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Del. Heather Bagnall,
Del Bonnie Cullison
Heath Committee
241 Taylor House Office Building
Annapolis, Maryland 21401

Dear Chair Bagnall, Vice Chair Cullison, and members of the committee:

I am a licensed child psychologist practicing in Maryland, and I am urging a FAVORABLE report for HB 1021. This legislation would create a pathway to prescriptive authority for psychologist; it also ensure that we become adequately and rigorously trained to provide safe psychiatric care to our patients.

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

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

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

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

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

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

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

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

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

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

The families I work with cannot afford to wait for a system that works. I urge the committee to support HB 1021.

Respectfully submitted,

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