

BY MICHAEL S. VICTOROFF, MD

Psychologist Prescribing: Not Such a Crazy Idea



New Mexico has just granted medication-prescribing authority to psychologists—a development with broad potential implications for the field of mental health. I say “potential” because New Mexico is, after all, far from the centers of influence, and it’s possible no one will notice. But it’s a bold precedent.

The intent is to allow better access to mental health services for underserved populations in this largely rural state. Besides physicians and dentists, New Mexico also gives prescribing authority to physician assistants, nurse practitioners, nurse midwives, nurse anesthetists, and “pharmacist clinicians.” But you have to go to Guam to find another civilian U.S. jurisdiction where psychologists can prescribe drugs. (There are also seven PhDs in the Department of Defense with prescriptive authority, trained in a pilot program a few years ago.)

Beyond turf war

So, what do New Mexico, Guam, and the DOD know about mental health, that the rest of us don’t? Is psychologist-prescribing a huge step for mental health care in America? A threat to patient safety? Another fracture in the arthritic guild system that currently handicaps U.S. medicine? (Sorry, that just slipped out.)

Critics see this new licensure as a challenge to historic physician prerogatives, and an opportunity for erosion of the quality of care. They ask, “What educational preparation—other than medical school—is adequate before someone gets access to a prescription pad?” Once that barrier breaks, what keeps us from giving prescribing authority to police, flight attendants, and postal supervisors? Here is New Mexico’s answer, patterned on the DOD model.

The candidate must:

- Have a doctoral degree from an accredited institution;
- Pass a national certification exam on phar-

macology in the diagnosis, care, and treatment of mental disorders;

- Attend no fewer than 450 classroom hours in neuroscience, pharmacology, psychopharmacology, physiology, pathophysiology, appropriate and relevant physical and laboratory assessment, and clinical pharmacotherapeutics;
- Complete 80 hours of clinical assessment and pathophysiology, and an additional 400 hours treating no fewer than 100 patients with mental disorders.

These, plus other hoops, get a psychologist a two-year “conditional certificate,” permitting him or her to prescribe psychotropic medications—including scheduled drugs—under the supervision of an officially designated physician who is “individually responsible for the acts and omissions of the psychologist while under his supervision.” After two years and a process of peer review, the psychologist may apply for a certificate that allows independent prescribing.

Filtering out

Independent or not, the psychologist “must maintain an ongoing collaborative relationship with the health care practitioner who oversees the patient’s general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient’s medical condition, and significant changes in the patient’s medical or psychological condition are discussed.”

Whether these prerequisites are precisely “enough” is not as important as whether they deter most of the candidates who would be inappropriate. To my eye, this seems plausible, although long experience shows that credentialing is not a substitute for ongoing peer review.

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In terms of formal preparation, however, it would be hard to ask for more.

So, what's at stake from an ethical perspective? The grimy issues about money and territory are easy to see, so let's skip them. In terms of risk and benefit, the root question is, "Is it more practical to build on the skills of current PhDs or to recruit additional providers with prescribing authority?" The issues are analogous to any new medical device: safety and effectiveness.

In terms of safety, the question has to be, "Will this policy improve care enough to justify hazards it may add?" "Is a critical gap in men-

hold onto difficult cases that should be punted to subspecialists. As with other clinicians, this known temptation needs to be monitored and guarded against.

But, with the notable exception of chronic pain, the main problem in treating the mentally ill is not inexperienced practitioners hanging on too long, but too few physicians interested in mental health management. Neither of these issues is new to psychologists. On balance, there is a calculated benefit in broadening the scope of practice of some experienced mental health providers.

A foreseeable hazard of prescribing powers is the potential for prescribers to become exhilarated in providing all sorts of pharmaceuticals with which they might not be familiar. It's scary enough that the drugs psychologists are going to be responsible for presumably include amphetamines, narcotics, antidepressants, tranquilizers, sedatives, and Viagra — all the fun stuff. Then, add the temptation to refill antibiotics, anticoagulants, and antiseizure meds, or anything else a patient needs on a weekend when the regular doc isn't around. This will need discipline to resist. But it amounts to the same problem for all primary care practitioners. Smart providers know their boundaries.

On balance, if the risks and benefits prove favorable, the next hurdle is to justify the medical necessity of psychologist-prescribing.

According to the American Psychological Association, 72 percent of New Mexico's people live outside of Albuquerque and Santa Fe. That works out to 1.3 million people, based on the 2000 census. There are apparently 18 psychiatrists for this population. The APA tells us that 20 percent of us suffer from mental illness at any given time. If all of these need a psychiatrist, that would mean 14,400 patients for each of the available docs. The APA also reports waiting times for a psychiatrist to be six weeks to five months outside the cities, and that 75 percent of those with mental health disorders in New Mexico are not receiving treatment. Using statistics from the World Health Organization, a ratio of 1.4 psychiatrists per 100,000 population

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tal health care in New Mexico found in access to medication management?" If both answers are affirmative, then this is a clever solution.

Given what we know about errors and abuses of prescribing authority by physicians themselves, adding to the number of active DEA licenses might seem to be a bad move. But, would bringing in 100 additional family physicians accomplish what's needed in mental health care? (Not that this is a realistic option.)

The standard that psychologists must meet is not that of psychiatrists. The test of PhD-prescribing is against the benchmark of all others who now write drugs for the mentally ill, including physicians and midlevel practitioners in almost every specialty, with a range of interests and competencies. Is it easier to teach a PhD to prescribe drugs, or to teach an MD or PA to manage mental illness? It's possible that PhDs might actually prove better at managing psych drugs than some of these clinicians. Hopefully, somebody will study this.

Boundaries

On the other hand, one way this quality improvement could fail is if overly confident PhDs

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puts rural New Mexico on a par with Tibet.

There are 176 psychologists for this same population. So, the new law potentially multiplies the number of “medical” providers by a factor of 10.

In comparison, Washington D.C. has 47.8 psychiatrists per 100,000 citizens, or 34 times the resources of rural New Mexico. The ratio of psychiatrists per legislator tells a different story, however. With 535 legislators and 274 psychiatrists, Washington D.C. has barely 0.5 psychi-

cism that many patients are thoughtlessly denied drugs that would help them. This message is inescapable, at least from the pharma companies. To the extent that lack of access is due to the unavailability of prescribers, the new law will alleviate it. Hopefully, some of the PhDs applying for prescribing privileges will actually be in shortage areas.

In the U.S. as a whole, mental health care is highly problematic — particularly in states such as New Mexico, with significant rural geography. There have never been enough practitioners to go around, regardless of qualifications. Nor is it clear that we use those we have to best effect. This may not have mattered so much 100 years ago, since psychopharmacology wasn't central to mental health management. But, today, pharmacotherapy is indispensable in treating mental illness. Any vision of better care for the mentally ill must include wider access to medication management.

Last year, legislatures in eight other states — Connecticut, Georgia, Hawaii, Illinois, Louisiana, Tennessee, Texas and Missouri — debated prescriptive authority for psychologists, although none passed it. But, stay tuned to this channel. I predict more incursions into the domain of medication management by psychologists and others.

Prescribing medicine has long been one of the most secure privileges of the physician class. But advances in health care delivery and medical science require continuous assessment of old assumptions. There will be — and should be — intense scrutiny of New Mexico's psychologists as they implement this optimistic program. If early outcomes are good, the New Mexico model will provide both an opportunity and a standard for other professions and states. Managed care organizations, especially those specializing in behavioral health, will be most interested in how this reengineering of providers plays out. It will be fun to be a member of a credentialing committee during this period. **MC**

atrists per legislator, compared with New Mexico, which has 178 psychiatrists and 112 legislators — a much healthier ratio. (So much for statistics.)

Service, not savings

So, as a strategy, expanding the powers of psychologists looks good on paper. Will New Mexico enjoy any cost savings from this move? Not likely. If anything, the availability of more services should increase utilization, in both drugs and visits. It's conceivable that PhD-prescribers are a lower-cost alternative to MDs, or that they'll somehow drive down the cost of psychiatry through market pressure. But this is wishful thinking, as the reimbursement differential isn't big enough to offset the increase in utilization, and physicians historically tend to raise fees in the face of competition. Plus, the shortage of psychiatrists is so acute in most areas that there will probably be plenty of volume to sustain their current activity.

Psychologist-prescribing will certainly lead to increased utilization of psych meds. You can see this as either good or bad. I sympathize with critics of thoughtless prescribing of psych drugs, just as with thoughtless prescribing of antibiotics. But there's equal time for the criti-

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