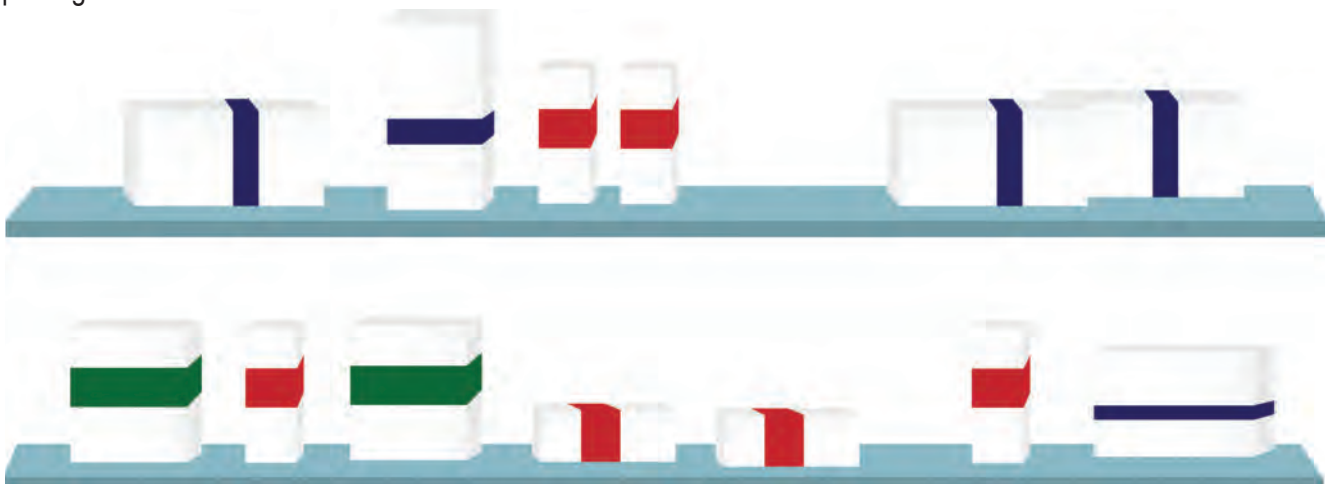
The Provision of Prescription Privileges for Psychotherapists: An Ethical and Legal Dilemma

By Francis McGivern

Abstract

With the advent of greater influence from 'pharmaland' in the domain of psychotherapy, so too has the debate loomed over granting mental health practitioners the right to prescribe psychoactive medication (Lavoie and Barone 2006). With the pharmacological industry occupying an increasingly larger stakehold in the mental health field, particularly over the past two decades or so, it is incumbent upon us as ethical psychotherapy practitioners to explore what direction we wish our profession to take, moving forward in the context of how and by whom prescribing of psychotropic medication is done. Ethical and legal arguments for and against gaining prescription privileges are discussed.



Introduction

The so called 'RxP' movement is one that perhaps few psychotherapists in Ireland are familiar with as it has predominated in North America and in the UK. Furthermore, amongst the mental health profession (beyond the domain of psychiatry), this issue has, to date, permeated only as far as the profession of psychology, with the first fully-trained prescribing mental health practitioners being US Department of Defence psychologists, graduating in 1994. Legislation since then was passed in a number of States to grant limited prescription privileges whilst the legalisation of prescriptive authority still eludes other States to this day (Lavoie and Barone 2006).

The author makes an urgent call, however, to psychotherapy organisations who represent the profession in Ireland and, indeed, to psychotherapists themselves to reflect upon the future positioning of the profession in light of the rapidly burgeoning pharmacological industry. With both psychotherapists and psychotherapy service users having greater exposure to psychotropic medication on an increasingly regular basis, we need to explore the ethical and legal ramifications surrounding who *does* and *does not* possess prescriptive authority in order that clients receive optimum care at all stages. Below, a framework is proposed for conceptualising ethical conduct within psychotherapy and one that could prove useful in managing the dilemma of whether or not to extend prescriptive authority to encompass our own profession.

Ethical/Moral Responsibility

Whilst there is no real clear distinction between the terms *ethics* and *morals*, it is argued that *"the main difference in common usage would be perhaps that morals are usually seen as the system adopted by an individual whereas ethics is the science of morality or of duty"* (Palmer-Barnes and Murdin 2001:1-2). Rowson (2001) offers two very different positions regarding the nature of ethics. The first, the *teleological* position (from the Greek word *telos* meaning 'end') relates to ultimately achieving the optimum benefit or the best consequence for all concerned. Unlike the teleological view, the *deontological* position (from the Greek word *deon* meaning 'duty') concerns itself more with the virtue of actions one takes rather than the end result, positing that certain actions are intrinsically good whilst others are intrinsically bad.

The author champions a third view, the *ethical pluralist* position which holds to both and reflects the complex nature of resolving ethical dilemmas, none more complex than the issue of providing prescriptive authority to psychotherapists. By adopting an ethical pluralist approach, we, as practitioners, can strive to achieve *"optimum standards of conduct"* (Corey 2001:45) known as *aspirational ethics* rather than merely operate standards within minimal parameters. Thus, whilst the issue of prescriptive privileges for the psychotherapy profession in Ireland appears currently to be a non-entity, it is vital that the profession be proactive and find its voice on this issue sooner rather than later, rather than find themselves reacting to a rapidly changing landscape within mental health service delivery, that sees them become less attractive an option for service provision. In fact, Robiner *et al.* (2002) suggest that the mental health landscape has been transforming subtly for at least the past ten years.

"Advances in neuroscience, the development of safer, efficacious drugs such as SSRIs, and changing realities in health care economics are transforming the delivery of mental health services." Robiner *et al.* (2002:231)

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Arguments in Favour of Granting Prescription Privileges

Devotees of the 'RxP' movement champion the view that granting of privileges to prescribe would have an almost immediate positive impact on mental health care services. This would be primarily due to their belief that the service as it stands is faltering due to increasingly limited access to psychiatrists and poor GP prescribing practices. A review of the literature, which is almost all

based within North America, would suggest that the US mental health system is underperforming with respect to lengthy and unacceptable waiting times to see psychiatrists (Lavoie and Barone 2006). Whilst General Practitioners are more immediately available to their patients, it is claimed that an alarming proportion of those seen by GPs are diagnosed inappropriately, and are subsequently either given a prescription unnecessarily or prescribed inappropriate medication (DeLeon and Wiggins 1996).

Research conducted over twenty years ago revealed that in women alone, depression was not only being misdiagnosed on thirty to fifty percent of occasions, but also their prescribed medication was later poorly monitored (McGrath *et al.* 1990). As the number of both diagnosable disorders and psychoactive medications have increased over the last two decades it is feasible to imagine that not much has improved and that this situation applies as much to Ireland and, indeed, the rest of Europe as it does to the US. Proponents of gaining prescriptive authority for psychotherapists might argue that appropriately trained, our profession would be in a better position to develop a longer-term relationship with clients and thereby, diagnose, prescribe, and monitor more efficaciously than GPs.

Those in favour of granting prescriptive privileges are responding also to the gradual shift that health services are taking towards brief interventions within managed care. Since cognitive behavioural and brief solution-focused therapies are being advocated within the public sector above more expensive longer-term approaches, mental health practitioners posit that the ability to prescribe would act as a coherent adjunct to these brief approaches (Freimuth 1996). If one also considers the currently challenging economic environment, it would prove more cost-effective for individuals to consult with a single care provider who can provide a more comprehensive psychotherapeutic *and* medical intervention rather than moving between professionals who may possess fundamentally different conceptualisations of mental health. Continuity of care is a contentious issue for many service users who are discontent at having follow-up appointments with *locum* GPs and psychiatrists who have very limited insight into their lived experience. Psychotherapists can offer a continuity of care which other service providers struggle to achieve.

Finally, reflecting upon the fact that there is a "*powerful seductiveness about medications*", DeNelsky (1996: 207) concedes that gaining prescriptive privileges could mean shorter and less frequent sessions of psychotherapy, thereby being more cost-effective for the client but ironically more financially rewarding for psychotherapists. With the ever-growing demand by consumers of mental health care for more immediate symptom relief, psychotherapists with prescriptive privileges would be more available to meet this need.

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Arguments Against Granting Prescription Privileges

As much as there are numerous advocates that champion the granting of authority to prescribe psychoactive medication, there are as many, if not more, detractors. This is particularly evident amongst talking therapists themselves who have demonstrated a lack of consensus on this topic. This forms the basis of one of the most obvious arguments which is that pursuing prescription privileges would serve to alter the collaborative approach between therapist and client toward a more traditional medical-model (Gitlin 1990).

With the ever increasing influence from the pharmaceutical industry it is likely that psychotherapists would end up placing emphasis upon medical intervention as much as, if not more than, psychological intervention. Current literature is increasingly claiming that viewing mental illness as a disease requiring large-scale usage of psychoactive drugs is an illusion. Keith (2003) describes psychiatric diagnosis and prescription as the "*quantification illusion*" as it reduces the human being and all his complexities into a singularly measurable disorder of genes or chemistry. Were psychotherapists to be granted prescription rights it would serve to create another doctor-patient type dynamic in which 'the professional' is seen to provide a solution and the 'patient' experiences a

relief from ambiguity. Ultimately this would see psychotherapeutic skills being slowly eroded over time. This would go against the very ethos underpinning psychotherapy which supports agency remaining with the client, self empowerment, and working through difficult thoughts and feelings.

Many of those disfavouring psychotherapists gaining privileges to prescribe believe that they are in effect, campaigning to safeguard against the very essence of psychotherapy itself from being eradicated. They conceptualise psychotherapy as an unquantifiable art form and, therefore, assert that introducing the power to prescribe would compromise many of the core conditions attributable to psychotherapy, conditions which the profession hold dear.

Advocates of the psychotherapy profession gaining prescriptive authority posit that with increasingly greater collaboration amongst health care professions, particularly within primary care settings, having prescriptive authority would open up a common language amongst these professions ultimately benefiting all service users. However, despite the *apparent* evolution toward a multidisciplinary approach, in practice it still appears that only one route proliferates within this health care system, the biological approach. Regardless of our professional training, it would seem that we have all been conditioned to perceive the 'biological' as the definitive source of all our 'dis-eases' whether physiological or psychological. This creates a position in which multidisciplinary treatment looks 'as if' collaboration is taking place but in reality is being dominated by a single intervention which favours a biological basis for all ills (Prosky 2003). Sharfstein (2006) poignantly conceptualises this argument as the bio-psychosocial model having given way to the *bio-bio-bio* model. Thus, were we to gain prescriptive privileges would we be seduced by the ever encroaching pharmaceutical empire; host regular meetings with medical representatives touting psychotropics; and ultimately be enveloped by the dominant biological discourse?

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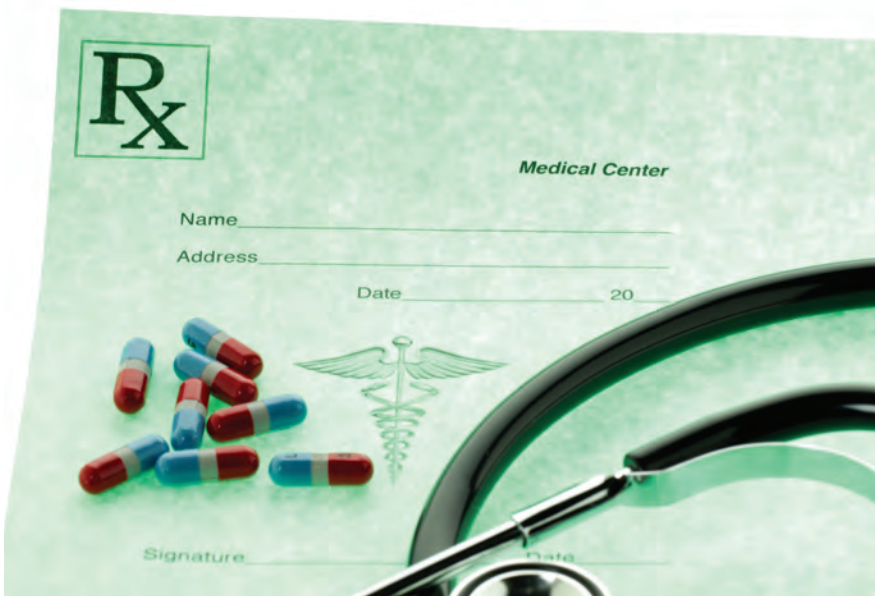

So how might psychotherapy with prescriptive authority manifest negatively within a therapy session? Freimuth (1996) describes the complexities surrounding the decision to recommend medication and suggests a number of scenarios in which a 'medical psychotherapist' might find themselves ethically compromised. A therapist who struggles to sit with intense feelings may be quicker to medicate a client experiencing prolonged grief or one who experiences anger outbursts and acts out this anger during psychotherapy sessions. If a psychotherapist was to assess progress for a client to be slow or lacking s/he, due to feelings of professional inadequacy, may be more easily drawn to medicating the client. On the other hand, a medical psychotherapist might be *less* prone to medicating during periods when, in fact, medication might be warranted, for example, chronic insomnia or anxiety, due to the therapist's unwillingness to acknowledge the limitations of psychotherapy or due to

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the therapist's strong desire to appear conservative in their prescribing practices. Finally, a psychotherapist might prescribe a course of psychoactive medication in response to either an unconscious or, indeed, conscious desire for the client to terminate counselling.

Of note when considering the ethical implications of gaining prescriptive authority is the responsibility related to becoming an independent prescriber. An important issue in this context, therefore, would be the legal and medical liability attached to prescribing for medically complex clients. For example, a client who takes daily medication for a heart condition; a client with Hepatitis C who is on antiviral medication; a teenage client who takes medication for acne; a client who has diabetes and/or high blood pressure and, indeed, the client who is on daily medication which was not mentioned at assessment. Should these clients experience any adverse reactions as a result of contra-indications not being heeded by the prescribing therapist, s/he could ultimately be held liable. Thus, the ethical argument against therapists gaining privileges is that they would eventually be investing disproportionate amounts of time studying medicine rather than psychotherapy in order to minimise such occurrences.

Conclusion

The ethical and legal debate surrounding the provision of prescriptive privileges to the psychotherapy profession is an intriguing yet difficult one to manage. Since it has multiple layers encompassing social, political, economic, and legal aspects, it is a debate that will require an *ethically pluralist* position in order to account for the complexities inherent in it. If we as a profession can remain client-centred as we have historically managed to do so, then ethical principles such as beneficence, non-malfeasance, autonomy, and competence will be maintained. However, it may prove inevitable that our profession falls victim to the allure of the ever encroaching body of research that suggests biological predispositions for mood and anxiety disorders (Hammond 2005) culminating in our conceding to clients that their locus of control lies externally to them in the form of a psychoactive drug. We must also temper this with acknowledgement of our client's agency in deciding whether to comply with a prescription. Clinical experience would suggest that clients can often feel ambivalent about medication and compliance can tend to be more *miss* than hit. In a field that has invested much effort in demonstrating validity in psychotherapeutic intervention, the author suggests that we continue to safeguard our 'heritage' but champion the introduction of limited

prescriptive authority for psychotherapists that would require collaboration between therapist, GP and client. This would enable a healthy collaborative decision regarding the requirement of medication *initially* to occur between psychotherapist and client, then devolving responsibility for signing off, monitoring, and liaising on medical aspects to GPs.

This article was originally published by the same author in IAHIP's *Inside Out* journal.

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