**Psychologists Opposed to Prescription Privileges for Psychologists (POPPP)**

The Society for a Science of Clinical Psychology (SSCP - http://www.sscpweb.org/) whose members are committed "to empirical research and the ideal that scientific principles should play a role in training, practice, and establishing public policy for health and mental health concerns" and Psychologists Opposed to Prescription Privileges for Psychologists (POPPP - https://www.poppp.org/) whose members are "committed to preserving the integrity of our profession and to protecting the safety and well-being of those we serve" jointly share our deep concerns about proposed changes. This comprehensive response addresses concerns related to proposed changes to model legislation, model curriculum and designation criteria as well as their intersections. Several of the issues raised relate to all documents, but when comments apply more specifically they will be noted.

**1. All training and coursework counting for psychologist RxP certification should be done *post*-graduation from an APA-accredited doctoral program only. The proposed "creep" of RxP training into the predoctoral arena (by allowing didactics to be completed at this stage and for course transfer later) could have a damaging effect on the field.**

The current guidelines are silent as to exactly how much pre-doctoral coursework will be allowed and how quality will be assured. It is our belief that RxP training should not be done during doctoral education itself or concurrently with it, so as not to dilute training or give short shrift to the areas of study required for the primary degree in psychology. Otherwise, such training would result in both inadequately trained psychologists and prescribers. We think it appropriate to point out that our view is what the proponents of RxP felt was necessary at the very beginnings of their efforts – reserve RxP education and training for the postdoctoral level so as not to dilute the focus on psychology during doctoral training.

Shifting portions of this post-doctoral specialization into the predoctoral educational experience is problematic given the lack of cohesion across existing programs (e.g.,

Chicago School of Professional Psychology only requires a bachelor's degree, whereas all other RxP training programs require a Ph.D.). Although the "Model Designation Criteria" require a prescribing psychology fellowship and capstone competency evaluation, none of the current training programs seems equipped to meet these standards. Moving portions of the training predoctorally would further complicate the picture in terms of who is then responsible for ensuring that a piecemeal didactic and supervised clinical experience provides trainees sufficient knowledge and skill to ultimately become safe and effective prescribers.

On a related note, this specialty and the expansion of clinical psychopharmacology should include a discussion of undergraduate preparation and admissions standards that would appeal to students with a strong background and propensity in the biological bases of the field. Initial calls for RxP suggested that "retraining of practicing psychologists for prescription privileges would require careful selection criteria, focusing on those psychologists with the necessary science background" (Smyer et al., 1993, p. 400). In the final report of the DoD Psychopharmacology Demonstration Project (PDP) the importance of a strong grounding in the sciences was also noted: "it will be essential to select trainee psychologists with an adequate background for advanced training in psychopharmacology… background in chemistry, biology and mathematics." (ACNP, 1991, p. 60). However, there are currently no safeguards in place to ensure that psychologists who pursue this specialty training have any prerequisite coursework in the sciences.

Gaining entry into a clinical doctoral program does not currently require any background in the basic sciences, with most programs admitting students with either a baccalaureate degree in the arts or sciences. Earning a doctorate in clinical psychology does not require taking a single basic biological science class. Nor does it require any intensive study or lab work in anatomy/physiology or biochemistry. In fact, students entering MS Clinical Psychopharmacology training programs typically have fewer science courses than even dental hygienists (see Figure 1, from Robiner, Tumlin, & Tompkins, 2013).

These "designated" RxP training programs are not accredited. Designation is a less stringent process than accreditation. It should be noted that the programs do not meet the APA's standards for the accreditation of postdoctoral fellowships or residencies (and are not accredited like other prescribers' clinical training). None of the current programs has admissions standards in place that suggest they would be selecting to train those with an aptitude and background in the sciences. This is of the utmost concern given currently lax standards across states and programs with regard to academic rigor and excellence. None of the programs has a minimum GRE or MCAT score required for admission. The Chicago School of Professional Psychology requires a 3.0 undergraduate GPA in

psychology or another allied discipline. Most of the programs make use of online education and training using a "pass-no pass" system. For example, Alliant University/CSPP requires “an average test score at or above our program criterion of 70% in each course… one low exam score can be made up on other exams. If you do not pass a class, we will develop a plan for you to do remedial work and retake an exam.” Three of the 13 original DoD PDP trainees didn’t graduate. Although the modifications to the model designation criteria and curriculum are noted as being responsive to “knowledge and experience,” with such lax standards and no reports or data referenced it is likely that few, if any inappropriate students, actually fail in pursuing this training. Given the lack of selection standards and lax graduation standards, this is highly concerning. With postdoctoral training, even though there are currently no mechanisms to require a strong background in the basic sciences, the model designation criteria could require prerequisite coursework that would open admissions to the program only to students who have sufficient background (e.g., pre-medical professional undergraduates, neuroscience minors). Relatedly, it is unclear how any of the existing programs will meet competency capstone evaluation requirements or even have the capacity to evaluate applied skills and knowledge in an online environment (especially with students who may have never taken a lab-based course since high school).

Furthermore, for over a decade professionals (Baker et al., 2008; Lilienfeld et al., 2013; Stewart & Chambless, 2007) have expressed grave concern over the fact that so few practitioners and graduate students value research data in informing their clinical decisions. It is unclear how introducing so many additional areas of specialized knowledge required of this new area of expertise (e.g., psychopharmacokinetics, pharmacogenomics, ethno-pharmacologics) will be managed by practitioners who self-report seeing the psychotherapeutic literature as largely irrelevant to their practice. The current climate is one of increased mental health care utilization with medication use on the rise and psychotherapy use on the decline (Gaudiano & Miller, 2013). Until we are able to reliably ensure that the average patient is receiving access to empirically-supported therapy, it seems questionable to expand in this way versus working to improve existing programs’ abilities to develop effective Level 1 and 2 practitioners as identified in the APA Ad Hoc Task Force on Psychopharmacology (Smyer et al., 1993), who are prepared to thrive in interdisciplinary, collaborative settings. To quote Baker and McFall (2014), “We are much more concerned with training in *psychological clinical science*, which we believe requires a change in mindset about both training and application. We want to shift the field’s focus from justifying individual practice per se to promoting public health benefit by considering the multiple roles that scientifically trained psychologists might play if their professional activities were truly informed by a comprehensive analysis and application of available data” (p. 485).

The proposed guidelines do not require previous training in the physical sciences as a precursor to pursuing this advanced RxP training. It is difficult to understand how a psychologist with little or no background in the physical sciences and limited (i.e., abbreviated and unaccredited) post-doctoral training can become a competent prescriber. Alliant International, the largest provider of MS Psychopharmacology training, states in recruitment materials that they will adjust their curriculum based on specific legislation that is passed across the country. New Mexico State University, in a course outline on the use of medication states, "we will cover as many drug classes as we can in the time allotted." This shortcut training is particularly alarming in light of the fact that admission is guaranteed to anyone who can get through graduate school, pass the licensing examination (that is minimally focused on biology and chemistry which are most relevant to psychopharmacology), and pay for the additional education. In fact, all ten graduates of the DoD PDP considered short-cut programs such as those outlined in the model legislation to be "ill-advised". There is no evidence that prescribing psychologists whose training almost exclusively relies on distance education, open-book exams and limited coverage of material that is tailored to what is stipulated by law, who "pass" a final 150 question multiple choice exam whose "pass" rate fluctuates but averages 70%, would be able to pass competency exams used by other non-physician prescribers. The model legislative criteria do not delineate the need (and process by which) to evaluate this class of prescribers, despite the fact that the original report of the PDP graduates called for this assessment so that they could be compared with other classes of prescribers.

**2. There is a lack of attention to current non-evidence-based prescribing practices that are known problems in the field. Such issues should be thoroughly addressed in the training of any new prescribers and RxP curricula must specify how these problems will be reduced during prescribing psychologists' practice. Specific coursework addressing these issues is recommended.**

Absent is an honest look at the sizeable influence that the pharmaceutical industry has on both research (including bias in meta-analyses – see Ebrahim, Bance, Athalte, Malachowski, & Ioannidis, 2016) and prescribing practices (Spielmans & Parry, 2010; Cosgrove & Bursztajn, 2010). Also lacking is a broad perspective about how encouraging a new class of additional prescribers fails to curtail concerns about the dangers (Hampton, Daubresse, Chang, Alexander, & Budnitz, 2014) and overuse of psychotropics (Olfson, Blanco, Liu, Wang, & Correll, 2012). Thus, a substantial focus of proposed educational curricula should emphasize not only how to prescribe safely and effectively, but also how to actively decrease known problems in this area (e.g., pharmaceutical company influence, direct to consumer marketing, overprescribing, use of polypharmacy, proliferation of certain medications as firstline treatment when psychosocial treatments are better justified in terms of cost-benefits analysis).

Psychologists advocating for prescription privileges claim that they are in a position to prescribe less and yet we know from examining trends in psychiatry that the profession has increasingly relied on medications (because it is quicker and financially expedient to do so given current insurance reimbursement practices and delivery of care models). Proponents provide no evidence to support their claims that they do not and will not succumb to the same pressure. In fact, in the only published study referenced (Linda & McGrath, 2017), 2/3 of prescribing psychologists reported increased income. As an empirically-driven profession, psychologists should be data-driven in their approach to improve patient care.

**3. The RxP documents do not sufficiently justify how these recommendations are based on current standards of evidence-based practice and scientific support as outlined by APA ethics and policies. Further study may be necessary before proceeding with implementation or there is a significant risk of getting ahead of the data, posing significant risks to individuals and the profession.**

Evidence supporting RxP competence, quality and safety is limited in scope, quantity, and quality. Existing research (Levine, Wiggins, & Masse, 2011; Linda & McGrath, 2017) provides insufficient guidance about competency or safety given extremely small sample sizes, low response rates, and reliance on self-report of prescribing and other practice behaviors. Lawsuits in Louisiana and recent data from the Part D Prescriber Public Use File from the Centers for Medicare and Medicaid Service suggest that some prescribing psychologists from New Mexico and Louisiana have been prescribing beyond the legislative bounds of their licenses to the potential detriment or peril of mental health consumers. For example, not only have some prescribing psychologists been prescribing powerful psychotropic medications (e.g., antipsychotics), but also anti-Parkinsonian agents like benztropine mesylate, likely to help control extrapyramidal disorders associated with anti-psychotic use. In addition, prescribing psychologists used several classes of drugs used to treat medical problems (e.g., Hytrin – anti-hypertensive, Plavix – anti-coagulant, Zenaflex – muscle relaxant) that reflect prescribing practices well beyond their training (and in some cases the statutory limits of the prescribing license). Given that these data are only available for two years (2013, 2014) and only include prescriptions provided to approximately 70% of all Medicare beneficiaries it is unclear to what degree these instances of inappropriate prescribing may reflect more widespread problems with prescribing psychologists prescribing outside their bounds of competence. In addition, there has been at least one case of disciplinary action against a medical psychologist who failed to comply with the act requiring consultation and collaboration with a licensed physician. Several lawsuits have also been filed against Louisiana medical psychologists, the most serious of which was filed by the parents of a 4-year-old child with ADHD who

suffered a Tenex overdose that led to hospitalization and the worsening of an underlying seizure disorder. These emerging cases and patterns seem to suggest that some currently practicing in this specialty are clearly not respecting their ethical bounds of competence. As noted, the model legislation fails to address the need for ongoing, objective, systematic evaluation of this new class of prescribers (including access, prescriptive behavior and errors) to assess the impact on public health.
Given current limits to proposed training models, 73% of members of the Association for Behavioral and Cognitive Therapies (ABCT; a large, national association of cognitive-behavioral clinicians) surveyed reported that they would not refer clients to prescribing psychologists (Deacon, 2014). This reveals a level of opposition to RxP that accords with other surveys of psychologists that demonstrate it is a controversial matter within the profession. Nevertheless, APA has refused to acknowledge or take appropriate steps to ameliorate identified problems. In the same survey, 89% agreed that RxP advocates should produce empirical evidence in support of the models being proposed prior to passing further legislation and 67% favored collaboration versus prescriptive authority to address access issues.

If APA continues to promote RxP, prescribing psychologists have a professional obligation to be transparent about each allegation of problems as well as legal, institutional, or regulatory action related to psychologist prescribing. The APA has not been transparent about how their financial and political resources have been used to promote RxP versus other professional issues of import to the broader profession. We call on APA to forthrightly acknowledge and address such concerns, issues, and problems as well as limitations of its impact rather than disavow any knowledge of them. Such issues are not addressed in the proposed documents.

**4. The standards for RxP training programs should be as high or higher than those of predoctoral training programs given the potential greater risks associated with medication errors identified by the Institute of Medicine (Kohn, Corrigan, & Donaldson, 1999). A formal <u>accreditation</u> (not "designation") process is a likely necessity to sufficiently justify RxP certification. Online or primarily distance learning RxP programs are insufficient for meeting acceptable RxP training standards.**

Why after many years has the level of quality assurance not yet risen to the level of accreditation? Although this process may be currently under consideration, it is clear that more effort should be put toward this process before establishing new training program standards that will require change later on. Psychologist RxP training methods and criteria that deviate significantly from those currently established in non-psychologist prescriber training programs need to be carefully considered. If such deviations are

proposed, they must be properly justified based on significant supporting evidence to ensure safety and competency. Otherwise, ethical and legal peril would be anticipated based on the lack of lower educational standards for prescribing psychologists that would have to be defended.

An additional layer of concern lies in the quality of programs providing this specialty training and the lack of admissions' standards beyond licensure. Sayette, Norcross, and Dimoff (2011) surveyed all APA-accredited clinical Ph.D. programs and found evidence that stand-alone institutions favor quantity over quality, with lower admissions standards (some do not require the GRE or other objective tests) and higher admittance rates.

Given that programs providing online psychopharmacology training require no basic science prerequisites and no objective qualifying entrance exams (or other gatekeeping mechanisms to ensure competency and excellence), it is concerning that half (Alliant and the Chicago School of Professional Psychology) of the programs are stand-alone, professional-degree granting institutions of higher learning. The University of Hawaii-Hilo, which was affiliated with other health professional training, is no longer accepting applications. New Mexico State University, which is the only training program requiring *some* in-person classes that focus on physical exams, will begin to accept applications again in August, 2019 after not accepting new students for several years. In online descriptions of curricula and programs, there appears to be a clear drive to market to students who may have minimal time to devote to specialty training (e.g., "ALL instruction is provided on the weekends" – NMSU which shares testimonial quotes from former students) and an acknowledgement that some students may not have a strong background who enter the specialty ("The course work is based on the assumption that you will spend about 6-10 hours a week on the program. Actual amount of time spent depends on you. Some people are able to do it in 6 hours a week. Students who do not have a strong background in medicine report spending 12-20 hours a week on the program. It's up to you to decide what you need to meet the requirements of the program." - Fairleigh Dickinson). The model designation criteria seem to depend heavily on the presence of high-quality faculty that contribute to curriculum planning and evaluation and yet the instability of these programs is notable. The sole full-time faculty member at the Chicago School of Professional Psychology received his MS in Clinical Psychopharmacology from an institution that no longer exists as a RxP training program (Nova Southeastern). The problems associated with sustaining training need to be addressed forthrightly by the profession.

There is also wide variation in collaboration and supervised practicum experiences required across states and various training programs. It is unclear how well clinical competencies can be taught and assessed or otherwise monitored in an online

environment alone. The model designation criteria do not seem to directly address the quality of the training setting, despite the fact that all existing programs rely so heavily on online platforms for training.

The DoD PDP, which has been portrayed as the primary source of empirical evidence to support the efficacy of psychopharmacology training programs (Sammons, 2013), allowed prescribing psychologists to practice in academic medical settings where they had access to laboratory testing equipment and other diagnostic instruments, resources that are available to very few, if any, aspiring prescribing psychologists. None of the current training programs come close to the depth, breadth, or intensity of training that was provided in the DoD PDP program. With such wide variation in training programs and practicum settings, it is a major oversight that the current documents do not seek to provide even minimum guidance with regard to criteria for ensuring quality of the training settings (e.g., mechanisms of providing site visits in the clinical contexts where learners' services are supervised).

Finally, prescribing psychology fellowships do not seem to exist in some programs (at least not as described in online materials). If supervised training of 100 patients is recommended, it further needs to be stipulated how this minimum training should limit practice (e.g., some legislation does not allow prescribing psychologists to treat children/adolescents or geriatric patients). This is one of several examples where model designation and curriculum criteria could explicitly address the need for breadth and depth to match prescribing practice in high-risk populations (e.g., if only one of those patients is a child this person should not be equipped to treat youth; if only two elderly patients are seen this person should not be treating geriatric populations).

Model legislation is also problematic in that it proposes that prescribing psychologists be licensed, reviewed and sanctioned by Psychology boards despite the fact that there is existing variation across current prescribing states and deep concerns about the capacity of psychologists to evaluate complaints made against prescribing psychologists whose medical practice (i.e., prescribing) is being questioned.

**5. The documents fail to adequately address the unique role that psychologist prescribers would play in the larger healthcare system and how their work would contribute to advance patient care while simultaneously not harming it.**

Prescribing does not occur in a vacuum. Most glaring is the lack of a discussion of successful collaborative care and patient-centered medical home models that involve integration across disciplines and specialties and obviate the very need for the specialty care that the RxP proponents seek (Robiner et al., 2013). Minimally acknowledged by the

those advocating for prescription privileges is the lack of data that current prescribing psychologists are safely and effectively addressing unmet needs, whether prescribing psychologists are providing evidence-based care to underserved communities (Tompkins & Johnson [2016] suggest that current "specialists" are not addressing rural access), and/or whether this specialization provides a unique skill-set that allows them to more effectively serve in integrative care settings.

***In summary: a) the standards should specify that psychologists choosing to undergo additional RxP training first be graduates of an APA-accredited doctoral program. The proposed RxP guidelines do not stipulate that a trainee must come from an APA-accredited doctoral program, and thus does not establish that the psychologist has adequate training in the primary profession of psychology to justify expansion into RxP. b) The APA Ad Hoc Task Force on Psychopharmacology also stipulated that for psychologists seeking prescriptive authority, postdoctoral training would exclusively select applicants with a strong science background and provide commensurate training to that of other disciplines' prescribers. c) Finally, all RxP work should be focused on the postdoctoral period so as not to negatively affect predoctoral training.***

Although by no means an assurance of sufficient prerequisite training in pharmacotherapy and the basic sciences, appropriate doctoral training is necessary to ensure a more consistent foundation of psychology education before even considering advanced training in pharmacotherapy. Overall, physicians, nurse practitioners, and physician assistants have more than three times the number of clinical training hours than prescribing psychologists relevant to prescribing medication. Although psychologists complete a significant number of clinical hours that focus on assessment, diagnosis, and treatment with behavioral interventions, the other prescribing professionals receive significantly more supervised practice in physical assessment and medication monitoring and have much greater experience prescribing and understanding the management of psychoactive drugs in the context of patients' complex drug regimens.

While no research has been conducted to determine the minimum number of hours needed to establish competence with prescribing, the standard for other health professionals involves a significantly higher number of clinical training hours. It is concerning that the APA and psychopharmacology training programs require so few clinical hours compared to the training programs for other prescribing professionals, require no basic foundation in the sciences (either through admissions exams and/or prerequisite courses), and have an average number of clinical training hours that is less than one-quarter of the clinical hours required of the DoD PDP psychologists, which is the only training program which has actually been objectively evaluated. As a side note, the

military discontinued the PDP program because it was not cost-effective (despite the fact that given rising mental health concerns among vets, they have chosen to devote resources to psychosocial interventions, not develop more prescribers through an active RxP program).

Similarly, it is unclear why neither the model legislation nor other documents reflect the relatively more stringent standards for psychologist prescribing stipulated in Illinois. In 2014, the State of Illinois enacted a law with more stringent requirements than those advocated by APA or RxP proponents. It permits psychologists to prescribe some psychotropic medications (e.g., excluding narcotics and benzodiazepines) to a limited population (excluding youth, the elderly, pregnant women, the physically ill, and those with developmental disabilities). The Illinois RxP training requirements are more similar than the APA model to what is required of Physician Assistants, including completing undergraduate pre-medical science training before studying post-degree psychopharmacology. This training includes 7 undergraduate and 20 graduate courses along with a 14-month practicum in multiple medical rotations. The training program must be accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). In fact, this is the only legislation that aligns more closely with other non-physician prescribers. We believe that if psychologists seek to prescribe, such scientific training, should be a prerequisite to entry to any psychopharmacology training program. A propos of this, it suggest that if psychologists wish to prescribe, they should enroll in established programs.

We appreciate your careful consideration of our concerns regarding changes to the model legislation, designation and curriculum.

Sincerely,

POPPP
SSCP*

*To date, SSCP has not taken a formal stance on RxP. As such, comments regarding the proposed updates to the RxP Model Curriculum, RxP Designation Criteria, and RxP Model Legislation documents should not be taken as implicit SSCP support for the RxP agenda. Nonetheless, SSCP has carefully reviewed the proposed documents given the potential impact on the field of clinical psychology, and believes that the concerns raised by POPPP in the attached document are valid and warrant serious consideration.

References

American College of Neuropsychopharmacology. (1991). Prescribing privileges for non-physicians in the military: Accepted as a consensus statement by the ACNP council, March 22, 1991. *Neuropsychopharmacology, 4*, 290-291.

Baker, T. B., & McFall, R. M. (2014). Commentary: The promise of science-based training and application in psychological science. *Psychotherapy, 51(4),* 482-486. doi: 10.1037/a0036563.

Baker, T. B., McFall, R. M., & Shoham, V. (2009). Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental and behavioral care. *Psychological Science in the Public Interest, 9*, 67–103. doi: 10.1111/j.1539-6053.2009.01036.x.

Cosgrove, L., & Bursztajn, H. J. (2010). Undue pharmaceutical influence on psychiatric practice. *Psychiatric Times, 27(5)*, 36-38.

Deacon, B. J. (2014). Prescriptive authority for psychologists: A survey of the ABCT membership. *The Behavior Therapist, 37,* 163-169.

Ebrahim, S., Bance, S., Athale, A., Malachowski, C., & Ioannidis, J. P. A. (2016). Meta-analyses with industry involvement are massively published and report no caveats for antidepressants. *Journal of Clinical Epidemiology, 70*, 155-163. doi: 10.1016/j.jclinepi.2015.08.021.

Gaudiano, B. A., & Miller, I. W. (2013). The evidence-based practice of psychotherapy: Facing the challenges that lie ahead. *Clinical Psychology Review, 33,* 813-824. doi:10.1016/j.cpr.2013.04.004.

Hampton, L. M., Daubresse, M., Chang, H., Alexander, G. C., & Budnitz, D. S. (2014). Emergency department visits by adults for psychiatric medication adverse events. JAMA Psychiatry, 71(9),1006–1014. doi:10.1001/jamapsychiatry.2014.436.

Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.) (1999). *To err is human: building a safer health system.* Washington, DC: National Academy Press, Institute of Medicine.

LeVine, E., Wiggins, J., & Masse, E. (2011). Prescribing psychologists in private practice: The dream and the reality of the experiences of prescribing psychologists. *Archives of Medical Psychology, 2*, 1–14.

Lilienfeld, S. O., Ritschel, L. A., Lynn, S. J., Cautin, R. L., & Latzman, R. D. (2013). Why many psychologists are resistant to evidence-based practice: Root causes and constructive remedies. *Clinical Psychology Review, 33*, 883-900.

Linda, W. P., & McGrath, R. E. (2017). The current status of prescribing psychologists: Practice patterns and medical professional evaluations. *Professional Psychology: Research and Practice, 48(1),* 38-45. doi: 10.1037/pro0000118

Olfson, M., Blanco, C., Liu, S., Wang, S., & Correll, C.U. (2012). National trends in the office-based treatment of children, adolescents, and adults with antipsychotics. *Archives of General Psychiatry, 69(12),* 1247–1256. doi:10.1001/archgenpsychiatry.2012.647.

Robiner, W. N., Tumlin, T. R., & Tompkins, T. L. (2013). Psychologists and medications in the era of interprofessional care: Collaboration is less problematic and costly than prescribing. *Clinical Psychology: Science and Practice, 20*, 489–907. doi: 10.1111/cpsp.12054.

Sammons, M. T. (2013). The Department of Defense Psychopharmacology Demonstration Project. In B. A. Moore and J. E. Barnett (Eds.), *Military psychologists' desk reference* (pp. 122-126). New York, NY: Oxford University Press.

Sayette, M. A., Norcross, J. C. and Dimoff, J. D. (2011), The heterogeneity of clinical psychology Ph.D. programs and the distinctiveness of APCS programs. *Clinical Psychology: Science and Practice, 18*, 4-11. doi:10.1111/j.1468-2850.2010.01227.x

Smyer, M. A., Balster, R. L., Egli, D., Johnson, D. L.,Kilbey, M. M., Leith, N. J., et al. (1993). Summary of the report of the Ad Hoc Task Force on Psychopharmacology of the American Psychological Association. *Professional Psychology: Research and Practice, 24,* 394–403.

Spielmans, G. I., & Parry, P. I. (2010). From evidence-based medicine to marketing-based medicine: Evidence from internal industry documents. *Journal of Bioethical Inquiry. 7,* 13-29. doi:10.1007/s11673-010-9208-8.

Stewart, R. E., & Chambless, D. (2007). Does psychotherapy determine treatment decisions in private practice? J*ournal of Clinical Psychology, 63*, 267–283. doi: 10.1002/jclp.20347.

Tompkins, T. L., & Johnson, J. D. (2016). What Oregon psychologist think and know about prescriptive authority: Divided views and data-driven change. *Journal of Applied Biobehavioral Research, 21,* 126-161.