

# **Serving the Underserved: Preparing Psychologists for Effective Practice in the Public Sector**

Plenary 4: Speaker 1

## **Psychology Education for the Future: Some Imperatives-- Psychopharmacology: Its Role in Consultation and Prescribing**

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Hi everybody. So I'm going to talk a little bit today about psychopharmacology in terms of the recovery oriented model of treatment and the role that we as psychologists play in terms of consultation and prescribing. I'm going to start off by talking about some of the recent trends in the last 15, 20 years that I think have really impacted this whole issue of psychopharmacology.

There's a number of studies that are done periodically with the National Medical Ambulatory Database, huge database of all these medical providers who provide outpatient mental health services and looking at trends in psychotherapy over the last couple decades. And what we're seeing overall is a slow decrease in the amount of psychotherapy that's offered but a dramatic increase in the use of medications, probably no surprise to anyone here. In fact in one of these studies where we're comparing about 30,000 randomly selected providers from 1998 to 2007, these are all MDs, mostly psychiatrists but also some internists who are doing some mental health treatment as well as part of their work. For people seeking treatment for depression we see a real drop in psychotherapy over the course of this timeframe from 16% to 11%. The combination of meds and therapy from 40% to 32%, and medications only rising from 44% to 57% so more and more in fact a majority of these clients who are seeking help for depression were getting medications only with no therapy.

We look at the empirical literature and hardly outline it all here but there's a ton of it as you probably all know. What we see over and over again is that the combination of medications and therapy is optimal for the treatment of serious mental illness. We look at things like Bipolar 1, Psychotic Disorders, Major Depression Recurrent, and even serious Anxiety Disorders, the combination seems to be the most effective. So this trend of medications only is one that could really garner some concern.

Some of the rationale for combined treatment is that medications offer more immediate distress so people feel a little bit better and then what you have from the psychotherapy is more lifestyle changes and attributional changes that can sustain a higher quality of life over time. So we follow people who've had both therapy and medications, they tend to have lower recidivism rates to major mood episodes, major psychotic episodes, than people who've had just medications.

So what has contributed to some of these changes? One of the things that we have to look at is we've had this whole change in the kinds of antidepressants that are offered. Starting in 1988 with Prozac with the advent of the selective serotonin reuptake inhibitors, Paxil, Zoloft

and also the SNRIs Effex or Imrimeron we started to see people be able to tolerate antidepressants much more readily than they had before because as you may know the older antidepressants had really problematic side effects so people usually only took them if they were really, really depressed. So with the talking back to Prozac era we started to see these medications being prescribed more broadly for lots of different things, life changes, stress, things like that.

But when we look at the increase there was an increase from 1997 to 2005 of doubling of the rates of prescribing of these medications this was true in all groups except for African Americans and Latino Americans whose rates of prescribing of these antidepressants were significantly less than the rest of the population. So already we're starting to see some real inequities. Again I mentioned that the public became also I think much more open to taking these medications and part of this is what I'm going to talk about in a minute which is the direct to consumer advertising that was going on by the pharmaceutical companies. But people taking things for depression, anxiety, panic, problem in one's personal life, coping with stress, pretty broad stuff.

Some of the other contributors I think to these changes to this medication only trend is the advent of the second generation atypical antipsychotics and again Clozapine came on line in 1990 followed by Risperidone in 1994 and Zyprexa in 1996. Again they had many fewer side effects than the older traditional antipsychotic agents where you could get Parkinsonian symptoms, tardive dyskinesia, very serious disabling chronic situations, and also some really problematic anticholinergic side effects. So again another large national sample study of MDs and particularly prescribers, psychiatrists primarily 1996 to 2002 found almost a doubling of the rates of antipsychotic medications. And of these the second generation of antipsychotics were tripling in this time frame.

And one of the ways we see this impacting is on kids and teens because prior to these newer antipsychotics kids and teens weren't that widely prescribed antipsychotic medications. Psychosis was relatively infrequent especially in kids and so they weren't used that often and that's what they're FDA approved for. But what we started to see again starting in 1993 to 2002 we look at 200,000 such prescriptions for kids in 93 compared to in 2002 1.2 million prescriptions. And when you look at what they were being used to prescribe for, and 92% of these were these atypical or second generation antipsychotics, they're prescribing them for behavior problems, mood problems, autism and finally psychotic symptoms. They're FDA approved for psychotic symptoms and as probably many of you know most of these medications up until the late 90s were being normed basically on males and women and kids and adolescents were not included in these FDA trials. And most of the males who were involved tended to be white middle class males. So all of the dosages and the toxicity, all this was established on a sort of more rarefied sample which is another problem.

Again we're seeing the same thing with adults in terms of these atypical antipsychotics now today. There's a recent study 40% are being prescribed for bipolar disorder, 35% for schizophrenia, 7% for cognitive problems and 5% for anxiety. There's also tremendous inequities in anti psychotic prescribing when we look across different demographic groups and particularly where we see African Americans are significantly more likely to receive these

injections of the meds and higher dosages than comparable Caucasian clients. And again when we look at just the prescribing for psychosis alone African Americans less likely to be prescribed the second generation antipsychotics.

So another trend that I think is really serious in addition to these already problematic trends is this role of direct consumer advertising. In 1997 congress liberalized the legislation so the pharmaceutical companies could start directly advertising to the consumer. So on our television sets at night we get these commercials, are you feeling a little blue, do you feel a little sad today, try Abilify. And the whole idea was you were supposed to go and nag your doctor usually your internist for these particular medications. So we started to see less of these being prescribed by psychiatrists, more of them being prescribed by the internists. When we look at the pharmaceutical advertising rates after this legislation was passed it really was again almost tripling, 11 billion in 1996 to 30 billion in 2005 with an increase of 330% in the direct to consumer advertising. And in 2005 we had 4.2 billion on direct consumer advertising alone, 7.2 on the MDs.

At the same time and I think this was a little bit ominous is that in terms of FDA regulations of violations in drug advertising there was 142 charges in 1997 compared to only 21 in 2006. So again less regulation as well as there's increased levels of advertising to the public.

Changes in reimbursement with the expansion of managed care is becoming sort of the primary delivery system for mental health services in the 90s, we saw the undercutting of the reimbursement of mental health and substance abuse services. Again while that was going on there was a ratcheting up of medications for treatment. So by 2006 about 51% of our total mental health care spending was on psychotropic medications in mental health. And when we look at the per capita expenditure this figure had tripled from 1996 to 2005. The other thing I should just mention is that it's no longer when you have a serious mental illness are you given just one medication. The rule of thumb today is the cocktail so most people receive two, three, four, sometimes five medications at the same time--and this trend was already in place in the 90s but we're seeing it really accelerating. So now we're up to 60% of folks who are seeking psychotropic medications are getting at least two. The most common combination is an antianxiety med with an antidepressant, followed by two antidepressants of different mechanisms of action, followed by two different antipsychotics. But more and more we're also seeing three or more, four or more medications.

And finally a very interesting study by Allegria et al looking at they took large samples of Asian Americans and again this is the large group of folks with multiple diversities within it but Asian American, Latino Americans, African Americans and non Hispanic white Americans, and they basically described different symptoms of depression and said in the last year have you experienced any of these symptoms. And if they seemed to have enough symptoms that would meet criteria for being treated, they asked them if they had been treated and if so what treatment they got and if they didn't get treatment was there any reason why they didn't choose to seek treatments. They also came up with a minimal standard, which I think most of us in the room would think of as very minimal, for the treatment of pretty serious depression, as four or more visits of 30 minutes each to a therapist plus a month of antidepressants, or eight or more visits to a therapist lasting at least 30 minutes and no antidepressants.

So given this, it's kind of shocking, they found that those who experienced treatable depressive symptoms in the past year, 64% of the Latino Americans in the sample who did that, 69% of Asian Americans, 59% of African Americans and 40% of the non Hispanic white Americans received no treatment at all. And in terms of those whose treatment met these minimal standards, it was 33% for non Hispanic whites compared to 25% for Latino Americans, 19% for Asians and 10% for African Americans. But even more problematic than even that which is pretty problematic, is that when they basically looked at equal access, those groups who had access to services, what they found was that for the clients of color they were much more likely to receive poor quality of services overall. And this was true when education, poverty status and insurance coverage were controlled for.

When they asked people about what stopped them from seeking treatment there were a number of different responses but these are some of the primary ones that came up. One is that people felt that they did tell their doctors about how they felt but that the doctors didn't think there was anything that needed to be treated. So they felt that there was perhaps an under detection of depression going on by different mental health providers. Also many people said they couldn't afford to leave work to seek treatment, they couldn't afford to do that. Others spoke of feeling like people in their family and in their community would look down on them or that they would experience some stigma for receiving services and some had already gone in the past to seek services and had found that they hadn't been treated very well so they didn't want to repeat that, they didn't go back. And finally they didn't know where to go, people didn't have any idea what kind of treatment they could get and it wasn't offered to them.

So what does this have to do with the recovery oriented model? A little bit about this model, we're looking at cultivating a sense of hope and in line with Mark Snyder's hope scale, hope involves two things, a vision of a better future and what that would look like, and pathways to get there. If you have a vision without pathways you can't have real hope and if you have pathways without a vision you can't have hope. So you've gotta have both, we gotta help people know what their vision is and then help them to get there.

Promoting a sense of social inclusion, feeling part of a greater community, a sense of self efficacy in clients and families and a sense of engagement and meaning are part of the task. So how do we do this? Well one way is through shared decision making—it's essential that clients and families feel that they are prime movers in their treatment, that the treatment isn't being imposed on them but that they are equally deciding what they're going to do. Also the importance of offering supportive recovery relationships with not just providers but peers as well. Peer mentoring, peer modeling can be important. And certainly wrap around comprehensive services with a continuity of care so that providers are working in a team based way but at the heart of that is basically the personalized needs of the client.

So what is our role of psychologists in terms of medication management in this recovery model if we don't have prescribing privileges? Well we really have to know what medications our clients are on, we need to know why they're on those medications, we need to know the side effects of these medications, what the possible toxicities are, how long it's going to take them to start to feel better, what that might look like on these medications. And then we really in some

ways as therapists in these situations on the front lines of monitoring clients more so than the MDs also doing psychoeducation around some of the psychotropic medications, advocating with and for our clients, and working collaboratively with the MDs. I always think it's a good idea to really feel like you can work with an MD if you can where you both sort of think alike and can really take into consideration the client's needs.

This is the statement by the American Psychiatric Association on collaborative treatment. It said in a collaborative relationship the psychiatrist and therapist share responsibility for patients care in accord with the qualifications and limitations of each person's discipline and abilities. The patient must be informed of the respective abilities of each clinician and both the psychiatrist and non-medical therapist are responsible for the period evaluation of the patient status to ascertain that the collaboration continues to be appropriate. So usually the way it works is that if the psychologist is doing the therapy, then you're in charge of the therapy and the MD is in charge of the medications. There can be all kinds of turf battles that can occur sometimes when people encroach on each other's territory and that's a whole issue in and of itself which we don't have time to go into so much today. But I think many of you who've been in that situation may know some of the difficulties that can cause sometimes.

So what is the role of medication in the recovery model? It's to obviously manage symptoms so clients can go after desired goals. I think really the flexibility and openness of providers is essential in this and it needs to be used in conjunction with a host of other supports to basically whether it be substance abuse treatment, management of medical illness, case management, job training, all of these things have to work in sync with the medication management.

There was a fascinating study, a qualitative study that was done in Canada where they asked 60 individuals with serious mental illness about what medication meant to their recovery from mental illness. And there were five themes that emerged. The first one was the this was no small matter, finding a medication that works. I think many of you know that when clients first go on a medication it can sometimes not work at all and they have all kinds of side effects and really have a very, very difficult time. And yet desperate to feel some relief they're sort of funneled from one medication to another and that can sometimes take quite a bit of time. So this a whole process in and of itself. Taking medication in combination with other supports and services. There should be some synchronicity in the continuity of care people get, that their medications aren't being given in isolation. Also complying with medication is a critical issue and a real struggle for many, many clients that I think we have to be really empathic about. Most important, having a say about medication, really feeling they have a voice in their treatment, being able to complain, being able to bring questions and to say no finally, the right to live without medication, which has to be honored.

In looking at another study at what was most important in terms of the relationship with the MD, feeling there was a good fit was critical, feeling that they could trust this person, that the person really cared about them. Feeling that they were open and flexible so if they were non-compliant would they be punished, would they be judged, these kinds of things obviously don't work well. The MDs willingness also to hang in there with them, where if they were noncompliant not giving up on them but being willing to really see what could be done to get

them the best fit for them and maybe it was no medication. But staying with them through the long haul. In the quantitative part of the study they found it better experiences of medication treatment and stronger working alliance were significantly correlated with lower psychotic symptoms and higher reported quality of life.

So what about the role of prescribing privileges for psychologists. We've seen huge changes. These first psychotropic medications weren't available until the 50s. Lithium came on line I think it was 1949, thiorazine in 1952, imipramine and the first MAO inhibitor in the mid 1950s. So it's been relatively recent, and at that time the American Psychological Association really rejected this idea that psychologists would prescribe. The feeling was we do the social and behavioral treatments, that's our scope of practice. But as time has gone on and the biopsychosocial cultural model of treatment has become so core to our training and our curriculum, I think this is really shifting the attitude and in 1989 indeed the American Psychological Association prioritized the gaining prescription privileges for psychologists and started to put resources towards this. And in 1991 they launched the Department of Defense Pharmacology Demonstration Project. This involved ten military psychologists, very carefully selected, who went through 1900 hours of didactic training and 1,000 supervised hours to finally get a license where they then could provide medications. Although they only provided medications in community clinics, not in hospital settings initially.

In addition there's been momentum in at least 14 states to have prescribing privileges for psychologists and this has not been successful, it's been rejected in most states. But in Louisiana in 2004 and New Mexico in 2002 we gained prescribing privileges in those states. And I think one thing that probably contributed to this was that these states have large numbers of rural areas that some have no psychiatrists at all. For example in New Mexico there were 90 psychiatrists in 2002 and only 18 of these served in rural areas. The rest of them were in Albuquerque and Santa Fe. And that's true in a lot of states. We see a real scarcity of psychiatrists who can provide medication management who are not at all in these rural areas. Also geropsychiatrists and child psychologists are at a premium, even in some major metropolitan areas for that matter.

So what are some of the arguments for us gaining prescription privileges? One is that currently at least 60% of all psychotropic meds are prescribed by internists and internists have far less knowledge than we do to do psych assessments and assess clinical symptoms relevant to this med eval. There is a study that just came out last year comparing the academic training of psychiatrist nurse practitioners with internists and pharmaceutically trained psychologists and they found that psychologists gain on average two and a half to four years more graduate training compared to these two other counterparts. Also the scarcity of mental health services in our country, particularly in these rural areas where people are much less likely to receive mental health care. For example in one study 20% of the rural counties in this country offered no mental health services at all compared to 5% in urban counties. So this is a place where psychologists with proper pharmaceutical training and licensing can service these areas, can provide the mental health care and evidenced based practice that could provide comprehensive care to these communities.

Also psychologists have been prescribing in the military for over ten years, very, very successfully. We've developed a training model that has been found to be quite effective. One

study, I couldn't find a lot of studies on this, but in one study of military psychologists they found that when they compared their prescribing practices to those of psychiatrists, psychologists were much less likely to prescribe and they relied more on psychotherapy. So I think psychologists may be more judicious in the use of medications when they have prescribing privileges.

Some of the arguments against, one is that people, and believe me the American Medical Association, the American Psychiatric Association, the American Nurses Association, none of these organizations is actually excited about psychologists gaining prescribing privileges, probably no surprise there. Although some of the pharmaceutical companies are actually for it. But the current training of psychologists basically deemphasizes the medical model and the feeling is that if you don't have a background in the hard sciences, how can you prescribe. And I just want to say from my own experience I did my internship at California Pacific Medical Center which was in the outpatient psychiatry department. And there were five of us who were psychology interns and there were five psychiatry residents who were in their second year of residency. So they were just starting to prescribe so and we got very close and we took a lot of seminars together and I would ask them well how do you know what to prescribe, how do you learn these things. And they said well my supervisor will give me a protocol and so there's the top medication for this particular diagnosis that I try first and then I see how that goes. And then if that doesn't work we go down to the next one on the list. So they were not drawing on their microbiology and organic chemistry backgrounds to come up with this. So I just need to say that.

And the other argument against is because these medications are powerful and potentially lethal, we know the Vioxx scandal for example, that these things do happen. Some argue that you have to have an extensive medical background to prescribe which the training psychologists for licensure in prescribing does not currently involve an extensive medical background and there is also the argument that many of our clients who are on psychotropic medications have another or several medical illnesses which creates a lot of complexity. And so I think there's certainly some merit to this argument perhaps but what we need is there's very little research right now on studying the psychologists who are doing the prescribing and I think we need to have more data on this in order to make a more powerful argument because I think we definitely need to think about prescribing privileges being gained by psychologists.

So a little bit about my final recommendations. Given that there's so many consumers currently who have inadequate access or receive poor quality of care in mental health treatment I think psychologists are in a very important position to provide these services. I'm actually very hopeful that this Paul Wellstone equity act will expand services to more communities, we'll see. I'm cautiously optimistic these days.

Also psychologists can offer leadership in public policy to implement recovery oriented treatment models, to evaluate these models and demonstrate outcomes. And to provide evidence based therapy because evidence based therapy does not cause side effects like medications do. So I think that this is really critical if we can make sure that the treatment we're providing is really going to have better outcomes. It may do better than medications in some situations. And we need to expand prescription privileges for psychologists in order that we can provide

adequate mental health services in both rural areas and to communities of color and to just the public at large who is underserved. And finally ongoing studies need to be done of the psychologists who currently have prescribing privileges and the efficacy and the outcomes in that. So thank you very much.

GARCIA-SHELTON

Okay so we are hearing many new and many familiar ideas for increasing pieces of our curriculum in these new areas, and again we're talking about change. Our final plenary presentation of this section which is again Psychology Education for the Future, Some Imperatives, is on the title of changing structures of education to fit needs for the future. And this is a presentation that has been shared in its development by Dr. Morgan Sammons and Dr. Stephen Tulkin.