MARYLAND PSYCHOLOGICAL ASSOCIATION

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March 3, 2026

Senator Pam Beidle, Chair
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, MD 21401
RE: Senate Bill 568 - Health Occupations - Licensed Psychologists - Prescriptive Authority
Position: SUPPORT

Dear Chair Beidle, Vice Chair Hayes, and Members of the Committee:

The Maryland Psychological Association, (MPA), which represents over 1,000 doctoral level psychologists throughout the state, asks the Senate Finance Committee to report FAVORABLY on Senate Bill 568.

The Maryland Psychological Association (MPA) is committed to working with stakeholders to develop a model that allows for the prescribing/unprescribing of psychotropic medications for only those currently licensed psychologists who choose to attain the necessary additional education and training and pass the "Psychopharmacology Examination for Psychologists offered by the Association of State and Provincial Psychology Boards".

This would offer patients additional pathways to manage and coordinate all aspects of their mental health care (psychological testing, psychotherapy, and medication management, if needed).

Specifically, **Senate Bill 568 does the following:**

- Gives authority to the Board of Psychological Examiners to certify licensed psychologists to prescribe
- Requires the Board to develop and implement the certification process in consultation with a Prescriptive Authority Advisory Committee consisting of 3 Psychologists Board members, I Physician Board and 1 Pharmacy Board member.
- Establishes the criteria that licensed psychologists must meet to be eligible for certification
- Requires the Board to establish a policy for a licensed psychologist to renew certification
- Establishes the scope of a prescribing psychologist
- Prohibits prescribing without certification
- Requires prescribing psychologists to collaborate with patient's licensed medical provider; and requires prescribing psychologist to document efforts to encourage the patient to maintain relationship with licensed medical provider
- Requires prescriptions to be issued in accordance with state and federal law and regulation; and clearly identify the prescribing psychologist on the prescription
- Requires record of all prescriptions be maintained in the patient record
- Prohibits prescribing psychologist from delegating authority to anyone else to prescribe drugs
- Requires the prescribing psychologist to report to the State Prescription Drug Monitoring Program
- Requires prescribing psychologists to file with the Board their DEA and State CDS licenses; and the Board shall maintain records of every prescribing psychologist
- Requires the Board to share the list and information of all prescribing psychologists to the Board of Physicians and Board of Pharmacists.

We urge the Committee to issue a favorable report on Senate Bill 568. If we can be of any further assistance, please do not hesitate to contact MPA's Legislative Chair, Dr. Stephanie Olarte, Ph.D. at mpalegislativecommittee@gmail.com.

Respectfully submitted,

Stephanie Wolf, JD, Ph.D.	*Stephanie Olarte, Ph.D.*
Stephanie Wolf, JD, Ph.D.	Stephanie Olarte, Ph.D.
President	Chair, MPA Legislative Committee

cc: Chris Dean and Gordan Feinblatt, Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

ATTACHMENTS

1. Brief Background on RxP
2. Psychologist Prescribing – Facts and Figures
3. Written Testimony - Kim Sanschagrin, J.D., Ph.D. - Law & Mental Health Associates, Inc.
4. Written Testimony – James Phelps M.D. Medical Director, DepressionEducation.org and @PsychEducation
5. Written Testimony - Kara R. Koenig, Psy.D. - K2 Psych Services, LLC
6. Written Testimony - Stephanie Wolf, JD, PhD Licensed Psychologist - Founder andd Partner, Maven Psychology Groupu
7. Written Testimony - Paul C. Berman, Ph.D.
8. Written Testimony - Laura Goldstein, LCMFT, Owner and Executive Director - Montgomery County Counseling Center
9. Written Testimony - StephanielOlarte, PhD, Psychologist and CEO: Slow Down Psychology, LLC
10. Written Testimony - Sherry D. Goldman M.D. Psychiatrist and Pediatrician
11. Written Testimony - R. Patrick Savage, Jr., PhD.
12. Written Testimony - Morgan Sammons, PhD, ABPP
13. Written Testimony - Phillip Hughes, PhD, MS - Assistant Professor, School of Pharmacy and Pharmaceutical Sciences, Binghamton University

ATTACHMENT 1:

BACKGROUND

Beginning in 1994, the following states and federal jurisdictions have permitted prescription authority for psychologists.

States			Federal Jurisdictions	
1. New Mexico	2002		1. US Armed Forces	1994
2. Louisiana	2004		2. US Public Health Service	2000s
3. Illinois	2014		3. Indian Health Service	2010s
4. Iowa	2016		4. Indiana – Dept of Defense Facilities	2010s
5. Idaho	2017			
6. Colorado	2023			
7. Utah	2024			

PATHWAY TO PSYCHOLOGIST PRESCRIBING (14 + YEARS)

STEP 1:

- Bachelor's Degree BA/BS (4 years)
- Masters Degree MS/MA (2 years)
- Ph.D/Psy.D (4 years)
- Clinical Internship (1 year)
- Post-Doctoral Fellowship (1 year)
- ***National Exam and Licensure***
  - ***for Authority to Diagnose and Treat mental Illness***

STEP 2: For currently licensed Psychologists who choose to pursue RxP:

- Post-Doctoral MS Clinical Pharmacology (2 years)
- Supervised Clinical Practicum (1 year)
- **National Licensing Exam in Psychopharmacology**
  - ***For Authority to prescribe/unprescribe psychotropic medications with coordination or collaboration***

EDUCATION AND TRAINING (SLIGHT VARIATIONS ACROSS STATES)

- Licensed psychologists, in order to prescribe, must complete a 2-year master's degree in clinical psychopharmacology, pass a national standardized exam, and complete hundreds of hours of approved supervised clinical experience on top of standard supervision requirements.
- The **model curriculum** officially recommended by American Psychological Association (APA) consists of at least 400 hours of supervised prescribing experience with at least 100 unique patients, as well as an 80-hour supervised practicum on physical assessment.

SAFEGUARDS THAT WOULD BE IN PLACE

- **All State legislation** has ongoing collaborative relationships with medical providers to ensure multidisciplinary care (i.e. medical needs are met).
- **All State legislation** makes it an additional level of licensure for psychologists, making it available only to those who want to achieve the additional requirements.
- **All State legislation** establishes guardrails around the types of drugs that can be prescribed (i.e. limiting to psychotropic drugs).
- **All State legislation** requires an ongoing renewal of prescription authority including completion of a mandatory number of continuing education hours relevant to prescriptive authority.

ATTACHMENT 2:

Psychologist Prescribing – Facts and Figure

Workforce Data:

- Workforce leverage: Psychologists are far more numerous than psychiatrists; enabling qualified psychologists to prescribe expands the provider pool at relatively low marginal cost compared with training new psychiatrists, improving access in underserved and rural areas where cost burdens are highest.

- In LA there are about 760 Psychologists and 120 prescribers. There are about 600 psychiatrists so RxP increased the prescribing workforce by almost 20%

- In NM there are about 925 Psychologists and 60 prescribers. There are about 400 psychiatrists so this increased the prescribing workforce by 15%

- In Maryland there are 1250 Psychologists, if we average the other 2 states % of psychologists who prescribe, we would expect 10% of psychologists to pursue RxP. This would mean >120 new prescribers. Several years ago, an MPA survey had 15% of members saying they were "likely" or "very likely" to pursue RxP within 5 years. Using that metric RxP would increase prescribers by almost 200, which would be an increase the prescribing workforce by 10%.

Safety & "Deprescribing" (Pharmacy Savings):

- The concern that more prescribers = more pills (and higher pharmacy costs). The data suggests the opposite with psychologists.

- The Data: Research indicates that prescribing psychologists may actually reduce pharmacy costs through "deprescribing." A study comparing prescribing patterns found that patients of prescribing psychologists had a 24% lower rate of adverse drug events compared to psychiatrists and were less likely to engage in "polypharmacy" (prescribing multiple drugs at once).

- The Argument: Because psychologists are trained to use therapy first or alongside medication, they are less likely to rely solely on high doses of expensive psychotropic drugs compared to general practitioners who may lack time for therapy.

Cost-Effectiveness in Suicide Reduction (Avoided Costs):

- New research specifically targets the economic impact of RxP on public health crises.

- The Data: A 2023 study by Hughes, Phillips, et al. analyzed data from New Mexico and Louisiana (early adopters). They found RxP laws were associated with a 4.8% to 7% reduction in suicide rates.

- The Cost Argument: The study explicitly calculated the "cost-effectiveness" of this policy, finding it to be highly efficient (approx. $12,800 per Quality-Adjusted Life Year). By preventing suicides and crisis-level events, the state avoids the massive costs associated with emergency response, inpatient psychiatric hospitalization, and loss of economic productivity.

Elimination of the "Split Treatment" Cost (Direct Savings):

- Lower system inefficiency: RxP reduces fragmentation (fewer redundant referrals and fewer hand-offs), shortens time-to-treatment, and improves medication adherence (all of which lower overall utilization and improve outcomes).

- The Current Expensive Model: Currently, a Medicaid patient often sees a therapist for counseling and a psychiatrist (or GP) for medication. This generates two separate claims and requires coordination between two providers.

- The RxP Model: A prescribing psychologist provides both psychotherapy and medication management in a single visit.

- The Data: Economic models (such as those analyzed in Arizona and Hawaii legislative reports) suggest this consolidates care, reducing the administrative burden and the total number of reimbursable encounters required to treat the same condition.

The "Medical Cost Offset" Effect:

- This is a well-established health economics concept: Treating mental health lowers physical healthcare costs.

- Untreated anxiety and depression lead to higher emergency room visits for physical symptoms (e.g., panic attacks mimicking heart attacks) and poor management of chronic diseases (diabetes, heart disease).

- Supply & Demand: With the current shortage of psychiatrists (especially in Medicaid networks), patients wait months for care, during which their conditions worsen and become more expensive to treat. RxP increases the supply of providers, allowing for earlier, less expensive intervention.

Studies:

1. Patient and Clinic Characteristics of a Prescribing Psychology Practice in New Mexico

"Prescribing psychologists appear to treat rural, underserved patients with a diversity of psychiatric conditions using both medication and therapy."
https://pubmed.ncbi.nlm.nih.gov/40820782/

2. Supply of mental health practices after prescriptive authority expansion for psychologists

"We find the policy increased the number of psychology and counseling practices without decreasing the number of psychiatric practices, implying that these practices are complements rather than substitutes."
https://onlinelibrary.wiley.com/doi/10.1111/coep.12643

3. Simulating the Impact of Psychologist Prescribing Authority Policies on Mental Health Prescriber Shortages

"Our results suggest that granting prescriptive authority to licensed psychologists would reduce the shortage of mental health professionals with prescriptive authority."
https://pubmed.ncbi.nlm.nih.gov/40012851/

4. Prescriptive Authority of Psychologists and Suicides

"they find that the rate of suicide decreased for males, White populations, individuals who are married or single, and for people between the ages of 35 and 55."
https://www.thecgo.org/research/deaths-of-despair/

5. Prescribing psychologists: Forgotten providers in the battle against opioid use disorder

"Despite this extensive training, the RxP laws in every state except New Mexico explicitly prohibit prescribing psychologists from prescribing opioids, including buprenorphine. ...Importantly, there is a substantial need for additional providers to treat OUD in the states with RxP laws, with age-adjusted opioid overdose rates ranging from 14.3 to 42.7 per 100 000 people"
https://onlinelibrary.wiley.com/doi/10.1111/add.16204

6. Evaluating the impact of prescriptive authority for psychologists on the rate of deaths attributed to mental illness

"Immediately following the start of psychologist prescribing, the rate of deaths attributable to mental illness declined by 4.55 deaths per 100,000 in New Mexico relative to the control, ...the annual change in the overall suicide rate was 0.12 suicides per 100,000 (95% CI: [-0.18, -0.06]) per year lower than expected in Louisiana following implementation."
https://pubmed.ncbi.nlm.nih.gov/36567208/

7. Scope-of-Practice Expansions Associated with Reduced Racial Disparities in Pediatric Mental Health Care
"The psychologist SoP expansion-associated reduction in unmet need was 15.8 percentage-points larger for Other-race children than for White children....Racial disparities in both outcomes were lower in psychologist SoP expansion states but varied in NP SoP states"
https://link.springer.com/article/10.1007/s10597-024-01310-6

8. Assessing the safety and efficacy of prescribing psychologists in New Mexico and Louisiana.
"Compared to patients of psychiatrists, patients of prescribing psychologists had a 24% lower rate of ADEs a 20% lower rate of psychotropic polypharmacy and similar rates of psychiatric ED utilization and medication nonadherence", and "Using robust pharmacoepidemiological methods, we noted that among mental health specialists, prescribing psychologists appear to be as safe and efficacious as psychiatrists in a large sample of privately insured patients.."
https://psycnet.apa.org/doiLanding?doi=10.1037%2Famp0001373

9. Demographics and clinical characteristics of patients of prescribing psychologists, psychiatrists, and primary care physicians.
"Prescribing psychologists treat patients who are more similar to those of psychiatrists than patients of primary care physicians; they are less likely to prescribe antipsychotics and more likely to prescribe antidepressants."
https://psycnet.apa.org/doiLanding?doi=10.1037%2Famp0001352

To whom it may *benefit* --

Jim Phelps, M.D. here. A few words from a **psychiatrist** in support of **SB568**, psychologist prescribing privileges.

It's simple: not enough psychiatrists and the shortage increasing. Prescribing psychologists could offer *both* psychotherapy and medications, decreasing over-reliance on the latter (e.g. antidepressants, now given to 13% of the U.S. adult population).

Psychologists are far better trained in psychotherapy than psychiatrists. Then, in addition to their PhD, prescribing psychologists must complete rigorous subsequent training in psychopharmacology. In my experience, they are very conservative in their use of medications. If any medical issues arise, they routinely consult with their primary care colleagues (thus the argument for safety around such issues is spurious).

DO NOT make the mistake of restricting their privileges to antidepressants. That's not where we need the help! We need psychologists to help with complex diagnostic challenges that include mixtures of PTSD, severe anxiety, and bipolar disorders. We need prescribers who can use mood stabilizers and antipsychotics, not just antidepressants. Primary care providers already have that covered.

Rigorously trained psychologists will be more likely to be thorough and cautious in their use of a broad range of psychotropics than those upon whom prescribing is now forced by circumstance, namely primary care providers – often nurse practitioners and increasingly, physicians' assistants.

The shortage of medical providers is bad, but the shortage of prescribing mental health professionals is extreme. Please help us broaden the workforce. Should anyone wish to hear more from me on this crucial issue, I've recorded a 10-minute video with more detail.

Respectfully,

James Phelps, M.D.
Medical Director, DepressionEducation.org and @PsychEducation

Written Testimony in Support of SB0568/HB1021

Psychopharmacology Prescription Privileges for Psychologists (RXP)

Name: Dr. Kimberly A. Sanschagrin
Credentials: Licensed Psychologist, Maryland
Affiliation: Board Secretary, Maryland Psychological Association
Position: Favorable

Dear Chair, Vice-Chair, and Members of the Committee:

Thank you for the opportunity to provide written testimony in support of SB0568/HB1021, legislation that establishes a carefully regulated pathway allowing appropriately trained psychologists to obtain certification to prescribe a limited range of psychotropic medications within a collaborative medical framework.

I am a licensed psychologist practicing in Maryland and work extensively with youth and families involved in the juvenile justice system. I am also a barred attorney, which has given me additional experience in court systems and insight into how gaps in behavioral health access affect legal outcomes. In addition, I am completing graduate-level training in clinical psychopharmacology through a postdoctoral program in New Mexico, in anticipation of the adoption of a prescribing psychologist pathway in Maryland.

For twenty years, I have evaluated children and adolescents with significant mental health needs, including depression, trauma-related disorders, suicidality, ADHD, and severe anxiety. A consistent barrier I encounter is not diagnosis. It is not treatment planning. It is access to medication providers.

I cannot count the number of times families have told me:
"We called everywhere."
"No one is accepting new patients."
"The waitlist is months long."
"The psychiatrist only sees medication management for 10 minutes every three months."

In many jurisdictions, particularly outside urban centers, psychiatric care is simply unavailable in a clinically meaningful timeframe. Courts order treatment. Schools require treatment. Therapists recommend treatment. Yet families are unable to obtain an appointment.

As a result, children deteriorate while waiting.

This legislation does not allow psychologists to automatically or broadly prescribe. Instead, it creates a rigorous, voluntary certification that requires:

- A two-year post-doctoral master's degree in clinical psychopharmacology
- Passage of a national standardized examination
- Extensive supervised prescribing experience
- Ongoing collaboration with medical providers
- Continuing education and license renewal requirements
- A restricted formulary limited to psychotropic medications

This is not independent medical practice. It is structured, collaborative behavioral health care.

Prescribing psychologists would be uniquely positioned to improve treatment continuity because we already conduct comprehensive psychological evaluations, provide psychotherapy, monitor treatment response weekly or bi-weekly, and coordinate care with families, schools, and courts. Currently, however, treatment is fragmented: one provider evaluates, another provides therapy, and a third briefly manages medication, often with minimal communication between them.

Allowing qualified psychologists to integrate psychotherapy, assessment, and medication management, when clinically appropriate, would strengthen coordinated care, reduce delays, and improve adherence and monitoring, especially for high-risk youth.

Importantly, this bill does not replace psychiatrists. Rather, it complements psychiatric care by expanding the behavioral health workforce in a targeted and safe manner. Psychiatrists remain essential, particularly for complex medical comorbidity and broader pharmacologic management. The proposed pathway instead addresses the well-documented gap in access to basic psychiatric medication management.

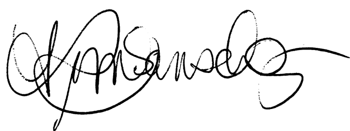
Maryland families do not lack diagnoses. They lack access to timely treatment.

SB0568/HB1021 provides a thoughtful, highly regulated solution that expands care while maintaining strong safeguards for patient safety and interprofessional collaboration.

For these reasons, I respectfully request a favorable vote on this legislation.

Thank you for your time and consideration.

Respectfully,



Kimberly A. Sanschagrin, J.D., Ph.D.
Licensed Psychologist, Maryland

K2 Psych Services
11350 McCormick Road
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Hunt Valley, MD 21031
410-213-3633

February 27, 2026

Sen. Pamela Beidle
Sen. Antonio Hayes
Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Dear Sen. Beidle, Sen. Hayes, and members of the Finance Committee:

I am writing as a licensed clinical psychologist practicing in Hunt Valley, Maryland, at K2 Psych Services, where I specialize in providing comprehensive evaluations and therapeutic services to children, teens, and young adults. I am submitting this testimony in strong support of SB568, which would grant prescriptive authority to properly trained psychologists in our state.

Across my experience in medical, outpatient, and community mental health settings, I have seen firsthand the pervasive issue of limited access to timely, appropriate mental health care, especially when it comes to obtaining necessary medication for mood and behavioral difficulties. After completing evaluations, I am frequently asked by individuals and families if I can prescribe medication to follow up on my recommendations for stabilization. Unfortunately, I must refer them to another provider, who may not have availability for weeks or months, further delaying access to care and increasing distress for these families. In many cases, these delays have forced families to seek emergency services, such as walk-in psychiatric clinics or emergency room departments, to access medication more quickly for their children or teens.

I also want to share my perspective as a mother. My own 14-year-old daughter struggled academically, socially, and with her mental health for some time. We engaged in therapeutic and assessment services with licensed clinical psychologists to help identify her ADHD, generalized anxiety, and learning disorders. After her comprehensive evaluation, we were recommended to consider medication management, but we faced the same challenge as many families: needing to find yet another provider qualified to prescribe medication for children and teens. This led to additional delays and further time before she could access the care she needed. Experiencing these barriers as both a professional and a parent has deepened my understanding of the urgent need for more integrated and accessible mental health care.

This legislation strengthens coordinated care by allowing psychologists, who are uniquely positioned to integrate psychological testing, psychotherapy, and medication management, to provide comprehensive services within a collaborative medical framework. Importantly, SB568

establishes a rigorous, voluntary certification process that includes a two-year post-doctoral master's degree in clinical psychopharmacology, passage of a national standardized exam, hundreds of hours of supervised prescribing experience, ongoing collaboration with medical providers, and continued education requirements. Prescribing authority would be limited to psychotropic medications, ensuring patient safety and quality of care. Other states have successfully implemented similar models with strong safeguards and demonstrated positive outcomes.

Granting prescriptive authority to properly trained psychologists would help bridge these gaps, ensuring timely, integrated care and reducing the need for emergency interventions. Maryland patients deserve expanded access to high-quality, coordinated mental health care, delivered by providers who know them best.

I urge you to support SB568 for the benefit of Maryland families and individuals struggling with mental health challenges.

Thank you for your time and consideration.

Respectfully,

Kara R. Koenig, Psy.D.
Owner and Licensed Clinical Psychologist (MD 06224)
K2 Psych Services, LLC

TESTIMONY IN SUPPORT OF SENATE BILL 568

My name is Dr. Stephanie Wolf, and I am the current President of the Maryland Psychological Association and a practicing clinical and forensic psychologist. I am the owner of a multijurisdictional practice, Maven Psychology Group, and an adjunct professor at George Washington University. I have been a licensed psychologist for over ten years.

I specialize in trauma and thus have many patients with severe psychological symptoms such as suicidality and psychosis. I see patients weekly or biweekly and continuously monitor symptoms and functional changes. During treatment, patients will frequently report an increase in symptoms, especially as we delve into their trauma histories to enable them to heal. Unfortunately, when this happens, the patients encounter extreme difficulty in either beginning medication or adjusting current medication. It has been disturbing to me to witness the unnecessary suffering of my patients as I try to help them access the care they need. It is especially frustrating because, given my training (including in an acute psychiatric inpatient hospital), I am usually knowledgeable as to what medication changes or additions are needed, but I have no ability to help.

The barriers to medical treatment are many. Often, psychiatrists and medication providers will not respond to their patients in a timely manner. Patients will tell me they have called offices, emailed providers, and yet no one gets back to them. My patients will sign consents for me to reach out to the provider, and my outreach will also often be ignored. With hundreds of patients on prescribers' caseloads, this is often not intentional but rather a result of overburdened practices and a shortage of providers.

When my patients can reach their providers and get a response, they often cannot schedule an appointment for several weeks or even months. For a person who is starting to have command hallucinations or suicidal thoughts, such a wait time is dangerous. An inability to be seen will often result in my sending patients to the hospital emergency rooms. Here, they will have to be admitted inpatient to have the proper adjustments made- an unnecessary, burdensome, and costly approach to a situation that could be handled on an outpatient basis with coordinated care and safety planning.

Sometimes, emergency rooms will not admit such patients and instead discharge them because they are working with a psychologist. These discharges cause the patient to lose faith that anyone can help, as they are in the same position they were in before I sent them to the hospital. It also leaves me, the clinician, impotent, only being able to increase the number of times I see the patient per week and sending them again to the hospital if the danger continues.

For all these reasons, the current bill is needed and necessary to help patients access crucial medical care. Allowing psychologists to get additional training in psychopharmacology, receive supervision and treat patients helps address the shortage of providers and improves the continuity of care for patients.

I would not hesitate to send a patient of mine to a psychologist with such training for medication. In fact, I would seek such a provider out, as I would understand that, with their underlying training in psychology, they would have a deeper understanding of how important coordination of care with therapy providers is and would likely be much more attuned to my patients and their needs. For all the above-mentioned reasons I am strongly in support of SB568 and ask for a favorable vote.
Sincerely,

Stephanie Wolf, JD, PHD

Stephanie Wolf, JD, PhD | Licensed Psychologist
Founder and Partner, *Maven Psychology Group*
President, *Maryland Psychological Association*
Adjunct Professor, *George Washington University*

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February 26, 2026

Senator Pamela Beidle, Chair
Senator Antonio Hayes, Vice Chair
Finance Committee
Miller Senate Office Building, 3 East
Annapolis, MD 21401

RE: SB 568 – Health Occupations – Licensed Psychologists – Prescriptive Authority

Position: SUPPORT

Dear Chair Beidle, Vice-Chair Hayes, and Members of the Committee:

I am a licensed psychologist and practice in Towson, Maryland. I am writing in strong support of Senate Bill 568 (SB 568), which would authorize appropriately trained and certified licensed psychologists in Maryland to prescribe psychotropic medications under carefully defined statutory safeguards. These bills represent a thoughtful, evidence-based response to Maryland's ongoing mental-health crisis and are grounded in decades of empirical research, clinical experience, and successful implementation in other states.

You will hear opposition testimony raise concerns that allowing psychologists to prescribe medication is unsafe or that psychotropic medications are too complex for psychologists to manage. These assertions are not supported by the best available scientific evidence or by the structure of the training required of prescribing psychologists. To the contrary, the evidence demonstrates that prescribing psychologists provide care that is at least as safe as—and in several important respects safer than—other categories of prescribing providers, while bringing a depth of mental-health expertise that many existing prescribers do not possess.

I. Maryland's Mental-Health Workforce Crisis Requires Evidence-Based Solutions

Maryland, like most states, faces a persistent and worsening shortage of mental-health prescribers that has become a significant public-health concern. Recent workforce analyses indicate that Maryland currently has approximately 34,600 behavioral-health professionals but is short more than 18,000 workers needed to meet existing demand. If current trends continue, the state will require more than 32,000 additional behavioral-health professionals within the next several years to adequately serve residents in need. Nearly every county in Maryland is designated as a mental-health professional shortage area, and in some jurisdictions there are few—if any—

psychiatrists available to provide medication management. Even where psychiatrists are present, patients frequently face wait times of many weeks or months for non-urgent appointments, delaying care and increasing the risk of symptom escalation, emergency-department utilization, and hospitalization.

As a result of these systemic shortages, most psychotropic medications in the United States—including in Maryland—are prescribed not by psychiatrists, but by primary-care clinicians, often in brief visits with limited opportunity for comprehensive behavioral assessment, psychotherapy integration, or longitudinal monitoring. Expanding prescriptive authority for psychologists is an evidence-based strategy to address this gap by increasing access to competent, specialized mental-health care without compromising safety.

II. Equity, Rural Access, and Public Health Impact

Maryland's mental-health workforce shortages do not affect all communities equally. Rural jurisdictions and historically underserved communities—particularly low-income populations, communities of color, and individuals relying on public insurance—experience the longest wait times and the most limited access to psychiatric prescribers. In many rural counties, residents must travel long distances or wait months for medication management, increasing reliance on emergency departments, primary-care prescribing, or foregoing care altogether. Expanding prescriptive authority for appropriately trained psychologists is a targeted equity intervention: psychologists are more evenly distributed across the state, are already embedded in community mental-health settings, and are more likely to practice in rural and underserved areas. Allowing these clinicians to provide integrated psychotherapy and medication management improves continuity of care, reduces geographic and financial barriers, and advances Maryland's public-health goals of equity, access, and prevention of avoidable psychiatric crises.

III. Empirical Evidence Demonstrates That Prescribing Psychologists Are Safe

Dr. Phillip Hughes will be testifying before this Committee. The most rigorous and comprehensive evaluation of psychologist prescribing safety comes from the doctoral research of Phillip M. Hughes, PhD (2024), which examined patient-level outcomes for prescribing psychologists compared to psychiatrists and primary-care physicians in New Mexico and Louisiana—the two states with the longest history of psychologist prescriptive authority. Using large insurance-claims datasets and advanced statistical methods to control for patient characteristics and case mix, Dr. Hughes evaluated adverse drug events, psychiatric emergency-department utilization, medication adherence, psychotropic polypharmacy, and deprescribing practices.

His findings were clear and consistent:
- Prescribing psychologists demonstrated safety and efficacy profiles comparable to psychiatrists.
- Prescribing psychologists had lower rates of adverse drug events than primary-care physicians.
- Prescribing psychologists exhibited lower rates of psychotropic polypharmacy.
- Prescribing psychologists deprescribed medications at rates equal to or greater than other

prescribers.

These outcomes reflect careful clinical judgment, conservative prescribing practices, and the integration of medication management with psychotherapy. Critically, there was no evidence of increased harm associated with psychologist prescribing.

IV. Psychotropic Medications and Clinical Complexity

While some psychotropic medications carry FDA "black box warnings" and require careful monitoring, safe prescribing depends on training, clinical judgment, and longitudinal knowledge of the patient—not professional title alone. Prescribing psychologists receive advanced biomedical and clinical education in neurobiology, pathophysiology, pharmacology, and the systemic effects of medications across major body systems. Their training emphasizes integrated management of psychiatric and medical factors that influence treatment outcomes.

Psychologists are uniquely positioned to identify when medication is appropriate, when it should be adjusted or discontinued, and when non-pharmacological interventions are indicated. Their expertise in behavioral assessment, suicide-risk evaluation, and psychotherapy supports safer medication use and improved outcomes.

V. Comparing Psychologists to Nurse Practitioners and Physician Assistants: A Critical Distinction

Opponents often argue that nurse practitioners (NPs) and physician assistants (PAs) can safely prescribe medications and therefore psychologists should not be granted similar authority. This comparison overlooks a critical distinction.

NPs and PAs receive broad medical training but typically receive limited specialized education in mental-health diagnosis, psychological assessment, psychotherapy, and longitudinal behavioral treatment. By contrast, doctoral-level psychologists complete extensive education and supervised training focused almost exclusively on mental-health assessment, differential diagnosis, psychotherapy, suicide-risk assessment, and behavioral intervention.

Research demonstrates that prescribing psychologists treat patient populations that closely resemble those treated by psychiatrists—not those treated by primary-care providers—and that their prescribing patterns are conservative and clinically appropriate. Allowing psychologists to prescribe aligns prescriptive authority with mental-health expertise and enhances patient safety rather than diminishing it.

VI. SB 568 Includes Robust Safeguards and Oversight

SB 568 does not grant blanket prescribing authority. Instead, they require doctoral-level licensure in psychology, completion of rigorous postdoctoral education in clinical psychopharmacology,

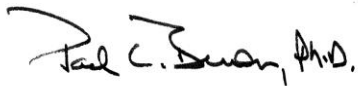
supervised clinical prescribing experience, certification by the State Board of Examiners of Psychologists, ongoing regulatory oversight, and establishment of a Prescriptive Authority Advisory Committee to guide implementation and ensure patient safety.

VI. Conclusion

The question before the General Assembly is not whether psychologists should replace psychiatrists. Rather, it is whether Maryland will continue to rely on an insufficient and overburdened prescriber workforce or adopt a measured, evidence-based expansion of prescriptive authority that improves access, safety, and mental-health outcomes.

The empirical evidence is clear: prescribing psychologists are safe, effective, conservative in their use of psychotropic medications, and associated with improved population-level outcomes, including reduced suicide rates. For these reasons, I respectfully urge a favorable report on SB 568.

Respectfully submitted,



Paul C. Berman, Ph.D.
Licensed Psychologist

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Dear Senator Beidle, Senator Hayes, and Members of the Finance Committee:

I respectfully request a favorable report on SB0568.

My name is Laura Goldstein, LCMFT. I have been a licensed marriage and family therapist since 2012 and a small business owner in Montgomery County, Maryland since 2017. Throughout my career, I have seen firsthand the hardships families face when attempting to access adequate mental health treatment for their children. In addition to longstanding systemic barriers (i.e. cost, insurance limitations, and workforce shortage) families must also navigate the fragmented nature of our behavioral health system.

These silos between service providers create unnecessary financial and logistical burdens, including multiple appointments at different locations, conflicting schedules, and duplicated evaluations. Most significantly, they create clinical barriers to truly collaborative care. While providers strive to coordinate treatment, the reality is that professionals are not always available to consult or collaborate at the frequency necessary to deliver comprehensive, timely care.

Establishing a pathway for appropriately trained and clinically qualified psychologists to obtain prescriptive authority in Maryland would help streamline care for many families. Allowing a single, well-trained provider who is already deeply familiar with a client's symptoms, history, and treatment plan to manage both psychotherapy and indicated medication needs would reduce delays, lower costs, and ease scheduling burdens.

Most importantly, timely access to appropriate medication management, when clinically indicated, can significantly reduce suffering and improve overall outcomes. Empowering qualified providers to respond efficiently to their clients' needs strengthens not only individual and family well-being, but also the health and safety of our communities as a whole.

Thank you for your consideration of SB0568 and for your continued commitment to strengthening Maryland's behavioral health workforce. I respectfully urge a favorable report.

Laura Goldstein, LCMFT
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February 27, 2026

Sen. Pamela Beidle
Sen. Antonio Hayes
Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Dear Chair Beidle, Vice Chair Hayes, and members of the committee,

I am a licensed child psychologist practicing in Maryland, and I am urging a FAVORABLE report for SB 568. This legislation would create a pathway to prescriptive authority for psychologist; it also ensure that we become adequately and rigorously trained to provide safe psychiatric care to our patients.

As a Spanish-speaking Latina psychologist, who has been working with the Latine population for my entire 10 plus years as a mental health provider, I have experienced over and over the shortage of psychiatric prescribers who can meet the cultural and linguistic needs of Maryland's Spanish-speaking population. On an even broader level, the glaring shortage of child and adolescent psychiatric prescribers has been an issue that has continuously plagued my practice. This second issue is one that I have witnessed among families across all levels of socioeconomic status and access to social capital.

The mental health care shortage in Maryland and across the United States has created a harmful paradox: many children go without needed psychiatric medication; and many who do access psychiatric care are too frequently overmedicated or misdiagnosed. Both failures stem from the same root cause: too few providers, too little time, and too little coordination between the providers who are involved.

In my practice, I routinely work with families who—despite having financial resources and living in areas with robust provider networks—were unable to find a psychiatric prescriber for their child in a timely manner. As a result, they were redirected to pediatricians or primary care physicians for conditions that require more specialized training and close monitoring than their general practitioner can provide. While physicians as a whole are highly skilled professionals who treat a range of health disorders, psychiatric care for children and families requires an abundance of additional training to manage family dynamics, educational needs, and complex symptomology. Even when a psychiatrist is available, the level of care is at times insufficient to the clinical need.

Across my current caseload, not a single child is seen in person by their prescribing provider. All medication management occurs virtually, in appointments lasting 15 to 30 minutes, once a month *at most.* More often, these appointments are occurring every 2-3 months. These brief and infrequent check-ins are expected to safely oversee powerful medications for children with complex and acute presentations. This model does not allow for the careful monitoring, relationship-building, and developmental understanding that safe and effective pediatric psychopharmacology requires. These families deserve better.

As a result, I routinely treat children who have been misdiagnosed or placed on inappropriate medication regimens by well-intentioned psychiatric prescribers and pediatricians who do not have the resources or training to effectively provide more comprehensive, complex care. I have also seen families wait far too long before seeking such care due to lack of access to prescribers who resonate with their cultural experiences. For example:

- I have seen multiple children under the age of seven who were prescribed ADHD medication before ever receiving a course of evidence-based psychotherapy despite clinical guidelines recommending behavioral intervention/psychotherapy as a first-line treatment for this age group.
- Children diagnosed with Oppositional Defiant Disorder at a young age—even by a board-certified child psychiatrists—without a direct assessment of the child This is a diagnosis that can carry lifelong consequences. More than once, I have seen this occur based entirely on parent report. In several cases, the child was later found to have co-occurring autism and ADHD, a distinction that fundamentally changes both how the condition presents and how it should be treated. This issue in particular is especially common among for Black children.
- Patients receiving incorrect instructions about when to administer a newly prescribed ADHD medication. In one case, a child went without sleep for two weeks before being hospitalized for psychiatric reasons associated with sleep deprivation.
- Children who are prescribed multiple antidepressant or antipsychotic medications (often used to treat irritability) simultaneously because parents could not tolerate the distress of their child's behavior when tapering off of one medication.
- Children whose parents wait for several years between receiving a diagnosis and referral for psychiatric care before actually consulting with a psychiatric provider due to lack of access to a Spanish-speaking provider and general mistrust in the medical system. When these children finally do receive adequate psychiatric care, their lives are dramatically improved, but they nevertheless carry emotional trauma of living with severe mental needs that went unmedicated.

None of these outcomes were inevitable. They are the predictable result of a system in which prescribers do not have the time, continuity, or collaborative infrastructure necessary to provide safe, developmentally informed care. Psychologists are uniquely positioned to help address this crisis. Our training centers on comprehensive diagnostic evaluation, evidence-

based therapy, and sustained collaboration with families, schools, and medical providers. We see our clients more frequently and over long periods of time, allowing us to closely monitor response to treatment and make thoughtful, data-informed adjustments. With appropriate postdoctoral training in clinical psychopharmacology and ongoing collaboration with our patients' medical providers, psychologists can provide medication management that is integrated, closely supervised, and grounded in a deep understanding of the whole client.

Having worked with hundreds of families during my career, I have had the pleasure of collaborating with plenty of psychiatric providers who are highly skilled at managing the added complexity of working with children and their families; the ones who are bold enough to assert "I don't medicate family dysfunction" when parental distress leads to overmedication. However, these trusted colleagues are often the exception, not the norm.

Granting prescriptive authority to properly trained psychologists would immediately expand Maryland's pool of prescribers while also improving the quality, safety, and continuity of care. It would allow clients to receive medication management from providers who already know them, who see them regularly, and who can integrate pharmacological and therapeutic interventions into a single, coherent treatment plan.

The families I work with cannot afford to wait for a system that works. I urge the committee to support SB 568.

Respectfully submitted,

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I am a pediatrician and child, adolescent, and adult psychiatrist in solo practice of the latter since 1988 in Rockville, MD. Having both medical and psychiatric training has helped me feel confident in prescribing medications as indicated over the years. As a pediatrician, I was trained to treat several common mental health conditions. But to be honest, to provide the kind of detailed care needed, it took too much time. As a psychiatrist, I received even more training in psychopharmacology and had the time to evaluate, make medication recommendations, and educate the client/parent. I also had the time to gather necessary data from schools, co-therapists, and other sources to manage the medication clinically. So, I feel strongly that most psychopharmacotherapy should be provided by psychiatrists.

The reason I am supporting this legislation is that access to psychiatrists is often difficult. Many patients are put on waitlists, which can be months long before they are actually seen and evaluated. In the field of child and adolescent psychiatry, there is actually a shortage in our country of providers available, while the need is ever-increasing.

In my practice, I provide counseling and medication management to my clients. It is my belief that medication without therapy is malpractice. Medication can decrease or eliminate symptoms, but it does not help the person develop better coping skills, understand brain health and emotional needs, or learn how to live in a way that better addresses their mental health needs.

I realize that a lot of my psychiatric colleagues do not practice this way. They are content just providing medication. But I feel that it would be better if a practitioner could bring the full complement of mental health interventions (therapy and medication) in one well-trained provider.

I have had the wonderful opportunity to collaborate with many other mental health providers, psychologists, social workers, and other types of counselors. If I feel comfortable with the quality of care they provide, I am willing to assume the role of medication consultant/manager and delegate the therapy to them.

But wouldn't it be better if psychologists, with adequate training and supervision, also be able to prescribe medication? That would provide many patients who first seek help from a psychologist with continuity of care that is less fragmented. Since psychologists receive post-

February 27, 2026

Senator Pamela Beidle, Chair
Senator Antonio Hayes, Vice Chair
Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401

Bill: Senate Bill 568 -Health Occupations – Licensed Psychologists – Prescriptive Authority

Position: Strong Support

I am Dr. Pat Savage, a retired psychologist in Maryland who provided mental health services for 40 years to the residents of Maryland. I am also the current chair of the Maryland Psychological Association's Political Action Committee (MPAPAC), a past Chair of the Maryland Psychological Association's (MPA) Legislative Committee as well as a Past President of the Association. Today I am writing in support of SB 568.

The Issues

As you know, this bill is an effort to both increase **access to care** as well as **improve coordination of care** that has the potential to make seeking quality mental health services easier for the residents of Maryland. The bill allows those psychologists, who choose to engage in extensive and focused training, on the knowledge and skills necessary to provide psychotropic medications to the people they serve, the opportunity to prescribe a limited formulary of medications designed to optimize treatment outcomes.

You may ask how this bill might **increase access to care?**

1. It is well known that if one chooses to utilize psychotropic medications as an intervention to treat their mental health issues, waiting times to see psychiatrists/physicians can be weeks to months. If the treating psychologist could prescribe medication an individual could be provided with medication in days rather than weeks or months.
2. By providing psychologists with this opportunity, the number of qualified prescribers is likely to increase. According to the 2024 Maryland behavioral health workforce report from the Maryland Health Care Commission, it is estimated that there are 1196 psychiatrists and 1,266 psychologists treating people in Maryland. The potential to increase access to medication seems quite clear.
3. People who are already in treatment with psychologists are more likely to move forward, when medication can be of help to them, if they can work with someone, they have already established a trusting relationship.

You may ask how this **bill improves the quality of care** received by Marylanders?

1. Many people require psychotropic medication whose effects, both intended and unintended (side effects), are well known and generally safe when properly prescribed and monitored. Allowing psychologists to prescribe will unburden physicians and psychiatrists from more routine cases to focus on more complicated cases, hence improving outcomes for those more complicated individuals.
2. Coordination of care is enhanced by housing an array of interventions (psychotherapy and medication) in one provider who may not need to spend copious amounts of valuable and unreimbursed time attempting to work with other providers, i.e., primary care, internal medicine, psychiatry, pediatricians, etc.
3. One provider regularly seeing the effects of both the behavioral and psychotropic interventions is likely to result in the best treatment outcomes.

4. Marylanders will appreciate spending less of their valuable time seeking the care they need when they can receive multiple interventions from one well-trained provider.
5. This bill requires prescribing psychologists to collaborate with their medical colleagues to ensure the best care is provided to our citizens.

Does this bill allow for psychotropic medications to be provided to our residents **safely**?

1. By requiring an additional master's degree to one's Doctoral degree psychologists will receive adequate training, both coursework and supervised practice, allowing them to safely prescribe a limited formulary of psychotropic drugs.
2. If one reviews the training, supervision, and examinations required to obtain this authority, you will see that attention to patient safety is priority number one.
3. The Department of Defense has long allowed qualified psychologists to prescribe medications and demonstrated that psychologists can do so safely.
4. Multiple states have allowed psychologists to obtain the authority to prescribe demonstrating that psychologists can do so safely. In fact, in several states the rate of suicide has declined after psychologists were granted prescribing privileges.
5. Contrary to what some have said, psychologists do receive course work adequate to develop a basic to complex understanding of the interaction between the brain and the body prior to seeking the additional education this bill requires.
6. This bill also requires psychologists to keep the knowledge necessary to safely prescribe up to date by requiring additional Continuing Education credits to that required to maintain their license as a psychologist.

What happens when an individual has underlying or complicated medical issues?

1. You will note that this bill requires psychologists to coordinate care with medical professionals to provide the highest levels of care for individuals electing to utilize psychotropic medications for their mental health.
2. Many psychologists are already collaborating with their physician colleagues to provide care to individuals with complex medical conditions or those medical conditions that might present as a psychological condition.

My Experiences

I worked with pediatric, adolescent and adult populations to provide both counseling and formal evaluations. As a result, I was initially trained and then continued to be educated in the interaction between one's brain and body. In fact, because I received significant additional training in Neuropsychology, it was imperative to understand a myriad of medical conditions that affected one's cognitive and emotional function. To suggest that psychologists do not receive training of this type is untrue.

To those who say psychologists are not trained to adequately recognize medical conditions, I would offer the following. My training as a psychologist allowed me to be able to consider that what might look like an inattentive child, adolescent, or even adult, more commonly seen in children, might be a person experiencing an absence seizure (simple or complex). So rather than refer a child for psychostimulant medication I would have referred that child to a neurologist to diagnose and then target medication that would treat their condition. When an individual is depressed, considering that you might be dealing with an endocrine disorder such as a hypo or hyper thyroid condition is important and would warrant completely different medications to successfully treat one's condition. I could go on but I hope you see my point that even those of us who have not had the additional training required by this bill to prescribe are well versed in recognizing that biological issues can and do affect cognitive, emotional, and behavioral function.

During my time as a practicing psychologist, I would often provide a child, adolescent or adult with the evaluation necessary to diagnose a mental health condition and then with the individual make the determination that utilizing medication was an important component of their self-care or in our parlance treatment. An example would be the hundreds of people I diagnosed to be struggling with AD/HD, a complex and often misunderstood condition

that is mediated by areas of the brain that do not function “normally” and can result in significant impairments in one’s ability to successfully manage their environments, i.e. home life, social life, school, and/or work. When it was determined that medication might be a helpful tool, I would then spend a great deal of time working with other medical professionals, an array of physicians, to ensure that the individual would receive the best treatment we could provide, generally, a combination of cognitive-behavioral therapy, environmental engineering, and medication. What I found fascinating was that in many instances I would speak to the physician who specialized in pediatrics, internal medicine, and at times neurology, provide my recommendation and the individual’s desire to utilize psychotropics and be asked….” What medication would you recommend?” While this is currently outside the scope of practice for psychologists, I would often help direct the physician in choosing a medication based on the client’s genetics, family history, and any known medical conditions that they had reported to me. It would have been far easier and quicker for the newly diagnosed individual, should I have been trained to do so, to contact the physician, say this is what I’m thinking of prescribing, is there any medical condition that you are aware of that might be a problem with this individual. We both could have been off the phone quickly and the person would have walked away with a prescription and follow up care instructions that day. Time would have been saved for me, the physician, and the person seeking treatment. A win, win, win.

A second commonly encountered situation, that prescription authority would alleviate, is the wait time often required between an individual receiving a diagnosis and the implementation of psychotropic medication. For kids this would mean being able to intervene and adjust dosages more quicklly based on an individual’s response to the medication, hence more time the child is able to absorb educational materials presented by teachers and less time presenting behavioral challenges to a teacher that require time that a teacher could have spent providing education rather than managing behaviors.

These are just a few of the examples that come to mind that I hope convince you that granting prescription privileges to psychologists’ time has come.

I have reviewed the training requirements and know that I received a hefty does of coursework addressing biological issues affecting cognitive and emotional functioning, as well as the results of the DOD and several other states and believe that psychologists can and should be offered the opportunity to prescribe psychotropic medications as safely as any other group that currently possess that authority. I also believed and was trained that when I was concerned about biological/medical issues consulting with one’s medical colleagues was the most appropriate standard of care. This bill would not change that but would most likely result in increased levels of collaboration all to the good of the person seeking treatment.

Lastly, if I was in practice today, I would not hesitate to refer to a psychologist who possessed the authority in Maryland to prescribe.

Thank you for your attention and consideration of this bill. I hope and urge you to provide a Favorable Recommendation in Support of SB0586. Should you have any questions or concerns, I would be glad to make myself available to you to answer those questions or address your concerns.

R. Patrick Savage, Jr., Ph.D.
6703 Ilex Court
New Market, MD 21774
Licensed Psychologist: MD#2219

Testimony of Morgan Sammons, PhD, ABPP, in re: SB568/HB1021

I am Morgan Sammons, a psychologist and a retired Navy captain, providing testimony on behalf of SB568/HB1021, a measure that will allow appropriately trained psychologists to utilize certain medications in their practice. Although I now live in Oregon, I was a resident of Maryland for over 20 years, and was long-time member of the Maryland Psychological Association, including a term as its president. During that time, I was in the first cohort of a program that existed in the Department of War to train psychologists to prescribe. I did so safely and effectively for almost 20 years, providing prescribing services to military members and their families in Maryland and throughout the world. In both metropolitan areas where I worked alongside my psychiatric colleagues, such as the National Naval Medical Center, and in places where no mental health prescribers existed, such as Iceland and combat outposts in Iraq, I was able to assist servicemembers and their families with both psychological and pharmacological treatments.

I prescribed a full range of psychotropic drugs to active-duty members and their dependents in the DoW. I treated diagnoses from depression to severe psychosis with a full range of drugs from agents for insomnia to lithium and powerful antipsychotic drugs. All psychotropic agents have some degree of risk, several, including lithium, require close monitoring. As my training gave me the ability to interpret laboratory findings, I was able to administer complex regimens. After my military experience, I became Systemwide Dean of the California School of Professional Psychology, where I oversaw a civilian training program for clinical psychopharmacology, and have since consulted with other training programs for psychologist prescribers.

Maryland like most other states in our country faces a shortage of qualified prescribers of psychotropic drugs. Such shortages are of long-standing duration, and it has been demonstrated that in states where psychologists have been allowed to prescribe they have safely and effectively assisted in alleviating this problem. Such services are especially needed in rural and underserved areas, in this instance, significant areas of Western and Eastern Maryland.

Safety is an issue for all health care providers, no less so for psychologist prescribers. But the safely record of all non-physician healthcare specialties that have been given prescriptive authority is clear. Professions who add prescriptive authority to their scope of practice have uniformly done so safely and effectively.

Allowing psychologists to prescribe will be to allow mental health providers with extensive training and experience to incorporate medication, where indicated, into treatment. Because psychologists are fundamentally trained in behavioral and psychological, not just medication interventions, that are best equipped to provide a complete range of mental health services to patients rather than simply medication management.

I respect my psychiatric colleagues and have welcomed their collaboration in patient care. When I first began training in 1991, suffice to say my program was not popular in psychiatry. This changed rapidly when our training site, Walter Reed Hospital, faced a sudden shortage of psychiatric residents and I am happy to report that we became accepted and valued service providers alongside our fellow residents. The program I began in was truly an experiment. Now, with psychologist providers in 7 states, the DoD, Indian Health Service and US Public Health Service, we are an accepted component of comprehensive mental health care who have proven efficacy in meeting rising demand for services.

Prescribing psychologists will continue to work collaboratively with psychiatry and other providers to improve patient care. At the same time, we remain independently licensed providers who should be able to determine our own scope of practice, and not have it dictated by other professions. History speaks loudly that when other professions expand into areas once considered the exclusive purview of medicine, they do so safely and effectively, just as nurse practitioners have already done so in the state of Maryland and throughout the nation.

I am happy to answer any further questions you may have.

February 17, 2026

Dear Senate Finance Committee,

My name is Dr. Phillip Hughes, and I am an assistant professor at the Binghamton University School of Pharmacy and Pharmaceutical Sciences. My research focuses on mental health and substance use treatment policy, and scope-of-practice regulation is a topic I regularly study. I am writing to you in relation to SB 0568, which would expand prescriptive authority to psychologists. Below, I summarize my research on this topic.

Prescribing Psychologists are Safe and Effective

1. The rate of adverse drug events is 24% **lower** among patients treated by prescribing psychologists than among patients treated by psychiatrists.[1]
2. The rate of psychotropic polypharmacy (a risk factor for complications) is 20% **lower** among patients treated by treated by prescribing psychologists than among patients treated by psychiatrists.[1]
3. The rate of psychiatric emergency room visits and medication adherence is the same for patients of prescribing psychologists as for patients of psychiatrists.[1] This study accounted for all patient-level clinical factors, including mental health conditions and physical comorbidities.
4. Prescribing psychologists at a clinic in New Mexico provided psychotherapy in 87.5% of all visits.[2]

Prescribing Psychology Improves Population Mental Health

5. Suicide rates decreased in Louisiana when psychologists began prescribing[3]
6. Mental health mortality decreased in New Mexico when psychologists began prescribing[3]
7. In all states where psychologists can prescribe, the suicide rate decreased by 5-7%.[4,5]
8. Prescriptive authority for psychologists is a cost-effective suicide reduction policy, estimated to save millions of U.S. dollars over a 20-year span.[6]

Prescribing Psychology Increases Access to Mental Health Care

9. Unmet need for pediatric health care is 5.4 percentage points lower in states where psychologists can prescribe.[7]
10. This policy may reduce unmet mental health prescribing needs in Maryland by an estimated 8.8%, a notably larger impact than expected in many other states (US average: 4.3%).[8] See Figure 1 below for the estimated reductions for different levels of psychologist uptake.
11. Psychologists currently already prescribe approximately 2% of all psychotropic medications nationally.[9]
12. Prescribing psychologists treat a population of patients that are very similar to psychiatrists – including their physical health and chronic health conditions.[10]

13. Prescribing psychologists at a clinic in Las Cruces, New Mexico treat patients who are on Medicaid (33% of their patients), live in rural counties (95% of their patients), and patients from low-resource areas (average deprivation score of 92 out of 100).[2] See Figure 2 below for the distribution of their patients.

Figure 1. Simulated reductions in unmet mental health prescribing needs for Maryland if psychologists become prescribers.

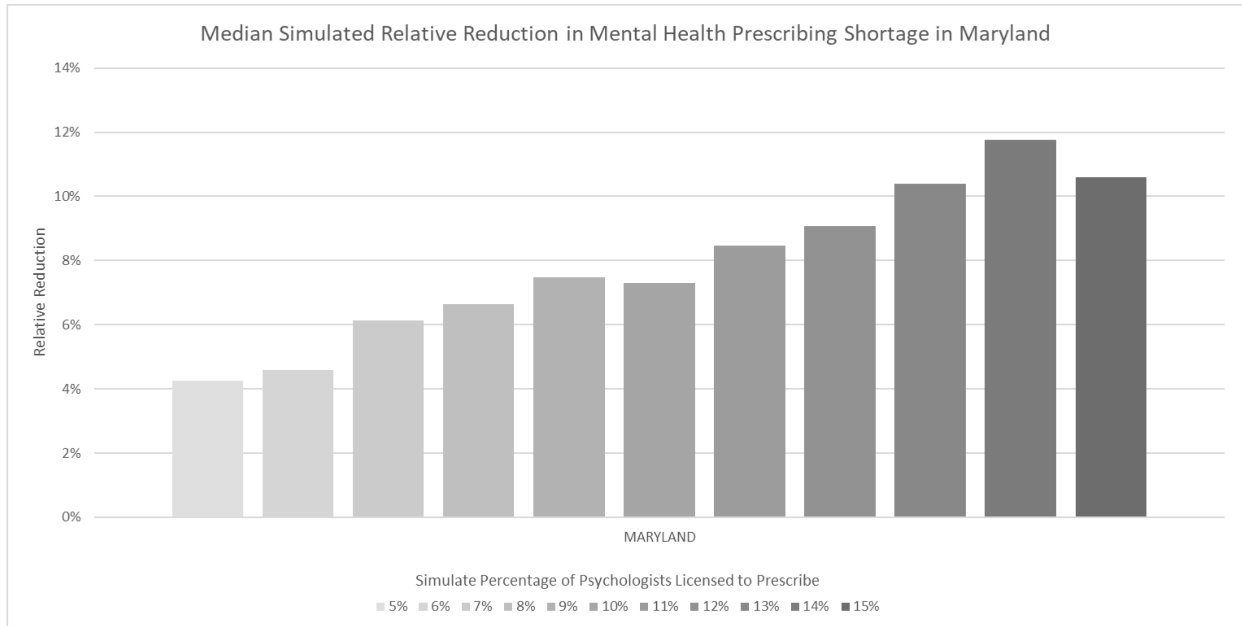
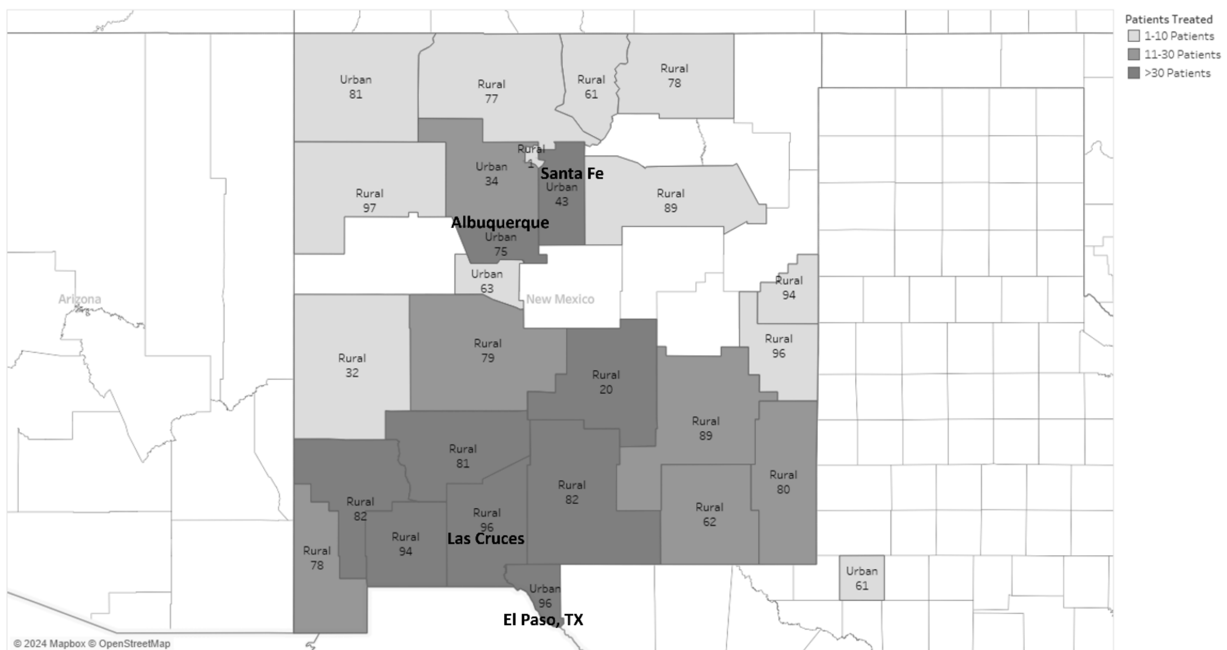


Figure 2. Distribution of Patients Treated at a Prescribing Psychology Clinic in Las Cruces, New Mexico.

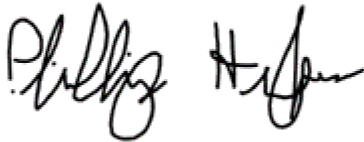


Shading shows the number of patients treated by the clinic per county (darker = more patients). Counties are identified as either Urban or Rural based on the Office of Management and Budget designations of Metropolitan (Urban), Micropolitan (Rural), or neither (Rural). Counties are labeled with their Social Deprivation Index score, with 1 being minimal deprivation and 100 being extreme deprivation.

The scientific record clearly demonstrates that prescribing psychologists are **safe and effective**, **improve population mental health**, and **increase access to mental health care**. I also want to be clear that this work is not rooted in any one paradigm, but instead was conducted with a team of researchers from multiple fields: health services research, pharmacoepidemiology, health economics, psychology, psychiatry, social work, and nursing.

I implore you to please consider this information as you work to decide how to proceed with SB 0568. I would be more than happy to find a time to meet with you to answer any questions you may have on this issue.

Sincerely,



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