not customarily used for the management of mental, nervous, emotional, behavioral, substance abuse and cognitive diseases or disorders;

2 order, administer, prescribe or distribute narcotics, as defined in this Part;

3. utilize controlled substances for the treatment of non-cancer related chronic or intractable pain, as set forth in §§6915-6923 of the board's rules or for the treatment of obesity, as set forth in §§6901-6913 of the board's rules;

4. prescribe medications outside his or her areas of competency consistent with his or her training and experience as defined by the board;

5. delegate the administration, prescription, or distribution of a drug to any other individual;

6. engage in practice beyond the authority conferred by license or certificate approved by the board; or

7. employ a physician or enter into an independent contractor or similar contractual or financial relationship with a physician with whom he or she consults or collaborates. The board may grant an exception to this requirement on a case-by-case basis where it has been shown to its satisfaction that such relationship is structured so as to prohibit interference with the physician's relationship with patients, his or her exercise of independent medical judgment and satisfaction of the obligations and responsibilities imposed by law and the board's rules on a physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:896 (March 2011).

§6115. Standards for Prescribing by Medical Psychologists without a Certificate of Advanced Practice

A. Medical psychologists shall prescribe only in consultation and collaboration with the patient's primary or attending physician, and with the concurrence of that physician.

B. The medical psychologist shall also re-consult with the patient's physician prior to making changes in the patient's medication treatment protocol, as established with the physician, or as otherwise directed by the physician.

C. In the event that the primary or attending physician does not concur with the psychopharmacologic treatment protocol planned by a MP, the MP shall defer to the medical judgment of the physician.

D. In the event a patient does not have a primary or attending physician, the medical psychologist shall not prescribe for that patient.

E. Documentation of Physician Consultation. When psychopharmacologic management of a patient is indicated, the initial plan shall include consultation with the patient's primary or attending physician. The medical psychologist shall document the consultation with the primary or attending physician in the patient's medical record. Documentation shall include, but is not necessarily limited to:

1. patient authorization. In order to permit the necessary coordination of care for the patient, the MP shall obtain a release of information from the patient and/or the patient's legal guardian to contact the patient's primary or attending physician in all cases in which psychopharmacologic management is planned. If the patient or the patient's legal guardian declines to sign a release of information authorizing coordination of care with his or her primary or attending physician, the MP shall inform the patient and/or the patient's legal guardian that he or she cannot treat the patient pharmacologically without such consultation;

2. patient identity. The physician's name; date of consultation; and contact information for the patient, physician and MP;

3. purpose. The purpose of consultation (e.g., new medication, change in medication, discontinuance of medication, adverse treatment

effects, treatment failure, change in medical status, etc.);

4. psychological evaluation and diagnosis. If known, the psychological evaluation of the patient, including any relevant psychological history, laboratory or diagnostic studies and psychological diagnosis; and any other information the MP or physician deems necessary for the coordination of the care for patient;

5. medication. The specific drug(s) the MP plans to utilize, including the starting dosage and titration plan if any; frequency of use, the number of refills and anticipated duration of therapy; relevant indications and contraindications, any previously utilized psychopharmacologic therapy, and any alternatives;

6. treatment plan. The MP's treatment and/or management plan for the patient;

7. results of consultation. The results of the consultation (e.g., concurrence, deferring or denying medication recommended by the MP); medications ordered (e.g., generic or trade; starting dosage and titration plan, if any; number of refills; etc.) and any other information that might be necessary for the appropriate coordination of care for the patient (e.g., review of prior labs or diagnostic procedures; new labs or diagnostic procedures requested by the physician, if any; etc.);

8. responsibilities. Any specific responsibilities of the MP and physician respecting the patient's care;

9. reporting. Any reporting and documentation requirements between the MP and the physician and/or a schedule by which such are to take place; and

10. immediate consultation. A plan to accommodate immediate consultation between the MP, physician, and/or patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:896 (March 2011).

§6117. Standards for Prescribing by Medical Psychologists Holding a Certificate of Advanced Practice

A. Patients receiving care from a medical psychologist who holds a certificate of advanced practice issued under this Part shall have an established primary, attending or referring physician licensed by the board who shall be responsible for the patient's overall medical care.

B. The primary, attending or referring physician shall evaluate the patient for medical conditions in accordance with customary practice standards, and as might be indicated based on the medications that the patient is receiving and/or risk factors that may be present. If the patient has been referred to a medical psychologist holding a certificate of advanced practice for the express purpose of evaluation and treatment to include drug management by the primary, attending or referring physician, this condition shall be considered met.

C. The medical psychologist shall provide the primary, attending or referring physician with a summary of the treatment planned at the initiation of treatment.

D. The medical psychologist shall provide the primary, attending or referring physician with follow-up reports as may be dictated by the patient's condition.

E. The medical psychologist shall provide the patient's primary, attending or referring physician with a summary of the patient's condition and treatment no less than annually.

F. The medical psychologist may treat common side effects of medications used in the treatment of mental illness as defined in this Chapter after consultation with the patient's primary or attending physician and with the concurrence of that physician.

G. The requirements for Subsections C, D and E of this Section shall be considered satisfied if the medical psychologist provides the physician with a copy of the initial examination and follow-up visit records or, in those instances in which the medical psychologist is providing services authorized under this Section in a hospital or clinic setting on referral of the attending or referring physician on the medical staff of that hospital or clinic, the medical psychologist documents those services in the patient's medical record at that hospital or clinic.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:897 (March 2011).

§6119. Informed Consent

A. In addition to the written release and authorization set forth in Section 6115.E, a MP shall insure that each of his or her patients subject to consultation and collaboration with a physician is informed:

1. of the relationship between the MP and physician and the respective role of each with respect to the patient's psychopharmacologic management;

2. that he or she may decline to participate in such a practice and may withdraw at any time without terminating the MP-patient relationship;

3. of the MP's decision to withdraw from consultation and collaboration with a physician; and

4. by written disclosure, of any contractual or financial arrangement that may impact the MP's decision to engage in consultation and collaboration with a physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:897 (March 2011).

Subchapter D. Grounds for Administrative Action

§6121. Causes for Administrative Action

A. The board may refuse to issue, or may suspend or revoke any license or certificate, or impose probationary or other restrictions on any license or certificate issued under this Part, for violation of the board's rules relative to medical psychologists or for any of the causes set forth in MP Act, R.S. 37:1360.67A.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1360.51-1360.72.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 37:897 (March 2011).

Appendix E

State of New Mexico

Board of Psychologist Examiners

Rules and Statutes

NEW MEXICO

BOARD
OF

PSYCHOLOGIST EXAMINERS

RULES and STATUTES

2015

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 1 GENERAL PROVISIONS

16.22.1.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners
[16.22.1.1 NMAC - Rp, 16.22.1.1 NMAC, 11/15/06]

16.22.1.2 SCOPE: This part applies to the board, licensees, applicants for licensure, and the general public.
[16.22.1.2 NMAC - Rp, 16.22.1.2 NMAC, 11/15/06]

16.22.1.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-6, 61-9-8, 61-9-16. Section 1 of Part 1 is authorized by NMSA 1978 Section 10-15-1.C (1993 Repl.)
[16.22.1.3 NMAC - Rp, 16.22.1.3 NMAC, 11/15/06]

16.22.1.4 DURATION: Permanent.
[16.22.1.4 NMAC - Rp, 16.22.1.4 NMAC, 11/15/06]

16.22.1.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of a section.
[16.22.1.5 NMAC - Rp, 16.22.1.5 NMAC, 11/15/06]

16.22.1.6 OBJECTIVE: The objective of Part 1 is to set forth the provisions, which apply to all of Chapter 22, and to all persons affected or regulated by Chapter 22 of Title 16.
[16.22.1.6 NMAC - Rp, 16.22.1.6 NMAC, 11/15/06]

16.22.1.7 DEFINITIONS:

A. As used in these regulations, the following words and phrases have the following meanings, unless the context or intent clearly indicates a different meaning:

(1) "Act" means the Professional Psychologist Act, Section 61-9-1 through 61-9-19 NMSA 1978.

(2) "Administrator" or "board administrator" means the staff person assigned certain express or implied executive and administrative functions of the board as defined by board regulations or as required to carry out the provisions of the act.

(3) "Adult" means all persons 18 years of age or older.

(4) "Applicant" means a person who has completed all educational requirements of the eligibility requirements for licensure and has submitted a complete application to the board. An applicant is seeking approval of his or her application by the board to advance him or her to candidacy for licensure.

(5) "Board" means the New Mexico state board of psychologist examiners.

(6) "Board administrator" or "administrator" means the staff person assigned certain express or implied executive and administrative functions of the board as defined by board regulations or as required to carry out the provisions of the act.

(7) "Board certified psychiatrist" means a physician licensed in New Mexico who has been certified by the American board of psychiatry and neurology in the specialty of psychiatry or the subspecialty of child and adolescent psychiatry.

(8) "Board regulations" or "regulations" means any part adopted by the board pursuant to authority under the act and includes any superseding regulation.

(9) "Candidate" is an applicant whose application has been approved by the board and is eligible to take the online jurisprudence examination.

(10) "Children/adolescents" mean all persons through 17 years of age (children 2-12 years; adolescents 13-17 years).

(11) "Client" means a person, corporate entity, patient or organization that is a recipient of psychological services. A corporate entity or other organization is a client when the purpose of the professional contract is to provide services of benefit primarily to the organization rather than to the individuals. In the case of individuals with legal guardians, including minors and legally incompetent adults, the legal guardian shall be the client for decision-making purposes, except that the individual receiving services shall be the client for:

(a) issues directly affecting the physical or emotional safety of the individual, such as sexual or other exploitative dual relationships; and

(b) issues specifically reserved to the individual, and agreed to by the guardian prior to rendering of services, such as confidential communication in a therapy relationship;

(c) all matters specifically designated to individuals in the Mental Health Code and Children's Code, NMSA 1978.

(12) "Collaborative relationship" means a cooperative working relationship between a conditional prescribing or prescribing psychologist and a health care practitioner in the provision of patient care, including cooperation in the management and delivery of physical and mental health care, to ensure optimal patient care.

(13) "Confidential information" means information revealed by a patient or clients or otherwise obtained by a psychologist, as a result of a confidential relationship where there is reasonable expectation that the information is not to be disclosed by the psychologist without the informed written consent of the patient or client in accordance with the Public Health Act, Section 24-1-20 NMSA 1978. A confidential relationship, as used here, results from:

(a) the relationship between the patient(s) or client(s) and the psychologist, or

(b) the circumstances under which the information was revealed or obtained; when such information is revealed or obtained through the psychologist's interaction with an individual from within a client corporation or organization, and that interaction is the result of the professional contract between the psychologist and the client, the confidential relationship is between the psychologist and the client, not between the psychologist and an individual within the organization; in this instance, information obtained by the psychologist from the individual shall be available to the organization unless such information was obtained in a separate professional relationship with that individual and is therefore subject to confidentiality requirements in itself.

(14) "Conditional prescribing psychologist" means a licensed psychologist who holds a valid conditional prescription certificate.

(15) "Conditional prescription certificate" means a document issued by the board to a licensed psychologist that permits the holder to prescribe psychotropic medication under the supervision of a licensed physician pursuant to the act.

(16) "Conflict of interest" means any situation or relationship that compromises or impairs, or appears to compromise or impair, the neutrality, independence or objectivity of a psychologist, psychologist associate, supervising physician, or board member, including relationships or situations that arise from past or present familial, social, fiduciary, business, financial, health care provider-patient relationship, agency, or other personal relationship. Paying or receiving an appropriate fee for supervisory services is not a conflict of interest. Conflict of interest includes dual relationships as provided herein at 16.22.2.9 NMAC. If a conflict of interest or dual relationship arises during the performance of the professional duties of a psychologist, psychologist associate, supervising physician, or board member, he shall immediately report the conflict of interest or dual relationship to the board and shall cease that professional relationship.

(17) "Consultant" means a licensed psychologist who provides professional advice or opinion to a another licensed psychologist and who has no professional relationship with the patient or client, has no authority over the case, or has no responsibility for the services performed for the patient or client or the welfare of the patient or client.

(18) "Continuing professional education" means educational opportunities beyond doctoral education and initial entry level training as a psychologist or psychologist associate for which hourly credit is earned. It is the process through which professional licensees review psychological concepts and techniques, acquire new knowledge or skills relevant to their work, and improve their competence in current skills. These activities are intended to supplement what has already been attained in training and practice. It is an ongoing process consisting of formal learning activities at the postgraduate level that are:

(a) relevant to psychological practice, education, and science;

(b) enable psychologists to keep pace with emerging issues and technologies; and

(c) allow psychologists to maintain, develop and increase competencies in order to improve services to the public and enhance contributions to the profession.

(19) "Controlled substance" means any drug, substance or immediate precursor enumerated in schedules I through V of the U.S. Drug Enforcement Administration, Controlled Substance Act and in Sections 30-31-6 thru 30-31-10 of the act.

(20) "Court order" means the written communication of a member of the judiciary, or other court magistrate or administrator, if such authority has been lawfully delegated to such magistrate or administrator that is under the authority of law.

(21) "Criminal Offender Employment Act", Sections 28-2-1 thru 28-2-6 NMSA 1978 is the statutory provision regulating the relevance and weight to be given an applicant, candidate, or licensee's criminal record, by the board, during the licensure or renewal process.

(22) "Cultural competence" means the ability and the will to respond to the unique needs of an individual patient that arise from the patient's culture, and the ability to use aspects of the person's culture as a resource or tool to assist with the intervention. Cultural competence includes being able to:

(a) recognize and respond to health related beliefs and cultural values;

(b) incorporate research about disease incidence and prevalence, and treatment efficacy; and

(c) know when to seek consultation about the patient's culture.

(23) "Currently enrolled" means enrolled as a student in a college or university.

(24) "Custodian" means the board administrator.

(25) "Doctoral program in psychology" includes programs whose degree specify a doctoral degree in counseling, clinical or school psychology, as well as those programs the board deems to be equivalent to the requirements contained in the Professional Psychologist Act, using the standards and guidelines set forth by the APA or the ASPPB as a guide.

(26) "Drug or substance" means substances recognized as drugs in the official United States pharmacopoeia, official homeopathic pharmacopoeia of the United States or official national formulary or any respective supplement to those publications. It does not include devices or their components, parts or accessories.

(27) "Electronic signatures" means an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

(28) "Electronic transmission" means the sending of information through the telephone lines, cable or internet, as in e-mail or facsimile (fax).

(29) "Ethno-pharmacology" means the basic and clinical sciences of treatment of specific mental illness with ethnically or culturally appropriate drugs.

(30) "Filed with the board" means hand delivered or postal mail received during normal business hours by the board office in Santa Fe, New Mexico.

(31) "Geriatric" means all persons 65 years of age and over.

(32) "Good cause" means the inability to comply because of illness, undue hardship, or extenuating circumstances that are not willful and are beyond the control of the person asserting good cause. The person asserting good cause shall have the burden to demonstrate good cause.

(33) "Governmental Conduct Act" 10-16-1 thru 10-16-18 NMSA 1978 is the statutory provision which sets forth standards of conduct and ethical principles for public service.

(34) "Health care practitioner" means a licensed physician, osteopathic physician or nurse practitioner with independent, licensed prescribing privilege.

(35) "Inactive status" means a procedure of the board to affirm that a licensee is not engaged in active practice.

(36) "Initial application" means the initial application for licensure filed with the board by an applicant not previously or currently licensed in any jurisdiction.

(37) "Inspection of Public Records Act", 14-2-1 thru 14-2-12 NMSA 1978 is the statutory provision acknowledging the fundamental right of access to public records afforded citizens and media in a democracy, and governing the administration of that right.

(38) "Licensed" means licensed or certified, registered, or any other term including temporary, provisional, emergency, unrestricted, active or inactive license or licensure, when such term identifies a person whose professional behavior is subject to regulation by the board by authority of the act.

(39) "Licensee" means a psychologist licensed pursuant to the provisions of the act and board regulations.

(40) "Licensee in good standing" means a licensed psychologist who is not the subject of a pending investigation, adjudicatory proceeding, or petition on appeal or review, or whose license is not restricted, suspended, or revoked in New Mexico or any other state or licensing jurisdiction.

(41) ""Medical supervision" means direct oversight of the psychologist trainee's psychopharmacological practice by a qualified supervising physician approved by the board. Supervision may be on-site or off-sit as specified in the rule.

(42) "Medical supervisor" means a qualified supervising physician approved by the board.

(43) "Member of the family" means a parent, spouse, child, stepchild, grandchild, grandparent, sibling, uncle, aunt, niece or nephew, or other relative by blood, marriage, or legal process with whom the supervisor or physician supervisor has or has had a close familial relationship.

(44) "Member of the household" means residing within the same dwelling unit, either continuously or intermittently, regardless of whether fee or rent is paid or received.

(45) "National certification exam" means an examination that evaluates the psychopharmacological knowledge base of the applicant, is developed with the intention to administer it to psychologists seeking certificates or licenses to prescribe psychotropic medication in any state with prescriptive authority for psychologists, and meets standards acceptable to the board and the medical board.

(46) "Nationwide criminal history record" means information concerning a person's arrests, indictments, or other formal criminal charges and any dispositions arising there from, including convictions, dismissals, acquittals, sentencing and correctional supervision, collected by criminal justice agencies and stored in the computerized databases of the federal bureau of investigation, the national law enforcement telecommunications systems, the department of public safety or the repositories of criminal history information in other states."

(47) "Nationwide criminal history screening" means a criminal history background investigation of an applicant for licensure by examination or endorsement through the use of fingerprints reviewed by the department of public safety and submitted to the federal bureau of investigation, resulting in the generation of a nationwide criminal history record for that applicant."

(48) "New Mexico administrative code" or "NMAC", Section 14-4-7.2 NMSA 1978 is the official compilation of current rules filed by state agencies in accordance with New Mexico statutes.

(49) "New Mexico statutes annotated 1978 or NMSA 1978" is the official compilation of state laws.

(50) "Non-licensed person" means a student, an applicant or postdoctoral person working under supervision in order to satisfy licensure requirements in psychology, and employees or staff of a licensed psychologist

(51) "Open Meetings Act , 10-15 NMSA 1978 is the statutory provision requiring that public business be conducted in full public view; providing guidelines governing both public and closed meetings, and regulating the notice, agenda and minutes of such meetings.

(52) "Outdated test" means a test for which a revision has been available for three (3) or more years.

(53) "Out-of-state psychologist" means a psychologist licensed in another state, a territorial possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico, the U.S. Virgin Islands, or a Canadian province who is in good standing in his or her licensing jurisdiction(s).

(54) "Patient" means a person who is treated, examined, assessed, or interviewed by a licensed psychologist or licensed psychologist associate or a non-licensed person working under supervision as provided in these regulations. In the case of minor patients or adult patients who are legally incompetent, the legal guardian shall represent the patient for decision-making purposes, except that the patient shall be directly consulted by the psychologist or psychologist associate for:

(a) issues directly affecting the physical or emotional safety of the individual, such as sexual or other exploitative dual relationships;

(b) issues specifically reserved to the individual, and agreed to by the guardian prior to rendering of services, such as confidential communication in a therapy relationship, and

(c) all matters specifically designated to individuals in the Mental Health and Developmental Disabilities Code (MHDDC), Section 43-1-19 NMSA 1978, and the Children's Code, Section 32A-1-1 thru 32A-1-20 NMSA 1978.

(55) "Physician" means an allopathic or osteopathic physician.

(56) "Practice of psychology" means the observation, description, evaluation, interpretation and modification of human behavior by the application of psychological principles, methods and procedures for the purpose of preventing or eliminating symptomatic, maladaptive or undesired behavior and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health and mental health, and further means the rendering of such psychological services to individuals, families or groups, regardless of whether payment is received for services rendered. The practice of psychology includes psychological testing or neuropsychological testing and the evaluation or assessment of personal characteristics such as intelligence, personality, abilities, interests, aptitudes and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, psychopharmacotherapy, hypnosis, biofeedback, behavior analysis and therapy; diagnosis and

treatment of any mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct and the psychological aspects of physical illness, accident, injury and disability, and psycho-educational evaluation, therapy, remediation and consultation.

(57) "Practicum" means a period of supervised clinical training and practice in which specific scientific and clinical techniques and diagnoses are learned.

(58) "Prescribing applicant" means a licensed psychologist who has made application to the board for a conditional prescribing or prescribing certificate.

(59) "Prescribing psychologist" means a licensed psychologist who holds a valid prescription certificate.

(60) "Prescription" means an order given individually for the person for whom prescribed, either directly from the prescriber to the pharmacist or indirectly by means of a written order signed by the prescriber, and bearing the name and address of the prescriber, his license classification, the name and address of the patient, the name and quantity of the drug prescribed, directions for use and the date of issue. No person other than a practitioner shall prescribe or write a prescription.

(61) "Prescription certificate" means a document issued by the board to a licensed psychologist that permits the holder to prescribe psychotropic medication pursuant to the act.

(62) "Primary treating health care practitioner" means the health care practitioner who is directly responsible for treating a specific illness or condition of a patient. The primary treating health care practitioner may be a primary care practitioner, or may be a medical specialist.

(63) "Professional relationship" means a mutually agreed-upon relationship between a psychologist and a patient(s) or client(s) for the purpose of the patient(s) or client(s) obtaining the psychologist's professional services.

(64) "Professional service" means all actions of the psychologist in the context of a professional relationship with a client or patient.

(65) "Properly made application" means a completed form for a psychologist or psychologist associate license filed with the board that is complete in all particulars and appears on its face to satisfy all minimum age, educational, supervision, payment, and other requirements except examination requirements for licensure as required by the act and these regulations.

(66) "Psychologist" means a person who engages in the practice of psychology or holds himself or herself out to the public by any title or description of services representing himself or herself as a psychologist, which incorporates the words "psychological", "psychologist", "psychology", or when a person describes himself or herself as above and, under such title or description offers to render or renders services involving the application of principles, methods and procedures of the science and profession of psychology to persons for compensation or other personal gain.

(67) "Psychopharmacology" [aka RxP] means the basic and clinical science of drugs used to treat mental illnesses.

(68) "Psychopharmacotherapy" means the application of pharmacotherapeutics to psychological problems. A key principle is the assessment of a patient's history that helps establish the appropriate role of drug therapy. Essential steps include evaluation, physical assessment, recognizing the disorder, adequate understanding of efficacy safety, pharmaco-kinetics, pharmaco-dynamics and application in the clinical setting.

(69) "Psychotropic medication" means a controlled substance or dangerous drug that may not be dispensed or administered without a prescription, whose indication for use has been approved by the federal food and drug administration for the treatment of mental disorders and is listed as a psychotherapeutic agent in drug facts and comparisons or in the American hospital formulary service.

(70) "Public Health Act", 24-1-1 thru 24-1-30 NMSA 1978, governs the confidentiality of patient or client record.

(71) "Restricted license" means a psychologist who holds a temporary, provisional, emergency or inactive license.

(72) "Rule" means board regulations.

(73) "Socio-cultural" means aspects of mental illness related to social and cultural mores and traditions of varied social and cultural groups.

(74) "School" means a college or a university or other institution of higher education that is regionally accredited and that offers a full-time graduate course of study in psychology as defined by rule of the board or that is approved the American psychological association.

(75) "Sponsoring psychologist" means a licensed psychologist in New Mexico who agrees to provide adequate oversight of an out-of-state psychologist ordered by a court to perform an independent

examination; the sponsoring psychologist remains responsible for the professional conduct of the out-of-state psychologist and the welfare of the patient or client.

(76) "State Rules Act", Sections 14-4-1 thru 14-4-5 NMSA 1978, is the statutory provision that ensures that state agencies file with the state records center and archives all rules and regulations including amendments or repeals.

(77) "Statute" means a law that governs conduct within its scope. A bill passed by the legislature becomes a statute; and "statutory authority" means the boundaries of the board's lawful responsibility as laid out by the statute that created it.

(78) "Substantial compliance" means sufficient compliance with the statutes or rules so as to carry out the intent for which the statutes or rules were adopted and in a manner that accomplishes the reasonable objectives of the statutes or rules.

(79) "Supervisee" means any person who functions under the authority of a licensed psychologist to provide psychological services as provided in the act or board regulations.

(80) "Supervisor" means a licensed psychologist who agrees to provide adequate supervision over a student, applicant, employee, staff, or other non-licensed person and who remains ultimately responsible for the professional conduct of the non-licensed person and the welfare of the patient.

(81) "Supervisory plan" means a written document signed by an applicant for psychology license or a conditional prescribing certificate and the supervisor of the applicant that describes the nature of the supervisory relationship including but not limited to the number of hours of supervision, population served, and credentials of supervisor, and is presented to the board for approval.

(82) "Uniform Licensing Act", Section 61-1-1 thru 61-1-33 NMSA 1978 is the statutory provision that governs the major duties of the board in areas of:

(a) procedures which must be followed to accord due process to applicants for licensure and to licensees if the board takes action against the licensee for acts of misconduct that would adversely affect public health, safety and welfare, and

(b) rule making procedures that the board shall follow in adopting valid regulations affecting psychologists and psychologist associates.

(83) "Unrestricted license" means a license in psychology with full privileges and responsibilities as described in these regulations but is renewed annually or biennially. It does not have a limitation of a provisional license, temporary license, emergency license or inactive license as described herein.

(84) "Year of supervised experience" means 1500 hours of psychological work conducted under supervision satisfactory to the board. The 1500 hours may be accumulated in one or two consecutive calendar years in the case of an internship, three consecutive years in the case of post-doctoral experience, or over the course of graduate training in the case of predoctoral experience.

(85) "Doctoral training program" means the program from which the applicant received his or her doctoral degree to fulfill the educational requirements for licensure (NMAC)

B. Definitions in Subsection B pertain to conditional prescribing and prescribing psychologists only.

(1) "Adults" mean all persons over 18 years of age through 65 years of age.

(2) "Board" means the New Mexico state board of psychologist examiners.

(3) "Children/adolescents" mean all persons through 18 years of age (children, 2-12 years; adolescents 12-18 years).

(4) "Collaborative relationship" means a cooperative working relationship between a conditional prescribing or prescribing psychologist and a health care practitioner in the provision of patient care, including cooperation in the management and delivery of physical and mental health care, to ensure optimal patient care.

(5) "Conditional prescribing psychologist" means a licensed psychologist who holds a valid conditional prescription certificate.

(6) "Conditional prescription certificate" means a document issued by the board to a licensed psychologist that permits the holder to prescribe psychotropic medication under the supervision of a licensed physician pursuant to the Professional Psychologist Act.

(7) "Conflict of interest" means past or present familial, social, fiduciary, business, financial, health care provider-patient relationship, agency, or other personal relationship that impairs or compromises or appears to impair or compromise the supervisor's neutrality, independence or objectivity. Paying or receiving an appropriate fee for supervisory services is not a conflict of interest. Conflict of interest includes dual relationship. If a conflict of interest or dual relationship arises during the supervision, the supervisor shall immediately report the conflict of interest or dual relationship to the board and shall cease supervision of the supervised psychologist.

(8) "Controlled substance' means any drug, substance or immediate precursor enumerated in schedules I through V of the Controlled Substance Act.

(9) "Drug" or "substance" means substances recognized as drugs in the official United States pharmacopoeia, official homeopathic pharmacopoeia of the United States or official national formulary or any respective supplement to those publications. It does not include devices or their components, parts or accessories.

(10) "Ethno-pharmacology" means the basic and clinical sciences of treatment of specific mental illness with ethnically or culturally appropriate drugs.

(11) "Geriatric" means all persons over 65 years of age.

(12) "Health care practitioner" means a licensed physician, osteopathic physician or nurse practitioner with independent, licensed prescribing privilege.

(13) "Log" means a written record of patient examination and treatment that contains elements specified in the regulations and which is required as a basis for evaluation of the applicant for licensure.

(14) "Member of the family" means a parent, spouse, child, stepchild, grandchild, grandparent, sibling, uncle, aunt, niece or nephew, or other relative by blood, marriage, or legal process with whom the supervisor or physician supervisor has or has had a close familial relationship.

(15) "Member of the household" means residing within the same dwelling unit, either continuously or intermittently, regardless of whether fee or rent is paid or received.

(16) "National certification exam" means an examination that evaluates the psychopharmacological knowledge base of the applicant, is developed with the intention to administer it to psychologists seeking certificates or licenses to prescribe psychotropic medication in any state with prescriptive authority for psychologists, and meets standards acceptable to the board and the medical board.

(17) "Physician" means an allopathic or osteopathic physician.

(18) "Practice of psychology" means the observation, description, evaluation, interpretation and modification of human behavior by the application of psychological principles, methods and procedures for the purpose of preventing or eliminating symptomatic, maladaptive or undesired behavior and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health and mental health, and further means the rendering of such psychological services to individuals, families or groups regardless of whether payment is received for services rendered. The practice of psychology includes psychological testing or neuropsychological testing and the evaluation or assessment of personal characteristics such as intelligence, personality, abilities, interests, aptitudes and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, behavior analysis and therapy; diagnosis and treatment of any mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct and the psychological aspects of physical illness, accident, injury and disability; and psycho-educational evaluation, therapy, remediation and consultation.

(19) "Practicum" means a period of supervised clinical training and practice in which specific scientific and clinical techniques and diagnoses are learned.

(20) "Prescribing psychologist" means a licensed psychologist who holds a valid prescription certificate.

(21) "Prescription" means an order given individually for the person for whom prescribed, either directly from the prescriber to the pharmacist or indirectly by means of a written order signed by the prescriber, and bearing the name and address of the prescriber, his license classification, the name and address of the patient, the name and quantity of the drug prescribed, directions for use and the date of issue. No person other than a practitioner shall prescribe or write a prescription.

(22) "Prescription certificate" means a document issued by the board to a licensed psychologist that permits the holder to prescribe psychotropic medication pursuant to the Professional Psychologist Act.

(23) "Primary treating health care practitioner' means the health care practitioner who is directly responsible for treating a specific illness or condition of a patient. The primary treating health care practitioner may be a primary care practitioner, or may be a medical specialist.

(24) "Psychologist' means a person who engages in the practice of psychology or holds himself out to the public by any title or description of services representing himself as a psychologist, which incorporates the words "psychological", "psychologist", "psychology", or when a person describes himself as above and, under such title or description, offers to render or renders services involving the application of principles, methods and procedures of the science and profession of psychology to persons for compensation or other personal gain.

(25) "Psychopharmacology" means the basic and clinical sciences of drugs used to treat mental illnesses.

(26) "Psychopharmacotherapy" means the application of pharmaco-therapeutics to psychological problems. A key principle is the assessment of a patient's history that helps establish the appropriate role of drug therapy. Essential steps include recognition of the disorder, adequate understanding of efficacy safety, pharmaco-kinetics, pharmaco-dynamics and application in the clinical setting.

(27) "Psychotropic medication" means a controlled substance or dangerous drug that may not be dispensed or administered without a prescription, whose indication for use has been approved by the federal food and drug administration for the treatment of mental disorders and is listed as a psychotherapeutic agent in drug facts and comparisons or in the American hospital formulary service.

(28) "School" means a college or a university or other institution of higher education that is regionally accredited and that offers a full-time graduate course of study in psychology as defined by rule of the board or that is approved by the American psychological association.

(29) "Socio-cultural" means aspects of mental illness related to social and cultural mores and traditions of varied social and cultural groups.

(30) "Supervision" means direct oversight of the psychologist trainee's psychopharmacological practice by qualified supervising physician approved by the board. Supervision may be on or off site as specified in the rule.

(31) "Applicant" means a licensed psychologist who has made application to the board for a conditional prescribing or prescribing certificate.

(32) "Supervisor" means a qualified supervising physician approved by the board.

[16.22.1.7 NMAC - Rp, 16.22.1.7 NMAC, 11/15/06; A, 03/21/09; A, 09/16/10; A, 04/11/12; A, 04/30/15]

16.22.1.8 ACRONYMS USED THROUGHOUT THESE REGULATIONS INCLUDE:

A. AUCC - Association of universities and colleges of Canada.
B. ASPPB - Association of state and provincial psychology boards.
C. CANA -Child Abuse and Neglect Act.
D. CMHDDA -Children's Mental Health and Development Disability Act.
E. CPE - continuing professional education.
F. CPQ - certification of professional qualification.
G. EPPP - examination for professional practice in psychology.
H. GCA - Governmental Code Act
I. HIPDB - healthcare integrity and protection data bank.
J. IPRA - Inspection of Public Records Act.
K. MHDDC - Mental Health and Development Disabilities Code.
L. NMAC - New Mexico administrative code.
M. NMSA - New Mexico statutes annotated
N. NCA - notice of contemplated action.
O. OMA - Open Meetings Act.
P. PES - professional examination service.
Q. RxP - psychopharmacology.
R. RANA - Resident Abuse and Neglect Act.
S. ULA - Uniform Licensing Act.

[16.22.1.8 NMAC - N, 11/15/06]

16.22.1.9 BOARD MEMBERSHIP:

A. Number. Board members under the provisions of Subsection A of 61-9-5 NMSA 1978, the board of psychologist examiners consists of eight (8) members appointed by the governor who are bona fide residents of New Mexico and serve for three-year staggered terms.

B. Appointments. The members shall be appointed as follows:

(1) four (4) members shall be professional members who are psychologists licensed under the act, appointed by the governor from a list of names nominated by the New Mexico psychological association, the New Mexico school psychologist association and the New Mexico state psychologist association;

(2) one (1) member shall be an additional professional member who is licensed under the act as a psychologist or psychologist associate; and

(3) three (3) public members who are laymen and have no significant financial interest, direct or indirect, in the practice of psychology.

C. Successive appointments. Each member shall be appointed for a term of three (3) years and hold office until the expiration of his/her appointed term or until a successor is duly appointed. When the term of a member ends, the governor shall appoint that member's successor pursuant to Subsection B of 16.22.1.9 above, which was applicable to the expiring member's appointment.

D. Unexpired vacancy. Any vacancy occurring in the board membership other than by expiration of term shall be filled by appointment by the governor for the unexpired term of the member.

[16.22.1.9 NMAC - Rp, 16.22.1.8 NMAC, 11/15/06]

16.22.1.10 BOARD OPERATIONS:

A. Elections. At its annual meeting in July, the board shall elect a chair, vice chair, and secretary treasurer.

B. Duties of officers. All board officers shall exercise authority subject to the act, board regulations, and specific directions of the board.

(1) The chair shall preside at board meetings and adjudicatory hearings unless another presiding officer is named by the board. At the direction of the board, the chair shall respond to inquiries and correspondence, execute orders of the board in any pending adjudicatory proceeding unless a hearing officer is appointed, sign, or designate another board member to sign decisions of the board, appoint board members to formal committees, and provide direction to the board administrator on routine matters to facilitate the efficient operation of board functions between meetings.

(2) The vice chair shall preside at board meetings and adjudicatory hearings in the absence of the chair. If the office of chair becomes vacant, the vice chair shall serve as chair until a new chair is elected.

(3) The secretary-treasurer shall preside at board meetings and adjudicatory proceedings in the absence of the chair and vice chair.

C. Vacancy. If the office of board chair becomes vacant, the board shall elect a chair at the next meeting or any subsequent meeting. If the office of vice chair or secretary-treasurer becomes vacant, the board may hold elections as it deems necessary and advisable.

D. Duties of board administrator. The board administrator shall at all times perform those tasks directed by the board pursuant to and those duties prescribed by the act, board regulations, the ULA, Sections 61-1-1 thru 61-1-33 NMSA 1978, and other applicable state laws. In addition, the board administrator shall supervise other personnel, to ensure the responsiveness and efficiency of board operations, and assume the role of custodian of records.

E. Board office. The board office is located in Santa Fe, New Mexico.

F. Board meetings. The board shall conduct meetings in accordance with the Open Meetings Act (OMA), Sections 10-15-1 thru 10-15-4 NMSA 1978.

G. Annual meeting. The board shall hold an annual meeting in July and shall hold other meetings as it deems necessary and advisable.

H. Conduct of meetings. The board shall conduct its meetings in an orderly fashion, with due regard for each board member and the public. The board may refer to Robert's Rules of Order, Revised, when necessary and advisable.

I. Agenda. The board administrator shall prepare the meeting agenda in accordance with the OMA and board regulations, except that the board may change the order of agenda items during the meeting.

J. Quorum. The board shall transact official business only at a legally constituted meeting with a quorum present. A quorum shall consist of five (5) members. The board is in no way bound by any opinion, statement, or action of any board member, the board administrator, or other staff except when such action is pursuant to a lawful instruction or direction of the board.

K. Addressing the board. Except for proceedings to adopt, amend, or repeal regulations in accordance with the ULA, Section 61-1-29 NMSA 1978, the board, at its sole discretion, may provide a reasonable opportunity for persons attending an open meeting to address the board on an agenda item. The request to speak shall be timely made and shall not delay or disrupt the board's meeting. No person shall be permitted to address the board on any pending or concluded application, complaint, investigation, adjudicatory proceeding, or matter in litigation, except to confer for the purpose of settlement or simplification of the issues. Any public comment to the board shall be brief, concise, and relevant to the agenda item. The board may limit the total time allotted for comments and the time allotted to any person.

L. Telephonic attendance. Pursuant to the OMA, Section 10-15-1 (C) NMSA 1978, a board member may participate in a meeting of the board by means of a conference telephone or other similar communications equipment when it is otherwise difficult or impossible for the member to attend the meeting in person, and shall give advance notice to the board administrator in ample time to arrange such accommodation.

M. Conflict of interest, recusal. Any board member who cannot be impartial in the determination of a matter before the board and who cannot judge a particular matter or controversy fairly on the basis of its own merits shall not participate in the any board deliberation or vote on the matter. A board member with a personal, social, family, financial, business, or pecuniary interest in a matter shall recuse himself or herself and shall not participate in a hearing, consideration, deliberation, or vote on the matter, except as provided by law.

N. Confidentiality. Board members shall not disclose to any non-member the content of any executive session discussion or deliberation, or any other confidential matters that may be the subject of an executive session or attorney-client privileged communications except as ordered by a court of competent jurisdiction or where the board knowingly and intentionally permits disclosure. Nothing herein shall preclude the board from including in executive session discussions or confidential committee meetings the board administrator or other persons the board deems necessary to assist the board in carrying out its operations. Such other persons shall be bound by the same rules of executive session as board members.

O. Code of conduct. Board members shall adhere to the standards set forth in the GCA, Chapter 10, Article 16 NMSA 1978, and shall sign a code of conduct agreement as provided by the regulation and licensing department or its designee adopting provisions in the GCA.

[16.22.1.10 NMAC - Rp, 16.22.1.9 NMAC, 11/15/06]

16.22.1.11 BOARD RECORDS:

A. Inspection of Public Records Act (IPRA). Public records shall be available for inspection in accordance with the provisions of the IPRA, Section 14-2-1 through 14-2-12 NMSA 1978 and Section 61-9-5.1 NMSA 1978.

B. Copying charges. The custodian shall charge a copying charge of $.25 per page or the regulation and licensing department standard IPRA fee, whichever is higher.

C. Creating records. The board shall not be required to create any document or compile data for an individual or private entity.

D. Reasonable access. Consistent with the IPRA and taking into account the available staff, space, and the needs of other legitimate public business, the custodian may determine the reasonable time, place, and conditions for access to public records.

E. Removal. Public records shall not be removed from the board office except by board members, board staff, or agents of the board for official public business.

[16.22.1.11 NMAC - Rp, 16.22.1.10 NMAC, 11/15/06; A, 03/21/09]

16.22.1.12 BOARD RULES AND REGULATIONS 2000 (as revised**).** Board regulations may be adopted, amended, repealed, or superseded by rulemaking proceedings pursuant to applicable provisions of the act, the ULA, and the State Rules Act.

[16.22.1.12 NMAC - Rp, 16.22.1.11 NMAC, 11/15/06]

16.22.1.13 ELECTRONIC SIGNATURES: The board will accept electronic signatures on all applications and renewals submitted for professional licensure.

[16.22.1.13 NMAC - N, 04/30/15]

HISTORY OF 16.22.1 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives under:

SBPE 10, Status of Non-Certified Personnel, filed 11/15/79;
Rule 13, Status of Non-Certified Personnel, filed 11/1/83;
NMBPE Rule 9, Status of Non-Licensed Personnel, filed 12/28/89;
NMBPE Rule 9, Status of Non-Licensed Personnel, filed 2/7/90;
Rule No. 9, Status of Non-Licensed Personnel, filed 4/24/95;
SBPE 11, Areas of Practice, filed 11/15/79;
Rule 11, Changing or Adding Areas of Practice, filed 11/1/83;
NMBPE Rule 10, Board Files, filed 8/28/90;

Rule No. 10, Board Records, filed 4/24/95;
Rule No. 16, Superseding Rule, filed 4/24/95;
Rule No. 18, Meetings By Telephone, filed 4/24/95.

History of Repealed Material:
16 NMAC 22.1, General Provisions - Repealed, 04/16/00.
16.22.1 NMAC, General Provisions - Repealed 11/15/06.

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 2 CODE OF CONDUCT

16.22.2.1 ISSUING AGENCY: Regulation and Licensing Department, New Mexico State Board of Psychologist Examiners.
[16.22.2.1 NMAC - Rp, 16.22.2.1 NMAC, 11/15/06]

16.22.2.2 SCOPE: The psychologist shall be governed by this code of conduct while providing psychological services in any context or whenever he is functioning in a professional capacity as a psychologist. This code shall not supersede state, federal, or provincial statutes. This code shall apply to the conduct of all licensees and applicants, including the applicant's conduct during the period of education, supervision, training, and employment, which is required for licensure. The term "psychologist," as used within this code, shall apply to both licensee and applicant.
[16.22.2.2 NMAC - Rp, 16.22.2.2 NMAC, 11/15/06]

16.22.2.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologists Act, Section 61-9-6.
[16.22.2.3 NMAC - Rp, 16.22.2.3 NMAC, 11/15/06]

16.22.2.4 DURATION: Permanent.
[16.22.2.4 NMAC - Rp, 16.22.2.4 NMAC, 11/15/06]

16.22.2.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of a section.
[16.22.2.5 NMAC - Rp, 16.22.2.5 NMAC, 11/15/06]

16.22.2.6 OBJECTIVE: This part establishes the standards against which the required professional conduct of a psychologist is measured. Each licensee and applicant will be governed by this part whenever providing psychological services. A violation of this part is sufficient reason for disciplinary action pursuant to the Act.
[16.22.2.6 NMAC - Rp, 16.22.2.6 NMAC, 11/15/06]

16.22.2.7 DEFINITIONS: [RESERVED.]
[Refer to 16.22.1.7 NMAC]

16.22.2.8 RULES OF COMPETENCE

A. Limits on practice. The psychologist shall limit practice and supervision to the areas of competence in which proficiency has been gained through education, training, and experience.

B. Maintaining competency. The psychologist shall maintain current competency in the areas in which he practices, through continuing professional education, consultation, and/or other procedures, in conformance with current standards of scientific and professional knowledge.

C. Psychologists with restricted and unrestricted licenses and psychologist associates shall complete eight (8) hours of cultural competence coursework promulgated by the board during the first year of licensure; and also shall take four (4) additional hours in cultural competence, as deemed satisfactory to the board, every two (2) years as detailed in 16.22.9 NMAC.

D. Adding new services and techniques. The psychologist, when developing competency in a service or technique that is either new to the psychologist or new to the profession, shall engage in ongoing consultation with other psychologists or relevant professionals, and shall seek appropriate education and training in the new area. The psychologist shall inform clients or patients of the innovative nature and the known risks and benefits associated with the services, so that the client or patient can exercise freedom of choice concerning such services.

E. Referral. The psychologist shall make or recommend referral to professional, technical, or administrative, or public resources when such referral is clearly in the best interest of the clients or patient(s).

F. Sufficient professional information. A psychologist shall not render a formal professional opinion about a person or diagnose or treat a person without direct and substantial professional contact and a formal assessment of that person.

G. Maintenance and retention of records.

(1) The psychologist rendering professional services to a client or patient shall maintain professional records that include:

(a) the presenting problem(s) or the reason the client(s) or patient(s) sought the psychologist's services;

(b) diagnosis and/or clinical formulation;

(c) the fee arrangement;

(d) the date and substance of each billed contact or service;

(e) any test results or other evaluative results obtained and any basic test data from which they were derived;

(f) notation and results of formal consultations with other providers;

(g) a copy of all test or other evaluative reports prepared as part of the professional relationship;

(h) the date of termination of services.

(2) The psychologist shall ensure that all data entries in the professional records are maintained for a period of not less than five (5) years after the last date that service was rendered. The psychologist shall comply with other legal requirements for record retention, even if longer periods of retention are required for other purposes.

(3) The psychologist shall store and dispose of written, electronic, and other records in a manner that protects confidentiality.

(4) For each person professionally supervised, the psychologist shall maintain for a period of not less than five (5) years after the last date of supervision a record of the supervisory session that shall include, among other information, the type, place, and general content of the session.

(5) Upon request by the client, patient, or legal representative of the client or patient, the psychologist shall release records under his control, except as otherwise provided in these rules and regulations or state law. Lack of payment for services does not constitute grounds for refusing to release client or patient records.

H. Continuity of care. The psychologist shall make arrangements for another appropriate professional or professionals to deal with emergency needs of his clients, as appropriate, during periods of his foreseeable absences from professional availability.

[16.22.2.8 NMAC - Rp, 16.22.2.8 NMAC, 11/15/06; A, 09/16/10]

16.22.2.9 IMPAIRED OBJECTIVITY AND DUAL RELATIONSHIPS

A. Impaired psychologist. The psychologist shall not undertake or continue a professional relationship with a client when the psychologist is impaired due to mental, emotional, physiologic, pharmacologic, or substance abuse conditions. If such a condition develops after a professional relationship has been initiated, the psychologist shall terminate the relationship in an appropriate manner, shall notify the client in writing of the termination, and shall assist the client in obtaining services from another professional.

B. Prohibited dual relationships.

(1) The psychologist shall not undertake or continue a professional relationship with a client or patient when the objectivity or competency of the psychologist is compromised because of the psychologist's present or previous familial, social, sexual, emotional, or legal relationship with the client or a relevant person associated with or related to the client.

(2) The psychologist, in interacting with a current or former client or patient to whom the psychologist has at any time within the previous twelve (12) months rendered counseling, psychotherapeutic, or other professional psychological services for treatment or amelioration of emotional distress or behavioral inadequacy, shall not:

(a) engage in any verbal or physical behavior toward the client or patient which is sexually seductive, demeaning, or harassing; or

(b) engage in sexual intercourse, or sexual contact or other sexual intimacies with the client or patient; or

(c) enter into a business or financial (other than fees for professional services) or other potentially exploitative relationship with the client or patient.

(3) The prohibitions set out in Paragraph (2) of Subsection B of 16.22.2.9 NMAC shall not be limited to the 12-month period but shall extend longer unless the psychologist can demonstrate that the client or patient is not vulnerable to exploitative influence by the psychologist. The psychologist who engages in such sexual or financial relationship after the twelve (12) months following cessation or termination of treatment bears the burden of proving that there has been no exploitation, in light of all relevant factors, including:

(a) the amount of time that has passed since the therapy terminated;
(b) the nature and duration of the therapy;
(c) the circumstances of termination;
(d) the client or patient's personal history;
(e) the client or patient's mental status;
(f) the likelihood of adverse impact on the client or patient and others; and
(g) any statements or actions made by the psychologist during the course of therapy suggesting or inviting the possibility of a post-termination sexual or other potentially exploitative relationship with the patient or client.

(4) The psychologist shall not serve in varied capacities that confuse the role of the psychologist. Such confusion is most likely when the psychologist changes from one role to another and fails to make clear who is the client or patient. The psychologist is responsible for taking appropriate precautions to avoid harmful dual relationships and is responsible for informing all affected individuals, preferably in writing, when such a change is necessary. Examples of situations requiring extra caution include:

(a) treating a person who is the family member of a current or former patient or client;
(b) treating a family as a unit after treating a family member or, conversely, treating a family member after treating the family as a unit;
(c) moving from a confidential role to a non-confidential one, such as from therapist or mediator to evaluator, arbitrator, or "wise-person"; and
(d) moving from a position of authority into a confidential role, such as from court-appointed evaluator to the role of therapist.

(5) If one family member is a minor, the psychologist shall ensure that the child understands how the role of the psychologist is changing (for example, moving from therapist for the child to therapist for the family) and shall explain the limits of confidentiality that result from this changed role.

(6) When a psychologist agrees to provide services to several persons who have a relationship (such as husband and wife or parents and children), the psychologist shall clarify at the outset:

(a) which of the individuals are patients or clients and
(b) the relationship the psychologist will have with each person; this clarification includes the role of the psychologist and the possible uses of services provided or information obtained.

(7) As soon as it becomes apparent that the psychologist may be called on to perform potentially conflicting roles (such as marital counselor to husband and wife and then witness for one party in a divorce proceeding), the psychologist shall clarify and withdraw from or adjust roles, as appropriate.

[16.22.2.9 NMAC - Rp, 16.22.2.9 NMAC, 11/15/06; A, 03/21/09]

16.22.2.10 PATIENT WELFARE

A. Informed consent for therapy and evaluation.

(1) The psychologist shall appropriately document and obtain appropriate informed consent for therapy or related procedures or evaluation. Informed consent means that the person:

(a) has the capacity to consent;
(b) has been informed of significant information concerning the therapy or evaluation in language that is understandable; and
(c) has freely and without undue influence expressed consent.

(2) When persons are legally incapable of giving informed consent, the psychologist shall obtain informed consent from a legally authorized person, if such substitute consent is permitted by law.

(3) In addition, the psychologist shall:

(a) inform those persons who are legally incapable of giving informed consent about the proposed interventions or evaluations in a manner commensurate with the persons' psychological capacities;
(b) seek or obtain their assent to those interventions or evaluations; and
(c) consider such person's preferences and best interests.

B. Limits of confidentiality in forensic, court-ordered, or child custody evaluations.

(1) The psychologist shall explain the limits of confidentiality to parties at the outset, before the evaluation begins, and the explanation should be documented. The psychologist shall also clarify how the information will be used and which parties or entities will have access to the evaluation. The procedures of the evaluation and their purpose should be described to the parties.

(2) In the case of child custody evaluations, the limits of confidentiality shall be explained at the initial meeting with each parent and the children.

C. Terminating the professional relationship.

(1) The psychologist shall not abandon his clients or patients.

(2) The psychologist shall terminate a professional relationship when it becomes clear that the patient no longer needs the service, is not benefiting from the service, is being harmed by continued service, or if the psychologist is acting outside of his or her area of competence.

(3) Prior to termination, for whatever reason, except where precluded by the patient's conduct (for example, the patient or client moves to another state without giving notice to the psychologist and the patient is not a danger to self or others), the psychologist shall discuss the patient's views and needs, provide appropriate pre-termination counseling, suggest alternative service providers as appropriate, and take other reasonable steps to facilitate transfer of responsibility to another provider, if the patient needs one immediately.

D. Stereotyping. The psychologist shall not impose any stereotypes, which would interfere with the psychologist's obligation to provide objective psychological services to the client or patient.

E. Sexual or other dual relationship. The psychologist shall not enter into a sexual or other dual relationship, as specified in Subsection B of 16.22.2.9 NMAC of this code of conduct.

F. Exploitative relationships.

(1) The psychologist shall not exploit persons over whom the psychologist has supervisory, evaluative, or other authority such as applicants, supervisees, employees, research participants, and clients or patients.

(2) The psychologist shall not engage in sexual relationships with applicants, supervisees in training over whom the psychologist has evaluative or direct authority.

G. Solicitation of business by patients. The psychologist shall not induce the patient to solicit business on behalf of the psychologist.

H. Referrals. The psychologist providing services to a client or patient shall make an appropriate referral of the client or patient to another professional when requested to do so by the client or patient, when such a referral is in the best interest of the client or patient or when the client or patient presents symptoms or behaviors that are outside the psychologist's area of practice.

I. Consultations. When consulting with colleagues, the psychologist:

(1) shall not share confidential information that could lead to the identification of a patient, client, research participant, or other person or organization without prior written consent; and

(2) shall share information only to the extent necessary to achieve the purposes of the consultation.

J. Avoiding harm. Psychologists take reasonable steps to avoid harming their patients, research participants, applicants and others with whom they work, and minimize harm where it is foreseeable and unavoidable.

[16.22.2.10 NMAC - Rp, 16.22.2.10 NMAC, 11/15/06]

16.22.2.11 WELFARE OF SUPERVISEE AND RESEARCH SUBJECTS

A. Welfare of supervisees. The psychologist shall not exploit a supervisee in any way sexually, financially, or otherwise.

B. Welfare of research subjects. The psychologist shall respect the dignity and protect the welfare of his research subjects, and shall comply with all relevant statutes and the board's regulations concerning treatment of research subjects.

[16.22.2.11 NMAC - Rp, 16.22.2.11 NMAC, 11/15/06]

16.22.2.12 PROTECTING CONFIDENTIALITY

A. Safeguarding confidential information. The psychologist shall safeguard confidential information obtained in the course of practice, teaching, research, or other professional services. The psychologist shall disclose confidential information to others only with the written informed consent of the patient or client in accordance with the Public Health Act, Section 24-1-20 NMSA 1978, except as provided in these regulations.

B. Discussing the limits of confidentiality.

(1) The psychologist shall discuss with persons and organizations with whom the psychologist establishes a professional or scientific relationship (including, to the extent feasible, minors and their legal representatives):

(a) the relevant limitations on confidentiality, including limitations where applicable in group, marital, and family therapy or in organizational consulting; and

(b) the foreseeable uses of the information generated through his services.

(2) Unless it is not feasible or is contraindicated, the psychologist shall discuss confidentiality at the outset of the relationship and thereafter as new circumstances warrant.

C. Disclosure without informed written consent. Except as otherwise permitted under the provisions of the MHDDC, Section 43-1-19 NMSA, 1978, and the CMHDDA, Sections 32A-6-1 thru 32A-6-22 NMSA 1978 and as amended, a psychologist may disclose confidential information without the informed written consent of the patient/client when the psychologist judges that disclosure is necessary to protect against a substantial and imminent risk of serious harm being inflicted by the patient on the patient or another person. In such case, the psychologist shall limit disclosure of the otherwise confidential information to only those persons and only that content necessary to address the imminent risk of harm. When the client is an organization, disclosure shall be made only after the psychologist has made a reasonable and unsuccessful attempt to have the problems corrected within the organization.

D. Services involving more than one interested party. In a situation in which more than one party has an appropriate interest in the professional services rendered by the psychologist to a patient(s) and client(s), the psychologist shall, to the extent possible, clarify to all parties prior to rendering the services the dimensions of confidentiality and professional responsibility that shall pertain in the rendering of services. The relevant limitations on confidentiality shall be clarified, including limitations where applicable in group, marital, or family therapy or in organizational consulting. Such clarification is specifically indicated, among other circumstances, when the patient or client is an organization. The psychologist shall also communicate the foreseeable uses of the information generated through his services.

E. Legally dependent patients. At the beginning of a professional relationship, to the extent that the patient or client can understand, the psychologist shall inform a patient or client who is below the age of majority or who has a legal guardian of the limit the law imposes on the right of confidentiality with respect to the patient or client's communications with the psychologist.

F. Limited access to client records. The psychologist shall limit access to patient or client records to preserve the patient or client's confidentiality and shall make effort to ensure that all persons working under the psychologist's authority comply with the requirements for confidentiality of patient or client material.

G. Release of confidential information. The psychologist may release confidential information upon court order, or to conform to state or federal law, rules or regulations. The psychologist shall consult with others and take appropriate action if a court order appears to violate confidentiality rights under state or federal law, rules or regulations.

H. Reporting of abuse of children and vulnerable adults. The psychologist shall be familiar with the Child Abuse and Neglect Act (CANA), Sections 32A-4-1 thru 32A-4-34 NMSA 1978, Resident Abuse and Neglect Act (RANA), Sections 30-47-1 thru 30-47-10 NMSA 1978, and any other relevant law concerning the reporting of abuse of children and vulnerable adults, and shall comply with the mandatory requirements of such laws.

I. Discussion of client information among professionals. When rendering professional services as part of a team or when interacting with other appropriate professionals concerning the welfare of the client, the psychologist may share confidential information about the client provided the psychologist ensures that all persons receiving the information are informed about the confidential nature of the information and abide by the rules of confidentiality.

J. Disguising confidential information. When a case report or other confidential information is used as the basis of teaching, research, or other published reports, the psychologist shall exercise reasonable care to ensure that the case report or information is appropriately disguised to prevent client identification.

K. Observation and electronic recording. The psychologist shall ensure that diagnostic interviews or therapeutic sessions with a patient are observed or electronically recorded only with the informed written consent of the patient or his legal guardian, if any. The patient may withdraw consent at any time verbally or in writing unless otherwise required by law.

L. Confidentiality after termination of a professional relationship. The psychologist shall continue to treat information regarding a patient as confidential after the professional relationship between the psychologist and the patient has ceased.

M. Confidentiality of electronic transmission. The psychologist shall ensure that confidential information is not transmitted in any way that compromises confidentiality.

[16.22.2.12 NMAC - Rp, 16.22.2.12 NMAC, 11/15/06]

16.22.2.13 DISCLOSURE AND MISREPRESENTATION OF SERVICES

A. Definition of public statements. Public statements include but are not limited to paid or unpaid advertising, brochures, printed matter, directory listings, personal resumes or curriculum vitae, interviews or comments for use in media, statements in legal proceedings, lectures, and public oral presentations.

B. Display of license. The psychologist shall display his current New Mexico license to practice psychology, on the premises of his primary professional office.

C. Misrepresentation of qualifications. The psychologist shall not misrepresent directly or by implication his professional qualifications such as type of licensure, education, experience, and areas of competence.

D. Misrepresentation of affiliations. The psychologist shall neither misrepresent nor permit the misrepresentation of his professional qualifications, affiliations, or purposes, or those of the institutions, organizations, products, and/or services with which he is associated.

E. False or misleading information regarding professional services. The psychologist shall not include false or misleading information in public statements concerning professional services offered.

(1) When announcing or advertising professional services and/or describing his professional qualifications, the psychologist may list the following:

(a) degrees obtained (Ph.D. or Psy.D.) and the area in which the degree is obtained (clinical, counseling, or school);

(b) the institutions from which the degrees were obtained;

(c) date, type, and level of certification or licensure;

(d) diploma status; membership status in professional organizations;

(e) address; telephone number; office hours;

(f) a brief listing of the type of psychological services offered;

(g) an appropriate presentation of fee information;

(h) foreign languages spoken; and

(i) policy with regard to third-party payments.

(2) Additional relevant or important consumer information may be included if not prohibited by other sections of the code. The psychologist must disclose and list whether his New Mexico license is regular, provisional, temporary, emergency or inactive, and include its expiration date.

(3) When announcing or advertising the availability of psychological products, publications, or services, the psychologist shall not display any affiliation with an organization in a manner that falsely implies the sponsorship or certification of that organization. In particular, the psychologist shall not offer professional organization or fellowship status in a way that implies specialized professional competence or qualifications. Public statements shall not contain:

(a) any statement likely to mislead or deceive because it makes only a partial disclosure of relevant facts;

(b) a statement of a patient's laudatory statements about the psychologist or his services or products;

(c) a statement intended or likely to create false or unjustified expectations of favorable results;

(d) a statement implying unusual, unique, or one-of-a-kind abilities;

(e) a statement intended or likely to appeal to a prospective patient's fears, anxieties; or emotions concerning the possible consequences of the prospective client's failure to obtain the offered services;

(f) a statement concerning the comparative desirability of offered service;

(g) a statement of direct solicitation of individual clients.

F. Promotion of psychological services and products. Psychologists associated with the development or promotion of psychological devices, books, or other products offered for sale must ensure that announcements and advertisements are presented in an accurate and truthful manner.

(1) The psychologist shall offer his/ her services, products, and publications in an accurate and truthful manner, avoiding statements or claims likely to deceive or mislead such as misrepresentation through sensationalism, exaggeration, or superficiality. The psychologist shall be guided by the primary obligation to aid the public in forming their own informed judgments, opinions, and choices.

(2) The psychologist shall make efforts to ensure that statements in catalogues, workshops, and seminar outlines are not false, misleading, or inaccurate. Announcements, brochures, or advertisements describing workshops, seminars, or other programs shall accurately represent the intended audience, eligibility requirements, educational objectives, and nature of the material to be covered, as well as the education, training, and experience of the persons presenting the programs. The psychologist shall make clear the nature of the services, costs, and other obligations to be accepted by research participants whenever fees or clinical or other professional services are offered as inducement.

G. Misrepresentation of services or products. The psychologist shall not associate with or permit his name to be used in connection with any services or products in such a way as to misrepresent:

(1) the services or products;

(2) the degree of his responsibility for the services or products; or

(3) the nature of his association with the services or products.

H. In-person solicitation. The psychologist shall not engage, directly or through agents, uninvited, in-person solicitation of business from actual or potential psychotherapy patients, or other persons who, because of their particular circumstances, are vulnerable to undue influence.

[16.22.2.13 NMAC - Rp, 16.22.2.13 NMAC, 11/15/06]

16.22.2.14 FEES AND STATEMENTS

A. Disclosure of charges for services. The psychologist shall provide complete and accurate information about the charge of professional services to the client or patient, a prospective client or patient, or third-party payor.

B. Accuracy in reports to payors and funding sources. In reports to payors for services or sources of research funding, the psychologist shall accurately state the nature of the research or services provided, the fees or charges, and, where applicable, the identity of the provider, the findings, and the diagnosis.

C. Referrals and fees. When a psychologist pays, receives payment from, or divides fees with another professional other than in an employer-employee relationship, the payment to each shall be based on the services (clinical, consultative, administrative, or other) provided and shall not be based on the referral itself. Referral fees are prohibited.

D. Fees and financial arrangements. As early as is feasible in a professional or scientific relationship, the psychologist and the patient, or client, should reach an agreement specifying the compensation and the billing arrangements.

(1) The psychologist shall not misrepresent his fees.

(2) If limitations to services can be anticipated because of the client or patient's finances, the psychologist should discuss such anticipated limitations with the patient or client.

(3) If the patient or client does not pay for services as agreed, and if the psychologist wishes to use collection agencies or legal measures to collect the fees, the psychologist shall first inform the patient or client that such measures will be taken and provide an opportunity for the patient or client to make prompt payment.

(4) Prior to conducting a custody evaluation, the psychologist shall clarify to the parties involved the charges, or estimation of costs, and the manner in which fees will be collected. A specific written fee agreement shall be signed by all parties.

(5) A psychologist's fee shall include indirect costs of conducting a private practice (for example, secretarial fees, office supplies, durable materials, etc.) A psychologist shall not bill the client or patient for additional indirect costs beyond those included in the psychologist's fee.

[16.22.2.14 NMAC - Rp, 16.22.2.14 NMAC, 11/15/06]

16.22.2.15 ASSESSMENT PROCEDURES

A. Confidential information. The psychologist shall treat the results of a psychological assessment as confidential information subject to the same rules and regulations as other patient information.

B. Use of assessment in general and with special populations. Psychologists who administer, score, interpret, or use assessment techniques shall be familiar with reliability, validity, standardization, comparative, and outcome studies of the techniques they use and with the proper application and use of those techniques.

(1) The psychologist shall recognize limits of the confidence with which diagnoses, judgments, or predictions can be made about individuals.

(2) The psychologist shall identify situations in which particular assessment techniques or norms may not be applicable or may require adjustment in administration or interpretation because of factors such as an individual's gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language, or socioeconomic status.

C. Communication of results. The psychologist shall communicate results of the assessment to the client or patient, parents, legal guardians, or other agents of the client or patient in as clear and understandable a manner as reasonably possible and with respect for the client or patient.

D. Reservations concerning results. The psychologist shall include in the assessment report the results of any limitations of the assessment procedures as may apply to the reliability or validity of the assessment techniques or the interpretation of results.

(1) Issues of individual differences, such as language, ethnicity, culture, socioeconomic, religion, disability, and lifestyle differences, should be carefully considered and addressed whenever relevant.

(2) Any limitations of results derived from the factors in Paragraph (1) of Subsection D of 16.22.2.15 NMAC should be clearly stated in the psychological report. The psychological report of an individual on whom psychological tests are not normed or adequately normed should clearly indicate the limitations of the assessment and the need for caution in interpreting test results.

E. Information for professional users.

(1) The psychologist offering an assessment procedure or automated interpretation service to non-psychologist professionals shall accompany this offering with information that fully describes:

(a) the development of the assessment procedure or service;

(b) evidence of validity and reliability; and

(c) characteristics of the normative population.

(2) The psychologist shall explicitly state the purpose and application for which the procedure is recommended and identify special qualifications required to administer and interpret it properly. The psychologist shall ensure that advertisements for the assessment procedure or interpretive service are factual and accurately descriptive.

F. Opinions about individuals who are not directly evaluated. The psychologist shall not render public or professional opinions regarding the psychological functioning of any individual who has not been personally evaluated by that psychologist.

G. Assessing quality of parenting in child custody evaluations. There may be situations in which one parent is unavailable for direct evaluation due to geographic distance, severe pathology, or refusal to participate. While the psychologist can assess the quality of parenting of the available parent, no comparison can be made in terms of which parent is better; nor can conclusions be derived about the fitness or level of psychological functioning of the unavailable parent.

H. Collateral contacts in child custody evaluations. The identification, extent, and purpose of collateral contacts made in the course of an evaluation shall be clearly explained early, even within the referral process. Collateral contacts include people who represent a major presence in the children and parents' environment.

I. Test settings. Clients or patients should take standardized tests in a setting that will preserve the integrity of the tests and the information. When possible, all assessment procedures and techniques should be administered in a clinical setting.

J. Single-test assessments. A single-test assessment should not be the sole basis for major opinions or decisions.

K. Outdated tests. The psychologist shall not base assessments, decisions, or recommendations on outdated tests or test data as defined in Paragraph (49) of Subsection A of 16.22.1.7 NMAC.

[16.22.2.15 NMAC - Rp, 16.22.2.15 NMAC, 11/15/06]

16.22.2.16 TEST SECURITY

A. Limits of reproduction and description of test materials. The psychologist shall not reproduce or describe in public or in publications subject to general distribution any psychological tests or other assessment devices, the value of which depends in whole or in part on the naiveté of the subject, in ways that might invalidate the techniques. The psychologist shall limit access to such tests or devices to persons with professional interests who will safeguard their use.

B. Safeguarding test materials. The psychologist shall safeguard testing materials in accordance with the necessity to maintain test security. The psychologist should take all reasonable measures to protect test manuals, testing stimuli, and raw test data from disclosure to those who are not qualified to properly appraise those materials. The psychologist is required to release such materials only to those licensed and qualified in the use and interpretation of psychological tests and testing materials. If test materials are sought by subpoena or discovery request, the psychologist shall seek a protective order from a court of competent jurisdiction in order to maintain test security. Thereafter, the psychologist shall comply with the court order.

[16.22.2.16 NMAC - Rp, 16.22.2.16 NMAC, 11/15/06]

16.22.2.17 VIOLATIONS OF LAW

A. The psychologist shall not use fraud, misrepresentation, or deception in applying for or obtaining a psychologist license.

B. The psychologist shall not use fraud in:

(1) assisting another to obtain a psychologist license;

(2) billing clients or third-party payors;

(3) providing psychological service;

(4) reporting the results of psychological evaluations or services; or

(5) conducting any other activity related to the practice of psychology.

[16.22.2.17 NMAC - Rp, 16.22.2.17 NMAC, 11/15/06]

16.22.2.18 AIDING ILLEGAL PRACTICE

A. Aiding unauthorized practice. The psychologist shall not aid or abet another person in misrepresenting his professional credentials or illegally engaging in the practice of psychology.

B. Delegating professional responsibility. The psychologist shall not delegate responsibilities:

(1) to persons who are not appropriately licensed, credentialed, or otherwise qualified to provide assessment, diagnosis, or treatment; or

(2) to persons who are not psychology predoctoral or postdoctoral trainees.

C. Providing supervision. The psychologist shall exercise appropriate supervision over supervisees, as set forth in the board regulations.

[16.22.2.18 NMAC - Rp, 16.22.2.18 NMAC, 11/15/06]

16.22.2.19 RESOLVING ETHICAL ISSUES

A. Improper complaints. The psychologist shall not file or encourage the filing of ethics complaints to the board that are frivolous.

B. Familiarity with this code. The psychologist has an obligation to be familiar with the code, other applicable ethics codes, and their application to psychologists' work. Lack of awareness or misunderstanding of the code is not a defense to a charge of unethical conduct.

C. Confronting ethical issues. When a psychologist is uncertain whether a particular situation or course of action would violate this code, the psychologist shall consult with other psychologists knowledgeable about ethical issues, with state or national psychology ethics committees, or with other appropriate authorities in order to choose a proper course of action. Such consultation is not a defense to a charge of unethical conduct.

D. Mandatory reporting. If a psychologist has reason to believe that another psychologist is engaged in a prohibited dual relationship with a client or patient, exhibits habitual or excessive use of drugs and alcohol that adversely affect professional practice or commits fraud or gross incompetence, he must report the suspected violation to the board.

E. Cooperating with complaint and ethics committees. The psychologist shall cooperate in investigations, proceedings, and requirements of this code, the ethical principles of psychologists and code of conduct of the American psychologist association, or any affiliated state psychological association to which he belongs. In doing so, the psychologist shall make reasonable efforts to resolve any issues of confidentiality. Failure to cooperate is a separate violation of the code.

[16.22.2.19 NMAC - Rp, 16.22.2.19 NMAC, 11/15/06]

HISTORY OF 16.22.2 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives under:

SBPE 3, Code of Conduct, filed 11/15/79.
SBPE 3, Code of Conduct, filed 10/29/82.
NMSBPE Rule 3, Code of Conduct, filed 4/22/85.
NMBPE Rule 1, Code of Conduct, filed 12/28/89.
Rule No. 1, Code of Conduct, filed 4/24/95.

History of Repealed Material:

16 NMAC 22.2, Code of Conduct - Repealed, 4/16/00.
16.22.2 NMAC, Code of Conduct - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 3 NON-LICENSED PSYCHOLOGIST/APPLICANT WITH AN INDEPENDENT MENTAL HEALTH LICENSE

16.22.3.1 ISSUING AGENCY: Regulation and Licensing Department, New Mexico State Board of Psychologist Examiners.
[16.22.3.1 NMAC - Rp, 16.22.3.1 NMAC, 11/15/06]

16.22.3.2 SCOPE: This part applies to the board, licensees, applicants for licensure, non-licensed employees or agents of licensees, and the general public.
[16.22.3.2 NMAC - Rp, 16.22.3.2 NMAC, 11/15/06]

16.22.3.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist act, NMSA 1978 Section 61-9-6, 61-9-8, 61-9-16. Part 3 is authorized by NMSA 1978 Section 10-15-1.C (1993 Repl.)
[16.22.3.3 NMAC - Rp, 16.22.3.3 NMAC, 11/15/06]

16.22.3.4 DURATION: Permanent.
[16.22.3.4 NMAC - Rp, 16.22.3.4 NMAC, 11/15/06]

16.22.3.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of a section.
[16.22.3.5 NMAC - Rp, 16.22.3.5 NMAC, 11/15/06]

16.22.3.6 OBJECTIVE: The objectives of this part are to:

A. set forth the limitations and conditions on the practice of psychology that apply to applicants while supervised in a course of study at a school or college, non-licensed persons who practice under supervision in order to satisfy the requirements for licensure, non-licensed staff or employees of licensees, and non-licensed persons licensed in another jurisdiction who perform court-ordered evaluations in New Mexico, and

B. establish the extent that licensees who supervise or sponsor non-licensed persons are responsible for the conduct of the non-licensed person.
[16.22.3.6 NMAC - Rp, 16.22.3.6 NMAC, 11/15/06]

16.22.3.7 DEFINITIONS: [RESERVED]
[Refer to 16.22.1.7 NMAC]

16.22.3.8 NON-LICENSED PERSONS

A. **Limits of practice**. Unless licensed by the board or exempted from licensure as provided in the act, no non-licensed person shall render, perform, or offer to render or perform psychological services except as provided under this part. The provisions of this part shall be strictly construed to ensure that the public is adequately protected from the practice of psychology by unqualified persons.

B. **Required consent by patient or client**. Except for normal office management, administrative, and secretarial support roles and functions, the patient or client shall be fully informed of the tasks and assignments performed by non-licensed persons. The supervisor shall obtain informed consent as appropriate when non-licensed persons will have access to confidential patient or client information or if other non-licensed persons are or will be performing or rendering psychological services under supervision.

C. **Non-licensed employees or staff**.

(1) A licensed psychologist may employ office staff or agents to perform nonprofessional office management, administrative, and secretarial duties and functions. The licensee shall make every effort to ensure that the office staff is trained in a protect patient or client confidential information. The psychologist shall be responsible for any breach of confidentiality by his employees or staff.

(2) A licensed psychologist may employ qualified non-licensed persons to administer and score psychological tests or gather historical data from patients or clients. The employee shall work under the psychologist's direct supervision. The psychologist is ultimately responsible for the accuracy and competent administration, scoring and interpretation of tests and data.

[16.22.3.8 NMAC - Rp, 16.22.3.8 NMAC, 11/15/06]

16.22.3.9 SUPERVISION OF NON LICENSED PERSONS

A. Responsibility of supervisors and violations. The supervisor shall not assist a non-licensed person in the performance of any activity that constitutes the practice of psychology except as allowed by this part. A supervisor shall have functional authority over and professional responsibility for the work of the non-licensed person. A supervisor who assists a non-licensed person in the practice of psychology in violation of this part, by acts of omission or commission, or who provides inadequate supervision over a non-licensed person is subject to disciplinary action. The grounds for disciplinary action may include, without limitation, aiding and abetting the practice of psychology by a non-licensed person; incompetent practice of psychology; willful or negligent violation of the act; allowing the supervisor's name or license to be used in connection with a non-licensee who performs psychological services outside of the area of the non-licensed person's training, experience, or competency; or abandonment of the patient or client.

B. **Qualifications of supervisors**. The supervisor shall be a licensed psychologist. The supervisor shall have training or experience in the specific area of practice being supervised. The supervisor may assign non-licensed persons to other qualified specialists under the supervisor's authority for specific skill training. The other specialist shall have a clearly established practice and shall possess demonstrable teaching skills. The supervisor shall limit the number of non-licensed persons under supervision, taking into account the requirements of the supervisor's principal work or practice and clinical responsibilities, to ensure that the supervision provided and the practice are consistent with professional standards. The supervisor shall not supervise an applicant who is a member of the supervisor's immediate or extended family, who has a financial interest in the supervisor's business or practice, or with whom the supervisor has a dual relationship.

C. **Duties of the supervisor**. The supervisor has the following duties to his patients or clients, the non-licensed person, and the public.

(1) The supervisor has ultimate responsibility to the patient or client for all professional psychological services rendered, whether rendered by the supervisor or the non-licensed person.

(a) The supervisor shall ensure that the patient or client knows the supervisory status of the non-licensed person and that consent is obtained.

(b) The supervisor shall ensure that the patient or client understands the possibility that a third-party payor may not reimburse for services rendered by the non-licensed person.

(c) The supervisor shall ensure that the patient or client is aware of the non-licensed person's qualifications and functions.

(d) The supervisor shall be available to patients or clients, shall be available to the non-licensed person for professional guidance and direction and intervention as needed, and shall be responsible for proper record-keeping and proper documentation in the patient's or client's case file, progress notes, or medical record.

(2) Unless the applicant holds an independent mental health license issued by the New Mexico counseling and therapy practice board or is an independent social worker licensed by the New Mexico board of social work examiners, the supervisor shall be responsible for billing for services and receipt or collection of payment. Bills, statements, invoices, or requests for payment in any form shall accurately and clearly identify the work performed and by whom.

(3) The supervisor maintains ultimate responsibility for and has an ongoing duty to actively supervise the non-licensed person's work performance and conduct to ensure adherence to the act and to board regulations.

(4) The supervisor shall ensure that a non-licensed person for whose work the supervisor is responsible does not engage in any activity, which, if engaged in by the supervisor, would constitute a violation of the act or the board regulations. The supervisor shall ensure, for example, that the non-licensed person:

(a) does not engage in a dual relationship;

(b) preserves the confidentiality of patient or client information;

(c) does not misrepresent his status, credentials, or qualifications to the patient or client or to others;

(d) does not mislead others or misrepresent his status to collect fees for services; and

(e) does not abuse drugs, substances, or alcohol to an extent or manner that endangers himself or another or impairs his ability to perform the duties required.

(5) The supervisor shall ensure that the non-licensed person works within his area of training, education, and competence.

(6) The supervisor shall adequately monitor the work of the non-licensed person to the extent necessary to protect the welfare of the patient or client. The supervisor shall ensure that the patient or client is properly evaluated and treated. The supervisor shall assess the skills and functioning of the non-licensed person on an ongoing basis to ensure that the non-licensed person is acting within his area of training, education, and competence. The supervisor shall prepare and document the plan of supervision, if applicable.

D. **Students/applicants under supervision**. Students/applicants enrolled in a graduate-level clinical counseling or school psychology training program who are rendering services under supervision and who have not applied for licensure are exempt from the act. Students/applicants shall not directly charge a patient or third-party payor a fee for the services performed. The supervisor shall accept only supervisory responsibility over students/applicants currently enrolled in a graduate-level program, who are under the auspices of a bona fide internship or externship program with a designated faculty advisor who shall be responsible for coordinating student/applicant services and training. Students/applicants shall not render any psychological services that are not supervised by a qualified supervisor as defined in this part.

[16.22.3.9 NMAC - Rp, 16.22.3.8 NMAC, 11/15/06]

16.22.3.10 LIMITED PERMISSION TO LICENSEES FROM OTHER JURISDICTIONS TO PERFORM COURT-ORDERED INDEPENDENT EXAMINATION.

A. A licensed or certified psychologist from another state, a territorial possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico (an out-of-state psychologist) may conduct a court-ordered independent psychological examination, which shall be limited to performing psychological assessments, tests, or evaluations, only in accordance with the provisions of this Subsection.

B. The out-of-state psychologist shall file with the board in writing a request for permission to conduct a court-ordered independent examination at least thirty (30) days in advance of providing any professional psychological services in New Mexico. The out-of-state psychologist shall attach a copy of the court order, shall attach a copy of a current resume or curriculum vitae, and shall identify a New Mexico licensed psychologist in good standing who agrees to sponsor the out-of-state psychologist. The out-of-state psychologist shall be a licensee in good standing in each jurisdiction in which the psychologist holds a license. A $150.00 fee will be assessed for the processing of the request.

C. The board will grant limited permission to conduct a court-ordered independent examination only if the out-of-state psychologist acknowledges and agrees to the following limitations and conditions.

(1) The psychologist shall agree to perform the court-ordered examination in accordance with applicable provisions of the act and board regulations.

(2) The psychologist shall agree that the psychological services shall be limited to only services reasonable and necessary to satisfy the requirements of a specific court-ordered examination in an individual cause of action. In no event shall the board grant permission to the out-of state psychologist to render services for the purpose of preventing, eliminating, or treating symptomatic, maladaptive, or undesired behavior or for the purpose of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral heath, or mental health.

(3) The psychologist shall agree to perform the services in New Mexico within the number of days specified by the board.

(4) The psychologist shall agree to claim no right, entitlement, or privilege to engage in the practice of psychology in the state of New Mexico except as allowed under the act and board regulations.

(5) The psychologist shall agree that the limited permission granted shall not be used or construed as a determination by the board that the psychologist qualifies for a license to practice psychology in New Mexico or that the psychologist is competent to perform the court-ordered examination.

(6) The board may impose other limitations or conditions as necessary to ensure compliance with the provisions of the act or board regulations.

(7) If the out-of-state psychologist violates the conditions imposed by the board or violates the act or board regulations, the board shall file an official complaint in any jurisdiction in which the psychologist is licensed or certified alleging that the psychologist has willfully or negligently violated the New Mexico professional psychologist act.

(8) The sponsoring psychologist shall agree in writing to sponsor an out-of-state psychologist as provided in this part. The sponsor shall certify that (a) the sponsor has made reasonable inquiry regarding the out-

of-state psychologist's qualifications and reputation; (b) to the sponsor's knowledge, the out-of-state psychologist is a licensee in good standing qualified by skill, education, and experience to conduct the court-ordered examination; and (c) the out-of-state psychologist has not used fraud or deception in requesting or obtaining permission from the board to conduct the court-ordered examination. The sponsor shall agree that willful or negligent certification or a violation by the out-of-state psychologist of the conditions imposed by the board or of the act or board regulations may be grounds for the board to take disciplinary action against the sponsor for aiding or abetting the practice of psychology by a person not licensed by the board.
[16.22.3.10 NMAC - Rp, 16.22.3.8 NMAC, 11/15/06]

HISTORY OF 16.22.3 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives under:
SBPE 10, Status of Non-Certified Personnel, filed 11/15/79.
Rule 13, Status of Non-Certified Personnel, filed 11/1/83.
NMBPE Rule 9, Status of Non-Licensed Personnel, filed 12/28/89.
NMBPE Rule 9, Status of Non-Licensed Personnel, filed 2/7/90.
Rule No. 9, Status of Non-Licensed Personnel, filed 4/24/95

History of Repealed Material:
16 NMAC 22.1, General Provisions - Repealed 4/16/00.
16.22.3 NMAC, Non Licensed Psychologists/Applicants With An Independent Mental Health license- Repealed 11/15/06.

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 4 PSYCHOLOGISTS: EDUCATION REQUIREMENTS

16.22.4.1 ISSUING AGENCY: Regulation and Licensing Department, New Mexico State Board of Psychologist Examiners.
[16.22.4.1 NMAC - Rp, 16.22.4.1 NMAC, 11/15/06]

16.22.4.2 SCOPE: The provisions of Part 4 apply to all applicants for licensure.
[16.22.4.2 NMAC - Rp, 16.22.4.2 NMAC, 11/15/06]

16.22.4.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, Section NMSA 61-9-4.1, 61-9-6, 61-9-10 61-9-11, 61-9-11.1.
[16.22.4.3 NMAC - Rp, 16.22.4.3 NMAC, 11/15/06]

16.22.4.4 DURATION: Permanent.
[16.22.4.4 NMAC - Rp, 16.22.4.4 NMAC, 11/15/06]

16.22.4.5 EFFECTIVE DATE: November 15, 2006 unless a later date is cited at the end of a section.
[16.22.4.5 NMAC - Rp, 16.22.4.5 NMAC, 11/15/06]

16.22.4.6 OBJECTIVE: This part establishes the minimum educational requirements for applicants applying for licensure.
[16.22.4.6 NMAC - Rp, 16.22.4.6 NMAC, 11/15/06]

16.22.4.7 DEFINITIONS: [RESERVED.]
[Refer to 16.22.1.7 NMAC]

16.22.4.8 EDUCATIONAL REQUIREMENTS

A. The board shall issue a license as a psychologist to an applicant, otherwise qualified, who furnishes evidence satisfactory to the board that the applicant is a graduate of a doctoral program that is designated as a doctoral program in psychology by association of state and provincial psychology boards (ASPPB) or that is accredited by a nationally recognized accreditation body and hold a degree with a major in clinical, counseling or school psychology from a university offering a full-time course of study in psychology.

B. It is the responsibility of the prospective applicant to provide evidence, at the time of application that the program from which he or she graduated is in substantial compliance with the requirements of the Professional Psychology Act.
[16.22.4.8 NMAC - Rp, 16.22.4.8 NMAC, 11/15/06; A, 03/21/09; A, 09/16/10]

HISTORY OF 16.22.4 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives under:
Rule 4, Requirements for Certifications Psychologists filed 11/1/83.
Rule 4, Requirements for Certification Psychologists filed 4/19/85.
NMBPE Rule 2 Requirements for Certification Licensure Psychologists filed 12/28/89.
NMBPE Rule 2, Requirements for Certification Licensure Psychologists filed 8/28/90.
Rule No. 2, Requirements for Licensure filed 4/24/95.
Rule 5, Requirements for Certification Psychologist Associate filed 11/1/83.
MBPE Rule 3, Requirements for Licensure filed 12/28/89.
Rule No. 3, Educational Requirements filed 4/24/95.
Rule 6, Psychologist Associates Conditions of Practice filed 1/3/84.
NMBPE Rule 4, Psychologist Associates filed 12/28/89.
Rule No. 4, Supervised Practice Leading Towards Licensure filed 4/24/95.
Rule 8, Examination-Psychologist Associate filed 11/1/83.
Rule 8, Examination-Psychologist Associate filed 3/19/84.
Rule 8, Examination-Psychologist Associate filed 4/19/85.

NMBPE Rule 6, Examination-Psychologist Associate filed 12/28/89.
NMBPE Rule 6, Examination-Psychologist Associate filed 8/28/90.
Rule No. 6, Examination for Licensure Psychologist-Psychologist Associate filed 4/24/95.
NMBPE Rule 15 Senior Psychologist filed 8/28/90.
Rule No. 15, Section 61-9-10 Licensure filed 4/24/95.

History of Repealed Material:
16 NMAC 22.3, Licensure, Educational and Examination Requirements - Repealed 4/16/00
16.22.4 NMAC, Education Requirements for Psychologists - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 5 PSYCHOLOGISTS: APPLICATION REQUIREMENTS; PROCEDURES

16.22.5.1 ISSUING AGENCY: Regulation and Licensing Department, New Mexico State Board of Psychologist Examiners.
[16.22.5.1 NMAC - Rp, 16.22.5.1 NMAC, 11/15/06]

16.22.5.2 SCOPE: The provisions of Part 5 apply to all applicants for licensure.
[16.22.5.2 NMAC - Rp, 16.22.5.2 NMAC, 11/15/06]

16.22.5.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist act, Section NMSA 61-9-4.1, 61-9-6, 61-9-10 61-9-11, 61-9-11.1.
[16.22.5.3 NMAC - Rp, 16.22.5.3 NMAC, 11/15/06]

16.22.5.4 DURATION: Permanent.
[16.22.5.4 NMAC - Rp, 16.22.5.4 NMAC, 11/15/06]

16.22.5.5 EFFECTIVE DATE: November 15, 2006 unless a later date is cited at the end of a section.
[16.22.5.5 NMAC - Rp, 16.22.5.5 NMAC, 11/15/06]

16.22.5.6 OBJECTIVE: This part establishes requirements for eligibility to apply and establishes application procedures and supervisory requirements.
[16.22.5.6 NMAC - Rp, 16.22.5.6 NMAC, 11/15/06]

16.22.5.7 DEFINITIONS: [RESERVED.]
[Refer to 16.22.1.7 NMAC]

16.22.5.8 APPLICATION; EXAMINATION; PROCESS

A. A non-refundable application fee set by the board is due at the time of each initial application. Additional fees may be charged and will be collected by the board, as necessary, for the administration of examinations.

B. The applicant may be considered for licensure if he fulfills conditions of 16.22.5.9, 16.22.5.10, 16.22.5.11, 16.22.5.12, 16.22.5.13, 16.22.5.14 or 16.22.5.15 NMAC.

C. NATIONWIDE CRIMINAL HISTORY SCREENING. All applicants for initial licensure in any category in New Mexico are subject to a national criminal history screening at their expense. All applicants must submit two (2) full sets of fingerprints, completed fingerprint certificate form, signed authorization for criminal background screening and fee at the time of application.

(1) Applications for licensure will not be processed without submission of fingerprints, completed fingerprint certificate form, signed authorization for criminal background screening and fee.

(2) Applications will be processed pending the completion of the nationwide criminal background screening.

(3) If the criminal background screening reveals a felony or a violation of the Psychologist Examiners Practice Act, the applicant/licensee will be notified to submit copies of legal documents and other related information to the board which will make the determination if the applicant is eligible for licensure or if disciplinary action will be taken.
[16.22.5.8 NMAC - Rp, 16.22.5.9 NMAC, 11/15/06; A, 09/16/10; A, 04/11/12]

16.22.5.9 APPLICATIONS NOT PREVIOUSLY LICENSED IN ANY JURISDICTION

A. Initial application procedure. To open an initial application file, the applicant shall submit the following to the satisfaction of the board:

(1) a completed and signed application;
(2) verification of predoctoral internship and supervision as described in 16.22.5 NMAC;
(3) the application fee as required by the board;
(4) official transcripts directly from the institution's office of the registrar;

(5) if the applicant chooses, a notarized letter from the graduate office of the degree-granting institution that documents the date of the doctoral degree; indicating (a) the date of completion of all requirements for the doctoral degree, and (b) the specific psychology program that the applicant completed;

(6) three (3) letters of reference; dated within the last two (2) years and two (2) of the letters must be from a licensed practicing psychologist familiar with their clinical work, and can attest to their competency and moral character;

(7) verification of postdoctoral supervision as described in 16.22.6 NMAC.

B. The applicant must have all documents in the board office at least sixty (60) days prior to taking the examination for professional practice in psychology (EPPP).

C. Complete applications will be reviewed by the board or its designee and a notification of approval, denial or need for additional information will be issued to the applicant.

D. The written examination for licensure is the EPPP, developed by the association of state and provincial psychology boards (ASPPB) and administered by the professional examination service (PES). An applicant shall be eligible to take the EPPP three (3) times within the eighteen 18 months following the date the applicant was notified of the board's approval of their application.

(1) If the applicant does not pass the EPPP any of the three (3) times it is administered within eighteen (18) months, the applicant shall submit a new initial application.

(2) Upon the submission of the new application, the rules and regulations in effect at the time the new initial application is received will be used to determine whether an applicant meets the requirements for licensure.

E. The applicant shall take and pass a jurisprudence examination.

F. During the first year of licensure an applicant shall furnish evidence to the board that demonstrates an awareness and knowledge of New Mexico cultures.

G. When the applicant fulfills all the requirements of this section, a license will be issued. If postdoctoral supervised experience is incomplete, the applicant will be issued an 18-month provisional license. This is not subject to renewal or extension. The applicant will be issued an unrestricted license when the applicant has met the postdoctoral supervised experience as defined in 16.22.6 NMAC.

H. The applicant may request an additional twelve (12) months to complete necessary supervisory hours in accordance with the act, but the applicant will be practicing under supervision and under the supervisor's license and can no longer hold a provisional license. This request will only be honored one (1) time.

[16.22.5.9 NMAC - Rp, 16.22.5.10 NMAC, 11/15/06; A, 03/21/09; A, 09/16/10; A, 04/11/12]

16.22.5.10 APPLICANTS HOLDING A VALID LICENSE IN ANOTHER STATE FOR TEN YEARS OR MORE SEEKING LICENSURE UNDER SECTION 61-9-10 - RECIPROCITY

A. An applicant seeking licensure under this section may obtain a license pursuant to Section 61-9-10 of the act if the applicant fulfills the following conditions.

(1) At the time of application, the applicant shall possess a current license to practice psychology in another state, territory, possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or other country.

(2) The applicant shall possess a doctoral degree in psychology or a degree that is substantially equivalent and is acceptable by the board.

(3) The applicant shall have no pending disciplinary actions, no formal disciplinary actions issued against the license in the last five (5) years and no past suspensions or revocations.

(4) The applicant shall have been licensed for a minimum of ten (10) years.

B. Application under this board regulation shall be made on a form approved by the board. The applicant shall submit the following to the satisfaction of the board:

(1) completed and signed application;

(2) application fee as required by the board; (for fee schedule, see 16.22.13.8 NMAC)

(3) license verification from all jurisdictions in which the applicant is or has been granted a psychologist license;

(4) official doctoral degree college or university transcripts; and

(5) three (3) current letters of reference; applicants under this section are not required to submit verification of predoctoral internship and postgraduate experience.

C. Applicant must take and pass a jurisprudence examination and during the first year of licensure furnish evidence to the board that demonstrates an awareness and knowledge of New Mexico cultures.

[16.22.5.10 NMAC - Rp, 16.22.5.11 NMAC, 11/15/06, A, 03/21/09; A, 04/11/12; A, 02/22/13]

16.22.5.11 APPLICANTS HOLDING AN ASPPB CERTIFICATION OF PROFESSIONAL QUALIFICATION OR A NATIONAL REGISTER HEALTH SERVICE PROVIDER IN PSYCHOLOGY CREDENTIAL: RECIPROCITY

A. Eligibility. A licensee in good standing for a minimum of five (5) years in another jurisdiction is eligible for licensure pursuant to Section 61-9-10 of the act if the applicant holds current certification of professional qualification (CPQ) or holds a current national register (HSPP) credential at the doctoral level, pursuant to Subsection A of 16.22.4.8 NMAC. In addition, the applicant shall have passed the EPPP with a minimum score required for licensure as set forth in Paragraph (6) of Subsection A of Section 61-9-11 of the act, have no disciplinary actions within five (5) years immediately preceding the date of application, and shall have no prior license suspensions or revocations in any jurisdiction in which the applicant is or has been licensed.

B. Application procedure. The applicant shall submit the following to the satisfaction of the board:

(1) a verified or certified copy of the applicant's CPQ or national register HSPP credential or other evidence satisfactory to the board that the applicant holds a CPQ or national register HSPP credential;

(2) a completed application on a form approved by the board;

(3) license verification from any jurisdictions in which the applicant is or has been granted a psychologist license;

(4) verification of passing the EPPP with a minimum score required for licensure as defined in Paragraph (6) of Subsection A of Section 61-9-11 of the act; and

(5) the non-refundable application fee established by the board.

C. Examination. Upon approval by the board or its designee, an applicant must take and pass a jurisprudence examination and during the first year of licensure furnish evidence to the board that demonstrates an awareness and knowledge of New Mexico cultures.

D. Applicability of other provisions. The provisions of Section 61-9-13 of the act shall apply to applications filed under this section. A psychologist licensed pursuant to this section is subject to all requirements and obligations applicable to licensees under the act and board regulations.

[16.22.5.11 NMAC - Rp, 16.22.5.13 NMAC, 11/15/06; A, 03/21/09; A, 04/11/12]

16.22.5.12 APPLICANTS LICENSED IN ANOTHER JURISDICTION WHO DO NOT QUALIFY UNDER SECTION 16.22.5.10, 16.22.5.11, 16.22.5.12, 16.22.5.13, 16.22.5.14 OR 16.22.5.15 NMAC

A. Application procedure. An applicant seeking licensure under this section may obtain a license pursuant to Section 61-9-12 of the act if the applicant submits the following conditions:

(1) a completed and signed application;

(2) the application fee as required by the board;

(3) official doctoral degree transcripts sent directly from the institution's office of the registrar;

(4) if the applicant chooses, a notarized letter from the graduate office of the degree-granting institution that documents the date of the doctoral degree; the letter shall indicate (a) the date of completion of all requirements for the doctoral degree, and (b) the specific psychology program the applicant completed;

(5) license verification from all jurisdictions in which the applicant is or has been granted a psychologist license;

(6) three (3) letters of reference dated within the last two (2) years and two (2) of the letters must be from a licensed practicing psychologist familiar with their clinical work, and can attest to their competency and moral character;

(7) verification of predoctoral internship and supervision as defined in 16.22.6 NMAC;

(8) verification of postdoctoral supervised experience as defined in 16.22.6 NMAC; and

(9) verification of passing the EPPP as defined in 16.22.7.8 NMAC.

B. Applicant must take and pass a jurisprudence examination with a score of 75% and during the first year of licensure furnish evidence to the board that demonstrates an awareness and knowledge of New Mexico cultures.

[16.22.5.12 NMAC - Rp, 16.22.5.12 NMAC, 11/15/06; A, 03/21/09; A, 09/16/10; A, 04/11/12]

16.22.5.13 APPLICANTS SEEKING A TEMPORARY LICENSE

A. A temporary six (6) month license may be issued to a psychologist who meets the following conditions:

(1) the applicant is licensed in another jurisdiction and in good standing, and the out-of-state-license meets current licensing criteria for New Mexico;

(2) the applicant qualifies under 16.22.5.10, 16.22.5.11, 16.22.5.12 or 16.22.5.15 NMAC of this part;

(3) the applicant completes a form approved by the board that includes required information and the appropriate fees set by the board;

(4) the temporary license will expire in six (6) months; and

(5) the temporary license may be extended at the discretion of the board with a written request thirty (30) days prior to the expiration, stating the reason for extension.

B. Nothing in this section should be construed to prevent an applicant with a temporary license from applying for an unrestricted license. The applicant may apply for an unrestricted license by completing a form approved by the board, remitting appropriate fees, and taking and passing the online jurisprudence examination.

[16.22.5.13 NMAC - N, 11/15/06; A, 09/16/10; A, 04/11/12]

16.22.5.14 APPLICANTS FROM FEDERAL DISASTER AREAS SEEKING A FOUR-MONTH EMERGENCY LICENSE- RECIPROCITY

A. An emergency license may be issued to a psychologist who is from a state in which a federal disaster has been declared, holds that state's active unrestricted license, and is in good standing or otherwise meets requirements for New Mexico licensure. This applicant may obtain a New Mexico license for a period of four (4) months following the declared disaster, at no cost and upon satisfying the following requirements:

(1) the board received a completed, signed and notarized application accompanied by proof of identity in the form of a copy of a driver's license, passport or other photo identification issued by a governmental entity;

(2) the applicant qualifies for a license as set forth in 16.22.5.10, 16.22.5.11, 16.22.5.12 or 16.22.5.15 NMAC of this part;

(3) the board may waive the specific forms required under the immediately preceding section if the applicant is unable to obtain documentation from the federally declared disaster area;

(4) nothing in this paragraph shall constitute a waiver of licensure requirements set forth in 16.22.5.8 NMAC above; and

(5) a license issued under this emergency provision shall expire four (4) months after issuance, unless a renewal application is received and approved by the board or its designee in a timely fashion; a renewal application shall commence no later than three (3) months after the issuance date in order to allow at least one month for renewal process and avoid a late renewal fee set by the board (see fee schedule in 16.22.13.8 NMAC of these regulations); the board reserves the right to request additional documentation, including but not limited to recommendation forms and work experience verification forms prior to approving emergency license renewal.

B. The emergency license shall terminate upon:

(1) four (4) months from issuance date, if not renewed;

(2) the issuance of an unrestricted license as set forth in 16.22.5.8 NMAC above;

(3) proof that the emergency license holder has not engaged in fraud, deceit or misrepresentation in procuring or attempting to procure a license under 16.22.5.14 NMAC, and

(4) termination of an emergency license shall not preclude application for unrestricted licensure.

[16.22.5.14 NMAC - N, 11/15/06; A, 03/21/09]

16.22.5.15 APPLICANTS WHO ARE GRADUATES FROM PROGRAMS OUTSIDE THE UNITED STATES AND CANADA

A. Graduates of programs outside the United States and Canada shall be evaluated according to the following criteria for New Mexico licensure:

(1) applicants shall meet the requirements set forth in Subsection A of 16.22.4.8 NMAC of these regulations; "substantial equivalencies" of professional schools in the United States, Canada, or any other jurisdiction under ASPPB shall meet the requirements set forth in 16.22.4 NMAC;

(2) applicants for licensure whose applications are based on graduation from universities outside the United States and Canada shall provide the board with such documents and evidence to establish that their formal education is equivalent to a doctoral program in psychology granted by a United States university that is regionally accredited; equivalency will be reviewed by a board approved agency specializing in the credentialing of foreign graduates; such documents and evidence include:

(a) an original diploma or other certificate of graduation which will be returned, and a photocopy of such a document which will be retained;

(b) an official transcript or comparable document of all course work completed;

(c) a certified translation of all documents submitted in a language other than English;

(d) satisfactory evidence of supervised experience; and

(e) a statement prepared by the applicant listing studies and research based on documents referenced in this section in a format as comparable as possible to a transcript issued by a United States university.

B. After evaluation and acceptance by the board, the applicant shall take and pass the EPPP and an online jurisprudence examination to obtain licensure.

[16.22.5.15 NMAC - N, 11/15/06; A, 09/16/10; A, 02/22/13]

HISTORY OF 16.22.5 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives under:

Rule 4, Requirements for Certifications Psychologists, 11/1/83.
Rule 4, Requirements for Certification Psychologists, 4/19/85.
NMBPE Rule 2 Requirements for Certification Licensure Psychologists, 12/28/89.
NMBPE Rule 2, Requirements for Certification Licensure Psychologists, 8/28/90.
Rule No. 2, Requirements for Licensure, 4/24/95.
Rule 5, Requirements for Certification Psychologist Associate, 11/1/83.
NMBPE Rule 3, Requirements for Licensure, 12/28/89.
Rule No. 3, Education Requirements, 4/24/95.
Rule 6, Psychologist Associates Conditions of Practice, 1/3/84.
NMBPE Rule 4, Psychologist Associates, 12/28/89.
Rule No. 4, Supervised Practice Leading Towards Licensure, 4/24/95.
Rule 8, Examination-Psychologist Associate, 11/1/83.
Rule 8, Examination-Psychologist Associate, 3/19/84.
Rule 8, Examination-Psychologist Associate, 4/19/85.
NMBPE Rule 6, Examination-Psychologist Associate, 12/28/89.
NMBPE Rule 6, Examination-Psychologist Associate, 8/28/90.
Rule No.6 Examination for Licensure Psychologist-Psychologist Associate, 4/24/95.
NMBPE Rule 15 Senior Psychologist, 8/28/90.
Rule No. 15, Section 61-9-10 Licensure, 4/24/95.

History of Repealed Material:

16 NMAC 22.3, Licensure, Educational and Examination Requirements - Repealed, 4/16/00.
16.22.5 NMAC, Application Procedures and Requirements for Licensure as a Psychologist - Repealed 11/15/06.

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 6 PSYCHOLOGISTS: PREDOCTORAL AND POSTDOCTORAL SUPERVISED EXPERIENCE

16.22.6.1 ISSUING AGENCY: Regulation and Licensing Department, New Mexico State Board of Psychologist Examiners
[16.22.6.1 NMAC - Rp, 16.22.6.1 NMAC, 11/15/06]

16.22.6.2 SCOPE: The provisions of Part 6 apply to all applicants for licensure.
[16.22.6.2 NMAC - Rp, 16.22.6.2 NMAC, 11/15/06]

16.22.6.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act Section NMSA 61-9-4.1, 61-9-6, 61-9-10 61-9-11, 61-9-11.1.
[16.22.6.3 NMAC - Rp, 16.22.6.3 NMAC, 11/15/06]

16.22.6.4 DURATION: Permanent.
[16.22.6.4 NMAC - Rp, 16.22.6.4 NMAC, 11/15/06]

16.22.6.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of a section.
[16.22.6.5 NMAC - Rp, 16.22.6.5 NMAC, 11/15/06]

16.22.6.6 OBJECTIVE: This part establishes supervisory requirements for applicants applying for licensure and establishes application procedures.
[16.22.6.6 NMAC - Rp, 16.22.6.6 NMAC, 11/15/06]

16.22.6.7 DEFINITIONS:

A. "Year of supervised experience" means 1500 hours of psychological work conducted under supervision satisfactory to the board. The 1500 hours may be accumulated in one or two consecutive calendar years in the case of an internship, three consecutive years in the case of post-doctoral experience, or over the course of graduate training in the case of predoctoral experience.

B. "Doctoral training program" means the program from which the applicant received his or her doctoral degree to fulfill the educational requirements for licensure.
[16.22.6.7 NMAC - N, 04/11/12]

16.22.6.8 PREDOCTORAL/POSTDOCTORAL SUPERVISED EXPERIENCE

A. Supervised experience leading toward licensure:

(1) two (2) years (3,000 hours) of supervised experience are required for licensure;

(a) up to one year (1500 hours) of the supervised experience may be obtained in predoctoral practicum hours overseen by the doctoral training program and consistent with the guidelines on practicum experience for licensure promulgated by the association of state and provincial psychology board; and

(b) up to one year (1500 hours) of the supervised experience may be obtained in a predoctoral internship approved by the American psychological association; or

(c) up to one-half year (750 hours) of the supervised experience may be obtained in a predoctoral internship not approved by the American psychological association; and

(d) after totaling approved predoctoral practicum hours and allowed hours for predoctoral internship, the remainder of the (3000 hours) supervised experience must be obtained in supervised postdoctoral psychological work.

(2) predoctoral and postdoctoral experience from all supervisors shall be documented on forms provided by the board.

B. Predoctoral practicum experience. Predoctoral practicum training is an organized, sequential series of supervised experiences of increasing complexity, serving to prepare the student for internship and partially meeting the requirements for licensure. Training experiences shall follow appropriate academic preparation and shall be overseen by the doctoral training program. Not all supervised experience accumulated during graduate training may count toward licensure. The board requires that all predoctoral practicum experiences counting toward licensure be of high quality and carefully approved and monitored by the doctoral training program. In particular,

these experiences should advance the doctoral student's role and identity as a psychologist. All experiences counting toward licensure must be supervised one hour per week by a licensed psychologist or clinical faculty member who is allowed to practice psychology under the laws of the state. The director of clinical training of the doctoral training program, or designee of that program's chair, shall certify, in a form satisfactory to the board, that the hours meet the following specifications of type of clinical activity and supervision:

(1) The practicum setting was approved by, integrated with and monitored by the doctoral training program;

(2) The hours were obtained in the course of an organized, sequential series of supervised experiences of increasing complexity, serving to prepare the student for internship and partially meeting the requirements for licensure.

(3) Supervised practicum experience occurred in psychological service settings that had, as part of the organizational mission, a goal of training professional psychologists.

(4) Each practicum setting had an identified, licensed psychologist who was responsible for maintaining the integrity and quality of the experience for each trainee. The doctoral training program shall assign a licensed psychologist to serve in this role if none is available on site.

(5) All supervisors were qualified by education, licensure and experience to provide supervision of doctoral students.

(6) Where experiences counted for licensure were obtained in various settings, each setting was an appropriate experience in itself, the particular student was academically prepared for that experience and the combination of experiences was appropriate to the student's training needs.

(7) The following clinical experiences and supervision were present across settings:

(a) At least 50% of the total hours of supervised experience were in service-related activities, defined as treatment/intervention, assessment, interviews, report-writing, case presentations, and consultations.

(b) At least 25% of the total hours were face-to-face patient/client contact.

(c) Supervision by a licensed psychologist or clinical faculty member who is allowed to practice psychology under the laws of the state was at least one hour for each day (eight (8) hours including the supervision; 12 ½ % of total) of supervised experience for experienced students. The doctoral training program shall assure that higher levels of supervision are provided for less experienced students. All supervision time, whether individual or group, including additional supervision beyond that may be counted as part of the total supervised experience.

(8) The board requires that all predoctoral practicum experiences counting toward licensure be of high quality and carefully approved and monitored by the doctoral training program. In particular, these experiences should advance the doctoral student's role and identity as a psychologist. All experiences counting toward licensure must be supervised one hour per week by a licensed psychologist or clinical faculty member who is allowed to practice psychology under the laws of the state.

(9) The board may, at its discretion, require documentation that above system of training was in place for the applicant. Possible forms of documentation include but are not limited to:

(a) individual written training plans between the doctoral training program and each practicum training cite;

(b) policies and procedures of the doctoral training program designating the expectations for practicum training sequences;

(c) program descriptions or self-study documents submitted for program approval to the American psychological association or the American association of state and provincial psychology boards.

C. Internship or fellowship accredited by the APA. If the predoctoral or postdoctoral experience is obtained in an internship or fellowship accredited by the APA, a board form completed by the director of training will satisfy the requirement of certifying all supervision received during the internship or fellowship.

D. Internship not accredited by the APA. If the predoctoral experience is obtained in an internship that is not accredited by the APA, it will be counted for 750 hours of the required 3,000 hours if it meets the following criteria:

(1) the agency or institution offers internship education and training in psychology, one goal of which is to prepare applicants for the practice of professional psychology;

(2) the internship program is sponsored by an institution or agency, which has among its primary functions the provision of service to a population of recipients sufficient in number and variability to provide interns with adequate experiential exposure to meet its training purposes, goals, and objectives;

(3) the internship is completed within twenty-four (24) consecutive months at a minimum of twenty (20) hours per week:

(a) an internship that involves more than one agency, organization, or institution will be accepted if the primary supervisor and the applicant can demonstrate that the internship program is organized under a unifying or coordinating structure (e.g. a consortium with a core clinical faculty) and central leadership (e.g., one director of training or central supervisor overseeing the entire internship program and the supervision of the intern);

(b) internships consisting of less than twenty (20) hours per week will not be accepted;

(4) the director of clinical training of the applicant's doctoral training program certifies in a manner acceptable to the board that the internship was approved as part of the degree requirements for obtaining the doctoral degree.

E. Postdoctoral supervised practice leading toward licensure.

(1) The applicant may complete a predoctoral supervised practicum up to fifteen hundred (1500) hours and a predoctoral internship up to 1500 hours before completing the doctorate. Depending on the number of hours of predoctoral supervised experience, the applicant shall complete the remainder of the required 3,000 hours through postdoctoral supervision.

(2) If the applicant chooses, the applicant may submit a postdoctoral supervisory plan to the board for review before beginning supervised practice. Once a plan for supervision is submitted to the board, the board or a designated board member will respond in writing to the acceptability of such a plan within sixty (60) days. If the plan is found unacceptable, the board or a designated board member will specify the areas of deficiency based on the guidelines specified in Part 3. If the board approves the plan, the applicant will be assured that postdoctoral experience, if completed according to the plan, will meet the postdoctoral requirements.

(3) If the applicant does not obtain a board-approved postdoctoral supervisory plan, the applicant shall submit documentation of the postdoctoral supervised practice after its completion. However, if the board does not approve this experience, part or all of the postdoctoral supervised experience shall be repeated. In this case, the board will require the applicant to submit a supervisory plan, and the supervisory plan must be approved by the board before the applicant's supervised practice begins.

[16.22.6.8 NMAC - Rp, 16.22.6.8 NMAC, 11/15/06; A, 04/11/12]

16.22.6.9 CONDITIONS OF POSTDOCTORAL SUPERVISION

A. Primary supervisors.

(1) One licensed psychologist who serves as a primary supervisor shall be responsible for the overall supervision of the supervisee's professional growth. Specific skill training may be assigned to other licensed specialists, under the authority of the supervising psychologist. The other licensed specialists shall have clearly established practice and teaching skills demonstrable to the satisfaction of both the primary supervisor and the supervisee.

(2) The primary supervisor shall limit the number of applicants supervised to the number that the supervisor's work position and clinical responsibilities reasonably permit, so as to maintain a level of supervision and practice consistent with professional standards and ensure the welfare of the supervisees and their clients or patients.

(3) The supervisor shall not be a member of the supervisee's immediate family or in a dual relationship that would compromise the supervisor's objectivity.

B. Supervisory contact.

(1) The applicant shall have on-site supervision. The on-site supervisor may be either the primary supervisor or a licensed specialist designated by the primary supervisor.

(2) At a minimum, supervision by the primary supervisor shall be provided on a one-to-one basis for one (1) hour per week for a total at least forty-six (46) hours of one-to-one supervision per year. If the primary supervisor is more than 100 miles from the site, in person supervision shall be at least two (2) hours per month and telephonic or videoconference may be substituted for the rest of this supervision requirement. The applicant and supervisor must arrange on-site supervision by a licensed psychiatrist, social worker, professional clinical mental health counselor, or marriage and family therapist. The on-site licensed mental health professional shall provide supervision to the applicant on a one-to-one basis for one (1) hour per week and shall be available to the applicant whenever decisions about patients are made.

C. Conduct of supervision.

(1) The board recognizes that variability in preparation for practice of the applicant will require individually tailored supervision. The specific content of the supervision procedures shall be worked out between the primary supervisor and the applicant.

(2) The primary supervisor who provides supervision for the applicant for licensure shall have clinical and professional responsibility for the work of the applicant.

(3) A supervisor, either primary or designated, shall be available to the applicant whenever decisions about clients or patients are made.

(4) The primary supervisor shall be responsible for the delivery of services, the representation to the public of services, and the supervisor/applicant relationship. This responsibility includes, but is not limited to, the following requirements.

(a) All clients or patients shall be informed of the availability or possible necessity of meetings with the primary supervisor at the request of the client or patient, the applicant, or the psychologist. The supervisor shall be available for emergency consultation or intervention.

(b) All written communication shall clearly identify the primary supervisor as clinically and professionally responsible for all psychological services provided. Public announcement of services and fees and contact with the public or professional community shall be offered in the name of the primary supervisor, business, or agency. Both the primary supervisor and the applicant shall inform the client or patient, to whatever extent is necessary for the client or patient to understand, of the supervisory status and other specific information as to the applicant's qualifications and functions.

(c) The primary supervisor shall oversee the maintenance of information and files relevant to the client or patient during the supervisory period.

(d) The primary supervisor shall not be a member of the applicant's extended or immediate family or be involved in a dual relationship.

(e) The supervision shall not be delivered in an agency or business in which the applicant has a financial interest.

D. Inappropriate representation. In the event the applicant publicly represents himself inappropriately, or supervision is not conducted according to Subsection C of 16.22.6.9 NMAC, conduct of supervision, any experience gained under such circumstances does not comply with these rules and regulations and will not be accepted as experience toward licensure. Any psychologist providing supervision under such circumstances is in violation of these rules and regulations and may be subject to disciplinary action.

[16.22.6.9 NMAC - Rp, 16.22.6.9 NMAC, 11/15/06; A, 04/11/12]

16.22.6.10 POSTDOCTORAL SUPERVISORY PLAN

A. Evaluation of the supervisory plan. The supervisory plan shall include the following information and shall be signed by both the primary supervisor and the applicant:

(1) name of applicant;

(2) name of primary supervisor, address, license number, and state in which the license was granted; area of specialization;

(3) names of additional licensed specialists, if applicable;

(4) dates of practice covered by the plan;

(5) number of practice hours during the period covered by the plan;

(6) number of one-on-one supervisory hour per week;

(7) the setting(s) in which the applicant will practice and the hours per week worked at each setting;

(8) the applicant's duties;

(9) the clinical and professional responsibilities of the applicant;

(10) the location where the supervision will take place;

(11) the areas in which the primary supervisor has specialized skills to render competent supervision and, if applicable, whether specific training will be assigned to other specialists; if non-psychologist specialists are assigned, their practice and teaching skills as they pertain to supervision of the applicant and their degrees and licenses;

(l2) the number of applicants the primary supervisor will supervise during this time period;

(13) the way in which the primary supervisor will demonstrate clinical and professional responsibility for the applicant's work;

(14) the way in which the applicant will be represented to the public, and the way in which all written communications and public announcements will identify the primary supervisor as clinically and professionally responsible for all psychological services;

(15) other information necessary to clarify the nature and scope of supervision.

B. As listed in this part, the board or a designated board member will respond in writing to the acceptability of such plan within sixty 60 days.

[16.22.6.10 NMAC - Rp, 16.22.6.10 NMAC, 11/15/06]

HISTORY OF 16.22.6 NMAC:

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NMBPE Rule 2, Requirements for Certification Licensure Psychologists, 8/28/90.
Rule No. 2, Requirements for Licensure, 4/24/95.
Rule 5, Requirements for Certification Psychologist Associate, 11/1/83.
NMBPE Rule 3, Requirements for Licensure, 12/28/89.
Rule No. 3, Education Requirements, 4/24/95.
Rule 6, Psychologist Associates Conditions of Practice, 1/3/84.
NMBPE Rule 4, Psychologist Associates, 12/28/89.
Rule No. 4, Supervised Practice Leading Towards Licensure, 4/24/95.
Rule 8, Examination-Psychologist Associate, 11/1/83.
Rule 8, Examination-Psychologist Associate, 3/19/84.
Rule 8, Examination-Psychologist Associate, 4/19/85.
NMBPE Rule 6, Examination-Psychologist Associate, 12/28/89.
NMBPE Rule 6, Examination-Psychologist Associate, 8/28/90.
Rule No.6 Examination for Licensure Psychologist-Psychologist Associate, 4/24/95.
NMBPE Rule 15 Senior Psychologist, 8/28/90.
Rule No. 15, Section 61-9-10 Licensure, 4/24/95.

History of Repealed Material:

16 NMAC 22.3, Licensure, Educational and Examination Requirements - Repealed, 4/16/00
16.22.6 NMAC, Pre Doctoral and Post Doctoral Supervised Experience - Repealed, 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 7 EXAMINATION REQUIREMENTS

16.22.7.1 ISSUING AGENCY: Regulation and Licensing Department, State Board of Psychologist Examiners.
[16.22.7.1 NMAC - Rp, 16.22.7.1 NMAC, 11/15/06]

16.22.7.2 SCOPE: The provisions of Part 7 apply to all applicants for licensure.
[16.22.7.2 NMAC - Rp, 16.22.7.2 NMAC, 11/15/06]

16.22.7.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, Section NMSA 61-9-4.1, 61-9-6, 61-9-10 61-9-11, 61-9-11.1.
[16.22.7.3 NMAC - Rp, 16.22.7.3 NMAC, 11/15/06]

16.22.7.4 DURATION: Permanent.
[16.22.7.4 NMAC - Rp, 16.22.7.4 NMAC, 11/15/06]

16.22.7.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of a section.
[16.22.7.5 NMAC - Rp, 16.22.7.5 NMAC, 11/15/06]

16.22.7.6 OBJECTIVE: This part establishes the examination requirements for all licensure applicants.
[16.22.7.6 NMAC - Rp, 16.22.7.6 NMAC, 11/15/06]

16.22.7.7 DEFINITIONS: [RESERVED.]
[Refer to 16.22.1.7 NMAC]

16.22.7.8 DEMONSTRATION OF COMPETENCE

A. Examinations.

(1) To qualify for licensure, an applicant must demonstrate professional competence by taking and passing a written examination called the EPPP, promulgated by ASPPB. The passing score on the EPPP taken before January 1,1993 is 140 (70%) or taken after January 1, 1993 is the score equal to or greater than the passing score recommended by ASPPB.

(2) All persons applying for licensure shall take and pass an online jurisprudence examination on ethical standards, New Mexico laws, and board regulations as they apply to psychologists and their clients or patients. The passing score will be determined by the board.

(3) If the score of either the EPPP or jurisprudence examination meets the requirements for licensure as a psychologist but the other score does not, the examination passed will not have to be retaken.

(4) Re-examination. An applicant may retake the EPPP or jurisprudence examination and pay the appropriate examination fee as required by the board. Such fee is nonrefundable and due at the time of the request.

B. An applicant shall furnish evidence to the board that demonstrates an awareness and knowledge of New Mexico cultures.
[16.22.7.8 NMAC - Rp, 16.22.7.8 NMAC, 11/15/09; A, 03/21/09]

HISTORY OF 16.22.7 NMAC:
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NMBPE Rule 2 Requirements for Certification Licensure Psychologists, 12/28/89.
NMBPE Rule 2, Requirements for Certification Licensure Psychologists, 8/28/90.
Rule No. 2, Requirements for Licensure, 4/24/95.
Rule 5, Requirements for Certification Psychologist Associate, 11/1/83.
NMBPE Rule 3, Requirements for Licensure, 12/28/89.
Rule No. 3, Education Requirements, 4/24/95.
Rule 6, Psychologist Associates Conditions of Practice, 1/3/84.

NMBPE Rule 4, Psychologist Associates, 12/28/89.
Rule No. 4, Supervised Practice Leading Towards Licensure, 4/24/95.
Rule 8, Examination-Psychologist Associate, 11/1/83.
Rule 8, Examination-Psychologist Associate, 3/19/84.
Rule 8, Examination-Psychologist Associate, 4/19/85.
NMBPE Rule 6, Examination-Psychologist Associate, 12/28/89.
NMBPE Rule 6, Examination-Psychologist Associate, 8/28/90.
Rule No.6 Examination for Licensure Psychologist-Psychologist Associate, 4/24/95.
NMBPE Rule 15 Senior Psychologist, 8/28/90.
Rule No. 15, Section 61-9-10 Licensure, 4/24/95.

History of Repealed Material:
16 NMAC 22.3, Licensure, Educational and Examination Requirements - Repealed, 4/16/00.
16.22.7 NMAC, Examination Requirements - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 8 LICENSE EXPIRATION AND RENEWAL

16.22.8.1 ISSUING AGENCY: Regulation and Licensing Department, State Board of Psychologists Examiners.
[16.22.8.1 NMAC - Rp, 16.22.8.1 NMAC, 11/15/06]

16.22.8.2 SCOPE: The provisions of Part 8 apply to all psychologists and psychologist associates with a license to practice in New Mexico.
[16.22.8.2 NMAC - Rp, 16.22.8.2 NMAC, 11/15/06]

16.22.8.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act Section 61-9-6, 61-9-7.
[16.22.8.3 NMAC - Rp, 16.22.8.3 NMAC, 11/15/06]

16.22.8.4 DURATION: Permanent.
[16.22.8.4 NMAC - Rp, 16.22.8.4 NMAC, 11/15/06]

16.22.8.5 EFFECTIVE DATE: November 15, 2006 unless a later date is cited at the end of a section.
[16.22.8.5 NMAC - Rp, 16.22.8.5 NMAC, 11/15/06]

16.22.8.6 OBJECTIVE: This part establishes the procedures for license expiration and license renewal.
[16.22.8.6 NMAC - Rp, 16.22.8.6 NMAC, 11/15/06]

16.22.8.7 DEFINITIONS:

A. "Nationwide criminal history record" means information concerning a person's arrests, indictments, or other formal criminal charges and any dispositions arising there from, including convictions, dismissals, acquittals, sentencing and correctional supervision, collected by criminal justice agencies and stored in the computerized databases of the federal bureau of investigation, the national law enforcement telecommunications systems, the department of public safety or the repositories of criminal history information in other states.

B. "Nationwide criminal history screening" means a criminal history background investigation of a licensee applying for licensure renewal through the use of fingerprints reviewed by the department of public safety and submitted to the federal bureau of investigation, resulting in the generation of a nationwide criminal history record for that applicant.
[16.22.8.7 NMAC - N, 09/16/10; A, 04/11/12]

16.22.8.8 LICENSE RENEWAL: Licensees shall renew their licenses to practice psychology biennially on or before July 1 of alternate years by remitting to the board office a renewal fee of six hundred dollars ($600) with the renewal application form provided by the board. Continuing education hours shall be documented every two (2) years at the time of license renewal as described in Part 9. Background fees shall be the amount established by the department of public safety for the processing of criminal history background checks.

A. All renewal applications will be subject to a one time nationwide criminal history screening. Renewal applications will be processed pending the completion of the criminal history screening.

B. If the nationwide criminal background screening reveals a felony or a violation of the Psychologist Examiners Act, the licensee will be notified to submit copies of legal documents and other related information to the board which will make the determination if the applicant is eligible for licensure or if disciplinary action will be taken.
[16.22.8.8 NMAC - Rp, 16.22.8.8 NMAC, 11/15/06; A, 09/16/10; A, 04/11/12]

16.22.8.9 LICENSE RENEWAL DEADLINE: Licenses shall be renewed biennially before July 1 and must be submitted through the online renewal system, post-marked or hand-delivered.
[16.22.8.9 NMAC - Rp, 16.22.8.9 NMAC, 11/15/06; A, 09/16/10]

16.22.8.10 LICENSE RENEWAL NOTICES: Renewal post card notices will be mailed to each current licensee prior to the expiration date of the license.

[16.22.8.10 NMAC - Rp, 16.22.8.10 NMAC, 11/15/06; A, 09/16/10]

16.22.8.11 LICENSEE RESPONSIBILITY: Renewal application notices will be mailed to the last known address on file with the board. It is the responsibility of the licensee to keep the board informed of any changes in address and phone numbers. Failure to receive the renewal application notice shall not relieve the licensee of the responsibility of renewing his license before the expiration date.
[16.22.8.11 NMAC - Rp, 16.22.8.11 NMAC, 11/15/06]

16.22.8.12 RENEWAL AFTER JULY 1

A. The board shall initiate license suspension proceedings and thereafter shall suspend a license for failure to renew if the licensee failed to renew his license by July 1 of the appropriate year. Any person who renders or offers to render psychological services while his license is suspended is subject to disciplinary action. A licensee who chooses to permanently retire from practice shall inform the board in writing previous to the expiration date of the license and will be considered honorary retired as a non-disciplinary revocation.

B. A license suspended for failure to renew may be renewed within a period of one (1) year after the suspension upon payment of the renewal fee plus a late fee and proof of continuing education satisfactory to the board.

C. The license shall be revoked if the license has not renewed within one (1) year of the suspension for failure to renew. Any licensee whose license is revoked for failure to renew shall be required to make a new application and shall satisfy all requirements for licensure in effect at the time the application is filed.

D. Unless currently licensed to practice psychology under the act, no person shall:

(1) engage in the practice of psychology;

(2) use the title or represent himself as a psychologist or psychologist associate; or

(3) use any other title, abbreviation, letters, signs or devices that indicate the person is a psychologist or psychologists associate.

E. It is a misdemeanor:

(1) for any person not licensed under the act to practice psychology or represent himself as a psychologist or a psychologist associate;

(2) for any person to practice psychology during the time that his license as a psychologist or psychologist associate is suspended, revoked, or lapsed.

[16.22.8.12 NMAC - Rp, 16.22.8.12 NMAC, 11/15/06; A, 09/16/10]

16.22.8.13 APPROVAL OF RENEWAL APPLICATION: Upon approval of the licensee's renewal application, the board will issue a renewal to the licensee.
[16.22.8.13 NMAC - Rp, 16.22.8.13 NMAC, 11/15/06]

HISTORY OF 16.22.8 NMAC:

History of Repealed Material:
16.22.8 NMAC, License Expiration and Renewal - Repealed, 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 9 CONTINUING PROFESSIONAL EDUCATION REQUIREMENTS

16.22.9.1 ISSUING AGENCY: Regulation and Licensing Department, State Board of Psychologist Examiners
[16.22.9.1 NMAC - Rp, 16.22.9.1 NMAC, 09/16/10]

16.22.9.2 SCOPE: The provisions of Part 9 apply to psychologists and psychologist associates licensed to practice in New Mexico.
[16.22.9.2 NMAC - Rp, 16.22.9.2 NMAC, 09/16/10]

16.22.9.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Examiners Act, Section 61-9-6, 61-9-7.
[16.22.9.3 NMAC - Rp, 16.22.9.3 NMAC, 09/16/10]

16.22.9.4 DURATION: Permanent.
[16.22.9.4 NMAC - Rp, 16.22.9.4 NMAC, 09/16/10]

16.22.9.5 EFFECTIVE DATE: September 16, 2010, unless a later date is cited at the end of a section.
[16.22.9.5 NMAC - Rp, 16.22.9.5 NMAC, 09/16/10]

16.22.9.6 OBJECTIVE: This part establishes criteria for continuing professional education for psychologists and psychologist associates licensed in New Mexico.
[16.22.9.6 NMAC - Rp, 16.22.9.6 NMAC, 09/16/10]

16.22.9.7 DEFINITIONS: [RESERVED]
[Refer to 16.22.1.7 NMAC]

16.22.9.8 REQUIRED HOURS:

A. Purpose. The purpose of continuing professional education (CPE) requirements for psychologists is to ensure that licensees update and advance their skills such that the public shall benefit from the most current and effective standards of professional practice. To further the goal of public benefit, all psychologists are required to fulfill a portion of their CPE in the areas of ethics and cultural diversity as related to the profession of psychology.

B. Required hours. The board requires forty (40) hours of CPE for licensed psychologists and psychologist associates during every two (2) years. For conditional prescribing and unrestricted prescribing psychologists the board requires sixty (60) hours of CPE every two (2) years.

C. Program types. CPE credits are divided into two (2) categories depending on the design and approval process for the experience and on the monitoring of the psychologist. Psychologists must obtain at least fifteen (15) of their forty (40) hours every two (2) years in category I, which is the most stringent in terms of presentation standards and monitoring. Any additional hours to complete the forty (40) hour requirement may be from category I or category II.

(1) Cultural Diversity: a minimum of four (4) hours every two (2) years from either category must be in the area of cultural diversity as described in 16.22.9.9 NMAC. At least two (2) hours of cultural diversity CPE must be in the area of ethnic diversity.

(2) Ethics: a minimum of five (5) hours every two (2) years from either category must be in the area of ethics as described in 16.22.9.9 NMAC.

(3) Psychopharmacology or psychopharmacotherapy: for conditional prescribing or unrestricted prescribing psychologists, forty (40) hours every two (2) years out of the sixty (60) hour CPE requirement must be in the area of psychopharmacology or psychopharmacotherapy.

D. Criteria. The board accepts the criteria of the national professional organizations listed in 16.22.9.9 NMAC in accrediting continuing education hours. The following criteria adapted from *Standards and Criteria for Approval of Sponsors of Continuing Education for Psychologists* (American Psychological Association, 2009) shall apply to the board and to New Mexico accrediting organizations when approving continuing education requests.

(1) Sponsors must be prepared to demonstrate that information and programs presented are based on methodical, theoretical, research, or practice knowledge base. This requirement must be met by at least one (1) of the following:

(a) Program content has obtained credibility, as demonstrated by the involvement of the broader psychological practice, education, and science communities in studying or applying the findings, procedures, practices, or theoretical concepts.

(b) Program content has been supported using established research procedures and scientific scrutiny.

(c) Program content has peer reviewed, published support beyond those publications and other types of communications devoted primarily to the promotion of the approach.

(d) Program content is related to ethical, legal, statutory or regulatory policies, guidelines, and standards that impact psychology.

(2) Sponsors must select instructors with expertise in the program content and who are competent to teach this program content at a level that builds upon a completed doctoral program in psychology.

(3) Sponsors are required to ensure that instructors, during each CE presentation, include statements that describe the accuracy and utility of the materials presented, the basis of such statements, the limitations of the content being taught and the severe and the most common risks.

(4) Sponsors must offer program content that builds upon the foundation of a completed doctoral program in psychology.

(5) Sponsors must be prepared to demonstrate that content is relevant to psychological practice, education, or science.

(6) Sponsors must clearly describe any commercial support for the CE program, presentation. Or instructor to program participants at the time the CE program begins. Any other relationship that could be reasonably construed as a conflict of interest also must be disclosed.

[16.22.9.8 NMAC - Rp, 16.22.9.9 NMAC, 09/16/10; A, 04/30/15]

16.22.9.9 CPE PROGRAM CATEGORIES:

A. Category I shall consist of formally designed programs presented in a group setting with monitored attendance. The following types of programs qualify as category I:

(1) Formally organized workshops, seminars, grand rounds or classes aimed at the graduate or professional level which maintain an attendance roster and are approved by or under the auspices of an accredited institution of higher education offering graduate instruction.

(2) Workshops, seminars, or classes which maintain an attendance roster and are certified or recognized by one of the following organizations:

(a) the American psychological association;
(b) the American psychiatric association;
(c) the American medical association;
(d) the American association for marriage and family therapy;
(e) the American counseling association;
(f) the international congress of psychology;
(g) the national association of social workers;
(h) the New Mexico psychological association;
(i) the national association of school psychologists; or
(j) the New Mexico state board of psychologist examiners.

(3) Formal graduate level college or university courses relevant to scientific or professional psychological activities, including but not limited to neuropsychology, forensic psychology, development, language skills, statistics, and cultural knowledge, as deemed satisfactory to the board. Five (5) CPE credits will be granted for each university semester credit listed for the course. Documentation may be provided by college transcript showing credit obtained or letter from the instructor documenting hours of attendance for audited courses.

(4) Participation in the board will be granted hour-for-hour CPE credit up to twenty (20) hours. These hours satisfy the ethics CPE requirement.

(5) Achieving advanced certification, diplomate status or specialization in a field of psychology or psychopharmacology may be granted up to fifteen (15) CPE credits if approved by one (1) of the organizations designated in Paragraph (2) of Subsection A of 16.22.9.9 NMAC using their own criteria or the criteria of Paragraph (2) of Subsection D of 16.22.9.8 NMAC.

(6) Online education qualifies as category I if:

(a) it meets the above criteria;

(b) attendance is verified by the instructor's organization, e.g., electronically monitoring when the learner is online;

(c) a limit of eleven (11) CPE credits come from online coursework, that is that at least four (4) CPE credits be face-to-face interactions.

B. Category II shall consist of high quality and relevant experiences outside the format of formal presentations and classes. The following types of programs qualify as category II:

(1) Non-supervised independent study or home study programs, including online programs, conducted by accrediting agencies listed in Paragraph (2) of Subsection A of 16.22.9.9 NMSA will be granted hour-for-hour CPE credit.

(2) Symposia or presentations at annual conventions of national or regional professional organizations in psychology (for example, American psychological association, and Rocky Mountain psychological association) or a closely related discipline may be claimed for CPE credit. Four (4) hours may be claimed for the first time each scientific or professional presentation was made; two (2) hours may be claimed for a poster session.

(3) Publications related to the practice of psychology: CPE hours may be claimed for each publication of an article in a professional journal or book chapter authored by the licensee according to author listing:

(a) eight (8) hours for the first author;

(b) six (6) hours for the second author;

(c) four (4) hours for the third author; and

(d) two (2) hours for any subsequent author.

(4) Books related to the practice of psychology: Authoring or editing a book may be claimed for fifteen (15) hours.

(5) A presenter providing continuing education or teacher of a graduate course that qualifies as a category I program may claim hour per hour credit up to eight (8) CPE credit hours for the first time the presentation is made or the course is taught. New material in an existing course or program may be claimed hour per hour up to eight (8) hours the first time it is presented.

(6) Participation in the New Mexico psychological association executive board, or formal offices or committees established by the board, the New Mexico psychological association, the American psychological association, or other professional organizations, if the tasks are clearly related to issues of ethics, professional standards, or practice-related skills shall be granted CPE credit of one (1) hour for every two (2) hours of participation up to twenty (20) hours.

C. Cultural Diversity shall consist of the following types of programs: A course containing attention to cultural diversity, as specifically noted in the title, description of objectives, or curriculum of the presentation, symposium, workshop, seminar, or course. A course in cultural diversity focuses on increasing scientific understanding and training in regard to those aspects that pertain to but are not limited to culture, class, race/ethnicity, gender, sexual orientation, aging and disability. The aim of such courses is the promotion of culturally sensitive models for the delivery of psychological services. The topic of the presentation, symposium, workshop, seminar, or course need not be on cultural diversity; however one (1) of the objectives or the description of topics covered must clearly indicate attention to cultural diversity, as deemed satisfactory to the board. Four (4) hours of cultural diversity CPE from either category I or II are required for each two (2) year reporting period.

D. Ethics shall consist of the following types of programs: A course containing attention to the ethics of practice related to psychology. The topic of the presentation, symposium, workshop, seminar, or course need be on ethics and the objectives or the description of topics covered must clearly indicate attention to ethics, as deemed satisfactory to the board. Five (5) hours of ethics CPE from either category I or II are required for each two (2) year period.

[16.22.9.9 NMAC - Rp, 16.22.9.8 NMAC, 09/16/10; A, 04/30/15]

16.22.9.10 CARRY-OVER HOURS; EXEMPTIONS; TIME EXTENSIONS

A. Carry-over hours. No hours shall be carried over from one compliance-reporting period to another compliance reporting period.

B. Exemptions and extensions of time.

(1) Licenses on retirement or inactive status as provided in Part 10 are not exempt from CPE requirements of this Part 9.

(2) Extensions of time for completing and reporting CPE requirements shall be granted for good cause only upon a written request filed with the board by the licensee prior to the date for compliance. Unless

extenuating circumstances beyond the control of the licensee cause extraordinary hardship, the extension of time for completing and reporting CPE requirements shall not exceed one (1) year. The board may grant one extension of time of up to sixty (60) calendar days for filing a request for the extension of time upon a finding of good cause
[16.22.9.10 NMAC - Rp, 16.22.9.10 NMAC, 09/16/10]

16.22.9.11 COMPLIANCE: FAILURE TO COMPLY AND LICENSE RENEWAL

A. Compliance reporting requirements. Every two (2) years during the designated annual renewal period, each licensee shall submit an attestation that he has completed the CPE requirements. The board reserves the right to audit any licensee to submit evidence or documentation of the CPE credits (e.g. course or program certificate of training, transcript, course or workshop brochures or published descriptions, copies of registration forms, payment invoices or receipts, specific evidence of attendance, etc.). Therefore, it is the responsibility of each licensee to establish and maintain detailed records of CPE compliance for two (2) years after the reporting period. The board shall not allow continuing education credit for personal psychotherapy, workshops for personal growth, the provision of paid or volunteer services to professional associations other than APA or statewide associations of licensed psychologists in New Mexico, foreign language courses, computer training, office management, or practice building.

B. Failure to comply. Failure to complete or report continuing professional education requirements as provided in this part is grounds for withholding renewal of a license or for suspension or revocation of a license as provided in the act. Fraud or deception in reporting CPE credit is a separate violation of the code and is grounds for withholding renewal of a license or for suspension or revocation of a license as provided in the act.
[16.22.9.11 NMAC - Rp, 16.22.9.11 NMAC, 09/16/10]

16.22.9.12 REQUIREMENTS FOR NEWLY LICENSED INDIVIDUALS:

A. No CPE requirements until first renewal. Individuals licensed for the first time in New Mexico as psychologists or psychologist associates shall renewal their license for two (2) years at the first renewal period following the issuing of their license. They shall have no CPE requirement during this initial licensing period from issuance to renewal, but shall complete cultural awareness coursework prior to their first renewal.

B. Cultural awareness coursework. Newly licensed psychologists and psychologist associates with restricted and unrestricted licenses shall complete eight (8) hours of cultural awareness coursework approved by the board prior to their first license renewal. Cultural awareness coursework shall be courses designed to provide knowledge and awareness of the cultures of New Mexico. Course titles and descriptions must make clear a breadth of cultural awareness training and the specific content of New Mexico cultures.
[16.22.9.12 NMAC - N, 04/30/15]

HISTORY OF 16.22.9 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center and Archives under:
SBPE 9*, Renewal of Certificate filed 11/15/79;
Rule 12, Renewal of Certificate filed 11/1/83;
Rule 12, Renewal of Certificate filed 3/19/84;
Rule 12, Renewal of Certificate filed 4/19/85;
Rule 12, Renewal of Certificate filed 2/9/87;
NMBPE Rule 8 Renewal of License filed 12/28/89;
NMBPE Rule 8, Renewal of License filed 8/28/90;
Rule No. 8, Renewal of License filed 4/24/95.

History of Repealed Material:
16 NMAC 22.5, Licensure Renewal, filed 11/14/97 - Repealed effective 4/16/2000.
16.22.9 NMAC, Continuing Professional Education Requirements, filed 3/17/2000 - Repealed effective 11/15/2006.
16.22.9 NMAC, Continuing Professional Education Requirements, filed 10-16-2006 - Repealed effective 9/16/2010.

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 10 INACTIVE STATUS AND REINSTATEMENT

16.22.10.1 ISSUING AGENCY: Regulation and Licensing Department, State Board of Psychologist Examiners
[16.22.10.1 NMAC - Rp, 16.22.10.1 NMAC, 11/15/06]

16.22.10.2 SCOPE: The provisions of Part 10 apply to all licensed psychologists who plan to place their license on inactive status, or reinstate their inactive license to active status.
[16.22.10.2 NMAC - Rp, 16.22.10.2 NMAC, 11/15/06]

16.22.10.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-6.
[16.22.10.3 NMAC - Rp, 16.22.10.3 NMAC, 11/15/06]

16.22.10.4 DURATION: Permanent.
[16.22.10.4 NMAC - Rp, 16.22.10.4 NMAC, 11/15/06]

16.22.10.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of a section.
[16.22.10.5 NMAC - Rp, 16.22.10.5 NMAC, 11/15/06]

16.22.10.6 OBJECTIVE: This part establishes the requirements and procedures to place an active license in inactive status or to reinstate the license to active status.
[16.22.10.6 NMAC - Rp, 16.22.10.6 NMAC, 11/15/06]

16.22.10.7 DEFINITIONS: [RESERVED.]
[Refer to 16.22.1.7 NMAC]

16.22.10.8 INACTIVE STATUS

A. The following criteria must be met for inactive status eligibility:

(1) the licensee must be in good standing; and

(2) his license must be current; a licensee who failed to renew a license by July 1 of any year shall renew the licensee in accordance with Part 8 before the licensee can be considered for inactive status.

B. A licensee who wishes to be placed on inactive status shall:

(1) notify the board administrator in writing before his current license expires and the board administrator will acknowledge receipt of the notification; and

(2) pay the fees established by the board to be placed on inactive status.

C. A licensee on inactive status shall not practice psychology in New Mexico as defined in the act.

D. Rendering or offering to render psychological services or engaging in the practice of psychology while on inactive status shall be considered sufficient grounds for disciplinary action by the board.

E. When a psychologist holds an inactive license and represents himself in public statements that include but are not limited to, paid or unpaid advertising, brochures, printed matter, directory listings, personal resumes or curricula vitae, interviews or comments for use in media, statements in legal proceedings, lectures, and public oral presentations, he must disclose that with an inactive license, he shall not provide psychotherapy.

F. A licensee on inactive status shall at all times comply with the provisions of Part 2, including, without limitation, Subsection B of 16.22.2.10 NMAC and 16.22.2.12 NMAC.
[16.22.10.8 NMAC - Rp, 16.22.10.8 NMAC, 11/15/06]

16.22.10.9 REINSTATEMENT FROM INACTIVE STATUS

A. If the inactive licensee requests reinstatement to active status within three (3) years, he shall:

(1) complete an application for reinstatement form provided by the board;

(2) provide satisfactory proof of completion of the continuing education requirements described in Part 9;

(3) not have violated any rule of the Professional Psychologist Act or the rules and regulations of the board;

(4) pay the appropriate renewal fee established by the board.

B. If the inactive licensee requests reinstatement to active status after three (3) years, he shall:

(1) complete an application for reinstatement form provided by the board;

(2) provide satisfactory proof of completion of the continuing education requirements described in Part 9;

(3) take and pass the online jurisprudence examination;

(4) not have violated any rule of the Professional Psychologist Act or the rules and regulations of the board;

(5) pay the appropriate renewal fee established by the board.

C. A licensee on inactive status shall not render or offer to render psychological services or otherwise engage in the practice of psychology until he receives a new license issued by the board.

[16.22.10.9 NMAC - Rp, 16.22.10.9 NMAC, 11/15/06; A, 03/21/09]

HISTORY OF 16.22.10 NMAC:

Pre-NMAC History: The material in this part was derived form that previously filed with the State Records Center and Archives under:

NMBPE Rule 11, Inactive Status filed 8/28/90.

Rule No. 11, Inactive, Retirement Status and Reinstatement filed 4/24/95.

History of Repealed Material:

16 NMAC 22.6, Inactive, Retirement Status and Reinstatement - Repealed, 4/16/00.

16.22.10 NMAC, Inactive Status and Reinstatement - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES:
PART 11 COMPLAINT PROCEDURES; ADJUDICATORY PROCEEDINGS

16.22.11.1 ISSUING AGENCY: Regulation and Licensing Department State Board of Psychologist Examiners
[16.22.11.1 NMAC - Rp, 16.22.11.1 NMAC, 11/15/06]

16.22.11.2 SCOPE: The provisions of Part 11 shall apply to all licensees and applicants for license entitled to notice and hearing under the Uniform Licensing Act, (ULA) Section 61-1-1 through 61-1-33 NMSA 1978 and to any interested person who may file a complaint against a licensee or applicant.
[16.22.11.2 NMAC - Rp, 16.22.11.2 NMAC, 11/15/06]

16.22.11.3 STATUTORY AUTHORITY: Part 11 is adopted pursuant to the Professional Psychologist Act Section 61-9-6, 61-9-13, and 61-9-14 NMSA 1978
[16.22.11.3 NMAC - Rp, 16.22.11.3 NMAC, 11/15/06]

16.22.11.4 DURATION: Permanent.
[16.22.11.4 NMAC - Rp, 16.22.11.4 NMAC, 11/15/06]

16.22.11.5 EFFECTIVE DATE: November 15, 2006 unless a later date is cited at the end of a section.
[16.22.11.5 NMAC - Rp, 16.22.11.5 NMAC, 11/15/06]

16.22.11.6 OBJECTIVE: This part establishes procedures for filing, processing, and investigating complaints against licensees and applicants and establishes procedures for the conduct of adjudicatory proceedings.
[16.22.11.6 NMAC - Rp, 16.22.11.6 NMAC, 11/15/06]

16.22.11.7 DEFINITIONS: [RESERVED.]
[Refer to 16.22.1.7 NMAC]

16.22.11.8 COMPLAINT PROCEDURES

A. Inquiries regarding filing of complaints.

(1) Inquiries made to the board or to a board member regarding a potential complaint will be referred to the board administrator or compliance liaison for a response.

(2) Upon receipt of an inquiry, the board administrator or compliance liaison shall forward to the potential complainant a complaint form with instructions on how to file the complaint. Complaints shall be submitted in writing on the prescribed form, signed and notarized, and state the facts upon which the complaint is based. Anonymous complaints will not be investigated, unless the board determines an exception is valid due to unusual circumstances.

(3) Once a complaint, is made, it will come under the provisions of this section and cannot be withdrawn.

B. Procedures for processing complaints. The board administrator or compliance liaison shall:

(1) log in the date the complaint is received;

(2) determine if the subject of the complaint is a licensed psychologist, psychologist associate or an applicant or person otherwise within the jurisdiction of the board;

(3) assign an individual file with a complaint number, which numbering sequence shall begin each new calendar year;

(4) send a letter to the complainant confirming receipt of the complaint;

(5) forward the complaint to respondent with a letter requesting a response to the allegations and any documents or materials relevant to the complaint, unless it will impede an investigation or interfere with the acquisition of documents or relevant papers or the development of the case; and

(6) forward the complaint file to the chair of the complaint committee.

C. Review by the complaint committee.

(1) The chair of the complaint committee is appointed by the board chair and shall consist of a board member and may include the board administrator and compliance liaison.

(2) The complaint committee shall review the entire complaint file to determine if the allegations in the complaint are substantiated and constitute grounds for disciplinary action.

(3) The complaint committee or its designee may employ experts, consultants, or private investigators to assist in investigations of complaints.

(4) The complaint committee, or its designee, on behalf of the board, may issue investigative subpoenas, pursuant to Section 61-1-4)A) NMSA 1978.

(5) Upon completion of an investigation and review, the complaint committee shall submit to the full board a case summary containing alleged violations of the code, board regulations or the act and recommendations for disposition. Throughout this process, confidentiality of interested parties will be maintained.

D. Review by the full board.

(1) Any board member or any member of the complaint committee who is partial or who believes he is not capable of judging a particular controversy fairly on the basis of it own circumstances shall not participate in the decision whether to issue a notice of contemplated action and shall not participate in the hearing, deliberation, or decision of the board.

(2) The board shall review the case summary presented by the complaint committee, relevant documents, witness statements, and other pertinent information regarding the complaint. If the board has sufficient evidence that a violation may have occurred, the board shall forward the evidence to the administrative prosecutor for issuance of an notice of contemplated action.

(3) Following the issuance of a notice of contemplated action, the board may at its option authorize a board member, or the administrative prosecutor to confer with the applicant or the licensee for the purpose of settlement of the complaint. Such settlement must be approved by the board, must be with the consent of the applicant or licensee, and shall include a knowing and intentional waiver by the applicant or the licensee of his rights to hearing under the Uniform Licensing Act.

(4) The board may refer a complaint to the attorney general for injunctive proceedings or to the district attorney for criminal prosecution.

[16.22.11.8 NMAC - Rp, 16.22.11.8 NMAC, 11/15/06; A, 02/22/13]

16.22.11.9 ADJUDICATORY PROCEEDINGS

A. General provisions and pre-hearing and preliminary matters.

(1) All hearings shall be conducted either by the board or, at the election of the board, by a hearing officer.

(2) If the board appoints a hearing officer, the hearing officer shall have authority to decide pre-hearing matters, preside over the hearing, and direct post-hearing matters in accordance with the requirements of the case in a manner that ensures an efficient and orderly hearing and expedites the final resolution of the case. Except as otherwise limited in this part, the hearing officer shall have the authority to rule on all non-dispositive motions. If the board does not appoint a hearing officer or if the hearing officer is unavailable or unable to proceed, the board chair or other board member designated by the board shall have the authority to decide pre-hearing or preliminary matters on behalf of the board. This authority shall be in accordance with the requirements of the case in a manner that ensures an efficient and orderly hearing and expedites the final resolution of the case, including, without limitation.

(a) Unopposed or stipulated motions to change venue.

(b) Motions for continuance of a hearing date. A motion to vacate the hearing must contain an affirmative statement that the licensee or applicant waives his right to a hearing held not more than sixty (60) days from the date of service of the notice hearing.

(c) The granting of one notice of pre-emptory excusal to each party if the notice is timely and if the pre-emptory excusal does not result in a loss of a quorum of the board.

(d) Motions regarding discovery.

(3) The original of any papers and pleadings shall be filed with the board. Copies shall be sent to the hearing officer and attorneys or parties of record.

(4) The hearing officer or designated board member shall issue appropriate orders to control the course of the proceedings.

(5) Consistent with provisions of the Uniform Licensing Act and to the extent practicable, the rules of civil procedure for the district courts shall apply unless the hearing officer or designated board member orders otherwise.

(6) A request for an order shall be made by a motion filed with the board. Except for motions made during the course of the hearing, a motion shall be in writing. A motion shall state with particularity the grounds for the motion and shall set forth the relief and order sought.

(7) A motion shall be accompanied by a memorandum brief in support of the motion. The brief shall state with particularity the grounds for the motion and shall contain citation to authorities, statutes, and references to the pleadings on file. If matters outside of the pleadings are considered, a copy of the referenced material shall be attached to the brief. Responsive briefs shall be permitted in accordance with the rules of civil procedure for the district courts to the extent practicable unless the hearing officer or designated board member orders otherwise.

(8) The hearing officer or the designated board member may order the filing of briefs or other documents and may set oral argument on any matter.

(9) No more than two (2) continuances of the hearing date will be granted without the approval of the board for good cause shown.

(10 All dispositive motions shall be decided by the board.

(11) No proposed settlement, consent agreement, voluntary surrender of a license in lieu of prosecution, or other proposal for the resolution of a pending disciplinary case shall be effective unless approved by the board and executed by the board and the licensee or applicant. The board or hearing officer may seek information from the administrative prosecutor and the licensee or applicant concerning circumstances of the case relevant to a consideration of the proposed settlement or clarification of the proposed terms and conditions. No board member is presumed to be biased and shall not be excused based solely on the reason that the member considered a proposed settlement, consent agreement, or other proposal for the resolution of a pending disciplinary case. The board may submit a counterproposal for the settlement or resolution of the case.

(12) Any proposed settlement, consent agreement, voluntary surrender of a license in lieu of prosecution, or other proposal for the resolution of a pending disciplinary case shall contain at least the following:

(a) an admission of all jurisdictional facts; an acknowledgment of the rights contained in the Uniform Licensing Act and an express waiver of those rights and of all rights to hearing and judicial review or any other opportunity to contest the validity of the board order in any other proceeding or forum;

(b) a statement that the proposal resolves only the violations alleged in the notice of contemplated action and a statement that the board reserves the right to initiate other proceedings for any other violations of the act or board regulations;

(c) a general nature of the evidence underlying each alleged violation;

(d) if appropriate, a list of provisions of the acts or practices from which the licensee or applicant will refrain in the future;

(e) a statement of the type, terms, and conditions of the proposed disciplinary action of the board;

(f) a statement that the licensee will be responsible for all costs of disciplinary proceedings or a statement setting forth the reason why the licensee should be excused from paying costs; the affidavit of the board administrator concerning the costs incurred to date shall accompany the proposal;

(g) a statement that the decision and order of the board shall be a public record and reported, as required by law. If the proposed settlement involves an action of the type specified in the Uniform Licensing Act Subsections D-(i) thru 61-1-3 K(n), NMSA 1978 or voluntary surrender of a license in lieu of prosecution, the decision and order shall be reported by the board to the ASPPB disciplinary data report, healthcare integrity and protection data bank (HIPDB), and to other appropriate entities;

(h) other provisions necessary to ensure the complete and final resolution of the proceedings.

(13) A proposal to settle a matter shall not stay the proceedings or vacate the hearing date unless otherwise ordered by the hearing officer or presiding officer upon the filing of a timely motion.

B. Duties of the board administrator. The board administrator shall:

(1) after consultation with the board or hearing officer, issue a notice of hearing stating the date, time, and place of the hearing;

(2) execute on behalf of the hearing officer or board notices, scheduling orders, subpoenas, and subpoenas duces tecum, and other routine procedural documents that facilitate the efficient conduct of adjudicatory proceedings;

(3) maintain the official record of all papers and pleadings filed with the board in any matter;

(4) prepare an affidavit as to costs of any disciplinary proceeding at the conclusion of any hearing or upon request by a party submitting a proposed settlement, consent agreement, or voluntary surrender of a license in lieu of prosecution;

(5) prepare, certify, and file with the district court the record of the case on appeal or review;

(6) unless the board orders otherwise, have the authority to sign the decision of the board to grant or refuse a request to reopen the case.

C. Conduct of hearings.

(1) The hearing officer, or presiding officer if the case is heard by the board, shall ensure the fair, efficient, and orderly conduct of the hearing in accordance with the Uniform Licensing Act.

(2) Unless the board orders otherwise, a board member hearing officer, the board chair, or presiding officer shall have the authority to sign the written decision of the board.

(3) The board administrator shall serve the decision of the board on the licensee or applicant in accordance with law.

(4) A motion for an order staying the operation of a board decision shall be decided by the board.

[16.22.11.9 NMAC - Rp, 16.22.11.9 NMAC, 11/15/06]

16.22.11.10 SURRENDER OF LICENSE

A. If a license is restricted, suspended, or revoked by the board for any reason specified in the rules and regulations of the board or in the act, the licensee shall immediately surrender his license in person or by registered mail to the board.

B. If the licensee's scope of practice is restricted or limited or otherwise subject to conditions, the license may reflect the restriction, limitations, or condition.

[16.22.11.10 NMAC - Rp, 16.22.11.10 NMAC, 11/15/06]

HISTORY OF 16.22.11 NMAC:

Pre-NMAC History:

Part 11 was derived from material previously filed with the State Records Center and Archives under:
Rule No. 19, Complaint Procedures filed 4/24/95.
Rule No. 17, Surrender of License filed 4/24/95.

History of Repealed Material:

16 NMAC 22.7, Complaint Procedures - Repealed, 4/16/00
16.22.11 NMAC, Complaint Procedures and Adjudicatory Proceedings - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 12 PSYCHOLOGIST ASSOCIATES: EDUCATION REQUIREMENTS AND CONDITIONS OF PRACTICE

16.22.12.1 ISSUING AGENCY: Regulation and Licensing Department, State Board of Psychologist Examiners.
[16.22.12.1 NMAC - Rp, 16.22.12.1 NMAC, 11/15/06]

16.22.12.2 SCOPE: The provisions of Part 12 apply to all applicants and licensees who apply or are licensed as psychologist associates in New Mexico.
[16.22.12.2 NMAC - Rp, 16.22.12.2 NMAC, 11/15/06]

16.22.12.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act Section 61-9-6, 61-9-11-1.
[16.22.12.3 NMAC - Rp, 16.22.12.3 NMAC, 11/15/06]

16.22.12.4 DURATION: Permanent.
[16.22.12.4 NMAC - Rp, 16.22.12.4 NMAC, 11/15/06]

16.22.12.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of a section.
[16.22.12.5 NMAC - Rp, 16.22.12.5 NMAC, 11/15/06]

16.22.12.6 OBJECTIVE: This part sets forth the conditions of practice for psychologist associates and defines the professional relationship with doctoral-level supervision.
[16.22.12.6 NMAC - Rp, 16.22.12.6 NMAC, 11/15/06]

16.22.12.7 DEFINITIONS: [RESERVED.]
[Refer to 16.22.1.7 NMAC]

16.22.12.8 CONDITIONS OF PRACTICE FOR PSYCHOLOGIST ASSOCIATES

A. Supervision by a licensed psychologist or board-certified psychiatrist.

(1) Psychologist associates who engage in the practice of psychology shall be supervised by a licensed psychologist or a board-certified psychiatrist, except in the area of psychological or cognitive testing. If the psychologist associate conducts psychological and/or cognitive testing, the psychologist associate shall be supervised in this area of practice by a licensed psychologist. The psychologist shall explicitly agree to supervise the psychologist associate.

(2) The supervisor shall assume professional and ethical responsibility for the work of the psychologist associate performed in the course of their professional relationship.

(3) The supervisor shall provide supervision only in those areas of practice in which he/she is qualified to render services.

(4) The supervisor shall not provide supervision to one who is his/her administrative superior(s) or is a member of his or her family.

(5) The supervisor shall keep records of supervision. Such records shall be kept separately from the client's records and shall include dates of supervision, without reference to the client's name. Such records shall be submitted to the board on an annual basis as a condition of the renewal process.

(6) The supervisor shall not exploit the psychologist associate for financial gain or with excessive work demands. The supervisor shall make every effort to avoid exploitation of the psychologist associate by an agency with which the supervisor and psychologist associate are affiliated.

(7) Financial arrangements between the supervisor and the psychologist associate shall be clear and shall not interfere with or compromise the ethical, professional, and legal responsibilities each party has to the client or patient and to each other. Psychologist associates may bill clients or patients independently from the supervisor, provided that this arrangement does not interfere with or compromise those responsibilities.

B. Nature of supervision from licensed supervisor.

(1) Supervision of a psychologist associate shall cover all aspects of the psychologist associate's work and shall include at least two (2) hours a month of one-to-one supervision between the psychologist associate

and the supervisor. If the psychologist associate who is supervised by a board-certified psychiatrist also conducts psychological or cognitive testing in his practice, the psychologist associate must be supervised by a licensed psychologist at least two (2) additional hours per month in this area of practice.

(2) The client or patient shall always be informed about the nature of the professional relationship that exists between the supervisor and the psychologist associate. The client shall be informed of his/her right to meet with the supervisor upon request and that the supervision of the psychologist associate by the supervisor may involve a review of the content of the evaluation documents and intervention plans.

C. Supervisory agreement with licensed supervision.

(1) The psychologist associate and his supervisor shall file a notarized letter of agreement signed by all parties setting forth the terms of the supervisory arrangements. This agreement shall be updated and provided to the board as a condition of the yearly renewal of the psychologist associate's license. If there is no change in the agreement, a letter informing the board that there is no change, signed by both parties, shall accompany the yearly renewal of the psychologist associate's license.

(2) Both the supervisor and the psychologist associate shall notify the board in writing within thirty (30) days of termination if the supervisory agreement is terminated or the supervisory relationship ends for any reason. Most importantly, termination of the supervisory relationship shall be accomplished in a context of primary concern for the clients receiving care.

D. Ethical responsibilities of psychologist associates.

(1) The psychologist associate shall assume legal, ethical, and professional responsibility for the welfare of the client or patient, including client or patient diagnosis, intervention, and outcome of intervention.

(2) The psychologist associate shall provide services only in those areas of practice for which he is qualified.

E. Disclosure requirements. Any person licensed as a psychologist associate who advertises or solicits services to the general public shall specifically state: "Licensed psychologist associate - supervised practice." [16.22.12.8 NMAC - Rp, 16.22.12.8 NMAC, 11/15/06]

16.22.12.9 EDUCATION REQUIREMENTS

A. An applicant who received a master's degree prior to July 1, 1985, shall hold a master's degree from a department of psychology in a school or college as defined in the Professional Psychologist Act or a master's degree which is primarily psychological in nature from a school or college whose program had substantially equivalent requirements as those set forth in this rule.

B. An applicant who received a master's degree after July 1, 1985, shall hold a master's degree from a department of psychology, counseling psychology, or school psychology in a school or college as defined in the Professional Psychologist Act.

C. The applicant shall show that his program of graduate studies included a minimum of three (3) graduate semester hours (six (6) graduate quarter hours) directly related to psychological theory in three of the nine following content areas (no course may be counted for more than two areas):

(1) biological aspects of behavior: physiological psychology, comparative psychology, neuropsychology, sensation and perception, psychopharmacology, biological bases of development;

(2) cognitive and affective aspects of behavior: learning, thinking, motivation, emotion, and cognitive development;

(3) social aspects of behavior: social psychology, group processes, community psychology, social development, organizational and systems theory;

(4) human development: developmental psychology, human development, lifespan development, and developmental psychopathology;

(5) individual differences: personality theory, human development, and abnormal psychology;

(6) professional and scientific ethics and standards: professional and ethical problems in clinical, counseling, or school psychology, legal, ethical, and professional issues in psychotherapy or counseling;

(7) research design, methodology, statistics, and data analysis: research methods in clinical, counseling, or school psychology; research design in psychology; statistical analysis in psychology; multivariate statistical methods;

(8) cultural competence, as deemed satisfactory to the board, multicultural counseling, counseling the culturally different, feminist psychology, counseling gay and lesbian populations, treating persons with disabilities;

(9) methods of assessment and diagnosis: psychological assessment, clinical diagnosis, and intellectual and personality assessment.

D. The applicant shall have completed at least two (2) semesters (or four (4) quarter hours) of clinical, counseling, or school psychology practicum.
[16.22.12.9 NMAC - Rp, 16.22.12.9 NMAC, 11/15/06]

16.22.12.10 [RESERVED]
[16.22.12.10 NMAC - Rp, 16.22.12.10 NMAC, 11/15/06]

16.22.12.11 DEMONSTRATION OF COMPETENCE

A. Description of examination and general information. All persons applying for licensure shall be examined by the board. The examination consists of two parts:

(1) a written examination, called the EPPP, that demonstrates professional competence;

(2) an online jurisprudence examination constructed, administered, and graded by the board and its designees, which assesses knowledge, ethical standards, New Mexico laws, and the board regulations as they apply to psychologists and their clients or patients.

B. Passing scores.

(1) The passing score on the EPPP taken before January 1, 1993 is 140 (70%) or taken after January 1, 1993 is the score equal to or greater than the passing score recommended by ASPPB.

(2) The passing score for the jurisprudence examination will be as determined by the board. Applicants will be notified within thirty (30) days following the jurisprudence examination of their test results.

(3) If the score of either the EPPP or the jurisprudence examination meets the requirement for licensure as a psychologist associate but the other score does not, the examination passed will not have to be retaken.
[16.22.12.11 NMAC - Rp, 16.22.8.11 NMAC, 11/15/06]

16.22.12.12 APPLICATION PROCESS

A. Initial application procedure. To open an initial application file, the applicant shall submit the following:

(1) a completed and signed application;
(2) the application fee as required by the board;
(3) official transcripts directly from the institution's office of the registrar; and
(4) three (3) letters of reference.

B. If the application is not complete, the applicant will be notified of all deficiencies within thirty (30) days of the board's receipt. The application process shall be completed within thirty (30) days of the receipt at the board office of all materials listed in Subsection A of 16.22.12.12 NMAC. The applicant must have all documents in the board office at least sixty (60) days prior to taking the examination for professional practice in psychology (EPPP).

C. Complete applications will be reviewed by the board and a notification of approval, denial or need for additional information will be issued to the applicant within thirty (30) days.

D. The written examination for licensure is the EPPP, developed by the association of state and provincial psychology boards (ASPPB) and administered by the professional examination service (PES). An applicant shall be eligible to take the EPPP three (3) times within the eighteen (18) months following the date the applicant was notified of the board's approval of their application.

(1) If the applicant does not pass the EPPP any of the three (3) times it is administered within eighteen (18) months, the applicant shall submit a new initial application.

(2) Upon the submission of the new application, the rules and regulations in effect at the time the new initial application is received will be used to determine whether an applicant meets the requirements for licensure.

E. The applicant shall take and pass an online jurisprudence examination after the board has received his EPPP score from the ASPPB reporting service, indicating that the applicant received a passing score pursuant to the act.

F. During the first year of licensure, an applicant shall furnish evidence to the board that demonstrates an awareness and knowledge of New Mexico cultures.
[16.22.12.12 NMAC - N, 03/21/09]

HISTORY OF 16.22.12 NMAC:
Pre-NMAC History:
Rule No. 5, Conditions of Practice for Psychologist Associate filed 4/24/95.
Rule No. 5, Requirements for Certification Psychologist Associate filed 11/1/83.

NMBPE Rule 3, Requirements for Licensure Psychologist Associate filed 12/28/89.
Rule No. 3, Educational Requirements-Psychologist filed 4/24/95.

History of Repealed Material:
16 NMAC 22.8, Educational Requirements and Conditions of Practice for Psychologist Associates, Repealed 4/16/00
16.22.12 NMAC, Education Requirements and Conditions of Practice for Psychologists Associates - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 13 FEES

16.22.13.1 ISSUING AGENCY: Regulation and Licensing Department, State Board of Psychologist Examiners.
[16.22.13.1 NMAC - Rp, 16.22.13.1 NMAC, 11/15/06]

16.22.13.2 SCOPE: The provisions of Part 13 apply to all applicants for licensure and the general public.
[16.22.13.2 NMAC - Rp, 16.22.13.2 NMAC, 11/15/06]

16.22.13.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologists Act, NMSA 1978, Sections 61-9-7, 61-9-10, 61-9-11 and 61-9-11(1) and the Inspection of Public Records Act, Section 14-2-9(B).
[16.22.13.3 NMAC - Rp, 16.22.13.3 NMAC, 11/15/06]

16.22.13.4 DURATION: Permanent.
[16.22.13.4 NMAC - Rp, 16.22.13.4 NMAC, 11/15/06]

16.22.13.5 EFFECTIVE DATE: November 15, 2006 unless a later date is cited at the end of a section.
[16.22.13.5 NMAC - Rp, 16.22.13.5 NMAC, 11/15/06]

16.22.13.6 OBJECTIVE: To establish fees within statutory limitations to generate revenue adequate to fund the cost of program administration.
[16.22.13.6 NMAC - Rp, 16.22.13.6 NMAC, 11/15/06]

16.22.13.7 DEFINITIONS: [RESERVED.]
[Refer to 16.22.1.7 NMAC]

16.22.13.8 FEE SCHEDULE:

A. All fees payable to the board are non-refundable. The fees for the (EPPP), and the (PEP) are in addition to the fees described below, and determined by the professional examination service offering the examination on behalf of the board. Background fees shall be the amount established by the department of public safety for the processing of criminal history background checks.

B. Application fees. (psychologists, psychologist associates, conditional prescribing and prescribing psychologists):

(1) initial application fee- [initial application fee expires 24 months from the date application is received in the board office] $300.00

(2) jurisprudence examination: $75.00

(3) re-examination fee for jurisprudence exam: $75.00

(4) application for an out of state psychologist to conduct court-ordered independent examination (per case): $150.00

(5) initial conditional prescription certificate: $75.00

(6) 60 day extension of conditional prescription: $100.00

(7) second-year conditional prescription certificate: $75.00

(8) prescription certificate: $75.00

(9) temporary license fee: $300.00

C. Biennial/annual renewal fees psychologists, psychologist associates, conditional prescribing and prescribing psychologists:

(1) one-time annual renewal by psychologists and psychologist associates meeting first-year New Mexico licensure requirements: $300.00

(2) biennial renewal active status psychologists and psychologist associates: $600.00

(3) biennial renewal active status (conditional prescribing and prescribing psychologists): $150.00

(4) annual renewal inactive status: $150.00

(5) late fee (received after July 1 and within 1 year of suspension): active status (psychologists, psychologist associates, conditional prescribing and prescribing psychologist): $100.00

(6) reinstatement fee from inactive to active status: $300.00

D. Other miscellaneous charges

(1) duplicate/replacement wall certificate: $25.00
(2) licensee lists: $100.00
(3) licensee labels: $150.00
(4) per page copy fee for public information request: $ .25 cents
(5) license verification fee: $15.00

[16.22.13.8 NMAC - Rp, 16.22.13.8 NMAC, 11/15/06; A, 03/21/09; A, 09/16/10; A, 04/11/12]

HISTORY OF 16.22.13 NMAC:

History of Repealed Material:
16.22.13 NMAC, Fees - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 14 LICENSURE FOR MILITARY SERVICE MEMBERS, SPOUSES AND VETERANS

16.22.14.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners.
[16.22.14.1 NMAC - N, 04/30/15]

16.22.14.2 SCOPE: This part sets forth application procedures to expedite licensure for military service members, spouses and veterans.
[16.22.14.2 NMAC - N, 04/30/15]

16.22.14.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to Professional Psychology Act, NMSA 1978.
[16.22.14.3 NMAC - N, 04/30/15]

16.22.14.4 DURATION: Permanent.
[16.22.14.4 NMAC - N, 04/30/15]

16.22.14.5 EFFECTIVE DATE: April 30, 2015, unless a later date is cited at the end of a section.
[16.22.14.5 NMAC - N, 04/30/15]

16.22.14.6 OBJECTIVE: The purpose of this part is to expedite licensure for military service members, spouses and veterans.
[16.22.14.6 NMAC - N, 04/30/15]

16.22.14.7 DEFINITIONS:

A. "Military service member" means a person who is serving in the armed forces of the United States or in an active reserve component of the armed forces of the United States, including the national guard.

B. "Recent Veteran" means a person who has received an honorable discharge or separation from military service within the two years immediately preceding the date the person applied for an occupational or professional license pursuant to this section.
[16.22.14.7 NMAC - N, 04/30/15]

16.22.14.8 APPLICATION REQUIREMENTS:

A. Applications for registration shall be completed on a form provided by the department.

B. The information shall include:

(1) Completed application and fee.

(2) Satisfactory evidence that the applicant holds a license that is current and in good standing, issued by another jurisdiction, including a branch of armed forces of the United States, that has met the minimal licensing requirements that are substantially equivalent to the licensing requirements for the occupational or professional license the applicant applies for pursuant to Chapter 61, Articles 2 through 34 NMSA 1978.

C. Electronic signatures will be acceptable for applications submitted pursuant to Section 14-16-1 through Section 14-16-19 NMSA 1978.
[16.22.14.8 NMAC - N, 04/30/15]

16.22.14.9 FEES:

A. The fee for application registration is three hundred dollars ($300.00).

B. The fee for renewal of registration is six hundred dollars ($600.00).
[16.22.14.9 NMAC - N, 04/30/15]

16.22.14.10 RENEWAL REQUIREMENTS:

A. A license issued pursuant to this section shall not be renewed unless the license holder satisfies the requirements for the issuance and for the renewal of a license pursuant to Chapter 61, Articles 2 through 34 NMSA 1978.

B. The licensee must submit the following documents at the time of renewal:

(1) official doctoral degree transcripts sent directly from the institution's office of the registrar;

(2) license verification from all jurisdictions in which the applicant is or has been granted a psychologist license;

(3) three (3) letters of reference dated within the last two (2) years and two (2) of the letters must be from a licensed practicing psychologist familiar with their clinical work, and can attest to their competency and moral character;

(4) verification of pre-doctoral internship and supervision as defined in 16.22.6 NMAC; and

(5) verification of passing the examination for professional practice in psychologist (EPPP) as defined in 16.22.7.8 NMAC.

C. Licensee must take and pass a jurisprudence examination with a score of seventy-five percent (75%).

D. Prior to the expiration of the license, all licensed psychologists shall apply for registration renewal and shall pay the renewal fee as set forth in 16.22.13 NMAC.

[16.22.14.10 NMAC - N, 04/30/15]

HISTORY OF 16.22.14 NMAC: [RESERVED]

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 20 CONDITIONAL PRESCRIPTION CERTIFICATE; PRESCRIPTION CERTIFICATE: HEALTH CARE PRACTITIONER COLLABORATION GUIDELINES

16.22.20.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners.
[16.22.20.1 NMAC - Rp, 16.22.20.1 NMAC, 11/15/06]

16.22.20.2 SCOPE: This part applies to psychologists with conditional prescription certificate, and the general public.
[16.22.20.2 NMAC - Rp, 16.22.20.2 NMAC, 11/15/06]

16.22.20.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-17.2
[16.22.20.3 NMAC - Rp, 16.22.20.3 NMAC, 11/15/06]

16.22.20.4 DURATION: Permanent.
[16.22.20.4 NMAC - Rp, 16.22.20.4 NMAC, 11/15/06]

16.22.20.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of the section.
[16.22.20.5 NMAC - Rp, 16.22.20.5 NMAC, 11/15/06]

16.22.20.6 OBJECTIVE: The objective of Part 20 is to set forth the provisions, which apply to all of Chapter 22, and all persons affected or regulated by Chapter 22 of Title 16.
[16.22.20.6 NMAC - Rp, 16.22.20.6 NMAC, 11/15/06]

16.22.20.7 DEFINITIONS: [RESERVED]
[Refer to 16.22.1.7 NMAC]

16.22.20.8 CONDITIONAL PRESCRIPTION CERTIFICATE OR PRESCRIPTION CERTIFICATE HEALTH CARE PRACTITIONER COLLABORATION GUIDELINES:

A. A conditional prescribing or prescribing psychologist shall obtain a release of information from the patient or the patient's legal guardian authorizing the psychologist to contact the patient's primary treating health care practitioner, as required by law.

B. If a patient or the patient's legal guardian refuses to sign a release of information for the patient's primary treating health care practitioner, the conditional prescribing or prescribing psychologist shall inform the patient or the patient's legal guardian that the psychologist cannot treat the patient pharmacologically without an ongoing collaborative relationship with the primary treating health care practitioner. The psychologist shall refer the patient to another mental health care provider who is not required to maintain an ongoing collaborative relationship with a health care practitioner.

C. A conditional prescribing or prescribing psychologist shall contact the primary treating health care practitioner prior to prescribing medication to the patient.

(1) The conditional prescribing or prescribing psychologist shall inform the primary treating health care practitioner the medications the psychologist intends to prescribe for mental illness and any laboratory tests that the psychologist ordered or reviewed and shall discuss the relevant indications and contraindications to the patient of prescribing these medications.

(2) The conditional prescribing or prescribing psychologist shall document the date and time of contacts with the primary treating health care practitioner, a summary of what was discussed, and the outcome of the discussions or decisions reached.

(3) If the primary treating health care practitioner and the conditional prescribing or prescribing psychologist do not agree about a particular psychopharmacological treatment strategy, the psychologist shall document the reasons for recommending the psychopharmacological treatment strategy that is in disagreement and shall inform the primary treating health care practitioner of that recommendation. If the primary treating health care practitioner believes the medication is contraindicated because of a patient's medical condition, the conditional prescribing or prescribing psychologist shall defer to the judgment of the primary treating health care practitioner and shall not prescribe.

(4) If a conditional prescribing or prescribing psychologist determines that an emergency exists that may jeopardize the health or well being of the patient, the psychologist may, without prior consultation with the patient's primary treating health care practitioner, prescribe psychotropic medications or modify an existing prescription for psychotropic medication previously written for that patient by that psychologist. The conditional prescribing or prescribing psychologist shall consult with the primary treating health care practitioner as required herein as soon as possible. The conditional prescribing or prescribing psychologist shall document in the patient's psychological evaluation/treatment file the nature and extent of the emergency and the attempt(s) made to contact the primary treating health care practitioner prior to prescribing or other reason why contact could not be made.

(5) If a conditional prescribing psychologist or prescribing psychologist is working in a declared emergency/disaster area, the on-site medical staff can serve as the evaluating primary care physician.

D. If a patient does not have a primary treating health care practitioner, the conditional prescribing or prescribing psychologist shall refer the patient to a health care practitioner prior to psychopharmacological treatment. The psychologist must receive the results of the health care practitioner's assessment and shall contact the health care practitioner as required herein prior to prescribing.

E. Once the collaborative relationship is established with the primary treating health care practitioner, the conditional prescribing or prescribing psychologist shall maintain and document the collaborative relationship to ensure that relevant information is exchanged accurately and in a timely manner. The ongoing collaborative relationship shall be maintained pursuant to the following guidelines.

(1) A conditional prescribing or prescribing psychologist shall contact the primary treating health care practitioner for any changes in medication not previously discussed with the primary treating health care practitioner.

(2) A conditional prescribing or prescribing psychologist shall contact the primary treating health care practitioner if and when the patient experiences adverse effects from medications prescribed by the psychologist that may be related to the patient's medical condition for which he or she is being treated by a health care practitioner.

(3) A conditional prescribing or prescribing psychologist shall contact the primary treating health care practitioner regarding results of laboratory tests related to the medical care of the patient that have been ordered by the psychologist in conjunction with psychopharmacological treatment.

(4) The patient's treating health care practitioner shall inform a conditional prescribing or prescribing psychologist of any new medical diagnosis or changes in the patient's medical condition that may affect the treatment being provided by the psychologist.

(5) A conditional prescribing or prescribing psychologist shall inform a treating health care practitioner as soon as possible of any change in the patient's psychological condition that may affect the medical treatment being provided by the health care practitioner.

(6) The patient's primary treating or other health care practitioner shall inform the conditional prescribing or prescribing psychologist of any psychotropic medications prescribed or discontinued by the primary or other treating health care practitioner, the dates of any subsequent changes in psychotropic medications prescribed by the primary or other treating health care practitioner, and the efforts to coordinate the mental health care of the patent as soon as possible.

[16.22.20.8 NMAC - Rp, 16.22.20.8 NMAC, 11/15/06]

HISTORY OF 16.22.20 NMAC:

History of Repealed Material:

16.22.20 NMAC, Health Care Practitioner Collaboration Guidelines - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 21 CONDITIONAL PRESCRIBING OR PRESCRIBING PSYCHOLOGISTS: LIMITS OF PRACTICE

16.22.21.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners.
[16.22.21.1 NMAC - Rp, 16.22.21.1 NMAC, 11/15/06]

16.22.21.2 SCOPE: This part applies to the board, licensees, applicants for licensure seeking licenses under prescriptive authority, and the general public.
[16.22.21.2 NMAC - Rp, 16.22.21.2 NMAC, 11/15/06]

16.22.21.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-17.2
[16.22.21.3 NMAC - Rp, 16.22.21.3 NMAC, 11/15/06]

16.22.21.4 DURATION: Permanent.
[16.22.21.4 NMAC - Rp, 16.22.21.4 NMAC, 11/15/06]

16.22.21.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of the section.
[16.22.21.5 NMAC - Rp, 16.22.21.5 NMAC, 11/15/06]

16.22.21.6 OBJECTIVE: The objective of Part 21 is to set forth the provisions, which apply to all of Chapter 22, and all persons affected or regulated by Chapter 22 of Title 16.
[16.22.21.6 NMAC - Rp, 16.22.21.6 NMAC, 11/15/06]

16.22.21.7 DEFINITIONS: [RESERVED]
[Refer to 16.22.1.7 NMAC]

16.22.21.8 LIMITS OF PRACTICE:

A. A conditional prescribing/prescribing psychologist shall limit practice and supervision to the areas of competence in which proficiency has been gained through education, training and experience.

B. As defined in the collaboration guidelines of 16.22.20.8 NMAC, unless specifically agreed to by the primary treating health care practitioner, a conditional prescribing or prescribing psychologist shall not prescribe medications for patients with the following conditions:

(1) patients with a serious co-morbid disease of the central nervous system;
(2) patients with cardiac arrhythmia;
(3) patients who are being pharmacologically treated for coronary vascular disease;
(4) patients with blood dyscrasia;
(5) patients who are hospitalized for an acute medical condition; or
(6) women who are pregnant or breast feeding.

C. A conditional prescribing or prescribing psychologist shall not prescribe a drug, substance or controlled substance that is not contained in the formulary described in 16.22.27 NMAC, of these regulations.

D. A conditional prescribing or prescribing psychologist may order and review laboratory tests that are necessary to maximize the psychopharmacological effectiveness and to minimize the potential untoward effects of medications that are prescribed. In consultation with the PCP, the psychologist may also order neurovascular imaging procedures that use contrast media; neuro imaging that require the use of radioactive material; roentgenological procedures (x-rays) or other appropriate tests. The psychologist shall not:

(1) perform medical procedures such as spinal taps, intramuscular or intravenous administration of medication, or phlebotomy; or
(2) perform amytal interviews.

E. A conditional prescribing or prescribing psychologist shall not self-prescribe medication and shall not prescribe medication to any person who is a member of the psychologist's family or household, or with whom the psychologist has a conflict of interest, including a prohibited dual relationship, as defined in 16.22.1 NMAC, of these regulations and the code of conduct adopted by the board.

F. A conditional prescribing or prescribing psychologist is subject to provisions of the Professional Psychologist Act and board regulations. A psychologist who violates the Professional Psychologist Act or board regulations is subject to disciplinary action by the board, which may include denial, suspension, or revocation of a conditional prescription certificate or prescription certificate or suspension or revocation of a license to practice psychology.

G. A conditional prescribing or prescribing psychologist must comply with all other state and federal laws regulating the administrating and prescribing of controlled substances.

[16.22.21.8 NMAC - Rp, 16.22.21.8 NMAC, 11/15/06]

HISTORY OF 16.22.21 NMAC:

History of Repealed Material:

16.22.21 NMAC, Limits of Practice - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 22 CONDITIONAL PRESCRIBING OR PRESCRIBING PSYCHOLOGISTS: APPLICATION COMMITTEE

16.22.22.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners.
[16.22.22.1 NMAC - Rp, 16.22.22.1 NMAC, 11/15/06]

16.22.22.2 SCOPE: This part applies to the board, licensees, applicants for licensure, and the general public.
[16.22.22.2 NMAC - Rp, 16.22.22.2 NMAC, 11/15/06]

16.22.22.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-17.1
[16.22.22.3 NMAC - Rp, 16.22.22.3 NMAC, 11/15/06]

16.22.22.4 DURATION: Permanent.
[16.22.22.4 NMAC - Rp, 16.22.22.4 NMAC, 11/15/06]

16.22.22.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of the section.
[16.22.22.5 NMAC - Rp, 16.22.22.5 NMAC, 11/15/06]

16.22.22.6 OBJECTIVE: The objective of Part 22 is to set forth the provisions, which apply to all of Chapter 22, and all persons affected or regulated by Chapter 22 of Title 16.
[16.22.22.6 NMAC - Rp, 16.22.22.6 NMAC, 11/15/06]

16.22.22.7 DEFINITIONS: [RESERVED]
[Refer to 16.22.1.7 NMAC]

16.22.22.8 PSYCHOPHARMACOLOGY (RxP) APPLICATION COMMITTEE:

A. The chair of the board may appoint one or more RxP application committee(s) to review application(s) for conditional prescription and prescription certificates and to make recommendations to the board.

B. The RxP application committee will consist of a minimum of three (3) members who shall reside in New Mexico and who shall hold active, unrestricted New Mexico licenses in their respective profession. The committee shall consist of:

(1) one person appointed by the chair of the board who is experienced in psychopharmacology;

(2) one person appointed by the chair of the board, in collaboration with the New Mexico medical board, who is an allopathic or osteopathic physician or a nurse practitioner or physicians assistant with clinical experience in mental health or psychopharmacology; and

(3) a public member appointed by the chair of the board.

C. The professional members appointed by the chair of the board to the committee may include:

(1) a psychologist with a conditional prescribing certificate or a prescription certificate;

(2) a physician or osteopathic physician with clinical experience in mental health or psychopharmacology;

(3) a pharmacist clinician, or certified, or certified nurse practitioner, RNCS or physician's assistant with specialized training in psychopharmacology; or

(4) a licensed psychologist.

D. Members of the RxP application committee shall not be in a psychopharmacology training program, and shall not be seeking licensure as a psychologist.

E. Members of the RxP application committee shall not participate in the review, deliberation, or decision of an application if the applicant is a member of the member's family or household or if the member has a conflict of interest as defined in 16.22.25 NMAC, of these regulations.

F. The New Mexico medical board or its designee shall be available upon request to consult with the RxP application committee or the board regarding the applicability of the regulations adopted pursuant to Section 61-9-17.1 NMSA 1978 of the act to a particular application.

G. The RxP application committee shall provide the board a recommendation to accept or reject an application for a conditional prescription or prescription certificate. A recommendation to reject an application shall state the reasons for the recommendation.
[16.22.22.8 NMAC - Rp, 16.22.22.8 NMAC, 11/15/06]

HISTORY OF 16.22.22 NMAC:

History of Repealed Material:
16.22.22 NMAC, Prescribing Psychologists: Application Committee - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 23 REQUIREMENTS FOR EDUCATION AND CONDITIONAL PRESCRIPTION CERTIFICATE

16.22.23.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners.
[16.22.23.1 NMAC - Rp, 16.22.23.1 NMAC, 11/15/06]

16.22.23.2 SCOPE: This part applies to the board, licensees, applicants for licensure seeking licenses under prescriptive authority, and the general public.
[16.22.23.2 NMAC - Rp, 16.22.23.2 NMAC, 11/15/06]

16.22.23.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-17.1
[16.22.23.3 NMAC - Rp, 16.22.23.3 NMAC, 11/15/06]

16.22.23.4 DURATION: Permanent.
[16.22.23.4 NMAC - Rp, 16.22.23.4 NMAC, 11/15/06]

16.22.23.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of the section.
[16.22.23.5 NMAC - Rp, 16.22.23.5 NMAC, 11/15/06]

16.22.23.6 OBJECTIVE: The objective of Part 23 is to set forth the provisions, which apply to all of Chapter 22, and all persons affected or regulated by Chapter 22 of Title 16.
[16.22.23.6 NMAC - Rp, 16.22.23.6 NMAC, 11/15/06]

16.22.23.7 DEFINITIONS: [RESERVED]
[Refer to 16.22.1.7 NMAC]

16.22.23.8 QUALIFICATIONS AND EDUCATION REQUIREMENTS FOR CONDITIONAL PRESCRIPTIVE CERTIFICATE:

A. Qualifications of applicant. The board shall issue a conditional prescription certificate pursuant to 16.22.24.8 NMAC, of these regulations to each applicant who submits evidence satisfactory to the board that the applicant:

(1) has completed a doctoral program in psychology from an accredited institution of higher education or professional school or, if the program was not accredited at the time of the applicant graduation, that the program meets professional standards determined acceptable by the board;

(2) holds an active unrestricted license to practice psychology in New Mexico;

(3) has successfully completed psychopharmacological training that meets the standards set forth in Subsection B below from either:

(a) an institution of higher education that has a postdoctoral program of psychopharmacology education for psychologists and that is accredited by a regional body recognized by the U.S. department of education or the council for higher education accreditation; or

(b) a continuing education provider approved by the American psychological association that offers a program of psychopharmacology education for psychologists; or

(c) a continuing education program of professional development in psychopharmacology for psychologists that is administered in collaboration with a school and that is a formal and organized program of study leading to a credential in psychopharmacology from that school; or

(d) a continuing education program of professional development in psychopharmacology for psychologists that is administered in collaboration with a school if the applicant successfully completed the four-hundred-fifty (450) classroom hours of didactic study referred to in 16.22.23.8 NMAC, of these regulations below prior to January 1, 2004.

B. RxP training program. The psychopharmacology training program referred in Subparagraph (c) above, shall meet the following criteria.

(1) The program shall be an integrated and organized program of study.

(2) The program shall have an identifiable body of students at different levels of matriculation.

(3) The program shall be clearly identified and labeled as a psychopharmacology program and shall specify in pertinent institutional catalogues and brochures its intent to educate and train psychologists to prescribe psychotropic medication.

(4) The program shall have a formally designated training director who is a psychiatrist or a doctoral psychologist, trained in the area of psychopharmacology, and licensed to practice in the jurisdiction in which the program resides.

(5) The training director shall be primarily responsible for directing the training program and shall have administrative authority commensurate with those responsibilities.

(6) The training director's credentials and expertise shall be consistent with the program's mission and goals to train psychologists to prescribe psychotropic medication.

(7) The program shall provide information regarding the minimal level of achievement required for postdoctoral trainees to satisfactorily progress through and complete the psychopharmacological training program, as well as evidence that it adheres to the minimum levels of achievement.

(8) The program shall have formally designated instructors and supervisors in sufficient number to accomplish the program's education and training.

(9) Supervisors shall hold an active, unrestricted license in their field of practice in the jurisdiction in which the program resides or where the supervision is being provided.

(10) The program instructors and supervisors shall have sufficient expertise, competence, and credentials in the areas in which they teach or supervise.

(11) The program instructors and supervisors shall participate actively in the program's planning, implementation and evaluation.

(12) The program, with appropriate involvement from its training supervisors, instructors, and trainees, shall engage in a self-study process that addresses:

(a) expectations for the quality and quantity of the trainees' preparation and performance in the program;

(b) training goals and objectives for the trainees and the trainees' views regarding the quality of the training experiences and the program;

(c) procedures to maintain current achievements or to make changes as necessary; and

(d) goals, objectives, and outcomes in relation to local, regional, and national changes in the knowledge base of psychopharmacology training.

(13) The program shall follow the guidelines for psychopharmacology training of post-doctoral psychologists established by the American psychological association.

(14) As part of the admission and training process, the training program shall evaluate and assure that every student completes necessary prerequisite training in basic science (e.g. physiology, chemistry, and biochemistry), the biological bases of behavior, and psychopharmacology.

(15) When students are not in residence, the program provides on-line access to a library of sufficient diversity and level to support the advanced study of the psychopharmacological treatment of mental disorders from wherever the student resides. This access shall remain available throughout all didactic and clinical phases of the training program. Frequent face-to-face evaluation and discussions shall be included in the didactic training.

(16) The program provides formal, written measurement of the mastery of course content.

(17) The program demonstrates in its written materials or course syllabi that it integrates into the training the following areas; socio-cultural issues in psychopharmacological treatment, ethno-pharmacology, use of translators, the cultural context of compliance and noncompliance with prescribed medication, creating a culturally appropriate environment to meet patient care treatment and language needs, and working collaboratively with traditional healers.

C. Didactic instruction.

(1) Within the five (5) years immediately preceding the date of application for a conditional prescription certificate, the applicant shall have successfully completed didactic instruction of no fewer than four-hundred-fifty (450) classroom hours in at least the following core areas of instruction:

(a) neuroscience;

(b) pharmacology;

(c) psychopharmacology;

(d) physiology;

(e) pathophysiology;

(f) appropriate and relevant physical and laboratory assessment;

(g) clinical pharmaco-therapeutics; and

(h) cultural competence.

(2) At least three-fourths (3/4) of the four-hundred-fifty (450) classroom hours of didactic instruction shall be awarded by one certification or degree-granting institution or continuing education program.

D. Eighty (80) hour practicum in clinical assessment and pathophysiology.

(1) The 80 hour practicum shall be part of the psychopharmacology training program from which the applicant obtains the certification or degree.

(2) The 80 hour practicum shall provide the opportunity for the applicant to observe and demonstrate competence in physical and health assessment techniques within a medical setting under the supervision of a physician.

(3) The 80 hour practicum shall be completed in a timeframe of full-time over two (2) weeks to thirty (30) weeks.

(4) If the applicant cannot complete the 80 hour practicum within the time frame designated in Paragraph (3) of Subsection D of 16.22.20.8 NMAC, because of illness or other extenuating circumstances, the applicant may request an extension from the board explaining in writing the extenuating circumstances and the additional time requested.

(5) The supervising physician and the training director of the psychopharmacology training program shall certify in writing that the applicant:

(a) assessed a diverse and significantly medically ill patient population;

(b) observed the progression of illness and continuity of care of individual patients;

(c) adequately assessed vital signs;

(d) demonstrated competent laboratory assessment; and

(e) successfully completed the 80-hour practicum.

E. **Four-hundred hour practicum**. Requirements for the general 400 hour practicum treating a minimum of 100 patients with mental disorders include:

(1) The 400 hour practicum shall be part of the psychopharmacology training program from which the applicant obtains the certification, degree or certification of completion.

(2) One-hundred (100) patients shall mean 100 separate patients.

(3) The four-hundred hours shall refer to four-hundred (400) face-to-face hours. The four-hundred (400) face-to-face hours shall include only time spent with patients to provide evaluation and treatment for medical psychopharmacotherapy of patients and time spent in collaboration with the patient's treating health care practitioner(s).

(4) The applicant must have supervised experience in the evaluation and treatment of 100 patients, representing as diverse a patient population as possible, including diversity in the patients:

(a) gender;

(b) different ages throughout the life cycle, including adults, children/adolescents, and geriatrics; as possible and appropriate;

(c) range of disorders listed in the most recent diagnostic and statistical manual of mental disorders published by the American psychiatric association and acute and chronic disorders;

(d) ethnicity;

(e) socio-cultural background; and

(f) economic background.

(5) The applicant and the training program shall maintain a log on patient seen, which shall include: a coded identification number for the patient, patient's age, gender, diagnosis, date and time seen, amount of time seen for psychopharmacotherapy. The log shall be available to the RxP application committee or the board upon request. The log shall contain the name and signature of the supervisor.

(6) The applicant and the training program shall keep records of the time spent during this practicum. The records shall be available to the psychopharmacology application committee or the board upon request. The records shall not contain patient identifying information.

(7) A psychiatrist or other appropriately trained physician, licensed in good standing in the jurisdiction in which the psychiatrist or other physician rendered supervision shall be the primary supervising physician of the practicum. The primary supervising physician shall be responsible for the overall supervision of the applicant; however, training may be assigned to other licensed physicians, i.e., secondary supervisors, as designated by the primary supervising physician and the training director of the program.

(8) The primary or secondary supervisor shall be on site. The applicant shall consult with the primary or secondary supervising physician as appropriate, before the applicant makes a decision about the psychopharmacological treatment of the patient.

(9) The primary or secondary supervising physician shall review the charts and records of any patient seen by the applicant during the practicum while under the supervision of the primary or secondary supervising physician.

(10) The practicum shall be completed in a period of time of not less than six (6) months and not more than three (3) years.

(11) If the applicant cannot complete the 400 hour practicum within the timeframe designated in Subsection E of 16.22.23.8 because of illness or other extenuating circumstances, the applicant may request an extension from the board explaining in writing the extenuating circumstances and the additional time requested. The applicant shall receive a minimum of one hour of supervision for every eight (8) hours of patient time. The applicant is responsible to keep a log of the dates and time of supervision. The supervisor may meet with the applicant for additional education at his or her discretion.

(12) The practicum shall be completed within the five years immediately preceding the date of application for a conditional prescription certificate.

(13) Upon request of the RxP application committee or the board, the primary supervising physician shall provide an affidavit stating that:

(a) the supervisor does not have conflict of interest and is not a member of the applicant's family or household as defined in 16.22.26 NMAC, of these regulations;

(b) the supervisor or a designated secondary supervisor reviewed and discussed with the applicant the charts and records of patients seen by the applicant during the practicum;

(c) the practicum included a diverse group of patients, as defined in these regulations; and

(d) the applicant did not write any prescriptions without the primary or secondary supervisor's supervision and signature or authorization.

(14) The primary supervising physician shall conduct a formal, written evaluation on at least two occasions, at the midpoint and at the end of the practicum. The evaluation shall assess the applicant's progress and competencies and shall describe any deficiencies or areas where competency has not been achieved. The primary supervisor shall submit copies of the evaluations to the applicant and the training director.

(15) In the event of documented deficiencies the training director of the psychopharmacology program shall specify in writing:

(a) the areas in need of remediation;

(b) the process and procedures by which these areas are to be re-mediated; and

(c) the method by which the training director and supervisor shall determine that the applicant has achieved the competencies necessary to successfully complete the practicum.

(16) The psychologist in practicum training or the conditional prescribing psychologist is responsible for informing the patient or the patient's legal guardian, when appropriate, or explain to the patient through the recommendation system at an institution if the institution itself generally handles such informed consent. The name and role of the supervisor and sufficient information of the expectation and requirements of the practicum shall be provided to the patient or the patient's legal guardian at the initial contact necessary to obtain informed consent and appropriate releases. The applicant shall provide additional information requested by the patient or the patient's legal guardian concerning the applicant's education, training and experience.

(17) The primary supervising physician and the training director of the psychopharmacology program from which the applicant obtained a certification of successful completion or a degree in psychopharmacology shall certify to the board in writing that the applicant has successfully completed the practicum.

F. National examination. To qualify for a conditional prescription or prescription certificate, the applicant must demonstrate competency by passing a national examination.

(1) Applicant must pass the psychopharmacology examination for psychologists (PEP), developed by the American psychological association practice organization's college of professional psychology and its contractor, the professional examination service.

(2) Applicant must be eligible to take the PEP after the applicant successfully completes the didactic portion of the postdoctoral program of education in psychopharmacology.

(3) The passing score shall be the passing score recommended by the American psychological association's practice organization college of professional psychology for the occasion.

(4) If the applicant fails the examination, the applicant may take the examination a second time after a mandatory 90-day waiting period.

(5) If the applicant fails the examination on the second attempt, the applicant will be required to wait one year before repeating the examination.

(6) If the applicant fails the examination on the third attempt, the applicant is required to take the remedial didactic program recommended by the psychopharmacology application committee and approved by the board before the applicant is allowed to repeat the examination.

G. An applicant who has successfully completed a psychopharmacology educational program, an eighty (80) hour practicum in clinical assessment and pathophysiology, a four-hundred (400) hour/100 patient practicum treating patients with mental disorders or the national certification examination prior to the effective date of these regulations may include the completed portion(s) of the training in the application for a conditional prescription certificate. The applicant who has completed the four-hundred (400) hour practicum shall include certification in writing from the primary supervising physician that the applicant has successfully completed the practicum and is trained to competently treat a diverse patient population as defined in these regulations. The board shall approve the prior training program(s) that satisfy the requirements as listed in 16.22.23 NMAC, of these regulations.

[16.22.23.8 NMAC - Rp, 16.22.23.8 NMAC, 11/15/06; A, 03/21/09]

HISTORY OF 16.22.23 NMAC:

History of Repealed Material:

16.22.23 NMAC, Requirements for Education and Conditional Prescription Certificate - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 24 APPLICATION PROCEDURES: TWO-YEAR SUPERVISED PRACTICE

16.22.24.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners.
[16.22.24.1 NMAC - Rp, 16.22.24.1 NMAC, 11/15/06]

16.22.24.2 SCOPE: This part applies to the board, licensees, applicants for licensure seeking licenses under prescriptive authority, and the general public.
[16.22.24.2 NMAC - Rp, 16.22.24.2 NMAC, 11/15/06]

16.22.24.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-17.1
[16.22.24.3 NMAC - Rp, 16.22.24.3 NMAC, 11/15/06]

16.22.24.4 DURATION: Permanent.
[16.22.24.4 NMAC - Rp, 16.22.24.4 NMAC, 11/15/06]

16.22.24.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of the section.
[16.22.24.5 NMAC - Rp, 16.22.24.5 NMAC, 11/15/06]

16.22.24.6 OBJECTIVE: The objective of Part 24 is to set forth the provisions, which apply to all of Chapter 22, and all persons affected or regulated by Chapter 22 of Title 16.
[16.22.24.6 NMAC - Rp, 16.22.24.6 NMAC, 11/15/06]

16.22.24.7 DEFINITIONS: [RESERVED]
[Refer to 16.22.1.7 NMAC]

16.22.24.8 APPLICATION PROCEDURES AND PRESCRIBING PRACTICES FOR CONDITIONAL PRESCRIPTION CERTIFICATE; TWO-YEAR SUPERVISED PRACTICE

A. An applicant for a conditional prescription certificate shall submit a completed application on the form provided by the board. The applicant is responsible to ensure that the application is complete and that all application fees are paid.

B. Application procedure, the applicant shall submit the following:

(1) a copy of the degree, certificate or certification of completion of a post-doctoral psychopharmacology training program;

(2) certification by the supervising physician and program training director of successful completion of the eighty (80) hour practicum in clinical assessment and pathophysiology;

(3) certification by the primary supervising physician and the program-training director of successful completion of the general (400) hour practicum treating a minimum of 100 patients with mental disorders;

(4) evidence of passing the psychopharmacology examination for psychologists(PEP);

(5) a proposed supervisory plan; on a form provided by the board that is signed by the psychologist and the supervising physician;

(6) evidence of proof of insurance or insurance binder as described in 16.22.24.9 NMAC, of these regulations; and

(7) a non-refundable application fee.

C. Only a complete application will be considered. The board may request additional information from the applicant to verify or confirm the information contained in the application.

D. The applicant will be notified in writing within sixty (60) days whether the application, including the supervisory plan, is accepted or rejected. If the application is rejected, the notice shall state the reason for rejection.
[16.22.24.8 NMAC - Rp, 16.22.24.8 NMAC, 11/15/06]

16.22.24.9 CONDITIONS OF PRACTICE; MALPRACTICE INSURANCE

A. The conditional prescribing psychologist shall maintain malpractice insurance covering claims for personal injury arising out of his or her performance of professional services and claims arising out of his or her act,

errors or omissions in providing professional services, including prescribing psychotropic medication. Such malpractice insurance coverage shall be no less than one (1) million dollars per occurrence with an aggregate limit of three (3) million dollars.

B. The conditional prescribing psychologist shall submit to the board the declaration page of his or her malpractice insurance policy, when instituted, and thereafter on the policy renewal date, as proof of this required insurance upon making application for the conditional prescription certificate, and proof that the policy covers the prescribing of psychotropic drugs.

[16.22.24.9 NMAC - Rp, 16.22.24.8 NMAC, 11/15/06; A, 03/21/09]

16.22.24.10 TWO YEAR SUPERVISED PRACTICE

A. The conditional prescribing psychologist shall be supervised by a licensed physician(s) knowledgeable of the administration of psychotropic medication. If more than one supervisor is selected, one supervisor shall be designated the primary supervising physician.

B. The board shall approve the supervisory plan before the conditional prescription certificate is issued. The proposed supervisory plan shall include the information contained in 16.22.24 NMAC, and shall be signed by the primary supervising physician.

C. After the board approves the supervisory plan, the conditional prescribing psychologist shall within thirty (30) days submit to the New Mexico medical board the name, address and phone number of the conditional prescribing psychologist and the name(s), address(s) and phone number(s) of the primary supervising physician and secondary supervising physicians, if any. During the period of supervised practice, the conditional prescribing psychologist shall provide to the New Mexico medical board the name(s), address(s) and phone number(s) of any supervising physician or physician serving as a substitute or replacement for primary or secondary supervisor(s).

D. Each supervisor shall have clinical expertise or training with the patient population that the psychologist with a conditional prescription certificate is evaluating and treating.

E. During the initial contact between the patient or the patient's legal guardian, if any, and the conditional prescribing psychologist, the patient or the patient's legal guardian shall be informed that the psychologist has received specialized training in the prescription of psychotropic medication, that the psychologist is transitioning to independent psychopharmacological practice, and that the psychologist is practicing under supervision with respect to the prescribing of psychotropic medication. The name and role of the supervisor shall be provided to the patient or the patient's legal guardian and informed consent and appropriate releases shall be obtained. The conditional prescribing psychologist shall provide additional information requested by the patient or the patient's legal guardian concerning the psychologist's education, training, and experience.

F. Supervision by the primary supervising physician shall be provided on a one-to-one basis for at least four hours a month and should total at least forty-six (46) hours of one-to-one supervision per year, unless altered, in accordance with Subsection K of 16.22.24.10 NMAC of these regulations.

G. Each supervising physician is responsible to review only the cases he or she is supervising. The supervising physician at all times shall have access to and shall review records relating to the treatment of patients under his or her supervision. The supervising physician may require face-to-face consultation(s) with the conditional prescribing psychologist.

H. If there is more than one supervisor, each supervisor shall inform the other supervisor of any concerns about a conditional prescribing psychologist whom he or she is supervising.

I. The primary supervising physician shall contact any secondary supervisor(s) at least every six (6) months to obtain written or verbal progress reports concerning how the conditional prescribing psychologist is performing.

J. One-to-one supervision must be provided either face-to-face, telephonically, or by tele-video live communication.

K. At any time during the two-year conditional prescribing periods the supervising physician, after consultation with the conditional prescribing psychologist, may amend the supervisory plan, to increase or decrease the hours of supervision. The board shall approve amendments to the supervisory plan set forth in Subsection M below.

L. At any time during the two-year conditional prescribing period a primary supervising physician shall not supervise more than three (3) conditional prescribing psychologists.

M. The supervisory plan described in Paragraph (5) of Subsection B of 16.22.24.8 NMAC shall include the following information and shall be signed by the primary supervising physician:

(1) name of the applicant;

(2) name, address, license number, and area of specialization of the primary supervising physician and the secondary supervisor(s), if any;

(3) beginning and ending dates of the two-year supervised practice covered by the plan;

(4) number of one-on-one supervisory hours per month and by whom;

(5) setting(s) where supervision will occur and with whom;

(6) duties and clinical responsibilities of the conditional prescribing psychologist;

(7) location(s) where supervision will occur and with whom;

(8) areas in which the primary and secondary supervisor(s), if any, have specialized skills to render competent supervision;

(9) number of psychologists with conditional prescription certificates that the primary supervising physician will supervise during this time period;

(10) the manner in which the conditional prescribing psychologist will be represented to the public including, all written communications and public announcements;

(11) any direct or indirect financial agreements between or among the conditional prescribing psychologist and the primary and secondary supervisor(s), if any;

(12) other information necessary to clarify the nature and scope of supervision; and

(13) a statement specifying the manner in which supervision and clinical and professional responsibility will be provided during the supervisor's absence (during vacations or unexpected events that require the supervisor to be absent for any period of time),

N. The board or its designee shall notify the applicant in writing within sixty (60) days of application date, whether the application and the proposed supervisory plan are accepted or rejected. The board or its designee shall notify a conditional prescribing psychologist within thirty (30) days whether a proposed amendment to an approved supervisory plan is accepted or rejected. If rejected, the notice shall state the reasons for rejection.

O. Each supervising physician shall maintain a supervision log containing the dates, duration, and place or method of supervision, the same identification code for patients as used by the psychologist with a conditional prescribing certificate in the summary reports, and a brief description of the content of supervision. The log shall be submitted to the board upon request.

P. The primary supervising physician shall also maintain a log of the contacts with the secondary supervisor(s) that includes the dates of contact, and a brief description of the outcome of this contact, including a statement stating whether the conditional prescribing psychologist is progressing satisfactorily.

Q. The supervisor shall review the results of laboratory tests as appropriate and shall be skilled and experienced in such interpretation.

R. The supervising physician(s) shall hold an active unrestricted license in good standing and appropriate drug enforcement administration certificate and shall be experienced and skilled in the prescription of psychopharmacological drugs.

S. The conditional prescribing psychologist shall see a minimum of fifty (50) separate patients within the two-year period who are seen for the purpose of evaluation and treatment with psychotropic medication. The duration of the two-year supervisory period shall not be accelerated or reduced.

T. At the end of the two-year period, the primary supervising physician shall provide an affidavit on a form provided by the board certifying that:

(1) the supervising physician has not received any financial payments from the applicant except appropriate fees for supervisory services, the supervising physician is not a member of the applicant's family or household, the supervising physician is not in a prohibited dual relationship with the applicant or a member of the applicant's family or household, and that the supervising physician has not had an interest that conflicts with the supervising physician's duties as supervisor;

(2) each supervising physician discussed with the psychologist the charts and records of patients seen by the psychologist under that physician's supervision during the two-year period or any extension; and

(3) the psychologist has successfully completed two years of evaluating for or prescribing psychotropic medication to at least 50 patients.

U. The primary supervising physician in consultation with any secondary supervisor shall evaluate and describe any deficiencies at the end of the two-year period. In the event of documented deficiencies, the primary supervising physician(s) shall specify in writing the areas in need of remediation and the process and procedures by which these areas are to be remediated.

V. The supervisory period and the conditional prescriptive certificate may be extended with approval of the board if the conditional prescribing psychologist does not successfully complete the two-year conditional period of supervision. A supervisory plan shall be submitted to the board for the proposed extended period of

practice under supervision. The conditional prescribing psychologist shall continue to maintain malpractice insurance.

W. At the end of the extended two-year period, the primary supervising physician shall provide to the board an affidavit on a form provided by the board certifying: the method by which the supervisor(s) determined that the conditional prescribing psychologist obtained the competencies necessary to prescribe psychotropic medication, supported by a written evaluation addressing areas of remediation.

[16.22.24.10 NMAC - Rp, 16.22.24.8 NMAC, 11/15/06; A, 03/21/09]

16.22.24.11 EXPIRED PRACTICE OR CERTIFICATE

A. The conditional prescribing psychologist shall notify the board in writing if a supervising physician fails to meet any of the supervisory requirements as set forth in this section and the supervisory plan approved by the board. The notification shall include a clear and detailed description of the supervisor's failure(s) to perform.

B. The conditional prescribing psychologist shall notify the board within fourteen (14) days of discovery of any event or circumstance that requires the psychologist to interrupt or cease prescribing practices for any period of time that exceeds sixty (60) days. In no event shall the conditional prescribing psychologist continue prescribing psychotropic medications without an active, responsible supervising physician and valid malpractice insurance.

C. The conditional prescribing certificate shall expire two years after issuance, unless extended in writing as provided in 16.22.24.8 NMAC. A psychologist shall not administer or prescribe drugs or medicines unless the psychologist holds a valid conditional prescription certificate or prescription certificate issued by the board. The board may extend the conditional prescribing certificate up to sixty (60) days pending peer review if the board has received at the board office a complete application for a prescription certificate no later than ten (10) days before the expiration of the conditional prescription certificate.

D. The psychologist shall not administer or prescribe drugs or medicines after the expiration of the conditional prescription certificate. The psychologist shall notify the board in writing if the psychologist decides not to immediately apply for a prescription certificate upon expiration of the conditional prescription certificate. A psychologist who successfully completes all of the requirements of conditional prescription certificate may apply for a prescription certificate after the expiration of the conditional prescription certificate, so long as the psychologist satisfies all the education, training, and supervision criteria within the time limits established by NMSA 1978, Section 61-9-17.1 and 16.22.23.8 NMAC, of these regulations. The psychologist is solely responsible to obtain patient records for peer review and all other evidence of satisfactory completion of practice under supervision, including supervising physician affidavit(s).

[16.22.24.11 NMAC - Rp, 16.22.24.8 NMAC 11/15/06]

HISTORY OF 16.22.24 NMAC:

History of Repealed Material:

16.22.24 NMAC, Application Procedures: Two-Year Supervised Practice - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 25 PRESCRIPTION CERTIFICATE: APPLICATION; PEER REVIEW; EVALUATION OUTCOME

16.22.25.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners.
[16.22.25.1 NMAC - Rp, 16.22.25.1 NMAC, 11/15/06]

16.22.25.2 SCOPE: This part applies to the board, licensees, applicants for licensure seeking licenses under prescriptive authority, and the general public.
[16.22.25.2 NMAC - Rp, 16.22.25.2 NMAC, 11/15/06]

16.22.25.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-17.1
[16.22.25.3 NMAC - Rp, 16.22.25.3 NMAC, 11/15/06]

16.22.25.4 DURATION: Permanent.
[16.22.25.4 NMAC - Rp, 16.22.25.4 NMAC, 11/15/06]

16.22.25.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of the section.
[16.22.25.5 NMAC - Rp, 16.22.25.5 NMAC, 11/15/06]

16.22.25.6 OBJECTIVE: The objective of Part 25 is to set forth the provisions, which apply to all of Chapter 22, and all persons affected or regulated by Chapter 22 of Title 16.
[16.22.25.6 NMAC - Rp, 16.22.25.6 NMAC, 11/15/06]

16.22.25.7 DEFINITIONS: [RESERVED]
[Refer to 16.22.1.7 NMAC]

16.22.25.8 APPLICATION FOR PRESCRIPTION CERTIFICATE:

A. An applicant for a prescription certificate shall submit a complete application on a form approved by the board. The applicant is responsible to ensure that the application is complete and timely and that all application fees are paid.

B. The application procedure, shall commence no sooner than sixty (60) days and no later than ten (10) days prior to expiration of the conditional prescription certificate, whereby the applicant shall submit a non-refundable fee (see fee schedule at 16.22.13.8 of these regulations) established by the board and shall submit evidence satisfactory to the board that the applicant:

(1) has been issued a conditional prescription certificate and has successfully completed or anticipates successfully completing two (2) years of prescribing psychotropic medication, as certified by the primary supervising physician pursuant to 16.22.24 NMAC of these regulations;

(2) holds an active and unrestricted license to practice psychology in New Mexico;

(3) has malpractice insurance as required in 16.22.24 NMAC, of these regulations; the psychologist shall submit to the board a copy of the declaration page of his malpractice insurance policy with the application.

C. Only a complete application will be considered. The board may request additional information from the applicant to verify or confirm the information in the application.
[16.22.25.8 NMAC - Rp, 16.22.25.8 NMAC, 11/15/06]

16.22.25.9 PEER REVIEW:

A. Panel membership. The applicant for a prescription certificate shall successfully complete a process of independent peer review that meets the requirements set forth below before the board shall issue a prescription certificate.

(1) One or more peer review panel(s) shall be appointed by the chair of the board. Peer review panels shall consist of three (3) members from at least two (2) of the following professions and categories:

(a) conditional prescribing psychologists, prescribing psychologists or licensed psychologists with specialized training and experience in psychopharmacology;

(b) licensed, board-certified psychiatrists, other physicians, nurse practitioners or physician assistants with specialized training and experience in psychopharmacology;

(c) doctoral level licensed pharmacists or pharmacist clinicians with specialized training and experience in psychopharmacology.

(2) A panel member shall not be a member of the applicant's family or household, shall not be in a prohibited dual relationship with the applicant or a member of the applicant's family or household, shall not have supervised the applicant, and shall not have a conflict of interest as defined in 16.22.1 NMAC, of these regulations.

(3) No panel member may be a psychologist enrolled in a psychopharmacology training program.

B. Review process.

(1) A panel shall examine at least ten (10) randomly selected charts of patients treated by the conditional prescribing psychologist during the two-year supervised period and any approved extensions. The applicant shall be solely responsible for obtaining the patient charts for peer review. The charts shall be reviewed to determine whether the following information is timely, accurately, and properly recorded:

(a) a full medical history and family history;

(b) a mental status examination and complete differential diagnosis of the patient by the conditional prescribing psychologist;

(c) risk factors for the diagnostic condition were identified, including absence of drug, alcohol, suicide and homicide;

(d) drug and food allergies;

(e) patient medications;

(f) patient education on prescription, including evidence of informed consent to treatment;

(g) appropriate laboratory tests ordered and reviewed;

(h) the patient's diagnosis;

(i) adequate dosing requirements for prescription;

(j) treatment, including psychopharmacotherapy and psychotherapy, adverse affects from prescriptions, documentation of outcome measures for prescriptions;

(k) progress notes;

(l) a follow-up plan, including a discharge plan, and

(m) documentation of collaboration with the patient's treating health care practitioner as required pursuant to 16.22.20 NMAC, of these regulations;

(2) The peer review panel shall complete an evaluation form approved by the psychopharmacology application committee, which shall certify whether the charts reviewed are in compliance and are satisfactory, and shall forward the evaluation form to the board.

[16.22.25.9 NMAC - Rp, 16.22.25.8 NMAC, 11/15/06]

16.22.25.10 EVALUATION OUTCOME:

A. Board action. Within sixty (60) days, the board shall issue an unrestricted prescription certificate to the applicant or inform the applicant of deficiencies.

B. Remedial period. If the peer review panel documents deficiencies in the patient charts or the applicant otherwise does not demonstrate competency to prescribe independently, the panel shall specify in writing:

(1) the areas in need of remediation;

(2) the process and procedures by which these areas are to be remediated; and

(3) the time period, not to exceed six (6) months, allowed for remediation of deficiencies or demonstration of competency before the applicant can undergo another peer review.

C. Additional peer review(s).

(1) Another peer review shall be conducted at the end of the remedial period. The applicant may have a total of three (3) peer reviews, after which the applicant shall re-enroll in psychopharmacology program meeting all criteria in 16.22.23.8 NMAC, and apply for another conditional prescription certificate prior to applying for a prescription certificate.

(2) The evaluation or results of any deficient peer review shall be forwarded to the board and the New Mexico medical board. The board, in consultation with the medical board or it designee, shall have the discretion to extend a conditional prescription certificate pursuant to Subsection V of 16.22.24.10 NMAC, pending the outcome of the second or subsequent peer review process.

[16.22.25.10 NMAC - Rp, 16.22.25.8 NMAC, 11/15/06]

HISTORY OF 16.22.25 NMAC:

History of Repealed Material:
16.22.25 NMAC, Application For Prescription Certificate: Peer Review - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 26 GRADUATES OF THE DEPARTMENT OF DEFENSE PSYCHOPHARMACOLOGY DEMONSTRATION PROJECT

16.22.26.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners.
[16.22.26.1 NMAC - Rp, 16.22.26.1 NMAC, 11/15/06]

16.22.26.2 SCOPE: This part applies to the board, licensees, applicants for licensure seeking licenses under prescriptive authority, and the general public.
[16.22.26.2 NMAC - Rp, 16.22.26.2 NMAC, 11/15/06]

16.22.26.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-17.1 and 61-9-10
[16.22.26.3 NMAC - Rp, 16.22.26.3 NMAC, 11/15/06]

16.22.26.4 DURATION: Permanent.
[16.22.26.4 NMAC - Rp, 16.22.26.4 NMAC, 11/15/06]

16.22.26.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of the section.
[16.22.26.5 NMAC - Rp, 16.22.26.5 NMAC, 11/15/06]

16.22.26.6 OBJECTIVE: The objective of Part 26 is to set forth the provisions, which apply to all of Chapter 22, and all persons affected or regulated by Chapter 22 of Title 16.
[16.22.26.6 NMAC - Rp, 16.22.26.6 NMAC, 11/15/06]

16.22.26.7 DEFINITIONS: [RESERVED]
[Refer 16.22.1.7 NMAC]

16.22.26.8 GRADUATES OF THE DEPARTMENT OF DEFENSE PSYCHOPHARMACOLOGY DEMONSTRATION PROJECT: REQUIREMENTS

A. Conditional prescription certificate. Graduates of the department of defense psychopharmacology demonstration project who have been actively engaged in prescribing psychotropic medication for at least two (2) of the last five (5) years immediately preceding the date of application may apply for a conditional prescription certificate and shall meet these requirements:

(1) Additional supervision training. The RxP application committee shall make recommendations to the board concerning additional supervision and training that may be required. The board shall review the committee recommendations and determine the additional supervision and training required of the applicant in order to qualify for a prescription certificate.

(2) Supervision plan. The period of supervised practice shall be determined by the board based on the applicant's education, training, and experience and shall not be less than three (3) months or more than two (2) years. The applicant shall submit to the psychopharmacology application committee a supervisory plan as outlined in Subsection H of 16.22.24.10 NMAC, of these regulations. The same requirements set forth in 16.22.24.10 NMAC, shall apply to the supervisory period.

(3) Issuance of prescription certificate. The RxP application committee shall recommend to the board issuance of a prescription certificate to a graduate of the department of defense psychopharmacology demonstration project who qualifies in accordance with these regulations.

B. Prescription certificate. Graduates of the department of defense psychopharmacology demonstration project shall be issued a prescription certificate if they hold an active unrestricted New Mexico license as a psychologist and present to the board evidence that they hold a valid certificate as a department of defense prescribing psychologist.
[16.22.26.8 NMAC - Rp, 16.22.26.8 NMAC, 11/15/06]

HISTORY OF 16.22.26 NMAC:

History of Repealed Material:

16.22.26 NMAC, Graduates of the Department Of Defense Psychopharmacology Demonstration Project - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 27 CONDITIONAL PRESCRIBING OR PRESCRIBING PSYCHOLOGISTS: FORMULARY

16.22.27.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners.
[16.22.27.1 NMAC - Rp, 16.22.27.1 NMAC, 11/15/06]

16.22.27.2 SCOPE: This part applies to the board, licensees, applicants for licensure seeking licenses under prescriptive authority, and the general public.
[16.22.27.2 NMAC - Rp, 16.22.27.2 NMAC, 11/15/06]

16.22.27.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-17.2 and 61-9-3
[16.22.27.3 NMAC - Rp, 16.22.27.3 NMAC, 11/15/06]

16.22.27.4 DURATION: Permanent.
[16.22.27.4 NMAC - Rp, 16.22.27.4 NMAC, 11/15/06]

16.22.27.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of the section.
[16.22.27.5 NMAC - Rp, 16.22.27.5 NMAC, 11/15/06]

16.22.27.6 OBJECTIVE: The objective of Part 27 is to set forth the provisions, which apply to all of Chapter 22, and all persons affected or regulated by Chapter 22 of Title 16.
[16.22.27.6 NMAC - Rp, 16.22.27.6 NMAC, 11/15/06]

16.22.27.7 DEFINITIONS: [RESERVED]
[Refer to 16.22.1.7 NMAC]

16.22.27.8 FORMULARY:

A. Conditional prescribing or prescribing psychologists shall exercise prescriptive authority using psychotropic medications, as defined in 16.22.1 NMAC, of these regulations, within the recognized scope of practice for the treatment of mental disorders and for which the psychologist has been properly educated and trained.

B. As provided by Section 61-9-17.2, of the act, when prescribing psychotropic medication for a patient, a conditional prescribing psychologist or a psychologist with a conditional prescription certificate shall maintain an ongoing collaborative relationship with a health care practitioner who oversees the patient's general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition and significant changes in the patient's medical or psychological condition are discussed. The collaborative relationship shall be utilized to coordinate the patient's ongoing care, including, determining whether non-psychotropic medications should be prescribed to provide the patient with optimized care. In such cases, all non-psychotropic medications shall be prescribed by the health care practitioner who oversees the patient's general medical care, or by other health care practitioners involved in the patient's care who are authorized by law to prescribe such medications.

C. A conditional prescribing or prescribing psychologist shall not prescribe psychotropic medication to treat patients for the following conditions:

(1) chronic pain;
(2) endocrine, cardiovascular, orthopedic, neurological, and gynecological illness or disorders;
(3) allergies; or
(4) other non-psychiatric illnesses, disorders, or illnesses causing mental disorders.

D. A conditional prescribing or prescribing psychologist shall treat psychopharmacologically only mental disorders listed in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

E. A conditional prescribing psychologist or prescribing psychologist who prescribes outside the scope of practice specified in the act and these regulations is subject to disciplinary action by the board.
[16.22.27.8 NMAC - Rp, 16.22.27.8 NMAC, 11/15/06; A, 02/22/13]

HISTORY OF 16.22.27 NMAC:

History of Repealed Material:
16.22.27 NMAC, Formulary - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 28 CONDITIONAL PRESCRIBING OR PRESCRIBING PSYCHOLOGISTS: COMPLAINT PROCEDURES

16.22.28.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners.
[16.22.28.1 NMAC - Rp, 16.22.28.1 NMAC, 11/15/06]

16.22.28.2 SCOPE: The provisions of Part 28 shall apply to all licensees and applicants for licensure, and the general public.
[16.22.28.2 NMAC - Rp, 16.22.28.2 NMAC, 11/15/06]

16.22.28.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-17.1
[16.22.28.3 NMAC - Rp, 16.22.28.3 NMAC, 11/15/06]

16.22.28.4 DURATION: Permanent.
[16.22.28.4 NMAC - Rp, 16.22.28.4 NMAC, 11/15/06]

16.22.28.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of the section.
[16.22.28.5 NMAC - Rp, 16.22.28.5 NMAC, 11/15/06]

16.22.28.6 OBJECTIVE: The objective of Part 28 is to set forth the provisions, which apply to all of Chapter 22, and all persons affected or regulated by Chapter 22 of Title 16.
[16.22.28.6 NMAC - Rp, 16.22.28.6 NMAC, 11/15/06]

16.22.28.7 DEFINITIONS: [RESERVED]
[Refer to 16.22.1.7 NMAC]

16.22.28.8 COMPLAINT PROCEDURES:

A. Any complaint against a conditional prescribing or prescribing psychologist shall be made according to the complaint procedures described in 16.22.11 NMAC of these board regulations.

B. The board shall notify the New Mexico medical board, the board of osteopathic medical examiners, or the board of nursing in writing upon receipt of any complaint that implicates the collaborative relationship between a conditional prescribing or prescribing psychologist and a physician, an osteopathic physician, a nurse practitioner, or a physician's assistant respectively.

C. A joint board complaint committee shall be appointed to evaluate any complaint arising out of the collaboration between a conditional prescribing or prescribing psychologist and a health care practitioner. The committee shall evaluate compliance with provisions of the collaboration guidelines as set forth in 16.22.20.8 NMAC. If the committee determines that the complaint does not involve the collaboration guidelines, the committee shall return the complaint to the board for appropriate action.

D. A joint board complaint committee will consist at a minimum of the following members, appointed as follows:

(1) one person appointed by the board who has experience in the field of psychopharmacology;

(2) one person appointed by the appropriate board of the health care practitioner having a collaborative relationship with the conditional prescribing or prescribing psychologist; and

(3) a public member appointed by the board.

E. Members of a joint board complaint committee shall not be in a pharmacological training program or seeking a prescription certificate, shall not be seeking licensure as a psychologist, physician, or nurse, and shall be a licensee in good standing in his or her respective profession.

F. Members of a joint board complaint committee shall not participate in any complaint review involving the member's family, household or a conflict of interest as defined in 16.22.1.7 NMAC, of these regulations.

G. The professional members of a joint board complaint committee may include:

(1) a psychologist with specialized training and experience in psychopharmacology;

(2) a licensed physician or osteopathic physician with clinical experience in mental health or psychopharmacology;

(3) a licensed pharmacist or pharmacist clinician with specialized training and experience in psychopharmacology;

(4) a licensed psychologist with a prescription certificate;

(5) a nurse practitioner, or physicians assistant with specialized training and experience in psychopharmacology; or

(6) a licensed psychologist.

H. Upon receipt and review of a complaint, a joint board complaint committee shall attempt an informal resolution of a complaint between a treating health care practitioner and a conditional prescribing or prescribing psychologist, consistent with the collaboration guidelines, in order to optimize patient care.

I. If an informal resolution cannot be achieved, a joint board complaint committee shall report its findings to the board and to the health care practitioner's licensing board. The report shall specify the area of alleged non-compliance with the collaboration guidelines and shall provide recommendations to each board for each board's appropriate action.

[16.22.28.8 NMAC - Rp, 16.22.28.8 NMAC, 11/15/06]

HISTORY OF 16.22.28 NMAC:

History of Repealed Material:

16.22.28 NMAC, Prescribing Psychologists: Complaint Procedures - Repealed 11/15/06

TITLE 16 OCCUPATIONAL AND PROFESSIONAL LICENSING
CHAPTER 22 PSYCHOLOGISTS AND PSYCHOLOGIST ASSOCIATES
PART 29 CONDITIONAL PRESCRIBING OR PRESCRIBING PSYCHOLOGISTS: CONTINUING PROFESSIONAL EDUCATION AND CERTIFICATE RENEWAL

16.22.29.1 ISSUING AGENCY: Regulation and Licensing Department Board of Psychologist Examiners.
[16.22.29.1 NMAC - Rp, 16.22.29.1 NMAC, 11/15/06]

16.22.29.2 SCOPE: This part applies to the board, conditional prescribing and prescribing psychologists.
[16.22.29.2 NMAC - Rp, 16.22.29.2 NMAC, 11/15/06]

16.22.29.3 STATUTORY AUTHORITY: This part is adopted pursuant to the Professional Psychologist Act, NMSA 1978 Section 61-9-17.1
[16.22.29.3 NMAC - Rp, 16.22.29.3 NMAC, 11/15/06]

16.22.29.4 DURATION: Permanent.
[16.22.29.4 NMAC - Rp, 16.22.29.4 NMAC, 11/15/06]

16.22.29.5 EFFECTIVE DATE: November 15, 2006, unless a later date is cited at the end of the section.
[16.22.29.5 NMAC - Rp, 16.22.29.5 NMAC, 11/15/06]

16.22.29.6 OBJECTIVE: The objective of Part 29 is to set forth the provisions, which apply to all of Chapter 22, and all persons affected or regulated by Chapter 22 of Title 16.
[16.22.29.6 NMAC - Rp, 16.22.29.6 NMAC, 11/15/06]

16.22.29.7 DEFINITIONS: [RESERVED]
[Refer to 16.22.1.7 NMAC]

16.22.29.8 REQUIREMENTS: Conditional prescribing and prescribing psychologists shall complete CPE requirements as specified 16.22.9 NMAC.
[16.22.29.8 NMAC - Rp, 16.22.29.8 NMAC, 11/15/06; A, 04/30/15]

16.22.29.9 CERTIFICATE RENEWAL:

A. Concurrent renewal of certificate and license. The prescription certificate shall be renewed concurrently with the active unrestricted license. The conditional prescribing or prescribing psychologist shall submit the certificate renewal application on forms approved by the board. The conditional prescribing or prescribing psychologist shall provide evidence of malpractice insurance and additional CPE required by the board, and shall pay a certificate renewal fee established by the board.

B. Voluntary surrender. A licensee in good standing may voluntarily surrender a conditional prescription certificate or prescription certificate.
[16.22.29.9 NMAC - Rp, 16.22.29.8 NMAC, 11/15/06]

HISTORY OF 16.22.29 NMAC:

History of Repealed Material:
16.22.29 NMAC, Prescribing Psychologists: Continuing Professional Education and Certificate Renewal - Repealed 11/15/06.

ARTICLE 9
Psychologists

Section

61-9-1. Short title. (Repealed effective July 1, 2022.)

Chapter 61, Article 9 NMSA 1978 may be cited as the "Professional Psychologist Act".

History: 1953 Comp., § 67-30-1, enacted by Laws 1963, ch. 92, § 1; 2002, ch. 100, § 3.

61-9-2. Legislative findings and purpose. (Repealed effective July 1, 2022.)

A. The legislature finds that the practice of psychology affects the public health, safety and welfare and that appropriate regulation is necessary to protect the public.

B. It is the purpose of the Professional Psychologist Act to insure that the public is adequately protected from the practice of psychology by unqualified persons and from unprofessional conduct by persons licensed to practice psychology.

History: 1978 Comp., § 61-9-2, enacted by Laws 1989, ch. 41, § 2.

61-9-3. Definitions. (Repealed effective July 1, 2022.)

As used in the Professional Psychologist Act:

A. "board" means the New Mexico state board of psychologist examiners;

B. "conditional prescription certificate" means a document issued by the board to a licensed psychologist that permits the holder to prescribe psychotropic medication under the supervision of a licensed physician pursuant to the Professional Psychologist Act;

C. "person" includes an individual, firm, partnership, association or corporation;

D. "prescribing psychologist" means a licensed psychologist who holds a valid prescription certificate;

E. "prescription certificate" means a document issued by the board to a licensed psychologist that permits the holder to prescribe psychotropic medication pursuant to the Professional Psychologist Act;

F. "psychotropic medication" means a controlled substance or dangerous drug that may not be dispensed or administered without a prescription and whose primary indication for use has been approved by the federal food and drug administration for the treatment of mental disorders and is listed as a psychotherapeutic agent in drug facts and comparisons or in the American hospital formulary service;

G. "psychologist" means a person who engages in the practice of psychology or holds himself out to the public by any title or description of services representing himself as a psychologist, which incorporates the words "psychological", "psychologist", "psychology", or when a person describes himself as above and, under such title or description, offers to render or renders services involving the application of principles, methods and procedures of the science and profession of psychology to persons for compensation or other personal gain;

H. "practice of psychology" means the observation, description, evaluation, interpretation and modification of human behavior by the application of psychological principles, methods and procedures for the purpose of preventing or eliminating symptomatic, maladaptive or undesired behavior and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health and mental health, and further means the rendering of such psychological services to individuals, families or groups regardless of whether payment is received for services rendered. The practice of psychology includes psychological testing or neuropsychological testing and the evaluation or assessment of personal characteristics such as intelligence, personality, abilities, interests, aptitudes and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, behavior analysis and therapy; diagnosis and treatment of any mental and emotional disorder or disability, alcoholism and

substance abuse, disorders of habit or conduct and the psychological aspects of physical illness, accident, injury and disability; and psychoeducational evaluation, therapy, remediation and consultation; and

I. "school" or "college" means a university or other institution of higher education that is regionally accredited and that offers a full-time graduate course of study in psychology as defined by rule of the board or that is approved by the American psychological association.

History: 1953 Comp., § 67-30-3, enacted by Laws 1963, ch. 92, § 3; 1989, ch. 41, § 3; 1993, ch. 12, § 1; 1996, ch. 51, § 5; 1996, ch. 54, § 1; 1999, ch. 106, § 1; 2002, ch. 100, § 4.

61-9-4. Criminal offender's character evaluation. (Repealed effective July 1, 2022.)

The provisions of the Criminal Offender Employment Act [28-2-1 to 28-2-6 NMSA 1978] shall govern any consideration of criminal records required or permitted by the Professional Psychologist Act.

History: 1953 Comp., § 67-30-3.1, enacted by Laws 1974, ch. 78, § 31.

61-9-4.1. License required. (Repealed effective July 1, 2022.)

Unless licensed to practice psychology under the Professional Psychologist Act, no person shall engage in the practice of psychology or use the title or represent himself as a psychologist or psychologist associate or use any other title, abbreviation, letters, signs or devices that indicate the person is a psychologist or psychologist associate.

History: 1978 Comp., § 61-9-4.1, enacted by Laws 1989, ch. 41, § 4; 1993, ch. 12, § 2; 1996, ch. 54, § 2.

61-9-5. State board of examiners; psychology fund. (Repealed effective July 1, 2022.)

A. There is created a "New Mexico state board of psychologist examiners". The board shall be administratively attached to the regulation and licensing department. The board shall consist of eight members appointed by the governor who are residents of New Mexico and who shall serve for three-year staggered terms. The members shall be appointed as follows:

(1) four members shall be professional members who are licensed under the Professional Psychologist Act as psychologists. The governor shall appoint the professional members from a list of names nominated by the New Mexico psychological association, the state psychologist association and the New Mexico school psychologist association;

(2) one member shall be licensed under the Professional Psychologist Act as a psychologist or psychologist associate; and

(3) three members shall be public members who are laymen and have no significant financial interest, direct or indirect, in the practice of psychology.

B. A member shall hold office until the expiration of his appointed term or until a successor is duly appointed. When the term of a member ends, the governor shall appoint his successor for a term of three years. A vacancy occurring in the board membership other than by expiration of term shall be filled by the governor by appointment for the unexpired term of the member. The governor may remove a board member for misconduct, incompetency or neglect of duty.

C. All money received by the board shall be credited to the "psychology fund". Money in the psychology fund at the end of the fiscal year shall not revert to the general fund and shall be used

in accordance with the provisions of the Professional Psychologist Act. The members of the board may be reimbursed as provided in the Per Diem and Mileage Act [10-8-1 through 10-8-8 NMSA 1978], but shall receive no other compensation, perquisite or allowance.

History: 1978 Comp., § 61-9-5, enacted by Laws 1989, ch. 41, § 5; 1993, ch. 251, § 1; 1996, ch. 51, § 6; 1996, ch. 54, § 3; 2003, ch. 408, § 9.

61-9-5.1. Actions of board; immunity; certain records not public records. (Repealed effective July 1, 2022.)

A. A member of the board or person working on behalf of the board shall not be civilly liable or subject to civil damages for any good faith action undertaken or performed within the proper functions of the board.

B. All written and oral communications made by a person to the board relating to actual or potential disciplinary action shall be confidential communications and are not public records for the purposes of the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978]. All data, communications and information acquired by the board relating to actual or potential disciplinary action shall not be disclosed except:

(1) to the extent necessary to carry out the board's functions;

(2) as needed for judicial review of the board's actions; or

(3) pursuant to a court order issued by a court of competent jurisdiction.

C. Notwithstanding the provisions of Subsection B of this section, at the conclusion of an actual disciplinary action by the board, all data, communications and information acquired by the board relating to an actual disciplinary action taken against a person subject to the provisions of the Professional Psychologist Act shall be public records pursuant to the provisions of the Inspection of Public Records Act.

History: Laws 1996, ch. 54, § 12; 2003, ch. 428, § 7.

61-9-6. Board; meeting; powers. (Repealed effective July 1, 2022.)

A. The board shall, annually in the month of July, hold a meeting and elect from its membership a chairman, vice chairman and secretary-treasurer. The board shall meet at other times as it deems necessary or advisable or as deemed necessary and advisable by the chairman or a majority of its members or the governor. Reasonable notice of all meetings shall be given in the manner prescribed by the board. A majority of the board constitutes a quorum at a meeting or hearing.

B. The board is authorized to:

(1) adopt and from time to time revise such rules and regulations not inconsistent with the law as may be necessary to carry into effect the provisions of the Professional Psychologist Act. The rules and regulations shall include a code of conduct for psychologists and psychologist associates in the state;

(2) adopt a seal, and the administrator shall have the care and custody of the seal;

(3) examine for, approve, deny, revoke, suspend and renew the licensure of psychologist and psychologist associate applicants as provided in the Professional Psychologist Act;

(4) conduct hearings upon complaints concerning the disciplining of a psychologist or psychologist associate; and

(5) cause the prosecution and enjoinder of persons violating the Professional Psychologist Act and incur necessary expenses therefor.

C. Within sixty days after the close of each fiscal year, the board shall submit a written report, reviewed and signed by the board members, to the governor concerning the work of the board during the preceding fiscal year. The report shall include the names of psychologists and psychologist associates to whom licenses have been granted; cases heard and decisions rendered in relation to the work of the board; the recommendations of the board as to future policies; and an account of all money received and expended by the board.

History: 1953 Comp., § 67-30-5, enacted by Laws 1963, ch. 92, § 5; 1983, ch. 334, § 1; 1989, ch. 41, § 6; 1996, ch. 51, § 7; 1996, ch. 54, § 4; 2003, ch. 408, § 10.

61-9-7. Fees; license renewal. (Repealed effective July 1, 2022.)

A. All fees from applicants seeking licensure under the Professional Psychologist Act and all license renewal fees received under the Professional Psychologist Act shall be credited to the psychology fund. No fees shall be refunded.

B. The board shall set the charge for an application fee of up to six hundred dollars ($600) to applicants for licensure under Sections 61-9-9 through 61-9-11.1 NMSA 1978.

C. The board may establish a method to provide for staggered biennial terms. The board may authorize license renewal for one year to establish the renewal cycle.

D. A licensee shall renew a license biennially on or before July 1 by remitting to the board the renewal fee set by the board not exceeding six hundred dollars ($600) and providing proof of continuing education as required by regulation of the board. Any license issued by the board may be suspended if the holder fails to renew the license by July 1 of any year. A license suspended for failure to renew may be renewed within a period of one year after the suspension upon payment of the renewal fee plus a late fee of one hundred dollars ($100), together with proof of continuing education satisfactory to the board. The license shall be revoked if the license has not been renewed within one year of the suspension for failure to renew. Prior to issuing a new license, the board may in its discretion require full or partial examination of a former licensee whose license was revoked because of failure to renew.

History: 1953 Comp., § 67-30-6, enacted by Laws 1963, ch. 92, § 6; 1969, ch. 34, § 2; 1978, ch. 188, § 1; 1981, ch. 239, § 2; 1983, ch. 334, § 2; 1987, ch. 65, § 1; 1989, ch. 41, § 7; 2006, ch. 6, § 1.

61-9-8. Records. (Repealed effective July 1, 2022.)

A. The board shall keep a record of its proceedings and a register of all applications for licensure which shall show:

(1) the name, age and residence of each applicant;
(2) the date of the application;
(3) the place of business of the applicant;
(4) a summary of the educational and other qualifications of the applicant;
(5) whether an examination was required;
(6) whether a license was granted;
(7) the date of the action of the board; and
(8) such other information as may be deemed necessary or advisable by the board in aid of the requirements of this subsection.

B. Except as provided otherwise in the Professional Psychologist Act, the records of the board are public records and are available to the public in accordance with the Public Records Act [Chapter 14, Article 3 NMSA 1978].

History: 1953 Comp., § 67-30-7, enacted by Laws 1963, ch. 92, § 7; 1989, ch. 41, § 8; 1996, ch. 54, § 5.

61-9-9. Licensure of psychologists without examination. (Repealed effective July 1, 2022.)

The board at its discretion may license without written examination any person who has been certified by the American board of examiners in professional psychology and who passes an oral examination as provided in Subparagraph (b) of Paragraph (6) of Subsection A of Section 61-9-11 NMSA 1978.

History: 1978 Comp., § 61-9-9, enacted by Laws 1989, ch. 41, § 9.

61-9-10. Licensure of psychologists from other areas; reciprocity. (Repealed effective July 1, 2022.)

Subject to the provisions of Section 61-9-10.1 NMSA 1978, upon application accompanied by a fee as required by the Professional Psychologist Act, the board may, without written or oral examination, issue a license to a person who furnishes, upon a form and in such manner as the board prescribes, evidence satisfactory to the board that the person has been licensed or certified as a psychologist by another state, a territorial possession of the United States, the District of Columbia or another country for a minimum of five years. An applicant seeking reciprocity shall demonstrate to the satisfaction of the board that the training and education received by the applicant is equivalent to the requirements for a doctoral degree in psychology as provided in the Professional Psychologist Act.

History: 1953 Comp., § 67-30-9, enacted by Laws 1963, ch. 92, § 9; 1989, ch. 41, § 10; 2006, ch. 6, § 2; 2009, ch. 51, § 1.

61-9-10.1. Provisional and temporary licensure. (Repealed effective July 1, 2022.)

A. A temporary license may be issued to an applicant previously licensed in another jurisdiction and in good standing whose out-of-state license meets current licensing criteria for New Mexico. A temporary license shall be valid for six months and is not subject to extension or renewal. The granting of a temporary license to the applicant does not include issuance of a conditional prescription certificate unless the board finds the applicant meets the requirements of Section 61-9-17.1 NMSA 1978.

B. A provisional license may be issued to an applicant never previously licensed and who does not meet New Mexico's experience requirements for psychology licensure, but who otherwise meets criteria for education and training. A provisionally licensed psychologist must practice under the supervision of a New Mexico licensed psychologist until fully licensed. A provisional license shall be valid for eighteen months and is not subject to extension or renewal.

History: Laws 2006, ch. 6, § 5.

61-9-11. Licensure; examination. (Repealed effective July 1, 2022.)

A. The board shall issue a license as a psychologist to an applicant who files an application upon a form and in such manner as the board prescribes, accompanied by the fee required by the Professional Psychologist Act, and who furnishes evidence satisfactory to the board that the applicant:

(1) has reached the age of majority;

(2) is of good moral character;

(3) is not in violation of any of the provisions of the Professional Psychologist Act and the rules adopted pursuant to that act;

(4) is a graduate of:

(a) a doctoral program that is designated as a doctoral program in psychology by a nationally recognized designation system or that is accredited by a nationally recognized accreditation body and holds a degree with a major in clinical, counseling or school psychology from a university offering a full-time course of study in psychology; or

(b) a doctoral program outside the United States or Canada that is equivalent to a program in Subparagraph (a) of this paragraph and holds a degree with a major in clinical, counseling or school psychology from a university offering a full-time course of study in psychology; the board shall promulgate by rule a list of board-approved credential inspection and verification services to appraise foreign degree programs;

(5) has had at least two years of supervised experience in psychological work of a type satisfactory to the board; provided that:

(a) up to one year of the supervised experience may be obtained in predoctoral practicum hours overseen by a graduate training program and consistent with the guidelines on practicum experience for licensure promulgated by the association of state and provincial psychology boards;

(b) up to one year of the supervised experience may be obtained in a predoctoral internship approved by the American psychological association;

(c) up to one-half year of the supervised experience may be obtained in a predoctoral internship that is not approved by the American psychological association; and

(d) any portion of the required supervised experience not satisfied pursuant to Subparagraphs (a), (b) and (c) of this paragraph shall be obtained in postdoctoral psychological work;

(6) demonstrates professional competence by passing the examination for professional practice in psychology promulgated by the association of state and provincial psychology boards with a total raw score of 140 (seventy percent), before January 1, 1993 or, if after January 1, 1993, a score equal to or greater than the passing score recommended by the association of state and provincial psychology boards;

(7) demonstrates an awareness and knowledge of New Mexico cultures as determined by the board; and

(8) passes such jurisprudence examination as may be given by the board through an online testing and scoring mechanism.

B. Upon investigation of the application and other evidence submitted, including a criminal background check, the board shall, not less than thirty days prior to the examination, notify each applicant that the application and evidence submitted for licensure are satisfactory and accepted or unsatisfactory and rejected. If rejected, the notice shall state the reasons for rejection.

C. The place of examination shall be designated in advance by the board, and examinations shall be given at such time and place and under such supervision as the board may determine.

D. In the event an applicant fails to receive a passing grade, the applicant may apply for reexamination and shall be allowed to take a subsequent examination upon payment of the fee required by the Professional Psychologist Act.

E. The board shall keep a record of all examinations, and the grade assigned to each, as part of its records for at least two years subsequent to the date of examination.

History: 1953 Comp., § 67-30-10, enacted by Laws 1963, ch. 92, § 10; 1983, ch. 334, § 3; 1989, ch. 41, § 11; 1996, ch. 54, § 6; 1999, ch. 106, § 2; 2006, ch. 6, § 3; 2009, ch. 51, § 2; 2011, ch. 135, § 1.

61-9-11.1. Psychologist associates; licensure; examination. (Repealed effective July 1, 2022.)

A. The board shall issue a license as a psychologist associate to each applicant who files an application upon a form and in such manner as the board prescribes, accompanied by the fee required by the Professional Psychologist Act, and who furnishes evidence satisfactory to the board that the applicant:

(1) has reached the age of majority, is of good moral character and is not in violation of any of the provisions of the Professional Psychologist Act and the rules and regulations adopted pursuant to that act;

(2) holds a master's degree in psychology from a department of psychology of a school or college;

(3) demonstrates professional competence by passing the examination for professional practice in psychology promulgated by the association of state and provincial psychology boards with a score equivalent to or greater than the statistical mean as reported by the association of state and provincial psychology boards for all master's-level candidates taking the examination on that occasion;

(4) demonstrates awareness and knowledge of New Mexico cultures as determined by the board; and

(5) passes such jurisprudence examination as may be given by the board through an on-line testing and scoring mechanism.

B. Upon investigation of the application and other evidence submitted, the board shall, not less than thirty days prior to the examination, notify each applicant that the application and evidence submitted for licensure is satisfactory and accepted or unsatisfactory and rejected. If rejected, the notice shall state the reasons for rejection.

C. The place of examination shall be designated in advance by the board, and examinations shall be given at such time and place and under such supervision as the board may determine.

D. In the event an applicant fails to receive a passing grade, the applicant may apply for reexamination and shall be allowed to take a subsequent examination upon payment of the fee required by the Professional Psychologist Act.

E. The board shall keep a record of all examinations, and the grade assigned to each, as part of its records for at least two years subsequent to the date of examination.

F. The board may adopt reasonable rules and regulations classifying areas and conditions of practice permissible for psychologist associates.

History: 1978 Comp., § 61-9-11.1, enacted by Laws 1983, ch. 334, § 4; 1989, ch. 41, § 12; 1996, ch. 54, § 7; 2003, ch. 428, § 8; 2006, ch. 6, § 4.

61-9-11.2. Criminal background checks. (Repealed effective July 1, 2022.)

A. The board may adopt rules that provide for criminal background checks for all licensees to include:

(1) requiring criminal history background checks of applicants for licensure pursuant to the Professional Psychologist Act;

(2) requiring applicants for licensure to be fingerprinted;

(3) providing for an applicant who has been denied licensure to inspect or challenge the validity of the background check record;

(4) establishing a fingerprint and background check fee not to exceed seventy-five dollars ($75.00) to be paid by the applicant; and

(5) providing for submission of an applicant's fingerprint cards to the federal bureau of investigation to conduct a national criminal history background check and to the department of public safety to conduct a state criminal history check.

B. Arrest record information received from the department of public safety and the federal bureau of investigation shall be privileged and shall not be disclosed to persons not directly involved in the decision affecting the applicant.

C. Electronic live fingerprint scans may be used when conducting criminal history background checks.

History: Laws 2009, ch. 51, § 4.

61-9-12. License. (Repealed effective July 1, 2022.)

The board shall issue a license signed by the chairman and vice chairman or their designee whenever an applicant for licensure successfully qualifies as provided for in the Professional Psychologist Act.

History: 1953 Comp., § 67-30-11, enacted by Laws 1963, ch. 92, § 11; 1989, ch. 41, § 13; 1996, ch. 54, § 8.

61-9-13. Denial, revocation or suspension of license. (Repealed effective July 1, 2022.)

A. The board, by an affirmative vote of at least five of its eight members, shall withhold, deny, revoke or suspend a psychologist or psychologist associate license issued or applied for in accordance with the provisions of the Professional Psychologist Act or otherwise discipline a licensed psychologist or psychologist associate upon proof that the applicant, licensed psychologist or psychologist associate:

(1) has been convicted of a felony or an offense involving moral turpitude, the record of conviction being conclusive evidence thereof;

(2) is using a drug, substance or alcoholic beverage to an extent or in a manner dangerous to the psychologist or psychologist associate, any other person or the public or to an extent that the use impairs the psychologist's or psychologist associate's ability to perform the work of a professional psychologist or psychologist associate with safety to the public;

(3) has impersonated another person holding a psychologist or psychologist associate license or allowed another person to use the psychologist's or psychologist associate's license;

(4) has used fraud or deception in applying for a license or in taking an examination provided for in the Professional Psychologist Act;

(5) has accepted commissions or rebates or other forms of remuneration for referring clients to other professional persons;

(6) has allowed the psychologist's or psychologist associate's name or license issued under the Professional Psychologist Act to be used in connection with a person who performs psychological services outside of the area of that person's training, experience or competence;

(7) is legally adjudicated insane or mentally incompetent, the record of such adjudication being conclusive evidence thereof;

(8) has willfully or negligently violated the provisions of the Professional Psychologist Act;

(9) has violated any code of conduct adopted by the board;

(10) has been disciplined by another state for acts similar to acts described in this subsection, and a certified copy of the record of discipline of the state imposing the discipline is conclusive evidence;

(11) is incompetent to practice psychology;

(12) has failed to furnish to the board or its representative information requested by the board;

(13) has abandoned patients or clients;

(14) has failed to report to the board adverse action taken against the licensee by:

(a) another licensing jurisdiction;

(b) a professional psychologist association of which the psychologist or psychologist associate is or has been a member;

(c) a government agency; or

(d) a court for actions or conduct similar to acts or conduct that would constitute grounds for action as described in this subsection;

(15) has failed to report to the board surrender of a license or other authorization to practice psychology in another jurisdiction or surrender of membership on a health care staff or in a professional association following, in lieu of or while under a disciplinary investigation by any of those authorities for acts or conduct that would constitute grounds for action as defined in this subsection;

(16) has failed to adequately supervise a psychologist associate;

(17) has employed abusive billing practices; or

(18) has aided or abetted the practice of psychology by a person not licensed by the board.

B. A person who has been refused a license or whose license has been restricted or suspended under the provisions of this section may reapply for licensure after more than two years have elapsed from the date the restriction or suspension is terminated.

History: 1953 Comp., § 67-30-12, enacted by Laws 1963, ch. 92, § 12; 1983, ch. 334, § 5; 1989, ch. 41, § 14; 1996, ch. 54, § 9; 2009, ch. 51, § 3.

61-9-14. Violation and penalties. (Repealed effective July 1, 2022.)

A. It is a misdemeanor:

(1) for any person not licensed under the Professional Psychologist Act to practice psychology or to represent himself as a psychologist or a psychologist associate;

(2) for any person to practice psychology during the time that his license as a psychologist or psychologist associate is suspended, revoked or lapsed; or

(3) for any person otherwise to violate the provisions of the Professional Psychologist Act.

B. Such misdemeanor shall be punishable upon conviction by imprisonment for not more than three months or by a fine of not more than one thousand dollars ($1,000) or by both such fine and imprisonment. Each violation shall be deemed a separate offense.

C. Such misdemeanor shall be prosecuted by the attorney general of the state or any district attorney he designates.

History: 1953 Comp., § 67-30-13, enacted by Laws 1963, ch. 92, § 13; 1983, ch. 334, § 6; 1989, ch. 41, § 15; 1993, ch. 12, § 3.

61-9-15. Injunctive proceedings. (Repealed effective July 1, 2022.)

A. The board may, in the name of the people of the state of New Mexico, through the attorney general of the state of New Mexico, apply for an injunction in any court of competent jurisdiction to enjoin any person from committing any act declared to be a misdemeanor by the Professional Psychologist Act.

B. If it be established that the defendant has been or is committing an act declared to be a misdemeanor by the Professional Psychologist Act, the court, or any judge thereof, shall enter a decree perpetually enjoining said defendant from further committing such act.

C. In case of violation of any injunction issued under the provisions of this section, the court, or any judge thereof, may summarily try and punish the offender for contempt of court.

D. Such injunctive proceedings shall be in addition to, and not in lieu of, all penalties and other remedies in the Professional Psychologist Act provided.

History: 1953 Comp., § 67-30-14, enacted by Laws 1963, ch. 92, § 14.

61-9-16. Scope of act. (Repealed effective July 1, 2022.)

A. Nothing in the Professional Psychologist Act shall be construed to limit:

(1) the activities, services and use of an official title on the part of a person in the employ of a federal, state, county or municipal agency or of other political subdivisions or any educational institution chartered by the state insofar as such activities, services and use of any official title are a part of the duties of his office or position with the agency or institution;

(2) the activities and services of a student, intern or resident in psychology pursuing a course of study in psychology at a school or college if these activities and services constitute a part of his supervised course of study and no fee is charged directly by the student, intern or resident; or

(3) the activities of an applicant working under supervision seeking licensure pursuant to the Professional Psychologist Act.

B. Nothing in the Professional Psychologist Act shall in any way restrict the use of the term "social psychologist" by any person who has received a doctoral degree in sociology or social psychology from an institution whose credits in sociology or social psychology are acceptable by a school or college and who has passed comprehensive examinations in the field of social psychology as a part of the requirements for the doctoral degree or has had equivalent specialized training in social psychology and who has notified the board of his intention to use the term "social psychologist" and filed a statement of the fact demonstrating his compliance with this subsection. A social psychologist shall not practice in any psychological specialty outside that of social psychology without complying with the provisions of the Professional Psychologist Act.

C. Lecturers in psychology from any school or college may utilize their academic or research titles when invited to present lectures to institutions or organizations.

D. Nothing in the Professional Psychologist Act prohibits qualified members of other professional groups who are licensed or regulated under the laws of this state from engaging in activities within the scope of practice of their respective licensing or regulation statutes, but they shall not hold themselves out to the public by any title or description of services that would lead the public to believe that they are psychologists, and they shall not state or imply that they are licensed to practice psychology.

E. Nothing in the Professional Psychologist Act shall be construed to prevent an alternative, metaphysical or holistic practitioner from engaging in nonclinical activities consistent with the standards and codes of ethics of that practice.

F. Specifically exempted from the Professional Psychologist Act are:

(1) alcohol or drug abuse counselors working under appropriate supervision for a nonprofit corporation, association or similar entity;

(2) peer counselors of domestic violence or independent-living peer counselors working under appropriate supervision in a nonprofit corporation, association or similar entity;

(3) duly ordained, commissioned or licensed ministers of a church; lay pastoral-care assistants; science of mind practitioners providing uncompensated counselor or therapist services on behalf of a church; and Christian science practitioners;

(4) students enrolled in a graduate-level counselor and therapist training program and rendering services under supervision;

(5) hypnotherapists certified by the American council of hypnotist examiners or the southwest hypnotherapists examining board, providing nonclinical services from July 1, 1994 to June 30, 1998;

(6) pastoral counselors with master's or doctoral degrees, who are certified by the American association of pastoral counselors; and

(7) practitioners of Native American healing arts.

History: 1953 Comp., § 67-30-15, enacted by Laws 1963, ch. 92, § 15; 1989, ch. 41, § 16; 1993, ch. 12, § 4; 1996, ch. 54, § 10.

61-9-17. Drugs; medicines. (Repealed effective July 1, 2022.)

A. Except as provided in Subsections B and C of this section, psychologists or psychologist associates shall not administer or prescribe drugs or medicine or in any manner engage in the practice of medicine as defined by the laws of this state.

B. A licensed psychologist holding a conditional prescription certificate may prescribe psychotropic medication under the supervision of a licensed physician pursuant to the Professional Psychologist Act.

C. A prescribing psychologist may prescribe psychotropic medication pursuant to the Professional Psychologist Act.

History: 1953 Comp., § 67-30-16, enacted by Laws 1963, ch. 92, § 16; 1983, ch. 334, § 7; 1989, ch. 41, § 17; 2002, ch. 100, § 5.

61-9-17.1. Conditional prescription certificate; prescription certificate; application; requirements; rulemaking by board; issuance, denial, renewal and revocation of certification. (Repealed effective July 1, 2022.)

A. A psychologist may apply to the board for a conditional prescription certificate. The application shall be made on a form approved by the board and be accompanied by evidence satisfactory to the board that the applicant:

(1) has completed a doctoral program in psychology from an accredited institution of higher education or professional school, or, if the program was not accredited at the time of the applicant's graduation, that the program meets professional standards determined acceptable by the board;

(2) holds a current license to practice psychology in New Mexico;

(3) has successfully completed pharmacological training from an institution of higher education approved by the board and the New Mexico board of medical examiners [New Mexico medical board] or from a provider of continuing education approved by the board and the New Mexico board of medical examiners [New Mexico medical board];

(4) has passed a national certification examination approved by the board and the New Mexico board of medical examiners that tests the applicant's knowledge of pharmacology in the diagnosis, care and treatment of mental disorders;

(5) within the five years immediately preceding the date of application, has successfully completed an organized program of education approved by the board and the New Mexico board of medical examiners [New Mexico medical board] and consisting of didactic instruction of no fewer than four hundred fifty classroom hours in at least the following core areas of instruction:

(a) neuroscience;

(b) pharmacology;

(c) psychopharmacology;

(d) physiology;

(e) pathophysiology;

(f) appropriate and relevant physical and laboratory assessment; and

(g) clinical pharmacotherapeutics;

(6) within the five years immediately preceding the date of application, has been certified by the applicant's supervising psychiatrist or physician as having successfully completed a supervised and relevant clinical experience, approved by the board and the New Mexico board of medical examiners [New Mexico medical board], of no less than an eighty-hour practicum in clinical assessment and pathophysiology and an additional supervised practicum of at least four hundred hours treating no fewer than one hundred patients with mental disorders, the practica to have been supervised by a psychiatrist or other appropriately trained physician and determined by the board and the New Mexico board of medical examiners to be sufficient to competently train the applicant in the treatment of a diverse patient population;

(7) has malpractice insurance in place, sufficient to satisfy the rules adopted by the board and the New Mexico board of medical examiners [New Mexico medical board], that will cover the applicant during the period the conditional prescription certificate is in effect; and

(8) meets all other requirements, as determined by rule of the board, for obtaining a conditional prescription certificate.

B. The board shall issue a conditional prescription certificate if it finds that the applicant has met the requirements of Subsection A of this section. The certificate shall be valid for a period of

two years, at the end of which the holder may again apply pursuant to the provisions of Subsection A of this section. A psychologist with a conditional prescription certificate may prescribe psychotropic medication under the supervision of a licensed physician subject to the following conditions:

(1) the psychologist shall continue to hold a current license to practice psychology in New Mexico and continue to maintain malpractice insurance;

(2) the psychologist shall inform the board and the New Mexico board of medical examiners [New Mexico medical board] of the name of the physician under whose supervision the psychologist will prescribe psychotropic medication and promptly inform the board and the New Mexico board of medical examiners [New Mexico medical board] of any change of the supervising physician; and

(3) a physician supervising a psychologist prescribing psychotropic medication pursuant to a conditional prescription certificate shall inform the board and the New Mexico board of medical examiners [New Mexico medical board] that he is supervising the psychologist. The physician shall be individually responsible for the acts and omissions of the psychologist while under his supervision. This provision does not relieve the psychologist from liability for his acts and omissions.

C. A psychologist may apply to the board for a prescription certificate. The application shall be made on a form approved by the board and be accompanied by evidence satisfactory to the board that the applicant:

(1) has been issued a conditional prescription certificate and has successfully completed two years of prescribing psychotropic medication as certified by the supervising licensed physician;

(2) has successfully undergone a process of independent peer review approved by the board and the New Mexico board of medical examiners [New Mexico medical board];

(3) holds a current license to practice psychology in New Mexico;

(4) has malpractice insurance in place, sufficient to satisfy the rules adopted by the board, that will cover the applicant as a prescribing psychologist; and

(5) meets all other requirements, as determined by rule of the board, for obtaining a prescription certificate.

D. The board shall issue a prescription certificate if it finds that the applicant has met the requirements of Subsection C of this section. A psychologist with a prescription certificate may prescribe psychotropic medication pursuant to the provisions of the Professional Psychologist Act if the psychologist:

(1) continues to hold a current license to practice psychology in New Mexico and continues to maintain malpractice insurance; and

(2) annually satisfies the continuing education requirements for prescribing psychologists, as set by the board, which shall be no fewer than twenty hours each year.

E. The board shall promulgate rules providing for the procedures to be followed in obtaining a conditional prescription certificate, a prescription certificate and renewals of a prescription certificate. The board may set reasonable application and renewal fees.

F. The board shall promulgate rules establishing the grounds for denial, suspension or revocation of conditional prescription certificates and prescription certificates authorized to be issued pursuant to this section, including a provision for suspension or revocation of a license to practice psychology upon suspension or revocation of a certificate. Actions of denial, suspension

or revocation of a certificate shall be in accordance with the Uniform Licensing Act [61-1-1 through 61-1-31 NMSA 1978].

History: Laws 2002, ch. 100, § 6.

61-9-17.2. Prescribing practices. (Repealed effective July 1, 2022.)

A. A prescribing psychologist or a psychologist with a conditional prescription certificate may administer and prescribe psychotropic medication within the recognized scope of the profession, including the ordering and review of laboratory tests in conjunction with the prescription, for the treatment of mental disorders.

B. When prescribing psychotropic medication for a patient, the prescribing psychologist or the psychologist with a conditional prescription certificate shall maintain an ongoing collaborative relationship with the health care practitioner who oversees the patient's general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition and significant changes in the patient's medical or psychological condition are discussed. The ongoing collaborative relationship shall be maintained pursuant to guidelines developed by the board and the New Mexico board of medical examiners [New Mexico medical board], which shall optimize patient care. The guidelines shall ensure that the prescribing psychologist or the psychologist with a conditional prescription certificate and the treating physician coordinate and collaborate the care of the patient to provide optimal care. A committee composed of members of both boards shall be established and, pursuant to the guidelines, shall evaluate complaints. The committee shall report its findings and recommendations to each board for each board's appropriate actions.

C. A prescription written by a prescribing psychologist or a psychologist with a conditional prescription certificate shall:

(1) comply with applicable state and federal laws;

(2) be identified as issued by the psychologist as "psychologist certified to prescribe"; and

(3) include the psychologist's board-assigned identification number.

D. A prescribing psychologist or a psychologist with a conditional prescription certificate shall not delegate prescriptive authority to any other person. Records of all prescriptions shall be maintained in patient records.

E. When authorized to prescribe controlled substances, a prescribing psychologist or a psychologist with a conditional prescription certificate shall file with the board in a timely manner all individual federal drug enforcement agency registrations and numbers. The board and the New Mexico board of medical examiners [New Mexico medical board] shall maintain current records on every psychologist, including federal registrations and numbers.

F. The board shall provide to the board of pharmacy and the New Mexico board of medical examiners [New Mexico medical board] an annual list of prescribing psychologists and psychologists with conditional prescription certificates that contains the information agreed upon between the board, the New Mexico board of medical examiners [New Mexico medical board] and the board of pharmacy. The board shall promptly notify the board of pharmacy of psychologists who are added or deleted from the list.

G. For the purpose of this section:

(1) "collaborative relationship" means a cooperative working relationship between a prescribing psychologist or a psychologist with a conditional prescription certificate and a health

care practitioner in the provision of patient care, including diagnosis and cooperation in the management and delivery of physical and mental health care; and

(2) "health care practitioner" means a physician, osteopathic physician or nurse practitioner.

History: Laws 2002, ch. 100, § 7.

61-9-18. Privileged communications. (Repealed effective July 1, 2022.)

A licensed psychologist or psychologist associate shall not be examined without the consent of his client as to any communication made by the client to him or his advice given in the course of professional employment; nor shall a licensed psychologist's or psychologist associate's secretary, stenographer, clerk or any person supervised by the psychologist or psychologist associate be examined without the consent of his employer concerning any fact the knowledge of which he has acquired in such capacity.

History: 1953 Comp., § 67-30-17, enacted by Laws 1963, ch. 92, § 17; 1983, ch. 334, § 8; 1989, ch. 41, § 18.

61-9-19. Termination of agency life; delayed repeal. (Repealed effective July 1, 2022.)

The New Mexico state board of psychologist examiners is terminated on July 1, 2021 pursuant to the Sunset Act [12-9-11 through 12-9-21 NMSA 1978]. The board shall continue to operate according to the provisions of the Professional Psychologist Act until July 1, 2022. Effective July 1, 2022, the Professional Psychologist Act is repealed.

History: 1953 Comp., § 67-30-18, enacted by Laws 1978, ch. 188, § 2; 1981, ch. 241, § 22; 1985, ch. 87, § 7; 1989, ch. 41, § 19; 1996, ch. 51, § 8; 1996, ch. 54, § 11; 1997, ch. 46, § 9; 2003, ch. 428, § 9; 2009, ch. 96, § 6; 2015, ch. 119, § 7.

Appendix I

Psychologists Prescribing:

Concerning Findings within CMS Medicare Part D

Prescriber Data in Louisiana and New Mexico from 2014 and 2015

Psychologists Prescribing: Concerning Findings within CMS Medicare Part D Prescriber Data in Louisiana and New Mexico from 2014 and 2015

As part of the federal government's ongoing efforts to drive data transparency in healthcare, the Centers for Medicare and Medicaid Services releases prescription claims data from the Medicare prescription drug benefit (also known as Part D). The data release covers more than 3,000 drugs ordered by over 1 million clinicians annually and provides data on prescriber-level claims.

A previous review of 2013 data revealed concerning examples of psychologists prescribing outside the scope of medications used for mental health treatment. The data from 2014 and 2015 show that clinical psychologists, who have wholly insufficient training to prescribe psychiatric drugs, continue to prescribe non-psychiatric medications, well beyond any training they may have.

This behavior has crossed the line of legislative intent in the few states where psychologists are permitted to practice medicine after crash course training and certification.

While many of the medications within the most recent datasets consist of powerful psychotropic medicines (e.g., antipsychotics and controlled substances including stimulants) with potentially harmful side effects for which psychologists are not adequately trained to administer and monitor, there are even more alarming examples of non-psychotropic drugs that should be managed by a highly qualified medical professional. These include muscle relaxants (which can have a high risk of abuse), as well as medications for asthma, diabetes, and seizures.

Examples of Medications Ordered by Prescribing Psychologists in Louisiana and New Mexico, According to Medicare Data

Drug Name (Brand Name)	Indication	System(s)	Possible Side Effect(s)	FDA-approved for Mental Health Treatment?
Albuterol sulfate (ProAir, Proventil, Ventolin)	Difficulty breathing (such as in asthma and COPD)	Respiratory, Cardiovascular	Tremor, nausea, agitation, restlessness, palpitations, fast or irregular heartbeat, high blood pressure, chest pain, low potassium	No
Alendronate sodium (Fosamax)	Osteoporosis, Paget's disease (bone disease)	Musculoskeletal	Chest pain, trouble swallowing, heartburn, vomiting, joint pain or swelling, dizziness, headache, bloody stools, skin blisters	No
Armodafinil (Nuvigil)	Narcolepsy, sleep disorders such as obstructive sleep apnea	Nervous	Potential drug abuse, nausea, dry mouth, dizziness, trouble sleeping, fast or irregular heartbeat, depression, hallucinations, suicidal thoughts, chest pain	No
Atenolol (Tenormin)	Cardiac medication (beta blocker) used for arrhythmia, high blood pressure, chest pain	Cardiovascular	Dizziness, fatigue, nausea, lightheadedness, fainting, trouble breathing, depression, mood swings, confusion	No
Baclofen (Gablofen, Lioresal)	Muscle relaxant	Musculoskeletal, Nervous	Drowsiness, dizziness, fatigue, trouble sleeping, increased urination, nausea, constipation, confusion, depression, hallucinations, withdrawal seizures	No

Drug Name (Brand Name)	Indication	System(s)	Possible Side Effect(s)	FDA-approved for Mental Health Treatment?
Clozapine (Clozaril, FazaClo)	Schizophrenia - used only in patients who have failed to respond adequately to standard antipsychotic treatments	Nervous, Immune, Cardiovascular, Gastrointestinal, Musculoskeletal	Severe neutropenia (low white blood cell counts leading to compromised immune system), low blood pressure, slow heartbeat, fainting, seizures, life-threatening/fatal damage to muscles or the heart, increased mortality in the elderly, life-threatening toxic megacolon	Yes, but requires extremely close monitoring - has a national registry to which both prescribers and pharmacies that dispense must register and log labwork for each patient. There is a very specific protocol to follow with regard to dosing and titrating this medication, as well as a specific protocol with regards to monitoring bloodwork. This is due to the risk of severe or life-threatening side effects associated with this medication.
Dextromethorphan HBr/Quinidine HCl (Nuedexta)	Neurological and cardiac conditions	Nervous, Cardiovascular	Diarrhea, flu-like symptoms, vomiting, dizziness, urinary tract infection, changes in heart rhythm, elevation of liver enzymes, muscle spasms	No
Esomeprazole magnesium (Nexium)	Acid reflux, ulcers	Gastrointestinal	Stomach pain, change in heartbeat (fast, slow, or irregular), muscle spasms, vitamin-B12 deficiency, infectious diarrhea	No
Insulin glargine (Lantus)	Diabetes	Endocrine, Gastrointestinal	Hypoglycemia, headache, weakness, tremor, irritability, fainting, changes in breathing or heartbeat, seizure	No
Levetiracetam (Keppra)	Seizures/epilepsy	Nervous	Change in personality, irritability, irregular heartbeat, depression, paranoia, mood swings, inflammation liver, neutropenia, pancreatitis	No
Levocetirizine dihydrochloride (Xyzal)	Antihistamine for allergy symptoms	Respiratory, Nervous	Dry mouth, drowsiness, fatigue, fever, cough, difficulty urinating, weakness, aggression/disinhibition	No
Levothyroxine sodium (Synthroid)	Hypothyroidism	Endocrine	Tremor, labored breathing, changes in heartbeat (fast, slow, irregular, or racing), changes in weight, anxiety, depression	No
Lisinopril (Prinivil, Zestril)	Cardiac medication (ACE inhibitor) used for high blood pressure and congestive heart failure	Cardiovascular, Renal	Cough, dizziness, depression, fatigue, decreased urination, vomiting, fainting, life-threatening allergic reaction (angioedema), slow or irregular heartbeat, rapid weight gain, psoriasis	No
Metoprolol succinate (Toprol XL)	High blood pressure, angina, congestive heart failure	Cardiovascular	Confusion, dizziness, slow heartbeat, shortness of breath, rash, depression, worsening chest pain or heart failure	No
Metoprolol tartrate (Lopressor)	High blood pressure, angina, congestive heart failure, arrhythmia	Cardiovascular	Confusion, dizziness, slow heartbeat, shortness of breath, rash, depression, low blood pressure	No

Drug Name (Brand Name)	Indication	System(s)	Possible Side Effect(s)	FDA-approved for Mental Health Treatment?
Modafinil (Provigil)	Narcolepsy, sleep disorders such as obstructive sleep apnea	Nervous	Potential drug abuse, nausea, dry mouth, dizziness, trouble sleeping, fast or irregular heartbeat, depression, hallucinations, suicidal thoughts, chest pain	No
Ondansetron HCl (Zofran)	Severe nausea and vomiting	Gastrointestinal	Dizziness, drowsiness, fatigue, constipation, muscle spasm/stiffness, blurred vision, temporary vision loss, chest pain, changes in heartbeat, fainting, serotonin syndrome (life-threatening), hallucinations, fever, agitation	No
Ropinirole HCl (Requip, Requip XL)	Parkinson's disease, restless leg syndrome (RLS)	Nervous	Vomiting, constipation, dizziness, drowsiness, dry mouth, low or high blood pressure, depression, confusion, hallucinations, changes in heartbeat, vision changes, unusual strong urges (increased gambling, increased sexual urges), sudden falling asleep (even while driving, sometimes without previous drowsiness)	No
Simvastatin (Zocor)	High cholesterol	Cardiovascular	Loss of consciousness, fast or irregular heartbeat, difficulty breathing, muscle cramps/pain, rhabdomyolysis (life-threatening muscle damage), inflammation of liver, confusion, memory loss, joint pain	No
Tizanidine HCl (Zanaflex)	Muscle relaxant	Musculoskeletal	Chest pain, vomiting, blurred vision, irregular heartbeat, kidney stones	No
Zonisamide (Zonegran)	Seizures/epilepsy	Nervous	Dizziness, trouble sleeping, lack of coordination, lightheadedness, diarrhea, double vision, confusion, agitation, painful urination, sudden abdominal pain, speech problems, depression, suicidal thoughts or attempts, metabolic acidosis, kidney and liver damage	No

Data retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Part-D-Prescriber.html

Appendix J

Considerations with regard to prescribing privileges for Psychologists in Connecticut

Considerations with Regards to Prescribing Privileges for Psychologists in Connecticut

Introduction

- There is a shortage of mental health providers in Connecticut, as has been noted across the nation. However, expanding psychologists' scope of practice to include "prescribing privileges" is not a safe or evidence-based intervention to address this shortage.
- Definitions
    - A *prescribing psychologist* is a licensed, fully independent mental health provider with a doctorate in clinical psychology (PsyD or PhD) who has completed a Masters in Clinical Psychopharmacology in order to be able to prescribe psychotropic medications. They must pass a national exam, typically the Psychopharmacology Examination for Psychologists, which was developed by the American Psychological Association.
    - A *psychiatrist* is a medical doctor (MD or DO) who has completed four years of medical school and a minimum four-year general psychiatry residency in order to provide mental health care incorporating both the mental and physical components of psychiatric illness. Psychiatrists must pass multiple exams* throughout medical school and during and after residency in order to practice as a licensed, board-certified psychiatrist.
- Many psychologists have stated that they do not support psychologist prescribing, including the Society for the Science of Clinical Psychology (CCSP, a section of the American Psychological Association), Psychologists Opposed to Prescription Privileges for Psychologists (POPPP), and a significant majority of the Association for Behavioral and Cognitive Therapies (see Supplement).
- The National Alliance for the Mentally Ill (NAMI), a consumer group advocating for mental health parity, does not support psychologist prescribing.[1]
- Multiple medical associations and societies, including the American Medical Association, the American Psychiatric Association, and the International Society of Psychiatric-Mental Health Nurses, do not support psychologist prescribing.
- A recent survey of Oregon psychologists found that only a minority were interested in or planned to obtain the training and prescribe medications.[2]
    - Only 14.9% were interested in completing appropriate training as recommended by the APA for prescription privileges.
    - Only 6.7% planned to obtain training and prescribe medications.
    - Of note, when asked whether the prescriptive training model for psychologists should resemble the medical training model, only 19.2% disagreed. 69.2% felt that psychologists should receive the same amount of training in prescribing medication as other non-physician professionals who have prescription privileges.

[1] https://www.nami.org/About-NAMI/Policy-Platform/3-Treatment

[2] Tompkins, TL, & Johnson, JD (2016). What Oregon Psychologists Think and Know About Prescriptive Authority: Divided Views and Data-Driven Change. *Journal of Applied Biobehavioral Research, 21*(3), 126-161.

Psychiatry and Mental Health Care in Connecticut and the United States

- In Connecticut, there are 824 actively practicing psychiatrists, with approximately 4340 patients per psychiatrist.[3]
- Connecticut ranked 5th in the country in a Mental Health America study entitled "The state of mental health in America 2018,", where higher ranking indicates lower prevalence of mental illness and higher rates of access to care.[4]
- In recent years, more and more medical students have chosen to specialize in psychiatry.
    - In 2017, 2641 applicants applied for 1495 positions in psychiatric residencies, and 99.7% of these positions were filled.
    - Over the last five years, there has been a minimum 5% (and up to 5.4%) yearly increase in the number of applicants matching into a first-year psychiatry residency position.[5]

Training and Safety

- The Connecticut Psychological Association proposed curriculum
    - "Shall not be less than 30 graduate credit hours or its equivalent of approximately total 270 academic credit hours of biological sciences and clinical instruction"
    - A practicum with a minimum of 100 patients (approximately 400 hours) under the supervision of a licensed physician (MD/DO) or advanced practice registered nurse (APRN)
        - Does not have to be a psychiatrist!
    - Following the program, practice will require supervision by a licensed physician or APRN for one year (1000 hours)
        - Again, does not have to be a psychiatrist!
- Masters of Clinical Psychopharmacology programs
    - No formal accreditation process
        - In fact, "the programs do not meet the APA's (2007) own accreditation criteria that are in effect for psychology graduate, internship, and postdoctoral training. That is, they are not required to be carefully scrutinized externally as are other levels of clinical training in psychology and as are other prescribing disciplines' training programs."[6]
        - Medical schools are accredited by the LCME, and residencies/fellowships are accredited by the ACGME.
    - Most PsyD and PhD applicants to these programs have very little background in the physical sciences, and their doctoral training does not translate to the knowledgebase needed for the practice of medicine, of which prescribing is just one small component.
    - Programs vary in format, length, faculty, and curriculum. There is no standardized curriculum.
        - Most courses are primarily online or on weekends, with limited in-person experience.

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[3] AAMC State Physician Workforce Data Report (2017) https://www.aamc.org/download/484522/data/connecticutprofile.pdf

[4] http://www.mentalhealthamerica.net/issues/ranking-states

[5] National Residency Matching Program: 2017 Main Residency Match Results and Data http://www.nrmp.org/main-residency-match-data

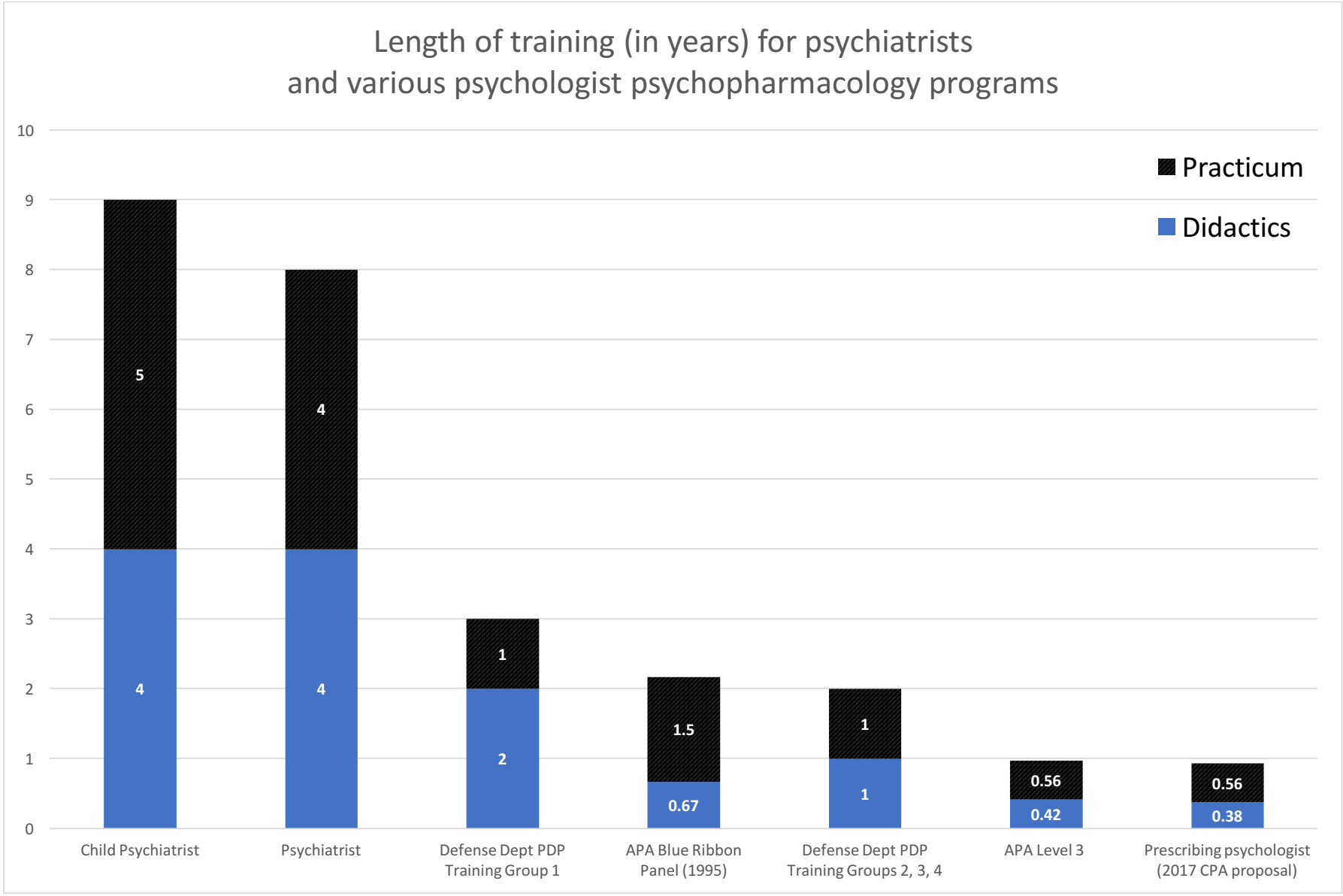
[6] Robiner, William N.; Tumlin, Tim R.; and Tompkins, Tanya, "Psychologists and Medications in the Era of Interprofessional Care: Collaboration is Less Problematic and Costly Than Prescribing" (2013).

        - "Two prominent post-doctoral psychopharmacology programs (AIU, 2012; FDU, 2012) follow a distance-learning model which, given the dangerous nature of drug interactions, may be insufficient to ensure psychologists' competence. This is notable given that no APA-accredited doctoral program allows a predominantly distance-learning approach. Thus, there appears to be a consensus within accreditation bodies that long-distance training is not sufficient. For attaining and maintaining necessary clinical knowledge."[7]
    - Typically designed for "part-time" study
        - Fairleigh Dickinson University's website states that the estimated study time per week is "6-10 hours."
        - By comparison, on average, medical students typically spend 4-5 hours per day studying – after a full day of courses. The hours of out-of-class studying are usually even higher on weekends or closer to exams.
    - Ransom (2014) wrote about his experience completing a clinical psychopharmacology program. Per online records, this program was through Fairleigh Dickinson University.
        - "My positive view of the training took a great blow, however, with each exam. Exams universally consisted of a few dozen multiple-choice questions, open-book, open-note, unproctored, untimed. I had studied as if I was preparing for a medical board exam. I was being tested as if I were in a community college remedial class. As would be expected, the class average for most exams was in the high-90s."[8]
    - Didactics reportedly include some teaching toward working with "special" populations including children and adolescents. Psychiatrists who plan to work with children and most adolescents complete a two-year fellowship in child and adolescent psychiatry in order to gain expertise in this specialized and oftentimes complicated patient population.
    - No requirements for specific clinical experiences (e.g., inpatient)

- Psychotropic medications are potentially some of the most dangerous and powerful pharmaceuticals that can be prescribed to a patient. Two major classes of psychotropic medications have an FDA "black box" warning.
    - Have effects on multiple organ systems
    - Can increase risk factors for significant diseases
        - Metabolic disease, pancreatitis, hypothyroidism, liver failure
    - Can cause adverse reactions or side effects
        - Serotonin syndrome, hyponatremia secondary to SIADH, dyskinesias (can be life-threatening, e.g. laryngospasm), agranulocytosis, Stevens-Johnson Syndrome (up to 5% mortality rate, which rises higher if toxic epidermal necrolysis develops), Neuroleptic Malignant Syndrome (up to 50% mortality rate if renal failure develops)

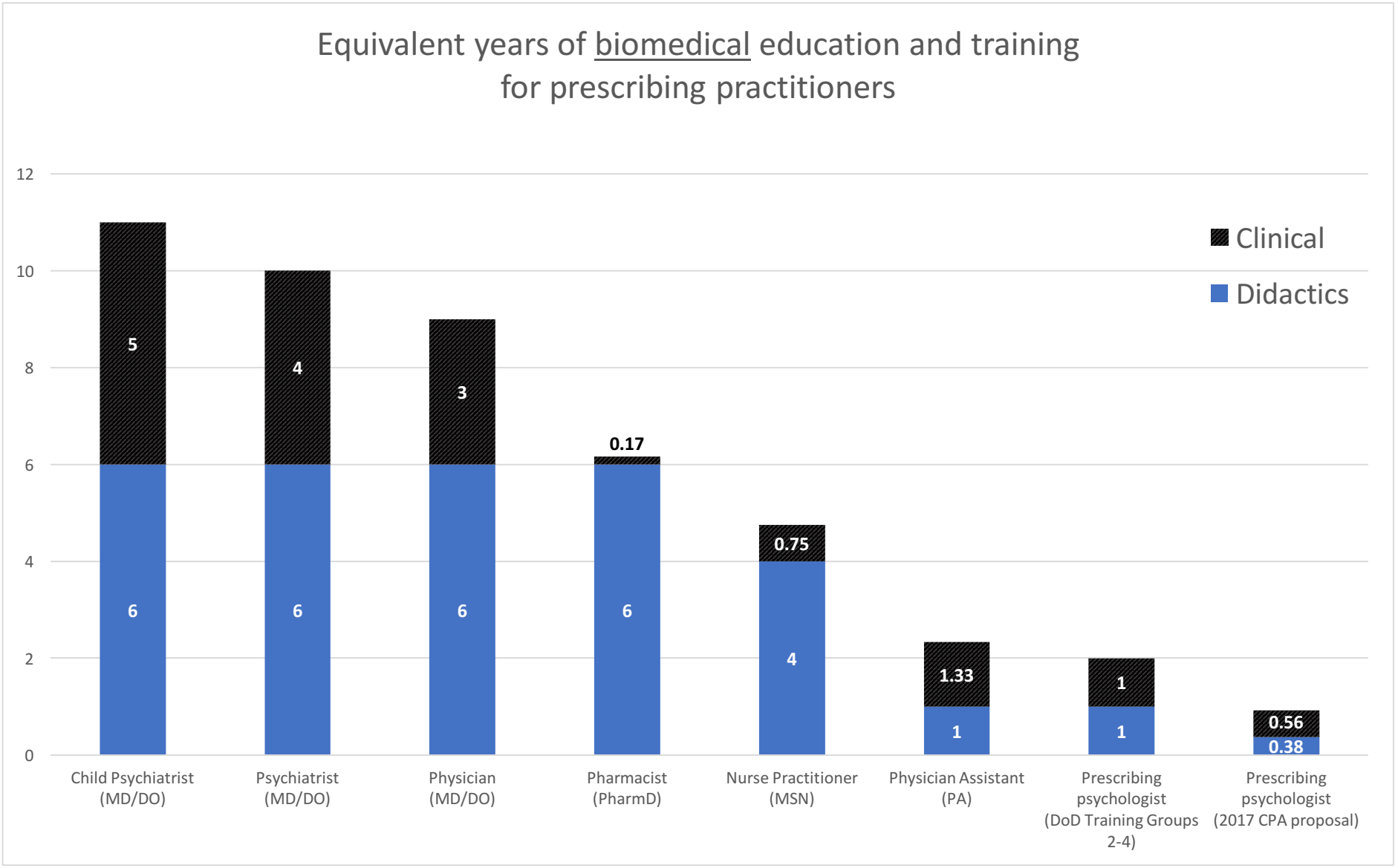
[7] Shafron, GR (2014). Prescription Privileges and the Ethics Code: A Modern Look into the Right to Prescribe among Applied Psychologists. *Graduate Student Journal of Psychology, 15,* 95-102.
[8] Ransom, S (2014). The RxP Conundrum: How Prescriptive Authority Makes (Some of) My Patients Better and My Practice Worse. *The Behavior Therapist, 37*(6), 152-157.

- Medicare Part D prescribing data from New Mexico and Louisiana (2013)
    - Psychologists are prescribing medications that have no psychiatric purpose. Some of these medications require careful monitoring of blood levels due to the risk of toxicity or serious complications and/or have significant side effect profiles and potential medication interactions.
        - Warfarin (Coumadin) – a blood thinner
        - Simvastatin (Zocor) – used for hyperlipidemia
        - Ramipril (Altace) – ACE inhibitor, used for hypertension
        - Clopidogrel (Plavix) – a blood thinner



‡Adapted from the American Medical Association's Scope of Practice Data Series

‡‡Child psychiatrists spend four years in medical school, followed by three to four years in a general psychiatry residency, and an additional two years in a child and adolescent psychiatry fellowship. Adult psychiatrists spend four years in medical school, followed by four years in a general psychiatry residency. Of note, though the four years of medical school are categorized under "didactics," clinical experience and training is included in the first two years and is the primary focus of the last two years.



‡‡‡For standardization, a conversion rate of 60 contact or academic credit hours equaling one month of full-time study was applied.
‡Adapted from the American Medical Association's Scope of Practice Data Series, Yale University's Physician Assistant Program, University of St. Joseph's MSN Program, and the Connecticut Psychological Association's Proposed Curriculum (Appendix D)

Psychologists Prescribing: Release of Data Reveal Facts on the Ground in Louisiana and New Mexico

As part of the federal government's ongoing efforts to drive data transparency in healthcare, the Centers for Medicare and Medicaid Services recently released prescription claims data from the Medicare prescription drug benefit (also known as Part D). The data release covers more than 3,000 drugs ordered by over 1 million clinicians in 2013 and provides data on prescriber-level claims. For the first time, this data reveals that clinical psychologists, who have wholly insufficient training to prescribe *psychiatric* drugs, are also prescribing non-psychiatric medications, well beyond any training they may have.

This behavior has crossed the line of legislative intent in the few states where psychologists are permitted to practice medicine after crash course training and certification.

While many of the medications within the dataset consist of powerful psychotropic medicines (e.g., antipsychotics and controlled substances including stimulants) with potentially harmful side effects for which psychologists are not adequately trained to administer and monitor, the data reveal even more alarming examples of non-psychotropic drugs that should be managed by a highly qualified medical professional.

Examples of Medications Ordered by Prescribing Psychologists in New Mexico and Louisiana, According to Medicare Data

Drug Name (Brand Name)	Indication	System(s)	Possible Side Effect(s)	Indicated for Mental Health Tx?
Warfarin sodium (Coumadin)	Blood clots/atrial fibrillation	Cardiovascular, Nervous	Increased risk of bleeding, sudden and severe leg or foot pain, jaundice, vomiting	**No**
Metoprolol succinate (Lopressor)	Cardiac medication (beta blocker)	Cardiovascular	Confusion, dizziness, slow heartbeat, rapid weight gain, shortness of breath	**No**
Ramipril (Altace)	Cardiac medication (ACE inhibitor)	Cardiovascular	Blurred vision, confusion, chest pain, fainting, fast or irregular heartbeat	**No**
Simvastatin (Zocor)	Hypercholesterol	Cardiovascular	Loss of consciousness, fast or irregular heartbeat, difficulty breathing, joint pain	**No**

Pilocarpine HCL (Salagen)	Cholinergic agonist	Nervous, Immune, Endocrine	Joint pain, flushing or redness of skin, nausea, fast heartbeat, trouble swallowing	**No**
Potassium chloride (K-Dur)	Hypokalemia	Cardiovascular	Severe allergic reactions (e.g., hives, difficulty breathing), vomiting, diarrhea	**No**
Dextromethorphan/ quinidine (Nuedexta)	Neurological and cardiac conditions	Nervous, cardiovascular	Urinary tract infection, vomiting, dizziness, diarrhea, flu-like symptoms	**No**
Levetiracetam (Keppra)	Antiseizure	Nervous	Change in personality, irregular heartbeat, depression, paranoia, mood swings	**No**
Levothyroxine sodium (Synthroid)	Thyroid	Endocrine	Labored breathing, tremors, fast, slow, irregular, or racing heartbeat or pulse	**No**
Carvedilol (Coreg)	Cardiac medication (beta blocker)	Cardiovascular	Chest pain, slow heartbeat, dizziness, swelling of feet, ankles, or legs	**No**
Pravastatin sodium (Pravachol)	Hypercholesterol	Cardiovascular	Confusion, chest pain, weight gain, jaundice, diarrhea, dizziness, fever	**No**
Clopidogrel (Plavix)	Stroke (platelet inhibitor)	Cardiovascular	Chest pain, collection of blood under the skin, red or purple spots on the skin	**No**
Terazosin HCL (Hytrin)	Cardiac medication (hypertension)	Cardiovascular	Fast or irregular heartbeat, sudden fainting, dizziness, shortness of breath	**No**
Tizanidine HCL (Zanaflex)	Muscle relaxant	Musculoskeletal	Chest pain, vomiting, blurred vision, irregular heartbeat, kidney stones	**No**

Source:
http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Part-D-Prescriber.html

Clinical psychologists are behavioral professionals with competencies in psychological assessment and psychotherapy (e.g., talk therapy) treatment. They are not medical practitioners. Under legislation that has been introduced in several states, psychologists would be permitted to prescribe powerful medications after a haphazard online training program consisting of as little as 400 hours. Some of these programs claim to teach all of the basic biological foundations of prescribing medications for individuals with zero required educational background in chemistry, biology, and anatomy in as little as 90 total hours. This would serious jeopardize the health and safety of Americans with mental illness, who are likely to suffer from co-morbid medical conditions.

We urge policymakers to reject these proposals in favor of real reforms that improve access to safe, effective and integrated treatment of individuals that suffer from mental illness and other co-occurring conditions.

SUPPLEMENT

Association for Behavioral and Cognitive Therapies: 2014 Survey[1]

- Survey sent out via email to all professional and student members in April 2014 (n=4795), with 976 completing the entire survey (20.4%)
    - The highest degree for 62.3% of respondents was a Ph.D, and for 4.5% was a Psy.D. 1.2% of respondents held an M.D.
    - For 85.5% of respondents, their highest degree was within the field of clinical psychology.
- Of the respondents,
    - Only 34.5% agreed that psychologists "should expand their scope of licensed clinical practice to include the administration and clinical management of psychotropic medications."
    - 89.2% agreed that advocates of prescriptive authority for psychologists should produce objective, empirical evidence for the safety and efficacy of existing training models before seeking prescriptive authority in more states, given that the abbreviated training model had been active in New Mexico and Louisiana for over 10 years at the time of the survey.
    - 62.5% felt that collaboration with medical colleagues who already prescribe would be more helpful to their clients than prescriptive authority for psychologists.
    - **81.9% felt that online training programs run by psychology schools did <u>not</u> provide enough medical education to allow psychologists to prescribe psychotropic medications competently and independently.**
    - **57.8% felt that it was inappropriate to generalize the findings of the Department of Defense study**, which trained 10 psychologists and included extensive on-site training (i.e., 1 year of didactics, 1 year of clinical practicum including a 6-month inpatient rotation), **to the APA training model that is less intensive and has less clearly defined experience requirements (e.g., no inpatient psychiatric requirement)**. Another 27.6% were unsure about the appropriateness of this generalization.
    - 0.07% believed that "psychologists who obtain prescriptive authority are likely to relocate their practices to rural settings in order to improve access to psychotropic medications among underserved clients."
    - **68.7% would <u>not</u> feel comfortable referring their own clients for medication management services to a prescribing psychologist under the current training model (with biomedical education equaling 30 semester hours of online courses from a psychology school).**
    - 70.2% felt that prescribing psychologists should be regulated under a state or provincial board of medicine rather than a board of psychology.

[1] Deacon, B.J. (2014). Prescriptive Authority for Psychologists: A Survey of the ABCT Membership. *The Behavior Therapist, 37*(6), 163-169.

Data on Prescribing Psychologists in New Mexico and Louisiana (as of 2016)[2]

- New Mexico: bill passed in 2002
  - Total number of psychologists licensed to prescribe in New Mexico: 22**
  - 59.1% of these psychologists practice in metro areas, which contain 63.2% of the population.
  - 18.2% of these psychologists practice in non-metro areas, which include 36.8% of the population.
  - 20.8% of these psychologists are licensed in New Mexico, but do not practice in the state.

Distribution of psychologists authorized to prescribe medications in New Mexico

Rural-Continuum Codes	NM	Percent	Populace	Percent
1 = County in metro area with 1 million population or more	0	0%	0	0%
2 = County in metro area of 250,000 to 1 million	9	37.5%	729,649	40.2%
3 = County in metro area with fewer than 250,000	5	20.8%	417,775	23.0%
4 = Nonmetro county with 20,000 or more, adjacent to metro area	0	0%	137,096	7.6%
5 = Nonmetro county with 20,000 or more, not adjacent to metro area	2	8.3%	213,595	11.8%
6 = Nonmetro county with population 2,500–19,999, adjacent to metro area	0	0%	171,618	9.5%
7 = Nonmetro county with population 2,500–19,999, not adjacent to metro area	2	8.3%	133,366	7.4%
8 = Nonmetro county completely rural or less than 2,500, adjacent to metro area	0	0%	5,180	0.3%
9 = Nonmetro county completely rural or less than 2,500, not adjacent to metro area	1	4.2%	3,543	0.2%
Out-of-State*	5	20.8%		
TOTAL	24**		1,814,872	

*Out-of-State means they are licensed in NM but are no longer practicing in the state
**Two New Mexico psychologists have 2 practices in different areas (one in 2 and 3; the other in 7 and 9); thus the actual number of NM psychologists is actually 22

- Louisiana: bill passed in 2004
  - Total number of psychologists licensed to prescribe in Louisiana: 61**
  - 80.7% of these psychologists practice in metro areas, which contain 74.8% of the population.
  - 4.8% of these psychologists practice in non-metro areas, which include 25.2% of the population.
  - 14.5% of these psychologists are licensed in Louisiana, but do not practice in the state.

Distribution of psychologists authorized to prescribe medications in Louisiana

Rural-Continuum Codes	La	Percent	Populace	Percent
1 = County in metro area with 1 million population or more	6	9.7%	1,316,510	29.5%
2 = County in metro area of 250,000 to 1 million	24	38.7%	1,081,938	24.2%
3 = County in metro area with fewer than 250,000	20	32.3%	942,219	21.1%
4 = Nonmetro county with 20,000 or more, adjacent to metro area	2	3.2%	522,762	11.7%
5 = Nonmetro county with 20,000 or more, not adjacent to metro area	0	0%	0	0%
6 = Nonmetro county with population 2,500–19,999, adjacent to metro area	1	1.6%	483,625	10.8%
7 = Nonmetro county with population 2,500–19,999, not adjacent to metro area	0	0%	81,510	1.8%
8 = Nonmetro county completely rural or less than 2,500, adjacent to metro area	0	0%	10,560	0.2%
9 = Nonmetro county completely rural or less than 2,500, not adjacent to metro area	0	0%	29,852	0.7%
Out-of-State*	9**	14.5%		
TOTAL	62		4,468,976	

*Out-of-State means they are licensed in Louisiana but are no longer practicing in the state
**One medical psychologist in Louisiana is "out-of-state" but also licensed as a prescriber in NM; this psychologists' information regarding practice can be found in the NM data; thus, there are actually 61 medical psychologists licensed in Louisiana

[2] Tompkins, T.L. & Johnson, J.D. (2016). What Oregon Psychologists Think and Know about Prescriptive Authority: Divided Views and Data-Driven Change. *Journal of Applied Biobehavioral Research, 21*(3), 126-161.

FAQs on Psychiatric Training

The practice of medicine involves extensive training with a rigorous course of study involving the biomedical sciences and thousands of hours of clinical experience. Prescribing medications is only one component of this training, but requires the psychiatric provider to be well-versed in all aspects of medicine: from information gathering and physical examination to utilization of laboratory studies and other testing to development of an assessment and plan including both medical and psychological/psychiatric diagnoses and the methods by which one plans to address these diagnoses.

In order to ensure that physicians are ready to practice medicine independently, competently, and cost-effectively, there are multiple "checkpoints" (often examinations or evaluations) along the way to assess their readiness to move onto the next phase of training, including (but not limited to) the United States Medical Licensing Examinations (USMLEs).

- Before medical school:
    - Medical College Admissions Test (MCAT) – one-day exam that is approximately 7.5 hours in length
        - Assesses knowledge of basic scientific concepts and principles, problem solving, and critical thinking
        - Used by medical schools in the application and selection process to determine who can even start medical school
    - The admissions process looks at everything from academic performance to MCAT score to community service, healthcare, and research experience.
        - In 2017, only 41% of applicants were accepted into medical school.[3]
- During medical school:
    - Years 1 & 2
        - Examinations during and after each basic medical science course
        - USMLE Step 1 – one-day exam that is approximately 8 hours in length
            - Assesses knowledge of basic medical sciences from the first two years of medical school, application to the practice of medicine, and clinical skills
            - Successful attempt required to move onto third and fourth year of medical school
    - Years 3 & 4
        - National Board of Medical Examiners (NBME) "shelf" exams – standardized examinations typically ranging in length from 3-4 hours
            - Assess knowledge specific to the clinical clerkship completed, and either NBME exam or equivalent must typically be passed to progress through the third and fourth years of medical school
        - Additional examinations and evaluations through medical school
            - Students may also be required to complete oral examinations or objective structured clinical examinations (OSCEs) following each clerkship rotation.
            - They must also receive satisfactory evaluations from their clinical rotation supervisors.

[3] AAMC Applicant and Matriculant Data Tables (2017). https://aamc-black.global.ssl.fastly.net/production/media/filer_public/5c/26/5c262575-52f9-4608-96d6-a78cdaa4b203/2017_applicant_and_matriculant_data_tables.pdf

        - USMLE Step 2 Clinical Knowledge (CK) – one-day exam that is approximately 9 hours in length
            - Assesses medical knowledge, skills, and understanding of clinical science necessary for the provision of patient care under supervision and emphasizes health promotion and disease prevention
            - Completed during the fourth year of medical school
            - Successful completion required before acceptance into a residency program
        - USMLE Step 2 Clinical Skills (CS) – one-day exam that is approximately 8 hours in length
            - Uses standardized patients to test students on their ability to obtain a history, perform a physical examination (including using medical instruments), develop an assessment and treatment plan, and communicate findings to patients and colleagues
            - Completed during the fourth year of medical school
            - Successful completion required before acceptance into a residency program
- Residency training
    - USMLE Step 3 – exam spans two days, with testing lasting approximately 7 hours on the first day and 9 hours on the second day
        - Assesses knowledge of basic medical and scientific principles required for effective health care, knowledge of diagnosis and management, critical analysis of scientific abstracts and pharmaceutical advertisements, and clinical decision-making in the context of an evolving manifestation of disease over time
        - Usually completed after the first year of residency
        - Must pass in order to be licensed as an independently practicing physician and typically must pass by the end of the second year of residency training
    - ACGME Milestones – developed by the Accreditation Council for Graduate Medical Education and used as an evaluation and feedback tool to monitor a resident's progression through the stages of training
        - Define the essential competencies within each specialty in the six domains of patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice
        - In psychiatry, these milestones include assessment of the resident's knowledgebase and clinical skills in multiple areas, including psychopharmacology, somatic therapies, and the different modalities of psychotherapy.
    - Psychiatric residents are required to complete three CSVs. These are Clinical Skills Evaluations in which a resident is observed during a patient interview and then must present the patient, examination, and formulation including assessment and treatment plan to trained examiners. The resident's performance is scored based on the standardized criteria developed by the American Board of Psychiatry and Neurology (ABPN).
- Fellowship training and/or post-residency practice
    - ABPN General Psychiatry Board Exam - completed after graduation from residency, required to be board-certified in psychiatry.

- Additional subspecialty examinations are available in order to become board-certified in these specialties, although some require a fellowship to be completed before one becomes eligible.
    - For example, a psychiatrist must complete a 2-year child and adolescent psychiatry fellowship in order to take the ABPN Child and Adolescent Psychiatry Board exam, and must pass this exam in order to be board-certified in child and adolescent psychiatry.
- For successful completion of a fellowship, fellows are required to successfully complete another three CSVs and are monitored closely to ensure appropriate progression through their specialty-specific ACGME Milestones.

Evolution of prescribing psychologists' recommended training curriculum

- The **Department of Defense Psychopharmacology Demonstration Project (PDP)** began in the summer of 1991 and graduated its final class in the summer of 1997. After the first year, the curriculum of this program was modified, as described below.
    - Training Group 1
        - Clinical psychologists in this group completed two years of full-time classroom training in medical school science courses, approximating 1400 hours of course time.
            - Of note, a 1995 evaluation report by the American College of Neuropsychopharmacology (ACNP) indicated that some program participants were struggling in some of the courses.[4]
                - The report noted that grades were "normalized" in at least one class for PDP trainees. The grade of the PDP trainee who performed the best was normalized to 100, and the other PDP trainees were given grades as a percentage of this trainee's grade.
                - In an anatomy/cellular biology course, 6 out of 8 nurse anesthetists in the class performed better on the written final than the PDP trainees, and 7 out of 8 nurse anesthetists performed better on the practical final than the PDP trainees.
        - Following didactic coursework, the trainees then spent three months serving on the psychiatric on-call service, completing one month on the consultation-liaison service, and reviewing outpatient mental health charts (as there was no outpatient component to their training). They also finished this third and last year of training with nine months on a psychiatric inpatient service.
    - Training Groups 2, 3, and 4
        - The two-year-long didactic coursework was compacted into one year, approximating 700 hours of course time.
            - The 1995 evaluation report by the ACNP indicated that PDP trainees performed better in these courses that had been "tailored to their needs" and in the graduate nursing courses than they received in the unmodified medical school courses taken by Training Group 1.[5]
        - Clinical experience after the year of didactic training included six months of inpatient service and six months of outpatient service. Some trainees also spent time in emergency departments.
    - PDP graduates primarily served healthy individuals between the ages of 18 and 65, who presented with adjustment disorders, anxiety, and/or depression. Medications prescribed by the graduates were primarily newer (at the time) antidepressants and anti-anxiety medications, such as the SSRIs.
    - While PDP graduates were generally well-regarded in this specific environment, concerns were raised by supervisors regarding their medical knowledge being on par with that of a third- or fourth-year medical student.
        - "The most common concern cited by most of the psychiatric supervisors in one form or another was that the fellows knew too little medicine to

[4,5] Merrick, L (2007). Prescriptive Authority for Psychologists: Issues and Considerations. Hawaii Legislative Bureau. Retrieved from http://lrbhawaii.org/reports/legrpts/lrb/rpts07/rxauth.pdf.

prescribe psychotropic drugs safely. They worried about the lack of medical sophistication."[6]

- "Psychologists seeking prescriptive authority represent this single study involving ten participants as a representative sample of the more than 70,000 psychologists. They believe this despite a 23% attrition rate, with 20% of the graduates receiving twice the amount of didactic training, and an additional graduate repeating the clinical internship."[7]
- PDP graduates were noted to be skeptical of any training programs that decreased training requirements below that of the latter three training groups as noted above.
- The ACNP's final report in 1998 on the DoD PDP program recommended a minimum of one year of full-time didactic coursework and one year of full-time clinical work, including six months on an inpatient service.
- In June 2003, members of the ACNP evaluation panel were asked to comment on their opinions about the differences between the PDP and the APA training model. Five responded – under guarantee of anonymity.[8]
    - On a scale of 1 to 7, with 1 being "seriously deficient" and 7 being "completely satisfactory:
        - An average rating of 3.8 was the response to the item: "The PD curriculum was designed to train military psychologists. How adequate do you think it would be as a training model for psychologists in civilian practice?"
        - An average rating of 1.0 was the response to the item: "How adequate do you think the APA model curriculum is as a training model for psychologists in civilian practice?"
    - They were also asked open-ended questions about their overall opinion of the differences between the PDP and APA curricula, the changes they thought would be needed to make the PDP program completely satisfactory for training civilian psychologists, and the changes they thought would be needed to make the APA model completely satisfactory.
        - Despite their 1998 report giving generally high marks to the PDP program for training military psychologists, the ACNP evaluators were lukewarm about its adequacy for training civilians.
        - Regarding the APA model? "In a nutshell, they condemned it – unanimously."

- The **American Psychological Association Blue Ribbon Panel** (1995) recommended 260-435 didactic hours over a six-month to nine-month period, up to an additional 135 didactic hours of laboratory training, and an 18-month practicum with a minimum of 100 patients and at least two hours/week of supervision by a qualified practitioner.
- The **American Psychological Association's Level 3** (1996) recommendations include a minimum of 300 didactic hours, a clinical practicum with a minimum of 100 patients, and two hours/week of supervision by a qualified practitioner.

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[6] American College of Neuropsychopharmacology (2000). DoD prescribing psychologists external analysis, monitoring, and evaluation of program and its final report. *American College of Neuropsychopharmacology Bulletin*, 6(3). Retrieved from http://www.acnp.org/Docs/BulletinPdfFiles/vol6no3.pdf.

[7] Pollitt, B (2003). Fool's Gold: Psychologists Using Disingenuous Reasoning to Mislead Legislatures into Granting Psychologists Prescriptive Authority. *American Journal of Law & Medicine, 29*, 489-524.

[8] Bush, J (2004). APA's training model: Is it really based on the Defense Department experiment? Retrieved from http://protectnjpatients.com/userfiles/critique-of-apa-model-by-bush.pdf.

- The **National Register of Health Service Providers in Psychology and the Association of State and Provincial Psychology Board** (2005) recommended a minimum of 350 didactic hours, as well as a clinical practicum with a minimum of 100 patients.

The **Connecticut Psychological Association** is proposing a minimum of 270 didactic hours, which is even less than the current APA recommendation. While they propose a supervised practicum of 400 hours/100 patients, and one year of supervised practice (1000 hours), there are no requirements for clinical setting, diagnoses, or complexity of patients seen. In addition, there is no requirement that the supervisor – "a Connecticut licensed prescriber" – be a psychiatrist or a psychiatric APRN.

Becoming a Child & Adolescent Psychiatrist

In order to enter medical school, students go through a challenging admissions process where their academic achievements, coursework and GPA, community service, healthcare experience, employment history, research experience, **MCAT** score, and personal statement determine whether they get an interview, let alone a spot in the student body.

Undergraduate Studies

Premedical training typically involves two years of “hard” sciences including biology, chemistry, organic chemistry, anatomy and histology, genetics, and physics. Premedical students often volunteer or work in clinical settings and obtain healthcare experience prior to medical school.

Medical School: Years 1 & 2

The first two years of medical school usually involve a clinical component but are focused primarily on the basic sciences of medicine. Each course involves multiple exams, with some exam days lasting up to 8 hours, and a passing grade is required to move on from Year 1 to Year 2. At the end of Year 2, it is required to pass **USMLE Step 1**, an 8-hour national standardized exam, in order to progress to Year 3.

Medical School: Years 3 & 4

The last two years of medical school are composed of full-time clinical rotations through a variety of medical specialties, including internal medicine, family medicine, pediatrics, neurology, psychiatry, surgery, obstetrics & gynecology, critical care/intensive care, and emergency medicine. Passing each clerkship involves satisfactory clinical evaluations by supervising physicians, a passing score on the NBME “shelf exam” for the specialty (or similar standardized examination), and often objective structured clinical examinations (OSCEs) or oral examinations. It is also required to successfully complete both **USMLE Step 2 CK** and CS before graduating and beginning residency.

Psychiatry Residency

General psychiatry residency is a total of 4 years, though those wishing to specialize in child and adolescent psychiatry may complete all required training in 3 years before entering a fellowship program. After the first year of residency training, which includes 4 months of inpatient and outpatient internal medicine and/or pediatrics and 2 months of neurology, residents take the final portion of the national licensing examination, **USMLE Step 3**. This must be passed in order to graduate from residency. Residents are also required to pass three Clinical Skills Evaluations (CSVs) during their residency. In addition, the ACGME requires residents to be reviewed by curriculum committees on an ongoing basis, in order to ensure that residents are progressing through the nationally delineated “ACGME Milestones” appropriately.

Child & Adolescent Psychiatry Fellowship

During the two-year child and adolescent psychiatry fellowship, fellows receive intensive training in the nuances of providing psychiatric services to children and adolescents. Clinical experiences are comprised of a range of settings including inpatient units, emergency departments, outpatient clinics, consultation-liaison services, partial hospitalization programs, amongst others. In addition, fellows receive training in neurology, genetics, and substance abuse treatment. As in residency, fellows must pass three CSVs and are monitored closely for their progress along the ACGME Milestones. Fellows typically take the **ABPN General Psychiatry board certification exam** during fellowship and the **ABPN Child and Adolescent Psychiatry board certification exam** after fellowship.