

How Prescriptive Authority for Psychologists Would Help Service Members in Iraq

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The Department of Defense Psychopharmacology Demonstration Project was an important precursor to the gaining of prescriptive authority for psychologists at the state level. However, there has been limited progress in this area within the military since that program's discontinuation. The authors discuss the unique challenges faced with regard to providing adequate psychiatric care in Iraq, including excessive reliance on nonpsychiatric physicians and physician assistants for psychiatric services, the risks associated with transporting personnel to psychiatric services, and issues in continuity of care. Increasing the number of military psychologists able to prescribe would improve the level and quality of care available for service members and potentially have a positive impact on prescriptive authority for psychologists at the state level.

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The lengthy process of acquiring prescriptive authority for psychologists in every state is now under way. Legislation has been passed in Guam, New Mexico, and Louisiana and was introduced in eight more states during the 2004–2005 legislative sessions (Connecticut, Georgia, Hawaii, Illinois, Missouri, Oregon, Tennessee, and Wyoming). More important, as the number of civilian prescribers increases without raising risk to patients, it will become more difficult for opponents of the legislation to use public safety as an argument against prescriptive authority. In those states that first achieved prescriptive authority, the public safety concern was neutralized largely through reference to the experiences of the graduates of the Department of Defense Psychopharmacology Demonstration Project (PDP).

The PDP has already been described in great detail elsewhere (Dunivin & Orabona, 1999; Sammons & Brown, 1997), so it is only outlined here. On the basis of congressional action in 1988, the Department of Defense trained 10 psychologists—approximately equally divided between the Army, Navy, and Air Force—in pharmacotherapy between 1991 and 1997. The PDP involved 2 years of training. The curriculum underwent marked changes over its lifetime, the largest change being a reduction of

over 800 didactic hours. Although the program existed for only 7 years and graduated only 10 students, there were four large-scale evaluations of the PDP (Newman, Phelps, Sammons, Dunivin, & Cullen, 2000). These reports were consistently positive concerning the quality of care provided by the PDP graduates.

There is an irony in using the PDP to demonstrate psychologists' effectiveness as prescribers to state legislators. Although momentum is building for prescriptive authority at the state level, little progress has been made toward prescriptive authority for psychologists in the military since the end of the PDP. In a survey of military health care providers, Klusman (1998) found that a majority of active duty psychologists, primary care physicians, and social workers (though not psychiatrists) from the U.S. Army, Navy, and Air Force favored extending prescriptive authority to appropriately trained psychologists, primarily for the purpose of increasing access to care. Although the study did not deal directly with operational environments, it is reasonable to assume that this logic would extend to combat zones.

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Mental Health Services in Iraq

The U.S. Armed Forces have recognized the emotional demands placed on their personnel in Iraq and have responded by incorporating trained behavioral health providers into both combat and combat support units. Currently, there are hundreds of behavioral health providers deployed to Iraq in support of Operation Iraqi

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Freedom. Included among these are psychologists, psychiatrists, psychiatric nurses, social workers, occupational therapists, and mental health technicians.

As a means of providing the highest level of care possible to the approximately 135,000 troops currently deployed, these behavioral health providers are placed throughout the Iraqi theater of operations. This often means they may be found in remote locations with minimal medical assets. Regardless of placement, these professionals are required to perform significant work, in a challenging environment, with limited resources (e.g., providing services to those on combat missions, with limited access to reference materials; cf. Moore & Reger, 2006). This is particularly the case with psychiatric care.

The Challenges of Providing Psychiatric Care in Iraq

Although the ratio of deployed psychiatrists to service members in Iraq is substantially higher than the various estimates of the prevalence of psychiatrists in the U.S. population (Lohr, Vanselow, & Detmer, 1996; West, Kohout, Pion, & Wicherski, 2000), there are unique challenges faced with regard to providing adequate psychiatric care in this environment. The most prominent are the reliance on nonpsychiatric physicians and physician assistants for psychiatric services, location of psychiatrists and the need for travel, and continuity of care.

Nonpsychiatric Providers and Psychiatric Care

A major challenge of providing psychiatric care in Iraq is that nonpsychiatric physicians, physician assistants, and nurse practitioners are required to prescribe the majority of psychotropic medications and to manage psychiatric cases. Again, the situation is, on the surface, not very different from that in the civilian sector (Schulberg & Burns, 1988). Beardsley, Gardocki, Larson, and Hildalgo (1988) reported that primary care physicians prescribe as much as 70% of psychotropic medications. Similarly, Pincus et al. (1998) found that only 25% of office visits in which psychotropic medications were prescribed involved psychiatrists. Approximately 50% were visits with primary care physicians, and the remaining 25% consisted of other medical specialists (e.g., internists, gynecologists). It should be noted that this is not a trivial issue and that the psychiatric community is aware of this reality (cf. Sharfstein, 2006).

Although the issues of lack of specialized training in assessing and treating psychiatric disorders and potential hesitancy toward managing complex psychiatric cases are similar, there are important differences. Nonpsychiatric providers in a combat environment are required to provide triage at a rate typically unmatched by their civilian counterparts. In addition to providing routine and emergent medical care for what can be thousands of service members, they may also be required to function as flight surgeons for aeromedical evacuation cases, participate in rescue missions, supervise humanitarian programs, train coalition health care providers, and occupy demanding administrative roles. Furthermore, this is typically done while remaining on call 24 hr a day, 7 days a week. Therefore, any reduction in professional responsibilities (e.g., less management of psychiatric cases) will allow nonpsychiatric providers to focus on their primary objectives of managing

the physical ailments of service members and focusing on critical military operations, such as those mentioned above.

A separate but related issue is that psychologists in Iraq are often called upon to make recommendations to primary care providers about the treatment of psychiatric disorders with psychotropic medications. While serving in Iraq, Bret A. Moore was not only asked on numerous occasions to recommend specific psychotropic medications for patients but was also consulted on issues of dosing and side effects. The most common reasons for requesting the consults were the prescribing providers' unfamiliarity with the medication, lack of expertise about the psychiatric disorder being treated, and the belief that psychologists have considerable knowledge about psychotropic medications in general. Although this was the case more so with physician assistants, it was not uncommon for the psychologist to receive consults from pediatricians, internists, and family practitioners. Obviously, this presents significant ethical and legal issues for the psychologist who is not credentialed to prescribe psychotropic medications. Nevertheless, it is an issue that often emerges in the combat environment, where there are fewer alternatives than in the civilian sector.

Location and Travel

In order to ensure that medical resources in short supply are best utilized, military commanders strategically place these resources in areas of operation to promote centralized access. In theory, as well as in fact, this practice creates a series of "health care hubs" that allow troops throughout the military theater to receive specialty medical care. As a result, many specialty health care disciplines, including psychiatric services, are often provided only through larger facilities, such as combat support hospitals, restoration teams of combat stress control units, or division mental health services. This model has two important implications for the provision of behavioral health care.

First, because psychiatric services are centralized, service members from outlying camps may be required to travel long distances in order to receive appropriate psychiatric care. This is relevant in that most of the combat casualties in Iraq are not a result of direct engagement of the enemy, but they are due to enemy attacks on military convoys or patrols by insurgents using improvised explosive devices. Consequently, travel to and from bases and camps within the military theater is extremely dangerous. A simple psychiatric consultation may place unnecessary stress on an already vulnerable service member. The following real-world vignette may help illustrate the point.

A 32-year-old infantry soldier was being seen at the base's combat stress clinic for anxiety and depressive symptoms after his vehicle was hit with an improvised explosive device. After several weeks of cognitive behavioral therapy provided by the psychologist and medication management by one of the base's physicians, the soldier showed no significant improvement. It was decided that because of his lack of response to treatment and the complexity of the case, he would be sent to a camp approximately 75 miles (120 km) away that had a psychiatrist on staff.

Within 30 min of leaving for the base that had a psychiatrist, the soldier's convoy was hit with an improvised explosive device and several individuals were injured. As a result, the convoy was redirected back to the originating base and the soldier was not able to make his appointment. Although he was able to successfully make the

journey a few days later, he developed an increase of anxiety symptoms and was exposed to a second stressful event.

Second, the transport and movement of service members to other bases and camps can be disruptive to the activity of the military unit. In some instances, a 1-hr psychiatric evaluation can involve several days of the service member's time when considering such factors as the coordination of transportation or the limited availability of ground or air transport. During that transport, the unit may be required to function as usual with fewer resources. Depending on the unit's mission and the tactical role of the service member in question, this can place the remaining members of the unit at greater risk or jeopardize the success of military operations. Another example helps illustrate this point.

Two soldiers from an infantry platoon were referred to Bret A. Moore after their platoon sergeant identified them as having a difficult time coping with the stress resulting from a recent rocket attack on their military vehicle. Both were having difficulties sleeping, experiencing panic attacks, and had developed an intense fear of going on future missions. In conjunction with cognitive behavioral therapy provided by the psychologist, the soldiers were also referred to the local medical treatment facility on base. Because of the complexity of the case, the treating physician decided to send the soldiers to a larger facility about 1 hr away. The soldier's superiors were informed that the soldiers would be away from the unit for approximately 3 days. However, because of treatment complications and a lack of available transportation back to their base, the soldiers were gone for over 7 days. As a result, the unit was required to continue understaffed with its mission, which placed the remaining unit members at increased risk. Furthermore, they were forced to cancel a mission for the same reason.

The two preceding case examples help illustrate the challenges that the location of appropriate psychiatric services and the potential need to travel to those locations can cause. Not only can important military operations be hindered but the safety and welfare of service members at both the individual and unit levels can also be compromised. In these two cases, each of the service members had access to psychologists for the purpose of psychological care. With the appropriate training and credentialing in pharmacotherapy for psychologists, these two counterproductive situations would have been avoided.

Continuity of Care

A potential benefit often cited for extending psychologists prescriptive authority in the civilian sector is the increased likelihood that psychologists would use a biopsychosocial approach as opposed to a purely medical one (McGrath et al., 2004). The hope is that in combat situations the problems of the service member would be viewed broadly and most likely be seen as resulting from the psychological stress of the combat environment, the stress of being separated from loved ones, and any possible biological underpinnings of the disorder. Psychologists would be more likely to appreciate the limitations of pharmacotherapy alone and to recognize the added benefits of evidenced-based psychological treatments. The latter possibility is particularly relevant considering that some studies have acknowledged a definite decline in the frequency with which psychiatrists engage in psychotherapy (e.g., Gabbard & Kay, 2001; Luhrmann, 2000). This is no different for

psychiatrists in Iraq. As a result, it is oftentimes necessary for the psychiatric care of service members to be managed by multiple providers. This can be far more logistically complicated and frustrating for all parties involved than is true for civilians. For example, as mentioned previously in this article, because of the relatively limited access to psychiatrists in the combat environment, after the initial psychiatric evaluation, follow-up may be assigned to the nonpsychiatric physician or physician assistant assigned to the service member's camp. Combined with a range of psychotherapeutic interventions provided by the psychologist, a considerable amount of time and effort goes into providing appropriate psychiatric care for the service member. The following case example illustrates this point.

A 24-year-old soldier was referred for a psychiatric evaluation because of several months of unremitting depression and anxiety. After traveling 1 hr to the nearest camp where a psychiatrist was stationed, the soldier was evaluated and placed on an antidepressant, an anxiolytic, and a hypnotic for his symptoms. The soldier was instructed to follow up with his primary medical provider (a physician assistant) for his medication reviews and refills upon his return to camp. Approximately 3 weeks after his initial psychiatric evaluation, the soldier presented to Bret A. Moore's office indicating that he was required to maintain regular appointments with a psychologist.

During the interview, the soldier acknowledged frustration that he was required to see multiple providers for his care. He indicated that not only was he required to see a psychologist on a regular basis but he also had to make an appointment every 2 weeks with the base's physician assistant and present for an additional evaluation by the psychiatrist who originally prescribed the medications. More important, the soldier indicated that he felt the coordination of the appointments and the time he was forced to be away from his unit because of the different appointments was not worth the benefits of being on medication.

The vignette above illustrates the potential challenges for service members requiring psychiatric treatment, particularly when it comes to management by multiple providers. Specifically, this can create frustration on the part of the service member, which can potentially impact follow-through with treatment. Also, it places increased time demands on the service member, resulting in less time spent in critical training and operations with his or her unit.

A separate, but important, issue with this scenario is that there may be an overreliance on psychiatric medications by the nonpsychiatric provider who is unfamiliar or uncomfortable with psychosocial alternatives. Utilizing powerful medications, such as anxiolytics and hypnotics, can be an operational issue for the soldier. Considering that it is crucial for the soldier to remain alert and vigilant during dangerous military operations, the use of certain pharmacological interventions that blunt the soldier's reactions when a nonpharmacological alternative is available can create undue risk for the service member and the unit as a whole. An example is the treatment of acute posttraumatic anxiety and stress. In Bret A. Moore's experience, it was not uncommon for service members to be prescribed multiple medications to alleviate the acute stress symptoms commonly seen after traumatic events (e.g., sleep disturbance, hyperarousal, decreased mood). In many of these cases, utilizing tested and proven psychological treatments (e.g., exposure therapy, relaxation training, cognitive restructuring) would have been equally, if not more, effective. It is situations

such as this one in which the comprehensive training of prescribing psychologists could allow them to consider issues of medical side effects, effectiveness of psychological interventions, and the duty performance of the soldier in treatment decision making.

How Psychologists Can Help

Extending military psychologists the authority to prescribe medication in a theater of operations can help mitigate the challenges noted above. First, the number of doctoral-level behavioral health professionals who have training in the provision of psychiatric medications could potentially double. This would allow for a greater area within the theater of operations to be covered. Consequently, psychologists could decrease the workload strain on nonpsychiatric physicians and physician assistants. Becoming the primary case manager for psychiatric cases would allow these professionals the ability to focus on other critical duties, such as providing sick call, performing follow-up care for physical ailments, and ensuring the training and supervision of medics and other frontline medical staff. It would also guarantee that service members dealing with complex psychiatric issues would be able to see behavioral health professionals with expertise in managing psychiatric disorders.

A second benefit of allowing psychologists the authority to prescribe in a combat environment would be a reduction in the need for travel along dangerous roads for the purpose of receiving psychiatric care. It would also help ensure that military units would be able to keep much-needed service members in place. As mentioned earlier, maintaining unit strength is one important component of successful military operations.

Finally, the continuity of care as related to psychiatric services would be improved. The management of psychiatric cases could potentially be accomplished by one provider. The psychologist with prescriptive authority could operate within a biopsychosocial framework and ensure that all aspects of the service member's problems are addressed. Obviously, management by one provider allows for greater understanding of individuals and their unique needs and can have a positive impact on issues such as medication compliance and follow-up care. It can also ensure that the potential for overreliance on medications is limited. For example, although there is considerable, mounting evidence that psychotropics, particularly selective serotonin reuptake inhibitors, can be effective treatments for acute and chronic posttraumatic stress disorder, limitations have been acknowledged in the current evidence base, and more effective agents are needed (Stein, Ipser, & Seedat, 2006). Some researchers have even posited that the current evidence for the use of selective serotonin reuptake inhibitors is of limited value, and these medications are not recommended as a frontline treatment for posttraumatic stress disorder (National Collaborating Centre for Mental Health, 2005). Regardless of this debate, as stated previously, psychologists are more likely to recognize the effectiveness of evidence-based psychological treatments. Therefore, as a result of their specialized training and skills, psychologists will not be forced to rely solely on pharmacotherapy.

Conclusion

The end of the PDP program resulted in a shift of emphasis within the movement for prescriptive authority from the military to

the civilian sector. For all the reasons listed above, we believe that increasing the number of prescribing psychologists in the military should be an integral component of any agenda related to prescriptive authority. This proposition has several implications.

First, targeting legislative efforts at those states in which military psychologists tend to be licensed would increase momentum for prescribing psychologists in both the civilian and military sectors. One example is Alabama, where many military psychologists are licensed.

Second, increasing training for military psychologists in psychopharmacology at the postdoctoral level will increase the number of military psychologists who can at least serve as competent consultants for psychiatric services and in some cases is likely to result in the awarding of prescriptive authority at the local level. Although this is done to some degree already (e.g., seminars and curricula integrated into some of the formal postdoctoral military fellowships), providing training across the board for all military psychologists would be useful. One suggestion would be to develop an alliance with one or more of the schools that provide formal training to psychologists in psychopharmacology. Military psychologists could be encouraged to participate in these programs through financial reimbursement and time for training or through the creation of formal postdoctoral military fellowships in psychopharmacology in collaboration with these schools.

Third, the military has already shown that properly trained psychologists can prescribe effectively and safely. Increasing the number of military psychologists with prescriptive authority would contribute important data in support of these issues. And last, military psychologists would be able to rely on a greater set of clinical skills when providing care to service members. The men and women of the armed forces serving in hostile and stressful environments deserve the highest and most professional level of psychiatric care possible. The prescribing psychologist could help ensure that this level of care is provided.

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