Is RxP good for NPA?

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This is a complex and multifaceted question that does not have any easy answers. To begin with I will offer a full disclosure of acknowledging that I am a prescribing psychologist. I am licensed in Nebraska, but I am currently serving in the United States Air Force, which allows appropriately trained psychologists to prescribe psychotropic medications. It is my hope and intent to return to Nebraska after my military career, and I would very much like to continue to practice as I have been, with the ability to provide all of the care my clients may need. This is due in no small part to the level of comprehensive care I am able to provide my clients, but also to the convenience that this practice offers my clients. There are many reasons I have chosen to pursue prescriptive privileges, however, my own preferences and beliefs are hardly reason enough for the NPA to pursue legislative action to alter the scope of practice allowed clinical psychologists.

The first question we should examine is that of need. Is there a need for more providers to be able to provide psychotropic medications? Are there underserved populations that may have access to a psychologist, but not to a psychiatrist? It has been my experience while living in western Nebraska that this is very much the case (I am originally from North Platte NE and still have friends and family in that region). We have all, at some point, had to answer an ethical question, whether on a licensing exam, or in via course work, that reads something to the effect "You are a psychologist practicing in a rural area and a client comes in with a disorder that you are not well trained to treat. There are no other providers in the area who specialize in this disorder and it is not practical for them to travel to the nearest specialty care. What do you do?" There is then a list of choices ranging from refuse the client to obtain as much training as possible and treat with consultation. Of course the correct choice is to obtain as much training as you can and treat with consultation. Unfortunately our current scope of practice does not allow us to pursue this option when it comes to psychotropic medication, but I would argue that as a state organization we have an ethical obligation to try and change the current state of affairs. Of course the training and consultation will be more involved and everyone will not choose to pursue that training, however, as an organization we should allow for that training with the eventual goal of having providers who can prescribe dispersed sufficiently so that a patient does not have to travel to the extent that they do now.

In addition to the above concerns regarding locality, there is also a concern about immediacy. When I was involved in providing mental health care in NE I often found that wait times to see a psychiatrist were prohibitive and left people without needed care for weeks or even a month or more. Again not everyone will choose to pursue the training to prescribe, but I feel we have an ethical obligation to do what we can to put more prescribers in the field in an effort

to ensure that our clients receive timely care. This also increases the likelihood that clients will be followed in closer intervals so that adjustments can be made to their medication in a more responsive fashion. It is vital that mental health clientele in Nebraska be treated based on need and clinical decisions. Nebraskans should not receive treatment that is driven by availability of a service.

So I assert that it is clear that mental health care recipients in our state would benefit from a market place where there more options and more prescribers available, but that doesn't answer the question about whether or not the NPA should support such a move. There are some psychologists who fear that prescriptive authority will change the landscape of psychology and alter how psychologists provide care. Additionally, some providers fear that if prescriptive authority is allowed than they will be forced to either get the training or be edged out of the market place. To the first point, yes my experience has been that prescribing has changed my practice. I am more thorough and thoughtful about their physical concerns. I ask more questions about each medication my patient's take so I can ensure that I am avoiding interactions and not duplicating treatment. I am also able to monitor their responses and titrate medications in close concert with their therapy and therapy progress. That said, about fifty percent of my current case load does not take medication, and of the patients who came to me already on medication nearly fifty percent are on fewer medications or a lower dose. With the power to prescribe comes the power to un-prescribe, and I have found as much benefit from taking patients off of medication as putting others on. I have also had the experience of explaining to a patient what the medication(s) they were already taking when I started seeing them are intended to do and how they work. I have had many tell me that no one ever took the time to provide these explanations. For those patients that I do not prescribe medications the reasons vary from the patient not wanting medicine to patients who would not benefit from medication. Often a client wants a quick answer, but what they need is education and therapy and I firmly believe that our profession is the positioned to provide that education and treatment. To the second point of fear that providers will be forced out of the market place if they choose not to pursue training in psychopharmacology, I would encourage you to think back…way back to undergraduate courses that taught you the history of the development of clinical psychology. We used to only be allowed to provide assessments, only a psychiatrist could do therapy. That was a barrier that we were able to overcome, and yet there are still today psychologists whose primary and perhaps only practice is assessments. A psychologist can make a place for themselves and build a practice only doing testing and evaluation. We also have other specialties and specialists that have not impinged upon the general practitioner, such as neuropsychologists, health psychologists and others, who have additional specialty training, but have not impacted the ability of general practitioners to find clientele. Choosing not to be a prescriber, will not negatively impact your practice, however, choosing to not let other providers receive the training, I believe will negatively impact our profession and our clients.

So is it the right thing for our state organization to pursue this matter? As much as we already have to fight for parity, that battle will only get tougher if we don't also fight for advancement. We must fight for our patients to have access to the care they need. We should fight for psychologists to be able to pursue the training and certification that will allow them to best treat our neighbors. Psychologists have more mental health specific training than any other profession. We are the best educated and informed, often have closer relationships with our clients than any other healthcare provider they interact with, by virtue of more frequent interactions of longer duration. We are more apt to spend time with our patients explaining the medication, asking about side effects, ensuring that their treatments are complimentary. In short, the NPA owes it to our provider's, our patients and our state to pursue a widened scope of practice. In addition, there is no better way to draw additional providers to our community and to grow the NPA roles than to advocate for psychologists. I believe that this is right for psychologists, I believe that this is right for our state, and I believe that this is right for the NPA!

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