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ARTICLE: **Fool's Gold:** Psychologists Using Disingenuous Reasoning to Mislead Legislatures into Granting Psychologists Prescriptive Authority

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SUMMARY:

... Mental illness is a serious problem in the United States. ... The American Psychological Association offers five main reasons why legislatures should grant psychologists this privilege: 1) psychologists' education and clinical training better qualify them to diagnose and treat mental illness in comparison with primary care physicians; 2) the Department of Defense Psychopharmacology Demonstration Project ("PDP") demonstrated non-physician psychologists can prescribe psychotropic medications safely; 3) the recommended post-doctoral training requirements adequately prepare psychologists to prescribe safely psychotropic medications; 4) this privilege will increase availability of mental healthcare services, especially in rural areas; and 5) this privilege will result in an overall reduction in medical expenses, because patients will visit only one healthcare provider instead of two-one for psychotherapy and one for medication. ... The psychologists' contention that granting them prescriptive authority would significantly allay un-met mental health needs in rural areas is also highly questionable. ... Psychologists seeking prescriptive authority conclude that granting them this privilege will increase patient access to psychotropic medication, especially in rural areas. ... Instead of working on collaborative models in which physicians prescribe medication and psychologists provide therapy, they seek to supplant psychiatry and non-prescribing psychologists by creating a "new breed" of psychologist (a.k.a. pseudo-psychiatrist). ...

TEXT:

[*489] I. INTRODUCTION

Mental illness is a serious problem in the United States. Based on "current epidemiological estimates, at least one in five people has a diagnosable mental disorder during the course of a year." [n1] Fortunately, many of these disorders respond positively to psychotropic medications. While psychiatrists write some of the prescriptions for psychotropic medications, primary care physicians [n2] write more of them. [n3] State legislatures, seeking to expand patient access to pharmacological treatment, granted physician assistants and nurse practitioners prescriptive authority for psychotropic

medications. [n4] Over the past decade other groups have gained some **[*490]** form of prescriptive authority. [n5] Currently, psychologists [n6] comprise the primary group seeking prescriptive authority for psychotropic medications. [n7]

The American Society for the Advancement of Pharmacotherapy ("ASAP"), [n8] a division of the American Psychological Association ("APA"), [n9] spearheads the drive for psychologists to gain prescriptive authority. The American Psychological Association offers five main reasons why legislatures should grant psychologists this privilege: 1) psychologists' education and clinical training better qualify them to diagnose and treat mental illness in comparison with primary care physicians; [n10] 2) the Department of Defense Psychopharmacology Demonstration Project ("PDP") demonstrated non-physician psychologists can prescribe psychotropic medications safely; [n11] 3) the recommended post-doctoral training requirements adequately prepare psychologists to prescribe safely psychotropic medications; [n12] 4) this privilege will increase availability of mental healthcare services, especially in rural areas; [n13] and 5) this privilege will result in an overall reduction in medical expenses, because patients will visit only one healthcare provider instead of two-one for psychotherapy **[*491]** and one for medication. [n14] Conversely, some organizations challenge these contentions as unfounded and oppose granting psychologists prescriptive authority.

The American Psychiatric Association (the "Association") [n15] is the strongest opponent to granting psychologists prescriptive authority. The Association argues "safe and effective use of potent psychotropic medications requires extensive medical training and a thorough understanding of the brain and body." [n16] Accordingly, psychologists lack the requisite education and training to safely prescribe such medication. [n17] The Association contends "the needs of rural and other underserved patients can best be met through collaboration between psychiatrists and other medical professionals." [n18] Along with the Association, the Committee Against Medicalizing Psychology opposes granting psychologists prescriptive authority because they believe this privilege would diminish the traditional benefits of talk-therapy. [n19]

This Article challenges the psychologists' arguments, favoring legislative approval that grants them prescriptive authority. While the data show primary care physicians do lack expertise at treating mental illness, [n20] psychologists are at an immensely greater deficit of assessing and treating non-mental health illnesses, even with additional post-doctorate training. [n21] As for the PDP study, it did show successful training of non-physician psychologists, [n22] however, it did so under controlled, military settings. [n23] It is grossly inappropriate to argue this study "conclusively demonstrated psychologists' ability to prescribe safely and **[*492]** effectively," [n24] especially in regard to non-military psychologists prescribing independently. [n25]

The psychologists seeking prescriptive authority further contend their behavioral science education [n26] ensures they can prescribe safely. [n27] Yet, these psychologists complete fewer science courses and shorter clinical internships than nurses trained under the medical model, [n28] and who possess no prescriptive authority. [n29] The psychologists skew their arguments, avoiding discussion of the potentially catastrophic effects on patients suffering from missed or incorrect diagnoses, missed drug interactions, missed drug side-effects, incorrect test interpretations, or missed necessary test orders due to the psychologists' inferior medical background. [n30]

The psychologists' contention that granting them prescriptive authority would significantly allay un-met mental health needs in rural areas is also highly questionable. [n31] Less than one-seventh of very rural counties, and less than one-half of rural counties [n32] have a practicing psychologist, compared to all of those counties having a family physician. [n33] Moreover, the majority of mental health patients choose treatment from their family physician instead of from psychologists. [n34] Due to the stigma attached to mental illness and the dynamics of close-knit rural societies, [n35] there is no guarantee any significant number of rural inhabitants with a mental health disorder would even seek treatment from a psychologist.

In regard to the psychologists' argument that granting them prescriptive authority would reduce monetary costs associated with a patient seeing multiple providers, [n36] the savings they boast do not take into consideration all of the **[*493]** economical expenses associated with granting this privilege. [n37] They ignore the likely possibility that prescribing psychologists would significantly increase fees, though 75% of a sample of practicing psychologists "agreed

or strongly agreed that RxP [prescription privilege] would lead to higher incomes for psychologists." [n38] They assume malpractice premiums will not increase, yet 85% of a sample group of practicing psychologists believed that obtaining prescription privileges would increase malpractice rates. [n39] Psychologists also overlook the additional fees associated with prescribing, such as the cost of out-of-office testing, [n40] and they neglect the issue of how patients will deal with medications after treatment ends. [n41] While there are savings in having a patient see only one mental healthcare provider, [n42] there are many real and potential hidden costs not recognized or acknowledged by the psychologists seeking prescriptive authority. [n43]

Granting psychologists prescriptive authority will also adversely affect the mental healthcare system by reducing the number of psychiatrists and non-prescribing psychologists in urban areas where they are most needed. [n44] Prescription **[*494]** writing psychologists would be *de facto* psychiatrists. [n45] Possessing only a fraction of the education and experience, these psychologists propose to offer the same services provided by psychiatrists, but for commensurately lower fees. [n46] If existing geographic distributions for psychologists and psychiatrists remain stable, the data show the majority of prescription-writing psychologists will work in urban areas. [n47] This places them in direct competition with psychiatrists, but offering cheaper pseudo-psychiatric treatment. With the current difficulty in retaining psychiatrists, this increased competition will further reduce the number of practicing psychiatrists. [n48] The majority of prescription-writing psychologists will also compete directly with non-prescription-writing psychologists in urban areas. [n49] Although charging higher fees than non-prescribing psychologists, managed care organizations certainly will fund prescribing psychologists over non-prescribing psychologists because they get *de facto* psychiatric services at cheaper rates. Thus, one very real consequence of granting psychologists prescriptive authority is a backlash reduction in much needed psychiatrists and non-prescription-writing psychologists. [n50]

While the lack of available psychopharmaceutical treatment is a serious concern for all healthcare professionals, patient safety must remain paramount. Increased availability of harmful, substandard treatment is not the solution. The crux of the problem centers on what constitutes satisfactory education and training to grant prescriptive authority. The minimum standard for granting prescriptive authority needs to maximize the availability of psychotropic medication to rural and underserved populations while concurrently providing maximum protection to patients. The current minimum standard for psychopharmaceutical prescriptive authority, established by physician assistants and nurse practitioners, accomplishes this goal. [n51] Lowering this standard to allow psychologists to prescribe poses too great a risk to patient safety. Several much more effective and practical alternatives **[*495]** exist for safely increasing access to psychopharmaceutical treatment for rural and under-served populations. [n52] Ultimately, the potential harm to children, the elderly, and society in general, [n53] by granting psychologists prescriptive authority under the current guidelines, [n54] far outweighs the speculative benefits touted by psychologists seeking this privilege. [n55] For the reasons and evidence stated in this Article, legislatures should not grant psychologists any prescription privileges without requiring a medical model-based education equivalent to physician assistants or nurse practitioners, including prerequisites and clinical internships. [n56]

II. HEALTHCARE PROVIDERS WITH PSYCHOPHARMACEUTICAL PRIVILEGES

In the United States, physicians, including psychiatrists, possess virtual carte blanche prescriptive authority, [n57] which includes authorization to write prescriptions for psychopharmaceuticals. [n58] When addressing mental health issues, physician assistants and nurse practitioners also possess some prescriptive authority for psychopharmaceuticals. [n59] All of these professions require strict licensing, with physicians facing the strictest licensing criteria with respect to required education and experience.

A. PHYSICIANS

Prior to applying for medical licensure in the United States, one must complete medical school. Medical schools throughout the United States share similar prerequisites and curricula for acceptance into medical school and for conferring a medical degree. [n60] These schools desire a strong, broad science foundation in **[*496]** preparation for advanced medical science courses. [n61] Typical prerequisite science courses include one year of college Biology, two

years of college Chemistry, and one year of Physics, each with an accompanying lab. [n62] Many schools also require one year of Calculus. [n63] Because of the nature of the study of medicine, medical schools recommend that "students take their [prerequisite] course of study in the most demanding curricular environment possible." [n64] Medical schools also require submission of Medical College Admission Test ("MCAT") scores. [n65] Competition remains high on MCAT scores and grade-point-average for entering students. [n66]

The first two years of the four-year medical school curriculum involve classroom study of basic medical science courses and physician-patient interaction. [n67] The typical curriculum includes the study of pharmacology, neurology, and mental disorders. [n68] Many medical programs now also require an additional course in behavioral and social science. [n69] In the third and fourth years, students participate in clinical rotations, which include a required six unit rotation in psychiatry. [n70] In addition to the unit and clinical requirements, medical students must pass a three-step national exam for graduation and medical licensure. [n71]

[*497] Each state establishes its own regulations and licensing boards for physicians, [n72] which serve a variety of medically related functions. [n73] Establishing and verifying licensing requirements are primary functions. [n74] These boards also enforce minimum requirements for medical education and clinical training, [n75] and mandate specific topics of study for licensure. [n76]

Psychiatrists are specialized medical doctors, and thus, must complete a four-year medical program of extensive clinical training [n77] and a residency program. [n78] At the completion of residency, a psychiatrist qualifies to take a board-certifying exam, [n79] making psychiatrists the most extensively trained, mental health providers. [n80]

B. PHYSICIAN ASSISTANTS (PA)

In the mid 1960s, the advent of the physician assistant ("PA") extended limited prescriptive authority to non-physicians. [n81] Since that time, "forty-seven states have enacted laws or regulations that allow supervising physicians to delegate prescriptive authority to PAs." [n82] As of 2001, "eighty-five percent of these states allow PAs to prescribe controlled medications." [n83] Students applying to PA programs typically possess a college degree, have significant experience in the health field, [n84] and have also completed the same foundational prerequisite science courses as those required for medical students. [n85] Though the course length is shorter than a medical program, the curricula share similar features. [n86] PA students typically receive more than 1,500 **[*498]** hours of education based on the medical model. [n87] In addition to PA programs adhering to the same set of national accreditation standards, [n88] PA licensure requires 100 hours of continuing education every two years and re-licensure every six years. [n89] Advanced PA degrees in specialties are available, including psychiatry. [n90] Despite completing almost 40% more education and training than that recommended by psychologists to write prescriptions, [n91] *no state allows PAs to prescribe independently of a physician.*

C. NURSES WITH PRESCRIPTIVE AUTHORITY

Nurses complete approximately two-thirds of the prerequisite course load required for medical students. [n92] Notwithstanding, the prerequisites serve the same preparatory function of building a foundation for future advanced nursing science courses. [n93] The actual nursing program typically requires three years to complete and consists of courses similar to those taken in medical school. [n94] Despite completing more education and training than that recommended for psychologists to write prescriptions, [n95] *no state permits nurses to prescribe medications* without a minimum of a masters degree. [n96] Currently there are 58,000 certified advanced practice nurses in the United States. [n97] All of these nurses possess a masters degree and have **[*499]** completed a certification exam. [n98] Nurse practitioners may choose an adult or family specialty in mental health. [n99]

Over the past decade, legislatures across the country began granting these specially qualified nurses limited prescriptive authority. [n100] All states require some form of collaboration or supervision with a physician and many place restrictions on the Schedules of medications these nurses may prescribe. [n101] Some states only permit authority to

prescribe non-controlled drugs, [n102] while other states permit prescriptive authority for controlled drugs, but on limited basis. [n103] The most restrictive state is Georgia, which does not permit independent prescriptive authority. [n104] The least restrictive state is Arizona, permitting full prescriptive and dispensing privileges to nurses with advanced practice certification, but still requiring a consultative or referral relationship with a physician. [n105] *Only after completing three years of nursing school and obtaining a Master of Science in Nursing degree or Master of Nursing degree,* [n106] do states grant these specially trained nurses some level of prescriptive authority within the scope of their respective practice. [n107]

The important theme among physicians, physician assistants, and nurse practitioners is their extensive education in foundational and advanced medical **[*500]** science courses, [n108] and their daily practical experience working with patients prescribing myriad medications. [n109] All three professions require years of experience in a medical environment, working with hundreds of patients, at a minimum, for licensure. [n110] Such training exposes students daily to such important aspects of pharmaceutical treatment as: 1) diagnosis of mental and non-mental illnesses; 2) knowledge of necessary tests and ability to comprehend the results; 3) identification of appropriate medications to administer and dosages to prescribe; and 4) knowledge of possible drug interactions and side-effects of hundreds of medications, not limited to psychopharmaceuticals. [n111] The education proposed for granting psychologists prescriptive authority lacks the medical instruction required to prescribe safely, especially independently, based on inferior prerequisites, inferior core requirements, and inferior practical experience. [n112]

III. EDUCATIONAL REQUIREMENTS FOR PSYCHOLOGISTS

Most American universities offer a Bachelors of Arts ("BA") degree in Psychology that requires the equivalent of at least 120 semester hours for completion. [n113] The awarding of this degree typically requires 12 semester hours of general education, non-behavioral, science courses. [n114] Some universities, however, place few restrictions on which science courses will satisfy this unit requirement. [n115] Students, for example, can complete the general education requirements by completing a single three unit, non-major biology course, [n116] and completing the remaining nine required science units with non-medical science courses. [n117] **[*501]** Additionally, BA Psychology degree programs typically require 36 to 40 psychology units for graduation, [n118] but all units may consist of non-medical science courses. [n119] There is no assured consistency in the non-behavioral science education acquired by students graduating with a BA degree in Psychology. [n120]

Many American universities also offer a Bachelor of Science (BS) degree in Psychology that requires the equivalent of at least 120 semester hours for completion. [n121] BS Psychology degree programs, when supplemented with a science minor, require approximately 27 science units for the BS degree and approximately 22 science units for the minor. [n122] Universities often permit students, however, to "double count" these courses, thereby reducing the overall actual number of units completed. [n123] Moreover, some of the science courses offered, just as with the BA degree in Psychology, have no connection with the medical field. [n124] Students completing a BS degree in Psychology, with a science minor, may actually complete substantially fewer than the required 49 science units for graduation. Additionally, a student may complete the typical 36 psychology units required for graduation **[*502]** without taking any medical science courses. [n125] As with the BA degree in Psychology, there is no assured consistency in the adequacy of the non-behavioral science education of students completing the BS degree in Psychology with a science minor; they can satisfy all requirements with non-medical courses. [n126] Only under the most favorable circumstances do students graduating with a BS degree in Psychology begin to complete the prerequisite medical science education and training obtained by medical, physician assistant, and nursing students. [n127]

Almost all graduate programs in psychology require General Graduate Records Exam scores with applications for admittance, [n128] and almost all programs also require a Psychology Graduate Records Exam score. [n129] Most psychology graduate programs offer a Master of Arts ("MA") degree that typically requires the equivalent of 30 semester hours for completion. [n130] Many psychology graduate programs also offer a Master of Science ("MS") degree that typically requires the equivalent of 30 to 79 semester hours for completion. [n131] MA and MS degrees in Psychology generally offer, *but do not require,* medical science courses for graduation. [n132] These programs almost

invariably require a master's thesis, project, or a comprehensive exam for completion of the degree. [n133] Unlike the medical science-based professions, however, there is no uniformity among the required science courses for BA, MA, or MS degrees in Psychology. Additionally, some Doctor of Philosophy in Psychology ("PhD") degree programs do not require a masters degree for entrance. [n134]

Clinical psychology doctorate programs also require relatively few medical science courses similar to those taken by physician, physician assistants, and nurse practitioners. [n135] Clinical psychology PhD programs typically focus on research **[*503]** issues and developing counseling skills. [n136] Many PhD in Psychology programs are now offered at professional schools, [n137] and focus heavily on developing counseling skills that include diagnosis and treatment of mental disorders, which is not provided in traditional PhD degree programs. [n138] Clinical psychology programs often provide courses on psychopharmacology, brain anatomy, and physiology, but clinical psychologists generally lack the foundational and advanced medical science education, and receive no practical training for treating non-mentally ill patients. [n139] In contrast, all three of the other mental healthcare providers receive clinical training with both mentally ill and non-mentally ill patients. [n140]

All states require licensure for psychologists. [n141] State Psychology Boards determine what activities a licensed psychologist may perform. [n142] These Boards often offer certificate programs for specialty areas, [n143] and typically require **[*504]** continuing education for re-licensing, [n144] but at this time, State Boards lack the power to grant prescriptive authority.

IV. AVAILABILITY AND ACCESS TO HEALTH AND MENTAL HEALTH SERVICES PROVIDERS IN THE UNITED STATES

There exists a shortage of health and mental health providers in rural America that is of serious concern for all health professionals. Physician assistants and nurse practitioners gained prescriptive authority primarily to increase patient access to healthcare. [n145] Psychologists seeking prescriptive authority argue a shortage of mental health providers with prescriptive authority exists in rural America and among under-represented populations. [n146] They contend legislatures should grant them prescriptive authority as a means to alleviate this shortage. [n147] This section examines availability of health and mental health treatment in the United States.

A. METROPOLITAN VERSUS NON-METROPOLITAN AREAS

The Office of Management and Budget uses a zero-sum approach for defining metropolitan and non-metropolitan areas. A metropolitan area is any location "having either a city with more than 50,000 residents or a Census Bureau defined urbanized area and a total population of at least 100,000." [n148] Subsequently, "all counties not classified as metropolitan are by definition non-metropolitan." [n149] Approximately 80% of all Americans live in metropolitan areas, and approximately 89% of licensed physicians practice in metropolitan areas. [n150] "In 1995, there were 56,635 office-based patient care MDs in non-metropolitan areas compared with 370,000 office-based patient care MDs in metropolitan areas." [n151] More than half of the non-metropolitan physicians practiced in the areas of "primary care specialties of family or general practice, general internal medicine, pediatrics, [or] obstetrics/gynecology, compared with 38% of metropolitan physicians." [n152]

In 1994, the Frontier Mental Health Services Resource Network ("FMHSRN") examined availability of physicians, psychiatrists, and psychologists by county. [n153] **[*505]** The FMHSRN defined six categories based on number of people per square mile, with the first two groups considered rural areas: Group I consisted of a population density of 0-1.9 persons per square mile, representing 129 counties; Group II consisted of a population density of 2-6.9 persons per square mile, representing 296 counties; Group III consisted of a population density of 7-9.9 persons per square mile, representing 126 counties; Group VI consisted of a population density of 10-14.9 persons per square mile, representing 163 counties; Group V consisted of a population density of 15-99.9 persons per square mile, representing 1,625 counties; and Group VI consisted of a population density of 100-plus persons per square mile representing 742 counties. [n154] The data show a significant shortage of physicians, psychiatrists, and psychologists in the rural areas. [n155]

While "rural Americans experience incident and prevalence rates of mental illnesses and substance abuse which are equal to or greater than their urban counterparts . . . they also suffer from chronic shortages of mental health providers and services. . . ." [n156] In rural America, the most common provider of all healthcare is a family physician. [n157] "According to the de facto model, as much as half of mental healthcare may be obtained in the general medical sector, and much of this care will be from physicians in family or general primary care practices." [n158] In Group I, as many as two-thirds of the counties do not have a physician in family practice. [n159] Conversely, two-thirds of the counties in Group II do have a physician in family practice, [n160] and Group II has the highest rate of family physicians at 25.8 per 100,000 persons. [n161] These data indicate "the family practitioner is a common form of medicine in frontier areas . . .[, and] the family practitioner is also the most common medical practitioner who is likely to provide mental health services." [n162] The FMHSRN report "noted that many family practice physicians obtain additional training in psychiatry, not only as a general requirement of their residencies, but because of interest in mental health in family settings." [n163] While most healthcare in rural America comes from family practice physicians, access to mental healthcare from a psychiatrist remains extremely limited. [n164]

[*506] Approximately 10% of the counties in Group I and Group II, combined (425 counties), reported having a resident psychiatrist. [n165] This availability pales in comparison to the high 91% reported in Group VI. [n166] Groups III-V reported percentages of counties with psychiatrists of 11.1%, 19.0%, and 30.6%, respectively. [n167] The prevalence rate ranged from a low of 0.1 psychiatrists per 100,000 persons in Group I to a high of 10.5 psychiatrists per 100,000 persons in Group VI. [n168] The availability of psychologists fared only a little better.

Only 13.3% of the Group I counties and 43.1% of the Group II counties reporting having a psychologist, [n169] compared to 79.5% of the most densely populated counties in Group VI. [n170] Groups III-V reported percentages of counties with psychologists of 43.7%, 48.5%, and 52.2%, respectively. [n171] The prevalence rate ranged from a low of 13.0 psychologists per 100,000 persons in Group I to a high of 28.9 psychologists per 100,000 persons in Group VI. [n172] Thus, while the more populated counties enjoy reasonable availability of health and mental healthservices, the rural counties in America clearly do not.

B. PREVALENCE AMONG SPECIAL POPULATION GROUPS

Minorities, children, and the homeless are the more likely populations in rural and urban counties that lack access to health and psychiatric care. [n173] Even when care is available, a homeless patient may wait months for treatment. [n174] Although 100% of the Group VI counties had a family practice physician, the prevalence rate was the third lowest of the groups at 20.9 per 100,000 persons. [n175] Ninety-one percent of the Group VI counties had a psychiatrist, and the prevalence rate was the highest at 10.5 per 100,000 persons. [n176] Group VI also reported the highest percentage of psychologists at 79.5%, and the highest prevalence rate at 28.9 per 100,000 persons. [n177] Although these numbers represent far greater access to health and mental health services compared to non-metropolitan areas, unduly long delays to mental healthcare do exist for certain populations. [n178] The question then becomes **[*507]** how best to increase and expedite access to mental healthcare. Several important concerns arise when considering granting psychologists prescriptive authority.

V. QUESTIONS CONCERNING GRANTING PSYCHOLOGISTS PRESCRIPTIVE AUTHORITY

Legislatures began considering granting psychologists prescriptive authority in the mid-1980s. [n179] The American Psychological Association supported this legislation, arguing that with prescriptive authority they could "provide broader service to the public and more effectively meet the psychological and mental health needs of society." [n180] They continue to support prescriptive authority for psychologists, [n181] and in 2000, the American Society for the Advancement of Pharmacotherapy, a division of the APA, began. [n182] Over the years, many state legislatures considered bills intended to grant psychologists prescriptive authority, [n183] and several states currently have legislation pending. [n184] In March 2002, New Mexico became the first state to grant psychologists prescriptive authority. [n185]

The American Psychiatric Association and the Committee Against Medicalizing Psychology comprise the primary

opposition to granting psychologists prescriptive authority, [n186] arguing psychologists lack the medical education, training, and experience to prescribe safely. [n187]

A. ARE PSYCHOLOGISTS BETTER QUALIFIED THEN PHYSICIANS TO DIAGNOSE MENTAL ILLNESS?

Psychologists seeking prescriptive authority often present themselves as the highest educated and trained mental health provider, [n188] neglecting the fact psychiatrists complete the most demanding educational and experiential curriculum **[*508]** among mental health providers. [n189] Notwithstanding, psychologists do complete an extensive behavioral science education, including clinical internships. [n190] Because of their background in mental health, psychologists seeking prescriptive authority consider themselves better qualified than family practice physicians to diagnose and treat mental disorders. [n191] They also consider themselves uniquely qualified to evaluate and monitor psychopharmaceutical prescriptions. [n192] Despite their expertise, however, the majority of patients prefer treatment from primary care physicians for mental health issues. [n193] As a result, primary care physicians currently treat the bulk of mental health patients requiring pharmaceutical treatment. [n194]

While most medical school curricula now include specific courses on social and behavioral sciences and pharmacology, [n195] a number of articles have concluded that non-psychiatrist or primary care physicians are, by and large, inadequately prepared to recognize, refer, or treat mental disorders. [n196] Notwithstanding, Anderson and Harthorn (1989) found that primary care physicians recognized the presence of mental disorder essentially as well as mental health professionals (e.g., psychiatrists, psychologists). [n197] The problem, however, is these physicians were less accurate in their diagnoses of affective, anxiety, somatic, and personality disorders. Generalist physicians were most accurate (81%) in recognizing organic disorders and least accurate (14%) in identifying personality disorders, though only about one-half of the physicians correctly identified anxiety (49%), somatic (49%), and affective (47%) disorders. [n198] Subsequently, rural physicians state "they do the best they can, but clearly were not adequately trained to provide a full range of mental health services." [n199] Although family practice physicians lack the expertise psychologists have in treating mental illness, they still possess some knowledge and skill in dealing with mentally ill patients. [n200] More importantly, this "red herring," that physicians lack expertise to treat mental disorders, detracts from the real issue, which is psychologists possess negligible training in diagnosing and treating non-mental **[*509]** health illnesses. [n201] The Department of Defense Psychopharmacology Demonstration Project clearly indicates the psychologists' proposed additional training lacks the educational and clinical requirements to compensate for this deficit. [n202]

B. ASSESSING THE RELIABILITY OF THE DEPARTMENT OF DEFENSE PSYCHOPHARMACOLOGY DEMONSTRATION PROJECT: CAN PSYCHOLOGISTS PRESCRIBE SAFELY?

In the early 1990s, the Department of Defense funded the Psychopharmacology Demonstration Project to test the feasibility of training psychologists to safely and effectively prescribe psychotropic medication. [n203] Psychologists seeking prescriptive authority present this study as "*clearly demonstrating* that psychologists can be trained to prescribe safely and effectively." [n204] The report does give high praise for the success of the participants. [n205] The psychologists seeking prescriptive authority, however, omit extremely significant facts that challenge their categorical belief the PDP can be generalized to a non-military population, which is a belief seriously questioned by the PDP itself. [n206]

The PDP ran from 1991 to 1997. [n207] Thirteen psychologists began the program with ten completing the full training. [n208] Four classes graduated from the program between 1994 and 1997. [n209] Two participants graduated from Group A completing a total of 1,418 hours of didactic training. [n210] After this class, the PDP determined approximately half of the didactic training to be unnecessary, reducing this component to 712 hours. [n211] "The result was that the fellows in Groups B, C, and D experienced a very different academic program." [n212] The two Group A participants completed a nine-month inpatient program similar to a second year psychiatry **[*510]** residency program. [n213] They also spent three months taking on-call duty and "reviewing charts of psychopharmacologically treated patients from a chronic care outpatient clinic . . .. The two Group A fellows who completed the program treated a total of 223 inpatients during the 9-month experience. The treated group included about 50% men and 50% active duty personnel. Median age

was 37-38." [n214] They treated a variety of mental disorders and prescribed a variety of psychotropic medications. [n215] The remaining groups participated in a six-month inpatient and six-month outpatient clinical internship experience, [n216] with one Group C psychologist retaking the clinical internship and graduating with Group D. [n217] They dealt with similar numbers of patients, with comparable experiences in types of mental illnesses treated and medications prescribed. [n218] No participant prescribed to children under age 18 or adults over age 65. [n219] After completion of their clinical internships, the participants continued to receive guidance through proctorship. [n220] The study evaluation panel ("Evaluation Panel") concluded no intention existed to replace psychiatrists with these psychologists, [n221] but some participants suggest this is what happened in a couple of instances. [n222]

Three of the graduates were Air Force Officers and three were Army Officers, all holding the rank of Captain or higher. [n223] The remaining four graduates were Navy officers all holding the rank of Lieutenant Commander or Commander. [n224] The evaluators considered the participants an exceptional group and stated: "one indicator of the quality and the success of this group of graduates was that eight out of 10 were serving as chiefs or assistant chiefs of an outpatient psychology clinic or a mental health clinic." [n225] The Evaluation Panel also concluded the participants **[*511]** showed tremendous ability in overcoming "their limited background in traditional scientific prerequisites for medical school," [n226] although the two Group A participants did complete 706 hours additional didactic medical school training during the program. [n227] Notwithstanding these exceptional characteristics,

> The Evaluation Panel heard much skepticism from psychiatrists, physicians, and some of the graduates about whether prescribing psychologists could safely and effectively work as independent practitioners in the civilian sector. The usual argument was that the team practice that characterized military medicine was an essential ingredient in the success of the PDP that could not be duplicated in the civilian world. [n228]

The Evaluation Panel made the recommendation:

> For a successful new program or a retraining program, it will be essential to select trainee psychologists with an adequate background for advanced training in psychopharmacology. Two areas are particularly important--a preparatory science background and competence in clinical nosology. In order to study pharmacology at the advanced level needed to manage pharmacotherapies, trainees must have a background in chemistry, biology and mathematics. Chemistry should include post-baccalaureate biochemistry and the necessary preparation for a course at this level. Typically, this would include undergraduate general and organic chemistry. Biology should include undergraduate level general biology, vertebrate and human anatomy, and other course work adequate for a post-baccalaureate level course in mammalian physiology. It would be important for the graduate physiology course to contain exposure to human pathophysiology. It would also be essential that trainees have an adequate background in the biological basis of behavior. Understanding of clinical pharmacokinetics and many relevant biochemical phenomena requires a background in mathematics, including at a minimum, college-level algebra. [n229]

The Evaluation Panel determined from the curriculum adjustments, starting with Group B, that the 712 hours of didactic education, the six-month inpatient internship, and the six-month outpatient internship are the minimum standard for a successful program designed to prepare psychologists for "limited prescribing authority." [n230] The Evaluation Panel further stated: "we could not approve and would question the educational soundness of any 'crash' or 'cram' course format. **[*512]** Ample evidence exists that retention of usable knowledge from such formats is very limited." [n231] They conclude the study with a list of other professionals they consider appropriate for this type of education. [n232]

Psychologists seeking prescriptive authority represent this single study involving ten participants as a representative sample of the more than 70,000 practicing psychologists. [n233] They believe this despite a 23% attrition rate, with 20% of the graduates receiving twice the amount of didactic training, and an additional graduate repeating the clinical

internship. [n234] They apparently assume the average psychologist holds the position of chief or assistant chief of a mental health clinic, [n235] and is a high-ranking military officer. [n236] They emphatically state the PDP conclusively illustrated that psychologists can be trained to prescribe safely, [n237] yet they fail to acknowledge the strict limitations placed on the participants, such as age and existing health problems. [n238] They mislead legislatures into believing psychologists can safely prescribe to children, the elderly, and patients with existing illnesses, [n239] but the PDP never allowed participants to prescribe to any of these populations. [n240] The psychologists seeking prescriptive authority assure legislatures the PDP contained excessive training even after the restructuring, [n241] but the Evaluation Panel clearly stated otherwise and admonished the soundness of any "crash" or "cram" course format. [n242] The Evaluation Panel even reiterated the importance of an extensive medical science foundation for the advanced courses to follow. [n243] Psychologists seeking prescriptive authority appear blinded by their own self-interest associated with prescribing medication, willing to distort and totally disregard a multitude of opposing facts, placing patients at harm.

[*513] C. THE SUGGESTED TRAINING REQUIREMENTS IN PSYCHOPHARMACOLOGY FOR POST-GRADUATE PSYCHOLOGISTS WOULD NOT ASSURE SAFE PRESCRIPTION PRACTICES

Psychologists seeking prescriptive authority argue that completion of New Mexico's requirement of a 450-hour (30-unit) [n244] degree program, including a 480-hour internship requiring interaction with 100 patients, qualifies them to prescribe psychotropic medications. [n245] This program, however, reduced the education and training requirements by more than 50% of what the PDP recommended, [n246] which is the same study the psychologists rely on to prove they can prescribe safely. [n247] When confronted with this discrepancy, the psychologists state facts about the original purpose of the PDP, but fail to realize the 700-hour didactic program and one-year clinical internship are the scaled-down, revised recommendation of the PDP. [n248] The PDP clearly stated what a satisfactory program required when it adjusted the curriculum after Group A. [n249] The New Mexico program lacks almost 40% of the didactic recommendations, [n250] requires none of the recommended prerequisite education, [n251] lacks more than 80% of the recommended clinical internship time, [n252] and excludes the additional weekly seminar classes completed by the PDP participants. [n253] The New Mexico clinical internship requirements disregard the PDP's specific recommendation of six months in-patient and six months out-patient clinical experience, [n254] components considered absolutely critical by the PDP for a **[*514]** satisfactory program. [n255] Perhaps in an effort to make the program more marketable, [n256] though definitely much more dangerous to patients, the psychologists disingenuously present the findings of the PDP and recommend the very watered-down version the PDP warned against. [n257] Psychologists seeking prescriptive authority defend the dearth of education and training requirements by arguing that their seven and one-half years of behavioral science training makes up the difference. [n258]

Through existing graduation and licensing requirements, a psychologist can graduate with a doctorate degree and gain licensure while completing no college-level basic science courses. [n259] Additionally, physicians opposing granting psychologists prescriptive authority argue:

> *Psychiatrists and other physicians are trained to diagnose and treat human illness, which includes the brain and the rest of the body and the use and side effects of medication in treating those illnesses*. Psychologists are trained in human behavior. Medications are used to treat body chemistry and are biologically based. Physicians are also trained to find a biological disorder of one part of the body masking itself in another part of the body, including the brain. [n260]

Under New Mexico's system, [n261] a psychologist completing the post-doctorial requirements may qualify to prescribe medication by completing less than one-quarter of an education ostensibly comparable to that of physicians, and less than one-half of the education completed by physician assistants and nurse **[*515]** practitioners. [n262] Again, the psychologists typically respond to challenges to this paucity of education in the recommended program by implying their behavioral science education equates to the medical science education completed by physician assistants and nurse practitioners. [n263] Not only are they patently wrong, [n264] but this argument emphasizes the fact these psychologists totally disregard their inadequacy at diagnosing and treating non-psychological health issues. [n265]

The issue of whether psychologists can prescribe psychotropic medications safely becomes irrelevant when one examines the issue of co-morbidity. [n266] Psychologists seeking prescriptive authority imply physicians waste their time learning about non-mental health issues at medical school, [n267] seemingly ignoring the connection between the mind and body. They state psychologists under the New Mexico plan receive "approximately three (3) times the training pharmacology [sic] that MDs have in medical school," [n268] but neglect the fact medical students complete approximately 2,000 hours of clinical rounds during their third and fourth years, addressing pharmacological issues with hundreds of patients; [n269] physician assistants and nurse practitioners complete hundreds of hours of clinical internship experience, addressing pharmacological issues with hundreds of patients, which psychologists do not include in their calculations. [n270] More importantly, these psychologists consider their time wasted if spent learning about the safe uses, interactions, and side-effects of non-psychopharmaceutical medications. [n271] While few health professionals know the characteristics of all 9,482 general medicine pharmaceuticals, [n272] a prescribing mental healthcare provider requires knowledge of **[*516]** more than just the 80 or so psychopharmaceutical medications. [n273] Psychologists seeking prescriptive authority also diminish the importance of co-morbidity and argue they possess the capability to differentiate psychological disorders and medical illnesses. [n274] These unfounded beliefs and assumptions stand as the most important reasons not to grant psychologists prescriptive authority.

Psychologists seeking prescriptive authority rely on the overly dangerous practice of assuming a behavioral problem is non-medical and waiting to see if it responds to talk or psychopharmaceutical therapy. This delay of proper medical intervention greatly jeopardizes the safety of all patients. For instance, what if the psychological symptoms mask a non-mental health illness? Can a psychologist accurately distinguish violent behavior caused by a brain tumor versus a violent personality by simply observing the patient or analyzing a blood test? What about depression that accompanies coronary heart disease (35-45%), diabetes (10-15%), cancer (almost 50% with a mental disorder), and HIV/AIDS (22-32% in United States with a mental disorder). [n275] Is the psychologist going to determine accurately through a blood test and observation of behavior the patient has one of these diseases or any other disease? Will the psychologist take blood pressure readings, temperature, listen for heart or lung abnormalities, or perform other tests routinely performed by physicians? These are tests that can save lives if performed early in an illness by a person capable of understanding the test results. Is the psychologist going to assess the danger of Tardive Dyskinesia, blurred vision, constipation, urinary retention, dystonias, akathisia, or orthostatic hypotension through a blood test and behavior observation? [n276] Additionally, even if the psychologist determines the behavior is not responding to treatment and may originate from a non-psychological illness, the belated medical referral causes the patient to suffer unnecessarily. Their deficient education, skill, and knowledge of recognizing non-mental health illness, accompanied by their determination that time is wasted by learning about many of the common non-psychotropic medications patients poses too great a danger for society to warrant granting psychologists prescriptive authority. They even argue, "if there is a knock on psychology, it is the lack of documentation of the skills they have in diagnosing symptoms that do not fit the psychological functioning of the patient," [n277] but then erroneously determine "this **[*517]** lack of documentation is overcome by the RxP training protocol approved by APA." [n278] Physician assistants spend more than 1,500 hours learning how to prescribe safely under the supervision of a physician, nurse practitioners spend more than 2,000 hours learning how to prescribe safely and independently, and physicians spend more than 4,000 hours learning how to diagnose and prescribe safely for a multitude of both mental and non-mental illnesses. Psychologists, however, propose to carry-out these same tasks safely with fewer than 1,000 hours of training. [n279]

D. GRANTING PRESCRIPTION PRIVILEGE WOULD NOT FILL EXISTING GAPS IN PSYCHOPHARMACEUTICAL MENTAL HEALTH TREATMENT AVAILABILITY

Psychologists seeking prescriptive authority conclude that granting them this privilege will increase patient access to psychotropic medication, especially in rural areas. [n280] However, one state medical organization director stated, "that psychologists aren't where psychiatrists aren't," [n281] and "there is more likely to be a psychiatrist in some of the rural areas." [n282] This means where shortages of psychiatrists exists, shortages of psychologists also exist. Because patients have access to psychotropic medication, [n283] the central mental healthcare problem faced by patients in rural areas becomes access to psychotherapy! [n284]

Psychologists seeking prescriptive authority accurately state a shortage exists of psychologists and psychiatrists in rural areas. [n285] The data show 13.3% of very rural counties and 43.6% of all other rural counties have a psychologist. [n286] Only 10.1% of all rural counties have a psychiatrist. [n287] Family physicians, however, reside in one-third of the very rural counties and in two-thirds of all other rural areas. [n288] Based on this distribution of psychologists, less than one-in-seven very rural (Group I) counties and less than half of all other rural areas (Group II) even have a psychologist. The most probable outcome of this distribution also places the bulk of prescription-writing psychologists *in urban areas* where prescription-writing healthcare providers already exist. [n289] In the majority of rural counties, *no psychologist exists to treat patients whether possessing prescription privilege or not!* [n290] And if a psychologist does exist, this still does not guarantee treatment will take place.

[*518] "More than 54 million Americans have a mental disorder in any given year, although fewer than 8 million seek treatment." [n291] When patients do seek treatment, they prefer meeting with primary care physicians, not psychologists. [n292] This is even truer in rural areas partially because of the stigma of mental illness and the general belief everyone knows everyone else's business. [n293] The majority of rural counties have a family practice physician who can prescribe medication. Psychologists seeking prescriptive authority assume rural area patients lack access to psychotropic medication and would seek this treatment if made available. The unique characteristics of rural communities suggest otherwise. [n294]

Finances, however, is another issue that affects access to mental health treatment. [n295] If patients lack access to mental health treatment because they cannot afford it, one must ask how granting psychologists prescriptive authority will fund treatment for these patients. [n296] Psychologists seeking prescriptive authority claim they will increase access to prescription-writing mental healthcare providers for under-represented populations. [n297] While rural residents generally lack health insurance more often than urban residents, [n298] financial concerns also often restrict mental health treatment for under-represented populations in urban areas. [n299] The data, however, indicate no real shortage of mental health providers who can prescribe exists in urban areas. [n300] The problem of delay in access to treatment revolves around the fact the poor, incarcerated, and homeless comprise the majority of under-represented populations in urban areas. [n301] This raises an issue of funding, not an issue of lack of prescription-writing mental healthcare providers. Granting psychologists prescriptive authority will have little effect on increasing access to mental healthcare for rural or under-served populations.

[*519] E. GRANTING PSYCHOLOGISTS PRESCRIPTIVE AUTHORITY WOULD NOT REDUCE COSTS

Psychologists argue granting them prescriptive authority will significantly reduce mental healthcare costs. [n302] By utilizing the "best practice" model, [n303] in which one healthcare provider offers psychotherapy and psychopharmacology, the patient has fewer treatment visits resulting in lower fees. [n304] These psychologists state:

> Significant cost savings can be obtained using "full service" professionals to provide this type of care over the split treatment model where one doctor prescribes the medication and another manages the patient's care with psychotherapy. This reduces the costs of extra consultations with doctors. It prevents costly delays in prompt treatment due to having to schedule an extra doctor appointment. Full service professional care is an added convenience to the patient by reducing doctor visits and taking time from work. [n305]

The psychologists, however, incorrectly assume patients only suffer from mental illnesses that require no medical intervention. They further claim they will reduce medical fees by recognizing psychological disorders masquerading as non-mental health illness. [n306] What about the increase in costs and patient suffering from medical illnesses masquerading as psychological disorders? How many patients need to suffer at the hands of unqualified psychologists making wrong medical decisions before the monetary gains are outweighed? Their calculations fail to show any reduction in the savings they boast for medical errors, and they fail to include an estimate of how many patients a psychologist might expect to refer each year. [n307] If the referral number is high, no cost savings accrue, which leaves no reason for granting this privilege. If the referral number is low, patients likely are suffering needlessly, which

presents a strong reason for not granting this privilege.

The savings boasted also rely on the assumption prescribing psychologists will not raise their fees, despite the personal increase in cost of additional education and increased liability. [n308] Practicing psychologists, however, realistically expect fees to increase in conjunction with prescriptive authority. [n309] Psychologists seeking such authority also assume they will pay similar malpractice rates as those paid by other non-physician prescribing professionals, yet they admit "advanced nurse practitioners, physician assistants and optometrists who prescribe all pay lower liability premiums than psychologists [pay now] for the same coverage." [n310] They conclude, "if it turned out there was a significant added risk to psychologists prescribing this cost could be passed on to those who prescribe rather than increasing the cost to all psychologists." [n311] If prescribing psychologists must bear **[*520]** the increase without subsidy from non-prescribing psychologists, this indicates higher fees not lower ones. They further conclude, "this cost might be sustained by the insurer in order to save the contract rather than inure the cost of finding other businesses or professions to insure." [n312] This is *very* unlikely. [n313] Finally, they argue the malpractice rates for prescribing psychologists may actually decrease because of a reduction in malpractice suits for sexual misconduct between psychologists who can prescribe and patients! [n314] They argue:

> When examining the risk factor of prescribing psychotropics in psychiatric contracts we find the risk load on premium dollars is only about 8%. The risk load against premium for liability for sexual misconduct for a discontinued intimate relationship is much greater than the risk load for prescribing medications to patients. In counseling and psychotherapies treatment success relies heavily upon the doctor/patient relationship. When treatment founders, there is a tendency to intensify the doctor/patient relationship to overcome "therapeutic resistances." Under these circumstances both the patient and the doctor are in a vulnerable state. Resolution of the need for a greater therapeutic relationship may result in sexual intimacy creating the potential for a professional liability suit if and when the personal (sexual) relationship is discontinued. Use of psychotropic medication in a combined psychotherapy/pharmacotherapy treatment approach tends to reduce the need for intensifying the doctor/patient relationship and may reduce the risk of professional liability risk for sexual misconduct between the patient and the therapist. There are no reported data to support this hypothesis. However, there are anecdotal reports of the premiums of the nurse practitioners being lowered after they obtained prescriptive authority. [n315]

Interestingly, while the psychologists know actuaries will calculate malpractice rates based on the minimal education, training, and experience of prescribing psychologists, [n316] they still offer speculative scenarios like those above. Admittedly, single-provider treatment does offer reductions in costs when provided safely, but the hypothetical cost-reduction scenarios posed by the psychologists seeking prescriptive authority clearly omit pertinent information, which legislatures need in order to make decisions in the best interests of mentally ill patients. [n317]

[*521] F. WHAT EFFECT WOULD GRANTING PSYCHOLOGISTS PRESCRIPTIVE AUTHORITY HAVE ON OTHER MENTAL HEALTHCARE PROVIDERS?

Unfortunately, the psychologists seeking prescriptive authority view the situation as a "turf" war instead of what best serves the patient. [n318] They recognize that psychopharmaceutical treatment continues to gain in popularity with insurance companies and patients, and they want to ensure their place in the future of mental health treatment. [n319] Instead of working on collaborative models in which physicians prescribe medication and psychologists provide therapy, they seek to supplant psychiatry and non-prescribing psychologists by creating a "new breed" of psychologist (a.k.a. pseudo-psychiatrist). [n320] They cite the tremendous shortage of psychiatrists in some areas as a reason for granting them this privilege, [n321] yet the data indicate psychologists tend to work in the same locations as psychiatrists. [n322] These psychologists seem willing to do away with the field of psychiatry, believing they can replace it adequately. [n323] Managed healthcare will likely support these pseudo-psychiatrists because of lower fees. [n324] Non-prescribing psychologists will become obsolete also. Middle level mental health providers will take over counseling because they are cheaper than non-prescribing psychologists. This situation drops the entire mental health profession down one

notch. Psychiatrists are gone, and psychologists become the prescription-writers.

VI. PRACTICAL, EFFECTIVE, AND SAFER ALTERNATIVES TO INCREASING MENTAL HEALTHCARE COMPARED TO GRANTING PSYCHOLOGISTS PRESCRIPTIVE AUTHORITY

Psychologists seeking prescriptive authority conclude such authority is the only possible answer to increasing access to psychotropic medication. [n325] Several current trends, however, appear to offer better service and availability to rural areas. The "*integration* of mental health and general medical services in a unified clinic structure" is one current goal. [n326] As the phrase implies, patients receive medical and psychological treatment in one center. [n327] This may induce rural area patients to seek **[*522]** treatment because of potentially better anonymity due to people not knowing which service a patient enters the clinic to receive. [n328] Another goal is *reaching out* through a "circuit rider" or "satellite clinics" where patients can meet for therapy. [n329] *Building up* increases access to mental healthcare by making rural communities more self-reliant through the "use of natural helpers and local healers; use of paraprofessionals; use of local (non-mental health) professionals; public education; support groups and systems; and providing self-help resources." [n330] *Connecting* is a fourth option used to increase availability of mental health treatment in rural areas through the use of telemedicine. [n331] Although still new to the field of mental health, telemedicine, in which a mental health professional works with family practice physicians to treat patients through video conferencing, is showing promising results for rural areas. [n332] Because of the extensive role family physicians play in mental healthcare in rural areas, [n333] a collaborative approach with mental health professionals is paramount.

VII. CONCLUSION

In their desire to have legislatures grant prescriptive authority "as soon as possible," [n334] psychologists seeking such authority place the health and welfare of many thousands of mentally ill patients in jeopardy. Under their plan, a psychologist determines when a patient's symptoms require medical intervention, not a physician. If psychologists fail to refer appropriately, patients suffer needlessly. If psychologists refer appropriately, patients receive the care and treatment they deserve, but this greatly diminishes one of the benefits of having prescribing psychologists.

Legislatures, understandably, rely on psychologists seeking prescriptive privileges to give truthful, straightforward interpretations. Instead they get disingenuous responses skewed to fulfill the psychologists' own agenda. [n335] Psychologists have extensive training in data collection and interpretation. [n336] They know to rely on one study, or even a few, for any finding is tenuous at best, and totally inappropriate when dealing with patient welfare. The PDP is a small, non-representative **[*523]** study with very limited results, [n337] yet psychologists seeking prescriptive authority use this study to persuade legislatures to grant them prescriptive privileges. Based on this one study, these psychologists propose running a state-wide, poorly controlled, experiment on patients. [n338] Using mentally ill children and elderly persons who may lack any real ability to consent to treatment and who rely on healthcare providers to act in their best interest, these psychologists will study them like "white mice" in an unprecedented social experiment. [n339] New Mexico's law allows psychologists to prescribe medication with less than half of the minimum recommended education prescribed by the PDP, [n340] and allows psychologists to eventually prescribe independently. [n341] This is a privilege severely questioned by the PDP. [n342] One must seriously question the ethics of the American Society for the Advancement of Pharmacotherapy and the American Psychological Association in this endeavor. [n343]

Psychologists seeking prescriptive authority also fail to accurately consider how many rural patients likely would receive their help. They promise eradication of mental health service shortages in rural America, but only half of these counties even have a psychologist. [n344] Patients have access to psychotropic medication. [n345] What they lack is access to psychotherapy! To think psychologists, with greater debt from post-graduate education and higher malpractice insurance, will flock to rural America to help patients is absurd. [n346] With their superior abilities compared to non-prescribing psychologists, prescribing psychologists will surface in urban areas and compete with psychiatrists and non-prescribing psychologists. The psychologists' fees will increase as the population of other mental healthcare providers diminishes and managed care organizations shift their funding practices to support these new pseudo-psychiatrists.

Most disturbing about this debate is the unwillingness on the part of the psychologists seeking prescriptive authority to acknowledge a safety issue even exists. [n347] The psychologists propose a "cram" course on pharmacology and self **[*524]** proclaim its adequacy. [n348] They describe the slashing of the PDP recommendations by more than 50% as "quibbling" over ideals or even as "enhancements" to the training. [n349] They state a concern for patient welfare but then seek prescriptive authority as a "non-debatable item," unwilling to consider more effective, safer, and practical solutions. [n350] Their response that "it may not be perfect but it is better than what is available to most people," [n351] demonstrates their narrow perspective on this multifaceted problem. They present legislatures the issue of psychologists prescribing psychotropic medication by exclaiming "EUREKA, GOLD!" Legislatures eager to find a solution to a difficult situation understandably are lured by the psychologists' glimmering statements. Upon assaying the psychologists' arguments, however, only **Fool's Gold** appears. [n352] The New Mexico solution puts vulnerable mental health patients at unnecessary risk, for little overall social value, and will save far less money than proposed with untold effects on the entire mental health system. For the facts and reasons given in this Article, Legislatures should not grant psychologists prescriptive authority based on the New Mexico design.

Legal Topics:

For related research and practice materials, see the following legal topics:
EvidencePrivilegesPsychotherapist-Patient PrivilegeElementsEvidencePrivilegesPsychotherapist-Patient PrivilegeScopeHealthcare LawBusiness Administration & OrganizationLicensesRequirements

FOOTNOTES:

n1 DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 45 (1999), *available at* http://www.surgeongeneral.gov/library/mentalhealth/pdfs/C2.pdf.

n2 Here, primary care physician includes family and general practice physicians.

n3 *See* Sara Martin, *DeLeon Elected APA President for 2000: His Agenda Calls for Implementing Others 'Good Ideas,'* 30 APA MONITOR 1 (Jan. 1999) (quoting American Psychological Association president as saying that "eighty percent of the prescriptions written for mental health disorders are written by physicians with little or no mental health training"), *available at* http://www.apa.org/monitor/jan99/pat.html; Glenn D. Walters, *A Meta-Analysis of Opinion Data on the Prescription Privilege Debate,* 42 CAN. PSYCH. 119-120 (May 2001) (stating, "physicians with no mental health expertise currently write 83% of the scripts for psychotropic medication") (citing Marc A. Zimmerman & Louis A. Wienckowski, *Revisiting Health and Mental Health Linkages: A Policy Whose Time Has Come. . . Again,* 12 J. PUB. HEALTH POLICY (1991) 510-524).

n4 *See* AMERICAN PSYCHIATRIC NURSES ASSOCIATION, PRESCRIPTIVE AUTHORITY FOR ADVANCED PRACTICE PSYCHIATRIC NURSES, *at* http://www.apna.org/resources/positionpapers.html (Sept. 15, 1995) [hereinafter APNA PRESCRIPTIVE AUTHORITY]; AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, INFORMATION ON PAS AND THE PA PROFESSION, *at* http://www.aapa.org/geninfol.html (last visited Nov. 9, 2003) [hereinafter AAPA INFORMATION].

n5 *See* AMERICAN SOCIETY FOR THE ADVANCEMENT OF PHARMACOTHERAPY, WEEKLY READER # 112, *at*

http://www.apa.org/divisions/div55/WR112.html (Sept. 10, 2001) ("Pharmacists now have prescriptive authority in 27 states using a defined protocol developed for each patient by the attending physician."); CALIFORNIA PSYCHIATRIC ASSOCIATION, PSYCHOLOGIST PRESCRIBING BILLS PSYCHOLOGISTS' CLAIMS VS. REAL FACTS, *at* http://www.calpsych.org/legislation/1999/claimvsfact.html (Mar. 3, 1998) [hereinafter CPA PSYCHOLOGIST PRESCRIBING].

n6 Here, the term "psychologist" refers to doctorate level practitioners, which includes "clinical" psychologists. The group "clinical psychologists" occasionally includes those with doctoratal degrees in education counseling and school psychology, but in this Article the terms precludes those degrees.

n7 *See* Nancy Ann Jeffrey, *Psychologists Demand Power to Prescribe,* WALL ST. J., Apr. 10, 1998, at B1 ("Psychologists are increasingly fixated on one of psychiatrists' most valuable assets: the prescription pad.").

n8 The American Society for the Advancement of Pharmacotherapy ("ASAP") is a division of the American Psychological Association, which "was created to enhance psychological treatments combined with psychopharmacological medications." ASAP, *at* http://www.apa.org/divisions/div55/ORGchrs.html (last visited Nov. 9, 2003).

n9 The American Psychological Association ("APA") has more than 150,000 members, making it the largest association of psychologists worldwide. APA, *at* http://www.apa.org (last visited Nov. 9, 2003).

n10 *See infra* Part III.

n11 AMERICAN COLLEGE OF NEUROPSYCHOPHARMACOLOGY, DOD PRESCRIBING PSYCHOLOGISTS: EXTERNAL ANALYSIS, MONITORING, AND EVALUATION OF THE PROGRAM AND ITS PARTICIPANTS, 6 ACNP BULL. (Summer 2000), *available at* http://www.acnp.org/pdffiles/vol6no3.pdf [hereinafter ANCP DOD].

n12 *See* N.M. STAT. ANN. § 61-9-17.1 (repealed effective July 1, 2010) (indicating 450 didactic hours and a total of 480 hours of clinical internship hours comprise the total 930 hours of the program); APA, NEW MEXICO GOVERNOR SIGNS LANDMARK LAW ON PRESCRIPTION PRIVILEGES FOR PSYCHOLOGISTS, *available at* http://www.apa.org/practice/nm_rxp.html (Mar. 6, 2002) (stating that New Mexico requires psychologists to complete 450 hours of coursework, a 400 hour/100 patient practicum under physician supervision, and pass a national certification examination) [hereinafter APA Press Release].

n13 *See Bill Granting Psychologists Prescription Authority Moves Forward,* 8 CAL. HEALTH L. MONITOR 2 (June 26, 2000). *See also,* Charles E. Holzer III et al., *The Availability of Health and Mental Health Providers by Population Density, Letter to the Field No. 11, at* http://www.wiche.edu/MentalHealth/Frontier/letter11.html (last visited Nov. 9, 2003) (discussing the availability of mental health care providers in rural America); Dennis F. Mohatt, *Access to Mental Health Services in Frontier America, Letter to the Field No. 4, at* http://www.wiche.edu/MentalHealth/Frontier/letter4.html (last revised Nov. 4, 1997) (discussing the shortages of health care providers in

rural America).

n14 ASAP, WEEKLY READER # 115, *at* http://www.apa.org/divisions/div55/WR115.html (Oct. 21, 2001) ("The 'split' treatment model where one professional prescribes, and another provides the treatment and monitors the medical [sic] requires extra appointments at an extra cost and added inconvenience to the patient. Delays in treatment complicate recovery and add to costs.").

n15 The APA is a medical specialty society recognized world-wide. Its 37,000 U.S. and international physicians specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders. AMERICAN PSYCHIATRIC ASSOCIATION, *at* http://www.psych.org/aboutapa.cfm (last visited Nov. 9, 2003). *See also* Andrew Julien, *M.D.s, Ph.D.s Prepare for Battle: Psychologists Asking Legislature's Approval to Dispense Medicine,* HARTFORD COURANT, Feb. 27, 2001, at A1 (quoting John Winston Bush, as stating prescriptive authority for psychologists "would undermine psychology's historic reliance on talk-therapy and other strategies to confront emotional and behavioral problems")

n16 PHYSICIAN'S WEEKLY, POINT/COUNTERPOINT: SHOULD PSYCHOLOGISTS HAVE PRESCRIBING PRIVILEGES?, *at* http://www.physweekly.com/archive/01/07_02_01/pc.html (July 2, 2001) (stating viewpoint of president of the APA).

n17 *Id.*

n18 *Id.*

n19 Julien, *supra* note 15. *See generally* COGNITIVE BEHAVIOR THERAPY, *at* http://www.cognitivetherapy.com/index.html (updated Nov. 5, 2002).

n20 Jack M. Geller, *The Role of Rural Primary Care Providers in the Provision of Mental Health Services: Voices from the Plains, Letter to the Field No. 10, at* http://www.wiche.edu/MentalHealth/Frontier/letter10.html (last visited Nov. 9, 2003); Jack M. Geller & Kyle J. Muus, *The Role of Rural Primary Care Physicians in the Provision of Mental Health Services, Letter to the Field No. 5, at* http://www.wiche.edu/MentalHealth/Frontier/letter5.html (last visited Nov. 9, 2003). *See also infra* Part IV.A.

n21 *See infra* Part IV.C.

n22 ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf (finding that the training program could transform licensed clinical psychologists into safe and effective prescribing psychologists, and suggesting that the participants performed well with the focus of the PDP on "the training of clinical psychologists in preparation for limited prescribing privileges").

n23 *See infra* Part V.C. The study involved an extremely small, non-representative, military population under ostensibly laboratory settings, pre-screening patients for non-psychological health problems, prohibiting treatment of children and the elderly, with the prescribing psychologists completing more than double the education and training currently required.

n24 PHYSICIAN'S WEEKLY, *supra* note 16, at http://www.physweekly.com/archive/01/07_02_01/pc.html (quoting Russ Newman, Ph.D., J.D., Executive Director for Professional Practice, American Psychological Association).

n25 *See infra* Part V.B.

n26 *See infra* Part III. (detailing the weight given to non-medical, behavioral sciences by undergraduate and graduate psychology degree programs).

n27 APA, PRESCRIPTIVE AUTHORITY FOR PSYCHOLOGISTS: AN UPDATE FROM APA, *at* http://www.apa.org/apags/profdev/rxpauthority.html (Winter 2002) (discussing, in part, the PDP study's findings that psychologists can be effectively trained to prescribe safely).

n28 *See, e.g.,* Judith Felson Duchan, Graduation Speech, *Learning and Leveling Learning, available at* http://www.acsu.buffalo.edu/duchan/leveling.html (May 12, 2001) (describing the medical model as "a way of thinking...[that presumes] that the physician's task is to diagnose diseases, to discover their causes and symptoms, and design treatments. . . . The medical model is made up of causal chains, of primary, secondary, and tertiary causes.").

n29 *Compare infra* Part II.C., *with infra* Part III.

n30 *Cf. infra* Part III. (referring to psychologists' lack of medical training).

n31 *See infra* Part V.D. (arguing that a grant of prescriptive authority to psychologists cannot overcome social and geographic impediments to care).

n32 *E.g.,* SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD, OFFICE OF RESEARCH & STATISTICS, SOUTH CAROLINA RURAL HEALTH REPORT, *at* http://www.ors2.state.sc.us/rural_health.asp (last visited Nov. 9, 2003) (describing the largest towns in rural communities as having populations of less than 25,000 as compared to populations of 10,000 or less in the largest towns in very rural communities).

n33 *See infra* notes 159-60, 169-71 and accompanying text. This statement assumes perfect distribution of only one psychologist or physician per county.

n34 *See infra* note 288, 292 and accompanying text.

n35 *See generally,* Courtenay M. Harding et al. *Problems Faced by Consumers of Mental Health Services out in a Frontier Community; Letter to the Field No. 23, at* http://www.wiche.edu/MentalHealth/Frontier/letter23.html (last visited Nov. 9, 2003).

n36 *See infra* Part V.E.

n37 *See* Jack G. Wiggins, *Increasing Access to Mental Health Care, Improving Quality of Care and Reducing Costs through Prescriptive Authority for Licensed Psychologists with Specialty Training, at* http://www.apa.org/divisions/div55/AHCCCS.htm (last visited Nov. 13, 2003) (discussing cost saving potentials for the state of Arizona if psychologists were granted prescriptive authority). *See also infra* Part V.E. for a discussion on whether granting psychologist prescriptive authority will reduce costs generally.

n38 ASAP, WEEKLY READER # 123, *at* http://www.apa.org/divisions/div55/WR123.html (Feb. 7, 2002) (quoting survey results of Brian Ramirez, doctoral candidate at Wright State University).

n39 *Id.* "Only 6% of respondents disagreed or strongly disagreed and 9% were neutral." *Id.* Fifty-five percent of the same psychologists "agreed or strongly agreed that they would be willing to pay higher malpractice rates for RxP [prescriptive authority]." *Id.* Only "30% disagreed or strongly disagreed with the statement, and 15% were neutral." *Id.*

n40 While the New Mexico law allows prescribing psychologists to order necessary tests, many of these psychologists will have to order blood tests, urine tests, electroencephalograms, electrocardiograms, and the like, outside of their office. Family practice physicians' offices are set up to conduct many such tests without requiring an additional office visit. See *infra* Part V.E., for a discussion on the difficulty patients and psychologists will face if patients' mental illnesses require additional medical intercession.

n41 Who will monitor medication for patients requiring maintenance treatment? Patients will likely see their family physicians more often

than their psychologists after treatment, yet patients will now have to see their psychologists, on separate appointments, and miss work for medication level monitoring. In addition to reducing costs, physicians are the better choice for this monitoring because of their expertise. This becomes even more evident for patients requiring blood serum level monitoring (e.g., mood stabilizers such as Lithium, Carbamazepine, or Divalproex). *See* John Preston, *Quick Reference to Psychotropic Medication, 2003 Update,* ASAP, *available at* http://www.apa.org/divisions/div55/PrestonMedicationCard2003.pdf (last visited Nov. 9, 2003). See *infra* Part V.E., for a discussion on the probability patients will have to see both a psychologist and a physician if the former prescribes medication.

n42 Wiggins, *supra* note 37, at http://www.apa.org/divisions/div55/AHCCCS.htm.

n43 See *infra* Part V.E., for a discussion on increased patient costs as a result of additional medical appointments and the likelihood that psychologists will increase their fees to offset the expense of their additional education and increased liability.

n44 *See, e.g.,* Myrle Croasdale, *Prescribing Rights Dominate Scope-of-Practice Bills: The Debate Over Passage Pits Psychiatrist Against Allied Professionals,* AM. MED. NEWS, *available at* http://www.ama-assn.org/amednews/2003/04/14/prsc0414.htm (Apr. 14, 2003) ("Even in Chicago's suburbs, the wait to see a psychiatrist is six weeks to two months."); Andis Robeznieks, *Psychologists See Rural Areas as Entry Point to Prescribing,* AM. MED. NEWS, *available at* http://www.ama-assn.org/amednews/2002/12/02/prl21202.htm (Dec. 2, 2002) ("With less than a dozen psychiatrists to serve the rural communities in the western part of the state, officials with both the Nebraska Medical Assn. and Nebraska Psychiatric Society acknowledge that the state is in the midst of a mental health crisis--in both rural and urban areas.").

n45 *See* Wiggins, *supra* note 37, at http://www.apa.org/divisions/div55/AHCCCS.htm ("Psychology is proposing to enhance the quality of mental health services and expand access to care by integrating cognitive behavioral therapy with psychopharmacology. This is known as the 'best practices' model of mental health treatment since it combines the two forms of treatment demonstrated to be effective."). Wiggins' description of combining talk therapy with psychopharmacology is the job description of a psychiatrist. See *infra* Parts V.E.-F., for mention of the best practice model and the role of psychiatrists in the healthcare profession.

n46 See *infra* Parts II.A., III, and V.B., for a comparison of educational and experiential requirements for psychiatrist and prescribing psychologists.

n47 *See* Holzer et al., *supra* note 13, at http://www.wiche.edu/MentalHealth/Frontier/letter11.html (discussing distribution of mental health providers by population, indicating high employment overlap for health care providers in heavily populated geographical areas, moderate overlap in suburban areas, and the absence of psychiatrists, the paucity of psychologists, and virtual non-existence of family practice physicians in one-third of counties for very rural areas); *infra* Part IV.A. (comparing practitioners in metropolitan and non-metropolitan areas).

n48 *See* Letter from E. Mario Marquez, Clinical Psychologist, to Gary E. Johnson, Governor, New Mexico, ASAP, *available at* http://www.apa.org/divisions/div55/RxPResources.htm (Feb. 23, 2002) (citing a September 2000 article in the Albuquerque Journal stating that "22 child psychiatrists have left New Mexico, leaving the state with a number that is half the national average," and "the NM Psychiatric Association's membership declined by about 50 psychiatrists during the previous five years"). Psychiatrists are already leaving some less populated states such as New Mexico. Regardless of why these psychiatrists chose to leave, increasing competition will only cause more to

leave. *See infra* Part V.F. (discussing the effect on other mental healthcare providers).

n49 *See* Holzer et al., *supra* note 13, at http://www.wiche.edu/MentalHealth/Frontier/letter11.html.

n50 *See infra* Part V.F.

n51 *See infra* Parts II.B.-C. (indicating physician assistants and nurse practitioners require the least amount of training while possessing some psychopharmaceutical prescriptive authority).

n52 *See infra* Part V.F.

n53 *See infra* text accompanying notes 239-40, 250-55.

n54 N.M. STAT. ANN. § 61-9-17 (repealed effective July 1, 2010). *See also* APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n55 *See infra* text accompanying notes 297, 302, 314-15.

n56 To work under a physician, psychologists should be required to complete the same prerequisites, course work, and clinical practicum experience required for physician assistants. *See infra* text accompanying notes 85-87. Alternatively, psychologists should be required to complete the same prerequisites, course work, and clinical practicum experience required for nurse practitioners. *See infra* text accompanying notes 92-94, 96, 98. Readers should take the phrase "prescribe independently" to mean that 10% of all prescriptions made are reviewed by a physician who may alter the prescription. Similar regulations applying to nurses with prescriptive authority should apply to psychologists. *See infra* notes 102-03 and accompanying text.

n57 *See, e.g.*, CAL. BUS. & PROF. CODE § 2501 (West 2003). In this Article, the term "physician" includes allopathic and osteopathic practitioners, and the term "psychiatrist" includes all sub-specialties within the field.

n58 *Id.*

n59 *See infra* notes 82-83, 100-05 and accompanying text.

n60 *Compare* STANFORD UNIVERSITY, SCHOOL OF MEDICINE CATALOG, MD PROGRAM, *available at* http://www.med.stanford.edu/school/catalog/bookone/mdprogram.html (last visited Nov. 9, 2003) [hereinafter STANFORD MD PROGRAM], *and* STANFORD UNIVERSITY, SCHOOL OF MEDICINE CATALOG, MD CURRICULUM, *available at* http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html (last visited Nov. 9, 2003) [hereinafter STANFORD MD CURRICULUM], *with* UNIVERSITY OF CALIFORNIA SAN DIEGO, SCHOOL OF MEDICINE, CATALOG, 2002-03, *available at* http://meded.ucsd.edu/Catalog/56.html (last visited Nov. 9, 2003) (requiring similar prerequisites--chemistry, biology and physics--and similar graduation requirements) [hereinafter UCSD MEDICINE CATALOG].

n61 *See, e.g.,* SAN DIEGO STATE UNIVERSITY CATALOG, SPRING 2002 CLASS SCHEDULE, *available at* http://www.sdsu.edu/cgi-bin/schedule/semester=spring02 (last visited Nov. 9, 2003) (indicating prerequisite courses for medical school require 40 units of science course work) [hereinafter SDSU CATALOG SPRING 2002].

n62 *E.g.,* STANFORD MD PROGRAM, *supra* note 60, at http://www.med.stanford.edu/school/catalog/bookone/mdprogram.html; STANFORD MD CURRICULUM, *supra* note 60, at http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html.

n63 *E.g.,* UCSD MEDICINE CATALOG, *supra* note 60, at http://meded.ucsd.edu/Catalog/56.html.

n64 *Id.*

n65 " The Medical College Admission Test (MCAT) is a standardized, multiple-choice examination designed to assess problem solving, critical thinking, and writing skills in addition to the examinee's knowledge of science concepts and principles prerequisite to the study of medicine. Scores are reported in each of the following areas: Verbal Reasoning, Physical Sciences, Writing Sample, and Biological Sciences." ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ABOUT THE MCAT, *at* http://www.aamc.org/students/mcat/about/start.htm (last visited Nov. 9, 2003).

n66 " In 2000, the average GPA for medical school matriculants [was] 3.6, continuing an upward trend since the 1980s. MCAT scores for each of the testing categories (verbal reasoning, physical sciences, and biological sciences) [were] either on par or better than last year." AMERICAN ASSOCIATION OF MEDICAL COLLEGES, U.S. MEDICAL SCHOOL APPLICANTS STILL EXCEED AVAILABLE POSITIONS: UNDERREPRESENTED MINORITY APPLICANTS INCREASE FOR THE FIRST TIME SINCE 1996, *at* http://www.aamc.org/newsroom/pressrel/2000/001025.htm (Oct. 25, 2000).

n67 *E.g.,* STANFORD MD CURRICULUM, *supra* note 60, at http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html (listing the course requirements on range of courses in human physiology and biology, including molecular biology, human genetics, immunology, endocrinology, psychiatry and other relevant courses, such as Health Care Systems and Health Policy, and Physicians and Patients).

n68 *Id.* (requiring a total of 10 units of pharmacology, 9 units of nervous system, and 5 units of psychiatry in the first two years of study).

n69 UCSD, SCHOOL OF MEDICINE, CATALOG, 2002-03, CURRICULUM: THE NEVER ENDING DIALOGUE, *available at* http://medschool.ucsd.edu/Catalog/08.html (last visited Nov. 13, 2003) (indicating the Social and Behavioral Science course "looks at the patient as a person, with all that implies, but also as a unique 'biopsychosocial matrix' with a history and a future").

n70 *See, e.g.,* STANFORD MD CURRICULUM, *supra* note 60, at http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html.

n71 The exam is called the United States Medical Licensing Examination ("USMLE"). Results of the USMLE "are reported to medical licensing authorities in the United States and its territories for use in granting the initial license to practice medicine" and are used to "assess a physician's ability to apply knowledge, concepts, and principles that are important in health and disease and that constitute the basis of safe and effective patient care." USMLE-UNITED STATES MEDICAL LICENSING EXAMINATION, *at* http://www.usmle.org (last visited Nov. 13, 2003).

n72 *E.g.,* ARIZ. REV. STAT. ANN. § 32-1402 (West 2002); CAL. BUS. & PROF. CODE § 2001 (West 2003). For a list of state medical licensing boards and links to their webpages, see ADMINISTRATORS IN MEDICINE, *at* http://www.docboard.org (last visited Nov. 9, 2003).

n73 *See, e.g.,* MEDICAL BOARD OF CALIFORNIA, *at* http://www.medbd.ca.gov (last visited Nov. 9, 2003) ("The Medical Board of California is the State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.").

n74 *See, e.g.,* ARIZ. REV. STAT. ANN. § 32-1403 (West 2002); CAL BUS. & PROF. CODE § 2089; GA. CODE ANN. § 43-34-27 (2002).

n75 *See, e.g.,* CAL. BUS. & PROF. CODE § 2089.

n76 *See, e.g., id.*

n77 *E.g.,* UCSD, DEPARTMENT OF PSYCHIATRY, RESIDENCY CURRICULUM, *at* http://psychiatry.ucsd.edu/residencyCurriculum.html (last visited Nov. 13, 2003).

n78 " Residency education is the period of clinical education in a medical specialty that follows graduation from medical school, and prepares physicians for the independent practice of medicine." ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION, *at* http://www.acgme.org (last visited Nov. 9, 2003) (giving definition under heading "About the ACGME").

n79 *See, e.g.,* AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC., GENERAL INFORMATION, WHAT IS AN APBN BOARD-CERTIFIED PSYCHIATRIST?, *at* http://207.229.182.32/geninfo/what_psychiatrist.html (last visited Nov. 9, 2003).

n80 *See* CPA PSYCHOLOGIST PRESCRIBING, *supra* note 5, at http://www.calpsych.org/legislation/1999/claimvsfact.html (comparing psychologists' four years of graduate school and one year of clinical training to psychiatrists' four years of medical school and additional four years of residency training).

n81 AAPA INFORMATION, *supra* note 4, at http://www.aapa.org/geninfol.html.

n82 AAPA, PHYSICIAN ASSISTANTS AS PRESCRIBERS OF CONTROLLED MEDICATIONS, *at* http://www.aapa.org/gandp/control.html (last revised June 2, 2003) [hereinafter AAPA PA PRESCRIBERS].

n83 *Id.*

n84 *See id.* (stating that with prior experience in health care field consequently comes prior training and/or clinical experience in pharmacology).

n85 *Id.* (including biology, biochemistry, organic chemistry, physiology, microbiology and mathematics courses).

n86 *Id.* (discussing the similarities between a physician assistant program and medical school).

n87 *See, e.g.,* UNIVERSITY OF WISCONSIN-MADISON, PHYSICIAN ASSISTANT PROGRAM, EMPLOYMENT GUIDE AND RESOURCES, *available at* http://www.medsch.wisc.edu/pa/employment/employment.html (last updated Feb. 2003).

n88 AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, PHYSICIAN ASSISTANT EDUCATIONAL PREPARATION FOR PRESCRIBING, *at* http://www.aapa.org/gandp/pharmpre.html (last revised July 16, 2003).

n89 AAPA PA PRESCRIBERS, *supra* note 82.

n90 *See* ASSOCIATION OF POSTGRADUATE PHYSICIAN ASSISTANT PROGRAMS, AAPAP PROGRAMS BY SPECIALTY, *at* http://www.appap.org/prog_specialty.html (last visited Nov. 12, 2003) (listing graduate specialties).

n91 *Compare supra* note 87 and accompanying text, *with* sources cited *supra* note 12.

n92 *Compare* SAN DIEGO STATE UNIVERSITY SCHOOL OF NURSING, *at* http://www.rohan.sdsu.edu/dept/chhs/nursing/index.html (last vistied Nov. 9, 2003) (listing course and grade requirements for its nursing school under "Preparation for Major & Sequence of Courses"), *with* STANFORD MD CURRICULUM, *supra* note 60, at http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html, *and* SDSU CATALOG SPRING 2002, *supra* note 61, at http://www.sdsu.edu/cgi-bin/schedule/semester=spring02 (listing course and grade requirements of respective medical schools).

n93 *See, e.g.,* SAN DIEGO STATE UNIVERSITY SCHOOL OF NURSING, *supra* note 92, at http://www.rohan.sdsu.edu/dept/chhs/nursing/index.html (indicating care systems).

n94 *Id.* (stating the SDSU nursing program requires "a minimum of 45 upper division units in nursing" and 10 units in natural science and 16 pre-requisite science courses, amounting to 1,065 hours of education based on the medical model). This time does not include labs and clinical internship hours. *Compare* SAN DIEGO STATE UNIVERSITY, GENERAL CATALOG 2001-02, *at* http://coursecat.sdsu.edu/0102/index.html (Apr. 16, 2001), *with* STANFORD MD CURRICULUM, *supra* note 60, at http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html (listing the requirements for a medical degree).

n95 *Compare* SAN DIEGO STATE UNIVERSITY SCHOOL OF NURSING, *supra* note 92, at http://www.rohan.sdsu.edu/dept/chhs/nursing/index.html, *with* APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html (detailing course hour requirements).

n96 *See* AMERICAN NURSES ASSOCIATION, STATES WHICH RECOGNIZE CLINICAL NURSE SPECIALIST IN ADVANCED PRACTICE, *at* http://www.nursingworld.org/gova/charts/cns.htm (last updated Feb. 1, 2000).

n97 AMERICAN NURSES CREDENTIALING CENTER, FREQUENTLY ASKED QUESTIONS ABOUT ANCC CERTIFICATION, *at* http://www.nursingworld.org/ancc/certification/cert/certfaqs.html (last visited Nov. 9, 2003).

n98 *Id.*

n99 *Id.*

n100 *E.g.,* ARK. CODE ANN. § 17-87-310 (Michie 1987); COLO. REV. STAT. ANN. § 12-38-111.6 (West 2002); HAW. REV. STAT. ANN. § 457-8.6 (Michie 2002); IND. CODE ANN. § 25-23-1-19.5 (West 2001); KEN. REV. STAT. ANN. § 314.042 (Michie 2001); N.M. STAT. ANN. § 61-3-23.2 (Michie 2002); VA. CODE ANN. § 54.1-2957.01 (Michie 2002); W. VA. CODE ANN. § 30-7-15a (Michie 2002). *See* ANA, 2000 PRESCRIPTIVE AUTHORITY CHART, *at* http://www.nursingworld.org/gova/charts/dea.htm (revised Feb. 1, 2000) (displaying the type of nurse practitioner, permitted drug schedule, and whether a practice agreement, collaboration, or required protocol to prescribe exists for each state) [hereinafter ANA CHART].

n101 *See, e.g.,* 21 U.S.C.A. § 812(b) (1999) (giving criteria for controlled drugs Schedules I-V, Schedules I and II having high abuse potential); ARK CODE ANN. § 17-87-310 (Michie 2002) (limiting the prescriptive authority of nurses to Schedules III-V drugs); COLO. REV. STAT. ANN. § 12-36-106.3 (West 2002) (requiring a collaborative agreement with a physician); CONN. GEN. STAT. § 20-87a (West 1999) (requiring a special procedure for a nurse to prescribe drugs from Schedules II and III); ILL. COMP. STAT. § 65/15-20 (West 1993) (requiring a mid-level practitioner controlled substance license to prescribe drugs from Schedules III-V); IND. CODE ANN. § 25-23-1-19.4 (West 2001) (requiring a collaborative agreement); KEN. REV. STAT. ANN. § 314.042 (Michie 2001) (requiring a collaborative agreement); ANA CHART, *supra* note 100, at http://www.nursingworld.org/gova/charts/dea.htm.

n102 *See* ANA CHART, *supra* note 100, at http://www.nursingworld.org/gova/charts/dea.htm; AMERICAN ACADEMY OF NURSE PRACTITIONERS, DATA AND SURVEY INFORMATION, *at* http://www.aanp.org/Practice+Policy+and+Legislation/Regulation/DEARegulation/DEA.asp (last visited Nov. 10, 2003) (linking to Nurse Practitioner Prescriptive Authority) [hereinafter AANP DATA].

n103 *See* ANA CHART, *supra* note 100, at http://www.nursingworld.org/gova/charts/dea.htm.

n104 *See* GA. CODE ANN. § 16-13-72 (2003); ANA CHART, *supra* note 100, at http://www.nursingworld.org/gova/charts.dea.htm; AANP DATA, *supra* note 102, at http://www.aanp.org/Practice+Policy+and+Legislation/Regulation/DEARegulation/DEA.asp.

n105 ARIZ. ADMIN. CODE R4-19-507 (2003); ARIZONA NURSE PRACTITIONER CONNECTION, ARIZONA NURSE PRACTITIONER SCOPE OF PRACTICE, *at* http://aznpconnection.netfirms.com/azscope.htm (last visited Nov. 12, 2003) (stating that a nurse practitioner has a generalized ethical and moral duty to discuss a patient's care with a qualified practitioner if there is any doubt about what care is optimal, but is no longer legally required to supply the name of the consulted practitioner).

n106 *See supra* note 96 and accompanying text.

n107 *See* sources cited *supra* note 100.

n108 " Medical science courses" refers to college biology, college general and organic chemistry, calculus, physics, physiology, anatomy, microbiology, biochemistry, and all advanced courses within these areas of study. *See supra* notes 62-63, 68-70, 85-87, 92-94 and accompanying text. In comparison, behavioral science courses focus on the identification, cause, and treatment of behavioral disorders, not requiring completion of medical science courses. *See infra* notes 259-60 and accompanying text.

n109 *See supra* Parts II.A.-C.

n110 *Id.*

n111 *Id.*

n112 *See infra* Part III.

n113 *See, e.g.,* UNIVERSITY OF ARIZONA, 2002-03 GENERAL CATALOG, BACHELOR OF ARTS -- PSYCHOLOGY, *available at* http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBAxzxxx.html (last updated Oct. 30, 2003) [hereinafter ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY]; CALIFORNIA STATE UNIVERSITY, FRESNO, 2003-04 GENERAL CATALOG, DEPARTMENT OF PSYCHOLOGY, *available at* http://www-catalog.admin.csufresno.edu/current/pdf/psych.pdf (last visited Nov. 12, 2003) [hereinafter CSU, FRESNO CATALOG-PSYCHOLOGY].

n114 *See, e.g.,* CSU, FRESNO CATALOG-PSYCHOLOGY, *supra* note 113, at http://www-catalog.admin.csufresno.edu/current/pdf/psych.pdf (stating that...education requirement); CALIFORNIA STATE UNIVERSITY, FRESNO, 2003-04 GENERAL CATALOG, GENERAL EDUCATION, *at* http://www-catalog.admin.csufresno.edu/current/gened.html (last visited Nov. 12, 2003) (indicating general quantitative reasoning) [hereinafter CSU, FRESNO CATALOG-GENERAL].

n115 *Id.* (showing that CSU, Fresno, like the majority of universities, considers psychology to be a behavioral science, and does not accept psychology courses in satisfaction of natural and physical science course requirements).

n116 *See infra* Part III. (discussing the increased difficulty of science courses taken by science majors (e.g., biology, chemistry) compared to non-major science courses). Physicians and physician assistants most often take the same science courses as science majors. Nursing students, however, may fulfill their organic chemistry and a few of their biology prerequisites with organic chemistry and biology courses falling outside the science major requirements.

n117 *See, e.g.,* CSU, FRESNO CATALOG-GENERAL, *supra* note 114, at http://www-catalog.admin.csufresno.edu/current/gened.html (explaining that a student may complete undergraduate science requirements with only 12 units of science courses, including one upper division science class).

n118 *See, e.g.,* ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY, *supra* note 113, at http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBAxzxxx.html; CSU, FRESNO CATALOG-PSYCHOLOGY, *supra* note 113, at http://www-catalog.admin.csufresno.edu/current/pdf/psych.pdf.

n119 *See, e.g.,* ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY, *supra* note 113, at http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBAxzxxx.html (explaining that the psychobiology and neuroscience requirements can be satisfied with non-medical related courses); UNIVERSITY OF ARIZONA, 2002-03 GENERAL CATALOG, FALL 2002 COURSE DESCRIPTIONS, *at* http://catalog.arizona.edu/2002-03/courses/024/PSYC.html (last updated Feb. 13, 2003).

n120 *See supra* Parts II.A.-C., explaining medical, physician assistant, and nursing student programs all require a uniformed set of pre-requisite and co-requisite science courses for graduation.

n121 *See, e.g.,* UNIVERSITY OF WISCONSIN-MADISON, DEPARTMENT OF PSYCHOLOGY, FREQUENTLY ASKED QUESTIONS, *at* http://psych.wisc.edu/ugstudies/topten.html (last updated Apr. 3, 2003); UNIVERSITY OF WISCONSIN-MADISON, DEPARTMENT OF PSYCHOLOGY, REQUIREMENTS FOR THE MAJOR, *at* http://psych.wisc.edu/ugstudies/requirementsPost2001.html (last updated Apr. 3, 2003).

n122 Students earning BS degrees in psychology with a science minor at the University of Arizona, for example, complete 18-22 science

units for the minor as well as additional science units required for the major, bringing the total to approximately 27 science units for completion of the BS degree. *See* UNIVERSITY OF ARIZONA, 2003-04 GENERAL CATALOG, BACHELOR OF SCIENCE-PSYCHOLOGY, *available at* http://www.arizona.edu/academic/oncourse/data/034/A8zPSYCzBSxzxxx.html (last updated Nov. 5, 2003) (outlining the "supporting science requirement" of additional coursework in mathematics, biology and chemistry or physics); UNIVERSITY OF ARIZONA, 2003-04 GENERAL CATALOG, DEPARTMENT OF PSYCHOLOGY, *available at* htpp://catalog.arizona.edu/2003-04/dept/PSYC.shtml (last updated June 6, 2003) (stating that the BS in psychology is a "science-intensive major," requiring both a science minor and additional coursework in mathematics, biology, and chemistry or physics); UNIVERSITY OF ARIZONA, 2003-04 GENERAL CATALOG, MINOR REQUIREMENT REPORTS, *available at* http://www.arizona.edu/academic/oncourse/data-minors/interface/ (last updated Oct. 8, 2003) (providing links stating that to complete the science minors requirement for a Bachelor of Science in Psychology students must complete 18-22 units).

n123 CSU, FRESNO, 2001-02 GENERAL CATALOG, ACADEMIC REGULATIONS, *available at* http://www-catalog.admin.csufresno.edu/archives/0102/acadreg.html (last visited Nov. 10, 2003) (defining double-counting as"allowing one course to fulfill two separate requirements concurrently; e.g., allowing one course to fulfill both a major requirement and the upper-division writing skills requirement, or allowing one course to fulfill both a major requirement and General Education requirement").

n124 Students may graduate with Bachelor of Science of Psychology degrees having taken few medically related science courses. *See* ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY, *supra* note 113, at http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBAxzxxx.html.

n125 *See, e.g., id.* (requiring only 3 units from psychobiology & neuroscience distribution).

n126 *See* UNIVERSITY OF ARIZONA, 2002-03 GENERAL CATALOG, DEPARTMENT OF PSYCHOLOGY, *available at* http://catalog.arizona.edu/2002-03/dept/PSYC.shtml (last updated Mar. 12, 2002) ("BS students are required to select a minor in one of the following areas: Biochemistry, Computer Science, Ecology and Evolutionary Biology, Mathematics, Molecular and Cellular Biology, Physics, or the Pre-Health Professions minor.") [hereinafter ARIZONA CATALOG-PSYCHOLOGY].

n127 *See supra* Parts II.A.-C.

n128 *See, e.g.,* PETERSON'S GRADUATE & PROFESSIONAL PROGRAMS: AN OVERVIEW (37th ed. 2003). *See generally* EDUCATIONAL TESTING SERVICE, GRADUATE RECORD EXAMINATION, FREQUENTLY ASKED QUESTIONS ABOUT THE NEW GENERAL TEST, *at* http://www.gre.org/faqnew.html (last updated July 15, 2003) (explaining the general format of the test, what it measures, how it is scored, and other information for potential test takers); ETS, GRE, COMPUTER BASED GENERAL TEST DESCRIPTION, *at* http://www.gre.org/cbttest.html#description (last updated June 23, 2003).

n129 PETERSON'S GRADUATE & PROFESSIONAL PROGRAMS: AN OVERVIEW, *supra* note 128.

n130 *E.g.,* CSU, FRESNO, GRADUATE PROGRAMS, DEPARTMENT OF PSYCHOLOGY, *available at* http://psych.csufresno.edu/psychweb/graduate (last visited Nov. 10, 2003) (link to Master of Arts degree requirements) [hereinafter CSU, FRESNO GRADUATE-PSYCHOLOGY].

n131 *Id.* (link to M.S. degree requirements); UNIVERSITY OF ARIZONA, GRADUATE CATALOG 2003-04, REQUIREMENTS FOR MASTER'S DEGREES, *available at* http://grad.admin.arizona.edu/catalog/masters/ (last visited Nov. 12, 2003) (stating that minimum of 30 units of graduate work, including thesis, is required for master of science degree).

n132 CSU, FRESNO GRADUATE-PSYCHOLOGY, *supra* note 130, at http://psych.csufresno.edu/psychweb/graduate (linking to requisite courses in the programs).

n133 *Id.*

n134 ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY, *supra* note 113, at http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBSxzxxx.html.

n135 *Compare* UNIVERSITY OF ARIZONA, DEPARTMENT OF PSYCHOLOGY, CURRICULUM, CLINICAL PSYCHOLOGY PROGRAM, *at* http://psych.arizona.edu/clinical/curriculum.html (last visited Nov. 10, 2003) (listing the required courses for a degree in clinical psychology), *with* COLUMBIA UNIVERSITY, HEALTH SCIENCES CURRICULUM ONLINE, *at* http://www.columbia.edu/itc/hs/medical/histology/course_online/index.html (last visited Nov. 10, 2003) (listing the required courses for a medical doctorate), *and* COLUMBIA UNIVERSITY SCHOOL OF NURSING, ENTRY TO PRACTICE PRORGAM FOR NON-NURSE COLLEGE GRADUATES, *at* http://www.healthsciences.columbia.edu/dept/nursing/academics-programs/etp.html (last visited last update July 2003) (listing the required course for a nursing degree), *and* EASTERN VIRGINIA MEDICAL SCHOOL, *at* http://www.evms.edu/hlthprof/mpa/curriculum.html (last revised Apr. 15, 2003) (listing the required courses necessary for obtaining Master of Physician Assistant degree).

n136 *See, e.g.,* UNIVERSITY OF ARIZONA, GRADUATE PROGRAMS, CLINICAL PSYCHOLOGY, *at* http://www.psychology.arizona.edu/programs/g_each/clinical.php?option=2 (last updated Oct. 20, 2003).

n137 *E.g.,* ALLIANT INTERNATIONAL UNIVERSITY, CALIFORNIA SCHOOL OF PROFESSIONAL PSYCHOLOGY, *at* http://www.alliant.edu/cspp/psydclin.htm (last modified June 13, 2003).

n138 *Id.;* ARIZONA CATALOG-PSYCHOLOGY, *supra* note 126, at http://catalog.arizona.edu/2002-03/dept/PSYC.shtml.

n139 Psychiatrists oppose granting psychologists prescriptive authority because the emphasis of training in psychology is on a behavioral model that severely lacks adequate educational and experiential training in non-mental health issues. Ultimately, psychologists lack any understanding of non-mental health illnesses. Whether they can prescribe psychotropic medication safely is irrelevant. *See, e.g.,* CPA PSYCHOLOGIST PRESCRIBING, *supra* note 5, at http://www.calpsych.org/legislation/1999/claimvsfact.html (arguing that psychiatrists and physicians are trained to treat biological illness and chemical imbalances as opposed to psychologists who are trained to treat human behavior).

N.M. STAT. ANN. § 61-9-3(D) (repealed effective July 1, 2004) (defining the "practice of psychology" as "the observation, description, evaluation, interpretation and modification of human behavior by the application of psychological principles, methods and procedures for the purpose of preventing or eliminating symptomatic, maladaptive or undesired behavior and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health and mental health . . . including psychological testing or neuropsychological testing and the evaluation or assessment of personal characteristics[,] . . . counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, behavior analysis and therapy; diagnosis and treatment of any mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct and the psychological aspects of physical illness, accident, injury and disability; and psychoeducational evaluation, therapy, remediation and consultation"). *Compare* N.M. STAT. ANN. § 61-3-3 (repealed effective July 1, 2004), *with* N.M. STAT. ANN. § 61-3-3(K) (Michie 1978) (defining "professional registered nursing" as "requiring substantial knowledge of the biological, physical, social and behavioral sciences and nursing theory...[including] establishing a nursing diagnosis . . . [and] collaborating with other health care professionals in the management of health care"), *and* N.M. STAT. ANN. § 61-3-3(L) (Michie 1978). *See also supra* Part II.B.

n140 *See supra* Part II.

n141 *E.g.,* CAL. BUS. & PROF. CODE § 2903 (West 2003).

n142 *E.g., id.* § 2961.

n143 *See, e.g., id.* § 101.6 (describing as one purpose of the board to "register or otherwise certify persons in order to identify practitioners and ensure performance according to set and accepted professional standards").

n144 *See, e.g.,* CALIFORNIA BOARD OF PSYCHOLOGY, MANDATORY CONTINUING EDUCATION REQUIREMENTS, *at* http://www.psychboard.ca.gov/licensing/education.html (last visited Nov. 10, 2003) (requiring 36 hours of continuing education between licensing periods).

n145 APNA PRESCRIPTIVE AUTHORITY, *supra* note 4, at http://www.apna.org/papers/positionpapers.html ("In increasing numbers, states are legislating prescriptive practice authority for advanced practice nurses . . . to increase access to health care and to utilize nurses to their full capacity as accessible, cost effective, full service providers."); AAPA INFORMATION, *supra* note 4, at http://www.aapa.org/geninfo1.html (stating that the purpose in creating physician assistant position was to supplement the need for primary care physicians).

n146 *See* APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n147 *Id.*

n148 James A. Ciarlo, et al., *Focusing on "Frontier": Isolated Rural America, Letter to the Field No. 2,* at http://www.wiche.edu/MentalHealth/Frontier/letter2.html (last revised Apr. 11, 1996).

n149 *Id.* (defining and classifying rural areas).

n150 FEDERAL OFFICE OF RURAL HEALTH POLICY, FACTS ABOUT . . . RURAL PHYSICIANS, *at* http://www.shepscenter.unc.edu/research_programs/rural_program/phy.html (last visited Nov. 10, 2003).

n151 *Id.*

n152 *Id.*

n153 *See* Holzer et al., *supra* note 13, at http://www.wiche.edu/MentalHealth/Frontier/letter11.html; Geller & Muus, *supra* note 20, at http://www.wiche.edu/MentalHealth/Frontier/letter5.html; Mohatt, *supra* note 13, at http://www.wiche.edu/MentalHealth/Frontier/letter4.html.

n154 Holzer et al., *supra* note 13, at http://www.wiche.edu/MentalHealth/Frontier/letter11.html (referring to chart at figure 1).

n155 *See* Richard Sherer, *Mental Health Care Shortages Will Need Creative Solutions,* PSYCHIATRIC TIMES (Sept. 2001) (on file with author) ("A given community is designated as underserved when it has '(a) a population-to-core mental health professional ratio greater than or equal to 6,000:1 and a population-to-psychiatrist ratio greater than or equal to 20,000:1, or (b) a population-to-core-professional ratio greater than or equal to 9,000:1, or (c) a population-to-psychiatrist ratio greater than or equal to 30,000:1,' according to BPHC [Bureau of Primary Health Care] guidelines.").

n156 Mohatt, *supra* note 13, at http://www.wiche.edu/MentalHealth/Frontier/letter11.html.

n157 *See* Holzer et al., *supra* note 13, at http://www.wiche.edu/MentalHealth/Frontier/letter11.html; Geller & Muus, *supra* note 20, at http://www.wiche.edu/MentalHealth/Frontier/letter5.html.

n158 *See id. (citing* Darrel A. Regier et al., *The De Facto US Mental Health Services System: A Public Health Perspective,* 35 ARCHIVES GEN. PSYCHIATRY 685, 688 (1978)).

n159 Holzer et al., *supra* note 13, at http://www.wiche.edu/MentalHealth/Frontier/letter11.html.

n160 *Id.*

n161 *Id.*

n162 *Id.*

n163 *Id.*

n164 *Id.*

n165 *Id.*

n166 *Id.*

n167 *Id.*

n168 *Id.*

n169 *Id.* (defining psychologist as "M.A. or greater psychologists working in health-related settings by population per square mile"). These percentages obviously decrease by removing masters-level psychologists from consideration for prescriptive authority.

n170 *See id.*

n171 *Id.*

n172 *Id.*

n173 *See* Editorial, *Ignoring Mental Illness in Kids,* CHI. TRIB., July 23, 2001, *available at* 2001 WL 4096611; *Culture Counts in Mental Health Services and Research Finds New Surgeon General Report,* U.S. NEWSWIRE, Aug. 26, 2001, *available at* 2001 WL 21897399; Allison Sherry, *Mentally Ill Swamp ER Staffs: Some Fear Treatment of Other Cases Impaired,* DENV. POST, Aug. 27, 2001, *available at* 2001 WL 6760857; NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL, BASICS OF HOMELESSNESS, *at* http://www.nhchc.org/Publications/basics_of_homelessness.htm (last updated Apr. 7, 2003) [hereinafter NHCHC].

n174 *See* NHCHC, *supra* note 173, at http://www.nhchc.org/Publications/basics_of_homelessness.htm.

n175 Holzer et al., *supra* note 13, at http://www.wiche.edu/MentalHealth/Frontier/letter11.html.

n176 *Id.*

n177 *Id.*

n178 *See supra* notes 173-74 and accompanying text.

n179 *See* Ronald E. Fox, & Morgan T. Sammons, *A History of Prescription Privileges,* 29 APA MONITOR ONLINE (Sept. 1998), *available at* http://www.apa.org/monitor/sep98/prescrip.html.

n180 *Id.*

n181 *See* Ronald F. Levant, *We Have Come a Long Way: The Prescriptive Authority Initiative,* 32 MONITOR ON PSYCHOL. (Nov. 2001), *available at* http://www.apa.org/monitor/nov01/sp.html.

n182 *See* ASAP, *at* http://www.apa.org/divisions/div55/ (last visited Nov. 10, 2003).

n183 *E.g.,* H.B. 139, 1999 Leg., 21st Sess. (Ala. 1999); S.B. 777, 1995-96 Reg. Sess. (Cal. 1995); S.B. 2050, 1997-98 Reg. Sess. (Cal. 1997); S.B. 202, 145th Gen. Assemb., 1999-00 Reg. Sess. (Ga. 1999); H.B. 353, 1999 Gen. Assemb., 1999-00 Reg. Sess. (Ga. 1999); H.B. 1311, 1997 19th Leg. (Haw. 1997); S.B. 1402, 1999 91st Gen. Assem., 1999-00 Reg. Sess. (Ill. 2000); H.B. 1736, 1999 91st Gen. Assemb. (Ill. 1999); S.B. 677, 1999 Reg. Sess. (La. 1999); H.B. 1286, 1999 Reg. Sess. (La. 1999).

n184 " Legislation has been introduced in nine states: AK, CA, FL, IL, GA, HI, LA, MO and MT (although the MT bill was not supported). Of these, Louisiana has made the most progress." Carol Williams-Nickelson, *Prescription Privileges Fact Sheet: What Students Should Know About the APA's Pursuit of Prescription Privileges for Psychologists (RxP), at* http://www.apa.org/apags/profdev/prespriv.html (last visited Nov. 10, 2003).

n185 N.M. STAT. ANN. § 61-9-17 (repealed effective July 1, 2010).

n186 *See* Julien, *supra* note 15; AMERICAN PSYCHIATRIC ASSOCIATION, STATE OF THE STATES: PSYCHOLOGISTS' PRESCRIBING PRIVILEGES, *at* http:www.psych.org/pub_pol_adv/statecostex.cfm (March 2003) (discussing assistance of grassroots advocacy efforts to oppose prescriptive authority for psychologists); ASAP, ASAP READER # 125, *at* http://www.apa.org/divisions/div55/ASAPReader125.htm (Mar. 27, 2002) (listing the Committee Against Medicalizing Psychology as one of the organizations opposing prescriptive authority for psychologists in New Mexico).

n187 See discussion *supra* Part III.

n188 *See* Letter from E. Mario Marquez, *supra* note 48, at http://www.apa.org/divisions/div55/RxPResources.htm.

n189 *See supra* Part II.A.

n190 *See supra* Part III.

n191 *See generally* discussion *supra* Part III.

n192 *See, e.g.,* Julien, *supra* note 15 (quoting president of the Connecticut Psychological Association, arguing that because of the close psychologist-patient relationship, psychologists are "in an ideal position to make judgments about these medications--and to monitor it").

n193 *See* Geller, *supra* note 20, at http://www.wiche.edu/MentalHealth/Frontier/letter10.html ("At that time [1978], . . . approximately 60 percent of the total persons affected by mental disorders sought treatment in a primary care setting. Subsequent studies have continued to affirm the presence and importance of this. . . .").

n194 *See id.;* sources cited *supra* note 3.

n195 *See* STANFORD MD CURRICULUM, *supra* note 60, at http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html.

n196 *See* W. Eugene Broadhead et al., *Tricyclic Antidepressant Prescribing Nonpsychiatric Disorders: An Analysis Based on Data from the 1985 National Ambulatory Medical Care Survey,* 33 J. FAM. PRAC. 24 (1991); Arnold Feldman, *The Family Practitioner As Psychiatrist,* 135 AM. J. PSYCHIATRY 728 (1978); L. Ralph Jones et al., *Mental Health Training of Primary Care Physicians: An Outcome Study,* 18 INT'L J. PSYCHIATRY MED. 107, 119 (1988); Harold A. Pincus et al., *Models of Mental Health Training in Primary Care,* 249 JAMA 3065, 3065, 3067-68 (1983); Marc A. Zimmerman & Louis A. Wienckowski, *Revisiting Health And Mental Health Linkages: A Policy Whose Time Has Come . . . Again,* 12 J. PUB. HEALTH POL. 510, 519 (1991).

n197 Susan M. Anderson & Barbara Herr Harthorn, *The Recognition, Diagnosis, and Treatment of Mental Disorders by Primary Care Physicians,* 27 MEDICAL CARE 869, 881-82 (1989).

n198 *Id.* at 882.

n199 Geller, *supra* note 20, at http://www.wiche.edu/MentalHealth/Frontier/letter10.html.

n200 *See supra* text accompanying note 198.

n201 *See supra* Part III. This is the crucial fact distinguishing psychologists from other prescribing healthcare providers (physician assistants and nurse practitioners) discussed in this Article.

n202 ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf.

n203 *Id.*

n204 APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html (emphasis added) (quoting Russ Newman, the Executive Director for Professional Practice, American Psychological Association). *See also,* Letter from E. Mario Marquez, *supra* note 48, at http://www.apa.org/divisions/div55/RxPResources.htm (asserting that the PDP "project *proved* that psychologists could be trained to safely and effectively prescribe psychotropics to their patients) (emphasis added)).

n205 *See* ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf (stating that the PDP participants "performed with excellence wherever they were placed," and that the graduates "filled different niches and brought unique perspectives to their various assignments").

n206 *See infra* text accompanying note 228.

n207 *See* ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf.

n208 *Id.* (representing a 23% attrition rate in Table 1).

n209 *Id.*

n210 *Id.* (referring to Table 2's didactic curriculum for the PDP groups for a breakdown of courses and hours).

n211 *Id.* (comparing Group A's curriculum to Groups B, C, and D's coursework in Table 2).

n212 *Id.* Groups B, C, and D "took a combination of four standard USUHS Medical School core courses, five modified and abbreviated Medical School courses taught by Medical School faculty, and two Graduate School of Nursing (GSN) courses . . ., including interviewing, history taking, and physical examination. The total didactic instruction for the final class was approximately 700 hours, and curriculum differences from Group B-to-C-to-D were relatively minor." *Id.*

n213 *Id.* (stating that Group A's practicum was closely linked with the psychiatry residency program).

n214 *Id.* (discussing the Clinical Practicum Program).

n215 *Id.* (prescribing 41 psychotropic medications for diagnoses including: substance abuse, non bi-polar disorder major depression, generalized anxiety, panic, obsessive-compulsive and post traumatic stress disorders, schizophrenia spectrum, dysthymia, anorexia/bulimia, and somatiform disorder).

n216 *Id.* (describing Group B's rotations in psychiatry clinic and consultation/liaison services, Groups C and D's rotations including psychiatry and psychology clinics, emergency room call training, biological psychiatry seminars, and case conferences).

n217 *Id.* (referring to Table 1).

n218 *Id.* (describing the practice profiles of the graduates).

n219 *Id.*

n220 *Id.* ("All graduates were initially proctored by psychiatrists. Half of them had advanced to independent provider status with its standard minimum review of 10% of medication cases.").

n221 *Id.* ("The PDP was not designed to replace psychiatrists or produce mini-psychiatrists or psychiatrist extenders, and it did not do so. Instead, the program 'products' were extended psychologists with a value-added 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.").

n222 *Id.* ("On posts where there was a shortage of psychiatrists, the graduates tended to work side-by-side with psychiatrists, performing many of the same functions a 'junior psychiatrist' might perform. . . . "They [the psychologists] essentially mirrored what psychiatrists did with the same population, and, in fact, they differed little from the private practices of the psychiatrists on the Evaluation Panel.").

n223 *Id.*

n224 *Id.*

n225 *Id.* "Two of these chiefs completed their PDP training less than a year earlier. Other indicators of quality and achievement that characterized this cohort were present when they entered the program. They all had not only a doctorate in clinical psychology but also clinical experience that ranged from a few to more than 10 years. All but two had military experience." *Id.*

n226 *Id.* "They generally had minimal education in the traditional premedical courses." *Id.* Unfortunately, with such a small sample size, only a few science courses for one or two participants could make a significant difference in outcome reports.

n227 *Id. See supra* text accompanying note 210 (indicating that despite the a limited background in pre-medical courses, two of the ten participants (20%) completed an additional 700 hours of medical school science courses compared to the other participants. Thus, the Group A psychologists overcame any deficit in their science backgrounds).

n228 *Id.*

n229 *Id.*

n230 *Id.* (stating that the curriculum was adapted to the proposed role of a prescribing psychologist after evaluating Group A's performance).

n231 *Id.*

n232 *Id.* (listing other professionals who would benefit from training (psychiatric nurses who hold a masters of science in nursing, M.D. practitioners who have little clinical experience in psychiatric treatment, and those holding doctorates in clinical pharmacy)).

n233 Rebecca A. Clay, *State Leaders Convene in Washington, D.C.: Meeting Emphasizes Organizational and Advocacy Issues,* 29 APA MONITOR No. 4 (Apr. 1998), *available at* http://www.apa.org/monitor/apr98/state.html (indicating there were 70,000 licensed psychologists in 1995).

n234 *See* ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf (referring to Table 2)

n235 *Id.*. ("Eight out of ten [of the graduates] were serving as chiefs or assistant chiefs of an outpatient psychology clinic or a mental health clinic.").

n236 *Id.*

n237 *See supra* text accompanying note 11; Letter from E. Mario Marquez, *supra* note 48, at http://www.apa.org/divisions/div55/RxPResources.htm.

n238 *See* ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf.

n239 *See* Letter from E. Mario Marquez, *supra* note 48, at http://www.apa.org/divisions/div55/RxPResources.htm (citing facts about the lack of treatment of children as part of psychologists' intention to treat this population).

n240 *See* ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf.

n241 *Id.* (discussing the need to shorten and tailor certain courses in the medical school didactic program to reflect the "specific needs of prescribing psychologists").

n242 *Id. Contra* ASAP, WEEKLY READER # 105, *at* http://www.apa.org/divisions/div55/WR105.html (May 31, 2001) (responding to accusation that the new American Psychological Association's didactic standard recommendation of 300 didactic hours is inadequate).

n243 ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf.

n244 Letter from E. Mario Marquez, *supra* note 48, at http://www.apa.org/divisions/div55/RxPResources.htm (overstating the number of credit hours by 20% when claiming that "approximately 36 graduate semester credit hours" are required).

n245 *See* N.M. STAT. ANN. § 61-9-17.1 (repealed effective July 1, 2010); APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n246 *See* ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf; *infra* text accompanying notes 250-54. *Compare* APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html, *with* text accompanying text *supra* notes 211, 229.

n247 *See supra* text accompanying note 11; Letter from E. Mario Marquez, *supra* note 48, at http://www.apa.org/divisions/div55/RxPResources.htm.

n248 *See* ASAP, WEEKLY READER # 105, *supra* note 242, at http://www.apa.org/divisions/div55/WR105.html (explaining that the original Department of Defense program was not designed to train psychologists, but rather had to be modified many times); ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf.

n249 *See* ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf.

n250 *Compare id.* (requiring 712 didactic hours for the PDP), *with* Letter from E. Mario Marquez, *supra* note 48, at http://www.apa.org/divisions/div55/RxPResources.htm (requiring 450 didactic hours for New Mexico). The New Mexico requirement equals only 63% of the PDP didactic requirements.

n251 *See supra* text accompanying note 229.

n252 *See* ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf; ASAP, WEEKLY READER # 125, *supra* note 186, at http://www.apa.org/divisions/div55/ASAPReader125.htm (alleging that the New Mexico clinical practicum translates into approximately one year and one-half of experience with new patients rather than merely four months). John Winston Bush's approximation of four months appear more realistic based on 400 hours equaling 20% of a normal 2,000-hour work year amounting to ten weeks (two and one-half months) of fulltime work. Although unrealistic for educational purposes, a psychologist could easily treat 100 patients in this time and receive permission to prescribe medications though totally unqualified to do so. Also, the PDP psychologists average about 13 patients per month, whereby they could see 100 patients in less than eight months. *Id*. Either scenario allows completion of training in less than the one year recommended by the PDP. *See supra* text accompanying note 230.

n253 *See* ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6/no3.pdf.

n254 *See* N.M. STAT. ANN. § 61-9 (repealed effective July 1, 2010); ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf.

n255 *See* ACNP DOD, *supra* note 11, *at* http://www.acnp.org/pdffiles/vol6no3.pdf.

n256 *See* ASAP, ASAP READER # 123, *supra* note 38, at http://www.apa.org/divisions/div55/WR123.htm (quoting from Brian Ramirez's survey results that 40% of practicing psychologists would seek additional training if given prescriptive authority). With only 40% indicating a desire to gain this privilege, there is no indication or guarantee of how many of these practitioners would be willing to work in rural areas, especially with the likely increase in debt from the additional education requirements.

n257 *See supra* text accompanying notes 229, 242.

n258 *See* ASAP, ASAP READER # 124, *at* http://www.apa.org/divisions/div55/ASAPReader124.html (Mar. 11, 2002) (arguing that psychologists' doctorates should be taken into account in determining the amount of medical education necessary to ensure that medications are prescribed safely). *Contra,* CPA PSYCHOLOGIST PRESCRIBING, *supra* note 5, at http://www.calpsych.org/legislation/1999claimvsfact.html (arguing that psychologists have an average of five years of full-time training including only one year of clinical work).

n259 PHYSICIAN'S WEEKLY, *supra* note 16, at http://www.physweekly.com/archive/01/07_02_01/pc.html ("Psychologists' education

deals with human behavior--not human biology and pathology. They can earn a PhD by taking a single course in the biological basis of behavior."). *See, e.g.,* ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY, *supra* note 113, at http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBAxzxxx.html (requiring two natural science courses at a level below college biology, one nature science course like ecology or geology, one mathematics course like intermediate algebra and one psychobiology course). Thus, a student can graduate without taking one basic college science course (i.e. college level chemistry, biology, physics or calculus). UNIVERSITY OF ARIZONA, GRADUATE PROGRAMS, CLINICAL PSYCHOLOGY PROGRAMS, CURRICULUM INFORMATION OF THE CLINICAL PSYCHOLOGY PROGRAM, *available at* http://psychology.arizona.edu/programs/g_each/clinical.php?option=4 (last updated Oct. 20, 2003) (stating that although the doctorate in clinical psychology requires psychology-related science courses, students are not required to take any basic college health science courses).

n260 CPA PSYCHOLOGIST PRESCRIBING, *supra* note 5, at http://www.calpsych.org/legislation/1999/claimvsfact.html (emphasis added).

n261 N.M. STAT. ANN. § 61-9 (repealed effective July 1, 2010) (referring to the entire article called the "Professional Psychologist Act"). *See* APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n262 *Compare* N.M. STAT. ANN. § 61-9-17.1(5)-(6) (repealed effective July 1, 2010) (indicating a total didactic and practicum education requirement of 930 hours for granting psychologists prescriptive authority), *with* CAL. BUS. & PROF. CODE § 2089 (West 2003) (indicating a 4,000-hour class and practicum minimum education requirement for physician licensure). Psychologists get only 23.35% (930 versus 4,000 hours) of the training required of a licensed physician). The physicians' time does not include prerequisite and residency education and experience. The psychologists' time ignores any medical science background. *See* discussion *supra* Parts II. & III.

n263 *See* ASAP, ASAP READER # 124, *supra* note 258, at http://www.apa.org/divisions/div55/ASAPReader124.html.

n264 *Compare* discussion *supra* Part II.B., *and* discussion *supra* Part II.C., *with* discussion *supra* Part III.

n265 ASAP, WEEKLY READER # 107, *at* http://www.apa.org/divisions/div55/WR107.html (June 28, 2001) (stating that psychologists are properly trained to distinguish between psychological and physiological illnesses when symptoms are present that do not fit within the psychological profile, but need medical consultation to diagnose or treat the illness).

n266 LEARNING DISABILITIES ASSOCIATION OF ONTARIO, *at* http://www.ldao.on.ca/ldao_projects/pei/defsupp/e8.html (last visited Nov. 13, 2003) ("Comorbidity is described as a situation where two or more conditions that are diagnostically distinguishable from one another tend to occur together.").

n267 *See* ASAP, WEEKLY READER # 105, *supra* note 242, at http://www.apa.org/divisions/div55/WR105.html (responding to criticism that the PDP recommended 712 hours of instruction while the APA recommended only 300 hours, citing the conclusion that the many hours

of medically related training were unnecessary).

n268 *Id.*

n269 STANFORD MD CURRICULUM, *supra* note 60, at http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html.

n270 *See supra* Parts II.B.-C.

n271 *See supra* note 258 and accompanying text.

n272 Associated Press, *Prescription Drug Costs Surge--Again, at* http://www.cnn.com/2002/HEALTH/03/29/prescription.spending.ap/ (Mar. 29, 2002) (stating there are 9,482 drugs on the retail market).

n273 *See* ASAP, WEEKLY READER # 105, *supra* note 242, at http://www.apa.org/divisions.div55/WR105.html ("The goal of this intense APA program focuses on the FDA approved psychoactive medications, which currently numbers about 80 drugs, rather than the thousand or more drugs currently used in general medicine today."). See Preston, *Quick Reference to Psychotropic Medication, supra* note 41, at http://www.apa.org/divisions/div55/PrestonMedicationCare2003.pdf, for a list of the current psychotropic medications commonly used.

n274 *See, e.g.,* ASAP, WEEKLY READER # 107, *supra* note 265, at http://www.apa.org/divisions/div55/WR107.html.

n275 *See* HEALTH RESOURCES AND SERVICES ADMINISTRATION, BUREAU OF PRIMARY HEALTH CARE, MENTAL HEALTH IN PRIMARY CARE, *at* http://www.bphc.hrsa.gov/bphc/mental/Default.htm (last visited Nov. 13, 2003) ("Numerous studies demonstrate excess mortality, morbidity, and health care use for those with mental health and substance abuse disorders. . . . The relationships between mental health and physical health are complex, and the excess morbidity and mortality cannot be completely explained by behavioral factors. There are several examples of a [sic] physical health issues that demonstrate this complexity. Depression has been the most widely examined of these relationships.").

n276 *See* Preston, *supra* note 41, at http://www.apa.org/divisions/div55/PrestonMedicationCare2003.pdf.

n277 ASAP, WEEKLY READER # 107, *supra* note 265, at http://www.apa.org/divisions/div55/WR107.html.

n278 *Id.*

n279 *See* APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n280 Rebecca Kayo et al., *Advancing the Profession: A Prescription for* Success, *available at* http://www.apa.org/apags/profdev/advancingprof.html (last visited Nov. 13, 2003).

n281 Sherer, *supra* note 155 ("States with the lowest ratios of psychiatrists-to-population also have low ratios of psychologists-to-population. Mississippi has only 11.3 psychologists per 100,000 population, roughly one-third of the national ratio.").

n282 *Id.*

n283 *See supra* Part IV.

n284 *Id.*

n285 *See* Norine G. Johnson, *Psychology Builds a Healthy World: Bringing It All Together,* 2 ASAP TABLET 1, 1-2 (Feb. 20, 2001), *available at* http://www.apa.org/divisions/div55/Tablet%2010/01/index.html; ASAP, WEEKLY READER # 115, *supra* note 14, at http://www.apa.org/divisions/div55/WR115.html.

n286 See Holzer et al., *supra* note 13, at http://www.wiche.edu/mentalhealth/frontier/letter11.html.

n287 *See id.*

n288 *Id.*

n289 *Id. See infra* Part V.F.

n290 APA, PRACTICE DIRECTORATE OFFICE OF RURAL HEALTH, APA RURAL HEALTH INITIATIVE: 1999 YEAR IN REVIEW, *at* http://www.apa.org/rural/report99.html (last visited Nov. 13, 2003) ("The Center for Mental Health Services reports that 55% of U.S. counties are not served by a psychologist, psychiatrist, or social worker and all of the counties are rural/frontier.").

n291 DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 1, at http://www.surgeongeneral.gov/library/mentalhealth/pdfs/C2.pdf.

n292 *See* Holzer et al., *supra* note 13, *at* http://www.wiche.edu/MentalHealth/Frontier/index.htm.

n293 *See* Harding et al., *supra* note 35, at http://www.wiche.edu/MentalHealth/Frontier/letter11.html.

n294 *Id.*

n295 *See, e.g.,* UNIVERSITY OF MINNESOTA, SCHOOL OF MEDICINE DULUTH, CENTER FOR RURAL MENTAL HEALTH STUDIES, *at* http://penguin.d.umn.edu/Departments/Rural_Mental_Health/home.htm (last modified Oct. 30, 2000) ("Financial barriers exist due to inadequacies in health insurance coverage and large numbers of rural residents with incomes below the poverty level.").

n296 *See* CME INC., RESOURCES, MENTAL HEALTH INFORMATION AND STATISTICS, *at* http://www.mhsource.com/resource/mh.html (last visited Nov. 13, 2003) (referring to the high costs of mental health treatment, its effects on society, and the importance of health insurance); *Ignoring Mental Illness in Kids, supra* note 173 (discussing cost impediments to child mental healthcare); NHCHC, *supra* note 173, at http://www.nhchc.org/Publications/basics_of_homelessness.htm (discussing costs associated with mental health treatment for the homeless).

n297 *See Bill Granting Psychologists Prescription Authority Moves Forward, supra* note 13; Wiggins, *supra* note 37, at http://www.apa.org/divisions/div55/AHCCCS.htm.

n298 AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, HEALTH CARE COSTS AND FINANCING, *at* http://www.ahrq.gov/research/jan98/ra2.htm#head3 (last visited Nov. 13, 2003).

n299 *See* sources cited *supra* note 296.

n300 *See supra* Part IV.A.

n301 *See* sources cited *supra* note 296.

n302 *See* Wiggins, *supra* note 37, at http://www.apa.org/divisions/div55/AHCCCS.htm.

n303 *Id.*

n304 *Id.* ("Savings in salaries of psychologists compared to those of psychiatrists are estimated at $ 0.7 Million" annually, in regard to eliminating the need for a psychiatry consultation.).

n305 *Id.*

n306 *Id.*

n307 *Id.* (referring to Appendix 1).

n308 *Id.*

n309 ASAP, ASAP READER # 123, *supra* note 38, at http://www.apa.org/divisions/div55/WR123.html (quoting Brian Ramirez's survey results).

n310 *Id.* (referring to comments by Dr. Wiggins).

n311 *Id.*

n312 *Id.*

n313 *See id.* (noting that 85% of the psychologists surveyed agreed that malpractice rates would increase as a result of obtaining prescriptive authority); ASAP, WEEKLY READER # 115, *supra* note 14, at http://www.apa.org/divisions/div55/WR115.html ("There is a shortage of mental health specialists who can prescribe.").

n314 ASAP, WEEKLY READER # 109, *at* http://www.apa.org/divisions/div55/WR109.html (July 18, 2002).

n315 *Id.*

n316 *Id.* ("Regardless of a theoretical prediction of lowered rates of liability premiums for psychologists who prescribe, the professional liability premiums of psychologists will be determined by the experience of the insurance market place.").

n317 *See* Wiggins, *supra* note 37, at http://www.apa.org/divisions/div55/AHCCCS.htm (hypothesizing savings by the State of Arizona if psychologists were given prescriptive authority without addressing aspects of higher fees and insurance premiums).

n318 *See* ASAP, WEEKLY READER # 118, *at* http://www.apa.org/divisions/div55/WR118.html (Nov. 21, 2001) ("Mental health care is now a turf issue based on an entrenched mental health system dominated by medical values of care with medical doctors doing what they know best.").

n319 *See* Mark Olfson et al., *National Trends in the Outpatient Treatment of Depression,* 287 JAMA 203, 206 (2002) (indicating an increased acceptance of the use of medication for the treatment of mental disorders).

n320 ASAP, ASAP READER # 124, *supra* note 258, at http://www.apa.org/divisons/div55/ASAPReader124.html ("The future of psychiatry was held in the balance. The expansion of the scope of practice of psychological treatments for mental conditions was at its threshold.").

n321 ASAP, ASAP READER # 123, *supra* note 38, at http://www.apa.org/divisions/div55/WR123.html.

n322 Theresa Prescott, *Patients Lose If Psychologists Prescribe,* 36 PSYCHIATRIC NEWS 24 (Aug. 3, 2001), *available at* http://pn.psychiatryonline.org/cgi/content/full/36/15/24.

n323 *See* ASAP, ASAP READER # 123, *supra* note 38, at http://www.apa.org/divisions/div55/WR123.html.

n324 *See* Williams-Nickelson, *supra* note 184, at http://www.apa.org/apags/profdev/prespriv.html.

n325 *See* ASAP, WEEKLY READER # 90, *at* http://www.apa.org/divisions/div55/WR90.html (Sept. 4, 2000).

n326 *See* Jack M. Geller et al., *Frontier Mental Health Strategies: Integrating, Reaching Out, Building Up, and Connecting, Letter to the Field No. 6, at* http://www.wiche.edu/MentalHealth/Frontier/letter6.html (last visited Nov. 13, 2003) (emphasis added).

n327 *See* Ali Hashmi, *Commentary: The Prescription Jihad,* 18 PSYCHIATRIC TIMES (July 2001), *available at* http://www.psychiatrictimes.com/p010720.html.

n328 *See* Geller & Muus, *supra* note 20, at http://www.wiche.edu/MentalHealth/Frontier/letter5.html ("Some rural residents will not seek or utilize mental health care because of a lack of anonymity in treatment, the stigma associated with treatment, and clashes between treatment and traditional rural values such as independence and privacy." (citation omitted)).

n329 Geller et al., *supra* note 326, at http://www.wiche.edu/MentalHealth/Frontier/letter6.html.

n330 *Id.*

n331 *Id.* Telemedicine is the "practice of healthcare delivery, diagnosis, consultation, treatment and transfer of medical data and education using telecommunications." *Id.*

N332 *See* Sherer, *supra* 155.

n333 *See supra* Part IV.A.

n334 ASAP, WEEKLY READER # 90, *supra* note 325, at http://www.apa.org/divisions/div55/WR90.html ("There is a clear understanding that we are attempting to get RxP legislation introduced in as many states as possible, as soon as possible. . . . This is no secret and is consistent with APA policy, APA Council actions, CAPP, PEPTO and why Division 55 has the acronym ASAP. This message needs to get out to the membership as a non-debatable item.").

n335 *Id.*

n336 *See, e.g.,* UNIVERSITY OF ARIZONA 2003-04 GENERAL CATALOG, FALL 2003 COURSE DESCRIPTIONS, *available at* http://catalog.arizona.edu/2003-04/courses/034/PSYC.html#GRAD (last updated Aug. 7, 2003).

n337 *See* ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6/no3/pdf; *supra* Part V.B.

n338 *See* N.M. STAT. ANN. § 61-9 (repealed effective July 1, 2010); APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n339 Seldom are organizations permitted to experiment on the society as a whole to test a hypothesis (such as whether psychologists can prescribe safely in rural America) independently without significant safeguards and preparation.

n340 *See* APA Press Release, *supra,* note 12. *Compare* ACNP DOD, *supra* note 11, at htt://www.acnp.org/pdffiles/vol6no3.pdf, *with supra* text accompanying notes 229-30.

n341 N.M. STAT. ANN. § 61-9-17 (repealed effective July 1, 2010). *See* APA Press Release, *supra,* note 12, at http://www.apa.org/practice/nm_rxp.html.

n342 *See supra* text accompanying note 228.

n343 *See, e.g.,* APA, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT § 1.14, *available at* http://www.apa.org/ethics/code1992.html#1.14 (last visited Nov. 13, 2003) ("Psychologists take reasonable steps to avoid harming their patients or clients, research participants, students, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable."); APA, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT § 6.06, *available at* http://www.apa.org/ethics/code1992.html#6.06 (last visited Nov. 13, 2003) (revised in 2002 with differences in language).

n344 *See supra* Part IV.

n345 *See supra* notes 157-58, 162 and accompanying text.

n346 *See supra* Part V.F.

n347 *See* ASPA, ASAP READER # 124, *supra* note 258, at http://www.apa.org/divisons/div55/ASAPReader124.html ("The New Mexico psychologists to the end always took the high road and argued their case on its merits rather than trying to create political pressure under the guise of unsupported public safety issues," implying the issues of drug interactions, drug overdose, drug side-effects, and a concern for a lack of sufficient education are 'unsupported public safety issues.'").

n348 *But see* ACNP DOD, *supra* note 11, at http://www.acnp.org/pdffiles/vol6no3.pdf ("Virtually all graduates of the PDP considered the "short-cut" programs proposed in various quarters to be ill-advised. Most, in fact, said they favored a 2-year program much like the PDP program conducted at Walter Reed Army Medical Center, but with somewhat more tailoring of the didactic training courses to the special needs, and skills of clinical psychologists. Most said an intensive full-time year of clinical experience, particularly with inpatients, was indispensable.").

n349 *See* ASAP, WEEKLY READER # 118, *supra* note 318, at http://www.apa.org/divisions/div55/WR118.html ("We may quibble over whether ideally we should have more of this and less of that in this APA psychologically-oriented postdoctoral psychopharmacology curriculum. We may wish to tweak the model to enhance training in other ways."). From their recommendations "quibble" and "enhance" means to reduce the minimum recommendation of the PDP by more than 50%! *See supra* text accompanying notes 229-30.

n350 *See supra* Part V.F. (recommending a collaborative approach along with other effective, safe alternatives to granting psychologists prescriptive authority).

n351 ASAP, WEEKLY READER # 118, *supra* note 318, at http://www.apa.org/divisions/div55/WR118.html.

n352 *See* THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 1427 (4th ed. 2000) (defining iron pyrite as a "brass-colored mineral" also known as "**fool's gold**").