

February 23, 2026

Re: OPPOSITION to HB 1021 expanding practice to allow prescriptive authority for psychologists

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 HB 1021 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](#)).

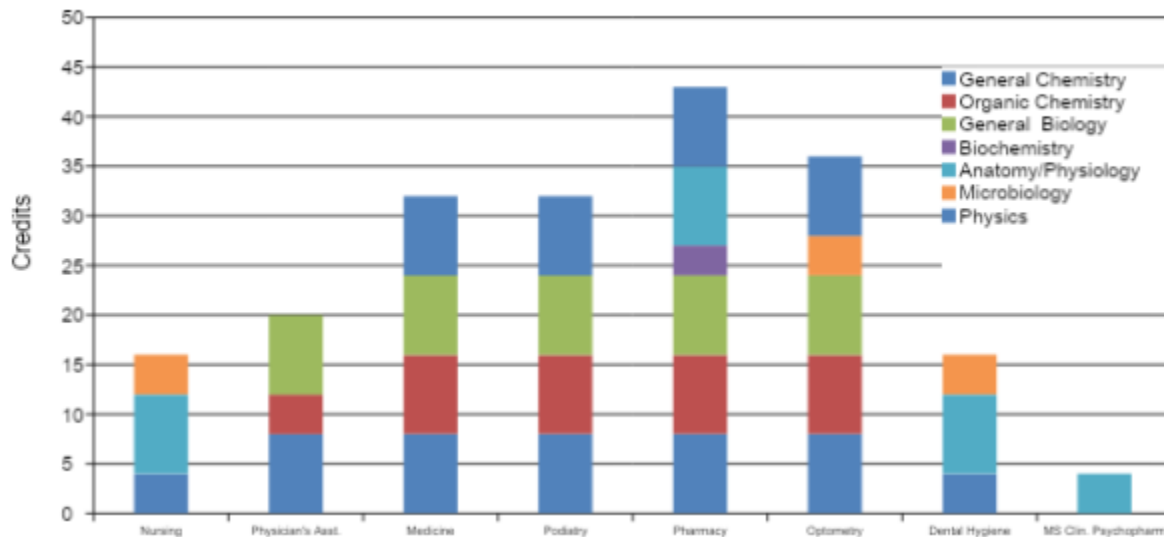
Below I detail my most serious concerns. I also reference several recent peer-reviewed articles as they contain figures demonstrating several key points of concern: failed efforts across many states that drain time and money away from finding real-time solutions (vs. promises) to mental health challenges; 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.

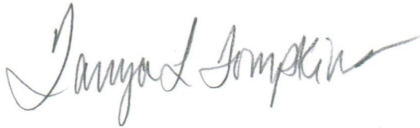
**There are many alternatives to psychologists prescribing that more appropriately enhance access to the prescription of psychoactive medications in those individuals who would benefit from them and expand access to mental health care.**

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 written in a cursive style with a long, sweeping underline.

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