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February 26, 2026

Delegate Heather Bagnell, Chair
Delegate Bonnie Cullison, Vice Chair
Health Committee
240 Taylor House Office Building
241 Taylor House Office Building
Annapolis, MD 21401

RE: HB 1021 – Health Occupations – Licensed Psychologists – Prescriptive Authority

Position: SUPPORT

Dear Chair Bagnell, Vice Chair Cullison, and Members of the Committee:

I am a licensed psychologist and practice in Towson, Maryland, I am writing in strong support of House Bill 1021 (HB 1021), 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. HB 1021 Includes Robust Safeguards and Oversight

HB 1021 does not grant blanket prescribing authority. Instead, they require doctoral-level licensure in psychology, completion of rigorous postdoctoral education in clinical psychopharmacology, supervised clinical prescribing experience, certification by the State Board of Examiners of Psychologists, ongoing regulatory oversight, and establishment of a Prescriptive Authority Advisory

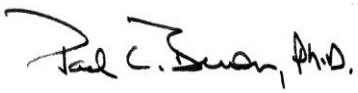
Committee to guide implementation and ensure patient safety.

VI. Conclusion

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

The empirical evidence is clear: prescribing psychologists are safe, effective, conservative in their use of psychotropic medications, and associated with improved population-level outcomes, including reduced suicide rates. For these reasons, I respectfully urge a favorable report on HB 1021.

Respectfully submitted,



Paul C. Berman, Ph.D.
Licensed Psychologist

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