A Debate on Prescription Privileges for Psychologists

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This article presents the comments of Elaine M. Heiby and Patrick H. DeLeon during a debate on prescription privileges for psychologists held at the August 2002 convention of the American Psychological Association (APA). The debate began with DeLeon presenting arguments in favor of the APA policy on this issue, followed by Heiby presenting arguments against the policy. The presenters discussed the justification for the APA model of training for prescription privileges and the impact of training for prescription privileges on university-based departments of psychology. Timothy Anderson provided a summary and discussion of the debate.

A debate on the American Psychological Association’s (APA’s) policy on prescription privileges (also referred to as RxP) for psychologists was held at APA’s August 22–25, 2002, convention in Chicago. The debate, organized and chaired by Timothy Anderson, was entitled “The Role of Prescription Authority for the Psychologist.” Patrick H. DeLeon presented arguments in favor and Elaine M. Heiby presented arguments against APA’s policy on RxP. This article is based on a partly unclear audiotape of the debate transcribed by Heiby. Because some portions of the audiotape were unclear, all authors were given the opportunity to complete and edit the transcript (using their notes, overheads, and recollections).

Debate Structure

In the months preceding the debate both Heiby and DeLeon were involved and cordial in agreeing to the terms of the debate. The debate structure consisted of opening statements to a proposition (10 min each), followed by two debate questions (3 min each, with 1 min each for rebuttal) and closing statements (2 min each). In all cases, including rebuttals, the debate participants agreed that DeLeon would speak first and that Heiby would speak last. The debate proposition was general, and the two debate questions focused on the issues surrounding the training of psychologists for prescription authority. The first question concerned the justification of the APA model of training for prescription privileges in light of the Department of Defense (DoD) demonstration project and training for other professions with prescription privileges. The second question concerned the impact of training for prescription privileges on university-based departments of psychology—in terms of curriculum, staffing, and financial costs to the universities and students.

Opening Statements

The debate began with a proposition stated in the positive for DeLeon and in the negative for Heiby as follows. Proposed: “The science and practice of clinical psychology will [not] benefit from psychologists having the authority to prescribe medicine.”

Opening Statement: DeLeon

The Institute of Medicine recently reported that as many as 98,000 Americans may die each year as a direct result of medical errors committed within U.S. hospitals (Kohn, Corrigan, & Donaldson, 1999). During Congressional hearings, an Institute of Medicine witness suggested that this was a conservative figure not including errors committed on an outpatient basis, in nursing homes, long-term care facilities, and so forth. Medications are the most frequent medical intervention, with an average of 11 prescriptions per person each year in the United States. Keeping track of new drugs (i.e., their interactions and side effects) is extraordinarily difficult; approximately 48% of the prescription drugs today have become available only since 1990. Even in large, urban teaching hospitals, the rate of preventable adverse drug events related to prescribing decreases significantly—by 66%—merely by ensuring that clinical pharmacists actively participate in hospital rounds with residents and other staff, thereby participating at the time that drug decisions are being made. Eventually technology will make a significant contribution to quality care; however,
today, our health care system is still in the horse-and-buggy days of appreciating its potential contributions (Jerome et al., 2000).

On a more personal note, I was diagnosed with bladder cancer a number of years ago. The surgeon asked if I wanted chemotherapy for “emotional reasons.” There was no doubt in his mind that chemotherapy was not necessary for clinical reasons. Once it became clear that this invasive treatment would merely be “to make me feel better,” I respectfully declined. The surgeon was excellent. The surgery was conducted at a large, urban teaching hospital. I appreciate that he actively involved me in the treatment process as the patient. However, chemotherapy would not have been quality care. My subsequent review of the available information on the Web regarding the expected longevity of patients with this diagnosis was unsettling, until a colleague explained that most receive this diagnosis considerably later in life. There is no question in my mind that quality care requires that behavioral scientists be active participants in all clinical treatment decisions, including those involving medications. Our nation’s health care system today simply does not provide the type and quality of health care that our citizens deserve. We can do much better.

With us today is a former president of the Hawaii Psychological Association, Tom Merrill. He has a baccalaureate degree, plus over 7 years of additional training. Psychologists are the nation’s educated elite. Only 25.6% of the adults in this country possess even a baccalaureate degree. We need senior colleagues, like Tom Merrill, to be personally involved in deciding what truly is quality care and in making sure that psychology and the behavioral sciences are an active component of the clinical and policymaking process. One should not take a specific medication merely because it is advertised on television or in magazines; it should be taken only if it is clinically appropriate. Back in the late 1980s and early 1990s, a special demonstration program was established in the DoD to train psychologists to prescribe psychotropic medications. Ultimately, 10 psychologists graduated and prescribed within military facilities. There have been numerous objective studies of their clinical skills. Each of them provides outstanding care, including improving the quality of medication utilization. They modify previously ordered dosage levels, substitute more-appropriate medications, and ensure that the all-important psychosocial aspects of therapy are incorporated into the treatment regime. They often take patients off inappropriate medications. In essence, they effectively utilize their psychological expertise (Newman, Phelps, Sammons, Dunvin, & Cullen, 2000).

My daughter Kate had to use an emergency room in a large hospital in New England when she was only a few months old. It was a snowy, icy evening. They did not have the right size needles to fit her arms; they did have the necessary equipment to take her blood pressure. They told us she would be dead by morning. The next day, they said she would be brain damaged for life. There seemed to be no awareness that her parents might have strong feelings or might need assistance in discussing her critical situation with her older brother. Today, she is a freshman in college and doing quite well. Kids are not little adults. They have unique needs and respond differently to trauma and to various medications. A federal pediatric emergency service program has been established, funded at approximately $20 million annually, to improve the quality of emergency care in hospitals across the nation. We will ensure that behavioral science expertise is an integral component of pediatric emergency care. We need experts, such as DoD psychopharmacology graduate Anita Brown, in the forefront of providing necessary care.

I believe prescriptive authority is important for psychology because this is the future. The future is holistic health care. The future is educated consumers. The future is ensuring that one’s professional training, regardless of discipline, becomes readily available to those in need. It is no longer acceptable to wait a month or 6 weeks to see a specialist. Our nation’s health care system must become more responsive to consumer needs.

During my tenure as APA president, APA made a special point of meeting with the leadership of professional pharmacy. Almost every time our Board of Directors met in Washington, DC, we scheduled an informal event with them. During our last Board meeting, we had a special dinner in their building across from the Vietnam memorial. In fact, the president of the American Pharmaceutical Association was the only national association president I met with that year. He represented 200,000 frontline pharmacists, of whom 25,000 to 30,000 would characterize their practices as being clinical in nature. He believed that psychology already had prescription privileges. His membership is steadily evolving into primary care with the goal of providing services such as biofeedback back care, screening for skin cancers, review of medication orders, and counseling for anxiety, family problems, and so forth in a consumer-friendly environment. Pharmacy has “prescription privileges” in 38 states, under varying conditions. Similarly, there are 75,000 advanced practice nurses (nurse practitioners, clinical specialists, nurse midwives) in all 50 states. That profession and others are providing quality primary care. Psychology must accept this professional challenge and become actively engaged in the primary care arena. We must provide high-quality care in community health centers, the true safety net for our nation’s uninsured and underinsured. It is our societal responsibility (DeLeon, 2002).

Where Elaine and I absolutely agree, and where we have always agreed, is that psychopharmacology training should be at the postdoctoral level, and not at the undergraduate or even graduate level. It is important for psychologists to be well schooled in the foundation of psychology and the behavioral sciences. We should learn how to accurately diagnose and treat. Our internship experiences are invaluable. The prescribing psychologist must foremost be a psychologist. He or she can then obtain the pharmacology expertise as an additional clinical skill. Once one has obtained his or her primary professional identity (including how one interacts with patients) one sees the world somewhat differently than individuals with other professional identities do. I went to law school after obtaining my doctorate in clinical psychology. I soon realized that I heard the law professors differently than my fellow law students had. Although I grew up in a family of lawyers, my psychology training had shaped my view of the world far more than I had realized, especially, for example, when we discussed family-violence issues. A marine who goes to law school is qualitatively different than a lawyer who enters the Marine Corps. Obtaining prescriptive authority is the future, and with this additional clinical skill, our clinicians will serve society very well. Other nonprescription providers are increasingly obtaining this clinical responsibility. If psychology ever decided not to invest in the future, future generations of the best and brightest undergraduates would no longer seek out psychology (DeLeon, 2003). Aloha.
Opening Statement: Heiby

I would like to thank APA for holding this debate. First, I believe the proposed statement (the science and practice of clinical psychology will [not] benefit from having the authority to prescribe medicine) represents a number of misunderstandings of the issues raised by the opponents to APA policy on prescription privileges. Therefore, I would like to start by pointing out the positions of the opposition to APA policy for RxP.

The first misunderstanding in need of clarification is the belief that the opponents of APA policy object to psychologists obtaining the authority to prescribe. Indeed, prescribing authority is supported under certain conditions. The opponents officially do not, and never have, objected to psychologists obtaining such authority. Rather, opponents support obtaining such authority through already established routes, such as joint or executive track nursing programs. Using established avenues to obtain such authority would not require new laws, would not divide the profession, would not alienate our medical colleagues, and would not cost millions of dollars in lobbying.

What opponents object to is APA policy on Level 3 (independent practice) training in terms of the locus of training (which is at both the doctoral and postdoctoral levels) and the quality of training (which is far less than that of any prescribing profession). Pat just mentioned that he agrees that training should be postdoctoral, but the APA policy places such training at both levels. I’ll expand on concerns about the locus and quality of training later in the debate.

A second important misunderstanding in this debate concerns the size and nature of opposition to APA policy on RxP. Opponents include five significant organizations of applied and academic psychologists who are concerned about the preservation and growth of the scientist–practitioner model of clinical practice and university-based departments of psychology. Surveys of rank-and-file psychologists also indicate opposition to RxP.

The following five organizations expressed objection to RxP before it became APA policy in August 1995: (a) the American Association of Applied and Preventive Psychology, (b) the Society for a Science of Clinical Psychology, (c) the Council of University Directors of Clinical Programs, (d) the Council of Graduate Departments of Psychology, and (e) the Committee Against Medicalizing Psychology. While the membership numbers of these five organizations are smaller than the total membership of APA, the roles these organizations play and the people they represent are central to the preservation of clinical science and the raison d’être for professional practice. The American Association of Applied and Preventive Psychology, the Society for a Science of Clinical Psychology, the Council of University Directors of Clinical Programs, and the Committee Against Medicalizing Psychology have officially opposed APA policy and have officially supported and encouraged psychologists who wish to prescribe to do so through already established avenues. The Council of Graduate Departments of Psychology’s position before APA RxP policy was adopted was that RxP should not be implemented until all university-based departments of psychology support it and find it feasible.

The objections of these five organizations obviously were not heeded. According to DeNelsky (2001), the procedure that led to APA’s RxP policy suspended council rules “before the vote so that full debate and review of this important policy issue with APA governance did not occur” (p. 5). When APA and some state psychology associations proceeded to introduce RxP-enabling legislation even though they were fully aware that there were organizations of psychologists who objected to these bills, the debate moved from within the profession to state legislatures where psychology is presented as divided in a public forum.

Many surveys conducted after 1996 (when APA adopted its RxP policy and published its training and legislation models) reported that less than one third of those surveyed strongly supported the policy and, of those who did support it, less than 10% would pursue the training (e.g., Bush, 2002, Plante, Boccaccini, & Andersen, 1998). A meta-analysis of surveys concluded that psychologists are about equally split on the RxP issue (Walters, 2001).

A third common misunderstanding of the opposition to APA’s RxP policy concerns the importance of medical training. Opponents to APA’s RxP policy recognize the advantages to psychologists of obtaining medical training outside the discipline of psychology. Opponents have asserted that psychologists are generally very smart people and that many psychologists also obtain a degree in law, nursing, business management, and so on. The positive contributions of these cross-trained psychologists are obvious. The benefits of psychologists obtaining training in medicine through already established avenues are enormous. There could be greater cross-fertilization between the medical and psychological sciences and their applications, which now tends to occur through collaboration and consultation. Psychotropic medications have become a major form of treatment, and psychologists should know about them. Psychologists also would be able to provide empirically supported psychosocial treatments instead of or in addition to medical ones.

Along the same lines, opponents also acknowledge advantages to enhancing the training in psychopharmacology within the discipline. APA’s underscoring of the importance of having a background in psychopharmacology has forced departments of psychology to review undergraduate- and graduate-level curricula in terms of the adequacy of what’s called Level 1 training (basic psychopharmacology). APA’s 1995 Board of Educational Affairs working group and others have argued that Level 1 training would require adding one additional three- or four-semester credit course in psychopharmacology, which many psychology departments already offer. Level 1 training is not opposed by organized psychology, and there are good reasons for APA to include Level 1 training in its accreditation criteria. In addition, APA’s underscoring of the importance of making Level 2 training (collaborative practice) available, given that most psychoactive medications are prescribed by nonpsychiatric physicians, would address concerns about consumers having the option for psychological interventions about which a primary care physician may be unaware. Level 2 training builds on Level 1 training. It is recommended to occur at the practicum level, the internship level, and the continuing education level. Level 2 training has not been opposed by organized psychology. There are some practicum and internship sites that are prepared to provide Level 2 training. It would be difficult to make Level 2 training a standard for doctoral and postdoctoral training because the resources are not available at all training sites.

Opponents of APA’s RxP policy argue, because of the concerns delineated so far, that it is time for a moratorium on pursuing enabling legislation. Opponents also argue that it is time to explore
the implications for the discipline of psychology of adopting RxP Level 3 training, particularly as APA’s policy currently recommends this training at both the doctoral and the postdoctoral level.

A moratorium would provide time to evaluate the effect of the law in New Mexico. In December 2003, we’ll see what has happened in developing the rules and regulations of the New Mexico law. The rules and regulations must be agreed on by both the psychology and medical boards. A moratorium would permit us to learn what the medical board determines is adequate training. An article in a recent issue of The National Psychologist noted that the boards might increase the amount of training anywhere from 500 to 1,500 additional hours (Saeman, 2002). A moratorium would allow an evaluation of the training in terms of consumer safety, the number of psychologists who are interested in pursuing the training, the number of prescribing psychologists who serve the underserved, the changes in malpractice insurance, and the number and type of prescription-related lawsuits filed against psychologists and supervisors. A moratorium would also permit an inspection of the impact of the law on the University of New Mexico, which is the only university in the state that has a doctoral-level clinical psychology program.

DeLeón’s Reply to Question 1

How is the APA model of training for prescription privileges justified in light of the DoD demonstration project and training for other professions with prescription privileges?

DeLeón’s Reply to Question 1

The bottom line is that the DoD program is excessively comprehensive. It is as if we wanted to train colleagues to build computers, rather than to utilize them effectively in their clinical practices. In conceptualizing the DoD program, we talked with a wide range of professional educators, health professions’ deans, relevant national associations, and health care administrators. We carefully reviewed the literature, including the ill-fated California effort to train a new breed of practitioner, the doctor of mental health. One lesson learned is that it is extraordinarily difficult to license a new profession. DoD has a long history of establishing innovative, functionally based health-professions initiatives not limited by state licensure constraints. It has the resources to develop a truly comprehensive program.

A significant number of federal psychologists were already prescribing without any additional formal training; they worked within the DoD, the Department of Veterans Affairs, and the Indian Health Service. The medical staff bylaws at the Santa Fe, New Mexico, Indian Health Service facility expressly recognized prescribing by psychologists. Federal chief psychologists expressed their support, feeling it positively addressed a pressing clinical need. Discussions with state psychologists provided a similar picture; private sector colleagues reported that they are functionally prescribing, controlling their patients’ medications in collaboration with supportive physicians. We reiterate that this was without additional formal education. Frontline clinicians were leading the way (Burns, DeLeón, Chemtob, Welch, & Samuels, 1988).

In May 1994, the California Psychological Association, collaborating with what was then the California School of Professional Psychology, convened a special Blue Ribbon Panel of nationally renowned health professionals chaired by former APA president Ron Fox. The goal was to identify a model curriculum. Since the 1984 challenge of Senator Inouye to the Hawaii Psychological Association, Ron actively explored various RxP-training models, both in his role as dean of a school of professional psychology and as chair of the Committee for the Advancement of Professional Practice. A frequent scenario he encountered was that physicians would indicate that a particular didactic subject matter was not necessary, while psychologists would insist that it be included.

Ron’s modified model curriculum became APA policy at the Toronto meeting of Council in 1996, after evolving through all elements of APA governance. In 1997, Council authorized the College of Professional Psychology to develop an examination in psychopharmacology for use by state licensing boards. DoD prescribing psychologists were involved in creating the exam, which covers 10 knowledge-based content areas, including biopsychosocial and pharmacologic assessment and monitoring. All prescribing mental health providers (including those from medicine) should be strongly encouraged to take this exam. I am confident that in a practical and not theoretical way, the exam accurately measures one’s ability to prescribe in a competent manner (to provide quality health care).

It is important to place the evolution of psychology’s prescribing in the context of the health professional training literature. In 1982, the California Office of Statewide Health Planning and Development summarized 10 prescribing and dispensing projects in which over one million patients were seen over a 3-year period by trainees (State of California, 1982): No quality-of-care problems were reported. Only 56% of trainees in these projects possessed a bachelor degree or higher; the principal teaching methods used were lectures and seminars, varying in length from 16 hours to 95 hours (State of California, 1982). Doctoral-level psychologists can learn just as well. The critical underlying issue is what additional educational knowledge is actually, and not theoretically, required?

Heiby’s Reply to Question 1

APA’s model of training involves less than half the amount of medical training of any prescribing profession, including the 10 prescribing psychologists who were trained by the DoD. Such minimal training is difficult to justify, particularly given that the APA model is completely experimental, unlike the evaluated DoD project.

Figure 1 compares the APA model of training with the typical medical training of five professions that have prescription privileges in most or all states already, with the DoD training, with the RxP training recommendations of two panels organized by APA (Olmedo & Faltz, 1995; Smyer et al., 1993), and with training requirements in New Mexico.

Figure 1 shows that present training for professionals who already have some type of prescription privileges—psychiatrists, dentists, physician’s assistants, nurse practitioners, and optometrists—includes extensive undergraduate background in the natural and life sciences (the bottom, dotted part of the bars). The DoD project did not include undergraduate prerequisites. The 1993 APA ad hoc RxP training panel included explicit and extensive undergraduate requirements. In the APA model of training, it is noted
that demonstrated knowledge in biology, anatomy, biochemistry, neuroanatomy, and psychopharmacology are prerequisites to undertaking the RxP training. However, the APA model does not indicate explicit admissions requirements in premedical sciences for RxP training programs. Program descriptions on the Internet that advertise the APA model of training do not indicate prerequisites in the natural and life sciences.

Figure 1 also indicates the degree to which doctoral-level medical training (didactic and practicum) required in the APA training model differs from that of prescribing professionals, including the 10 evaluated DoD graduates, and the recommendations of two APA training panels. The 1993 and 1995 panels suggested training similar to the training provided in the second wave of the DoD project. (The 1993 panel indicated a need for extensive practicum but did not specify an amount.) The doctoral- or postdoctoral-level training adopted by APA is less than half the training of the DoD project and less than half the training of other prescribing professions. It is not possible to justify the APA training model without evaluation of data similar to those acquired during the DoD project. On what evidence did APA adopt so little training to practice medicine? One of the concerns of the opponents is that the APA model of training leaves psychology with the dubious reputation of having the lowest professional standards in terms of medical training in the country.

Another point about Figure 1 is that at state legislatures, when supporters of RxP-enabling legislation argue that the APA model is adequate training, they point to the outcome of the evaluation of the DoD model. Generalizing from the training in the DoD model to the APA model is unwarranted because of their different amounts of training. It is also unwarranted when one considers that the DoD trainees dealt with a population that had already been screened, were highly supervised, worked in a collaborative setting, and were educated in a brick-and-mortar institution. Many of the RxP-training programs claiming to offer the APA model currently provide correspondence training. It is clear that the APA model and current training programs are not comparable with the DoD project.

DeLeon’s Rebuttal to Heiby’s Reply to Question 1

Morgan Sammons, a graduate of the DoD Psychopharmacology Demonstration Project, has reported on numerous occasions that psychologists have more relevant didactic and clinical training than any other mental health specialty (e.g., Sammons, Paige, & Levant, 2003). Our colleagues, on average, possess seven or more years of education beyond the baccalaureate degree, with almost all courses being highly relevant to personality assessment and clinical diagnostic decision making. The appropriate utilization of psychotropic medications represents just one small part of the treatment process. The key to quality care is accurate clinical assessment. It is simply wrong to suggest that psychology’s clinicians are undertrained. The truth is just the opposite. Those interested should talk directly to educators from the other professions. Talk to former surgeon generals and university presidents. As a profession, we can be obsessive to the point of absurdity. Ron Fox observed that in 1894, the Massachusetts medical society sought legislation, which if enacted, would have prevented citizens at that time from taking a “full bath” without a doctor’s prescription. Medicine’s public-health-hazard allegations against nurse midwifery training simply have no basis in fact. We should trust the consumer’s good judgment.

Heiby’s Rebuttal to DeLeon’s Reply to Question 1

I repeat my question. On what evidence, not anecdotes, did APA adopt such a low level of training? Again, pointing to the DoD as the evidence that psychologists can learn to prescribe safely with-
out going to medical school does not justify the APA training model.

Having the lowest level of training in the country would put practitioners at risk for lawsuits for at least two major reasons: (a) their amount of training and (b) the nature of most current training programs, most of which are correspondence schools with no entry requirements like the Medical College Admission Test or the prerequisite requirements in the natural and life sciences. The precedent set by the APA model in crossing professional boundaries with so little training would be to promote social workers and other master’s-level counselors to obtain prescription privileges. This precedent has been stated by Pat himself and by the 1996 Board of Educational Affairs working group. Any financial benefits that psychologists would accrue through prescription privileges would be short-lived as other professions flood the market.

Debate Question 2

What is the impact of RxP training on university-based departments of psychology—in terms of curriculum, staffing, and financial costs to the universities and students?

DeLeon’s Reply to Question 2

The most honest answer is “Who cares?” If the faculty at the University of Hawaii, for example, are not interested in providing psychopharmacology training, so be it. The local professional school will. Professional schools are fundamentally different from traditional university-based departments of psychology. They represent an entirely different way of thinking, a different set of priorities and values. They may select different types of students. Those schools (or departments) that ultimately decide to embrace the psychopharmacology agenda will attract students who are excited about their professional futures. They will recruit faculty who have a programmatic vision for the 21st century and who will target the pressing needs of rural America, ethnic minorities, and the unique challenges of serving children and the elderly (DeLeon, Wakefield, & Hagglund, 2003). These agendas reflect the federal government’s priorities, and I am confident that necessary resources will be provided.

In my judgment, today’s professional school movement is focusing on the future. Over time, educational priorities change. When my wife was at the University of Hawaii, Roland Tharp ensured that behavior therapy was a priority. Departments of psychology across the nation are not identical. They can be fundamentally different. Above all else, graduate education teaches one how to think. The consequences of attending the University of Hawaii or the University of Illinois are probably quite different. Faculty decide what they want to teach, which areas they wish to research. At Nova Southeastern, Gene Shapiro administers the postdoctoral clinical psychopharmacology program where the university’s own faculty members have taken the lead. As their program matures, credible research programs will evolve, undoubtedly stressing interdisciplinary collaboration. Fantastic.

If some programs wish to keep their heads in the sand and ignore society’s priorities, so be it. However, if taxpayers’ dollars are paying faculty salaries, it may matter to others. Personally, I’m not going to waste my time. Those programs that pursue evolving opportunities will do very well. Those that provide educational services that society values will excel. Pharmacy programs are expanding exponentially. Today, it’s probably harder to get into pharmacy than any other health profession. If psychology faculty want to develop a nonfocused program, fine; however, there are consequences.

In 1968, the University of Illinois established the first PsyD program in the nation (DeLeon, Paige, Smedley, & Sammons, 2004). Several years later, the faculty decided to eliminate it. That was their decision. No one can criticize the University of Illinois. It is a great program. However, when one thinks of psychology’s role in today’s health care arena, PsyDs are critical. Professional schools currently graduate approximately 58% of all clinical students. My position is that we should encourage educational institutions to expand on their own unique expertise and interests. Students will seek out different programs, depending on their individual interests. If I were a university president and the psychology faculty were not interested in pursuing the psychopharmacology agenda, I would not object. However, when I had faculty positions to allocate, I would definitely favor departments with greater vision.

Heiby’s Reply to Question 2

There is no question about it. The organizations that oppose the RxP training model of the APA are concerned about the quality and preservation of psychological science at universities. The importance of preservation and growth of university-based departments of psychology may be one of the core issues of disagreement here.

The APA model of training for RxP is designed to be implemented at the doctoral or postdoctoral level (APA, 1998). The training would overhaul and revolutionize departments of psychology at the undergraduate, doctoral (includes internship), and postdoctoral levels (DeLeon, 2002). Universities would, of course, follow the trends of the profession and the discipline at large. It is unknown whether the modest amount of training in the APA model could become standard, but it is still possible to estimate the impact of including medical training in the undergraduate and graduate curricula. Such estimates are based on the consideration that most departments of psychology do not have faculty who could provide medical training.

The undergraduate psychology major would have to adopt up to 2 years of requirements in the natural and life sciences to maintain the standards of other prescribing professions, possibly alienating students interested in psychological science and extending the time to complete the bachelor’s degree. The doctoral course work would either expand by 2 to 4 years or eliminate much training in psychology, thereby either increasing the cost of training or reducing students’ expertise in psychological science and practice. The doctoral practicums and internship would either expand or involve far less applied psychology in order to include medical training, again either increasing the cost or reducing the amount of training in applied psychology.

The cost to universities to implement the APA training model has been estimated for a southern state university (Wagner, 2002), so this is a low estimate. The estimates also assume hiring adjunct psychology faculty rather than more expensive medical or tenure-track faculty. Wagner (2002) estimated it would cost over half a million dollars for a southern state university to offer the APA
training model, assuming a class size of five students. For the student, Wagner estimated $118,000—this estimate is based on $9,000 tuition, being able to live on $10,000 a year, and an income loss of $40,000 a year. So these are clearly very conservative figures. The cost of training if the DoD model was adopted at universities would be twice as much—just over a million dollars for the university and $236,000 per student.

Most universities are nonprofit institutions and could not bear the cost of either the experimental APA training model or the evaluated DoD training model. Universities would face eliminating clinical programs as too expensive, eliminating psychological science training in clinical programs, and/or eliminating faculty and doctoral programs in basic psychology. Radically reducing psychology training at universities would decimate the scientific basis of clinical psychology. And it is the scientific basis that distinguishes it from other behavioral health professions and provides a raison d’être for professional schools and the PsyD degree.

**DeLeon’s Rebuttal to Heiby’s Reply to Question 2**

What does one say when the opposition has not read the literature? With all due respect, highly qualified colleagues were actively involved throughout the APA governance deliberations. Mitch Smyer’s 1992 report to Council concluded,

> Practitioners with combined training in psychopharmacology and psychosocial treatments can reasonably be viewed as a new form of health care professional, expected to bring to health care delivery the best of both psychological and pharmacological knowledge. . . . This . . . [has] the potential to improve dramatically patient care and make important new advances in treatment. (Smyer et al., 1993, p. 9)

APA’s best scientists, educators, and practitioners were actively involved at every point. I would suggest members of the opposition do not respect the judgment of their own colleagues.

**Heiby’s Rebuttal to DeLeon’s Reply to Question 2**

Those opposing APA’s RxP policy have repeatedly stated that they are clueless about how to integrate training for prescription privileges into programs and still maintain the integrity of psychological science. The proponents of APA’s policy have not provided university-based programs with guidelines for how to accommodate this training and how to maintain the integrity of psychological science and still have a high quality of medical training. Without that direction, there are going to be continuous objections from the opponents. If APA were to work with universities to help them understand how to implement RxP training given their structures, which are far different from those of professional schools, then there would be more dialogue around this issue and less debate.

**Closing Statements**

**DeLeon**

I would like to express my sincerest appreciation to everyone attending. The first point I wish to make is that it is our collective duty, as educated citizens, to do all that we can to improve the quality of life of our nation’s citizenry. This is our societal responsibility. Many who served in the military (including my father) report that if it were not for the GI bill, they would never have obtained an education. They have never forgotten what they owe society. As psychologists, we represent the nation’s educated elite. Those on the APA Board of Directors appreciate this obligation. However, far too many colleagues do not. As professionals, at times we are overly self-centered. In my judgment, prescriptive authority represents the future of psychology, including academia. Over the years, outstanding members of APA—scientists, educators, and practitioners—have worked hard to develop a viable training model. Psychology, like the rest of society, is in constant flux. Many elected officials and leaders within the health care system expect our practitioners to prescribe. If, as an individual, one does not wish to pursue this clinical modality, so be it. No one will object. However, that does not provide license to impede others. If one relies on taxpayer support, one should be especially mindful of society’s pressing needs. My final point is that life can be surprisingly brief. We should enjoy the journey. We should listen to the objections, but insist on making society just a little bit better. I am confident that by obtaining RxP authority our profession will ultimately make the health care system significantly better. This is our societal obligation. Psychologists’ active involvement as prescribing professionals will make a real difference in the lives of our nation’s citizens. We will provide comprehensive and quality psychological care. Aloha.

**Heiby**

APA can play a role, a very vigorous and constructive role, in enhancing psychologists’ practice in this era of managed care, the popularity of drug treatment, and the oversupply of applied psychologists. APA can survey the membership in terms of its priorities regarding RxP and other missions of the APA. We’ve seen already that surveys are mixed, and there is not a consensus regarding the RxP agenda. APA can work with those who train psychologists at universities and address the feasibility of implementing radical changes in the discipline. APA can take the lead in arranging joint and executive track nurse practitioner and medical training at an affordable price for those psychologists who do wish to obtain prescriptive authority. Doing so would not divide the profession, would not require legislation, would not alienate our medical colleagues, would not open up our licensing laws for inspection and control by the medical community, would not set a precedent for social workers and other master’s-level providers to obtain prescription privileges, and would not require APA to spend what will be millions of dollars to lobby in all 50 states and Washington, DC.

APA can develop and promote continuing education modules to advance interprofessional collaboration (Level 2) in order to address concerns about the provision of psychoactive medication by nonpsychiatric physicians. APA can offer a training model based on an enhanced DoD curriculum that would meet most objections based on concerns for public safety. APA’s curriculum would need to be enhanced because of differences in the populations treated by the DoD graduates and civilian psychologists. Above all, APA can make psychologists more competitive with other professions by stepping up dissemination of the evidence-based forms of psychotherapy and assessment that have burgeoned in the past decade. The research supporting psychological services that are reimburs-
able has advanced rapidly since the introduction of the RxP proposal. Thank you.

Summary and Discussion: Anderson

This debate focused not so much on whether psychologists should attain prescription authority, but on how and when psychology should look to undertake this change in its professional identity. Heiby states that a “misunderstanding in need of clarification is the belief that the opponents of APA policy object to psychologists obtaining the authority to prescribe. Indeed, prescribing authority is supported under certain conditions” (p. 338). While it should be noted that there is a vocal group of psychologists who believe that prescription authority would dilute the uniquely psychological nature of psychological practice, both Heiby and DeLeon generally agree that psychology as a profession could add the authority to prescribe medicine. More in question are the procedures for training psychologists, which for DeLeon already appear streamlined for immediate implementation, but for Heiby appear to be a poorly planned hodgepodge.

It would appear that the problem for Heiby is that prescription authority would require more training and empirical study. Her basic position is an endorsement of the so-called Level 1 and Level 2 training models (which include graduate didactic and practicum training in psychopharmacology). She clearly draws the line there, claiming that psychology is not prepared for attaining actual prescription authority. She recommends a moratorium until the new law in New Mexico can be fully evaluated. However, a more specific plan for the number of training hours is not in the offing, and in fairness, perhaps it is beyond the scope of this debate.

Still, it is hard to imagine if any proposal for prescription authority would fully satisfy Heiby, and from her perspective, there is good reason for this. It is clear that Heiby believes that the broad-based proposal for prescription authority for psychologists would result in substantial damage to the scientist–practitioner model of graduate training.

DeLeon counters that it is not necessary for the profession to delay pursuit of prescription authority because some clinicians are already “functionally prescribing” (p. 339) and that there is a substantial social need, as evidenced in the present shortfall of professionals who can currently prescribe psychoactive drugs. DeLeon’s enthusiasm for prescription authority is substantial, and yet it is not clear how psychologists prescribing medicine will ameliorate the apparently high number of medical errors that are already being made by those who currently have prescription authority. DeLeon argues that there has already been a stepwise procedure followed for attaining prescription authority, and he cites the DoD project and the development of the APA curriculum model, which began in the 1980s.

Perhaps the sharpest point of disagreement between DeLeon and Heiby is over the number of training hours needed for psychologists to become competent in prescribing medicine. DeLeon believes that the DoD training model was experimental and “excessively comprehensive” (p. 339) and that other professions who have attained prescription authority have often done so without significant additional training. He cites the California health planning study in which training was didactic and involved only 16 to 95 hours of training. Heiby is completely at odds with DeLeon here and counters that the APA training model would leave psychologists uniquely undertrained among other professionals who prescribe medicines. She states that the APA model, if realized, would leave psychologists “with the dubious reputation of having the lowest professional standards in terms of medical training in the country” (p. 340).

Evaluating these more disparate claims can be difficult. It might be useful to consider how these data would apply to psychologists who would be receiving postdoctoral medical training. On the one hand, DeLeon is fond of citing anecdotal examples, such as midwives who have attained prescription authority with minimal hours of additional training. Yet psychologists who prescribe would rarely be in a medical situation as delimited, acute, and focused the one in which midwives work. On the other hand, Heiby cites equally impressive data showing that the APA training model for prescriptive authority requires the fewest number of training hours among other medical professions. Here the comparisons are with professions like dentistry and optometry in which the physiological aspects of care are constant and involve treatment for often chronic and complicated medical situations. Psychological practice may not fully be addressed by either set of data. Psychological practitioners of medicine will be involved with relatively complicated and enduring physiological interactions, but most of those same psychologists will continue using psychological procedures, and the nature of the medical care will be unique. Perhaps both Heiby and DeLeon would agree that psychologists should attain prescriptive authority in a very clear and deliberate manner, including clear definitions of the limits and context in which prescriptive authority should be granted and the decision points at which psychologists would refer to other medical professionals in more complex cases.

DeLeon notes that psychologists have “more relevant didactic and clinical training than any other mental health specialty” (p. 340). Psychologists are extremely well trained. However, this statement can cut both ways. Given the large number of hours that are currently devoted to training and the extreme breadth of the field, is it possible that psychologists may acquire additional areas of expertise, especially in an area like medicine? At what point is the weight on the training cart simply too great? DeLeon and Heiby clearly have different answers, but it seems reasonable to assume that those who choose to receive medical training will necessarily have to sacrifice training in other areas. Heiby clearly believes that the scientific training of clinicians will necessarily be compromised, while DeLeon sees the issue as one of psychologists and clinical programs being granted the freedom to choose their future.

DeLeon believes that the effect on training programs is not at issue or is inconsequential because all training programs can choose to provide training without prescriptive authority. This might be thought of as a free-market approach to training since all programs can choose whether to include medical training, but DeLeon also notes that he anticipates that there will be grave consequences (i.e., market-driven consequences) for those programs that “keep their heads in the sand and ignore society’s priorities” (p. 341; i.e., fail to include prescriptive training). In other words, programs should be free to choose whether to provide prescriptive training, but those who fail to add this training could be drummed out of existence. However, what remains less clear is where DeLeon perceives the limits of such a free-market approach. Does this include training for anything as long as society and the
profession perceive an unmet need? It is similarly less clear where Heiby might consider compromising empirically supported practice in the face of substantial need.

This debate might best be understood as a choice between two highly meaningful professional values that are in conflict. On the one hand, there are pragmatic issues (too few providers, limitations of practice due to medications). On the other hand, there are more idealistic principles of fidelity to science. The reader will ultimately decide how to cast his or her lot in our profession of practice due to medications). On the other hand, there are pragmatic issues (too few providers, limitations of practice due to medications). On the other hand, there are more idealistic principles of fidelity to science. The reader will ultimately decide how to cast his or her lot in our profession’s continuing struggle with science and practice. Heiby and DeLeon both articulate cogent and thoughtful positions. These comments are designed not as a separate argument, or to take sides, but only as a means of providing an additional perspective on the debaters’ already fine arguments. The arguments deserve careful consideration. Both debaters are likely to agree even more on one final point: The future of the profession is likely to be shaped more by the outcome of this choice than by any other contemporary issue.

References