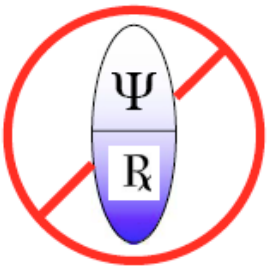

PSYCHOLOGISTS OPPOSED TO PRESCRIPTION PRIVILEGES FOR PSYCHOLOGISTS

Annotated Bibliography of Articles and Readings That Raise Concerns About Prescription Privileges for Psychologists

http://www.poppp.org

Contents

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Index to Issues Raised in the Prescription Privileges Debate

(*Numbers correspond to number of reference in the table of contents – not the page*)

Annotated Bibliography of Articles and Readings That Raise Concerns About Prescription Privileges for Psychologists

Overview: This annotated bibliography was created by Psychologists Opposed to Prescription Privileges for Psychologists (POPPP). It is intended to give the reader ready access to concerns that have been raised in the professional literature of Psychology, as well as more broadly in nursing and law. Some of the information is taken verbatim from the texts and abstracts. At times, editorial emphasis and commentary are provided by using bold print or by inserting text in brackets. The reader is encouraged to become more familiar with these concerns so as to consider key issues that raise questions about the prudence of granting psychologists prescription privileges. Follow the contents above is an index that may be used to address some specific issues that are part of this controversy.

1. American College of Neuropsychopharmacology (2000). DoD prescribing psychologists external analysis, monitoring, and evaluation of program and its final report. *American College of Neuropsychopharmacology Bulletin, 6*, Retrieved on January 15, 2007 from http://www.acnp.org/Docs/BulletinPdfFiles/vol6no3.pdf.

Reports an evaluation of the performance of 10 psychologists trained in a pilot project to prescribe in the military. Prescribing was limited to adults 18 to 65 years old who already have been medically cleared by a physician, and therefore may have less pathology than non-screened patients. The 2-year, full-time training program included 712 classroom hours on medical didactics and a year of supervised practice in a military hospital with routine physician back-up.

All 10 of the prescribing psychologists who were trained recommended *against* any reduction in required training. Most said an intensive full-time year of clinical experience, particularly with inpatients, was indispensable. They also favored a structured 2-year program, such as theirs *at a medical hospital* for training psychologists. The Evaluation Panel heard much skepticism from psychiatrists, physicians, and some of the graduates who participated in the program about whether prescribing psychologists could safely and effectively work as independent practitioners in the civilian sector. **[Despite such considerations, the APA model *in fact* decreased the training required to prescribe from that of the PDP, and effectively deleted the prerequisites.]**

The Final Report of the American College of Neuropsychopharmacology on the PDP assessed graduates ”for the most part highly esteemed, valued, and respected, there was essentially unanimous agreement that the **graduates were weaker medically than psychiatrists.”** Their medical knowledge was variously judged as on a level of students rather than physicians.

The report indicated that some graduates had limited formularies, and continued to have dependent prescriptive practice (i.e., supervised by a physician). PDP participants were

atypical of psychologists in that eight out of 10 had leadership positions. **[It would not be appropriate to assume that the experiences of a skewed population would be fully predictive of training for less accomplished psychologists].**

The report emphasized,

> "it will be ***essentia***l 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."

[The APA model for training in psychopharmacology does not require the prerequisites or other aspects of the actual training that was recommended by this report.]

2. American Psychological Association (2008). *Guidelines and principles for accreditation of programs in professional psychology.* Washington DC: Author. http://www.apa.org/ed/accreditation/G&P0522.pdf

This document presents the standards for accreditation for doctoral level training in Psychology. Accreditation is "intended to protect the interests of students, benefit the public, and improve the quality of teaching, learning, research, and professional practice…. Accreditation is a voluntary, non-governmental process of self-study and external review intended to evaluate, enhance, and publicly recognize quality in institutions and in programs of higher education."

[The document does not cover *any* training in psychopharmacology. Indeed, the word "psychopharmacology" does not appear anywhere in this 43 page document. No coursework in psychopharmacology is required to obtain a doctoral degree in psychology. The training of doctoral level psychologists does *not* require that students obtain any education in "Psychopharmacology", "Chemistry" or any specific courses in human Biology other than a single course in the "biological aspects of behavior."

No programs for training psychologists in psychopharmacology have been accredited by the American Psychological Association as meeting APA accreditation standards for a postdoctoral residency or any other level of doctoral or postdoctoral training. Unlike other training in psychology, there is not an internal mechanism for accrediting training or supervised experiences in psychopharmacology. This is

in contrast to training mechanisms in prescribing disciplines as well]

3. Association of State and Provincial Psychology Boards (2001). *ASPPB Guidelines For Prescriptive Authority.* Montgomery, AL: Author. http://asppb.org/publications/guidelines/paq.aspx

The mission of the Association of State and Provincial Psychology Boards (ASPPB) is to assist member boards in their mission to protect the public. "**As a matter of policy, ASPPB neither endorses nor opposes the current movement within many professional organizations to promote prescription privileges for psychologists. "**

"These guidelines were prepared in an effort both to provide guidance to jurisdictions that have received, or are anticipating statutory approval of, prescription privileges for psychologists, and also to continue ASPPB's efforts to achieve greater uniformity of standards among jurisdictions when making changes to their acts and regulations. **There is not yet a standard for how boards of psychology should regulate prescriptive authority for psychologists if legislatures enact this authority through statutory change."**

"**The most appropriate standard of care for psychologists to meet in prescribing medications is a complex, weighty matter that is subject to controversy.** A potential advantage in establishing the standard of care as that of a "reasonably prudent psychologist who is trained to prescribe drugs" is that it affords direct comparisons between prescribing psychologists. On the other hand, **a standard of care that compares psychologist prescribers to physicians (i.e., psychiatrists, primary care physicians) might be argued to provide a higher level of public protection by setting a threshold standard that is equivalent to that which exists in current practice….** Some case law has established the standard of care of other health professions as needing to meet that of physicians, while other cases have not upheld this standard. In the event that dependent authority is granted in some jurisdictions, not only standards of care but also standards for supervision, may become complex issues for boards, legislatures, and the courts."

"As psychologists pursue prescriptive authority, it may be anticipated that there will be questions and challenges to regulatory models, standards, and procedures, as well as to the definition of the scope of practice, training models, and other requirements for prescriptive authority… **Thus far, there are no accreditation mechanisms in place for training programs for psychologists in clinical psychopharmacology**. It is highly desirable that psychopharmacology programs become accredited…c.learly it is in the public's interest for programs to undergo some type of external review, as is done in psychological doctoral programs and internships, psychiatric residencies, and other professional training programs. "

"Defining the qualifications of supervisors for the supervised applied training in psychopharmacology continues to be a challenge. As an emerging field in psychology, there are a limited number of psychologists who are qualified to serve as supervisors…The APA (1996b) recommendations for postdoctoral training… do[es] not

address the duration of supervised applied training in psychopharmacology" [and] do[es] not delineate specific qualifications or the basis for demonstrating skills in psychopharmacology….Currently, the profession has no accepted standards for supervisors' experience in prescribing psychoactive medications prior to serving as supervisors.

Further information is available through the ASPPB website. http://www.asppb.org.

4. Bush, J.W. (2002). Prescribing privileges: Grail for some practitioners, potential calamity for interprofessional collaboration in mental health. *Journal of Clinical Psychology, 58*, 681-696.

Focuses on the probable consequences of prescription privileges (RxP) upon collaboration between psychologists and physicians. The current state of collaboration between psychologists and medical professionals is reviewed. Data are presented from a small survey of clinical psychologists indicate consequences of RxP include: (1) psychiatrists and other medical professionals would receive fewer referrals from psychologists; (2) psychologists would receive fewer referrals for psychosocial services from medical professionals; (3) most psychologists anticipate an adverse effect upon collaboration with physicians; and (4) psychologists are at best divided over RxP.

5. DeNelsky, G. Y. (1996). The case against prescription privileges for psychologists. *American Psychologist, 51*, 207-212.

The authority to prescribe psychoactive medications could have major negative effects on the practice, education, and training of psychologists. Prescription authority also would have major changes how psychological services are marketed and on the public's perception of the profession. Although it is APA policy to pursue prescription privileges, APA cannot require that states actually change scope of practice laws their licensing laws.

6. Dozois, D. J. A., Dobson, K. S. (1995). Should Canadian psychologists follow the APA trend and seek prescription privileges? A Reexamination of the (R)evolution. *Canadian Psychology, 36*, 288-304.

This paper critically examines three key issues surrounding the prescription debate (quality of care, marketability, and psychology's heritage) and demonstrates that, with respect to professional psychology as a whole, obtaining prescription privileges may not be the optimal way to enhance its practice. A second purpose is to place these developments within the context of Canadian psychology. Although American "gains in professional autonomy have usually followed in (Canada" (Dohson el al., 1993), Canadian psychologists face far more impediments to seeking prescription privileges than their southern colleagues. Despite the fact that such obstacles do not preclude our profession from determining its own destiny and advocating for this privilege, we argue at both a practical and conceptual level; 1) **that the benefit is not worth the battle** and,

2) that obtaining prescription privileges may have austere ramifications for the basic identity and core philosophy of professional psychology in Canada.

7. Fowles, D. (2005). Prescription privileges for psychologists. *Clinical Science, 5,* 6, 7. [Electronic Version]. Retrieved November 25, 2007 from http://www.bsos.umd.edu/sscp/Fall_2005_Newsletter.pdf

The Society for the Science of Clinical Psychology, which is a Section of Division 12 (Clinical) of the APA, had posted on its website the results of a survey on prescription privileges. The results showed the membership was ***strongly opposed*** to prescription privileges. The author describes how APA leadership required the Section to remove any information from its website that suggests there is opposition to official APA policy or be thrown out of the organization. The Section elected to remove the information. However, the SSCP's Task Force statement on RxP is posted at http://www.mspp.net/SSCPscriptpriv.htm

8. Guiterrez, P. M., & Silk, K. R. (1998). Prescription Privileges for Psychologists: A review of the Psychological literature. *Professional Psychology: Research and Practice, 29*, 213-222.

The article provides a general overview of the prescription privileges debate and the related policy issues is presented. Various experiments with psychologists prescribing medications are then reviewed. Next, the survey data to date are summarized. Finally, position papers on both sides of the issue are reviewed. The authors attempt to review objectively both sides of the argument, to critique the existing data, and to assist readers in appreciating the breadth and scope of the prescription privileges debate. The purpose of this article was not to support either side but, rather, to provide a sufficient review of the literature, which will allow psychologists to form more informed opinions on where they stand on the issue.

"It should be possible to compare the psychology fellows to psychiatry residents working in similar settings …Existing data support the positions that clinical psychologists can be adequately trained to independently prescribe medication and that this is a cost-effective alternative, at least within the military health care system. These data must now be replicated in a variety of settings before an informed decision for or against prescription privileges can be made."

[The article provides an overview of the DOD, including General Accounting Office's report, which found that there is no need for prescribing psychologists in the military. They review previous surveys of psychologists, such Boswell & Litwin (1992), who found 49% of hospital-based psychologists were opposed to RxP.] Whereas several surveys indicate majorities of psychologists agree with the RxP agenda, many are not interested in pursuing it.]

9. Hayes, S.C. (1995, Spring). Using behavioral science to control guild excesses. *The Clinical Behavior Analyst*, 1, 17.

The author proposes ways for applied psychology to respond to capitated systems of health care. He argues prescription privileges do not address the profession's survival. Scientifically-oriented applied psychology can survive market pressures by advocating effective interventions to managed care because such treatments are cost effective and cheaper in the long run. Psychologists are also trained to develop and evaluate programs, train Masters level providers, and supervise.

10. Hayes, S. C., & Heiby, E. M. (Eds.). (1998). *Prescription Privileges for Psychologists: A Critical Appraisal.* Reno, NV: Context Press.

This authoritative book presents the first critical and comprehensive examination of the issue of prescription privileges for psychologists. The editors and authors review issues discussed at a conference sponsored by the American Association of Applied and Preventative Psychology (AAAPP), a professional organization of psychologists, that opposes prescription privileges for psychologists. The book includes both con and pro positions from experts in the field.

11. Hayes, S. C., & Heiby, E. M. (1996). Prescription privileges: Does psychology need a fix? *American Psychologist, 51*, 198-206.

The article identifies reasons some psychologists are seeking prescription privileges now. Reasons offered include: (1) Over-reliance on psychotherapy as a way to earn a living; (2) An oversupply of doctoral-level psychotherapists; (3) The rise of managed care and concerns about cost-effectiveness of services when Masters level providers are less expensive; (4) The hegemony of syndromal classifications (i.e., DSM); and (5) Medical guild and drug company interests. Offers ways applied psychologists readily can adapt to these five conditions without becoming medical specialists via prescription privileges.

12. Hayes, S.C., Walser, R.D., & Bach, P. (2002). Prescription privileges for psychologists: Constituencies and Conflicts. *Journal of Clinical Psychology, 58*, 697-708.

The pros and cons of training for prescription privileges within the discipline rather than through established avenues (such as nursing) vary from the point of view of constituencies involved. One constituency involves scientist-practitioners who tend to oppose prescription privileges. However, there has not been much organized opposition from the basic science organizations. A second constituency is the practice-based organizations that have been in support of prescription privileges. However, there is not much support from rank and file private practitioners. The resistance to prescription privileges can be understood in terms of what costs and benefits are valued. **Opposition is not arbitrary or unreasonable and is likely to continue.**

13. Hayes, S.C., Walser, R.D., & Follette, V.M. (1995). Psychology and the temptation of prescription privileges. *Canadian Psychology, 36*, 313-320.

The article describes the proposal to pursue prescription privileges (PP) as reflecting an identify crisis in psychology. It argues that psychology is a science in its own right and does not have the adequate bases for prescribing drugs. Notes **prescription privileges will harm training, and is unethical.** Reports on the Resolution Against Prescription Privileges passed by the American Association of Applied and Preventive Psychology in Jan. 1995.

14. Heiby, E. M. (2002a). Prescription privileges for psychologists: Can differing views be reconciled? *Journal of Clinical Psychology, 58,* 589-597.

The article summarizes six arguments made in testimony at state legislatures by psychologists who oppose prescription privileges bills. The main topics concern whether there is a societal need for psychologists to practice medicine, whether psychology as a discipline has evolved in this direction, how training would change the discipline, what the addition of medical training would cost financially, and whether the current collaborative model is adequate. The author concludes that the debate reflects a deep schism in the field of clinical psychology. The schism is seen as a divide between those primarily trained to be psychotherapists and those primarily trained to be scientist-practitioners. It is argued that the former type of clinical psychologists are more likely to support prescribing and are interested in the survival of professional schools. In contrast, the later type tends to oppose privileges and are interested in the survival of university departments of psychology. Suggestions are offered for the unification of the discipline. Since 1995, AAAPP official policy has been to oppose RxP based upon a survey indicating a majority of the membership opposes PPP.

> "It is probably fair to say that prescription privileges for psychologists...is one of the most controversial proposals debated by the discipline in many decades." (p. 589)

> "High quality and cost-effective mental health treatment is commonly accomplished through collaborations between psychologists and physicians and there is no reason this cannot continue when psychotropic medications are indicated" (p. 594)

15. Heiby, E.M. (2002b). It is Time for a moratorium on legislation enabling prescription privileges for psychologists. *Clinical Psychology: Science and Practice, 9,* 256-258.

The article argues that it is premature to pursue prescriptive authority. Psychologists have taken the debate over this issue to state legislatures and present as a house divided. Rather than seek a radical change in scope of practice by legislative fiat, changes to the field must evolve from within if the field of clinical psychology is to remain unified.

16. Heiby, E.M., Deleon, P.H., & Anderson, T. (2004). A debate on prescription privileges for psychologists. *Professional Psychology: Research and Practice, 35*, 336-344.

The article summarized a debate held at the 2002 convention of the APA. Pro and con positions were presented on the following topics: (1) Whether the science and practice of clinical psychology will benefit from prescription authority; (2) How the APA Training Model is justified given the evaluation of the DoD project and the amount of training required of other professions with prescribing authority; and (3) The impact of medical training upon university-based psychology departments in relation to curriculum, faculty staffing, and financial costs both to the university and students. Heiby argues that the science and practice of clinical psychology will be harmed given resources and time will be reallocated to medical training and practice. She asserts there is no evidence to support the APA Training Model, which would give psychology the dubious reputation of being a prescribing profession with the least amount of medical training. She notes that medical training in psychology departments at traditional universities would lead to fewer courses in psychology, fewer faculty with degrees in psychology, duplication of resources already available in nursing and medical schools. The cost of tuition would increase dramatically to cover these expenses. DeLeon argued there is a societal need for more psychoactive drugs, that expert opinion is sufficient to justify the APA Training Model, and that it does not matter if traditional universities are harmed.

17. International Society of Psychiatric-Mental Health Nurses Position Statement: Response to Clinical Psychologists Prescribing Psychotropic Medications: November 2001
http://www.ispn-psych.org/docs/11-01prescriptive-authority.pdf

It is the position of ISPN membership that nurses **have an ethical responsibility to oppose the extension of the psychologist's role into the prescription of medications.** This is not a turf issue or an attempt to limit a perceived competing profession. This belief is rooted in the ethical guidelines of our own profession. The professional standards for nursing require nurses who prescribe pharmacologic agents to have their prescriptive actions based on an awareness of pharmacological and physiological principles and knowledge (ANA, 1996, p. 14). We should expect the same from other professionals. The *Scope and Standards of Advanced Practice Registered Nursing* (ANA, 1996) mandates the advanced practice nurse to "contribute to resolving the ethical problems or dilemmas of individuals or systems" (p. 19). It would seem inappropriate and contrary to our profession, therefore, for nurses to assist clinical psychologists in the development of limited training modules for the sanctioning of prescriptive knowledge.

Clinical psychologists represent an important and effective profession that has a long and honored history of working with the mentally ill and facilitating the mental health of their patients. Clinical psychologists have a long and distinguished history of theory-based care practices, and their contributions have come from their unique perspective, which has historically not been somatically based. The current paradigm of psychology rejects the neurobiological basis of mental illness and this theoretical

perspective is reflected in traditional educational practices that limit the exposure to and knowledge of biological sciences.

Psychopharmacology is a critical aspect of today's treatments for mental illness. Safe and effective utilization of medications requires (a) an in-depth knowledge of the human body, and (b) the requisite knowledge to understand the impact of medications on the body, and the physiology of drug-drug and drug-food interactions. **Clinical psychologists do not possess this knowledge and receive little to no clinical supervision in this role. Therefore, they cannot safely prescribe medications to patients with complex, holistic health needs.**

The needs of the mentally ill are many. Limited access, limited availability of prescribers, and limited job positions for clinical psychologists cannot influence nurses to undertake inappropriate action. The desire to meet the needs of our patients is great, but this pressure cannot allow nurses to be drawn into behaviors that are ethically dangerous. The battle over prescriptive authority for clinical psychologists has been going on for many years. It is an issue that challenges nurses, and one around which nursing as a profession needs to respond. As advocates for our patients, we need to speak out against practices that may be harmful to patients. It is our ethical responsibility to speak out and for each nurse to uphold the standards of the profession.

[The above statement is one of only 9 position statements on the website of this organization of nurses. The others address diversity, cultural competence and access to mental health care, youth violence, the global burden of disease, restraint and seclusion, rights of children in treatment, palliative care, and alcohol withdrawal. This speaks to the importance of opposing prescription privileges on various grounds, including ethics, and reflects the concern of professionals who are in an excellent position to recognize the boundaries of professional competence.]

18. Kingsbury, S.J. (1992). Some effects of prescribing privileges. *Professional Psychology: Research and Practice, 23,* 3-5.

The author obtained his M.D. after practicing as a clinical psychologist, giving him a unique window on the debate. He indicates how medical practice consumes most of his professional time. He criticizes proponents of RxP for not mentioning (1) psychologists' possible selfish motivation, (2) the negative impact of RxP, or (3) the issues some psychologists raise in opposing prescribing privileges. He notes, "…it is clear to me that recent discussions of the advantages of psychologists having prescription privileges have been simplistic."

In describing the differences in the training for physicians and psychologists, he stated:

> **"Studying the effects of medications on the kidney, the heart, and so forth is important for the use of many medications. Managing these effects is often crucial and has more to do with biochemistry and physiology than with psychology. I was surprised to discover how little about medication use has to do with psychological principles and mow much of it is just medical"** (p. 6.)

In other words, preparation for prescribing has less to do with the types of activities psychologists are trained for and does require the scientific underpinnings more than some might think.

19. Kingsbury, S. J. (1987). Cognitive differences between clinical psychologists and psychiatrists. *American Psychologist, 42*, 152-156.

Differences in perspective about psychopathology and its treatment may create many of the difficulties in communication between clinical psychologists and psychiatrists. These differences, engendered by different training experiences, include how the professions view science, diagnosis, clinical experience, other disciplines, and the hierarchical nature of organizations. Some ways these differences may adversely affect communications between psychiatrists and clinical psychologists are explored.

The author describes significant differences between psychologists and physicians in their training, experiences, and thinking. For example he reports, **"In my first month of residency training in psychiatry at a psychiatry emergency service I believe I saw more patients individually than in my entire graduate [Psychology] training**." (p. 155) Often health professionals have little understanding of each others' training models and difference in perspectives and activities.

20. Lavoie, K. L., & Barone, S. (2006). Prescription privileges for Psychologists: A comprehensive review and critical analysis of current issues and controversies. *CNS Drugs, 20*, 51-66.

The debate over whether clinical psychologists should be granted the right to prescribe psychoactive medications has received considerable attention over the past 2 decades in North America and, more recently, in the UK. Proponents of granting prescription privileges to clinical psychologists argue that mental healthcare services are in crisis and that the mental health needs of society are not being met. They attribute this crisis primarily to the inappropriate prescribing practices of general practitioners and a persistent shortage of psychiatrists. It is believed that, as they would increase the scope of the practice of psychology, prescription privileges for psychologists would enhance mental health services by increasing professionals who are able to prescribe. The profession of psychology remains divided on the issue, and opponents have been equally outspoken in their arguments.

The purpose of the present article is to place the pursuit of prescription privileges for psychologists in context by discussing the historical antecedents and major forces driving the debate. The major arguments put forth for and against prescription privileges for psychologists are presented, followed by a critical analysis of the validity and coherence of those arguments. Through this analysis, the following question is addressed. Is there currently sufficient empirical support for the desirability, feasibility, safety and cost effectiveness of granting prescription privileges to psychologists?

Although proponents of granting prescription privileges to psychologists present several compelling arguments in favor of this practice, there remains a consistent lack of empirical evidence for the desirability, feasibility, safety and cost effectiveness of this proposal. More research is needed before we can conclude that prescription privileges for psychologists are a safe and logical solution to the problems facing the mental healthcare system.

> "The debate about whether psychologists should be granted prescription privileges is still in its infancy…**There does not appear to be compelling evidence of the desirability of granting prescription privileges for psychologists.** Pilot projects relating to the feasibility, safety, and cost effectiveness of prescription privileges for psychologists are either sparse or unavailable. Although proponents present several compelling arguments in favour of granting prescription privileges for psychologists, more research is needed before we can conclude that prescription privileges for psychologists are a safe and logical solution to the problems affecting the mental healthcare system.
>
> In the meantime, psychologists should concentrate their efforts on improving both the professional and public dissemination of the services they already provide. In particular, they could work on improving collaboration with GPs and psychiatrists to ensure that medicated patients are properly monitored and advised of available psychotherapy options. Psychologists need not go beyond the boundaries of psychological practice to expand into new treatment areas. There have already been important advances in the areas of health psychology and behavioural medicine, where psychologists have demonstrated success in improving treatment adherence, health behaviours and disease outcome in cancer patients,[107-109]obese patients,[110]coronary artery disease patients[111,112]and patients with HIV.[113]**Expanding the quality and scope of these interventions may represent a more desirable, feasible, safe and cost-effective goal than the pursuit of prescription privileges at this time."** (p. 66)

21. Pollitt, B. (2003). Fool's gold: Psychologists using disingenuous reasoning to mislead legislatures into granting psychologists prescriptive authority. *American Journal of Law & Medicine, 29*, 489-524.

This Article challenges the psychologists' arguments, favoring legislative approval that grants them prescriptive authority. The author provides a critique of each of the American Psychological Associations' reasons for attempting to convince legislatures to grant psychologists prescription privileges: 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 author persuasively counters these contentions, and others, such as that granting them prescriptive authority would significantly allay un-met mental health needs in rural areas, which he argues is also highly questionable.]

Psychologists seeking prescriptive authority assert that granting 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, which is a highly workable model, proponents seek to supplant psychiatry and non-prescribing psychologists by creating a "new breed" of psychologist (a.k.a. pseudo-psychiatrist**). [This article, from outside of Psychology itself, also reflects that other stakeholders, beyond psychologists, have legitimate concerns about psychologist prescribing.]**

22. Robiner, W. N., Bearman, D. L., Berman, M., Grove, W. M., Colón, E., Armstrong, J., & Mareck, S. (2002). Prescriptive authority for psychologists: A looming health hazard? *Clinical Psychology: Science and Practice, 9,* 231-248.

Surveys of psychologists and trainees have yielded inconsistent estimates of psychologists' support of the notion of psychologists prescribing drugs and there has been considerable debate in the field about it. Ambivalence about the prescription privilege agenda raises questions about why psychologists have reservations about it. Although many psychologists are interested in pursuing prescription privileges, the historical training paradigm in psychology comprises limited education in the physical sciences that is directly relevant to prescribing medications. Issues related to prescriptive authority for psychologists, including training gaps, attitudes, and accreditation and regulation are discussed.

The authors' primary concern is the risk of suboptimal care if psychologists undertake prescribing that could arise from their limited breadth and depth of knowledge about human physiology, medicine, and related areas. This risk would be compounded by psychologists' limited supervised physical clinical training experiences. The authors review various concerns addressed in the literature. For example, In one survey, more than two thirds of psychologists in independent practice described their training related to psychopharmacological issues as "**poor**".

The American Psychological Association's Ad Hoc Task Force on Psychopharmacology, the group that provided the basic analysis of psychologists' potential activities and training related to psychoactive medications**,** noted that other health professions (e.g., nursing, allied health professions) **require** undergraduate preparation in anatomy, biology, inorganic and organic chemistry, pharmacology, human physiology, (and some require physics); undergraduate psychology degrees and **admission to psychology graduate school *do not*.** In fact, one study found **only 7% had completed the recommended undergraduate biology and chemistry prerequisites required for medical or nursing school.** Even though the APA's own Task Force recognized the importance of such relevant training, the APA's model for training psychologists to prescribe medications deleted the prerequisite coursework in the biological and physical sciences for such

training. This makes the APA training model for prescribing remarkably weaker than the training required for all other health professionals who are trained to prescribe.

Current proposals also fail to delineate clear requirements for several key aspects of supervised practical training and there has not been any external accreditation mechanism to even evaluate the quality of training. For example, the APA model failed to specify minimal criteria for: (a) the **breadth** of patients' mental health conditions; (b) the **duration** of treatment (i.e., to allow for adequate monitoring and feedback) or requirements for outpatient or inpatient experiences; (c) **exposure** to adverse medication effects; nor (d) **exposure** to patients with comorbid medical conditions and complex drug regimens. Also, the **qualifications** for supervisors are vague. The training advocated by the APA even fails to meet APA's own requirements for accreditation of psychology training. The existing psychology doctoral and internship programs generally lack the faculty capable of teaching courses and supervising practical experiences related to prescribing. Similarly, it is unclear how well psychology boards would be equipped to regulate this aspect of psychologists' practice.

The authors also note that proponents of psychologist prescribing tend to focus on certain charged and arguably disingenuous issues to promote their cause, rather than on the inadequacies noted above. Rather than addressing issues such as the potential benefits to patient care of increasing psychologists' collaborations with prescribes, they focus on underserved populations. For example, they decry the shortage of mental health services in rural areas without promoting other ways in which psychologists could better serve rural populations, such as collaborating better with other rural healthcare professionals. Moreover, they ignore the demographic fact that few psychologists practice in rural areas and that there is no reason to expect that if they were allowed to prescribe that they would resettle in rural areas.

The authors also recognize that certain populations, such as older adults might be at higher risk of adverse outcomes of psychologists prescribing given the foreseeable drug interactions and more complex issues that would likely complicate their care. Quality care is likely to require greater medical expertise than is likely to result from training psychologists to prescribe.

23. Robiner, W. N., Bearman, D. L., Berman, M., Grove, W. M., Colón, E., Armstrong, J., Mareck, S., Tanenbaum, R. (2003). Prescriptive authority for psychologists: Despite deficits in education and knowledge? *Journal of Clinical Psychology in Medical Settings, 10*, 211-222.

As some psychologists advocate for prescription privileges, the need for closer analysis of the differences between psychologists and psychiatrists grows. The authors' survey and test data reveal key statistically significant gaps in psychologists' training and their significant limitations in their knowledge pertaining to prescribing relative to psychiatrists. Attitudes toward prescribing and estimates of psychologists' competence in prescribing are presented. The authors believe that psychologists' deficits in training and pertinent knowledge constitute major hurdles to competent prescribing. They recommend that caution is warranted about expanding psychologists' scope of practice to include prescribing.

24. Sechrest, L. & Coan, J.A. (2002). Preparing psychologists to prescribe. *Journal of Clinical Psychology, 58,* 649-658.

This report is an investigation of the training received by professionals currently authorized to prescribe medications is considered as a step toward understanding what might be involved in preparing psychologists appropriately if prescription privileges for psychology were to be obtained. Information about admission and curriculum requirements was collected from medical schools, dental schools, physician assistant programs, nurse practitioner programs, and schools of optometry. Results suggest a high level of pharmacologically relevant coursework is required for admission to, and the completion of, programs that currently prepare their professionals to prescribe. It is argued that preparing psychologists to prescribe would likely entail similar training requirements in addition to, or instead of, those already in place, leaving clinical psychology dramatically and permanently altered.

The authors conclude the APA training model represents an experimental reduction in American standards for medical practice. The medical training in the model is less than that required for other prescribing professions, including physician assistants, advanced nurse practitioners, physicians, dentists, and optometrists (Sechrest & Coan, 2002). The author notes that only one psychology graduate program in the U.S. requires any background in the natural and life sciences for admission and that psychologists do not have the pre-requisites for medical training required of all other prescribing professions.

Only three (of 168) doctoral programs in psychology have specific physical or life science prerequisites. By contrast, Prescribing Professions have undergraduate prerequisites, generally in highly competitive classes.

Prerequisite Hours for Prescribing Professions

Prerequisite	*Medicine*	*Dentistry*	*Physician Assistant*	*Optometry*	*Nurse Practitioner*	*Psychology (Ph.D.)*
Biology	8.0	8.5	4.9	7.3	30	0
Physics	7.7	7.6	0.5	8.1	3.5	0
Inorganic Chemistry	7.8	8.2	6.8	8.1	3.1	0
Organic Chemistry	7.5	7.3	2.1	4.6	1.1	0

25. Smyer, M. A., Balster, R. L., Egli, D., Johnson, D. L., Kilbey, M. M., Leith, N. J., & Puente, A.E. Summary of the Report of the Ad Hoc Task Force on Psychopharmacology of the American Psychological Association. (1993). *Professional Psychology: Research and Practice, 24,* 394-403.

The American Psychological Association Board of Directors established an ad hoc task force on psychopharmacology to explore the desirability and feasibility of psychopharmacology prescription privileges for psychologists. In this context, the Task Force's charges were to determine the competence criteria necessary for training psychologists to provide service to patients receiving medications and to develop and evaluate the necessary curricular models. This article summarizes the Task Force's major recommendations and provides specific information regarding its training recommendations. It is hoped that this article will encourage broad discussion of psychology's most appropriate integration of psychopharmacology knowledge and its applications into its training programs and professional activities.

[The Task Force indicated the need for more stringent training than the APA model ultimately required, such as when APA abolished the scientific prerequisites for the psychopharmacology training. The APA has also never promoted the Level 2 type of training, which the Task Force discussed, would have promoted psychologists' *collaboration* with other health care professionals in terms of prescribing. It would have provided a mechanism for psychologists to obtain advanced training in psychopharmacology, but would not have resulted in their direct prescribing, so that their limited knowledge of relevant topics, such as pathophysiology and other central scientific areas would not put patients at unprecedented risk.]

Excerpts from the Task Force report include:

> "It is likely that only a small percentage of psychological service providers have a high degree of experience and expertise with pharmacological treatment and are actively working with physicians in assessing, selecting, and managing psychoactive medications…" (p. 396)
>
> "When APA Division 42 (Independent Practice) recently polled its members, the majority of the 440 participants described both their graduate training and opportunities for continuing education in psychopharmacology as inadequate. More than two thirds characterized their training for dealing with psychopharmacological issues as "poor," and 78% felt that continuing education opportunities were insufficient to allow them to expand their knowledge and skill base in drug therapy…this lack of training, coupled with current regulations, requires psychologists to defer to physicians on medication matters for their clients." (p. 396)
>
> "At the doctoral level…[only] 14% of private and 7% of public institutions require a psychopharmacology course." (p. 397)
>
> "When considering the training of psychologists in psychopharmacology and related sciences, it is useful to consider the science curricula for other health service professionals. Programs in such health professions as allied health, pharmacy, optometry, dentistry, nursing, medicine, and osteopathy differ in the length and intensity of their science training, but certain features are common to all. All of these professions require undergraduate preparation in general biology and chemistry. For the allied health professions (such as medical technology, dental hygiene, occupational therapy, and physical therapy) as well as nursing and pharmacy, where professional training typically occurs at the bachelor's-degree level, students also receive undergraduate preparation in human physiology and anatomy, and some programs require organic chemistry and physics as well. Nurses, pharmacists, and most allied health professionals also receive advanced undergraduate-level instruction in pharmacology.
>
> Entrance requirements for post-baccalaureate dental, medical, and osteopathic medical schools generally include course-work in organic chemistry, at least general biology, mathematics through college-level algebra, and physics. Most students admitted to these professional schools have had additional biology and chemistry

coursework. Doctoral-level training in dentistry, osteopathy, and medicine almost invariably includes advanced coursework in human anatomy and physiology, biochemistry, cellular biology, pharmacology, microbiology and immunology, and pathology. Most schools of dentistry, osteopathy, and medicine require 2 full years of intensive classroom training in these health sciences. Clinical pharmacists with Pharm.D. degrees have completed their bachelor's-level pharmacy degree and typically at least two additional years of advanced training in pharmacology.

A survey of 102 U. S. schools of medicine for 1989–1990 conducted by the Association for Medical School Pharmacology (1990) revealed that medical students received an average of 104 teaching hours in pharmacology." (p. 397)

"It is unlikely that this competence can be developed through continuing education, because approximately 2 years' full-time didactic training with additional supervised clinical experience in medication decision making is envisioned. **Retraining of practicing psychologists for prescription privileges would require careful selection criteria, focusing on those psychologists with the necessary science background… It would require students to have undergraduate science training similar to that required of other health service providers (e.g., nurses, pharmacists, allied health professionals, dentists, and/or physicians).** It would also require a postdoctoral period of supervised clinical experience. (p. 400)

"Undergraduate Prerequisites

A psychopharmacology track should recruit students with a strong background in the biological sciences. Some background in anatomy, physiology, and chemistry would be necessary to take the graduate-level courses that make up the proposed curriculum. This background could be obtained during undergraduate studies, as a post-baccalaureate student, or in some circumstances, during early years of the graduate program.

The Task Force believes the following areas of undergraduate instruction are needed.

Biology

A minimum of 12 to 15 semester hours in undergraduate biology is recommended. This would include courses in general biology, cellular and human genetics, vertebrate anatomy, and mammalian physiology. Ideally, some laboratory experience would accompany one or more of these courses. Prospective students also would be well advised to obtain undergraduate preparation in cell and molecular biology to prepare themselves for the advances in psychopharmacology being made using these approaches.

Chemistry

A minimum of 9 to 12 semester hours would be recommended. Students need sufficient preparation to take a graduate-level biochemistry course; typically this would require two semesters of general chemistry and at least one semester of organic chemistry.

Mathematics

College-level algebra would be a minimum. This would not typically be a problem for psychology graduate students, who usually have good quantitative backgrounds. Pharmacology and/or substance abuse

A number of colleges and universities offer undergraduate courses in pharmacology or a substance abuse course that covers the basic pharmacology of drugs of abuse. These courses would be desirable but not mandatory." (p. 400)

"It would be difficult, however, to provide Level 3 training through traditional continuing education mechanisms. It was assumed [for prescriptive authority] that

the medical management of the patient was being done by a physician (i.e., a general practitioner, pediatrician, or internist), and that **psychiatric management was restricted or not available.** (p. 401)

26. Society for a Science of Clinical Psychology (2001). Task force statement on prescribing privileges (RxP). http://www.mspp.net/SSCPscriptpriv.htm

The Task Force notes the vast majority of SSCP members strongly oppose RxP. The Task Force calls for a moratorium on APA's expenditure on RxP, a survey of the membership, and a balanced peer-reviewed mini-convention on the pro's and con's of RxP. **The Task Force presents the following 9 reasons to oppose APA's policy on RxP:**

"1. RxP would not fill unmet needs for service as claimed by proponents.

(a) The psychiatrically underserved population is not very large. Even in the aggregate, it is smaller than RxP advocates in APA's central office wish us to believe.

(b) The geographic distribution of psychologists largely follows that of psychiatrists. Thus little net gain in coverage is even possible.

© Few psychologists have chosen to practice in places like rural Montana or the South Bronx. There is no reason to think that RxP would make an appreciable difference.

(d) Organizations of consumers of mental health services (e.g., NAMI) have not come forth to endorse RxP. At the last RxP bill hearing in the Hawaii legislature, several consumers testified against RxP but none in favor.

2. No satisfactory precedents exist, either for designing suitable training programs, or for predicting psychologists' performance as prescribers.

(a) The definition of what would constitute adequate training remains highly speculative and controversial. APA's model program is far from being a final or even an authoritative statement of what would be needed.

(b) The Department of Defense program, with 10 graduates, was about twice as intensive as that envisioned by the APA model program. It cannot be reproduced on a broad scale. It is therefore not a meaningful precedent.

© Guam — small, remote, and atypical in other respects — requires medical oversight of its handful of prescribing psychologists. It is not a precedent for RxP in the form espoused by APA.

(d) APA's training model specifies three sequential levels. Current RxP training programs offer Level 3 (see section 3 below), but omit the prerequisite Levels 1 and 2. They also omit the undergraduate prerequisites in biology (12-15 semester hours), chemistry (9-12 hours) and algebra (one course).

(e) Some programs claiming to meet APA standards are conducted via distance learning — quite unlike the Defense Department program or those offered to

optometrists.

(f) In short, there is no existing program that meets even APA's scaled-down criteria.

3. Few existing psychologists would be able to complete any acceptable training program.

(a) The APA Level 3 model, skimpy as many believe it to be, entails 350 classroom/lab hours, plus one year of closely supervised practicum experience involving 100 patients. This is equal to approximately two years of full-time work.

(b) This time requirement does not include prerequisite undergraduate-level work (see section 2[d] above), some or all of which most prospective candidates would need.

© The cost of APA-model training — even when no undergraduate work is needed — is estimated at $20,000 to $30,000 per student if received in a university or professional school setting. This does not include income sacrificed in order to make time available for RxP training.

4. Graduate education in basic psychological science and psychosocial treatments would be severely diminished and distorted unless most or all biomedical coursework were at the post-doctoral level.

(a) Many currently practicing psychologists are already under-trained in psychological science and empirically supported treatments. Displacing traditional curriculum content in graduate schools with RxP-focused coursework would render this deficiency still worse.

(b) Making RxP training wholly post-doctoral would add two years and $20,000 to $30,000 — plus the cost of any undergraduate prerequisites needed and the years of earning ability forever lost — just as it would for existing psychologists.

© By changing the prerequisites for doctoral programs, RxP would attract a different population of applicants and further diminish the emphasis on psychosocial/behavioral treatments.

5. In addition to the direct costs of RxP training, there are a number of externalities — so far, not widely recognized — that argue strongly against RxP.

(a) Malpractice premiums would go up for those who elect to prescribe, and possibly for all licensed psychologists whether they prescribe or not.

(b) Should even a few malpractice suits against prescribing psychologists based on claims of inadequate medical training be successful, insurance coverage would become prohibitively expensive or disappear altogether. Legislatures that had previously authorized RxP would face an onslaught of pressures to rescind it, and those that had not yet authorized it would reject RxP bills out of hand. The damage that would be done to psychologists and to the profession is incalculable — much worse than the damage done to physicians and medicine

when they are sued.

© Student loan debt would increase sharply as a result of additional borrowings and years of delay in commencing repayment.

(d) Adding faculty to departments of psychology to teach the RxP curriculum would cost an estimated $800,000 to $1,000,000 annually. Only schools wholly supported by tuition could hope to recover these outlays. Universities relying on state funds and endowments would have to absorb a large share of additional faculty costs without recourse.

(e) RxP would widen the existing gap between university and professional-school programs, and in effect create two divergent spinoffs of clinical psychology. It would be only mildly facetious to say that we would come to be seen, at least by outsiders, as either underpaid psychiatrists or overpriced social workers. In the process, the cross-fertilization between psychological science and practice — psychology's trump card in the mental health field — would have been severed.

(f) If psychologists obtain RxP, master's-level social workers and counselors will almost certainly try to follow. (Pat DeLeon has in fact written in support of social workers seeking RxP.) Should they succeed, the market will be flooded with Rx-eligible personnel, and the competitive advantage sought by psychology's RxP advocates would quickly vanish.

6. Psychologists would be exposed to patients' demand for "pill fixes" and the blandishments of the pharmaceutical industry, just as psychiatric and other medical professionals already are.

(a) It is naïve to assume that psychologists' background in psychosocial treatments would significantly "inoculate" them against such powerful pressures.

(b) By de-specializing psychologists in psychosocial treatments and their scientific underpinnings, their commitment and competence in this area is likely to be further eroded.

7. Contrary to claims made by key people in APA's central office, psychology is not united behind RxP. A series of surveys over the past 10 years has shown sentiment to be about equally divided.

(a) APA's much-cited 1995 data, which showed a majority in favor of RxP, relied upon a single, highly biased questionnaire item in the context of an omnibus survey on membership issues. More objective studies suggest that a majority is actually opposed to RxP.

(b) Recent survey evidence suggests that many psychologists nominally classified as "favorable" to RxP are willing to endorse RxP simply out of an altruistic desire to help colleagues — while having little or no interest in pursuing such training themselves.

© There is reason to believe that few psychologists — even those who find the RxP idea attractive — are aware of and have given careful thought to the length and cost of any plausible training requirements. What their attitudes would be if they

were fully informed remains unknown.

8. **Organized psychiatry and medicine can be counted upon to oppose RxP in state legislatures far more vigorously and effectively than they have opposed previous expansions in our scope of practice.**

(a) They have the financial and political ability to turn the RxP campaign into a rout for psychology, and are fully prepared to do so if necessary.

(b) Faced with RxP bills in the legislatures, they are likely to seize the opportunity to roll back gains in our scope of practice that have been painstakingly eked out over decades.

© There is evidence from New York that medicine's sabotage of scope-of-practice legislation sought by NYSPA was intended as a shot across our bow to head off RxP.

(d) Fruitful collaboration between psychologists and medical professionals would be undermined — and possibly damaged quite seriously — by the battle over RxP.

(e) APA has spent over $800,000 pressing its RxP agenda, and has recently escalated its efforts still further. Yet all that it will take to defeat RxP bills in state legislatures is for psychologists opposed to RxP to expose its lack of solid support among psychologists. (This has already happened in Hawaii).

9. **RxP opponents fully recognize the need for psychologists to have education and experience relevant to biomedical treatments. But this does not imply a general need for prescribing authority. Good alternatives exist that have none of the drawbacks cited above.**

(a) For psychologists who want to prescribe drugs on their own, nurse practitioner (NP) training would prepare them far better than any RxP program that has been seriously proposed. It would provoke less opposition from the medical establishment. No new legislation — costly, time-consuming and dangerous to pursue — would be required. And it would probably be supported by the nursing profession, which as matters now stand is likely to join organized medicine in opposing RxP.

(b) For psychologists who do not want to prescribe, or who cannot afford the time and money to obtain the requisite training, well-designed CE offerings would enable them to participate collegially and knowledgeably in collaboration with medical professionals. A large percentage of psychologists are already so equipped, and they collaborate routinely and effectively with their medical colleagues.

© Training is particularly needed for collaboration with primary care physicians — who write about 75% of the prescriptions for psychoactive medications in this country, yet often have skimpy knowledge of the proper use of such drugs, and are even less well acquainted with the advantages of psychological treatments. Such collaboration would also do more than RxP to meet the needs of underserved areas and populations.

(d) APA can play a vigorous and constructive role in enhancing psychological practice via these alternatives. It can take the lead in arranging NP training at an affordable cost, and it can develop and promote modules to advance interprofessional collaboration. These things can be done at much less cost and risk than pursuing the present quixotic campaign for RxP — and they would do away with the divisive atmosphere that APA's unilateral promotion of RxP has needlessly brought upon our profession." (n.p.)"

27. Stuart, R. B., & Heiby, E. E. (2007). To prescribe or not to prescribe: Eleven exploratory questions. *Scientific Review of Mental Health Practice. 5*, 4-32.

Many psychologists believe that gaining prescription authority (RxP) would benefit them, their patients, and the field. Prescribing could extend the boundaries of psychological services, but doing it responsibly requires many changes in knowledge acquisition and clinical practice. Since organized psychology is firmly committed to this change, the 11 questions presented here are intended to help individual clinicians decide whether they should seek prescriptive authority. The questions address significant challenges in obtaining the necessary education about human biology; the ways in which organ systems are affected by drugs; methods of prescribing and monitoring treatment results; and preparing for a possible increased risk of malpractice actions. Those considering the pursuit of prescribing authority will also want to determine whether the few psychologists who can currently prescribe drugs have used their authority safely and effectively. In addition, it is important to realize that to meet high standards of care for psychological services, prescribers must both keep abreast of the evolving body of psychological theory and research and devote equal or greater time to maintaining the most current knowledge about the predictable effects of drugs. The latter task is difficult due to common flaws in drug research and flaws in the policies and procedures used by the FDA to regulate drugs. Psychologists should be prepared to adjust their practices to meet these and other challenges *before* they put pen to the prescription pad.

The authors review a variety of problems related to RxP and note that Psychology is in the awkward position of being a scientifically based profession that is seeking to expand its scope based on a small pilot program (i.e., the PDP) that reaches well beyond the parameters of the available data. The authors raise a series of questions to help students and psychologists weigh the costs and potential risks of prescribing against its hoped-for benefits, which will not necessarily be realized, including:

- ? How will you minimize the risk of a misdiagnosis that leads you to prescribe the wrong drug?
- ? How will you minimize the risk of making prescription errors that lead to adverse drug events?
- ? How accurately will you be able to predict the effects of the drugs that you prescribe?
- ? How will you find the accurate information needed for sound decisions about drugs?
- ? How will you avoid choosing a drug that is generally correct for the diagnosis but incorrect for a given patient?
- ? How will you gain access to the resources that you will need to adequately assess patients

before prescribing drugs, and then to monitor medication effects?
? How will you be able to resist the pressure to prescribe unnecessary drugs?
? Do you know enough to make a data-based decision about prescribing authority now?

28. Wagner, M.K. (2002). The high cost of prescription privileges. *Journal of Clinical Psychology, 58*, 677-680.

If the APA medical training model (APA 1996b) is adopted, the cost of the additional graduate training at a southern state university was estimated to be at least $155,000 for students, assuming the student lives on $20,000 per year. This estimated cost to the student does not include the additional costs involved in undergraduate pre-medical training or the higher tuition costs at private universities' graduate programs, including professional schools. Data are presented relative to the financial burden it will place on students, universities, internship sites, **and the consumers** of psychological Services, and the authors question who is going to pay for it?

29. Walker, K. (2002). An ethical dilemma: Clinical psychologists prescribing psychotherapeutic medications. *Issues in Mental Health Nursing, 23*, 17-29.

The use of psychotropic medication to treat psychiatric disorders has surged in recent years, and while commonly prescribed, the question of who should be allowed to prescribe such medication has become an increasingly important issue to nurses. Psychologist shave historically functioned in roles such as psychotherapy and psychological testing, but as standards of care for psychiatric disorders incorporate medication, reimbursement for psychotherapy is declining. Medication prescription and management have not been traditionally seen as the role of the psychologist, however, many clinical psychologists have begun to advocate for prescription authority as a legally sanctioned role for their profession. This article addresses the issues of clinical psychologists seeking prescriptive privilege. It is argued that the current paradigm of psychology rejects the neurobiological basis of mental illness and that **psychologists prescribing medication presents an ethical dilemma for nurses.** It is the contention of the author that nurses have an ethical responsibility to advocate against the extension of the psychologist's role into the prescription of medications. This article also reveals that other mental health professionals (i.e., not just physicians) have significant concerns about psychologists' proposed role in prescribing.

30. Walters, G.D. (2001). A meta-analysis of opinion data on the prescription privilege debate, *Canadian Psychology, 42*, pp. 119-125.

The author concludes psychologists are about evenly divided over whether the profession should pursue prescription privileges. Proponents of privileges ignore the divisiveness over this issue. The results, based on 17 samples, showed minimal consensus and a general split of opinion on the advisability of pursuing the prescription privilege agenda. These findings suggest that prescription privileges have the potential to confuse issues of

training and identity for future generations of psychologists. Although the difference is not statistically significant, **more psychologists than not believe that professional/ scientific organizations like APA should not be spearheading efforts to gain prescription privileges.** At the least, psychologists are evenly divided on this issue. Second, professional psychologists are more supportive of prescription privileges in principle than they are of obtaining the training necessary to prescribe medication.

31. Westra, H. A., Eastwood, J. D., Bouffard, B. B., & Gerritsen, C. J. (2006). Psychologist's pursuit of prescriptive authority: Would it meet the goals of Canadian health care reform? *Canadian Psychology, 47,* 77-95.

The authors seek to facilitate reflection on the important issue of prescriptive authority for Canadian psychologists. The paper contextualizes the discussion of prescriptive authority in the broader context of health care reform in Canada. More specifically, the authors review pharmacotherapy and psychological services in view of how effectively each of these currently meets three major challenges in health care reform: reducing costs, increasing treatment efficacy, and improving access to treatment.

The authors conclude that psychological services are less costly than pharmacotherapy. Prescription drugs clearly and vastly exceed spending on psychological services. In their view, there are very few valid arguments supporting the expansion of prescriptive authority to psychologists, when considering important indices on which future health care services will be judged. In contrast, on the basis of the present review and analysis, it seems to us that a fuller promotion of existing psychological expertise would more result in reduced health care costs, increase treatment efficacy, and improve access to treatment.

The authors believe that "the change that would appear to most benefit consumers, psychologists, other health care providers, and payers, is increased access to psychological services and fuller utilization of psychological expertise. **The best way to realize the benefits of pharmacotherapy may not be through having prescription authority ourselves, but rather through offering strongly desired and much needed complementary expertise grounded in psychological science** (e.g., knowledge of relationship and other psychosocial contextual factors, compliance enhancement, specific psychological treatments, psychoeducation, and so on). Stated differently, if you were a marketer with a choice as to which product to market – one that is widely available, incurs substantive costs, and is less preferred, or one that consumers want, is not currently widely available, is desirable to payers in terms of cost-reduction potential, and is highly effective which would you choose?"