Testimony and Appendix re SB 300 November 16, 2016

1) **Need for Mental Health Specialists who can prescribe medication**
   a) Infographic: Mental Health in Ohio With and Without Prescribing Psychologists
   b) Dayton Daily News Article
   c) Psychologists Prescribing: The Best Thing That Can Happen to Psychiatry (The Carlat Psychiatry Blog)
   d) RxP and Serving the Poor in New Mexico – January 2015
   e) The NIMH Director's blog (June 2011) quoted these numbers

2) **Medical Staff Satisfaction with Prescribing Psychologists**
   a) Primary Care Prescribing Psychologist Model: Medical Provider Ratings of the Safety, Impact and Utility of Prescribing Psychology in a Primary Care Setting-2012
   b) Department of Defense Evaluations
   c) New Mexico State Licensing Board Letter
   d) Study of Medical Co-workers of Prescribing Psychologists-2015

3) **Training**
   a) Comparison of Entry Level Training Models Leading to Prescriptive Authority
   b) Examples of Masters in Clinical Psychopharmacology Curriculum from Four Universities
   c) Comparison of One Clinical Psychopharmacology Degree with Physician Assistant and Nurse Practitioner Program Examples from Case Western
   d) Formal Education Training Compared
   e) Key Facts About Prescriptive Authority for Psychologists

1a

MENTAL HEALTH in OHIO...

WITHOUT PRESCRIBING PSYCHOLOGISTS

ONE MENTAL HEALTH PRESCRIBER serves an Ohio population of 6,118.

1,755,639 ADULTS in Ohio suffer from mental illness. Of those, 380,974 have unmet mental health care needs which is equal to filling "The Shoe" 3 1/2 times.

298,164 CHILDREN in Ohio suffer from emotional, behavioral or developmental issues. Of those, 100,481 have unmet mental health care needs which is equal to filling "The Shoe."

72 OF OHIO'S 88 COUNTIES have areas deemed "Mental Health Shortage Areas."

How does your county rank?

WITH PRESCRIBING PSYCHOLOGISTS

IMPROVEMENT in access to mental health prescribers **29%**

If ONLY 25% of Ohio Psychologists become prescribers, ONE MENTAL HEALTH PRESCRIBER would serve an Ohio population of 4,333.

NO STATE FUNDING REQUIRED.
SB 300 is COMPLETELY SELF-FUNDED by psychologists.

ZERO COST TO TAXPAYERS

$0

PSYCHOPHARMACOLOGY MASTERS PROGRAMS at Ohio universities & colleges will create new jobs, attract more students and boost the economy.

PRESCRIBING PSYCHOLOGISTS: A SAFE and ECONOMICAL SOLUTION, PROVEN to be EFFECTIVE in addressing access to mental health care challenges.

Counties With NO Prescribers or Psychologists *

Carroll
Coshocton
Harrison
Monroe
Morgan
Noble
Vinton

** Counties with No Psychiatrists, Psych NPs, or Psychologists*

Counties With Psychologists but NO Psychiatrists

Champaign
Hardin
Meigs
Mercer
Morrow
Ottawa
Paulding
Pike
Preble
Putnam
Shelby
Van Wert
Williams
Wyandot

Counties Ranked by Specialty Mental Health Prescriber to Population Ratio... with one offering the best access

1. Cuyahoga
2. Hamilton
3. Athens
4. Summit
5. Greene
6. Ross
7. Montgomery
8. Lucas
9. Franklin
10. Allen
11. Warren
12. Belmont
13. Erie
14. Mahoning
15. Gallia
16. Stark
17. Geauga
18. Hancock
19. Fulton
20. Henry
21. Muskingum
22. Defiance
23. Clark
24. Guernsey
25. Licking
26. Richland
27. Lake
28. Butler
29. Wood
30. Marion
31. Trumbull
32. Washington
33. Portage
34. Fairfield
35. Medina
36. Scioto
37. Miami
38. Jefferson
39. Seneca
40. Clinton
41. Hocking
42. Fayette
43. Sandusky
44. Logan
45. Lorain
46. Tuscarawas
47. Ashtabula
48. Darke
49. Columbiana
50. Union
51. Clermont
52. Knox
53. Highland
54. Madison
55. Ashland
56. Delaware
57. Adams
58. Pickaway
59. Wayne
60. Huron
61. Lawrence
62. Jackson
63. Perry
64. Crawford
65. Holmes
66. Brown
67. Auglaize

SB 300

- Improves the prescriber population ratio in counties that do not currently have any mental health prescribers,
- Costs taxpayers nothing, as it is a self-funded solution,
- Presents opportunities for job growth,
- Attracts new students and professionals to Ohio, while
- Efficiently and safely addressing the need for improved access to mental health care which in turn supports a healthy and productive environment of all Ohioans.

***Reference**: Data based on July 14, 2015 NPI data available at http://download.cms.gov/nppes/NPI_Files.html*

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1b

Dayton Daily News 11-7-16

Bill could improve mental health care

Psychologists in Ohio would be able to prescribe medicine.

By Michael Cooper
Staff Writer

SPRINGFIELD — A bill recently introduced in the Ohio Senate that would allow psychologists to prescribe medicine could improve much-needed access to mental health care in Clark County, local health leaders said.

However a statewide psychiatrists group believes the training requirements in the bill aren't enough to allow them to prescribe drugs.

Senate Bill 300 was introduced earlier this year by state Sen. Bill Seitz, R-Cincinnati. It would allow psychologists to obtain a certificate from the State Board of Psychology to prescribe medications to patients, similar to physician assistants and advanced practice nurses.

The bill will address the shortage of psychiatrists in Ohio and Clark County, which puts a strain on mental health services, Springfield-based psychologist Dr. H. Owen Ward said.

Currently there's 1,070 people for every one mental health provider in Clark County, according to the most recent County Health Rankings. That ranks behind both the state (at 640 to one) and the top performers in the United States (at 370 to one).

Four states – New Mexico, Louisiana, Illinois and Iowa – allow psychologists with appropriate training to prescribe drugs for mental health issues such as depression and anxiety.

"A number of psychiatrists that are in practice are aging and the number entering psychiatry are low," Ward said.

Psychiatrists and psychologists are both doctors. However psychologists typically earn a doctorate degree in psychology, while psychiatrists attend medical school and are medical doctors – which allows them to write prescriptions.

About a handful of psychiatrists have private practices in Clark County, which Ward said typically have a two- to three-month waiting list. He usually works with a patient's family doctor to write prescriptions for his patients.

Psychologists are well-trained in the field of psychotherapy and behavioral treatment. If approved, Ward said the bill would allow them to prescribe anti-depressants and anti-psychotic medications.

More than 21 percent of Clark County residents surveyed by the Clark County Combined Health District had days when their physical or mental health limited activities, according to the 2016 Community Health Assessment – which also ranks higher than both the 2013 numbers for both Ohio (20.6 percent) and the nation (19.7 percent). Clark County adults also struggle to pay for mental health care. About 17 percent of Clark County's population is uninsured, according to the health rankings. The recent Medicaid expansion has improved access to mental health care here, Ward said, but psychiatrists often won't accept those types of insurance. In the past, he's sent patients out of the county for treatment.

The training required in the proposal is equivalent to a Master's degree in psycho-pharmacology, Ward said, including two years of education and two to three years of training and supervision – similar to physician assistants and nurse practitioners.

About 25 psychologists would be able to prescribe in the short-term, Ward said, but the bill could also lead to programs at colleges and universities offering similar programs, creating an influx of doctors who can prescribe medications.

"We're not talking about an immediate change overnight," Ward said. "Over the span of 10 years, it would make a huge difference and that will have an effect on Clark County."

The Ohio Psychiatric Physicians Association opposes the bill, citing what it called an insufficient level of training set to allow psychologists to safely prescribe drugs, said President Dr. Alan Levy, a Columbus-based psychiatrist. The bill calls for a 425-hour training course, Levy said, which is all done online.

They want to see psychologists complete a two-year program similar to nurse practitioners and physician assistants, he said.

"They would be able to achieve that in a much safer fashion," Levy said.

There are many different ways to use current resources effectively, Levy said, including tele-psychiatry options for rural patients and integrated behavioral health care at primary physicians' offices.

About 80 percent of people with depression receive medication from their family doctor, he said.

Access to care is a concern, Levy said, but the No. 1 concern is patient safety. That includes knowing the other medical systems within the body, he said, because physical illnesses can often look like mental illness.

"We wouldn't want someone who is inadequately trained to prescribe to be able to do so just because a physician is not handy to prescribe that medication or someone needs to travel an hour to see a psychiatrist," Levy said. "If inadequately trained (people) are prescribing, it's not safe for the people who are getting these medications."

The legislation can provide greater access to care, Mental Health and Recovery Board of Clark, Greene and Madison Counties Chief Executive Officer Greta Mayer said.

Dayton Daily News 11-7-16

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1c

The Carlat Psychiatry Blog

Keeping Psychiatry Honest Since 2007

Monday, March 22, 2010

Psychologists Prescribing: The Best Thing That Can Happen to Psychiatry

First, I apologize to readers of my blog for the paucity of posts lately. The reason has nothing to do with my health (I had a mitral valve repair surgery at the end of March and have recovered uneventfully). I've been too busy with a bunch of things, all of which are coming to fruition this May. These includes a book called *Unhinged*: The Trouble with Psychiatry; an article to be published in the *New York Times Magazine*; launching a new newsletter called *The Carlat Child Psychiatry Report*, to be edited by Dr. Caroline Fisher; and new blog columns for both *Psychiatric Times* and *Psychology Today*.

So I won't be able to keep up the twice weekly pace that I think is truly minimal for a good blog, but I'll do the best I can.

Today I want to touch on what is probably the hottest topic in psychiatry: whether psychologists should obtain prescription privileges. This is topical because Oregon just overwhelmingly passed a law authorizing prescriptive privileges for psychologists, although it is unclear whether the governor will sign the bill.

I endorse psychologists prescribing, and here's why: it would be the single best thing that could happen to psychiatry. Yes, I know it sounds ridiculous, but here's my reasoning. Psychiatry has boxed itself into a tiny corner of medicine called "psychopharmacology." It's a silly way to practice our craft, because the essence of what we do is to understand the mind and to help people live better lives. Drugs are effective but only one of the tools available to us, and we have largely ceded psychotherapy to psychologists and social workers. The result is a fragmentation of care. You see your "p-doc" for your meds, and you see your therapist for your mind. Each professional is far too busy to communicate with the other.

While there are plenty of patients out there who do so well on meds that they don't need therapy, the majority of patients do best with both meds and therapy. But psychiatrists rarely provide the full package of treatment, because we are trapped in a system of incentives that discourage integrative care. Insurance companies pay more for med visits. Drug companies throw the full force of their marketing machinery into pushing medications. The top psychiatrists find that the road to academic glory lies in psychopharm research. And our anachronistic training system, which requires that psychiatrists attend medical school, selects for practitioners who see people in terms of discrete diagnoses, and who are rarely psychologically minded.

Enter psychologist prescribers. These are professionals who went into their field because they are fascinated by the human mind. From early in their training, they learn about psychiatric diagnosis, psychological testing, psychotherapy, interpreting behavioral science research, neuropsychology, etc…. They don't go to medical school, so they learn nothing about such crucial psychiatric topics (being sarcastic here) as gross anatomy, histology, pathology, or the physical exam, nor do they have clinical rotations that psychiatrists draw upon daily, such as Ob/Gyn, surgery, internal medicine, radiology, and others. Thus, psychologists don't learn how to deliver a baby or how to tie a surgical knot, but they do learn how to get at the root of anxiety and how to keep patients coming back for treatment.

Psychologists first obtained prescriptive privileges in the military through the Department of Defense demonstration project, and since then have been awarded privileges in both New Mexico (2002) and Louisiana (2004). The lengths of the training programs vary, though they are typically two year programs incorporating both didactics and a clinical practicum. Many have charged that these two

year mini-programs cannot possible produce safe prescribers. But the evidence contradicts this position. There have been no adverse events reported in any of the programs operating thus far.

As the safety data gradually accrues, I predict that psychologists will attain prescriptive privileges in most states over the next 10 to 20 years. We saw the same pattern in the 1970s with nurse practitioners—psychiatrists and other physicians engaged in bitter turf wars initially, arguing that they didn't have enough training, but large scale health services research studies eventually demonstrated that NPs operated competently and safely, and now they are accepted as independent practitioners in most states. As it turned out, there is so much business to go around that psychiatric nurse clinicians have not eaten into psychiatrist's practices or incomes. On the contrary, since NP's must receive regular supervision, many psychiatrists have developed side gigs supervising nurses, charging $200 to $300/hour—more than you can make seeing patients.

According to some psychologists I have spoken with, the early experience in New Mexico and Louisiana is that psychiatrists and medical psychologists (that's what they are termed in Louisiana) are accommodating to one another and that psychiatrists are not losing business. But as more and more states approve prescribing psychologists, this will probably change. I predict that patients will vote with their feet and preferentially see prescribing psychologists once they realize that such practitioners provide one-stop shopping—meds and therapy combined.

And herein lies the great opportunity for psychiatry. As psychologists gradually become serious competitors for our patients, we will have to re-evaluate how we practice and how we are trained. We will have to take a close look at our catastrophically inefficient medical school-based curriculum. We will have to decide which medical courses are truly necessary and which are not. I suggest that the process begin with a work group created jointly by the American Psychiatric Association and the American Psychological Association. Yes, let's get psychiatrists and psychologists in the same room, and create an ideal curriculum for integrative psychiatric practitioners. Let's face it, going to 5 to 7 years of psychology graduate school, then capping it with 2 years of psychopharmacology is not an efficient use of training resources. It's almost as inefficient as going to four years of medical school, one year of medical internship, then three years of psych residency.

There must be a middle path—perhaps a five year program that would interweave coursework in physiology, pharmacology, and psychology from day one. The specifics would require much thought and discussion, and would best be done by reverse engineering. Start with the ideal psychiatric practitioner, list the core competencies such a person requires, and then figure out the very best way to teach those competencies.

On the other hand, organized psychiatry can continue on its current path, which involves throwing millions of dollars into lobbying efforts to fight psychologists. The money is being wasted, I can guarantee that. At the end of the day, we will be on the sidelines as patients flock to prescribing psychologists and our professional sphere constricts further and further into a narrowly defined neuropsychiatry role. We can do much, much better than that.

1d

RxP and Serving the Poor in New Mexico – January 2015

Background

Individuals from lower socioeconomic classes in general have a much higher risk of mental health problems (http://epirev.oxfordjournals.org/content/26/1/53.full), due to a number of factors including: job insecurity, exposure to violence, humiliation and a higher number of stressful events in general.

Mental health problems, especially among the poor and severely mentally ill are a highly significant issue in New Mexico. New Mexico has approximately 2 million residents. Of these, approximately 72,000 adults have serious mental health challenges. The public mental health system provides service to only about 24% of the adults with these problems. About 1,500 of these adults are incarcerated. Approximately 22,000 children have serious mental health conditions, and over 40 percent of the children with serious mental health conditions dropped out of high school during the 2006 – 2007 school year. http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93510).

Prior to the Affordable Care Act implementation, New Mexico had the 5th highest uninsured rate in the United States at almost 25%. Another 23% were enrolled in Medicaid and 3% had health coverage from other public sources. (http://www.cnbc.com/id/101751045#.).

In short, about one half of New Mexicans had no insurance, Medicaid or other public aid for their health care, prior to the Affordable Care. This Act is expected to make a great impact in New Mexico, increasing Medicaid eligibility, given the lower socio economic status and uninsured rates (http://www.cnbc.com/id/101751045#).

Present Services

The 2012 OptumHealth New Mexico Behavioral Health Provider Directory (https://www.optumhealthnewmexico.com/consumer/en/docs/OHNM_Provider_Directory.pdf) indicated in New Mexico there were approximately 38 psychiatrists and 17 psychiatric nurse practitioners for a total of 55 providers accepting Medicaid in New Mexico. Given the total of 72,000 adults and 22,000 children needing evaluation and likely continuing psychiatric care, this averages about 1,700 patients for each practitioner. Further, a number of these practitioners are concentrated in the Albuquerque, Santa Fe and Las Cruces areas. For most of New Mexico there are simply no psychiatric services within a reasonable distance.

How Prescribing Psychologists Have Increased Access to Care

As of December 2014, there were 42 psychologists licensed to prescribe in New Mexico. About five of these are working out of State in the Indian Health Service and in the military. The remaining 37

consistently accept Medicaid patients (see Vento, Archives of Medical Psychology, June 2014). Importantly, at least half of them are located in rural areas. By these numbers, prescribing psychologists are doubling the number of doctorally-level trained medication managers of psychotropics. In addition to increasing the number of doctors able to care by 100%, many are also located in rural areas.

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Prescribing Psychologist
Affiliate Associate Professor,
New Mexico State University

Chair, Southwestern Institute for the

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1e

The NIMH Director's blog (June 2011) quoted these numbers:

While 37.6% of practicing physicians are age 55 or older, in psychiatry nearly 55% are in this age range, ranking as the second oldest group of physicians, surpassed only by preventive medicine. Part of this aging cohort effect is the low rate of medical school graduates choosing psychiatry. Only 4% of US medical school seniors (n = 698) applied for one of the 1097 post-graduate year one training positions in psychiatry[2]. As Dr. Roberts noted, it is troubling that the area of medicine addressing the leading source of medical disability is also facing a shortage of new talent. Indeed, over the past decade the number of psychiatry training programs has fallen (from 186 to 181) and the number of graduates has dropped from 1,142 in 2000 to 985 in 2008. In spite of the national shortage of psychiatrists, especially child psychiatrists, 16 residency training programs did not fill with either U.S. or foreign medical graduates in 2011[3].

2015 match data by state & specialty: http://www.nrmp.org/wp-content/uploads/2015/05/Main-Match-Results-by-State-and-Specialty-2015.pdf. It looks like Ohio had 51 total resident matches in psychiatry.

In 2014, U.S. seniors filled only 52% of psychiatry residency positions, and 14 of the 203 psychiatry programs did not fill all their available spots. By comparison, plastic surgery, neurosurgery, and otolaryngology had 0 unfilled programs, and U.S. seniors filled greater than 90% of the positions, according to the National Resident Matching Program's (NRMP) 2014 report, (see Table 1).

Psychiatry also is a common "back-up" option. In 2014, 7.5% of U.S. seniors and 26% of non-U.S. seniors applying to psychiatry ranked another specialty as their first choice (see Table 13 in the NRMP report. By comparison, in dermatology, the numbers were 1.3% and 5.1%, respectively.

From US Residency Match 2014 (page 26): National Resident Matching Program, Results and Data: 2014 Main Residency Match®. National Resident Matching Program, Washington, DC. 2014.
Copyright © 2014 National Resident Matching Program

	2014			2013			2012			2011			2010		
	Offered	%US	%tot	Offered	%US	%tot	Offered	%US	%tot	Offered	%US	%tot	Offered	%US	%tot
Psychiatry (Categorical)	1,322	51.8	97.7	1,297*	52.5	98.8*	1,117*	55.1	96.7*	1,097	58.3	97.4	1,091	61.4	98.5

The VA vacancy rates for psychiatrists in VISN 10 (all of Ohio, southern Michigan, northern Indiana) is in double digits except for two of the 11 major medical facilities. For example, Cleveland (which is the 3rd largest VA system in the U.S.) has a vacancy rate of 14.4%. Battle Creek is 25%, Chillicothe is 15.5%, Dayton is 38.9%, Indianapolis is 28.6% and Northern Indiana is 27.5%

2a

Table 1 Survey responses of medical providers

	Strongly disagree *n* (%)	Disagree *n* (%)	Neither[a] *n* (%)	Agree *n* (%)	Strongly agree *n* (%)
I find it helpful to consult with a prescribing psychologist about patients with psychiatric issues[b]	0 (0)	1 (2.2)	1 (2.2)	18 (39.1)	26 (56.5)
I am confident in the ability of a prescribing psychologist to identify when patients need to be referred for additional medical evaluation	0 (0)	0 (0)	3 (6.4)	14 (29.8)	30 (63.8)
I am confident managing a mental health crisis in my clinic	0 (0)	8 (17.0)	14 (29.8)	22 (46.8)	3 (6.4)
I believe the prescribing psychologist has adequate knowledge of medical terminology	0 (0)	0 (0)	1 (2.1)	18 (38.3)	28 (59.6)
I am confident it is safe to refer my patients to a prescribing psychologist for psychotropic medication management	0 (0)	1 (2.1)	2 (4.3)	14 (29.8)	30 (63.8)
I believe my patients' care has NOT improved as a result of the availability of a prescribing psychologist in the family medicine clinic	25 (53.2)	16 (34.0)	5 (10.6)	1 (2.1)	0 (0)
I am confident managing a mental health crisis in my clinic when consultation with a prescribing psychologist is available	0 (0)	1 (2.1)	3 (6.4)	23 (48.9)	20 (42.6)
I am concerned patients will be prescribed inappropriate medications and/or dosages if I refer them to a prescribing psychologist	23 (48.9)	22 (46.8)	0 (0)	2 (4.3)	0 (0)
Please rate the following potential benefits of having a prescribing psychologist embedded in the family medicine clinic	Undecided n (%)	No benefit *n* (%)	Small benefit *n* (%)	Moderate benefit *n* (%)	Large benefit *n* (%)
Improves patient care	0 (0)	0 (0)	2 (4.3)	10 (21.3)	35 (74.5)
Decreases time I spend managing patients with psychiatric symptoms	1 (2.1)	0 (0)	8 (17.0)	8 (17.0)	30 (63.8)
Improves access to Behavioral Health care	0 (0)	0 (0)	1 (2.1)	5 (10.6)	41 (87.2)
Decreases number of patients I refer out for psychiatric care in the community	0 (0)	1 (2.1)	2 (4.3)	12 (25.5)	32 (68.1)
Improves ease of access for me to obtain psychiatric consultation	0 (0)	0 (0)	6 (12.8)	6 (12.8)	35 (74.5)
	Less skilled *n* (%)		Similarly skilled *n* (%)		More skilled *n* (%)
Compared to other **mental health prescribers**, prescribing psychologists provide care that is:	3 (6.4)		30 (63.8)		14 (29.8)

[a] Neither agree nor disagree

[b] One respondent indicated "NA-I have not consulted with a prescribing psychologist"

2b

Department of Defense Demonstration Project (DOD)

When asking the DOD prescribing psychologists' supervisors about the graduates, ***"without exception, these supervisors—all psychiatrists—stated that the graduates' quality of care was good…The supervisors noted that the graduates are aware of their limitations and know when to ask for advice or consultation or when to refer a patient to a psychiatrist."*** (p. 9 Letter from GAO)

In 1991, the Dept. of Defense developed a Military Health System Psychopharmacology Demonstration Project to investigate if psychologists could be trained to prescribe psychotropic medication in a safe and effective manner. The main purpose was to enhance access to care for military personnel during combat. The training was initially 3 years, but after the first class, was cut to two years in length (one year in the classroom and one year in clinical training). Supervision was provided with psychiatrists and was reduced for all graduates as they demonstrated their competence.

Ten psychologists completed the training and provided psychological care and prescriptions as needed to service members and family members in the Air Force, Army, and Navy military medical facilities across the country.

Results of the Department of Defense Demonstration Project
The demonstration project was evaluated in four studies and results sent to the Congress. The General Accounting Office reported to the Chair of the Committee on Armed Services in 1999. Their report indicated that:

- The Prescribing Psychologists were well integrated into the health services and were accepted by their medical colleagues.
- Prescribing Psychologists performed safely and effectively as prescribing psychologists and there were no adverse outcomes associated with their performance.
- Their supervising psychiatrists rated their quality of care as good.
- They cut down on wait times for certain military personnel and dependents.
- Due to the extra training provided by the DOD, they cost more than non-prescribing psychologists.

Enhanced Peacetime Readiness
GAO reported that clinic and hospital officials said that the prescribing psychologists reduced the time that military personnel and dependents had to wait for services and therefore the prescribing psychologists enhanced the peacetime readiness at the locations where they were serving.

Cost-effectiveness
The Dept. of Defense Demonstration project was completed before the military operations in Afghanistan and Iraq. The GAO did not imagine that prescribing psychologists would be used in time of war* which they saw as the primary focus of the Dept. of Defense. The only question that the report raised was that of cost effectiveness when only using the prescribing psychologists in peacetime. According to the GAO, including them was more costly than hiring a combination of only psychiatrists and clinical psychologists.

Recent Use in Military Operations
Dr. Alan Hopewell used his prescribing experience while serving in Iraq.

"During my deployment, my duties involved writing over 2000 prescriptions and "circuit riding" between Restoration Center at Camp Liberty… to Camp Stryker…home of the 101st Airborne Division. Prescriptive authority allowed me to serve as a potent "force multiplier" in terms of services rendered, especially at Camp Stryker, where I was often the sole medication provider for psychotropics."

C. Alan Hopewell, PhD, Prescribing Psychologist, Major, Medical Service Corps, US Army (RET).

2c

New Mexico Regulation and Licensing Department
BOARDS AND COMMISSIONS DIVISION
Toney Anaya Building ▪ 2550 Cerrillos Road ▪ Santa Fe, New Mexico 87505
(505) 476-4600 ▪ Fax (505) 476-4620 ▪ www.rld.state.nm.us

Susana Martinez
GOVERNOR

Robert "Mike" Unthank
SUPERINTENDENT

Tania Maestas
ACTING CHIEF GENERAL COUNSEL

Enrique Knell
DIRECTOR

April 16, 2015

Ohio Psychology Association
Dr. Bobbie Celeste
Director of Professional Affairs

Dear Dr. Celeste,

This letter is in response to your email inquiry regarding lawsuits or deaths as a result of prescribing psychologists in the State of New Mexico.

The New Mexico Board of Psychology Examiners has not been notified of any incidences of death or lawsuits associated with NM RxP.

Please contact me with any questions or need additional information.

Thank you,

Vanessa Montoya

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2d

From Practice Patterns and Medical Professional evaluations of Prescribing Psychologists
By Wendy P. Linda Dissertation, February 8, 2016, Farleigh Dickinson University
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Table 2

Ratings by Prescribing Psychologists and Medical Colleagues.

Item	*N*	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Prescribing Psychologists						
Adequately trained to prescribe medication*	28	0.00	0.00	0.00	32.14	67.86
Not enough knowledge of how to safely* prescribe to patients	27	74.07	25.93	0.00	0.00	0.00
Adequate knowledge of medical terminology*	28	0.00	0.00	3.57	46.43	50.00
Adequate knowledge of medical tests relevant* to prescribing	28	0.00	0.00	0.00	50.00	50.00
Safe prescribers*	28	0.00	0.00	0.00	7.14	92.86
Know when it is appropriate to refer a patient* to other medical professionals.	28	0.00	0.00	0.00	10.71	89.29
Appropriately consult with other medical professionals about patient care*	28	0.00	0.00	0.00	3.57	96.43
Medical professionals are confident in my ability to prescribe/monitor medication	28	0.00	0.00	3.57	21.43	75.00
Increase patient access to care*	28	0.00	0.00	3.57	7.14	89.29
Medical Colleagues						
Adequately trained to prescribe medication	22	0.00	0.00	4.55	27.27	68.18
Not enough knowledge of how to safely Prescribe	22	68.18	27.27	4.55	0.00	0.00
Adequate knowledge of medical terminology	22	0.00	0.00	4.55	18.18	77.27
Adequate knowledge of medical tests relevant to prescribing	22	0.00	4.55	4.55	22.73	68.18
Safe prescribers	22	0.00	0.00	0.00	22.73	77.27
I would refer to a PP	21	0.00	0.00	4.76	19.05	76.19
Increase patient access to care	22	0.00	0.00	4.55	22.73	72.73
I support the movement for psychologists to prescribe	22	0.00	0.00	4.55	27.27	68.18
Appropriately consult with me about patient Care	22	0.00	0.00	4.55	27.27	68.18
Doesn't know when to refer to other medical providers	22	68.18	31.82	0.00	0.00	0.00
Concerned will prescribe inappropriate medications and/or dosages	22	59.09	36.36	4.55	0.00	0.00

Table 3

Practice Variables for Prescribing Psychologists

Variable	*N*	%	*M*	*SD*	Median
Patient Population					
No change	9	30.00			
Increased diagnostic severity	20	66.67			
Decreased diagnostic severity	0	0.00			
More patients of minority status	7	23.33			
Fewer patients of minority status	0	0.00			
More low SES patients	9	30.00			
Fewer low SES patients	0	0.00			
More rural patients[a]	12	40.00			
Fewer rural patients	0	0.00			
Other population changes[b]	4	13.33			
Income					
Higher income	19	63.30			
Same income	10	33.30			
Lower income	0	0.00			
Ethics complaints related to prescribing	0	0.00			
Malpractice claims related to prescribing	0	0.00			
Hospitalized or harmed by a med prescribed	1	3.33			
Distribution of Treatments (last 12 months)					
# patients seen	30		453.53	443.67	275.00
% patients given a prescription	30		83.00	47.14	82.50
% patients seen for therapy alone	30		16.33	22.13	10.00
% patients seen for medication alone	30		39.30	38.27	25.00
% patients seen for both	30		42.17	30.95	35.00
% patients seen for other reasons[c]	30		6.40	14.27	1.00
% patients seen for medication alone with separate provider for therapy	25		57.80	35.76	65.00
% time start treatment with medication alone	30		27.70	20.00	33.07
% time start treatment with therapy alone	30		27.60	32.53	20.00
% time start treatment with therapy and medication	30		44.70	31.27	50.00
Patient Characteristics					
% patients from urban area[a]	30		39.90	39.21	31.50
% patients from urban center[a]	30		20.60	31.34	0.00
% patients from rural area[a]	30		39.50	41.52	20.00
% patients on Medicaid	28		53.79	38.22	60.00
% patients on Medicare	27		13.96	16.28	10.00
% patients receiving SSI	24		18.83	23.66	10.00
# of physician refusals of med prescribed	21		0.81	1.47	0.00
Average salary in last 12 months	27		$125,444	$50,901	$125,000
Last full day of patient care					
# patients seen	30		9.53	4.55	8.00
# patients taking meds prescribed by PP	28		15.29	23.60	8.50
Average time per patient (minutes)	28		39.16	11.28	40.00
# prescriptions written	30		12.70	12.18	9.00
# patients with compliance issues with meds	30		1.90	2.11	1.00
Total # meds prescribed that day	29		17.10	11.50	15.00

3a

Table 1
Comparison of Entry-Level Training Models Leading to Prescriptive Authority

Profession	Minimum years post-baccalaureate	Graduate contact hours mean (and standard deviation)						
		Biochemistry-neuroscience	Pharmacology	Clinical practicum	Research-statistics	Behavioral assessment/diagnosis & psychometrics	Psychosocial interventions-psychotherapy	Other mental health/psychology course work
Psychiatric nurse practitioner[a]	2.5	48 (7)	56 (7)	146 (33)	99 (41)	30 (23)	32 (29)	128 (77)
Medicine[b]	4	216 (20)	59 (28)	855 (101)	33 (20)	18 (25)	9 (20)	15 (21)
Psychology[c]	6.5	161 (43)	288 (63)	680 (83)	225 (64)	267 (61)	255 (161)	351 (152)

Note. Values were computed equating one academic credit with 15 contact hours.
[a]Based on nurse practitioner master's degree programs at the Medical University of North Carolina, St. Joseph's College, University of Virginia, Vanderbilt University, and Yale University.
[b]Based on M.D. or D.O. programs, without further specialization residency, at the Mayo College of Medicine, Yale University, Tufts University, Stanford University, and A.T. Still University.
[c]Based on Ph.D., Ed.D., or Psy.D. programs plus the postdoctoral M.S. program at Alliant University, Fairleigh Dickinson University, the Massachusetts School of Professional Psychology, New Mexico State University, and NOVA Southeastern University.

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3b

University of Hawaii

M.S. in Clinical Psychopharmacology

Prerequisites: Ph.D. in psychology and state licensure. GPA of at least 3.0 in graduate program or 3.0 from last 60 hours of undergraduate.
Approximate Length: 2 years
Practicum Requirement: 400 hours, 100 separate patients
Coursework: 34 semesters hours of credit
Required courses:

Fall Year 1:

- PHPS 450 Biochem I - Biomolecules (3)
- PHPS 451 Biochem II - Metabolism (3)
- PHPS 606 Human Physiology (3)

Spring Year 1:

- PHPS 601 Integrated Pharmacotherapy I (7)

Summer Year 1:

- PHPS 602 Integrated Pharmacotherapy II (5)

Fall Year 2:

- PHPS 603 Integrated Pharmacotherapy III (4)
- PHPS 604 Adv Psychopharmacology I (2)
- PHPS 607 Psychopharmacology Practicum (2)

Spring Year 2:

- PHPS 605 Adv Psychopharmacology II (2)
- PHPS 608 Law and Pharmacotherapy (2)
- PHPS 607 Psychopharmacology Practicum (2)

Summer Year 2:

- PHPS 607 Psychopharmacology Practicum (2)

Fairleigh Dickinson University

M.S. in Clinical Psychopharmacology

- **Prerequisites:** Ph.D. in psychology with current, valid state license in good standing
- **Approximate Length:** 2 years
- **Practicum Requirement:** Optional, length and patients dependent upon prescribing authority laws of the state of the student
- **Coursework:** 30 semesters hours of credit
- **Required courses:**
- PSYC7910- Biological Foundations of Pharmacological Practice I (3)
- PSYC7915- Biological Foundations of Pharmacological Practice I (3)
- PSYC7920- Neuroscience (3)
- PSYC7925- Neuropsychopharmacology (3)
- PSYC7930- Clinical Pharmacology (3)
- PSYC7935- Professional Issues & Practice Management (3)
- PSYC7940- Treatment Issues in Psychopharmacology: Affective Disorders (3)
- PSYC7945- Treatment Issues in Psychopharmacology: Psychotic Disorders (3)
- PSYC7950- Treatment Issues in Psychopharmacology: Anxiety Disorders (3)
- PSYC7955- Treatment Issues in Psychopharmacology: Other Disorders (3)
- Clinical Lab/PEP Prep (optional)
- PSYC7960- Clinical Practicum Elective (optional)

New Mexico State University

M.A. in Clinical Psychopharmacology

- **Prerequisites:** Ph.D. in psychology
- **Approximate Length:** 25 months
- **Practicum Requirement:** 400 hours, 100 separate patients
- **Coursework:** 36 semesters hours of credit
- **Required courses:**
- CEP 801- Introduction to Psychopharmacology for Psychologists I (3)
- CEP 802- Introduction to Psychopharmacology for Psychologists II (3)
- CEP 803- Clinical Psychopharmacology I (3)
- CEP 806- Pathophysiology for Psychologists I (3)
- CEP 807- Pathophysiology for Psychologists II (3)
- CEP 808- Pathophysiology for Psychologists III (6)
- CEP 804- Clinical Psychopharmacology II (3)
- CEP 809- Psychopharmacological Treatment in Special Populations I (3)

- CEP 810- Psychopharmacological Treatment in Special Populations II (3)
- CEP 811/SPED 598- Practica (6)

Alliant University

M.S. in Clinical Psychopharmacology

Prerequisites: Ph.D. in psychology with current, valid state license in good standing
Approximate Length: 28 months
Practicum Requirement:
Coursework: 29.6 semesters hours of credit
Required courses:

Spring Year 1

- PPH 6905- Clinical Biochemistry (1.6)
- PPH 6921- Neuroscience: Neuroanatomy/Neuropathology (2.4)
- PPH 6925- Neuoroscience: Neurochemistry (1.6)

Fall Year 1

- PPH 6930- Neurophysiology and Clinical Medicine/Pathophysiology (5.6)

Spring Year 2

- PPH 6935- Pharmacology/Clinical Pharmacology (4)
- PPH 7925- Physical assessment (2.4)

Fall Year 2

- PPH 7900- Special Populations 1: Child, Geriatric, Chronic Pain, Chronic Medical Conditions, Trauma (2.4)
- PPH 7918- Advanced Psychopharmacology and Molecular Nutrition (4)

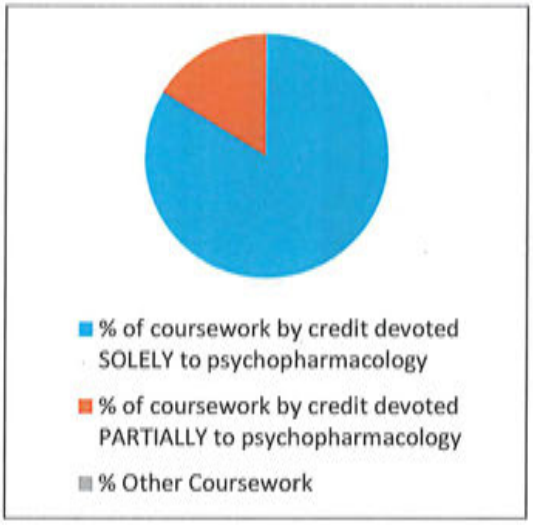
Spring Year 3

- PPH 7095- Special Populations 2: Gender, Ethnicity, Chemical Dependency (2.4)
- PPH 7920- Pharmacotherapeutics (2.4)
- PPH 7930- Case Seminar (.8)

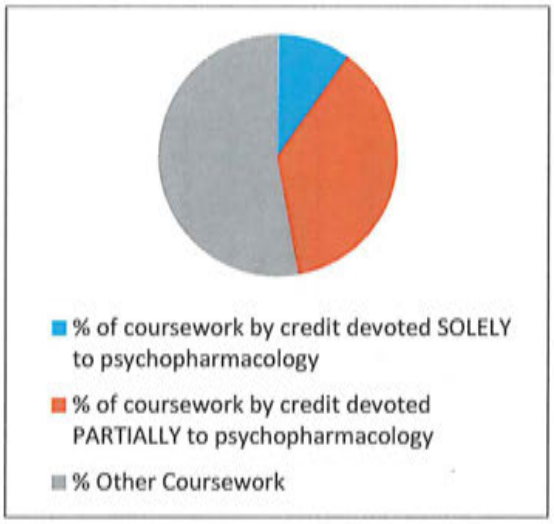
3c

	Alliant Psychopharmacology MA	CWRU PA	CWRU NP
Perquisite	Licensed PhD	BA	Licensed RN
Length	28 months	24 months	18 months
Number of Terms	5 terms	5 terms	4 terms
Clinical Requirement	1 year / 100 patient hours under sup.	48wks	600 hours clinical
Delivery format	distance friendly format	Brick & Mortar only	distance friendly format
% of coursework by credit devoted **SOLELY** to psychopharmacology	83.78%	9.80%	0.00%
% of coursework by credit devoted **PARTIALLY** to psychopharmacology	16.22%	37.25%	25.00%
% Other	0.00%	52.94%	75.00%

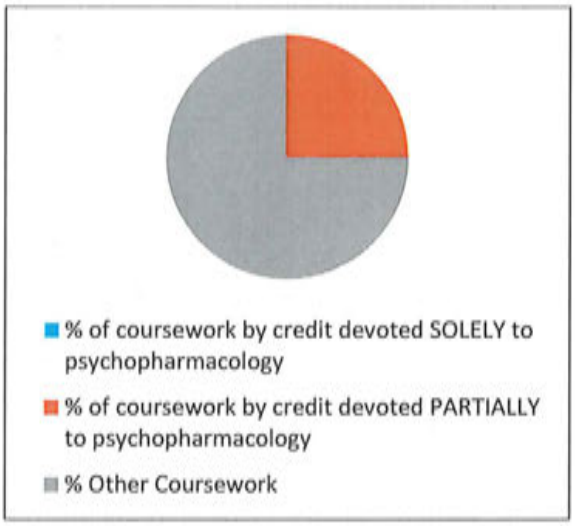
Alliant Psychopharmacology Masters



CWRU PA



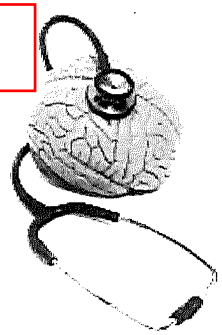
CWRU NP



Alliant University, Masters in Psychopharmacology (5 Semesters)		Case Western Reserve University, PA Program (5 Semesters)		Frances Payne Bolton School of Nursing at CWRU NP - (4 Semesters)	
Courses Devoted to Psychopharm	*Courses with Psychopharm Components*	*Courses Devoted to Psychopharm*	*Courses with Psychopharm Components*	*Courses Devoted to Psychopharm*	*Courses with Psychopharm Components*
1st Term					
Clinical Biochem	Neuroanatomy/ Neuropathology		Diagnostic Methods – Clinical Lab		Advanced Pathophysio
Neurochemistry			Clinical Correlations		
2nd Term					
Neurophysiology & Clinical Med/ Pathophysiology		Pharmacology for PAs			
3rd Term					
Pharm/ Clinical Pharmacology	Physical Assessment	Pharmacotherap	PCM*- Surgery & EMER Med		Evidence Based Nursing Practice
		PCM* - Behavioral Med	PCM* - OB/GYN		
			PCM* - Peds		
4th Term					
Adv Rx[Ŧ]: Depression			Intro to Epidemiology, Bio Stats & EBM[Ψ]		Child & Adolescent Clinical Management
Adv Rx[Ŧ]: Anxiety					
Adv Rx[Ŧ]: Schizophrenia					
Adv Rx[Ŧ]: Polypharm & Bipolar					
Adv Rx[Ŧ]: Molecular Nutrition					
Spec Pop 1: Chronic Pain/Trauma, Geriatric, Chronic Med Cond, Child & Adolescent					
5th Term					
Spec Pop 2: Gender, Ethnicity & Chem Depend		CR[α] - Psychiatry	CR[α] - EMER Med		
PharmTx: Research, Ethics & Lega;, Psychotherapy-Pharmacology			CR[α] - Fam Med		
			CR[α] - Geriatrics		
			CR[α] - OB/GYN		
Case Seminar			CR[α] - Peds		
			CR[α] – Surgery		
			CR[α] - Primary Care Elective		
			CR[α] - Intensive Care Elective		

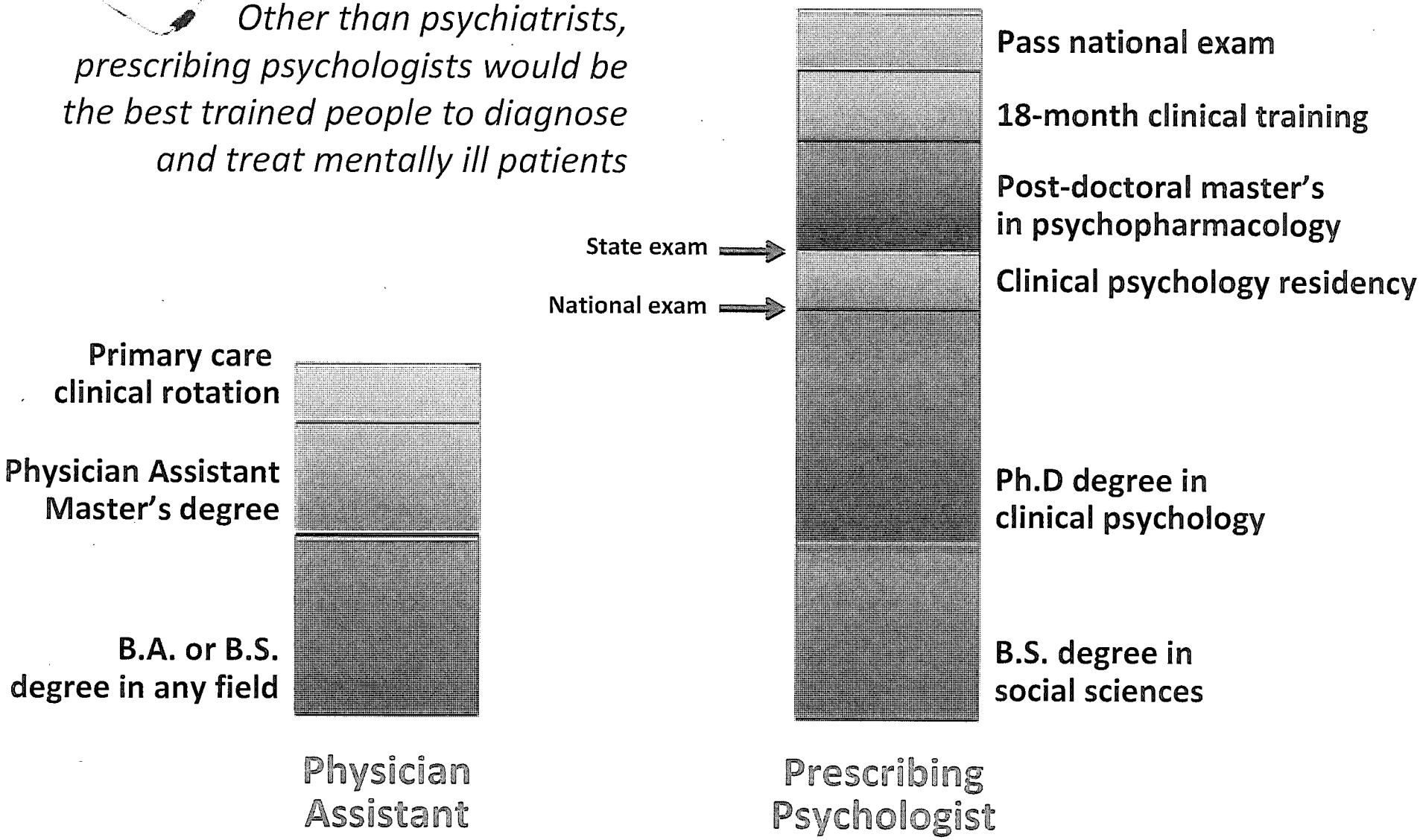
*PCM = Principles of Clinical Medicine [Ψ]EBM = Evidence Based Medicine [Ŧ]Adv Rx = Advanced Prescription [α]CR = Clinical Residency

3d



Formal Education Training Compared

Other than psychiatrists, prescribing psychologists would be the best trained people to diagnose and treat mentally ill patients



3e

Key Facts About Prescriptive Authority for Psychologists

How does the prescriptive authority training for psychologists in the M.S. Program in Clinical Psychopharmacology at Fairleigh Dickinson University compare to that of physicians?

- Licensure as a psychologist requires 5-6 years of graduate psychological course work plus one year of clinical experience plus a licensing exam
- Licensure as a prescribing psychologist requires the licensed psychologist complete 2 more years of graduate medical course work plus one year of clinical experience plus another licensing exam
- The 3 years of medical education focuses on about 100 medications plus procedures appropriate to the use of those medications (e.g., reading lab test results, physical exams)
- In contrast, after 5 years of graduate education the physician is authorized to prescribe over 4000 medications approved by the FDA and can perform any procedure in medicine.

How does the curriculum compare to physician preparation to prescribe?

- The FDU curriculum includes every component of medical training that is relevant to prescribing (see Table 1)
- Significant time savings are achieved by omitting all elements of medical school that are irrelevant to prescribing medications
- Because of its focus on 100 medications, psychologists actually receive more formal training in the side effects and drug-drug interactions of these medications than physicians do
- The psychology and prescribing psychologist licensing exams combined cover every topic covered in the board exam for psychiatry (see Table 2)

What is the track record of psychologists as prescribers?

- Psychologists have prescribed in the military for 20 years, in Louisiana and New Mexico for 10 years, and also prescribe in the Public Health Service and Indian Health Service. Here are the results:
  - Number of serious adverse events reported: 0
  - Number of complaints to licensing board or federal authorities: 0
  - Number of complaints by physicians working with prescribing psychologists: 0
  - Number of malpractice suits filed: 0
- A recent survey of medical providers, including physicians and residents, working with prescribing psychologists in a U.S. Army Family Medicine clinic produced the following statistics:
  - 96% agreed consulting with a prescribing psychologist is helpful
  - 93% agreed prescribing psychologists can identify when patients need additional medical evaluation
  - 98% thought prescribing psychologists had adequate knowledge of medical terminology
  - 94% thought it was safe to refer patients to a prescribing psychologist for medication management
  - 96% thought the prescribing psychologist improves patient care

Opponents of this bill claim psychologists will be unsafe. They've said this about every other profession that has ever requested prescriptive authority, and they have been wrong every time. They're wrong again.

Will psychologists serve the underserved?

- New Mexico prescribing psychologists were recently surveyed about their practices
  - 90% see Medicaid patients
  - 63% of patients were living in rural areas
- In contrast, *JAMA Psychiatry* (published online 12/11/13) reported
  - Only 55% of psychiatrists accepted insurance by 2010, the lowest rate of any physician specialty.
  - About the same number accepted Medicare
  - Only 43% accepted Medicaid, versus 73% of other physician specialties

Table 1. Comparison of Course Content

Content	Prescribing Psychology	Psychiatry
Ambulatory Care		Med School
Anatomy/Gross Anatomy	Courses 1-2	Med School
Anesthesiology		Med School
Biochemistry	Course 3	Med School
Statistics	Doctoral	Med School
Epidemiology/Public Health	Doctoral	Med School
Cell Biology/Histology/Microanatomy	Course 3	Med School
Central Nervous System/Neuroanatomy/Neuroscience	Courses 3-4	Med School
Cognitive/Emotional Bases of Behavior	Doctoral	
Critical Care		Med School
Development	Doctoral	Med School
Emergency Medicine		Med School
Ethics in Psychological/Psychiatric Practice	Doctoral/Course 6	Resid
Family/Community Medicine		Med School
Genetics	Multiple courses	Med School
Geriatrics	Course 10	Med School
Gerontology (Psychology of Aging)	Doctoral	Resid
Immunology/Microbiology	Course 5	Med School
Internal Medicine	Courses 1-2	Med School
Intro to Clinical Medicine/Intro to Ambulatory Care		Med School
Clinical Skills	Doctoral/Courses 7-10	Med School/Resid
Neurology	Doctoral/Courses 3-4	Med School/Resid
Nutrition		Med School
Obstetrics-Gynecology		Med School
Pathology	Courses 1-2	Med School
Pathophysiology	Courses 1-2	Med School
Pediatrics	Course 10	Med School
Personality, Normal	Doctoral	Resid
Personality, Abnormal	Doctoral	Resid
Pharmacology--General	Course 5	Med School
Pharmacology--Psychopharmacology	Courses 4-10	Med School
Pharmacotherapy--Psychological/Psychiatric Disorders	Courses 7-10	Med School/Resid
Physiology	Courses 1-2	Med School/Resid
Primary Care	Course 6	Med School
Psychiatry	Doctoral/Courses 6-10	Med School/Resid
Psychological Testing	Doctoral/Course 4	
Radiology		Med School
Research Methodology	Doctoral	
Social Bases of Behavior	Doctoral	
Surgery		Med School
Treatment Modalities: Psychological Therapies	Doctoral	Resid

Prescribing Psychology covers doctoral training (Doctoral) and courses in the FDU psychopharmacology program (Courses). Psychiatry covers medical school (Med School) and psychiatric residency (Resid).

Table 2. Comparison of Licensing Exams

Content Area	Psychology	Psychopharm	Psychiatry
Biological Bases of Behavior	11%	8%	10%
Advanced Pharmacology		12%	10%
Clinical Psychopharmacology		13%	10%
Nervous System Pathology		9%	
Cognitive-Affective Basis of Behavior	13%		5%
Social and Multicultural Bases of Behavior	12%		5%
Growth and Life Span Development	13%		6%
Assessment and Diagnosis	14%	13%	39%
Treatment Intervention	16%		10%
Research Methods	6%		
Research Methods – Psychotropic Medications		4%	
Ethical/Legal/Professional Issues	15%		
Ethical/Legal Issues Specific To Pharmacotherapy		7%	5%
Integrating Psychopharmacology, Psychotherapy, & Assessment		15%	
Physiology and Pathophysiology		9%	
Assessment and Monitoring in Pharmacological Practice		10%	

Information about psychology licensing exams comes from the Association of State and Provincial Psychology Boards and the American Psychological Association. Information about the psychiatry licensing exam comes from the American Board of Psychiatry and Neurology.