

May 21, 2018

Ohio Legislature

HOUSE HEALTH COMMITTEE

Re: Psychologist who OPPOSES HB326 relating to authorizing psychologists to prescribe psychotropics

Dear Chair Huffman and other honorable representatives:

This is individual testimony that is informed from my experience as a doctoral-level psychologist since 2002. My experience includes being a Professor of Psychology at Linfield College since 2002 and conducting research on this issue to try to understand psychologists' knowledge and views of prescriptive authority as well as psychologists' likelihood of training to pursue prescriptive authority. My opinions do not represent the College. My opinions are consistent with testimony submitted by Psychologists Opposed to Prescriptions Privileges for Psychologists (POPPP) and I am on the Board of Advisors of POPPP.

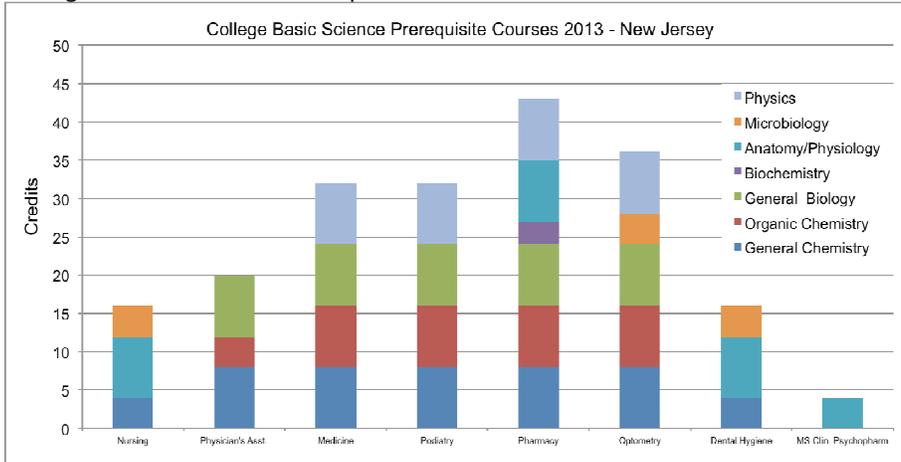
I am writing to request that you oppose HB326 and any future initiatives that would allow psychologists to prescribe psychotropic medications in Ohio. I have been active in opposing legislation in Oregon and was a part of the team that convinced our Governor to veto a bill in 2010 that was pushed through both the house and senate in a short special session. Governor Kulongoski cited concerns about the lack of evidence to support both the safety and efficacy of such a drastic change in scope of practice. Hawaii's Governor Lingle, echoing worries about safety, cited consumer protection concerns in her rationale for vetoing Hawaii's bill nearly a decade ago. I fought alongside consumers and colleagues from allied health and mental health disciplines in 2017 to again convince our Governor to veto another psychologist prescribing bill. Governor Brown cited significant risks with no clear evidence it would improve care or access. Below I detail my most serious concerns. I also reference two recent peer-reviewed articles as they contain figures demonstrating several key points of concern: failed efforts across many states that drain time and money away from real solutions to mental health problems; vast discrepancy between psychologists' preparation relative to other non-physician prescribers; lack of evidence to support arguments of improved access. I strongly believe that the stigma that surrounds mental illness serves as a more formidable barrier to accessing care than any other factor and is one that would not be addressed by establishing a lesser-trained class of psychologist prescribers. In fact, I would suggest that bills like HB 326 promulgate the stigma that those suffering from mental health problems currently face. During the legislative process, there is typically wrangling over the bare minimum training acceptable to medically treat the mentally ill. This race to the bottom echoes the message that is acceptable to provide sub-standard care to folks who suffer from mental illness. It is not. They deserve better care.

Reasons for Opposition involve Risk to the Consumer

- Training for a doctorate in clinical psychology does not include pre-medical or medical training (see Figure 1 from Robiner et al., 2013 - psychologists are not prepared with even the most basic science courses prior to entering graduate school).

Figure 1

College Basic Science Prerequisite Courses for Admission to Health Science Programs



Note: Multiply credits by 10 for estimated hours of instruction. These data were derived by 2013 survey of admission requirements to the largest programs in New Jersey (e.g., Farleigh Dickinson University, University of Medicine and Dentistry of New Jersey, Rutgers University). Although there were no physical or health sciences prerequisites for entry into the Ph.D. programs in Clinical Psychology, both the FDU and Rutgers curriculum included one course in biopsychology or behavioral neuroscience.

- There is virtually no evidence that reducing medical training to about 10% of that required for physicians and about 20% of that required for advanced practice nurses (advanced nurse practitioners) will protect the consumer.
- 89.2% of members of the multi-disciplinary Association for Behavioral and Cognitive Therapies (ABCT) argue that medical training for psychologists to prescribe **should be equivalent to other non-physician prescribers** (*The Behavior Therapist*, September 2014). A survey of Illinois psychologists and Oregon psychologists yielded similar findings (78.6%; Baird, K. A. [2007]. A survey of clinical psychologists in Illinois regarding prescription privileges. *Professional Psychology: Research and Practice*, 38, 196-202. doi:10/1037/0735-7028.38.2.196; 69.2%; Tompkins & Johnson [2016]. What Oregon psychologists think and know about prescriptive authority: Divided views and data-driven change. *Journal of Applied Biobehavioral Research*).
- The 2014 ABCT survey found only 5.8% endorsed the effectiveness of online medical training, which is permitted in this bill and only 10.9% would refer a patient to a prescribing psychologist whose medical training is what is required in similar bills.
- Proponents claim that the lack of a reported death or serious harm by prescribing psychologists somehow provides evidence of safety. It does not! It only provides evidence that any harm done by these psychologists was not identified and reported by the psychologists themselves or their patients. A lack of evaluation of safety, and the absence of any credible, comprehensive system to identify problems, does not constitute evidence for safety. Psychologists' meager training to diagnose physical problems suggests that psychologists probably would not even know if their prescribing had caused medical problems.
- Recent data from the Part D Prescriber Public Use File (PUF) from the Centers for Medicare and Medicaid Service (CMS) suggests that some medical psychologists from Louisiana and prescribing psychologists from New Mexico have been prescribing beyond the legislative bounds of their licenses. For example, not only have they 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, several classes of drugs used to treat cardiovascular disease (e.g., metropol succinate, lisinopril), neurological problems (e.g., memantine) and other systems (e.g., potassium chloride) reflect prescribing practices well beyond the competence of 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.

- The 2014 ABCT survey found that 88.7% of psychologists agreed that there should be a moratorium on bills like this one until there is objective evidence that the training involved adequately protects consumers.
- The impact of prescribing privileges in New Mexico and Louisiana should be objectively evaluated for consumer safety before any experiment in psychologist prescribing is allowed in Idaho. Consumer safety outcome in the military is difficult to evaluate owing to the Feres Doctrine and the small number of prescribing psychologists (e.g., 2 in the Navy and 4 in the Air Force). Recent lawsuits in Louisiana call into question proponent's arguments that short-cut training equips psychologists to be effective and safe prescribers.
- Given proponents of prescriptive authority for psychologists (RxP) spent over \$500,000 to pass a prescribing bill in Louisiana alone speaks to the availability of funds to conduct such a consumer safety study for the amount of medical training required in this bill.

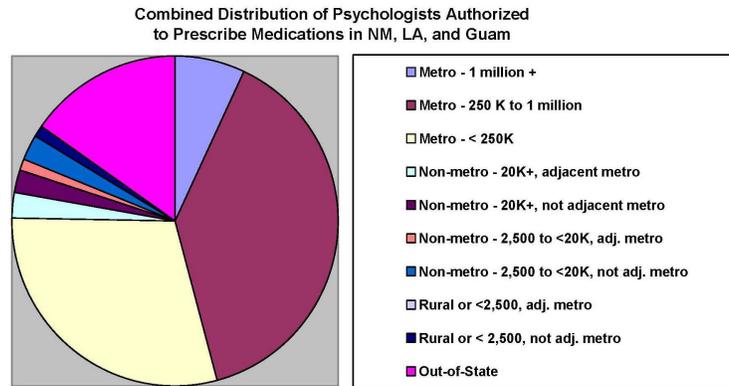
The State of Illinois has set a more appropriate standard for prescription privileges for psychologists

- In 2014, the State of Illinois enacted a law to permit 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 training requirement is similar 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).
- No online medical training is acceptable.
- The Illinois Psychological Association, Nursing and Medical associations, and POPPP support the Illinois law, as it requires, at minimum, the same medical training as other non-physician prescribers. This is more appropriate than the APA model in that it meets an existing standard for healthcare providers, rather than establishing a new lower standard.

Solutions to Access to Psychoactive Drugs

The stated rationale for proposing such bills is to improve access. There is NO EVIDENCE to suggest that allowing psychologists to prescribe will improve access in any meaningful way. Additionally, there are many alternatives to psychologists prescribing that more appropriately enhance access to the prescription of psychoactive medications in those individuals who would benefit from them.

1. Collaboration between psychologists and physicians.
2. Completion of medical or nurse practitioner or physician assistant education by psychologists. Encouraging medical and nursing schools to offer executive track programs for psychologists.
3. Use of tele-psychiatry, which is promoted by the Department of Veterans Affairs, the military, and the U.S. Bureau of Prisons, and rural health centers, is an effective means of transcending distance between psychiatrists and patients. It is a mechanism for providing direct patient care by psychiatrists as well as a technology for providing primary care providers with appropriate consultation to develop appropriate treatment regimens, thereby extending the reach and impact of psychiatrists.
4. Encouraging all professionals to serve rural areas. The prescribing laws in New Mexico and Louisiana did not result in psychologists moving their practices to rural areas as they had declared would happen (see attached chart from Tompkins & Johnson, 2016; used with permission; no prescribing psychologists in Guam identified despite enabling legislation in 1999). A recent survey in Oregon is consistent with prior studies (94% - Baird, 2007) in showing that the vast majority of psychologists sampled (96%) practiced in metropolitan areas and those practicing in non-metro areas were no more likely than urban psychologists to express an interest in pursuing prescriptive authority. Additionally, few (less than 7%) Oregon psychologists expressed an interest in pursuing training to become prescribers; in fact, results support prior survey results of both Oregon (Campbell et al., 2006) and Illinois (Baird, 2007) psychologists in suggesting that few have an interest in pursuing training and even fewer plan to prescribe.



*Note: There are no prescribing psychologists practicing in Guam despite legislation being passed granting prescriptive authority to psychologists in 1999.

Thank you for your kind consideration of this opinion,

Respectfully,

Tanya L. Tompkins, Ph.D.
 Professor of Psychology
 Linfield College