

Prescribing and Primary Care Psychology: Complementary Paths for Professional Psychology

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Two paths have been suggested for the future evolution of professional psychology. Prescribing psychology has already been legally authorized in two states, the military, and the Indian Health Service. Primary care psychology does not require legal recognition and has been slowly growing as a career option for psychologists across the nation. Both paths have their obstacles and limitations, but both are also associated with great potential. This article provides a brief summary of the strengths and weaknesses of each path and suggests an integrated perspective for planning the future of the profession. Each is seen as complementary to the other and providing a basis for pursuing the other.

Keywords: primary care, integrated primary care, prescriptive authority, healthcare systems

Doctoral-level healthcare psychology faces several serious threats to its status quo and perhaps even its survival. The first comes from the pressures all healthcare professions are experiencing from managed care and other third-party reimbursement systems. Involvement in managed care has been associated in psychologists with longer working hours, larger caseloads, less participation in supervision, greater stress, higher rates of premature termination, reduced flexibility, and greater pressure to compromise quality of care (Chambliss, Pinto, & McGuigan, 1997; Cohen, Marecek, & Gillham, 2006; Gold & Shapiro, 1995; Murphy, DeBernardo, & Shoemaker, 1998; Rothbaum, Bernstein, Haller, Phelps, & Kohout, 1998; Rupert & Baird, 2004). Although some of this literature can be criticized as potentially out of date, revelations in the past year about conflicts of interest in the setting of usual and customary fees for providers (Hakim & Abelson, 2009), and recent revelations of substantial increases in health insurance premiums in the face of record profits by certain managed care entities (Department of Health and Human Services,

2010), suggest psychologists will experience continuing pressure from third-party payers attempting to improve profit margins.

The second threat is the growing number of masters-level providers of psychotherapy. According to the *Occupational Outlook Handbook* (2008–2009; <http://www.bls.gov/oco>), there were over 200,000 counselors in 2006 in the fields of mental health, substance abuse and behavioral disorders, and marriage and family therapy, as well as more than 120,000 social workers in mental health and substance abuse. Manderscheid and Henderson (2004) estimated in 2002 that there were approximately 18,269 psychiatric nurses. The number of nondoctoral mental health workers is expected to grow another 30% by 2016. In contrast, the 150,000 school, clinical, and counseling psychologists are expected to grow by only half that much (U.S. Department of Labor, 2008). The rapid growth in the number of masters-level providers partly reflects the creation of new professional identities in response to increased demand for mental health services. It also reflects the preference in managed care organizations for the cheapest provider, a preference reinforced by a lack of evidence suggesting that doctoral-level providers are associated with better psychotherapy outcomes than masters-level providers (Bickman, 1999; Lambert & Ogles, 2004; Seligman, 1995). This failure to find consistent evidence of an advantage for doctoral-level care could be a generally valid finding for traditional psychosocial mental health services, but it may also reflect the more restricted range of pathology commonly seen by professionals in private practice settings.

Finally, the model of the solo independent practitioner that has defined much of mental health practice for the last 40 years has come under closer scrutiny. This model emerged out of a fee-for-service system of reimbursement that rewarded specialty services and maximizing the level of care provided. There are at least two initiatives in progress that challenge the existing fee-for-service system. Pilot testing has begun evaluating an episode-based alternative in which a treatment team receives bundled payment for the complete treatment of a condition (Robert Wood Johnson Foundation, 2009). Unlike traditional service-based fee-for-service or population-based capitation, a diagnosis-based system allows the

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insurer greater precision in the projection of costs per episode. This is a feature likely to make episodic reimbursement very attractive to insurers.

The second factor is growing interest in the concept of a medical home (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association, 2007), in which a personal primary-care physician becomes responsible for the coordination and integration of care across specialists and ancillary care providers. There is growing interest in establishing the medical home as the focus of healthcare services. This interest is demonstrated in the development of standards for the medical home by the National Committee for Quality Assurance (www.ncqa.org/tabid/1034/Default.aspx); the formation of an organization dedicated to the topic, the Patient Centered Primary Care Collaborative (www.pcpc.net), which enrolled over 500 member organizations in 5 years; and extensive discussion of the topic in other organizations devoted to healthcare policy such as the Collaborative Family Healthcare Association (www.cfha.net). The recently enacted Patient Protection and Affordable Care Act includes several sections demonstrating a preference for the development of integrated healthcare practices, e.g., in awarding of loans for the establishment of nonprofit health insurers and in various demonstration projects. Episodic reimbursement and collaborative healthcare are clearly complementary initiatives (de Brantes, Gosfield, Emery, Rastogi, & D'Andrea, 2009), and the widespread adoption of either would dramatically increase pressure for psychologists to join multidisciplinary teams, usually under the control of physicians.

Other healthcare professions have responded to the flux in the system by pursuing expansion in their scope of practice and enhancement of their status. Nurses are attempting to expand the roles of specialty practitioners such as advanced practice nurses and nurse anesthetists. A recent survey finds the latter group is attracting higher salaries than primary care physicians (Kavilanz, 2010). Nurses are also pursuing independent practice as primary care providers (PCPs) through the Doctor of Nursing Practice degree. Optometrists are similarly expanding their formulary in some states, and in others they are pursuing the authority to perform surgical procedures (see Fox et al., 2009, for a review of advances by nonphysician health care providers relative to psychologists). Masters-level mental health providers are vigorously pursuing authorization to engage in activities that were previously considered doctoral-level such as independent diagnosis and assessment.

The challenge professional psychology faces is whether to maintain its current stance within the healthcare system or whether to move aggressively into new markets. The former option must be seriously considered. It is clear there remains a tremendous need for traditional mental health services. Mental disorders have joined the list of the five most costly conditions (Soni, 2009), and it has been argued that the growing number of masters-level providers involved in the treatment of mental health issues is required to fill the unmet need (Annapolis Coalition on the Behavioral Health Workforce, 2007). Furthermore, there is growing evidence that psychotherapy is effective as an alternative or adjunct to medications (e.g., Hollon et al., 2005; Jensen et al., 2007; Kennard, Silva, Vitiello, Curry, & Kratochvil, 2009). It is therefore possible that the market for psychotherapy services will continue to grow for quite some time and provide enough opportunity for all.

At the same time, some worrisome statistics can be noted. Olfson and Marcus (2009, 2010) presented evidence that although the number of individuals receiving psychotherapy since the late 1990s has increased, the role of psychotherapy in the treatment of mental disorders is declining, resulting in a net decline in total expenditures for psychotherapy. Although the proportion of gross domestic product devoted to healthcare more than doubled in the period from 1970 to 2003, the proportion devoted to mental health care remained flat at less than 1% (Frank & Glied, 2006). Troubling findings specific to psychology indicate it was the only one of four professions (psychiatrists, nurses, and counselors being the other three) in which the number working in community mental health centers was declining (Cypres, Landsberg, & Spellmann, 1997), suggesting a growing emphasis on medication management concurrent with a shift in therapy services to masters-level providers. So long as the healthcare system is largely governed by professions based in biomedicine, there is the danger that psychotherapy will continue to be treated as a secondary alternative to biological interventions regardless of the evidence. The increasing reliance on masters-level therapists could further undermine the status of psychosocial interventions relative to medical procedures that continue to be offered primarily by doctoral-level providers. A recent statistical analysis concluded that only 18% of U.S. counties needed additional nonprescribing mental health providers (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Finally, data from the *Occupational Outlook Handbook* (Bureau of Labor Statistics, 2010) reveals that psychologists have the lowest median income of any of the doctoral-level healthcare professions. Increased competition from masters-level providers can only dampen those salaries further.

If simply maintaining the status quo is not an option, or does not adequately ensure the future of the profession, then psychologists should aggressively pursue new professional opportunities. Two such opportunities have been discussed, involving increased participation in primary care and acquiring prescriptive authority. So far, these initiatives have been pursued in relative isolation from each other. The purpose of this article is to suggest primary care psychology and prescribing psychology as complementary approaches to the future of the profession and to describe how they can be combined to create a flexible model of advocacy for the future of the profession. The next two sections will briefly review key issues in primary care and prescribing psychology.

Primary Care Psychology

Primary care represents the most common site of treatment for individuals with mental disorders (Kessler et al., 2005). Between the years 1998 and 2003, the percentage of patients receiving mental health care only in medical settings increased 154%, and the number of patients treated in community health centers for mental health or substance abuse issues increased from 210,000 to 800,000 annually (Mauer & Druss, 2009, April 2). Among people who successfully committed suicide, far more saw a PCP in the year before their deaths than saw a mental health professional (Luoma, Martin, & Pearson, 2002), and some studies suggest more than 50% of patients seen in primary care settings meet criteria for a mental disorder (Spitzer et al., 1994; Toft et al., 2005). At the same time, a survey of PCPs indicated that the barriers to accessing mental health care for their patients exceed those for other spe-

cialty services, for a variety of reasons (Cunningham, 2009). As a result, various governmental agencies are encouraging greater sensitivity to behavioral and mental health issues in the primary care setting (e.g., Kates, Ackerman, Crustolo, & Mach, 2006; Kirkcaldy & Tynes, 2006; Power & Chawla, 2008).

Blount (2003) offered three dimensions for characterizing collaborative activities between psychologists and PCPs. The first dimension has to do with the relationship between providers, and he described three types of relationship. *Coordinated care* occurs when the psychologist and PCP operate independently of each other but share information, *colocated care* when the psychologist and PCP share physical space, and *integrated care* when the psychologist and PCP serve together as part of a team responsible for treatment planning. The second dimension has to do with the population being treated. A *targeted* population means cases are preselected for collaborative treatment, usually because of the presence of a specific diagnosis or problem. The population is *nontargeted* when collaborative care is offered to any patient for whom initial evaluation suggests behavioral or mental health services would contribute to outcome. The third dimension has to do with the type of treatment offered by the psychologist through the collaboration. A *specified* treatment program means a pre-established treatment program is offered to all patients, whereas an *unspecified* treatment program involves an individualized decision about what form of behavioral intervention would be most helpful.

In traditional mental health practice, psychologists' collaboration with PCPs is usually restricted to coordinated or in some cases, colocated care. That is, the patient is seen by both the psychologist and a PCP who share information as necessary. Colocation can offer some advantages over coordination in terms of ease of referral and information-sharing, but the primary care and mental health treatments proceed in relative isolation from each other.

The emergence of health psychology created the potential for integrated care models combining psychologists and PCPs. However, the health psychology model has often involved a specified treatment (e.g., relaxation training for individuals with various medical diagnoses), a targeted population (e.g., individuals with sleep disorders), or both (e.g., a structured program for the treatment of chronic pain).

Primary care psychology is distinct from the mental health and health psychology models in that it involves *integrated care* (psychologists and PCPs determining care together) using an *unspecified treatment* (whatever clinical tools are appropriate for a patient) for a *nontargeted population* (any patient for which psychological interventions could be helpful). Gruber (2010) indicated that primary care psychology can be further distinguished from more traditional psychological models by a relatively greater emphasis on the treatment of individuals with acute problems. To summarize, the primary care psychologist is a full participant in the primary medical care, providing varying interventions for patients with various types of problems including acute medical conditions.

Given the frequency of psychological, interpersonal, or behavioral difficulties in the primary care patient, the primary care psychologist has the potential to become an integral element of the primary care practice. However, successful integration into the primary care setting will in part require demonstration that this integration results in cost reductions, clear improvements in

healthcare outcomes, or both. Although some research suggests that the cost of incorporating behavioral interventions into primary care is more than offset by reduced healthcare use (Chiles, Lambert, & Hatch, 2002), there is still insufficient data available to conclude that the integration of psychologists into primary care is cost effective.

The medical home model also implicitly acknowledges the importance of integrating psychological and behavioral services into the primary care setting. Although the statement of principles developed to describe the medical home refers to *whole person* care, the document does not mention that achieving such a level of care would require a broad range of evaluation and treatment options including behavioral, mental health, and substance abuse services. For example, as part of its efforts to integrate the medical home model into its primary care services, a Health Behavior Coordinator will be hired for every one of the Department of Veterans Affairs' 153 medical centers. This will likely have a significant impact on the implementation of the medical home in other settings as well.

A brief list of functions the primary care psychologist can fill includes the following (see also McDaniel & Fogarty, 2009), many of which combine the traditional skills of the psychologist with new skills relevant to the primary care setting:

1. Identifying and addressing emotional concomitants to medical disorders.
2. Consulting to the PCP about how best to interact with the medical patient who is difficult to manage because of, for example, severe mental illness or personality-based resistance.
3. Determining whether the patient's emotional needs exceed the services available at the site and overseeing referral for specialty services in psychopharmacotherapy, psychotherapy, or health psychology.
4. Screening for depression, substance abuse, cognitive impairment, personality disorders, and other psychobiosocial disorders that are potentially overlooked in primary care evaluations.
5. Providing supportive services to patients who are finding it difficult to participate in their care effectively.
6. Offering specialized treatments for smoking, obesity, and other common behavioral disorders in the general primary care population.
7. Offering behavioral interventions for individuals whose primary medical diagnosis calls for a treatment with a substantial behavioral component. Examples would include individuals with diabetes, asthma, chronic infectious disease, and heart disease.
8. Developing outcomes assessment and program evaluation systems as called for by outside agencies.
9. Aiding in the design of research protocols.

These activities require that the psychologist become embedded within the primary care practice, although it is possible in the future that some of this embedding will be accomplished through telehealth options.

The work regimen of the primary care psychologist is quite different than that of the psychologist providing psychotherapy. The primary care psychologist often serves as a consultant to PCPs as well as a direct care provider. Treatment is often time limited both in duration and in length of sessions: a patient may be seen for no more than 15 min at a time with long intervals between contacts. The primary care psychologist needs the flexibility to handle cases immediately when the PCP concludes a behavioral or

psychological consult is warranted. Psychotherapy is a specialty activity, much like a medical specialty, for which the primary care psychologist serves as the coordinator and referral source rather than as the therapist.

Despite the potential opportunities for integrating psychologists into primary care settings, achieving this integration can be difficult for several reasons. A very important one is the current character of the training received by psychologists, which is often singularly focused on the traditional weekly 50-min hour of psychotherapy. Admittedly, this is universally acknowledged among psychologists as a difficult skill to master. However, the degree of focus on this single activity leaves little additional time for mastery of nontraditional skill sets. As a result, few psychologists have much understanding of the knowledge and skills needed in the primary care setting (O'Donohue, Cummings, & Cummings, 2009). For example, many psychologists are largely unaware of the economics of healthcare in systems that traditionally do not tend to incorporate mental health services, such as large capitated practices and community health centers. In fact, many psychologists have never heard of community health centers, although they provide primary healthcare services for 19 million Americans. Psychologists also receive little training in basic medical concepts, in healthcare terminology outside the mental health arena, in providing consultation to and collaborating with other professionals, and in basic clinical medicine. In response to this gap, various authors have provided lists of the core competencies needed for psychologists to practice effectively in primary care (e.g., Robinson & Reiter, 2007) and have described elements of training programs of varying lengths (McDaniel, Hargrove, Belar, Schroeder, & Freeman, 2004; O'Donohue, 2009), although few psychologists currently pursue this training.

Another factor that will slow the process of integration into primary care is the lack of coordination between healthcare entities in the United States. Convincing healthcare agencies to hire psychologists must be accomplished one primary care agency at a time.

There are also reimbursement barriers to successful integration of psychologists into primary care. These include restrictions on billing for multiple professionals in a single day, a policy that reinforces the role of nonphysicians in primary care either as physician extenders or as ancillary service providers who require a separate contact. There are also restrictions on the Current Procedural Terminology codes accessible by psychologists working in settings that rely on insurance reimbursement. The existence of the health and behavior codes acknowledges the role psychologists can play in the treatment of individuals with primary physical illnesses, but insurers vary in their willingness to reimburse these codes. Psychologists also remain unable to use evaluation and management codes, a policy that institutionalizes their distinction from primary treatment coordinators in healthcare settings.

Other economic factors create obstacles to the growth of primary care psychology. Medical cost offset can be perceived as a long-term, and therefore only potential, gain when compared with the immediate increase in cost resulting from treatment by multiple providers. Furthermore, the case for offset is clearest for those patients with the highest rate of medical service use. More normative integrated care, such as expanded screening for mental health problems, the dissemination of treatment guidelines, and the colocation of mental health specialists in primary care settings

have not resulted in desired improvements in care (Thielke, Vanoy, & Unutzer, 2007). Accordingly, psychologists should be selective in their assertions about the cost savings resulting from psychologists' integration into primary care or risk outcomes that undermine the enterprise in the future.

One final and extremely important barrier is the competition psychologists face from other mental health providers who have also indicated interest in increasing their presence in the primary care setting (e.g., Claiborne & Vandenberg, 2001; Schneider & Levenson, 2008). This competition is particularly acute with masters-level providers, who tend to be cheaper alternatives to psychologists.

In offering a rationale for psychologists in particular as psychosocial partners in primary care, two factors stand out. One is that psychological treatments are not restricted to psychotherapy or even the treatment of psychological disorders but encompass a variety of interventions that are relevant to treatment of individuals seen in primary care settings (Barlow, 2004). Increasingly, psychologists join the workforce with an understanding of behavioral medicine and/or neuropsychology that sets them apart from other providers whose training is restricted to mental health. The second factor that can potentially play an important role in identifying the psychologist as a desirable alternative to the masters-level provider or to the more expensive psychiatrist in the primary care setting is prescriptive authority.

Prescribing Psychology

A great deal of progress has been made toward establishing an infrastructure for prescribing psychology over the last 10 years, primarily because of the efforts of the American Psychological Association. This has included the development of education and training standards, the creation of a system for designating programs consistent with those standards, and the underwriting of a competency examination called the Psychopharmacology Examination for Psychologists (McGrath, 2010). It is estimated that approximately 1500 psychologists have already completed post-doctoral didactic coursework in preparation for prescribing (Ax, Fagan, & Resnick, 2009), whereas approximately 60 psychologists were prescribing in New Mexico and Louisiana as of Fall 2008 (LeVine & Wiggins, 2010). Psychologists are also prescribing in all three branches of the military with healthcare services and in the Public and Indian Health Services.

Even in the absence of prescriptive authority, increased training in the use of psychopharmacological agents will inevitably influence the practice of pharmacotherapy. A recent study found that approximately 60% of prescriptions for a psychotropic medication are written by primary care physicians (Mark, Levit, & Buck, 2009), even though more than 60% of family medicine residencies offer no formal training in clinical pharmacology let alone clinical psychopharmacology (Bazaldua et al., 2005). Psychologists with little formal training are already called upon to provide advice to PCPs on an appropriate medication regimen; psychologists with advanced training in pharmacotherapy will increasingly find physicians using their expertise.

So far, 14 states have explicitly defined consultation with prescribers on medication decision-making as within the scope of practice of psychology (McGrath, 2010). The appropriateness of psychologists with advanced training in pharmacotherapy serving

as medication consultants in other states is uncertain. Even when the authority to engage in this type of collaboration has not been explicitly defined, however, psychologists with advanced training will find themselves in situations where they believe they are ethically obliged to advise physicians who have little or no formal training in either psychopharmacology or psychodiagnosis.

Given the central role awarded to medication in the treatment of mental disorders in the current healthcare system, even if large numbers of psychologists start to prescribe, they are likely to have little effect on the rate at which the services of psychiatrists are accessed. Where psychologists will probably have their greatest impact is on the use of psychotropic medications in primary care. Current laws authorizing psychologists to prescribe in New Mexico and Louisiana actually contribute to the creation of stable relationships with PCPs by mandating collaborative relationships, at least under certain circumstances.

The psychologist with prescriptive authority represents the only mental health professional who has received extensive training in all modalities appropriate to the amelioration of mental conditions. Familiarity with both psychosocial and biological interventions, combined with training in the critical evaluation of research, can potentially help psychologists resist excessive reliance on medications and use of medications without consideration of its interpersonal and experiential context. The prescribing psychologist should also be more effective than the general practitioner at determining when psychosocial versus biological interventions are warranted and at informing the patient about the potential benefits of psychosocial intervention. In this way, the prescribing psychologist can actually enhance participation in psychotherapy.

Prescriptive authority allows psychologists to address a compelling and demonstrable need. The same analysis that concluded most counties across the nation have enough nonprescribing mental health professionals also found that 96% of counties face a shortage of prescribers competent to address psychological and behavioral disorders (Thomas et al., 2009). In those states where psychologists can prescribe, the shape of clinical practice has already started to change. Among the roles prescribing psychologists are now filling, or are filling in ways very different than in the past, are the following (Ally, 2009):

1. Sharing on-call duties with psychiatrists in both agency and private practice settings.
2. Contracting for difficult-to-fill positions formerly reserved for psychiatrists.
3. Providing voluntary care to the indigent.
4. Providing administrative services in state agencies.
5. Serving as officers and even owners in hospitals.
6. Becoming involved in policy making at the state level.
7. Participating in pharmaceutical research.

As was true for primary care psychology, the traditional skills of the psychologist contribute to the quality of care offered by the prescribing psychologist in various ways. Training in the critical analysis of research, assessment and psychodiagnosis that includes contextual and cultural considerations, complex multidimensional disorders, outcomes assessment, research design, and understanding the psychosocial aspects of the interpersonal relationships, all of these will contribute to psychologists' effectiveness at developing a model of prescriptive practice that can distinguish psychology from the other prescribing professions.

Prescribing psychology is also similar to primary care psychology in its increasing the likelihood of brief intermittent interactions with patients, some of whom are not intimately familiar to the psychologist. The practice of pharmacotherapy also means a greater emphasis in sessions on the biological as well as psychosocial, on clinical medicine as well as clinical psychology. However, conversations with prescribing psychologists indicate patients adapt well to the seamless transition between one and the other. The sharp distinction providers draw between pharmacotherapy and psychotherapy services has more to do with the reality of the provider, who is traditionally trained almost exclusively in one or the other, than with that of the patient.

The most serious obstacle to the advance of prescriptive authority is opposition both within and outside the profession. Psychologists opposed to prescriptive authority have raised concerns about whether prescribing will undermine the traditional psychosocial roots of the discipline, whether the additional training is sufficient, whether prescribing psychologists in the long run will be able to resist pressures to become medication managers, and whether prescriptive authority as an advanced authority will create two tiers of psychologists (e.g., Robiner et al., 2002). McGrath (2010) provided responses to many of these arguments, noting that the creation of advanced practice nursing has not undermined the traditional identity of the nurse, the greater focus on psychosocial factors in the undergraduate and graduate preparation of psychologists, and the continuing critical analysis of medications by psychologists who are not prescribing (McGrath, 2005) as potential protective factors.

Psychiatrists see prescriptive authority for psychologists as a potential threat to the survival of their profession, so it is not surprising to find they are adamantly opposed. As a result, physicians have mounted aggressive resistance to enabling legislation across the country. It took 30 years to achieve licensure for psychologists in every U.S. state and 30 years to achieve licensure in every Canadian province (Reaves, 2006), so it is reasonable to anticipate that prescriptive authority for all appropriately trained psychologists may not be achieved until at least 2030 in the United States.

Complementary Agendas

Prescribing psychology and primary care psychology represent complementary paths to re-engineering the future of professional healthcare practice in psychology. The greatest advantage of primary care psychology over prescribing psychology as a goal is its reliance on the traditional tools of the psychologist as a psychosocial care provider, making it more palatable to key audiences within psychology and medicine. Furthermore, it requires no legislative action.

On the other hand, prescriptive authority involves service to the same patient population that is most familiar to psychologists. Although the legislative barriers can be daunting, once overcome, the shift in psychologists' roles is inevitable. There is an existing funding stream for medication management that becomes available to psychologists through third-party payers so that the authorized prescribers can quickly create practice opportunities.

Both paths would substantially enhance the reach of psychology in terms of patient populations and potential for enhancing public health. Each can also be treated as a stepping stone to the other.

This complementarity creates an opportunity for a flexible approach to advancing the profession.

The optimal balance between the two agendas will vary from state to state. In some cases, a vigorous effort to achieve prescriptive authority has already emerged. If the number of states authorizing psychologists to prescribe reaches a critical mass, and if research demonstrates that prescribing psychologists reduce costs and are safe and effective as has been the case with other nonphysician prescribers (Lenz, Mundinger, Kane, Hopkins, & Lin, 2004; Speer & Bess, 2003), these efforts are likely to become more successful. Given the inevitable outcomes once legislation is enacted, pursuit of prescriptive authority represents the most efficient option for enhancing clinical practice.

Even so, once prescriptive authority is achieved, there are good reasons to pursue increased involvement in primary care as the next phase in the evolution of the profession. First, the exclusive biological focus in psychiatry in part emerged in response to external pressures such as managed care (Luhmann, 2000). Despite the protective factors noted earlier, it is reasonable to assume prescribing psychologists will eventually be confronted with the same pressures. One potential offshoot of psychologists' becoming involved in integrated primary care is enhanced status for psychosocial interventions in healthcare in general.

Involvement in primary care also opens access to new populations of patients. This has potential economic benefits. It also has implications for the profession's contribution to the public good through the enhancement of services for individuals with emotional and behavioral concomitants to their physical disorders.

Finally, the combination of prescriptive authority, an understanding of psychosocial diagnosis and intervention, and behavioral management skills will enhance the attractiveness of psychologists as partners to PCPs. The ability to prescribe will allow the PCP to feel comfortable transferring more of the care for individuals with concomitant psychological disorders to the psychologist, whether the psychologist ultimately prescribes medication or not. Furthermore, psychologists with expertise in neuropsychology, treatment of substance abuse, and/or behavioral medicine can contribute to the establishment of true integrated care for primarily medical patients as well as better care for primarily mental health patients.

In other states where it is not deemed realistic to achieve passage of authorizing legislation in the foreseeable future, psychologists may be better served by turning their attentions to enhanced integration into primary care. This process begins by educating primary care entities such as the state primary care association about the roles the psychologist can fill. In the case of psychologists with advanced training in pharmacotherapy, those roles can include collaboration with PCPs on medication decision-making. However, conversations with psychologists involved in primary care around the country suggest this role has to be addressed with some sensitivity because reactions have been quite mixed. Some report they found primary care organizations very interested in the opportunity, whereas other organizations have rejected this option to avoid involvement in the debate over prescriptive authority for psychologists.

In some cases, offering traditional colocated mental health services in primary care settings may provide the foot in the door from which psychologists can move to discussing integrated healthcare services. This approach may be particularly effective in

training settings where there is a preference for the use of doctoral-level mental health providers or in communities where there are few alternative mental health resources. In others, psychologists may find that primary care entities are more interested in employing masters-level providers to provide mental health services, in which case psychologists must make their case for integration directly on the basis of their behavioral services for patients with traditional medical disorders.

Once psychologists are participating in primary care, the contribution they can make to the medication management of patients will start to emerge. Through improved diagnosis of mental health conditions, comprehensive treatment planning, and direct advice on appropriate medication management by psychologists who have also received postdoctoral training in psychopharmacology, PCPs can learn about the value of allowing psychologists a greater role in this arena. This strategy has been used to great effect in Hawaii and several other states where the placement of psychologists knowledgeable in pharmacotherapy in primary care settings has been ongoing for a number of years.

Whichever approach psychologists pursue, both prescribing and primary care psychology will have predictable effects on the field. Psychologists will be working with sicker, more medically complex, needier, and more culturally diverse populations than they have in the past. Although medicine is likely to remain the dominant profession in primary care settings, psychologists can adopt greater leadership in the management and design of healthcare systems. This will be particularly true for psychologists who combine prescriptive authority with work in a primary care setting. This role will allow psychologists to advocate more effectively for the increased use of psychosocial intervention even as traditional weekly psychotherapy becomes more of a specialty service; for enhanced use of assessment and psychological principles to predict treatment adherence and to identify the emotional and behavioral concomitants of medical illness; and for the development of treatment plans that truly considers the needs of the whole person.

Preparing psychologists to pursue these opportunities will require creating additional educational opportunities for psychologists. Doctoral-level training will need to evolve if it is to remain relevant to the survival of the practitioner. It is noteworthy that the current accreditation documents in doctoral-level psychology do not even mention several topics that are essential to behavioral healthcare, including training in substance abuse, psychopharmacology, or clinical medicine.

Even in the absence of change in the curriculum, there are opportunities for preparing students through practica. Advanced-level practicum experiences in primary care settings provide a cost-effective method for both preparing psychologists in primary care psychology and exposing PCPs to the roles psychologists can fill in those settings. The main obstacle slowing the progress of such placements (beyond lack of awareness among psychologists) is a shortage of psychologists who can supervise in the primary-care setting. This is slowly changing, but in the meantime, some training programs are providing the supervision services themselves to make the opportunity available. At the same time, supervisors for all levels of psychology students should be discussing medication in any case where it is a consideration or where the patient is currently receiving medication. Students in healthcare psychology are rarely encouraged to consider the extent to which their patients' medications are actually working because this is

considered the task of the prescriber. Such reflections can contribute to a more objective evaluation of the appropriate role for medication in clinical practice. Primary care placements will enhance these opportunities to discuss medication issues. At the same time, postdoctoral programs in pharmacotherapy for psychologists should acknowledge and prepare their students for a future involving greater collaboration with PCPs.

Conclusions

The profession of psychology must evolve or risks withering. The healthcare system can benefit from the emergence of a discipline with a strong empiricist tradition that examines health from a psychobiosocial rather than a biopsychosocial model (LeVine & Foster, 2010). Psychologists will help identify circumstances in which biological interventions should be ancillary to the psychosocial rather than vice versa, teach patients to advocate for themselves, and understand why this patient behaved this way in this situation and how the doctor can behave differently to achieve the desired end.

The pressures identified at the beginning of this article created a troubling picture for the future of psychology. With lower-cost providers competing effectively with psychologists, psychology could well become increasingly marginalized, a profession perhaps respected by other healthcare providers but offering a boutique service.

Alternatively, psychology can work to redefine what is meant by doctoral-level psychological care. Doing so will require formidable effort. To summarize the various actions mentioned in this article, it will require addressing limitations in same-day billing, educating stakeholders in the primary care community about the role psychologists can play in the medical home, training psychologists to work in these settings, increasing the number of psychologists collaborating with physicians on medication decision-making, and convincing legislators that psychologists can prescribe. Psychologists will have to get used to dealing with medically complex patients and more severely mentally ill individuals, working collaboratively with other professionals, and understanding the practices of primary care. We believe these changes are necessary if we are to secure the future of our profession.

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