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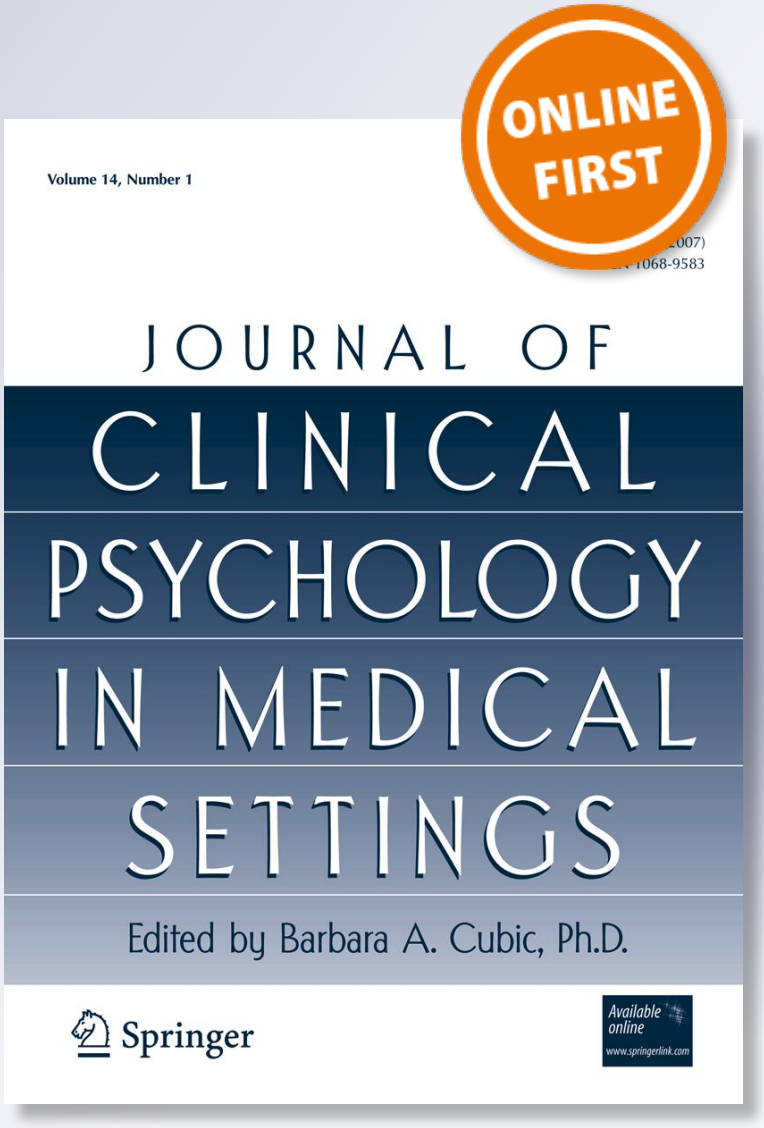

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Prescribing in Integrated Primary Care: A Path Forward

Robert E. McGrath

Abstract McGrath and Sammons (2011) have suggested prescriptive authority and involvement in integrated primary care represent complementary paths for the future of psychology. The articles in this special section of the *Journal of Clinical Psychology in Medical Settings* describing models of psychologists prescribing in primary care demonstrate that convergence of paths has already begun. This commentary on the papers in this special section addresses a variety of issues raised in the preceding articles, including the benefits of combined prescribing and primary care practice for psychologists and patients, the challenges likely to be faced by psychologists in integrated primary care if we do not also pursue prescriptive authority, obstacles associated with breaking out of our traditional mold, the importance of training specifically for working in primary care settings, and billing obstacles. Several topics are also raised that will need to be addressed by future studies of prescribing psychologists in primary care.

Keywords Prescriptive authority · Primary care · Integrated primary care · Health care reform

For many years, probably since the advent of managed care, healthcare psychology has been reeling. The explosive growth of master's level mental health disciplines, even while participation in and payments for psychotherapy are declining (Olfson & Marcus, 2009, 2010), are signs of a profession in danger. We ignore this danger at our peril.

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I am pleased that Sutherland and Tulkin (2012) saw in our article (McGrath & Sammons, 2011) a road map for the reinvention of our profession. Through the combination of prescriptive authority and integration into primary care, psychology has the opportunity to (1) become the only one-stop source of mental health services, (2) alleviate the burden of mental health care that has fallen on to primary care practices, and (3) influence the relative reliance on medical versus psychosocial interventions for mental and even for physical disorders.

Recently, there has been a great deal of interest in greater integration of psychology into medical settings without discussion of prescriptive authority as a complementary pursuit (e.g., Beacham, Kinman, Harris, & Masters, 2012; Runyan, 2011). Psychologists have a variety of skills that render them particularly valuable in primary care settings. The expertise psychologists have in health psychology, research and patient monitoring, program development, interpersonal interactions and team building, and assessment in addition to their strong traditional psychotherapy skills provide a full spectrum of skills needed to complement the biomedical training of the traditional primary care professions. It is not surprising then that many integrated care sites have valued the contribution of psychologists to the services they provide (McDaniel & Fogarty, 2009).

At the same time, the history of the community mental health movement reveals the long-term risks of involvement in integrated care without simultaneously seeking prescriptive authority. At one time psychologists were among the most ardent supporters of community mental health, and provided a good deal of the movement's conceptual rationale (e.g., Albee, 1992; Sarason, 1981). Today, psychologists are leaving the community mental health system (Cypress, Landsberg, & Spellman, 1997), with most psychosocial services within these settings now provided by

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master's level providers. It is not unreasonable to expect a similar pattern to emerge in health care integration as provisions of the Patient Protection and Affordable Care Act (ACA) [P.L. 111–148] are made and the health care delivery system shifts further towards Patient Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs). Conversations with representatives of major stakeholders in health care suggest those organizations are in the throes of reinventing themselves in response to the ACA, and they appreciate the involvement of doctoral-level mental health providers in system redesign. Once such systems become commonplace, though, and a broader spectrum of mental health professions are preparing students for serving as behavioral health consultants, it is my concern that agency administrators will start to ask why the organization is paying for doctoral-level psychologists when master's level providers come much more cheaply. In fact, I have already had communications from psychologists in a setting that integrated 5 years ago who are undergoing this process now. We can respond by pointing to our leadership, assessment, or program evaluation skills, but history suggests this argument works for only so long. The power to prescribe, and to un-prescribe or not prescribe, offers a powerful additional skill that all agencies would recognize as a valuable complement to the psychosocial services psychologists already offer.

The articles in this special section of the *Journal of Clinical Psychology in Medical Settings* celebrate the marriage of prescriptive authority and integrated care. This combination of skills is not just about reversing a negative trajectory in our profession; it is also about the affirmative re-creation of the health care domain through the marriage of the psychosocial and the medical.

The survey by Shearer, Harmon, Seavey, and Tiu (2012) is an exciting starting point for a discussion of blending prescribing and integration. Opponents of prescriptive authority have succeeded largely through resort to emotional claims that psychologists will be unsafe prescribers. Response to these claims has in the past rested on logical arguments such as the lack of evidence for unsafe prescribing, the ethical obligations of psychologists to practice within one's scope of competence, and the length and breadth of the training. The data from Shearer and his colleagues provide strong support for these arguments. Finding that 87 % of physicians responded in a manner indicating psychologists have improved patient care, and 94 % considered the prescribing psychologist safe, reveals the safety claims as nothing more than fear mongering. I particularly appreciated that the open-ended question about the least helpful aspect of having a prescribing psychologist available did not even produce a category of responses reflecting concerns about the performance of the psychologist. This article should be required reading for anyone interested in contributing to the prescriptive authority movement.

Since the remaining manuscripts focus on personal accounts of life as a prescribing psychologist in the primary care setting, I will devote the remainder of my comments to general themes and questions that struck me as I read them. One issue that will need to be addressed by any prescribing psychologist who enters into the primary care setting is overcoming prior expectations. Several of the papers indicated they were recruited for the setting specifically to fill the role of prescriber for mental disorders. McGuinness (2012) does the best job of describing his struggles to overcome the limitations on his role resulting from those expectations. To make the point more explicit, prescribing psychologists who enter the primary care arena, where the perceived need for psychotropic medications is substantial, will have several preconceptions to overcome:

1. *Prescribing psychologists can only treat mental disorders*. Truly integrated psychologists are behavioral health, not mental health, professionals. As McGuinness points out, psychologists can (and should) play a role in the treatment of any patient who can benefit from psychosocial and behavioral interventions, whether the etiology of the diagnosis is primarily psychosocial or biological.
2. *Prescribing psychologists represent co-located specialty care*. It is often the expectation of primary care staff members that the professional who prescribes for mental disorders stands apart from the rest of the team, and is only available for pre-scheduled appointments. As several of the accounts demonstrate, psychologists sometimes naturally evolve into integrated members of the care team. That means availability for curbside consults ("I have this patient in my office and I have no idea what's going on. Any ideas?"), warm handoffs ("Mr. Johnson, meet Dr. Smith. She's going to talk to you some more about the anxiety we've been discussing."), and emergency triage ("Dr. Smith, this patient just walked in the door crying her eyes out. Can you see her?").
3. *Prescribing psychologists are there to prescribe*. One of the important distinguishing features of the prescribing psychologist is that exclusive reliance on medications would represent a violation of our ethical standards as psychologists; this statement is true for no other mental health prescribing profession. Since medication, psychotherapy, and full psychosocial assessment are all basic competencies of the prescribing psychologist, the ethical obligation to provide the best service possible within the competence of the psychologist means a combination of those skills must be employed as they fit the needs of the patient. There

is growing evidence that various disorders are better treated with basic education or psychotherapy than with medication (e.g., Mack & Rybarczyk, 2011; Muse, 2010). The ethical prescribing psychologist applies that combination of skills believed to be most likely to result in an optimal outcome for the patient.

Another theme that I take from these accounts is the importance of preparation for the primary care setting. Hoover and Andazola's (2012; see their Table 1) comparison of the psychologist and the family physician does a particularly nice job of highlighting the issue. Becoming a primary care psychologist requires much more than being a psychologist who works in a primary care setting. There are dramatic differences between the culture of psychology, which has kept itself to some extent removed from the rest of health care, and the culture of primary practice. I have often said even our tendency to refer to the individuals with whom we work as clients is indicative of our marginalization in the health care system. Gruber (2010), who was trained as both a psychologist and physician, did a nice job of elucidating the perils of arrogantly assuming as a psychologist that we can simply walk into the primary care setting and function as normal. He relayed one anecdote in which the simple failure to learn the jargon of primary care undermined the long-term prospects for psychologists in a medical practice. Of course, the entrance of psychologists into primary care as prescribers, a role seen as essential by primary care providers, will likely afford the psychologist more leeway for such errors during the integration process.

Beyond mastery of the cultural differences, psychologists must become adept at applying their psychosocial skills in the primary care setting if they are to be seen by staff as more than prescribers. Ideally, the psychologist in primary care is knowledgeable about psychosocial interventions specifically developed for treatment resistant patients, such as motivational interviewing and acceptance and commitment therapy (Robinson, Gould, & Strosahl, 2011; Rollnick, Miller, & Butler, 2007). The psychologist is comfortable tailoring the level and length of intervention to the needs and capacity of the patient (O'Donohue & Draper, 2011). The psychologist is able to conduct rapid evaluation and triage when necessary. These are very different skills than the ones we learn in graduate school, and simply flying blind until they are mastered does not represent an optimal strategy for surviving in primary care. Ironically, it calls for specialized training in generalist practice, but that is what happens when a member of a specialty profession wants to join general medical care.

There were other lesser themes that I thought merited comment. References to electronic health records in several articles attest to the value of the collaborative care team. This is in fact the perfect setting for justifying the use of the prescribing psychologist, as any misguided concerns about the safety of psychologists as prescribers are irrelevant in a setting in which the psychologist is regularly sharing information with other medical professionals. I was also pleased by the frequency of references to reducing the use of medications. No justification for awarding psychologists prescriptive authority is stronger than the potential to reduce polypharmacy and overmedication for mental disorders. Finally, though billing issues were raised in only one of the articles, I think this represents the most serious impediment to psychologists' involvement in primary care. To some extent these problems may ease if the ACO model succeeds and health providers become primarily responsible for decision-making about the allocation of financial resources, but for the near future this will remain a thorny issue for psychologists involved in primary care.

Since this is the first in depth discussion of the value of psychology as prescribers in integrated primary care, I found myself left with many questions. How difficult is it to manage scheduling when the psychologist is providing both integrated and co-located prescribing services? How much time is left for specialty psychotherapy care? To what extent are psychologists getting referrals for behavioral treatment of health complaints rather than mental disorders? In what percent of pre-existing cases do psychologists end up reducing the use of medication? Are primary care patients resistant to treatment that is more psychosocial than allopathic? To what extent are the primary care settings in which psychologists prescribe integrated (so the psychologist participates as a member of the primary care team) or co-located (so the psychologist provides traditional mental health services in the same location as the primary care team)? Final answers to such questions probably will have to wait until we approach a steady state as primary care providers.

Psychology has been reeling, but these articles in this special section of the *Journal of Clinical Psychology in Medical Settings* point to an important path for psychologists to redefine our profession in a way that both enhances our prospects, and that can potentially contribute to the quality of life for millions of individuals who currently have little or no access to psychosocial alternatives to traditional medicine. At a time when many see no way forward, the articles in this special section provide a road map for our future.

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