

Preface

Many years ago, when symptoms of most psychological disorders were just beginning to be identified, the prevailing belief was that these symptoms were the result of deeply embedded psychogenic conflicts that required psychoanalysis to work through. Over the past five decades, however, a plethora of research revealed that many individuals with these disorders exhibit structural and functional differences in their brains. Since brain changes are likely to be reflected in feelings and behaviors, psychopharmacological approaches were developed to try to address some of the biological factors that may be responsible, at least in part, for the symptoms. Indeed, many of these have proven effective in reducing (and, sometimes, eliminating) the symptoms of some psychological disorders, and intervening pharmacologically may be beneficial (and in some cases is indispensable) since without medications some symptoms (for example, psychosis) are not likely to resolve.

When treating disorders with known biological etiology, many nonmedical mental health professionals seek to minimize pharmacological approaches and initially try psychosocial treatment. This is a reasonable approach, especially with children. However, many factors may contribute to the decision to utilize pharmacological approaches, in conjunction with or instead of psychotherapy.

The Use of Medications to Treat Mental Health Disorders

Severity of the symptoms often influences the decision of whether or not treatment with medications is needed. For example, milder forms of depression, impulsivity, anxiety, or agitation may respond well to psychotherapy. However, severe variants of these symptoms may be difficult to treat with talk therapies, and intense symptoms are likely to require psychopharmacological treatment. For example, it may be very difficult to communicate with a severely depressed or agitated patient, and a severely anxious patient may have difficulties coming in for psychotherapy. Thus, most clinicians find that symptoms that are very impairing usually require an approach that includes pharmacological treatment.

When psychotherapy is effective, progression of improvement is gradual and requires several sessions to become evident. Even those variants that are called

“brief therapy” generally require 8–15 sessions before significant improvement is expected. When the patient is very uncomfortable, and when the symptoms debilitate the patient and significantly interfere with normal functioning, waiting this long for improvement may not be prudent. Conversely, many pharmacological treatments produce at least some improvement within days of the onset of treatment, although a few weeks (in some cases, 4–6) may be needed for more comprehensive response. Still, this is usually faster than psychotherapy, and the amount of improvement seen with medications may be greater than the improvement seen with psychotherapy over the same period of time.

In order for psychotherapy to be effective, patients need to attend sessions regularly. If rapid progress is needed, sessions need to be scheduled at least weekly. However, driving to the therapist’s office once per week, and spending an hour in the office, may be difficult for some patients (or families) with significant time obligations. When the patient is a child or adolescent, psychotherapy must be done outside of school hours, since missing school 1 day/week to attend psychotherapy is neither practical for the family nor beneficial to the student.

The cost of weekly psychotherapy is also likely to constitute a significant expense for many families, and few are able to cover such costs out of pocket. In the United States, most children and adolescents who have healthcare coverage are covered by private plans, usually purchased through the parent’s employer. The quality of this coverage varies widely. Unfortunately, mental health care is often considered to be the “step-child” of the healthcare industry, and levels of coverage for mental health treatment are often much lower than they are for medical care. Although laws on the federal and state levels have been passed to close that gap, many exclusions exist and the disparity between medical and mental health coverage continues.

Limiting the patient’s access to care is one common method of containing healthcare costs. Many individuals with managed healthcare coverage have benefits that primarily are evident “on paper” and virtually disappear when the insured seeks treatment. Gatekeepers are assigned who review the need for care, and these reviews delay sessions and interrupt the continuity of care. Usually, four to six sessions may initially be authorized, and additional reviews are needed for each subsequent block. It is up to the discretion of the gatekeeper to authorize further treatment, and when the gatekeeper feels that sufficient progress was attained, or that sufficient progress is not evident, further authorization may not be issued. Although every insurer has appeals procedures that may be utilized, these appeals are internal to the insurer, and usually no external review exists that may be invoked if the insurer continues to refuse to authorize care. To make matters worse, appeals often take months, and meanwhile, the patient is getting no care.

In addition, millions of children and adolescents in the US have no healthcare coverage. While federal and state authorities are striving to close this gap, there continues to be a significant portion of our society that cannot afford mental health care and has no insurance coverage. Various agencies exist that may service these individuals, including networks of community mental health centers (CMHCs) that provide care to those who need it, sometimes without (or with minimal) cost.

However, in many states, CMHCs are overextended and long wait times are necessary (in some cases, up to 8 weeks) before the agency is able to provide care. Meanwhile, patients are suffering and are receiving no treatment. In addition, in rural states, the nearest CMHC may be quite a distance away.

For all of the reasons reviewed above, patients and/or their families may need to utilize psychopharmacological treatment either instead of, or in addition to, psychosocial interventions.

Availability of Medical Mental Health Professionals

When the decision is made that a patient needs to be treated with medications, patients must have access to necessary medical care to obtain the prescription. Traditionally, psychiatrists have been considered as the providers of choice to dispense prescriptions for psychotropic medications. However, this is changing rapidly, especially in the US, where 96% of counties do not have enough psychiatrists (or related mental health prescribers) to meet the needs in the community (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). This shortage of psychiatrists is worsening, since the number of physicians pursuing a residency in psychiatry continues to decline (Rao, 2003). This is especially evident in the treatment of children and adolescents. According to the US Bureau of Health Professions National Center for Health Work Force Information and Analysis, at least 12,500 pediatric psychiatrists are currently needed to match the level of service provided in 1995, but only 8,300 are available (Kim, 2003). Others have suggested that the shortage may be even greater (Brauer, 2010).

In addition, most mental health problems initially come to the attention of the general physician which, for children and adolescents, is the pediatrician. Pediatricians encounter a wide variety of medical problems and must make a decision about which will be treated “in-house” and which will be referred to specialists. At one time, patients needing psychiatric mental health care were immediately referred to psychiatrists. However, this is changing and pediatricians now often find it necessary to treat many mental health disorders in their offices.

Pediatricians as Providers of Mental Health Care

Many factors influence the pediatrician’s decision to eschew a referral to a psychiatrist and treat a mental health problem within the pediatrician’s office. For one, managed healthcare plans severely curtail the primary physician’s referrals to specialists, thus forcing a shift of mental health care onto primary care physicians. Since family doctors must weigh whether to use up a precious referral to address psychological symptoms (like ADHD or depression) or a potentially life-threatening medical disorder (like a heart problem), most physicians opt to address many psychological problems in-house.

This trend is especially evident among pediatricians (Koppelman, 2004), who face additional pressures because of the shortage of pediatric psychiatrists. Thus, referring patients to pediatric psychiatrists does not necessarily lead to the delivery of needed mental health services because psychiatrists often refuse new patients and require several months' wait time for the initial appointment. Not surprisingly, it is evident that most psychotropic medications are now prescribed to children by their pediatricians (Olfson, Marcus, Weissman, & Jensen, 2002).

Although highly knowledgeable about medicine and medications in general, most physicians complete only 6 weeks of exposure to psychiatry during medical training (Serby, Schmeidler, & Smith, 2002) and receive no further required training in psychiatry during pediatric residency (Kersten, Randis, & Giardino, 2003). Thus, pediatricians are caught in a double bind – they are compelled to treat mental health disorders “in house,” but they lack the training (and the time) to deliver this treatment competently and comfortably.

Psychology and Psychopharmacology

Psychology has recognized this shortage of mental health prescribers for some three decades, when a task force report to the American Psychological Association (APA) Board of Professional Affairs proposed that psychologists should become more involved in the provision of physical and biological interventions for mental disorders (APA Board of Professional Affairs, 1981). By 1989, the APA Board of Professional Affairs endorsed advanced training in psychopharmacology for psychologists.

As psychologists began to show more interest in being involved in psychopharmacological treatment, it became important to determine what role was appropriate for pharmacologically trained psychologists to take. Eventually, APA came to recognize three levels of psychopharmacology training for psychologists.

Level 1 refers to the amount of training that all psychologists involved in health care should receive. Because psychotropic medications are increasingly prescribed to patients seen by all psychologists, all psychologists should have at least a rudimentary understanding of psychotropic medications and their desired and adverse effects.

Level 2 denotes a level of training that prepares psychologists for active collaboration with primary care physicians (for example, pediatricians) about treatment with medications. This level of training allows psychologists to gain enough knowledge about psychotropic medications to participate in the decision making (for example, selection of medications and monitoring of response and side effects). Psychologists who complete this level of training are prepared to consult with pediatricians about the use of medications to treat their patients.

Level 3 describes training that prepares psychologists for the independent authority to prescribe psychotropic medications, and efforts have continued to pass legislation allowing psychologists with Level 3 training to prescribe. In 1999, the US Territory of Guam approved prescriptive authority to appropriately trained psychologists (Guam Public Law 24-329), and in 2002, the state of New Mexico enacted prescriptive authority for psychologists (New Mexico Administrative Code

16.22.20-16.22.29), followed in 2004 by Louisiana (Louisiana Revised Statutes 37:1360.51-1360.72). The fight for prescriptive authority continues in many other states, although opposition from psychiatry is fierce and thus far many other legislative efforts have been defeated.

Despite legislative struggles, to date some 1,500 psychologists have completed postdoctoral training in psychopharmacology (Ax, Fagan, & Resnick, 2009), and it is expected that many of them have significant expertise in working with children and adolescents. Thus, even in states where psychologists do not prescribe, pharmacologically trained psychologists are available to consult with pediatricians and can play an important role in addressing the shortage of appropriate medication management for pediatric patients.

Pediatrician/Psychologist Collaboration

Because of their busy schedules, pediatricians spend a limited amount of time with each patient and cannot perform in-depth reviews of personal, family, developmental, health, and social history necessary for proper diagnosis of most psychological disorders. Conversely, psychologists are specifically trained in the diagnosis and treatment of mental disorders and traditionally see patients for 1-h appointments, usually weekly or biweekly. Thus, pediatricians can benefit from collaborative relationships with clinical child psychologists.

After accurate diagnosis, treatment options must be considered. Often, the question of whether or not to use medications must first be considered. Where psychological treatment is likely to be effective and the use of medications is not necessarily indicated, psychologists can make such a recommendation to the pediatrician and the patient's family. If the family is receptive to this recommendation, the psychologist then may be able to deliver this treatment. When this option is utilized, the psychologist needs to provide the pediatrician with periodic updates about the patient's progress.

When a decision is made to treat a patient with medications, pediatricians who have developed an active collaborative relationship with a pharmacologically trained psychologist may choose to write the prescriptions, especially when the disorder is one with which they have some familiarity and the level of severity does not appear unusually high. When medications are used, the patients' progress and side effects must be monitored. Many pediatricians, however, may not be conversant with dose-response profiles and side effects of psychotropics. In addition, pediatricians may not be able to see their patients frequently enough, and long enough during each visit, to accurately screen these issues. Psychologists with pharmacological training can perform medication monitoring and track the patient's progress and adverse effects. When medication changes are warranted, psychologists with R_xP training can have input into the nature of the adjustments. In providing this service, psychologists can offer relief to busy pediatricians who, instead of spending office visits troubleshooting psychotropic medications, will be able to devote these appointment times to the care of patients with medical problems. In this way,

efficiency of the use of the pediatricians' time is greatly improved. Consequently, clinical child psychologists with extensive, formal training in psychopharmacology can be an invaluable resource to pediatricians.

Definition of Terms

As psychology continues to expand its scope into the area of psychopharmacology, it is necessary to differentiate those psychologists who completed Level 2 or 3 training in psychopharmacology from other practicing psychologists. Two competing terms are now in use. In New Mexico, psychologists with authority to prescribe medications are referred to as "prescribing psychologists." In Louisiana, however, psychologists with authority to prescribe are referred to as "medical psychologists."

While some may dismiss these differences as a matter of semantics, both terms have their proponents and critics. The term "medical psychologist" has sometimes been used by health psychologists who treat medical (not mental health) disorders (for example, diabetes). Thus, some argue that the use of "medical psychologist" as described in Louisiana legislation is confusing because the terms have been used by nonpharmacologically trained health psychologists. Conversely, proponents of the term argue that it is more descriptive of the depth and breadth of medical training that must be completed in order to obtain prescriptive authority, and that prescribing a medication is a medical service.

While this dispute is far from over, both terms are used throughout this volume. It is important for the reader to remember that for the purposes of this book, the terms "pharmacologically trained," "medical," and "R_xP-trained" psychologist are used interchangeably and refer to the same level of training (at least Level 2).

It is also important for readers to remember that this book primarily focuses on collaborating with pediatricians. Since the vast majority of the US has not yet enacted prescriptive authority for psychologists, the book aims to help psychologists with Level 2 or Level 3 training develop collaborative relationships with pediatricians practicing in a state that does not allow psychologists to prescribe medications. Of course, the contents of this book are also applicable to states that have enacted prescriptive authority for psychologists (R_xP), and in those states, psychologists consulting with pediatricians will be able to take on a more autonomous role.

Organization of This Volume

This book is organized into four sections. Part I summarizes the basic principles and professional issues involved in collaborative relationships with pediatricians. Muse, Brown, and Cothran-Ross describe a model that helps readers conceptualize when patients are usually treated by pediatricians in-house or referred to outside

professionals. The algorithm developed by the authors can help both medical and psychological professionals make this important decision. In the next chapter, McGrath outlines the history of the R_xP movement and its applicability to the pediatric patient population. McGrath outlines important professional, ethical, and legal issues that should be reviewed by all who aspire to venture into this practice area.

Part II reviews the various practice settings where pediatricians and pharmacologically trained psychologists are likely to collaborate. Kozak and Kozak Miller discuss collaboration that takes place between pediatricians and R_xP -trained psychologists in states that have not enacted prescriptive authority for psychologists. Since this encompasses the vast majority of the US, the information provided in this chapter is likely to be highly relevant to most readers. To balance the contents, Nemeth, Franz, Kruger, and Schexnayder discuss collaboration in an R_xP state, primarily based on their experiences while practicing in Louisiana. Readers can compare these two chapters to contrast methods of collaboration in non- R_xP vs. an R_xP state.

Part II also includes chapters that review specific situations that affect collaborative relationships. Alford describes methods of collaboration in rural settings, outlining the unique challenges that these locations pose to professionals and patients alike. Tilus and colleagues describe emerging efforts to meet the mental health needs of the American Indian population, and how R_xP training allows psychologists to make a meaningful contribution within portions of the country that experience especially difficult conditions. Finally, Courtney describes his account of a practice within a medical children's hospital in a state that permits prescriptive authority for psychologists.

Part III reviews specific disorder categories that are excellent candidates for collaborative care. Kapalka reviews the treatment of disruptive and mood disorders, Evers discusses the treatment of anxiety disorders, and Sanzone reviews the treatment of eating disorders. Collectively, these constitute the vast majority of disorders for which children and adolescents receive psychological care, and many of these patients are treated with medications, usually prescribed by pediatricians. Psychologists working with children are likely to find much relevant information within these three chapters.

Part III also contains chapters that focus on collaborative treatment of medical disorders. Kotkin discusses the treatment of diabetes, a common medical disorder that often presents significant psychological complications. The section is rounded out by Clendaniel, Hymanand, and Courtney who discuss collaborative treatment of gastrointestinal disorders in children and adolescents. Collectively, Part III of this volume covers many disorders that psychologists are likely to encounter in their practice.

Part IV outlines the future directions of pharmacological consultations and collaboration with pediatricians. Alvarez discusses the use of brain markers to assist in diagnosis and treatment planning, an emerging area that offers exciting opportunities for greater precision in developing treatments to address individual needs of the patients. Chapters by Raggi and Olivier review important training aspects, pre- and postdoctoral, to make sure that psychologists who wish to expand into the area

of psychopharmacology attain a solid base of knowledge during their professional development. The volume concludes with a chapter by Lopez-Williams who discusses ways in which pharmacological training informs the practice of supervision of nonpharmacologically trained mental health professionals. This emerging area has not yet received much attention in the professional literature, and therefore, Lopez-Williams' chapter makes an important contribution in this area.

In addition, to a wide diversity of topics, this book also outlines a wide variety of styles utilized by R_xP-trained psychologists who regularly collaborate with pediatricians. Some chapters present a formal approach, based on scientific evidence and findings of relevant literature. Other chapters provide a more personal account, filled with practical information that one acquires through years of practice and extensive "on the ground" experience. It is hoped that the wide variety of topics and styles provides a good overview of the practice of collaboration with pediatricians, and that the chapters within this book are representative of the wide breadth of approaches and activities that such collaboration traditionally entails.

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