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Civilian Primary Care Prescribing Psychologist in an Army Medical Center

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Abstract The present article discusses the integration of a civilian prescribing psychologist into a primary care clinic at Madigan Army Medical Center. A description of the role of the prescribing psychologist in this setting is provided. The author asserts that integrating prescribing psychology into primary care can improve patient access to skilled behavioral health services including psychotherapeutic and psychopharmacologic treatment. Potential benefits to the primary care providers (PCPs) working in primary care clinics are discussed. The importance of collaboration between the prescribing psychologist and PCP is emphasized. Initial feedback indicates that integration of a prescribing psychologist into primary care has been well received in this setting.

Keywords Prescribing psychologist · Army behavioral health · Primary care psychology · Integrated behavioral health consultant

Introduction

The idea of placing clinical psychologists in primary care settings is not a new phenomenon (Blount, 2003; Blount, Shoenbaum, Kathol, Rollman, Thomas, O'Donohue, & Peek, 2007). Some authors have suggested that prescribing psychology, in which psychologists receive additional training in prescribing psychotropic medication, is a natural fit for integration into primary care clinics as well (McGrath & Sammons, 2011). The purpose of the present article is to describe how this integration of prescribing psychology into primary care has been implemented in one military hospital setting.

Brief History of Prescribing Psychology

It is interesting to note that the specialty of prescribing psychology had its practical beginning within the Armed Services in a Department of Defense (DOD) program called the Psychopharmacology Demonstration Project (PDP) that spanned from 1991 to 1997 (e.g., Laskow & Grill, 2003; Newman, Phelps, Sammons, Dunivin, & Cullen, 2000). The goal of the PDP was to train psychologists to become independent prescribers of psychotropic medication. The Project was successful in training psychologists to prescribe psychotropic medication, but was discontinued due to claims the training was not cost-effective and did not improve military readiness (GAO, 1997, 1999). The American College of Neuropsychopharmacology (ACNP) monitored and evaluated the psychologists' training throughout the Project. In their report the ANCP (1998) states "All 10 graduates of the PDP filled critical needs, and they performed with excellence wherever they were placed (p 1)."

The State of Indiana passed legislation authorizing a limited form of prescription privileges for psychologists in 1994 followed by Guam in 1998 (Fox, Deleon, Newman, Sammons, Dunivin, & Baker, 2009). New Mexico and

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Louisiana successfully passed and implemented legislation permitting psychologists to prescribe in 2002 and 2004 respectively. At this time psychologists are prescribing in New Mexico, Louisiana, the Public Health Service, Indian Health Service, Armed Services and are working to expand into other states and federal programs. The Army, Navy and Air Force each have each delineated specific criteria that permit psychologists to prescribe (US Army Medical Command, 2009; Department of the Navy, 2003; Secretary of the Air Force, 2007). These criteria apply to both civilian DOD employees as well as active duty service members in the respective services.

Prescribing Psychologist Training

Education and training in psychopharmacology for psychologists follows guidelines adopted by the American Psychological Association in 2009: *Recommended Postdoctoral Education and Training Programs In Psychopharmacology for Prescriptive Authority* (APA, 2009). Guidelines have evolved over the past two decades and interested readers can find a more detailed history elsewhere (e.g., Campbell & Fox, 2010). According to this model, the training is designed as a postdoctoral program requiring the following for matriculation; a doctoral degree in psychology, licensure to practice as an independent psychologist, and practice as a health services provider as defined by a state or other regulating agency (APA, 2009). The guidelines require at least 400 didactic contact hours of instruction in the following domains: Basic Science, Neurosciences, Physical Assessment and Laboratory Exams, Clinical Medicine and Pathophysiology, Clinical and Research Pharmacology and Psychopharmacology, Clinical Pharmacotherapeutics, Research, and Professional, Ethical and Legal Issues. McGrath (2010) notes that most training programs require at least 450 didactic contact hours. Additionally, a supervised clinical experience is required for learning and assessment of competency in applied knowledge and skills. Upon completion of didactic training the student must pass an examination such as the Psychopharmacology Examination for Psychologists (PEP). To use New Mexico regulations as an example, the following requirements must be met: an 80 h practicum in pathophysiology and clinical assessment, a 400 h/100 patient practicum supervised by a physician, and two additional years of supervised experience as a "conditional" certificated prescriber. Upon successful completion of these requirements the psychologist may apply for a certificate permitting independent prescribing. The author of this article has an independent prescribing certificate from New Mexico and is credentialed to prescribe as a DOD civilian psychologist based on guidelines established by the US Army Medical Command (US Army Medical Command, 2009). Note that within the Armed Services a State prescribing license is not required, rather the aspiring prescribing psychologist must meet the specific criteria established by each branch of the Armed Services. Employment as a prescribing psychologist in other federal programs may require a prescribing psychologist license issued by a State agency.

Description of Services

Madigan Army Medical Center, as part of the Madigan Healthcare System is located on Joint Base Lewis-McChord near Tacoma, Washington. Madigan is the largest military treatment facility in the Army's Western Regional Medical Command, which is responsible for 10 other military treatment facilities in the western United States.

Staff includes both civilian and military physicians, nurses, residents and fellows. As a teaching institution it supports graduate medical and nursing education programs. Three psychologists, one being a prescribing psychologist, currently work full time in the Department of Family Medicine's largest clinic, the Family Medicine Clinic (FMC). Patients seen by the prescribing psychologist include active duty military members, dependents of active duty military personnel, retirees and their spouses. On average the FMC handles almost 33,000 outpatient visits a year. The FMC has approximately 70 medical providers including physicians, nurse practitioners, and physician's assistants. The FMC's mission includes training medical interns, residents and fellows. The department is staffed by both civilian and military providers.

The Department of the Army and the Madigan Healthcare System are integrating psychologists into primary care clinics. It is anticipated that integrating psychology into primary care will result in improved access to behavioral health care, improve multidisciplinary coordination, and a sharing of the work load of busy Primary Care Providers (PCPs). Psychologists now have a presence in several clinics at Madigan Hospital including primary care, obstetrics and gynecology, internal medicine and pediatric medicine. A more thorough description of prescribing psychology practices in primary care can be found in the special section of *JCPMS* (December 2012) in an article by Shearer, Harmon, Seavey and Tiu.

Assigning a prescribing psychologist to primary care is a natural outgrowth of needs within the primary care setting. Among other services, an integrated prescribing psychologist can provide on-the-spot consultation, crisis intervention, risk assessment, and psychotropic medication recommendations as well as carry a patient caseload.

Collaboration between PCPs and prescribing psychologists leads to more comprehensive care for patients, increases access to behavioral health, and validates the importance of patient behavioral health care needs. Reciprocal collaboration allows the prescribing psychologist to be aware of patient medical issues that may impact treatment or prescribing practices.

The majority of the prescribing psychologist's time is spent providing clinical services to patients; seeing patients individually for assessment, diagnosis and treatment with either psychotherapy and/or psychotropic medication. A vital part of the role in primary care is the provision of consultation in both formal and informal settings. The author operates with an "open door policy" meaning that any provider can knock on the prescribing psychologist's door at any time with a question or issue. This provides PCPs with immediate consultation regarding psychotropic medication management issues and other behavior health issues. More structured consultations are also provided in which the PCP meets with the prescribing psychologist to discuss broader programmatic issues or to plan for future visits/treatment of existing patients. A portion of time is contributed to training psychology interns and medical residents. The prescribing psychologist is on the teaching faculty of both the Department of Behavioral Health and Family Medicine Department.

Patient Needs

Patients seen by the prescribing psychologist in this setting are active duty service members, dependents of active duty service members, or retirees and their dependents. Typical ages range from 18 years to elderly. There is a broad representation of socioeconomic status. More females are seen than males of either active duty status or civilian. There is a full range of needs represented including most categories of psychological disorders. The author is available to evaluate any psychological or behavioral patient issues that a primary care provider might encounter. There is a greater frequency of issues related to PTSD and the effect of multiple combat deployments on family members than might be seen in other clinics. Conversely, providers may see fewer patients with frank psychotic symptoms than might be encountered in community mental health.

Prescribing Patterns

Examining the prescribing history of the prescribing psychologist over a two year period revealed that prescription of antidepressants (AD) far outnumbered prescription of any other class of psychotropic medication by a margin of ten to one. Note that in many cases ADs were prescribed to treat anxiety and/or depression as well as depression alone. Also prescribed are sedative-hypnotics, anxiolytics, atypical antipsychotics, mood stabilizers, and stimulant medications. The medications most likely to be discontinued by the prescribing psychologist are benzodiazepines and stimulant medication. Also seen are patients referred for medication management who are being prescribed medications by multiple providers. In these cases it is important to evaluate issues related to polypharmacy such as drug–drug interactions. Drug–drug interaction software is routinely utilized to evaluate safety and to determine if presenting psychological symptoms are related to drug–drug interactions. If drug–drug interactions are suspected, the prescribing psychologist will consult with the primary care provider responsible for that patient's healthcare and may also seek a consultation with the clinical pharmacist or other specialist.

Patients are routinely provided information regarding possible side effects of psychotropic medication as well as any likely drug–drug interactions. This information is part of the informed consent process in which patients are provided with pros and cons, risks and benefits of starting/stopping medication. Additionally, patients are informed about potential alternative treatments. Patients are encouraged to ask questions and the most common side effects are described so that they can be anticipated and understood (if they occur). Patients are given contact information to reach the prescribing psychologist if they have any questions about side effects. Black box warnings and any potentially serious side effects are discussed. It is hoped that this approach will decrease the number of patients who discontinue medication before therapeutic effect can be evaluated. In some cases laboratory studies and screening of vital signs are necessary to track potential side effects that may not be readily identified by patients (e.g., changes in insulin resistance, elevated triglycerides, hypertension).

The side effects of psychotropic medications that most often concern patients in this setting are weight gain, decreased libido/sexual dysfunction, sedation and agitation. Having good communication with patients allows for productive conversations about side effects and strategies for managing them (if they occur) before starting a medication. The management strategy depends on many factors including the seriousness/risk of the side effect, how problematic the side effect is for the patient, the pros/cons of switching medications or stopping, the likelihood that the side effect(s) will resolve in time, and the availability of adjunctive medication to address side effects. At times cross-titration to another psychotropic medication in the same or different class, or discontinuation of the medication(s), is a prudent course of action. Some side effects are the result of stopping/tapering a medication (e.g., discontinuation syndrome of venlafaxine or paroxetine). Again,

preparing patients for this possibility helps them tolerate some discomfort and to understand that many side effects may resolve with time. In this provider's experience the key to management of side effects rests in educating the patients about the medication and treating them as partners in a collaborative therapeutic relationship.

System Response to Prescribing Psychologist

The overwhelming response to the presence of a prescribing psychologist in the Madigan Hospital family medicine clinics has been enthusiastic and positive. Some of this feedback has been documented in an earlier online article (Shearer & Etherage, 2010). Many medical providers have expressed their appreciation of having psychological expertise as well as psychotropic prescribing expertise available in their own clinics. Having a prescribing psychologist available for immediate consultation and to provide ongoing care of patients' started on psychotropic medication is often a relief to the medical practitioners. The administrations of both the Department of Family Medicine and the Department Psychology (now Department of Behavioral Health) have been supportive and accommodating.

Conclusion

The integration of prescribing psychology in primary care is a natural outgrowth of the biopsychosocial model of treatment. It provides the type of continuity and access envisioned in the concept of the Patient Centered Medical Home (PCMH). Patients have access to safe, effective multimodal treatment including psychotropic medication management. Medical providers have access to expertise in psychopharmacological treatment and psychological treatment. Because patients are shared between the prescribing psychologist and the PCP collaboration is inherently integrated into the service delivery model. The whole person can be treated in this manner with validation that behavioral health issues are important targets of intervention. In sum, prescribing psychology is a safe and effective way to deliver behavioral health treatment to patients in a primary care setting.

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