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Prescribing Authority During Emergencies Challenges for Mental Health Care Providers

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INTRODUCTION

The short- and long-term consequences of natural and man-made disasters present unique challenges for those who work to protect the public's health. Lessons learned from emergencies, including the September 11, 2001 terrorist attacks, Hurricane Katrina in 2005, and the H1N1 pandemic in 2009–2010, have led to heightened preparedness efforts at the local, state, and national levels. This work significantly has improved the nation's preparedness infrastructure, particularly to address individuals' physical health needs during and after a disaster.¹ Equally important, however, is work that focuses on the mental and behavioral health issues that will be exacerbated or emerge because of an emergency. While virtually any major emergency or disaster impacts affected individuals' mental health, these conditions, unlike physical injuries, are not often visibly identified, making them much more difficult to recognize, diagnose, and address.

Individuals may find it extremely challenging or impossible to access mental health services during and after emergencies. For example, a study of mental health services use among individuals impacted by Hurricane Katrina found that over one-fifth of persons with a pre-existing mental disorder reduced or terminated their treatment.² Three-quarters of these individuals indicated that their mental health treatment was affected by structural barriers, including a lack of available services after the hurricane.³

Mental health services involve therapeutic interventions as well as the prescription of psychotropic and other drugs, making access to a legally-authorized prescriber critical to the treatment of those with mental health needs during and after an emergency. Because the

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strict laws governing the prescribing of psychotropic and other medications remain in effect during an emergency, access to prescribers is a paramount concern.

This article explains how the prescribing authority of mental health care providers can be impacted by an emergency. The term “mental health care provider” is used broadly and includes all medical professionals who deliver some form of mental health services (for example, diagnosis of mental health conditions; provision of behavior-based therapies; prescription of psychotropic medications), even if they might not self-identify as primarily a mental health care provider. The article begins by reviewing existing prescribing authority, under state and federal law, for physicians, nurses, physician assistants, and psychologists. It then discusses challenges to the continuity of mental health care prescribing that are likely to arise during emergencies. Finally, a series of recommendations is offered to address the identified challenges.

I. PRESCRIBING AUTHORITY IN NON-EMERGENCY CONTEXTS

In the United States, the federal Food and Drug Administration determines whether a medication requires a prescription from an authorized health care provider to be dispensed.⁴ This determination includes several considerations, such as the medication’s toxicity, its potential for harmful side effects, and the need for expert advice about dosing and usage.⁵ Some prescription medications, including several that are critical to treating mental health conditions (such as benzodiazepines for anxiety or amphetamines for ADHD), are labeled “controlled substances” because they have the “potential for abuse and psychological and physical dependence.”⁶

Although controlled substances account for only about 10% of all prescriptions, they are heavily regulated at the federal and state levels.⁷ Under federal law, controlled substances are divided into five Schedules. Schedule I drugs cannot be prescribed for any purpose.⁸ These drugs, such as heroin, have a high potential for abuse and no accepted medical use.⁹ Drugs falling into Schedules II through V can be dispensed with a prescription. Schedule II drugs have a high potential for abuse and restricted medical uses. Drugs in Schedules III through V have accepted medical uses and decreasing likelihoods of dependence or abuse. Prescription medications not listed on Schedules I through V are considered “non-controlled” and comprise approximately 90% of all United States prescriptions.¹⁰ The federal government also regulates the content of prescriptions for controlled substances, requiring that certain information (drug name, dosage, directions for use, date of issue) be included in every prescription.¹¹ The states can then add their own requirements, such as mandating that these prescriptions contain a patient’s name and address.¹²

The authority to issue a prescription is tied to professional licensure through state governments. Professional licensure is designed to ensure that individuals meet minimum levels of competence before they are legally allowed to practice their profession.¹³ It also provides a mechanism for state oversight of providers.

Once a health care provider has attained a license to practice, he or she may legally provide services and care that fall within his or her scope of practice, as defined by the state’s licensure regulations. Individuals can face disciplinary action, civil liability, or even criminal sanctions for providing care without a license or that exceeds the scope of activities permitted by their licensure.¹⁴ For certain types of mental health care providers, including physicians, physician assistants (PAs), and some advanced practice nurses (APNs), professional licensure includes the ability to prescribe medications. Because licensure is state-specific, however, mental health care providers’ prescribing authority varies throughout the United States

PAs and APNs can be essential prescribers for those who need psychotropic medications to manage a mental health condition. Most prescriptions for psychotropic and other mental health medications are not written by providers with specialized training in mental and behavioral health;¹⁵ instead they are written by a combination of non-psychiatrist physicians and other prescribers, such as PAs and APNs.¹⁶ Some attribute this, in part, to the uneven distribution of psychiatrists in the United States, and the subsequent dependence in some communities upon non-specialist providers for mental health care.¹⁷

While every state allows physicians to prescribe medications, most states limit the types of medications PAs and APNs may prescribe and the circumstances under which they may issue prescriptions. PAs are trained to practice medicine under the supervision of a physician, and, within specified limits, they can prescribe medications in every state.¹⁸ For example, Missouri allows PAs to prescribe Schedule III through V drugs and non-controlled substances, but PAs can only prescribe a five-day supply of Schedule III drugs, and no refill can be provided.¹⁹ In West Virginia, PAs can prescribe non-controlled drugs and Schedule III through V medications, but only after they have been in practice for two years.²⁰

APNs are trained to provide a range of health care services, including nursing care, sometimes in conjunction with a collaborating physician. Their prescribing authority often depends upon a collaborative practice agreement with a physician, but there is significant variation among the states. For example, in Florida, APNs may not prescribe controlled substances, but Maryland allows them to prescribe medications in Schedules II through V.²¹ Some of the medications used to treat mental health conditions are controlled substances, limiting the ability of PAs and APNs in certain states to fully treat some individuals in need of mental health care.

The prescription of psychotropic and other medications is further complicated by the fact that some clinically-trained mental health professionals, namely psychologists, cannot prescribe at all. This highly contentious issue has, on one side of the debate, those who argue that, as mental health care providers with doctoral-level training, psychologists have the background and expertise that should permit prescribing authority.²² Opponents assert that psychologists do not receive appropriate training to prescribe medications with significant side effects and a high potential for abuse.²³ To date, only Louisiana and New Mexico have granted any prescribing authority to psychologists,²⁴ pending additional training and collaboration with a physician.

II. PRESCRIBING AUTHORITY DURING EMERGENCIES

Two distinct populations need access to health care providers with prescribing authority during and after an emergency: individuals who were using prescription medications to address a pre-existing condition; and those who need medication to address a new health issue that arises during, and often as a result of, the emergency. Access to prescribers is particularly important for individuals with mental health conditions. Persons with certain mental disorders, such as schizophrenia and bipolar disorder, depend upon prescription medications; in the absence of these drugs, their conditions can deteriorate rapidly.²⁵ For others, an emergency and its associated stresses may trigger severe anxiety and depression or symptoms indicative of post-traumatic stress disorder.²⁶ These individuals, too, may need access to a mental health care provider who can prescribe medications to help manage an emerging condition, particularly in the months after a disaster.²⁷

To meet surge capacity during and after an emergency, mental health care providers with prescribing authority may be asked to practice across state lines in jurisdictions where they are not licensed. Numerous legal provisions facilitate the emergency deployment of health care providers and allow them to temporarily practice and prescribe medications in the state

experiencing the emergency.²⁸ Once a state's governor officially declares an emergency, certain licensure waiver or reciprocity laws become active. For example, the Emergency Management Assistance Compact (EMAC), which all states have joined, allows health care providers licensed in one state to provide care in the state affected by the emergency.²⁹ This includes the ability to write prescriptions, consistent with the terms of the health care provider's licensure. EMAC, however, generally only applies to state and local government agents. Thus, a physician working for a local health department may be covered via EMAC, but a nurse working in a private hospital would not be.

Many states have enacted emergency laws to allow out-of-state health care providers to practice and, when appropriate, prescribe medications during an emergency.³⁰ For example, at least 13 states and localities have legislatively adopted a provision of the Model State Emergency Health Powers Act (MSEHPA) which, during a declared emergency, waives licensure requirements for health care providers serving in the affected jurisdiction—as long as they are properly licensed in their home state.³¹ In addition, the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA), which has been adopted in 11 states, allows registered volunteer health care providers to offer their services during a declared disaster through a local host organization.³² Like MSEHPA, provisions in the UEVHPA allow mental health care providers with prescribing authority in other jurisdictions to practice and prescribe in affected jurisdictions for the duration of the emergency. In addition, federal health care workers licensed in any state are authorized to practice and prescribe in any federal facility (such as a VA hospital) before, during, and after emergencies, thus facilitating their mobilization and abilities to reach affected populations.

Emergency laws, provisions, and compacts, including EMAC, MSEHPA, and UEVHPA, contain civil liability protections for health care providers who serve during emergencies. These protections extend to prescribing authority, as long as the health care provider is legally allowed to prescribe in his or her home state. For example, if a nurse is lawfully authorized to prescribe in his home state, he may be protected from liability for prescribing medications in a host state during an emergency. If the host state does not allow nurses to prescribe, however, then the nurse may not be able to issue prescriptions during the emergency, because some licensure reciprocity provisions require out-of-state nurses to practice according to the host state's licensing requirements.

During an emergency, whether they are providing care in their home state or elsewhere, mental health care providers must adhere to the federal and state laws that regulate the prescribing of medications. These laws contain limited emergency provisions, which may help to facilitate the prescription and dispensing of certain psychotropic medications to individuals who depend upon these drugs to treat a chronic mental health condition. For example, under federal law, in normal circumstances Schedule II drugs can only be prescribed via a written prescription. If certain conditions are met, including a prescriber's determination that an individual requires "immediate administration of the controlled substance ... and no appropriate alternative treatment is available,"³³ an oral prescription may be issued for a Schedule II drug. This prescription, however, can only contain the amount of medication necessary to provide treatment during the period that the individual faces an emergency situation.³⁴

III. CHALLENGES TO PRESCRIBING AUTHORITY DURING EMERGENCIES

Although some systems are in place to facilitate mental health care providers' prescribing authority during emergencies, significant challenges remain. These challenges arise, in part, from the twin needs of complying with emergency laws once they are activated and simultaneously adhering to non-emergency laws that remain in place during emergencies.

Emergency laws and agreements for licensure reciprocity or waiver among mental health care providers can facilitate the deployment of prescribers across state lines.³⁵ These emergency provisions, however, are vague in their treatment of certain providers who offer mental health care, namely PAs and APNs. These provisions are unclear about the status of the collaborative and supervisory arrangements that these providers often must maintain before they are allowed to prescribe medications. For example, if, in her home state, a PA can only prescribe controlled substances in consultation with her supervisory physician, must she establish a new supervisory agreement with an on-site physician during an emergency? Or, must she remain in contact with the supervising physician in her home state? Similarly, if an APN can only prescribe medications while part of an active collaborative agreement with a physician, can he prescribe psychotropic medications during an emergency if his collaborative agreement involves a physician in his home state? Should he, instead, create a new, temporary collaborative agreement with a physician in the jurisdiction facing the emergency? Also, until the emergency treatment of collaborative and supervisory arrangements is clarified, it remains uncertain whether PAs and APNs are fully protected by the liability provisions in emergency laws like MSEHPA and UEVHPA, because these protections require all health care providers to practice in accordance with the terms of their licensure.

Non-emergency prescribing laws, which may remain in place during an emergency, can also impact mental health care providers' ability to issue valid prescriptions to individuals in the affected jurisdiction. For example, the federal Drug Enforcement Administration recently promulgated regulations to allow health care providers to use electronic prescriptions for Schedule II through V controlled substances, which include some psychotropic drugs.³⁶ While this could expedite the process by which prescriptions are issued, particularly for Schedule II drugs that otherwise would require a written prescription,³⁷ states must first resolve inconsistencies or prohibitions in their own laws, which may impede e-prescribing of controlled substances.³⁸ During an emergency, mental health care providers must comply with the affected state's laws for the prescription of controlled substances, even if these laws have not yet been amended or otherwise revised to allow e-prescribing of controlled substances to the extent allowed under federal law.

Some states' laws will not allow health care providers to write prescriptions for an individual they have not examined or with whom they have not established a provider/patient relationship.³⁹ During an emergency in these states, particularly if there is a high demand for mental health services and a dearth of providers, mental health care providers will have limited time to take an individual's history, provide or confirm a diagnosis, and assess prescription medication needs. Unless this specific provision of law is waived during a declared emergency, mental health care providers will have to determine, on a case-by-case basis, whether they have had a sufficient opportunity to examine an individual and establish a professional relationship, in accordance with the state's law, before issuing a prescription. This judgment is made more difficult because there is not an established crisis standard of care for the provision of mental and behavioral health services during emergencies.⁴⁰ The Institute of Medicine has explained that a crisis standard of care is "a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive ... or catastrophic ... disaster."⁴¹ The development of a mental health crisis standard of care would greatly benefit mental health care providers who seek guidance about prescription-related decisions and compliance with state prescribing laws during emergencies.

IV. RECOMMENDATIONS

The challenges faced by prescribers during an emergency can seriously impede their ability to meet surge capacity and provide mental health care services to affected individuals. There are, however, measures that could be taken now—before the next emergency occurs—to respond to each of the challenges identified above. As the following recommendations explain, by building on existing systems and clarifying or revisiting current laws, prescribing authority for mental health care providers can be ensured and improved during emergencies.

Encourage states to enact their own emergency laws or adopt the UEVHPA to facilitate emergency coordination with out-of-state mental health care providers

Emergency interjurisdictional coordination among licensed mental health care providers can be greatly expedited if emergency laws are already in place. By adopting or updating emergency laws now, states can enhance their ability to meet surge capacity by permitting out-of-state mental health care providers to prescribe during emergencies. States may also consider extending the duration of their emergency declarations in limited contexts to allow out-of-state mental health care providers to continue to treat affected individuals whose mental health conditions persist.

Expand prescribing authority for PAs and APNs during emergencies

During an emergency where PAs and APNs cross state lines to provide care, variations in their prescribing authority under their home states' laws can lead to logistical complexities that impede the provision of mental health care (for example, some PAs will need to consult with a physician before prescribing controlled substances while others will not; some APNs will be able to prescribe Schedule II drugs while others will not). To avoid these difficulties, emergency laws could include a description of a standardized prescribing authority for PAs and APNs, which would remain in place for the duration of the declared emergency.

Clarify how emergency laws will treat collaborative and supervisory arrangements for PAs and APNs

Emergency laws and compacts like MSEHPA and EMAC do not address how collaborative and supervisory arrangements for PAs and APNs will be handled during declared emergencies. Until these laws incorporate language that clearly explains the status of these arrangements during emergencies, PAs and APNs will not know if they are in compliance with the law when they prescribe medications in an affected jurisdiction during a disaster.

Explore the expansion of limited prescribing authority for psychologists during emergencies

Only Louisiana and New Mexico grant psychologists the authority to prescribe medications as part of their clinical mental health care practice.⁴² While the remaining states may be reluctant to allow psychologists to prescribe medications, they may want to consider granting psychologists limited prescribing authority during declared emergencies to ensure that they have enough prescribers on hand to meet surge capacity. These states could, in non-emergency settings, offer coursework and training to provide additional certification to psychologists who would like to have prescribing authority during emergencies. States could also draw on the training materials used in the 1990s by the United States Department of Defense for its favorably evaluated Psychopharmacology Demonstration Project, which trained a group of military psychologists to prescribe psychotropic medications.⁴³ Temporary prescribing authority might be limited to Schedule III through V drugs, or even limited to non-controlled substances.

Encourage states to update their laws to allow e-prescribing

In states that have not yet updated their laws to allow e-prescribing of controlled substances to the extent permitted by federal law, health care providers are still legally required to comply with long-standing written and oral prescription requirements for controlled substances. If states update their prescribing laws to reflect the federal government's new e-prescribing regulations, prescribers could utilize this convenient technology in emergency and non-emergency contexts. During emergencies, when prescribers may need to act quickly, e-prescribing could lessen opportunities for mistakes and ensure that prescriptions reach pharmacies directly, as opposed to relying upon individuals affected by an emergency to deliver hard copies of their prescriptions to their pharmacists.

Allow dispensing of emergency refills by pharmacists in the absence of a valid prescription

Although pharmacists do not have prescribing authority, their training provides them with knowledge about controlled and non-controlled medications.⁴⁴ Subject to additional oversight, states may want to consider allowing pharmacists to refill prescription medications during a declared emergency even if an individual's usual prescription has expired and they do not have a refill prescription. California's Board of Pharmacy issued guidance about this practice after Gulf Coast residents relocated to California could not produce documentation of their prescription medication needs.⁴⁵ Other states could grant similar emergency privileges to pharmacists, perhaps allowing them to dispense only several day's worth of prescription medication at a time, to lessen opportunities for abuse of medications.

Publicize existing laws that allow prescribers to increase individuals' supplies of prescription medications

While federal law prohibits refilling prescriptions for Schedule II drugs,⁴⁶ federal regulations contain a loophole that could be important when prescribers are aware of an imminent emergency, such as an approaching hurricane. Prescribers can, by law, write multiple prescriptions for a Schedule II drug, providing up to a 90-day supply. The prescriber must specify on each prescription the earliest date when it can be filled and must use his or her best judgment about whether the issuance of multiple prescriptions is likely to lead to drug abuse.⁴⁷ Because this practice must be sanctioned at the state level, the states should revisit their prescribing laws to ensure that this option is available to prescribers.

Develop emergency prescribing guidelines for providers who have little time to establish a provider/patient relationship

Previous disasters have demonstrated that, during an emergency, there may be a high demand for particular services, such as mental health care, and a shortage of providers.⁴⁸ Those who have been deployed may feel overwhelmed and have only a few minutes to spend with an individual before making a prescribing decision. Professional associations should develop guidance to help prescribers understand how, during crises, their standard of care changes to allow them to rapidly make prescribing assessments and also meet the health care needs of a large number of individuals.

Expand electronic repositories for prescription information

After individuals displaced by Hurricane Katrina experienced significant difficulties in recalling or proving which chronic prescription medications they used, a collaboration of public and private entities created the In Case of Emergency Prescription History Service (ICERx.org).⁴⁹ This service contained information about individuals' medication histories that prescribers could access directly. Medication histories were drawn from participating

pharmacies and state Medicaid offices. This database, however, did not contain information about prescription medications used to treat mental illnesses, due to concerns about “sensitive healthcare conditions” and health information privacy.⁵⁰ On April 15, 2011, ICERX.org was discontinued.⁵¹ Lessons can be learned from this database for future endeavors. For example, perhaps through the use of an additional level of passwords or other security measures, similar database services could be developed and expanded to include information about individuals’ past prescriptions for mental health conditions.

CONCLUSION

The series of recommendations proposed in this article provides a starting point to ensure that mental health care providers maintain their prescribing authority during emergencies, allowing individuals to retain access to needed medications. Additionally, the recommendations suggest steps that could facilitate the ease with which mental health care providers write prescriptions in emergencies. Professional groups, such as associations of mental health care providers, can raise awareness about these recommendations by engaging in advocacy efforts at the local and state levels. Other stakeholders, such as emergency planners, can work with state legislators and regulators to develop and implement the types of solutions proposed in these recommendations. By acting now, the policy-making and preparedness communities can guarantee that, during and after an emergency, mental health care providers legally may offer individuals thorough treatment options, including, when appropriate, the prescription of psychotropic medications.

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