

Prescription Privileges and the Ethics Code: A Modern Look into the Right to Prescribe among Applied Psychologists

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The primary distinguishing element between the practice of clinical psychiatry and applied psychology is the right to prescribe psychotropic medications for psychiatrists and the absence of that right for applied psychologists (Clinical or Counseling Psychologists holding either Ph.D, Psy.D, or Ed.D degrees) (Andrews, 2011). Since 1995, the American Psychological Association has made it official policy to pursue such rights for those holding doctoral degrees in applied psychology (Ph.Ds, Psy.Ds and Ed.Ds), much to the resistance of their colleagues in psychiatry (Johnson, Hay, Murray, Lucas & Tompkins, 2012; Martin, 1995). This paper assesses the history and current state of affairs of the debate to further psychologists' right to prescribe through a review of current literature, utilizing the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (APA, 2002). This paper adds to the debate as to whether psychologists' prescription privileges, without the full training in medicine afforded to psychiatrists, falls within a psychologists' scope of practice. It is argued that, with the current state of policy and training for prescription privileges, the risks appear to outweigh the gains. Steps can be taken to ensure proper doctoral training, and continuing education in order for prescription privileges to be viable for applied psychologists. Several important considerations reviewed herein must be addressed before such training could be ethically feasible.

Prescription Privileges and the Ethics Code: A Modern Look into the Right to Prescribe among Applied Psychologists

The primary distinguishing factor between the applied practices of professional psychology and psychiatry is the right of psychiatrists to prescribe psychotropic medications (DeNelsky, 1996; Hale, 1995). Psychotherapeutic interventions, once practiced primarily by psychiatrists, have now become the domain of applied psychology (DeNelsky, 1996; Hale, 1995), and the practice of psychiatry primarily emphasizes the prescription of medication for the treatment of mental illnesses (Andrews, 2011). The two professions are academically distinct, with psychologists earning professional doctorates including the Doctor of Philosophy in Psychology (Ph.D), Doctor of Psychology (Psy.D), and Doctor of Education in Psychology (Ed.D), all of which focus on research and/or clinical training. Psychiatrists, conversely, hold a doctorate in medicine (M.D.), receiving broad-based medical training before completing a psychiatric residency (Andrews, 2011; Back, Book, Santos & Brady, 2011; Stricker, 1975). Yet another difference is the salary disparity between applied

psychology and psychiatry. Though psychiatrists still often out-earn applied psychologists, the field of psychiatry earns comparatively less than all other specialties of medicine. As a result, newly trained medical professionals have chosen psychiatric residencies in greatly diminished numbers in recent years, likely due to the dramatic pay disparity between psychiatry and other M.D. specialties. (Andrews, 2011; Back, Book, Santos & Brady, 2011; Smith, 2012; Murray, 2003). This has expanded the debate as to whether prescription privileges, complicated by the comparatively short psychological training which psychiatrists receive in comparison to applied psychologists, should be granted to the increasing numbers of applied psychologists (Andrews, 2011; Back, Book, Santos & Brady, 2011; Murray, 2003). For the purposes of this article, prescription privileges, the right to prescribe, and RxP (Rx connoting prescription, and P, connoting privileges) will be used interchangeably.

History of Prescription Privileges in the United States

In response to the dwindling numbers of new psychiatrists, the American Psychological Association (APA) has advocated for the right of psychologists to prescribe psychotropic medications with appropriate pre- or post-doctoral training and certification (Johnson, Hay, Murray, Lucas & Tompkins, 2012; Martin, 1995). The APA has maintained this

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stance for the past 18 years, making the pursuit of prescription privileges part of its official policy since 1995 (Johnson et al., 2012; Martin, 1995). However, this campaign for RxP has been consistently countered by lobbying groups made up of physicians and psychiatrists arguing against such a privilege. The groups have cited numerous issues, the most pertinent of which is a lack of psychologists' competency to prescribe medications (DeNelsky, 1996; Faust, 2011). The APA Ethical Standard 2.01 specifically forbids practicing outside one's "scope-of-practice," and yet the APA advocates the advancement of psychologists' right to prescribe (APA, 2002, pg. 4; Johnson et al., 2012; Martin, 1995). Therefore, the main questions of this issue are as follows: Does the APA's promotion of RxP represent a fundamental contradiction in policy given the stipulations set forth in APA's Ethics Code? Is there such a thing as 'enough' training for psychologists to engage in psychopharmacological interventions? Are pre- or post-doctoral certifications sufficient in the absence of the pharmacological training that is afforded to psychiatrists? Further, does this debate reflect the conflicting interests of psychiatry and advancing applied psychology, as psychiatric practitioners see their cohort shrinking and their standing in the mental health field challenged? These will be the questions addressed in this review through an analysis of the current state of the debate, considered within the context of APA's Ethical Principles of Psychologists and Code of Ethics (referred to herein as the APA Ethics Code).

The first administrative agency to grant prescription rights to psychologists was the Department of Defense in 1998 (Dittman, 2003). This trial program was designed to test the effectiveness of training of RxP and to make up for the dearth of psychiatric providers in the military (Dittman, 2003). This (now terminated) training program is said to have established the proficiency of psychologists as psychopharmacologically trained prescribers (Dittman, 2003). Further recognizing the proficiency of RxP among psychologists, the U.S. military and Indian Health Service both grant RxP to psychologists with appropriate training (Cullen & Newman, 1997).

Since the argument for prescription privileges began, Louisiana, New Mexico and the Territory

of Guam have all passed laws granting prescription privileges to psychologists. Simultaneously, other states struck down majority approval of such laws via gubernatorial veto, whereby the governor of the states blocked voter-approved legislation (Faust, 2011). Several other states have failed to achieve majority legislative approval. However, mixed legislative results have not prevented advocates from continuing the argument for RxP (Faust, 2011). Most recently, Illinois' latest bid to legalize RxP for psychologists has failed while Ohio's legislators in support of RxP appear to have no current plan to reintroduce previously rejected legislation (Grohol, 2013).

The Argument for Prescription Privileges

The argument for prescription privileges is grounded in the shortage of psychiatrists entering the profession or already in practice (Back, Book, Santos & Brady, 2011; Cullen & Newman, 1997; Martin, 1995). Proponents of RxP argue that the reduction of available psychiatrists has made obtaining an appointment with a psychiatrist increasingly difficult, with non-emergency cases often being deferred for weeks or, in some cases, up to nearly a month for appointments (Maughan, 2010). Furthermore, proponents argue that in rural areas, there may only reside a handful of psychiatrists, rendering new appointments (emergency or otherwise) nearly impossible to obtain. Indeed, the strain felt within the field is evident in the increasing number of general practitioners prescribing psychotropic medications outside of their specialty, and potentially outside of their competence (Maughan, 2010; Mojtabei & Olfson, 2011).

Many within professional psychology argue that the solution to this issue is granting applied psychologists the right to obtain training and legal authority for RxP (Martin, 1995). Along with the policy of the APA in favor of RxP, several pre- and post-doctoral training programs have been established at major psychology training institutions, such as Alliant International University (AIU, 2012) and Fairleigh Dickinson University (FDU, 2012). These programs follow the increasingly popular model of integrating psychopharmacological training into clinical and counseling psychology as a post-doctoral master's program to be followed by applied clinical train-

ing (Resnick, Ax, Fagan, & Nussbaum, 2011). This model of RxP training is the most prominent of those that have been proposed, whereby only those who engaged in specialized and rigorous coursework would be eligible to administer psychotropic drugs (Resnick et al., 2011; Smyer et al., 1993).

Proponents of RxP argue that there is no group of professionals better equipped to prescribe psychotropic medication in the absence of a psychiatrist than applied psychologists (Resnick et al., 2011; Smyer et al., 1993). This contention is based on psychologists' preexisting understanding of mental illness thereby (according to this argument) enabling psychologists to provide the best applications for psychotropic treatment. (Resnick et al., 2011; Smyer et al., 1993). Furthermore, proponents envision prescription privileges for applied psychologists as existing within a psychologist's training model, just as optometrists, podiatrists, and other specialized medical professionals do not have broad-based medical training but are granted limited and highly specialized privileges (Smyer et al., 1993). Finally, proponents also argue that psychologists are far better equipped to prescribe psychotropic medications than are general medical practitioners, who possess limited understanding of psychology but have become the primary providers of psychotropic drugs as psychiatrists' numbers have dwindled in recent years (Back et al., 2011; Cullen & Newman, 1997; Martin, 1995; Resnick et al., 2011; Smyer et al., 1993).

The Argument Against Prescription Privileges

Opponents of psychologists' right to prescribe point to a number of factors, including unnecessary risks to patients and additional risks to the integrity of the practice of professional psychology itself (DeLeon, Bennett, & Bricklin, 1997; DeNelsky, 1996). Among the most compelling arguments against prescription privileges is the risk of harm to the patient. Physicians are educated in the complex interactions between psychiatric and non-psychiatric medications (DeNelsky, 1996). Opponents of RxP argue that one danger of allowing psychologists prescription privileges is that there is no way to ensure psychologists' understanding of potentially harmful interactions with patients' non-psychotropic pre-

scription medications, constituting systemic malpractice (DeNelsky, 1996; Hayes & Heiby, 1996). This risk reflects a potential violation of Ethical Standard 3.04, which states that psychologists are to prevent, avoid, and minimize harm to their patients whenever possible (APA, 2002). It also represents a potential danger to the patient and underscores the possible risks of psychologists with RxP practicing outside their scope of competence (DeLeon, Bennett, & Bricklin, 1997; DeNelsky, 1996; Hayes & Heiby, 1996).

Opponents of RxP also argue that the nature of the practice of applied psychology would dramatically change, transforming applied psychologists into lesser-educated psychiatrists and thereby damaging and potentially eliminating the field of clinical psychiatry (DeNelsky, 1996; Moyer, 1995). Furthermore, DeNelsky (1996) suggests that, were psychologists to move increasingly toward prescribing psychotropic medications in lieu of practicing psychotherapy, the resulting gap would put significant pressure on mental health counselors, social workers, and marriage and family therapists to take over primary psychotherapeutic duties. Additionally, much in the same way that medicine and psychiatry are dominated by the financial influence of the pharmaceutical industry, some suggest that the field of applied psychology would ultimately succumb to these influences as well if prescription privileges are granted (DeNelsky, 1996; Hayes & Heiby, 1996). The fear appears to be that, without the vast knowledge of medication interactions attained by psychiatrists and physicians, psychopharmacologically trained clinicians could be unduly influenced by the marketing tactics of a multi-billion dollar industry, once again reflecting a violation of Ethical Standard 3.04 (DeLeon, Bennett, & Bricklin, 1997; DeNelsky, 1996; Hayes & Heiby, 1996).

Finally, similar to some previous arguments, concerns have been posed regarding how specialty training would take place (Bieliauskas, 1992; Bütz, 1994; DeNelsky, 1996; Robiner et al., 2002). Of particular interest is the question of whether mandates would be imposed at the state level to ensure proper training. Further, one wonders whether the addition of such training would be a sufficient pharmacological education. Furthermore, would adding a tremendous amount of psychopharmacology classes to al-

ready rigorous doctoral programs require a sacrifice of core training coursework integral to applied psychology programs? (Bieliauskas, 1992a; Bütz, 1994; DeNelsky, 1996; Robiner et al., 2002). DeNelsky (1996) also argues that for any standardized training to occur, numerous programs must be preexisting and established within the field to draw new students.

Unfortunately, a current reduction in the number of such programs threatens the state of RxP training for psychologists. Many programs, such as the post-doctoral Master of Science in Clinical Psychopharmacology from the Massachusetts School of Professional Psychology, have closed down due to lack of enrollment (Resnick et al., 2011). While the APA policy regarding RxP still stands, investing financially in further education and clinical training after already extensive and rigorous doctoral training may render the RxP specialization prohibitive for many (Resnick et al., 2011). It has been argued that legislative policy can only take place once psychopharmacological training has become widespread, which might present a problem if training opportunities continue to be limited (Resnick et al., 2011). Yet the inverse could also be true; without local laws supporting RxP, it is likely that training programs will continue to struggle to attract and retain students, further endangering the viability of the current training model.

Beneficence, Nonmaleficence, and Boundaries of Competence

Principle A of the APA Ethics Code states that psychologists must “do good,” never risk harm to their patients, and prioritize the rights, welfare, and benefit of the patient and those they encounter both professionally and outside of the professional sphere (APA, 2002, p. 3). This raises the question of whether or not patients benefit from psychologists gaining RxP. If the risks of harmful drug interactions, incorrect prescribing, and poor standards of training are indeed too high, as opponents argue, then RxP would be a violation of Principle A. In addition, Ethical Standard 2.01a states that “psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education,

training, supervised experience, consultation, study, or professional experience” (APA, 2002, p.4). While those in favor of RxP have outlined a multitude of training options, the consensus within the literature advocating RxP appears to favor a post-doctoral master’s program with a clinical training component focused completely on psychopharmacology, and indeed this appears to be the current dominant training model. (Alliant International University, 2012; Fairleigh Dickenson University 2012; Resnick et al., 2011, 2011; Smyer et al., 1993). However, in its current form, this format may not be sufficient to ensure competence and thereby reduce the risk of harm when considering potentially dangerous drug interactions between psychotropic and non-psychotropic medications. This is illustrated by the vastly more intensive training both inside and outside of the physiological sphere afforded to psychiatrists.

Initial RxP training must be sufficient for providers to understand the complex physiological reactions between pharmacological interventions (DeNelsky, 1996; Moyer, 1994). This may require more than the currently outlined post-doctoral training model. Moreover, two prominent post-doctoral psychopharmacology programs (AIU, 2012; FDU, 2012) follow a distance-learning model which, given the dangerous nature of drug interactions, may be insufficient to ensure psychologists’ competence (DeNelsky, 1996; Moyer, 1994). This is notable given that no APA-accredited doctoral program allows a predominantly distance-learning approach (Clay, 2012). Thus, there appears to be a consensus within accreditation bodies that long-distance training is not sufficient for attaining and maintaining necessary clinical knowledge (Clay, 2012). This may also be the case with regard to RxP, therefore necessitating a change in the training model. Furthermore, insufficient training reflects a violation of Ethical Standard 2.01, as these programs cannot directly ensure that RxP psychologists are practicing within their boundaries of competence. Indeed, Ethical Standard 7.01 (Design of Education and Training Programs) states that psychologists must take steps to ensure that training programs provide the necessary knowledge for competency within their scope of practice (APA, 2002). This is reinforced by APA Ethical Standard 2.03, which

similarly recommends that “psychologists undertake ongoing efforts to develop and maintain their competence” (APA, 2002, p.5). Yet, the current framework for RxP training does not maintain any provisions or mandates at the legislative level to achieve pharmacological proficiency (DeNelsky, 1996).

Before RxP would be ethically viable, psychologists must be mandated to bolster their RxP proficiency through continuing education, just as they are required to do for ongoing psychotherapeutic proficiency (Department of Consumer Affairs, 2012). Yet, the current licensure framework for most states only mandates a number of hours and allows psychologists to choose the form and content of their continuing education, while other states have no continuing education requirements. Due to the risks involved with complex drug interactions, continuing education for RxP psychologists must be stringently regulated to ensure the greatest degree of competency in this domain.

Fidelity, Responsibility and Standards of Care

The APA Ethics Code, Principle B, states that psychologists develop a relationship of trust with their patients (APA, 2002). Psychologists are instructed to keep the best interests of their patients at the forefront of all of their decisions and to manage any conflicts of interest that could potentially result in the harm of another (APA, 2002). Psychologists must ask themselves whether or not it is truly in the best interests of the patient to be pursuing RxP, or whether the pursuit of such privileges is confounded by the desire to add legitimacy and financial profitability to the field of applied psychology.

Standards of care for clinical practice can be said to relate to the relationship of trust between a psychologist and patient, as appropriate standards of care are necessary to provide assurances to the patient that they are well protected. Thus ethical as well as legal considerations to be taken into account seem to be highly interrelated in any argument addressing RxP (Shafron & Van Moorleghem, 2012). The current standard of care for practicing psychologists is the “reasonably prudent professional” convention, meaning that any medical decision should be exercised a reasonable level of caution that an individual

of “ordinary prudence” would observe (Johnson, 2012; McWay, 2003, p. 45; Vaughn v. Menlove, 1837 as cited in Robinson, 2014, p. 444-445). This convention, however, does not currently specify standards of care pertaining to RxP-licensed psychologists. In the case for RxP, the argument must be expanded to conceptualize the RxP-licensed psychologist as in line with the ‘reasonably prudent psychiatrist’ (Johnson, 2009; Shafron & Van Moorleghem, 2012). This conceptualization would require an expanded standard of care from that to which applied psychologists are currently held, given the risks involved with RxP (Shafron & Van Moorleghem, 2012). Additional issues could arise if there are multiple standards of care based on different competencies within applied psychology (Shafron & Van Moorleghem, 2012).

Furthermore, along with doing more to secure the relationship of trust between patient and professional, the added responsibility of RxP requires that psychologists reflect on the same scientific and cultural issues related to pharmacological interventions that psychiatrists must address. These responsibilities include achieving cultural competence. In order for psychologists to earn the relationship of trust outlined in Principle B, a psychologist must strive to achieve the utmost cultural competency.

Cultural Considerations

The field of applied psychology is increasingly moving toward models emphasizing the understanding of cultural considerations in the application and administration of psychological interventions. For example, many researchers have explored the ways in which cultural background can shape and influence one’s personality and belief system (e.g., Bhugra & Bhui, 1999). This has been shown to influence patients’ choices of treatment (Chapa, 2004), as well as medication compliance (Lin, 1996) and even physiological response to medication (Bhugra & Bhui, 1999; Exner et al., 2001).

At the level of personality and belief system, it is possible to surmise that some individuals may favor the current model of seeing a medical professional to obtain psychotropic treatment for certain disorders. The possibility of RxP psychologists serving roles

traditionally occupied by psychiatrists could be problematic for these individuals, who might be uneasy seeing a psychologist for biomedical concerns. Yet the inverse may also be true; individuals who were previously reluctant to see a psychologist for therapy may be more likely to seek psychotherapy as an alternative form of treatment outside of the realm of psychotropic medications if the RxP psychologist becomes a primary source of psychotropic medications. In essence, prescription privileges might serve as a draw for individuals initially seeking psychotropic treatments to become more open to psychotherapy.

The RxP psychologist must also be mindful of the physiological effects of medications in different racial and ethnic groups. When reviewing tricyclic antidepressant usage cross-culturally, differences are seen at the physiological level when comparing individuals of Asian, Indian, and Caucasian descent. Caucasian individuals have demonstrated lower levels of tricyclic medications within their blood plasma, which has been attributed to differences in rates of hydroxylation between ethnic groups (Kilow, 1982). Hydroxylation is defined as the introduction of a drug into the body and the process by which it is activated and deactivated (Kilow, 1982). Additionally, differences have been found between individuals of Hispanic descent and other ethnic groups on rates of sensitivity to tricyclic antidepressants (Lin, 1995). Individuals of Hispanic descent have been shown to require lower dosages to achieve the drug's full effect, but at the same time experience greater side effects while on the reduced dose (Lin, 1995). Any pre- or post-doctoral training in RxP must maintain and integrate cross-cultural awareness to the administration of psychotropic drugs.

While a review of current literature found no significant differences relating to RxP treatment or outcomes with regard to gender, and LGBTQ status, RxP-trained psychologists must still be mindful of potential differences which may exist between these cultural groups. For example, it may be difficult to prescribe medications for very young individuals, as many medications are not approved for those under the age of 18. The RxP psychologist must do more than just understand the basic interactions of psychotropic drugs; there needs to be an overall aware-

ness of any possible contraindications (Buelow & Chafetz, 1996; Shafron & Van Moorleghem, 2012).

Conclusion

This paper addresses the history of granting prescription privileges to psychologists, followed by a review of arguments for and against RxP within the context of the APA Ethics Code. The possibility of granting RxP to applied psychologists remains an ongoing debate within the mental health professions. As psychiatry's numbers diminish due to lack of financial incentive, it is clear that general practitioner M.D.s alone cannot support the overflow of patients who need psychopharmacological treatment, and critics question whether general medical practitioners have the expertise necessary to treat mental disorders. Despite the APA's support of RxP to compensate for the dwindling numbers of practicing psychiatrists, psychologists must only accept such privileges if they can attest that the training afforded to them is fundamentally comparable to the years of pharmacological education provided to psychiatrists. Regardless of whether psychologists are permitted only to prescribe psychotropic drugs, their training and continuing education must exceed that of psychotropic medications alone to ensure the well-being of those they treat. Such training must also employ the same cultural competencies mandated academically within clinical and counseling psychology, particularly since pharmacological responses have been shown to differ across ethnic groups. Striving for patient health, both mentally and physically, must remain central to the field as it moves toward new applications.

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