

From California Psychiatric Association

SUMMARY/KEY POINTS, June 2000 Report of the American College of Neuropsychopharmacology (ACNP)* on the Department of Defense Psychopharmacology Demonstration Project

Key Notes: There is **no evidence** that anyone, other than one who was authorized to prescribe Adderall, has had any authority to prescribe any Schedule 2 medications such as **Ritalin**, Adderall and Dexedrin, commonly used to treat ADHD, and no evidence any are authorized to prescribe Clozaril.

Most of the medications they prescribe are the newer antidepressants, and individual graduates have either very limited, or no, experience with the medications used to treat bipolar disorder (manic-depression) or psychosis. The ones who are allowed to prescribe those medications often also have a requirement that they must consult with a psychiatrist before doing so and/or were closely proctored on their treatment of the patients on these medications.

–**All have physician backup**, and for all but the one in Iceland, that physician is a psychiatrist.

–None of them have treated long-term seriously mentally ill patients (those folks are sent to VA).

–**Apparently there is no patient outcome data**, because the supervisor of one of the psychologists (see page 18) suggested that any future programs “ought to collect patient outcome data (distress scales, hospitalization rates, suicide incidents, improvement rates, etc.) That would enable systematic comparisons of prescribing psychologists with relevant contrast groups.”

KEY POINTS FROM EXECUTIVE SUMMARY

“There was essentially unanimous agreement that the graduates were weaker medically than psychiatrists. ...In a few quarters, the criterion for ‘medical safety’ was equated with the knowledge and experience acquired from completing medical school and residency, and, of course, no graduate of the PDP could meet such a test.” (Page 6, point 2)

“The Evaluation Panel heard **much skepticism from psychiatrists, [other] physicians, and some of the graduates about whether prescribing psychologists could safely and effectively work as independent practitioners in the civilian sector.** The usual argument was that the team practice that characterized military medicine was an essential ingredient in the success of the PDP that could not be duplicated in the civilian world.” (Point 4, page 7)

*“Each had an expert proctor who was available by phone, page, and e-mail,...they were doing excellent work by all accounts, the Evaluation Panel believed as a matter of principle that **they would benefit more from the experience of closer daily liaison with an expert practitioner.**”* (Point 5, page 7)

“Scope of practice and formulary: The practice of pharmacotherapy was restricted to adults age 18-65 for all graduates. ...One graduate who was completing a third of proctorship could not prescribe lithium or a number of new agents. Another prescribing psychologist [the only one stationed in California] was the most restricted of all graduates. He could treat only active duty patients even though dependents and retirees attended his clinic, and he could not prescribe lithium, depakote [both are used to treat bipolar disorder (manic-depression)] and some newer antipsychotics. The MAOIs [used to treat depression] were the most common exclusions, being included on only one graduate’s formulary.” (page 7)

Nature of patients: 3 treated 90 to 100% active duty military, 2 treated 60 to 80% dependents, 3 saw no retirees, one had 75% retirees and spouses. Most treated primarily or exclusively persons who had adjustment disorders [behavioral symptoms that develop in response to an identifiable stressor, typically including anxiety and depressed mood], anxiety disorders [panic disorder, phobias, obsessive-compulsive disorder, posttraumatic stress disorder], or depression. Most of the medications they used were the new antidepressants and anti-anxiety medications. (P 8)

Few of them had even limited experience with the medications used to treat bipolar disorder (manic-depression) or psychosis.

“Ward psychiatrists, civilian attendings, and the PDP Training Director (all psychiatrists) supervised the fellows. For medical and legal reasons, the fellows had to have medication orders, laboratory and radiology requests, restart orders, and admission and discharge summaries co-signed by the supervising psychiatrists.” (P. 13)

“The most common concern cited by most of the psychiatrist supervisors in one form or another was that the fellows knew too little medicine to prescribe psychotropic drugs safely. They worried about the lack of medical sophistication. These concerns applied more strongly to two graduates but were ascribed to a lesser extent to all fellows at the point of graduation. Nevertheless, most of the psychiatrist supervisors also said that the fellows knew very well when they were medically over their heads and when they needed consultation.”

INDIVIDUAL PRACTICE PROFILES ON EACH OF THE 10

Graduate AB (on east coast, page 17)

–64% of patients were medically-healthy active duty airmen, 23% dependents, 9% retirees, 4% retiree dependents.

–62% were depression or mood disorders, 19% anxiety disorders, 17% adjustment disorders.

--Mostly prescribed SSRIs [selective serotonin reuptake inhibitors such as Prozac, Paxil, Zoloft and Celexa].

He prescribed 2 antipsychotics in the past year, and he first discussed both with his supervising psychiatrist. He prescribed no MAOIs or stimulants.

Graduate AC: (page 19, in southeast U.S.)

- Treated 30% active duty, 35% dependents, and 35% retirees. There is no list of their diagnoses.
- There were no "persons with unstable medical conditions."
- he has "independent status", with its standard 10% of medication chart review each month.
- His formulary excluded MAOIs.

Graduate DC: (page 20, in the southeast)

- Treated 80% young, active duty airmen.
- Orders were physician countersigned
- The typical patient he or she saw was a homesick young airman who "spoke suicidal notions."
- The supervising psychiatrist countersigned admission and discharge orders and orders for medications not on his formulary.
- Disorders treated were 34% adjustment disorders, 27% major depression, and 12% bipolar disorder.
- 90% of his prescriptions were for Zoloft, Wellbutrin, Prozac, Deseryl, and Effexor (all are newer antidepressants).
- He was described as a "great team player."

Graduate CC: (p. 22, in the Southwest)

- treated only active duty
- typical cases were "young, physically healthy men who were acutely unhappy with the service or distressed by relationships."
- No more than 25% of patients got medications.
- almost all the patients were depression and anxiety disorders, only one schizoaffective disorder, and only one patient was prescribed an antipsychotic.

Graduate AD (p. 24) (in Columbus, Georgia)

- Scope of practice specifically limited to those "without unstable medical conditions."
- he had the broadest formulary and was the only graduate allowed to use MAOIs.
- He had a clear, detailed proctoring agreement.
- Treated 25% active duty, 23% retirees, and 52% dependents.
- Almost all medications he used were antidepressants and antianxiety medications. He gave 9 patients lithium and no antipsychotics.
- Diagnoses were: 49% depressive and mood disorders, 22% anxiety disorders , 12% schizophrenia and dementia [yet he prescribed no antipsychotics], 8% adjustment disorders, and 6% alcohol and substance abuse.
- All patients were medically screened by physicians. The supervising psychiatrist thought he was great but "doubted how much one could extrapolate to the civilian world."

Graduate BD: (page 26, in the southwest)

- In a family care center.

- Most patients were dependents who had been pre-screened for medical conditions, 20% were active duty military.
- Most diagnoses were affective, anxiety, or adjustment disorders.
- His scope excluded patients with “unstable medical conditions.” It also contained specific guidelines for supervision.
- all patients he placed on mood stabilizers [medications for manic-depression] or neuroleptics [antipsychotics] had to be proctored. His supervising psychiatrist and he discussed patients who might need mood stabilizers or antipsychotics and patients with medical problems before treatment was started.
- 30 to 40% of his patients were given medications.
- “Physicians were near-at-hand...to help prescribing psychologists compensate for any medical weaknesses.”
- No information on his formulary.

Graduate AA: (p. 29, at East coast, then Iceland)

- Had a formulary of specific drugs.
- 60% of patients active duty, 40% retirees and dependents.
- Most patients were referred by primary care docs
- Most prescriptions were SSRIs.
- Did not do physical exams, but could order laboratory tests.
- Still in proctored status.
- Was being transferred to Iceland to a post with 9 M.D.s.
- He treated medically-uncomplicated patients, mostly depression, anxiety, and adjustment disorders.

Graduate BA: (page 31, stationed at Portsmouth, VA, then Camp Pendleton)

-This is the only one in California

- Still on proctored status.
- could admit patients to inpatient unit, but not treat them.
- “He had limited privileges and a restricted formulary.”
- Formulary listed 36 specific drugs, excluding the newer antipsychotics.
- Could prescribe only for active duty personnel.
- could not initiate or discontinue lithium or depakote [used for manic-depression], only order refills. Ritalin was removed from his formulary.
- Most of the patients he saw were depression, anxiety, and adjustment disorders.
- Mostly used SSRI antidepressants and antianxiety agents.
- Only 13% of his patients received medications.
- 2 supervising psychiatrists reported on 2 incidents of what they considered “mistakenly managed patients” where the supervising psychiatrist had to intervene and transfer the patient to another provider.
- he treated a moderate number of patients with “a narrow range of relatively mild pathology. He rarely prescribed medication. When he did it was mostly SSRIs.”

Graduate BC : (P. 33, in Bremerton WA)

- Works with 3 psychiatrists and 2 psychologists
- Formulary is by drug class.
- Is under 10% chart review, ie., “independent privileges.”
- practices interactively with psychiatrists and psychologists
- Is privileged to do physical exams, but does not do them.
- Has hospital admitting privileges and on-call duty in the ER
- He estimates 25% of his practice involves pharmacotherapy
- Uses mostly SSRIs and buspirone ([BuSpar, an antianxiety medication]).
- Could start and stop medications with sailors, but had to consult before doing either with dependents. He was “also expected to discuss concomitant medical conditions with the supervisor.”
- Was supervised about 90 minutes weekly.
- “-He reported his concern about granting prescription privileges to clinical psychologists in the general community. He regarded them as generally naive about medical and biological matters, and he feared that without rigorous training there would be problems.”
- His supervising psychiatrist, who supported him and the program, thought that these psychologists can work well as collaborators and complements to psychiatrists in the military, but this would not work in the civilian world and would probably be dangerous. Other supervisors had similar views.

Graduate CD: (at Portsmouth, VA., going to medical school, page 34)

- Proctored by a psychiatrist, with review of 10% of his medication charts, and required to consult with her before initiating lithium or an antipsychotic
- Formulary is 40 specific medications, and specifically excludes carbamazepine [Tegretol, used to treat manic-depression], Clozaril [an antipsychotic] and MAOI antidepressants. Is authorized to prescribe Adderall [the only stimulant mentioned for any of the graduates, probably because he has more ADD patients than the others].
- 90% of patients are active duty, 80% of those are under 40, and 2/3 are male. The patients are young and have no, or only minor, medical problems.
- 2/3 of his prescriptions are for newer antidepressants, and 10-15% are for anxiolytics [the benzodiazepines used to treat anxiety, such as Xanax, Valium and Librium].
- Does not do physicals, take night call, and has almost no ER interaction.
- Has used Risperdal [a newer antipsychotic] once.
- Dr. Stewart viewed both of the psychologists she had supervised as having third-year medical student knowledge and 2d to 3d-year psychiatry resident knowledge of psychopharmacology.

*ACNP is an organization of clinicians, scientists, and educators, which includes both psychiatrists and psychologists. ACNP contracted with the federal government to evaluate the project.