



PHARMACOLOGY – ITS ROLE IN CONSULTATION & PRESCRIBING



SOME RECENT TRENDS IN OUTPATIENT THERAPY & PHARMACOLOGICAL TREATMENT

Trends in outpatient therapy

- Two large national studies drawing from data from the National Medical Ambulatory Database examined trends in psychotherapy over the last 2 decades found little change in overall incidence of outpatient treatment, but found *a decrease in psychotherapy* both in terms of the average number of sessions per consumer as well as whether people receive it therapy at all (Olfson et al, 2002; Olfson & Marcus, 2009).

More Trends

- Also *combined treatment* (medication provided by an MD and therapy with the MD or a non medical professional such as a psychologist providing the therapy) is *less frequent* than 10 years ago
- More and more mental health treatment involves *medication only* without therapy (Olfson & Marcus, 2009)

Comparison of 1998 to 2007 in outpatient depression treatment

• TYPE OF TREATMENT	1998	2007
• Psychotherapy only	16%	11%
• Meds & therapy	40%	32%
• Medications only	44%	57%
• Olfson & Marcus, 2009		

Evidence for Combined treatment

- Much empirical literature has demonstrated that for serious mental illness, a combination of psychotherapy and medications are needed for optimal outcomes. This has been demonstrated for severe major depression (Elkin et al, 95; Emslie et al, 04); for Bipolar disorder (Miklowitz & Goldstein, 97; Newman et al, 2002); for severe panic disorder (Roy-Byrne et al, 2005) and for psychotic disorders (Gould et al, 2001; Weinroth et al, 2010)

Rationale for Combined Treatment

- While medications can offer some immediate relief from acute distress – they are also often accompanied by problematic side effects; non compliance with medications is common
- Psychotherapy promotes attitudinal and life style changes that can sustain remission from major mood & psychotic episodes. This promotes a higher overall quality of life so consumers and their families can pursue desired dreams & goals.



**SO WHAT HAS
CONTRIBUTED TO
THESE CHANGES?**

Changes in Anti-Depressants

- The advent starting in 1988 of SSRI and later SNRI antidepressants that had many fewer side effects than older style antidepressants
- From 1997 to 2005 the rates of prescribing of antidepressants doubled as a result of these newer agents . This was true across all groups with the exception of African Americans and Latino Americans who were prescribed antidepressants significantly less frequently than non Hispanic whites (Olfen & Marcus, 2009; Mojtabi, 2008).

Broadening of publics' attitudes about antidepressants

- A study tracking changes from 1996 to 2005 found a significant increase in consumers' willingness to take antidepressants to treat a variety of issues including depression (49% stated they would take an antidepressant if they were depressed), panic attacks (64%), "trouble in one's personal life (29%)," or to cope with stress (47%). Mojtabai et al, 2009.

More Contributors

- Advent of 2nd generation antipsychotic medications in 1990 had many fewer side effects than 1st generation agents
- In a study with a large national sample of those seeking mental health services from outpatient MD's from 1996 to 2002, those receiving anti-psychotic prescriptions almost doubled in that timeframe: In 1996 4.6 million mental health visits resulted in the prescription of an anti-psychotic and in 2002, this had risen to 8.6 million - the use of 2nd generation anti-psychotic medications tripled in this period (Aparasu et al, 05)

Changes in prescribing anti-psychotics to kids and teens

- In a study of anti-psychotic prescriptions to those 20 and younger from 1993 to 2002, 201,000 such prescriptions were written by MD's in office based practice in 1993 compared to 1,224,000 prescriptions in 2002 – 92% of the visits in 2002 involved a 2nd generation anti-psychotic. In terms of diagnosis in 2002, 38% were prescribed to clients for behavior problems, 32% for mood problems, 17% for autism and 14% for psychotic symptoms. (Olfson et al, 2006)

Broadening of Prescription of Anti- psychotics

- In a study of adult patients prescribed anti-psychotics by 4000 psychiatrists, 39% were prescribed them for bipolar disorder, 35% for schizophrenia, 7% for cognitive problems & 5% for anxiety (Mark et al, 2010)

Inequities in anti-psychotic prescribing

- Data from clients seeking emergency psychiatric services found significant differences between African Americans and Caucasian clients in the prescription of anti-psychotic medications. African Americans were significantly more likely to receive more injections of the meds and received higher dosages than comparable Caucasian clients. Most of the MD's in this study were Caucasian. (Segal, Boa & Watson, 1996)

More inequities

- In a study tracing MD prescribing practices for anti-psychotics from 1992 to 2000, in 1992 African Americans had half the odds of being prescribed a 2nd generation AP & Latino Americans had 40% the odds vs. Caucasian clients. By 2000 African Americans treated for psychosis were prescribed 2nd generation AP's 25% less than whites (Daumit et al, 2003)

Role of Direct Consumer Advertising

- In 1997, Congress passed a bill that liberalized the existing laws around direct consumer advertising of psychotropic medications.
- Total spending on pharmaceutical advertising grew from \$11.4 billion in 1996 to \$29.9 billion in 2005. During that same period spending on direct-to-consumer advertising increased by 330%. (Donohue et al, 2007).
- In 2005 pharmaceutical companies spent \$4.2 billion on direct consumer advertising and \$7.2 billion on promotion to MD's (Shaw, 2008).
- At the same time regulation by the FDA of violations in drug advertising fell from 142 charges in 1997 to only 21 in 2006 (Donohue et al, 2007).

Changes in reimbursement

- Expansion of managed care in mental health treatment in the 1990's involved strategies to undercut the reimbursement of mental health and substance abuse services especially psychotherapy.
- By 2006 reimbursement for psychotropic medications accounted for 51% of total mental health care spending. Looking at per capita expenditure of medications, this figure tripled from 1996 to 2005 (cited by Nordal, 2010)

Polypharmacy is more the rule

- More and more clients with chronic mental illness who are medicated with psychotropic meds are receiving the “cocktail” which involves 2 or more medications. In a national sample of psychiatrists, 42% of clients were prescribed 2 or more meds in 1996; this was up to 60% in 2005 – for those receiving 3 or more meds, this rate went from 18% to 25% in 2005; for those receiving 4 or more meds the rate went from 7% to 15% and 5 or more meds went from 2% to 5% (Mojtabai & Olfson, 09)

Inequities in spite of access

- In a national study comparing mental health services in Asian American, Latino American, African American and non Hispanic White American samples, access and quality of care were compared across samples – a minimal standard for depression treatment was defined as 4 or more visits to a therapist with antidepressants for at least 30 days or 8 or more visits to a therapist lasting at least 30 minutes and no antidepressants (Alegria et al, 2008).

Inequities Continued

- For those who reported experiencing treatable depression symptoms in the past year 64% of Latino Americans, 69% of Asian Americans, 59% of African Americans & 40% of non Hispanic White Americans received no treatment.
- In terms of those whose treatment met the minimal standard of care for depression, 33% of non Hispanic whites met this standard of care compared to 25% for Latinos, 19% for Asians and 10% for African Americans in this sample (Alegria et al, 2008)

Alegria et al Study

- Another significant finding of this study was that even when all groups had access to mental health services and received treatment, people of color in this study received poorer quality of care than non Hispanic whites even when education, poverty status and insurance coverage were controlled for (Alegria et al, 2008)

Barriers to Care cited in study (Alegria et al, 2008)

- Some of the barriers to care for people of color cited in the study were
- An under detection of depression by medical and mental health providers in those of different ethnic groups
- Consumers who couldn't afford to lose time from work to seek help
- The stigma of receiving mental health services
- The experience of mistreatment from prior mental health providers which discouraged care
- Poor referral networks (Alegria et al, 2008)



THE RECOVERY ORIENTED MODEL AND PHARMACOLOGY

Principles of the Recovery Model

- Cultivating a sense of hope: vision and pathways to the vision
- Promoting a sense of social inclusion – being part of the community not apart from it
- Providing a sense of self efficacy relative to treatment and one's desired goals and coping skills to engender empowerment
- Providing a sense of engagement & meaning

Pathways

- Providing collaborative care with shared decisionmaking so clients and families can determine their treatment
- Offering supportive recovery oriented relationships not just with providers but with peers as well
- Promoting opportunities *for* peer mentoring and modeling around recovery
- Wrap around comprehensive services with strong community & family involvement, continuity of care, open communication & strong collaborative team alliances

Current role of psychologists in recovery model in medication mg't

- In terms of medication management, psychologists doing therapy with clients monitor clients on medications and discuss medication issues that are impactful to treatment, provide psycho-education re. meds, advocate for and with clients and work collaboratively with MD's and clients to address client's personalized needs in regard to medications.

American Psychiatric Association on Collaborative Treatment

- In a collaborative relationship, the psychiatrist and therapist share responsibility for the patient's care in accordance with the qualifications & limitations of each person's discipline & abilities. The patient must be informed of the respective abilities of each clinician. Both the psychiatrist & the nonmedical therapist are responsible for the periodic evaluation of the patient's status to ascertain that the collaboration continues to be appropriate (APA, 1980)

Role of medication in the recovery model

- To manage symptoms so desired goals and outcomes can be achieved – flexibility and openness of providers is important
- Provides help in conjunction with other supports that might include therapy, support groups, substance abuse treatment, management of medical illness, case mgt, job training, support for the family; all providers need to respect and be aware of client's personalized needs for care
- Important that full informed consent is provided in order to build a strong therapeutic alliance with the MD for best outcome

Importance of medications in recovery from serious mental illness

- A qualitative multi-site study in Canada was conducted with 60 consumers with serious mental illness to understand the meaning of recovery relative to medications. Five themes emerged:
 - Finding a medication that works
 - Taking meds in combination with supports & services
 - Complying with medication
 - Having a say about medication
 - The right to live without medication
- (Piat, Sabetti & Bloom, 2009)

Importance of treating relationship

- In a study of consumers with schizophrenia about the clinician-client relationship & outcome, 92 women & 85 men were interviewed. Themes incl:
- Feeling like there was a good “fit” with the MD; this involved having a relationship with someone who could be trusted & cared – “like friendship.”
- Flexibility & openness of the MD in regard to medications was critical.
- The MD’s willingness to continue care when the client was non compliant and to explore all possible options when meds weren’t working (Green et al, 2008).

Study on treatment relationship

- In the quantitative findings, better experiences of medication treatment and stronger working alliance with MD were significantly correlated with lower psychotic symptoms and higher reported quality of life in the majority of participants (Green et al, 2008)



ROLE OF PRESCRIBING PRIVILEGES FOR PSYCHOLOGISTS

Changes in Psychology

- In last 50 years there have been tremendous changes in the field of psychology
- In the 1950's when psychotropic medications were first introduced the APA rejected the idea that psychologists would prescribe; the focus instead was on behavioral and social treatment of the individual

Prescribing Privileges

- Over the past 40 years psychologists have consistently adopted the bio-psycho-social-cultural model & our APA curriculum reflects this
- In 1989 the APA prioritized the gaining of prescription privileges for psychologists & put resources towards this effort
- They introduced the Dept of Defense Pharmacology Demonstration Project (DDPDP) which was first launched in 1991

History of Prescribing Privileges

- The DDPDP involved a training model of 1900 hours of clinical training and 1000 supervised hours in addition to the existing psychological training – by 1998 10 military psychologists were prescribing regularly
- However selection criteria for the program was very strict & practice took place in community clinics - not hospitals. The training program was at least 2 years of coursework followed by the additional supervised hours

More History

- In addition to DDPDP since 1990 12 states have rejected legislation for psychologists to receive prescribing privileges with the exception of Louisiana (2004) & New Mexico (2002) which have passed such legislation
- Both states have large underserved areas that are largely rural where there is limited access to mental health care – In New Mexico for example, only 18 of 90 psychiatrists are located in rural areas outside of Santa Fe & Albuquerque

Arguments for Prescription Privileges

- Currently over 60% of psychotropic meds are prescribed by internists (Olfson & Marcus, 08) yet psychologists are better trained to do psych assessments & assess clinical symptoms relevant for a med evaluation compared to an internist.
- A study compared the academic training of psychiatric nurse practitioners, internists and pharmaceutically trained psychologists and found that psychologists get from 2.5 to 4 years more graduate training than these counterparts & have more rigorous applied training (Muse & McGrath, 10)

Scarcity of mental health services

- Large numbers of people in the US are underserved in terms of mental health esp. in rural areas. A study found that rural individuals are significantly less likely to receive mental health care vs. those living in urban areas (Wang et al, 05) Indeed some 20% of rural counties offer no mental health services compared to 5% of urban counties (Gamm et al, 03)
- Psychologists with proper pharmaceutical training & licensing can service these areas and provide both evidenced based therapy & medications that provide comprehensive care

More arguments for

- Psychologists have been prescribing in the military for over 10 years very successfully – a training model has been developed that has been found to be effective
- In a study of military psychologists compared to psychiatrists' prescribing practices, psychologists relied more on therapy and prescribed medications less frequently than MD's (Reaves et al, 2008)

Arguments against

- The current training of psychologists deemphasizes the medical model in favor of psycho-social & behavioral treatments. Patient safety could be endangered because of a psychologist's lack of training in the hard sciences. As the argument goes – if a psychologist wants to prescribe they can get a nurse practitioner degree and license

More arguments against

- Because medications are powerful and potentially harmful those who prescribe need an extensive medical background to monitor medications. Also significant numbers of clients on medications have a comorbid medical illness; this makes for tremendous potential complexity in medication management which psychologist's applied training makes them ill prepared to address
- There is currently insufficient research to support psychologists prescribing



RECOMMENDATIONS

Recommendations

- Given the amount of consumers who have inadequate access & receive poor quality of care in mental health treatment, psychologists can offer comprehensive evidenced based treatments that are culturally sensitive and comprehensive in scope
- It is hoped that the Paul Wellstone Equity Act of 2008 will significantly improve the numbers of Americans who receive mental health treatment, particularly psychotherapy, from non MD mental health providers

More Recommendations

- Psychologists can offer leadership in public policy to implement recovery oriented treatment models and can do the research necessary to empirically support new treatments and demonstrate outcomes – this will be important for future funding and reimbursement of mental health services
- Evidenced based therapy needs to be offered as a matter of course given that – unlike medications - it doesn't have side effects & provides lifestyle changes that can sustain a higher quality of life

More Recommendations

- Need to expand prescription privileges for psychologists in order to provide adequate mental health services in both rural areas and to serve communities of color which are currently so underserved
- Ongoing studies need to be done of the care provided by pharmacologically trained psychologists to demonstrate their efficacy in providing high quality services to consumers that involve both medication and psychotherapy