2023 Prescribing Psychologist Practice Survey

Robert Chang, Ph.D., M.S.C.P., A.B.M.P.
Board Certified Prescribing Medical Psychologist
Licensed Clinical Psychologist
Christus St Vincent
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Background

Despite the enactment of legislation in 2002 allowing for the practice of prescribing psychology in New Mexico, there has been a notable absence of formal initiatives aimed at surveying and compiling information regarding the clinical practices of prescribing psychologists in the state. While two informal surveys focusing on salary were previously conducted, there has been no systematic process in place to gather critical practice-related data. Such information is essential for enhancing understanding and assessing the impact of prescribing psychologists on the mental healthcare landscape of the state. Having access to up-to-date data covering various areas of practice would be highly beneficial for various purposes, including identifying community needs, evaluating strengths and weaknesses within prescribing psychologists' clinical practices, exploring potential avenues for advancement in the field, and providing support for advocacy efforts. Additionally, possessing such information facilitates the establishment of benchmarks or reference points concerning various practice variables. For example, the absence of such reference points puts job seekers at a disadvantage when negotiating benefits with potential employers. In addition, it is often argued that prescribing psychologists have been serving much of the underserved New Mexican population but to this date, there has not been any specific data to support this claim. At the end of 2023, a formal request for regular surveying of this nature was submitted to the SPA Board during the organization's last business meeting of the year. The request was approved by vote, recognizing the importance of gathering practice data to enhance the general understanding of how prescribing psychologists are practicing and to provide valuable information for advocacy purposes.

Methodology

Data collection was conducted through an online survey utilizing SPA's Survey Monkey account. The survey was developed by incorporating select questions from prior informal salary surveys and introducing additional questions designed to address four key areas of interest:

1. Provider demographics (e.g., age, gender identity, race/ethnicity, length of experience with RxP and psychology, expected retirement timeframe).
2. Practice characteristics (e.g., location, type of employment, Medicaid acceptance).
3. Benefits package (e.g., salary, types of fringe benefits).

4. Practice demographics (e.g., patient volume, percentage of patients from inpatient/ED, provider-admitted hospitalizations, appointment wait times, patient age group, acuity, income level).

The SPA Board reviewed the finalized survey, comprising 25 questions. Recipients of the survey were identified through SPA membership records, with a total of 81 email invitations sent after removing duplicate contacts. The survey was launched in the second week of January 2024 via Survey Monkey, accompanied by an email from the SPA president encouraging member participation. Follow-up reminders were sent approximately one week after the initial invitation and one week after the first reminder email.

Results

Data collection began in the second week of January 2024. Categorical data were analyzed using Survey Monkey's integrated tool, while numerical data were analyzed using Excel. Respondents from out-of-state (n=4, California, Iowa, Montana, Washington) and those who identified as non-prescribing psychologist (n=1) were excluded from the analysis due to their lack of relevance to exploring the practice of prescribing psychologists in New Mexico. The response rate was 41%, with a total of 34 respondents out of the invitees. As of January 26, 2024, one email invitation had bounced. After excluding out-of-state and a non-prescribing psychologist, a total of 29 respondents were included in the analysis, representing 44% of the prescribing psychologist workforce in New Mexico as of that date (n=66, from SPA website).

1. Provider Demographics

VARIABLES	**RESPONSES**
Age	M=57.43 (SD=11.23)
Gender Identity	
Male	62%
Female	38%
Race/Ethnicity	
White	79%
Black or African-American	0%
Hispanic/Latino	10%
Asian or Asian American	3%
American Indian or Alaskan Native	3%
Native Hawaiian or other Pacific Islander	0%
Choose not to answer	3%
Highest level of licensure	
Independent	83%
Conditional	14%
Years of RxP practice	M=9.83 (SD=5.99)
Years of practice prior to RxP licensure	M=16.86 (SD=9.73)

Estimated years of practice until retirement from full time practice	
1-4 years	21%
5-9 years	21%
10-15 years	28%
16-20 years	10%
21+ years	14%
already semi-retired	7%
Estimated years of practice until full retirement from the workforce	
1-4 years	21%
5-9 years	10%
10-15 years	31%
16-20 years	21%
21+ years	17%
already retired	0%

FULL RETIREMENT, TYPE OF EMPLOYMENT, AGE

Type of Employment by age	
Full time (n=17)	M=53.65 (SD=9.65)
Part time (n=12)	M=63.27 (SD=11.39)
Estimated year of practice until full retirement from the workforce|Full time	
1-4 years	12%
5-9 years	12%
10-15 years	24%
16-20 years	24%
21+ years	29%
Estimated year of practice until full retirement from the workforce|Part time	
1-4 years	33%
5-9 years	8%
10-15 years	42%
16-20 years	17%
21+ years	0%

Discussion: The data showed prescribing psychologists as a seasoned workforce, with an average age of approximately 57 years, indicating extensive experience in their respective fields. This contrasted with the average age of non-prescribing psychologists, which was reported to be 49 years old according to the American Psychological Association (2022). The notable age difference likely stemmed from the relatively young movement of prescriptive

authority, which initially attracted experienced providers deep into their careers. To this date, some of the pioneers of the movement continue to practice in New Mexico. With an average of 17 years of diagnostic, case conceptualization, testing, psychotherapy, and treatment planning experience prior to obtaining a prescribing license, these veteran clinicians bring a wealth of expertise to their practice. This is particularly significant as psychologists are commonly recognized as the gold-standard providers of non-pharmacological treatment and research for mental health interventions. Moreover, the results also denoted that on average, prescribing psychologists also have an additional 10 years of prescribing practice. It is likely that the convergence of these factors supports the field's continual safety record.

Nonetheless, this considerable length of service also raises concerns regarding succession planning and workforce expansion, as many providers have expressed their intention to retire within the next 15 years. With further examination, the data suggest that among those who were working part time, with an average age of 63 years, the majority (83%) of the workforce reported planning to retire within 15 years or earlier and 41% within the next 9 years or earlier. Among those who reported working full time, the average age was 54 years and 24% noted intention to retire fully in 9 or less years. The gender distribution among prescribing psychologists revealed a notable difference, with a majority being males; nonetheless, this gender distribution difference was not as large compared to non-prescribing psychologists. As per APA data in 2021, almost 70% of non-prescribing psychologists were female providers. Similar to non-prescribers, the racial and ethnic composition of prescribers reflected broader societal disparities, with a significant majority identifying as White (79%). This is particularly noteworthy considering that about 50% of the population of New Mexico (Wikipedia, 2024) is composed of Hispanic and Latino individuals. Addressing these disproportions is important for fostering a more representative and inclusive prescribing psychologist workforce, which is of high relevance for improving healthcare access and outcomes for diverse patient populations.

2. Practice Characteristics

VARIABLES	**RESPONSES**
Location of practice	
Urban	76%
Rural	38%
Pueblo	3%
Cities:	Farmington, Aztec, Bloomfield, Crownpoint, Quemado, Bernalillo, Albuquerque, Edgewood, Las Lunas, Belen, Socorro, Raton, Ojo Caliente, Angel Fire, Raton, Santa Fe, Las Vegas, Moriarty, Las Vegas, Cannon AFB, Tularosa, Alamogordo, Hollomon AFB, Truth or Consequences, Las Cruces, Anthony, Deming, Lordsburg, Hatch, Hobbs, Donna Ana, Pena Blanca, Los Alamos, Grants
Type of employment	
Full time	59%
Part time	41%

Work status	
Salary	45%
Contract work	38%
Private practice	52%
Multiple (any combination of the above)	31%
Type of employer	
Federal Gov	10%
State Gov	7%
Local Gov/City	0%
Private sector for profit	45%
Private sector non-profit	28%
Academia	7%
Took Medicaid	
Yes	97%
No	3%

Discussion: Based on the responses, the majority of healthcare providers practiced in urban areas (76%); however, it was noteworthy that a significant portion also served in rural areas (38%), highlighting the need for access to care in underserved communities. Several respondents mentioned serving in both urban and rural areas, such that they were employed by community clinics in a major city with satellite locations in rural regions of the state. Furthermore, the integration of telehealth into healthcare practices has enabled many providers to extend their services to rural areas while primarily working from an urban locale. Consequently, the distinction between geographical locations is becoming increasingly blurred, suggesting that geographic limitations may pose less significant challenges with time. Nonetheless, it is notable that close to 40% of the workforce serving rural areas by prescribing psychologist is remarkable, underscoring the significant contribution of these clinicians who are treating the underserved populations in New Mexico. Approximately 59% of responders worked full-time, while 41% worked part-time. On the one hand, this distribution suggested that there is flexibility in employment arrangements within the behavioral healthcare sector of the state. On the other hand, as noted in the previous section, a relatively large portion of providers working part-time may be influenced in part by their age (average 63 years old), with some nearing retirement. This is in contrast to those working full time (average age 54 years old). The majority were in private practice (52%), followed by those on salary positions (45%) and those who engaged in contract work (38%). It should also be noted that these employment types were not mutually exclusive, as many providers (31%) also noted having a combination of sources of work, such as salary and/or private practice and/or contract work together. This diversity in employment types reflected a range of opportunities available to providers. The most common type of employer was the for-profit private sector (45%). Non-profit private sector employers also played a substantial role (28%), and federal government entities (10%) as well. An important finding was that the vast majority of providers (97%) accepted Medicaid, again highlighting prescribing psychologists' commitment to serving low-income and vulnerable

populations. This high participation rate suggested a strong commitment to addressing access to essential services for underserved communities in New Mexico.

3. Benefits package

VARIABLES	RESPONSES
Fringe benefits	
No benefits (private practice, contract)	48%
Health insurance	45%
401k/403b	38%
Paid vacation	48%
Paid sick days	38%
Paid continuing education	45%
Bonus	24%
Income:	
All full time (salary, contract, private practice, n=17)	M=$191,000 (SD=$66,247)
Salary only, full time (n=7)	M=$223,571 (SD=$70,752)
Part time (n=11)	M=$63,2998 (SD=$76,618) Median=$30,000, (Range=$244,000)

Discussion: A significant portion of the respondents (48%) reported receiving no fringe benefits, particularly those in private practice or on contract. This suggests that a notable portion of providers may lack traditional employment benefits, but expectedly given the nature of the type of income source. However, health insurance, paid vacation, and continuing education benefits were prevalent among respondents who received a salary, with 45%, 48% and 45% respectively, denoting that access to these benefits is relatively common in this type of employment. When examining income, a surprising finding was noted: responders solely on salary and working full-time had a higher average income of $223,571 (SD=$70,752), compared to the average income of $191,000 (SD=$66,247) for all full-time responders, which included those with any combination of salary, contract, and private practice. This difference was unexpected, as one might assume that a salary alone-based arrangement would yield a lower income compared to private practice or clinicians with various sources of income. This underscores the necessity of having current reference data to be easily accessible, as job seekers considering different employment avenues could have leveraged this information to negotiate more favorable compensation packages. The income of part-time respondents exhibited significant variability, as evidenced by the standard deviation being larger than the mean. Consequently, both the median and range were provided to offer a better understanding of the income distribution. This considerable variation in earnings could again be attributed to the lack of readily available salary benchmarks which could have been used during benefit negotiations.

4. Practice Demographics

VARIABLES	RESPONSES
Number of patients seen in a day	
Full time (n=17)	M=11.88 (SD=3.53)
Part time (n=12)	M=6.00 (SD=5.62) Median=4.00 (Range=19)
Hours worked per week	
Full time (n=6)	M=38.67 (SD=4.55)
Part time (n=9)	M=11.33 (SD=5.41)
Percentage of patients directly from inpatient/emergency room	M= 7% (SD=10%) Median= 5% (Range= 50%)
Number of patients provider hospitalized	M= 6.93 (SD=8.55) Median= 4.00 (Range= 35)
Wait times for an intake	
< 1 month	48%
1-2 months	31%
3-4 months	10%
5-6 months	7%
7+ months	3%
Wait times for a follow up	
< 1 month	62%
1-2 months	34%
3-4 months	3%
5-6 months	0%
7+ months	0%
Age groups of patients	
children	M=18.21% (SD=24.80%) Median= 10% (Range=90%)
adolescents	M=17.59% (SD=13.61%)
adults	M=51.48% (SD=25.45%)
seniors	M=16.46% (SD=10.05%)
Income group of patients	
low income	M=49.11% (SD=31.27%)
low middle income	M=21.92% (SD=12.25%)
middle income	M=25.21% (SD=20.98%)
middle high income	M=9.47% (SD=6.64%)
high income	M=5.00% (SD=5.27%) Median=5.00% (Range=20.00%)
Acuity of patients	
mild to moderate	M=25.54% (SD=23.97%)
moderate to severe	M= 37.86% (SD=15.24%)

severe/persistent	M= 31.07% (SD=20.88%)
crisis/acute	M=6.35% (SD=4.37%)

Discussion: Expectedly, full-time providers saw more patients per day compared to part-time providers, with an average of almost 12 patients and 6 patients for part-time (although with considerable variability). Similarly, full-time providers work longer hours per week, averaging 39 hours compared to 11 for part-time providers (not all responders provided the hours worked per day). Although the responses noted relatively small percentage (7%) of patients directly from inpatient or emergency room settings, there was significant variability in the report. Similarly, this was also the case for average number of patients that were hospitalized by the providers. The median and range are noted in the table above and these data points should be interpreted cautiously. Wait times for appointments were relatively short, with the majority of openings for intakes and follow-up appointments being available within a month suggesting a good sense of accessibility for the much-needed services provided by prescribing psychologists. The patient population served by the responders was diverse, spanning different age and income groups. Adults made up the largest proportion of patients (51%), followed by adolescents (18%), children (18%), and seniors (16%). The children age group had the most variability as a significant portion of providers did not see children and some providers focused on seeing this age group. Additionally, patients come from various income backgrounds, with a significant proportion falling into low-income (49%) and low-middle-income (22%) categories. Providers encounter patients with varying levels of acuity, with the majority falling into the moderate to severe category (38%) followed by severe/persistent mental health problems (31%).

A noteworthy point to highlight is the similarity of workload between prescribing psychologists and community based psychiatrists. According to McQuistion and Zinns (2019), a sample of approximately 30 full-time psychiatrists in outpatient clinics from different states also reported seeing approximately 12 patients a day when describing their workload. This finding underscores the significant role that prescribing psychologists play in delivering mental health services, particularly in areas where access to psychiatrists may be limited.

Conclusion and Discussion

In conclusion, the findings from the survey shed light on various aspects of clinical practices and demographics of the group. This survey has provided valuable insights into the workforce, revealing a seasoned group of clinicians with extensive experience in both psychology and psychopharmacology treatments. Related to this, as a group, retirement of providers may become an issue in the next 10-15 years if the growth of younger prescribing psychologists does not keep up with outflow of senior providers. In addition, there are important disparities in race and gender representation that would be worthy to address to ensure a more inclusive and representative workforce reflective of the population in New Mexico.

The responses also highlighted the significant contribution of prescribing psychologists in addressing behavioral healthcare inequalities by serving rural and underserved populations, often through community clinics and telehealth services. The majority of respondents demonstrated a commitment to Medicaid acceptance, emphasizing the group's dedication to providing essential services to low-income and vulnerable communities with significant mental health challenges.

Furthermore, the survey revealed similarities in workload between prescribing psychologists and community-based psychiatrists, emphasizing the crucial role of prescribing psychologists in delivering mental health services, particularly in areas with limited access to psychiatrists.

While the survey conducted among prescribing psychologists in New Mexico provided valuable insights into their clinical practices and demographics, there is a notable limitation. Although at first glance, 29 respondents may seem like a small sample size; however, this represented 44% of the prescribing psychologist workforce in the state. Given this, interpretation of the results should be taken with some caution in mind but can also be considered as generally meaningful. Future surveys should account for this limitation at the planning stage to find ways to increase participation. Overall, the data gathered from this survey can serve as a foundational resource for understanding and advocating for the continued advancement of prescribing psychologists' practices in New Mexico.

References

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