CLINICAL
PSYCHOPHARMACOLOGY:

Training to prescribe is for some, but not for all

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OVER THE LAST COUPLE OF YEARS, I COMPLETED A POST-DOCTORAL Master’s degree in Clinical Psychopharmacology. New Mexico (NM) is one of a few places where specially trained doctoral-level psychologists can prescribe psychotropic medication. I am the first non-United States-based psychologist to complete the New Mexico State University program (www.siaprxp.com). The NMSU program includes both theoretical and clinical training. I was trained to conduct a thorough assessment including psychological, physical and laboratory tests, develop a non-pharmacological and pharmacological appropriate treatment plan and both prescribe and monitor psychopharmacological medications with the use of evidence-based principles. In this article, I describe the program I completed, my experiences while attending the
program, and the impact this advanced training has had on my practice. Lastly, I share results of a survey I conducted of patients for whom I provided treatment in primary care supervised by family physicians.

One motivator to advance my training was a 24-year-old woman who lived with her parents and worked in an unskilled labour-type position. She was initially referred to me because she had been sexually assaulted by a co-worker. Her symptoms were consistent with Acute Stress Disorder. The assault compromised her IQ and a gross estimate of her pre-assault IQ was 90. After several appointments, she made improvements with anxiety symptoms, however, her catatonic depressive and Posttraumatic Stress Disorder symptoms were still very problematic. Psychotherapy alone was insufficient and she required pharmacological treatment. She did not have a family physician and she lacked the personal agency to phone the names I provided to her at her request. With her present in the office, I made contact with several family physician offices, and each one was unable to take her. As a professor in family medicine, I have access to some physicians who may not have otherwise taken her on. This ‘please family physician, can you do a favour for me and see one of my clients’ approach to primary mental health care is unsustainable. If I had been trained and licensed to prescribe the needed medication, I would have been able to provide the more complete care she needed rather than requesting a favour of a colleague. Her distrust of others made attending her physician appointments difficult.

TRAINING PROGRAM IN CLINICAL PSYCHOPHARMACOLOGY

The program in NM was easier to manage than I had expected. The program has 3 components: one weekend a month of classes over 2 years, a rotation in physical examination in a primary care setting, and a clinical practicum of 400 hours in a primary care setting. The course work was divided between real-time online lectures and in-person clinical courses. Although burdensome, the in-person clinical courses were invaluable and included a review of systems involving physical and laboratory examination training. I completed the physical exam rotation at a primary care clinic in NM where family practice medical residents, pre-doctoral psychology interns, and psychologists in the clinical psychopharmacology program are all trained. The clinic faculty include both prescribing psychologists and family physicians. A full complement of nurses is also on staff. The mutual respect between medicine and psychology was refreshing. The most jarring experience while completing this rotation was having to wear a lab coat (all doctors were expected to wear lab coats) and have the patients look with unnerving expectancy at me and say, “Doctor, please tell me what to do.”

The most challenging part of the training was arranging the practicum (100 patients over 400 hours), which I had to complete locally due to its’ length. After several months of conversation, planning, contract and document signing, the day before my practicum was to start at a local community clinic, the medical director (a family physician) phoned me and said, “We have to put a hold on your practicum.” Two weeks of no information passed before he invited me to a meeting with the family physicians, a nurse and a psychiatrist. If I read the meeting correctly, the family physicians were supportive of having me at their clinic. However, the psychiatrist’s words burned in my ear. He said, “I am a fellow of the American Psychiatric Association. The American Psychiatric Association opposes psychologists prescribing medication. Therefore I oppose this practicum. This is a turf issue.” The decision
to proceed or not was the medical director’s to make and the psychiatrist’s words sealed the opportunity for my training at that clinic.

Very thankfully, the can-you-do-a-favour-for-me approach came in handy again and several family physician colleagues supervised me at their own clinics. I was able to complete my practicum at 3 different primary care clinics in the Vancouver area. Although I wrote the prescriptions, I could not sign them. The supervising physician signed. Since completing this degree, the most significant change to my practice is my increased confidence in speaking about medical-related issues. I am able to speak with confidence about physical symptoms, lab tests, dosing and monitoring medications. There have been several clients in my own practice who reported that their physician expressed uncertainty about psychotropic medications and I was able to help. If I were licensed to prescribe psychotropic medication, I would be able to work more directly with the family physician.

The referral reason is seen in Table 1. Depression and anxiety were the most common reasons for referral. Although sleep disturbance was not a primary referral reason, every patient I saw in the 3 clinics complained of sleep struggles.

In Table 2, responses to efficacy questions are illustrated for the ratings ranging between very unhelpful, unhelpful, a little unhelpful, a little helpful, helpful and very helpful. These results reflect the patients who scored ‘helpful’ or ‘very helpful’ on the questions. I was surprised to see 97.5% said they found it helpful (30%) or very helpful (67.5%) that they were able to see a psychologist. Of the patients who responded, 92.5% said they found it helpful (17.5%) or very helpful (75%) that I could prescribe certain medications. The other two results that struck me were that 90% said they found it helpful (15%) or very helpful (75%) that I had a close relationship with their physician, and 90% said they found it helpful (5%) or very helpful (85%) that no fees were charged.

Seeing the result of the survey question about my relationship with the patient’s physician, I would
like to say I work to have a close relationship with my clients’ family physicians. At this point, I have not worked to improve the relationship with every client’s physician. I expect if I were able to prescribe, I would consult with the physicians much more.

Despite the compelling survey results and positive client feedback, the most common reaction I get regarding my training is the question wondering if I want to be a ‘baby psychiatrist’. Answering a question that engenders a defensive response is difficult. I confess that I enjoy being a psychologist and I do not want to be a full-scope physician. I am happy to be trained in a broad range of psychotherapeutic and research techniques that the APA/CPA accredited scientist-practitioner program I completed provided. This post-doctoral degree filled a gap in my scope of practice that is now more complete. If I were given the authority to prescribe psychotropics, it would be much easier to work closely with the family physicians.

While I sought out and appreciate the psychopharmacology degree and wish I was licensed to use it in BC, I recognise this is not true for all psychologists. The degree helped me be more competent with the medically-related issues I see in my office. Anecdotally, the clients who benefit from this training express their appreciation. Several of them express that they would enjoy my being able to prescribe them their psychotropics. I recognise not all psychologists want or feel the need for this. Like any empirical intervention, there are some who use it and some who choose a different empirical intervention. Overall, I believe my training and experience assists me to provide a more comprehensive range of services for my clients and has enhanced my collaboration with medical colleagues.