

JRomeo Testimony for SB0568 and HB1021.pdf

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Position: FAV

**WRITTEN TESTIMONY IN SUPPORT OF
HB1021 / SB0568**

Health Occupations – Licensed Psychologists – Prescriptive Authority

Position: FAVORABLE

Jess Romeo, PMHNP-BC, MSW

Dear Members of the Committee,

My name is Jess Romeo. I'm a Maryland resident, a board-certified psychiatric nurse practitioner, and a licensed clinical social worker. I'm writing in support of HB1021/SB0568 because my own pathway to prescribing was similar to what psychologists are asking you to make possible. I firmly believe that an expansion of their scope will:

1. Improve patient access to expert psychopharmacologic care
2. Diversify the psychopharmacologic workforce in a meaningful and helpful way
3. Be consistent with Maryland's existing commitment to a diverse healthcare workforce

A Wider Lens Makes a Better Prescriber

Before I became an NP, I was a social worker. Early in my career, I accompanied a client to see his psychiatrist, as was a common task in my role at the time. This was someone my client had been seeing for years and trusted deeply — someone whose advice he followed religiously, unlike my own, as the lowly social worker. At the visit, the psychiatrist sat behind a desk, barely looked up, and in a perfunctory social history update, asked, "You don't have family, do you?"

This client had just returned from visiting an extended family of about thirty people. And his prescriber didn't know they existed. That was one of maybe seven questions in a ten-minute visit where nothing meaningful was exchanged other than a paper prescription for the same medications at the same doses he'd been on for years.

I wasn't astounded because this psychiatrist was incompetent. I was astounded because the system we'd built made it possible for someone to prescribe medications that alter your brain chemistry without knowing the first thing about your life. When people ask me why I went back to school to earn prescriptive authority myself, that moment, and many similar ones like it, are the reason why.

Since then, I've worked with countless patients who've suffered from a lack of access to a provider whose lens is wide enough to take in the full picture of their personhood while applying evidence-based assessment and treatment. My social work lens didn't

disappear when I became a prescriber — it became the solid foundation for every diagnostic and prescribing decision I’ve made. And patients continue to seek me out because the depth and richness of that perspective allows them to feel seen, safe, and supported in ways they couldn’t get from psychiatrists they’d seen in the past who treated them in similar ways.

We Can’t Fix the Whole System — But We Can Do This

We can’t fix everything about a healthcare system that squeezes providers into fifteen-minute visits and separates the people who prescribe your medication from the people who actually know you. But we can expand the diversity of the workforce, and create more pathways for people with considerable training to see the full picture of who they’re treating.

Psychologists carry that same depth I describe in my own practice. Thousands of hours of diagnostic training, therapeutic relationships, and context. The training requirements laid out in this bill are rigorous — intensive didactic education in neuroscience, pharmacology, clinical medicine, and pathophysiology, followed by a supervised postdoctoral fellowship and a national psychopharmacology examination. Their training is far from a crash course. It is a different pathway to the same destination, informed by a different — and valuable — clinical foundation.

The Data Supports This

All the years of training that this bill’s opponents will cite as reasons to oppose it — in reality, those years and that specific training pathway are not demonstrated to produce superior outcomes for patients. We have this data already.

In states that have granted psychologists prescriptive authority, suicide mortality decreased by five to seven percentage points, with statistically significant effects across multiple demographic groups (Choudhury & Plemmons, 2023). Analysis of over 300,000 patients shows that prescribing psychologists treat populations remarkably similar to psychiatrists — including those with bipolar disorder, schizophrenia, and other serious mental illnesses — while integrating psychotherapy with medication management (Hughes et al., 2024).

Maryland’s own experience with nurse practitioner independent practice tells a parallel story. A 2023 JAMA systematic review of over 150 studies concluded that removing restrictions on NP practice is associated with improved access to care without compromising quality or safety. Research demonstrates that NP independence increases the frequency of routine checkups, improves care quality, and decreases emergency room use (Kleiner et al., 2017). NP-owned practices average 24 minutes per patient visit — 33% longer than the national average — and are 86% more likely than

physician-owned practices to be located in designated health professional shortage areas.

In the pediatric mental health space specifically, psychologist scope-of-practice expansion is associated with a 5.4 percentage point reduction in unmet mental health needs and improved access to appropriate medication management (Hughes et al., 2024).

Maryland Has Already Said Yes to This Principle

Maryland has already demonstrated its commitment to the spirit of this legislation. While other states have restricted or rolled back scope of practice for nurse practitioners, this legislature expanded it — granting NPs full independent practice authority. You’ve already said, clearly, that diverse pathways to competent care make our healthcare system stronger. Passing this bill would be entirely consistent with that commitment, and would position Maryland among the growing number of states that trust rigorously trained professionals from multiple disciplines to meet the mental health needs of their residents.

Six states have already passed prescriptive authority for psychologists — New Mexico, Louisiana, Illinois, Iowa, Idaho, and Colorado — with Utah following in 2024. The evidence from these states is compelling. There are currently approximately 300–350 active prescribing psychologists across the country, with over 275 graduate students and psychologists enrolled in training programs. The pathway works. The outcomes are strong. And Maryland has every reason to join them.

I urge a favorable report on HB1021/SB0568. Thank you for your time and consideration.

Jess Romeo, MSW, LCSW-C, PMHNP-BC

Maryland Resident

References

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Hughes, P. M., Niznik, J. D., McGrath, R. E., et al. (2024). Demographics and clinical characteristics of patients of prescribing psychologists, psychiatrists, and primary care physicians. *The American Psychologist*.

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Kleiner, M. M., Marier, A., Park, K. W., & Wing, C. (2017). Nurse practitioner independence, health care utilization, and health outcomes. *Journal of Health Economics*.

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MPA 2026 Testimony - Support - Senate Bill 568 - H

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March 3, 2026

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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, 1 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 Wolf, JD, Ph.D.
President

Stephanie Olarte, Ph.D.
Stephanie Olarte, Ph.D.
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,

A handwritten signature in black ink, appearing to read "K. Sanschagrin", with a stylized, flowing script.

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



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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 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,

A handwritten signature in dark ink, reading "Kara R. Koenig, Psy.D." in a cursive style.

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

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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,

SB 568 – Prescriptive Authority
Letter in Support

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,

A handwritten signature in black ink, reading "Paul C. Berman, Ph.D." with a stylized, cursive script.

Paul C. Berman, Ph.D.
Licensed Psychologist

References

Hughes, P. M. (2024). Who gains and how? Assessing the safety and efficacy of extending prescriptive authority to psychologists. Doctoral dissertation, University of North Carolina at Chapel Hill.

Hughes, P. M., Phillips, D. C., McGrath, R. E., & Thomas, K. C. (2023). Examining psychologist prescriptive authority as a cost-effective strategy for reducing suicide rates. *Professional Psychology: Research and Practice*, 54(4), 284–294.

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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
Owner and Executive Director
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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.

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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 quickly 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 dose 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.
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Licensed Psychologist: MD#2219

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 prescribing³
6. Mental health mortality decreased in New Mexico when psychologists began prescribing³
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.

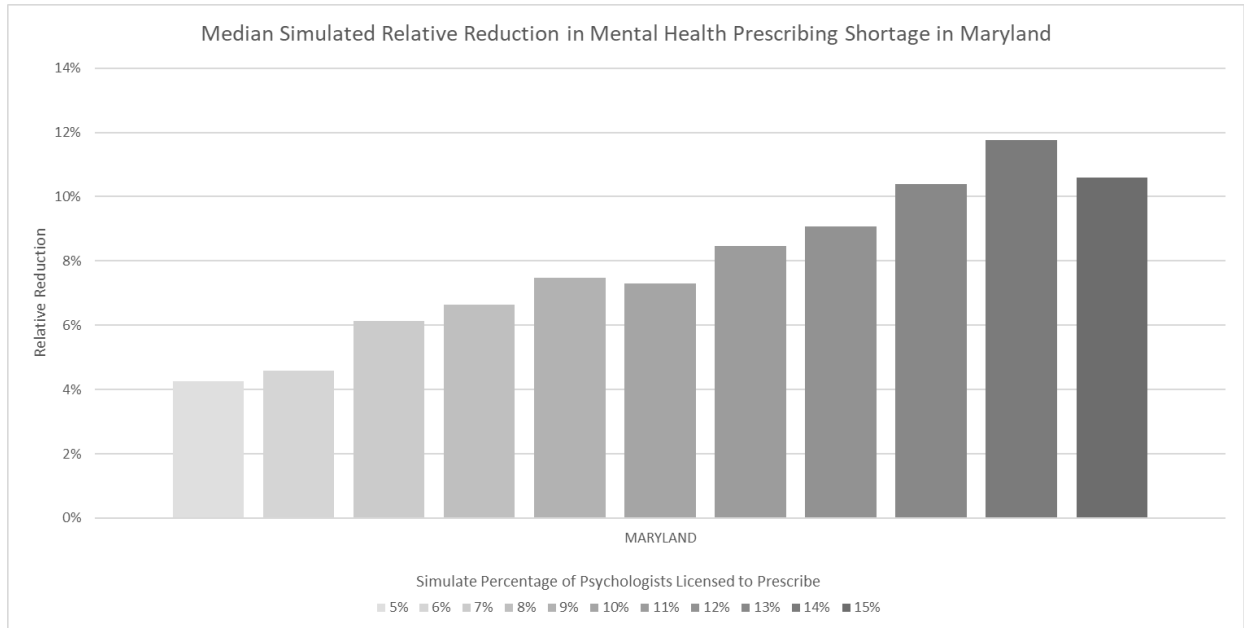
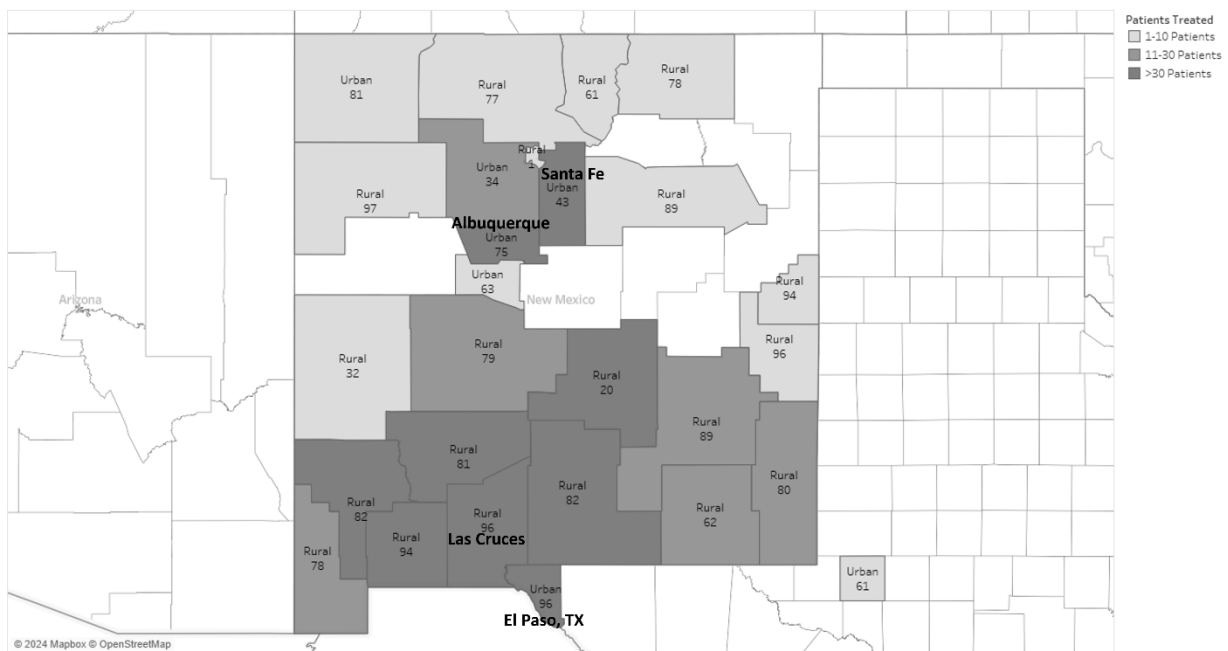


Figure 2. Distribution of Patients Treated at a Prescribing Psychology Clinic in Las Cruces, New Mexico.



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,

A handwritten signature in black ink, appearing to read "Phillip Hughes". The signature is fluid and cursive, with the first name "Phillip" being more prominent than the last name "Hughes".

Phillip Hughes, PhD, MS
Assistant Professor
School of Pharmacy and Pharmaceutical Sciences
Binghamton University
phughes2@binghamton.edu

References

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FAVORABLE HB1012 SB0568 Health Occupations - Licensure

Uploaded by: Jeremy Browning

Position: FAVORABLE



**Maryland Commission
on LGBTQIA+ Affairs**

Bill Title: Health Occupations - Licensed Psychologists - Prescriptive Authority

Bill Number(s): HB1012/SB0568

Position: FAVORABLE

Date: February 27, 2026

Submitted by: Jeremy Browning, Director of the Maryland Commission on LGBTQIA+ Affairs

To:

House Health Committee

The Hon. Heather Bagnall, Chair
The Hon. Bonnie Cullison, Vice Chair

Senate Finance Committee

The Hon. Heather Bagnall, Chair
The Hon. Bonnie Cullison, Vice Chair

Testimony on behalf of the Maryland Commission on LGBTQIA+ Affairs:

The Maryland Commission on LGBTQIA+ Affairs respectfully submits this testimony in support of HB1012/SB0568 to authorize prescriptive authority for licensed psychologists who meet rigorous education, training, and certification requirements.

The Commission was established by the Maryland General Assembly to assess the challenges facing LGBTQIA+ communities, collect data, and inform state policy. Our work consistently finds that access to timely, culturally competent mental health care remains a significant challenge for LGBTQIA+ Marylanders, particularly for transgender individuals, LGBTQIA+ youth, and those living in rural or underserved areas.

Preliminary findings from the Commission's [2026 Maryland LGBTQIA+ Community Needs Assessment](#) highlight the scope of these challenges. Nearly half of respondents (47%) reported experiencing obstacles or delays in receiving health care in Maryland, with barriers most pronounced in mental health and specialty services. More than one-third reported avoiding medical care due to anticipated discrimination.

The assessment also reflects substantial mental health need. Over 22% of respondents reported seriously considering suicide in the past 12 months, and more than 61% reported lifetime suicidal ideation.

At the same time, many LGBTQIA+ Marylanders rely on psychologists as their primary and most trusted behavioral health providers. However, shortages of psychiatric prescribers and fragmented care models can delay treatment, disrupt continuity of care, and create additional barriers for individuals already navigating stigma, transportation challenges, or limited provider networks.

Allowing licensed psychologists who complete advanced postdoctoral training in clinical pharmacology and supervised prescribing experience to provide medication management would expand the behavioral health workforce and support more integrated models of care. For patients already receiving therapy, the ability to obtain coordinated treatment from a qualified provider can reduce delays, improve treatment adherence, and strengthen engagement in care.

Expanding access to integrated mental health services is particularly important for LGBTQIA+ Marylanders, whose experiences of discrimination, social isolation, and minority stress are associated with higher rates of anxiety, depression, and suicidal ideation. Increasing the number of qualified professionals able to meet these needs supports both health equity and overall system capacity.

The Commission's Community Needs Assessment makes clear that improving access to affirming mental health care is a statewide priority that will require workforce development, expanded provider capacity, and more coordinated systems of care.

For these reasons, the Maryland Commission on LGBTQIA+ Affairs respectfully urges a favorable report.

Reference:

Maryland Commission on LGBTQIA+ Affairs. (2026). *Maryland LGBTQIA+ Community Needs Assessment: Preliminary Findings Report* (in partnership with the University of Maryland Eastern Shore).

<https://goci.maryland.gov/wp-content/uploads/sites/2/2026/02/2026-MDLGBTQIA-Community-Needs-Assessment-Preliminary-Findings-Report.pdf>

Jess Romeo SB0568 written testimony_favorable.pdf

Uploaded by: Jess Romeo

Position: FAV

**WRITTEN TESTIMONY IN SUPPORT OF
HB1021 / SB0568**

Health Occupations – Licensed Psychologists – Prescriptive Authority

Position: FAVORABLE

Jess Romeo, PMHNP-BC, MSW

Dear Members of the Committee,

My name is Jess Romeo. I'm a Maryland resident, a board-certified psychiatric nurse practitioner, and a licensed clinical social worker. I'm writing in support of HB1021/SB0568 because my own pathway to prescribing was similar to what psychologists are asking you to make possible. I firmly believe that an expansion of their scope will:

1. Improve patient access to expert psychopharmacologic care
2. Diversify the psychopharmacologic workforce in a meaningful and helpful way
3. Be consistent with Maryland's existing commitment to a diverse healthcare workforce

A Wider Lens Makes a Better Prescriber

Before I became an NP, I was a social worker. Early in my career, I accompanied a client to see his psychiatrist, as was a common task in my role at the time. This was someone my client had been seeing for years and trusted deeply — someone whose advice he followed religiously, unlike my own, as the lowly social worker. At the visit, the psychiatrist sat behind a desk, barely looked up, and in a perfunctory social history update, asked, "You don't have family, do you?"

This client had just returned from visiting an extended family of about thirty people. And his prescriber didn't know they existed. That was one of maybe seven questions in a ten-minute visit where nothing meaningful was exchanged other than a paper prescription for the same medications at the same doses he'd been on for years.

I wasn't astounded because this psychiatrist was incompetent. I was astounded because the system we'd built made it possible for someone to prescribe medications that alter your brain chemistry without knowing the first thing about your life. When people ask me why I went back to school to earn prescriptive authority myself, that moment, and many similar ones like it, are the reason why.

Since then, I've worked with countless patients who've suffered from a lack of access to a provider whose lens is wide enough to take in the full picture of their personhood while applying evidence-based assessment and treatment. My social work lens didn't

disappear when I became a prescriber — it became the solid foundation for every diagnostic and prescribing decision I've made. And patients continue to seek me out because the depth and richness of that perspective allows them to feel seen, safe, and supported in ways they couldn't get from psychiatrists they'd seen in the past who treated them in similar ways.

We Can't Fix the Whole System — But We Can Do This

We can't fix everything about a healthcare system that squeezes providers into fifteen-minute visits and separates the people who prescribe your medication from the people who actually know you. But we can expand the diversity of the workforce, and create more pathways for people with considerable training to see the full picture of who they're treating.

Psychologists carry that same depth I describe in my own practice. Thousands of hours of diagnostic training, therapeutic relationships, and context. The training requirements laid out in this bill are rigorous — intensive didactic education in neuroscience, pharmacology, clinical medicine, and pathophysiology, followed by a supervised postdoctoral fellowship and a national psychopharmacology examination. Their training is far from a crash course. It is a different pathway to the same destination, informed by a different — and valuable — clinical foundation.

The Data Supports This

All the years of training that this bill's opponents will cite as reasons to oppose it — in reality, those years and that specific training pathway are not demonstrated to produce superior outcomes for patients. We have this data already.

In states that have granted psychologists prescriptive authority, suicide mortality decreased by five to seven percentage points, with statistically significant effects across multiple demographic groups (Choudhury & Plemmons, 2023). Analysis of over 300,000 patients shows that prescribing psychologists treat populations remarkably similar to psychiatrists — including those with bipolar disorder, schizophrenia, and other serious mental illnesses — while integrating psychotherapy with medication management (Hughes et al., 2024).

Maryland's own experience with nurse practitioner independent practice tells a parallel story. A 2023 JAMA systematic review of over 150 studies concluded that removing restrictions on NP practice is associated with improved access to care without compromising quality or safety. Research demonstrates that NP independence increases the frequency of routine checkups, improves care quality, and decreases emergency room use (Kleiner et al., 2017). NP-owned practices average 24 minutes per patient visit — 33% longer than the national average — and are 86% more likely than

physician-owned practices to be located in designated health professional shortage areas.

In the pediatric mental health space specifically, psychologist scope-of-practice expansion is associated with a 5.4 percentage point reduction in unmet mental health needs and improved access to appropriate medication management (Hughes et al., 2024).

Maryland Has Already Said Yes to This Principle

Maryland has already demonstrated its commitment to the spirit of this legislation. While other states have restricted or rolled back scope of practice for nurse practitioners, this legislature expanded it — granting NPs full independent practice authority. You’ve already said, clearly, that diverse pathways to competent care make our healthcare system stronger. Passing this bill would be entirely consistent with that commitment, and would position Maryland among the growing number of states that trust rigorously trained professionals from multiple disciplines to meet the mental health needs of their residents.

Six states have already passed prescriptive authority for psychologists — New Mexico, Louisiana, Illinois, Iowa, Idaho, and Colorado — with Utah following in 2024. The evidence from these states is compelling. There are currently approximately 300–350 active prescribing psychologists across the country, with over 275 graduate students and psychologists enrolled in training programs. The pathway works. The outcomes are strong. And Maryland has every reason to join them.

I urge a favorable report on HB1021/SB0568. Thank you for your time and consideration.

Jess Romeo, MSW, LCSW-C, PMHNP-BC

Maryland Resident

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SB 568 Koenig Testimony.pdf

Uploaded by: Kara Koenig

Position: FAV



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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 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,

A handwritten signature in dark ink that reads "Kara R. Koenig, Psy.D." The signature is written in a cursive, flowing style.

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

RXP Written Testimony SB 568.pdf

Uploaded by: Kim Sanschagrin

Position: FAV

Law & Mental Health Associates, Inc.

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February 26, 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:

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,

A handwritten signature in black ink, appearing to read "K. Sanschagrin". The signature is fluid and cursive, with a large initial "K" and a long, sweeping underline.

Kimberly A. Sanschagrin, J.D., Ph.D.
Licensed Psychologist, Maryland #04602

SB 0568 Prescriptive Authority Testimony .pdf

Uploaded by: Laura Goldstein

Position: FAV

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
Owner and Executive Director
Montgomery County Counseling Center

SB568 RxP Student Testimony.pdf

Uploaded by: M Pease

Position: FAV

February 27, 2026

The Honorable Pamela Beidle
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Testimony of M Pease, M.S.

IN SUPPORT OF

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

To the Chair, Vice Chair, and honorable members of the Senate Finance Committee:

I am a Ph.D. candidate in counseling psychology at the University of Maryland, College Park. Over the course of my training toward becoming a psychologist, I have provided therapeutic services under supervision to communities across the State of Maryland for nearly four years.

In my practice, I have seen firsthand the need for integrated, comprehensive mental health services. Our communities are facing increasing demands for mental health support, including medication management, yet often face barriers to this care including long wait times and lack of available providers for referrals.

As a trainee, I am also experiencing the depth of training doctoral-level psychologists complete. This training, which generally takes over a decade for full independent licensure, provides psychologists with unique clinical expertise to provide holistic, client-centered, multiculturally competent healthcare.

This existing competence, when combined with the additional training provided for under this legislation, could uniquely position psychologists to meet this moment of need and provide the evidence-based standard of care as prescribers, as is already the case in seven states and several Federal jurisdictions.

Thinking of my own future career, I intend to be one of the psychologists to answer the call to make this care more accessible to Marylanders should this bill pass. I would be honored to have the opportunity to pursue further training and supervised experience to serve Marylanders as a prescribing psychologist. I urge a **favorable report** on SB 568 because all Marylanders deserve access to the mental health services they need to thrive.

Sincerely,
M Pease, M.S.
Ph.D. Candidate in Counseling Psychology
University of Maryland, College Park

Sammons SB 568 testimony 27 Feb 2026 (002).pdf

Uploaded by: Morgan Sammons

Position: FAV

Testimony of Morgan Sammons, PhD, ABPP, in re: SB 568

I am Morgan Sammons, a psychologist and a retired Navy captain, providing testimony on behalf of SB568, 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.

letter_SB_568_02.27.26.pdf

Uploaded by: Neal Morris

Position: FAV

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 Neal Morris, a practicing Licensed Psychologist providing services since 1984 to Marylanders; specializing in Sleep Psychology services. I completed the specialized Post-Doctoral training in Clinical Psychopharmacology over 20 years ago. I am a Past President of the Maryland Psychological Association. I am writing to urge you to support SB 568.

I believe there are three Key-points in regard to this proposed legislation: ACCESS to care will be improved, the QUALITY of comprehensive mental healthcare will continue to be high by ensuring that only psychologists with additional specialized training will be authorized to prescribe psychotropic medications and finally that comprehensive mental healthcare will become more affordable by reducing out-of-pocket COST.

ACCESS – by enacting this Bill there will be more expert providers able to prescribe medications if warranted. There are already dozens of psychologists with this specialized additional training in Maryland. There are simply too few prescribers given the vast numbers of those individuals seeking services.

QUALITY of care will be enhanced by granting authority to appropriately trained psychologists who are extremely well trained in providing psychological treatments. When individuals who need treatment can not get appointments or

can not afford the high out-of-pocket fees, they either go to their PCPs who do their best, but because of limited training in treating mental and behavioral problems do beginning services and are able to do only very limited follow through due to all the routine family practice demands they manage daily.

COST is a huge concern. Mental health physician prescribers who accept any insurance seem to be quite rare. Many of the psychologists in states where prescribing is presently authorized do accept insurance, both commercial and public (Medicare/Medicaid). And, there is solid evidence that the mental health crisis appears to have receded such as a lowering of the suicide rates of the underserved in these states.

I believe this Bill is a potential clear WIN for Marylanders!

Respectfully,

Neal R. Morris, EdD, MSCP, DBSM, ABPP-CL

Maryland Licensed Psychologist

Board Certified in Clinical Psychology and Behavioral Sleep Medicine

SB568 PCB Support.pdf

Uploaded by: Paul Berman

Position: FAV

PAUL C. BERMAN, PH.D.

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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,

SB 568 – Prescriptive Authority
Letter in Support

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,

A handwritten signature in black ink, reading "Paul C. Berman, Ph.D." with a stylized, cursive script.

Paul C. Berman, Ph.D.
Licensed Psychologist

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Written Testimony- R. Patrick Savage, Jr., Phd. -

Uploaded by: R. Patrick Savage Jr

Position: FAV

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 quickly 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 dose 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.
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Licensed Psychologist: MD#2219

SB0568_SponsorTestimony

Uploaded by: Senator Ellis

Position: FAV

ARTHUR ELLIS, CPA
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Charles County

DEPUTY MAJORITY LEADER

Finance Committee

Vice Chair, Rules Committee

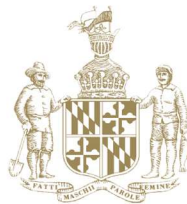
Senate Chair

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Management of Public Funds

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Joint Committee on
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Sponsor Written Testimony: Favorable

SB0568: Health Occupations – Licensed Psychologists – Prescriptive Authority

March 3, 2026

Dear Chair Beidle, Vice Chair Hayes, and colleagues on the Senate Finance Committee:

I respectfully submit this testimony in support of Senate Bill 0568. This legislation provides a thoughtful and structured pathway for licensed psychologists in Maryland to obtain prescriptive authority after completing advanced education, supervised clinical training, and meeting clearly defined regulatory standards.

Maryland, like many states, continues to experience provider shortages—particularly in rural counties, on the Eastern Shore, and in parts of Southern Maryland and Western Maryland. Patients frequently wait months for appointments with psychiatrists or other prescribing providers. In many communities, psychologists are the most accessible doctoral-level behavioral health professionals, yet they must refer patients elsewhere for medication management, even when they have developed a long-standing therapeutic relationship. This can delay care, fragment treatment, and increase costs. Senate Bill 0568 addresses this gap in a measured way. The bill does not grant automatic prescribing authority. Instead, it requires psychologists to complete postdoctoral education in clinical psychopharmacology, pass a national examination, complete supervised prescribing experience, and comply with collaboration and consultation standards. The Maryland Board of Examiners of Psychologists would maintain regulatory oversight, ensuring accountability and patient safety remain paramount.

Additionally, several states—including New Mexico, Louisiana, Illinois, Idaho, Utah, Colorado, Guam, already authorize professionally trained psychologists to prescribe. These jurisdictions have demonstrated that prescribing psychologists can safely expand access while maintaining high standards of care. For Maryland residents, particularly those in underserved communities, this bill represents improved access, greater continuity of care, and a more modern scope-of-practice framework that reflects today's training and healthcare realities.

For these reasons, I respectfully urge the Committee to issue a favorable report on Senate Bill 0568.

Sincerely,

A handwritten signature in blue ink that reads "Arthur Ellis".

Arthur Ellis, CPA

Dr. Goldman's Written Testimony SB0568.pdf

Uploaded by: Sherry Goldman, M.D.

Position: FAV

Sherry D. Goldman, M.D.
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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-

graduate training in mental health, they should have an understanding of psychopathology and neuroscience. That would be a good foundation for continued training to be certified and licensed to prescribe psychotropic medication.

Access to mental health care is a problem in Maryland for many individuals. In 2025, there were approximately 4,500 licensed psychologists in Maryland. As of April, 2025, there were approximately 1,826 licensed psychiatrists in Maryland. In 2024, there were approximately 300 psychiatric nurse practitioners in Maryland. The need for mental health care is increasing. Reports estimate that Maryland needs to add thousands of workers to the behavioral health field. This is only made more of a concern as 45% of current professionals are projected to leave or retire over the next five years.

Psychiatric nurse practitioners are licensed to prescribe medication, but as stated above, they are very limited in number. There are far more psychologists already providing mental health care. If some of those chose to get advanced training in prescribing medication, access to that kind of care would be substantially broadened.

We need all kinds of mental health care providers, as they bring different perspectives and levels of training. Psychiatrists will not be replaced by psychologists who prescribe medication. In fact, having this sub-discipline might free psychiatrists up to address more complicated cases.

For this reason, I fully support this legislation.

Sherry D. Goldman, M.D.

Board Certified by the American Academy of Psychiatry and Neurology

Child & Adolescent Psychiatry, General Adult Psychiatry

Maryland License No. D28863

SOlarte Testimony-SB 568.pdf

Uploaded by: Stephanie Olarte

Position: FAV

Dr. Stephanie Olarte
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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.

Slow Down Psychology, LLC
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hello@slowdownpsych.com

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,



Stephanie Olarte, PhD
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testimony SB 568 Psychologist prescriptive authori

Uploaded by: Joseph Adams, MD

Position: UNF



MDDCSAM is the Maryland state chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

SB 568 UNFAVORABLE

Health Occupations – Licensed Psychologists – Prescriptive Authority
Senate Finance Committee Hearing: March 3, 2026

The requirement to complete only 400 hours of psychopharmacological treatment is clearly inadequate in comparison to other professionals with prescriptive authority. Psychologists do not receive clinical prescriptive experience in their 1-year post-doctoral clinical internship. The number of recommended clinical hours for advanced-practice nurses rose from 500 to 750 in 2022 by the National Task Force on Quality Nurse Practitioner Education. This is also inadequate, considering that physicians often complete between 10,000 and 16,000 hours of clinical training.

If the State Board of Examiners of Psychologists is like Maryland's other health professional boards, it is unlikely to be capable of setting up this major new responsibility, or to provide appropriate oversight. **Many health professional boards in Maryland appear unable to keep up with their existing responsibilities. An April 2025 report detailed deficiencies within 20 Maryland boards and commissions that oversee and license practitioners. Thousands of licensee investigations, and 3,600 complaints against licensees, - the majority - remained open for over two years.** ¹

Granting psychologists prescriptive authority is likely to worsen the problem of over-prescribing of certain drugs, for example, benzodiazepines for anxiety such as Xanax. Demand is high from patients who see them as a quick fix. National guidelines explicitly recommend against long-term use, but they are routinely prescribed long-term, and are difficult to discontinue. **Adding a new profession with inadequate pharmacologic training to those already prescribing these drugs is likely to exacerbate the problem.** "Quietly, we have become a nation on benzodiazepines." ² Already, "current benzodiazepine prescribing patterns are concerning. . . they are widely overprescribed around the world." ³ "There has been more advocacy and research in opposition to the indiscriminate, widespread, and long-term use" of these agents, . . . referred to as 'our other prescription drug problem'." ^{4,5} Over 9 percent of American adults, or more than 21 million people, reported benzodiazepine use in 2023; they have contributed to overdose deaths. ⁶

Respectfully,

Joseph Adams, MD, FASAM, addiction & internal medicine; Co-Chair, MDDCSAM Public Policy Committee

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Position: UNF



Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

Board of Examiners of Psychologists

4201 Patterson Ave., Baltimore, MD 21215

<https://health.maryland.gov/psych>

March 3, 2026

The Honorable Pamela Beidle
Chair, Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401

Re: SB 568 Health Occupations – Licensed Psychologists – Prescriptive Authority – Letter of Concern

Dear Chair Beidle and Committee Members:

The Maryland Board of Examiners of Psychologists (the “Board”) is submitting this Letter of Concern for SB 568 Health Occupations – Licensed Psychologists – Prescriptive Authority.

This bill authorizes a licensed psychologist to use prescriptive authority under certain circumstances if the psychologist is certified by the Board; establishes the Prescriptive Authority Advisory Committee to advise the Board on oversight and implementation of certain provisions of the Act; establishes application and qualification requirements for certified prescribing psychologists; and establishes requirements for prescribing psychologists who use prescriptive authority.

The Board is theoretically and philosophically supportive of authorizing prescriptive authority to qualified licensed psychologists. The Board, however, has not conducted the research necessary to determine how best to protect the public when implementing prescriptive authority for psychologists and was not given the opportunity to conduct any research or to opine before the bill was introduced. The Board is not sure whether the training requirements in the bill are sufficient to ensure competency, or whether any other restrictions or limitations not included in this bill would be prudent. It is understood that various models are used in the seven states that currently allow psychologists to prescribe but given that there are only approximately 200-250 prescribing psychologists in the country, it is not clear which model is most effective.

The Board has two main concerns with the bill as written. First, the bill lacks specificity on how a prescribing psychologist is meant to coordinate with the patient’s medical provider. It does not define “coordinate,” does not provide minimum standards for coordination, does not account for medical providers and psychologists who disagree on proper treatment, and does not provide for a patient who has no medical provider. The bill is more aspirational on this topic than

standardizing; some states are much more specific about the relationship between prescribing psychologists and medical providers. Second, the Board is concerned about the makeup of the advisory committee. Three of the five members would be Board members, none of whom are currently experts in psychopharmacology. Only one of the five are prescribers, and only two of the five would be guaranteed to be knowledgeable in psychopharmacology. The Board would essentially be advising itself on something it has no expertise in.

There are also some technical concerns with the bill as written. For example, the bill requires the Board to adopt a policy that requires a psychologist with prescriptive authority to get 20 hours of continuing education that is relevant to prescriptive authority, which is exactly half of the 40 hours of continuing education required for license renewal. The Board believes that is too much to be required on just one of the innumerable topics relevant to competency in the practice of psychology. Also, the bill requires prescribing psychologists to report the prescription to the Prescription Drug Monitoring Program (the "PDMP") as applicable, but prescribers do not report to the PDMP; only dispensers do; prescribing psychologists would have to register with the PDMP and be subject to querying requirements if they prescribe opioids (unlikely) or benzodiazepines (more likely).

Finally, the Board is concerned that the bill as written would carry a prohibitive fiscal note. The increased administrative burdens on the Board, including issuing certifications to prescribing psychologists, recognizing and approving educational programs, maintaining and transmitting required records, administration of the advisory committee, and ensuring compliance with the law and any related regulations, would require additional full-time staff and increased infrastructure and technological costs, which would likely necessitate an increase in licensing fees. The bill would also increase costs on the Office of Controlled Substances Administration and the other boards involved in the advisory committee.

The Board believes that the bill raises an important issue that could be beneficial to the health of the citizens of Maryland. However, expanding psychologists' scope of practice to include prescriptive authority requires a deliberate study of prescriptive authority to ensure safeguards are in place to protect the public. Such a study will lead to a more practical bill and clear up the current ambiguities and inconsistencies.

The Board respectfully asks that you vote unfavorably on SB 568 as written and approve for the Board to conduct a Summer Study. The study will refine this bill and maximize efficiency, efficacy, and public protection. Representatives of the Maryland Psychology Association will be included in the discussion.

Thank you for your consideration. If you would like to discuss this matter further or have any questions, please contact Lorraine Smith, Executive Director, at lorraine.smith@maryland.gov.

Respectfully,
Stephen F. Bono, Ph.D.
Acting Chair, MD Board of Examiners of Psychologists

The opinion of the Board expressed in this letter of concern does not necessarily reflect that of the Department of Health or the Administration.

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Position: UNF

Prescribing is the culmination of extensive medical training and psychologists don't qualify

It was really disheartening to the psychiatric community that, in April 2017, the Idaho state legislature authorized prescriptive privileges to psychologists if they complete a 2-year curriculum. Apart from being medically unjustified, the legislature passed this law with the fallacious assumption that it will meet the mental health needs of rural inhabitants, despite evidence that psychologists cluster in the same urban areas as psychiatrists throughout the country.

Practicing medicine without a license is a crime, but it seems to have become a hollow law. Politicians are now cynically legalizing it by granting prescribing privileges to individuals with no prior foundation of medical training. Perhaps it is because of serious ignorance of the difference between psychiatry and psychology or MD and PhD degrees. Or perhaps it is a *quid pro quo* to generous donors to their re-election campaigns who seek a convenient shortcut to the 28,000 hours it takes to become a psychiatrist in 8 years of medical school and psychiatric residency—and that comes after 4 years of college.

I recently consulted an attorney to discuss some legal documents. When

he asked me what my line of work is, I then asked him if he knew the difference between a psychiatrist and a psychologist. He hesitated before admitting in an embarrassed tone that he did not really know and thought that they were all “shrinks” and very similar. I then informed him that both go through undergraduate college education, albeit taking very different courses, with pre-med scientific emphasis for future psychiatric physicians and predominately psychology emphasis for future psychologists.

However, psychiatrists then attend medical school for 4 years and rotate on multiple hospital-based medical specialties, such as internal medicine, surgery, pediatrics, obstetrics and gynecology, family medicine, neurology, pathology, psychiatry, ophthalmology, dermatology, anesthesia, radiology, otolaryngology, etc.

Psychologists, on the other hand, take additional advanced psychology courses in graduate school and write a dissertation that requires quite a bit of library time. After getting a MD, future psychiatrists spend 4 years in extensive training in residency programs across inpatient wards and outpatient clinics, assessing the physical and mental health of seriously sick patients with emphasis on both pharmacological and psychotherapeutic treatments for seri-



Henry A. Nasrallah, MD
Editor-in-Chief

Psychologists hold a valued role in mental health care; however, granting them prescribing privileges is medically unjustified and puts patients at risk

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From the Editor

ous psychiatric disorders in patients, the majority of whom have comorbid medical conditions as well. Psychologists, on the other hand, spend 1 year of internship after getting their PhD or PsyD degree, essentially focused on developing counseling and psychotherapy skills. By the time they complete their training, psychologists and psychiatrists have disparate skills: heavily medical and pharmacological skills in psychiatrists and strong psychotherapeutic skills in psychologists.

After this long explanation, I asked the attorney what he thought about psychologists seeking prescription privileges. He was astounded that psychologists would attempt to expand this scope of practice through state legislations rather than going through medical training like all physicians. "That would be like practicing medicine without a license, which is a felony," he said. He wryly added that his fellow malpractice and litigation lawyers will be the big winners while poorly treated patients will be the biggest losers. Being an avid runner, he also added that such a short-cut to prescribe without the requisite years of medical training reminded him of Rosie Ruiz, who snuck into the Boston marathon a couple of miles before the finish line and "won" the race, before she was caught and discredited.¹

Psychology is a respected mental health discipline with strong psychotherapy training and orientation. For decades, psychologists have vigorously criticized the medical model of mental disorders that psychiatric physicians employ to diagnose and treat brain disorders that disrupt thinking, emotions, mood, cognition, and behavior. However, about 25 years ago, a small group of militant psychologists brazenly decided to lobby state legislatures to give them the right to prescribe psychotropics, although they have no formal medical training. Psychiatric physicians,

represented by the American Psychiatric Association (APA), strongly opposed this initiative and regarded it as reckless disregard of the obvious need for extensive medical training to be able to prescribe drugs that affect every organ in the body, not only the brain. Psychiatric medications are associated with serious risks of morbidity and mortality.² The ability to safely prescribe any medication represents the tip of a huge iceberg of 8 years of rigorous medical school education and specialty training. Yet, one of the early proponents of prescription privileges for psychologists, Patrick De Leon, sarcastically likened the ability to prescribe drugs to learning how to operate a desktop computer!

Not all psychologists agreed with the political campaign to lobby state legislatures to pass a law authorizing prescriptive privileges for psychologists.³⁻⁶ In fact, most academic psychologists oppose it.⁷ Most of the early supporters had a PsyD degree from professional schools of psychology, not a PhD degree in psychology, which is obtained from a university department of psychology. The National Alliance on Mental Illness is opposed to psychologists prescribing medications.⁸ Psychiatrists are outraged by this hazardous "solution" to the shortage of psychiatrists and point to the many potential dangers to patients. Some suggested that this is a quick way to enhance psychologists' income and to generate more revenue for their professional journals and meetings with lucrative pharmaceutical ads and exhibit booths.

The campaign is ongoing, as Idaho became the fifth state to adopt such an ill-conceived "solution" to increasing access to mental health care, despite valiant effort by the APA to lobby against such laws. Although New Mexico (2002), Louisiana (2004), Illinois (2014), and Iowa (2016) have passed prescriptive authority for psychologists before Idaho, the APA has defeated such measures in

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Medical training and psychiatric residency are required for an accurate diagnosis of a mental disorder

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numerous other states. But the painful truth is that this has been a lengthy political chess game in which psychologists have been gradually gaining ground and “capturing more pieces.”

Here is a brief, common sense rationale as to the need for full medical training necessary before safely and accurately prescribing medications, most of which are synthetic molecules, which are essentially foreign substances, with both benefits and risks detailed in the FDA-approved label of each drug that reaches the medical marketplace.

First: Making an accurate clinical diagnosis. If a patient presents with depression, the clinician must rule out other possible causes before diagnosing it as primary major depressive disorder for which an antidepressant can be prescribed. The panoply of secondary depressions, which are not treated with antidepressants, includes a variety of recreational drug-induced mood changes and dysphoria and depression induced by numerous prescription drugs (such as antihypertensives, hormonal contraceptives, steroids, interferon, proton pump inhibitors, H2 blockers, malaria drugs, etc.).

After drug-induced depression is ruled out, the clinician must rule out the possibility that an underlying medical condition might be causing the depression, which includes disorders such as hypothyroidism and other endocrinopathies, anemia, stroke, heart disease, hyperkalemia, lupus and other autoimmune disorders, cancer, Parkinsonism, etc. Therefore, a targeted exploration of past and current medical history, accompanied by a battery of lab tests (complete blood count, electrolytes, liver and kidney function tests, metabolic profile, thyroid-stimulating hormone, etc.) must be done to systematically arrive at the correct diagnosis. Only then can the proper treatment plan be determined, which may or *may not* include prescribing an antidepressant.

Conclusion: Medical training and psychiatric residency are required for an accurate diagnosis of a mental disorder. Even physicians with no psychiatric training might not have the full repertoire of knowledge needed to systematically rule out secondary depression.

Second: Drug selection. Psychiatric drugs can have various iatrogenic effects. Thus, the selection of an appropriate prescription medication from the available array of drugs approved for a given psychiatric indication must be safe and consistent with the patient’s medical history and must not potentially exacerbate ≥ 1 comorbid medical conditions.

Conclusion: Medical training and psychiatric residency are required.

Third: Knowledge of metabolic pathways of each psychiatric medication to be prescribed as well as the metabolic pathway of *all other* medications (psychiatric and non-psychiatric) the patient receives is essential to avoid adverse drug-drug interactions. This includes the hepatic enzymes (cytochromes), which often are responsible for metabolizing all the psychiatric and non-psychiatric drugs a patient is receiving. Knowledge of inhibitors and inducers of various cytochrome enzymes is vital for selecting a medication that does not cause a pharmacokinetic adverse reaction that can produce serious adverse effects (even death, such as with QTc prolongation) or can cause loss of efficacy of ≥ 1 medications that the patient is receiving, in addition to the antidepressant. Also, in addition to evaluating hepatic pathways, knowledge of renal excretion of the drug to be selected and the status of the patient’s kidney function or impairment must be evaluated.

Conclusion: Medical training is required.

Fourth: Laboratory ordering and monitoring. Ordering laboratory data during follow-up of a patient receiving a

psychotropic drug is necessary to monitor serum concentrations and ensure a therapeutic range, or to check for serious adverse effects on various organ systems that could be affected by many psychiatric drugs (CNS, cardiovascular, gastrointestinal, sexual, endocrine, pulmonary, hepatic, renal, dermatologic, ophthalmologic, etc.).

Conclusion: Medical training is required.

Fifth: General medical treatment.

Many patients might require combination drug therapy because of inadequate response to monotherapy. Clinicians must know what is rational and evidence-based polypharmacy and what is irrational, dangerous, or absurd polypharmacy.⁹ When possible, parsimonious pharmacotherapy should be employed to minimize the number of medications prescribed.¹⁰ A patient could experience severe drug-drug reactions that could lead to cardiopulmonary crises. The clinician must be able to examine, intervene, and manage the patient's medical distress until help arrives.

Conclusion: Medical training is required.

Sixth: Pregnancy. Knowledge about the pharmacotherapeutic aspects of pregnant women with mental illness is critical. Full knowledge about what can or should not be prescribed during pregnancy (ie, avoiding teratogenic agents) is vital for physicians treating women with psychiatric illness who become pregnant.

Conclusion: Medical training is required.

Although I am against prescriptive privileges for psychologists, I want to emphasize how much I appreciate and respect what psychologists do for patients with mental illness. Their psychotherapy skills often are honed beyond those of psychiatrists

who, by necessity, focus on medical diagnosis and pharmacotherapeutic management. Combination of pharmacotherapy and psychotherapy has been demonstrated to be superior to medications alone. In the 25 years since psychologists have been eagerly pursuing prescriptive privileges, neuroscience research has revealed the neurobiologic effects of psychotherapy. Many studies have shown that evidence-based psychotherapy can induce the same structural and functional brain changes as medications^{11,12} and can influence biomarkers that accompany psychiatric disorders just as medications do.¹³

Psychologists should reconsider the many potential hazards of prescription drugs compared with the relative safety and efficacy of psychotherapy. They should focus on their qualifications and main strength, which is psychotherapy, and collaborate with psychiatrists and nurse practitioners on a biopsychosocial approach to mental illness. They also should realize how physically ill most psychiatric patients are and the complex medical management they need for their myriad comorbidities.

Just as I began this editorial an anecdote, I will end with an illustrative one as well. As an academic professor for the past 3 decades who has trained and supervised numerous psychiatric residents, I once closely supervised a former PhD psychologist who decided to become a psychiatrist by going to medical school, followed by a 4-year psychiatric residency. I asked her to compare her experience and functioning as a psychologist with her current work as a fourth-year psychiatric resident. Her response was enlightening: She said the 2 professions are vastly different in their knowledge base and in terms of how they conceptualize mental illness from a psychological vs medical model. As for prescribing medications, she added that even after 8 years of extensive medical training as a physician and a psychiatrist, she feels there is still much to learn

Many studies have shown that evidence-based psychotherapy can induce the same structural and functional brain changes as medications

Psychologists should reconsider the many potential hazards of prescription drugs compared with the relative safety and efficacy of psychotherapy

about psychopharmacology to ensure not only efficacy but also safety, because a majority of psychiatric patients have ≥ 1 coexisting medical conditions and substance use as well. Based on her own experience as a psychologist who became a psychiatric physician, she was completely opposed to prescriptive privileges for psychologists unless they go to medical school and become eligible to prescribe safely.

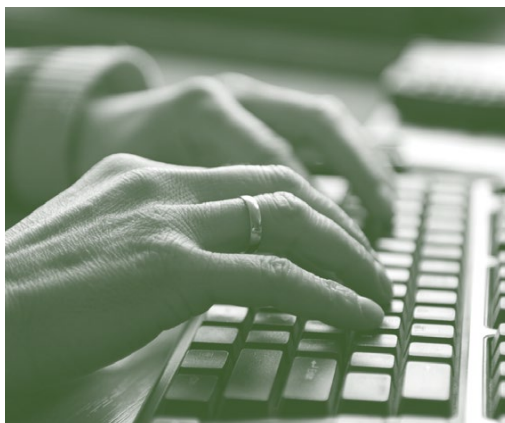
This former resident is now a successful academic psychiatrist who continues to hone her psychopharmacology skills. State legislators should listen to professionals like her before they pass a law giving prescriptive authority to psychologists without having to go through the rigors of 28,000 hours of training in the 8 years of medical school and psychiatric residency. Legislators should also understand that like psychologists, social work counselors have hardly any medical training, yet they have never sought prescriptive privileges. That's clearly rational and wise.



Henry A. Nasrallah, MD
Editor-in-Chief

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Position Statement, November 2001

Response to Clinical Psychologists Prescribing Psychotropic Medications

BACKGROUND:

The use of psychotropic medication to treat psychiatric disorders has surged in recent years. Research from the decade of the brain has increased understanding of the brain-based nature of mental illness and somatic treatments are increasingly being viewed as the mainstay of psychiatric treatment. As the mental illness paradigm slowly is shifted toward a neurobiological etiologic basis of illness, standards for practice and reimbursement for services are increasingly being shifted toward pharmacological interventions.

The field of psychology has long provided an etiological framework from which to view mental health and illness. The psychological view, which has been one of the most dominant frameworks until recently, is predicated on an in-depth understanding of developmental and environmental influences on the expression of mental illness (Brentar & McNamara, 1991; Martindale, Bateman, & Margison, 2000). This non-somatic model has been almost exclusively psychic in nature and has largely reflected a duality that separated the body's neurobiological brain from a concept of the mind. Consistent with this etiological philosophy, educational curricula for clinical psychologists have dealt very little with human anatomy, physiology, or biological principles (Troy & Shueman, 1996; Wiggins & Cummings, 1998). From psychotherapy to psychological testing to learning theory, psychology as a profession has provided understanding, insight, and a theoretical basis for care practices that have crossed discipline lines into nursing and medicine. The landscape, however, is shifting for the field of psychology. As reimbursement patterns and staff positions follow trends toward biological etiology models, the emphases and relative importance of the traditional psychology roles are decreasing, slowly being eroded by somatic-based treatments such as medications (Glod & Manchester, 2000; Pincus, et.al, 1998; Olfson, Marcus, & Pincus, 1999).

OVERVIEW OF THE ISSUES:

Reimbursement for psychotherapy is declining and standards of care for psychiatric disorders almost always incorporate medication (Cypres, Landsberg, & Spellmann, 1997; Pincus, et.al., 1998). Medication prescription and management have not been traditionally seen as the role of the psychologist. However, as new knowledge impacts treatment standards and reimbursement patterns shrink client bases, many clinical psychologists have begun to advocate for prescription authority for psychotropic medication as a legally sanctioned role for their profession.

Many clinical psychologists seeking prescriptive authority refer to nursing as the example of a group of non-physician care providers who were granted prescriptive authority (Pies, 1991; Sovner & Bailey, 1991). Nurses have been safe, effective, and well received by the public in the prescriptive role (Bailey, 1996). Using nursing as the example, some have proposed that prescriptive privileges are not the sole purview of the medical profession, and non-physician professionals can be just as safe and effective in this role (DeLeon, Sammons, & Sexton, 1995; DeLeon & Wiggins, 1996). While not arguing with the premise of the efficacy of nonphysician prescribers, one glaring flaw exists in this argument.

The difference between nursing and psychology is the depth and degree of the biological, scientific basis of nursing science and the holistic orientation that is the hallmark of our profession. Nursing is a scientifically-based profession that fought long and hard to obtain prescriptive privilege for advanced practice professionals. Nursing has been successful in this role because of its deep historical roots in the biological sciences, and because of the centrality of holistic, individualized assessment, and orientation toward the acceptance of the physiological bases of illness (Roberts, Tabloski, & Bova, 1997). None of these factors exist in the field of psychology. In a somewhat casual manner, many clinical psychologists suggest that the addition of one or two courses in pharmacology would be sufficient to provide the knowledge base for the prescription of psychotropic medications (Sammons, Sexton, & Meredith, 1996). This at best under-emphasizes the complexity of issues such as pharmaco-dynamics and pharmaco-kinetics, and at worst ignores knowledge required to understand, prevent and treat such things as drug interaction and dangerous side effects.

The success that nursing has realized with prescriptive privilege and the subsequent consumer support of this role has even led some to argue that nursing should provide the knowledge base for clinical psychologists to prescribe (Sovner & Bailey, 1991; Troy & Schueman, 1996). Nurses are being asked, in the spirit of collegiality, to assist clinical psychologists in building the requisite knowledge base for prescriptive practice. To do so would be, inherently, unethical.

Clinical psychologists have enrolled in MSN programs that do not require nursing baccalaureate preparation (APA, 1999). These programs, all with waiting lists for clinical psychologists are embracing the increased enrollment of a new pool of potential students, perhaps without full consideration of the ramifications. These clinical psychologists are anticipated to be the first wave of clinical psychologists to be given prescriptive privileges who will then be able, it is assumed, to provide training for clinical psychologists of the future (APA, 1999). Among many concerns is the reality that these initial clinical psychologists will prescribe as advanced practice nurses, while functioning in their roles as clinical psychologists.

Currently, prescriptive privilege is primarily reserved for nursing and medical professionals. Physicians, physician assistants, nurse practitioners, and clinical nurse specialists all may obtain prescriptive authority. The defining commonality among these professionals is, of course, the depth and degree of human biological and psychopharmacological knowledge that they possess. These professionals did not simply take one or two classes to obtain this knowledge base. The entire education and training for these professions are defined by immersion and concentration on the way in which the human body works, the impact on the body when it does not work as anticipated, and the role of pharmacotherapies in the treatment of health problems.

Content information regarding drugs is not analogous with prescriptive knowledge or ability. Pharmacotherapeutic prescription entails a complex array of information synthesis and clinical decision making that assumes a baseline of detailed knowledge of a wide range of biological data. In working with the mentally ill, effective prescription practices are predicated on a knowledge of anatomy and physiology, an understanding of pharmacologic principles, legal awareness, advocacy, interpretation of laboratory findings, knowledge of concomitant and co-morbid health states, and an ability to stay current in related topical areas such as advances in genetics, immunology, and other biologically based sciences.

Nursing is a separate and distinct discipline among the helping professions. While cognizant of our uniqueness, nurses have increasingly become aware of the importance of interdisciplinary interaction. This construct resonates strongly in mental health which has a rich history of interdisciplinary practice and collaboration. But despite this history, assisting the profession of psychology to obtain prescriptive authority would run counter to our roles as patient advocates and to knowledge that the role and orientation of psychology is ill suited to somatic-based treatments. The ethical dilemma of clinical psychologists seeking prescriptive authority is a real one. It is an issue in which nurses need to focus on and carefully consider in terms of what should be our profession's response.

Nursing has a strong history and tradition of advocacy (Carter, 1999; Lim, 1997; Turkeltaub, 1998). Advocacy assumes that nursing action will always focus on the protection of the patient and the safeguarding of the patient's rights. This role is borne out in the standards of our profession (ANA, 1998; 1996; 1992; 1985). Advocacy requires nurses to resist the financial benefit or status benefit of providing training modules for clinical psychologists in the area of psychopharmacology. Advocacy requires nurses to recognize the ethical dilemma created for nurses by clinical psychologists seeking prescriptive authority (Walker, 2001). The American Nurses Association (1985) *Code for Nurses with Interpretive Statements* supports an advocacy stance. The third stated code regarding the action of nurses states that "the nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person" (p. 1). To assist clinical psychologists to gain prescriptive authority would be in violation of our nursing professional standards.

THE POSITION OF ISPN

It is the position of ISPN membership that nurses have an ethical responsibility to oppose the extension of the psychologist's role into the prescription of medications. This is not a turf issue or an attempt to limit a perceived competing profession. This belief is rooted in the ethical guidelines of our own profession. The professional standards for nursing require nurses who prescribe pharmacologic agents to have their prescriptive actions based on an awareness of pharmacological and physiological principles and knowledge (ANA, 1996, p. 14). We should expect the same from other professionals. The *Scope and Standards of Advanced Practice Registered Nursing* (ANA, 1996) mandates the advanced practice nurse to "contribute to resolving the ethical problems or dilemmas of individuals or systems" (p. 19). It would seem inappropriate and contrary to our profession, therefore, for nurses to assist clinical psychologists in the development of limited training modules for the sanctioning of prescriptive knowledge.

Clinical psychologists represent an important and effective profession that has a long and honored history of working with the mentally ill and facilitating the mental health of their patients. Clinical psychologists have a long and distinguished history of theory-based care practices, and their contributions have come from their unique perspective, which has historically not been somatically based. The current paradigm of psychology rejects the neurobiological basis of mental illness and this theoretical perspective is reflected in traditional educational practices that limit the exposure to and knowledge of biological sciences.

Psychopharmacology is a critical aspect of today's treatments for mental illness. Safe and effective utilization of medications requires (a) an in-depth knowledge of the human body, and (b) the requisite knowledge to understand the impact of medications on the body, and the physiology of drug-drug and drug-food interactions. Clinical psychologists do not possess this knowledge and receive little to no clinical supervision in this role. Therefore, they cannot safely prescribe medications to patients with complex, holistic health needs.

The needs of the mentally ill are many. Limited access, limited availability of prescribers, and limited job positions for clinical psychologists cannot influence nurses to undertake inappropriate action. The desire to meet the needs of our patients is great, but this pressure cannot allow nurses to be drawn into behaviors that are ethically dangerous. The battle over prescriptive authority for clinical psychologists has been going on for many years. It is an issue that challenges nurses, and one around which nursing as a profession needs to respond. As advocates for our patients, we need to speak out against individuals without the necessary background being allowed to engage in clinical practices that may be harmful to patients. It is our ethical responsibility to speak out and for each nurse to uphold the standards of the profession.

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Psychologists and Medications in the Era of Interprofessional Care: Collaboration Is Less Problematic and Costly Than Prescribing

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Increasing emphasis on interprofessionalism and teamwork in healthcare renders psychologists' collaborations critical and invites reexamination of psychologists' roles related to medications. The Collaboration Level outlined by the American Psychological Association's Ad Hoc Task Force is more achievable and in synch with health reform than prescription privileges (RxP). RxP remains controversial due to training and safety concerns, lacking support from health professionals, psychologists, and consumers. Differences in educational preparation of psychologists relative to prescribing professionals are discussed. Enactment of only three of 170 RxP initiatives reveals RxP to be a costly, ineffectual agenda. Alternatives (e.g., integrated care, collaboration, telehealth) increase access without risks associated with lesser medical knowledge. Concerns about RxP and the movement toward team-based care warrant reconsideration of the profession's objectives regarding psychopharmacology.

Key words: integrative care, interprofessional, prescription privileges, prescriptive authority, psychologist, scope of practice. [*Clin Psychol Sci Prac* 20: 489–507, 2013]

The premise that doctoral-level psychologists should prescribe psychoactive medications to meet mental health needs that are unmet by current prescribers, while theoretically helpful if performed well, warrants reassessment as we enter an era emphasizing team-based healthcare. Concerns about the background, breadth, and comprehensiveness of training for prescribing that the American Psychological Association (APA) currently advocates to complement psychologists' doctoral training (i.e., most of which is *not* oriented toward preparing to prescribe) have been raised; many psychologists believe that if psychologists are to prescribe, their knowledge and training should be equivalent with that of other prescribers (Baird, 2007). Compromised training for prescribing raises questions about quality and safety that pose both regulatory and public health concerns and uneasiness for numerous stakeholders. Consideration of whether or not organized psychology should pursue prescriptive authority also should be assessed within the context of existing alternatives—for example, interdisciplinary care, in which psychologists collaborate with other professionals whose medical training allows more comprehensive management of medications (Butler et al., 2008; Institute of Medicine, Committee on Crossing the Quality Chasm: Adaptation to Mental Health & Addictive Disorder, 2006).

This article begins with a brief review of medications and then explores the roles of collaboration and interprofessional care in the context of increasingly compelling healthcare trends that provide psychologists

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opportunities to contribute substantively to patient care, but that lack the controversy of the agenda promoting prescription privileges for psychologists (RxP). We also review some of the history and concerns about psychologist prescribing, the relative limitations of the APA training model, and the impact of the pursuit of prescription privileges on the field, including the limited success and substantial costs of its legislative record.

MEDICATION TRENDS

Medications serve important roles in the arsenal of mental health treatments. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2012), use of psychoactive medications increased by 96% from 127.2 million prescriptions filled in 1998 to 248.8 million prescriptions filled in 2007 in the United States. In 1998, the market for adult psychoactive medication expenditures was an estimated \$10 billion. A decade later, psychoactive medication costs were estimated around \$25 billion (SAMHSA, 2012). During this same period, Americans receiving *medication-only* treatment for mental health problems increased by 13.5%. By contrast, Americans getting *combined psychotherapy and medication* decreased from 40.0% to 32.1%, yielding a 13.3% decrease from 55.9% to 42.6% in the percentage engaging in psychotherapy as part of their treatment. These trends exist in the context of emerging evidence of the relative benefits of combined treatments (Cuijpers, Dekker, Hollon, & Andersson, 2009).

The locus of care in which psychopharmacological approaches are used for treating mental health disorders is broad. Up to two-thirds of individuals with mental health or substance use disorders or both are treated by physicians or other healthcare providers in the United States (Wang et al., 2005) and internationally (Wang et al., 2007). Many additional patients who are seen in primary care settings have subclinical mental health issues that may complicate diagnosis/treatment for physical health problems (Kessler et al., 2005). Despite the heterogeneous settings where patients obtain some type of care, nearly 70% of individuals with mental health conditions have been estimated to receive no treatment for their underlying mental health problems (Kessler et al., 2005). Of the minority who do receive mental health treatment, few are treated with

evidence-based approaches that have been shown to be effective (Wang, Demler, & Kessler, 2002; Wang et al., 2007).

The number of prescriptions written by primary care physicians (PCPs) for psychotropic medications has increased dramatically since the mid-1990s (Lieberman, 2003). Physicians, physician assistants (PAs), and nurse practitioners, for example, wrote approximately 70% of all anxiolytic prescriptions, 68% of all antidepressant prescriptions, 57% of all prescriptions for stimulants, 43% of all antipsychotics, and 28% of mood stabilizers between August 2006 and July 2007 (DuBosar, 2009). Recent data question the efficacy of the most prescribed psychotropic medication, antidepressants, in treating all but severe symptoms (Fournier et al., 2010). There have been calls to rethink medications as a first-line form of treatment (Carlat, 2010) as concerns about whether medications might be partially responsible for worsening mental health outcomes (Whitaker, 2010) and for inducing various iatrogenic problems (Akiskal & Benazzi, 2006; Gentile, 2011) emerge.

Psychologists harbor a range of views of medications and what roles psychologists might best play vis-à-vis medications (Hayes, Walser, & Bach, 2002). Whereas most recognize the benefits medications confer for at least some of their patients, many are concerned about potential problems that can be associated with medications, such as adverse effects, risks of abuse, and trends toward overprescribing.

Although shortages of psychiatrists have long been recognized (Pardes & Pincus, 1983), as public acceptance of psychoactive medications has increased demand for psychopharmaceuticals, the limited access to psychiatrists has gained more attention. Psychologists have been remarkably silent about advocating for increased funding for training psychiatrists, which arguably would be the most direct solution to that problem. Instead, RxP proponents have identified access problems to psychiatrists as a main justification for RxP. Among psychologists, diverse views abound about how to ameliorate the problem of patients facing barriers to providers for psychoactive prescriptions. Advocates of RxP argue that securing prescription privileges provides psychologists direct roles, including the “power to not prescribe, or to help wean patients off medications” (Stambor, 2006, p. 30). On the other

hand, RxP opponents contend that collaboration and interprofessional practice are safer and more effective approaches by which psychologists can work in conjunction with prescribers to effectively address patients' health and mental health needs.

COLLABORATION: A COMPELLING ALTERNATIVE TO RxP

Whereas specialty mental health services are available from various mental health professionals (psychologists, marriage and family therapists, social workers, psychiatrists, etc.; Robiner, 2006) for individuals experiencing mental health problems, general medical settings present critical points of care within the healthcare system. Even patients who recognize their own mental health challenges may be reluctant to seek out specialty mental healthcare due to various concerns such as finances, insurance coverage, convenience, time, services location, referral inefficiencies, and stigma. This latter concern seems particularly true for ethnic minorities (Snowden & Pingitore, 2002; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). Providing mental health services in primary care settings facilitates patients' acceptance of referrals for service, provides greater convenience of co-located services, builds on the already established trust with primary care providers, and increasingly takes advantage of the proximity of multiple types of providers working as a team (Frank, Bray, McDaniel, & Heldring, 2003).

Primary care settings are important loci of mental healthcare delivery in that there are a far greater number of physicians and "mid-level providers" (i.e., nurse practitioners and PAs) than other mental health prescribers (i.e., psychiatrists, prescribing psychologists) who provide basic mental health services. Nationally, there are an estimated 83,600 PAs (Bureau of Labor Statistics, 2010) and 105,700 nurse practitioners (Bureau of Labor Statistics, 2012), who by virtue of their sheer numbers are likely to have a far greater impact on meeting medication needs of populations than the relatively small number of psychologists seeking to prescribe could.

Primary care providers are more widely distributed than mental health professionals, who tend to cluster in urban and suburban areas, and consequently are more likely to treat patients in rural areas (Xierali et al., 2013). Thus, integrated care models that incorporate

professionals who are skilled to coordinate a range of treatments, including psychological services, along with medical care by primary care providers, are promising avenues to improve mental healthcare access and outcomes (Butler et al., 2008).

Under the Patient Protection and Affordable Care Act (PPACA) and the Wellstone-Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), more Americans will have insurance with mental health benefits covered commensurately with general medical benefits. The PPACA has many features intended to enhance and expand healthcare, including promotion of interprofessional care. Consequently, interest in interprofessional collaborative care has been burgeoning. Recently, several organizations have drafted guidelines to support curricula to help prepare future health and mental healthcare providers to engage in interprofessional collaboration (Institute of Medicine, 2013). The World Health Organization (WHO, 2010) defines collaborative practice in healthcare as occurring "when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, ... and communities to deliver the highest quality of care across settings" (p. 13). Moreover, "a collaborative practice-ready health worker is someone who has learned how to work in an interprofessional team and is competent to do so" (p. 7).

The WHO considers interprofessional collaborations to be one of the most encouraging solutions regarding healthcare access and distribution problems and complex health-related challenges (APA, 2013; Health Resources and Services Administrator, 2010; WHO, 2010). Indeed, a shift is underway promoting interprofessional care in healthcare teams and the competencies clinicians need to provide team-based care (Interprofessional Education Collaborative Expert Panel, 2011). Models for providing integrated care (Heath, Wise, & Reynolds, 2013) and for preparing psychologists to function in integrated teams are emerging (Cubic, Mance, Turgesen, & Lamanna, 2012).

The Health Service Psychology Education Collaborative (2013) supported by the APA (2013) *Blueprint for Health Service Psychology Education and Training* delineated diverse competencies for health service psychology. These include the "interpersonal skills and

communication ... to relate effectively with professionals from other disciplines and demonstrate competence in interprofessional collaborative practice” (p. 29) as well as the consultation competence to “provide consultative psychological services to patients and their families, other health care professionals, and systems related to health and behavior” (p. 31) and that they “are familiar with evidence-based consulting skills and methods” (p. 31).

Such developments arguably render the pursuit of RxP less compelling. Noncontroversial measures are gaining ascendance, such as integrating psychologists in diverse healthcare settings, including primary care (American College of Neuropsychopharmacology, 2000; Bluestein & Cubic, 2009; Frank et al., 2003; Tavian, 2006). Deploying psychologists in primary care settings where they can provide interdisciplinary care in concert with prescribing health professionals (e.g., physicians, advanced practice nurses [APNs], PAs, consulting psychiatrists) who can manage medications in the context of patients’ other health care is not only less costly (Blount et al., 2007; Chomienne et al., 2011), but also obviates the risks of enabling prescriptive authority based on a training model considered controversial by various health professionals, including some psychologists, as will be discussed later in this article.

COLLABORATION AND PSYCHOPHARMACOLOGY TRAINING

Increasing psychologists’ education related to clinical psychopharmacology is generally accepted as having beneficial effects in enhancing how psychologists engage patients in regard to medications (Smyer et al., 1993). However, enhancing psychologists’ understanding about psychoactive medications has never necessitated pressing for RxP (Smyer et al., 1993). When the APA Ad Hoc Task Force on Psychopharmacology (Smyer et al., 1993) reviewed the desirability and feasibility of psychopharmacology prescription privileges for psychologists, it considered three potential levels of training for psychologists to consider. Level 2: Training for Collaborative Practice (a consultation–liaison model) was outlined by the APA Task Force (Smyer et al., 1993) but has been largely overlooked in favor of Level 3 training that provides a model for training psychologists to prescribe. Training for collaborative practice

would enhance psychologists’ knowledge of psychopharmacology to work cooperatively with other health professionals without taking the controversial step of seeking independent prescribing. The collaborative level of training was more strongly favored by psychology graduate students (77%) as an option for their own training than prescribing (50%; Tatman, Peters, Greene, & Bongar, 1997). The Task Force recognized that few psychologists would seek to prescribe (Smyer et al., 1993). Nevertheless, it seems curious that APA developed an agenda seemingly exclusively promoting RxP while consistently ignoring the collaboration model (i.e., we are not aware of guidelines developed for collaboration related to prescribing by other disciplines or efforts to promote the collaboration model).

Disregarding the APA Task Force’s Collaborative Practice level seems particularly regrettable in that the APA (2007) *Guidelines and Principles for Accreditation of Programs in Professional Psychology* already mandate education and training that prepares psychologists to effectively consult with other health and mental health-care providers so that graduates of all accredited programs presumably have basic skills in consultation, an important ingredient for successful collaboration.

Moreover, collaboration is much closer to what most psychologists *actually do*. According to the APA Center for Workforce Studies (CWS, 2009) Survey of Psychology Health Service Providers, the vast majority of psychologists collaborate with psychiatrists (89%), primary care physicians (79%), other medical specialists (50%), and nurse practitioners (51%), and over a quarter consult with PAs (27%). Moreover, about 90% of psychologists regularly discuss medications with physicians, and the majority provide information about medications to patients (APA CWS, 2009, Table 4a), an activity that enhances patient care but does not hinge on psychologists prescribing. These practice patterns of psychologists, in conjunction with the growing momentum of interprofessional team-based care, suggest that it is timely to take another, more serious look at Level 2 training outlined in the APA Task Force report (Smyer et al., 1993) as a potential means of achieving greater consensus in how the profession could most effectively establish collaborative roles for psychologists that capitalize on their clinical strengths. Our view on this is not unique. The

Canadian Psychological Association Task Force on Prescriptive Authority for Psychologists in Canada (2010) recently recommended that active collaborative practice with prescribing professions was “the optimal standard for contemporary psychological practices” (p. 27) rather than promoting RxP.

Psychologists’ contributions to collaborative care leverage their expertise and recognized competencies in psychological assessment, intervention, and consultation, and also present opportunities to undertake research that can enhance healthcare. Psychologists who wish to prescribe with training equivalent to other prescribers have always been free to explore more complete biomedical training available in other health professions (e.g., physicians, APNs, PAs). If they wish to be recognized as providing pharmacologic interventions that would indisputably be considered on par with other types of prescribing professionals, it is recommended that their education and training be equivalent to it, beginning with obtaining the undergraduate scientific training and ending with more intensive and broader clinical medical supervised experiences. For example, the Doctor of Nursing Practice degree, which is replacing the master’s-level nurse practitioner degree, requires a minimum of 1,000 supervised clinical hours.

Consumers, employers, and healthcare organizations, such as the Institute of Medicine, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorder (2006), are increasingly concerned with promoting quality care and preventing avoidable medical errors. In the current climate of increasing accountability within healthcare, it is imperative that providers be sufficiently trained to provide services that meet industry standards and that professionals practice within the contours of their competence.

PSYCHOPHARMACOLOGY DEMONSTRATION PROJECT

Two decades ago, the Department of Defense (DoD) undertook a pilot Psychopharmacology Demonstration Project (PDP) training 10 military psychologists to prescribe in a 2-year full-time program. When it was cancelled, the Government Accounting Office (GAO, 1997) report *Need for More Prescribing Psychologists Is Not Adequately Justified* concluded that “training

psychologists to prescribe medication is not adequately justified because the [Military Health Services System] MHSS has no demonstrated need for them, the cost is substantial, and the benefits are uncertain” (p. 3). NBC News later presented its Golden Fleece Award to the project because of its poor cost-effectiveness (California Psychiatric Association, n.d.).

The final report of the Evaluation Panel of the PDP considered that

... a 2-year program—one year didactic, one year clinical practicum that includes *at least a 6-month inpatient rotation*—can transform licensed clinical psychologists into prescribing psychologists who can function effectively and *safely in the military setting* to expand the delivery of mental health treatment to a variety of patients and clients.

It also deemed the psychologist PDP graduates to be *weaker medically* than psychiatrists (American College of Neuropsychopharmacology, 2000). Rather than being assessed at the level of physicians, the PDP psychologists’ medical knowledge was assessed at a *student level*, which does not allow independent prescribing in any discipline in any jurisdiction. PDP graduates, themselves, recommended against shortcuts and reductions in required training. Most said an intensive full-time year of clinical experience, involving inpatients, was indispensable in addition to the comprehensive didactics. These features were not, however, included in the APA training model that was originally developed nor are they in the more recent iteration (APA, 2009). Similarly, they are not systematically incorporated in contemporary clinical psychopharmacology training programs.

APA TRAINING MODEL AND CURRENT TRAINING

In 1996, the APA adopted the prescription privileges (RxP) agenda as a matter of policy, justifying it partly on the basis of the PDP. It seeks to enable psychologists to prescribe independently, which is not currently the case in most jurisdictions for mid-level nonphysician prescribers. The APA also endorsed a psychopharmacology training model that was shorter, less intensive, and less organized than the PDP. Eligibility for undertaking the training to prescribe merely

requires psychologists to graduate from an accredited doctoral psychology program, be licensed, and practice as a “health services provider” psychologist (APA, 2009). Programs are required to have 400 contact hours covering eight domains and an unspecified length, breadth, or intensity of clinical supervised experience (APA, 2009). The APA (2009) recommendations for education and training for prescribing are available online.

Several postdoctoral master’s-level psychopharmacology training programs have opened, although none are associated with medical schools. Some are highly reliant on distance learning. RxP programs are designed for psychologists to continue to practice during the training. In contrast to the PDP, contemporary training for psychologists to prescribe is part-time and requires no inpatient training. For example, the Alliant International University (2012) program advertises on its website, “Earn your degree at home on weekends.” New Mexico State University (2011) acknowledges on its website that this truncated schedule may shape course coverage of material: “We will cover as many drug classes as we can in the time allotted.”

Strikingly, the programs do not meet the APA’s (2007) own accreditation criteria that are in effect for psychology graduate, internship, and postdoctoral training. That is, they are not required to be carefully scrutinized externally as are other levels of clinical training in psychology and as are other prescribing disciplines’ training programs. Even the APA’s (2009) revised psychopharmacology training model describes training that is narrower and less rigorous than the PDP training.

Although RxP proponents have acknowledged that the PDP training was more consistent with core medical training models in terms of didactics focused on biochemistry, pathophysiology, and clinical medicine than current clinical psychopharmacology training programs (McGrath, 2010), they typically dismiss the relevance of this training and contend that supplementary hours in postdoctoral training in psychopharmacology address these deficiencies in training. The absence of rigorous testing of psychologists’ foundational biomedical and scientific deficits precludes understanding their effects. We question how sufficiently foundational deficiencies can be overcome *and* the advanced knowledge and clinical experience for prescribing can be

gained in relatively abbreviated and distance learning training programs. We remain skeptical of the proposition that psychologists might be able to master more quickly the complex nexus of knowledge and skills for prescribing and managing medications than learners in other disciplines.

Some might argue that the relatively cursory training for RxP currently available is a form of “bait and switch” from the more robust PDP training that was used to justify RxP originally. The relatively more condensed nature of existing training seems likely to render it inferior to that provided in the PDP as well as relative to the training of other prescribers. It also raises questions about the breadth, depth, and quality of such training. For example, how can consumers and policymakers be ensured what other prescribers learn in longer time frames, but that is excluded from an abbreviated curriculum, is not important in maximizing clinical outcomes? After all, when medications enter the human body, they do not just affect emotional regulation within the brain, but also have broader physical effects across organ systems (Stuart & Heiby, 2007) that may interact with other classes of medication.

DIFFERENCES BETWEEN PSYCHOLOGY AND (OTHER) PRESCRIBING DISCIPLINES

Graduate training in psychology differs substantively from other health professions from the start. It requires neither undergraduate prerequisites nor graduate coursework in basic scientific and biomedical domains (e.g., biology, chemistry, organic chemistry, biochemistry, physiology, and pathophysiology). Such courses are generally recognized as foundational to understanding biological and biochemical processes inherent in health and illness, how the human body responds to medications, and how interactions among systems and medications affect people (Heiby, 2010).

RxP proponents concede that among nonphysician health professionals, “...psychology has the core curriculum with probably the least overlap with traditional medical curricula” (Fox et al., 2009, p. 258). The training paradigms are so different that only 7% of psychology graduate students are estimated (Tatman et al., 1997) to have completed biology and chemistry undergraduate coursework considered adequate for prescribing by APA’s own Ad Hoc Task Force of experts

when considering possible levels of psychopharmacology training (Smyer et al., 1993).

In contrast to other health professions, to gain admittance to current RxP training programs, students are *neither* required to complete scientific foundational coursework *before* enrolling nor to demonstrate competence in those domains through standardized admissions examinations (e.g., MCAT). The Psychopharmacology Examination for Psychologists (PEP), a 150-item multiple-choice test that is the only required testing for psychologists to prescribe, contrasts with the more comprehensive, sequential testing such as the United States Medical Licensing Examinations (USMLE Step 1, 2 [CK and CS], and 3). Without more extensive objective testing following rigorous coursework, it is highly speculative to presume that the training psychologists receive could be equivalent to that of physicians or other prescribers, or be sufficient for managing medications, especially in people with complex comorbid conditions, such as older adults. Without broader and in-depth physical science education, biomedical knowledge, and experiential medical training, psychologist prescribing arguably constitutes an experiment for which there has been no objective, systematic, or comprehensive evaluation.

Proponents of RxP summarily dismiss the importance of training that aligns with a medical school model requiring students to have a strong foundation in the physical sciences (McGrath, 2010; Muse & McGrath, 2010). This contention contrasts with the view of many (78.6%) psychologists, who believe that to prescribe, psychologists *should* have equivalent training (Baird, 2007). RxP proponents argue that because nonphysician prescribers (e.g., nurse practitioners) provide quality care that results in health outcomes similar to that provided by physicians (e.g., comparable control of asthma, diabetes, and hypertension; health services utilization; patient satisfaction; Mundinger et al., 2000), even though they did not attend medical school, psychologists' training need not be equivalent to physicians either. However, as noted by Heiby (2010), all other nonphysician prescribers typically *do* have more extensive scientific (i.e., physical sciences) training at the undergraduate level than psychologists (Figure 1). Moreover, other prescribers and nonprescribing disciplines have broader and more intensive clinical medical

training at the graduate level than is afforded by clinical psychopharmacology training for psychologists.

The absence of scientific and medical training for psychologists in the undergraduate and graduate education sequence leads to questions about how abbreviated training *after* the education to become a psychologist could be adequate to enable prescribing at levels of knowledge and competence commensurate with other prescribers (Table 1; Robiner et al., 2002, 2003). The absence of *any* undergraduate premedical scientific prerequisites to enter training to prescribe violates recommendations of the APA's own experts on the APA (1992) Ad Hoc Task Force on Psychopharmacology, who stipulated that

...retraining of practicing psychologists for prescription privileges would need to carefully consider selection criteria, focusing on those psychologists with the necessary science background.... It would require students to have undergraduate science training similar to that required of other health service providers (e.g., nurses, pharmacists, allied health professionals, dentists, and/or physicians). It would also require a postdoctoral period of supervised clinical experience. (p. 400)

The potential for insufficient medical preparation is compounded by the reality that many psychologists train in settings *outside* of the healthcare system (e.g., schools, counseling centers, prisons, social service agencies). For the APA to unilaterally determine that the basic scientific foundation required in other prescribing professions is unnecessary for psychologists suggests an underestimation of the complexity of the human body and drugs' effects on it. It also could signify inadequate respect of the contributions of those scientific disciplines to the understanding of the mechanisms and effects of medications whose elements are omitted. This calculation to ignore scientific foundations assumedly derives from an objective to provide brief, affordable training so that more practicing psychologists might complete it. Yet, even with this shortcut, relatively small numbers of psychologists currently prescribe. Concerns about the abbreviated nature of the training fuel opposition to RxP, in various other health professions as well as among psychologists.

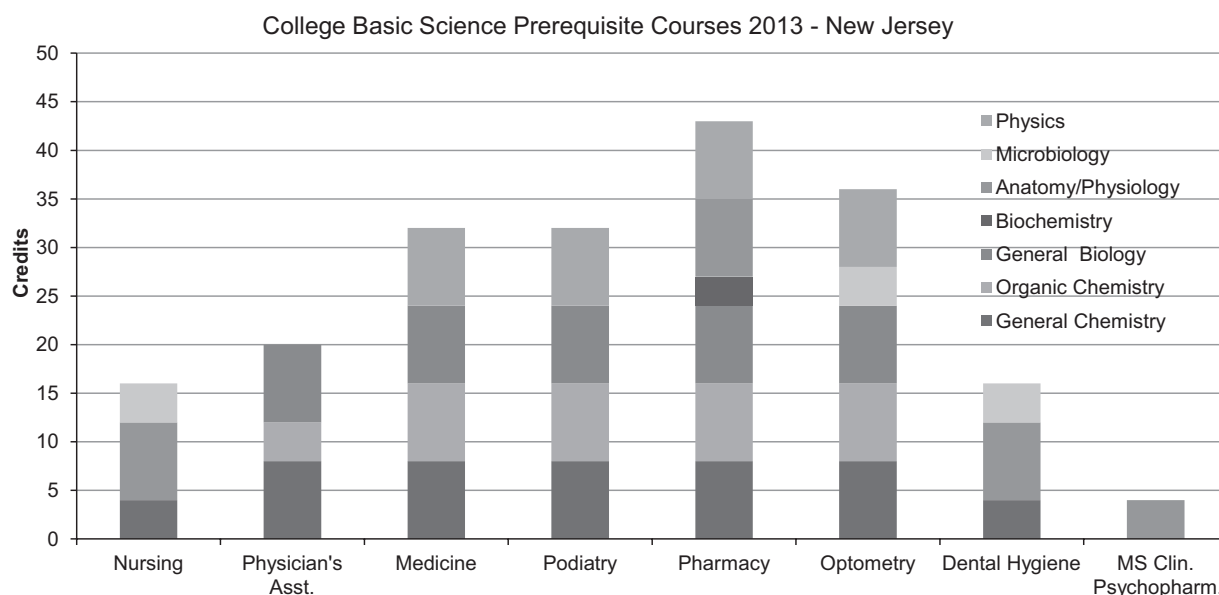


Figure 1. College basic science prerequisite courses for admission to health science programs.

Note. Multiply credits by 10 for estimated hours of instruction. These data were derived by a 2013 survey of admission requirements to the largest programs in New Jersey (e.g., Farleigh Dickinson University, University of Medicine and Dentistry of New Jersey, Rutgers University). Although there were no physical or health sciences prerequisites for entry into the PhD programs in Clinical Psychology, both the FDU and Rutgers curriculum included one course in biopsychology or behavioral neuroscience. The MS Clinical Psychopharmacology program is an example of a program intended to train psychologists to prescribe and requires considerably less than programs for other prescribers and nonprescribers.

Table 1. Knowledge base and clinical proficiencies required for prescribing

Psychopathology and Psychological Issues	Medical Status Prior to Prescribing	Response to Treatments
Primary psychiatric conditions	Comorbid medical conditions	Knowledge of adverse reactions 1. Side effects 2. Toxic effects
Comorbid psychiatric conditions	Contraindications	Ability to recognize, diagnose, and treat adverse reactions
Prevalence and course of psychiatric conditions	Medical effects of concurrent treatments 1. Drug interactions 2. Other treatments (e.g., dialysis, plasmapheresis)	Ability to differentiate between physical and psychiatric effects of psychoactive agents and concurrent medications
Knowledge of nonpharmacologic treatment options	Long-term effects of medications	Other issues related to monitoring, titrating, or discontinuing prescribed medications
	History of medication use	

Note. The education of psychologists typically addresses column 1, but neglects columns 2 and 3. Based on Robiner et al. (2002).

Whereas the interests and competencies of psychologists and psychiatrists overlap, there are differences in training and experience. As Steven Kingsbury, MD, PhD, a psychologist who later became a psychiatrist, observed:

Studying the effects of medications on the kidney, the heart, and so forth is important for the use of many medications. Managing these effects is often crucial and has more to do with biochemistry and physiology than with psychology. I was surprised to discover how little about medication use has to do with psychological principles and how much of it is just medical. (Kingsbury, 1992, p. 5)

He also contrasted the intensity and exposure to patients in his training in the two professions:

In my first month of residency training in psychiatry at a psychiatry emergency service I believe I saw more patients individually than in my entire graduate training [i.e., in psychology]. (Kingsbury, 1987, p. 155)

Although anecdotal, these concerns and differences are not trivial. They are likely representative of the gaps between the medical preparation of psychologists and that of other prescribers.

PSYCHOLOGISTS' PERSPECTIVES ON PSYCHOLOGIST PRESCRIBING

The RxP movement developed within psychology as some psychologists sought to expand their scope of practice and, thereby, their clinical and economic opportunities. It did not develop in response to entreaties from other health professions, public health officials, or consumers and was not supported by academic psychologists (Lavoie & Barone, 2006). Although many psychologists support RxP in principle, unlike other professions with prescriptive authority, RxP remains controversial *among psychologists*, particularly when details of legislative proposals are considered (Hayes & Heiby, 1998; Heiby, 2002a, 2010; Robiner et al., 2002, 2003; Wagner, 2002; Walters, 2001).

Within psychology, opposing groups have included the Society for a Science of Clinical Psychology (2001); American Association of Applied and Preventive Psychology (1998); Committee Against Medicalizing

Psychology (Pollitt, 2003); and most recently, Psychologists Opposed to Prescription Privileges for Psychologists (POPPP; see www.poppp.org).

In contrast to prescribing professions, most psychologists do not intend to prescribe (Baird, 2007; Campbell, Kearns, & Patchin, 2006), a trend that prevents RxP from becoming a viable strategy for counteracting the shortage of psychiatrists, for which it is often touted as a remedy. Even RxP advocates acknowledge that "...only a minority of practitioners has evinced interest in seeking the ability to prescribe" (Fox et al., 2009, p. 257).

Some psychologists seem to support RxP in theory, although practically speaking express no desire to pursue training or practice; others oppose it (Walters, 2001). Interestingly, psychologists' understanding of the details of prescribing training issues may be limited, so it is difficult to determine what individual psychologists think they support if they do endorse the RxP agenda. Baird's (2007) survey revealed that most (78.6%) psychologists believed that to prescribe, psychologists should receive training commensurate with other nonphysician prescribers. As noted above, APA's current training model does not meet that objective in terms of foundational knowledge, intensity, or breadth of clinical experience, nor oversight through national accreditation.

PROFESSIONALS' AND CONSUMERS' VIEWS OF PSYCHOLOGIST PRESCRIBING

Although there is consensus on the need for mental health services in the military, and more broadly throughout society, it is unclear whether training psychologists to prescribe is an effective means of addressing these needs. Instead, societal needs might be better served by investing resources toward ensuring all mental health consumers have improved access to psychological services, especially evidence-based therapies, which are typically first-line treatments for a host of common mental health issues. For example, after reviewing the published literature on antidepressants and other therapies, the National Health Service in England adopted cognitive behavioral therapy as a first-line treatment for mild and moderate depression and has invested £400 million over the next four years to increase patient access to psychotherapy to treat depression and anxiety disorders, including plans to train up to 6,000 therapists in cognitive behavioral therapy

(Center for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness, & Turning Point, 2012).

The RxP agenda is opposed by other health professionals, and it undermines interprofessional relations (Bush, 2002). The American Psychiatric Association and the American Medical Association have consistently lobbied against it, although conceding they would have no quarrel with psychologists obtaining prescriptive authority as mid-level medical practitioners if their training was equivalent to other mid-level practitioners (i.e., nurse practitioners, PAs). Opposition to RxP notably extends far beyond organized medicine. The International Society of Psychiatric-Mental Health Nurses (2001) contends that nurses have an “ethical responsibility” to oppose RxP.

Moreover, consumers are wary of RxP. The National Alliance on Mental Illness (NAMI), the largest mental health advocacy and support organization, does not support RxP. NAMI’s executive director noted that because “these [psychoactive agents] are serious drugs with serious side effects ... we feel strongly that [prescribing] should be handled by someone with medical training” (Andrews, 2011).

Although RxP advocates claim that psychologists prescribe without problems, there is little, if any, systematic, empirical evidence for the desirability, feasibility, safety, and cost-effectiveness of RxP (Lavoie & Barone, 2006). The unknown consequences of relative deficits in knowledge, experience, and competence associated with abbreviated training raise cautions (American College of Neuropsychopharmacology, 2000; Butler et al., 2008; Robiner et al., 2003). As a public health issue, the fundamental concerns about RxP are patient safety and the quality of care that psychologists could deliver in prescribing relative to other prescribing professions. Gaps in psychologists’ training to manage medications, relative to that of other prescribers, presumably persist even after a psychologist might complete training conforming to the APA model.

POTENTIAL ADVERSE EFFECTS AND LIMITATIONS OF PSYCHOACTIVE MEDICATIONS

Psychoactive medications are commonly used in the treatment of anxiety, depression, insomnia, psychosis, and other conditions and have become more accepted by

consumers. Nevertheless, they are powerful drugs with risks for significant adverse effects that require monitoring by qualified health professionals who can assess their effects. This includes being prepared to discern whether symptoms are due to the prescribed medications, to other medications, to interactions between psychoactive medications and other medications, or whether they might indicate other medical conditions for which treatment is needed; these are not conditions psychologists are trained to assess or treat.

The potential for harm from psychoactive medications is considerable. The U.S. Food and Drug Administration (FDA) requires black box warnings about risks of using antipsychotics with the elderly due to increased risk of death and other adverse effects (cardiac toxicity, stroke, infection, hyperglycemia) and for antidepressants in adolescents and young adults due to possible increased risk of suicidal ideation. Selective serotonin reuptake inhibitors (SSRIs) can cause hematological disorders, including gastrointestinal and retinal hemorrhage and other serious problems. One study found the odds of mortality were 3.22 times higher for those using anxiolytic and hypnotic medications in the past month (Belleville, 2010). A study of reports to the FDA from 1998 to 2005 revealed threefold increases in serious morbidity and mortality associated with adverse drug events (ADEs), with disproportionate incidence in the elderly (Moore, Cohen, & Furberg, 2007). Two antidepressants, paroxetine and venlafaxine, were among the agents with the most frequent, serious outcomes. Antipsychotics (clozapine, risperidone, olanzapine) and paroxetine were among drugs with the most frequently suspected associated deaths.

Complications associated with psychoactive medications include cardiac arrhythmias, insulin resistance, obesity, movement disorders, neuroleptic malignant syndrome, serotonin syndrome, sexual dysfunctions, and adverse drug event due to drug interactions (Stuart & Heiby, 2007). Antidepressants and mood stabilizers account for an estimated 20,000 ADEs requiring treatment in emergency departments (EDs; Budnitz et al., 2006). Antipsychotics and benzodiazepines, respectively, accounted for 13,635 and 9,299 ADEs resulting in ED visits. The medical risks and adverse effects associated with these agents, and the costs incurred with care to address them, warrant that prescribers have full

understanding of human pathophysiology, morbidity, pharmacology, and the formulary beyond psychopharmacology (Stuart & Heiby, 2007). Unfortunately, the truncated focus of psychopharmacology training programs for psychologists raises questions about whether the curriculum is sufficiently broad and intensive to address patients' overall functioning.

The rationale for RxP also is questioned as evidence mounts that antidepressants are used to treat mild to moderate conditions for which they may perform no better than placebo (Fournier et al., 2010), potentially resulting in overmedication. It is unclear how knowledgeable and discerning potential prescribing psychologists are about both the adverse effects and the bounds of therapeutic effects. Research suggests that some claims made to clinicians and the public through medical journals and direct-to-consumer advertisement may be misleading and lack sufficient empirical support (i.e., well-controlled and executed studies) and government oversight (Spielman, Thieges, Dent, & Greenberg, 2008), making it essential that prescribers be sufficiently educated to understand for themselves the science underlying drugs' action.

CONTROVERSIAL ISSUES ASSOCIATED WITH RXP

Despite such concerns, the APA Practice Organization (APAPO) and its affiliates have mounted campaigns lobbying state legislatures to authorize RxP to psychologists who obtain postgraduate training based on the APA model. Proponents contend that allowing psychologists to prescribe would expand patient access to medications. They posit that expanding psychologists' scope of practice could enhance services for the underserved, such as in rural areas. Whereas access problems do exist and warrant remedy, claims about how well RxP would solve those problems deserve closer scrutiny and have been disputed (Lavoie & Barone, 2006; Pollitt, 2003; Robiner et al., 2002).

For example, an article in the *American Journal of Law & Medicine* argues that RxP advocates disingenuously mislead legislatures to grant psychologists prescriptive authority (Pollitt, 2003). The reality is that psychologists and psychiatrists have similar demographic distribution patterns, tending to practice in urban and suburban areas, rather than rural areas (Figure 2). Consequently, RxP is not likely to meaningfully attenuate rural pre-

scriber workforce shortages. As noted earlier, developing interprofessional collaborations with PCPs is more likely to improve access to psychopharmacological services.

Furthermore, mental health access issues in obtaining psychotherapeutic interventions and psychological assessments in both rural and urban areas may be more challenging than accessing pharmacotherapy (Campbell et al., 2006; Westra, Eastwood, Bouffard, & Gerritsen, 2006). One study revealed that most family practitioners thought there were psychological and psychiatric services available in their communities for collaboration and consultation and that they would be reluctant to refer patients to psychologists for pharmacological management (Bell, Dignan, & McKenna, 1995). Other approaches, such as telepsychiatry, offer the potential to compensate for some psychiatric workforce shortages (O'Reilly et al., 2007). The shortage of psychiatrists neither logically nor prudently leads to the conclusion that psychologists should prescribe. As members of the "de facto" mental health system, primary care physicians and mid-level providers can prescribe sufficiently well to meet many patients' needs. Enhancing the systems and intensifying the training that underlies primary care providers' mental healthcare delivery has the potential to further improve their prescribing quality, as does enhancing psychologists' capacity to function effectively in healthcare teams to coordinate care that is based on the interplay of the respective clinical strengths of their disciplines.

THE RXP LEGISLATIVE RECORD

APA has allocated considerable resources to promoting RxP. By 2001, APA had spent more than \$1 million on the RxP legislative agenda (DeLeon, 2002). The APAPO has provided grants to state psychological associations to support RxP lobbying. The full amount that has been spent by the APA and groups of RxP supporters is unknown. The authors' requests to the APAPO for financial records related to RxP went unanswered. Conversely, the costs to counter legislative initiatives for RxP are not known. Were RxP not a battleground, such lobbying efforts alternatively could be used collaboratively to promote a broader consensual agenda to advance mental healthcare and education within and across disciplines.

The campaign to promote RxP has yielded modest success, which in behavioral terms might be characterized

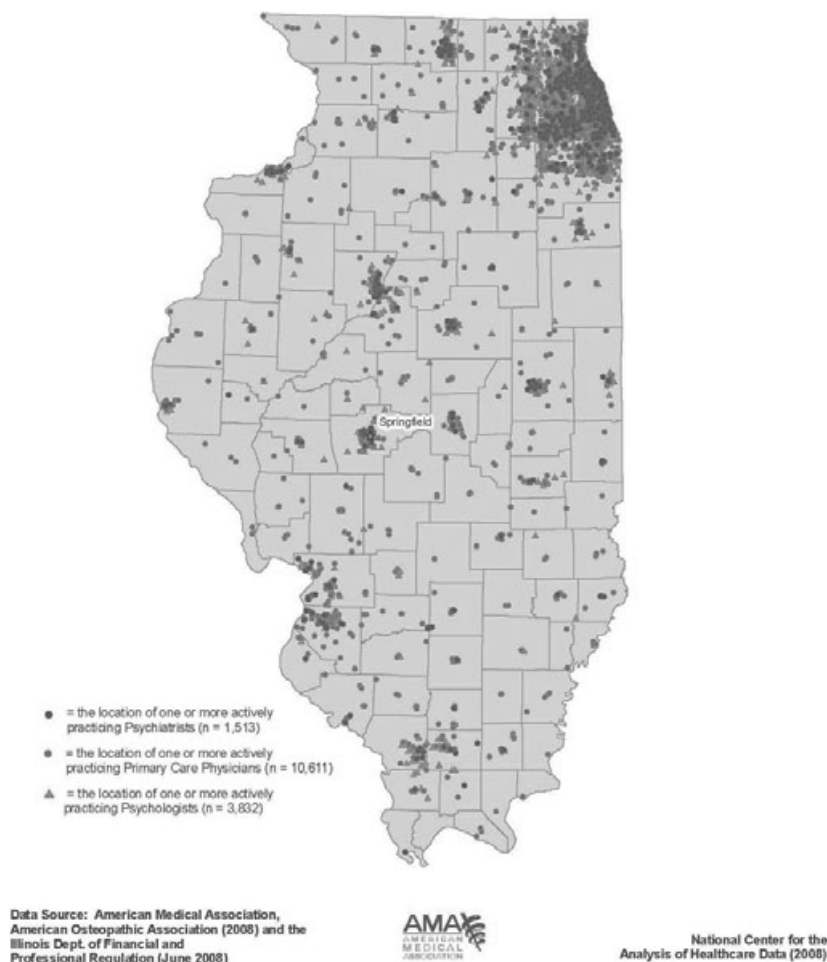


Figure 2. These data show the geographical distribution comparison for psychiatrists, primary care physicians (PCPs), and psychologists in Illinois. Data are provided for Illinois given that this state garnered the most attention and resources from the American Psychological Association during the 2013 legislative session. Arguments for improving rural access were advanced by proponents, but the data suggest similar practice locations with more PCPs in outlying rural areas. Other states present similar geographical distributions.

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as intermittent reinforcement, suggesting that the RxP agenda is not likely to extinguish readily. Guam was the first jurisdiction to pass RxP legislation in 1998. Whereas RxP proponents hail this as a historical milestone in their movement, and widely cite it to justify promoting legislation in other areas, it seems misleading in that none of the 14 psychologists licensed in Guam when this article was written are authorized to prescribe. To our knowledge, this absence of an actual impact of Guam's legislation on patient care in Guam or on psychologists' activities there has never been acknowledged by RxP proponents as they have rou-

tinely cited it when advocating for RxP in discussions with their colleagues and legislators.

New Mexico and Louisiana are the only states that have enacted RxP legislation, in 2002 and 2004, respectively. As of the writing of this article (i.e., about a decade after passage of enabling legislation), only 26 psychologists were authorized to prescribe in New Mexico (another nine are considered conditional) and only 71 in Louisiana. These numbers represent small percentages of the licensed psychologists by psychology boards in New Mexico (3.7%; 705) and Louisiana (10.7%¹; 665), and a trivial fraction (0.1%) of the

estimated 92,227 clinically trained psychologists nationally (SAMHSA, 2012). A review of the medical and nursing boards' annual reports of those states reveals that these numbers are also much smaller than the number of APNs and PAs who can prescribe in New Mexico (1,286 APNs; 688 PAs) and Louisiana (3,939 APNs; 712 PAs), respectively. The influence of psychologist prescribers in addressing the medication needs in these states relative to other physician and nonphysician prescribers would appear minimal based on the numbers alone, further raising questions about the actual impact of promoting RxP.

Prescribing psychologists' impact on the delivery of mental health services in those jurisdictions that authorize prescriptive authority has not been systematically assessed. No large-scale, objective evaluations of the impact of psychologists prescribing, or the potential problems associated with it, have been undertaken or published. To the authors' knowledge, none are planned. The bounds of the "mission creep" seeking to broaden psychology's purview to prescribing (Heesacker, 2005) are not known. Some proponents propose that psychologists' formulary should extend beyond psychopharmacology, on which the RxP movement was originally focused, and to which psychopharmacology training is principally dedicated, to other medications such as for weight loss, sleep disorders, chronic pain, and nicotine addiction (Earles, James, & Folen, 2006).

Despite the expansive vision of RxP proponents, the superficial appeal of their rhetoric, and the disproportionate attention they have garnered within the profession, the RxP legislative record has been lackluster. Fox et al. (2009) estimated that at least 88 RxP legislative initiatives had been introduced in 21 jurisdictions. Using a somewhat different methodology that counts specific bills, we estimate that 170 initiatives to authorize psychologist prescribing have been introduced in about half of the U.S. states and two territories. Figure 3 presents a map of RxP initiatives introduced between 1995 and 2012. Of these bills, 167 (98.2%) failed. No states have enacted RxP legislation since 2004. Some bills have failed to garner adequate support in legislatures. Two met gubernatorial veto. In 2013, additional bills in New Jersey and Illinois were defeated but are not included in this analysis because

they technically may still be introduced in 2013. Although a precise, cumulative tally of the lobbying and other resources APA has marshaled to promote RxP is not available, the paltry record of enactment of RxP legislation reveals that the RxP agenda has been costly for the profession. We believe the record deserves psychologists' close attention. It raises critical questions as to whether in lobbying for the still controversial RxP agenda professional organizations are exercising prudent stewardship of their resources (e.g., dues revenues).

OTHER EFFECTS OF PROMOTING THE RXP AGENDA

Pursuing RxP arguably has diverted the profession's attention and resources from dealing with other matters, such as lobbying for additional funding levels for psychological services, graduate education, scientific research, and preparing for medical homes and accountable care organizations. It has also distracted from focusing on the development of clinical practice guidelines and policies that might better meet the needs of the public and practitioners, and from addressing other pressing professional matters (e.g., workforce, internship imbalance, equity, health reform and health-care redesign, licensure mobility).

Moreover, psychologists' pursuit of RxP undermines interprofessional relations with disciplines that oppose RxP and is divisive among psychologists. Since just "a small minority of psychologists" has ever been expected to seek prescription privileges (Smyer et al., 1993), APA's and APAPO's allocations of resources to promote RxP have disproportionately served relatively few psychologists, rather than the broader profession. These priorities and the attendant stewardship of resources diminishes support for the APA among psychologists who view the RxP as a misguided agenda and as incompatible with their values, and/or irrelevant to their aspirations, activities, and needs.

Over a decade ago, Heiby (2002b) proposed a moratorium on legislation enabling RxP due to the absence of sound outcome data related to the training model and the RxP movement's divisiveness. To the authors' knowledge, only one published study has sought to evaluate the impact, utility, and safety of prescribing psychologists in practice. Shearer, Harmon, Seavey, and Tiu (2012) recently surveyed 47 primary care

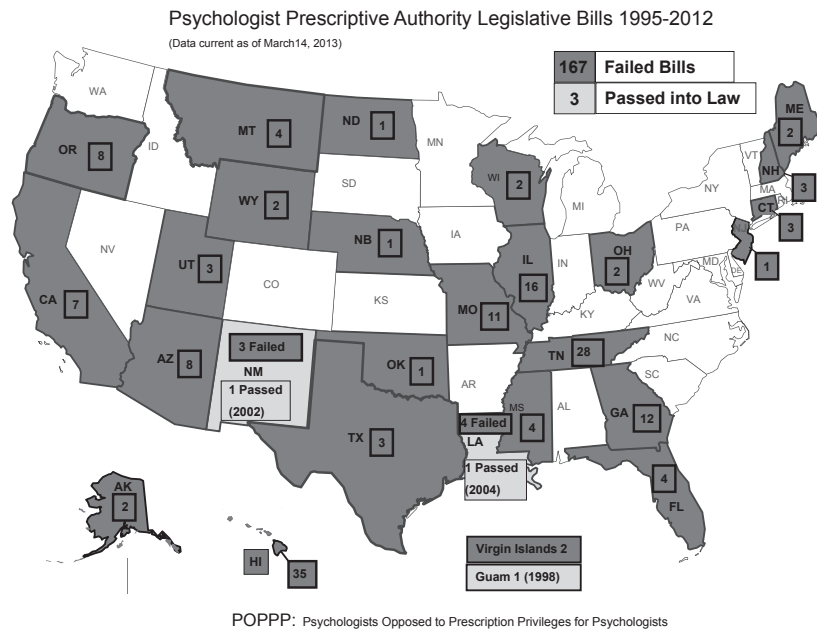


Figure 3. Psychologist prescriptive authority legislative bills from 1995 through 2012 (data current as of December 19, 2012).

providers and residents who worked closely with a *single* (i.e., $n = 1$) prescribing psychologist in a family medicine clinic in an Army medical center. Although they concluded their study provided evidence that prescribing psychologists “practice safely and effectively” (Shearer et al., 2012, p. 428), this conclusion based on essentially anecdotal data seems premature.

It is unclear to what degree Level 2 (i.e., collaboration) trained psychologists, or other psychologists, would receive similar positive ratings by providing consultation, but not prescribing, and what additional services they could provide if not prescribing. Additionally, as Shearer et al. (2012) note, the clear limitations in their methodology and sample limit their ability to answer questions about psychologist prescribing. For example, they did not ask whether it would have been preferable to have a psychiatrist provide the psychopharmacological consultation (in person or via telehealth) or what concerns they would have about referring ill and complex patients. They did not assess what medical phenomena related to prescribing psychologists might miss. Needed are more comprehensive investigations of prescribing psychologists (e.g., in New Mexico and Louisiana) outside the structured setting of military facilities that yield reliable and valid data

regarding patient outcomes (i.e., safety and effectiveness) and prescribing patterns in *independent* (i.e., not military) or less structured settings. Additionally, objective, independent data that evaluate error rates in psychologist prescribing and psychologists’ detection rates of adverse effects of medications and that move beyond anecdotal impressions are essential to addressing questions of whether and where prescribing psychologists might provide quality care. Similarly, assessments of whether RxP meaningfully affects access to psychoactive medications in underserved areas are warranted.

The history of RxP provides an important case study for psychologists’ role in promoting or supporting legislation. It clarifies that unlike other APA policies and guidelines, the outcome of legislative initiatives is not determined by the preferences of APA, its council, divisions, committees, task forces, and members, but rather by a much broader group of stakeholders including governmental authorities, public policy groups, other health professionals and social scientists, consumers, as well as dissenting psychologists. In promoting legislation, APA should fully consider the risks, benefits, and total capital needed to be expended to successfully pursue its legislative priorities such that it wisely manages its resources. The authors recom-

mend that APA's legislative agenda and efforts focus on the goals and professional activities that benefit its overall membership, rather than supporting RxP, which would appear to only benefit a small, if vocal, group of psychologists.

Psychologists contribute substantively to the public health through the provision of diverse mental health and broader health services, research, and education and deserve fuller recognition for the importance of their work. The opportunities for psychologists to flourish in the dawning era of team-based healthcare are before us. Psychologists' success in this new era will be determined by the quality of their services, their outcomes, and their capacity to collaborate effectively. We believe the public and the profession are best served by having psychologists provide those health services for which they are trained rigorously (e.g., assessment, psychotherapy, consultation, supervision, and research). In many cases, psychologists are indeed the most extensively trained among all health and mental health professionals for rendering them. As interprofessional team-based care revolutionizes the delivery of healthcare, refocusing the profession's psychopharmacology agenda to better prepare psychologists to *collaborate* with prescribers seems likely to be a more prudent, impactful, and promising strategy that would be fully in synch with broader healthcare trends than continuing its undistinguished record in the pursuit of RxP.

NOTE

1. Because prescribing psychologists in Louisiana are now licensed by the Louisiana State Board of Medical Examiners (LSBME) but still have the option of being duly licensed by the Louisiana State Board of Examiners of Psychologists (LSBEP) as well, we could not determine what the total number of psychologists is in the state. Hence, the figure cited, 665, is based on the LSBEP number data and may not include all of the psychologists. As such, the 10.7% estimated percentage of all Louisiana psychologists who can prescribe is probably an overestimate of the actual proportion of prescribing psychologists. Unfortunately, the LSBEP does not track the number of psychologists licensed with both boards.

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Letter to Maryland Senate Robiner.2.25.26.pdf

Uploaded by: Meagan Floyd

Position: UNF

2/25/26

Dear Honorable Senator,

I am a psychologist with a doctorate in clinical psychology writing to request that you *oppose* legislation that would allow psychologists to prescribe medications, including **SB 568**— Health Occupations - Licensed Psychologists - Prescriptive Authority

Quality Issues: Psychologists lack the training to prescribe safely, having less training in the scientific foundations related to medical practice than any other group that currently prescribes. Most psychologists (93%) have **not** taken the prerequisite courses that all nurses, dentists, physicians and other prescribers take at the undergraduate level as well as at the graduate school or professional school level. Psychologists are not required to obtain essentially any courses such as biology, chemistry, organic chemistry, physiology, and other courses that are related to understanding the effects of medications on the human body. Psychologists also lack training in physical diagnosis, which is necessary to detecting side effects and drug interactions, and would receive limited training in the proposed bill. They also have almost no overlapping course work with pharmacists or other health professionals who require expertise regarding the effects of chemical compounds on people.

This legislation is vague about prerequisites for entering clinical psychopharmacology master's programs. It does **not** specify whether any, or how many, courses or credits are required **prior** to entrance to the clinical psychopharmacology training. Such prerequisites to graduate level education **are required for training in all other professions** that prepare health professionals to prescribe. Only about 7% of psychologists have completed prerequisites such as courses in biology and chemistry. In fact, when the American Psychological Association (APA) first considered prescriptive authority for psychologists, its own experts contended,

“It would require students to have undergraduate science training similar to that required of other health service providers (e.g., nurses, pharmacists, allied health professionals, dentists, and/or physicians): (Smyer et al, 1993, p. 400.)

APA's experts' recommendations unfortunately were never incorporated in the APA model for training. These serious deficits in training relative to all other prescribers render granting prescriptive authority for psychologists a **reckless public health policy**. Educational shortcuts are inappropriate for health professionals, especially when it comes to prescribing medications with potentially serious side effects and drug interactions. There are safer alternatives to psychologist prescribing, such as fostering collaborative and integrative care that enable psychologists to use those skills in which they are well trained to provide psychological services in conjunction with the health services (such as

prescribing psychoactive medications) rendered by other health professionals. Similarly, telemedicine allows other professionals to provide services in areas that are underserved, without relying on minimally trained psychologists, who cannot be expected to manage the medications as expertly as other professionals, to provide prescriptions.

Although proponents of psychologist prescribing claim that the Department of Defense pilot program supported prescriptive authority, the final report on the DoD project revealed that the psychologists were “**weaker medically**” than psychiatrists and compared their medical knowledge to **students** rather than physicians. Nevertheless, the APA considers even less training than the DoD psychologists obtained to be adequate. Allowing psychologists, whose medical knowledge is closer to medical students than practicing physicians, to prescribe is not sound public policy.

Controversial: In other health professions whose workforces prescribe there is unanimity that prescribing is appropriate because of the adequacy of the training. However, in contrast, **prescribing by psychologists is a matter of controversy** within the field of Psychology itself, as well as among other health professionals and stakeholders. Surveys of psychologists reveal *some* support for psychologist prescribing, but it is *not* a majority view.

There is no evidence that reducing medical training to about 10% of that required for physicians and about 20% of that required for advanced practice nurses (advanced nurse practitioners) will protect consumers. Moreover, because psychologists tend to practice in urban and suburban areas, allowing psychologists to prescribe would do little to address health professional shortages in rural areas.

Various groups of psychologists oppose psychologist prescribing because of their concern that psychologists would not be sufficiently trained **even if they undertook the minimal training that has been endorsed by the APA** (which does not require prerequisites) or as would likely be proposed in future bills that might be brought before the legislature. For example, 89.2% of members of the multidisciplinary Association for Behavioral and Cognitive Therapies (ABCT) argue the medical training for psychologists to prescribe should be equivalent to other non-physician prescribers, which is not what the APA or Maryland Psychological Association advocate or what proponents of this bill would want.

The shortcuts to training would make psychologists the **least well-trained of any prescribers** and would create needless risk to patients, including some of the most vulnerable citizens. Consumer groups, such as the National Alliance on Mental Illness (NAMI) do not support such legislation. An international group of psychiatric nurses even considers it **unethical** to support psychologist prescribing.

Across the country the vast majority of bills proposing psychologist prescribing have rightfully been rejected by legislators and governors who recognize the risks and have reason to be skeptical about the overly simplistic, and rosy claims of its proponents about its impact. To promote quality mental health services, **there are clear alternatives to psychologist prescribing.** In addition to collaborative, interprofessional, integrated care and telehealth described earlier, expanding funding for training in all of the mental health professionals would facilitate development of robust workforces that are prepared to collaborate in service delivery. These are compelling alternatives, that do not rely on inadequately trained prescribers, and that deserve the full support of legislators and public health officials.

Workforce Issues: In addition to these quality concerns, another reason to oppose prescriptive authority for psychologists is related to **workforce.** APA's experts considered that only "a small, but important, minority of psychologists may seek specialty training leading to licensure for psychotropic prescribing (Smyer et al., 1993, p. 402). That prediction has been accurate! **Few psychologists actually are interested in prescribing,** and only a few hundred are authorized to prescribe nationally, even in the outlier states that have allowed psychologist prescribing for years. Consequently, any of the optimistic impacts of psychologist prescribing that its proponents assert, likely overstate any positive public health impact. There would be significant costs in developing the infrastructure and regulatory mechanisms for implementing psychologist prescribing.

Whereas there is a national shortage of psychiatrists, it is important to recognize that psychiatrists are not the only health professionals prescribing psychoactive medications. Most prescriptions for psychoactive medications are written by non-psychiatric physicians, nurse practitioners, and physician assistants. They *all* have more medical and scientific training than psychologists would have, even those who complete a psychopharmacology course. Current prescribers are better prepared to manage psychoactive and other medications in the broader context of patients' health.

According to the Bureau of Labor Statistics' (BLS) May 2024 *Occupational Employment and Wage Statistics* (<https://data.census.gov/profile/Maryland?g=040XX00US24>), Maryland has multiple prescribers including 18,180 non-psychiatric physicians, 620 psychiatrists, 7,610 nurse practitioners and other advanced practice registered nurses (APRNs), 2,920 physician assistants. All **29,330** of them are authorized to prescribe psychoactive medications.

It is not known how many psychologists would seek to prescribe, but it would likely be a small minority. **The two states that have allowed it for two decades have only had 8.2-14.8% of psychologists seek prescriptive authority.** Our recent article about workforce revealed that **99.77%** of prescribers in the six

states that allow psychologists to prescribe are *not* psychologists. In New Mexico, the first state that allowed psychologists to prescribe, psychologists account for only 1.19% of all prescribers. If Maryland were to permit psychologists to prescribe, New Mexico's and Louisiana's experiences suggests psychologist prescribers would account for a relatively *trivial* proportion of all prescribers in the state. Based on those two states. Extrapolating from the mean percentages of those two states, based on the 1,680 clinical and counseling psychologists estimated by the BLS to be in Maryland, would predict 188 prescribing psychologists over 20 years. **They would constitute 0.6% of all Maryland prescribers.**

Therefore, any touted benefits would be limited and would add minimally to the current workforce of prescribers in Maryland who are authorized to prescribe psychoactive medications. Also, it should be noted that if psychologists prescribe, they would have less time to provide traditional psychotherapeutic and assessment services. When considering the state's mental health service needs, there is a great need for psychotherapy services that psychologists do provide competently after extensive training in it, and for which there is also a shortage of clinicians.

Thank you for your kind consideration. I would be pleased to send you copies of additional articles described in the attached bibliography if you would like further information. Also, I would be pleased to discuss this matter with you or your staff if you wish. Additional resources that address concerns about psychologist prescribing are available at the website for **Psychologists Opposed to Prescription Privileges for Psychologists (POPPP)** <http://www.poppo.org>.

Attached are an annotated bibliography that addresses multiple concerns, a position statement of a nursing organization that opposes psychologist prescribing, and articles entitled:

Fool's Gold: Psychologists Using Disingenuous Reasoning to Mislead Legislatures into Granting Psychologists Prescriptive Authority

Prescriptive Authority for Psychologists: A Looming Health Hazard?

Prescriptive Authority for Psychologists: Despite Deficits in Education and Knowledge?"

Psychologists and Medications in the Era of Interprofessional Care: Collaboration is Less Problematic and Costly Than Prescribing.

Prescriptive authority: Psychologists' Abridged Training Relative to Other Professions' Training

The Workforce of Prescribing Psychologists: Too Small to Matter? Worth the Cost?

Sincerely,

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Pollitt. DisingenuousReasoning.2003.pdf

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ARTICLE: **Fool's Gold:** Psychologists Using Disingenuous Reasoning to Mislead Legislatures into Granting Psychologists Prescriptive Authority

NAME: Brent Pollitt +

BIO:

+ B.A. in Psychology and Speech Communication, B.S. in Criminology, California State University, Fresno (1995); M.A. in Psychology, California State University, Fresno (2001); J.D., California Western School of Law (2002). The author is also a second-year in the M.S. in Child Development degree program at San Diego State University, and is currently seeking admission to the University of Arizona's M.D./Ph.D. Neuroscience program (2004), with plans to complete a psychiatry/neurology residency.

SUMMARY:

... Mental illness is a serious problem in the United States. ... The American Psychological Association offers five main reasons why legislatures should grant psychologists this privilege: 1) psychologists' education and clinical training better qualify them to diagnose and treat mental illness in comparison with primary care physicians; 2) the Department of Defense Psychopharmacology Demonstration Project ("PDP") demonstrated non-physician psychologists can prescribe psychotropic medications safely; 3) the recommended post-doctoral training requirements adequately prepare psychologists to prescribe safely psychotropic medications; 4) this privilege will increase availability of mental healthcare services, especially in rural areas; and 5) this privilege will result in an overall reduction in medical expenses, because patients will visit only one healthcare provider instead of two-one for psychotherapy and one for medication. ... The psychologists' contention that granting them prescriptive authority would significantly allay un-met mental health needs in rural areas is also highly questionable. ... Psychologists seeking prescriptive authority conclude that granting them this privilege will increase patient access to psychotropic medication, especially in rural areas. ... Instead of working on collaborative models in which physicians prescribe medication and psychologists provide therapy, they seek to supplant psychiatry and non-prescribing psychologists by creating a "new breed" of psychologist (a.k.a. pseudo-psychiatrist). ...

TEXT:

[*489] I. INTRODUCTION

Mental illness is a serious problem in the United States. Based on "current epidemiological estimates, at least one in five people has a diagnosable mental disorder during the course of a year." ⁿ¹ Fortunately, many of these disorders respond positively to psychotropic medications. While psychiatrists write some of the prescriptions for psychotropic medications, primary care physicians ⁿ² write more of them. ⁿ³ State legislatures, seeking to expand patient access to pharmacological treatment, granted physician assistants and nurse practitioners prescriptive authority for psychotropic

medications. ⁿ⁴ Over the past decade other groups have gained some [*490] form of prescriptive authority. ⁿ⁵ Currently, psychologists ⁿ⁶ comprise the primary group seeking prescriptive authority for psychotropic medications. ⁿ⁷

The American Society for the Advancement of Pharmacotherapy ("ASAP"), ⁿ⁸ a division of the American Psychological Association ("APA"), ⁿ⁹ spearheads the drive for psychologists to gain prescriptive authority. The American Psychological Association offers five main reasons why legislatures should grant psychologists this privilege: 1) psychologists' education and clinical training better qualify them to diagnose and treat mental illness in comparison with primary care physicians; ⁿ¹⁰ 2) the Department of Defense Psychopharmacology Demonstration Project ("PDP") demonstrated non-physician psychologists can prescribe psychotropic medications safely; ⁿ¹¹ 3) the recommended post-doctoral training requirements adequately prepare psychologists to prescribe safely psychotropic medications; ⁿ¹² 4) this privilege will increase availability of mental healthcare services, especially in rural areas; ⁿ¹³ and 5) this privilege will result in an overall reduction in medical expenses, because patients will visit only one healthcare provider instead of two-one for psychotherapy [*491] and one for medication. ⁿ¹⁴ Conversely, some organizations challenge these contentions as unfounded and oppose granting psychologists prescriptive authority.

The American Psychiatric Association (the "Association") ⁿ¹⁵ is the strongest opponent to granting psychologists prescriptive authority. The Association argues "safe and effective use of potent psychotropic medications requires extensive medical training and a thorough understanding of the brain and body." ⁿ¹⁶ Accordingly, psychologists lack the requisite education and training to safely prescribe such medication. ⁿ¹⁷ The Association contends "the needs of rural and other underserved patients can best be met through collaboration between psychiatrists and other medical professionals." ⁿ¹⁸ Along with the Association, the Committee Against Medicalizing Psychology opposes granting psychologists prescriptive authority because they believe this privilege would diminish the traditional benefits of talk-therapy. ⁿ¹⁹

This Article challenges the psychologists' arguments, favoring legislative approval that grants them prescriptive authority. While the data show primary care physicians do lack expertise at treating mental illness, ⁿ²⁰ psychologists are at an immensely greater deficit of assessing and treating non-mental health illnesses, even with additional post-doctorate training. ⁿ²¹ As for the PDP study, it did show successful training of non-physician psychologists, ⁿ²² however, it did so under controlled, military settings. ⁿ²³ It is grossly inappropriate to argue this study "conclusively demonstrated psychologists' ability to prescribe safely and [*492] effectively," ⁿ²⁴ especially in regard to non-military psychologists prescribing independently. ⁿ²⁵

The psychologists seeking prescriptive authority further contend their behavioral science education ⁿ²⁶ ensures they can prescribe safely. ⁿ²⁷ Yet, these psychologists complete fewer science courses and shorter clinical internships than nurses trained under the medical model, ⁿ²⁸ and who possess no prescriptive authority. ⁿ²⁹ The psychologists skew their arguments, avoiding discussion of the potentially catastrophic effects on patients suffering from missed or incorrect diagnoses, missed drug interactions, missed drug side-effects, incorrect test interpretations, or missed necessary test orders due to the psychologists' inferior medical background. ⁿ³⁰

The psychologists' contention that granting them prescriptive authority would significantly allay un-met mental health needs in rural areas is also highly questionable. ⁿ³¹ Less than one-seventh of very rural counties, and less than one-half of rural counties ⁿ³² have a practicing psychologist, compared to all of those counties having a family physician. ⁿ³³ Moreover, the majority of mental health patients choose treatment from their family physician instead of from psychologists. ⁿ³⁴ Due to the stigma attached to mental illness and the dynamics of close-knit rural societies, ⁿ³⁵ there is no guarantee any significant number of rural inhabitants with a mental health disorder would even seek treatment from a psychologist.

In regard to the psychologists' argument that granting them prescriptive authority would reduce monetary costs associated with a patient seeing multiple providers, ⁿ³⁶ the savings they boast do not take into consideration all of the [*493] economical expenses associated with granting this privilege. ⁿ³⁷ They ignore the likely possibility that prescribing psychologists would significantly increase fees, though 75% of a sample of practicing psychologists "agreed

or strongly agreed that RxP [prescription privilege] would lead to higher incomes for psychologists." ⁿ³⁸ They assume malpractice premiums will not increase, yet 85% of a sample group of practicing psychologists believed that obtaining prescription privileges would increase malpractice rates. ⁿ³⁹ Psychologists also overlook the additional fees associated with prescribing, such as the cost of out-of-office testing, ⁿ⁴⁰ and they neglect the issue of how patients will deal with medications after treatment ends. ⁿ⁴¹ While there are savings in having a patient see only one mental healthcare provider, ⁿ⁴² there are many real and potential hidden costs not recognized or acknowledged by the psychologists seeking prescriptive authority. ⁿ⁴³

Granting psychologists prescriptive authority will also adversely affect the mental healthcare system by reducing the number of psychiatrists and non-prescribing psychologists in urban areas where they are most needed. ⁿ⁴⁴ Prescription [*494] writing psychologists would be *de facto* psychiatrists. ⁿ⁴⁵ Possessing only a fraction of the education and experience, these psychologists propose to offer the same services provided by psychiatrists, but for commensurately lower fees. ⁿ⁴⁶ If existing geographic distributions for psychologists and psychiatrists remain stable, the data show the majority of prescription-writing psychologists will work in urban areas. ⁿ⁴⁷ This places them in direct competition with psychiatrists, but offering cheaper pseudo-psychiatric treatment. With the current difficulty in retaining psychiatrists, this increased competition will further reduce the number of practicing psychiatrists. ⁿ⁴⁸ The majority of prescription-writing psychologists will also compete directly with non-prescription-writing psychologists in urban areas. ⁿ⁴⁹ Although charging higher fees than non-prescribing psychologists, managed care organizations certainly will fund prescribing psychologists over non-prescribing psychologists because they get *de facto* psychiatric services at cheaper rates. Thus, one very real consequence of granting psychologists prescriptive authority is a backlash reduction in much needed psychiatrists and non-prescription-writing psychologists. ⁿ⁵⁰

While the lack of available psychopharmaceutical treatment is a serious concern for all healthcare professionals, patient safety must remain paramount. Increased availability of harmful, substandard treatment is not the solution. The crux of the problem centers on what constitutes satisfactory education and training to grant prescriptive authority. The minimum standard for granting prescriptive authority needs to maximize the availability of psychotropic medication to rural and underserved populations while concurrently providing maximum protection to patients. The current minimum standard for psychopharmaceutical prescriptive authority, established by physician assistants and nurse practitioners, accomplishes this goal. ⁿ⁵¹ Lowering this standard to allow psychologists to prescribe poses too great a risk to patient safety. Several much more effective and practical alternatives [*495] exist for safely increasing access to psychopharmaceutical treatment for rural and under-served populations. ⁿ⁵² Ultimately, the potential harm to children, the elderly, and society in general, ⁿ⁵³ by granting psychologists prescriptive authority under the current guidelines, ⁿ⁵⁴ far outweighs the speculative benefits touted by psychologists seeking this privilege. ⁿ⁵⁵ For the reasons and evidence stated in this Article, legislatures should not grant psychologists any prescription privileges without requiring a medical model-based education equivalent to physician assistants or nurse practitioners, including prerequisites and clinical internships. ⁿ⁵⁶

II. HEALTHCARE PROVIDERS WITH PSYCHOPHARMACEUTICAL PRIVILEGES

In the United States, physicians, including psychiatrists, possess virtual *carte blanche* prescriptive authority, ⁿ⁵⁷ which includes authorization to write prescriptions for psychopharmaceuticals. ⁿ⁵⁸ When addressing mental health issues, physician assistants and nurse practitioners also possess some prescriptive authority for psychopharmaceuticals. ⁿ⁵⁹ All of these professions require strict licensing, with physicians facing the strictest licensing criteria with respect to required education and experience.

A. PHYSICIANS

Prior to applying for medical licensure in the United States, one must complete medical school. Medical schools throughout the United States share similar prerequisites and curricula for acceptance into medical school and for conferring a medical degree. ⁿ⁶⁰ These schools desire a strong, broad science foundation in [*496] preparation for advanced medical science courses. ⁿ⁶¹ Typical prerequisite science courses include one year of college Biology, two

years of college Chemistry, and one year of Physics, each with an accompanying lab. ⁿ⁶² Many schools also require one year of Calculus. ⁿ⁶³ Because of the nature of the study of medicine, medical schools recommend that "students take their [prerequisite] course of study in the most demanding curricular environment possible." ⁿ⁶⁴ Medical schools also require submission of Medical College Admission Test ("MCAT") scores. ⁿ⁶⁵ Competition remains high on MCAT scores and grade-point-average for entering students. ⁿ⁶⁶

The first two years of the four-year medical school curriculum involve classroom study of basic medical science courses and physician-patient interaction. ⁿ⁶⁷ The typical curriculum includes the study of pharmacology, neurology, and mental disorders. ⁿ⁶⁸ Many medical programs now also require an additional course in behavioral and social science. ⁿ⁶⁹ In the third and fourth years, students participate in clinical rotations, which include a required six unit rotation in psychiatry. ⁿ⁷⁰ In addition to the unit and clinical requirements, medical students must pass a three-step national exam for graduation and medical licensure. ⁿ⁷¹

[*497] Each state establishes its own regulations and licensing boards for physicians, ⁿ⁷² which serve a variety of medically related functions. ⁿ⁷³ Establishing and verifying licensing requirements are primary functions. ⁿ⁷⁴ These boards also enforce minimum requirements for medical education and clinical training, ⁿ⁷⁵ and mandate specific topics of study for licensure. ⁿ⁷⁶

Psychiatrists are specialized medical doctors, and thus, must complete a four-year medical program of extensive clinical training ⁿ⁷⁷ and a residency program. ⁿ⁷⁸ At the completion of residency, a psychiatrist qualifies to take a board-certifying exam, ⁿ⁷⁹ making psychiatrists the most extensively trained, mental health providers. ⁿ⁸⁰

B. PHYSICIAN ASSISTANTS (PA)

In the mid 1960s, the advent of the physician assistant ("PA") extended limited prescriptive authority to non-physicians. ⁿ⁸¹ Since that time, "forty-seven states have enacted laws or regulations that allow supervising physicians to delegate prescriptive authority to PAs." ⁿ⁸² As of 2001, "eighty-five percent of these states allow PAs to prescribe controlled medications." ⁿ⁸³ Students applying to PA programs typically possess a college degree, have significant experience in the health field, ⁿ⁸⁴ and have also completed the same foundational prerequisite science courses as those required for medical students. ⁿ⁸⁵ Though the course length is shorter than a medical program, the curricula share similar features. ⁿ⁸⁶ PA students typically receive more than 1,500 [*498] hours of education based on the medical model. ⁿ⁸⁷ In addition to PA programs adhering to the same set of national accreditation standards, ⁿ⁸⁸ PA licensure requires 100 hours of continuing education every two years and re-licensure every six years. ⁿ⁸⁹ Advanced PA degrees in specialties are available, including psychiatry. ⁿ⁹⁰ Despite completing almost 40% more education and training than that recommended by psychologists to write prescriptions, ⁿ⁹¹ *no state allows PAs to prescribe independently of a physician.*

C. NURSES WITH PRESCRIPTIVE AUTHORITY

Nurses complete approximately two-thirds of the prerequisite course load required for medical students. ⁿ⁹² Notwithstanding, the prerequisites serve the same preparatory function of building a foundation for future advanced nursing science courses. ⁿ⁹³ The actual nursing program typically requires three years to complete and consists of courses similar to those taken in medical school. ⁿ⁹⁴ Despite completing more education and training than that recommended for psychologists to write prescriptions, ⁿ⁹⁵ *no state permits nurses to prescribe medications* without a minimum of a masters degree. ⁿ⁹⁶ Currently there are 58,000 certified advanced practice nurses in the United States. ⁿ⁹⁷ All of these nurses possess a masters degree and have [*499] completed a certification exam. ⁿ⁹⁸ Nurse practitioners may choose an adult or family specialty in mental health. ⁿ⁹⁹

Over the past decade, legislatures across the country began granting these specially qualified nurses limited prescriptive authority. ⁿ¹⁰⁰ All states require some form of collaboration or supervision with a physician and many place restrictions on the Schedules of medications these nurses may prescribe. ⁿ¹⁰¹ Some states only permit authority to

prescribe non-controlled drugs, ⁿ¹⁰² while other states permit prescriptive authority for controlled drugs, but on limited basis. ⁿ¹⁰³ The most restrictive state is Georgia, which does not permit independent prescriptive authority. ⁿ¹⁰⁴ The least restrictive state is Arizona, permitting full prescriptive and dispensing privileges to nurses with advanced practice certification, but still requiring a consultative or referral relationship with a physician. ⁿ¹⁰⁵ *Only after completing three years of nursing school and obtaining a Master of Science in Nursing degree or Master of Nursing degree,* ⁿ¹⁰⁶ do states grant these specially trained nurses some level of prescriptive authority within the scope of their respective practice. ⁿ¹⁰⁷

The important theme among physicians, physician assistants, and nurse practitioners is their extensive education in foundational and advanced medical [*500] science courses, ⁿ¹⁰⁸ and their daily practical experience working with patients prescribing myriad medications. ⁿ¹⁰⁹ All three professions require years of experience in a medical environment, working with hundreds of patients, at a minimum, for licensure. ⁿ¹¹⁰ Such training exposes students daily to such important aspects of pharmaceutical treatment as: 1) diagnosis of mental and non-mental illnesses; 2) knowledge of necessary tests and ability to comprehend the results; 3) identification of appropriate medications to administer and dosages to prescribe; and 4) knowledge of possible drug interactions and side-effects of hundreds of medications, not limited to psychopharmaceuticals. ⁿ¹¹¹ The education proposed for granting psychologists prescriptive authority lacks the medical instruction required to prescribe safely, especially independently, based on inferior prerequisites, inferior core requirements, and inferior practical experience. ⁿ¹¹²

III. EDUCATIONAL REQUIREMENTS FOR PSYCHOLOGISTS

Most American universities offer a Bachelors of Arts ("BA") degree in Psychology that requires the equivalent of at least 120 semester hours for completion. ⁿ¹¹³ The awarding of this degree typically requires 12 semester hours of general education, non-behavioral, science courses. ⁿ¹¹⁴ Some universities, however, place few restrictions on which science courses will satisfy this unit requirement. ⁿ¹¹⁵ Students, for example, can complete the general education requirements by completing a single three unit, non-major biology course, ⁿ¹¹⁶ and completing the remaining nine required science units with non-medical science courses. ⁿ¹¹⁷ [*501] Additionally, BA Psychology degree programs typically require 36 to 40 psychology units for graduation, ⁿ¹¹⁸ but all units may consist of non-medical science courses. ⁿ¹¹⁹ There is no assured consistency in the non-behavioral science education acquired by students graduating with a BA degree in Psychology. ⁿ¹²⁰

Many American universities also offer a Bachelor of Science (BS) degree in Psychology that requires the equivalent of at least 120 semester hours for completion. ⁿ¹²¹ BS Psychology degree programs, when supplemented with a science minor, require approximately 27 science units for the BS degree and approximately 22 science units for the minor. ⁿ¹²² Universities often permit students, however, to "double count" these courses, thereby reducing the overall actual number of units completed. ⁿ¹²³ Moreover, some of the science courses offered, just as with the BA degree in Psychology, have no connection with the medical field. ⁿ¹²⁴ Students completing a BS degree in Psychology, with a science minor, may actually complete substantially fewer than the required 49 science units for graduation. Additionally, a student may complete the typical 36 psychology units required for graduation [*502] without taking any medical science courses. ⁿ¹²⁵ As with the BA degree in Psychology, there is no assured consistency in the adequacy of the non-behavioral science education of students completing the BS degree in Psychology with a science minor; they can satisfy all requirements with non-medical courses. ⁿ¹²⁶ Only under the most favorable circumstances do students graduating with a BS degree in Psychology begin to complete the prerequisite medical science education and training obtained by medical, physician assistant, and nursing students. ⁿ¹²⁷

Almost all graduate programs in psychology require General Graduate Records Exam scores with applications for admittance, ⁿ¹²⁸ and almost all programs also require a Psychology Graduate Records Exam score. ⁿ¹²⁹ Most psychology graduate programs offer a Master of Arts ("MA") degree that typically requires the equivalent of 30 semester hours for completion. ⁿ¹³⁰ Many psychology graduate programs also offer a Master of Science ("MS") degree that typically requires the equivalent of 30 to 79 semester hours for completion. ⁿ¹³¹ MA and MS degrees in Psychology generally offer, *but do not require*, medical science courses for graduation. ⁿ¹³² These programs almost

invariably require a master's thesis, project, or a comprehensive exam for completion of the degree. ⁿ¹³³ Unlike the medical science-based professions, however, there is no uniformity among the required science courses for BA, MA, or MS degrees in Psychology. Additionally, some Doctor of Philosophy in Psychology ("PhD") degree programs do not require a masters degree for entrance. ⁿ¹³⁴

Clinical psychology doctorate programs also require relatively few medical science courses similar to those taken by physician, physician assistants, and nurse practitioners. ⁿ¹³⁵ Clinical psychology PhD programs typically focus on research [*503] issues and developing counseling skills. ⁿ¹³⁶ Many PhD in Psychology programs are now offered at professional schools, ⁿ¹³⁷ and focus heavily on developing counseling skills that include diagnosis and treatment of mental disorders, which is not provided in traditional PhD degree programs. ⁿ¹³⁸ Clinical psychology programs often provide courses on psychopharmacology, brain anatomy, and physiology, but clinical psychologists generally lack the foundational and advanced medical science education, and receive no practical training for treating non-mentally ill patients. ⁿ¹³⁹ In contrast, all three of the other mental healthcare providers receive clinical training with both mentally ill and non-mentally ill patients. ⁿ¹⁴⁰

All states require licensure for psychologists. ⁿ¹⁴¹ State Psychology Boards determine what activities a licensed psychologist may perform. ⁿ¹⁴² These Boards often offer certificate programs for specialty areas, ⁿ¹⁴³ and typically require [*504] continuing education for re-licensing, ⁿ¹⁴⁴ but at this time, State Boards lack the power to grant prescriptive authority.

IV. AVAILABILITY AND ACCESS TO HEALTH AND MENTAL HEALTH SERVICES PROVIDERS IN THE UNITED STATES

There exists a shortage of health and mental health providers in rural America that is of serious concern for all health professionals. Physician assistants and nurse practitioners gained prescriptive authority primarily to increase patient access to healthcare. ⁿ¹⁴⁵ Psychologists seeking prescriptive authority argue a shortage of mental health providers with prescriptive authority exists in rural America and among under-represented populations. ⁿ¹⁴⁶ They contend legislatures should grant them prescriptive authority as a means to alleviate this shortage. ⁿ¹⁴⁷ This section examines availability of health and mental health treatment in the United States.

A. METROPOLITAN VERSUS NON-METROPOLITAN AREAS

The Office of Management and Budget uses a zero-sum approach for defining metropolitan and non-metropolitan areas. A metropolitan area is any location "having either a city with more than 50,000 residents or a Census Bureau defined urbanized area and a total population of at least 100,000." ⁿ¹⁴⁸ Subsequently, "all counties not classified as metropolitan are by definition non-metropolitan." ⁿ¹⁴⁹ Approximately 80% of all Americans live in metropolitan areas, and approximately 89% of licensed physicians practice in metropolitan areas. ⁿ¹⁵⁰ "In 1995, there were 56,635 office-based patient care MDs in non-metropolitan areas compared with 370,000 office-based patient care MDs in metropolitan areas." ⁿ¹⁵¹ More than half of the non-metropolitan physicians practiced in the areas of "primary care specialties of family or general practice, general internal medicine, pediatrics, [or] obstetrics/gynecology, compared with 38% of metropolitan physicians." ⁿ¹⁵²

In 1994, the Frontier Mental Health Services Resource Network ("FMHSRN") examined availability of physicians, psychiatrists, and psychologists by county. ⁿ¹⁵³ [*505] The FMHSRN defined six categories based on number of people per square mile, with the first two groups considered rural areas: Group I consisted of a population density of 0-1.9 persons per square mile, representing 129 counties; Group II consisted of a population density of 2-6.9 persons per square mile, representing 296 counties; Group III consisted of a population density of 7-9.9 persons per square mile, representing 126 counties; Group VI consisted of a population density of 10-14.9 persons per square mile, representing 163 counties; Group V consisted of a population density of 15-99.9 persons per square mile, representing 1,625 counties; and Group VI consisted of a population density of 100-plus persons per square mile representing 742 counties. ⁿ¹⁵⁴ The data show a significant shortage of physicians, psychiatrists, and psychologists in the rural areas. ⁿ¹⁵⁵

While "rural Americans experience incident and prevalence rates of mental illnesses and substance abuse which are equal to or greater than their urban counterparts . . . they also suffer from chronic shortages of mental health providers and services. . . ." ⁿ¹⁵⁶ In rural America, the most common provider of all healthcare is a family physician. ⁿ¹⁵⁷ "According to the de facto model, as much as half of mental healthcare may be obtained in the general medical sector, and much of this care will be from physicians in family or general primary care practices." ⁿ¹⁵⁸ In Group I, as many as two-thirds of the counties do not have a physician in family practice. ⁿ¹⁵⁹ Conversely, two-thirds of the counties in Group II do have a physician in family practice, ⁿ¹⁶⁰ and Group II has the highest rate of family physicians at 25.8 per 100,000 persons. ⁿ¹⁶¹ These data indicate "the family practitioner is a common form of medicine in frontier areas . . . [, and] the family practitioner is also the most common medical practitioner who is likely to provide mental health services." ⁿ¹⁶² The FMHSRN report "noted that many family practice physicians obtain additional training in psychiatry, not only as a general requirement of their residencies, but because of interest in mental health in family settings." ⁿ¹⁶³ While most healthcare in rural America comes from family practice physicians, access to mental healthcare from a psychiatrist remains extremely limited. ⁿ¹⁶⁴

[*506] Approximately 10% of the counties in Group I and Group II, combined (425 counties), reported having a resident psychiatrist. ⁿ¹⁶⁵ This availability pales in comparison to the high 91% reported in Group VI. ⁿ¹⁶⁶ Groups III-V reported percentages of counties with psychiatrists of 11.1%, 19.0%, and 30.6%, respectively. ⁿ¹⁶⁷ The prevalence rate ranged from a low of 0.1 psychiatrists per 100,000 persons in Group I to a high of 10.5 psychiatrists per 100,000 persons in Group VI. ⁿ¹⁶⁸ The availability of psychologists fared only a little better.

Only 13.3% of the Group I counties and 43.1% of the Group II counties reporting having a psychologist, ⁿ¹⁶⁹ compared to 79.5% of the most densely populated counties in Group VI. ⁿ¹⁷⁰ Groups III-V reported percentages of counties with psychologists of 43.7%, 48.5%, and 52.2%, respectively. ⁿ¹⁷¹ The prevalence rate ranged from a low of 13.0 psychologists per 100,000 persons in Group I to a high of 28.9 psychologists per 100,000 persons in Group VI. ⁿ¹⁷² Thus, while the more populated counties enjoy reasonable availability of health and mental health services, the rural counties in America clearly do not.

B. PREVALENCE AMONG SPECIAL POPULATION GROUPS

Minorities, children, and the homeless are the more likely populations in rural and urban counties that lack access to health and psychiatric care. ⁿ¹⁷³ Even when care is available, a homeless patient may wait months for treatment. ⁿ¹⁷⁴ Although 100% of the Group VI counties had a family practice physician, the prevalence rate was the third lowest of the groups at 20.9 per 100,000 persons. ⁿ¹⁷⁵ Ninety-one percent of the Group VI counties had a psychiatrist, and the prevalence rate was the highest at 10.5 per 100,000 persons. ⁿ¹⁷⁶ Group VI also reported the highest percentage of psychologists at 79.5%, and the highest prevalence rate at 28.9 per 100,000 persons. ⁿ¹⁷⁷ Although these numbers represent far greater access to health and mental health services compared to non-metropolitan areas, unduly long delays to mental healthcare do exist for certain populations. ⁿ¹⁷⁸ The question then becomes [*507] how best to increase and expedite access to mental healthcare. Several important concerns arise when considering granting psychologists prescriptive authority.

V. QUESTIONS CONCERNING GRANTING PSYCHOLOGISTS PRESCRIPTIVE AUTHORITY

Legislatures began considering granting psychologists prescriptive authority in the mid-1980s. ⁿ¹⁷⁹ The American Psychological Association supported this legislation, arguing that with prescriptive authority they could "provide broader service to the public and more effectively meet the psychological and mental health needs of society." ⁿ¹⁸⁰ They continue to support prescriptive authority for psychologists, ⁿ¹⁸¹ and in 2000, the American Society for the Advancement of Pharmacotherapy, a division of the APA, began. ⁿ¹⁸² Over the years, many state legislatures considered bills intended to grant psychologists prescriptive authority, ⁿ¹⁸³ and several states currently have legislation pending. ⁿ¹⁸⁴ In March 2002, New Mexico became the first state to grant psychologists prescriptive authority. ⁿ¹⁸⁵

The American Psychiatric Association and the Committee Against Medicalizing Psychology comprise the primary

opposition to granting psychologists prescriptive authority, ⁿ¹⁸⁶ arguing psychologists lack the medical education, training, and experience to prescribe safely. ⁿ¹⁸⁷

A. ARE PSYCHOLOGISTS BETTER QUALIFIED THEN PHYSICIANS TO DIAGNOSE MENTAL ILLNESS?

Psychologists seeking prescriptive authority often present themselves as the highest educated and trained mental health provider, ⁿ¹⁸⁸ neglecting the fact psychiatrists complete the most demanding educational and experiential curriculum [*508] among mental health providers. ⁿ¹⁸⁹ Notwithstanding, psychologists do complete an extensive behavioral science education, including clinical internships. ⁿ¹⁹⁰ Because of their background in mental health, psychologists seeking prescriptive authority consider themselves better qualified than family practice physicians to diagnose and treat mental disorders. ⁿ¹⁹¹ They also consider themselves uniquely qualified to evaluate and monitor psychopharmaceutical prescriptions. ⁿ¹⁹² Despite their expertise, however, the majority of patients prefer treatment from primary care physicians for mental health issues. ⁿ¹⁹³ As a result, primary care physicians currently treat the bulk of mental health patients requiring pharmaceutical treatment. ⁿ¹⁹⁴

While most medical school curricula now include specific courses on social and behavioral sciences and pharmacology, ⁿ¹⁹⁵ a number of articles have concluded that non-psychiatrist or primary care physicians are, by and large, inadequately prepared to recognize, refer, or treat mental disorders. ⁿ¹⁹⁶ Notwithstanding, Anderson and Harthorn (1989) found that primary care physicians recognized the presence of mental disorder essentially as well as mental health professionals (e.g., psychiatrists, psychologists). ⁿ¹⁹⁷ The problem, however, is these physicians were less accurate in their diagnoses of affective, anxiety, somatic, and personality disorders. Generalist physicians were most accurate (81%) in recognizing organic disorders and least accurate (14%) in identifying personality disorders, though only about one-half of the physicians correctly identified anxiety (49%), somatic (49%), and affective (47%) disorders. ⁿ¹⁹⁸ Subsequently, rural physicians state "they do the best they can, but clearly were not adequately trained to provide a full range of mental health services." ⁿ¹⁹⁹ Although family practice physicians lack the expertise psychologists have in treating mental illness, they still possess some knowledge and skill in dealing with mentally ill patients. ⁿ²⁰⁰ More importantly, this "red herring," that physicians lack expertise to treat mental disorders, detracts from the real issue, which is psychologists possess negligible training in diagnosing and treating non-mental [*509] health illnesses. ⁿ²⁰¹ The Department of Defense Psychopharmacology Demonstration Project clearly indicates the psychologists' proposed additional training lacks the educational and clinical requirements to compensate for this deficit. ⁿ²⁰²

B. ASSESSING THE RELIABILITY OF THE DEPARTMENT OF DEFENSE PSYCHOPHARMACOLOGY DEMONSTRATION PROJECT: CAN PSYCHOLOGISTS PRESCRIBE SAFELY?

In the early 1990s, the Department of Defense funded the Psychopharmacology Demonstration Project to test the feasibility of training psychologists to safely and effectively prescribe psychotropic medication. ⁿ²⁰³ Psychologists seeking prescriptive authority present this study as "*clearly demonstrating* that psychologists can be trained to prescribe safely and effectively." ⁿ²⁰⁴ The report does give high praise for the success of the participants. ⁿ²⁰⁵ The psychologists seeking prescriptive authority, however, omit extremely significant facts that challenge their categorical belief the PDP can be generalized to a non-military population, which is a belief seriously questioned by the PDP itself. ⁿ²⁰⁶

The PDP ran from 1991 to 1997. ⁿ²⁰⁷ Thirteen psychologists began the program with ten completing the full training. ⁿ²⁰⁸ Four classes graduated from the program between 1994 and 1997. ⁿ²⁰⁹ Two participants graduated from Group A completing a total of 1,418 hours of didactic training. ⁿ²¹⁰ After this class, the PDP determined approximately half of the didactic training to be unnecessary, reducing this component to 712 hours. ⁿ²¹¹ "The result was that the fellows in Groups B, C, and D experienced a very different academic program." ⁿ²¹² The two Group A participants completed a nine-month inpatient program similar to a second year psychiatry [*510] residency program. ⁿ²¹³ They also spent three months taking on-call duty and "reviewing charts of psychopharmacologically treated patients from a chronic care outpatient clinic The two Group A fellows who completed the program treated a total of 223 inpatients during the 9-month experience. The treated group included about 50% men and 50% active duty personnel. Median age

was 37-38." ⁿ²¹⁴ They treated a variety of mental disorders and prescribed a variety of psychotropic medications. ⁿ²¹⁵ The remaining groups participated in a six-month inpatient and six-month outpatient clinical internship experience, ⁿ²¹⁶ with one Group C psychologist retaking the clinical internship and graduating with Group D. ⁿ²¹⁷ They dealt with similar numbers of patients, with comparable experiences in types of mental illnesses treated and medications prescribed. ⁿ²¹⁸ No participant prescribed to children under age 18 or adults over age 65. ⁿ²¹⁹ After completion of their clinical internships, the participants continued to receive guidance through proctorship. ⁿ²²⁰ The study evaluation panel ("Evaluation Panel") concluded no intention existed to replace psychiatrists with these psychologists, ⁿ²²¹ but some participants suggest this is what happened in a couple of instances. ⁿ²²²

Three of the graduates were Air Force Officers and three were Army Officers, all holding the rank of Captain or higher. ⁿ²²³ The remaining four graduates were Navy officers all holding the rank of Lieutenant Commander or Commander. ⁿ²²⁴ The evaluators considered the participants an exceptional group and stated: "one indicator of the quality and the success of this group of graduates was that eight out of 10 were serving as chiefs or assistant chiefs of an outpatient psychology clinic or a mental health clinic." ⁿ²²⁵ The Evaluation Panel also concluded the participants [***511**] showed tremendous ability in overcoming "their limited background in traditional scientific prerequisites for medical school," ⁿ²²⁶ although the two Group A participants did complete 706 hours additional didactic medical school training during the program. ⁿ²²⁷ Notwithstanding these exceptional characteristics,

The Evaluation Panel heard much skepticism from psychiatrists, physicians, and some of the graduates about whether prescribing psychologists could safely and effectively work as independent practitioners in the civilian sector. The usual argument was that the team practice that characterized military medicine was an essential ingredient in the success of the PDP that could not be duplicated in the civilian world. ⁿ²²⁸

The Evaluation Panel made the recommendation:

For a successful new program or a retraining program, it will be essential to select trainee psychologists with an adequate background for advanced training in psychopharmacology. Two areas are particularly important--a preparatory science background and competence in clinical nosology. In order to study pharmacology at the advanced level needed to manage pharmacotherapies, trainees must have a background in chemistry, biology and mathematics. Chemistry should include post-baccalaureate biochemistry and the necessary preparation for a course at this level. Typically, this would include undergraduate general and organic chemistry. Biology should include undergraduate level general biology, vertebrate and human anatomy, and other course work adequate for a post-baccalaureate level course in mammalian physiology. It would be important for the graduate physiology course to contain exposure to human pathophysiology. It would also be essential that trainees have an adequate background in the biological basis of behavior. Understanding of clinical pharmacokinetics and many relevant biochemical phenomena requires a background in mathematics, including at a minimum, college-level algebra. ⁿ²²⁹

The Evaluation Panel determined from the curriculum adjustments, starting with Group B, that the 712 hours of didactic education, the six-month inpatient internship, and the six-month outpatient internship are the minimum standard for a successful program designed to prepare psychologists for "limited prescribing authority." ⁿ²³⁰ The Evaluation Panel further stated: "we could not approve and would question the educational soundness of any 'crash' or 'cram' course format. [***512**] Ample evidence exists that retention of usable knowledge from such formats is very limited." ⁿ²³¹ They conclude the study with a list of other professionals they consider appropriate for this type of education. ⁿ²³²

Psychologists seeking prescriptive authority represent this single study involving ten participants as a representative sample of the more than 70,000 practicing psychologists. ⁿ²³³ They believe this despite a 23% attrition rate, with 20% of the graduates receiving twice the amount of didactic training, and an additional graduate repeating the clinical

internship. ⁿ²³⁴ They apparently assume the average psychologist holds the position of chief or assistant chief of a mental health clinic, ⁿ²³⁵ and is a high-ranking military officer. ⁿ²³⁶ They emphatically state the PDP conclusively illustrated that psychologists can be trained to prescribe safely, ⁿ²³⁷ yet they fail to acknowledge the strict limitations placed on the participants, such as age and existing health problems. ⁿ²³⁸ They mislead legislatures into believing psychologists can safely prescribe to children, the elderly, and patients with existing illnesses, ⁿ²³⁹ but the PDP never allowed participants to prescribe to any of these populations. ⁿ²⁴⁰ The psychologists seeking prescriptive authority assure legislatures the PDP contained excessive training even after the restructuring, ⁿ²⁴¹ but the Evaluation Panel clearly stated otherwise and admonished the soundness of any "crash" or "cram" course format. ⁿ²⁴² The Evaluation Panel even reiterated the importance of an extensive medical science foundation for the advanced courses to follow. ⁿ²⁴³ Psychologists seeking prescriptive authority appear blinded by their own self-interest associated with prescribing medication, willing to distort and totally disregard a multitude of opposing facts, placing patients at harm.

[*513] C. THE SUGGESTED TRAINING REQUIREMENTS IN PSYCHOPHARMACOLOGY FOR POST-GRADUATE PSYCHOLOGISTS WOULD NOT ASSURE SAFE PRESCRIPTION PRACTICES

Psychologists seeking prescriptive authority argue that completion of New Mexico's requirement of a 450-hour (30-unit) ⁿ²⁴⁴ degree program, including a 480-hour internship requiring interaction with 100 patients, qualifies them to prescribe psychotropic medications. ⁿ²⁴⁵ This program, however, reduced the education and training requirements by more than 50% of what the PDP recommended, ⁿ²⁴⁶ which is the same study the psychologists rely on to prove they can prescribe safely. ⁿ²⁴⁷ When confronted with this discrepancy, the psychologists state facts about the original purpose of the PDP, but fail to realize the 700-hour didactic program and one-year clinical internship are the scaled-down, revised recommendation of the PDP. ⁿ²⁴⁸ The PDP clearly stated what a satisfactory program required when it adjusted the curriculum after Group A. ⁿ²⁴⁹ The New Mexico program lacks almost 40% of the didactic recommendations, ⁿ²⁵⁰ requires none of the recommended prerequisite education, ⁿ²⁵¹ lacks more than 80% of the recommended clinical internship time, ⁿ²⁵² and excludes the additional weekly seminar classes completed by the PDP participants. ⁿ²⁵³ The New Mexico clinical internship requirements disregard the PDP's specific recommendation of six months in-patient and six months out-patient clinical experience, ⁿ²⁵⁴ components considered absolutely critical by the PDP for a **[*514]** satisfactory program. ⁿ²⁵⁵ Perhaps in an effort to make the program more marketable, ⁿ²⁵⁶ though definitely much more dangerous to patients, the psychologists disingenuously present the findings of the PDP and recommend the very watered-down version the PDP warned against. ⁿ²⁵⁷ Psychologists seeking prescriptive authority defend the dearth of education and training requirements by arguing that their seven and one-half years of behavioral science training makes up the difference. ⁿ²⁵⁸

Through existing graduation and licensing requirements, a psychologist can graduate with a doctorate degree and gain licensure while completing no college-level basic science courses. ⁿ²⁵⁹ Additionally, physicians opposing granting psychologists prescriptive authority argue:

Psychiatrists and other physicians are trained to diagnose and treat human illness, which includes the brain and the rest of the body and the use and side effects of medication in treating those illnesses. Psychologists are trained in human behavior. Medications are used to treat body chemistry and are biologically based. Physicians are also trained to find a biological disorder of one part of the body masking itself in another part of the body, including the brain. ⁿ²⁶⁰

Under New Mexico's system, ⁿ²⁶¹ a psychologist completing the post-doctorial requirements may qualify to prescribe medication by completing less than one-quarter of an education ostensibly comparable to that of physicians, and less than one-half of the education completed by physician assistants and nurse **[*515]** practitioners. ⁿ²⁶² Again, the psychologists typically respond to challenges to this paucity of education in the recommended program by implying their behavioral science education equates to the medical science education completed by physician assistants and nurse practitioners. ⁿ²⁶³ Not only are they patently wrong, ⁿ²⁶⁴ but this argument emphasizes the fact these psychologists totally disregard their inadequacy at diagnosing and treating non-psychological health issues. ⁿ²⁶⁵

The issue of whether psychologists can prescribe psychotropic medications safely becomes irrelevant when one examines the issue of co-morbidity. ⁿ²⁶⁶ Psychologists seeking prescriptive authority imply physicians waste their time learning about non-mental health issues at medical school, ⁿ²⁶⁷ seemingly ignoring the connection between the mind and body. They state psychologists under the New Mexico plan receive "approximately three (3) times the training pharmacology [sic] that MDs have in medical school," ⁿ²⁶⁸ but neglect the fact medical students complete approximately 2,000 hours of clinical rounds during their third and fourth years, addressing pharmacological issues with hundreds of patients; ⁿ²⁶⁹ physician assistants and nurse practitioners complete hundreds of hours of clinical internship experience, addressing pharmacological issues with hundreds of patients, which psychologists do not include in their calculations. ⁿ²⁷⁰ More importantly, these psychologists consider their time wasted if spent learning about the safe uses, interactions, and side-effects of non-psychopharmaceutical medications. ⁿ²⁷¹ While few health professionals know the characteristics of all 9,482 general medicine pharmaceuticals, ⁿ²⁷² a prescribing mental healthcare provider requires knowledge of [*516] more than just the 80 or so psychopharmaceutical medications. ⁿ²⁷³ Psychologists seeking prescriptive authority also diminish the importance of co-morbidity and argue they possess the capability to differentiate psychological disorders and medical illnesses. ⁿ²⁷⁴ These unfounded beliefs and assumptions stand as the most important reasons not to grant psychologists prescriptive authority.

Psychologists seeking prescriptive authority rely on the overly dangerous practice of assuming a behavioral problem is non-medical and waiting to see if it responds to talk or psychopharmaceutical therapy. This delay of proper medical intervention greatly jeopardizes the safety of all patients. For instance, what if the psychological symptoms mask a non-mental health illness? Can a psychologist accurately distinguish violent behavior caused by a brain tumor versus a violent personality by simply observing the patient or analyzing a blood test? What about depression that accompanies coronary heart disease (35-45%), diabetes (10-15%), cancer (almost 50% with a mental disorder), and HIV/AIDS (22-32% in United States with a mental disorder). ⁿ²⁷⁵ Is the psychologist going to determine accurately through a blood test and observation of behavior the patient has one of these diseases or any other disease? Will the psychologist take blood pressure readings, temperature, listen for heart or lung abnormalities, or perform other tests routinely performed by physicians? These are tests that can save lives if performed early in an illness by a person capable of understanding the test results. Is the psychologist going to assess the danger of Tardive Dyskinesia, blurred vision, constipation, urinary retention, dystonias, akathisia, or orthostatic hypotension through a blood test and behavior observation? ⁿ²⁷⁶ Additionally, even if the psychologist determines the behavior is not responding to treatment and may originate from a non-psychological illness, the belated medical referral causes the patient to suffer unnecessarily. Their deficient education, skill, and knowledge of recognizing non-mental health illness, accompanied by their determination that time is wasted by learning about many of the common non-psychotropic medications patients poses too great a danger for society to warrant granting psychologists prescriptive authority. They even argue, "if there is a knock on psychology, it is the lack of documentation of the skills they have in diagnosing symptoms that do not fit the psychological functioning of the patient," ⁿ²⁷⁷ but then erroneously determine "this [*517] lack of documentation is overcome by the RxP training protocol approved by APA." ⁿ²⁷⁸ Physician assistants spend more than 1,500 hours learning how to prescribe safely under the supervision of a physician, nurse practitioners spend more than 2,000 hours learning how to prescribe safely and independently, and physicians spend more than 4,000 hours learning how to diagnose and prescribe safely for a multitude of both mental and non-mental illnesses. Psychologists, however, propose to carry-out these same tasks safely with fewer than 1,000 hours of training. ⁿ²⁷⁹

D. GRANTING PRESCRIPTION PRIVILEGE WOULD NOT FILL EXISTING GAPS IN PSYCHOPHARMACEUTICAL MENTAL HEALTH TREATMENT AVAILABILITY

Psychologists seeking prescriptive authority conclude that granting them this privilege will increase patient access to psychotropic medication, especially in rural areas. ⁿ²⁸⁰ However, one state medical organization director stated, "that psychologists aren't where psychiatrists aren't," ⁿ²⁸¹ and "there is more likely to be a psychiatrist in some of the rural areas." ⁿ²⁸² This means where shortages of psychiatrists exists, shortages of psychologists also exist. Because patients have access to psychotropic medication, ⁿ²⁸³ the central mental healthcare problem faced by patients in rural areas becomes access to psychotherapy! ⁿ²⁸⁴

Psychologists seeking prescriptive authority accurately state a shortage exists of psychologists and psychiatrists in rural areas. ⁿ²⁸⁵ The data show 13.3% of very rural counties and 43.6% of all other rural counties have a psychologist. ⁿ²⁸⁶ Only 10.1% of all rural counties have a psychiatrist. ⁿ²⁸⁷ Family physicians, however, reside in one-third of the very rural counties and in two-thirds of all other rural areas. ⁿ²⁸⁸ Based on this distribution of psychologists, less than one-in-seven very rural (Group I) counties and less than half of all other rural areas (Group II) even have a psychologist. The most probable outcome of this distribution also places the bulk of prescription-writing psychologists *in urban areas* where prescription-writing healthcare providers already exist. ⁿ²⁸⁹ In the majority of rural counties, *no psychologist exists to treat patients whether possessing prescription privilege or not!* ⁿ²⁹⁰ And if a psychologist does exist, this still does not guarantee treatment will take place.

[*518] "More than 54 million Americans have a mental disorder in any given year, although fewer than 8 million seek treatment." ⁿ²⁹¹ When patients do seek treatment, they prefer meeting with primary care physicians, not psychologists. ⁿ²⁹² This is even truer in rural areas partially because of the stigma of mental illness and the general belief everyone knows everyone else's business. ⁿ²⁹³ The majority of rural counties have a family practice physician who can prescribe medication. Psychologists seeking prescriptive authority assume rural area patients lack access to psychotropic medication and would seek this treatment if made available. The unique characteristics of rural communities suggest otherwise. ⁿ²⁹⁴

Finances, however, is another issue that affects access to mental health treatment. ⁿ²⁹⁵ If patients lack access to mental health treatment because they cannot afford it, one must ask how granting psychologists prescriptive authority will fund treatment for these patients. ⁿ²⁹⁶ Psychologists seeking prescriptive authority claim they will increase access to prescription-writing mental healthcare providers for under-represented populations. ⁿ²⁹⁷ While rural residents generally lack health insurance more often than urban residents, ⁿ²⁹⁸ financial concerns also often restrict mental health treatment for under-represented populations in urban areas. ⁿ²⁹⁹ The data, however, indicate no real shortage of mental health providers who can prescribe exists in urban areas. ⁿ³⁰⁰ The problem of delay in access to treatment revolves around the fact the poor, incarcerated, and homeless comprise the majority of under-represented populations in urban areas. ⁿ³⁰¹ This raises an issue of funding, not an issue of lack of prescription-writing mental healthcare providers. Granting psychologists prescriptive authority will have little effect on increasing access to mental healthcare for rural or under-served populations.

[*519] E. GRANTING PSYCHOLOGISTS PRESCRIPTIVE AUTHORITY WOULD NOT REDUCE COSTS

Psychologists argue granting them prescriptive authority will significantly reduce mental healthcare costs. ⁿ³⁰² By utilizing the "best practice" model, ⁿ³⁰³ in which one healthcare provider offers psychotherapy and psychopharmacology, the patient has fewer treatment visits resulting in lower fees. ⁿ³⁰⁴ These psychologists state:

Significant cost savings can be obtained using "full service" professionals to provide this type of care over the split treatment model where one doctor prescribes the medication and another manages the patient's care with psychotherapy. This reduces the costs of extra consultations with doctors. It prevents costly delays in prompt treatment due to having to schedule an extra doctor appointment. Full service professional care is an added convenience to the patient by reducing doctor visits and taking time from work. ⁿ³⁰⁵

The psychologists, however, incorrectly assume patients only suffer from mental illnesses that require no medical intervention. They further claim they will reduce medical fees by recognizing psychological disorders masquerading as non-mental health illness. ⁿ³⁰⁶ What about the increase in costs and patient suffering from medical illnesses masquerading as psychological disorders? How many patients need to suffer at the hands of unqualified psychologists making wrong medical decisions before the monetary gains are outweighed? Their calculations fail to show any reduction in the savings they boast for medical errors, and they fail to include an estimate of how many patients a psychologist might expect to refer each year. ⁿ³⁰⁷ If the referral number is high, no cost savings accrue, which leaves no reason for granting this privilege. If the referral number is low, patients likely are suffering needlessly, which

presents a strong reason for not granting this privilege.

The savings boasted also rely on the assumption prescribing psychologists will not raise their fees, despite the personal increase in cost of additional education and increased liability. ⁿ³⁰⁸ Practicing psychologists, however, realistically expect fees to increase in conjunction with prescriptive authority. ⁿ³⁰⁹ Psychologists seeking such authority also assume they will pay similar malpractice rates as those paid by other non-physician prescribing professionals, yet they admit "advanced nurse practitioners, physician assistants and optometrists who prescribe all pay lower liability premiums than psychologists [pay now] for the same coverage." ⁿ³¹⁰ They conclude, "if it turned out there was a significant added risk to psychologists prescribing this cost could be passed on to those who prescribe rather than increasing the cost to all psychologists." ⁿ³¹¹ If prescribing psychologists must bear [*520] the increase without subsidy from non-prescribing psychologists, this indicates higher fees not lower ones. They further conclude, "this cost might be sustained by the insurer in order to save the contract rather than inure the cost of finding other businesses or professions to insure." ⁿ³¹² This is *very* unlikely. ⁿ³¹³ Finally, they argue the malpractice rates for prescribing psychologists may actually decrease because of a reduction in malpractice suits for sexual misconduct between psychologists who can prescribe and patients! ⁿ³¹⁴ They argue:

When examining the risk factor of prescribing psychotropics in psychiatric contracts we find the risk load on premium dollars is only about 8%. The risk load against premium for liability for sexual misconduct for a discontinued intimate relationship is much greater than the risk load for prescribing medications to patients. In counseling and psychotherapies treatment success relies heavily upon the doctor/patient relationship. When treatment founders, there is a tendency to intensify the doctor/patient relationship to overcome "therapeutic resistances." Under these circumstances both the patient and the doctor are in a vulnerable state. Resolution of the need for a greater therapeutic relationship may result in sexual intimacy creating the potential for a professional liability suit if and when the personal (sexual) relationship is discontinued. Use of psychotropic medication in a combined psychotherapy/pharmacotherapy treatment approach tends to reduce the need for intensifying the doctor/patient relationship and may reduce the risk of professional liability risk for sexual misconduct between the patient and the therapist. There are no reported data to support this hypothesis. However, there are anecdotal reports of the premiums of the nurse practitioners being lowered after they obtained prescriptive authority. ⁿ³¹⁵

Interestingly, while the psychologists know actuaries will calculate malpractice rates based on the minimal education, training, and experience of prescribing psychologists, ⁿ³¹⁶ they still offer speculative scenarios like those above. Admittedly, single-provider treatment does offer reductions in costs when provided safely, but the hypothetical cost-reduction scenarios posed by the psychologists seeking prescriptive authority clearly omit pertinent information, which legislatures need in order to make decisions in the best interests of mentally ill patients. ⁿ³¹⁷

[*521] F. WHAT EFFECT WOULD GRANTING PSYCHOLOGISTS PRESCRIPTIVE AUTHORITY HAVE ON OTHER MENTAL HEALTHCARE PROVIDERS?

Unfortunately, the psychologists seeking prescriptive authority view the situation as a "turf" war instead of what best serves the patient. ⁿ³¹⁸ They recognize that psychopharmaceutical treatment continues to gain in popularity with insurance companies and patients, and they want to ensure their place in the future of mental health treatment. ⁿ³¹⁹ Instead of working on collaborative models in which physicians prescribe medication and psychologists provide therapy, they seek to supplant psychiatry and non-prescribing psychologists by creating a "new breed" of psychologist (a.k.a. pseudo-psychiatrist). ⁿ³²⁰ They cite the tremendous shortage of psychiatrists in some areas as a reason for granting them this privilege, ⁿ³²¹ yet the data indicate psychologists tend to work in the same locations as psychiatrists. ⁿ³²² These psychologists seem willing to do away with the field of psychiatry, believing they can replace it adequately. ⁿ³²³ Managed healthcare will likely support these pseudo-psychiatrists because of lower fees. ⁿ³²⁴ Non-prescribing psychologists will become obsolete also. Middle level mental health providers will take over counseling because they are cheaper than non-prescribing psychologists. This situation drops the entire mental health profession down one

notch. Psychiatrists are gone, and psychologists become the prescription-writers.

VI. PRACTICAL, EFFECTIVE, AND SAFER ALTERNATIVES TO INCREASING MENTAL HEALTHCARE COMPARED TO GRANTING PSYCHOLOGISTS PRESCRIPTIVE AUTHORITY

Psychologists seeking prescriptive authority conclude such authority is the only possible answer to increasing access to psychotropic medication. ⁿ³²⁵ Several current trends, however, appear to offer better service and availability to rural areas. The "*integration* of mental health and general medical services in a unified clinic structure" is one current goal. ⁿ³²⁶ As the phrase implies, patients receive medical and psychological treatment in one center. ⁿ³²⁷ This may induce rural area patients to seek [*522] treatment because of potentially better anonymity due to people not knowing which service a patient enters the clinic to receive. ⁿ³²⁸ Another goal is *reaching out* through a "circuit rider" or "satellite clinics" where patients can meet for therapy. ⁿ³²⁹ *Building up* increases access to mental healthcare by making rural communities more self-reliant through the "use of natural helpers and local healers; use of paraprofessionals; use of local (non-mental health) professionals; public education; support groups and systems; and providing self-help resources." ⁿ³³⁰ *Connecting* is a fourth option used to increase availability of mental health treatment in rural areas through the use of telemedicine. ⁿ³³¹ Although still new to the field of mental health, telemedicine, in which a mental health professional works with family practice physicians to treat patients through video conferencing, is showing promising results for rural areas. ⁿ³³² Because of the extensive role family physicians play in mental healthcare in rural areas, ⁿ³³³ a collaborative approach with mental health professionals is paramount.

VII. CONCLUSION

In their desire to have legislatures grant prescriptive authority "as soon as possible," ⁿ³³⁴ psychologists seeking such authority place the health and welfare of many thousands of mentally ill patients in jeopardy. Under their plan, a psychologist determines when a patient's symptoms require medical intervention, not a physician. If psychologists fail to refer appropriately, patients suffer needlessly. If psychologists refer appropriately, patients receive the care and treatment they deserve, but this greatly diminishes one of the benefits of having prescribing psychologists.

Legislatures, understandably, rely on psychologists seeking prescriptive privileges to give truthful, straightforward interpretations. Instead they get disingenuous responses skewed to fulfill the psychologists' own agenda. ⁿ³³⁵ Psychologists have extensive training in data collection and interpretation. ⁿ³³⁶ They know to rely on one study, or even a few, for any finding is tenuous at best, and totally inappropriate when dealing with patient welfare. The PDP is a small, non-representative [*523] study with very limited results, ⁿ³³⁷ yet psychologists seeking prescriptive authority use this study to persuade legislatures to grant them prescriptive privileges. Based on this one study, these psychologists propose running a state-wide, poorly controlled, experiment on patients. ⁿ³³⁸ Using mentally ill children and elderly persons who may lack any real ability to consent to treatment and who rely on healthcare providers to act in their best interest, these psychologists will study them like "white mice" in an unprecedented social experiment. ⁿ³³⁹ New Mexico's law allows psychologists to prescribe medication with less than half of the minimum recommended education prescribed by the PDP, ⁿ³⁴⁰ and allows psychologists to eventually prescribe independently. ⁿ³⁴¹ This is a privilege severely questioned by the PDP. ⁿ³⁴² One must seriously question the ethics of the American Society for the Advancement of Pharmacotherapy and the American Psychological Association in this endeavor. ⁿ³⁴³

Psychologists seeking prescriptive authority also fail to accurately consider how many rural patients likely would receive their help. They promise eradication of mental health service shortages in rural America, but only half of these counties even have a psychologist. ⁿ³⁴⁴ Patients have access to psychotropic medication. ⁿ³⁴⁵ What they lack is access to psychotherapy! To think psychologists, with greater debt from post-graduate education and higher malpractice insurance, will flock to rural America to help patients is absurd. ⁿ³⁴⁶ With their superior abilities compared to non-prescribing psychologists, prescribing psychologists will surface in urban areas and compete with psychiatrists and non-prescribing psychologists. The psychologists' fees will increase as the population of other mental healthcare providers diminishes and managed care organizations shift their funding practices to support these new pseudo-psychiatrists.

Most disturbing about this debate is the unwillingness on the part of the psychologists seeking prescriptive authority to acknowledge a safety issue even exists. ⁿ³⁴⁷ The psychologists propose a "cram" course on pharmacology and self [*524] proclaim its adequacy. ⁿ³⁴⁸ They describe the slashing of the PDP recommendations by more than 50% as "quibbling" over ideals or even as "enhancements" to the training. ⁿ³⁴⁹ They state a concern for patient welfare but then seek prescriptive authority as a "non-debatable item," unwilling to consider more effective, safer, and practical solutions. ⁿ³⁵⁰ Their response that "it may not be perfect but it is better than what is available to most people," ⁿ³⁵¹ demonstrates their narrow perspective on this multifaceted problem. They present legislatures the issue of psychologists prescribing psychotropic medication by exclaiming "EUREKA, GOLD!" Legislatures eager to find a solution to a difficult situation understandably are lured by the psychologists' glimmering statements. Upon assaying the psychologists' arguments, however, only **Fool's Gold** appears. ⁿ³⁵² The New Mexico solution puts vulnerable mental health patients at unnecessary risk, for little overall social value, and will save far less money than proposed with untold effects on the entire mental health system. For the facts and reasons given in this Article, Legislatures should not grant psychologists prescriptive authority based on the New Mexico design.

Legal Topics:

For related research and practice materials, see the following legal topics:

EvidencePrivilegesPsychotherapist-Patient PrivilegeElementsEvidencePrivilegesPsychotherapist-Patient PrivilegeScopeHealthcare LawBusiness Administration & OrganizationLicensesRequirements

FOOTNOTES:

n1 DEPARTMENT OF HEALTH AND HUMAN SERVICES, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 45 (1999), available at <http://www.surgeongeneral.gov/library/mentalhealth/pdfs/C2.pdf>.

n2 Here, primary care physician includes family and general practice physicians.

n3 See Sara Martin, *DeLeon Elected APA President for 2000: His Agenda Calls for Implementing Others 'Good Ideas,'* 30 APA MONITOR 1 (Jan. 1999) (quoting American Psychological Association president as saying that "eighty percent of the prescriptions written for mental health disorders are written by physicians with little or no mental health training"), available at <http://www.apa.org/monitor/jan99/pat.html>; Glenn D. Walters, *A Meta-Analysis of Opinion Data on the Prescription Privilege Debate*, 42 CAN. PSYCH. 119-120 (May 2001) (stating, "physicians with no mental health expertise currently write 83% of the scripts for psychotropic medication") (citing Marc A. Zimmerman & Louis A. Wienckowski, *Revisiting Health and Mental Health Linkages: A Policy Whose Time Has Come. . . Again*, 12 J. PUB. HEALTH POLICY (1991) 510-524).

n4 See AMERICAN PSYCHIATRIC NURSES ASSOCIATION, PRESCRIPTIVE AUTHORITY FOR ADVANCED PRACTICE PSYCHIATRIC NURSES, at <http://www.apna.org/resources/positionpapers.html> (Sept. 15, 1995) [hereinafter APNA PRESCRIPTIVE AUTHORITY]; AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, INFORMATION ON PAS AND THE PA PROFESSION, at <http://www.aapa.org/geninfo.html> (last visited Nov. 9, 2003) [hereinafter AAPA INFORMATION].

n5 See AMERICAN SOCIETY FOR THE ADVANCEMENT OF PHARMACOTHERAPY, WEEKLY READER # 112, at

<http://www.apa.org/divisions/div55/WR112.html> (Sept. 10, 2001) ("Pharmacists now have prescriptive authority in 27 states using a defined protocol developed for each patient by the attending physician."); CALIFORNIA PSYCHIATRIC ASSOCIATION, PSYCHOLOGIST PRESCRIBING BILLS PSYCHOLOGISTS' CLAIMS VS. REAL FACTS, at <http://www.calpsych.org/legislation/1999/claimvsfact.html> (Mar. 3, 1998) [hereinafter CPA PSYCHOLOGIST PRESCRIBING].

n6 Here, the term "psychologist" refers to doctorate level practitioners, which includes "clinical" psychologists. The group "clinical psychologists" occasionally includes those with doctoral degrees in education counseling and school psychology, but in this Article the terms precludes those degrees.

n7 See Nancy Ann Jeffrey, *Psychologists Demand Power to Prescribe*, WALL ST. J., Apr. 10, 1998, at B1 ("Psychologists are increasingly fixated on one of psychiatrists' most valuable assets: the prescription pad.").

n8 The American Society for the Advancement of Pharmacotherapy ("ASAP") is a division of the American Psychological Association, which "was created to enhance psychological treatments combined with psychopharmacological medications." ASAP, at <http://www.apa.org/divisions/div55/ORGchrs.html> (last visited Nov. 9, 2003).

n9 The American Psychological Association ("APA") has more than 150,000 members, making it the largest association of psychologists worldwide. APA, at <http://www.apa.org> (last visited Nov. 9, 2003).

n10 See *infra* Part III.

n11 AMERICAN COLLEGE OF NEUROPSYCHOPHARMACOLOGY, DOD PRESCRIBING PSYCHOLOGISTS: EXTERNAL ANALYSIS, MONITORING, AND EVALUATION OF THE PROGRAM AND ITS PARTICIPANTS, 6 ACNP BULL. (Summer 2000), available at <http://www.acnp.org/pdffiles/vol6no3.pdf> [hereinafter ANCP DOD].

n12 See N.M. STAT. ANN. § 61-9-17.1 (repealed effective July 1, 2010) (indicating 450 didactic hours and a total of 480 hours of clinical internship hours comprise the total 930 hours of the program); APA, NEW MEXICO GOVERNOR SIGNS LANDMARK LAW ON PRESCRIPTION PRIVILEGES FOR PSYCHOLOGISTS, available at http://www.apa.org/practice/nm_rxp.html (Mar. 6, 2002) (stating that New Mexico requires psychologists to complete 450 hours of coursework, a 400 hour/100 patient practicum under physician supervision, and pass a national certification examination) [hereinafter APA Press Release].

n13 See *Bill Granting Psychologists Prescription Authority Moves Forward*, 8 CAL. HEALTH L. MONITOR 2 (June 26, 2000). See also, Charles E. Holzer III et al., *The Availability of Health and Mental Health Providers by Population Density*, Letter to the Field No. 11, at <http://www.wiche.edu/MentalHealth/Frontier/letter11.html> (last visited Nov. 9, 2003) (discussing the availability of mental health care providers in rural America); Dennis F. Mohatt, *Access to Mental Health Services in Frontier America*, Letter to the Field No. 4, at <http://www.wiche.edu/MentalHealth/Frontier/letter4.html> (last revised Nov. 4, 1997) (discussing the shortages of health care providers in

rural America).

n14 ASAP, WEEKLY READER # 115, at <http://www.apa.org/divisions/div55/WR115.html> (Oct. 21, 2001) ("The 'split' treatment model where one professional prescribes, and another provides the treatment and monitors the medical [sic] requires extra appointments at an extra cost and added inconvenience to the patient. Delays in treatment complicate recovery and add to costs.").

n15 The APA is a medical specialty society recognized world-wide. Its 37,000 U.S. and international physicians specialize in the diagnosis and treatment of mental and emotional illnesses and substance use disorders. AMERICAN PSYCHIATRIC ASSOCIATION, at <http://www.psych.org/aboutapa.cfm> (last visited Nov. 9, 2003). See also Andrew Julien, *M.D.s, Ph.D.s Prepare for Battle: Psychologists Asking Legislature's Approval to Dispense Medicine*, HARTFORD COURANT, Feb. 27, 2001, at A1 (quoting John Winston Bush, as stating prescriptive authority for psychologists "would undermine psychology's historic reliance on talk-therapy and other strategies to confront emotional and behavioral problems")

n16 PHYSICIAN'S WEEKLY, POINT/COUNTERPOINT: SHOULD PSYCHOLOGISTS HAVE PRESCRIBING PRIVILEGES?, at http://www.physweekly.com/archive/01/07_02_01/pc.html (July 2, 2001) (stating viewpoint of president of the APA).

n17 *Id.*

n18 *Id.*

n19 Julien, *supra* note 15. See generally COGNITIVE BEHAVIOR THERAPY, at <http://www.cognitivetherapy.com/index.html> (updated Nov. 5, 2002).

n20 Jack M. Geller, *The Role of Rural Primary Care Providers in the Provision of Mental Health Services: Voices from the Plains, Letter to the Field No. 10*, at <http://www.wiche.edu/MentalHealth/Frontier/letter10.html> (last visited Nov. 9, 2003); Jack M. Geller & Kyle J. Muus, *The Role of Rural Primary Care Physicians in the Provision of Mental Health Services, Letter to the Field No. 5*, at <http://www.wiche.edu/MentalHealth/Frontier/letter5.html> (last visited Nov. 9, 2003). See also *infra* Part IV.A.

n21 See *infra* Part IV.C.

n22 ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdf/vol6no3.pdf> (finding that the training program could transform licensed clinical psychologists into safe and effective prescribing psychologists, and suggesting that the participants performed well with the focus of the PDP on "the training of clinical psychologists in preparation for limited prescribing privileges").

n23 *See infra* Part V.C. The study involved an extremely small, non-representative, military population under ostensibly laboratory settings, pre-screening patients for non-psychological health problems, prohibiting treatment of children and the elderly, with the prescribing psychologists completing more than double the education and training currently required.

n24 PHYSICIAN'S WEEKLY, *supra* note 16, at http://www.physweekly.com/archive/01/07_02_01/pc.html (quoting Russ Newman, Ph.D., J.D., Executive Director for Professional Practice, American Psychological Association).

n25 *See infra* Part V.B.

n26 *See infra* Part III. (detailing the weight given to non-medical, behavioral sciences by undergraduate and graduate psychology degree programs).

n27 APA, PRESCRIPTIVE AUTHORITY FOR PSYCHOLOGISTS: AN UPDATE FROM APA, at <http://www.apa.org/apags/profdev/rxpauthority.html> (Winter 2002) (discussing, in part, the PDP study's findings that psychologists can be effectively trained to prescribe safely).

n28 *See, e.g.*, Judith Felson Duchan, Graduation Speech, *Learning and Leveling Learning*, available at <http://www.acsu.buffalo.edu/duchan/leveling.html> (May 12, 2001) (describing the medical model as "a way of thinking...[that presumes] that the physician's task is to diagnose diseases, to discover their causes and symptoms, and design treatments. . . . The medical model is made up of causal chains, of primary, secondary, and tertiary causes.").

n29 *Compare infra* Part II.C., with *infra* Part III.

n30 *Cf. infra* Part III. (referring to psychologists' lack of medical training).

n31 *See infra* Part V.D. (arguing that a grant of prescriptive authority to psychologists cannot overcome social and geographic impediments to care).

n32 *E.g.*, SOUTH CAROLINA STATE BUDGET AND CONTROL BOARD, OFFICE OF RESEARCH & STATISTICS, SOUTH CAROLINA RURAL HEALTH REPORT, at http://www.ors2.state.sc.us/rural_health.asp (last visited Nov. 9, 2003) (describing the largest towns in rural communities as having populations of less than 25,000 as compared to populations of 10,000 or less in the largest towns in very rural communities).

n33 *See infra* notes 159-60, 169-71 and accompanying text. This statement assumes perfect distribution of only one psychologist or physician per county.

n34 *See infra* note 288, 292 and accompanying text.

n35 *See generally*, Courtenay M. Harding et al. *Problems Faced by Consumers of Mental Health Services out in a Frontier Community; Letter to the Field No. 23*, at <http://www.wiche.edu/MentalHealth/Frontier/letter23.html> (last visited Nov. 9, 2003).

n36 *See infra* Part V.E.

n37 *See* Jack G. Wiggins, *Increasing Access to Mental Health Care, Improving Quality of Care and Reducing Costs through Prescriptive Authority for Licensed Psychologists with Specialty Training*, at <http://www.apa.org/divisions/div55/AHCCCS.htm> (last visited Nov. 13, 2003) (discussing cost saving potentials for the state of Arizona if psychologists were granted prescriptive authority). *See also infra* Part V.E. for a discussion on whether granting psychologist prescriptive authority will reduce costs generally.

n38 ASAP, WEEKLY READER # 123, at <http://www.apa.org/divisions/div55/WR123.html> (Feb. 7, 2002) (quoting survey results of Brian Ramirez, doctoral candidate at Wright State University).

n39 *Id.* "Only 6% of respondents disagreed or strongly disagreed and 9% were neutral." *Id.* Fifty-five percent of the same psychologists "agreed or strongly agreed that they would be willing to pay higher malpractice rates for RxP [prescriptive authority]." *Id.* Only "30% disagreed or strongly disagreed with the statement, and 15% were neutral." *Id.*

n40 While the New Mexico law allows prescribing psychologists to order necessary tests, many of these psychologists will have to order blood tests, urine tests, electroencephalograms, electrocardiograms, and the like, outside of their office. Family practice physicians' offices are set up to conduct many such tests without requiring an additional office visit. *See infra* Part V.E., for a discussion on the difficulty patients and psychologists will face if patients' mental illnesses require additional medical intercession.

n41 Who will monitor medication for patients requiring maintenance treatment? Patients will likely see their family physicians more often

than their psychologists after treatment, yet patients will now have to see their psychologists, on separate appointments, and miss work for medication level monitoring. In addition to reducing costs, physicians are the better choice for this monitoring because of their expertise. This becomes even more evident for patients requiring blood serum level monitoring (e.g., mood stabilizers such as Lithium, Carbamazepine, or Divalproex). See John Preston, *Quick Reference to Psychotropic Medication, 2003 Update*, ASAP, available at <http://www.apa.org/divisions/div55/PrestonMedicationCard2003.pdf> (last visited Nov. 9, 2003). See *infra* Part V.E., for a discussion on the probability patients will have to see both a psychologist and a physician if the former prescribes medication.

n42 Wiggins, *supra* note 37, at <http://www.apa.org/divisions/div55/AHCCCS.htm>.

n43 See *infra* Part V.E., for a discussion on increased patient costs as a result of additional medical appointments and the likelihood that psychologists will increase their fees to offset the expense of their additional education and increased liability.

n44 See, e.g., Myrle Croasdale, *Prescribing Rights Dominate Scope-of-Practice Bills: The Debate Over Passage Pits Psychiatrist Against Allied Professionals*, AM. MED. NEWS, available at <http://www.ama-assn.org/amednews/2003/04/14/prsc0414.htm> (Apr. 14, 2003) ("Even in Chicago's suburbs, the wait to see a psychiatrist is six weeks to two months."); Andis Robeznieks, *Psychologists See Rural Areas as Entry Point to Prescribing*, AM. MED. NEWS, available at <http://www.ama-assn.org/amednews/2002/12/02/prl21202.htm> (Dec. 2, 2002) ("With less than a dozen psychiatrists to serve the rural communities in the western part of the state, officials with both the Nebraska Medical Assn. and Nebraska Psychiatric Society acknowledge that the state is in the midst of a mental health crisis--in both rural and urban areas.").

n45 See Wiggins, *supra* note 37, at <http://www.apa.org/divisions/div55/AHCCCS.htm> ("Psychology is proposing to enhance the quality of mental health services and expand access to care by integrating cognitive behavioral therapy with psychopharmacology. This is known as the 'best practices' model of mental health treatment since it combines the two forms of treatment demonstrated to be effective."). Wiggins' description of combining talk therapy with psychopharmacology is the job description of a psychiatrist. See *infra* Parts V.E.-F., for mention of the best practice model and the role of psychiatrists in the healthcare profession.

n46 See *infra* Parts II.A., III, and V.B., for a comparison of educational and experiential requirements for psychiatrist and prescribing psychologists.

n47 See Holzer et al., *supra* note 13, at <http://www.wiche.edu/MentalHealth/Frontier/letter11.html> (discussing distribution of mental health providers by population, indicating high employment overlap for health care providers in heavily populated geographical areas, moderate overlap in suburban areas, and the absence of psychiatrists, the paucity of psychologists, and virtual non-existence of family practice physicians in one-third of counties for very rural areas); *infra* Part IV.A. (comparing practitioners in metropolitan and non-metropolitan areas).

n48 See Letter from E. Mario Marquez, Clinical Psychologist, to Gary E. Johnson, Governor, New Mexico, ASAP, available at <http://www.apa.org/divisions/div55/RxPResources.htm> (Feb. 23, 2002) (citing a September 2000 article in the Albuquerque Journal stating that "22 child psychiatrists have left New Mexico, leaving the state with a number that is half the national average," and "the NM Psychiatric Association's membership declined by about 50 psychiatrists during the previous five years"). Psychiatrists are already leaving some less populated states such as New Mexico. Regardless of why these psychiatrists chose to leave, increasing competition will only cause more to

leave. *See infra* Part V.F. (discussing the effect on other mental healthcare providers).

n49 *See* Holzer et al., *supra* note 13, at <http://www.wiche.edu/MentalHealth/Frontier/letter11.html>.

n50 *See infra* Part V.F.

n51 *See infra* Parts II.B.-C. (indicating physician assistants and nurse practitioners require the least amount of training while possessing some psychopharmaceutical prescriptive authority).

n52 *See infra* Part V.F.

n53 *See infra* text accompanying notes 239-40, 250-55.

n54 N.M. STAT. ANN. § 61-9-17 (repealed effective July 1, 2010). *See also* APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n55 *See infra* text accompanying notes 297, 302, 314-15.

n56 To work under a physician, psychologists should be required to complete the same prerequisites, course work, and clinical practicum experience required for physician assistants. *See infra* text accompanying notes 85-87. Alternatively, psychologists should be required to complete the same prerequisites, course work, and clinical practicum experience required for nurse practitioners. *See infra* text accompanying notes 92-94, 96, 98. Readers should take the phrase "prescribe independently" to mean that 10% of all prescriptions made are reviewed by a physician who may alter the prescription. Similar regulations applying to nurses with prescriptive authority should apply to psychologists. *See infra* notes 102-03 and accompanying text.

n57 *See, e.g.*, CAL. BUS. & PROF. CODE § 2501 (West 2003). In this Article, the term "physician" includes allopathic and osteopathic practitioners, and the term "psychiatrist" includes all sub-specialties within the field.

n58 *Id.*

n59 *See infra* notes 82-83, 100-05 and accompanying text.

n60 *Compare* STANFORD UNIVERSITY, SCHOOL OF MEDICINE CATALOG, MD PROGRAM, *available at* <http://www.med.stanford.edu/school/catalog/bookone/mdprogram.html> (last visited Nov. 9, 2003) [hereinafter STANFORD MD PROGRAM], *and* STANFORD UNIVERSITY, SCHOOL OF MEDICINE CATALOG, MD CURRICULUM, *available at* <http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html> (last visited Nov. 9, 2003) [hereinafter STANFORD MD CURRICULUM], *with* UNIVERSITY OF CALIFORNIA SAN DIEGO, SCHOOL OF MEDICINE, CATALOG, 2002-03, *available at* <http://meded.ucsd.edu/Catalog/56.html> (last visited Nov. 9, 2003) (requiring similar prerequisites--chemistry, biology and physics--and similar graduation requirements) [hereinafter UCSD MEDICINE CATALOG].

n61 *See, e.g.*, SAN DIEGO STATE UNIVERSITY CATALOG, SPRING 2002 CLASS SCHEDULE, *available at* <http://www.sdsu.edu/cgi-bin/schedule/semester=spring02> (last visited Nov. 9, 2003) (indicating prerequisite courses for medical school require 40 units of science course work) [hereinafter SDSU CATALOG SPRING 2002].

n62 *E.g.*, STANFORD MD PROGRAM, *supra* note 60, at <http://www.med.stanford.edu/school/catalog/bookone/mdprogram.html>; STANFORD MD CURRICULUM, *supra* note 60, at <http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html>.

n63 *E.g.*, UCSD MEDICINE CATALOG, *supra* note 60, at <http://meded.ucsd.edu/Catalog/56.html>.

n64 *Id.*

n65 "The Medical College Admission Test (MCAT) is a standardized, multiple-choice examination designed to assess problem solving, critical thinking, and writing skills in addition to the examinee's knowledge of science concepts and principles prerequisite to the study of medicine. Scores are reported in each of the following areas: Verbal Reasoning, Physical Sciences, Writing Sample, and Biological Sciences." ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ABOUT THE MCAT, *at* <http://www.aamc.org/students/mcat/about/start.htm> (last visited Nov. 9, 2003).

n66 "In 2000, the average GPA for medical school matriculants [was] 3.6, continuing an upward trend since the 1980s. MCAT scores for each of the testing categories (verbal reasoning, physical sciences, and biological sciences) [were] either on par or better than last year." AMERICAN ASSOCIATION OF MEDICAL COLLEGES, U.S. MEDICAL SCHOOL APPLICANTS STILL EXCEED AVAILABLE POSITIONS: UNDERREPRESENTED MINORITY APPLICANTS INCREASE FOR THE FIRST TIME SINCE 1996, *at* <http://www.aamc.org/newsroom/pressrel/2000/001025.htm> (Oct. 25, 2000).

n67 *E.g.*, STANFORD MD CURRICULUM, *supra* note 60, at <http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html> (listing the course requirements on range of courses in human physiology and biology, including molecular biology, human genetics, immunology, endocrinology, psychiatry and other relevant courses, such as Health Care Systems and Health Policy, and Physicians and Patients).

n68 *Id.* (requiring a total of 10 units of pharmacology, 9 units of nervous system, and 5 units of psychiatry in the first two years of study).

n69 UCSD, SCHOOL OF MEDICINE, CATALOG, 2002-03, CURRICULUM: THE NEVER ENDING DIALOGUE, *available at* <http://medschool.ucsd.edu/Catalog/08.html> (last visited Nov. 13, 2003) (indicating the Social and Behavioral Science course "looks at the patient as a person, with all that implies, but also as a unique 'biopsychosocial matrix' with a history and a future").

n70 *See, e.g.*, STANFORD MD CURRICULUM, *supra* note 60, at <http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html>.

n71 The exam is called the United States Medical Licensing Examination ("USMLE"). Results of the USMLE "are reported to medical licensing authorities in the United States and its territories for use in granting the initial license to practice medicine" and are used to "assess a physician's ability to apply knowledge, concepts, and principles that are important in health and disease and that constitute the basis of safe and effective patient care." USMLE-UNITED STATES MEDICAL LICENSING EXAMINATION, *at* <http://www.usmle.org> (last visited Nov. 13, 2003).

n72 *E.g.*, ARIZ. REV. STAT. ANN. § 32-1402 (West 2002); CAL. BUS. & PROF. CODE § 2001 (West 2003). For a list of state medical licensing boards and links to their webpages, see ADMINISTRATORS IN MEDICINE, *at* <http://www.docboard.org> (last visited Nov. 9, 2003).

n73 *See, e.g.*, MEDICAL BOARD OF CALIFORNIA, *at* <http://www.medbd.ca.gov> (last visited Nov. 9, 2003) ("The Medical Board of California is the State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.").

n74 *See, e.g.*, ARIZ. REV. STAT. ANN. § 32-1403 (West 2002); CAL. BUS. & PROF. CODE § 2089; GA. CODE ANN. § 43-34-27 (2002).

n75 *See, e.g.*, CAL. BUS. & PROF. CODE § 2089.

n76 *See, e.g., id.*

n77 *E.g.,* UCSD, DEPARTMENT OF PSYCHIATRY, RESIDENCY CURRICULUM, *at* <http://psychiatry.ucsd.edu/residencyCurriculum.html> (last visited Nov. 13, 2003).

n78 " Residency education is the period of clinical education in a medical specialty that follows graduation from medical school, and prepares physicians for the independent practice of medicine." ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION, *at* <http://www.acgme.org> (last visited Nov. 9, 2003) (giving definition under heading "About the ACGME").

n79 *See, e.g.,* AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC., GENERAL INFORMATION, WHAT IS AN APBN BOARD-CERTIFIED PSYCHIATRIST?, *at* http://207.229.182.32/geninfo/what_psychiatrist.html (last visited Nov. 9, 2003).

n80 *See* CPA PSYCHOLOGIST PRESCRIBING, *supra* note 5, *at* <http://www.calpsych.org/legislation/1999/claimvsfact.html> (comparing psychologists' four years of graduate school and one year of clinical training to psychiatrists' four years of medical school and additional four years of residency training).

n81 AAPA INFORMATION, *supra* note 4, *at* <http://www.aapa.org/geninfo.html>.

n82 AAPA, PHYSICIAN ASSISTANTS AS PRESCRIBERS OF CONTROLLED MEDICATIONS, *at* <http://www.aapa.org/gandp/control.html> (last revised June 2, 2003) [hereinafter AAPA PA PRESCRIBERS].

n83 *Id.*

n84 *See id.* (stating that with prior experience in health care field consequently comes prior training and/or clinical experience in pharmacology).

n85 *Id.* (including biology, biochemistry, organic chemistry, physiology, microbiology and mathematics courses).

n86 *Id.* (discussing the similarities between a physician assistant program and medical school).

n87 *See, e.g.*, UNIVERSITY OF WISCONSIN-MADISON, PHYSICIAN ASSISTANT PROGRAM, EMPLOYMENT GUIDE AND RESOURCES, available at <http://www.medsch.wisc.edu/pa/employment/employment.html> (last updated Feb. 2003).

n88 AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, PHYSICIAN ASSISTANT EDUCATIONAL PREPARATION FOR PRESCRIBING, at <http://www.aapa.org/gandp/pharmpre.html> (last revised July 16, 2003).

n89 AAPA PA PRESCRIBERS, *supra* note 82.

n90 *See* ASSOCIATION OF POSTGRADUATE PHYSICIAN ASSISTANT PROGRAMS, AAPAP PROGRAMS BY SPECIALTY, at http://www.aappap.org/prog_specialty.html (last visited Nov. 12, 2003) (listing graduate specialties).

n91 *Compare supra* note 87 and accompanying text, with sources cited *supra* note 12.

n92 *Compare* SAN DIEGO STATE UNIVERSITY SCHOOL OF NURSING, at <http://www.rohan.sdsu.edu/dept/chhs/nursing/index.html> (last visited Nov. 9, 2003) (listing course and grade requirements for its nursing school under "Preparation for Major & Sequence of Courses"), with STANFORD MD CURRICULUM, *supra* note 60, at <http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html>, and SDSU CATALOG SPRING 2002, *supra* note 61, at <http://www.sdsu.edu/cgi-bin/schedule/semester=spring02> (listing course and grade requirements of respective medical schools).

n93 *See, e.g.*, SAN DIEGO STATE UNIVERSITY SCHOOL OF NURSING, *supra* note 92, at <http://www.rohan.sdsu.edu/dept/chhs/nursing/index.html> (indicating care systems).

n94 *Id.* (stating the SDSU nursing program requires "a minimum of 45 upper division units in nursing" and 10 units in natural science and 16 pre-requisite science courses, amounting to 1,065 hours of education based on the medical model). This time does not include labs and clinical internship hours. *Compare* SAN DIEGO STATE UNIVERSITY, GENERAL CATALOG 2001-02, at <http://coursecat.sdsu.edu/0102/index.html> (Apr. 16, 2001), with STANFORD MD CURRICULUM, *supra* note 60, at <http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html> (listing the requirements for a medical degree).

n95 *Compare* SAN DIEGO STATE UNIVERSITY SCHOOL OF NURSING, *supra* note 92, at <http://www.rohan.sdsu.edu/dept/chhs/nursing/index.html>, with APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html (detailing course hour requirements).

n96 See AMERICAN NURSES ASSOCIATION, STATES WHICH RECOGNIZE CLINICAL NURSE SPECIALIST IN ADVANCED PRACTICE, at <http://www.nursingworld.org/gova/charts/cns.htm> (last updated Feb. 1, 2000).

n97 AMERICAN NURSES CREDENTIALING CENTER, FREQUENTLY ASKED QUESTIONS ABOUT ANCC CERTIFICATION, at <http://www.nursingworld.org/ancc/certification/cert/certfaqs.html> (last visited Nov. 9, 2003).

n98 *Id.*

n99 *Id.*

n100 *E.g.*, ARK. CODE ANN. § 17-87-310 (Michie 1987); COLO. REV. STAT. ANN. § 12-38-111.6 (West 2002); HAW. REV. STAT. ANN. § 457-8.6 (Michie 2002); IND. CODE ANN. § 25-23-1-19.5 (West 2001); KEN. REV. STAT. ANN. § 314.042 (Michie 2001); N.M. STAT. ANN. § 61-3-23.2 (Michie 2002); VA. CODE ANN. § 54.1-2957.01 (Michie 2002); W. VA. CODE ANN. § 30-7-15a (Michie 2002). See ANA, 2000 PRESCRIPTIVE AUTHORITY CHART, at <http://www.nursingworld.org/gova/charts/dea.htm> (revised Feb. 1, 2000) (displaying the type of nurse practitioner, permitted drug schedule, and whether a practice agreement, collaboration, or required protocol to prescribe exists for each state) [hereinafter ANA CHART].

n101 See, *e.g.*, 21 U.S.C.A. § 812(b) (1999) (giving criteria for controlled drugs Schedules I-V, Schedules I and II having high abuse potential); ARK CODE ANN. § 17-87-310 (Michie 2002) (limiting the prescriptive authority of nurses to Schedules III-V drugs); COLO. REV. STAT. ANN. § 12-36-106.3 (West 2002) (requiring a collaborative agreement with a physician); CONN. GEN. STAT. § 20-87a (West 1999) (requiring a special procedure for a nurse to prescribe drugs from Schedules II and III); ILL. COMP. STAT. § 65/15-20 (West 1993) (requiring a mid-level practitioner controlled substance license to prescribe drugs from Schedules III-V); IND. CODE ANN. § 25-23-1-19.4 (West 2001) (requiring a collaborative agreement); KEN. REV. STAT. ANN. § 314.042 (Michie 2001) (requiring a collaborative agreement); ANA CHART, *supra* note 100, at <http://www.nursingworld.org/gova/charts/dea.htm>.

n102 See ANA CHART, *supra* note 100, at <http://www.nursingworld.org/gova/charts/dea.htm>; AMERICAN ACADEMY OF NURSE PRACTITIONERS, DATA AND SURVEY INFORMATION, at <http://www.aanp.org/Practice+Policy+and+Legislation/Regulation/DEARegulation/DEA.asp> (last visited Nov. 10, 2003) (linking to Nurse Practitioner Prescriptive Authority) [hereinafter AANP DATA].

n103 See ANA CHART, *supra* note 100, at <http://www.nursingworld.org/gova/charts/dea.htm>.

n104 See GA. CODE ANN. § 16-13-72 (2003); ANA CHART, *supra* note 100, at <http://www.nursingworld.org/gova/charts.dea.htm>; AANP DATA, *supra* note 102, at <http://www.aanp.org/Practice+Policy+and+Legislation/Regulation/DEARegulation/DEA.asp>.

n105 ARIZ. ADMIN. CODE R4-19-507 (2003); ARIZONA NURSE PRACTITIONER CONNECTION, ARIZONA NURSE PRACTITIONER SCOPE OF PRACTICE, at <http://aznpconnection.netfirms.com/azscope.htm> (last visited Nov. 12, 2003) (stating that a nurse practitioner has a generalized ethical and moral duty to discuss a patient's care with a qualified practitioner if there is any doubt about what care is optimal, but is no longer legally required to supply the name of the consulted practitioner).

n106 See *supra* note 96 and accompanying text.

n107 See sources cited *supra* note 100.

n108 "Medical science courses" refers to college biology, college general and organic chemistry, calculus, physics, physiology, anatomy, microbiology, biochemistry, and all advanced courses within these areas of study. See *supra* notes 62-63, 68-70, 85-87, 92-94 and accompanying text. In comparison, behavioral science courses focus on the identification, cause, and treatment of behavioral disorders, not requiring completion of medical science courses. See *infra* notes 259-60 and accompanying text.

n109 See *supra* Parts II.A.-C.

n110 *Id.*

n111 *Id.*

n112 See *infra* Part III.

n113 See, e.g., UNIVERSITY OF ARIZONA, 2002-03 GENERAL CATALOG, BACHELOR OF ARTS -- PSYCHOLOGY, available at <http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBAxxxx.html> (last updated Oct. 30, 2003) [hereinafter ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY]; CALIFORNIA STATE UNIVERSITY, FRESNO, 2003-04 GENERAL CATALOG, DEPARTMENT OF PSYCHOLOGY, available at <http://www-catalog.admin.csufresno.edu/current/pdf/psych.pdf> (last visited Nov. 12, 2003) [hereinafter CSU, FRESNO CATALOG-PSYCHOLOGY].

n114 *See, e.g.*, CSU, FRESNO CATALOG-PSYCHOLOGY, *supra* note 113, at <http://www-catalog.admin.csufresno.edu/current/pdf/psych.pdf> (stating that...education requirement); CALIFORNIA STATE UNIVERSITY, FRESNO, 2003-04 GENERAL CATALOG, GENERAL EDUCATION, *at* <http://www-catalog.admin.csufresno.edu/current/gened.html> (last visited Nov. 12, 2003) (indicating general quantitative reasoning) [hereinafter CSU, FRESNO CATALOG-GENERAL].

n115 *Id.* (showing that CSU, Fresno, like the majority of universities, considers psychology to be a behavioral science, and does not accept psychology courses in satisfaction of natural and physical science course requirements).

n116 *See infra* Part III. (discussing the increased difficulty of science courses taken by science majors (e.g., biology, chemistry) compared to non-major science courses). Physicians and physician assistants most often take the same science courses as science majors. Nursing students, however, may fulfill their organic chemistry and a few of their biology prerequisites with organic chemistry and biology courses falling outside the science major requirements.

n117 *See, e.g.*, CSU, FRESNO CATALOG-GENERAL, *supra* note 114, at <http://www-catalog.admin.csufresno.edu/current/gened.html> (explaining that a student may complete undergraduate science requirements with only 12 units of science courses, including one upper division science class).

n118 *See, e.g.*, ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY, *supra* note 113, at <http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBAxxxx.html>; CSU, FRESNO CATALOG-PSYCHOLOGY, *supra* note 113, at <http://www-catalog.admin.csufresno.edu/current/pdf/psych.pdf>.

n119 *See, e.g.*, ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY, *supra* note 113, at <http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBAxxxx.html> (explaining that the psychobiology and neuroscience requirements can be satisfied with non-medical related courses); UNIVERSITY OF ARIZONA, 2002-03 GENERAL CATALOG, FALL 2002 COURSE DESCRIPTIONS, *at* <http://catalog.arizona.edu/2002-03/courses/024/PSYC.html> (last updated Feb. 13, 2003).

n120 *See supra* Parts II.A.-C., explaining medical, physician assistant, and nursing student programs all require a uniformed set of pre-requisite and co-requisite science courses for graduation.

n121 *See, e.g.*, UNIVERSITY OF WISCONSIN-MADISON, DEPARTMENT OF PSYCHOLOGY, FREQUENTLY ASKED QUESTIONS, *at* <http://psych.wisc.edu/ugstudies/topten.html> (last updated Apr. 3, 2003); UNIVERSITY OF WISCONSIN-MADISON, DEPARTMENT OF PSYCHOLOGY, REQUIREMENTS FOR THE MAJOR, *at* <http://psych.wisc.edu/ugstudies/requirementsPost2001.html> (last updated Apr. 3, 2003).

n122 Students earning BS degrees in psychology with a science minor at the University of Arizona, for example, complete 18-22 science

units for the minor as well as additional science units required for the major, bringing the total to approximately 27 science units for completion of the BS degree. *See* UNIVERSITY OF ARIZONA, 2003-04 GENERAL CATALOG, BACHELOR OF SCIENCE-PSYCHOLOGY, *available at* <http://www.arizona.edu/academic/oncourse/data/034/A8zPSYCzBSxzx.html> (last updated Nov. 5, 2003) (outlining the "supporting science requirement" of additional coursework in mathematics, biology and chemistry or physics); UNIVERSITY OF ARIZONA, 2003-04 GENERAL CATALOG, DEPARTMENT OF PSYCHOLOGY, *available at* <http://catalog.arizona.edu/2003-04/dept/PSYC.shtml> (last updated June 6, 2003) (stating that the BS in psychology is a "science-intensive major," requiring both a science minor and additional coursework in mathematics, biology, and chemistry or physics); UNIVERSITY OF ARIZONA, 2003-04 GENERAL CATALOG, MINOR REQUIREMENT REPORTS, *available at* <http://www.arizona.edu/academic/oncourse/data-minors/interface/> (last updated Oct. 8, 2003) (providing links stating that to complete the science minors requirement for a Bachelor of Science in Psychology students must complete 18-22 units).

n123 CSU, FRESNO, 2001-02 GENERAL CATALOG, ACADEMIC REGULATIONS, *available at* <http://www-catalog.admin.csufresno.edu/archives/0102/acadreg.html> (last visited Nov. 10, 2003) (defining double-counting as "allowing one course to fulfill two separate requirements concurrently; e.g., allowing one course to fulfill both a major requirement and the upper-division writing skills requirement, or allowing one course to fulfill both a major requirement and General Education requirement").

n124 Students may graduate with Bachelor of Science of Psychology degrees having taken few medically related science courses. *See* ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY, *supra* note 113, at <http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBAxzx.html>.

n125 *See, e.g., id.* (requiring only 3 units from psychobiology & neuroscience distribution).

n126 *See* UNIVERSITY OF ARIZONA, 2002-03 GENERAL CATALOG, DEPARTMENT OF PSYCHOLOGY, *available at* <http://catalog.arizona.edu/2002-03/dept/PSYC.shtml> (last updated Mar. 12, 2002) ("BS students are required to select a minor in one of the following areas: Biochemistry, Computer Science, Ecology and Evolutionary Biology, Mathematics, Molecular and Cellular Biology, Physics, or the Pre-Health Professions minor.") [hereinafter ARIZONA CATALOG-PSYCHOLOGY].

n127 *See supra* Parts II.A.-C.

n128 *See, e.g.,* PETERSON'S GRADUATE & PROFESSIONAL PROGRAMS: AN OVERVIEW (37th ed. 2003). *See generally* EDUCATIONAL TESTING SERVICE, GRADUATE RECORD EXAMINATION, FREQUENTLY ASKED QUESTIONS ABOUT THE NEW GENERAL TEST, *at* <http://www.gre.org/faqnew.html> (last updated July 15, 2003) (explaining the general format of the test, what it measures, how it is scored, and other information for potential test takers); ETS, GRE, COMPUTER BASED GENERAL TEST DESCRIPTION, *at* <http://www.gre.org/cbtttest.html#description> (last updated June 23, 2003).

n129 PETERSON'S GRADUATE & PROFESSIONAL PROGRAMS: AN OVERVIEW, *supra* note 128.

n130 *E.g.*, CSU, FRESNO, GRADUATE PROGRAMS, DEPARTMENT OF PSYCHOLOGY, *available at* <http://psych.csufresno.edu/psychweb/graduate> (last visited Nov. 10, 2003) (link to Master of Arts degree requirements) [hereinafter CSU, FRESNO GRADUATE-PSYCHOLOGY].

n131 *Id.* (link to M.S. degree requirements); UNIVERSITY OF ARIZONA, GRADUATE CATALOG 2003-04, REQUIREMENTS FOR MASTER'S DEGREES, *available at* <http://grad.admin.arizona.edu/catalog/masters/> (last visited Nov. 12, 2003) (stating that minimum of 30 units of graduate work, including thesis, is required for master of science degree).

n132 CSU, FRESNO GRADUATE-PSYCHOLOGY, *supra* note 130, at <http://psych.csufresno.edu/psychweb/graduate> (linking to requisite courses in the programs).

n133 *Id.*

n134 ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY, *supra* note 113, at <http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBSxzxxx.html>.

n135 *Compare* UNIVERSITY OF ARIZONA, DEPARTMENT OF PSYCHOLOGY, CURRICULUM, CLINICAL PSYCHOLOGY PROGRAM, *at* <http://psych.arizona.edu/clinical/curriculum.html> (last visited Nov. 10, 2003) (listing the required courses for a degree in clinical psychology), *with* COLUMBIA UNIVERSITY, HEALTH SCIENCES CURRICULUM ONLINE, *at* http://www.columbia.edu/itc/hs/medical/histology/course_online/index.html (last visited Nov. 10, 2003) (listing the required courses for a medical doctorate), *and* COLUMBIA UNIVERSITY SCHOOL OF NURSING, ENTRY TO PRACTICE PRORGAM FOR NON-NURSE COLLEGE GRADUATES, *at* <http://www.healthsciences.columbia.edu/dept/nursing/academics-programs/etp.html> (last visited last update July 2003) (listing the required course for a nursing degree), *and* EASTERN VIRGINIA MEDICAL SCHOOL, *at* <http://www.evms.edu/hlthprof/mpa/curriculum.html> (last revised Apr. 15, 2003) (listing the required courses necessary for obtaining Master of Physician Assistant degree).

n136 *See, e.g.*, UNIVERSITY OF ARIZONA, GRADUATE PROGRAMS, CLINICAL PSYCHOLOGY, *at* http://www.psychology.arizona.edu/programs/g_each/clinical.php?option=2 (last updated Oct. 20, 2003).

n137 *E.g.*, ALLIANT INTERNATIONAL UNIVERSITY, CALIFORNIA SCHOOL OF PROFESSIONAL PSYCHOLOGY, *at* <http://www.alliant.edu/cspp/psydcn.htm> (last modified June 13, 2003).

n138 *Id.*; ARIZONA CATALOG-PSYCHOLOGY, *supra* note 126, at <http://catalog.arizona.edu/2002-03/dept/PSYC.shtml>.

n139 Psychiatrists oppose granting psychologists prescriptive authority because the emphasis of training in psychology is on a behavioral model that severely lacks adequate educational and experiential training in non-mental health issues. Ultimately, psychologists lack any understanding of non-mental health illnesses. Whether they can prescribe psychotropic medication safely is irrelevant. *See, e.g.*, CPA PSYCHOLOGIST PRESCRIBING, *supra* note 5, at <http://www.calpsych.org/legislation/1999/claimvsfact.html> (arguing that psychiatrists and physicians are trained to treat biological illness and chemical imbalances as opposed to psychologists who are trained to treat human behavior).

N.M. STAT. ANN. § 61-9-3(D) (repealed effective July 1, 2004) (defining the "practice of psychology" as "the observation, description, evaluation, interpretation and modification of human behavior by the application of psychological principles, methods and procedures for the purpose of preventing or eliminating symptomatic, maladaptive or undesired behavior and of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health and mental health . . . including psychological testing or neuropsychological testing and the evaluation or assessment of personal characteristics[,] . . . counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, behavior analysis and therapy; diagnosis and treatment of any mental and emotional disorder or disability, alcoholism and substance abuse, disorders of habit or conduct and the psychological aspects of physical illness, accident, injury and disability; and psychoeducational evaluation, therapy, remediation and consultation"). *Compare* N.M. STAT. ANN. § 61-3-3 (repealed effective July 1, 2004), *with* N.M. STAT. ANN. § 61-3-3(K) (Michie 1978) (defining "professional registered nursing" as "requiring substantial knowledge of the biological, physical, social and behavioral sciences and nursing theory...[including] establishing a nursing diagnosis . . . [and] collaborating with other health care professionals in the management of health care"), *and* N.M. STAT. ANN. § 61-3-3(L) (Michie 1978). *See also supra* Part II.B.

n140 *See supra* Part II.

n141 *E.g.*, CAL. BUS. & PROF. CODE § 2903 (West 2003).

n142 *E.g., id.* § 2961.

n143 *See, e.g., id.* § 101.6 (describing as one purpose of the board to "register or otherwise certify persons in order to identify practitioners and ensure performance according to set and accepted professional standards").

n144 *See, e.g.*, CALIFORNIA BOARD OF PSYCHOLOGY, MANDATORY CONTINUING EDUCATION REQUIREMENTS, at <http://www.psychboard.ca.gov/licensing/education.html> (last visited Nov. 10, 2003) (requiring 36 hours of continuing education between licensing periods).

n145 APNA PRESCRIPTIVE AUTHORITY, *supra* note 4, at <http://www.apna.org/papers/positionpapers.html> ("In increasing numbers, states are legislating prescriptive practice authority for advanced practice nurses . . . to increase access to health care and to utilize nurses to their full capacity as accessible, cost effective, full service providers."); AAPA INFORMATION, *supra* note 4, at <http://www.aapa.org/geninfo1.html> (stating that the purpose in creating physician assistant position was to supplement the need for primary care physicians).

n146 *See* APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n147 *Id.*

n148 James A. Ciarlo, et al., *Focusing on "Frontier": Isolated Rural America, Letter to the Field No. 2*, at <http://www.wiche.edu/MentalHealth/Frontier/letter2.html> (last revised Apr. 11, 1996).

n149 *Id.* (defining and classifying rural areas).

n150 FEDERAL OFFICE OF RURAL HEALTH POLICY, FACTS ABOUT . . . RURAL PHYSICIANS, at http://www.shepscenter.unc.edu/research_programs/rural_program/phy.html (last visited Nov. 10, 2003).

n151 *Id.*

n152 *Id.*

n153 See Holzer et al., *supra* note 13, at <http://www.wiche.edu/MentalHealth/Frontier/letter11.html>; Geller & Muus, *supra* note 20, at <http://www.wiche.edu/MentalHealth/Frontier/letter5.html>; Mohatt, *supra* note 13, at <http://www.wiche.edu/MentalHealth/Frontier/letter4.html>.

n154 Holzer et al., *supra* note 13, at <http://www.wiche.edu/MentalHealth/Frontier/letter11.html> (referring to chart at figure 1).

n155 See Richard Sherer, *Mental Health Care Shortages Will Need Creative Solutions*, PSYCHIATRIC TIMES (Sept. 2001) (on file with author) ("A given community is designated as underserved when it has '(a) a population-to-core mental health professional ratio greater than or equal to 6,000:1 and a population-to-psychiatrist ratio greater than or equal to 20,000:1, or (b) a population-to-core-professional ratio greater than or equal to 9,000:1, or (c) a population-to-psychiatrist ratio greater than or equal to 30,000:1,' according to BPHC [Bureau of Primary Health Care] guidelines.").

n156 Mohatt, *supra* note 13, at <http://www.wiche.edu/MentalHealth/Frontier/letter11.html>.

n157 See Holzer et al., *supra* note 13, at <http://www.wiche.edu/MentalHealth/Frontier/letter11.html>; Geller & Muus, *supra* note 20, at <http://www.wiche.edu/MentalHealth/Frontier/letter5.html>.

n158 See *id.* (citing Darrel A. Regier et al., *The De Facto US Mental Health Services System: A Public Health Perspective*, 35 ARCHIVES GEN. PSYCHIATRY 685, 688 (1978)).

n159 Holzer et al., *supra* note 13, at <http://www.wiche.edu/MentalHealth/Frontier/letter11.html>.

n160 *Id.*

n161 *Id.*

n162 *Id.*

n163 *Id.*

n164 *Id.*

n165 *Id.*

n166 *Id.*

n167 *Id.*

n168 *Id.*

n169 *Id.* (defining psychologist as "M.A. or greater psychologists working in health-related settings by population per square mile"). These percentages obviously decrease by removing masters-level psychologists from consideration for prescriptive authority.

n170 *See id.*

n171 *Id.*

n172 *Id.*

n173 *See* Editorial, *Ignoring Mental Illness in Kids*, CHI. TRIB., July 23, 2001, available at 2001 WL 4096611; *Culture Counts in Mental Health Services and Research Finds New Surgeon General Report*, U.S. NEWSWIRE, Aug. 26, 2001, available at 2001 WL 21897399; Allison Sherry, *Mentally Ill Swamp ER Staffs: Some Fear Treatment of Other Cases Impaired*, DENV. POST, Aug. 27, 2001, available at 2001 WL 6760857; NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL, BASICS OF HOMELESSNESS, at http://www.nhchc.org/Publications/basics_of_homelessness.htm (last updated Apr. 7, 2003) [hereinafter NHCHC].

n174 *See* NHCHC, *supra* note 173, at http://www.nhchc.org/Publications/basics_of_homelessness.htm.

n175 Holzer et al., *supra* note 13, at <http://www.wiche.edu/MentalHealth/Frontier/letter11.html>.

n176 *Id.*

n177 *Id.*

n178 *See supra* notes 173-74 and accompanying text.

n179 See Ronald E. Fox, & Morgan T. Sammons, *A History of Prescription Privileges*, 29 APA MONITOR ONLINE (Sept. 1998), available at <http://www.apa.org/monitor/sep98/prescrip.html>.

n180 *Id.*

n181 See Ronald F. Levant, *We Have Come a Long Way: The Prescriptive Authority Initiative*, 32 MONITOR ON PSYCHOL. (Nov. 2001), available at <http://www.apa.org/monitor/nov01/sp.html>.

n182 See ASAP, at <http://www.apa.org/divisions/div55/> (last visited Nov. 10, 2003).

n183 *E.g.*, H.B. 139, 1999 Leg., 21st Sess. (Ala. 1999); S.B. 777, 1995-96 Reg. Sess. (Cal. 1995); S.B. 2050, 1997-98 Reg. Sess. (Cal. 1997); S.B. 202, 145th Gen. Assemb., 1999-00 Reg. Sess. (Ga. 1999); H.B. 353, 1999 Gen. Assemb., 1999-00 Reg. Sess. (Ga. 1999); H.B. 1311, 1997 19th Leg. (Haw. 1997); S.B. 1402, 1999 91st Gen. Assemb., 1999-00 Reg. Sess. (Ill. 2000); H.B. 1736, 1999 91st Gen. Assemb. (Ill. 1999); S.B. 677, 1999 Reg. Sess. (La. 1999); H.B. 1286, 1999 Reg. Sess. (La. 1999).

n184 " Legislation has been introduced in nine states: AK, CA, FL, IL, GA, HI, LA, MO and MT (although the MT bill was not supported). Of these, Louisiana has made the most progress." Carol Williams-Nickelson, *Prescription Privileges Fact Sheet: What Students Should Know About the APA's Pursuit of Prescription Privileges for Psychologists (RxP)*, at <http://www.apa.org/apags/profdev/prespriv.html> (last visited Nov. 10, 2003).

n185 N.M. STAT. ANN. § 61-9-17 (repealed effective July 1, 2010).

n186 See Julien, *supra* note 15; AMERICAN PSYCHIATRIC ASSOCIATION, STATE OF THE STATES: PSYCHOLOGISTS' PRESCRIBING PRIVILEGES, at http://www.psych.org/pub_pol_adv/statecostex.cfm (March 2003) (discussing assistance of grassroots advocacy efforts to oppose prescriptive authority for psychologists); ASAP, ASAP READER # 125, at <http://www.apa.org/divisions/div55/ASAPReader125.htm> (Mar. 27, 2002) (listing the Committee Against Medicalizing Psychology as one of the organizations opposing prescriptive authority for psychologists in New Mexico).

n187 See discussion *supra* Part III.

n188 See Letter from E. Mario Marquez, *supra* note 48, at <http://www.apa.org/divisions/div55/RxPResources.htm>.

n189 *See supra* Part II.A.

n190 *See supra* Part III.

n191 *See generally* discussion *supra* Part III.

n192 *See, e.g.*, Julien, *supra* note 15 (quoting president of the Connecticut Psychological Association, arguing that because of the close psychologist-patient relationship, psychologists are "in an ideal position to make judgments about these medications--and to monitor it").

n193 *See* Geller, *supra* note 20, at <http://www.wiche.edu/MentalHealth/Frontier/letter10.html> ("At that time [1978], . . . approximately 60 percent of the total persons affected by mental disorders sought treatment in a primary care setting. Subsequent studies have continued to affirm the presence and importance of this. . . .").

n194 *See id.*; sources cited *supra* note 3.

n195 *See* STANFORD MD CURRICULUM, *supra* note 60, at <http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html>.

n196 *See* W. Eugene Broadhead et al., *Tricyclic Antidepressant Prescribing Nonpsychiatric Disorders: An Analysis Based on Data from the 1985 National Ambulatory Medical Care Survey*, 33 J. FAM. PRAC. 24 (1991); Arnold Feldman, *The Family Practitioner As Psychiatrist*, 135 AM. J. PSYCHIATRY 728 (1978); L. Ralph Jones et al., *Mental Health Training of Primary Care Physicians: An Outcome Study*, 18 INT'L J. PSYCHIATRY MED. 107, 119 (1988); Harold A. Pincus et al., *Models of Mental Health Training in Primary Care*, 249 JAMA 3065, 3065, 3067-68 (1983); Marc A. Zimmerman & Louis A. Wienckowski, *Revisiting Health And Mental Health Linkages: A Policy Whose Time Has Come . . . Again*, 12 J. PUB. HEALTH POL. 510, 519 (1991).

n197 Susan M. Anderson & Barbara Herr Harthorn, *The Recognition, Diagnosis, and Treatment of Mental Disorders by Primary Care Physicians*, 27 MEDICAL CARE 869, 881-82 (1989).

n198 *Id.* at 882.

n199 Geller, *supra* note 20, at <http://www.wiche.edu/MentalHealth/Frontier/letter10.html>.

n200 *See supra* text accompanying note 198.

n201 *See supra* Part III. This is the crucial fact distinguishing psychologists from other prescribing healthcare providers (physician assistants and nurse practitioners) discussed in this Article.

n202 ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>.

n203 *Id.*

n204 APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html (emphasis added) (quoting Russ Newman, the Executive Director for Professional Practice, American Psychological Association). *See also*, Letter from E. Mario Marquez, *supra* note 48, at <http://www.apa.org/divisions/div55/RxPResources.htm> (asserting that the PDP "project *proved* that psychologists could be trained to safely and effectively prescribe psychotropics to their patients) (emphasis added)).

n205 *See* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf> (stating that the PDP participants "performed with excellence wherever they were placed," and that the graduates "filled different niches and brought unique perspectives to their various assignments").

n206 *See infra* text accompanying note 228.

n207 *See* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>.

n208 *Id.* (representing a 23% attrition rate in Table 1).

n209 *Id.*

n210 *Id.* (referring to Table 2's didactic curriculum for the PDP groups for a breakdown of courses and hours).

n211 *Id.* (comparing Group A's curriculum to Groups B, C, and D's coursework in Table 2).

n212 *Id.* Groups B, C, and D "took a combination of four standard USUHS Medical School core courses, five modified and abbreviated Medical School courses taught by Medical School faculty, and two Graduate School of Nursing (GSN) courses . . . , including interviewing, history taking, and physical examination. The total didactic instruction for the final class was approximately 700 hours, and curriculum differences from Group B-to-C-to-D were relatively minor." *Id.*

n213 *Id.* (stating that Group A's practicum was closely linked with the psychiatry residency program).

n214 *Id.* (discussing the Clinical Practicum Program).

n215 *Id.* (prescribing 41 psychotropic medications for diagnoses including: substance abuse, non bi-polar disorder major depression, generalized anxiety, panic, obsessive-compulsive and post traumatic stress disorders, schizophrenia spectrum, dysthymia, anorexia/bulimia, and somatiform disorder).

n216 *Id.* (describing Group B's rotations in psychiatry clinic and consultation/liaison services, Groups C and D's rotations including psychiatry and psychology clinics, emergency room call training, biological psychiatry seminars, and case conferences).

n217 *Id.* (referring to Table 1).

n218 *Id.* (describing the practice profiles of the graduates).

n219 *Id.*

n220 *Id.* ("All graduates were initially proctored by psychiatrists. Half of them had advanced to independent provider status with its standard minimum review of 10% of medication cases.").

n221 *Id.* ("The PDP was not designed to replace psychiatrists or produce mini-psychiatrists or psychiatrist extenders, and it did not do so. Instead, the program 'products' were extended psychologists with a value-added component prescriptive authority provides. They continued to function very much in the traditions of clinical psychology (psychometric tests, psychological therapies) but a body of knowledge and experience was added that extended their range of competence.").

n222 *Id.* ("On posts where there was a shortage of psychiatrists, the graduates tended to work side-by-side with psychiatrists, performing many of the same functions a 'junior psychiatrist' might perform. . . . "They [the psychologists] essentially mirrored what psychiatrists did with the same population, and, in fact, they differed little from the private practices of the psychiatrists on the Evaluation Panel.").

n223 *Id.*

n224 *Id.*

n225 *Id.* "Two of these chiefs completed their PDP training less than a year earlier. Other indicators of quality and achievement that characterized this cohort were present when they entered the program. They all had not only a doctorate in clinical psychology but also clinical experience that ranged from a few to more than 10 years. All but two had military experience." *Id.*

n226 *Id.* "They generally had minimal education in the traditional premedical courses." *Id.* Unfortunately, with such a small sample size, only a few science courses for one or two participants could make a significant difference in outcome reports.

n227 *Id.* See *supra* text accompanying note 210 (indicating that despite the a limited background in pre-medical courses, two of the ten participants (20%) completed an additional 700 hours of medical school science courses compared to the other participants. Thus, the Group A psychologists overcame any deficit in their science backgrounds).

n228 *Id.*

n229 *Id.*

n230 *Id.* (stating that the curriculum was adapted to the proposed role of a prescribing psychologist after evaluating Group A's performance).

n231 *Id.*

n232 *Id.* (listing other professionals who would benefit from training (psychiatric nurses who hold a masters of science in nursing, M.D. practitioners who have little clinical experience in psychiatric treatment, and those holding doctorates in clinical pharmacy)).

n233 Rebecca A. Clay, *State Leaders Convene in Washington, D.C.: Meeting Emphasizes Organizational and Advocacy Issues*, 29 APA MONITOR No. 4 (Apr. 1998), available at <http://www.apa.org/monitor/apr98/state.html> (indicating there were 70,000 licensed psychologists in 1995).

n234 *See* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf> (referring to Table 2)

n235 *Id.* ("Eight out of ten [of the graduates] were serving as chiefs or assistant chiefs of an outpatient psychology clinic or a mental health clinic.").

n236 *Id.*

n237 *See supra* text accompanying note 11; Letter from E. Mario Marquez, *supra* note 48, at <http://www.apa.org/divisions/div55/RxPResources.htm>.

n238 *See* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>.

n239 *See* Letter from E. Mario Marquez, *supra* note 48, at <http://www.apa.org/divisions/div55/RxPResources.htm> (citing facts about the lack of treatment of children as part of psychologists' intention to treat this population).

n240 *See* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>.

n241 *Id.* (discussing the need to shorten and tailor certain courses in the medical school didactic program to reflect the "specific needs of prescribing psychologists").

n242 *Id. Contra* ASAP, WEEKLY READER # 105, at <http://www.apa.org/divisions/div55/WR105.html> (May 31, 2001) (responding to accusation that the new American Psychological Association's didactic standard recommendation of 300 didactic hours is inadequate).

n243 ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>.

n244 Letter from E. Mario Marquez, *supra* note 48, at <http://www.apa.org/divisions/div55/RxPResources.htm> (overstating the number of credit hours by 20% when claiming that "approximately 36 graduate semester credit hours" are required).

n245 *See* N.M. STAT. ANN. § 61-9-17.1 (repealed effective July 1, 2010); APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n246 *See* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>; *infra* text accompanying notes 250-54. *Compare* APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html, with text accompanying text *supra* notes 211, 229.

n247 *See supra* text accompanying note 11; Letter from E. Mario Marquez, *supra* note 48, at <http://www.apa.org/divisions/div55/RxPResources.htm>.

n248 *See* ASAP, WEEKLY READER # 105, *supra* note 242, at <http://www.apa.org/divisions/div55/WR105.html> (explaining that the original Department of Defense program was not designed to train psychologists, but rather had to be modified many times); ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>.

n249 *See* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>.

n250 *Compare id.* (requiring 712 didactic hours for the PDP), with Letter from E. Mario Marquez, *supra* note 48, at <http://www.apa.org/divisions/div55/RxPResources.htm> (requiring 450 didactic hours for New Mexico). The New Mexico requirement equals only 63% of the PDP didactic requirements.

n251 *See supra* text accompanying note 229.

n252 *See* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>; ASAP, WEEKLY READER # 125, *supra* note 186, at <http://www.apa.org/divisions/div55/ASAPReader125.htm> (alleging that the New Mexico clinical practicum translates into approximately one year and one-half of experience with new patients rather than merely four months). John Winston Bush's approximation of four months appear more realistic based on 400 hours equaling 20% of a normal 2,000-hour work year amounting to ten weeks (two and one-half months) of fulltime work. Although unrealistic for educational purposes, a psychologist could easily treat 100 patients in this time and receive permission to prescribe medications though totally unqualified to do so. Also, the PDP psychologists average about 13 patients per month, whereby they could see 100 patients in less than eight months. *Id.* Either scenario allows completion of training in less than the one year recommended by the PDP. *See supra* text accompanying note 230.

n253 *See* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6/no3.pdf>.

n254 *See* N.M. STAT. ANN. § 61-9 (repealed effective July 1, 2010); ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>.

n255 *See* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>.

n256 *See* ASAP, ASAP READER # 123, *supra* note 38, at <http://www.apa.org/divisions/div55/WR123.htm> (quoting from Brian Ramirez's survey results that 40% of practicing psychologists would seek additional training if given prescriptive authority). With only 40% indicating a desire to gain this privilege, there is no indication or guarantee of how many of these practitioners would be willing to work in rural areas, especially with the likely increase in debt from the additional education requirements.

n257 *See supra* text accompanying notes 229, 242.

n258 *See* ASAP, ASAP READER # 124, at <http://www.apa.org/divisions/div55/ASAPReader124.html> (Mar. 11, 2002) (arguing that psychologists' doctorates should be taken into account in determining the amount of medical education necessary to ensure that medications are prescribed safely). *Contra*, CPA PSYCHOLOGIST PRESCRIBING, *supra* note 5, at <http://www.calpsych.org/legislation/1999claimvsfact.html> (arguing that psychologists have an average of five years of full-time training including only one year of clinical work).

n259 PHYSICIAN'S WEEKLY, *supra* note 16, at http://www.physweekly.com/archive/01/07_02_01/pc.html ("Psychologists' education

deals with human behavior--not human biology and pathology. They can earn a PhD by taking a single course in the biological basis of behavior."). *See, e.g.,* ARIZONA 2002-03 CATALOG, BA-PSYCHOLOGY, *supra* note 113, at <http://www.arizona.edu/academic/oncourse/data/024/A8zPSYCzBAxzx.html> (requiring two natural science courses at a level below college biology, one nature science course like ecology or geology, one mathematics course like intermediate algebra and one psychobiology course). Thus, a student can graduate without taking one basic college science course (i.e. college level chemistry, biology, physics or calculus). UNIVERSITY OF ARIZONA, GRADUATE PROGRAMS, CLINICAL PSYCHOLOGY PROGRAMS, CURRICULUM INFORMATION OF THE CLINICAL PSYCHOLOGY PROGRAM, *available at* http://psychology.arizona.edu/programs/g_each/clinical.php?option=4 (last updated Oct. 20, 2003) (stating that although the doctorate in clinical psychology requires psychology-related science courses, students are not required to take any basic college health science courses).

n260 CPA PSYCHOLOGIST PRESCRIBING, *supra* note 5, at <http://www.calpsych.org/legislation/1999/claimvsfact.html> (emphasis added).

n261 N.M. STAT. ANN. § 61-9 (repealed effective July 1, 2010) (referring to the entire article called the "Professional Psychologist Act"). *See* APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n262 *Compare* N.M. STAT. ANN. § 61-9-17.1(5)-(6) (repealed effective July 1, 2010) (indicating a total didactic and practicum education requirement of 930 hours for granting psychologists prescriptive authority), *with* CAL. BUS. & PROF. CODE § 2089 (West 2003) (indicating a 4,000-hour class and practicum minimum education requirement for physician licensure). Psychologists get only 23.35% (930 versus 4,000 hours) of the training required of a licensed physician). The physicians' time does not include prerequisite and residency education and experience. The psychologists' time ignores any medical science background. *See* discussion *supra* Parts II. & III.

n263 *See* ASAP, ASAP READER # 124, *supra* note 258, at <http://www.apa.org/divisions/div55/ASAPReader124.html>.

n264 *Compare* discussion *supra* Part II.B., *and* discussion *supra* Part II.C., *with* discussion *supra* Part III.

n265 ASAP, WEEKLY READER # 107, at <http://www.apa.org/divisions/div55/WR107.html> (June 28, 2001) (stating that psychologists are properly trained to distinguish between psychological and physiological illnesses when symptoms are present that do not fit within the psychological profile, but need medical consultation to diagnose or treat the illness).

n266 LEARNING DISABILITIES ASSOCIATION OF ONTARIO, at http://www.ldao.on.ca/ldao_projects/pei/defsupp/e8.html (last visited Nov. 13, 2003) ("Comorbidity is described as a situation where two or more conditions that are diagnostically distinguishable from one another tend to occur together.").

n267 *See* ASAP, WEEKLY READER # 105, *supra* note 242, at <http://www.apa.org/divisions/div55/WR105.html> (responding to criticism that the PDP recommended 712 hours of instruction while the APA recommended only 300 hours, citing the conclusion that the many hours

of medically related training were unnecessary).

n268 *Id.*

n269 STANFORD MD CURRICULUM, *supra* note 60, at <http://www.med.stanford.edu/school/catalog/bookone/mdcurriculum.html>.

n270 *See supra* Parts II.B.-C.

n271 *See supra* note 258 and accompanying text.

n272 Associated Press, *Prescription Drug Costs Surge--Again*, at <http://www.cnn.com/2002/HEALTH/03/29/prescription.spending.ap/> (Mar. 29, 2002) (stating there are 9,482 drugs on the retail market).

n273 *See* ASAP, WEEKLY READER # 105, *supra* note 242, at <http://www.apa.org/divisions/div55/WR105.html> ("The goal of this intense APA program focuses on the FDA approved psychoactive medications, which currently numbers about 80 drugs, rather than the thousand or more drugs currently used in general medicine today."). *See* Preston, *Quick Reference to Psychotropic Medication*, *supra* note 41, at <http://www.apa.org/divisions/div55/PrestonMedicationCare2003.pdf>, for a list of the current psychotropic medications commonly used.

n274 *See, e.g.*, ASAP, WEEKLY READER # 107, *supra* note 265, at <http://www.apa.org/divisions/div55/WR107.html>.

n275 *See* HEALTH RESOURCES AND SERVICES ADMINISTRATION, BUREAU OF PRIMARY HEALTH CARE, MENTAL HEALTH IN PRIMARY CARE, at <http://www.bphc.hrsa.gov/bphc/mental/Default.htm> (last visited Nov. 13, 2003) ("Numerous studies demonstrate excess mortality, morbidity, and health care use for those with mental health and substance abuse disorders. . . . The relationships between mental health and physical health are complex, and the excess morbidity and mortality cannot be completely explained by behavioral factors. There are several examples of a [sic] physical health issues that demonstrate this complexity. Depression has been the most widely examined of these relationships.").

n276 *See* Preston, *supra* note 41, at <http://www.apa.org/divisions/div55/PrestonMedicationCare2003.pdf>.

n277 ASAP, WEEKLY READER # 107, *supra* note 265, at <http://www.apa.org/divisions/div55/WR107.html>.

n278 *Id.*

n279 See APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n280 Rebecca Kayo et al., *Advancing the Profession: A Prescription for Success*, available at <http://www.apa.org/apags/profdev/advancingprof.html> (last visited Nov. 13, 2003).

n281 Sherer, *supra* note 155 ("States with the lowest ratios of psychiatrists-to-population also have low ratios of psychologists-to-population. Mississippi has only 11.3 psychologists per 100,000 population, roughly one-third of the national ratio.").

n282 *Id.*

n283 See *supra* Part IV.

n284 *Id.*

n285 See Norine G. Johnson, *Psychology Builds a Healthy World: Bringing It All Together*, 2 ASAP TABLET 1, 1-2 (Feb. 20, 2001), available at <http://www.apa.org/divisions/div55/Tablet%2010/01/index.html>; ASAP, WEEKLY READER # 115, *supra* note 14, at <http://www.apa.org/divisions/div55/WR115.html>.

n286 See Holzer et al., *supra* note 13, at <http://www.wiche.edu/mentalhealth/frontier/letter11.html>.

n287 See *id.*

n288 *Id.*

n289 *Id. See infra* Part V.F.

n290 APA, PRACTICE DIRECTORATE OFFICE OF RURAL HEALTH, APA RURAL HEALTH INITIATIVE: 1999 YEAR IN REVIEW, at <http://www.apa.org/rural/report99.html> (last visited Nov. 13, 2003) ("The Center for Mental Health Services reports that 55% of U.S. counties are not served by a psychologist, psychiatrist, or social worker and all of the counties are rural/frontier.").

n291 DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 1, at <http://www.surgeongeneral.gov/library/mentalhealth/pdfs/C2.pdf>.

n292 *See* Holzer et al., *supra* note 13, at <http://www.wiche.edu/MentalHealth/Frontier/index.htm>.

n293 *See* Harding et al., *supra* note 35, at <http://www.wiche.edu/MentalHealth/Frontier/letter11.html>.

n294 *Id.*

n295 *See, e.g.*, UNIVERSITY OF MINNESOTA, SCHOOL OF MEDICINE DULUTH, CENTER FOR RURAL MENTAL HEALTH STUDIES, at http://penguin.d.umn.edu/Departments/Rural_Mental_Health/home.htm (last modified Oct. 30, 2000) ("Financial barriers exist due to inadequacies in health insurance coverage and large numbers of rural residents with incomes below the poverty level.").

n296 *See* CME INC., RESOURCES, MENTAL HEALTH INFORMATION AND STATISTICS, at <http://www.mhsource.com/resource/mh.html> (last visited Nov. 13, 2003) (referring to the high costs of mental health treatment, its effects on society, and the importance of health insurance); *Ignoring Mental Illness in Kids*, *supra* note 173 (discussing cost impediments to child mental healthcare); NHCHC, *supra* note 173, at http://www.nhchc.org/Publications/basics_of_homelessness.htm (discussing costs associated with mental health treatment for the homeless).

n297 *See Bill Granting Psychologists Prescription Authority Moves Forward*, *supra* note 13; Wiggins, *supra* note 37, at <http://www.apa.org/divisions/div55/AHCCCS.htm>.

n298 AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, HEALTH CARE COSTS AND FINANCING, at <http://www.ahrq.gov/research/jan98/ra2.htm#head3> (last visited Nov. 13, 2003).

n299 *See* sources cited *supra* note 296.

n300 *See supra* Part IV.A.

n301 *See* sources cited *supra* note 296.

n302 *See* Wiggins, *supra* note 37, at <http://www.apa.org/divisions/div55/AHCCCS.htm>.

n303 *Id.*

n304 *Id.* ("Savings in salaries of psychologists compared to those of psychiatrists are estimated at \$ 0.7 Million" annually, in regard to eliminating the need for a psychiatry consultation.).

n305 *Id.*

n306 *Id.*

n307 *Id.* (referring to Appendix 1).

n308 *Id.*

n309 ASAP, ASAP READER # 123, *supra* note 38, at <http://www.apa.org/divisions/div55/WR123.html> (quoting Brian Ramirez's survey results).

n310 *Id.* (referring to comments by Dr. Wiggins).

n311 *Id.*

n312 *Id.*

n313 *See id.* (noting that 85% of the psychologists surveyed agreed that malpractice rates would increase as a result of obtaining prescriptive authority); ASAP, WEEKLY READER # 115, *supra* note 14, at <http://www.apa.org/divisions/div55/WR115.html> ("There is a shortage of mental health specialists who can prescribe.").

n314 ASAP, WEEKLY READER # 109, at <http://www.apa.org/divisions/div55/WR109.html> (July 18, 2002).

n315 *Id.*

n316 *Id.* ("Regardless of a theoretical prediction of lowered rates of liability premiums for psychologists who prescribe, the professional liability premiums of psychologists will be determined by the experience of the insurance market place.").

n317 *See* Wiggins, *supra* note 37, at <http://www.apa.org/divisions/div55/AHCCCS.htm> (hypothesizing savings by the State of Arizona if psychologists were given prescriptive authority without addressing aspects of higher fees and insurance premiums).

n318 *See* ASAP, WEEKLY READER # 118, at <http://www.apa.org/divisions/div55/WR118.html> (Nov. 21, 2001) ("Mental health care is now a turf issue based on an entrenched mental health system dominated by medical values of care with medical doctors doing what they know best.").

n319 *See* Mark Olfson et al., *National Trends in the Outpatient Treatment of Depression*, 287 JAMA 203, 206 (2002) (indicating an increased acceptance of the use of medication for the treatment of mental disorders).

n320 ASAP, ASAP READER # 124, *supra* note 258, at <http://www.apa.org/divisions/div55/ASAPReader124.html> ("The future of psychiatry was held in the balance. The expansion of the scope of practice of psychological treatments for mental conditions was at its threshold.").

n321 ASAP, ASAP READER # 123, *supra* note 38, at <http://www.apa.org/divisions/div55/WR123.html>.

n322 Theresa Prescott, *Patients Lose If Psychologists Prescribe*, 36 PSYCHIATRIC NEWS 24 (Aug. 3, 2001), available at <http://pn.psychiatryonline.org/cgi/content/full/36/15/24>.

n323 *See* ASAP, ASAP READER # 123, *supra* note 38, at <http://www.apa.org/divisions/div55/WR123.html>.

n324 *See* Williams-Nickelson, *supra* note 184, at <http://www.apa.org/apags/profdev/prespriv.html>.

n325 *See* ASAP, WEEKLY READER # 90, at <http://www.apa.org/divisions/div55/WR90.html> (Sept. 4, 2000).

n326 *See* Jack M. Geller et al., *Frontier Mental Health Strategies: Integrating, Reaching Out, Building Up, and Connecting, Letter to the Field No. 6*, at <http://www.wiche.edu/MentalHealth/Frontier/letter6.html> (last visited Nov. 13, 2003) (emphasis added).

n327 *See* Ali Hashmi, *Commentary: The Prescription Jihad*, 18 PSYCHIATRIC TIMES (July 2001), available at <http://www.psychiatrictimes.com/p010720.html>.

n328 *See* Geller & Muus, *supra* note 20, at <http://www.wiche.edu/MentalHealth/Frontier/letter5.html> ("Some rural residents will not seek or utilize mental health care because of a lack of anonymity in treatment, the stigma associated with treatment, and clashes between treatment and traditional rural values such as independence and privacy." (citation omitted)).

n329 Geller et al., *supra* note 326, at <http://www.wiche.edu/MentalHealth/Frontier/letter6.html>.

n330 *Id.*

n331 *Id.* Telemedicine is the "practice of healthcare delivery, diagnosis, consultation, treatment and transfer of medical data and education using telecommunications." *Id.*

N332 *See* Sherer, *supra* 155.

n333 *See supra* Part IV.A.

n334 ASAP, WEEKLY READER # 90, *supra* note 325, at <http://www.apa.org/divisions/div55/WR90.html> ("There is a clear understanding that we are attempting to get RxP legislation introduced in as many states as possible, as soon as possible. . . . This is no secret and is consistent with APA policy, APA Council actions, CAPP, PEPTO and why Division 55 has the acronym ASAP. This message needs to get out to the membership as a non-debatable item.").

n335 *Id.*

n336 *See, e.g.*, UNIVERSITY OF ARIZONA 2003-04 GENERAL CATALOG, FALL 2003 COURSE DESCRIPTIONS, *available at* <http://catalog.arizona.edu/2003-04/courses/034/PSYC.html#GRAD> (last updated Aug. 7, 2003).

n337 *See* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6/no3/pdf>; *supra* Part V.B.

n338 *See* N.M. STAT. ANN. § 61-9 (repealed effective July 1, 2010); APA Press Release, *supra* note 12, at http://www.apa.org/practice/nm_rxp.html.

n339 Seldom are organizations permitted to experiment on the society as a whole to test a hypothesis (such as whether psychologists can prescribe safely in rural America) independently without significant safeguards and preparation.

n340 *See* APA Press Release, *supra*, note 12. *Compare* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf>, *with supra* text accompanying notes 229-30.

n341 N.M. STAT. ANN. § 61-9-17 (repealed effective July 1, 2010). *See* APA Press Release, *supra*, note 12, at http://www.apa.org/practice/nm_rxp.html.

n342 *See supra* text accompanying note 228.

n343 *See, e.g.*, APA, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT § 1.14, *available at* <http://www.apa.org/ethics/code1992.html#1.14> (last visited Nov. 13, 2003) ("Psychologists take reasonable steps to avoid harming their patients or clients, research participants, students, and others with whom they work, and to minimize harm where it is foreseeable and unavoidable."); APA, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT § 6.06, *available at* <http://www.apa.org/ethics/code1992.html#6.06> (last visited Nov. 13, 2003) (revised in 2002 with differences in language).

n344 *See supra* Part IV.

n345 *See supra* notes 157-58, 162 and accompanying text.

n346 *See supra* Part V.F.

n347 *See* ASPA, ASAP READER # 124, *supra* note 258, at <http://www.apa.org/divisions/div55/ASAPReader124.html> ("The New Mexico psychologists to the end always took the high road and argued their case on its merits rather than trying to create political pressure under the guise of unsupported public safety issues," implying the issues of drug interactions, drug overdose, drug side-effects, and a concern for a lack of sufficient education are 'unsupported public safety issues.'").

n348 *But see* ACNP DOD, *supra* note 11, at <http://www.acnp.org/pdffiles/vol6no3.pdf> ("Virtually all graduates of the PDP considered the 'short-cut' programs proposed in various quarters to be ill-advised. Most, in fact, said they favored a 2-year program much like the PDP program conducted at Walter Reed Army Medical Center, but with somewhat more tailoring of the didactic training courses to the special needs, and skills of clinical psychologists. Most said an intensive full-time year of clinical experience, particularly with inpatients, was indispensable.").

n349 *See* ASAP, WEEKLY READER # 118, *supra* note 318, at <http://www.apa.org/divisions/div55/WR118.html> ("We may quibble over whether ideally we should have more of this and less of that in this APA psychologically-oriented postdoctoral psychopharmacology curriculum. We may wish to tweak the model to enhance training in other ways."). From their recommendations "quibble" and "enhance" means to reduce the minimum recommendation of the PDP by more than 50%! *See supra* text accompanying notes 229-30.

n350 *See supra* Part V.F. (recommending a collaborative approach along with other effective, safe alternatives to granting psychologists prescriptive authority).

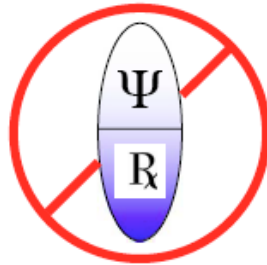
n351 ASAP, WEEKLY READER # 118, *supra* note 318, at <http://www.apa.org/divisions/div55/WR118.html>.

n352 *See* THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 1427 (4th ed. 2000) (defining iron pyrite as a "brass-colored mineral" also known as "**fool's gold**").

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PSYCHOLOGISTS OPPOSED TO PRESCRIPTION PRIVILEGES FOR PSYCHOLOGISTS

Annotated Bibliography of Articles and Readings
That Raise Concerns About Prescription Privileges for Psychologists

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Annotated Bibliography of Articles and Readings That Raise Concerns About Prescription Privileges for Psychologists

Overview: This annotated bibliography was created by Psychologists Opposed to Prescription Privileges for Psychologists (POPPP). It is intended to give the reader ready access to concerns that have been raised in the professional literature of Psychology, as well as more broadly in nursing and law. Some of the information is taken verbatim from the texts and abstracts. At times, editorial emphasis and commentary are provided by using bold print or by inserting text in brackets. The reader is encouraged to become more familiar with these concerns so as to consider key issues that raise questions about the prudence of granting psychologists prescription privileges. Follow the contents above is an index that may be used to address some specific issues that are part of this controversy.

1. American College of Neuropsychopharmacology (2000). DoD prescribing psychologists external analysis, monitoring, and evaluation of program and its final report. *American College of Neuropsychopharmacology Bulletin*, 6, Retrieved on January 15, 2007 from <http://www.acnp.org/Docs/BulletinPdfFiles/vol6no3.pdf>.

Reports an evaluation of the performance of 10 psychologists trained in a pilot project to prescribe in the military. Prescribing was limited to adults 18 to 65 years old who already have been medically cleared by a physician, and therefore may have less pathology than non-screened patients. The 2-year, full-time training program included 712 classroom hours on medical didactics and a year of supervised practice in a military hospital with routine physician back-up.

All 10 of the prescribing psychologists who were trained recommended *against* any reduction in required training. Most said an intensive full-time year of clinical experience, particularly with inpatients, was indispensable. They also favored a structured 2-year program, such as theirs *at a medical hospital* for training psychologists. The Evaluation Panel heard much skepticism from psychiatrists, physicians, and some of the graduates who participated in the program about whether prescribing psychologists could safely and effectively work as independent practitioners in the civilian sector. **[Despite such considerations, the APA model *in fact* decreased the training required to prescribe from that of the PDP, and effectively deleted the prerequisites.]**

The Final Report of the American College of Neuropsychopharmacology on the PDP assessed graduates "for the most part highly esteemed, valued, and respected, there was essentially unanimous agreement that the **graduates were weaker medically than psychiatrists.**" Their medical knowledge was variously judged as on a level of students rather than physicians.

The report indicated that some graduates had limited formularies, and continued to have dependent prescriptive practice (i.e., supervised by a physician). PDP participants were

atypical of psychologists in that eight out of 10 had leadership positions. **[It would not be appropriate to assume that the experiences of a skewed population would be fully predictive of training for less accomplished psychologists].**

The report emphasized,

“it will be *essential* to select trainee psychologists **with an adequate background** for advanced training in psychopharmacology. Two areas are particularly important--a preparatory science background and competence in clinical nosology. In order to study pharmacology at the advanced level needed to manage pharmacotherapies, **trainees must have a background in chemistry, biology and mathematics.** Chemistry should include post-baccalaureate biochemistry and the necessary preparation for a course at this level. Typically, this would include undergraduate general and organic chemistry. Biology should include undergraduate level general biology, vertebrate and human anatomy, and other course work adequate for a post-baccalaureate level course in mammalian physiology. It would be important for the graduate physiology course to contain exposure to human pathophysiology. It would also be essential that trainees have an adequate background in the biological basis of behavior. Understanding of clinical pharmacokinetics and many relevant biochemical phenomena requires a background in mathematics, including at a minimum, college-level algebra.”

[The APA model for training in psychopharmacology does not require the prerequisites or other aspects of the actual training that was recommended by this report.]

2. American Psychological Association (2008). *Guidelines and principles for accreditation of programs in professional psychology*. Washington DC: Author. <http://www.apa.org/ed/accreditation/G&P0522.pdf>

This document presents the standards for accreditation for doctoral level training in Psychology. Accreditation is “intended to protect the interests of students, benefit the public, and improve the quality of teaching, learning, research, and professional practice.... Accreditation is a voluntary, non-governmental process of self-study and external review intended to evaluate, enhance, and publicly recognize quality in institutions and in programs of higher education.”

[The document does not cover *any* training in psychopharmacology. Indeed, the word “psychopharmacology” does not appear anywhere in this 43 page document. No coursework in psychopharmacology is required to obtain a doctoral degree in psychology. The training of doctoral level psychologists does *not* require that students obtain any education in “Psychopharmacology”, “Chemistry” or any specific courses in human Biology other than a single course in the “biological aspects of behavior.”

No programs for training psychologists in psychopharmacology have been accredited by the American Psychological Association as meeting APA accreditation standards for a postdoctoral residency or any other level of doctoral or postdoctoral training. Unlike other training in psychology, there is not an internal mechanism for accrediting training or supervised experiences in psychopharmacology. This is

in contrast to training mechanisms in prescribing disciplines as well]

3. Association of State and Provincial Psychology Boards (2001). *ASPPB Guidelines For Prescriptive Authority*. Montgomery, AL: Author.
<http://asppb.org/publications/guidelines/paq.aspx>

The mission of the Association of State and Provincial Psychology Boards (ASPPB) is to assist member boards in their mission to protect the public. **“As a matter of policy, ASPPB neither endorses nor opposes the current movement within many professional organizations to promote prescription privileges for psychologists. “**

“These guidelines were prepared in an effort both to provide guidance to jurisdictions that have received, or are anticipating statutory approval of, prescription privileges for psychologists, and also to continue ASPPB’s efforts to achieve greater uniformity of standards among jurisdictions when making changes to their acts and regulations. **There is not yet a standard for how boards of psychology should regulate prescriptive authority for psychologists if legislatures enact this authority through statutory change.”**

“The most appropriate standard of care for psychologists to meet in prescribing medications is a complex, weighty matter that is subject to controversy. A potential advantage in establishing the standard of care as that of a “reasonably prudent psychologist who is trained to prescribe drugs” is that it affords direct comparisons between prescribing psychologists. On the other hand, **a standard of care that compares psychologist prescribers to physicians (i.e., psychiatrists, primary care physicians) might be argued to provide a higher level of public protection by setting a threshold standard that is equivalent to that which exists in current practice....** Some case law has established the standard of care of other health professions as needing to meet that of physicians, while other cases have not upheld this standard. In the event that dependent authority is granted in some jurisdictions, not only standards of care but also standards for supervision, may become complex issues for boards, legislatures, and the courts.”

“As psychologists pursue prescriptive authority, it may be anticipated that there will be questions and challenges to regulatory models, standards, and procedures, as well as to the definition of the scope of practice, training models, and other requirements for prescriptive authority... **Thus far, there are no accreditation mechanisms in place for training programs for psychologists in clinical psychopharmacology.** It is highly desirable that psychopharmacology programs become accredited...clearly it is in the public’s interest for programs to undergo some type of external review, as is done in psychological doctoral programs and internships, psychiatric residencies, and other professional training programs. “

“Defining the qualifications of supervisors for the supervised applied training in psychopharmacology continues to be a challenge. As an emerging field in psychology, there are a limited number of psychologists who are qualified to serve as supervisors...The APA (1996b) recommendations for postdoctoral training... do[es] not

address the duration of supervised applied training in psychopharmacology” [and] do[es] not delineate specific qualifications or the basis for demonstrating skills in psychopharmacology....Currently, the profession has no accepted standards for supervisors’ experience in prescribing psychoactive medications prior to serving as supervisors.

Further information is available through the ASPPB website. <http://www.asppb.org>.

4. Bush, J.W. (2002). Prescribing privileges: Grail for some practitioners, potential calamity for interprofessional collaboration in mental health. *Journal of Clinical Psychology*, 58, 681-696.

Focuses on the probable consequences of prescription privileges (RxP) upon collaboration between psychologists and physicians. The current state of collaboration between psychologists and medical professionals is reviewed. Data are presented from a small survey of clinical psychologists indicate consequences of RxP include: (1) psychiatrists and other medical professionals would receive fewer referrals from psychologists; (2) psychologists would receive fewer referrals for psychosocial services from medical professionals; (3) most psychologists anticipate an adverse effect upon collaboration with physicians; and (4) psychologists are at best divided over RxP.

5. DeNelsky, G. Y. (1996). The case against prescription privileges for psychologists. *American Psychologist*, 51, 207-212.

The authority to prescribe psychoactive medications could have major negative effects on the practice, education, and training of psychologists. Prescription authority also would have major changes how psychological services are marketed and on the public's perception of the profession. Although it is APA policy to pursue prescription privileges, APA cannot require that states actually change scope of practice laws their licensing laws.

6. Dozois, D. J. A., Dobson, K. S. (1995). Should Canadian psychologists follow the APA trend and seek prescription privileges? A Reexamination of the (R)evolution. *Canadian Psychology*, 36, 288-304.

This paper critically examines three key issues surrounding the prescription debate (quality of care, marketability, and psychology's heritage) and demonstrates that, with respect to professional psychology as a whole, obtaining prescription privileges may not be the optimal way to enhance its practice. A second purpose is to place these developments within the context of Canadian psychology. Although American "gains in professional autonomy have usually followed in (Canada" (Dohson et al., 1993), Canadian psychologists face far more impediments to seeking prescription privileges than their southern colleagues. Despite the fact that such obstacles do not preclude our profession from determining its own destiny and advocating for this privilege, we argue at both a practical and conceptual level; 1) **that the benefit is not worth the battle** and,

2) that obtaining prescription privileges may have austere ramifications for the basic identity and core philosophy of professional psychology in Canada.

7. Fowles, D. (2005). Prescription privileges for psychologists. *Clinical Science*, 5, 6, 7. [Electronic Version]. Retrieved November 25, 2007 from http://www.bsos.umd.edu/sscp/Fall_2005_Newsletter.pdf

The Society for the Science of Clinical Psychology, which is a Section of Division 12 (Clinical) of the APA, had posted on its website the results of a survey on prescription privileges. The results showed the membership was ***strongly opposed*** to prescription privileges. The author describes how APA leadership required the Section to remove any information from its website that suggests there is opposition to official APA policy or be thrown out of the organization. The Section elected to remove the information. However, the SSCP's Task Force statement on RxP is posted at <http://www.mspp.net/SSCPscriptpriv.htm>

8. Guiterrez, P. M., & Silk, K. R. (1998). Prescription Privileges for Psychologists: A review of the Psychological literature. *Professional Psychology: Research and Practice*, 29, 213-222.

The article provides a general overview of the prescription privileges debate and the related policy issues is presented. Various experiments with psychologists prescribing medications are then reviewed. Next, the survey data to date are summarized. Finally, position papers on both sides of the issue are reviewed. The authors attempt to review objectively both sides of the argument, to critique the existing data, and to assist readers in appreciating the breadth and scope of the prescription privileges debate. The purpose of this article was not to support either side but, rather, to provide a sufficient review of the literature, which will allow psychologists to form more informed opinions on where they stand on the issue.

"It should be possible to compare the psychology fellows to psychiatry residents working in similar settings ... Existing data support the positions that clinical psychologists can be adequately trained to independently prescribe medication and that this is a cost-effective alternative, at least within the military health care system. These data must now be replicated in a variety of settings before an informed decision for or against prescription privileges can be made."

[The article provides an overview of the DOD, including General Accounting Office's report, which found that there is no need for prescribing psychologists in the military. They review previous surveys of psychologists, such as Boswell & Litwin (1992), who found 49% of hospital-based psychologists were opposed to RxP.] Whereas several surveys indicate majorities of psychologists agree with the RxP agenda, many are not interested in pursuing it.]

9. Hayes, S.C. (1995, Spring). Using behavioral science to control guild excesses. *The Clinical Behavior Analyst*, 1, 17.

The author proposes ways for applied psychology to respond to capitated systems of health care. He argues prescription privileges do not address the profession's survival. Scientifically-oriented applied psychology can survive market pressures by advocating effective interventions to managed care because such treatments are cost effective and cheaper in the long run. Psychologists are also trained to develop and evaluate programs, train Masters level providers, and supervise.

10. Hayes, S. C., & Heiby, E. M. (Eds.). (1998). *Prescription Privileges for Psychologists: A Critical Appraisal*. Reno, NV: Context Press.

This authoritative book presents the first critical and comprehensive examination of the issue of prescription privileges for psychologists. The editors and authors review issues discussed at a conference sponsored by the American Association of Applied and Preventative Psychology (AAAPP), a professional organization of psychologists, that opposes prescription privileges for psychologists. The book includes both con and pro positions from experts in the field.

11. Hayes, S. C., & Heiby, E. M. (1996). Prescription privileges: Does psychology need a fix? *American Psychologist*, 51, 198-206.

The article identifies reasons some psychologists are seeking prescription privileges now. Reasons offered include: (1) Over-reliance on psychotherapy as a way to earn a living; (2) An oversupply of doctoral-level psychotherapists; (3) The rise of managed care and concerns about cost-effectiveness of services when Masters level providers are less expensive; (4) The hegemony of syndromal classifications (i.e., DSM); and (5) Medical guild and drug company interests. Offers ways applied psychologists readily can adapt to these five conditions without becoming medical specialists via prescription privileges.

12. Hayes, S.C., Walser, R.D., & Bach, P. (2002). Prescription privileges for psychologists: Constituencies and Conflicts. *Journal of Clinical Psychology*, 58, 697-708.

The pros and cons of training for prescription privileges within the discipline rather than through established avenues (such as nursing) vary from the point of view of constituencies involved. One constituency involves scientist-practitioners who tend to oppose prescription privileges. However, there has not been much organized opposition from the basic science organizations. A second constituency is the practice-based organizations that have been in support of prescription privileges. However, there is not much support from rank and file private practitioners. The resistance to prescription privileges can be understood in terms of what costs and benefits are valued. **Opposition is not arbitrary or unreasonable and is likely to continue.**

13. Hayes, S.C., Walser, R.D., & Follette, V.M. (1995). Psychology and the temptation of prescription privileges. *Canadian Psychology*, 36, 313-320.

The article describes the proposal to pursue prescription privileges (PP) as reflecting an identity crisis in psychology. It argues that psychology is a science in its own right and does not have the adequate bases for prescribing drugs. Notes **prescription privileges will harm training, and is unethical**. Reports on the Resolution Against Prescription Privileges passed by the American Association of Applied and Preventive Psychology in Jan. 1995.

14. Heiby, E. M. (2002a). Prescription privileges for psychologists: Can differing views be reconciled? *Journal of Clinical Psychology*, 58, 589-597.

The article summarizes six arguments made in testimony at state legislatures by psychologists who oppose prescription privileges bills. The main topics concern whether there is a societal need for psychologists to practice medicine, whether psychology as a discipline has evolved in this direction, how training would change the discipline, what the addition of medical training would cost financially, and whether the current collaborative model is adequate. The author concludes that the debate reflects a deep schism in the field of clinical psychology. The schism is seen as a divide between those primarily trained to be psychotherapists and those primarily trained to be scientist-practitioners. It is argued that the former type of clinical psychologists are more likely to support prescribing and are interested in the survival of professional schools. In contrast, the latter type tends to oppose privileges and are interested in the survival of university departments of psychology. Suggestions are offered for the unification of the discipline. Since 1995, AAAPP official policy has been to oppose RxP based upon a survey indicating a majority of the membership opposes PPP.

“It is probably fair to say that prescription privileges for psychologists...is one of the most controversial proposals debated by the discipline in many decades.” (p. 589)

“High quality and cost-effective mental health treatment is commonly accomplished through collaborations between psychologists and physicians and there is no reason this cannot continue when psychotropic medications are indicated” (p. 594)

15. Heiby, E.M. (2002b). It is Time for a moratorium on legislation enabling prescription privileges for psychologists. *Clinical Psychology: Science and Practice*, 9, 256-258.

The article argues that it is premature to pursue prescriptive authority. Psychologists have taken the debate over this issue to state legislatures and present as a house divided. Rather than seek a radical change in scope of practice by legislative fiat, changes to the field must evolve from within if the field of clinical psychology is to remain unified.

16. Heiby, E.M., Deleon, P.H., & Anderson, T. (2004). A debate on prescription privileges for psychologists. *Professional Psychology: Research and Practice*, 35, 336-344.

The article summarized a debate held at the 2002 convention of the APA. Pro and con positions were presented on the following topics: (1) Whether the science and practice of clinical psychology will benefit from prescription authority; (2) How the APA Training Model is justified given the evaluation of the DoD project and the amount of training required of other professions with prescribing authority; and (3) The impact of medical training upon university-based psychology departments in relation to curriculum, faculty staffing, and financial costs both to the university and students. Heiby argues that the science and practice of clinical psychology will be harmed given resources and time will be reallocated to medical training and practice. She asserts there is no evidence to support the APA Training Model, which would give psychology the dubious reputation of being a prescribing profession with the least amount of medical training. She notes that medical training in psychology departments at traditional universities would lead to fewer courses in psychology, fewer faculty with degrees in psychology, duplication of resources already available in nursing and medical schools. The cost of tuition would increase dramatically to cover these expenses. DeLeon argued there is a societal need for more psychoactive drugs, that expert opinion is sufficient to justify the APA Training Model, and that it does not matter if traditional universities are harmed.

17. International Society of Psychiatric-Mental Health Nurses
Position Statement: Response to Clinical Psychologists Prescribing
Psychotropic Medications: November 2001
<http://www.ispn-psych.org/docs/11-01prescriptive-authority.pdf>

It is the position of ISPN membership that nurses **have an ethical responsibility to oppose the extension of the psychologist's role into the prescription of medications.** This is not a turf issue or an attempt to limit a perceived competing profession. This belief is rooted in the ethical guidelines of our own profession. The professional standards for nursing require nurses who prescribe pharmacologic agents to have their prescriptive actions based on an awareness of pharmacological and physiological principles and knowledge (ANA, 1996, p. 14). We should expect the same from other professionals. The *Scope and Standards of Advanced Practice Registered Nursing* (ANA, 1996) mandates the advanced practice nurse to “contribute to resolving the ethical problems or dilemmas of individuals or systems” (p. 19). It would seem inappropriate and contrary to our profession, therefore, for nurses to assist clinical psychologists in the development of limited training modules for the sanctioning of prescriptive knowledge.

Clinical psychologists represent an important and effective profession that has a long and honored history of working with the mentally ill and facilitating the mental health of their patients. Clinical psychologists have a long and distinguished history of theory-based care practices, and their contributions have come from their unique perspective, which has historically not been somatically based. The current paradigm of psychology rejects the neurobiological basis of mental illness and this theoretical

perspective is reflected in traditional educational practices that limit the exposure to and knowledge of biological sciences.

Psychopharmacology is a critical aspect of today's treatments for mental illness. Safe and effective utilization of medications requires (a) an in-depth knowledge of the human body, and (b) the requisite knowledge to understand the impact of medications on the body, and the physiology of drug-drug and drug-food interactions. **Clinical psychologists do not possess this knowledge and receive little to no clinical supervision in this role. Therefore, they cannot safely prescribe medications to patients with complex, holistic health needs.**

The needs of the mentally ill are many. Limited access, limited availability of prescribers, and limited job positions for clinical psychologists cannot influence nurses to undertake inappropriate action. The desire to meet the needs of our patients is great, but this pressure cannot allow nurses to be drawn into behaviors that are ethically dangerous. The battle over prescriptive authority for clinical psychologists has been going on for many years. It is an issue that challenges nurses, and one around which nursing as a profession needs to respond. As advocates for our patients, we need to speak out against practices that may be harmful to patients. It is our ethical responsibility to speak out and for each nurse to uphold the standards of the profession.

[The above statement is one of only 9 position statements on the website of this organization of nurses. The others address diversity, cultural competence and access to mental health care, youth violence, the global burden of disease, restraint and seclusion, rights of children in treatment, palliative care, and alcohol withdrawal. This speaks to the importance of opposing prescription privileges on various grounds, including ethics, and reflects the concern of professionals who are in an excellent position to recognize the boundaries of professional competence.]

18. Kingsbury, S.J. (1992). Some effects of prescribing privileges. *Professional Psychology: Research and Practice*, 23, 3-5.

The author obtained his M.D. after practicing as a clinical psychologist, giving him a unique window on the debate. He indicates how medical practice consumes most of his professional time. He criticizes proponents of RxP for not mentioning (1) psychologists' possible selfish motivation, (2) the negative impact of RxP, or (3) the issues some psychologists raise in opposing prescribing privileges. He notes, "...it is clear to me that recent discussions of the advantages of psychologists having prescription privileges have been simplistic."

In describing the differences in the training for physicians and psychologists, he stated:

"Studying the effects of medications on the kidney, the heart, and so forth is important for the use of many medications. Managing these effects is often crucial and has more to do with biochemistry and physiology than with psychology. I was surprised to discover how little about medication use has to do with psychological principles and how much of it is just medical" (p. 6.)

In other words, preparation for prescribing has less to do with the types of activities psychologists are trained for and does require the scientific underpinnings more than some might think.

19. Kingsbury, S. J. (1987). Cognitive differences between clinical psychologists and psychiatrists. *American Psychologist*, 42, 152-156.

Differences in perspective about psychopathology and its treatment may create many of the difficulties in communication between clinical psychologists and psychiatrists. These differences, engendered by different training experiences, include how the professions view science, diagnosis, clinical experience, other disciplines, and the hierarchical nature of organizations. Some ways these differences may adversely affect communications between psychiatrists and clinical psychologists are explored.

The author describes significant differences between psychologists and physicians in their training, experiences, and thinking. For example he reports, **“In my first month of residency training in psychiatry at a psychiatry emergency service I believe I saw more patients individually than in my entire graduate [Psychology] training.”** (p. 155) Often health professionals have little understanding of each others’ training models and difference in perspectives and activities.

20. Lavoie, K. L., & Barone, S. (2006). Prescription privileges for Psychologists: A comprehensive review and critical analysis of current issues and controversies. *CNS Drugs*, 20, 51-66.

The debate over whether clinical psychologists should be granted the right to prescribe psychoactive medications has received considerable attention over the past 2 decades in North America and, more recently, in the UK. Proponents of granting prescription privileges to clinical psychologists argue that mental healthcare services are in crisis and that the mental health needs of society are not being met. They attribute this crisis primarily to the inappropriate prescribing practices of general practitioners and a persistent shortage of psychiatrists. It is believed that, as they would increase the scope of the practice of psychology, prescription privileges for psychologists would enhance mental health services by increasing professionals who are able to prescribe. The profession of psychology remains divided on the issue, and opponents have been equally outspoken in their arguments.

The purpose of the present article is to place the pursuit of prescription privileges for psychologists in context by discussing the historical antecedents and major forces driving the debate. The major arguments put forth for and against prescription privileges for psychologists are presented, followed by a critical analysis of the validity and coherence of those arguments. Through this analysis, the following question is addressed. Is there currently sufficient empirical support for the desirability, feasibility, safety and cost effectiveness of granting prescription privileges to psychologists?

Although proponents of granting prescription privileges to psychologists present several compelling arguments in favor of this practice, there remains a consistent lack of empirical evidence for the desirability, feasibility, safety and cost effectiveness of this proposal. More research is needed before we can conclude that prescription privileges for psychologists are a safe and logical solution to the problems facing the mental healthcare system.

“The debate about whether psychologists should be granted prescription privileges is still in its infancy... **There does not appear to be compelling evidence of the desirability of granting prescription privileges for psychologists.** Pilot projects relating to the feasibility, safety, and cost effectiveness of prescription privileges for psychologists are either sparse or unavailable. Although proponents present several compelling arguments in favour of granting prescription privileges for psychologists, more research is needed before we can conclude that prescription privileges for psychologists are a safe and logical solution to the problems affecting the mental healthcare system.

In the meantime, psychologists should concentrate their efforts on improving both the professional and public dissemination of the services they already provide. In particular, they could work on improving collaboration with GPs and psychiatrists to ensure that medicated patients are properly monitored and advised of available psychotherapy options. Psychologists need not go beyond the boundaries of psychological practice to expand into new treatment areas. There have already been important advances in the areas of health psychology and behavioural medicine, where psychologists have demonstrated success in improving treatment adherence, health behaviours and disease outcome in cancer patients,[107-109]obese patients,[110]coronary artery disease patients[111,112]and patients with HIV.[113]**Expanding the quality and scope of these interventions may represent a more desirable, feasible, safe and cost-effective goal than the pursuit of prescription privileges at this time.”** (p. 66)

21. Pollitt, B. (2003). Fool's gold: Psychologists using disingenuous reasoning to mislead legislatures into granting psychologists prescriptive authority. *American Journal of Law & Medicine*, 29, 489-524.

This Article challenges the psychologists' arguments, favoring legislative approval that grants them prescriptive authority. The author provides a critique of each of the American Psychological Associations' reasons for attempting to convince legislatures to grant psychologists prescription privileges: 1) psychologists' education and clinical training better qualify them to diagnose and treat mental illness in comparison with primary care physicians; 2) the Department of Defense Psychopharmacology Demonstration Project ("PDP") demonstrated non-physician psychologists can prescribe psychotropic medications safely; 3) the recommended post-doctoral training requirements adequately prepare psychologists to prescribe safely psychotropic medications; 4) this privilege will increase availability of mental healthcare services, especially in rural areas; and 5) this privilege will result in an overall reduction in medical expenses, because patients will

visit only one healthcare provider instead of two—one for psychotherapy and one for medication. [The author persuasively counters these contentions, and others, such as that granting them prescriptive authority would significantly allay un-met mental health needs in rural areas, which he argues is also highly questionable.]

Psychologists seeking prescriptive authority assert that granting this privilege will increase patient access to psychotropic medication, especially in rural areas. Instead of working on collaborative models in which physicians prescribe medication and psychologists provide therapy, which is a highly workable model, proponents seek to supplant psychiatry and non-prescribing psychologists by creating a "new breed" of psychologist (a.k.a. pseudo-psychiatrist). **[This article, from outside of Psychology itself, also reflects that other stakeholders, beyond psychologists, have legitimate concerns about psychologist prescribing.]**

22. Robiner, W. N., Bearman, D. L., Berman, M., Grove, W. M., Colón, E., Armstrong, J., & Mareck, S. (2002). Prescriptive authority for psychologists: A looming health hazard? *Clinical Psychology: Science and Practice*, 9, 231-248.

Surveys of psychologists and trainees have yielded inconsistent estimates of psychologists' support of the notion of psychologists prescribing drugs and there has been considerable debate in the field about it. Ambivalence about the prescription privilege agenda raises questions about why psychologists have reservations about it. Although many psychologists are interested in pursuing prescription privileges, the historical training paradigm in psychology comprises limited education in the physical sciences that is directly relevant to prescribing medications. Issues related to prescriptive authority for psychologists, including training gaps, attitudes, and accreditation and regulation are discussed.

The authors' primary concern is the risk of suboptimal care if psychologists undertake prescribing that could arise from their limited breadth and depth of knowledge about human physiology, medicine, and related areas. This risk would be compounded by psychologists' limited supervised physical clinical training experiences. The authors review various concerns addressed in the literature. For example, In one survey, more than two thirds of psychologists in independent practice described their training related to psychopharmacological issues as "**poor**".

The American Psychological Association's Ad Hoc Task Force on Psychopharmacology, the group that provided the basic analysis of psychologists' potential activities and training related to psychoactive medications, noted that other health professions (e.g., nursing, allied health professions) **require** undergraduate preparation in anatomy, biology, inorganic and organic chemistry, pharmacology, human physiology, (and some require physics); undergraduate psychology degrees and **admission to psychology graduate school do not**. In fact, one study found **only 7% had completed the recommended undergraduate biology and chemistry prerequisites required for medical or nursing school**. Even though the APA's own Task Force recognized the importance of such relevant training, the APA's model for training psychologists to prescribe medications deleted the prerequisite coursework in the biological and physical sciences for such

training. This makes the APA training model for prescribing remarkably weaker than the training required for all other health professionals who are trained to prescribe.

Current proposals also fail to delineate clear requirements for several key aspects of supervised practical training and there has not been any external accreditation mechanism to even evaluate the quality of training. For example, the APA model failed to specify minimal criteria for: (a) the **breadth** of patients' mental health conditions; (b) the **duration** of treatment (i.e., to allow for adequate monitoring and feedback) or requirements for outpatient or inpatient experiences; (c) **exposure** to adverse medication effects; nor (d) **exposure** to patients with comorbid medical conditions and complex drug regimens. Also, the **qualifications** for supervisors are vague. The training advocated by the APA even fails to meet APA's own requirements for accreditation of psychology training. The existing psychology doctoral and internship programs generally lack the faculty capable of teaching courses and supervising practical experiences related to prescribing. Similarly, it is unclear how well psychology boards would be equipped to regulate this aspect of psychologists' practice.

The authors also note that proponents of psychologist prescribing tend to focus on certain charged and arguably disingenuous issues to promote their cause, rather than on the inadequacies noted above. Rather than addressing issues such as the potential benefits to patient care of increasing psychologists' collaborations with prescribers, they focus on underserved populations. For example, they decry the shortage of mental health services in rural areas without promoting other ways in which psychologists could better serve rural populations, such as collaborating better with other rural healthcare professionals. Moreover, they ignore the demographic fact that few psychologists practice in rural areas and that there is no reason to expect that if they were allowed to prescribe that they would resettle in rural areas.

The authors also recognize that certain populations, such as older adults might be at higher risk of adverse outcomes of psychologists prescribing given the foreseeable drug interactions and more complex issues that would likely complicate their care. Quality care is likely to require greater medical expertise than is likely to result from training psychologists to prescribe.

23. Robiner, W. N., Bearman, D. L., Berman, M., Grove, W. M., Colón, E., Armstrong, J., Mareck, S., Tanenbaum, R. (2003). Prescriptive authority for psychologists: Despite deficits in education and knowledge? *Journal of Clinical Psychology in Medical Settings*, 10, 211-222.

As some psychologists advocate for prescription privileges, the need for closer analysis of the differences between psychologists and psychiatrists grows. The authors' survey and test data reveal key statistically significant gaps in psychologists' training and their significant limitations in their knowledge pertaining to prescribing relative to psychiatrists. Attitudes toward prescribing and estimates of psychologists' competence in prescribing are presented. The authors believe that psychologists' deficits in training and pertinent knowledge constitute major hurdles to competent prescribing. They recommend that caution is warranted about expanding psychologists' scope of practice to include prescribing.

24. Sechrest, L. & Coan, J.A. (2002). Preparing psychologists to prescribe. *Journal of Clinical Psychology*, 58, 649-658.

This report is an investigation of the training received by professionals currently authorized to prescribe medications is considered as a step toward understanding what might be involved in preparing psychologists appropriately if prescription privileges for psychology were to be obtained. Information about admission and curriculum requirements was collected from medical schools, dental schools, physician assistant programs, nurse practitioner programs, and schools of optometry. Results suggest a high level of pharmacologically relevant coursework is required for admission to, and the completion of, programs that currently prepare their professionals to prescribe. It is argued that preparing psychologists to prescribe would likely entail similar training requirements in addition to, or instead of, those already in place, leaving clinical psychology dramatically and permanently altered.

The authors conclude the APA training model represents an experimental reduction in American standards for medical practice. The medical training in the model is less than that required for other prescribing professions, including physician assistants, advanced nurse practitioners, physicians, dentists, and optometrists (Sechrest & Coan, 2002). The author notes that only one psychology graduate program in the U.S. requires any background in the natural and life sciences for admission and that psychologists do not have the pre-requisites for medical training required of all other prescribing professions.

Only three (of 168) doctoral programs in psychology have specific physical or life science prerequisites. By contrast, Prescribing Professions have undergraduate prerequisites, generally in highly competitive classes.

Prerequisite Hours for Prescribing Professions

Prerequisite	Medicine	Dentistry	Physician Assistant	Optometry	Nurse Practitioner	Psychology (Ph.D.)
Biology	8.0	8.5	4.9	7.3	30	0
Physics	7.7	7.6	0.5	8.1	3.5	0
Inorganic Chemistry	7.8	8.2	6.8	8.1	3.1	0
Organic Chemistry	7.5	7.3	2.1	4.6	1.1	0

25. Smyer, M. A., Balster, R. L., Egli, D., Johnson, D. L., Kilbey, M. M., Leith, N. J., & Puente, A.E. Summary of the Report of the Ad Hoc Task Force on Psychopharmacology of the American Psychological Association. (1993). *Professional Psychology: Research and Practice*, 24, 394-403.

The American Psychological Association Board of Directors established an ad hoc task force on psychopharmacology to explore the desirability and feasibility of psychopharmacology prescription privileges for psychologists. In this context, the Task Force's charges were to determine the competence criteria necessary for training psychologists to provide service to patients receiving medications and to develop and evaluate the necessary curricular models. This article summarizes the Task Force's major recommendations and provides specific information regarding its training recommendations. It is hoped that this article will encourage broad discussion of psychology's most appropriate integration of psychopharmacology knowledge and its applications into its training programs and professional activities.

[The Task Force indicated the need for more stringent training than the APA model ultimately required, such as when APA abolished the scientific prerequisites for the psychopharmacology training. The APA has also never promoted the Level 2 type of training, which the Task Force discussed, would have promoted psychologists' *collaboration* with other health care professionals in terms of prescribing. It would have provided a mechanism for psychologists to obtain advanced training in psychopharmacology, but would not have resulted in their direct prescribing, so that their limited knowledge of relevant topics, such as pathophysiology and other central scientific areas would not put patients at unprecedented risk.]

Excerpts from the Task Force report include:

"It is likely that only a small percentage of psychological service providers have a high degree of experience and expertise with pharmacological treatment and are actively working with physicians in assessing, selecting, and managing psychoactive medications..." (p. 396)

"When APA Division 42 (Independent Practice) recently polled its members, the majority of the 440 participants described both their graduate training and opportunities for continuing education in psychopharmacology as inadequate. More than two thirds characterized their training for dealing with psychopharmacological issues as "poor," and 78% felt that continuing education opportunities were insufficient to allow them to expand their knowledge and skill base in drug therapy...this lack of training, coupled with current regulations, requires psychologists to defer to physicians on medication matters for their clients." (p. 396)

"At the doctoral level...[only] 14% of private and 7% of public institutions require a psychopharmacology course." (p. 397)

"When considering the training of psychologists in psychopharmacology and related sciences, it is useful to consider the science curricula for other health service professionals. Programs in such health professions as allied health, pharmacy, optometry, dentistry, nursing, medicine, and osteopathy differ in the length and intensity of their science training, but certain features are common to all. All of these professions require undergraduate preparation in general biology and chemistry. For the allied health professions (such as medical technology, dental hygiene, occupational therapy, and physical therapy) as well as nursing and pharmacy, where professional training typically occurs at the bachelor's-degree level, students also receive undergraduate preparation in human physiology and anatomy, and some programs require organic chemistry and physics as well. Nurses, pharmacists, and most allied health professionals also receive advanced undergraduate-level instruction in pharmacology.

Entrance requirements for post-baccalaureate dental, medical, and osteopathic medical schools generally include course-work in organic chemistry, at least general biology, mathematics through college-level algebra, and physics. Most students admitted to these professional schools have had additional biology and chemistry

coursework. Doctoral-level training in dentistry, osteopathy, and medicine almost invariably includes advanced coursework in human anatomy and physiology, biochemistry, cellular biology, pharmacology, microbiology and immunology, and pathology. Most schools of dentistry, osteopathy, and medicine require 2 full years of intensive classroom training in these health sciences. Clinical pharmacists with Pharm.D. degrees have completed their bachelor's-level pharmacy degree and typically at least two additional years of advanced training in pharmacology.

A survey of 102 U. S. schools of medicine for 1989–1990 conducted by the Association for Medical School Pharmacology (1990) revealed that medical students received an average of 104 teaching hours in pharmacology.” (p. 397)

“It is unlikely that this competence can be developed through continuing education, because approximately 2 years' full-time didactic training with additional supervised clinical experience in medication decision making is envisioned. **Retraining of practicing psychologists for prescription privileges would require careful selection criteria, focusing on those psychologists with the necessary science background... It would require students to have undergraduate science training similar to that required of other health service providers (e.g., nurses, pharmacists, allied health professionals, dentists, and/or physicians).** It would also require a postdoctoral period of supervised clinical experience. (p. 400)

“Undergraduate Prerequisites

A psychopharmacology track should recruit students with a strong background in the biological sciences. Some background in anatomy, physiology, and chemistry would be necessary to take the graduate-level courses that make up the proposed curriculum. This background could be obtained during undergraduate studies, as a post-baccalaureate student, or in some circumstances, during early years of the graduate program.

The Task Force believes the following areas of undergraduate instruction are needed.

Biology

A minimum of 12 to 15 semester hours in undergraduate biology is recommended. This would include courses in general biology, cellular and human genetics, vertebrate anatomy, and mammalian physiology. Ideally, some laboratory experience would accompany one or more of these courses. Prospective students also would be well advised to obtain undergraduate preparation in cell and molecular biology to prepare themselves for the advances in psychopharmacology being made using these approaches.

Chemistry

A minimum of 9 to 12 semester hours would be recommended. Students need sufficient preparation to take a graduate-level biochemistry course; typically this would require two semesters of general chemistry and at least one semester of organic chemistry.

Mathematics

College-level algebra would be a minimum. This would not typically be a problem for psychology graduate students, who usually have good quantitative backgrounds. Pharmacology and/or substance abuse

A number of colleges and universities offer undergraduate courses in pharmacology or a substance abuse course that covers the basic pharmacology of drugs of abuse. These courses would be desirable but not mandatory.” (p. 400)

“It would be difficult, however, to provide Level 3 training through traditional continuing education mechanisms. It was assumed [for prescriptive authority] that

the medical management of the patient was being done by a physician (i.e., a general practitioner, pediatrician, or internist), and that **psychiatric management was restricted or not available.** (p. 401)

26. Society for a Science of Clinical Psychology (2001). Task force statement on prescribing privileges (RxP).
<http://www.mspp.net/SSCPscriptpriv.htm>

The Task Force notes the vast majority of SSCP members strongly oppose RxP. The Task Force calls for a moratorium on APA's expenditure on RxP, a survey of the membership, and a balanced peer-reviewed mini-convention on the pro's and con's of RxP. **The Task Force presents the following 9 reasons to oppose APA's policy on RxP:**

"1. RxP would not fill unmet needs for service as claimed by proponents.

- (a) The psychiatrically underserved population is not very large. Even in the aggregate, it is smaller than RxP advocates in APA's central office wish us to believe.
- (b) The geographic distribution of psychologists largely follows that of psychiatrists. Thus little net gain in coverage is even possible.
- © Few psychologists have chosen to practice in places like rural Montana or the South Bronx. There is no reason to think that RxP would make an appreciable difference.
- (d) Organizations of consumers of mental health services (e.g., NAMI) have not come forth to endorse RxP. At the last RxP bill hearing in the Hawaii legislature, several consumers testified against RxP but none in favor.

2. No satisfactory precedents exist, either for designing suitable training programs, or for predicting psychologists' performance as prescribers.

- (a) The definition of what would constitute adequate training remains highly speculative and controversial. APA's model program is far from being a final or even an authoritative statement of what would be needed.
- (b) The Department of Defense program, with 10 graduates, was about twice as intensive as that envisioned by the APA model program. It cannot be reproduced on a broad scale. It is therefore not a meaningful precedent.
- © Guam — small, remote, and atypical in other respects — requires medical oversight of its handful of prescribing psychologists. It is not a precedent for RxP in the form espoused by APA.
- (d) APA's training model specifies three sequential levels. Current RxP training programs offer Level 3 (see section 3 below), but omit the prerequisite Levels 1 and 2. They also omit the undergraduate prerequisites in biology (12-15 semester hours), chemistry (9-12 hours) and algebra (one course).
- (e) Some programs claiming to meet APA standards are conducted via distance learning — quite unlike the Defense Department program or those offered to

optometrists.

- (f) In short, there is no existing program that meets even APA's scaled-down criteria.

3. Few existing psychologists would be able to complete any acceptable training program.

- (a) The APA Level 3 model, skimpy as many believe it to be, entails 350 classroom/lab hours, plus one year of closely supervised practicum experience involving 100 patients. This is equal to approximately two years of full-time work.
- (b) This time requirement does not include prerequisite undergraduate-level work (see section 2[d] above), some or all of which most prospective candidates would need.
- © The cost of APA-model training — even when no undergraduate work is needed — is estimated at \$20,000 to \$30,000 per student if received in a university or professional school setting. This does not include income sacrificed in order to make time available for RxP training.

4. Graduate education in basic psychological science and psychosocial treatments would be severely diminished and distorted unless most or all biomedical coursework were at the post-doctoral level.

- (a) Many currently practicing psychologists are already under-trained in psychological science and empirically supported treatments. Displacing traditional curriculum content in graduate schools with RxP-focused coursework would render this deficiency still worse.
- (b) Making RxP training wholly post-doctoral would add two years and \$20,000 to \$30,000 — plus the cost of any undergraduate prerequisites needed and the years of earning ability forever lost — just as it would for existing psychologists.
- © By changing the prerequisites for doctoral programs, RxP would attract a different population of applicants and further diminish the emphasis on psychosocial/behavioral treatments.

5. In addition to the direct costs of RxP training, there are a number of externalities — so far, not widely recognized — that argue strongly against RxP.

- (a) Malpractice premiums would go up for those who elect to prescribe, and possibly for all licensed psychologists whether they prescribe or not.
- (b) Should even a few malpractice suits against prescribing psychologists based on claims of inadequate medical training be successful, insurance coverage would become prohibitively expensive or disappear altogether. Legislatures that had previously authorized RxP would face an onslaught of pressures to rescind it, and those that had not yet authorized it would reject RxP bills out of hand. The damage that would be done to psychologists and to the profession is incalculable — much worse than the damage done to physicians and medicine

when they are sued.

- © Student loan debt would increase sharply as a result of additional borrowings and years of delay in commencing repayment.
 - (d) Adding faculty to departments of psychology to teach the RxP curriculum would cost an estimated \$800,000 to \$1,000,000 annually. Only schools wholly supported by tuition could hope to recover these outlays. Universities relying on state funds and endowments would have to absorb a large share of additional faculty costs without recourse.
 - (e) RxP would widen the existing gap between university and professional-school programs, and in effect create two divergent spinoffs of clinical psychology. It would be only mildly facetious to say that we would come to be seen, at least by outsiders, as either underpaid psychiatrists or overpriced social workers. In the process, the cross-fertilization between psychological science and practice — psychology's trump card in the mental health field — would have been severed.
 - (f) If psychologists obtain RxP, master's-level social workers and counselors will almost certainly try to follow. (Pat DeLeon has in fact written in support of social workers seeking RxP.) Should they succeed, the market will be flooded with Rx-eligible personnel, and the competitive advantage sought by psychology's RxP advocates would quickly vanish.
- 6. Psychologists would be exposed to patients' demand for "pill fixes" and the blandishments of the pharmaceutical industry, just as psychiatric and other medical professionals already are.**
- (a) It is naïve to assume that psychologists' background in psychosocial treatments would significantly "inoculate" them against such powerful pressures.
 - (b) By de-specializing psychologists in psychosocial treatments and their scientific underpinnings, their commitment and competence in this area is likely to be further eroded.
- 7. Contrary to claims made by key people in APA's central office, psychology is not united behind RxP. A series of surveys over the past 10 years has shown sentiment to be about equally divided.**
- (a) APA's much-cited 1995 data, which showed a majority in favor of RxP, relied upon a single, highly biased questionnaire item in the context of an omnibus survey on membership issues. More objective studies suggest that a majority is actually opposed to RxP.
 - (b) Recent survey evidence suggests that many psychologists nominally classified as "favorable" to RxP are willing to endorse RxP simply out of an altruistic desire to help colleagues — while having little or no interest in pursuing such training themselves.
 - © There is reason to believe that few psychologists — even those who find the RxP idea attractive — are aware of and have given careful thought to the length and cost of any plausible training requirements. What their attitudes would be if they

were fully informed remains unknown.

8. Organized psychiatry and medicine can be counted upon to oppose RxP in state legislatures far more vigorously and effectively than they have opposed previous expansions in our scope of practice.

- (a) They have the financial and political ability to turn the RxP campaign into a rout for psychology, and are fully prepared to do so if necessary.
- (b) Faced with RxP bills in the legislatures, they are likely to seize the opportunity to roll back gains in our scope of practice that have been painstakingly eked out over decades.
- © There is evidence from New York that medicine's sabotage of scope-of-practice legislation sought by NYSPA was intended as a shot across our bow to head off RxP.
- (d) Fruitful collaboration between psychologists and medical professionals would be undermined — and possibly damaged quite seriously — by the battle over RxP.
- (e) APA has spent over \$800,000 pressing its RxP agenda, and has recently escalated its efforts still further. Yet all that it will take to defeat RxP bills in state legislatures is for psychologists opposed to RxP to expose its lack of solid support among psychologists. (This has already happened in Hawaii).

9. RxP opponents fully recognize the need for psychologists to have education and experience relevant to biomedical treatments. But this does not imply a general need for prescribing authority. Good alternatives exist that have none of the drawbacks cited above.

- (a) For psychologists who want to prescribe drugs on their own, nurse practitioner (NP) training would prepare them far better than any RxP program that has been seriously proposed. It would provoke less opposition from the medical establishment. No new legislation — costly, time-consuming and dangerous to pursue — would be required. And it would probably be supported by the nursing profession, which as matters now stand is likely to join organized medicine in opposing RxP.
- (b) For psychologists who do not want to prescribe, or who cannot afford the time and money to obtain the requisite training, well-designed CE offerings would enable them to participate collegially and knowledgeably in collaboration with medical professionals. A large percentage of psychologists are already so equipped, and they collaborate routinely and effectively with their medical colleagues.
- © Training is particularly needed for collaboration with primary care physicians — who write about 75% of the prescriptions for psychoactive medications in this country, yet often have skimpy knowledge of the proper use of such drugs, and are even less well acquainted with the advantages of psychological treatments. Such collaboration would also do more than RxP to meet the needs of underserved areas and populations.

- (d) APA can play a vigorous and constructive role in enhancing psychological practice via these alternatives. It can take the lead in arranging NP training at an affordable cost, and it can develop and promote modules to advance interprofessional collaboration. These things can be done at much less cost and risk than pursuing the present quixotic campaign for RxP — and they would do away with the divisive atmosphere that APA’s unilateral promotion of RxP has needlessly brought upon our profession.” (n.p.)”

27. Stuart, R. B., & Heiby, E. E. (2007). To prescribe or not to prescribe: Eleven exploratory questions. *Scientific Review of Mental Health Practice*. 5, 4-32.

Many psychologists believe that gaining prescription authority (RxP) would benefit them, their patients, and the field. Prescribing could extend the boundaries of psychological services, but doing it responsibly requires many changes in knowledge acquisition and clinical practice. Since organized psychology is firmly committed to this change, the 11 questions presented here are intended to help individual clinicians decide whether they should seek prescriptive authority. The questions address significant challenges in obtaining the necessary education about human biology; the ways in which organ systems are affected by drugs; methods of prescribing and monitoring treatment results; and preparing for a possible increased risk of malpractice actions. Those considering the pursuit of prescribing authority will also want to determine whether the few psychologists who can currently prescribe drugs have used their authority safely and effectively. In addition, it is important to realize that to meet high standards of care for psychological services, prescribers must both keep abreast of the evolving body of psychological theory and research and devote equal or greater time to maintaining the most current knowledge about the predictable effects of drugs. The latter task is difficult due to common flaws in drug research and flaws in the policies and procedures used by the FDA to regulate drugs. Psychologists should be prepared to adjust their practices to meet these and other challenges *before* they put pen to the prescription pad.

The authors review a variety of problems related to RxP and note that Psychology is in the awkward position of being a scientifically based profession that is seeking to expand its scope based on a small pilot program (i.e., the PDP) that reaches well beyond the parameters of the available data. The authors raise a series of questions to help students and psychologists weigh the costs and potential risks of prescribing against its hoped-for benefits, which will not necessarily be realized, including:

- ? How will you minimize the risk of a misdiagnosis that leads you to prescribe the wrong drug?
- ? How will you minimize the risk of making prescription errors that lead to adverse drug events?
- ? How accurately will you be able to predict the effects of the drugs that you prescribe?
- ? How will you find the accurate information needed for sound decisions about drugs?
- ? How will you avoid choosing a drug that is generally correct for the diagnosis but incorrect for a given patient?
- ? How will you gain access to the resources that you will need to adequately assess patients

- before prescribing drugs, and then to monitor medication effects?
- ? How will you be able to resist the pressure to prescribe unnecessary drugs?
- ? Do you know enough to make a data-based decision about prescribing authority now?

28. Wagner, M.K. (2002). The high cost of prescription privileges. *Journal of Clinical Psychology*, 58, 677-680.

If the APA medical training model (APA 1996b) is adopted, the cost of the additional graduate training at a southern state university was estimated to be at least \$155,000 for students, assuming the student lives on \$20,000 per year. This estimated cost to the student does not include the additional costs involved in undergraduate pre-medical training or the higher tuition costs at private universities' graduate programs, including professional schools. Data are presented relative to the financial burden it will place on students, universities, internship sites, **and the consumers** of psychological Services, and the authors question who is going to pay for it?

29. Walker, K. (2002). An ethical dilemma: Clinical psychologists prescribing psychotherapeutic medications. *Issues in Mental Health Nursing*, 23, 17-29.

The use of psychotropic medication to treat psychiatric disorders has surged in recent years, and while commonly prescribed, the question of who should be allowed to prescribe such medication has become an increasingly important issue to nurses. Psychologists have historically functioned in roles such as psychotherapy and psychological testing, but as standards of care for psychiatric disorders incorporate medication, reimbursement for psychotherapy is declining. Medication prescription and management have not been traditionally seen as the role of the psychologist, however, many clinical psychologists have begun to advocate for prescription authority as a legally sanctioned role for their profession. This article addresses the issues of clinical psychologists seeking prescriptive privilege. It is argued that the current paradigm of psychology rejects the neurobiological basis of mental illness and that **psychologists prescribing medication presents an ethical dilemma for nurses**. It is the contention of the author that nurses have an ethical responsibility to advocate against the extension of the psychologist's role into the prescription of medications. This article also reveals that other mental health professionals (i.e., not just physicians) have significant concerns about psychologists' proposed role in prescribing.

30. Walters, G.D. (2001). A meta-analysis of opinion data on the prescription privilege debate, *Canadian Psychology*, 42, pp. 119-125.

The author concludes psychologists are about evenly divided over whether the profession should pursue prescription privileges. Proponents of privileges ignore the divisiveness over this issue. The results, based on 17 samples, showed minimal consensus and a general split of opinion on the advisability of pursuing the prescription privilege agenda. These findings suggest that prescription privileges have the potential to confuse issues of

training and identity for future generations of psychologists. Although the difference is not statistically significant, **more psychologists than not believe that professional/scientific organizations like APA should not be spearheading efforts to gain prescription privileges.** At the least, psychologists are evenly divided on this issue. Second, professional psychologists are more supportive of prescription privileges in principle than they are of obtaining the training necessary to prescribe medication.

31. Westra, H. A., Eastwood, J. D., Bouffard, B. B., & Gerritsen, C. J. (2006). Psychologist's pursuit of prescriptive authority: Would it meet the goals of Canadian health care reform? *Canadian Psychology*, 47, 77-95.

The authors seek to facilitate reflection on the important issue of prescriptive authority for Canadian psychologists. The paper contextualizes the discussion of prescriptive authority in the broader context of health care reform in Canada. More specifically, the authors review pharmacotherapy and psychological services in view of how effectively each of these currently meets three major challenges in health care reform: reducing costs, increasing treatment efficacy, and improving access to treatment.

The authors conclude that psychological services are less costly than pharmacotherapy. Prescription drugs clearly and vastly exceed spending on psychological services. In their view, there are very few valid arguments supporting the expansion of prescriptive authority to psychologists, when considering important indices on which future health care services will be judged. In contrast, on the basis of the present review and analysis, it seems to us that a fuller promotion of existing psychological expertise would more result in reduced health care costs, increase treatment efficacy, and improve access to treatment.

The authors believe that “the change that would appear to most benefit consumers, psychologists, other health care providers, and payers, is increased access to psychological services and fuller utilization of psychological expertise. **The best way to realize the benefits of pharmacotherapy may not be through having prescription authority ourselves, but rather through offering strongly desired and much needed complementary expertise grounded in psychological science** (e.g., knowledge of relationship and other psychosocial contextual factors, compliance enhancement, specific psychological treatments, psychoeducation, and so on). Stated differently, if you were a marketer with a choice as to which product to market – one that is widely available, incurs substantive costs, and is less preferred, or one that consumers want, is not currently widely available, is desirable to payers in terms of cost-reduction potential, and is highly effective which would you choose?”

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Prescriptive authority: Psychologists' abridged training relative to other professions' training

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Abstract

Albeit psychologists were granted prescription authority in two states over a decade ago and in three states in recent years, the controversy over prescriptive authority persists within the profession and remains a concern of diverse stakeholders. The literature provides minimal research on the adequacy of psychopharmacology training programs and how commensurate psychologists' training is with other prescribers' training. Comparing psychopharmacology training for psychologists to other prescribing professionals' training reveals psychologists receive fewer didactic training hours in foundational sciences (e.g., biology, chemistry, and pathophysiology) and fewer clinical training hours directly related to prescribing and managing medications. Implications of these findings and legal and regulatory cautions are discussed along with recommendations for future research directions.

KEYWORDS

prescription privileges, prescriptive authority, psychologist, quality of care, training

1 | INTRODUCTION

In recent decades, the American Psychological Association (APA, 1996) adopted policy and procedures for pursuing prescriptive authority (RxP) for psychologists to expand their scope of practice, which could potentially increase the availability of psychoactive medication-related services. The first state legislative RxP initiatives were in Hawaii in 1984 (DeLeon, Fox, & Graham, 1991). Changes to Indiana's Psychology Code in 1993 permitted prescriptive authority for psychologists participating in specific federal programs (Levant, 2001) but not generally (IC25-33-1-2). In 1999, Guam became the first jurisdiction to pass prescription authority for psychologists. To date, five states have granted psychologists prescriptive authority (see Table 1). Despite these milestones and other initiatives, stakeholders, including psychologists, question the appropriateness and ponder the benefits, challenges, impact, and necessity of RxP (e.g., Robiner, Tumlin, & Tompkins,

2013; Stuart & Heiby, 2007). McKay (2014) noted a generation of psychologists has been exposed to a preponderance of messages about the virtues of, and relatively little about, the downsides of RxP (Baird, 2007; Fagan, Ax, Liss, Resnick, & Moody, 2007; Robiner et al., 2003, 2002; Sammons, Gorny, Zinner, & Allen, 2000; St. Pierre & Melnyk, 2004; Tompkins & Johnson, 2016; Walters, 2001). There remains division within the profession and a paucity of data regarding competencies, prescribing practices, and outcomes.

As this article was written, 171 psychologists had prescriptive authority nationwide (i.e., in New Mexico and Louisiana), accounting for equal or less than 0.18% of the estimated workforce of 95,180 FTE active psychologists (APA Center for Workforce Studies, 2018) and fewer than 0.35% of prescribing mental health professionals. Surveys gauging licensed psychologists' and psychology graduate students' interest in prescription authority have yielded mixed perspectives (e.g., Grandin & Blackmore, 2006;

Tatman, Peters, Greene, & Bongar, 1997). Graduate students appear divided in their interest and underestimate the cost and length of additional training to prescribe (Grandin & Blackmore, 2006). Tompkins and Johnson's (2016) survey of Oregon psychologists found low interest in, and little knowledge about, training required to prescribe. APA Division 55, which advocates for RxP, is the division with the second greatest proportional declines in membership (Robiner, Fossum, & Hong, 2015), losing more than a third of its membership since 2009.

The RxP controversy among psychologists has been "contentious and polarizing" (Deacon, 2014a) spanning multiple issues, including (a) whether granting prescriptive authority to psychologists would significantly remedy the shortage of psychopharmacological prescribers, especially in underserved areas (Ax et al., 2008; DeLeon et al., 1991; Moore & McGrath, 2007; Muse & McGrath, 2010a; Robiner et al., 2013; Sammons, 2010; Tompkins & Johnson, 2016); (b) ways in which prescribing might change the professional identity of psychologists and the field (Grohol, 2019; Gunn & Blount, 2009; Lavoie & Barone, 2006; McGrath & Muse, 2010; McGrath et al., 2004; Sammons, 2003); (c) ethical, legal, and regulatory quandaries psychologists might encounter (Lavoie & Barone, 2006); (d) individual, educational, and societal costs and risks associated with training to prescribe (Heiby, 2010; Lavoie & Barone, 2006; Newman, Phelps, Sammons, Dunivin, & Cullen, 2000; Robiner et al., 2002; Wagner, 2002); (e) potential negative interactions of medication and psychotherapy, and rebound effects of anxiolytic medications (McKay, 2014); and (f) medicalization of human problems implicitly overly endorsing the medical model (Hickey, 2014).

A primary challenge regarding RxP is concern over the comprehensiveness, depth, and rigor of the APA training

Public Health Significance

Psychologists' relatively abbreviated training to prescribe raises public health concerns about how potential gaps in learning and supervised experience affects the quality of care delivered. The risk of adverse effects of short cuts in training is likely greatest with more vulnerable and ill patient populations.

model. Advocates argue that while primary care physicians prescribe the majority of psychotropic medications (Ax et al., 2008; DeLeon & Wiggins, 1996; Gunn & Blount, 2009; Muse & McGrath, 2010a), psychologists receive more extensive training in the etiology, diagnosis, and treatment of mental disorders, making them more knowledgeable about mental illness than primary care doctors and advanced practice nurses (DeLeon et al., 1991; Muse & McGrath, 2010a, 2010b). They contend psychologists can fill unmet needs for prescribing and that psychologists, like other nonphysician prescribers, can be trained to safely and competently prescribe without completing medical school (DeLeon & Wiggins, 1996; Sammons, 2003).

Such assertions ignore the conspicuous difference that *all other prescribers* complete premedical, scientifically based, course prerequisites *before* entering training programs, whereas very few psychologists do (Tatman et al., 1997). Advocates acknowledge that psychology has "the least overlap" with medicine's curriculum (Fox et al., 2009). Discounting the importance of medical and scientific training is concerning given the complex issues that can arise from adverse drug effects, medication interactions, and improper physical diagnosis. Those at greatest

TABLE 1 Psychologists in jurisdictions that allow psychologist prescribing

State/territory	Year RxP legislation passed	Number of licensees	Number of prescribing psychologists	% of licensed psychologists prescribing	Population	Prescribing psychologists/100,000 population
Guam ^a	1999	16	0	0	162,742	0
New Mexico ^b	2002	745	67	9.0	2,088,070	3.21
Louisiana ^b	2004	764	104	13.6	4,684,333	2.22
Illinois ^b	2014	5,329	0	0	12,802,023	0
Iowa ^b	2016	673	0	0	3,145,711	0
Idaho ^b	2017	376	0	0	1,716,943	0
Total ^c			171 ^c		6,772,403 ^c	2.52 ^c

^aCensus data retrieved September 10, 2018, from <https://en.wikipedia.org/wiki/Guam> (estimated 2016).

^bCensus data retrieved September 10, 2018, from <https://www.census.gov/quickfacts/fact/map/la,US/PST045217?> (estimate) <https://www.census.gov/quickfacts/fact/map/la,US/PST045217?> (estimate) <https://www.census.gov/quickfacts/fact/map/la,US/PST045217?> (estimate) <https://www.census.gov/quickfacts/fact/map/la,US/PST045217?> (estimate).

^cIn Louisiana and New Mexico combined.

risk for medication mismanagement are likely the youngest, oldest, and sickest with complex conditions, numerous risk factors, and most complicated medication regimens.

Given interest in promoting training standardization in mental health professionals' core competencies, it is important to understand and enhance professionals' training (Hoge et al., 2005). This is true for prescribers (i.e., medical doctors, psychiatrists, nurse practitioners [NPs], and physician assistants [PAs]) of psychoactive medications for mental health disorders, warranting careful analysis of similarities and differences in training to prescribe.

2 | EDUCATION AND TRAINING OF PRESCRIBERS

2.1 | Physicians

Physicians (M.D./D.O) have the most comprehensive training for prescribing. NPs (both master's level and DNPs) and PAs prescribe based on their respective training models. Other professionals (e.g., dentists, optometrists, and podiatrists) prescribe within limited formularies. All prescribing disciplines, except psychology, require *undergraduate* coursework in biology, and organic and inorganic chemistry, and often physics prior to admission (see Table 2). Sechrest and Coan (2002) estimated medical students completed 98 hr of pharmacology, 133 hr of pathology, 130 hr of physiology, 200 hr of anatomy, 58 hr of cell biology, 83 hr of biochemistry, 93 hr of microbiology, 25 hr of genetics, 58 hr of cell biology, and 87 hr of clerkship within the medical school curriculum.

Coursework is augmented by experiential training for all medical specialties. Physicians complete three to five years in accredited residency programs under attending physicians' supervision and take specialty board examinations. Prior to residency, medical students complete approximately 700 hr of study in biological sciences and anatomy/physiology, almost 100 of which are in pharmacology.

2.1.1 | Psychiatry

Psychiatry residencies comprise four years (Rojnic Kuzman, Norstrom, Colin, Oakley, & Stoklosa, 2012). Subspecialization (e.g., child and adolescent) requires additional fellowship years. The Association of American Medical Colleges (AAMC) competency-based evaluation paradigm designates objective outcome measurements (Beresin & Mellman, 2002). Psychiatry residencies include clinical and didactic training in diverse health-care settings (i.e., inpatient, outpatient, and emergency), with multiple clinical populations and age-groups.

2.1.2 | Family medicine and primary care

Family medicine residencies require three years of supervised clinical practice and didactics. The Accreditation Council for Graduate Medical Education (ACGME) *Program Requirements for Graduate Medical Education in Family Medicine* (2018) stipulate residencies have faculty trained in and dedicated to integrating behavioral medicine into the medical curriculum. Family physicians are trained in mental health (including medication management) and supervised in integrated health-care settings. Other primary care specialties playing key roles in the de facto mental health system (Internal Medicine, Pediatrics, and Obstetrics and Gynecology) are not prescriptive in how accredited residencies address mental health training (Regier, Goldberg, & Taube, 1978; Regier et al., 1993), but strategic initiatives are ongoing to address gaps (e.g., McMillan, Land, & Leslie, 2017).

2.2 | Nurse practitioners

According to the American Academy of Nurse Practitioners (AANP, 2010), NP training resulting in doctoral (DNP) degrees follows undergraduate or master's training. In 2004, the American Association of Colleges of Nursing endorsed the Doctor of Nursing Practice (DNP) as the new standard for entry to the field by 2015. Sechrest and Coan's (2002) review of 45 NP programs noted most required bachelor's degrees in nursing (BSN). They noted BSNs require three semester hours of biology, physics, and inorganic chemistry, and one semester hour of organic chemistry. To practice, NPs must be licensed as registered nurses, graduate from a NP program, and pass a national board specialty certification examination (American College of Nurse Practitioners [ACNP], 2012).

2.3 | Physician assistants

Gifford, Haun, and Muma (2009) report most PA programs' prerequisites include two chemistry, human anatomy, and physiology courses, and one biology, microbiology, and statistics course. Organic chemistry and biochemistry prerequisites are under consideration at many PA programs. Sechrest and Coan's (2002) analysis of 45 PA programs found prerequisites: five semester hours of biology, seven of inorganic chemistry, and two of organic chemistry. In addition to didactics, PA trainees complete clinical rotations in diverse settings (e.g., outpatient clinics, hospitals, surgical departments, emergency departments, and long-term care facilities). Training standards for the Accreditation Review Committee for the Physician's Assistant, Inc. (ARC-PA), mandate students obtain practical experience in family medicine, internal

TABLE 2 Comparison of prerequisite hours of preparation across disciplines

	Degree	Foundational sciences	Pharmacology	Medical diagnosis, intervention, and assessment	Mental health diagnosis, intervention, and assessment	Professional issues
Medicine ^a	BA/BS ^b	326 (43.20) ^c	0	0	0	0
Nurse practitioner						
Master's ^d	BSN ^e	297 (6.71) ^f	48 (6.71)	51 (17.1)	132 (32.52) ^g	171 (43.21)
Doctorate ^h	BSN/MSN ⁱ	—	—	—	—	—
Physician's Assistant ^j	BA/BS ^b	243 (60.30) ^k	0	0	0	0
Prescribing Psychologist ^l	Doctorate ^m	45 (0) ⁿ	0	0	1,020 (126.22)	159 (27.25)

Note: One academic credit = 15 contact hours, and values represent mean contact hours (and standard deviations).

^aBased on allopathic medical school (excluding residency).

^bBachelor's degree in an academic area as long as prerequisite coursework is completed.

^cFour of the five programs listed prerequisite coursework required for admissions (other vetted candidates to determine whether they had completed the necessary coursework). Required coursework: two semesters of biology (all); two semesters of general chemistry and two semesters of organic chemistry (two programs); two semesters of either chemistry or organic chemistry (one program); four total semesters of chemistry (one program); two semesters of physics (three programs); and one semester of physics (one program).

^dBased on nurse practitioner master's degree programs.

^eOne MSN program required applicants to have a BSN for admission; another accepted a BSN or ASN with previous experience and additional undergraduate coursework as determined by admissions committee; two other programs accepted a BSN or bachelor's degree in another discipline in combination with an ASN.

^fAll MSN required students to have completed courses in chemistry, anatomy, physiology, and nutrition prior to beginning the nursing curriculum. Four programs also required coursework in microbiology. One program required a course in general biology, and another program required a course in biochemistry, and also completed an average of 372 hr ($SD = 66.58$) in pathophysiology. None of the other disciplinary programs included courses in pathophysiology as prerequisites. The DNP programs that admitted applicants with a BSN or a master's degree in another area combined with a BSN had different curriculum tracks for these applicants. Because this study only looked at DNP academic tracks for students who had already completed an MSN, it will be assumed that DNP students completed didactic and clinical training requirements similar to those found within the MSN programs.

^gAll programs required coursework in psychology and mental health nursing with four requiring general or introductory psychology. Another four programs also required coursework in developmental psychology or lifespan development. One program required abnormal psychology, and another program required a course on family systems.

^hBased on nurse practitioner doctoral degree programs.

ⁱThree programs required applicants to have a MSN and be licensed as a NP or a certified nurse specialist (CNS). A fourth accepted a BSN requiring completing additional coursework for DNP. The fifth program required MSN or a master's degree in another discipline in combination with a BSN (if previous work experience and coursework judged to adequately provide foundational knowledge base and rigor needed for the DNP).

^jBased on P.A. programs.

^kRequired coursework included anatomy (three programs required one course; one program required two courses), physiology (three programs required one course), general chemistry (three programs required one course; one program required two courses), biology (two programs required two courses), microbiology (three programs required one course), health-related biological science (one program required one course), organic chemistry (one program required one course; one program required two courses), medical genetics (one program required one course), and medical terminology (two programs required one course).

^lBased on Ph.D. and Psy.D. clinical/counseling degree programs plus the psychopharmacology postdoctoral programs.

^mAll programs require a doctoral degree and psychology license.

ⁿNone of the doctoral programs required undergraduate prerequisites in the foundational sciences; all five doctoral programs required one course on the biological basis of behavior.

medicine, general surgery, pediatrics, obstetrics and gynecology, and behavioral and mental health (ARC-PA, 2010a, 2010b, 2016).

2.4 | Prescribing psychologists and the APA psychopharmacology training model

For psychologists to prescribe, training recommendations emphasize integrating didactics and clinical experiences to enhance psychologists' application of knowledge to clinical settings (APA, 2019a) and encourage a competency-based model to measure knowledge and skill development. APA accredits doctoral programs, internships, and postdoctoral training. Accreditation "is intended to promote consistent quality and excellence in education and training in health service psychology" (APA, 2015, p. 3). Training in other fields that prescribe also requires training programs being accredited. By contrast, APA uses a *designation* system for programs training psychologists to prescribe to afford public *recognition* of education and training programs that meet certain *minimum standards* and published criteria. The designation criteria require 400 didactic hours and supervised clinical experience of at least 100 patients and recommend programs formulate capstone competency evaluations documenting mastery of critical competencies. APA's (2019a) training model does not stipulate *any* undergraduate biological or physical sciences prerequisites. Programs training psychologists to prescribe do not meet APA criteria for accredited postdoctoral residencies.

The nature and extent of requirements vary across jurisdictions (APA, 2019b; see Table 3). Continuing education related to prescribing is not required unless territory/state law requires it. States with enabling legislation typically require passing scores on the Psychopharmacology Examination for Psychologists (PEP), a 150-item multiple-choice examination of multiple content areas: integration of psychopharmacology with psychological practice (15%); neuroscience (8%); nervous system pathology (9%); physiology and pathophysiology (9%); biopsychosocial and pharmacological assessment and monitoring (10%); differential diagnosis (13%); pharmacology (12%); clinical pharmacology (13%); research (4%); and professional, legal, ethical, and interprofessional issues (7%). Designation criteria (2019b) do not specify how many clinical hours must be completed, or what constitutes a sufficiently diverse patient caseload. There is little specification of who oversees learners' clinical experiences/placements, or the qualifications of faculty and clinical supervisors. Unlike medicine, ongoing assessments (i.e., maintenance of competence; MOC) are not required for psychologists to demonstrate continued current knowledge or competency.

Sechrest and Coan (2002)'s survey found that only three of 168 psychology doctoral programs required *any*

undergraduate biology coursework for admission. Doctoral psychology programs' accreditation requires no prerequisites in natural and biological sciences (APA, 2015) despite the clear recommendation of the Health Service Psychology Education Collaborative (HSPEC; HSPEC, 2013), an interorganizational group including the APA, the Council of Graduate Departments of Psychology, and the Council of Chairs of Training Councils, that there should be clear and uniform guidelines regarding prerequisite coursework. The Collaborative, among other competencies, recommended that applicants have knowledge in human biology prior to admission. Although the Collaborative recommends doctoral programs preparing health service psychologists should include, "knowledge in human biology suitable for someone preparing to become a health service psychologist" (HSPEC, 2013, p. 5), in actuality graduate-level medically related scientific coursework and clinical training is less than that of other health professionals (see Table 2). The absence of scientific prerequisites for enrollment in psychopharmacology training programs suggests psychologists have less medically relevant scientific foundation relative to other disciplines. This could limit readiness to grasp complex biomedical concepts germane to managing medications, and require oversimplification of the curriculum. Indeed anecdotally, graduates of the training have opined their training did not adequately prepare them to prescribe (Ransom, 2014).

3 | OVERALL COMPARISONS: PHYSICIANS, NPS, PAS, AND PSYCHOLOGISTS

As the goals and foci of training differ across disciplines, standardization of minimal training for prescribing seems important. Few studies have addressed standardization. Muse and McGrath (2010b) compared five postdoctoral clinical psychopharmacology M.S. programs to five psychiatric NP programs and five medical schools, comparing content areas they deemed relevant to prescribing: biochemistry and neuroscience; pharmacology; clinical practicum; research and statistics required to critically evaluate the effectiveness of pharmacological agents and other therapeutic interventions; behavioral assessment and diagnosis, including the use of psychometrics; psychosocial interventions, psychotherapy, and other nonpharmacological therapeutic options; and foundations in mental health and the behavioral sciences (p. 97).

They correctly noted greater didactics in biochemistry and neuroscience as well as clinical hours for physicians than psychologists. They calculated psychologists accrued more training than physicians and psychiatric NPs in some areas. Despite their noteworthy relative deficiencies, they contended prescribing psychologists are equally, if not more,

TABLE 3 Summary of prescriptive authority legislation passed in five states

State	Year	Didactic training	Practicum	Examination	License information	Governing board
New Mexico ^a (prescribing psychologist)	2002	450 hr ^b 20 continuing education (CE) hours per year	80 hr (physical assessment and pathophysiology) 400 hr (supervised evaluation and pre-script to 100 patients)	PEP	Conditional (2 years): supervised by physician, at least 50 patients, collaborative agreement with primary provider Prescription Certificate: review of 10 patient charts (6-month re-review); attempt three times before repeat psychopharmacology training program	Psychology
Louisiana ^c (medical psychologist)	2004	Postdoctoral master's degree in clinical psychopharmacology ^d 20 CE hours per year	Broad training with no specific hours or numbers of patients specified	PEP ^e BLS	Supervised prescribing, collaborative agreement with primary provider	Psychology (2004–10) Medical (as of 2010)
Illinois ^f (prescribing psychologist)	2014	5–6 years of full-time education across the undergraduate and graduate levels ^g 10 hr CE per year	14-month (full-time, supervised) training of at least 36 credit hours including research project and completion of rotations in emergency medicine, family medicine, geriatrics, internal medicine, obstetrics and gynecology, pediatrics, psychiatrics, surgery, and one elective	PEP or PANCE	Prescribe only to clients between ages of 17 and 65; cannot prescribe to certain groups (pregnant women, intellectual disabilities, serious medical issues) Written collaborative agreement with primary care physician Limitations for prescribing Schedule II through V controlled substances	Psychology
Iowa ^h (Prescribing psychologist)	2016	5 years before application complete postdoctoral master's degree in clinical psychopharmacology approved by joint board 20 hr CE per year	5 years before application complete supervised and relevant clinical experience in assessment and pathophysiology and supervised practicum treating patients with mental disorders; sufficient practice to competently train as determined by joint rules by two boards	Examination ⁱ	Conditional (4 years): supervised by physician, collaborative agreement with primary provider with specifics to be determined by joint rules Prescription Certificate: successfully complete 2 years of supervised prescribing, ongoing collaborative relationship with primary provider	Joint Medical and Psychology Boards set joint rules

(Continues)

TABLE 3 (Continued)

State	Year	Didactic training	Practicum	Examination	License information	Governing board
Idaho ^j (Prescribing psychologist)	2017	Postdoctoral master's degree in clinical psychopharmacology CE to be determined by board	Broad training with no specific hours or numbers of patients specified	PEP	Provisional (2 years): supervised by physician with specifics to be determined by board Prescription Certificate: successfully complete 2 years of supervised prescribing (one year treating pediatric or geriatric populations if desire to prescribe for these populations); certificate by endorsement with rules to be determined by board or advisory board	Psychology

Abbreviations: PEP, Psychopharmacology Examination for Psychologists; BLS, Basic Life Support certification; PANCE, Physician Assistant National Certifying Exam.

^aNew Mexico Psychological Association (2009).

^bCourses in neuroscience, pharmacology, psychopharmacology, physiology, pathophysiology, physical and laboratory assessment, clinical pharmacotherapeutics, and cultural competence.

^cLouisiana Board of Examiners of Psychologists (2009).

^dHours not specified but must include anatomy and physiology, biochemistry, neuroscience, pharmacology, psychopharmacology, clinical medicine or pathophysiology, and health assessment. Practicum also broad but to include "range of clinical psychopathologies; medical conditions presenting as psychiatric illness; and treatment complexities, including complicating medical conditions; diagnostic questions; choice of medications; untoward side effects; compliance problems; alternative treatments; and treatment failures" (p. 9).

^eMust complete additional coursework if fail PEP three times; repeat all coursework if fail PEP fourth time.

^fIllinois Clinical Psychology Licensing Act (2014).

^gUndergraduate coursework includes one semester of medical terminology, two semesters of chemistry or biochemistry with laboratory, one semester of human physiology, one semester of anatomy and physiology, one semester of microbiology with laboratory, and one semester of general biology for science majors or cell and molecular biology; graduate coursework includes at least 60 credit hours; pharmacology, clinical psychopharmacology, clinical anatomy and integrated science, patient evaluation, advanced physical assessment, research methods, advanced pathophysiology, diagnostic methods, problem-based learning, and clinical procedural skills.

^hIowa Act Relating to Prescription Authority for Certain Psychologists (2016).

ⁱPassed national certification examination approved by both boards.

^jIdaho HB No. 2017 to Provide Prescriptive Authority for Psychologists (2017).

qualified to prescribe psychotropic medications than physicians and psychiatric NPs.

Heiby (2010) roundly criticized their approach and controversial interpretation on several grounds. She asserted the psychopharmacology master's degree "is of unknown quality" (p. 106), noted it does not meet APA accreditation standards, and critiqued their content classifications noting, "no rationale or evidence of this definition is presented in support of its content or ecological validity" (p. 107). Furthermore, essential content in physician and NP training (e.g., anatomy, genetics, pathology, and pathophysiology) and systemic effects of psychotropic drugs were excluded. Finally, Heiby (2010) criticized their conclusions for neglecting other professions' more intensive training (i.e., undergraduate physical/biological scientific prerequisites, predoctoral clerkships, apprenticeships, and postdegree supervised practice and residencies). Physicians also undergo multiple standardized (e.g., USMLE Step 1, Step 2 CK, Step 2CS, and Step 3) evaluations and nearly universally secure board certification based on additional evaluations.

The lack of data on the quality of psychopharmacology programs precludes conclusions about the comparability of training outcomes for prescribing disciplines. The review reported in the following section compared psychopharmacology training for psychologists to training for psychiatrists, family practice physicians, NPs, and PAs in terms of programs' didactic curricula, supervised practice hours, and clinical experiences.

4 | METHOD

At the time of data collection (2014), five programs were preparing psychologists to prescribe. Four APA-designated programs conferring master's degrees were assessed: (a) Daniel K. Inouye College of Pharmacy—University of Hawaii at Hilo; (b) Clinical Psychopharmacology Postdoctoral Master of Science Program at California School of Professional Psychology—Alliant International University; (c) Fairleigh Dickinson University; and (d) Southwestern Institute for the Advancement of Psychotherapy/New Mexico State University (SIAP/NMSU; November 2010). A certificate program was excluded because it did not provide sufficient information about admission requirements, curriculum, or clinical training online or in response to requests. To compare training among disciplines, five training programs for each of the following prescribing professionals were included: MD, NP (MSN and DNP), and PA. Five MSN programs were selected: Psychiatric/Mental Health Nurse Practitioner (PMHNP) and Primary Care Nurse Practitioner (PCNP) tracks were examined to explore training differences and compare with psychologists' training. Only MSN programs

offering both PMHNP and PCNP tracks were included to permit comparisons.

4.1 | Procedures

Programs were selected randomly from all accredited programs in disciplines to avoid bias based on location, program characteristics, or reputation. Programs' websites were examined for entrance criteria (i.e., admission requirements and prerequisite coursework), as well as programmatic overviews (e.g., program length, didactic instruction (in-person versus online), and total didactic hours). Clock hours or credit hours were recorded for (a) prerequisite undergraduate coursework; (b) required credit hours and coursework content; and (c) required experiential training hours. Required hours were compared within and between programs to determine variability among program types and across professions.

Six knowledge domains were established by examining general content of didactic curricula and identifying cross-cutting content: (a) scientific foundations (i.e., basic sciences, e.g., biology, chemistry, anatomy, physiology necessary for understanding structures, functions, and processes within humans); (b) pathophysiology (i.e., nature and function of disease processes within organ systems); (c) pharmacology (i.e., mechanisms of action of medications across drug classes and medical conditions); (d) interview and clinical assessment (i.e., diagnostic interviewing, performing physical examinations, and choosing and interpreting diagnostic tests); (e) professional practice (i.e., ethics, public policy, cultural diversity, patient advocacy, and multidisciplinary teamwork); and (f) assessment and treatment of psychiatric conditions (ATPC; i.e., diagnosis and treatment of psychiatric conditions, with a primary focus on psychopharmacological interventions, including integrating behavioral interventions with psychopharmacological practice and medication management). Required courses within programs' curricula were classified based on course title and description. Courses encompassing multiple areas were categorized based on the domain best capturing content. For example, a general pharmacology course that included a psychopharmacology section was categorized under pharmacology.

5 | FINDINGS

5.1 | Admission prerequisites

Entry requirements and prerequisite coursework differ across professions (see Table 2). Prescribing professionals' training requires basic science foundations *before* initiating

discipline-specific training with one exception—psychologists (see Table 2). Whereas psychology doctoral training provides training in mental health diagnoses, psychotherapeutic intervention, assessment, and research/statistics, psychologists' psychopharmacology training does not meet the APA's own Task Force experts' stipulation that prescribing psychologists have the "necessary science background" (APA, 1992, p. 66), including two courses of chemistry and biology (Smyer et al., 1993). APA's (2015) doctoral program accreditation criteria do not mandate undergraduate scientific prerequisites. Doctoral programs generally provide only one course covering "biological bases of behavior," which generally addresses minimal content critical to prescribing (e.g., organ systems).

5.2 | Didactic training models

5.2.1 | Overview and total hours

Courses were analyzed according to six domains based on Heiby (2010) revealing the total didactic hours completed by medical students greatly exceeded didactic requirements for other disciplines. This methodology yielded contrasting conclusions from Muse and McGrath (2010b), and revealed psychopharmacology programs' relative shortcomings in crucial areas, most notably in scientific foundations (i.e., receiving less than half the hours obtained by NPs and PAs) and pathophysiology.

MSN programs for PMHNPs and PCNPs consist of two years of full-time or longer part-time study. Among selected MSN programs, four required in-person didactic attendance for both tracks. Three required in-person attendance for all didactics. One combined in-person and online coursework for PMHNP and PCNP tracks, requiring in-person didactic attendance each semester. PMHNP tracks involve slightly fewer hours ($M = 500$, $SD = 110.20$) than PCNP tracks ($M = 547$, $SD = 134.98$). DNP programs generally comprise three years of full-time study or equivalent longer part-time matriculation. One program solely provided online instruction. Another combined online and in-person instruction.

PA programs entailed two years (24–27 months) of full-time study. Four required in-person attendance. One offered hybrid distance learning and in-person didactics. Didactic hours exceeded masters' graduate nursing programs' hours due to their bachelors' nursing requirements.

Psychologists' psychopharmacology training required fewer didactic hours than all other disciplines (other than DNP programs for which earlier master's level training provided content exposure). Programs allowed part-time study with completion within five years. Two programs' instruction was solely online. Only one required in-person attendance for

all didactics. One combined online and in-person formats, requiring students to attend 11 in-person didactic trainings. One program's website indicated "all instruction is provided on the weekends."

5.3 | Content of didactic training

5.3.1 | Scientific foundations

Medical students get the most foundational science training (see Table 4). Nursing programs excluded scientific foundations' coursework because students already had completed undergraduate basic science courses. Psychologists in psychopharmacology programs obtained about 85 hr of scientific foundations' coursework. Combined with their one predoctoral course, they received significantly less scientific training than other prescribers. In terms of scientific foundations, physicians training entails almost six times, and NPs and PAs over twice the scientific coursework of prescribing psychologists.

5.3.2 | Pathophysiology

Medical schools provide significantly more didactic coursework in pathophysiology than the other disciplines. PA programs provided similar pathophysiology contact hours to PMHNPs' programs. Psychologists' psychopharmacology training included significantly fewer contact pathophysiology hours. Prescribing psychologists receive 17 times less pathophysiology instruction than physicians, 8–12 times less than NPs, and 4.5 times less than PAs.

5.3.3 | Pharmacology

Pharmacology coursework was fairly similar across all disciplines. It was split between undergraduate and master's programs for NPs. DNP programs excluded pharmacology training presumably which was completed at the BSN and MSN levels. Psychopharmacology coursework was included in the ATPC domain.

5.3.4 | Diagnostic interviewing and clinical assessment

Medical schools provided the most didactics on diagnostic interviewing and clinical assessment among all fields, with years of residency beyond medical school. NP training (including BSN) in diagnostic interviewing and clinical assessment was nearly identical to PA coursework. Psychologists'

TABLE 4 Comparison of professions' didactic training models across domains

Type of professional	Time	Total didactic hours	Scientific foundations ^a	Pathophysiology	Pharmacology	Diagnostic interviewing and assessment	Professional practice	Assessment and treatment of psychiatric conditions
Medical Doctor	PA ^b T	1,686 (164.55)	425 (40.23) ^c 751	986 (181.43) ^d 986	60 (0) ^e 60	144 (32.86) 144	84 (53.67) 84	72 (65.73) 72
Nurse Practitioner								
Master's (PMHNP)	PA T	500 (110.20)	0 297	330 (134.58) 702	40 (9.81) 90	47 (7.16) 98	88 (85.81) 259	247 (73.89) 379
Master's (PCNP)	PA T	547 (134.98)	0 297	79 (69.45) 451	43 (3.29) 91	50 (7.26) 101	116 (59.23) 287	14 (20.12) 146
Doctorate	PA T	266 (91.78)	0 297	32 (19.14) (483–734)	0 (90–91)	0 (98–101)	234 (84.30) (493–521)	0 132
Physician's Assistant	PA T	653 (170.99)	111 (65.68) 354	257 (89.12) 257	62 (8.22) 62	100 (31.10) 100	101 (26.83) 101	24 (19.41) 24
Prescribing Psychologist	PA T	397 (116.20)	84 (38.43) 129	57 57	60 (28.06) 60	37 (28.07) 37	20 (19.11) 179	138 (35.72) 2,158

Note: The means (with *SD* presented in parentheses) represent contact hours with 15 contact hours being equal to one academic credit.

^aA significant portion (or all in the case of NP) of didactic training in the foundational sciences occurred as prerequisite coursework completed before admission to the training program.

^bFor each type of professional, the top number represents the mean number of hours postadmission (PA), whereas the bottom number represents the total (T) mean number of hours (including those accrued before entry into training program).

^cOne medical school integrated foundational sciences curriculum with pathophysiology coursework resulting in the number of hours of foundational science being lower than the other four programs (60 versus 425). Based on course descriptions, pathophysiology appeared to be the central focus on combined didactic training so they were counted in the pathophysiology domain. The other medical training programs were relatively similar ranging from 380 to 480 so the mean of the four programs ($M = 425$) was used as an estimate for foundational sciences rather than all five programs, given that the 60 hr of the purely foundational sciences of the integrated curriculum would have artificially diminished the average ($M = 352$).

^dAll didactic training in pathophysiology occurred after admission to the training program, except for NPs where most of this coursework was completed prior to obtaining a master's or doctorate in nursing.

^eOne medical program integrated content in pharmacology with the pathophysiology coursework and, as a result, the number of hours of pharmacology was only calculated across the other four programs, rather than averaging zero hours as it is covered coincident with pathophysiology but not easily quantifiable.

psychopharmacology programs entailed a third to half the interviewing and clinical assessment contact hours relative to physicians and NPs/PAs.

Psychologists undergo training in diagnostic interviewing during doctoral training. However, that doctorate training focuses on assessment related to phenomena other than the more comprehensive and targeted health assessment necessary for prescribing. It is unclear whether, and how fully, that training prepares them with diagnostic and clinical assessment skills for managing medications, and assessing for physical health, including drug effects and interactions. Similarly, it is not clear how relatively abbreviated training might limit understanding related to physical functioning and somatic treatments that may impact clinical management of mental health and comorbid medical disorders.

5.3.5 | Issues in professional practice

DNP programs provide nearly six times the coursework addressing professional practice issues in health care than medical schools (i.e., excluding residency) and PA programs. Combining doctoral and psychopharmacology training, psychologists receive considerable instruction addressing professional practice issues. However, their doctoral coursework addressing professional practice does not focus on prescribing matters.

5.3.6 | Assessment and treatment of psychiatric conditions

Physicians and PAs received less didactic coursework on assessment and treatment of psychiatric disorders than either PMHNPs or psychologists preparing for prescribing. Nurses generally completed 132 hr of didactics for assessing and treating psychiatric conditions at the BSN level. MSN and doctoral programs for PCNPs provided less mental health training than did PMHNPs' programs. While psychologists' psychopharmacology programs provided more ATPC hours than MD (not counting residency), PA, and PCNP programs, they provided fewer than PMHNP programs. Psychologists' doctoral training includes numerous hours of training in assessing and treating (i.e., psychotherapy) psychiatric conditions, but only modest training directly related to prescribing and medications.

5.4 | Clinical experience

5.4.1 | Physicians

Clerkship requirements during the third and fourth years ranged (68–82 weeks; $M = 76.8$; $SD = 5.4$) across primary care and specialties. ACGME work hour guidelines were

established in 2003 (Kogan et al., 2006). Residents are prohibited from working ≥ 80 hr/week and have $\geq$ one of every seven days off. Wald et al. (2007) survey of emergency medicine clerkship directors found 75% ($N = 132$) required medical students to work 32–45 hr/week (median = 40). Conservatively assuming medical students work only 40 hr/week for the mean number of weeks of clerkship ($M = 76.8$), they complete an estimated 3,072 hr of supervised practice during medical school (see Figure 1). The reality is they generally work considerably more than 40 hr/week.

5.4.2 | Psychiatry

Two medical schools' psychiatric clerkships required 6-week psychiatry rotations and two required 4-week psychiatry rotations. Assuming 40-hr work weeks and using length of psychiatric clerkships ($M = 5$ weeks), medical students conservatively obtain an estimated 200 hr of psychiatric clinical experience. They also gain mental health experience during other clerkships (i.e., family medicine and internal medicine). Our exploration yielded no data on medical students' exposure to mental health conditions outside of psychiatric rotations. Four allowed 16–28 weeks of elective clerkship (i.e., medical students can elect additional psychiatric training).

Psychiatrists complete four-year residencies focusing on clinical skills (i.e., diagnosing and treating mental health conditions). Assuming 40-hr work weeks for 48 weeks/year, psychiatry residents conservatively obtain an estimated 7,680 hr of supervised clinical practice. Total clinical hours in all areas by the end of residency are approximately 10,752 hr with more than 7,680 hr focusing on psychiatric conditions (see Figure 1). Both clerkships and residencies are widely recognized as exceeding 40 hr/week.

5.4.3 | Family medicine

In five family medicine residencies, based on 40-hr work weeks in 3-year residencies, a conservative estimate of residents' clinical experience is 6,240 supervised clinical hours. Most programs had two 6-week ($M = 4$, $SD = 1.63$) psychiatry rotations. Four to six weeks of training assuming 40-hr work weeks yields ≥ 160 –240 psychiatry hours. Residencies offered 3.75 to 6 months of elective rotations ($M = 4.93$, $SD = 1$) during which residents could pursue additional psychiatry training. One program had integrated behavioral health experiences spanning the residency rather than an actual psychiatry rotation. The clinical skills emphasized included clinical interviewing, crisis management, psychosocial assessment, psychiatric diagnosis, motivational

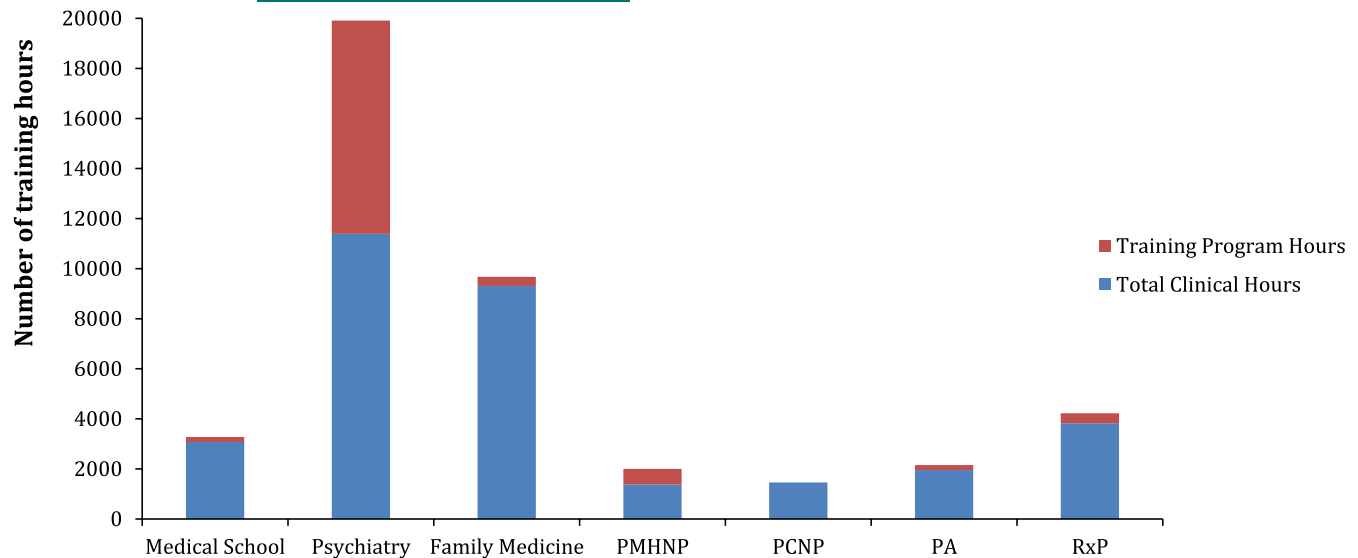


FIGURE 1 Number of Clinical and Training Program Hours in Mental Health. Graph presents the number of clinical training hours (total and specific program training in psychiatry) across disciplines' training programs. The five MSN programs that trained to act as Primary Care Nurse Practitioner (PCNP) required between 630 and 925 hr ($M = 701$, $SD = 127.89$) of clinical experience in a primary care setting. Nursing students in the PCNP track gain experience with the diagnosis and treatment of common mental health conditions within the primary care setting, but the percentage of time spent on these skills was not identified by programs, so zero reported for the PCNP programs, which is an underestimate. However, an estimate of 15–20 hr is provided in Adult-Geriatric or Family Nurse Practitioner training programs (personal communication, Sharon Smith, January 2, 2019) which are now at the doctoral level. Additional information about the mental health curriculum in nurse practitioner programs is available through the National Organization of Nurse Practitioner Faculty (<https://www.nonpf.org/page/14>)

interviewing, cognitive behavioral therapy (CBT), psychopharmacology, and managing co-occurring disorders. A conservative estimate of family physicians' training was 9,312 supervised clinical training hours across areas, assumedly providing ample medication management experiences.

5.4.4 | Nurse practitioners

Nursing training begins at the undergraduate level. Students complete clinical rotations based on diverse populations. Programs required clinical rotations providing nursing care to adults, children, mothers, and newborns. They also required mental health and public health rotations. Two programs included introductory clinical rotations on fundamentals of nursing. Two programs included final rotations wherein students integrate clinical skills pertaining to various nursing aspects. One program required rotations in gerontology and nursing leadership and management.

Bachelor's degrees in nursing programs' websites did not present clinical hours completed for each rotation. However, Li and Kenward's (2006) national survey indicated undergraduate nursing students complete extensive ($M = 758$) clinical hours. Associate-level RNs complete somewhere between 639.5 and 758 clinical hours. Four of five programs allowed admission to applicants with an ASN and a bachelor's degree in another area. Because the number of clinical hours for associate's degrees is unspecified, our analysis represents NPs with undergraduate

nursing degrees who have completed on average 758 clinical hours *before* their master's NP programs.

MSN PMHNP students complete 600–750 hr ($M = 622$, $SD = 77.59$) of supervised clinicals emphasizing diagnosing and treating mental health conditions. PCNP programs required 630 to 925 hr ($M = 701$, $SD = 127.89$) of clinical experience in primary care settings. PCNP students gain experience with mental health conditions, but the time spent on mental health is unspecified.

Master's level NPs seeking DNP degrees receive additional clinical experience. DNP programs required 400–585 clinical hours ($M = 497$, $SD = 65.54$). DNP students gain mental health experience in primary care. In sum, master's level PMHNPs and PCNPs complete an estimated 1,380–1,459 clinical hours. DNPs accrue an estimated 1,877 (PMHNPs)–1,956 (PCNPs) hours.

5.4.5 | Physician assistants

The American Academy of Physician Assistants (AAPA, 2013) contends PAs receive > 2,000 hr of clinical training emphasizing primary care. In four programs listing clinical rotations' length, students spent 44–54 weeks on clinical rotations ($M = 48$, $SD = 4.9$). Their clinical rotations are full-time; one program indicated students spend 40–60 hr/week on clinical rotations. Conservatively assuming 40-hr work weeks, PA students complete $\geq 1,630$ –2,220 clinical hours ($M = 1,950$,

$SD = 248.8$). Four programs required psychiatry or behavioral health rotations. The other did not specify a psychiatric/behavioral health rotation but included four weeks of exposure to specialty areas, which could include psychiatry. Three programs reported students spent 4–6 weeks on psychiatric/behavioral health rotations ($M = 5$, $SD = 1$), which assuming 40-hr work weeks, yields ≥ 160 –240 hr ($M = 200$, $SD = 40$). PA students also gain mental health experience during other rotations (e.g., primary care and emergency medicine).

5.4.6 | Prescribing psychologists

Psychology graduate students complete clinical practice as well as a one-year internship (APA, 2015). There are no national time requirements with institutions specifying practicum hour requirements. Academic advisors recommend students complete extensive ($M = 1,094$) practicum hours prior to internship, whereas internship directors think students should complete more ($M = 1,255$) hours (Ko & Rodolfa, 2005). The Association of Psychology Postdoctoral and Internship Centers (APPIC, 2014) calculated a range of practice hours ($M = 1,340$ –3,016).

Doctoral psychology internships comprise one year of supervised clinical practice. Conservatively assuming 40-hr work weeks, interns complete 2,000 hr of training. Combining practicum and internship hours, doctoral psychology trainees are estimated to complete $\geq 3,420$ hr of clinical training. Most jurisdictions require one year of postdoctoral, supervised practice for licensure. Some states have eliminated postdoctoral licensing requirements (Stambor, 2006). Doctoral psychologists complete clinical training in diagnosis and nonpsychopharmacological treatment, but not in managing medications.

APA-designated psychopharmacology training programs typically require 400 hr of didactic experience and treatment of at least 100 patients (APA, 2019a). Graduation from APA-designated program is not necessary for licensure in New Mexico or Louisiana. One psychopharmacology program required treating 100 patients and 250 clinical hours. Another required treating 100 patients and one year of clinical experience without specifying required hours. Three programs adhere to APA's requirement of treating 100 patients. One program also required 80 clinical assessment hours, meeting New Mexico's requirement.

6 | DISCUSSION

Prescribing psychologists complete most of their clinical training *prior to* entering psychopharmacology programs. They receive more mental health didactics than family medicine physicians, NPs, and PAs (Lavoie & Barone, 2006; Muse & McGrath, 2010a; Sammons et al., 2000). Their areas of relatively greater knowledge include mental health conditions,

study and prediction of human behavior, and psychotherapy/behavior change. These relative strengths, however, do not suggest they would be as competent prescribing as psychiatrists or nonpsychiatrist prescribers, who are more experienced prescribing generally as well as in prescribing psychoactive agents within the holistic framework of patients' total medication regimens and overall health. Whereas doctoral psychology training provides extensive ATPC experience, it does not address basic scientific/biological knowledge nor skills specifically related to addressing physical health conditions and managing medication. Psychologists' psychopharmacology programs typically entail 400 didactic hours to foster skills specifically for assessing need for and managing psychotropic medications. By comparison, physicians, NPs, and PAs accrue considerably more supervised clinical training hours than prescribing psychologists relevant to prescribing. Whereas empirical evidence identifying minimum time thresholds for establishing prescribing competence (including minimizing risk to patients) is lacking, training for all other prescribers involves more intensive basic education and clinical training addressing prescribing than prescribing psychologists obtain. APA's psychopharmacology training model and existing psychopharmacology training programs promote less-extensive medical training relative to programs for other prescribers and have limited and loose criteria for clinical experiences directly involving prescribing (e.g., Nasrallah, 2017).

The American Psychological Association's training model comprises less than half the training (Heiby, DeLeon, & Anderson, 2004) of the DoD's Psychopharmacology Demonstration Project (PDP), which RxP proponents cite as evidence for training psychologists to prescribe (Sammons, 2013) despite the striking differences between the more intensive PDP and current training. The American College of Neuropsychopharmacology's (1998) final report on the PDP judged graduates' medical knowledge on level of 3rd- or 4th-year medical students (i.e., individuals needing closely supervision rather than independently practicing). PDP graduates generally recommended two-year full-time programs including inpatient psychiatric training, as they experienced at Walter Reed Army Medical Center. Current training for RxP does not stipulate such intensity nor contact with specific populations, clinical severity, setting, or care parameters. Potential consequences of prescribing psychologists' relatively circumscribed training may include increased risks to patients, litigation, malpractice costs, and adverse publicity for the profession.

7 | PROPONENTS' RATIONALE FOR PRESCRIBING PSYCHOLOGISTS

Proponents contend that prescribing psychologists can increase patient access to psychiatric services in light of

shortages of psychiatrists (Balon, Coverdale, & Roberts, 2011; Bray et al., 2014; Thomas & Holzer, 2006; Wilk, West, Narrow, Rae, & Regier, 2005). However, the psychiatrist shortage does not logically lead to the conclusion that psychologists should fill gaps by prescribing based on relatively abbreviated training. In fact, research raises questions whether prescribing psychologists increase rural access (see Tompkins & Johnson, 2016). Most prescribing psychologists practice in mental health settings where they may lack access to medical resources (Tulkin, 2012). Claims (e.g., Shearer, Harmon, Seavey, & Tiu, 2012) that psychologists can effectively and safely increase patient access are not based on rigorous investigation. Linda and McGrath's (2017) report of favorable responses among physicians to prescribing psychologists is limited in scope, biased toward finding favorable outcomes (e.g., due to sampling procedure), and based on attitudes rather than competency or patient outcomes. The greatest benefit reported by physicians was availability of care, reduced use of physician time and insurance-related issues. Such benefits do not address more critical patient outcomes and are not unique to prescribing. For example, integrating (cf. coordinated care, co-located care; see Heath, Wise Romero, & Reynolds, 2013) psychologists in health-care settings, without psychologist prescribing, can yield meaningful benefits: (a) counteracting underutilization of mental health services (Huang, Fong, Duong, & Quach, 2016); (b) implementing evidence-based practices across disciplines; and (c) integrating funding, resource sharing, and billing.

Recent changes to the MCAT and competencies and principles outlined in *Scientific Foundations for Future Physicians* resulting from the AAMC partnership with the Howard Hughes Medical Institute (HHMI) suggest synergy between premedical and medical education that integrates broad-based science competencies and greater knowledge in behavioral and social health, communication, and cultural competence (AAMC/HHMI, 2009). Robiner et al. (2013) address the importance of psychologists' roles as members of interdisciplinary teams, noting that changes in care delivery highlight the need for psychologists to collaborate effectively rather than prescribe. Integrating mental health services in primary and specialty care settings may improve access and leverage psychologists' impact given that there are more physicians, NPs, and PAs who prescribe than mental health prescribers. Providing psychological services in primary care reduces barriers to accessing care (e.g., transportation, time, referral inefficiencies, and stigma). Approximately 10% of primary care patients meet criteria for major depressive disorders (Craven & Bland, 2013) and 20% meet criteria for anxiety disorders (Kroenke, Spitzer, Williams, Monahan, & Löwe, 2007). This epidemiology suggests health professional trainees gain considerable experience assessing and treating mental health concerns during primary care rotations. Adding

mental health specialists to interdisciplinary teams promotes effectively and holistically addressing patient needs.

If the profession wishes to present psychologist prescribers as high quality, comparable to other professions' prescribers, the APA designation criteria should more closely resemble training of other (including nonphysician) prescribers in other disciplines to confirm near equivalence of training (i.e., of didactics and experience) and readiness for prescribing. The training model should be upgraded to require *accreditation* (c.f. designation) criteria and processes, and alignment of the content and rigor of the PEP with other prescribers' board and clerkship (e.g., shelf) examinations. Otherwise, skepticism related to psychology's shortcut training for prescribing and about psychologist prescribers' expertise will continue.

Moreover, to meet APA's Ad Hoc Task Force's (Smyer et al., 1993) experts' recommendations for scientific prerequisites, psychopharmacology training programs would need to require and include significantly more training in the foundational sciences, pathophysiology, diagnostic interviewing and assessment, and issues related to professional practice. Adequate targeted medical training is needed, as psychotropic medication can adversely impact diverse organ systems (see Ransom, 2014).

No regulatory system for monitoring prescribing psychologists' outcomes has been established. The challenges with tracking legal and regulatory complaints and absence of any funding or organized effort to do so (i.e., within the DoD or jurisdictions granting prescriptive authority) preclude establishing a comprehensive system or database for monitoring psychologists' prescribing practices and clinical outcomes. It is inappropriate to consider the absence of quality data, especially when none is being systematically and scientifically collected, as evidence that there are no problems. Legal strategies, such as nondisclosure agreements, and regulatory limitations (e.g., limited medication expertise on psychology boards; no oversight mechanisms in the FDA or other federal or state agencies or pharmaceutical companies to assess the competence of prescribers), are factors that could preclude identifying and publicizing problems associated with psychologist prescribing.

Nevertheless, health regulatory board actions and litigation are potentially associated with prescribing based on truncated training. The field would benefit from research comparing the prevalence of health regulatory actions and litigation based on prescribing versus nonprescribing psychologists and other prescribers. The Louisiana State Board of Medical Examiners has sanctioned four prescribing psychologists, two for inappropriate practices. In addition, three lawsuits have been filed in Louisiana against prescribing psychologists. Whereas these indicators are difficult to interpret, their very existence necessitates that RxP proponents

no longer claim there have been no problems associated with psychologists prescribing.

For psychologists to pursue prescriptive authority, ethics training specific to the prescribing role is also crucial. Spurling et al.'s (2010) meta-analysis of physician prescribing found that increased exposure to pharmaceutical information led to *greater frequency* of prescribing and *decreased quality* of prescribing (as measured by appropriateness of medications prescribed and adherence to recommended guidelines). Mintzes et al. (2013) note physicians can misjudge the quality of information provided by pharmaceutical representatives when minimizing or not disclosing adverse effects. This seems to have been a contributing factor to the opioid epidemic. Limited scientific background and medical training theoretically render prescribing psychologists even more susceptible to misleading marketing by pharmaceutical companies. Moreover, data from the Part D Prescriber Public Use File (PUF) from the Centers for Medicare and Medicaid Service (CMS) suggest some prescribing psychologists have prescribed beyond the legislative bounds of their licenses.

Over a decade ago, Stuart and Heiby (2007) lamented the lack of data evaluating the risks and benefits of prescribing psychologists' performance, arguing that psychology was in an "awkward position of being a scientifically based profession ... seeking to expand its scope based on a small pilot program (e.g., the PDP) that reaches well beyond the parameters of the available data" (p. 26). The RxP movement seems to resist two precepts of evidence-based practice (Lilienfeld, Ritschel, Lynn, Cautin, & Latzman, 2013): (a) naïve realism (i.e., relying on one's own limited observations to judge safety and efficacy) and (b) the *ad ignorantiam* fallacy, that is, the "error of concluding that because a claim has not been proven wrong, it must be correct or at least possess substantial merit" (p. 892).

Evidence supporting prescribing psychologists' competence, quality, and safety is still limited in scope. LeVine and Wiggins (2010) and Linda and McGrath (2017) provide limited guidance about competence or safety given their extremely small sample sizes, low response rates, sampling bias, and reliance on self-report of prescribing and other practice behaviors. Deacon's (2014b) survey of the Association for Behavioral and Cognitive Therapies (ABCT), found 89% believed RxP advocates should produce empirical evidence in support of proposed models *prior* to promoting further legislation and 67% favored collaboration over prescriptive authority to address access issues. APA's continued dogged expansion and investment in RxP, despite a lack of data seems especially concerning in light of evidence of the public's increased reliance on pharmacological intervention (Marcus & Olfson, 2010), despite patients' strong preference for psychotherapy over psychotropic medication (McHugh, Whitton, Peckham, Welge, & Otto, 2013).

Further investigation into the didactic and clinical training for prescribing is essential to ensure that if psychologists prescribe, psychopharmacology programs prepare them to be safe, competent prescribers. Unless more equivalent training is required commensurate with other prescribers' training, and its integrity is assured (i.e., through rigorous evaluation and appropriate accreditation), doubt is warranted. Psychologists' doctoral training and internship training are governed by stringent accreditation mechanisms. Ironically, despite risks of psychoactive medications (various adverse reactions including death), psychologists' training to prescribe is not. Increasing the training rigor is essential to assure that prescribing psychologists' training meets standards for all health professionals.

7.1 | Limitations and future directions

Our analysis is based on a limited sample of training programs. Future studies could replicate the findings by sampling more programs to increase the reliability of results. Clinical training hours for physicians, PAs, and others were estimated based on a 40-hr work week, which likely significantly underestimated the total number of clinical hours completed, and thereby may underestimate differences with prescribing psychologists' training. We recognize the need for larger, objective, systematic studies of the knowledge and prescribing practices of psychologists who have prescriptive authority, especially patients' health outcomes. Such studies could better gauge the quality of psychologists' prescribing as well as the frequency of recognized and unrecognized adverse events. Additional research comparing psychologists' prescribing practices to those of other prescribing professionals could highlight areas of strength and weakness in psychopharmacology training programs and in other prescribing professionals' training programs, providing a basis for further identification of standards for prescribing that minimize safety risks.

Because NP training shifted toward requiring doctoral degrees (DNP) by 2015 (American Academy of Nurse Practitioners & AANP, 2013) in response to concerns that additional training was necessary to train competent nurse practitioners, DNPs should be included in future research comparisons instead of grandparented master's level NPs.

Future research exploring all prescribers' clinical training for treating psychiatric conditions would elucidate the extent of mental health training. Identified weaknesses in mental health knowledge and skills for nonpsychologist health providers could yield training recommendations to ensure primary care patients needing mental health services receive proper care. Finally, further research on how to better serve underserved areas and populations is needed (e.g., telehealth and integrated practice) to improve access to mental health

services for populations underserved by psychologists and other health professionals.

An unknown about prescribing psychologists is how much of what they have not learned during their relatively abbreviated training may adversely affect the care they render. More could be known about the quality of care for mental health patients if there were formal, objective, systematic, larger-scale assessments of their services and the outcomes of their services.

The profession of psychology has a responsibility to support methodologically rigorous, unbiased research that comprehensively (a) identifies problems associated with psychologist prescribing (e.g., create registries and other processes for tracking problems); (b) compares patient outcomes with those of professionals with more extensive training; (c) is transparent about funding and the scope and distribution of the prescribing psychologist workforce; and (d) evaluates how much impact psychologist prescribing is having on the health care of diverse populations and regions (e.g., rural) to determine whether the agenda is achieving its stated intents and whether it is cost-effective. Acknowledging to psychologists and the public that there have been regulatory and legal problems involving psychologists who prescribe is one step toward greater understanding of the risks that attend the authority to prescribe.

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Prescriptive Authority for Psychologists: Despite Deficits in Education and Knowledge?

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As some psychologists advocate for prescription privileges, the need for closer analysis of the differences between psychologists and psychiatrists grows. Our data reveal key gaps in psychologists' training and significant limitations in their knowledge pertaining to prescribing relative to psychiatrists. Attitudes toward prescribing and estimates of psychologists' competence in prescribing are presented. The authors believe that psychologists' deficits in training and pertinent knowledge constitute major hurdles to competent prescribing. Caution is warranted about expanding psychologists' scope of practice to include prescribing.

KEY WORDS: prescription privileges; psychologist; medication; prescriptive authority; psychopharmacology; education; training.

INTRODUCTION

The movement for psychologists to secure prescriptive authority has gained considerable momentum and resources within the American Psychological Association (APA) despite a number of concerns about its potential adverse impact on patients and the field (see Adams & Bieliauskas, 1994a, 1994b; Albee, 2002; Bieliauskas, 1992a, 1992b; Brandsma & Frey, 1986; Bush, 2002a, 2002b; Bütz, 1994; D'Afflitti, 1991; DeNelsky, 1991, 1996; Gutierrez & Silk, 1998; Hayes & Chang, 2002; Hayes & Heiby, 1996, 1998; Hayes, Walser, & Bach, 2002; Heiby, 1998, 2002a, 2002b, 2002c; Kennedy, 1998; Kingsbury, 1992; Kovacs, 1988; May & Belsky, 1992; Moyer, 1995; Pies, 1991; Robiner et al., 2002; Seime, 1996; Wagner, 2002). A recent meta-analysis of 17 opinion surveys of psychologists and psychology trainees revealed minimal consensus

and differing opinions regarding the pursuit of prescription privileges (Walters, 2001).

The original APA Report of the Ad Hoc Task Force on Psychopharmacology (APA, 1992) identified three possible levels for increasing psychologists' understanding of psychopharmacology: Level 1—Basic Psychopharmacology Education; Level 2—Collaborative Practice; and Level 3—Prescription Privileges. The highest of these levels of training, intending to train psychologists to prescribe, subsequently became the focus of APA's psychopharmacology objectives, as outlined in the APA Council of Representatives (APA CoR, 1996) recommendations for postdoctoral training in psychopharmacology for prescription privileges and APA (1996) model legislation for prescriptive authority. The APA Task Force did not advocate this option as being preferable over the other levels of training, but it did conceptualize training for prescription privileges as requiring the "necessary science background." The Task Force specified that such training would have prerequisites of several undergraduate courses (e.g., biology, chemistry) which are part of the standard premedical curriculum. Since then, these prerequisites have been relaxed considerably (APA, 1996; APA CoR, 1996) though, or perhaps because, it became evident

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that few psychologists actually have obtained the academic prerequisites for psychopharmacology training envisioned by the Task Force (Tatman, Peters, Greene, & Bongar, 1997). Currently, the APA (APA CoR, 1996) recommends 300 hr of instruction and supervision of 100 patients beyond the doctoral degree. The current APA model for training psychologists comprises essentially no undergraduate prerequisites, substantially less didactics (i.e., years less) than physicians and other prescribers complete, and limited supervised practical training with remarkably little guidance as to how the practical experience is organized.

The Association of State and Provincial Psychology Boards (ASPPB, 2001) neither endorses nor opposes prescription privileges for psychologists. Recent legislation in New Mexico and Guam is designed to permit psychologists who have undertaken additional training to prescribe. The New Mexico law requires more education and both jurisdictions require more explicit requirements for the supervised experiences than the APA advocated when seeking independent prescriptive authority.

Thus far, there is a paucity of empirically derived information related to psychologists' readiness to prescribe. One of the most noted sources of information is the Department of Defense Psychopharmacology Demonstration Project (PDP), whose results were summarized in the Final Report of the American College of Neuropsychopharmacology (1998). That demonstration was limited to only 10 psychologists trained in a military medical school and teaching hospitals. Although proponents of prescriptive authority perceive the PDP as a successful pilot, the final report documents a range of outcomes, including both the favorable assessments of graduates in some areas and limitations of their training, practice, and skills. The report also questions the generalizability of the results of the PDP beyond its few graduates and the environment of organized military medical services to potentially much larger numbers of psychologists trained in environments about which little is known. In other words, it is uncertain how clearly the DoD program would predict the performance of psychologists trained in other settings (i.e., generally neither medical schools nor teaching hospitals).

In this paper, we contrast psychologists' and psychiatrists' training in biological and physical sciences, knowledge of domains fundamental to prescribing, and attitudes toward psychologists' prescribing. The presumed linkage between quality of care in prescribing and clinicians' training and mastery of rel-

evant knowledge domains and acquisition of multiple skill sets makes it critical to examine these parameters closely. Our related paper (Robiner et al., 2002) provides a more comprehensive critique of the current training model for psychologist prescribing, addressing training, accreditation, and regulatory issues, as well as some of the justifications that proponents articulate in lobbying for the prescriptive authority agenda.

Aims

Our focus in this paper is on several issues. First, how do psychologists and psychiatrists differ in terms of graduate and undergraduate education in the biological and physical sciences relevant to prescribing? Second, how extensive is psychologists' knowledge related to prescribing psychoactive medications and how does it compare with psychiatrists' knowledge? Third, how do selected factors affect psychopharmacology knowledge? Lastly, how do psychologists and psychiatrists view psychologists' interest in obtaining prescriptive authority?

METHOD

Participants

Doctoral-level psychologists ($n = 49$) were recruited to complete surveys at the annual meetings of the Minnesota Psychological Association and the Pennsylvania Psychological Association in 1991. A majority of psychologists had completed APA-accredited doctoral programs (63%) and APA-accredited internships (53%). About half were trained in clinical psychology, a fifth had counseling degrees, and the remainder had training in other applied professional areas (e.g., educational, school) that can serve as the basis for psychology licensure. Their degrees included PhD (69%), EdD (12%), and PsyD (4%).

Psychiatric residents ($n = 20$) at the University of Minnesota Medical School and Hennepin County Medical Center were solicited at weekly meetings for psychiatric residents during which they typically discussed training and professional issues. Residents were at least at the G3 level. Data were collected from a few cohorts of psychiatric residents between 1991 and 1993, with a small number of additional residents surveyed in 1996 to increase the sample size.

The psychologists were older ($M = 47$ years) than the psychiatric residents ($M = 35$ years). The psychologists were mostly men (71%). Residents were mostly women (60%). Both groups were primarily from urban or suburban settings, although more psychologists (29%) than residents (5%) lived in rural areas. Survey administration was supervised by one of the investigators or their designees to ensure that participants' responses were entirely their own and that reference materials were not available. Written informed consent approved by the University of Minnesota Committee on the Use of Human Subjects in Research was obtained prior to survey administration.

Measures

Measures were developed (by WR, EC, and JA) for this study to assess educational backgrounds, knowledge related to psychopharmacology, readings related to prescribing, and attitudes about psychologist prescriptive authority. Parallel forms were created differing only in questions for the psychologists about their personal intentions regarding prescriptive authority. Surveys generally took less than 1 hr to complete. Pharmacology responses were scored by a board-certified psychiatrist (EC) and reviewed by other authors for consistency.

The survey assessing knowledge of psychopharmacology and related medical information had four sections. The first comprised a list of 58 side effects, toxic effects, and contraindications associated with common psychopharmacologic agents (from agranulocytosis to urticaria). The list was derived from the Physicians Desk Reference for benzodiazepines, antidepressants, antipsychotics, and mood stabilizers. In this section participants described symptoms or conditions and how they were diagnosed to indicate their awareness and understanding of medical risks that attend prescribing. The second section consisted of five drug-related clinical conditions (e.g., neuroleptic malignant syndrome, anticholinergic effects) associated with psychoactive medications that respondents were requested to describe and for which they were to delineate symptoms. The third section listed 13 types of medications, both psychoactive and nonpsychoactive classes, that have interactions with psychoactive medications. For each medication class, respondents were requested to name up to four medications (either generic or product name) to provide an index of gross familiarity with the other types of agents

that can affect prescribing of psychoactive agents. The fourth section was a 25-item psychopharmacology quiz based on a posttest for medical students' psychiatric rotation at the University of Minnesota Medical School.

Statistical Analyses

Data analysis comprised independent-sample t tests, for which equal variance was not assumed, and linear regression.

RESULTS

Educational Background

Psychologists' and psychiatric residents' undergraduate majors differ significantly ($\chi^2 = 18.5$; $p < .001$). As evident in Table I, most psychologists (78.6%) had undergraduate social sciences majors; few had physical science majors. By contrast, two thirds of the psychiatric residents had biological and physical science majors. Psychiatric residents reported considerably greater course work than did psychologists in terms of premedical and medical school curriculum ($t = 14.7$; $p < .007$). Psychiatric residents nearly universally indicated they had taken at least one course (either undergraduate or graduate) in most of 13 areas typical of a premedical or medical school curriculum ($M = 12$ courses): anatomy, neuroanatomy, biochemistry, biology, chemistry, microbiology, math, calculus, pharmacology, physics (with a lab), physiology, neurophysiology, or zoology (see Table II). Psychologists' backgrounds in these areas were more limited ($M = 4.7$ courses). Fewer than half the psychologists had courses in anatomy, biochemistry, microbiology, pharmacology, physics, physiology, or zoology. Ten percent reported course work in a single area; 24% in 2–3 areas; 24% in 4 areas; 22% in 5–6 areas; 15% in 7–9 areas; and only 5% in greater than 9 areas (i.e., approximating medical school prerequisites).

Table I. Undergraduate Majors of Psychologists and Psychiatrists

Area of major	Psychologists	Psychiatrists
Physical sciences	12%	67%
Social sciences	79%	28%
Humanities	7%	6%
Arts	2%	0%

Table II. Psychologists' and Psychiatrists' Scientific Course Work Relevant to Prescribing

Course Work	Psychologists	Psychiatrists
Anatomy or neuroanatomy	41.5%	100.0%
Biochemistry	14.6%	100.0%
Biology	65.9%	100.0%
Chemistry	58.5%	100.0%
Microbiology	7.3%	100.0%
Mathematics	85.4%	100.0%
Pharmacology	17.1%	100.0%
Physics (with lab)	48.8%	95.0%
Physiology or neurophysiology	43.9%	94.4%
Zoology	22.0%	60.0%

Note. For psychiatrists, presumably course work < 100% represents, in part, the training of foreign medical graduates. Items did not clarify how many courses were taken within each area, nor specify whether courses were at the undergraduate or graduate level.

Knowledge of Psychopharmacology and Related Medical Information

Psychologists and psychiatrists agreed with the APA Task Force (APA, 1992; Smyer et al., 1993) that an adequate scientific foundation is very important in prescribing. Consistent differences were evident between psychiatric residents' and psychologists' familiarity with knowledge domains required for prescribing (see Table III). Psychiatric residents outperformed psychologists significantly ($p \leq .001$) on all four of the psychopharmacology indices, scoring more than twice or thrice higher on them.

In absolute terms, psychologists generally performed quite poorly on indices of knowledge and understanding of psychopharmacology and the medical information pertinent to prescribing. More specifically, psychologists obtained mean scores of 30% in the knowledge of adverse drug effects and contraindications, 29% in the knowledge of drug-related clinical syndromes; 31% in recognizing psychoactive and

other medications with which they interact, and 36% on the psychopharmacology quiz. Psychiatrists obtained mean scores of 92, 96, 78, and 80% respectively on these measures.

In addition, a composite (i.e., total percent correct) score was derived to contend conservatively with missing data. The composite score was calculated for each participant by dividing the sum of his or her scores on the tests completed by the sum of the total possible scores for the tests completed, resulting in a score representing the proportion correct of completed items. Psychologists' mean composite was less than a third correct ($M = 31\%$; $t = -17.25$; $p < .001$). Psychiatric residents' fairly high composite scores ($M = 87\%$ correct) contrasted boldly with the psychologists' performance. Overall, psychologists generally performed poorly on indices of knowledge and understanding of psychopharmacology and the medical information pertinent to prescribing.

Reading About Psychopharmacology

Psychologists reported reading significantly less than psychiatric residents about psychopharmacology in terms of psychopharmacology books, paper on psychopharmacology in medical journals, and papers on psychopharmacology in psychiatric journals they had read in the past year (see Table IV). Psychiatric residents estimated reading more than eight times the number of papers and more than six times as much from psychopharmacology books than psychologists estimated having read. The groups did not differ significantly in terms of papers read about psychological (i.e., nonpharmacological) interventions. Psychiatrists reported significantly greater *understanding* of papers about psychoactive medications than did psychologists ($t = 4.8$; $p < .001$). Psychologists believed that most psychologists had

Table III. Psychologists' and Psychiatrists' Knowledge of Psychopharmacology and Medical Information Related to Prescribing

Domain	Psychologists				Psychiatrists				<i>t</i> -Test ^a
	Mean	SD	Range	<i>n</i>	Mean	SD	Range	<i>n</i>	
Adverse effects and contraindications (maximum = 116)	34.8	20.8	0-83	39	106.4	14.9	58-116	20	-15.17
Drug-related clinical syndromes (maximum = 10)	2.9	1.9	0-7	30	9.6	1.1	6-10	19	-15.46
Medications identification (maximum = 52)	16.1	7.5	4-32	35	40.8	5.2	31-52	19	-14.19
Psychopharmacology exam (maximum = 25)	8.9	4.8	0-19	39	20.4	3.1	14-25	20	-10.97
Total percent correct ^b	31%	16%	0-63%	39	87%	9%	60-99%	20	-17.25

^aAll *t* tests are independent samples without assuming equal variance; $p < .001$.

^bCalculated as the sum of all raw scores divided by the sum of the highest possible score on each test. Total percent correct scores for participants who did not complete all of the tests were derived by dividing the sum of the scores on their completed tests by the sum of the highest possible scores on those tests only. All other scores reported in table are raw scores.

Table IV. Psychologists' and Psychiatrists' Estimates of Reading Related to Psychopharmacology and Psychological Interventions in the Past Year

Estimate	Psychologists' mean ^a	Psychiatrists' mean ^b	<i>t</i>	<i>p</i>
No. of books about psychopharmacology	0.35	2.25	-4.75 ^c	<.001
No. of articles about choosing and using psychoactive medications	7.55	63.47	-3.7 ^c	<.01
No. of articles in a psychiatric journal about psychoactive medications	4.30	81.16	-3.00 ^c	<.01
No. of articles in a medical journal about psychoactive medications	4.17	17.11	-2.20 ^c	<.05
No. of articles about psychological intervention	32.39	21.70	0.98 ^d	<i>ns</i>

^aSample size range = 40–42.^bSample size range = 19–20.^cIndependent sample without assuming equal variance.^dIndependent sample, equal variance assumed.

relatively limited understanding of papers about psychoactive medications. While both psychiatrists and psychologists recognized that prescription privileges would require psychologists to read more psychopharmacology papers annually, psychiatrists estimated significantly more ($M = 53$ articles, $t = 3.1$, $p < .003$) than psychologists estimated. This may suggest a relative underestimate by psychologists of some of the complexities inherent in prescribing that psychiatrists believe are important to keep abreast of through relatively extensive, ongoing reading.

Effects of Education, Reading, and Knowledge of Psychopharmacology-Related Issues

The degree to which knowledge scores could be predicted from reported course work background and reported reading patterns was analyzed by multiple linear regression (see Table V for regression coefficient). Because of the relatively small number of subjects, rather than compute regressions for all scores, we focused only on the composite score. We first examined the ability of reported reading patterns to predict this score among all respondents, and found that only "psychopharmacology books read in last year" was a significant ($p \leq .001$) predictor. We then examined reported course work as predictors, and

Table V. Multiple Linear Regression of Knowledge Scores on Psychopharmacology Reading and Course Work

Predictor	Regression coefficient of composite score	<i>p</i>
Psychopharmacology books read last year	0.227	<.001
Anatomy course	-0.373	<.05
Neuroanatomy course	-0.150	<.05
Microbiology course	-0.327	<.01

found that three courses were significant predictors: anatomy, neuroanatomy, and microbiology.

We then checked whether these variables remained significant predictors once education (i.e., medical school vs. graduate school) was also included as a predictor. None did (coefficients and significance levels not shown). Hence, it is likely that these undergraduate courses work as predictors of psychopharmacology knowledge because they are simply acting as proxies for the more important variable: *Having attended medical school*. The same might possibly be said of the predictive value of reported book reading with this sample. However, this conjecture is less plausible because it confounds common sense; even with medical training, the physicians who read more psychopharmacology books would presumably gain increased knowledge of psychopharmacology.

Estimates of Prescribing Competence

Table VI presents respondents' estimates of the percentage of competent prescribers for selected types of practitioners. This included psychologists with three hypothetical lengths of training (but did not specify whether each year was full-time or part-time). Psychologists estimated that 40.3–64.6% of psychologists would prescribe competently on the basis of training of 1 to ≥ 2 years respectively. Psychiatric residents' rated few psychologists as competent to prescribe after the three specified lengths of proposed training, with a low of 5.8% for 1 year and high of 19.5% for more than 2 years of training.

Both psychiatric residents and psychologists rated majorities of psychiatrists as competent to prescribe, but minorities of nonpsychiatric physicians as competent in prescribing psychoactive medications. Unfortunately, the basis for these judgments was not assessed, nor were there queries about the effects of psychologist-physician collaborations in prescribing.

Table VI. Estimates of Practitioner Competence at Prescribing Psychoactive Medications

Estimate	Psychologists				Psychiatrists				<i>t</i> ^a	<i>p</i>
	Mean	SD	Range	<i>n</i>	Mean	SD	Range	<i>n</i>		
What percentage of psychologists would prescribe competently with										
1 year of training	40.3%	31.7%	0–99%	30	5.8%	9.2%	0–25%	15	5.48	<.001
2 years of training?	57.8%	35.5%	0–100%	30	15.0%	17.8%	0–60%	16	5.24	<.001
>2 years of training?	64.6%	37.3%	0–100%	29	19.5%	20.3%	0–50%	11	4.74	<.001
What percentage of psychiatrists prescribe competently	71.4%	19.0%	20–98%	34	80.2%	14.2%	50–98%	18	–2.41	<.02
What percentage of nonpsychiatrist physicians prescribe competently	43.1%	27.1%	5–85%	31	29.2%	23.3%	0–80%	15	1.93 ^b	<i>ns</i>

^abased on *t* tests without assuming equal variance.

^bbased on *t* test assuming equal variance.

Also, it should be noted that these data were collected before the effects of national efforts to enhance nonpsychiatric physicians' prescribing of psychoactive medications were recognized.⁶

Psychologists' Views on Prescription Privileges for Psychologists

Table VII reveals psychologists' heterogeneous attitudes about and interest in obtaining prescription privileges. Clearly, psychologists were divided. About half of the psychologists opposed prescriptive authority for psychologists and the APA's efforts to lobby for it. Similarly, about half were not inclined to seek prescriptive authority. About two thirds acknowledged that they were not ready to prescribe. One third thought that it was a good idea for psychologists to prescribe and that the APA should lobby for prescriptive authority. Fewer were interested in obtaining privileges or thought it likely they would seek privileges. Nontrivial minorities were neutral or undecided about these issues.

Psychologists' reported likelihood of seeking prescription privileges was modestly correlated with scores on one of the psychopharmacology knowledge

measures, the psychopharmacology examination ($r = .41$, $p < .05$), and the overall composite score showed a trend toward correlation with this question ($r = .29$, $p < .08$). However, given the number of secondary correlational analyses undertaken, these findings may be artifactual. Psychologists' self-reported readiness to prescribe did not correlate with any knowledge measure or with the composite score.

DISCUSSION

Psychologists' academic preparation differs fundamentally from that of psychiatrists (as well as other physicians and other prescribers). More specifically, psychologists obtain less scientific and clinical training directly relevant to prescribing than do other disciplines that prescribe. Major differences exist in undergraduate preparation, graduate education and training, and supervised clinical experiences between psychology and psychiatry. This presumably contributes to differences in how psychologists and psychiatrists approach their clinical experiences (Kingsbury, 1987). The differences between psychologists and psychiatrists parallel differences between psychology and other health care professions that have prescriptive authority.

In addition to differences in course work, psychiatrists generally see many more patients over the course of their training than do psychologists. For example, Kingsbury (1987) estimated that he saw more patients in his 1st month of psychiatric residency training in a psychiatric emergency department than he saw throughout his entire graduate training in clinical psychology. Similarly, psychiatrists routinely see more patients during their residencies than psychologists would (i.e., ≤ 100) see in the clinical

⁶For example, the N.I.M.H. Depression/Awareness, Recognition and Treatment (D/ART), the National Public Education Campaign on Clinical Depression, and the dissemination of practice guidelines (American Psychiatric Association, 2000; Depression Guideline Panel, 1993a, 1993b) have been instituted. Collectively, they appear to have increased primary care practitioners' awareness of psychological issues and improved their assessment and pharmacologic treatment of psychiatric patients (Coyne, Fechner-Bates, & Schwenk, 1994; Hirschfeld et al., 1997; Simon & VonKorff, 1995; Williams et al., 1999).

Table VII. Psychologists' Attitudes About Prescription Privileges

Response	Is it a good idea for psychologists to prescribe?	Do you have an interest in obtaining prescription privileges?	How likely would you be to seek privileges?	How ready are you currently to prescribe?	Should the APA lobby for prescription privileges?
Negative	45.2%	52.4%	50.0%	64.3%	50.0%
Positive	33.3%	14.3%	28.6%	2.4%	32.5%
Undecided/neutral	21.4%	33.3%	21.4%	33.3%	17.5%

psychopharmacology training proposed for psychologists (APA CoR, 1996).

Our data confirm important gaps in psychologists' knowledge and training in the biological and physical sciences that other authors have described (Tatman et al., 1997) and illuminate additional limitations in their scientific backgrounds. We are perplexed by the reason why psychologists' relatively meager academic preparation in the biological and physical sciences is of such apparently little concern to some proponents of prescriptive privileges (Hanson et al., 1999). Although doctoral education in psychology is lengthy (often six predoctoral years plus an additional year of supervised postdegree work to achieve licensure; APA, 1992), most of psychologists' education and training, including their scientific training, is *not* directly related to specific domains that are fundamental to competent prescribing (Robiner et al., 2002). Consequently, psychologists' overall *length* of training in obtaining their doctorates, which is touted by proponents of prescriptive authority as contributing to their qualifications to prescribe, may be only peripherally related to their readiness to prescribe. Rather, the *focus* of their training in specific, relevant, scientific, and clinical areas is the primary issue in gauging their readiness to prescribe. The absolute and relative (e.g., to psychiatrists and other prescribers) deficiencies in doctoral-level psychologists' knowledge and proficiency in key scientific and clinical areas directly related to prescribing are legitimate concerns (e.g., see Kingsbury, 1992).

The limitations in psychologists' scientific training directly relevant to clinical psychopharmacology seem likely to be associated with psychologists' limited knowledge about psychoactive and other medications. Our data revealed psychologists' limited knowledge in domains fundamental to prescribing competently. This included contraindications for frequently prescribed psychoactive medications, adverse effects associated with psychoactive medications, drug-related syndromes, the ability to identify medications that patients may take concurrently with psychoactive medications, as well as overall knowl-

edge of psychopharmacology.⁷ Psychologists' knowledge of domains that are central to prescribing is uniformly less extensive than psychiatric residents'. Presumably, such limitations would compromise prescribing practices. It seems likely that the relative deficiencies noted in our sample of psychologists are related to those reported in the American College of Neuropsychopharmacology (1998) review of the PDP graduates, who were perceived as comparatively less strong medically and psychiatrically than psychiatrists, even after they obtained additional training in psychopharmacology.⁸

Given the potential adverse consequences for patients of psychotropic medications (Antonuccio, Danton, & DeNelsky, 1995; Klein, 1996; Piasecki, 1998; Popkin, Callies, & Mackenzie, 1985; Preskorn, 1999; Riddle et al., 1991; Rivas-Vazquez, Johnson, Blais, & Rey, 1999), adequate knowledge in these domains and proficiency in physical examination and related medical skills for managing medications are essential (Robiner et al., 2002). Psychologists' limitations in these areas seem likely to contribute to limited sophistication in prescribing and may pose risks of suboptimal pharmacologic management, in both absolute and relative terms (i.e., to other prescribers) if they prescribe. They may also have greater difficulty keeping up with advances in medications than prescribers with greater depth and breadth of medical knowledge.

Thus far, empirical data regarding psychologists' lack of readiness to prescribe have been largely missing from the debate about prescriptive authority. Prescribing psychotropic medications effectively and

⁷Although the psychometric properties of our measures of these domains have not been established, their face validity and the process through which they were derived suggests that they are clearly relevant to, and necessary for, competent prescribing.

⁸Even so, the PDP training may be more extensive than training that could be provided to psychologists outside of the PDP who wish to prescribe. This seems likely given that it is based on a more abbreviated curriculum than the PDP graduates underwent and less is known about the organization, structure, and quality of the clinical supervised experiences that psychologists would receive.

safely entails greater education and understanding than the simplistic matching of types of drugs to types of disorders (Moyer, 1995). Our finding highlights the importance of the APA Task Force's (APA, 1992) recognition that psychology "... must train its personnel to recognize the effects of psychotropic medications" (p. 6). The gaps identified in psychologists' knowledge underscore the need for more psychopharmacology training for professional psychologists as well as caution about their preparedness to prescribe. If psychologists' goal is to enhance others' prescribing through collaboration about medication selection and monitoring, or to prescribe (e.g., as competently as psychiatrists do), they appear to have a substantial way to go in shoring up their knowledge base and medically relevant proficiencies. The proposed training for psychologists in psychopharmacology (APA CoR, 1996) falls short of psychiatrists' training. We doubt that the gaps we identified (i.e., multiple undergraduate- and graduate-level courses; limited understanding of psychopharmacology and related domains) could be surmounted in the time frame proposed by the APA (i.e., 1 year of part-time study plus supervision of 100 patients for an unspecified period of time).

Ongoing Education and Reading

Prescriptive authority for psychologists would necessitate greater levels of targeted continuing education (Smyer et al., 1993) and more intensive, ongoing reading related to psychopharmacology and clinical medicine. Our data revealed that psychologists spend fairly little time reading about psychopharmacology, notably less than psychiatric residents. Strict continuing education requirements would be warranted to keep psychologists up-to-date with the burgeoning formulary of psychotropic and nonpsychotropic medications (with which they may interact) and to assist them in overcoming gaps associated with their condensed training. Such efforts may distract from their clinical activities as psychologists, and their reading and continuing education related to other aspects of their psychological practices (DeNelsky, 1991).

Attitudes About Prescriptive Authority

Our data corroborate trends noted earlier (Gutierrez & Silk, 1998; Massoth, McGrath, Bianchi, & Singer, 1990; Robiner, Koehler, & Wedding, 1998)

that psychologists are divided about prescription privileges. The levels of support and opposition in our sample are comparable to some other surveys conducted around the same time, but suggest less support than Frederick/Schneiders' larger survey (Frederick/Schneiders, Inc., 1990). Our data suggest that psychologists' attitudes about prescriptive authority vary, in part on the basis of how much additional training psychologists would receive: the greater the training, the wider the support. Our sample of psychologists estimated that a majority of psychologists might be competent to prescribe after 2 years of training.

Unfortunately our survey did not specify whether 2 years of training would be part-time or full-time (e.g., akin to the early phase of the DoD project). Nor did we query whether that time period would cover basic scientific undergraduate prerequisites for training (i.e., that the APA Task Force recommended *before* training), or exclusively the psychopharmacology training itself after the prerequisites had been fulfilled. Given the limited hours of instruction, and the model for clinical psychopharmacology training programs to cater to practitioners who remain somewhat clinically active, the training is likely to fall short of the APA Task Force's recommendations, and of the full-time 2-year programs that some respondents to our survey (and other surveys) may presume when expressing attitudes related to psychologists prescribing.

The applied supervised training in psychopharmacology proposed for psychologists (APA CoR, 1996) lacks the intensity, breadth, and duration of psychiatric residency training. Furthermore, currently there are no mechanisms to accredit the psychopharmacology programs. Hence, psychologists' level of support reflected in surveys may be overstated because of presumptions that psychologists would receive more intensive training (i.e., two full-time years following completion of prerequisites) than they may in actuality, and may presume more intensive and well-organized supervised practical experiences in psychopharmacology than they may receive. Psychiatrists have relatively greater doubts that the proposed training would yield competent psychologist prescribers, corroborating concerns reported earlier (Klusman, 1998).

Limitations of This Study

The limitations to our study are self-evident. Comparisons of modest convenience samples of practicing psychologists with psychiatrists-in-training are

less preferable than larger samples of subjects at comparable stages in their careers. Our sample of psychologists was small, but notably, is larger than the PDP, about which much has been written in the psychology literature. Because the representativeness of our sample of psychologists and psychiatrists is not known, our data should be considered preliminary. Nevertheless, the highly significant differences across all domains between psychologists and psychiatric residents are quite compelling, especially in light of the limited sample size. We have no reason to believe that our sample was biased or that our results would be attributable to sampling problems. The delays⁹ in analyzing our data caution that our findings may not accurately reflect current attitudes or levels of knowledge.

Another limitation was the lack of assessment of clinical proficiency related to prescribing (e.g., recognizing side effects, interpreting relevant laboratory data). There is little reason to believe that psychologists would have done well on such assessments, given the historic lack of training in these areas within psychology graduate education.

A necessary limitation of our data is that we did not include any psychologists who had undergone psychopharmacology training akin to the PDP. Our data collection preceded the PDP. Ideally, future studies could compare psychologists who had undergone the three levels of training proposed by the APA Task Force with psychiatrists and other prescribers to see how much training is necessary to make them more comparable in terms of their performance on objective measures of psychopharmacology and related medical knowledge. Similarly, analyses of their respective clinical proficiencies related to medication management (e.g., clinical examination, interpretation of laboratory data) would elucidate comparisons that better inform the dialogue about prescriptive authority for psychologists. Such analyses would be meaningful to potential consumers and third-party payers, and provide an empirical basis to developing training models, curricula, and regulatory oversight of psychologists' prescriptive privileges.

⁹The delay in analyzing the data and preparing the manuscript were due principally to the time constraints related to the authors' other professional activities and the absence of external funding. There were no conflicts of interest that potentially might have compromised the integrity of the study or the interpretation of results. The developments within the prescriptive agenda movement, since the data were collected, render this project timely and increasingly relevant as a matter of policy.

CONCLUSIONS

Increased collaboration between psychologists and health professionals who currently prescribe appears to be a more prudent means of enhancing mental health services than psychologists' pursuit of prescription privileges. The results of our survey reveal significant disparities between psychologists and psychiatrists in terms of their education and knowledge related to psychopharmacology. Our results complement earlier reports about psychologists' limited training in the physical sciences (e.g., Tatman et al., 1997). Psychologists' relative limitations in training in the physical sciences and diverse medical areas are essential in considering their preparation for prescribing and, arguably, for undertaking further training to prescribe. We believe it would be counterproductive to trivialize these discrepancies in light of the importance of practitioners' scientific foundation and clinical proficiencies in prescribing currently and in being prepared to understand and integrate the advances in pharmacotherapy that are likely to guide future prescribing practices.

Psychologists' absolute and relative deficits in education and knowledge constitute hurdles to being able to prescribe competently. We question whether these gaps are likely to be surmounted sufficiently through abbreviated training programs, even those meeting the APA-recommended criteria (APA CoR, 1996). Unless the deficiencies in psychologists' training for the pharmacologic management of mental health problems are appropriately remedied (i.e., they are trained up to the level of other prescribers or substantially closer to it), the quality of psychopharmacologic care rendered to patients could be compromised and should not be presumed to be equivalent to that provided by other prescribers, especially psychiatrists. The conundrum inherent in psychologists' prescribing is that by not knowing what they do not know, they may unwittingly expose their patients to needless risks or suboptimal care. No matter the worthy intentions of psychologists who may seek prescriptive authority, and regardless of their strong competencies in their other clinical endeavors, the inadequacies in their preparation to prescribe pose risks that they could inadvertently harm the very patients they seek to help by prescribing.

Such risks could be eliminated by pursuing the APA Task Forces' Level-2 (collaborative practice) rather than Level-3 (prescription privileges). Such risks could be minimized to some degree by (a) increasing the biological and physical science

prerequisites for entry into doctoral-level graduate programs in psychology and related course work within doctoral programs; (b) restoring the biological and physical science undergraduate prerequisites to the requirements for the training of psychologists in clinical psychopharmacology who wish to prescribe; (c) developing clearer and clinically relevant guidelines than currently exist about the supervised practice of psychologists as they undergo applied, supervised training to prescribe (i.e., specifying minimum number of sessions per patient to manage medications, diversity of medical and mental health patients seen, minimal range of medications used, etc.); (d) developing stringent accreditation criteria and mechanisms for overseeing clinical psychopharmacology training programs, including their supervised practical experiences (e.g., qualifications of supervisors); and (e) conducting further research about training that could prepare psychologists to prescribe competently outside of the military with a broad range of patient populations (e.g., including the elderly, children, the medically ill, and the serious and persistently mentally ill).

In addition, risks could be reduced by (a) limiting prescribing to *dependent authority* (i.e., requiring medical supervision) with *limited formularies*; (b) developing a national database of critical incidents and signal events related to psychologist prescribing to track potential problems; (c) developing regulatory mechanisms (i.e., statutes, rules, and regulations) that appropriately address aspects of professional practice currently addressed in the regulation of current prescribers (e.g., physicians); and (d) allocating sufficient resources for regulatory boards to develop the necessary expertise for evaluating and monitoring psychologists' prescribing practices (e.g., expanding boards to include physicians or psychiatrists). These and other measures could ameliorate, at least in part, the potential effects of psychologists' limitations in education and knowledge relevant to prescribing, and lessen the risks for patients associated with psychologists' prescribing and other expanded activities related to medications.

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MARYLAND PSYCHIATRIC SOCIETY



February 26, 2026

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The Honorable Pamela Beidle
Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

OPPOSE: SB568 - Licensed Psychologists - Prescriptive Authority

Dear Chairwoman Beidle & Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS/WPS represent over 1200 psychiatrists and physicians currently in psychiatric training.

While the MPS/WPS deeply values the essential role psychologists play in supporting the mental health of Marylanders as members of the care team, we believe that granting prescriptive authority is not in the best interest of patient care. Our primary concern is patient safety, given the substantial differences between medical and psychological training. Safely prescribing psychotropic medications requires comprehensive knowledge of physiology, pharmacology, diagnostics, and the management of complex medical conditions—areas in which psychologists are not formally trained. Moreover, there is little evidence that expanding prescriptive authority to psychologists would meaningfully improve access to care, particularly in underserved areas. Finally, we believe it is vital to preserve the distinct, non-medicalized approach that psychologists bring to mental health care, a proven framework that could be compromised by expanding their scope of practice.

Patient Safety Risks and Vulnerable Populations

Psychotropic medications are among the most powerful drugs used in modern medicine, requiring comprehensive medical training for safe and effective prescribing. Many psychotropics carry U.S. Food and Drug Administration black box warnings, which signify potentially life-threatening side effects. These medications exert broad and significant effects on multiple body systems, including the cardiovascular, metabolic, nervous, gastrointestinal, endocrine, and hematologic systems. Even the most prescribed medications carry a direct risk of fatal events and increase morbidity. In addition to the inherent risks of prescribing psychotropic medications, licensed clinical psychologists (LCPs) lack the medical training and legal authority to conduct comprehensive evaluations necessary for safe prescribing. Numerous medical conditions, including thyroid dysfunction, neurological disorders, or infections, can closely mimic psychiatric symptoms. Failure to identify potential underlying medical issues can result in serious harm or even death. Unlike psychiatrists, LCPs are not equipped with the diagnostic tools and training needed to rule out additional clinical diagnoses before pursuing serious psychopharmacological interventions. Patient safety concerns are most acute among our most vulnerable populations, including children, older adults, individuals with substance use disorders, and those with serious mental illness (SMI). The heightened medical risks associated with psychotropic medications in these groups demand a prescriber who is extensively trained in pharmacology and its effects on the entire body.

Differences in Training Between Psychiatrists and Licensed Clinical Psychologists

A closer look at the educational requirements for psychiatrists and licensed clinical psychologists (LCPs) reveals why prescriptive authority should remain within the scope of medically trained professionals. As physicians, psychiatrists complete four years of medical school during which they receive extensive education in pharmacology and its integration into all branches of medicine, including psychiatry. Their understanding of pharmacotherapy, including implications for every organ system is tested as a component of the United States Medical Licensing Examination. After medical school, psychiatry residents undergo more than four additional years of intensive supervised training, completing 12,000 to 16,000 hours of patient care across diverse clinical settings. By the time they enter the workforce, a physician will have more than seven to 11 years of postgraduate clinical training under their belt. This hands-on experience allows them to develop

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MARYLAND PSYCHIATRIC SOCIETY



deep clinical judgment and manage complex cases involving co-occurring medical and psychiatric conditions. Such rigorous medical training is essential to ensuring the safe, effective use of pharmacological treatments in mental health care.

In contrast, LCPs typically complete three years of graduate coursework, followed by a one-year internship and 1,500 hours of supervised clinical experience. The stark difference in training between psychiatrists and LCPs demonstrates the critical importance of extensive medical education and clinical experience in safely managing pharmacological treatments. Psychiatrists' rigorous and comprehensive training equips them to understand the complex interactions, side effects, and medical considerations essential for prescribing psychiatric medications responsibly. In contrast, licensees whose training requires only a singular hard science course are woefully unprepared to assume the significant risks involved in prescribing these powerful medications.

Exhaustive as psychopharmacology programs may seem, fundamentally they amount to nothing more than fast-track courses in prescribing for individuals with no background in science and no medical training. The didactic program included in many psychologist prescribing proposals purports to thoroughly teach the nuances of all the following and more, in as little as 400 hours: anatomy, physiology, and biology (both pre-requisites and graduate level content); genetics; neuroscience; physical examinations; laboratory tests; the pathological basis of disease across multiple body systems; pharmacology; psychopharmacology; clinical decision-making; and ethical, professional, and legal issues. Even a full-time, two-year master's course would be insufficient to teach the entirety of this content with the depth and breadth necessary to safely manage patients' medication. Further, the fact that the educational program essentially aims to teach psychologists to practice in a medical specialty without first teaching the fundamentals of the medical model warrants scrutiny. In short, psychologists have no medical training, and a crash course in prescribing does not constitute a medical education. **There is no substitute for medical school and residency.**

Granting Prescriptive Authority to Psychologists Will NOT Improve Patient Access or Care

Despite legislative approval in some states, uptake of prescriptive authority among licensed clinical psychologists (LCPs) has remained minimal. In states that do allow psychologists to prescribe, psychologists are not seeking prescriptive authority in droves. Estimates report that there are fewer than 300 prescribing psychologists in the entire United States. Due to the small number of prescribing LCPs, high-quality research on the impact of prescriptive authority on access to mental health care remains limited. Available data from New Mexico and Louisiana—states where psychologists have had prescriptive authority for over two decades—suggests that prescribing psychologists primarily serve patients who are demographically akin to those seen by psychiatrists. Moreover, data suggests that LCPs in New Mexico and Louisiana primarily treat patients in urban areas rather than rural areas, offering little evidence that prescriptive authority improves access in underserved rural communities. In addition, **Medicare does not recognize prescribing privileges for psychologists, even in states where they are licensed to do so, because it does not classify them as "physicians" under the Social Security Act.**

We understand that there is an ongoing and very necessary dialogue around improving access to mental health care in Maryland, and we encourage these conversations to continue. However, we strongly believe, and the data shows, that granting prescriptive authority to psychologists is a high cost, low impact response to improving mental health treatment in Maryland. We therefore urge you to consider other actionable solutions to improve access to care. For example, the Collaborative Care Model and telehealth expansion are safe, evidence-based approaches known to improve access to mental health care without compromising patient safety or the quality of mental health care delivered in Maryland. We believe that Maryland's patients deserve the highest-quality mental health care provided by a physician with years of relevant medical training, and we stress that granting psychologists prescriptive authority is neither a safe nor effective option for improving mental health care in Maryland, even considering the training programs typically proposed by proponents of psychologist prescribing legislation.

If you have any questions regarding this testimony, please contact MPS lobbyist, Lisa Harris Jones at lisa.jones@mdlobbyist.com.

Respectfully Submitted,
The Maryland Psychiatric Society & Washington Psychiatric Society
Legislative Action Committee

APA SAFE PROVIDING

A FACT SHEET FOR YOUR REFERENCE

POWERFUL PSYCHIATRIC DRUGS AFFECT THE MIND AND THE BODY



Powerful **psychiatric drugs**, some of the most potent medications in modern medicine, affect not only the mind but the entire body and **can interact poorly with other drugs**.

More than half of patients living with mental illness also have an underlying physical illness.

Advanced medical training is required to understand how psychiatric drugs affect the entire body and interact with other medications.¹ in 5 adults in the US.

OUR POSITION

FOR SAFELY PRESCRIBING MENTAL HEALTH MEDICATION, MEDICAL DOCTORS LIKE PSYCHIATRISTS HAVE A CLEAR ADVANTAGE OVER PSYCHOLOGISTS.

It is essential to **patient safety** that a medically-trained clinician like a psychiatrist **prescribes and manages** a patient's mental health medications

Psychologists have no clinical medical training, compared to psychiatrists who have **12,000-16,000** hours of specialized clinical psychiatric training.

Graduating medical school, earning a state medical license, going through residency and often a specialty fellowship program, and years of on-the-job expertise, ensures **psychiatrists understand**:

- How psychiatric drugs **interact with other medications**.
- How psychiatric drugs **affect not only a person's mind, but other organ systems**.
- The difference between psychiatric conditions and other illnesses and diseases that may look like a mental health issue but require other medical treatments.



WHAT THE PUBLIC SAYS

ONLY MEDICALLY-TRAINED PROFESSIONALS SHOULD PRESCRIBE

78% of voters recently polled across the United States think only those with a **medical degree** and a license to practice medicine should be **allowed to prescribe powerful psychiatric drugs**.



NATIONAL PRECEDENT

MEDICARE REJECTED PSYCHOLOGISTS PRESCRIBING



Medicare does not reimburse psychologist prescribing because federal experts say psychologists do not have the “knowledge and ability to perform evaluation and management services.”

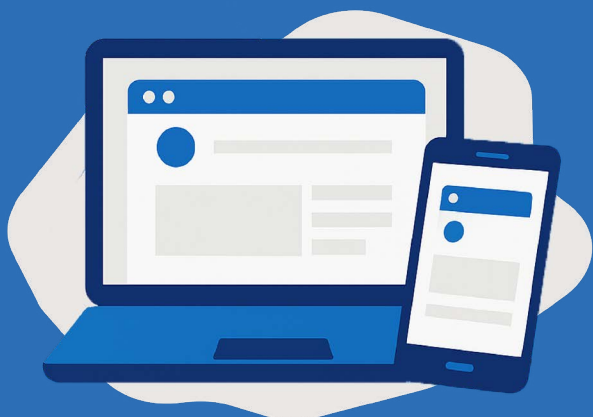
SOLUTIONS

GREATER ACCESS TO MENTAL HEALTH CARE

People believe **government should increase access to care** by:

- Making it easier for mental health care to be coordinated between different types of clinicians, so more people have **timely access to care** that's overseen by a physician.
- Making it easier to see a healthcare professional via **telemedicine**.
- Incentivizing healthcare professionals to practice in **rural and inner-city communities**.

State legislatures should enact policies that prioritize **care coordination** and ensure that when a patient's mental health condition requires medication, a trained medical doctor like a psychiatrist oversees prescribing.



Learn more about safe psychiatric prescribing:
www.SafeRxPrescribing.org

AMERICAN
PSYCHIATRIC
ASSOCIATION



Psychiatric Medications Affect All Body Systems

Safe, appropriate prescribing requires expert medical knowledge of all body systems.

Nervous

Medications affect the connection between brain and body, sometimes impairing alertness and reaction time. May cause seizures or stroke.



Respiratory

Medications are known to affect a patient's ability to breathe and rate of breath. May cause respiratory failure.



Cardiovascular Circulatory

The heart, arteries and veins are crucial to delivering oxygen and nutrients to organs and cells, and medications can alter their function. May cause cardiac arrest.



Endocrine

Medications can change patients' hormone production, secretion and metabolism. May cause abnormal breast development and lactation in men and women.



Musculoskeletal

Some medications can cause tremors or permanent involuntary movements. Others may affect calcium absorption, bone density and bone formation.



Skin

Medications may cause a potentially fatal rapid loss of skin (known as Stevens-Johnson syndrome).



Urinary

As part of the removal of waste, medications can impact one's kidneys, bladder and urinary tract. May cause kidney stones or failure.



Reproductive

Fertility, sex drive, and maternal and infant health all may be at risk because of certain medications. May cause birth defects.



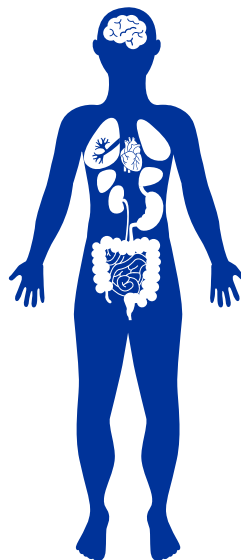
Immune

Medications can affect or destroy immune and lymphatic systems, impacting the body's ability to defend against disease-causing agents or even cancer.



Digestive

Medications are often taken by mouth, metabolized by the liver and can affect the stomach, pancreas, gallbladder and intestines. May cause liver failure.

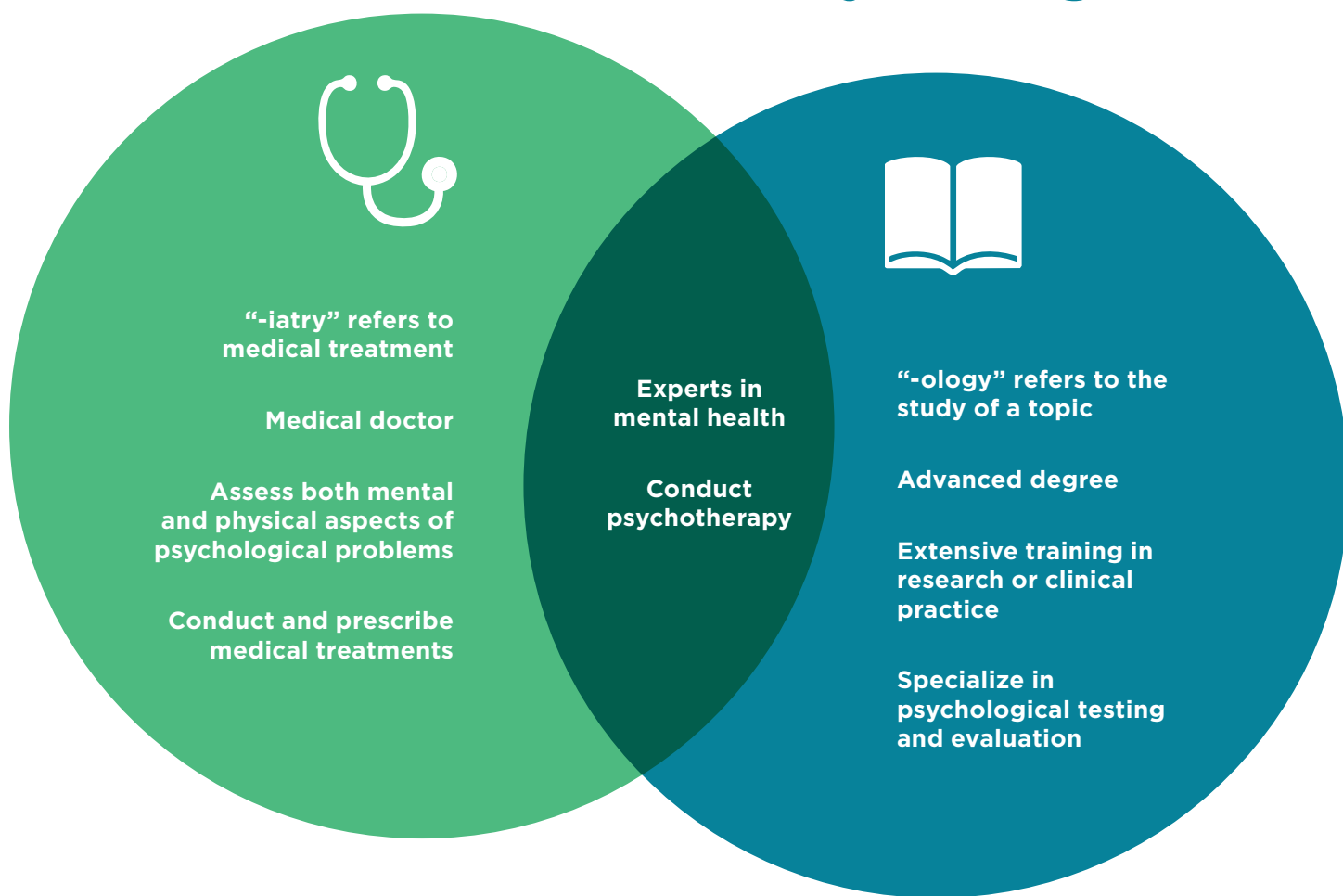


What's The Difference Between Psychiatrists And Psychologists?

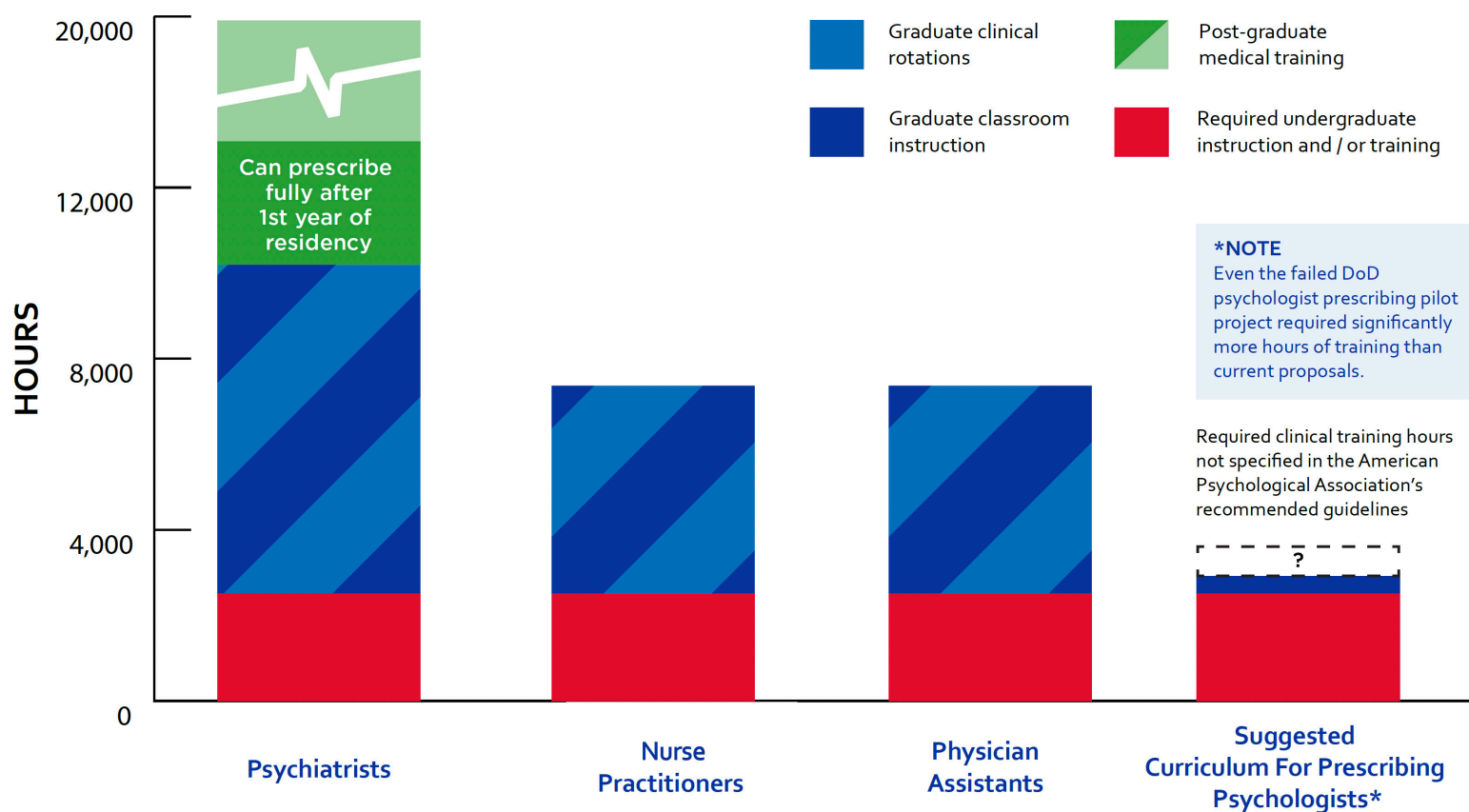


Psychiatrists

Psychologists

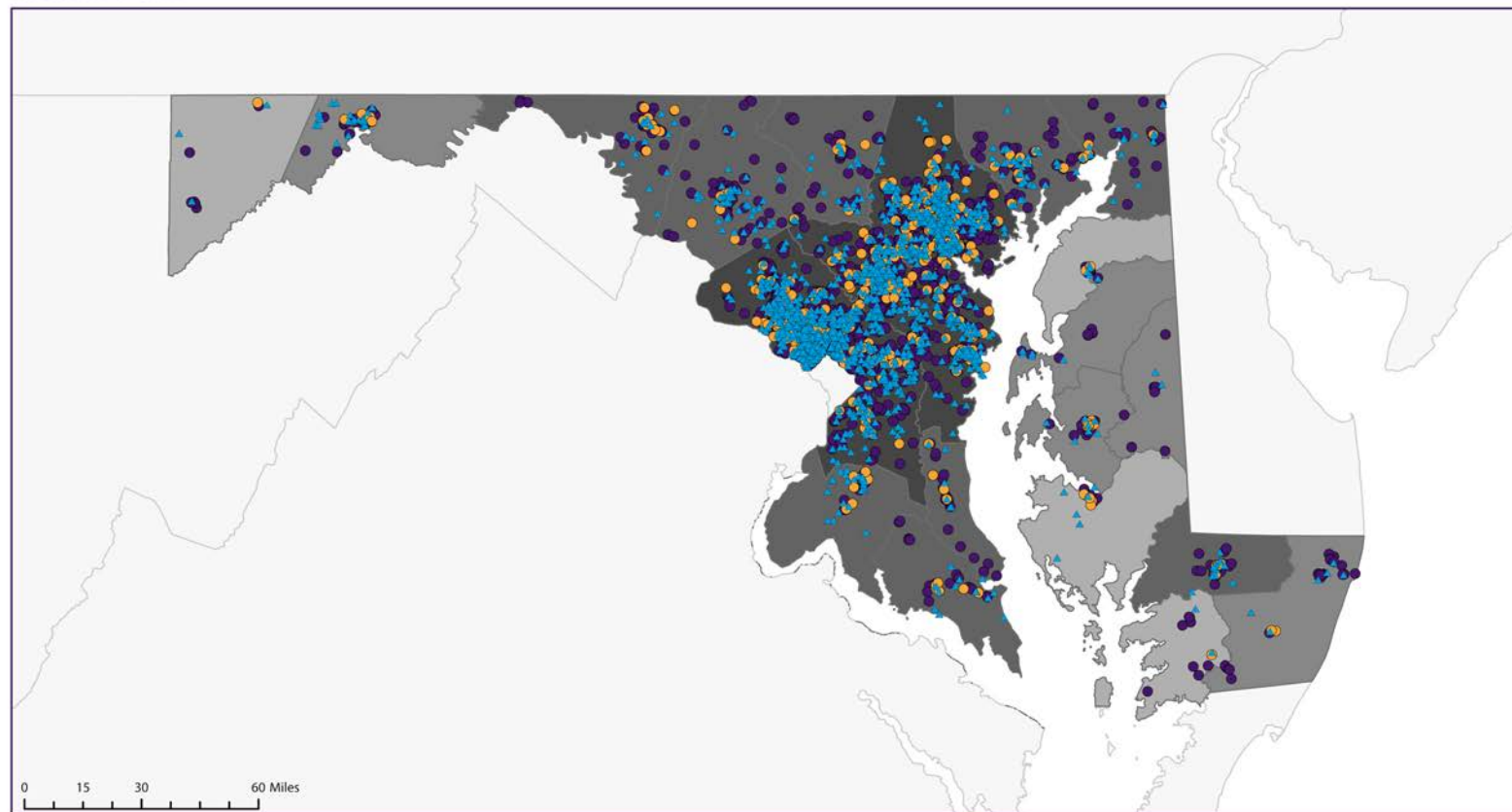


Biomedical Training is Necessary to Safely Prescribe



Prescribing Can't Be Taught In Just Ten Weeks

MARYLAND



- Primary Care Physicians (n=6,266)
- Psychiatrists (n=1,244)
- ▲ Psychologists (n=3,027)

Population per square mile

Source: 2019-2023 American Community Survey

<=25	26 - 75	76 - 250	251 - 1,000	>1,000
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Source Notes: AMA Physician Masterfile 2024; U.S. Centers for Medicare & Medicaid Services National Plan and Provider Enumeration System 2024; U.S. Census Bureau county and state shapefiles 2020

Workforce Prescribing Psychologists.12.24 Robiner.

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Clinical Psychology: Science and Practice

The Workforce of Prescribing Psychologists: Too Small to Matter? Worth the Cost?

William N. Robiner and Tanya L. Tompkins

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The Workforce of Prescribing Psychologists: Too Small to Matter? Worth the Cost?

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The prescriptive authority for psychologists (RxP) movement has been controversial. As of March 2024, 226 psychologists had prescriptive authority through the six states' health regulatory boards that have enacted RxP. This limited uptake contrasts with other prescribing professions' growth that more meaningfully addresses a psychiatric workforce shortage and warrants reevaluation of the RxP movement. Debates surrounding RxP have typically focused on the quality of training and other professional concerns. This article focuses on the quantity of prescribing psychologists. The comparatively small size of the prescribing psychologist workforce reveals its limited potential impact within the healthcare system. The relative limitations of the prescribing psychologist workforce cede supplementation of the psychiatry workforce to other professions with larger workforces that prescribe based on more comprehensive education and training and clinical experience.

Public Health Significance Statement

The small workforce of prescribing psychologists relative to the collective workforce of all prescribers suggests their impact is minimal. This along with the expansion of other groups of prescribers and concerns about psychologists' training to prescribe bring into question whether the profession should reconsider its support of the prescriptive authority movement.

Keywords: psychologist, prescriptive authority, prescription privileges, workforce

The American Psychological Association (APA) began to explore advocating for psychologists to prescribe medications in the 1980s. Since then, the prescriptive authority for psychologists (RxP) movement has been a controversial and contentious issue within and beyond the profession. Much of the resistance has been tied to the abridged training model (Heiby, 2010; Robiner et al., 2003, 2013, 2020; Tumlin & Klepac, 2014) proposed, adopted, and revised by the APA (1996, 2019). The various iterations of the training model have not aligned with substantive recommendations of the APA's own ad hoc task force convened to explore the issue (Smyer et al., 1993). Notably, the ad hoc task force recommended that participation in postdoctoral training be limited to those who held a doctorate in psychology, were licensed health service providers, and possessed

prerequisite (emphasis added) "knowledge of human biology, anatomy and physiology, biochemistry, neuroanatomy, and psychopharmacology" (APA, 1996, p. 2). Over the past nearly 30 years, these prerequisites have not been required by the APA and clinical psychopharmacology training programs. Neither designated clinical psychopharmacology programs nor legislative bills have included admissions requirements in line with other prescribing professions that do require prerequisite undergraduate coursework in the physical sciences (Robiner et al., 2013). The absence of prerequisites, along with condensed training and quality concerns (e.g., Ransom, 2014) related to training inherent in APA's training model, renders it less robust than the training of all prescribing professions (Robiner et al., 2003, 2013, 2020; Tumlin & Klepac, 2014). Although psychologists receive extensive training in diagnostic and clinical interviewing which is fundamental to their clinical competence in general, it is unclear how fully that equips them specifically to be managing medications in the context of patients' overall physical health and health care. Psychopharmacology training programs typically include significantly fewer interviewing and clinical assessment contact hours relative to physician and nonphysician prescribers (see Robiner et al. [2020] and McGrath [2020] for contrasting views about the adequacy of the training). Moreover, the APA reduced training requirements (Stuart & Heiby, 2007) relative to the Psychopharmacology Demonstration Project (PDP) of the Department of Defense (DoD; U.S. Genetal Accounting Office, 1999), which RxP proponents cite to justify psychologist prescribing. Such advocacy is despite criticisms that the DoD PDP program's graduates were comparatively

Kelly McClure served as action editor.

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William N. Robiner served as lead for conceptualization, data curation, formal analysis, methodology, writing—original draft, and writing—review and editing. Tanya L. Tompkins contributed equally to conceptualization, data curation, formal analysis, methodology, writing—original draft, and writing—review and editing.

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weak and judged to be at the level of medical students rather than physicians (American College of Neuropsychopharmacology, 1998). Steven Kingsbury (1992), a psychologist who retrained to become a psychiatrist, commented on the training for managing medication which “has more to do with biochemistry and physiology than with psychology. I was surprised to discover how little about medication use has to do with psychological principles and how much of it is just medical” (p. 5).

Even RxP proponents (Fox et al., 2009) recognize that “among all the disciplines whose members include non-physician health care providers who prescribe, psychology has the core curriculum with probably the least overlap with traditional medicine” (p. 258). It is no wonder that surveys of psychologists have consistently revealed a lack of consensus, including nontrivial opposition to RxP among psychologists (e.g., Walters, 2001). Deacon’s (2014) survey of the Association for Behavioral and Cognitive Therapies membership revealed that a majority (52.3%) opposed RxP and 89.2% believed that medical training for psychologists to prescribe should be equivalent to other nonphysician prescribers. Surveys of Illinois (Baird, 2007) and Oregon (Tompkins & Johnson, 2016) psychologists yielded similar consensus, 78.6% and 69.2%, respectively, about the importance of psychologists’ training to prescribe needing to be comparable to other professions’ training to prescribe.

In contrast, RxP proponents emphasize the role that prescribing psychologists could play in addressing unmet mental health needs, especially in underserved communities (McGrath, 2010). McGrath (2004) identified several factors that he predicted would guard against overreliance on psychotropic medications observed in other professions’ prescribers. These included comprehensive training in psychosocial interventions and research, growing cultural skepticism regarding the effectiveness of psychotropic medications, and an academic community committed to continuously questioning the appropriate use of these medications (e.g., Hollon, 2024). Limited studies based on self-report data raise concerns about whether prescribing psychologists have stayed true to the “psychosocial souls” described by McGrath (2004, p. 644).

For example, a convenience sample survey of 43 prescribing psychologists revealed that nearly all prescribing psychologists (97.1%) rated combined treatment as the best option (Peck et al., 2021). This preference translated into prescribing patterns that seem to stray from their psychotherapeutic roots. Respondents reported that the majority of their patients received combination treatment, a larger proportion of patients received medication only rather than psychotherapy alone, and patients, on average, were prescribed nearly three medications. Whereas such prescribing patterns may represent evidence-based treatment for certain diagnostic categories (e.g., bipolar disorder, schizophrenia), these primary diagnoses represented a minority (19.1%) of the patient populations they treated. The extent of polypharmacy reported in the study was concerning given the dearth of evidence to support use and factors that contribute to decision making around prescribing, such as questionable assumptions about the efficacy of combined medication and limited awareness about metabolic and neurological adverse drug events (e.g., Zito et al., 2021). It also seems out of step with experts who question both the science and wisdom of an “entrenched overreliance on the biomedical model” (World Health Organization, 2021, p. 19). Studies (Levine et al., 2011; Linda & McGrath, 2017; Peck et al., 2021) in which most prescribing psychologists reported prescribing medication to the majority of their patients, both as monotherapy and

in combination with psychotherapy, raise questions about McGrath’s (2004) contention that prescribing psychologists would be more conservative about prescribing and about polypharmacy because of their prior training in psychological clinical science.

Since the inception of discussions of RxP, the APA ad hoc task force presciently anticipated that only “a small but important minority of psychologists may seek specialty training leading to licensure for psychotropic prescribing” (Smyer et al., 1993, p. 402). Despite acknowledging relatively limited enthusiasm for RxP (e.g., Plante et al., 1998), and expecting few psychologists to pursue the training and eventually prescribe (Fox et al., 2009), the APA and its affiliates, have invested millions of dollars lobbying for RxP at the state level. APA’s tireless advocacy efforts and spending over the past 25 years has yielded hundreds of failed legislative bills seeking to enable psychologist prescribing. At the time this article was prepared seven states had passed legislation enabling psychologists to prescribe: New Mexico was the first in 2002.

Whereas the literature has focused on various issues, with some authors endorsing RxP (e.g., Bray et al., 2014; Curtis et al., 2023) and others opposing it (e.g., Tumlin & Klepac, 2017), this article focuses on workforce, which is central to determining the degree to which prescribing psychologists might potentially address unmet needs for psychoactive medications and access to health professionals who might prescribe them. Data from the Agency for Healthcare Research and Quality revealed that 252 million prescriptions were prescribed for mental health conditions in 2020, with the top 25 psychoactive medications accounting for \$19,348,000,000 in revenue (PsychCentral, 2022). Such data about the large number of psychoactive prescriptions written in the United States and their costs raise questions about how problematic access to prescribers for these medications actually is.

In the following sections, we examine the extent to which psychologists have attained prescriptive authority through state health regulatory boards, the representation of prescribing psychologists within the workforce of prescribing health professionals, and the limited extent of prescribing psychologists’ impact in increasing access to psychoactive medications.

The Workforce of Prescribing Psychologists

Table 1 presents state regulatory board data on the number of psychologists licensed to prescribe in New Mexico, Louisiana, Illinois, Iowa, Idaho, and Colorado as of March 2024. This information was obtained by the authors through correspondence with the boards and examination of their websites. Utah, which became the seventh to pass legislation as this article was being prepared in 2024, is excluded from our analyses. In total, state boards authorized 226 psychologists to prescribe in those six states that had enabled RxP, including psychologists with either full privileges or conditional prescribing privileges. This is about 125 more than had prescriptive authority a decade ago (Ransom, 2014), which would amount to an annual increase averaged over that interval of 12.5 additional psychologists per year. These numbers reflect a very modest adoption rate. Prescribing psychologists constitute only a small fraction (1.73%) of licensed psychologists in those six states. New Mexico, the first state to allow RxP, has 73 prescribing psychologists, comprising 8.17% of the state’s licensed psychologists after 22 years since the legislation was signed. Louisiana, the second state to pass prescribing legislation, has 116 prescribing psychologists. Their prescribing is

Table 1*Psychologists and Psychologist Prescribers in States Where Psychologists May Obtain Prescriptive Authority*

State ^a	No. of psychologist licensees	No. of psychologist licensees with prescriptive authority	% of psychologist licensees prescribing	Psychologists per 100,000 population ^b	Prescribing psychologists per 100,000 population ^b	Year RxP bill passed	Years since passage
Colorado	3,954	3	0.08	67.27	0.05	2023	1
Idaho	615	10 ^c	1.63	31.30	0.51	2017	7
Illinois	5,773	20	0.35	46.00	0.16	2014	10
Iowa	1,037	4	0.39	32.34	0.12	2016	8
Louisiana Psychology Board	784			18.93			
Louisiana Medical Board		116 ^d	14.80		2.54	2004	20
New Mexico	894	73 ^{d,e}	8.17	42.28	3.45	2002	22
Total	13,057	226	1.73	43.11	0.75		

Note. The number of doctoral psychologists in Louisiana was provided by the Executive Director of the LSBEP, February 12, 2024, as a personal communication. Some (34) Louisiana “medical psychologists” (i.e., prescribing psychologists) are licensed duly by both the LSBEP and the LSBME, that is, 29.3% of psychologists regulated by the LSBME. The other 82 (70.7%) medical psychologists regulated by the LSBME are not licensed by the LSBEP. We calculated a total unduplicated number of psychologists regulated by a Louisiana health regulatory board to be 866. It is the denominator used to calculate the percentage of psychologist licensees who prescribe in Louisiana and is the numerator for calculating psychologists per capita for Louisiana. Unduplicated count for Louisiana was derived by comparing all medical psychologists in 2024 with the LSBEP (2022) *Publication of Licensed Psychologists*. The LSBME regulates prescribing psychologists in Louisiana whereas the boards of psychology regulate prescribing psychologists’ entire practice, including prescribing, in other states. RxP = the prescriptive authority; LSBEP = Louisiana State Board of Examiners of Psychologists; LSBME = Louisiana State Board of Medical Examiners.

^a All data are from state boards of psychology obtained from websites or communications for board staff except for Louisiana data from the LSBME. ^b State population estimates are presented in Table 2 for 2023. ^c Five provisional prescribing licensees. ^d Twenty-one prescribing psychologists with addresses listed out of state (including one in Colorado, one in Illinois, and one in New Mexico). ^e Thirteen conditional prescribing licensees.

regulated by the Louisiana State Board of Medical Examiners (i.e., not the Louisiana State Board of Examiners of Psychologists) accounting for 14.80% of all Louisiana licensed psychologists since the enabling legislation 20 years ago. The four remaining states have relatively shorter histories of psychologist prescribing, so as would be expected, have fewer than those with longer histories of allowing psychologists to prescribe: Few licensed psychologists prescribe in the other four states. Even in Illinois, which has the largest number of licensed psychologists among them, only 20 (0.35%) licensed Illinois psychologists are authorized to prescribe a decade after the passage of enabling legislation.

The Association of State and Provincial Psychology Boards (ASPPB, 2023) estimated that in 2022 there were 156,087 licensed psychologists in the 50 U.S. states and the District of Columbia. This total number of U.S. licensed psychologists dwarfs the number of psychologists holding state licenses to prescribe, representing only 0.14% of all licensed psychologists in the country. The fact that only a small number of psychologists choose to pursue prescribing and actually obtain the authority to do so through state health regulatory boards, aligns with the initial predictions of the APA ad hoc task force (Smyer et al., 1993) and past research.

For example, Tompkins and Johnson’s (2016) survey of a random sample of Oregon psychologists during efforts to pass RxP legislation in Oregon, found few (6.7%) reported interest in pursuing training to become prescribers. Their results were consistent with prior survey data in Oregon (7%; Campbell et al., 2006), but signaled weaker intentions to pursue the training and to prescribe than some other surveys. Earlier, Baird (2007) found that 14% of sampled Illinois psychologists said they would definitely plan to obtain the necessary training to prescribe medication. Inconsistencies regarding those respondents’ reported views about the importance of the training model (23%) and relatively weak understanding of the DoD PDP (47% were not familiar) and APA training model (39% were not familiar), when combined with a strong (78%) belief that psychologists should receive the same amount of training as other

nonphysician professionals who have prescriptive authority makes it unclear how to interpret their willingness to pursue the training to become prescribers. Neither Baird (2007) nor Tompkins and Johnson (2016) found rural versus urban differences in psychologists’ interest in prescribing, raising the question of how effective enabling psychologist prescribing would be in addressing access problems in rural communities.

Similarly, Fagan et al. (2007) found that only minorities of private practice psychologists, directors of training, postdoctoral residents, and psychology interns indicated they would seek RxP if it were allowed; larger numbers supported it as an abstract principle. The gap between psychologists’ passive support for RxP and their intention and actual action to obtain it arguably reveals an ambivalence that matters greatly in terms of the ultimate impact RxP might have in expanding access to prescribers of psychoactive drugs. Moving beyond self-report data about future intentions to pursue psychopharmacology training and licensure to prescribe, our study examined the number of psychologists who are actually licensed to prescribe in states that permit it.

Despite being legally eligible after undergoing additional training and following passing the national Psychopharmacology Examination for Psychologists developed by the ASPPB, the percentage of psychologists who obtained licenses that permit them to prescribe is notably low. Assessing the potential impact of these prescribing psychologists reveals modest figures. Across those six states enabling RxP before 2024, there were only 0.75 prescribing psychologists per 100,000 people. This per capita ratio of prescribing psychologists to the population is remarkably lower than for other types of prescribers. It stands to reason that even if other states were to grant prescriptive authority to psychologists, only a small minority of psychologists would likely seek it, thereby limiting the overall potential impact of psychologist prescribers in managing psychopharmacological care for patients seeking it.

The number of psychologist prescribers stands in stark contrast to the total number of licensed psychologists in the six states that have

allowed psychologist prescribing. This count is considerably higher and somewhat consistent with earlier estimates for how many psychologists may be needed per capita to address population mental health needs (i.e., 35–40 per 100,000; VandenBos et al., 1991). These estimates of the number of licensed psychologists in these states are 41.57% higher than estimates in 2015 (IHS Markit, 2018), reflecting considerable growth in the total number of licensed psychologists in those states over the past decade. The growth in licensed psychologists contrasts sharply with the very modest growth of psychologist prescribers. APA Division 55, now known as the Society for Prescribing Psychology, underwent the second greatest proportional decline (–31.6%) in membership among all 54 APA divisions between 2008 and 2013 (Robiner et al., 2015). This membership decrease is another indication of psychologists' tepid support for RxP and limited intent to personally pursue RxP themselves. These trends caution against having unrealistically sanguine expectations about the future growth of the workforce of prescribing psychologists.

Psychologist Prescribers as a Proportion of the Prescriber Workforce

Appraisal of the potential impact of allowing psychologists to prescribe is informed by how many licensed prescribers across professions work in the states where psychologists obtain authorization to prescribe. Table 2 presents counts of three prescribing professions based on Bureau of Labor Statistics (BLS, 2024) 2023 data for physicians, advanced practice registered nurses (APRNs), and physician assistants (PAs) across the six states that had enacted RxP. Unlike psychologists, all individuals in those other professions can prescribe in those states. Additionally, Table 2 provides a summary of 2023 population estimates from the U.S. Census Bureau (2024) for those states, along with a reiteration of the number of psychologist prescribers in each state, to facilitate comparisons across prescribing professions and estimates of the rates of prescribers per capita.

Because few psychologists undergo the necessary training and complete the steps to obtain RxP, psychologists constitute very small proportions of all prescribers in the states where they legally

have been able to obtain RxP. States' prescribing workforces were heterogeneous in terms of the number of prescribers overall, but the number of psychologist prescribers was consistently small. As noted earlier, across the six states, there were a total of 226 psychologist prescribers and 96,591 nonpsychologist prescribers, with psychologists accounting for a mere 0.23% of all prescribers in those states. Conversely, 99.77% of prescribers in the six states that allowed psychologists to prescribe were not psychologists. The percentage of the prescribing workforces composed of psychologists ranged from a low of 0.02% of all prescribers in Colorado, the state that had most recently passed enabling legislation, to 1.19% of prescribers in New Mexico, the first state to pass the legislation.

Prescribing Psychologists and Other Prescribers per Capita

The relative impact of psychologist prescribers can also be assessed by examining the ratio of prescribers to each of the six states' populations where psychologists are licensed to prescribe. As noted earlier, nonpsychologist prescribers vastly outnumber psychologist prescribers universally. Table 2 presents each of the professions' prescriber-to-population ratios separately, as well as their collective prescriber-to-population ratio (i.e., 318.92 per 100,000). The other professions have remarkably higher prescriber-to-population ratios compared to prescribing psychologists' prescriber-to-population ratio (i.e., 0.75 per 100,000). Such workforce ratios serve as indicators of the availability of professionals to provide pharmacological care to citizens and of the relative quantity of prescribing that professions can potentially provide. In states with the longest histories of psychologist prescribing and the highest per capita rates of prescribing psychologists, namely Louisiana (2.54 per 100,000) and New Mexico (3.45 per 100,000), the per capita rates of prescribing psychologists are approximately one one-hundredth of the rates of other prescribers in those states.

These workforce data reveal that psychologist prescribers provide patients only marginally greater access to prescribers than otherwise exists in the interprofessional prescriber workforces in their states. This echoes findings from a recent simulation study (Hughes et al., 2024) using 2004–2021 data from the Merative MarketScan

Table 2
Prescribing Workforce in States Where Psychologists May Obtain RxP

Prescribers and population estimates	Colorado	Idaho	Illinois	Iowa	Louisiana	New Mexico	Total
Prescribing psychologists ^a	3	10	20	4	116	73	226
Physicians ^b	10,840	2,570	32,150	4,800	5,410	3,730	59,500
Physician assistants ^b	2,990	1,170	3,890	1,290	1,090	530	10,960
APRN ^b	4,490	1,391	10,750	3,140	4,550	1,810	26,131
Nonpsychologist prescribers	18,320	5,131	46,790	9,230	11,050	6,070	96,591
Total prescribers	18,323	5,141	46,810	9,234	11,166	6,143	96,817
Percentage of prescribers who are psychologists	0.02	0.19	0.04	0.04	1.04	1.19	0.23
Estimated state 2023 population ^c	5,877,610	1,964,726	12,549,689	3,207,004	4,573,749	2,114,371	30,287,149
Psychologist prescribers per 100,000 ^d	0.05	0.51	0.16	0.12	2.54	3.45	0.75
Nonpsychologist prescribers per 100,000 ^d	311.69	262.16	372.84	287.81	241.60	287.08	318.92

Note. RxP = prescriptive authority; APRN = advanced practice registered nurses; BLS = Bureau of Labor Statistics.

^a Based on information obtained from each state's psychology board with the exception of Louisiana's Board of Medical Examiners. ^b Obtained from the Bureau of Labor Statistics *Occupational Outlook Handbook* (2024) state profiles for each profession. The number of psychiatrists is not presented as a separate line in the table because it could not be disaggregated from the number of physicians overall for all of these states. BLS data provided for Idaho did not specify the number of psychiatrists separately from other types of physicians. ^c Based on U.S. Census Bureau (2024) estimate for 2023. ^d Per capita estimates were derived by dividing the number of prescribers by the U.S. Census Bureau's estimates of 2023 population and multiplying by 100,000.

Commercial Claims and Encounters Database that included deidentified, employer-sponsored insurance claims for over 255 million individuals receiving care in New Mexico and Louisiana. They found that only 1.5% of 307,478 patients received a prescription from a prescribing psychologist. Furthermore, Hughes and colleagues found that patients living in metropolitan service areas “were more likely to see a prescribing psychologist, meaning a smaller proportion of their patients were from rural areas” (p. 13).

If the main objective of the RxP movement was to meaningfully expand access to psychoactive medication prescribers, especially in underserved areas, its success would require a significantly larger number of psychologists pursuing prescribing than the limited number forecasted by the ad hoc task force (Smyer et al., 1993) and that we identified in states that have allowed it. Psychologists arguably should focus on addressing mental health care treatment gaps arising from barriers, such as stigma, unequal access to evidence-based care, workforce shortages, geographic disparities in provider distribution, lack of insurance coverage, and limited access to community-based interventions, and deliver those services for which they are most intensively trained, such as assessment, psychotherapy, and consultation. Rather than continuing to push for RxP, it would be more advantageous for the APA to join other professions in innovative, interprofessional, and collaborative efforts to expand and strengthen collaborative care models (CoCMs), telemental health, task sharing, and improving capacity, for example, by expanding National Health Service Corps clinicians (Han et al., 2019; Mongelli et al., 2020). Kazdin (2021) urges moving beyond traditional one-on-one interventions to expand scalability to address unmet needs. Investing resources toward such goals, rather than focusing on RxP, seems to be a more promising venture.

Adding Workforce to the Concerns About RxP

Concerns persist regarding the appropriateness and safety of psychologist prescribing given the lack of consensus in the field about the adequacy of the APA training model due to its downward deviation from other prescribing disciplines’ curricula (Robiner et al., 2020). To date, most critiques of RxP have been about quality and limitations of training, safety concerns, and other potential impacts of psychologist prescribing (e.g., Robiner et al., 2002). The data herein focus on quantity, that is, the number of psychologists who have actually obtained authorization by state licensing boards to prescribe. The workforce data reflect the limited impact of RxP on expanding patient access to psychoactive medications. Relative to other professions in which all clinicians can prescribe, few psychologists pursue RxP.

Arguing the case that the RxP movement has significantly benefited the profession, or could substantially address service delivery access issues, is seriously challenged by the reality of the limited number of psychologists who complete the pathway to prescribing. Concerns about the adequacy of training and preparation for psychologist prescribing, as well as the potential adverse impacts on the profession, persist, echoing issues voiced within the profession from earlier in the RxP movement (e.g., DeNelsky, 1996; Heiby, 2002; Tumlin & Klepac, 2014), and which have led others to conclude that it is not practical to pursue RxP (Canadian Psychological Association Task Force on Prescriptive Authority for Psychologists in Canada, 2010; Dozois & Dobson, 1995). These workforce data extend those concerns, suggesting that allowing psychologists to prescribe would, at

most, only marginally address service availability and delivery involving psychoactive medication since so few psychologists pursue RxP when allowed.

It is not clear why so few psychologists pursue RxP. As noted earlier, survey data of Oregon psychologists (Tompkins & Johnson, 2016) evidenced low interest in pursuing RxP. Moreover, it revealed low willingness to be involved in legislative efforts (7.9%), and a lack of knowledge of RxP. For example, only 6.3% could name the states that had passed RxP, most psychologists indicated they were unfamiliar with the training models in either the DoD PDP (66.9%) or the APA designation cf. accreditation model (60.6%). Similarly low levels of investment of time and financial support were found by Baird (2007) in his survey of Illinois psychologists. If prescribing truly was an individual’s committed, long-term aspiration, they might choose more direct, and possibly faster, alternative academic and career paths where preparation for prescribing was more centrally integrated into education and training from the beginning rather than as an afterthought following entry into the profession.

Many psychologists seem disinclined to pay attention to the topic of psychologist prescribing sufficiently to have well-considered beliefs about it, including understanding the differences between the APA training model and the curricula and more comprehensive training of other prescribing professions (e.g., as addressed in Robiner et al., 2020). As the APA (1992) ad hoc task force found, 43% of psychologists thought that full medical training would be required for psychologists to prescribe. Furthermore, many psychologists, even if they know the requirements of the APA training model, believe that that training should be more rigorous and aligned with a medical training model (Baird, 2007; Deacon, 2014; Tompkins & Johnson, 2016). Costs and the time to undertake additional training also appear to be demotivating factors for psychologists’ pursuit of the training to prescribe (Fagan et al., 2007).

Due to the controversial nature of RxP, to limited interest, and to avoid sharing sentiments inconsistent with official APA policy about RxP, many psychologists seem hesitant to engage with the issue, to question APA’s RxP policy, or take firm positions against it to avoid alienating colleagues who are in favor of prescribing, and to steer clear of potential backlash. Bradshaw’s (2005) report on contentious town hall discussion at the 2005 APA Convention captured the insularity and divisiveness of the issue. Several RxP proponents pushed back against recommendations advanced by the National Register of Health Services Providers in Psychology (National Register [NR]) and the ASPPB that would have made training for psychologists to prescribe more rigorous. For example, McGrath, director of the psychopharmacology program at Fairleigh Dickinson University, commented, “Basically, none of the programs in the nation could meet the criteria.” Caccavale, president of the National Society of Clinical Psychopharmacologist at that time, suggested that the Practice Directorate secede from the APA so that it might establish its own criteria. Judy Hall, the NR’s executive officer suggested that allowing an external group like the NR/ASPPB to develop and update training criteria would enhance legitimacy, rather than “letting the fox guard the chicken coop.” Nevertheless, since that time the APA has driven legislative efforts, developed and updated designation criteria rather than accreditation criteria, and developed the Psychopharmacology Examination for Psychologists. APA’s advocacy for RxP has persisted even though concerns related to the training for prescribing psychologists raised by psychologists and groups outside of the profession have also endured.

Growing Workforce of Prescribers in Other Professions

In addition to intraprofessional concerns, it is perhaps even more critical to reassess the RxP movement in light of workforce developments outside of psychology. Various professions play important roles in the mental health workforce (Ivey et al., 1998; Robiner, 2006) and the broader de facto mental health workforce (Regier et al., 1993). As formularies of psychoactive medications have expanded, as consumer acceptance of these drugs as part of their health care has increased, and as the overall demand for mental health services has proliferated, the need for competent prescribers and for mental health professionals in general has grown. To address this need, over the past decades there has been substantial growth in the numbers of physicians, nurse practitioners (NPs), and PAs. While the psychology workforce has also grown, the mental health workforce has been dynamic, changing notably since the RxP agenda was initially advanced. Although the shortage of psychiatrists has existed for decades, the increasing role of the de facto mental health workforce (Regier et al., 1993) was not fully recognized. Moreover, the proliferation of NPs and PAs in both mental health specialty roles and primary care was not anticipated to the extent that it has become a key workforce factor that is likely to continue to be important in extending access.

Psychiatrists and Other Physicians

Part of the impetus to consider RxP was the well-known, decades-long shortage of psychiatrists (Council on Graduate Medical Education, 1992; Pardes & Pincus, 1983; Plaut & Enzer, 1981). It is important to recognize progress addressing it. Medical education has undergone significant expansion since the introduction of RxP, leading to a substantial increase in the pipeline of physicians, including psychiatrists. Prior to 1990, there were 126 allopathic medical schools and 13 osteopathic schools. Since 1990, an additional 32 allopathic medical schools and 31 osteopathic schools have opened. In addition, many medical schools have expanded class sizes, and opened satellite campuses, increasing the number of medical students per year who can be educated and trained. Moreover, there has been a substantial rise in the number of U.S. psychiatric residency programs over the past decade with growth from 183 in 2011 to 352 programs in 2022 (Moran, 2022). These developments have implications for revisiting the original consideration of whether seeking to expand psychologists' scope of practice to prescribing based on the APA training model is as compelling as it may have seemed earlier.

According to BLS (2022a) estimates, the number of physicians and surgeons, 816,900, is expected to rise by 3% by 2032. A more robust growth trajectory for psychiatrists is anticipated (BLS, 2022b), expanding the current psychiatry workforce of 28,600 by 7% by 2032. While the projected employment growth rate for psychologists (BLS, 2022c) is slightly lower (6%) than that for psychiatrists, there is little reason to anticipate increased interest in prescribing among future psychologists compared to that seen in the past two decades in jurisdictions where psychologist prescribing has been allowed. There are, after all, increasing alternative training and career options for individuals seeking to prescribe outside of psychology.

APRNs

The estimated current workforce of 323,900 NP and other APRNs, is expected to expand by a stunning 38% over the next decade (BLS,

2022d). A notable percentage (6.5%) specialize in psychiatric mental health and another 79.2% specialize in family medicine in adult-gerontology primary care (American Association of Nurse Practitioners, 2024) where they are likely to prescribe psychoactive medications as part of the de facto mental health system. Delaney (2024) highlighted the lack of visibility of the 35,000 psychiatric-mental health advanced practice nurses and the additional 4,374 psychiatric-mental health clinical nurse specialists, that is, a total of 39,374 nurse prescribers in the behavioral health workforce. This is an important oversight for workforce planning given their practices and the volume of care they provide, including to underserved and geographically distributed populations. For example, Andrilla et al. (2022) found that the ratio of psychiatric NPs more than doubled in rural counties from 2014 to 2021. There were an estimated 17,318 advanced practice psychiatric nurses in 1996 (Manderscheid & Henderson, 2001), the year that APA's (1996) training model for RxP was finalized. The addition of 22,056 psychiatric NPs since then contrasts sharply with the lackluster development of the workforce of prescribing psychologists.

Moreover, the potential for further growth in prescribing mental health APRNs is great. There are over 208 training programs. This is orders of magnitude greater than the number of training programs preparing psychologists to prescribe. These numbers reveal that APRNs who specialize in psychiatric care have become a critical prescribing component of the mental health workforce.

PAs

Similar to APRNs, the number of PAs is forecasted to increase substantially. The current workforce of 148,000 PAs is predicted to expand by 27% by 2032 (BLS, 2022e). Whereas all PAs can prescribe psychoactive medications, the National Commission on Certification of Physician Assistants (NCCPA, 2022) reported that 2,594 PAs are board certified specifically in psychiatry. The number of PAs in the psychiatric specialty is more than 10 times the current number of prescribing psychologists. There are even more PAs involved in primary care, functioning in essential roles as part of the de facto mental health system. These trends highlight the evolving landscape of the mental health workforce and underscore the pivotal roles of APRNs and PAs, as well as nonpsychiatric physicians, in meeting the demand for psychopharmacological care, especially when compared to the relatively underwhelming number, and inevitably minimal impact, of prescribing psychologists.

Discussion

Whereas RxP proponents focus on the shortage of psychiatrists, there has been little attempt to reconsider the movement by expanding the lens to encompass the entire workforce of prescribers and, importantly, to contemplate how to consider the movement in light of how few psychologists actually pursue prescribing. As a proportion of the workforce of prescribing professionals, the cadre of psychologists authorized to prescribe by state health regulatory boards is absolutely and comparatively small. It represents a minimal fraction of both the overall psychology workforce and the overall workforce of prescribing health professionals. Where psychologist prescribing is permitted, only a small proportion of psychologists have elected to become prescribers. Consequently, the impact of prescribing psychologists in providing psychopharmacological care is

constrained by their limited numbers. This stands in stark contrast to the growing presence and impact of other types of prescribers, who are increasingly stepping in to address gaps in mental health care delivery that are associated with the historically limited, yet expanding, psychiatrist workforce. According to the BLS, these other groups, especially NPs and PAs, are on course to grow even more, at an accelerated pace relative to psychologists (BLS, 2022c), making it highly unlikely that psychologists would ever play more impactful roles in meeting demands for psychopharmacological care.

Moreover, the workforce data support strategies noted by others (Andrilla et al., 2021) to meaningfully address rural access issues; namely, how the expansion of Medicare's 2017 implementation of behavioral health integration model payments can strengthen telemedicine use and the psychiatric CoCM (Archer et al., 2012; Katon et al., 2010; Unützer et al., 2006) that may be staffed by psychiatric NPs and PAs, as well as psychiatrists. In fact, in a recent qualitative study, Al Achkar et al. (2020) identified that, beyond serving as an evidence-based model of patient care, the CoCM also provided a framework for training and workforce development in rural primary care settings that contributed to the development of resilient and sustainable treatment teams. Given the shortage of all providers in rural settings, this seems to be a critical approach to addressing treatment gaps.

These shifts in workforce dynamics demand that the RxP agenda be reconsidered by psychologists and their professional organizations. Not only are psychologists the least prepared for prescribing based on the training to prescribe that is abbreviated relative to all other prescribers (Robiner et al., 2013, 2020), but their share of the market of prescribers is dwarfed by the other disciplines. This is a seriously limiting factor in how consequential their potential impact could ever be.

Meanwhile, the RxP agenda remains contentious in the field (e.g., Deacon, 2014) and with other professions. It can undermine relationships and potential collaborations with some other professional groups (Bush, 2001, 2002; Ransom, 2014), such as psychiatrists, which affects the capacity to work cooperatively on potentially shared agendas, such as health equity and support for the National Institute of Mental Health as well as clinical matters (e.g., care delivery, reimbursement, and integrated care). The International Society of Psychiatric-Mental Health Nurses (2001) issued a statement stating, "Nurses have an ethical responsibility to oppose the extension of the psychologist's role into the prescription of medications" (p. 4).

While psychologists widely engage in collaboration and consultation (Leventhal et al., 2021) and support alternatives to prescribing, such as collaboration (Smyer et al., 1993) and extensive use of telehealth, psychologists appear to have limited collective interest and intent to actually pursue prescriptive authority themselves. APA's focus on promoting RxP diverts resources away from addressing and advocating for other issues related to clinical practice, research, education, and other important patient and professional agendas that garner greater support within the field and hold the potential to benefit larger numbers of psychologists and patients.

We urge psychologists to acknowledge the workforce within the profession and in prescribing professions as an increasingly salient issue that warrants reappraisal of any previously perceived need and support for RxP. An objective question raised by these data is whether the experiment of trying to cultivate a robust workforce of prescribing

psychologists has failed. During the time frame that RxP has been APA policy, other groups such as APRNs and PAs have been more proficient in addressing and filling gaps in patient access to clinicians who prescribe psychoactive medications. These other disciplines are positioned to do so even more effectively in the future given the BLS projections for their growth, which is anticipated to vastly outstrip the proportional growth of the psychologist workforce. We believe it would be more advantageous and constructive for the profession to devote its energies, resources, and advocacy to promoting objectives that leverage its areas of strength and unity rather than to continue to pursue the anemic, controversial, distracting, divisive, and costly ambition of RxP for a small minority of psychologists. From a workforce and a policy perspective within the field, is the RxP movement a case of the tail wagging the dog?

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SB0568_UNF_MedChi_Health Occs. - Licensed Psycholo

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Senate Finance Committee

March 3, 2026

Senate Bill 568 – *Health Occupations – Licensed Psychologists – Prescriptive Authority*

POSITION: OPPOSE

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **opposes** Senate Bill 568.

This legislation would authorize psychologists to prescribe, which includes not only the ability to prescribe prescription drugs, but also to order laboratory tests, medicines, devices, other treatments and diagnostic examinations. Additionally, rather than setting an independently defined entity to assess proper educational attainment, as most licensure boards do, Senate Bill 568 allows the Board of Examiners of Psychologists to determine whether an educational program should be recognized for purposes of allowing a psychologist to prescribe.

Senate Bill 568 attempts to put psychologists on equal footing with physicians in many respects. However, their training is substantially different and that difference raises serious concerns about patient safety. The patient care hours that a physician must acquire in order to be licensed range from 12,000 to 16,000 hours upon completion of a 4-year medical school. These hours include intensive experience across diverse clinical settings, requiring them to develop clinical judgment and manage complex cases involving co-occurring medical and psychiatric conditions.

In contrast, a psychologist, while required to obtain a doctoral degree, does not undertake anywhere near the number of patient care hours as a physician, and their training is not focused on both the physical and mental aspects of health in the same way as a physician is. There are two pathways to licensure as a psychologist under Maryland law, and while both require some level of supervised experience, it does not match that required of a physician, and most importantly does not require even close to the same level of patient care hours.

We recognize that this effort to expand the scope of psychologists to include prescribing is couched in terms of access, as many scope bills are. However, even in those few states where psychologists have been given such authority, very few have become authorized to prescribe. Furthermore, in those states, the psychologists who obtain the authority to prescribe tend to do so in areas that are not underserved.

For these reasons, MedChi opposes Senate Bill 568.

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OPPOSING SB 568 Tanya Tompkins testimony Maryland

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Position: UNF

February 25, 2026

Re: OPPOSITION to SB 568 expanding practice to allow prescriptive authority for psychologists

Dear Senators,

My testimony is informed from my experience as a doctoral-level trained clinical psychologist (UCLA). My experience includes being a Professor of Psychology at Linfield University since 2002 and conducting research on this issue to try to understand psychologists' knowledge and views of prescriptive authority as well as psychologists' likelihood of training to pursue prescriptive authority. My opinions do not represent my academic institution. As my testimony suggests, this is not simply a "turf" issue. Opposition stems from serious concerns about the lack of data to support the efficacy and safety of short-cut training. Proponents advance prescriptive authority bills with the promise of increasing the number of prescribers as a solution to problems accessing high-quality empirically-supported treatments (ESTs). Equating mental health treatment to prescribing and overlooking data that suggest those with the greatest barriers to accessing care reside in underserved areas without access to *any* mental health providers does nothing to improve treatment access to residents of Maryland. Psychologists should be working with other health professionals and legislators to develop innovative solutions that address unmet needs.

I am writing to request that you oppose SB 568 and any future initiatives that would allow psychologists to prescribe medications in Maryland. I have been active in opposing legislation in Oregon and was a part of the team that convinced our Governor to [veto a bill](#) in 2010 that was pushed through both the house and senate in a short special session. I fought alongside consumers and colleagues from allied health and mental health disciplines in 2017 to again convince another Governor to [veto another](#) psychologist prescribing bill. Consumer protection, concerns about quality of training, and lack of evidence of improving care or access have been central to gubernatorial vetoes of RxP legislation in Hawaii ([Lingle, 2007](#)) and Oregon ([Kulongoski, 2010](#); [Brown, 2017](#)).

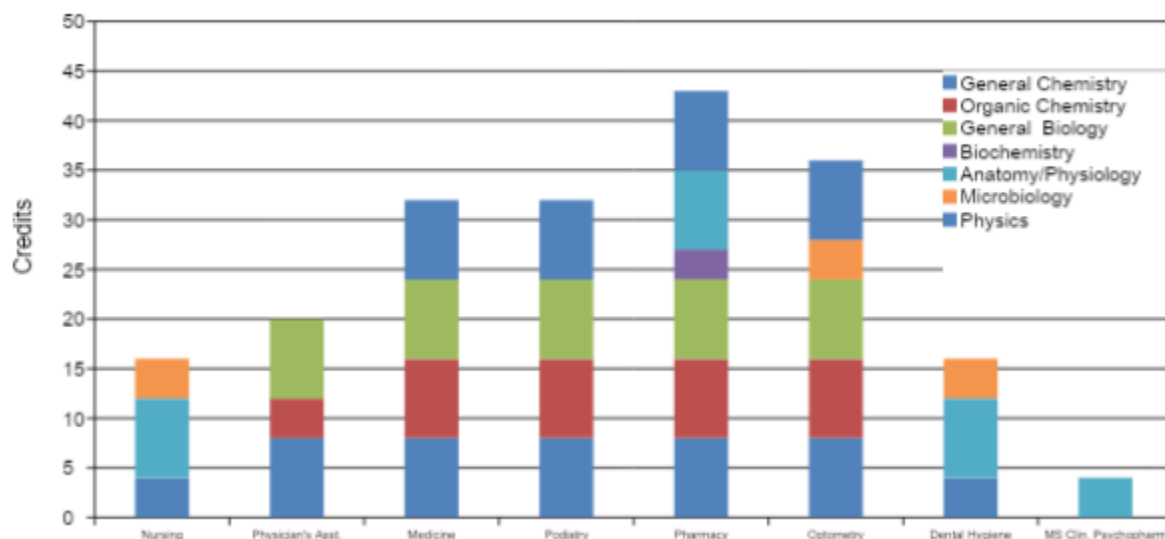
Below I detail my most serious concerns. I also reference several recent peer-reviewed articles as they contain figures demonstrating several key points of concern: failed efforts across many states that drain time and money away from finding real-time solutions (vs. promises) to mental health challenges; vast discrepancy between psychologists' preparation relative to other non-physician prescribers; lack of evidence to support arguments of improved access; failure to provide data about prescriptive patterns that speak to outcomes, safety and access to ESTs, including therapy vs. medication. I strongly believe that the stigma that surrounds mental illness serves as a more formidable barrier to accessing care than any other factor and is one that would not be addressed by establishing a lesser-trained class of psychologist prescribers. However, the American Psychological Association (APA) continues to invest significant time and money in providing boiler plate legislative bills to state organizations who then replicate the same unsupported arguments and initiate the process of wrangling over the bare minimum training acceptable to medically treat the mentally ill. This race to the bottom echoes the message that is acceptable to provide sub-standard care to folks who suffer from mental illness. It is not. They deserve better care.

Reasons for Opposition Involve Risk to the Consumer

- Training for a doctorate in clinical psychology does not include pre-medical or medical training (see Figure 1 from Robiner et al., 2013 - psychologists are not regularly prepared with even the most basic science courses prior to entering graduate school). There is NO requirement for any prerequisite training for the programs mentioned in the bill and testimony.

Figure 1

College Basic Science Prerequisite Courses for Admission to Health Science Programs



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

- There is virtually no evidence that reducing medical training to about 10% of that required for physicians and about 20% of that required for advanced practice nurses (advanced nurse practitioners) will protect the consumer (see also [Robiner et al., 2019](#)). In fact, the proposed training disconcertingly includes less than half the training of the DoD's PDP, which is typically cited as evidence for the effectiveness and safety of RxP, despite the striking differences in rigor and intensity. Concerns include: 1) non-selective admission process (i.e., the PDP by contrast recruited exemplary officers with strong science backgrounds); 2) abbreviated curriculum and training content and duration; 3) lack of standardized training (i.e., unspecified faculty qualifications, range of clinical settings); 4) no standards regarding limits to scope of practice (i.e., PDP psychologists treated adults aged 18 to 65, limited formulary). The bill indicates that clinical training will include a "diverse patient population under the direction of qualified practitioners". So they may spend less than a few days training in working with children, geriatric patients and/or pregnant women under the supervision of another prescriber (the bill doesn't specify their expertise or specialty) and be deemed sufficiently trained to independently prescribe psychotropic medication to these vulnerable populations? The continued development of programs based on controversies about the adequacy of training remains concerning. Why, after all, should training to prescribe, which arguably entails greater

safety risks for patients than other services rendered by psychologists, evade the quality mechanism of accreditation that governs all other post-baccalaureate psychology education and training in health service psychology?

- 89.2% of members of the multi-disciplinary Association for Behavioral and Cognitive Therapies (ABCT) argue that medical training for psychologists to prescribe **should be equivalent to other non-physician prescribers** (*The Behavior Therapist*, September 2014). A survey of Illinois (78.6%; Baird, 2007) and Oregon psychologists (69.2%; Tompkins & Johnson, 2016) yielded similar consensus
- The 2014 ABCT survey found only 5.8% endorsed the effectiveness of online medical training, which is not excluded in this bill and only 10.9% would refer a patient to a prescribing psychologist whose medical training is what is required in similar bills; the majority of training programs rely heavily or exclusively on online learning and testing for mastery of the material
- The psychology board, along with an advisory committee made up of three psychologists, one physician and one pharmacist will determine specifics with regard to reviewing education/training appropriate for licensing and will also be providing oversight of prescribing psychologists despite their lack of training or experience. In medical settings, confidence is only weakly correlated with competence and overconfidence is more prevalent than underconfidence, especially at lower levels of competence (Jaspan et al., 2021). Given that lower levels of competence have been associated with overconfidence in other medical professionals, there are legitimate concerns about prescribing psychologists' bias and blind spots in recognizing bounds of competence.
- Proponents claim that the lack of a reported death or serious harm by prescribing psychologists somehow provides evidence of safety. It does not! It only provides evidence that any harm done by these psychologists was not identified and reported by the psychologists themselves or their patients. A lack of evaluation of safety, and the absence of any credible, comprehensive system to identify problems, does not constitute evidence for safety. Psychologists' meager training to diagnose physical problems suggests that psychologists probably would not even know if their prescribing had caused medical problems (in fact, at least one person submitted testimony regarding the adverse effects of a psychologist prescribing Vyvanse). Lawsuits in Louisiana suggest the need for a more general survey of malpractice claims in these states to evaluate claims of "no adverse effects" (Robiner et al., 2019). Proponents, Linda and McGrath (2017), in their small study also noted that participants reported adverse effects - one reported a patient being hospitalized or harmed by medication, and a medical colleague reported a psychologist prescribed two medications with antagonistic effects. [Hughes et al. \(2025\)](#), using private insurance claim data that are not readily available to other researchers, recently claimed that adverse drug events (ADEs) "were rare for both prescribing psychologists (1.5%) and psychiatrists (2.4%)", and that the rates were 24% lower among patients treated by prescribing psychologists vs. psychiatrists. However, in their published Table 1 reporting descriptive statistics the rates were reversed (2.4% of those treated by prescribing psychologists reported ADEs vs. 1.5% for psychiatrists). I mention this in that some of these statistically complex analytic papers have not been pre-registered and submitted to APA journals where it is unclear whether reviewers or editors have the expertise to evaluate the analytic decisions being made as well as the interpretations of those analyses. Perhaps this was a typo in Table 1, but it leads to concerns about the rigor of the peer review process for this paper.

- The 2014 ABCT survey found that 88.7% of psychologists agreed that there should be a moratorium on bills like this one until there is objective evidence that the training involved adequately protects consumers. Proponents acknowledge that this training has, “the least overlap with traditional medical curricula” (Fox et al., 2009, p. 258) and that the “public sector might also serve as an experimental laboratory for society as elected officials explored expanding a health profession’s scope of clinical practice” (p. 263). Given the complexity and risks of prescribing, the fact that the evidence supporting RxP competence, quality and safety is woefully inadequate in scope, quantity, and quality as it relies on small convenience samples, poor response rates, and mostly self-report (Levine et al., 2011; Linda & McGrath, 2017; Peck et al., 2021) is deeply concerning. Across the limited published studies, prescribing psychologists reported increased income (Levine et al., 2011; Linda & McGrath, 2017), and treating individuals with more severe psychopathology. They also reported increased client load and income from their expanded practice, with over half reporting increased income owing to shifts in practice (i.e., discontinuing managed care in lieu of fee-for-service care and raising rates).
- Most prescribing psychologists reported prescribing medication to the majority of their patients, both as monotherapy and in combination with psychotherapy (Levine et al., 2011; Linda & McGrath, 2017; Peck et al., 2021). Also lacking is a broad perspective about how encouraging a new class of additional prescribers fails to curtail concerns about the dangers (Hampton et al., 2014; Gotzsche et al., 2015) and overuse of psychotropics (Olfson et al., 2012). Likewise the amount of polypharmacy reported in the limited number of self-report studies is concerning given the dearth of evidence to support use and factors that contribute, such as invalid assumptions about the efficacy of combined medication and limited awareness about metabolic and neurological adverse drug events (e.g., Zito et al., 2021). While Hughes and colleagues (2025) recently found, among privately insured patients, that prescribing psychologists performed slightly better than psychiatrists in terms of polypharmacy (20% lower rate), they also found significantly higher rates (175%) of psychotropic polypharmacy relative to Primary Care Physicians. Overall, the self-reported advantages and disadvantages of expanding practice paints a problematic picture of professionally-interested factors driving expanded scope of practice, especially in light of the lack of evidence with regard to actual behavior or outcomes (i.e., chart review or insurance database review). Perceptions and complaints about practice also seem to signal low meta-cognition about the dangers inherent in the role (i.e., overprescribing, practicing outside bounds of competence, need for medical screening and collaboration). Changes to scope of practice should be made centering patient safety and outcome, not professional desire or financial gain
- Given proponents of prescriptive authority for psychologists (RxP) spent over \$500,000 to pass a prescribing bill in Louisiana alone speaks to the availability of funds to conduct such a consumer safety study for the amount of medical training required in this bill. How much funding did the MSPA receive from the APA? I am a psychologist, full professor, and educator who was trained at the top clinical psychology graduate program in the U.S. I receive NO compensation for the work that I do opposing RxP and NO direct benefit from the work (having attained full professorship publications yield no additional career benefit). What drives my opposition is a strong belief in collaborative care grounded in ethics that one should respect bounds of competence

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

- In 2014, the State of Illinois enacted a law to permit psychologists to prescribe some psychotropic medications (e.g., excluding narcotics and benzodiazepines) to a limited population (excluding youth, the elderly, pregnant women, the physically ill, and those with developmental disabilities). While SB-847 stipulates training with high-risk patient groups, there are no specifics about the breadth, depth or quality of those clinical training opportunities. Leaving these standards to a Psychology board is problematic.
- The Illinois training requirement is similar to what is required of Physician Assistants, including completing undergraduate pre-medical science training before studying post-degree psychopharmacology. This training includes 7 undergraduate and 20 graduate courses along with a 14-month practicum in multiple medical rotations. The training program must be accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). None of the existing Psychopharmacology programs approved in SB-847 require *any* basic science prerequisites
- No online medical training is acceptable in Illinois
- The Illinois Psychological Association, Nursing and Medical associations, and POPPP support the Illinois law, as it requires, at minimum, the same medical training as other non-physician prescribers. This is more appropriate than the APA model in that it meets an existing standard for healthcare providers, rather than establishing a new lower standard
- That being said, there are concerns that attempts to get *any* legislation passed is favored in many states given longer-term strategies to seek later legislative changes that erode standards and expand scope of practice (e.g., in NM they have currently proposed a bill to allow the use of long-term anti-psychotic injectables by prescribing psychologists)

Alternative Solutions to Access to Psychoactive Drugs

The stated rationale for proposing such bills is to improve access. There is NO RELIABLE EVIDENCE to suggest that allowing psychologists to prescribe will improve access in any meaningful way. In our recent workforce study, psychologists in states that allow prescriptive authority represent only **0.23%** of the workforce of prescribers in those states. In a [blog post](#) accompanying the peer-reviewed article we demonstrate how other health professions have been filling gaps in psychiatric care. To underscore the potential underwhelming impact of RxP, In the two states (Louisiana and New Mexico) with the longest history of allowing psychologists to prescribe, the ratio of prescribing psychologists to the population is approximately one one-hundredth of the rates for other prescribers.

Several proponents have also suggested that prescribing psychologists have decreased suicide in states where they are allowed to practice. Drawing causal claims from correlational data is problematic.

Failing to mention that anti-depressants come with black box warnings given heightened suicide risk among youth and young adults is also disturbing. Equally concerning is the fact that proponents ignore the fact that researchers found ELEVATED rates of suicide in females (increases of 8%) in New Mexico and Louisiana in their unpublished study ([Choudhury & Plemmons, 2021](#)), but reported favorable changes for reductions for males and no significant change for women in their peer-reviewed, published paper two years later ([Choudhury & Plemmons, 2023](#)). Again, pre-registration and commitment to open science reduces concerns over researcher decision making that biases conclusions drawn. Moreover, a critique accepted for publication (McKay, Rizvi, Atkins, & Kerr, in press) highlights important limitations of additional research ([Hughes et al., 2023](#)) that RxP proponents have suggested reveals decreased suicide rates in states that have enacted prescriptive authority for psychologists. McKay et al.'s article has not been published by an APA journal for over one year since it has been accepted, apparently awaiting invited commentary by Hughes and colleagues. In fact, Hughes et al. reported an initial decrease in suicide in NM with no subsequent annual changes, while no changes were found for Louisiana.

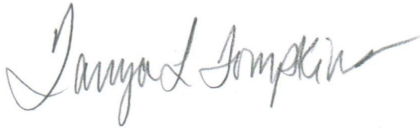
There are many alternatives to psychologists prescribing that more appropriately enhance access to the prescription of psychoactive medications in those individuals who would benefit from them and expand access to mental health care.

1. Collaboration between psychologists and physicians.
2. Completion of medical or nurse practitioner or physician assistant education by psychologists. Encouraging medical and nursing schools to offer executive track programs for psychologists. Funding existing efforts to improve current prescribers.
3. Use of telepsychiatry, which is promoted by the Department of Veterans Affairs, the military, and the U.S. Bureau of Prisons, and rural health centers, is an effective means of transcending distance between psychiatrists and patients. It is a mechanism for providing direct patient care by psychiatrists as well as a technology for providing primary care providers with appropriate consultation to develop appropriate treatment regimens, thereby extending the reach and impact of psychiatrists.
4. Encouraging all health professions to broaden their geographic distribution to better serve rural areas. The prescribing laws in New Mexico and Louisiana did not result in psychologists moving their practices to rural areas as they had intimated would happen. For example, in an Oregon survey and consistent with prior studies (94% - Baird, 2007), the majority of psychologists sampled (96%) practiced in metropolitan areas and those practicing in non-metro areas were no more likely than urban psychologists to express an interest in pursuing prescriptive authority (see attached chart from [Tompkins & Johnson, 2016](#); used with permission; no prescribing psychologists in Guam identified despite enabling legislation in 1999). Additionally, few (less than 7%) Oregon psychologists expressed an interest in pursuing training to become prescribers. In fact, results support prior survey results of both Oregon ([Campbell et al., 2006](#)) and Illinois ([Baird, 2007](#)) psychologists in suggesting that few have an interest in pursuing training and even fewer plan to prescribe. More recently, in proponents' recent simulation study evaluating millions of individuals receiving care, Hughes and colleagues (2024) similarly found that individuals living in metro service areas "were more likely to see a prescribing psychologist, meaning a smaller proportion of their patients were from rural areas" (p. 13).

Expanding mental health care demands innovative solutions to improve care for all Maryland residents.

I deeply appreciate your time and thoughtful consideration of this bill. If you have any questions that I can answer or would like for me to forward studies/data to you, please reach out.

Respectfully,

A handwritten signature in black ink, reading "Tanya L. Tompkins". The signature is fluid and cursive, with a long horizontal stroke at the end.

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

Petition POPPP SB Maryland 2026.pdf

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Petition-Testimony **OPPOSE SB 568**

A REQUEST TO OPPOSE LEGISLATION GRANTING PRESCRIPTION PRIVILEGES FOR PSYCHOLOGISTS (SB 568)

We, the undersigned psychologists, along with other stakeholders concerned about quality healthcare, OPPOSE efforts to allow psychologists to prescribe medications. Prescribing by psychologists is different from other services provided by psychologists and is controversial, even among psychologists. The movement for prescriptive privileges originated within the Psychology profession. It was not championed by other stakeholders, such as patient advocacy or public health groups. As psychologists, we oppose this proposal because we believe that it poses unnecessary risks to the public and would be an inappropriate and inefficient mechanism of addressing mental health needs of the population. Surveys of psychologists have revealed that psychologist prescribing is controversial among psychologists. We are a diverse group of psychologists, including clinicians, educators, and researchers. Psychologists have made major contributions to human health and wellbeing and will continue to do so. The profession of Psychology has made major contributions to understanding human development throughout the life cycle and to a multitude of dimensions of human functioning as individuals, groups, communities, societies and cultures. Psychologists provide important clinical services including assessment, psychotherapy, and consultation, that adds substantially to the mental health of the communities where they serve. Despite these contributions, there are limits to the practices that psychologists can undertake responsibly and competently as professionals. We believe that prescribing medications goes beyond psychologists' competence...even if they obtain the additional training advocated by the American Psychological Association. We consider the training model to be abbreviated, inadequate and inferior to that of physicians and other prescribing professionals.

Psychotropic drugs are medications that have multiple effects on the human body. These effects are complex and result from the interaction among patients' unique health status, their other prescribed medications, as well as their diets, lifestyles, and other factors. Although the therapeutic effects of prescribed medications can be very positive, unintended adverse drug reactions are common. To minimize the risk of potential adverse effects, some of which can have life-threatening consequences, we believe that medications should be prescribed only by professionals who have undergone suitable medical training that prepared them to manage these medications within the context of patients' overall health conditions. Patients have a right to expect that their medications will be managed by professionals whose education adequately trains them to understand their patients' health history and assess their current health status as well as the potential broad systemic effects of their medications. Unlike the training of current prescribers in other professions, the doctoral training of psychologists historically does not equip them to prescribe and manage medications safely or to diagnose most health conditions.

Unfortunately, the American Psychological Association's (APA) model for training doctoral psychologists to obtain limited training in psychopharmacology is minimalistic. It occurs after individuals complete graduate school, and does not match the levels required of other prescribing professionals (e.g., physicians, nurse practitioners, physician assistants, optometrists) in terms of their overall scientific foundation or their training in matters directly related to prescribing and managing medications. **The APA model is substantially less rigorous and comprehensive than the training required for all other prescribing disciplines.** Whereas the training of psychologists in certain professional activities, such as psychotherapy and psychological assessment, is generally more comprehensive than that of practitioners in other fields, this is not the case for training in clinical psychopharmacology. **The APA training model for prescribing even fails to meet the recommendations of APA's own experts** in its Ad Hoc Task Force of Psychopharmacology (e.g., in terms of undergraduate prerequisites in biology, chemistry, and other sciences) and has other inadequacies (e.g., lack of explicit requirements for supervision; no accreditation mechanism of programs). It does not meet APA's own standards for accrediting postdoctoral training. The APA training model is substantially less rigorous than the training that the 10 psychologists undertook in the experimental pilot program of the Department of Defense (DoD) that is often cited by proponents of psychologist prescribing. Despite the alarmingly small sample of that brief pilot program, which precludes generalizing from it, the fact that the current training model is far less comprehensive, and the fact that inadequacies were noted in some of the graduates of the DoD program, proponents of psychologist prescribing make the dubious claim that the DoD program justifies prescribing by psychologists. It does not! In fact, the final report on the DoD project revealed that the psychologists were **"weaker medically"** than psychiatrists and compared their medical knowledge to **students** rather than physicians. We oppose psychologist prescribing because citizens who require medication deserve to be treated by fully trained and qualified health professionals rather than by individuals whose expertise and qualifications have been independently and objectively assessed to be at the student level. The training advocated by the APA that would be the basis of proposed legislation to enable psychologist prescribing is simply less rigorous than that of all other prescribers. This raises questions about the competence of psychologists who would seek to prescribe based on that training and about the safety, knowledge, and skill with which they would practice. Research evaluating the master of science degree programs in clinical psychopharmacology that follow the APA model have revealed limitations of the training, criticized the inadequate prerequisites, and outlined how such training compares unfavorably to training of prescribers in other fields (i.e., physicians nurse practitioners, physician assistants). **Proponents of psychologist prescribing have misleadingly invoked a range of unrelated issues to advocate for their agenda.** An article in the *American Journal of Law & Medicine* entitled, "Fool's Gold: Psychologists Using Disingenuous Reasoning To Mislead Legislatures Into Granting Psychologists Prescriptive Authority" critiques the rationales that advocates of prescription privileges use to promote their cause. Proponents point to problems in the healthcare system, such as the fact that rural and other populations are underserved. Whereas such problems are indeed serious and warrant changes in the healthcare system, allowing psychologists to prescribe is neither an appropriate nor an effective response. Permitting relatively marginally trained providers to provide services is not an acceptable way to increase access to healthcare services where high quality health care is needed. Rather than relying on under-trained psychologists to prescribe, it would be much more sensible to develop mechanisms to facilitate psychologists' providing those services that they are highly qualified to provide (e.g., counseling) to those populations and to innovate other approaches for medically-qualified providers (for example, collaboration, telehealth) to leverage available services. It should be noted that most psychologists practice in urban and suburban areas: There is no reason to expect that prescribing psychologists would have a significant impact on compensating for the shortages of psychiatrists in rural and economically disadvantaged areas, where relatively few psychologists actually work. Other remedies are needed to address such problems that would not compromise the quality of care. For example,

the marked increase of telehealth during the pandemic provides alternatives that enable prescribers to provide treatment remotely.

Other health professionals, including nurses and physicians, are concerned about psychologist prescribing. It is inappropriate to dismiss such concerns as a turf battle. There are legitimate concerns that the training for psychologists to prescribe is too narrow and abbreviated. The International Society of Psychiatric-Mental Health Nurses position statement asserts, “nurses have an **ethical responsibility** to oppose the extension of the psychologist's role into the prescription of medications” due to concern about psychologists' inadequate preparation, even if they were to get *some* additional training, in accordance with the APA model. When it comes to prescribing psychoactive medications that have a range of potential therapeutic and adverse effects on the human body, including interactions with other medications, shortcuts to training are ill advised. Some psychoactive drugs come with black box warnings about their potential risks. Another concern is the limited expertise of psychology regulatory boards to effectively regulate prescriptive practicing. Given the similar limits in medication-related training of most psychologists who serve on these boards to that of other psychologists, and the fact that psychology boards historically have not overseen prescribing, we question whether regulatory boards have the expertise, resources and systems to provide effective oversight of psychologist prescribing.

When considering this controversial cause, we urge legislators, the Governor, the media, and all concerned with the public health to take a closer look at the issues. Rather than permitting psychologists to prescribe, we advocate enhancement of currently available collaborative models in the delivery of mental health care, in which licensed psychologists work collaboratively with fully qualified prescribers to provide safe and effective services for those individuals who may benefit from psychoactive medications. This is an innovative, safer model of care delivery that draws on psychologists' strong assessment, psychotherapeutic, and consultative skills in providing patient care in conjunction with healthcare teams in primary care and specialty care settings and expands access to more coordinated mental health services for patients who need them. In the decades since the American Psychological Association first proposed prescriptive authority for psychologists, very few states have passed it. The trivial impact of psychologist prescribing on the mental health services available is problematic. In the few states that have experimented with allowing psychologists to prescribe, very small minorities of psychologists have pursued it. The fact that so few psychologists could be expected to pursue the training suggests that the [impact](#) of allowing psychologists to prescribe is not likely to have substantive effects in expanding the number of prescribers or enhancing the quality of mental health services in your state. By contrast, in this same period, there have been large increases in the numbers of nurse practitioners and physician assistants who are now available to prescribe. Their training for managing medications is more extensive than psychologists who obtain limited, part-time training. The growth in the number of other prescribers has already expanded the number of health professionals who are adequately prepared to manage medications with holistic understanding of their patients' health. It has added far more prescribers than enabling psychologist prescribing would. Psychologists can collaborate with them as well as physicians in addressing the mental health needs of patients.

There are better and safer alternatives to psychologists prescribing that we believe will have a greater positive impact on mental health services. A more promising means for enhancing the mental health services available to all citizens than to allow psychologists to prescribe would be to dedicate efforts to better integrating mental health professionals, including psychologists, into the healthcare system, such as in primary care settings, where they can collaborate with other providers (including prescribers) in the care of people who may need medications and psychological services. The barriers to such care have been detailed in a recent report by the U. S. Department of Health and Human Services, *Reimbursement of Mental Health Services in Primary Care Settings*. Overcoming

the barriers to such care is an objective upon which psychologists agree with each other, and with other health professionals, and is clearly in the public interest. It would improve the quality of mental health care available in urban and rural areas and would not rely on a training model that does not match that of the other types of health professionals who prescribe. Whereas we are pleased to refer patients to psychologist colleagues for various psychological services, we would not personally refer any patients to a psychologist who prescribes based on the American Psychological Association training model as proposed in this legislation. **We respectfully request that you oppose SB 568 that would allow psychologists to prescribe based on training that we, and other health professionals, consider to be inadequate.**

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SB568_Miskimen_UNF

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Position: UNF



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March 3, 2026

The Honorable Pamela Beidle
Chair

Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

The Honorable Antonio Hayes
Vice Chair

Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401

Re: Maryland SB 568 - Oppose

Dear Chair Beidle, Vice Chair Hayes and Finance Committee Members:

On behalf of the American Psychiatric Association, a national medical specialty society representing over 39,000 psychiatric physicians, as well as their patients and families, we strongly urge you and the members of the Committee to oppose SB 568, which would authorize psychologists to prescribe powerful psychotropic medications without appropriate medical training. SB 568 will jeopardize the safety of patients with mental health and substance use disorders in Maryland.

Patient safety must be paramount when considering the change of any law, and this bill puts Maryland's most vulnerable patients at risk including the elderly, children, pregnant women, people with disabilities. Prescribers who are not medically trained could put patients who live with mental illness and substance use disorder (SUD) at risk, especially those with medical co-morbidities.

Supporters of SB 568 say this bill will increase access to needed mental health care. However, there is no data to support this, including in rural and underserved areas. We know in states that have allowed psychologists to prescribe that those states have seen no increased access to mental health and substance use disorder services. In addition, Medicare, which provides insurance for over a million people in Maryland, does not reimburse prescribing psychologists for pharmacologic management due to their lack of medical

education and training. Additionally, this bill will ultimately siphon psychologists off from providing the needed clinical therapies that fall within their expertise.

Psychologists often receive their education in research, therapies, psychological testing, and evaluation. They simply do not have the medical training needed to understand the effect psychotropic medications have on an individual. SB 568 requires approximately 1,500 – 1,750 hours of clinical training, which is dangerously inadequate compared to the training psychiatrists and other prescribing professionals receive.

In contrast, a psychiatrist completes their undergraduate degree, spending an additional 4 years in medical school learning basic science topics such as anatomy, biochemistry and pathophysiology and an additional 4 years in residency rotating at the patient bedside and accruing over 12,000 hours of training in the medical treatment of mental health and substance use disorders.

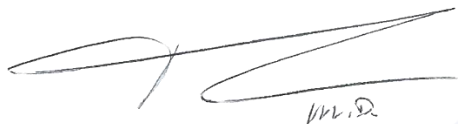
Psychiatrists also treat a significant number of patients with co-morbid medical conditions, such as mental illness along with heart disease or diabetes. Patients needing more than one drug at a time for mental and physical conditions are at risk for potentially serious drug interactions. The clinicians who treat these patients must be medically trained to understand and treat all systems of the body to recognize the warning signs of adverse effects.

We strongly encourage the committee to protect patient safety by opposing this bill and supporting and building-upon proven evidenced based solutions such as:

- Allocating funding to primary care practices to implement the Collaborative Care Model. This model is a multiplier for the psychiatric workforce and has over 100 randomized-control studies demonstrating its effectiveness to increase access to care, improve patient and provider satisfaction, as well as reduce costs to the overall healthcare system.
- Increasing loan repayment opportunities, which will lessen physician debt and is an encouraging factor in areas where physicians practice.
- Increasing residency slots for psychiatry, which allows for greater opportunities for students to specialize in psychiatry.
- Expanding telehealth services, including audio-only services.

I urge you to preserve patient safety and consider alternative solutions to psychologist prescribing privileges and oppose Senate Bill 568.

Sincerely,

A handwritten signature in black ink, appearing to read 'T. Miskimen Rivera, MD, DLFAPA'. The signature is stylized with a large, sweeping 'T' and 'M'.

Theresa Miskimen Rivera, MD, DLFAPA
President, American Psychiatric Association

MD SB568 2026.pdf

Uploaded by: Joana da Silva-Gonzalez

Position: INFO

February 26th, 2026
Finance Committee

Dear Chair Beidle, Vice Chair Hayes, and all distinguished members of the Finance Committee:

I appreciate the opportunity to comment on SB 568, which concerns prescriptive authority for psychologists. I am an assistant professor and director for the Knee Regulatory Research Center at West Virginia University where my research specializes in analyzing safety, efficacy, access, and cost of healthcare under different practice arrangements for non-physician providers. This comment is not submitted on behalf of any party or interest group.

I am one of the leading experts in the U.S. studying the effectiveness of prescriptive authority of psychologists. The two studies I am about to discuss were even cited as one of the drivers for the Department of Commerce's proposal for this policy change in Utah, which passed a few years ago.

Patient safety comes first and foremost. Mental health is tricky, in that there are so many moments where a person in need of support can drop out of the system. On average, it takes 6-8 weeks for an initial appointment with a psychologist, 6-8 weeks to then be referred and meet with a psychiatrist, and then between 0-6 weeks to be prescribed medication. During these long wait times, many patients give up hope.

New Mexico, Louisiana, Idaho, Illinois, Iowa, Utah, and Colorado allow for psychologists to start these medications earlier, reducing these long periods of time before a person in crisis gets care. My team has spent countless hours analyzing safety data to determine if this is an effective policy. We found no safety concerns. In fact, allowing medication to be started earlier decreased loss of life to suicide by 5-7 percent, and was more effective among middle-aged white men.¹ This did not stop patients from seeing psychiatrists, in fact, psychiatrist businesses were not affected at all.² Instead, there was a substantial set of new patients able to get time-sensitive psychopharmacological interventions in a timely manner.

The data finds that psychologist prescriptive authority after additional graduate training in psychopharmacological interventions is effective, safe, and gets care to those in need in a timely manner.

Best,



Alicia Plemmons, PhD
Director, Knee Regulatory Research Center

¹ <https://pubmed.ncbi.nlm.nih.gov/37271047/>

² <https://onlinelibrary.wiley.com/doi/full/10.1111/coep.12643>

SB 0568 Research Breifing Letter.pdf

Uploaded by: Phillip Hughes

Position: INFO

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 prescribing³
6. Mental health mortality decreased in New Mexico when psychologists began prescribing³
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.

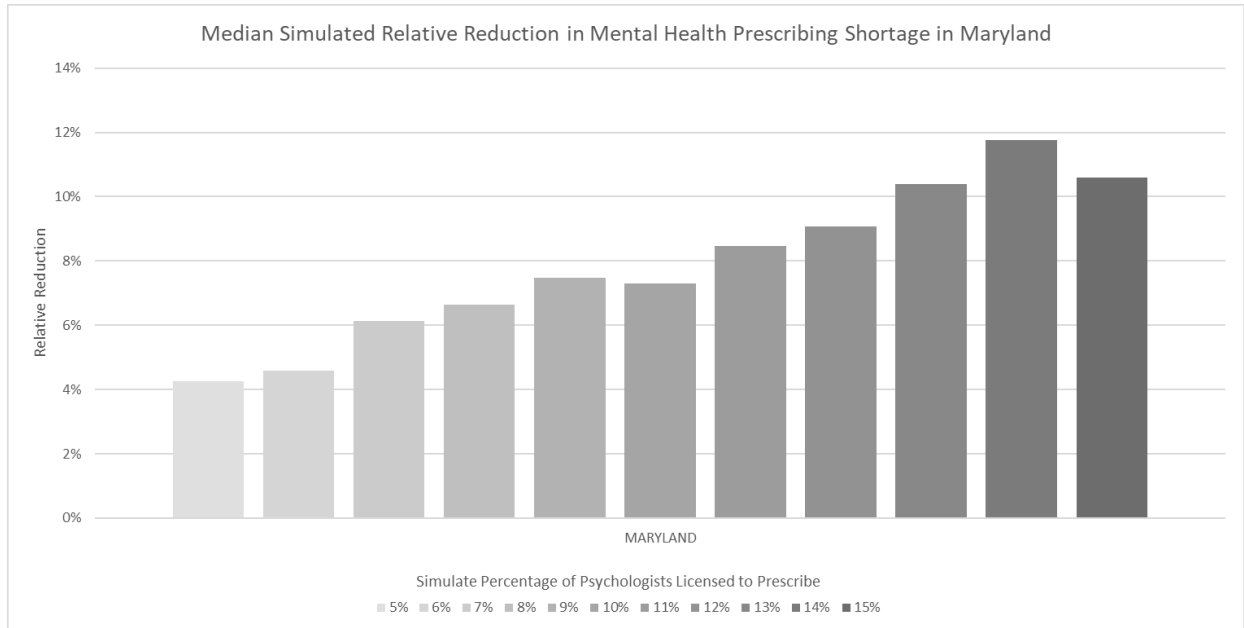
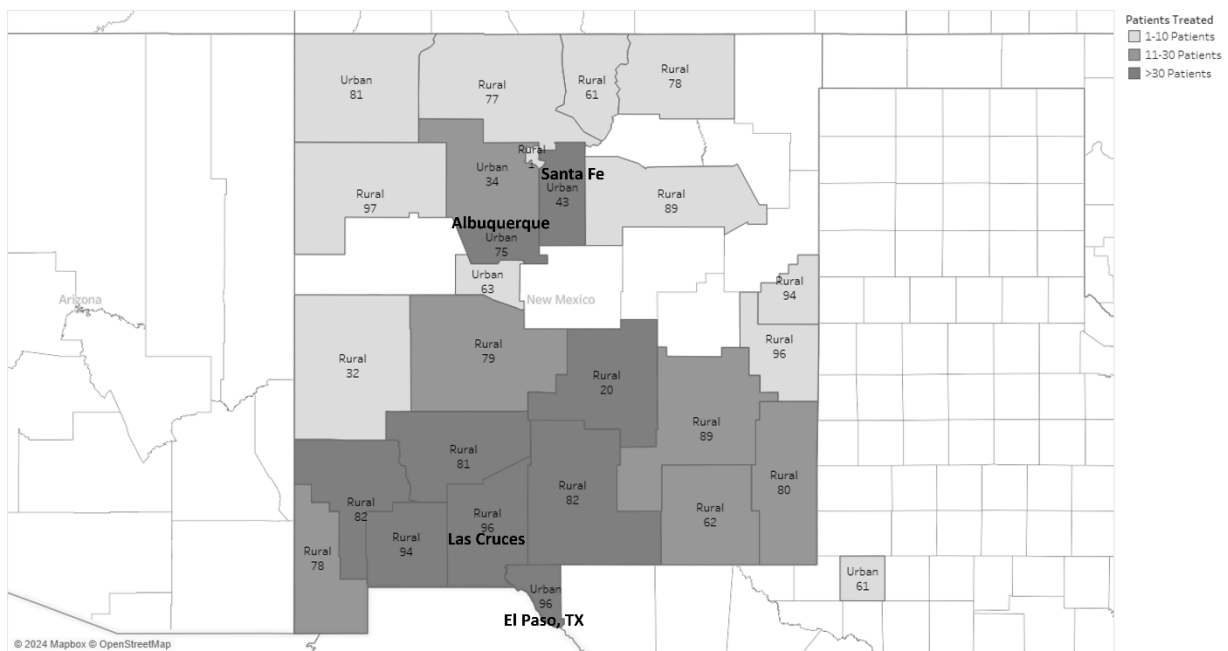


Figure 2. Distribution of Patients Treated at a Prescribing Psychology Clinic in Las Cruces, New Mexico.



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,

A handwritten signature in black ink, appearing to read "Phillip Hughes". The signature is fluid and cursive, with the first name "Phillip" being more prominent than the last name "Hughes".

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References

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SB 568 - FIN - BOP - LOI.docx (1).pdf

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Position: INFO



Board of Physicians

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2026 SESSION POSITION PAPER

BILL NO.: SB 568 - Health Occupations - Licensed Psychologists - Prescriptive Authority
COMMITTEE: Finance
POSITION: Letter of Information

The Maryland Board of Physicians (the Board) is respectfully submitting this Letter of Information for Senate Bill (SB) 568 - Health Occupations - Licensed Psychologists - Prescriptive Authority. SB 568 authorizes a licensed psychologist to use prescriptive authority under certain circumstances. In addition, SB 568 requires a report be transmitted to the Board of Physicians (1) if a psychologist is granted prescriptive authority, (2) if the prescriptive authority is revoked, suspended, or reinstated, or (3) if the license of a prescribing psychologist is revoked, suspended, or reinstated.

It is not within the scope of the Board to opine on whether a psychologist should be granted prescriptive authority, and the reports to the Board required under SB 568 are not within the Board's purview. The Board does not regulate psychologists, and there is no precedent for other health occupations authorized to prescribe to report this information.

In addition, there is little nexus between a prescribing psychologist and a physician. While HB 568 requires that a prescribing psychologist coordinate with the patient's medical provider, there are multiple other health occupations who may be acting as the patient's medical provider whose regulatory boards are not included in the reporting requirement, such as nurse practitioners.

The Board requests to be removed from the reporting requirement found on page 10 lines 9 through 18:

(B) (1) AT THE TIME THE BOARD CERTIFIES A PRESCRIBING PSYCHOLOGIST UNDER THIS SUBTITLE, THE BOARD SHALL PROMPTLY TRANSMIT THE INFORMATION LISTED IN SUBSECTION (A) OF THIS SECTION FOR THE PRESCRIBING PSYCHOLOGIST TO ~~[THE STATE BOARD OF PHYSICIANS AND]~~ THE STATE BOARD OF PHARMACY.

(2) THE BOARD SHALL PROMPTLY NOTIFY ~~[THE STATE BOARD OF PHYSICIANS AND]~~ THE STATE BOARD OF PHARMACY IF THE BOARD REVOKES, SUSPENDS, OR REINSTATES THE CERTIFICATION OR LICENSE OF A PRESCRIBING PSYCHOLOGIST OR HAS A CERTIFICATION OR LICENSE REVOKED, SUSPENDED, OR REINSTATED.

Thank you for your consideration. For more information, please contact Madeline DelGreco, Manager of Policy and Legislation, at 410-764-5053.

Sincerely,

A handwritten signature in cursive script that reads "Harbhajan Ajrawat".

Harbhajan Ajrawat, M.D.
Chair, Maryland Board of Physicians

**The opinion of the Board expressed in this document does not necessarily reflect that of the
Maryland Department of Health or the Administration.**