Papeles del Psicólogo, 2007. Vol. 28(2), pp. 2-12
http://www.cop.es/papeles

PSYCHOLOGY AND PSYCHOPHARMACOLOGY: NATURAL PARTNERS IN HOLISTIC HEALTHCARE

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The "prescription movement", involving psychologists gaining prescriptive authority in the United States, is not a new phenomenon. For approximately 25 years, psychologists and outside interested parties have been calling for this movement toward prescriptive privileges. The elected representatives of professional psychology have consistently supported this expansion of practice; voting has overwhelmingly endorsed the development of training models and legislation to enable psychologists with advanced training to prescribe. Since 1994, psychologists have been actively prescribing in the military with no significant negative outcomes and with evidence that they are practicing in a more holistic manner than psychiatric colleagues. Likewise, more recent data for psychologists prescribing in New Mexico, Louisiana, or Guam demonstrate that psychologists can prescribe effectively, and safely, within a biopsychosocial model of healthcare. Of particular note is that psychologists are 8 to 10 times less likely than physicans to prescribe for the same severity and type of presenting mental health conditions. Psychologists have begun to demonstrate that a true biopsychosocial approach, involving psychotherapy, psychological testing, and psychosocial approaches to treating mental illness is viable and effective. Prescribing psychologists view psychotropic medication as only one treatment option among many, permitting increased flexibility and involvement of patient choice. Marked reductions in healthcare cost have been demonstrated and are anticipated to continue due to this holistic approach to mental healthcare. This expansion of practice shows great promise and should be embraced to nurture increased access to cost-effective care and improved quality of mental health care.

Key words: *Prescription movement, prescriptive authority, psychopharmacology postdoctoral program*

El "movimiento de la prescripción", relativo a los psicólogos que reclaman la capacidad legal de prescribir psicofármacos en los Estados Unidos, no es un fenómeno nuevo. Durante aproximadamente 25 años, los psicólogos y otras personas ajenas interesadas han estado reclamando este movimiento hacia los privilegios prescriptivos. Los representantes electos de la psicología profesional han apoyado constantemente esta ampliación de la práctica; una mayoría aplastante de los votos han respaldado el desarrollo de modelos de formación y legislación para que los psicólogos con formación avanzada puedan prescribir. Desde 1994, los psicólogos han estado prescribiendo de forma activa en el ejército sin ningún resultado negativo significativo, y con evidencias de que están ejerciendo de forma más holística que sus colegas psiquiatras. De la misma forma, datos más recientes sobre los psicólogos que prescriben en Nuevo México, Lousiana o Guam demuestran que los éstos pueden hacerlo de forma eficaz y segura, dentro de un modelo biopsicosocial de salud. Es particularmente interesante que la probabilidad de que los psicólogos prescriban es de 8 a 10 veces menor que la de los médicos, para la misma gravedad y tipo de trastorno mental. Los psicólogos han empezado a demostrar que un verdadero enfoque biopsicosocial, que implica psicoterapia, evaluación psicológica, y enfoques psicosociales, es viable y efectivo para el tratamiento de la enfermedad mental. Los psicólogos que prescriben ven la medicación psicotrópica sólo como una opción dentro de muchas, permitiendo una mayor flexibilidad e implicación del paciente en su elección. Se han demostrado importantes reducciones en el coste de la asistencia sanitaria y se prevé que continúe gracias a este enfoque holístico de salud mental. Esta ampliación de la práctica tiene grandes expectativas y debería ser aprovechada para fomentar el aumento en el acceso a tratamientos rentables y la mejora de la calidad de la asistencia en salud mental.

Palabras clave: *Movimiento de la prescripción, capacidad legal para prescribir, programa postdoctoral en Psicofarmacología*

LOOKING BACK: THE HISTORY OF PSYCHOLOGY AND PSYCHOPHARMACOLOGY

When the topic of psychology's drive toward prescriptive authority is raised in the United States, there are several common reactions. The general public is often surprised because most people assume that psychologists *already* prescribe medications, partly because they confuse psychologists and psychiatrists and partly because they view psychologists as learned health professionals, as doctors, and assume this means they wield prescriptive authority. In the field, some older psychologists tend to believe that the movement is a recent one, more like a fad, and may soon die out, although this reaction has lessened in recent years due to advances in states such as New

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Mexico and Louisiana. A minority of psychologists have a very negative reaction, similar to the reaction several decades ago of some psychologists when it was proposed that psychologists could conduct psychotherapy in addition to performing psychodiagnostics. These psychologists view medications as "the enemy" of therapy and have concerns about how prescribing medications may alter the identity and discipline of psychology. Young psychologists, in graduate schools or recent graduates, largely react with excitement and a sense of possibility of their own futures as holistic or integrated healthcare providers.

In reviewing what is called the "prescriptive movement" in the United States, it is important to realize that the history of psychopharmacology and the drive towards prescription privileges in U.S. psychology is not a new phenomenon. This history is useful for understanding how psychologists could be genuine holistic healthcare providers practicing from a true biopsychosocial model as well as for understanding that calls for this expansion of practice have come from non-psychologists interested and invested in the adequacy of mental health care in America.

The quest for prescriptive authority for U.S. psychologists began in November, 1984, at the annual convention of the Hawaii Psychological Association (HPA). At that convention, U.S. Senator Daniel Inouye urged members of the HPA to seek prescriptive authority for psychologists. The Senator's concern and push was to improve the delivery of mental health care, primarily in rural areas of his state. As a non-psychologist, Senator Inouye was responding to the inadequate existing system of care; he saw psychologists as learned professionals who could provide valuable public service by increasing the availability of comprehensive, quality mental health care. In 1985, Richard Samuels, president of Division 42 (Independent Practice) of the American Psychological Association (APA) also urged that prescriptive authority for psychologists be sought in order to improve access to healthcare. These events demonstrate that legislative and professional awareness was increasing for the potential ways that prescribing psychologists could improve healthcare. Following this trend, in fiscal year 1989, the U.S. Congress appropriated money to fund the Psychopharmacology Defense Project (PDP).

The PDP was essentially a research effort; Congress believed that there was a significant need to improve access to psychiatric services, including the use of medications, to its service personnel. The purpose of the PDP was to "test" or evaluate whether or not psychologists could be adequately trained to provide these services in a cost effective way for the U.S. military. Although there has been some debate about the cost of the training program (see Vector Research, Inc., 1996; U.S. General Accounting Office, 1997; American College of Neuropsychopharmacology, 2000), there is no disagreement in the evaluation reports about the clinical effectiveness of the PDP graduates. The original PDP training program was a shortened form of medical school training. Based upon feedback from the PDP graduates, this training program was later shortened and modified to fit a more biopsychosocial perspective (see below for more details).

Opponents of this expansion of practice within the field have attempted to argue that the majority of psychologists do not support such a movement. This conclusion is inaccurate. In 1989 the American Psychological Association (APA) endorsed research into and supported the development of training curricula to provide the most appropriate and effective methods for psychologists to be able to safely prescribe. This was to be APA's highest priority. The APA Council of Representatives voted 118 to 2 to establish a Task Force on Psychopharmacology, an overwhelming margin of support. Further, based, in part, on data emerging from the PDP, the Task Force announced, in 1992, that training was feasible and that such training would create "a new healthcare professional" with potential for dramatically improved patient care and new advances in treatments. Three levels of training were proposed with only psychologists completing the highest level of training being able to prescribe independently. Following positive preliminary outcomes from the PDP, Indiana, in 1993, permitted PDP/federally trained graduates to practice in that state. The first psychologists graduated from the PDP in 1994 (Cullen & Newman, 1997).

In response to these developments, the APA Council of Representatives, the highest decision-making body in the association, endorsed psychopharmacology for psychologists in 1995 and called for model legislation and implementation of the training curriculum. Subsequently, the APA Council adopted a model curriculum and legislative bill in 1996. Also, in 1997, the APA Council requested that the College of Professional Psychology develop a national exam to ensure consistency in the knowledge base of trained psychologists and to permit state boards to require this

minimum national certification as a requirement for prescriptive authority. Having such an exam increases the credibility of training for prescribing psychologists. This exam was produced by 2000 and has been incorporated into the legislative statutes authorizing psychologists to prescribe in both New Mexico and Louisiana (Munsey, 2006). The APA Graduate Student organization (APAGS), representing the future of the profession, formally endorsed the APA position regarding prescribing privileges for psychologists in 1998 and the organization continues to educate students about this future option for psychological practice (Williams-Nickelson, 2000).

These events set the stage for legal prescribing authority for psychologists to be granted. In the American territory of Guam, the territorial legislature overrode a Governor's veto in 1998 to provide psychologists with limited prescriptive authority. By January of 1999, psychologists in Guam had obtained the right to prescribe psychotropic medications under the supervision of a physician (*Allied Health Practices Act*, 1998). New Mexico's Governor Gary Johnson signed a bill into law in March, 2002 giving psychologists prescriptive authority; Louisiana Governor Kathleen Blanco signed psychologist prescriptive authority legislation into law in May, 2004 (Holloway, 2004).

Efforts continue around the United States to expand prescription authority in additional jurisdictions. One review noted that, as of 2002, prescription task forces had been developed in at least 31 states, 13 states had introduced legislation to permit psychologists to prescribe, and 11 nationwide training programs had been developed (Daw, 2002).

As recently as this year (2006), the Hawaii Psychological Association and its allies came close to passing a bill to authorize psychologist prescribing in that state. The original bill was approved by the Hawaii Senate Health Committee, but it was deferred through the Senate Commerce, Consumer Protection, and Housing Committee. The compromise was a legislative resolution that called for the legislature's research committee to report on the curriculum and safety issues with psychologist prescribing, to evaluate the performance of PDP graduates, and to examine the experience of Louisiana and New Mexico. A report is to be delivered to the Hawaii legislature by next year (Munsey, 2006). Most notably, the original prescribing bill had the support of the Chair of the Senate Health Committee (a non-psychologist), and the Hawaii Primary Care Association, which ran newspaper articles in support of the bill. Additionally, primary care physicians and medical directors working in community health clinics testified in favor of the bill, focusing on discussions of inadequate access to mental health care in many parts of Hawaii. Clearly, the need for services exists, and many professionals outside the field of psychology as well as within the field view this as an important step in improving healthcare delivery.

Efforts are also being made to achieve improvement in holistic healthcare using legal means. In February of 2006, a lawsuit was filed in Federal court in Los Angeles alleging that patients in California are having their constitutional rights violated by not receiving constitutionally adequate treatment due to the state's and country's inability to provide competent psychiatric care to patients who are in state mental hospitals, in county jails, and in county mental health facilities. Three plaintiffs allegedly harmed by the State of California contend that the necessary numbers of competent psychiatrists are not available and never will be due to the declining numbers of practicing psychiatrists and the continued unattractiveness of psychiatry as a specialty to American medical school graduates. The lawsuit asks the court to amend a state law that prohibits psychologists from prescribing medication. In particular, the plaintiffs are asking the State of California to grant appropriately trained psychologists prescriptive authority as a remedy to California's access to care problem. Allowing appropriately trained psychologists to prescribe medication is the least restrictive way that California can provide constitutionally adequate treatment (*Walker, Jones, and Larson v State of California et al.*, County of Los Angeles, 2006). Currently, this lawsuit is proceeding, but no court decision has been made (Howard Rubin, personal communication, September 13, 2006).

Organized medicine, and psychiatry in particular, has opposed psychologists receiving prescription privileges. For decades, organized medicine has consistently opposed the expansion of practice for allied health professionals including nurses, optometrists, podiatrists, and others; thus, nothing is happening to psychology that has not occurred to other disciplines in the past. The arguments used by medicine against psychology's expansion of practice are likewise traditional and routine: that granting these privileges will result in harm to patients and that if psychologists want to practice medicine they

should attend medical school. However, medical history suggests that, although it may take time, medicine has consistently lost these types of struggles and is anticipated to continue this pattern.

Concerns within the field have argued that by learning to prescribe, psychologists will fall prey to the same market forces that have raised serious public doubts about the use of medications, the validity of drug trials, and collusion between medical research and pharmaceutical companies. To help prepare the profession for these issues and to begin an early dialogue concerning the use of pharmacotherapy, a Task Force of Division 55 of APA produced a set of draft practice guidelines for the collaborative and independent practice of pharmacotherapy by psychologists (McGrath, Berman, LeVine, Mantell, Rom-Rymer, Sammons, Stock, and Ax, 2005). These guidelines were reviewed by the Board of Division 55 and approved in June, 2005 and have recently completed the period of open comment. After review of the comments, the guidelines will proceed to APA review where they could become national policy. Among other discussions, the guidelines recommend that collaborating or prescribing psychologists adhere to the following general principles:

- ✔ sufficient education and training to be competent
- ✔ self-awareness of emotions and attitudes toward the use of medications
- ✔ awareness and training in dealing with subgroup-specific effects of medications (e.g. medical syndromes, cultural or genetic effects, gender effects)
- ✔ awareness of potential adverse effects
- ✔ assessment and treatment are specifically accomplished through a biopsychosocial lens and that treatment is considered to be a collaborative effort with the patient and
- ✔ sensitivity to the issues of marketing and potential bias in the representation of drug effectiveness from pharmaceutical companies (McGrath et al., 2005).

MAKING THE CASE FOR AN INTEGRATED HEALTHCARE MODEL

Psychologists are broadly trained mental health professionals with advanced training in human development, social and cultural factors affecting behavior, psychotherapy, and psychological assessment. Additionally, while extensive psychopharmacological training is not a requirement of doctoral clinical psychology training programs, study of biological basis of behavior is a requirement of all programs. Typically, such training involves a foundational understanding of neuroanatomy and functioning.

Of course, psychologists' pursuit of prescription privileges requires extensive additional training. In addition, many clinical psychology graduate students elect to take several additional courses such as neuropsychology, neuroscience, and psychopharmacology. Doctoral clinical psychology students often embark on gaining extensive training and clinical experience at the pre- and post-doctoral levels in areas such as neuropsychology and health psychology.

While many psychologists are quite knowledgeable of psychopharmacology as well as physiological factors affecting psychopharmacology, without more formal educational experiences other than pre and post-doctoral education and experience, psychologists have been left in a practice dilemma. For many years, psychologists have been "consulting" with physicians concerning the use of psychotropic medication; however this raises the problem of practicing beyond one's expertise and license. Thus, in the past, prior to the development of post-doctoral psychopharmacology programs, some psychologists also became pharmacists, or nurse practitioners, in order to gain the ability to prescribe that way. Consequently, psychologists who wished to prescribe were required to develop expertise in other fields in addition to psychology. Several important events have occurred which contributed to the notion that psychologists, with additional medical and psychopharmacological training, should be able to prescribe without adding an additional profession to their education.

Psychology is the only mental health care profession where training uniquely qualifies psychologists to utilize the broad range of psychodiagnostics and psychological treatments, including psychopharmacology if psychologists choose to pursue post-doctoral curricula and training in clinical psychopharmacology. Prescriptive authority will highlight that psychologists have advanced training in diagnosis and treatment of mental disorders and that psychologists' training spans a wide range of psychological treatments, not only "psychotherapy and counseling". Psychologists' emphasis on the importance of the broad range of psychological treatments over the sole focus on pharmacotherapy will only enhance collaboration between psychologists and other psychotherapists seeking a psychopharmacology consultation. Also, the prescribing practices of psychologists in the military indicate that they are much

more conservative than psychiatrists in their prescriptive practices. One review of practice showed that psychologists prescribed 13% of the time, opting instead for other psychological treatments while psychiatrists prescribed over 80% of the time for the same patient populations (Reeves, Hildebrandt, Samelson, Woodman, Ketola, Silverman and Bunce, n.d.). McGrath, Wiggins, Sammons, Levant, Brown, and Stock (2004) indicate that medicine, and to a lesser extent, psychiatry, have failed to meet the needs of individuals with mental disorders because all but one modality of treatment has been rejected. Consequently, most patients are prescribed medication without consideration of whether it represents the optimal treatment. Surveys of physicians' practice patterns suggest that nearly 100% of patients seen for depression in primary care settings receive a prescription of medication, with very few of these patients seeking other forms of treatment, such as psychotherapy (National Depressive and Manic Depressive Association, 2000).

The American Medical Association (AMA) has revealed that almost half (46%) of the more than 40,000 U.S. psychiatrists are 55 years or older, compared to approximately 35% of all U.S. physicians. Thus, there will soon likely not be enough well trained psychiatrists to fill the exploding needs of those with mental health problems. Approximately 80% of all psychotropic medications are now being prescribed by non-psychiatric physicians with little to no training in the diagnosis and treatment of mental illness or the use of psychotropic medications. Review of the safety record of currently prescribing psychologists in the military, Louisiana and New Mexico leaves no doubt that psychologists can be trained to safely prescribe despite the same patient safety warnings from psychiatry against psychology that have been proclaimed for over 50 years every time psychologists have attempted to increase scope of practice (Reeves, et al., n.d.).

Currently, approximately thirty-one state psychological associations have established task forces or committees to study feasibility or to draft legislation towards prescription privileges for psychologists with appropriate psychopharmacology education/training. Wiggins reported on a mental health treatment crisis in Arizona due to a shortage of prescribing mental health specialists. He indicates that significant cost savings can be obtained using "full service" professionals to provide both psychotherapy and psychopharmacology. This "full service" type of care is efficient over the current "usual practice" involving one doctor prescribing the medication and another managing the patient's care with psychotherapy. Prompt access to mental health care could save up to 32% of the cost of initial hospitalizations according to Smith, Rost and Kashner (1995). A "best practice" model is proposed by having psychologists enhance the quality of mental health services and expand access to care by integrating cognitive behavioral therapy with psychopharmacology. This form of healthcare combines the two forms of treatment demonstrated to be most effective. Additionally, Wiggins reports that approximately 44% of psychiatrists in training have to be recruited from graduates of international medical schools. Psychiatric residency training in recent years has emphasized psychopharmacology rather than psychotherapy. At best, physicians currently in psychiatric training in Arizona will replace rather than add to the current supply.

Tennessee psychologists (2003) have also provided a detailed report of why appropriately trained psychologists should have prescriptive authority. They indicate that the unmet need for appropriate mental health services are tremendous and costly: There is a severe shortage of psychiatrists in Tennessee and nationally, a state-wide survey documented patients' lack of access to Tennessee psychiatrists; American physicians in training are not entering psychiatry in sufficient numbers to meet either current or future needs; primary care physicians are over-burdened and ill-equipped to deal with mental health problems, and it is unreasonable to expect them to do so effectively; as an inevitable consequence of this situation, *medications are over-prescribed*, leading to out of control pharmacy costs; care is often inadequate and fragmented, *and therefore much more costly*; combining medication and psychotherapy is the most effective, and most cost-effective, treatment for most mental disorders; however, organized medicine has *relentlessly* opposed all other professions' efforts to expand their scope of practice. Yet, the Tennessee Psychological Association-endorsed prescriptive authority training program is rigorous, comprehensive, and significantly exceeds nationally recommended guidelines. In conclusion, prescribing psychologists are SAFE. Tennessee psychologists (2003) proposed that prescribing authority for appropriately trained psychologists would offer Tennesseans: *Greater access* to mental health care; *greater opportunity for* quality mental health care; a means of addressing *rising psychotropic drug costs*; *the opportunity for integrated care* combines behavioral and

lifestyle interventions with judicious and appropriate prescription of medication, resulting in more cost-effective care; and a chance to receive *care from providers uniquely qualified* in the fields of psychology and psychopharmacology.

In a recent article, Reeves, et al. describe the benefits that prescriptive authority for psychologists can provide to residents of California. The authors contend that prescriptive authority will facilitate parity for psychologists with psychiatrists in terms of reimbursement and professional opportunities, thus increasing the likelihood that psychologists will be more attracted to settings that are in desperate need of additional highly qualified professionals. This authority will provide opportunities for psychologists to obtain important leadership positions in hospitals, research settings, and other mental health care settings that have been the exclusive domain of psychiatrists, thus bringing a broader, more holistic viewpoint (including cognitive, developmental, and social understanding of persons) to the delivery of services. Prescriptive authority would lessen the perceived competency gap that obstructs psychologists' pursuit to practice to the full scope of their training and enable them to have a more direct impact to improve mental health services. For example, currently, most hospitals do not allow psychologists to be members of the medical staff with voting privileges. Psychologists are often relegated to Allied Health Professional membership status without voting privileges or the ability to meaningfully participate on committees, even though California state law mandates that psychologists are entitled to full medical staff privileges to practice within their full scope of training (*CAPP v Rank*, 1990). Permitting psychologists to have hospital and medical staff privileges will ensure the development of hospital policies and standards of care that are holistic and consider many aspects of the patient, not just their medical status. Patients in facilities operating primarily from a medical model often do not receive sufficient psychological services to manage their disorders, but instead tend to be mostly treated with medications to suppress symptoms (Bailey, 2006).

THE DEVELOPMENT OF A TRAINING MODEL AND ENABLING LEGISLATION

One of the contentions of psychologists opposed to prescriptive authority is that the field is not ready for this change and that it does not have popular support among psychologists, that this issue is one being promoted for self-serving interests by a few radical psychologists. The evidence is to the contrary. Sammons, Gorny, Zinner and Allen (2000) surveyed Maryland Psychologists. Most of the 435 psychologists surveyed were from full-time private practice, hospitals and public service. Sixty-seven percent agreed with authority to prescribe. A review of twenty previous surveys found overall 65%+ favor prescribing privileges (Sammons et al., 2000). Ramirez (2002) completed a dissertation surveying 500 licensed psychologists from a random national sample. The rate of survey return was 44%, with responding psychologists having an average length of practice of 8 years. Results revealed that 84% agreed or strongly agreed that psychologists who are trained should be able to prescribe; 10% disagreed or strongly disagreed. Sixty percent saw gaining knowledge in psychopharmacology as an extension of current knowledge. Overall, most psychologists see the value of this expansion of practice; no one will be required to practice psychopharmacology.

In Summary, for approximately 25 years, psychologists and outside interested parties have been calling for psychologists to move toward prescriptive privileges. APA governance have been involved for approximately 17 years and the votes have been overwhelming and consistently in support of psychologists gaining prescriptive authority. Since 1994, psychologists have been actively prescribing in the military with no significant negative outcomes. Additionally, no significant negative outcomes have been noted, in public forums, to date for psychologists prescribing in New Mexico, Louisiana, or Guam.

Regarding the Department of Defense's program for training psychologists in psychopharmacology (PDP), perhaps most importantly, the American College of Neuropsychopharmacology (ACNP) believes that the program has not turned out "mini-psychiatrists" or psychiatrist-extenders, but rather, "extended psychologists with a value added that component prescriptive authority provides. They continued to function very much in the traditions of clinical psychology (psychometric tests, psychological therapies) but a body of knowledge and experience was added that extended their range of competence" (ACNP, 1998, p. 4). The ACNP panel concluded their executive summary of the PDP project with what can only be described as a unquestionable endorsement:

> The PDP graduates have performed and are performing safely and effectively as prescribing

> psychologists. Without commenting on the social, economic, and political issues of whether a program such as the PDP should be continued or expanded, it seems clear to the evaluation panel that a 2-year program—one year didactic, on year of clinical practicum that includes at least a 6 month inpatient rotation—can transform licensed clinical psychologists into prescribing psychologists who can function effectively and safely in the military setting to expand the delivery of mental health treatment to a variety of patients and clients in a cost effective way. We have been impressed with the work of the graduates, their acceptance by psychiatrists (even while they may have disagreed with the concept of prescribing psychologists), and their contribution to the military readiness of the groups they have been assigned to serve. We have been impressed with the commitment and involvement of these prescribing psychologists to their role, their patients, and the military establishment. We are not clear about what functions the individuals can play in the future, but we are convinced that their present roles meet a unique, very professional need of the Department of Defense. As such, we are in agreement that the Psychopharmacology Demonstration Project is a job well done. (ACNP, 1998, p. 6).

Currently, post-doctoral psychopharmacology training programs either lead to a master's degree or a certificate upon completion. The PDP model of training was based on the medical school model and included roughly the first 2-3 years of medical school. PDP graduates noted that the knowledge base necessary for safe and effective prescribing that was identified through the PDP is now being taught in a context less dominated by the medical model and built more on a psychological model of health (Newman, Phelps, Sammons, Dunivin, and Cullen, 2000).

Currently, two levels of practice exist for psychologists who complete a postdoctoral program of study in psychopharmacology. Level 2 enables a psychologist to be a consultant with physicians and other psychopharmacologic prescribers. These psychologists have completed a minimum of 2 years of didactic training, with many programs also requiring the psychologist to successfully complete a national competency examination, the Psychopharmacology Exam for Psychologists (PEP). Level 3 classification also requires the completion of didactic training and typically the PEP exam (varying PEP requirements exist by jurisdiction), but also requires a practicum experience with 100 patients seen while supervised by a physician, or other appropriate prescribing clinician (as indicated by jurisdiction), with a minimum of 2 hours per week clinical psychopharmacological experience. At level 3 classification, the psychologist becomes a prescribing psychologist and a full spectrum care provider. These practice classifications were established based on lessons and feedback from PDP graduates.

LOOKING FORWARD: THE CONTINUED EVOLUTION OF THE PRESCRIPTIVE PRIVILEGES AGENDA

As states individually acquire prescription privileges for psychologists, they establish their own set of training and experience criteria. The New Mexico bill required additional training, which was agreed upon by the New Mexico Medical Society and the Board of Pharmacy. New Mexico Law requires 450 clinical "in seat" hours, in addition to passing the PEP examination. Following the 450 clinical "in seat" hours and successful PEP completion, two years of supervised practicum experience with a physician or nurse practitioner is required. If performance is satisfactory, the psychologist can then prescribe independently (New Mexico Psychological Association). Most post-doctoral training programs across the country have now adopted or exceeded this requirement in anticipation of similar laws being passed in the future across the country. Louisiana statute requires ongoing collaboration/approval with a physician following the afore-discussed didactic and clinical experience. Guam also requires a *Collaborative Practice Agreement* mandating supervised practice with a physician; it is important for psychologists to realize that this is more akin to "consultation" and is *not* the same as the type of supervision that occurs in psychology training programs where the supervisor must sign off on the candidate's work and is fully responsible for all actions of the supervisee (Allied Health Practices Act, 1998).

As noted above, several post-doctoral training programs exist throughout the United States. They continue to adapt to provide high quality training in psychopharmacology and to prepare psychologists to prescribe.

An example of such programs is the Clinical Psychopharmacology Master's Degree offered via distance learning through Fairleigh Dickinson University. The program provides videotaped lectures, online

resources, chats and discussions, text readings, case presentations and five onsite regional meetings over two years, all of which facilitate learning by students around the country. Successful completion of the PEP examination is also required for receipt of the Master's Degree. The program involves ten courses including biopsychosocial review of body systems, neuroscience, neuropharmacology, clinical psychopharmacology, professional issues and practice management, and case study based treatment issues, with approximately 15 hours of study required per week. Level 2 classification is achieved after completing the Master's Degree, with an elective for a clinical practicum with a supervising preceptor (as described above) for level 3 practice.

In addition, in light of the changes that legal statutes have created in the curriculum of training programs, and in light of the experience of prescribing psychologists in the military and especially in Louisiana and New Mexico, changes are currently being debated regarding the national training curricula as defined by APA. A national Task Force on Psychopharmacology Curricula has been convened. Ultimately, the Task Force will make recommendations for changes to Level 3 curricula that will affect all training programs across the country (McGrath, personal communication, September 14, 2006).

Of course, pro and con arguments will continue to exist regarding psychologists gaining prescription privileges until such practice is common across the country. Norcross (2005) reports on such pros and cons in the following way:

- ✔ Con or anti-prescribing position: Physicians contend that arguments surrounding the general practitioner or primary physician's role in the treatment of mental health are misleading:
  - ✔ Non-psychiatric physicians receive little mental health training during medical school; however, they receive 4-6 years of medical and pharmacological training during medical school
  - ✔ There is no evidence that the psychotropic prescribing patterns of general medical practitioners (GP) are problematic
  - ✔ Patient safety concerns
  - ✔ A more logical solution is to increase mental health training for GP's and encourage psychiatric and primary care collaboration
- ✔ Pro prescriptive authority for psychologist arguments/ replies:
  - ✔ There are non-physician precedents for expansion of practice to include prescribing (e.g. Nurse Practitioners, Physician Assistants, optometrists, pharmacists, podiatrists)
  - ✔ Psychologist affluence (industrialization of health care)
  - ✔ Psychological practitioners indicate a desire to prescribe (65 to 70% of psychologists "strongly favor prescriptive authority")
  - ✔ American Psychological Association has provided clear support for expansion of practice
- ✔ Strong Arguments for psychologist prescribing:
  - ✔ Public accessibility – there is a desperate need to increase the public's access to high quality mental health care, especially in rural and impoverished areas
  - ✔ At least 70-75% of psychotropic medication is prescribed by general practitioners (see Preston & Ebert, 1999), most having little training in psychopharmacology or in the diagnosis and treatment of mental disorders. There are data indicating that general practitioners often do not medicate appropriately, at least for depression, one of the most commonly seen disorders (Preston & Ebert, 1999); in addition, medically trained practitioners do not fully understand nor utilize psychotherapy as a treatment option.
  - ✔ Declining numbers of psychiatrists — psychiatric residency programs have shown a consistent decline in the number of applications to these programs by physicians from the United States.
- ✔ Psychologists will utilize pharmacotherapy within the context of a biopsychosocial model (systems-oriented, holistic, integrative, collaborative) in contrast to a medical model that is no longer considered very effective. Psychologists have a broader set of skills.
- ✔ By permitting psychologists to prescribe, we can achieve sophisticated, efficient and cost-efficient integration of psychotherapy and pharmacotherapy and can enhance collaborative treatment where the patient has an active say in how treatment proceeds.
- ✔ Better continuity of care is achieved because psychologists can manage all aspects of the patient's mental health needs.
- ✔ Psychologists will provide more evidence-based care because psychological training and ethics emphasize awareness and currency with research outcomes; treatment decisions are based on data, not on marketing. Psychologists are trained both as scientists and practitioners and have special expertise in

diagnosis based on psychometrics rather than clinical impressions alone.

Psychologists with expertise in psychopharmacology, in addition to psychosocial and psychotherapeutic assessment and interventions, will create new possibilities for dynamic and comprehensive-research based treatment. Clinical mental health research suggests that treatments cannot be uniformly driven by diagnoses. For example, with regards to patients with Obsessive Compulsive Disorder (OCD) with mostly compulsive symptoms, the best outcome is achieved with behavioral psychotherapeutic treatment. However, OCD patients with mostly obsessive symptoms experience the best outcomes with psychotropic medication combined with behavioral psychotherapeutic treatments (Hohagen et al., 1998). With regards to optimal mental health treatments for specific individuals there is much we do not know. Mental health care providers need to proceed with caution, with much more research. It is quite likely that psychologists, with their extensive research training and experience, will be in a critical position to carefully scrutinize existing research of psychotherapeutic and psychopharmacological treatments and enthusiastically drive ongoing research to more clearly delineate increasingly optimal mental health interventions; these interventions might include an array of psychotherapeutic approaches and/or psychopharmacological interventions as research and comprehensive clinical experience dictates. As psychologists increase their knowledge, awareness and appreciation of psychopharmacological treatment approaches, in addition to assessment and psychotherapy, psychologists will be in a key position to systematically dissect active treatment ingredients.

As we look toward the future of psychology, the history of psychology and its growth needs to be considered. For much of our history, psychology has been a "niche" profession – seen as relevant only to mental health issues, "carved out". Despite this, psychology has continued to grow and develop, e.g. neuropsychology, forensic psychology, health psychology. As a learned profession, psychology has an opportunity to contribute to society in more complete ways.

IMPLICATIONS AND CONCLUSIONS

- ✔ The concept of psychologists prescribing is not a new one; it has been extensively evaluated at the national level. It is widely accepted in the profession.
- ✔ The models of training that have been developed are more comprehensive than those of many other disciplines that are currently prescribing.
- ✔ There is documented evidence (from the PDP) that psychologists can prescribe safely.
- ✔ Legislative authorization will expand as the battle continues across the country and as data accumulates regarding the safety and effectiveness of prescribing psychologists in New Mexico and Louisiana.
- ✔ Being trained in psychopharmacology and prescribing will enhance the profession and treatment:
- ✔ Evidence indicates that prescribing psychologists will NOT be using a medical, but an *integrated* or psychosocial model of prescribing; emerging practice standards declare that this is the preferred model for both assessment and treatment in prescriptive or collaborative practice
- ✔ Combined treatment: this is another example of a potential area of growth for the profession in terms of both research and practice.

It is overwhelmingly clear that it is time to give up ideological, unimodal approaches in favor of customized, patient-centered, multi-modal assessment and treatment models that are more effective and permit psychologists to fully engage with the patient in a holistic way.

A PERSONAL TESTIMONIAL

As a clinical psychologist in a hospital setting, over 50% of Dr. Wautier's patients take psychopharmacologic medications. The Fairlegh Dickinson University Post-Doctoral Psychopharmacology Master's Program has offered him a means by which to systematically gain new biological knowledge, key to his functioning as a hospital-based clinical psychologist. With only his first year completed, the program has provided him with greater awareness and appreciation for the complexities of body systems, particularly nervous system functioning, and significance for mental health care.

Dr. Wautier states: "I have substantially increased my ability to more effectively communicate with physicians. I have begun to develop more thoughtful and comprehensive consideration of psychological, social, emotional, developmental and well as biological/medical factors impacting patient care. Also, I have begun to more thoughtfully and effectively consider the impact of psychotropic medications on my patients' mental health care, enabling me to more effectively monitor my patient's mental health treatment in collaboration with prescribing physicians".

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