Clinical Psychology: Science and Practice

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Online First Publication, December 2, 2024. https://dx.doi.org/10.1037/cps0000253

CITATION

Robiner, W. N., & Tompkins, T. L. (2024). The workforce of prescribing psychologists: Too small to matter? Worth the cost? *Clinical Psychology: Science and Practice*. Advance online publication. https://dx.doi.org/10.1037/cps0000253

AMERICAN PSYCHOLOGICAL ASSOCIATION
SOCIETY OF CLINICAL PSYCHOLOGY DIVISION 12

Clinical Psychology: Science and Practice

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ISSN: 0969-5893

https://doi.org/10.1037/cps0000253

The Workforce of Prescribing Psychologists: Too Small to Matter? Worth the Cost?

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The prescriptive authority for psychologists (RxP) movement has been controversial. As of March 2024, 226 psychologists had prescriptive authority through the six states' health regulatory boards that have enacted RxP. This limited uptake contrasts with other prescribing professions' growth that more meaningfully addresses a psychiatric workforce shortage and warrants reevaluation of the RxP movement. Debates surrounding RxP have typically focused on the quality of training and other professional concerns. This article focuses on the quantity of prescribing psychologists. The comparatively small size of the prescribing psychologist workforce reveals its limited potential impact within the healthcare system. The relative limitations of the prescribing psychologist workforce cede supplementation of the psychiatry workforce to other professions with larger workforces that prescribe based on more comprehensive education and training and clinical experience.

Public Health Significance Statement
The small workforce of prescribing psychologists relative to the collective workforce of all prescribers suggests their impact is minimal. This along with the expansion of other groups of prescribers and concerns about psychologists' training to prescribe bring into question whether the profession should reconsider its support of the prescriptive authority movement.

Keywords: psychologist, prescriptive authority, prescription privileges, workforce

The American Psychological Association (APA) began to explore advocating for psychologists to prescribe medications in the 1980s. Since then, the prescriptive authority for psychologists (RxP) movement has been a controversial and contentious issue within and beyond the profession. Much of the resistance has been tied to the abridged training model (Heiby, 2010; Robiner et al., 2003, 2013, 2020; Tumlin & Klepac, 2014) proposed, adopted, and revised by the APA (1996, 2019). The various iterations of the training model have not aligned with substantive recommendations of the APA's own ad hoc task force convened to explore the issue (Smyer et al., 1993). Notably, the ad hoc task force recommended that participation in postdoctoral training be limited to those who held a doctorate in psychology, were licensed health service providers, and possessed **prerequisite** (emphasis added) "knowledge of human biology, anatomy and physiology, biochemistry, neuroanatomy, and psychopharmacology" (APA, 1996, p. 2). Over the past nearly 30 years, these prerequisites have not been required by the APA and clinical psychopharmacology training programs. Neither designated clinical psychopharmacology programs nor legislative bills have included admissions requirements in line with other prescribing professions that do require prerequisite undergraduate coursework in the physical sciences (Robiner et al., 2013). The absence of prerequisites, along with condensed training and quality concerns (e.g., Ransom, 2014) related to training inherent in APA's training model, renders it less robust than the training of all prescribing professions (Robiner et al., 2003, 2013, 2020; Tumlin & Klepac, 2014). Although psychologists receive extensive training in diagnostic and clinical interviewing which is fundamental to their clinical competence in general, it is unclear how fully that equips them specifically to be managing medications in the context of patients' overall physical health and health care. Psychopharmacology training programs typically include significantly fewer interviewing and clinical assessment contact hours relative to physician and nonphysician prescribers (see Robiner et al. [2020] and McGrath [2020] for contrasting views about the adequacy of the training). Moreover, the APA reduced training requirements (Stuart & Heiby, 2007) relative to the Psychopharmacology Demonstration Project (PDP) of the Department of Defense (DoD; U.S. Genetal Accounting Office, 1999), which RxP proponents cite to justify psychologist prescribing. Such advocacy is despite criticisms that the DoD PDP program's graduates were comparatively

Kelly McClure served as action editor.
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The authors report no funding or conflicts of interest to disclose.
William N. Robiner served as lead for conceptualization, data curation, formal analysis, methodology, writing–original draft, and writing–review and editing. Tanya L. Tompkins contributed equally to conceptualization, data curation, formal analysis, methodology, writing–original draft, and writing–review and editing.
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weak and judged to be at the level of medical students rather than physicians (American College of Neuropsychopharmacology, 1998). Steven Kingsbury (1992), a psychologist who retrained to become a psychiatrist, commented on the training for managing medication which "has more to do with biochemistry and physiology than with psychology. I was surprised to discover how little about medication use has to do with psychological principles and how much of it is just medical" (p. 5).

Even RxP proponents (Fox et al., 2009) recognize that "among all the disciplines whose members include non-physician health care providers who prescribe, psychology has the core curriculum with probably the least overlap with traditional medicine" (p. 258). It is no wonder that surveys of psychologists have consistently revealed a lack of consensus, including nontrivial opposition to RxP among psychologists (e.g., Walters, 2001). Deacon's (2014) survey of the Association for Behavioral and Cognitive Therapies membership revealed that a majority (52.3%) opposed RxP and 89.2% believed that medical training for psychologists to prescribe should be equivalent to other nonphysician prescribers. Surveys of Illinois (Baird, 2007) and Oregon (Tompkins & Johnson, 2016) psychologists yielded similar consensus, 78.6% and 69.2%, respectively, about the importance of psychologists' training to prescribe needing to be comparable to other professions' training to prescribe.

In contrast, RxP proponents emphasize the role that prescribing psychologists could play in addressing unmet mental health needs, especially in underserved communities (McGrath, 2010). McGrath (2004) identified several factors that he predicted would guard against overreliance on psychotropic medications observed in other professions' prescribers. These included comprehensive training in psychosocial interventions and research, growing cultural skepticism regarding the effectiveness of psychotropic medications, and an academic community committed to continuously questioning the appropriate use of these medications (e.g., Hollon, 2024). Limited studies based on self-report data raise concerns about whether prescribing psychologists have stayed true to the "psychosocial souls" described by McGrath (2004, p. 644).

For example, a convenience sample survey of 43 prescribing psychologists revealed that nearly all prescribing psychologists (97.1%) rated combined treatment as the best option (Peck et al., 2021). This preference translated into prescribing patterns that seem to stray from their psychotherapeutic roots. Respondents reported that the majority of their patients received combination treatment, a larger proportion of patients received medication only rather than psychotherapy alone, and patients, on average, were prescribed nearly three medications. Whereas such prescribing patterns may represent evidence-based treatment for certain diagnostic categories (e.g., bipolar disorder, schizophrenia), these primary diagnoses represented a minority (19.1%) of the patient populations they treated. The extent of polypharmacy reported in the study was concerning given the dearth of evidence to support use and factors that contribute to decision making around prescribing, such as questionable assumptions about the efficacy of combined medication and limited awareness about metabolic and neurological adverse drug events (e.g., Zito et al., 2021). It also seems out of step with experts who question both the science and wisdom of an "entrenched overreliance on the biomedical model" (World Health Organization, 2021, p. 19). Studies (Levine et al., 2011; Linda & McGrath, 2017; Peck et al., 2021) in which most prescribing psychologists reported prescribing medication to the majority of their patients, both as monotherapy and in combination with psychotherapy, raise questions about McGrath's (2004) contention that prescribing psychologists would be more conservative about prescribing and about polypharmacy because of their prior training in psychological clinical science.

Since the inception of discussions of RxP, the APA ad hoc task force presciently anticipated that only "a small but important minority of psychologists may seek specialty training leading to licensure for psychotropic prescribing" (Smyer et al., 1993, p. 402). Despite acknowledging relatively limited enthusiasm for RxP (e.g., Plante et al., 1998), and expecting few psychologists to pursue the training and eventually prescribe (Fox et al., 2009), the APA and its affiliates, have invested millions of dollars lobbying for RxP at the state level. APA's tireless advocacy efforts and spending over the past 25 years has yielded hundreds of failed legislative bills seeking to enable psychologist prescribing. At the time this article was prepared seven states had passed legislation enabling psychologists to prescribe: New Mexico was the first in 2002.

Whereas the literature has focused on various issues, with some authors endorsing RxP (e.g., Bray et al., 2014; Curtis et al., 2023) and others opposing it (e.g., Tumlin & Klepac, 2017), this article focuses on workforce, which is central to determining the degree to which prescribing psychologists might potentially address unmet needs for psychoactive medications and access to health professionals who might prescribe them. Data from the Agency for Healthcare Research and Quality revealed that 252 million prescriptions were prescribed for mental health conditions in 2020, with the top 25 psychoactive medications accounting for $19,348,000,000 in revenue (PsychCentral, 2022). Such data about the large number of psychoactive prescriptions written in the United States and their costs raise questions about how problematic access to prescribers for these medications actually is.

In the following sections, we examine the extent to which psychologists have attained prescriptive authority through state health regulatory boards, the representation of prescribing psychologists within the workforce of prescribing health professionals, and the limited extent of prescribing psychologists' impact in increasing access to psychoactive medications.

The Workforce of Prescribing Psychologists

Table 1 presents state regulatory board data on the number of psychologists licensed to prescribe in New Mexico, Louisiana, Illinois, Iowa, Idaho, and Colorado as of March 2024. This information was obtained by the authors through correspondence with the boards and examination of their websites. Utah, which became the seventh to pass legislation as this article was being prepared in 2024, is excluded from our analyses. In total, state boards authorized 226 psychologists to prescribe in those six states that had enabled RxP, including psychologists with either full privileges or conditional prescribing privileges. This is about 125 more than had prescriptive authority a decade ago (Ransom, 2014), which would amount to an annual increase averaged over that interval of 12.5 additional psychologists per year. These numbers reflect a very modest adoption rate. Prescribing psychologists constitute only a small fraction (1.73%) of licensed psychologists in those six states. New Mexico, the first state to allow RxP, has 73 prescribing psychologists, comprising 8.17% of the state's licensed psychologists after 22 years since the legislation was signed. Louisiana, the second state to pass prescribing legislation, has 116 prescribing psychologists. Their prescribing is

Table 1
Psychologists and Psychologist Prescribers in States Where Psychologists May Obtain Prescriptive Authority

State[a]	No. of psychologist licensees	No. of psychologist licensees with prescriptive authority	% of psychologist licensees prescribing	Psychologists per 100,000 population[b]	Prescribing psychologists per 100,000 population[b]	Year RxP bill passed	Years since passage
Colorado	3,954	3	0.08	67.27	0.05	2023	1
Idaho	615	10[c]	1.63	31.30	0.51	2017	7
Illinois	5,773	20	0.35	46.00	0.16	2014	10
Iowa	1,037	4	0.39	32.34	0.12	2016	8
Louisiana Psychology Board	784			18.93			
Louisiana Medical Board		116[d]	14.80		2.54	2004	20
New Mexico	894	73[d,e]	8.17	42.28	3.45	2002	22
Total	13,057	226	1.73	43.11	0.75		

Note. The number of doctoral psychologists in Louisiana was provided by the Executive Director of the LSBEP, February 12, 2024, as a personal communication. Some (34) Louisiana "medical psychologists" (i.e., prescribing psychologists) are licensed duly by both the LSBEP and the LSBME, that is, 29.3% of psychologists regulated by the LSBME. The other 82 (70.7%) medical psychologists regulated by the LSBME are not licensed by the LSBEP. We calculated a total unduplicated number of psychologists regulated by a Louisiana health regulatory board to be 866. It is the denominator used to calculate the percentage of psychologist licensees who prescribe in Louisiana and is the numerator for calculating psychologists per capita for Louisiana. Unduplicated count for Louisiana was derived by comparing all medical psychologists in 2024 with the LSBEP (2022) *Publication of Licensed Psychologists*. The LSBME regulates prescribing psychologists in Louisiana whereas the boards of psychology regulate prescribing psychologists' entire practice, including prescribing, in other states. RxP = the prescriptive authority; LSBEP = Louisiana State Board of Examiners of Psychologists; LSBME = Louisiana State Board of Medical Examiners.
[a] All data are from state boards of psychology obtained from websites or communications for board staff except for Louisiana data from the LSBME. [b] State population estimates are presented in Table 2 for 2023. [c] Five provisional prescribing licensees. [d] Twenty-one prescribing psychologists with addresses listed out of state (including one in Colorado, one in Illinois, and one in New Mexico). [e] Thirteen conditional prescribing licensees.

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regulated by the Louisiana State Board of Medical Examiners (i.e., not the Louisiana State Board of Examiners of Psychologists) accounting for 14.80% of all Louisiana licensed psychologists since the enabling legislation 20 years ago. The four remaining states have relatively shorter histories of psychologist prescribing, so as would be expected, have fewer than those with longer histories of allowing psychologists to prescribe: Few licensed psychologists prescribe in the other four states. Even in Illinois, which has the largest number of licensed psychologists among them, only 20 (0.35%) licensed Illinois psychologists are authorized to prescribe a decade after the passage of enabling legislation.

The Association of State and Provincial Psychology Boards (ASPPB, 2023) estimated that in 2022 there were 156,087 licensed psychologists in the 50 U.S. states and the District of Columbia. This total number of U.S. licensed psychologists dwarfs the number of psychologists holding state licenses to prescribe, representing only 0.14% of all licensed psychologists in the country. The fact that only a small number of psychologists choose to pursue prescribing and actually obtain the authority to do so through state health regulatory boards, aligns with the initial predictions of the APA ad hoc task force (Smyer et al., 1993) and past research.

For example, Tompkins and Johnson's (2016) survey of a random sample of Oregon psychologists during efforts to pass RxP legislation in Oregon, found few (6.7%) reported interest in pursuing training to become prescribers. Their results were consistent with prior survey data in Oregon (7%; Campbell et al., 2006), but signaled weaker intentions to pursue the training and to prescribe than some other surveys. Earlier, Baird (2007) found that 14% of sampled Illinois psychologists said they would definitely plan to obtain the necessary training to prescribe medication. Inconsistencies regarding those respondents' reported views about the importance of the training model (23%) and relatively weak understanding of the DoD PDP (47% were not familiar) and APA training model (39% were not familiar), when combined with a strong (78%) belief that psychologists should receive the same amount of training as other nonphysician professionals who have prescriptive authority makes it unclear how to interpret their willingness to pursue the training to become prescribers. Neither Baird (2007) nor Tompkins and Johnson (2016) found rural versus urban differences in psychologists' interest in prescribing, raising the question of how effective enabling psychologist prescribing would be in addressing access problems in rural communities.

Similarly, Fagan et al. (2007) found that only minorities of private practice psychologists, directors of training, postdoctoral residents, and psychology interns indicated they would seek RxP if it were allowed; larger numbers supported it as an abstract principle. The gap between psychologists' passive support for RxP and their intention and actual action to obtain it arguably reveals an ambivalence that matters greatly in terms of the ultimate impact RxP might have in expanding access to prescribers of psychoactive drugs. Moving beyond self-report data about future intentions to pursue psychopharmacology training and licensure to prescribe, our study examined the number of psychologists who are actually licensed to prescribe in states that permit it.

Despite being legally eligible after undergoing additional training and following passing the national Psychopharmacology Examination for Psychologists developed by the ASPPB, the percentage of psychologists who obtained licenses that permit them to prescribe is notably low. Assessing the potential impact of these prescribing psychologists reveals modest figures. Across those six states enabling RxP before 2024, there were only 0.75 prescribing psychologists per 100,000 people. This per capita ratio of prescribing psychologists to the population is remarkably lower than for other types of prescribers. It stands to reason that even if other states were to grant prescriptive authority to psychologists, only a small minority of psychologists would likely seek it, thereby limiting the overall potential impact of psychologist prescribers in managing psychopharmacological care for patients seeking it.

The number of psychologist prescribers stands in stark contrast to the total number of licensed psychologists in the six states that have

allowed psychologist prescribing. This count is considerably higher and somewhat consistent with earlier estimates for how many psychologists may be needed per capita to address population mental health needs (i.e., 35–40 per 100,000; VandenBos et al., 1991). These estimates of the number of licensed psychologists in these states are 41.57% higher than estimates in 2015 (IHS Markit, 2018), reflecting considerable growth in the total number of licensed psychologists in those states over the past decade. The growth in licensed psychologists contrasts sharply with the very modest growth of psychologist prescribers. APA Division 55, now known as the Society for Prescribing Psychology, underwent the second greatest proportional decline (−31.6%) in membership among all 54 APA divisions between 2008 and 2013 (Robiner et al., 2015). This membership decrease is another indication of psychologists' tepid support for RxP and limited intent to personally pursue RxP themselves. These trends caution against having unrealistically sanguine expectations about the future growth of the workforce of prescribing psychologists.

Psychologist Prescribers as a Proportion of the Prescriber Workforce

Appraisal of the potential impact of allowing psychologists to prescribe is informed by how many licensed prescribers across professions work in the states where psychologists obtain authorization to prescribe. Table 2 presents counts of three prescribing professions based on Bureau of Labor Statistics (BLS, 2024) 2023 data for physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) across the six states that had enacted RxP. Unlike psychologists, all individuals in those other professions can prescribe in those states. Additionally, Table 2 provides a summary of 2023 population estimates from the U.S. Census Bureau (2024) for those states, along with a reiteration of the number of psychologist prescribers in each state, to facilitate comparisons across prescribing professions and estimates of the rates of prescribers per capita.

Because few psychologists undergo the necessary training and complete the steps to obtain RxP, psychologists constitute very small proportions of all prescribers in the states where they legally have been able to obtain RxP. States' prescribing workforces were heterogeneous in terms of the number of prescribers overall, but the number of psychologist prescribers was consistently small. As noted earlier, across the six states, there were a total of 226 psychologist prescribers and 96,591 nonpsychologist prescribers, with psychologists accounting for a mere 0.23% of all prescribers in those states. Conversely, 99.77% of prescribers in the six states that allowed psychologists to prescribe were not psychologists. The percentage of the prescribing workforces composed of psychologists ranged from a low of 0.02% of all prescribers in Colorado, the state that had most recently passed enabling legislation, to 1.19% of prescribers in New Mexico, the first state to pass the legislation.

Prescribing Psychologists and Other Prescribers per Capita

The relative impact of psychologist prescribers can also be assessed by examining the ratio of prescribers to each of the six states' populations where psychologists are licensed to prescribe. As noted earlier, nonpsychologist prescribers vastly outnumber psychologist prescribers universally. Table 2 presents each of the professions' prescriber-to-population ratios separately, as well as their collective prescriber-to-population ratio (i.e., 318.92 per 100,000). The other professions have remarkably higher prescriber-to-population ratios compared to prescribing psychologists' prescriber-to-population ratio (i.e., 0.75 per 100,000). Such workforce ratios serve as indicators of the availability of professionals to provide pharmacological care to citizens and of the relative quantity of prescribing that professions can potentially provide. In states with the longest histories of psychologist prescribing and the highest per capita rates of prescribing psychologists, namely Louisiana (2.54 per 100,000) and New Mexico (3.45 per 100,000), the per capita rates of prescribing psychologists are approximately one one-hundredth of the rates of other prescribers in those states.

These workforce data reveal that psychologist prescribers provide patients only marginally greater access to prescribers than otherwise exists in the interprofessional prescriber workforces in their states. This echoes findings from a recent simulation study (Hughes et al., 2024) using 2004–2021 data from the Merative MarketScan

Table 2

Prescribing Workforce in States Where Psychologists May Obtain RxP

Prescribers and population estimates	Colorado	Idaho	Illinois	Iowa	Louisiana	New Mexico	Total
Prescribing psychologists[a]	3	10	20	4	116	73	226
Physicians[b]	10,840	2,570	32,150	4,800	5,410	3,730	59,500
Physician assistants[b]	2,990	1,170	3,890	1,290	1,090	530	10,960
APRN[b]	4,490	1,391	10,750	3,140	4,550	1,810	26,131
Nonpsychologist prescribers	18,320	5,131	46,790	9,230	11,050	6,070	96,591
Total prescribers	18,323	5,141	46,810	9,234	11,166	6,143	96,817
Percentage of prescribers who are psychologists	0.02	0.19	0.04	0.04	1.04	1.19	0.23
Estimated state 2023 population[c]	5,877,610	1,964,726	12,549,689	3,207,004	4,573,749	2,114,371	30,287,149
Psychologist prescribers per 100,000[d]	0.05	0.51	0.16	0.12	2.54	3.45	0.75
Nonpsychologist prescribers per 100,000[d]	311.69	262.16	372.84	287.81	241.60	287.08	318.92

Note. RxP = prescriptive authority; APRN = advanced practice registered nurses; BLS = Bureau of Labor Statistics.
[a] Based on information obtained from each state's psychology board with the exception of Louisiana's Board of Medical Examiners. [b] Obtained from the Bureau of Labor Statistics *Occupational Outlook Handbook* (2024) state profiles for each profession. The number of psychiatrists is not presented as a separate line in the table because it could not be disaggregated from the number of physicians overall for all of these states. BLS data provided for Idaho did not specify the number of psychiatrists separately from other types of physicians. [c] Based on U.S. Census Bureau (2024) estimate for 2023. [d] Per capita estimates were derived by dividing the number of prescribers by the U.S. Census Bureau's estimates of 2023 population and multiplying by 100,000.

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Commercial Claims and Encounters Database that included deidentified, employer-sponsored insurance claims for over 255 million individuals receiving care in New Mexico and Louisiana. They found that only 1.5% of 307,478 patients received a prescription from a prescribing psychologist. Furthermore, Hughes and colleagues found that patients living in metropolitan service areas "were more likely to see a prescribing psychologist, meaning a smaller proportion of their patients were from rural areas" (p. 13).

If the main objective of the RxP movement was to meaningfully expand access to psychoactive medication prescribers, especially in underserved areas, its success would require a significantly larger number of psychologists pursuing prescribing than the limited number forecasted by the ad hoc task force (Smyer et al., 1993) and that we identified in states that have allowed it. Psychologists arguably should focus on addressing mental health care treatment gaps arising from barriers, such as stigma, unequal access to evidence-based care, workforce shortages, geographic disparities in provider distribution, lack of insurance coverage, and limited access to community-based interventions, and deliver those services for which they are most intensively trained, such as assessment, psychotherapy, and consultation. Rather than continuing to push for RxP, it would be more advantageous for the APA to join other professions in innovative, interprofessional, and collaborative efforts to expand and strengthen collaborative care models (CoCMs), telemental health, task sharing, and improving capacity, for example, by expanding National Health Service Corps clinicians (Han et al., 2019; Mongelli et al., 2020). Kazdin (2021) urges moving beyond traditional one-on-one interventions to expand scalability to address unmet needs. Investing resources toward such goals, rather than focusing on RxP, seems to be a more promising venture.

Adding Workforce to the Concerns About RxP

Concerns persist regarding the appropriateness and safety of psychologist prescribing given the lack of consensus in the field about the adequacy of the APA training model due to its downward deviation from other prescribing disciplines' curricula (Robiner et al., 2020). To date, most critiques of RxP have been about quality and limitations of training, safety concerns, and other potential impacts of psychologist prescribing (e.g., Robiner et al., 2002). The data herein focus on quantity, that is, the number of psychologists who have actually obtained authorization by state licensing boards to prescribe. The workforce data reflect the limited impact of RxP on expanding patient access to psychoactive medications. Relative to other professions in which all clinicians can prescribe, few psychologists pursue RxP.

Arguing the case that the RxP movement has significantly benefited the profession, or could substantially address service delivery access issues, is seriously challenged by the reality of the limited number of psychologists who complete the pathway to prescribing. Concerns about the adequacy of training and preparation for psychologist prescribing, as well as the potential adverse impacts on the profession, persist, echoing issues voiced within the profession from earlier in the RxP movement (e.g., DeNelsky, 1996; Heiby, 2002; Tumlin & Klepac, 2014), and which have led others to conclude that it is not practical to pursue RxP (Canadian Psychological Association Task Force on Prescriptive Authority for Psychologists in Canada, 2010; Dozois & Dobson, 1995). These workforce data extend those concerns, suggesting that allowing psychologists to prescribe would, at most, only marginally address service availability and delivery involving psychoactive medication since so few psychologists pursue RxP when allowed.

It is not clear why so few psychologists pursue RxP. As noted earlier, survey data of Oregon psychologists (Tompkins & Johnson, 2016) evidenced low interest in pursuing RxP. Moreover, it revealed low willingness to be involved in legislative efforts (7.9%), and a lack of knowledge of RxP. For example, only 6.3% could name the states that had passed RxP, most psychologists indicated they were unfamiliar with the training models in either the DoD PDP (66.9%) or the APA designation cf. accreditation model (60.6%). Similarly low levels of investment of time and financial support were found by Baird (2007) in his survey of Illinois psychologists. If prescribing truly was an individual's commited, long-term aspiration, they might choose more direct, and possibly faster, alternative academic and career paths where preparation for prescribing was more centrally integrated into education and training from the beginning rather than as an afterthought following entry into the profession.

Many psychologists seem disinclined to pay attention to the topic of psychologist prescribing sufficiently to have well-considered beliefs about it, including understanding the differences between the APA training model and the curricula and more comprehensive training of other prescribing professions (e.g., as addressed in Robiner et al., 2020). As the APA (1992) ad hoc task force found, 43% of psychologists thought that full medical training would be required for psychologists to prescribe. Furthermore, many psychologists, even if they know the requirements of the APA training model, believe that that training should be more rigorous and aligned with a medical training model (Baird, 2007; Deacon, 2014; Tompkins & Johnson, 2016). Costs and the time to undertake additional training also appear to be demotivating factors for psychologists' pursuit of the training to prescribe (Fagan et al., 2007).

Due to the controversial nature of RxP, to limited interest, and to avoid sharing sentiments inconsistent with official APA policy about RxP, many psychologists seem hesitant to engage with the issue, to question APA's RxP policy, or take firm positions against it to avoid alienating colleagues who are in favor of prescribing, and to steer clear of potential backlash. Bradshaw's (2005) report on contentious town hall discussion at the 2005 APA Convention captured the insularity and divisiveness of the issue. Several RxP proponents pushed back against recommendations advanced by the National Register of Health Services Providers in Psychology (National Register [NR]) and the ASPPB that would have made training for psychologists to prescribe more rigorous. For example, McGrath, director of the psychopharmacology program at Fairleigh Dickinson University, commented, "Basically, none of the programs in the nation could meet the criteria." Caccavale, president of the National Society of Clinical Psychopharmacologist at that time, suggested that the Practice Directorate secede from the APA so that it might establish its own criteria. Judy Hall, the NR's executive officer suggested that allowing an external group like the NR/ASPPB to develop and update training criteria would enhance legitimacy, rather than "letting the fox guard the chicken coop." Nevertheless, since that time the APA has driven legislative efforts, developed and updated designation criteria rather than accreditation criteria, and developed the Psychopharmacology Examination for Psychologists. APA's advocacy for RxP has persisted even though concerns related to the training for prescribing psychologists raised by psychologists and groups outside of the profession have also endured.

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Growing Workforce of Prescribers in Other Professions

In addition to intraprofessional concerns, it is perhaps even more critical to reassess the RxP movement in light of workforce developments outside of psychology. Various professions play important roles in the mental health workforce (Ivey et al., 1998; Robiner, 2006) and the broader de facto mental health workforce (Regier et al., 1993). As formularies of psychoactive medications have expanded, as consumer acceptance of these drugs as part of their health care has increased, and as the overall demand for mental health services has proliferated, the need for competent prescribers and for mental health professionals in general has grown. To address this need, over the past decades there has been substantial growth in the numbers of physicians, nurse practitioners (NPs), and PAs. While the psychology workforce has also grown, the mental health workforce has been dynamic, changing notably since the RxP agenda was initially advanced. Although the shortage of psychiatrists has existed for decades, the increasing role of the de facto mental health workforce (Regier et al., 1993) was not fully recognized. Moreover, the proliferation of NPs and PAs in both mental health specialty roles and primary care was not anticipated to the extent that it has become a key workforce factor that is likely to continue to be important in extending access.

Psychiatrists and Other Physicians

Part of the impetus to consider RxP was the well-known, decades-long shortage of psychiatrists (Council on Graduate Medical Education, 1992; Pardes & Pincus, 1983; Plaut & Enzer, 1981). It is important to recognize progress addressing it. Medical education has undergone significant expansion since the introduction of RxP, leading to a substantial increase in the pipeline of physicians, including psychiatrists. Prior to 1990, there were 126 allopathic medical schools and 13 osteopathic schools. Since 1990, an additional 32 allopathic medical schools and 31 osteopathic schools have opened. In addition, many medical schools have expanded class sizes, and opened satellite campuses, increasing the number of medical students per year who can be educated and trained. Moreover, there has been a substantial rise in the number of U.S. psychiatric residency programs over the past decade with growth from 183 in 2011 to 352 programs in 2022 (Moran, 2022). These developments have implications for revisiting the original consideration of whether seeking to expand psychologists' scope of practice to prescribing based on the APA training model is as compelling as it may have seemed earlier.

According to BLS (2022a) estimates, the number of physicians and surgeons, 816,900, is expected to rise by 3% by 2032. A more robust growth trajectory for psychiatrists is anticipated (BLS, 2022b), expanding the current psychiatry workforce of 28,600 by 7% by 2032. While the projected employment growth rate for psychologists (BLS, 2022c) is slightly lower (6%) than that for psychiatrists, there is little reason to anticipate increased interest in prescribing among future psychologists compared to that seen in the past two decades in jurisdictions where psychologist prescribing has been allowed. There are, after all, increasing alternative training and career options for individuals seeking to prescribe outside of psychology.

APRNs

The estimated current workforce of 323,900 NP and other APRNs, is expected to expand by a stunning 38% over the next decade (BLS, 2022d). A notable percentage (6.5%) specialize in psychiatric mental health and another 79.2% specialize in family medicine in adult-gerontology primary care (American Association of Nurse Practitioners, 2024) where they are likely to prescribe psychoactive medications as part of the de facto mental health system. Delaney (2024) highlighted the lack of visibility of the 35,000 psychiatric–mental health advanced practice nurses and the additional 4,374 psychiatric–mental health clinical nurse specialists, that is, a total of 39,374 nurse prescribers in the behavioral health workforce. This is an important oversight for workforce planning given their practices and the volume of care they provide, including to underserved and geographically distributed populations. For example, Andrilla et al. (2022) found that the ratio of psychiatric NPs more than doubled in rural counties from 2014 to 2021. There were an estimated 17,318 advanced practice psychiatric nurses in 1996 (Manderscheid & Henderson, 2001), the year that APA's (1996) training model for RxP was finalized. The addition of 22,056 psychiatric NPs since then contrasts sharply with the lackluster development of the workforce of prescribing psychologists.

Moreover, the potential for further growth in prescribing mental health APRNs is great. There are over 208 training programs. This is orders of magnitude greater than the number of training programs preparing psychologists to prescribe. These numbers reveal that APRNs who specialize in psychiatric care have become a critical prescribing component of the mental health workforce.

PAs

Similar to APRNs, the number of PAs is forecasted to increase substantially. The current workforce of 148,000 PAs is predicted to expand by 27% by 2032 (BLS, 2022e). Whereas all PAs can prescribe psychoactive medications, the National Commission on Certification of Physician Assistants (NCCPA, 2022) reported that 2,594 PAs are board certified specifically in psychiatry. The number of PAs in the psychiatric specialty is more than 10 times the current number of prescribing psychologists. There are even more PAs involved in primary care, functioning in essential roles as part of the de facto mental health system. These trends highlight the evolving landscape of the mental health workforce and underscore the pivotal roles of APRNs and PAs, as well as nonpsychiatric physicians, in meeting the demand for psychopharmacological care, especially when compared to the relatively underwhelming number, and inevitably minimal impact, of prescribing psychologists.

Discussion

Whereas RxP proponents focus on the shortage of psychiatrists, there has been little attempt to reconsider the movement by expanding the lens to encompass the entire workforce of prescribers and, importantly, to contemplate how to consider the movement in light of how few psychologists actually pursue prescribing. As a proportion of the workforce of prescribing professionals, the cadre of psychologists authorized to prescribe by state health regulatory boards is absolutely and comparatively small. It represents a minimal fraction of both the overall psychology workforce and the overall workforce of prescribing health professionals. Where psychologist prescribing is permitted, only a small proportion of psychologists have elected to become prescribers. Consequently, the impact of prescribing psychologists in providing psychopharmacological care is

constrained by their limited numbers. This stands in stark contrast to the growing presence and impact of other types of prescribers, who are increasingly stepping in to address gaps in mental health care delivery that are associated with the historically limited, yet expanding, psychiatrist workforce. According to the BLS, these other groups, especially NPs and PAs, are on course to grow even more, at an accelerated pace relative to psychologists (BLS, 2022c), making it highly unlikely that psychologists would ever play more impactful roles in meeting demands for psychopharmacological care.

Moreover, the workforce data support strategies noted by others (Andrilla et al., 2021) to meaningfully address rural access issues; namely, how the expansion of Medicare's 2017 implementation of behavioral health integration model payments can strengthen telemedicine use and the psychiatric CoCM (Archer et al., 2012; Katon et al., 2010; Unützer et al., 2006) that may be staffed by psychiatric NPs and PAs, as well as psychiatrists. In fact, in a recent qualitative study, Al Achkar et al. (2020) identified that, beyond serving as an evidence-based model of patient care, the CoCM also provided a framework for training and workforce development in rural primary care settings that contributed to the development of resilient and sustainable treatment teams. Given the shortage of all providers in rural settings, this seems to be a critical approach to addressing treatment gaps.

These shifts in workforce dynamics demand that the RxP agenda be reconsidered by psychologists and their professional organizations. Not only are psychologists the least prepared for prescribing based on the training to prescribe that is abbreviated relative to all other prescribers (Robiner et al., 2013, 2020), but their share of the market of prescribers is dwarfed by the other disciplines. This is a seriously limiting factor in how consequential their potential impact could ever be.

Meanwhile, the RxP agenda remains contentious in the field (e.g., Deacon, 2014) and with other professions. It can undermine relationships and potential collaborations with some other professional groups (Bush, 2001, 2002; Ransom, 2014), such as psychiatrists, which affects the capacity to work cooperatively on potentially shared agendas, such as health equity and support for the National Institute of Mental Health as well as clinical matters (e.g., care delivery, reimbursement, and integrated care). The International Society of Psychiatric-Mental Health Nurses (2001) issued a statement stating, "Nurses have an ethical responsibility to oppose the extension of the psychologist's role into the prescription of medications" (p. 4).

While psychologists widely engage in collaboration and consultation (Leventhal et al., 2021) and support alternatives to prescribing, such as collaboration (Smyer et al., 1993) and extensive use of telehealth, psychologists appear to have limited collective interest and intent to actually pursue prescriptive authority themselves. APA's focus on promoting RxP diverts resources away from addressing and advocating for other issues related to clinical practice, research, education, and other important patient and professional agendas that garner greater support within the field and hold the potential to benefit larger numbers of psychologists and patients.

We urge psychologists to acknowledge the workforce within the profession and in prescribing professions as an increasingly salient issue that warrants reappraisal of any previously perceived need and support for RxP. An objective question raised by these data is whether the experiment of trying to cultivate a robust workforce of prescribing psychologists has failed. During the time frame that RxP has been APA policy, other groups such as APRNs and PAs have been more proficient in addressing and filling gaps in patient access to clinicians who prescribe psychoactive medications. These other disciplines are positioned to do so even more effectively in the future given the BLS projections for their growth, which is anticipated to vastly outstrip the proportional growth of the psychologist workforce. We believe it would be more advantageous and constructive for the profession to devote its energies, resources, and advocacy to promoting objectives that leverage its areas of strength and unity rather than to continue to pursue the anemic, controversial, distracting, divisive, and costly ambition of RxP for a small minority of psychologists. From a workforce and a policy perspective within the field, is the RxP movement a case of the tail wagging the dog?

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Received April 20, 2024
Revision received September 26, 2024
Accepted October 1, 2024 ■

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