



## Response to Clinical Psychologists Prescribing Psychotropic Medications

### **BACKGROUND:**

The use of psychotropic medication to treat psychiatric disorders has surged in recent years. Research from the decade of the brain has increased understanding of the brain-based nature of mental illness and somatic treatments are increasingly being viewed as the mainstay of psychiatric treatment. As the mental illness paradigm slowly is shifted toward a neurobiological etiologic basis of illness, standards for practice and reimbursement for services are increasingly being shifted toward pharmacological interventions.

The field of psychology has long provided an etiological framework from which to view mental health and illness. The psychological view, which has been one of the most dominant frameworks until recently, is predicated on an in-depth understanding of developmental and environmental influences on the expression of mental illness (Brentar & McNamara, 1991; Martindale, Bateman, & Margison, 2000). This non-somatic model has been almost exclusively psychic in nature and has largely reflected a duality that separated the body's neurobiological brain from a concept of the mind. Consistent with this etiological philosophy, educational curricula for clinical psychologists have dealt very little with human anatomy, physiology, or biological principles (Troy & Shueman, 1996; Wiggins & Cummings, 1998). From psychotherapy to psychological testing to learning theory, psychology as a profession has provided understanding, insight, and a theoretical basis for care practices that have crossed discipline lines into nursing and medicine. The landscape, however, is shifting for the field of psychology. As reimbursement patterns and staff positions follow trends toward biological etiology models, the emphases and relative importance of the traditional psychology roles are decreasing, slowly being eroded by somatic-based treatments such as medications (Glod & Manchester, 2000; Pincus, et.al, 1998; Olfson, Marcus, & Pincus, 1999).

## **OVERVIEW OF THE ISSUES:**

Reimbursement for psychotherapy is declining and standards of care for psychiatric disorders almost always incorporate medication (Cypres, Landsberg, & Spellmann, 1997; Pincus, et.al., 1998). Medication prescription and management have not been traditionally seen as the role of the psychologist. However, as new knowledge impacts treatment standards and reimbursement patterns shrink client bases, many clinical psychologists have begun to advocate for prescription authority for psychotropic medication as a legally sanctioned role for their profession.

Many clinical psychologists seeking prescriptive authority refer to nursing as the example of a group of non-physician care providers who were granted prescriptive authority (Pies, 1991; Sovner & Bailey, 1991). Nurses have been safe, effective, and well received by the public in the prescriptive role (Bailey, 1996). Using nursing as the example, some have proposed that prescriptive privileges are not the sole purview of the medical profession, and non-physician professionals can be just as safe and effective in this role (DeLeon, Sammons, & Sexton, 1995; DeLeon & Wiggins, 1996). While not arguing with the premise of the efficacy of nonphysician prescribers, one glaring flaw exists in this argument.

The difference between nursing and psychology is the depth and degree of the biological, scientific basis of nursing science and the holistic orientation that is the hallmark of our profession. Nursing is a scientifically-based profession that fought long and hard to obtain prescriptive privilege for advanced practice professionals. Nursing has been successful in this role because of its deep historical roots in the biological sciences, and because of the centrality of holistic, individualized assessment, and orientation toward the acceptance of the physiological bases of illness (Roberts, Tabloski, & Bova, 1997). None of these factors exist in the field of psychology. In a somewhat casual manner, many clinical psychologists suggest that the addition of one or two courses in pharmacology would be sufficient to provide the knowledge base for the prescription of psychotropic medications (Sammons, Sexton, & Meredith, 1996). This at best under-emphasizes the complexity of issues such as pharmaco-dynamics and pharmaco-kinetics, and at worst ignores knowledge required to understand, prevent and treat such things as drug interaction and dangerous side effects.

The success that nursing has realized with prescriptive privilege and the subsequent consumer support of this role has even led some to argue that nursing should provide the knowledge base for clinical psychologists to prescribe (Sovner & Bailey, 1991; Troy & Schueman, 1996). Nurses are being asked, in the spirit of collegiality, to assist clinical psychologists in building the requisite knowledge base for prescriptive practice. To do so would be, inherently, unethical.

Clinical psychologists have enrolled in MSN programs that do not require nursing baccalaureate preparation (APA, 1999). These programs, all with waiting lists for clinical psychologists are embracing the increased enrollment of a new pool of potential students, perhaps without full consideration of the ramifications. These clinical psychologists are anticipated to be the first wave of clinical psychologists to be given prescriptive privileges who will then be able, it is assumed, to provide training for clinical psychologists of the future (APA, 1999). Among many concerns is the reality that these initial clinical psychologists will prescribe as advanced practice nurses, while functioning in their roles as clinical psychologists.

Currently, prescriptive privilege is primarily reserved for nursing and medical professionals. Physicians, physician assistants, nurse practitioners, and clinical nurse specialists all may obtain prescriptive authority. The defining commonality among these professionals is, of course, the depth and degree of human biological and psychopharmacological knowledge that they possess. These professionals did not simply take one or two classes to obtain this knowledge base. **The entire education and training for these professions are defined by immersion and concentration on the way in which the human body works, the impact on the body when it does not work as anticipated, and the role of pharmacotherapies in the treatment of health problems.**

Content information regarding drugs is not analogous with prescriptive knowledge or ability. Pharmacotherapeutic prescription entails a complex array of information synthesis and clinical decision making that assumes a baseline of detailed knowledge of a wide range of biological data. In working with the mentally ill, effective prescription practices are predicated on a knowledge of anatomy and physiology, an understanding of pharmacologic principles, legal awareness, advocacy, interpretation of laboratory findings, knowledge of concomitant and co-morbid health states, and an ability to stay current in related topical areas such as advances in genetics, immunology, and other biologically based sciences.

Nursing is a separate and distinct discipline among the helping professions. While cognizant of our uniqueness, nurses have increasingly become aware of the importance of interdisciplinary interaction. This construct resonates strongly in mental health which has a rich history of interdisciplinary practice and collaboration. But despite this history, assisting the profession of psychology to obtain prescriptive authority would run counter to our roles as patient advocates and to knowledge that the role and orientation of psychology is ill suited to somatic-based treatments. The ethical dilemma of clinical psychologists seeking prescriptive authority is a real one. It is an issue in which nurses need to focus on and carefully consider in terms of what should be our profession's response.

Nursing has a strong history and tradition of advocacy (Carter, 1999; Lim, 1997; Turkeltaub, 1998). Advocacy assumes that nursing action will always focus on the protection of the patient and the safeguarding of the patient's rights. This role is borne out in the standards of our profession (ANA, 1998; 1996; 1992; 1985). Advocacy requires nurses to resist the financial benefit or status benefit of providing training modules for clinical psychologists in the area of psychopharmacology. Advocacy requires nurses to recognize the ethical dilemma created for nurses by clinical psychologists seeking prescriptive authority (Walker, 2001). The American Nurses Association (1985) *Code for Nurses with Interpretive Statements* supports an advocacy stance. The third stated code regarding the action of nurses states that "the nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person" (p. 1). To assist clinical psychologists to gain prescriptive authority would be in violation of our nursing professional standards.

### **THE POSITION OF ISPN**

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 individuals without the necessary background being allowed to engage in clinical 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.

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