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Opinion

Prescribing Privileges for Psychologists: A Public Service or Hazard?

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Abstract:
The privilege to prescribe pharmacotherapeutics has been granted in limited areas to psychologists. The psychologist's role in society may be approaching a great evolution that can dramatically impact the state of mental healthcare and the discipline of psychiatry. Opponents argue drug company funding and cheaper non-PhD psychological professionals fuel the movement for prescription rights for PhD level psychologists. However, proponents claim that this right would equip psychologists with greater psychotherapeutic modalities and the capability of having richer doctor-patient relationships to diagnose and treat underserved populations. Nonetheless, the paucity of prescribing psychologist studies cannot allow the biopsychosocial community to make firm opinions, let alone a decision on this debate. This article reviews the history of clinical psychology and highlights the potential divergence into collaborative clinical and health psychologists and autonomous prescribing psychologists.
Key Words: Prescriptions, Psychologist, Psychiatrist, Pharmacology, Privileges, Collaboration

Introduction:

The difference between psychologists and psychiatrists – at least how most of the public perceives it – may soon disappear. In the last two decades, psychologists and their representative associations have made a serious attempt to gain prescribing privileges for psychotropic agents. Managed health care changes and the amplified output of non-PhD psychotherapists have jeopardized the autonomy of clinical psychologists. The profession of clinical psychology has only recently matured, yet organized psychology is campaigning for privileges that physicians and many psychologists oppose. The central debate is positioned around the public health impact of prescribing psychologists. Psychology and medicine are two professions that function on empirically based standards of practice for the benefit of the patient. The prescription discussion is argued on vague and limited published studies and demonstrations. As it stands, perusing privileges may fracture relations between psychologists and physicians and thereby affect quality of treatment.

In this article, a brief history of clinical psychology and the emergence of the modern theory of illness shared by many psychologists and physicians is first outlined. Secondly, the collaboration between psychology and medicine, which has contributed to development of the biopsychosocial model of health is discussed. Third, arguments for and against prescription privileges in the debate, including the monetary and survival mechanisms that are motivating psychologists to seek change are reviewed. Fourth, the implications for curriculum change and training of existing psychologists, and the impact this may have on existing care are reviewed. Finally, how legislation may impact clinical psychology as a profession is described. The central claim is that although prescription privileges are likely to occur, the psychosocial values that founded clinical psychology should not be forgotten.

A Brief History of Clinical Psychology:

Clinical psychology, at least the term, originated in 1896 from the American academic psychologist Lightner Witmer of the University of Pennsylvania.(1) Witmer urged psychologists to collaborate with physicians in the clinical environment. However, he did not favor psychotherapy (or psychotherapeutics as it was called) and some scholars say he even detested the practice.(1) He believed the primary activity of most psychologists to be administering tests and conducting research. The subject

remained largely an academic discipline until World War II, when there was a significant demand and financial incentive to provide mental health services.(2)

The Veterans Administration (VA) expanded the operations of psychologist and shaped the professional psychology of today. In 1949, the American Psychological Association (APA) developed a directional and curriculum focus for clinical psychologist following a "scientist-practitioner" model where the clinical psychologist was defined as both a scientist and a professional clinician.(3) The VA adopted the APA guidelines and a list of universities offering approved doctoral-level schooling as the premise for practicing in the VA program for psychological professionals. When the APA held scientist research as the paramount practice for psychologists and psychotherapy as their secondary function, psychiatry held that clinical psychologists lacked the proper training focus in psychotherapy. Psychologists eventually escaped the supervision of psychiatry, marked psychotherapy as their given therapeutic tool, and became a professional guild in the 1950s.(4)

In struggling for their psychotherapy authority, clinical psychologists ironically dismissed the opportunity to secure prescribing privileges for psychopharmacology agents during the 1950s. The psychologists felt that psychotherapy would treat the underlying psychological disturbance and rejected the biomedical disease model of mental illness.(5) After a great battle, the two professions kept their distance, but not for long.

Collaborative Psychology-Medicine

Psychology as a profession has rapidly changed since a half-century ago. Psychologists and other medical professionals are increasingly adopting the biopsychosocial model, a theory that states biological, psychological, and social processes are inherently, integrally, and interactively involved in physical health and illness.(6) A new breed of psychologists, health psychologists, currently performs basic and applied research attempting to uncover how psychosocial and biological factors influence the etiology and progression of disease. For instance, health psychologists have demonstrated the positive therapeutic benefits of employing behavioral and coping strategies with prostate cancer patients.(7) Psychologists are increasingly recognizing the therapeutic benefit of psychotropic medications, particularly in combination with psychotherapy.(8)

Clinical and health psychologists are now extensively collaborating in the medical setting and have found a genuine locus in clinical care. Psychologists and physicians, both psychiatrists and general medical providers, collaboratively perform extensive case-sharing, cross-referrals, patient education, and public policy for mental health.(9) The physician normally prescribes medication, evaluates responses, and performs follow-up clinical management, whereas the psychologist provides psychosocial interventions and often monitors and reports medical compliance and side effect profiles to the physician. Furthermore, psychologists are discussing psychoactive agents to their patients as an ethical discretion before securing informed consent for treatment.(10) Health psychologists prepare patients for anxiety triggering procedures (i.e. with mental imagery), offer stress coping techniques, and aid in the rehabilitation of chronic pain patients. Whether operating in the same clinical environment or different private offices, psychologists and their medical partners value their respective knowledge and therapeutic potentials.

Arguments in favour of prescription privileges

1.The profession cannot survive without prescription privileges

The key argument is favour of prescription privileges, is that clinical psychology cannot survive as a profession without them. In 1989, the APA highly prioritized the need for psychologically managed psychopharmacological intervention.(11) They claim psychologists cannot function as independent professionals without the legal right to prescribe. Prescription authority may help revive clinical psychologists who may be struggling to survive without a research or teaching portfolio. In a recent survey, APA members believed that prescribing was a logical extension of current practice, necessary for survival of the profession.(12) Psychologists increasingly find themselves in competition for counseling and psychotherapy services traditionally reserved for clinical psychologists. Managed health care organizations are creating "standards of care" that favor time-restrictive and symptom targeted therapeutic options that lean toward pharmacological interventions.(13) The Doctor of Philosophy (PhD) in Psychology has remained a research degree with extensive didactic and clinical research methods and applications. A new doctoral program, the Doctor of Psychology (PsyD), is catering solely to the practitioner model. Within free-standing professional schools, PsyD are graduating and practicing psychotherapy in record numbers. The psychotherapeutic role of the PhD-level psychologist is increasingly being taken over by other mental health professionals, including PsyD and masters-level psychologists, social workers, marriage and family therapists, and occupational therapists.(5) For example, in the institutional treatment setting, social workers cost less and generate just as much revenue for the organization.(14)

2. Pharmaceutical companies provide funding

Major pharmaceutical firms are funding training grants and conferences, promoting psychological research with heavy emphasis on psychopharmacology.(15) With appropriate guidelines in place, additional funding may support training and research. Antonuccio, Danton, and McClanahan (16) recommend guidelines that boundary the drug industry from psychological science. They advocate safeguards in various issues to be adopted by professional psychology organizations and psychology training programs, including conflicts of interest, journal advertising, continuing education, training programs, gifts, clinical consultations, and research.

3. The current medical system does not detect and treat the true prevalence of mental illness

There exists a great underserved population throughout the US. There are major national shortages of psychiatrists leaving many patients un- or misdiagnosed and treated, or treated by non-psychiatric physicians who have little or no training in psychological medicine. In fact, primary care physicians are often the first contact for patients suffering from psychological problems and they prescribe more than 60% of the total psychotropic medication prescriptions.(17) Psychologists argue they can better assess the patient's mental health status and offer a well-rounded treatment plan, especially if given the authority to prescribe.

4. Psychotropic medications influence behavior

Psychologists should be well-placed to evaluate the behavioral effects of psychotropic medications. Since psychotropic medications influence behavior, many psychologists claim that prescribing authority should be encom-

passed in their psychological practice.(18) Behavior is, after all, the domain of the psychologist.

5. Prescribing is the 'last outpost' in the psychologist's professional training

After psychological testing and psychotherapy, prescription authority is the 'last outpost'. That is, authority to prescribe is the last destination on the psychologist's journey toward becoming an independent and autonomous practitioner. A complete toolkit would allow a psychologist to offer a complete treatment package. The patient could establish a solid repertoire with the prescribing psychologist, make a single appointment for multi-modal treatment, and be actively monitored for medical compliance and side effects. In addition, prescribing psychologists could expand their practice to settings traditionally dominated by physicians and select non-physicians with prescribing authority, including nursing homes and hospital inpatient services.(19)

Arguments against prescription privileges

1. Market forces and pharmaceutical companies

Pharmaceutical companies have a vested business interest in psychologists. Not only will prescribing psychologists expand drug use, but there will be a major group of new prescribers that can be heavily influenced by marketing campaigns and gifts. Drug companies publicise and support a model of mental illness in which the brain is the chief determinant. Some psychologists argue that we should focus on the social determinants of mental illness, including poverty and injustice.(20) Others note that since the precise causes of most mental disorders are not known, the brain cannot be shown to be a 'cause'. For this reason, 'we are unable to design medications that target specific conditions'.(21, p.186)

2. Patient safety

Physicians, particularly psychiatrists, are naturally threatened and concerned about the encroachment of psychologists on their territory. They may fear their control over inpatient and hospital services is in jeopardy, question the medical competence of prescribing psychologists, and discount any claims that advocate prescribing psychologists will lower the overall cost of psychopharmacologic treatment.(22) Opponents question the medical competency of psychologists who have not undergone traditional medical school curricula and label prescribing psychologists a public health hazard. Currently, the vast majority of psychology graduate programs do not have the pre-medical/basic-science courses in their mandatory or even recommended admissions policies.(23) Most training programs are ill prepared and consequently clinical psychologists do not have proper training in neuroscience, physiology, organic chemistry, and biochemistry. Several commentators simply argue that prescribing is unnecessary. Under the task force recommendations, only a small number of psychologists would qualify for prescribing privileges. For this reason, Moyer (24, p. 589) asked, 'why develop an advanced curriculum at all? Would this group of practitioners be better trained as psychiatrists?'

3. Professional territory

The debate on the psychologists' right to prescribe rests for most persons on a key public health concern: Can prescribing psychologists properly serve the mentally ill with psychotropic agents? The American Psychiatric Association argues that they cannot, because prescribing psychologists would put patients in harm's way. Organized psychiatry claim psychologists have

not undergone the extensive didactic and clinical programs to measure the varied medical effects of psychoactive medications. Conversely, psychologists might claim that psychiatrists have not undergone sufficient training in the psychological, social and behavioral consequences of psychotropic medication.

4. Psychologists already have mechanisms to gain prescription authority

Psychologists already have current mechanisms to gain prescriptive authority, by earning a medical or nurse practitioner degree.(25,26) Psychologists have legally and seemingly successfully prescribed within the Department of Defense Psychopharmacology Demonstration Project (PDP), the VA (27), and the Indian Health Service.(28) The PDP program graduated ten psychologists after a two-year course divided into pharmacology study and clinical training. Additionally, New Mexico has allowed prescriptive authority to psychologists from 2002. The existing mechanisms are discussed in more detail below. However, it is important to note that nursing has not become a 'back alley' to prescribing for most. In a recent survey, 95% of respondents with qualifications in both nursing and psychology did not include prescribing as part of their practice.(29) The central issue here is not the current mechanisms in place, but the development of 'new legislation that would allow psychologists to complete a specified amount of additional psychopharmacological and biological training in clinical psychology and then to become eligible for a license to prescribe medications as psychologists'.(25, p. 667)

5. Insufficient research

I share the view that this debate can only be settled by research. The decision of who should and how to treat mental health should be due to rational and empirical considerations. There are some studies demonstrating that psychologists are competent to prescribe (i.e. the DoD-PDP and HIS programs). However, they are underpowered with small sample sizes. Psychologists and physicians cannot risk their inter-professional collaboration on incomplete pilot studies. The capacity to work with physicians on effective clinical management of mental disorders was determined by empirical research over the last four decades, and so it should be for prescribing capacity. Ultimately, data from the new prescribing psychologists in New Mexico will determine the fate of widespread prescription authority for – and the profession of – psychology. These data will need to focus on the risks and implications for patient care. However, a move toward prescribing seems likely, reflecting McGrath's view that 'there is nothing more to be gained from treating these risks as reasons not to move forward'.(30, p. 162). In the next section, I review the implications for curriculum change and care.

Implications for curriculum change

1. Changing the existing curriculum

One set of implications for the curriculum concerns the training of new psychologists. Indeed, it is the younger psychologists who show most interest in obtaining prescriptive authority, when compared with those already in possession of PhD and those in mid- to late-career. Psychologists early in their training are 'likely to have a considerable impact on the profession as these individuals move into positions of responsibility and influence in academia, public agencies, and state/provincial associations'.(31, p. 109) An ad hoc task force convened by the APA generated guidelines specific to the training for prescription privileges.(32) They proposed three levels of psychopharmacology training for doctoral-level licensed psychologists:

- **Level 1 (Basic Psychopharmacology Education)** – a single one semester course in psychopharmacology with a course in physiological psychology/behavior as a prerequisite.
- **Level 2 (Collaborative Practice)** – study into seven "topics" (not necessarily semester based courses), including psychodiagnostics, pathophysiology, physical function tests, and psychopharmacologic research. Also, incorporate simultaneous active collaboration with licenses prescribers but not independent authority for the psychologist.
- **Level 3 (Prescription Privileges)** – training with a "limited" scope of practice akin to dentists, optometrists, podiatrists, and nurse practitioners.

The task force vaguely proposed a graduate curriculum of 26 semester units and later introduced a national examination in psychopharmacology. Given the little or no basic science requirements for admissions to clinical psychology doctoral programs, such programs must significantly restructure their requirements to accommodate students in track for the psychopharmacology subspecialty. Otherwise, the concentration of psychology courses in the doctoral program would be replaced with Level 1 and 2 studies, thereby nullifying the essential characteristics that enable psychologists to successfully treat mental health.

Since 1988, psychologists in the Indian Health Service, an agency within the Department of Health and Human Services, have been prescribing under physician supervision. But, the limited pilot projects and demonstrations are inconclusive, though, often exploited for and against prescription privileges. The DoD spent more money in the PDP program than the traditional model of psychiatrists and psychologist, and labeled the program cost-ineffective. Also, psychologists in the program earned substandard and failing grades in conventional medical and pharmacology courses reflecting their poor basic science background.(33) Though, perhaps more importantly, there has yet to be a single quality-of-care complaint (34) and most (58%) of the treatment beneficiaries favored training for clinical psychologist.(35) Many of the psychopharmacologists now serve in high-level positions and actively advocate nationwide prescription authority for psychologists. The DOD PDP programs illustrates that psychologists can be trained to prescribe drugs, but does not address whether they should prescribe or whether it is clinically productive. Nor does it speak to optimal length and rigor of training for preparing psychologists to prescribe. Nonetheless, the APA proactively engaged in training recommendations.

In 2002, New Mexico became the first state to enact a law allowing psychotropic prescription privileges for psychologists.(36) Based on the APA guidelines, after completing coursework, supervised training, and passing the national Psychopharmacology Examination for Psychologists, state-licensed psychologists may gain two-years of physician supervised prescription privileges. After the two-years, the prescribing psychologist may achieve independent prescription authority if approved by the supervisor and is encouraged to maintain a collaborative relationship with the patient's primary care provider. In New Mexico, there is a server shortage of psychiatrists; however, psychologists are well numbered throughout the state.(37). Most residents live in rural populations serviced by only 18 psychiatrists (calculated at 14,400 patients per psychiatrist). There are 176 psychologists for this population, increasing potential medical service providers nearly 10 fold. Other states have pending legislation, including Georgia, Illinois, Hawaii, and Tennessee. Guam held limited prescriptive authority since 1998 under supervision of licensed physi-

cians on the similar ground – lack of physicians to address mental health.

The required curriculum changes are substantial. Authors of the clinical psychology curriculum would have to 're-examine and reevaluate their program brochures and recruitment materials, their selection criteria and procedures, their curricula and pedagogical methods, their mentoring and evaluations systems, and their training outcomes and placement records—all with an eye toward improving the effectiveness of training in clinical science'.(25, p. 674) Nonetheless, many schools are now offering psychopharmacology training programs, generally a combination of didactic and clinical practice. Current licensed psychotherapists can complete most of their studies are completed at a distance (i.e. via the internet, videotapes, and DVDs) and/or attending a few weekends on campus. The model curriculum meets or exceeds New Mexico laws requiring 450 hours of instruction. Some schools offer a master degree at program completion (i.e. Alliant International University and Fairleigh Dickinson University), while others officially transcript courses (i.e. New Mexico State University).

As additional states adopt prescription privilege laws for psychologists, there will undoubtedly be an increase in psychopharmacology training programs. The postdoctoral master's degree format seems to be most efficient model to gain privileges in New Mexico. However, as other states ratify laws, so too will required course-work change. Most postdoctoral psychotherapy programs can be completed in one to two years part-time, far less training than attending medical, nursing, optometry, dentistry, physician assistant, or pharmacy school. Harvard Medical School psychologist Steven Kingbury obtained prescribing rights by becoming a psychiatrist. He feels that average psychologists can competently prescribe without engaging in the full eight years of additional training that he undertook (38Kingsbury, 1992). However, the paucity of prescribing psychologist studies cannot allow the biopsychosocial community to make firm opinions, let alone a decision on this debate.

2. Training for existing psychologists

A second set of implications for the curriculum concerns the retraining of existing psychologists. Clearly, ongoing education and reading would be required. However, training in prescribing is likely to be expensive. Those most in favor of seeking prescription privileges, the young, 'are also those who can least afford the financial burden of a postdoctoral prescriptive authority training program.(31, p. 110) Fagan et al. (31) argue that modifications might better be made across undergraduate, graduate and postdoctoral levels, for new psychologists, as described above. Psychologists spend relatively little time reading about pharmacology. Robiner et al. (39, p. 218) argue that 'continuing education requirements would be warranted to keep psychologists up-to-date with the burgeoning formulary of psychotropic and nonpsychotropic medications (with which they may interact) and to assist them in overcoming gaps associated with their condensed training'. While 42 states require psychologists to participate in continuing education, only the state of Georgia currently requires psychologists to receive regular training in psychotropic medications. If prescription authority was expanded, this obligation would need to expand with it.(30) Robiner et al. (39) even doubt the capacity to surmount these gaps at all, even with APA-recommended criteria. In their view, pharmacologic knowledge would have to be increased 'up to the level of other prescribers or substantially close to it'. Otherwise, it 'should not be presumed to be equivalent to that provided by other prescribers, especially psychiatrists'. Psychologists obtain less scientific and clinical training directly relevant to prescribing than do other disciplines that pre-

scribe.(39, p. 216) Length of training is not the only issue, but also its focus. The deficiencies in 'doctoral-level psychologists' knowledge and proficiency in key scientific and clinical areas directly related to prescribing are legitimate concerns' to psychiatrists and other mental health professionals.(39, p. 217)

3. Impact on care

Prescription rights will inevitably have an impact on patient care. Psychologists are already asked to provide advice on appropriate biological treatments, 'frequently accompanied by an admission that psychologists feel uncomfortable with this role given their limited training in psychopharmacology but that the exigencies of the situation force the role on them'.(30, p. 161). If our colleagues and patients learn of the expansion in prescribing rights, might this pressure increase? Patients might find it difficult to distinguish between psychologists with the authority to prescribe, from psychologists who have not yet undertaken the requirements. We may see the development of a two-tiered system - consisting of those who can prescribe, and those who cannot. Such inequalities could impact patient care.

Conclusion

Clinical psychology reacts, but also contributes to, changes in social and health care. All professions seek to expand their special skills to new treatment settings, with the ultimate aim of autonomy. As psychologists increasingly follow the biopsychosocial model, psychopharmacology is the 'last outpost' to create an independent clinical psychologist. Other professions have been successful. Optometrists now have prescription privileges in 55 states, a change which took their profession three decades of work. This parallel example 'offers an interesting and exemplary model of the kind of change in scope of practice that can be – and likely will be – achieved by psychology in the 21st century'.(40, p. 328) However, psychology is founded on a biopsychosocial model, which I argue should not be forgotten. Psychologists must maintain interprofessional collaborations with physicians and continue to address the psychosocial aspects of medical problems. I concur with McGrath (30, p. 159) that changes in the curriculum should not 'occur at the expense of an education in the psychosocial fundamentals that continue to define our field'. A real dilemma may therefore face psychologists. A narrow focus on prescribing privileges and discounting the roots of clinical psychology risk replacing the biopsychosocial model with a 'bio-bio-bio' model of mental health.(41) According to Wiggins (42), if psychology is to preserve itself as a discipline, it must provide services based on its own science... It must exchange ideas and treatments with other disciplines such as biological, social, and psychological domains and help educate the public about the unique differences among these disciplines' (24, p. 589) To remain distinct from psychiatry, the focus should be on helping patients cope with psychological distress and preventing illness through psychological knowledge. The prescription debate is a politico-economic and public health issue that will ultimately be decided in state legislature. Hopefully, in the journey to a fully biopsychosocial discipline, with prescribing privileges as the last outpost; we will not forget the origin of psychology as a behavioral discipline on the way.

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