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The Case for the Efficacy of Prescribing Psychology: Utilizing Existing Research and Guidelines

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Supporters of prescribing psychology are often asked how we can determine if prescribing psychologists are effective prescribers of psychotropic medications. Those of us who have been prescribing safely and effectively for several years or more can find this question surprising. However, legislators, medical providers, patients, and others can reasonably expect us to be able to answer this question with data. This article briefly discusses how current literature can be used to support the efficacy of the practice of prescribing psychology today.

In order to evaluate the efficacy of prescribing psychologists we must first define what the prescribing psychologist uniquely brings to the provision of services. While it may seem obvious that prescribing psychologists bring the ability to provide a combination of psychotherapy and psychopharmacological services to their clients, this is a remarkably unique skill set. While some psychiatrists or psychiatric nurse practitioners may have expertise in providing psychotherapy, many in those respective fields do not. Only prescribing psychologists are by definition and training both highly skilled psychotherapists and psychopharmacologists. Prescribing psychologists may provide therapy and/or psychopharmacological services to different populations in virtually any setting that clinical psychologists typically practice. These include multidisciplinary/integrative settings, individual practitioner roles, inpatient, consultation, emergent services and others.

With regards to specific psychological, biological or social problems the prescribing psychologist is prepared to provide services at a comprehensive level that meets both practice guidelines and the standard of practice. While non-prescribing psychologists are also very capable of meeting the research-based guidelines from a psychotherapeutic standpoint, only prescribing psychologists have the added benefit of also meeting the research-based guidelines for psychopharmacologic treatment as well. As the astute reader will note, the first-line treatment for some psychological problems (e.g., specific phobias) is some form of psychological treatment (e.g., CBT) with psychopharmacological intervention not generally recommended (e.g., Muse and Stahl, 2018; Shearer et al., 2014). In this case the prescribing psychologist can choose to utilize the recommended treatment. In contrast, the prescribing provider who is not also a psychologist, who is not trained in psychotherapy, must either refer to an appropriate provider or use the only tool in their toolbox, medication. Conversely, in cases in which medication is the clearly the first-line treatment of choice (e.g., acute mania in bipolar disorder; Welton & Roman, 2018) the prescribing psychologist has the ability and tools to choose the most effective treatment approach, psychopharmacologic intervention.

Using Clinical Practice Guidelines (CPGs) as an example, this section will briefly review how the unique skill-set of the prescribing psychologist is applied to a two specific psychological problems; depressive disorders and posttraumatic stress disorder. There is agreement among experts that some psychological problems may respond well to combined psychological and psychopharmacological approach {e.g., Pfiffner & Haack, 2015 (ADHD), Dougherty, Rauch, & Jenike, 2015 (OCD); Cuijpers et al, 2014 (depression and anxiety)}. Other disorders are often treated with either medication or psychotherapy alone. In some cases the addition of medication to psychotherapy, or visa-versa, may improve outcomes (e.g., Cuijpers et al, 2014). The reader should keep in mind that patient preference is also a strong determining force in what treatment a patient receives. Even if the best current evidence suggests that a combined approach may be most successful, individual patients may strongly prefer medication only or psychotherapy only. Once again, the prescribing psychologist is able to meet the both the patient need and preferences in ways that most other psychotropic prescribers cannot.

Depressive Disorders

The American Psychological Association (APA) guidelines for the treatment of depressive disorders (APA, 2019) indicate that for a general adult population either medication, psychotherapy or both may be considered as first line treatment. For older adults, the APA guidelines recommend either a combined approach or group therapy. Similarly, the American Psychiatric Association (APA) has also published guidelines for the treatment of major depression (APA, 2010). These guidelines recommend either therapy or pharmacotherapy for mild to moderate depression in adults with optional combined treatment for patients with contributing psychosocial factors. For adults with severe depression, with or without psychotic features, the American Psychiatric Association guidelines recommend either medication alone or a combined approach (APA, 2010).

Posttraumatic Stress Disorder

The American Psychological Association practice guidelines for the treatment of posttraumatic stress disorder (APA, 2017) also make specific recommendations for both therapy and psychopharmacologic treatment. The Veterans Affairs/Department of Defense guidelines for the treatment of posttraumatic stress disorder (PTSD) has specific recommendations for the use of therapy as first line treatment and medication as alternative or adjunctive treatment (US Department of Veterans Affairs, 2017).

The guidelines referenced above, as well as much of the research on behavioral health treatment for specific psychological disorders, do not differentiate between categories of providers. Rather the focus is on treatment outcomes for the services provided. The underlying assumption is that any provider licensed to provide these recommended interventions will improve patient outcomes by following these guidelines. The prescribing psychologist can provide every level of recommended treatment per these guidelines as described above.

Conclusion

From a historical perspective McGrath (2019) has suggested that psychology could develop into a prescribing discipline for some psychologists similar to the way in which psychiatry evolved from predominantly a therapy-focused to a medication-focused discipline. Indeed, with the addition of prescription privileges the prescribing psychologist provides services comparable to psychiatrists, psychiatric nurse practitioners, and psychiatric physician assistants. However, it is the capacity to provide either medication management, therapy, or both that defines the current prescribing

psychologist. The two primary ways in which psychopharmacological prescribing professions can be compared, other than annual salary, are training and efficacy. Muse and McGrath (2010) have published the only comparison of prescribing psychologists' training vs. physicians and nurse practitioners. They conclude that… "The results suggest that pharmacologically trained psychologists have as much or more education in psychopharmacology as do other entry-level prescribers, including physicians" (p 101). This conclusion has been challenged by some based on the fact that the physicians used as a comparison point were those who had graduated medical school, yet had not completed their four year psychiatry residency. In other words, entry level prescribers as stated in the article. Nevertheless, the comparison shows comparable levels of didactic education in psychopharmacology. Another way to assess training is to compare psychotropic prescribers on a test of competence. This was undertaken by Cooper (2020) when he administered a 25 item exam on psychopharmacology to 66 providers: psychiatrists, general physicians, psychiatric nurse practitioners, general nurse practitioners, prescribing psychologists, and general psychologists. The results revealed that the best performance was by psychiatrists, followed respectively by prescribing psychologists and then psychiatric nurse practitioners. However, there was no statistically significant difference in performance between the three groups. This suggests that the competence level, as measured by written exam, is comparable for psychiatrists, prescribing psychologists and psychiatric nurse practitioners.

Yes, as of this date, there is a limited amount of research specifically focusing on prescribing psychologists. This is in part due to the relatively recent origin of the field, but also because both psychotherapy and psychopharmacology are often independently researched. As discussed above Clinical Practice Guidelines (CPG), dosing regimens, and indications for psychotropic medication are same for all prescribers regardless of discipline. Therefore, the data evaluating the efficacy of psychopharmacology applies equally across specific prescribing disciplines. Support for basic comparability of disciplines is found in comparisons of training programs for different prescribing specialties (Muse and McGrath, 2010), an absence of serious adverse errors for prescribing psychologists over three decades, and the fact that prescribing psychologists are providing similar services in similar settings as other prescribing providers. Currently, the best data supporting psychologists who prescribe comes from research that either independently evaluates psychotherapy and pharmacotherapy or evaluates the combination as provided by separate practitioners (prescribing and non-prescribing). Psychopharmacology is a practice that has a long and well-documented record of efficacy. The specialty of prescribing psychology is in its essence applying an already existent base of evidence, established over many decades by psychiatry, as adjunctive skill for full-scope clinical psychology. As this specialty develops there will be more studies focusing specifically on prescribing psychology. However, we do not need to wait for those studies to demonstrate the basis of our efficacy as prescribers; our current psychopharmacological practice is informed by a vast database of research, clinical practice guidelines and medical reference materials.

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(pg 558)

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