HEALTH & MEDICINE

Prescriptive Authority for Psychologists Is a Public Health Imperative

Policymakers must dismantle regulatory barriers that restrict access to needed care.

BY JACQUELINE MARIE GALLIOS

Many people assume the distinction between psychiatrists and psychologists is straightforward: Psychiatrists are doctors who can prescribe medication, while psychologists are doctors who specialize in assessment and psychotherapy and do not prescribe. That characterization, however, is no longer entirely accurate—and the nuance matters. Psychiatrists have traditionally served as the primary clinical pathway to psychiatric medication, a role that has shifted significantly as primary care providers—both physicians and mid-level clinicians—came to prescribe 60–80 percent of all medications to treat mental health conditions (Gruber 2010; Hughes, Annis, et al. 2024). Against this backdrop of workforce strain and shifting prescribing patterns, Prescriptive Authority for Psychologists (RxP) policies sit squarely at the center of the evolving mental health care landscape.

This shift comes as the nation faces a severe and escalating shortage of psychiatric prescribers (Aggarwal et al. 2022; Amezuca-Patino 2025; DeMello and Deshpande 2011; Kaiser Family Foundation 2024; Robertson 2025; Rotenstein et al. 2025; Wedell 2019). Over the past decade, the number of psychiatrists abandoning practice surged by 40 percent, making psychiatry the leading specialty in professional exodus. Today, 75 percent of US counties lack any psychiatrist, and wait times

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for psychiatric care have tripled while demand has doubled in the wake of the COVID-19 pandemic. In rural areas, 62 percent of psychiatrists are over age 60, and the supply of new psychiatrists is limited as psychiatry residency slots have remained relatively stagnant for over 20 years. America is now, by conservative estimates, less than 24 months from a mental health workforce collapse that could eclipse the access crisis experienced during the pandemic.

As alarming as that sounds, there is good news. The pool of clinicians qualified to diagnose and treat mental health conditions, both psychotherapeutically *and* psychopharmacologically, could be expanded safely and quickly. In some US jurisdictions—including Colorado, Guam, Idaho, Illinois, Iowa, Louisiana, New Mexico, Utah, and certain federal systems like the US Department of Defense and the Indian Health Service—specially trained psychologists with prescribing privileges are authorized to provide these services. Expanding prescriptive authority to all jurisdictions would meaningfully address the nationwide shortage of mental health prescribers and accelerate access to timely, evidence-based care.

Unfortunately, with good news comes bad. Despite the straightforward nature and strong evidentiary foundation of this solution, several professional medical organizations continue to complicate the process. These organizations have consistently resisted efforts to expand psychologists' scope of practice, even in the face of mounting evidence that such reforms significantly improve access without compromising safety (Hughes and McGrath 2025; Sammons 2010; Warner and Phillips 2025). Rather than engaging with the robust empirical record demonstrating the safety, oversight, and effectiveness of prescribing psychologists, traditional guild structures within organized medicine perpetuate a narrative of doubt that prioritizes professional protectionism over patient access and obscures viable solutions to the nation's mental health crisis in service of preserving entrenched hierarchies.

ROMAN LACHEEV / ALAMY

For decades, medical guild organizations have reflexively resisted any initiative deemed "scope creep" into their members' professions, no matter how well designed, evidence-based, or ethically implemented (American Medical Association 2025; Gallios 2025; Singer 2024). These efforts are not harmless rhetorical postures. Misinformation—especially when cloaked in professional authority—has demonstrable causal impacts on public beliefs, policy resistance, and access to needed care. Recent research confirms that the prevalence of misinformation and its influence on behavior are both measurable and consequential (Ecker et al. 2025). Policymakers must therefore treat misinformation not as background noise but as a public health threat deserving serious attention. This article aims to clarify the facts, correct the record, and counter the misinformation and scope resistance—because *RxP is not only safe and evidence-based, but also a vital solution to America's escalating mental health crisis*.

THE EDUCATION AND CLINICAL EXPERIENCE REQUIRED FOR RXP

As typified by a recent American Medical Association (AMA) op-ed (Garvey 2025), RxP resistance narratives often portray prescribing psychologists as newly minted PhDs or PsyDs seeking immediate prescribing privileges. That is categorically false. Psychologists seeking prescriptive authority must undertake additional graduate education, additional supervised clinical training, and additional licensure requirements (Gallios 2025).

Every prescribing psychologist in the United States must first be independently licensed as a practicing psychologist, a process that entails more than a decade of postsecondary education and thousands of hours of supervised clinical work. To obtain prescriptive authority, psychologists must also complete a Master of Science in Clinical Psychopharmacology (MSCP) degree, pass a national licensing exam in psychopharmacology called the Psychopharmacology Exam for Psychologists (PEP), and go beyond "book-learning" to complete additional extensive, competency-based supervised clinical hours focused on direct clinical application and integration

of medical and pharmacological principles.

By ignoring this rigorous additional training, RxP resistance narratives create the false impression that psychologists are seeking to practice medicine without medical education. In reality, prescribing psychologists complete specialized coursework in anatomy, physiology, pathophysiology, pharmacokinetics, and differential diagnosis, applied under the supervision of medical providers within an interdisciplinary model of care. All psychologists already receive 15 times more training than physicians and eight times more than psychiatric nurse practitioners (PNPs) in diagnosing mental health conditions, psychometric testing, and behavioral health assessment (Muse and McGrath 2010). In non-pharmacological treatments, all psychologists receive 27 times more graduate-level training than physicians and eight times more than PNPs. In foundational psychological science and mental health, prescribing psychologists complete 23 times more postdoctoral training than physicians and nearly three times more than PNPs. In research methodology and interpretation, prescribing psychologists receive over twice the training of PNPs and seven times that of physicians. This depth of preparation is not incidental—it is the core of psychology's professional identity. Psychologists already possess an unmatched depth of expertise in mental health assessment and intervention, and when this foundation is paired with advanced training in clinical psychopharmacology, their capacity to deliver comprehensive care becomes exceptional (Gallios 2025).

Equipped with rigorous training in *both* psychological science and clinical psychopharmacology, prescribing psychologists embody a uniquely comprehensive model of mental health care. Their depth of expertise in diagnosis, behavioral intervention, psychometric assessment, and evidence-based treatment—combined with applied medical knowledge—uniquely positions them to deliver safe, effective, and high-quality integrated care (Hughes 2024). Overall, psychologists preparing for prescriptive authority typically undergo an additional 2.5 to four years of graduate-level education, focused specifically on integrating pharmacotherapy into the treatment of mental, emotional, and behavioral conditions (Muse and McGrath 2010). This targeted focus ensures that expertise in prescribing within a defined scope (i.e., to treat psychiatric illnesses) is systematically integrated with supervised clinical application before independent prescribing authority is granted.

The quality and safety of mental health care delivered by prescribing psychologists is not merely adequate, it is *exemplary*. Research has found that prescribing psychologists outperformed primary care providers and nurse practitioners in psychopharmacotherapy and were as safe as (or safer than) psychiatrists (Cooper 2020; Dunivin and Orabona 1999; Hughes, Niznik, et al. 2025a; Muse and McGrath 2010; Newman et al. 2000). Patients of prescribing psychologists had a 24 percent lower rate of adverse drug events as well as a 20 percent lower rate of polypharmacy compared to those treated by psychiatrists (Hughes, Niznik, et al. 2025a). These outcomes reflect not only strong pharmacological competence but also a conservative, clinically grounded *de-prescribing* philosophy, as prescribing psychologists rely on a broad repertoire of behavioral and psychotherapeutic interventions and use medication only when clearly indicated (Hughes, Niznik, et al. 2025c). Comparison of prescribers' basic competence through examination has demonstrated no significant difference among psychiatrists, psychiatric nurse practitioners, and prescribing psychologists (Cooper 2020), supporting the conclusion that prescribing psychologists are successfully trained to treat patients with psychological complexities comparable to those seen by psychiatrists (Hughes, Niznik, et al. 2025a). Collectively, these findings demonstrate that prescribing psychologists provide care that is both effective and safety-focused, reinforcing the rigor and effectiveness of their training and directly rebutting claims that RxP expansion would compromise patient safety.

THE MSCP AND THE "400 CONTACT HOURS" MYTH

RxP resistance narratives consistently misrepresent the scope of *all* psychologists' foundational training. These characterizations rely on selective comparisons that omit critical contextual details about how training hours are defined, counted, and supervised across professions. For instance, Garvey (2025) writes that non-prescribing psychologists "do a one-year internship," as though that is the sum of their clinical experience. This minimization overlooks *thousands* of hours of supervised externships completed prior to internship and additional supervised postdoctoral hours. Unlike medical residents, psychologists are typically allowed to count only direct patient contact hours, not total shift time, which artificially deflates the comparison relative to Garvey's cited "12,000–16,000 hours" of clinical experience during a psychiatry residency. While dependent on individual training sites and state licensing laws, prescribing psychologists may accrue up to 16,800 supervised clinical hours before RxP licensure when accounting for dissertation, supervised practicum, internship, postdoctoral training, and prescribing fellowship (Gallios forthcoming). In addition, because psychologists must maintain unrestricted/independent licensure for a minimum of two years before being eligible for the PEP licensing exam, they typically accumulate roughly 2,000 to 4,000 *additional* hours of direct clinical practice—further expanding the depth and breadth of their real-world clinical experience. When viewed holistically, the training trajectory of prescribing psychologists reflects a cumulative and longitudinal model of competency development, not an abbreviated pathway.

Recent institutional objections to RxP also misrepresent the American Psychological Association (APA) model psychopharmacology educational program (2019), claiming it includes "only" 400 contact hours, and then suggesting this is grossly

inadequate for prescribing practice. The 400-hour figure pertains to the *minimum* supervised practicum hours *targeted for psychopharmacological treatment*; additional hours in psychiatric diagnosis would be redundant because this occurs during the initial doctoral training. Psychologists enter psychopharmacology training with advanced proficiency in mental health diagnosis, developed through doctoral education and clinical practice (Potash et al. 2025). The MSCP curriculum—built on rigorous 30+ credit hours of graduate-level coursework, extensive independent study, and applied learning outside the formal classroom—then builds upon this foundation by introducing differential diagnosis in medical contexts, ensuring comprehensive integration of psychological and biomedical perspectives.

Supervised clinical hours in physical assessment (i.e., history and physical exam), which are completed before trainees begin their targeted supervised prescribing hours and apply the medical knowledge acquired during MSCP training, typically get omitted in RxP resistance narratives. Importantly, every prescribing psychologist must also pass the national PEP licensing exam and meet continuing education and supervision requirements set by their state licensing boards—requirements that themselves entail additional time and training. Licensing boards may also impose additional requirements to ensure public safety and professional competence. Taken together, these safeguards create multiple checkpoints for competency verification prior to and following qualified psychologists' independent prescribing authority.

TRAINING IN BEHAVIORAL AND MEDICAL INTEGRATION

Narratives resisting RxP assert that psychiatrists receive training in "different types of patient care," implying that psychologists—including prescribing psychologists—do not. This assertion is misleading. Clinical psychologists are trained from the beginning of their doctoral studies to integrate behavioral, biological, and social models of illness (Gallios 2025). Psychologists are not merely experts in diagnosis and psychotherapy; they are experts in psychological assessment, treatment integration, and the human psyche. Ironically, many psychiatrists today receive minimal formal training in these areas (other than diagnosis), whereas psychologists' doctoral education is steeped in them (Potash et al. 2025). Thus, to suggest psychiatrists are trained in "behavioral care" while psychologists are not is grossly inaccurate. This mischaracterization is especially troubling given that 60–80 percent of psychotropic medications are prescribed by primary care providers (Gruber 2010; Hughes, Annis, et al. 2024)—meaning most patients receiving psychopharmacotherapy are never evaluated by a mental health specialist.

Psychopharmacologically trained psychologists receive intensive instruction on the medical dimensions of mental health. They study drug–drug interactions, adverse effect profiles, metabolic and endocrine implications, and lab monitoring protocols. Their coursework and clinical supervision explicitly cover physical examinations and medical differential diagnosis, ensuring that prescribing psychologists recognize when a patient's symptoms may have a medical etiology and when medical referral is warranted. The claim that prescribing psychologists would overlook conditions such as pulmonary emboli or arrhythmias is unfounded and unsupported by research or data from jurisdictions where RxP is established.

EVIDENCE, NOT ANECDOTE

Anti-RxP statements and efforts are strikingly devoid of empirical evidence. They offer anecdotes and conjecture but fail to reference peer-reviewed studies to support their claims or concerns about prescribing psychologists' safety, outcomes, and quality of care (Hughes and McGrath 2025; Sammons 2010; Warner and Phillips 2025). Policy debates of this magnitude demand data, not hypotheticals.

These omissions are glaring because over 30 years of research—including studies from the US Department of Defense and various jurisdictions that have enacted RxP—show that prescribing psychologists perform safely, effectively, and within scope (Hughes, Niznik, et al. 2025a; Kaylor and Gallios 2025; Peck et al. 2021; Wiggins and Cummings 1998). Available data show that prescribing psychologists pose no greater risk to patient safety than psychiatrists, underscoring comparable standards of care. In fact, evidence demonstrates comparable or *superior* safety relative to other non-physician prescribers based on research and malpractice data (Curtis et al. 2023; Younger 2012). Additionally, there are minimal liability insurance differences between prescribing and non-prescribing psychologists, further reflecting over three decades of safe and effective prescribing—not emerging risk (Curtis et al. 2023; DeAngelis 2023).

Multiple studies have found that prescribing psychologists' advanced training in prescribing medications to treat mental health conditions is on par with that of psychiatrists and *exceeds* that of primary care providers and non-psychiatric nurse practitioners, indicating that patients receive appropriate medications with minimized risk (Cooper 2020; Muse and McGrath 2010). When evaluated on clinical competency, effectiveness, and safety, prescribing psychologists are positively regarded by their medical colleagues and supervisors across multiple domains, even when managing complex comorbidities in primary care and rural mental health settings (American College of Neuropsychopharmacology 1998; Klusman 1998; Linda and McGrath 2017; Shearer et al. 2012). Despite institutional objections repeatedly asserting that RxP criticisms are grounded in safety concerns, they fail to cite *any* data indicating increased risk, while also neglecting to acknowledge the extensive oversight built into every RxP jurisdiction. This absence is not incidental; it reflects

the fact that *no* empirical evidence has demonstrated increased risk associated with RxP. Instead, RxP resistance narratives rely on worst-case hypotheticals rather than documented outcomes: scenarios of missed medical emergencies, poorly managed side effects, and medically complex cases that bear no resemblance to documented reality.

Among the most consequential outcomes of RxP implementation is its demonstrable role in suicide prevention. Far from endangering lives, prescribing psychologists are *saving* them. Data from RxP states show that improved access to timely, integrated care—including medication management by prescribing psychologists—has contributed to a measurable reduction in suicide rates, estimated at 5–7 percent (Choudhury and Plemmons 2021, 2023; Ekong 2022; Hughes, McGrath, et al. 2023; Hughes, Phillips, et al. 2023; Plemmons 2021; Singer 2023). This outcome reflects not only the safety of the model, but its life-saving potential in communities where psychiatric services are scarce or delayed. RxP is not just a policy innovation; it is a public health intervention that directly and meaningfully addresses the current mental health care access crisis. Applied to the 876,965 suicide deaths recorded between 1999 and 2023 in the 43 non-RxP states, even a conservative 5–7% reduction translates to approximately 43,000 to 61,000 lives that might have been saved—along with millions of family members and communities spared profound and lasting disruption (Centers for Disease Control and Prevention n.d.–a, n.d.–b). These are not marginal gains; they represent tens of thousands of preventable deaths and a measurable reduction in national suffering.

MISLEADING CLAIMS ABOUT ACCESS

Given the psychiatric provider shortage in America, mental health care access remains the central issue that RxP aims to address. This context helps explain why RxP resistance narratives consistently minimize access concerns and assert that the nation already has an adequate supply of psychiatrists. The availability of mental health care services varies widely across the nation, ranging from states that meet the needs of up to only 59.6 percent of their population to those where the figure falls to just 7.9 percent. Alarmingly, the District of Columbia and all US territories report meeting *0 percent* of their population's mental health needs, underscoring the urgency of expanding qualified prescribers in underserved regions. By contrast, US jurisdictions with existing RxP legislation have demonstrated marked improvements in mental health service availability in rural and minority communities, where psychiatrist shortages are most acute (Hughes 2024; Hughes, Graaf, et al. 2024a, 2024b; Hughes, McGrath, et al. 2024; Hughes, Niznik, et al. 2025b; Hughes, Velasquez, et al. 2025; Linda and McGrath 2017; Shoulders and Plemmons 2022, 2025).

While research demonstrates RxP is a viable way to increase access to psychiatric providers, RxP resistance narratives also falsely claim that granting prescriptive authority "has not improved access," citing the AMA's own "Health Workforce Mapper" to argue that psychologists practice in the same areas as psychiatrists. This conclusion misapplies the data. Psychologists, by sheer numbers, are far more evenly distributed across the country than psychiatrists (US Bureau of Labor Statistics 2019a, 2019b). Both psychologists and prescribing psychologists routinely practice in community mental health centers, integrated primary care settings, and rural regions where psychiatric coverage is limited or nonexistent (Committee on Ways and Means Majority 2020; Curtis et al. 2023; De La Cancela 2000; Holstein and Paul 2017; Hughes, Phillips, and Fagan 2023; Loscalzo 2025; Norfleet 2002; Zakreski 2025). Using the AMA's mapping this way obscures these differences and fails to account for the growing integration of prescribing psychologists into federally qualified health centers. Geographic overlap does not equate to workforce redundancy given to the dire shortages.

To dismiss RxP's broad reach, Garvey (2025) repeated an inaccurate claim that "only 226 psychologists were prescribing medicine." In addition to this number being an underestimation, lower numbers do not signal a weakness in the model; they are a direct consequence of sustained, organized resistance to RxP, including decades of medical organizations lobbying against RxP legislation. The fact that MSCP programs persist and thrive, while prescribing psychologists demonstrate safety despite sustained political resistance, is a testament to the interest, viability, and necessity of RxP (Hughes and McGrath 2025; Warner and Phillips 2025). In fact, Hughes, Warner, et al. (2024) noted that allowing psychologists with training in clinical psychopharmacology to prescribe medications reduces provider shortages by as much as 26 percent, highlighting the substantial effect RxP can have on expanding patient access to care. Their work also suggests that approximately 10–14 percent of psychologists in each state would pursue training in clinical psychopharmacology and obtain prescriptive authority if RxP legislation passes, thereby significantly expanding access to mental health care services. Importantly, the current number of prescribing psychologists compared to other prescribers reflects not a limitation of the model, but the fact that providers are restricted to only eight jurisdictions where RxP is established. Rather than signaling weakness, these data point to a clear opportunity—long resisted yet capable of transforming access, equity, and interdisciplinary mental health care.

OVERLOOKING COORDINATION OF CARE AND ETHICAL PRACTICE

One of the most persistent—and least substantiated—RxP resistance narratives is that prescribing psychologists would overlook medical complexities or fail to refer when appropriate. That assertion ignores not only the rigorous training prescribing psychologists receive, but also the culture of psychology itself; the profession is deeply rooted in ethical reflection and interdisciplinary care (APA 2025; LeVine and

Foster 2010; McGrath and Rom-Rymer 2010). All psychologists consult and refer routinely, guided by strict ethical codes and state laws governing scope of practice. In every RxP jurisdiction, prescribing psychologists also coordinate patient care with other healthcare providers to ensure that patients receive comprehensive and effective care.

It has been implied that psychiatrists uniquely follow patients longitudinally, insinuating that prescribing psychologists would only conduct initial intake evaluations. This is demonstrably false. Prescribing psychologists' practices are grounded in ongoing therapeutic relationships, with follow-up and monitoring that often *exceed* what psychiatrists typically provide (Linda and McGrath 2017). Prescribing psychologists regularly assess medication's therapeutic and side effects, along with treatment progress in conjunction with psychotherapy and other interventions. Patient monitoring is standard practice, and notably at higher frequency than in psychiatry.

The AMA's own position on "team-based care" should logically embrace, rather than resist, the RxP model. Instead, RxP resistance narratives suggest that psychiatrists alone possess "specialized training" for complex populations—which distorts reality. *All* psychologists complete postdoctoral training and advanced supervised practice. Postdoctoral fellowships in different areas of psychological practice (e.g., neuropsychology, health psychology, and pediatric psychology) parallel psychiatry's subspecialty residency in focus and rigor. Prescribing psychologists, in particular, complete the highest level of postdoctoral training required in any psychology specialty via an additional graduate degree (the MSCP), as well as an additional licensing exam (the PEP) and supervised clinical hours. This rigorous, APA-recognized specialty reflects a unique synthesis of psychological and medical expertise, tailored specifically for safe, evidence-based psychopharmacological prescribing in medically complex populations. Importantly, this training does not position prescribing psychologists as replacements for psychiatrists, but as collaborative partners within interdisciplinary systems of care where all clinicians contribute complementary expertise toward shared clinical goals. Effective team-based care is not hierarchical; it is integrative, grounded in mutual respect, and centered on patient outcomes. RxP operates squarely within that model, as we are partners in care.

REAL SOLUTIONS REQUIRE MUTUALITY, NOT GATEKEEPING

The AMA acknowledges the very real shortage of psychiatric providers. Physicians like Garvey (2025), resisting RxP, conclude by calling for "real fixes" to the mental health crisis: telehealth reimbursement, parity enforcement, and coordination of care. These recommendations are both pragmatic and consistent with longstanding calls for systemic reform, yet they fall short of addressing the full scope of the crisis, particularly the need to expand the prescribing workforce and integrate prescribing psychologists more fully into patients' health care teams.

True interdisciplinary care cannot exist when one profession categorically dismisses another's training. Access to safe, effective treatment requires *all* qualified providers to practice to the *full* extent of their training and competence. Prescribing psychologists, who have advanced psychopharmacological training, are part of that solution. Prescribing psychologists are not "trying to be psychiatrists," nor compete with them; research shows that prescribing psychologists train to be *highly specialized psychologists* who can meet the full scope of patients' needs while easing access barriers (Shoulders and Plemmons 2025). They ensure continuity of care that bridges psychological and pharmacological domains rather than segregating them into separate systems of care. In fact, research consistently shows that RxP legislation expands access to care while complementing—rather than replacing—psychiatric practice (Hughes, McGrath, et al. 2024; Shoulders and Plemmons 2025). This pattern underscores that prescribing psychologists enhance the system and work alongside psychiatrists rather than displacing them.

The data are clear: Prescribing psychologists improve access, enhance continuity of care, and maintain exemplary safety records. What is unsafe is perpetuating a fragmented system in which patients wait months—or longer—for psychiatric evaluation and ongoing care, particularly in rural and underserved areas (Hughes, Graaf, et al. 2024a; Linda and McGrath 2017). Resistance to RxP does not solve that problem; it prolongs it. Psychiatrists are welcome to pursue—and many have pursued—advanced psychotherapy training through institutes led by psychologists, an opportunity that organized psychology has consistently supported in the interest of expanding patient access to mental health care services. Yet when psychologists seek comparable integration via prescriptive authority, resistance emerges from the very group long embraced as partners in care. Mutuality cannot be selective. Expanding legislative pathways for qualified psychologists to provide psychopharmacological treatment will enhance access to care in rural and underserved communities, especially since teaching hospitals—where such training often occurs—are mission-driven to serve these populations (Elma et al. 2022).

RXP AS A PUBLIC HEALTH IMPERATIVE

For more than 30 years, prescribing psychologists have exemplified safe, evidence-based, and patient-centered psychopharmacological care, especially in underserved and rural communities. Their training is rooted in interdisciplinary care, biomedical science, and ethical practice. To overlook, minimize, or restrict their contribution is not only a disservice to the profession and those who completed the extensive training required to integrate psychological and medical expertise, but a profound missed opportunity for a country in urgent need of accessible,

high-quality mental health services. At a time when psychiatric workforce shortages, rising suicide rates, and prolonged waitlists define the status quo, maintaining artificial barriers to qualified prescribers is not caution—it perpetuates preventable harm. In the face of preventable suffering, inaction carries its own ethical weight. This explains why many physicians outside traditional guild structures within organized medicine recognize and support prescriptive authority for psychopharmacologically trained psychologists as a safe, evidence-based solution to expand mental health care access—particularly in underserved areas where collaborative models are essential (Singer 2022).

The time has come to move beyond rhetoric rooted in fear or professional protectionism. Policymakers, educators, and healthcare leaders must focus on what truly matters: expanding *access*, honoring *clinical competence*, and advancing *equity* in mental health care. The evidence is established, the safeguards are in place, and the need is *undeniable*. RxP is not an experiment; it is a proven, scalable public health solution whose broader adoption would directly strengthen the nation's mental health care infrastructure. The question is no longer whether the model works, but whether we are willing to implement it where patients need it most. *R*

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