# PRESCRIPTIVE AUTHORITY FOR PSYCHOLOGISTS: ISSUES AND CONSIDERATIONS

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# FOREWORD

This study was prepared in response to Senate Concurrent Resolution No. 113, S.D. 1 (2006). The Concurrent Resolution requested the Legislative Reference Bureau to study the issue of authorizing certain psychologists to prescribe psychotropic medications to mental health patients while practicing in federally qualified health centers, or community health centers by reviewing the United States Department of Defense Psychopharmacology Demonstration Project (PDP program or program), including an analysis of external evaluations of the program. The Bureau also was requested to include information relating to patient safety, trends in other states, arguments in favor and in opposition to prescribing psychologists, increasing access to mental health services, including psychiatric care, at community health centers, and nonphysicians who have prescriptive authority.

The Bureau appreciates the time and effort of all the individuals and representatives of various state agencies and professional associations and organizations who met with the Bureau, in person or by telephone, to discuss issues and express concerns relating to prescriptive authority for psychologists from a variety of viewpoints. We consulted with numerous interested parties in Hawaii and on the mainland who were willing to share their views and thoughts. As we reviewed the many and sensitive issues relating to this subject, we developed a deep appreciation for all who met with us. We thank you for your assistance and continued patience. Your generous cooperation made this study possible.

Ken H. Takayama
Acting Director

January 2007

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# EXECUTIVE SUMMARY

Prescriptive authority for psychologists has been the subject of legislative efforts and extensive debate for more than two decades. From 1991 through 1997, the United States Department of Defense's Psychopharmacology Demonstration Project (PDP) trained military clinical psychologists to prescribe psychoactive drugs to treat patients between the ages of 18 and 65 for mental illness, generally not of the serious mental illness category. All patients were treated at military medical facilities. External evaluations of the PDP program report that patients were screened to eliminate complicated medical conditions. Thirteen individuals participated, ten graduated. PDP participants had a minimum of one year of full time classroom training at the Uniform Services University of Health Sciences (USUHS) and one year of full time clinical training, supervised by a psychiatrist, at Walter Reed Army Medical Center or Malcolm Grow Medical Center.

A number of external evaluations reviewed the PDP program, its participants, and graduates and concluded that the program had met its goal of training military psychologists to prescribe safely and effectively for their mental health patients in military medical facilities. Program graduates interviewed as part of the final evaluation in 1998 were found to hold positions of head or assistant head of departments or clinics, indicating to interviewers that program graduates were well respected by their peers and suggesting that candidates for future psychopharmacology training programs should be held to high selection standards when admission decisions are made.

To date, only two states, New Mexico and Louisiana, have authorized prescriptive authority for psychologists. Both programs were implemented in 2005. As of this writing, there are only four conditional prescribing psychologists, who require supervision for two years, in New Mexico; there are no independent prescribing psychologists. Louisiana reports thirty-four psychologists have been issued certificates of prescriptive authority. Although both states require prescribing psychologists to have a collaborative relationship with a patient's primary care physician, whose approval must be received before a prescription can be written, Louisiana does not require an initial two year period of supervision. Also, both states have classroom and clinical training requirements for prescribing psychologists that appear less stringent than the PDP training model, although there have been no known adverse affects on patient safety in either state. However, the training requirements for either state have not been externally evaluated and there have been no external evaluations relating to patient safety or whether access to mental health care services has changed as a result of allowing psychologists to prescribe.

Even though only two states have authorized prescriptive authority for clinical psychologists, there are at least ten independent programs that offer postdoctoral training in psychopharmacology for clinical psychologists. These programs are not uniform in their requirements or approaches, although they all claim to meet the recommended standards of the American Psychology Association (APA). Because the APA recommended standards are less rigorous than the training requirements of the PDP, none of the current training programs meet the classroom or clinical training requirements of the PDP program. Similarly, none offer one year of fulltime classroom or clinical training or classroom and clinical training facilities equal to

the USUHS or Walter Reed or Malcolm Grow. Whether these independent programs can train clinical psychologists to prescribe safely has not been established by external evaluations.

Generally speaking, supporters of prescriptive authority for psychologists claim such authority would increase access to mental health services for the medically underserved. Opponents generally point to psychologists' lack of medical education and inability to distinguish between organic conditions that mimic mental illness and mental conditions. Opponents contend that psychologists' lack of scientific background would endanger patients. While psychologists point out that nonphysicians have safely prescribed drugs for some time, psychiatrists note that those prescribers include advance practice registered nurses, physician assistants, and others who have a medical based background that includes biological and neurosciences, anatomy, and other courses not taken by psychologists. Nonphysician prescribers, therefore, are better qualified to prescribe than psychologists, according to opponents of prescriptive authority for psychologists.

Federally qualified health centers, or community health centers, are required to provide medical services, including mental health care, to medically underserved areas or populations. There is no dispute that there is a shortage of mental health care services available to the medically underserved in Hawaii; however, there are differences in how to increase services. Community health centers are among the supporters of prescriptive authority for psychologists as a way to increase access to mental health care for their clients.

Whether clinical psychologists should be authorized to prescribe medication is a policy decision for the legislature. The ultimate decision should be guided by considerations of patient safety. Whatever the decision or solution on this issue, patient safety cannot be compromised.

# Chapter 1

# INTRODUCTION

The Legislature, through Senate Concurrent Resolution No. 113, S.D. 1, adopted during the 2006 Regular Session, requested the Legislative Reference Bureau to study the issues relating to authorizing certain psychologists with the appropriate training and experience to prescribe a limited formulary of psychotropic medications while practicing in federally qualified health centers located in medically underserved areas. The Concurrent Resolution also requested the Bureau to describe barriers to hiring psychiatrists at federally qualified health centers and to suggest solutions to removing such barriers. Senate Concurrent Resolution No. 113, S.D. 1 is attached as Appendix A.

## Background

The issue of prescriptive authority for psychologists has been the subject of debate and legislative activity across the nation for over twenty years. Legislation to authorize psychologists to write prescriptions was first introduced in the Hawaii Legislature in 1985. The related issue of increasing access to health care, including mental health services, to the medically underserved also has been a frequent subject of legislative discussion and task force study for a number of years.

On January 2, 1990, in response to House Resolution 334-90, the Center for Alternative Dispute Resolution submitted to the Sixteenth Legislature a report entitled: UNDERSERVED MENTAL HEALTH NEEDS AND PRESCRIPTIVE PRIVILEGES FOR PSYCHOLOGISTS IN HAWAII: A report on the Psychotropic Medications Roundtable. Members of the Roundtable included psychiatrists, psychologists, and other professionals. Their report included suggestions to improve mental health services for Hawaii's medically underserved mentally ill and a "Facilitator's Summary of Arguments For and Against Granting Prescriptive Privileges to Psychologists" as Attachment #3. The relevant material is attached as Appendix B.

More recently, Senate Concurrent Resolution No. 195, S.D. 1, H.D. 1, adopted by the Legislature in 2005, requested the State Health Planning and Development Agency (SHPDA) to identify and evaluate barriers to community-based access to specialty care, including mental health care, on the neighbor islands and rural Oahu and to make recommendations to improve access to specialty care.

SHPDA was requested to submit an interim report of its findings and recommendation to the Legislature no later than twenty days prior to the convening of the Regular Session of 2006 and a final report no later than twenty days prior to the convening of the Regular Session of 2007. A telephone interview with the Administrator of SHPDA confirmed that SHPDA had identified barriers and was working on recommendations and anticipated submitting a final report to the Legislature prior to the convening of the Regular Session of 2007.

Also, the Legislature, through House Concurrent Resolution No. 255, H.D. 2, adopted during the 2005 Regular Session, established an interim task force on the accessibility of mental health care to consider the feasibility of authorizing trained and supervised psychologists to prescribe psychotropic medications to treat mental illness. The task force consisted of Senator Rosalyn Baker, Chair; Representative Joshua Green, Vice-Chair; Jeffrey Akaka and Lili Kelly, of the Hawaii Psychiatric Medical Association; and Raymond Folen and Daryl Oliviera, of the Hawaii Psychological Association.

The task force met five times and submitted a report to the Legislature, which included recommendations that the Legislature establish training requirements for prescribing psychologists and authorize appropriately trained psychologists with a professional affiliation with a federally qualified community health center to prescribe psychoactive medications. Additionally, the report suggested specific acceptable training and education requirements sufficient to authorize prescriptive authority for psychologists. A copy of House Concurrent Resolution No. 255, H.D. 2 and the subsequent report is attached as Appendix C.

## Organization of the Study

This study is organized into seven chapters, including this introductory chapter. Chapter 2 provides an overview of United States Department of Defense's Psychopharmacology Demonstration Project, which admitted its first program participants in 1991 and which was terminated in 1997. The program trained ten clinical psychologists to prescribe psychotropic medications under certain conditions in military health care facilities after their graduation from the project's classroom and clinical training programs. As a politically controversial pilot program, the Psychopharmacology Demonstration Project had several external evaluations. Chapter 2 also reviews and analyzes those external evaluations of the program, including any patient safety issues. Chapter 3 discusses trends relating to the prescriptive authority for psychologists' movement in other jurisdictions. Chapter 4 reviews the arguments in support of and in opposition to authorizing clinical psychologists to prescribe psychotropic medications under certain circumstances. Chapter 5 compares the educational requirements for doctoral psychologists and psychiatrists as well as nonphysician providers currently authorized to prescribe medications. The applicable formulary and any supervision or other kinds of restrictions to which nonphysician prescribers are subject is reflected in a chart in Chapter 5. Chapter 6 looks at the barriers to hiring psychiatrists in federally qualified health centers and offers possible solutions to increase access to psychiatric and mental health services. The final chapter includes findings and a summary of the issues.

# Chapter 2

# THE UNITED STATES DEPARTMENT OF DEFENSE PSYCHOPHARMACOLOGY DEMONSTRATION PROJECT; EVALUATIONS; PATIENT SAFETY

## Introduction

Senate Concurrent Resolution No. 113, S.D. 1, requested the Legislative Reference Bureau (Bureau) to study the issue of authorizing qualified psychologists to prescribe medications to treat mental illness while practicing in federally qualified health centers. By definition, federally qualified health centers are required to be located in a medically underserved area or to provide services, including mental health services, to a medically underserved population. The Bureau was requested to review the United States Department of Defense's Psychopharmacology Demonstration Project, evidence of patient safety, and any evaluations of the program. The Psychopharmacology Demonstration Project is discussed in Part I of this chapter. Evaluations of the program and patient safety issues are discussed in Part II.

## Part I. The Department of Defense Psychopharmacology Demonstration Project

### Origins of the Psychopharmacology Demonstration Project

The United States Department of Defense's Psychopharmacology Demonstration Project got its start with a 1987 inquiry from Senator Daniel K. Inouye[1] to the then Assistant Secretary of Defense for Health Affairs concerning the possibility of establishing a pilot program to allow psychologists to prescribe psychotropic drugs[2] under certain circumstances. The Army Office of the Surgeon General was named as executive agent for the demonstration pilot program.[3] The

1. The prescriptive authority for psychologists movement has its roots in Hawaii. In 1984 at the annual meeting of the Hawaii Psychological Association, Senator Daniel K. Inouye urged psychologists to seek prescriptive authority. The Hawaii legislature considered legislation to study the feasibility of prescriptive authority for psychologists in 1985 and in numerous subsequent years. During the 2006 legislative session, H.B. No. 2589, H.D. 2, S.D. 1, Relating to Psychologists, sought to authorize qualified psychologists practicing at federally qualified health centers to prescribe certain medications to treat mental illness. The bill passed through the House of Representatives, but was deferred by the second Senate committee to which it was referred.

2. Psychotropic drugs are defined as drugs that affect psychic function, behavior, or experience. See United States General Accounting Office, DEFENSE HEALTH CARE: Need for More Prescribing Psychologists Is Not Adequately Justified, GAO/HEHS-97-83 (Washington, D.C.: April 1997) (hereafter 1997 GAO report) page 1, fn 1. See also Gregory B. Laskow and Dennis J. Grill, "The Department of Defense Experiment: The Psychopharmacology Demonstration Project" in Morgan T. Sammons, Ronald F. Levant, and Ruth Ullmann Paige, ed., *Prescriptive Authority for Psychologists: A History and Guide* (2003) (hereafter "DoD Experiment") page 79.

3. See 1997 GAO report, page 5.

Department of Defense hoped to have the pilot program operational by September 1988. That goal was not met.

Several years passed during which experts were consulted and blue ribbon panels were convened to determine the best training model and curriculum.[4] Finally, in 1991, the Psychopharmacology Demonstration Project (PDP program or program) began. The program's goal was to "prepare psychologists who, with the necessary training and supervision, could safely and effectively use psychotropic medication as one component of their clinical armentarium," giving patients comprehensive mental health care from a single provider.[5] The first class of four participants entered the PDP program in the summer of 1991 and the final of four classes graduated in the summer of 1997. Ultimately, thirteen clinical psychologists participated, but only ten clinical psychologists[6] completed the training to prescribe. After graduation, the prescribing psychologists[7] provided psychological services and issued prescriptions for active duty and retired military and their families in military medical health facilities, apparently, without incident.

## Development of a Training Model and Criteria for Participants

The appropriate training model for the PDP program was discussed by a blue ribbon panel and other committees for several years before the program was implemented. In addition to clinical psychologists and psychiatrists, representatives from the American Association of Medical Colleges, the Accreditation Council for Graduate Medical Education, the medical school of the Uniform Services University of Health Sciences, and the Walter Reed Army Medical Center were involved at various points in the development of the program's training model.[8] Ultimately, a two year postdoctoral training program was established that included one year of full time classroom training at the Uniformed Services University for the Health Sciences and one year of full time clinical training on inpatient wards and outpatient clinics at Walter Reed Army Medical Center in Washington, D.C. or the Malcolm Grow Medical Center at Andrews Air Force Base in Maryland.[9]

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4. See *DoD Prescribing Psychologists: External Analysis, monitoring, and Evaluation of the Program and its Participants Final Report*, ACNP Bulletin, Volume 7, Number 3, Summer 2000 (hereafter ACNP Final Report), pages 2 and 7.

5. See "DoD Experiment," page 78.

6. Of the three PDP program participants who left during the program's training, one individual transferred to medical school and two participants resigned from the service. See ACNP Final Report, pages 2, 8, and 10.

7. After rejecting the title of "pharmacopsychologist," PDP program graduates were given the title of "prescribing psychologist." See "DoD Experiment," page 94.

8. See "DoD Experiment," pages 80-81; and ACNP Final Report, page 7.

9. See 1997 GAO report, page 5.

### Criteria for Selecting Program Participants

The criteria for program participant selection were not well articulated. Generally, to participate in the PDP program, an individual was required to be an officer in an armed service, hold a doctorate in psychology, and be licensed and in good standing. Although not expressed as a requirement, all participants had clinical experience before entering the PDP program; some had a "few" years and others had more than ten years.[10]

### Classroom Training Requirements

PDP program participants received their classroom training at the Uniformed Services University of the Health Sciences (USUHS).[11] To meet the congressional timelines and other considerations, the first class of PDP program participants entered a training model that included two years of full time classroom training in "off-the shelf" medical school science courses at USUHS. The medical school science courses totaled about 1400 hours over the 2-year classroom training period.[12] The classroom training requirement for the later PDP program

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10. The success of PDP program graduates, as evidenced by their positions as chiefs or assistant chiefs of clinics in their post-graduate assigned military medical facility, indicated to the ACNP evaluation panel that selection of candidates for future prescribing psychologists training, military or civilian, should be held to high standards. Also, a minimum of two years of clinical experience was suggested as a requirement for future candidates seeking admission into similar training programs. See ACNP Final Report, page 3 and 1997 GAO report, page 10.

11. The Uniformed Services University of Health Sciences is the nation's federal school of medicine and graduate school of nursing. Founded by Congress in 1972, medical students at USUHS take a year-round, four-year curriculum that is approximately 20 weeks longer than most other United States medical school curriculums. The extra hours include epidemiology, health promotion, disease prevention, tropical medicine, leadership, and field exercises. The goal of USUHS is to train physicians and nurses to practice military medicine. The University is an academic health sciences center with a worldwide perspective for education, research, service, and consultation. It is located on the grounds of the National Naval Medical Center in Bethesda, Maryland. See http://www.usuhs.mil/

12. The initial program was designed to be a two year program that included taking two years of medical school courses with first and second year medical students, while concurrently undertaking a clinical practicum at Walter Reed Army Medical Center (Walter Reed). The first PDP class took medical school courses in gross anatomy, neuroanatomy, histology, biochemistry, physiology, clinical medicine I and II, pathology, pharmacology, clinical concepts, with seminars in clinical psychopharmacology, behavioral pharmacology, human genetics, and immunology. The practicum was essentially a full time psychiatry residency. PDP program participants were expected to spend half of their time in the classroom at USUHS and the other half of their time in supervised clinical practice with second year psychiatry residents at Walter Reed. While taking medical school science course, initial class members worked in Walter Reed's continuing care clinic, giving them outpatient experience managing patients on long term drug treatments. Early evaluations by the ACNP indicated that the concurrent model was difficult, PDP participants were having academic difficulties, and the concurrent model "would soon lead to absolute burnout for Fellows." Ultimately, upon ACNP's recommendation, the training model for the initial class was extended to include a year of clinical experience to be completed *after* completing classroom requirements. See "DoD Experiment," pages 82-88; and ACNP Final Report, page 10.

participants was eventually tailored to meet the needs of potential prescribing psychologists[13] because it was determined that the level of detail in the medical school courses in anatomy, historology, microscopic pathology, biochemistry, and endocrinology courses taken by the first class was not appropriate for the "proposed role of prescribing psychologists."[14] Accordingly, the classroom training requirement for the subsequent PDP participants compacted the two years of medical school courses into one year of classroom training by "combining courses with the second year medical students, advanced practice nurses (family practitioners and nurse anesthetists), and a fast track review course in biochemistry designed for medical students returning to the classroom after a break in academia since college."[15] The one year of classroom training included approximately 700 hours of medical school courses, modified medical school courses, and graduate school of nursing courses that covered anatomy, cell biology, biochemistry, neuroscience, pharmacology, clinical pharmacology, physiology, pathophysiology, and health assessment.[16] One of the graduate nursing courses included interviewing, history taking, and physical examination of patients.[17]

It has been reported that all PDP program participants performed well in their classroom training, which was ascribed to their maturity in contrast to younger medical students.[18] However, a 1995 ACNP evaluation report indicated that some program participants were having difficulty in some of the classroom courses and that grades were "normalized" in at least one class for PDP program participants. The grade of the participant who performed best was normalized to 100 and the other program participants were given grades as a percentage of the highest scoring participant's grade. In an anatomy/cellular biology course, 6 of the 8 nurse anesthetists in the class did better on the written final than the PDP participants, and 7 of the 8 did better on the practical final than the participants.[19] Program participants in subsequent classes received better grades in the courses that had been tailored to their needs and in the graduate nursing courses than they received in the unmodified medical school courses.

13. See ACNP Final Report, pages 2 and 7.

14. In addition, a 1995 ACNP evaluation indicated that some PDP participants were having academic difficulties and that some of their grades were "normalized." See ACNP Evaluation Panel, Evaluation #1, 1995, page 2.

15. See Debra Lina Dunivin, "Experiences of a Department of Defense Prescribing Psychologist: A Personal Account," in Morgan T. Sammons, Ronald F. Levant, and Ruth Ullmann Paige, ed., *Prescriptive Authority for Psychologists: A History and Guide* (2003) (hereafter "A Personal Account"), at 106.

16. See ACNP Final Report, pages 12-13.

17. One evaluation report states that PDP program participants also learned to take medical histories and incorporate them into treatment plans and to prescribe for patients with certain types of mental disorders during the clinical part of their training. See 1997 GAO report, pages 3-4.

18. See ACNP Final Report, page 13.

19. See ACNP Evaluation Panel, Evaluation #1, 1995, page 2.

**Clinical Training Requirements**

Clinical training took place at Walter Reed Army Medical Center (Walter Reed) or Malcolm Grow Medical Center (Malcolm Grow). All participants were required to complete one year of full time clinical training. Like the classroom training, the clinical training for the initial class also differed somewhat from the clinical training of the subsequent three classes. The initial participants' clinical training at Walter Reed included no outpatient clinical experience. At the end of their classroom training, and before beginning their nine month full time inpatient psychiatry service experience, the initial participants took three months of on call duty for the Psychiatry Admission Service of Walter Reed and reviewed charts of chronic care outpatient clinic patients who were on medications. The responsibilities and supervision of the initial class of participants was described as similar to those of psychiatry residents.[20] The second, third, and fourth classes of PDP program participants completed one year of full time clinical training[21] that included a six month inpatient clinical practicum and a six month outpatient clinical practicum.

During their clinical practicum, all participants treated patients between the ages of 18 to 65 who had mental conditions, but who were without medical complications as determined by supervisors.[22] All participants also had primary clinical responsibility for managing the patients that they treated; all were closely supervised by a psychiatrist, who frequently had advanced training in psychopharmacology; and all treated patients in a military health care facility. The military medical system allowed easy access to treatment records, including laboratory and radiology information, and close collaboration with the other treating health care providers.[23] A year of full time clinical training at Walter Reed or Malcolm Grow provided participants an optimum learning environment in a comprehensive medical center that offered a wide range of medical care, proximity to a large number of physician and nonphysician health care providers, available diagnostic and treatment equipment and facilities, and other advantages or learning experiences that may not be available at small medical facilities.

During their clinical experience, all of the PDP program participants were generally well regarded. Some psychiatrist supervisors expressed concern over their lack of medical

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20. Participants were required to have medication orders, laboratory and radiology requests, restraint orders, and admission and discharge summaries cosigned by a supervising psychiatrist. They could sign orders relating to patient ward status and some consultations independently. See ACNP Final Report, page 13.

21. Two members of the third class of PDP program fellows had their clinical training at a "medium-large [military] medical center on the east coast," instead of Walter Reed, but all PDP program participants in the third class attended a seminar in biological psychiatry and a case conference together once each week. The medical center is presumably Malcolm Grow Medical Center. See United States General Accounting Office, PRESCRIBING PSYCHOLOGISTS: DOD Demonstration Participants Perform Well but Have Little Effect on Readiness of Costs, GAO/HEHS-99-98 (Washington, D.C.: June 1999) (hereafter 1999 GAO report), page 3. The two participants at Malcolm Grow Medical Center took emergency room call regularly and considered it an invaluable experience. See ACNP Final Report, page 14.

22. See 1997 GAO report, page 6.

23. See "A Personal Account," page 107.

sophistication, but the supervisors also said that the PDP program participants were aware of their medical limitations and recognized when they needed a medical consult.[24]

## Advisory Council Recommendations on Training and Use of Program Graduates

After the graduation of the first class, it became clear that the military medical facilities to which graduates would be assigned needed help in determining how to safely and effectively use this "new breed of mental health provider."[25] An advisory council was established to recommend guidelines relating to: (a) scope of practice, (b) prerequisite selection criteria, (c) formulary, (d) privileging requirements, (e) extent of physical assessment, and (g) utilization of program graduates.[26] Recommendations regarding scope of practice, formulary, prerequisites, and use of prescribing psychologists in the military are discussed below.

### Scope of Practice

The advisory council recommended that graduates should be supervised after the first year of graduation by a psychiatrist, and thereafter by any physician authorized to prescribe psychotropic medication.[27] Two advisory council members dissented from the supervision recommendation because they felt that any required supervision after the initial post-graduate year of practice contradicted congressional intent in establishing the program. The dissenting advisory council members recommended that prescribing practices should be developed by each medical care facility, which is what ultimately occurred.[28] Thus, despite the recommendations,

24. See ACNP Final Report, page 15.

25. See "DoD Experiment," page 93.

26. The advisory council included the chief clinical psychologist and psychiatrist from the military services, representatives of the USUHS and the professional education and training committee at Walter Reed. The director of the PDP and the program's director of training were nonvoting members. See "DoD Experiment," pages 93-94.

27. The scope of practice recommendation was the only recommendation that was not unanimously approved by the advisory council. The subcommittee's recommended scope of practice was based on Florida's nurse practitioners, which require initial physician supervision and then reduced supervision as competence in prescribing was demonstrated. The subcommittee also recommended that the proposed scope of practice be re-evaluated in one year. See "DoD Experiment," page 95.

28. In describing the scope of practice recommendations, another evaluation states that the recommendations suggested that a graduate, under the indirect supervision of retrospective chart review, could do physical assessments, monitor and manage medication treatment of chronic patients with stable psychiatric conditions, and adjust medications and dosages according to treatment plans. To initiate or discontinue any medication in the formulary, direct supervision by a physician was required. This evaluation also stated that graduates were not to treat patients with concomitant, unstable medical conditions. See ACNP Final Report, page 15.

each military medical facility determined the terms of supervision for its prescribing psychologists, as well as the formulary, to meet the needs of the specific facility.[29]

### Formulary

The advisory council recommended that program graduates be restricted to a formulary of psychotropic drugs and adjunctive medication. The graduates' formulary is a listing of the pharmaceuticals by name or class for which the graduates were authorized to issue prescriptions when providing mental health care for their patients. Psychotropic drugs are drugs that affect psychic function, behavior, or experience, including antipsychotics; antidepressants; antimanics and mood stabilizers; anxioloytics and hypnotic agents; and medications to treat alcohol dependence and substance abuse.[30] Adjunctive medications are drugs that are commonly used to treat the side of effects of psychotropic medication.[31] As stated above, the formulary available to each prescribing psychologist ultimately was determined by the military medical facility where each graduate practiced as a prescribing psychologist.[32]

### Prerequisites to Entering the Psychopharmacology Training Program

Recognizing that the two years of "off-the-shelf" medical school science courses had been difficult for some participants, the advisory council recommended that the PDP program materials should inform any future program applicants that completion of a college level course in biological science, chemistry, physical chemistry, and mathematics up to and including basic calculus would be helpful preparation. Such preparation, however, was optional.[33]

### Utilization of PDP Program Graduates

The advisory council recommended that assignment of graduates should by guided be the goal of increasing access to mental health services. Members felt that, primarily, graduates should be assigned to outpatient settings, although inpatient service was possible.[34]

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29. See "DoD Experiment," pages 94-95.

30. New Mexico defines "psychotropic medication" to mean a controlled substance or dangerous drug that may not be dispensed or administered without a prescription, whose indication for use has been approved by the federal Food and Drug Administration for the treatment of mental disorders and is listed as a psychotherapeutic agent in drug facts and comparisons or in the American hospital formulary service. See 16.22.1, NMAC.

31. See 1999 GAO report, page 6, fn 11.

32. See "DoD Experiment," page 96.

33. See "DoD Experiment," page 98.

34. See "DoD Experiment," page 98.

Given that each military medical facility to which a PDP program graduate was assigned ultimately determined that graduate's supervision, credentialing, and formulary requirements to meet the facility's own individual needs, it is clear that the advisory council's recommendations were not mandatory, but used as guidelines only. In fact, one evaluation expressly stated that "it was expected that the guidelines would be flexible and adjustable to allow for individual differences, among graduates and the different needs of assignment stations."[35]

## Post-Graduate Practices as Prescribing Psychologists

After completing their classroom and clinical training, graduates were assigned to military hospitals and clinics.[36] Although graduates were initially supervised by a senior psychologist, most of them were eventually granted independent prescribing status, subject only to a standard retrospective review of ten percent of their charts. However, the length of supervision varied significantly from facility to facility.

Patients treated by program graduates included active duty military, retirees, and their dependents, ranging from 18 to 65.[37] Many graduates had an initial practice primarily consisting of medically healthy active duty military personnel. The graduates' patients have been described by various external evaluations as medically healthy or uncomplicated, noting that individuals with complicated medical diagnoses were excluded from their practice. One graduate, whose patients were described as "without unstable medical conditions," indicated that the medical disorders he most commonly encountered included hypertension, arthritis and other joint disorders, hypercholesterolemia, and diabetes.[38]

The majority of patients that the PDP program graduates treated with medications had mental health disorders in the adjustment, anxiety, and depression disorder spectra; their patients received mostly prescriptions of some "newer" (at that time) anti-anxiety and antidepressant drugs. Some graduates reduced or terminated medications, and generally, the graduates used medication in combination with psychosocial therapy treatments.

Initially, some of the graduates found that some of their supervising psychiatrists, primary care physicians, and other health care colleagues at their initial assigned facility had little faith in their ability to prescribe safely. However, the performance of the graduates generally convinced their supervising psychiatrists, primary care physicians, and other health care providers, during the time they worked together, that the graduates were well trained and knowledgeable. Overall, the mental health care they provided was rated by their supervisors

35. See ACNP Final Report, page 15.

36. For an excellent discussion of the practice profiles of the program graduates in 1998, see ACNP Final Report, pages 18-49.

37. See "A Personal Account," page 107.

38. See ACNP Final Report, page 30.

who were psychiatrists as no less than "good." Moreover, some physicians reported that they relied on the graduates for information about psychotropic medications.[39]

Ultimately, the graduates were described as "well integrated" into the military health system.[40] It was reported that "the diagnoses made and the medications prescribed by the graduates were functions of the military outpatient sample" and that they "essentially mirrored what psychiatrists did with the same population."[41] By 1999, one year after graduation of the final class, the nine graduates still in the military were serving in positions as chief of a clinic or department at their assigned military medical facility. That graduates held these positions of responsibility would seem to indicate that they were respected and trusted by their military health care colleagues.

## Termination of the Psychopharmacology Demonstration Project

Although the congressionally mandated Psychopharmacology Demonstration Project appears to have successfully trained ten military clinical psychologists to safely and effectively prescribe psychotropic and adjunctive medications under certain circumstances to patients between the ages of 18 to 65, the program was terminated on June 30, 1997.

# Part II. External Evaluations of the Psychopharmacology Demonstration Project; Patient Safety

In response to congressional mandates, and partly due to the politically controversial nature of the program, the United States Department of Defense's Psychopharmacology Demonstration Project had several external evaluations and reviews during its lifetime.[42] The PDP program and its participants were scrutinized both during the life of the program and after it was terminated. Under a contract with the United States Department of Defense, the American College of Neuropsychopharmacology (ACNP) evaluated all facets of the program over several years, culminating in a 1998 final report from ACNP's evaluation panel.[43] Other significant

39. See 1999 GAO report, page 5 and 8.

40. See 1999 GAO report, page 4.

41. The evaluation panel stated that the graduates differed little from the private practices of the psychiatrists on the evaluation panel. See ACNP Final Report 1998, page 5.

42. The numerous evaluations represent the largest single cost of the PDP program. The costs of the program's evaluations, which exceed $2,000,000, were reported to exceed the total classroom training costs. See Russ Newman and Randy Phelps, Morgan T. Sammons, Debra Lina Dunivin, and Elizabeth A. Cullen, "Evaluation of the Psychopharmacology Demonstration Project: A Retrospective Analysis," Vol. 31, No. 6 *Professional Psychology: Research and Practice*, 598-603, 598 (2000).

43. See ACNP Final Report, page 2. The ACNP is a multidisciplinary organization of approximately 600 members who represent psychiatrists, psychologists, neurologists, and other research related health care professionals. An evaluation panel that included psychiatrists and clinical psychologists made no less than 27

reviews of the program include a 1996 cost-effectiveness and feasibility report from Vector Research, Incorporated, and two separate evaluations by the Comptroller General of the United States General Accounting Office. Interestingly, the studies that evaluate the PDP program are cited by *both* proponents and opponents of prescription authority for psychologists to support their respective position.

Generally speaking, the evaluations of the Psychopharmacology Demonstration Project establish that the program was successful and that licensed military psychologists were trained to safely and effectively prescribe psychotropic drugs in certain circumstances. Patient safety was not at issue. Reviews and evaluations of the PDP program do *not* support an assertion that the program was terminated because it failed to achieve its purpose or because it is not possible to train clinical psychologists to safely prescribe psychotropic drugs. Rather, the reviews and evaluations confirm that the program was terminated because there was *no demonstrated need* to train clinical psychologists to prescribe psychoactive drugs to achieve medical readiness during combat[44] and because prescribing psychotropic drugs is not the treatment of choice for battle fatigue.[45]

## The Vector Report 1996

The Vector Research, Incorporated (Vector report) evaluation found the program to be not only feasible, but also cost-effective.[46] The Vector report was the first external evaluation of the program's cost effectiveness; it favored the continuation of the program.[47] The Vector report also found that:

- Potential benefits of prescriptive authority for psychologists included an increase in the number of mental health care providers in the Military Health Services

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visits to evaluate program and the performance of its graduates. ACNP was directed to evaluate the academic and clinical programs; recommend curriculum improvements; and evaluate the practice of program graduates. Over seven years, the ACNP evaluation panel interviewed participants, graduates, supervisors, medical center administrators, and others. The advisory panel's guidelines to help facilities determine scope of practice and credentialing issues for prescribing psychologists was developed in response to a recommendation by ACNP.

44. At the time of the pilot program, the military services had sufficient mental health care providers, including psychiatrists and clinical psychologists, to meet its wartime psychiatric caseload. See 1997 GAO report, page 7.

45. See 1999 GAO report, pages 9 and 10.

46. Vector compared the estimated life-cycle costs of program graduates with other military mental health providers and found that costs were lower for psychologists, and prescribing psychologists were "cost-effective if they were used in a prescribing capacity only 51% of the time. See "DoD Experiment," pages 99-100.

47. Military psychiatrists, primary care physicians, clinical social workers, psychologists, and medical beneficiaries were surveyed about the possible effects of providing prescription authority to psychologists. See "DoD Experiment," page 99.

Systems; an improved quality of care and access; and a reduction of psychiatrists' work loads;

- Potential limitations included PDP program graduates' lack of knowledge about medicine, physiology, and adverse drug interactions; and

- Most respondents were supportive of the PDP program, with the exception of psychiatrists.

## GAO Report 1997 - DEFENSE HEALTH CARE: Need for More Prescribing Psychologists is Not Adequately Justified

The National Defense Authorization Act for Fiscal Year 1996 mandated that the Psychopharmacology Demonstration Project be terminated by June 30, 1997. Congress also required the Comptroller General, or the General Accounting Office (GAO), to evaluate the PDP program and submit a report to Congress that included:[48]

(1) An assessment of the need for prescribing psychologists in the Military Health System Services;

(2) Information on the implementation of the PDP program; and

(3) Information on the PDP program's costs and benefits.

### Need: Military Services Have Sufficient Mental Health Care Providers for Medical Readiness Requirements

According to the 1997 GAO report, the principal mission of the Military Health Service is to provide medical readiness, including peacetime readiness and military or combat readiness.[49] Although the report acknowledged that prescribing psychologists provided a potential peacetime benefit by increasing the number of military mental health providers and reducing the workloads of military psychiatrists, it also recognized that the military services had more than enough psychiatrists to meet medical readiness requirements during wartime. Consequently, the report deemed it unnecessary to spend money to provide clinical psychologists with a skill that did not appear needed or useful.[50]

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48. National Defense Authorization Act for Fiscal Year 1996 (P.L. 104-106).

49. See 1997 GAO report, page 3. The United States Department of Defense states that medical readiness encompasses the ability to mobilize, deploy, and sustain field medical services and support for any operation requiring military services; to maintain and project the continuum of health care resources required to provide for the health of the force; and to operate in conjunction with beneficiary health care. See 1997 GAO report, page 3, footnote 4.

50. See 1997 GAO report, page 7.

### Implementation of PDP Program Faced Difficulties

While specifically acknowledging that the PDP program was *successful*, the 1997 GAO report pointed out difficulties encountered in its implementation,[51] including: no clearly defined role for prescribing psychologists; recruitment difficulties; unspecified selection criteria; curriculum changes; delay in granting prescribing privileges for some program graduates; and unresolved issues relating to supervision of graduates. While it is true that these issues may or did present difficulties in implementation, even taken together, they seem to present a somewhat questionable basis for completely opposing reinstatement of the Psychopharmacology Demonstration Project or implementation of any similar future training program.

### PDP Program was Costly and Benefits are Uncertain

Any potential benefits of having prescribing psychologists were perceived differently by psychiatrists, primary care physicians, and psychologists.[52] The report cited one article's suggested benefit: "training psychologists to prescribe psychotropic medication could be particularly beneficial if they were permitted to practice this skill in clinical settings such as nursing homes, mental institutions, or *medically underserved areas*."[53] The cost of training psychologists to prescribe, as determined in the 1997 GAO report, was deemed "substantial."[54] Although the report recognized that the PDP program produced graduates capable of prescribing drugs and acknowledged that some facilities reported "positive experiences" with program graduates, it nonetheless proclaimed that it was impossible to determine the PDP program's cost-effectiveness "at this time."[55]

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51. The report acknowledged that "some of these problems" were resolved. See 1997 GAO report, page 9.

52. Prescribing psychologists would reduce patients' waiting time between appointments and eliminate the need to see two health care providers for treatment and for pharmaceuticals. Not surprisingly, psychologists felt prescribing psychologists would improve the quality of military mental health care, while psychiatrists believed care would decline. Psychiatrists felt that prescriptive authority would hinder their relationships with psychologists, while primary care physicians perceived an improved collaboration with psychologists. Psychologists felt relationships with primary care physicians would improve, but they were split as to whether their collaborations with psychiatrists would improve. See 1997 GAO report, page 15.

53. See 1997 GAO report, page 6, emphasis added.

54. The evaluations do not use a uniform method of calculating the costs of the PDP program. For example, one report includes the evaluation contract costs, approximately $2,000,000, in its determination. Because the evaluation cost is a significant amount, unlikely to be repeated, the actual cost is debated. This study does not include a review of the costs of the PDP program.

55. See 1997 GAO report, page 12.

**Recommendations to Congress for Future Prescribing Psychologists**

If prescribing psychologists were deemed needed to meet any future medical readiness requirements of the United States Department of Defense, the report recommended that Congress should require the Department to:

- Clearly show that using prescribing psychologists has resulted in savings;
- Clearly define the role and scope of practice of a prescribing psychologist in the military health system;
- Design a curriculum appropriate to the defined role and scope of practice of prescribing psychologists; and
- Determine supervision requirements for prescribing psychologists.[56]

**Summary**

Although the 1997 GAO report clearly found the PDP program *effective*, stating that "DOD met its goal to train psychologists to prescribe drugs,"[57] it also supported termination of the program because each branch of the armed forces had more than enough psychiatrists and clinical psychologists to care for wartime psychiatric patients. Given the staff surplus, taken together with PDP implementation difficulties (largely irrelevant to the success of the program), the report concluded that there was no reason to reinstate the PDP program to train clinical psychologists to prescribe to meet medical readiness requirements.[58] In effect, although the program was *successful*, it just wasn't *needed* at the time.

## The American College of Neuropsychopharmacology Final Report 1998

The American College of Neuropsychopharmacology (ACNP) had helped to develop and evaluate the Psychopharmacology Demonstration Project over a number of years and issued the

56. See 1997 GAO report, page 20.

57. See 1997 GAO report, page 3.

58. The implementation problems included: a lack of clearly defined purpose for the prescribing psychologists; difficulties recruiting participants; a lack of specific criteria for participants; repeated curriculum changes; delays in granting prescription privileges, and unresolved issues regarding supervision. The report acknowledged that the lack of precedent and experience with prescriptive authority for psychologists was the source of many implementation problems. Additionally, the GAO 1997 report stated that the cost-effectiveness of having military health system psychologists prescribe psychotropic medications was unclear. See 1997 GAO report, pages 9 and 16.

final report of its evaluation panel in May 1998, after the program had been terminated.[59] In 1991, the Department of Defense had awarded a contract to ACNP to provide an independent assessment and evaluation of the PDP program's training curriculum and to monitor the progress of the program and its participants. An evaluation panel comprised of three board-certified psychiatrists and three licensed clinical psychologists was established to fulfill ACNP contractual obligations. All evaluation panel members had research and clinical experience and had served as directors of training programs. Over the years, evaluation panel members made numerous site visits to evaluate the academic and clinical experiences of the program's participants and graduates and to administer written and oral examinations at the end of each classroom training year. Significantly, the evaluation panel found that program participants generally did well on the written examinations and performed as well as psychiatry residents and post-residents on the oral examinations.[60]

In preparing for the 1998 final report, the evaluation panel visited all graduates of the PDP program, their clinical and administrative supervisors, and medical facility directors. The charts from recent cases were reviewed for each graduate.[61] Generally, the final report concluded that the PDP program had successfully trained clinical psychologists to prescribe psychotropic medications safely and effectively in a military setting to increase access to mental health treatment. It also recognized the uncertainty of possible future functions for prescribing psychologists.[62] The report's findings are summarized below.

### Effectiveness and Patient Safety

The final report found that all graduates performed "with excellence" in their post-graduate assignment, filling critical needs. The graduates had "filled different niches and brought unique perspectives to their various assignments."[63] The final report found that the

59. The American College of Neuroposychopharmacology is a professional organization of leading scientists who promote health and research causes and cures of diseases affecting emotions and behavior, including addictions. In 1991, before receiving the evaluation contract from the United States Department of Defense, ACNP published a "consensus statement" relating to "*Prescribing Privileges for Non-physicians in the Military"* in which the ACNP declared it "had no quarrel with the concept that nonphysicians may serve a useful role in society with regard to the use of medications as part of medical care, provided that such professional personnel have had the proper training and clinical experience to perform these tasks with skill and competence." ACNP noted, however, its concern with the availability and quality of such care. See ACNP Final Report, Appendix III and page 18.

60. See ACNP Final Report, page 17.

61. Prior to the interview, each graduate was asked to bring documents that include: privileges statement; scope of practice; formulary; case statistics; and recent written evaluations. See ACNP Final Report, page 18.

62. See ACNP Final Report, page 6.

63. For example, one supervising psychiatrist told the Evaluation Panel that he preferred to work with a PDP graduate over another psychiatrist because the PDP graduate brought a "nonphysician, psychological perspective" to the job not available elsewhere. Another graduate was the only prescriber for active duty sailors in a psychology clinic located near ships at a naval base. At one isolated base, a graduate was the only mental health provider, backed up by primary care physicians. See ACNP Final Report, pages 2-3.

graduates' patients had suffered no adverse effects from treatments by the graduates, which was "important evidence" of their medical safety. Although the graduates were universally deemed to be weaker medically than psychiatrists, they had demonstrated to their clinical and administrative supervisors that they "knew their own weaknesses, and that they knew when, where, and how to consult." By that standard, the evaluation panel concluded that the graduates were "medically safe."[64]

In recognizing the graduates as outstanding individuals, the evaluation panel noted that eight out of the ten graduates were already serving as chiefs or assistant chiefs of an outpatient psychology clinic or a mental health clinic. Another indication of the group's "quality and achievement" was that all participants had a doctorate in clinical psychology and clinical experience ranging from "a few" to more than ten years prior to entering the PDP program. The achievements of the graduates suggested to the evaluation panel that the selection standards for any similar psychopharmacology training program should be "high," whether military or civilian, and that a program to train clinical psychologists to prescribe medications must be a postdoctoral program.[65]

**Prescribing Authority in the Civilian Sector**

The evaluation panel recognized that prescription privileges for psychologists in the civilian sector was being discussed in a number of arenas. In discussing with interviewees the issue of training necessary to allow psychologists to prescribe in the civilian sector, the evaluation panel found that most PDP program graduates felt that any "short-cut" training program would be ill-advised; they favored a two year training program, similar to their own PDP training, but with the classroom training more tailored to the needs and skills of clinical psychologists. A full-time year of clinical experience, emphasizing inpatients, was deemed indispensable by most PDP graduates.[66]

There was skepticism from physicians, including psychiatrists, whether psychologists could be trained to prescribe independently in the civilian sector because the "team practice" that characterized military medicine was an essential ingredient in the PDP's success. The evaluation panel urged program PDP trained prescribing psychologists to develop an agreed-upon "optimal" program.

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64. See ACNP Final Report, page 3.

65. See ACNP Final Report, page 3.

66. See ACNP Final Report, pages 3-4.

### Scope of Practice and Formulary

The program graduates' scope of practice was uniform in that all treated patients aged 18 to 65. Generally, they treated outpatients[67] who had adjustment, anxiety, and depression disorders, with no complicated medical conditions.[68] The graduates considered their respective formulary restrictions to be "no more than a minor nuisance."[69] The final report found that PDP program graduates practiced traditional clinical psychology, but with an added body of knowledge and experience that extended their range of competence.[70]

### Unexpected Benefit – PDP Program Graduates as Educators

The final report noted that PDP program graduates unexpectedly enriched the education and practice of psychology graduate students and other physicians[71] with whom they practiced at military medical facilities by developing classes or seminars relating to psychopharmacology or clinical psychopharmacology. Some psychology interns even reported learning more from PDP program graduates than from psychiatrists because the graduates understood the psychology interns' perspective.[72]

### Summary

The evaluation panel expressly acknowledged that PDP program graduates performed and continued to perform safely and effectively as prescribing psychologists. They agreed that a two year training program (one year of full time classroom training and one year of full time clinical training that includes at least a 6 month inpatient component), can successfully "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 in a cost effective way." While uncertain of the future role of prescribing psychologists, the evaluation panel was "convinced that their present roles meet a

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67. Although the ACNP Final Report states that one graduate treated inpatients exclusively, a review of the evaluation panel's 1998 interviews with graduates fails to clarify this claim. Two graduates apparently treated both inpatients and outpatients, but it is not clear which, if any, graduate treated inpatients exclusively. See ACNP Final Report, pages 2 and 5, 18-49.

68. See ACNP Final Report, page 5.

69. Six graduates had no noteworthy formulary restrictions, even though the formularies were not identical. Formularies used by a few graduates were listed as specific agents, instead of drug classes, which resulted in difficulties if a change in the medication used in treatment was necessary or desired. See ACNP Final Report, page 4.

70. See ACNP Final Report, page 4.

71. The 1999 GAO report confirms that several physicians relied on PDP graduates for information about psychotropic medications. See 1999 GAO report, page 8.

72. See ACNP Final Report, pages 4-5.

unique, very professional need of the DoD. As such, we are in agreement that the Psychopharmacology Demonstration Project is a job well done."[73]

## GAO Report 1999 - PRESCRIBING PSYCHOLOGISTS: DOD Demonstration Participants Perform Well But Have Little Effect on Readiness or Costs

Although the Psychopharmacology Demonstration Project was terminated by June 30, 1997, the Senate report on the National Defense Authorization Act for Fiscal Year 1999 directed the Comptroller General to study the results of the PDP program, including the use and performance of graduates.[74] In response, the General Accounting Office submitted *PRESCRIBING PSYCHOLOGISTS DOD Demonstration Participants Perform Well but Have Little Effect on Readiness or Costs* (1999 GAO report), which included:

(1) A description of how graduates have been integrated into the military health services;

(2) Information on the quality of care provided by graduates;

(3) Graduates' effect on medical readiness; and

(4) A comparison of the costs of graduates to the costs of other military psychologists and psychiatrists.

### PDP Program Graduates Well Integrated Into Military Hospitals and Clinics

The report found that PDP program graduates were "well integrated" at their assigned military medical facilities, as reflected by their serving in positions of authority, such as clinic or department chief or assistant chief.[75] Graduates provided care for a variety of mental health patients, prescribing from formularies, and their case loads were the same as other psychologists or psychiatrists at the same facility. The 1999 GAO report noted that a few graduates had experienced some reluctance in being accepted at the very beginning of their assignment, but their supervisors and others reported that the graduates' performance subsequently convinced them that they were well trained and knowledgeable.

73. See ACNP Final Report, page 6.

74. See Senate Report 105-189, Department of Defense Authorization Act for Fiscal Year 1999 Report.

75. At the time of the report, nine of ten graduates were still working in military medical facilities. In preparing the report, the GAO interviewed all PDP program graduates, their files, performance reviews, and relevant reports that reflected the performance of the graduates. See 1999 GAO report, page 5.

### PDP Program Graduates Provide Good Quality of Care (Patient Safety)

It is significant to note that individuals interviewed for the 1999 GAO report "overwhelmingly" evaluated the quality of care provided by graduates as good to excellent, reporting that there had been no adverse patient outcomes.[76] Similarly, there was "no evidence of quality problems" found in the credential files of the graduates.[77]

### PDP Program Graduates Have Minimal Effect on Medical Readiness

Although the report concluded that PDP program graduates were well integrated at their respective assigned military medical facilities and that they provided good care, the report also noted that the ten prescribing psychologists did not "substantially affect" the medical readiness of the military during wartime, since the military already had more than 800 psychiatrists and psychologists on staff. Further, the military psychologists and psychiatrists interviewed opined that it was unlikely that the ten graduates' prescribing abilities would be needed during a time of war since psychotropic drugs are not the treatment of choice in combat.[78] However, the graduates are reported to have enhanced *peacetime* medical readiness in their assigned facilities.[79]

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76. The officials interviewed by the General Accounting Office included each of the graduates' clinical supervisors—all psychiatrists—and an outside panel of psychiatrists and psychologists who rated the graduates. See 1999 GAO report, pages 8-9.

77. See 1999 GAO report, page 8.

78. During times of war, to return active duty personnel to the front lines, military personnel are generally provided rest and counseling, which does not require prescribing authority. Because psychotropic drugs are generally not prescribed during times of combat, medical readiness is not improved by providing prescriptive authority to psychologist. Those soldiers whose treatment required medication are usually evacuated out of combat areas and into distant hospitals. However, military clinic and hospital officials reported to GAO that PDP graduates "have enhanced the peacetime readiness" of their assigned locations because their presence has reduced patients' wait time and increased the number of patients who may be treated with psychotropic medications. See 1999 GAO report, pages 3-4.

79. The prescribing psychologists improved peacetime medical readiness by decreasing the waiting period for medical assistance and increasing the number of patients who can be treated. Patients needing mental health care treatment that includes medication would need to see only one health care provider, reducing the patient's time and effort expended for medical care. In addition, in deploying a division that includes a psychiatrist and a prescribing psychologist, if the psychiatrist is deployed, individuals who remain at the division's permanent location would still have a prescribing mental health provider in the left behind prescribing psychologist. Finally, prescribing psychologists further contributed to peacetime medical readiness by caring for dependents, causing fewer active duty personnel to worry about their family's medical care. See 1999 GAO report, pages 10-11.

### PDP Graduates are More Costly Than Traditional Psychologist and Psychiatrist Treatment

The 1999 GAO report projected that the Department of Defense would spend "somewhat more" on the prescribing psychologists than the "traditional" mix of psychologists, approximately seven percent higher than the combination of psychologists and psychiatrists who would have provided mental health services comparable to treatments provided by the graduates.[80]

### Summary

Overall, the 1999 GAO report found that the ten program graduates were well integrated in their assigned military facilities and that their supervisors were collectively complementary about the quality of patient care provided by the graduates, with no reports of problems. The report concluded that granting prescriptive authority to ten clinical psychologists would not substantially affect the medical readiness during wartime of an organization already staffed by more than 800 psychiatrists and psychologists.[81] However, military clinical and hospital officials reported that the graduates had enhanced the *peacetime* medical readiness in a number of ways.[82]

## Patient Safety and the Psychopharmacology Demonstration Project

The success of the Psychopharmacology Demonstration Project is often cited to support the claim that psychologists can be trained to safely prescribe psychoactive prescription drugs. Evaluations of the program discussed above indicate that the PDP program, infact, did successfully train clinical psychologists to prescribe safely and effectively.

Initially, the PDP program itself attempted to address patient safety by limiting the scope of practice to the treatment of mental health patients between the ages of 18 and 65 who had no serious medical diagnosis. Patients were limited to active duty and retired military and their dependents. It has been reported that patients with medical complications were screened out. Medications to be prescribed were limited to psychotropic drugs and adjunctive medications. During the clinical training and for the first year after graduation, PDP program participants and graduates were supervised by a psychiatrist.

In addition to those initial safety parameters, the actions of the program participants and graduates were closely monitored and scrutinized over the life of the PDP program and after the program was ended. Even though the 1997 GAO Report found that the military did not need

80. See 1999 GAO report, pages 11-12.

81. Psychiatrists and psychologists interviewed for the report opined that it was unlikely that graduates' prescription authority and knowledge of psychotropic drugs would be required in combat since those medications are not the "treatment of choice" during wartime. See 1999 GAO report, pages 2-3.

82. See footnote 79 above.

prescribing psychologists to meet Department of Defense health care needs, the report acknowledged that the Department had "met its goal to train psychologists to prescribe drugs."[83]

In 1998, members of the evaluation panel of the American College of Neuropsychopharmacology agreed that graduates were medically safe because they had demonstrated an awareness of any weakness by consulting when appropriate.[84] They found that the graduates filled critical needs and performed with excellence wherever they served.[85] Their 1998 evaluation of the program acknowledged that the graduates were sensitive and responsive to medical issues, stating: "Important evidence on this point is that there have been no adverse effects associated with the practices of these graduates."

In 1999, a subsequent GAO report noted that the graduates' quality of care was overwhelmingly rated by their clinical supervisors and others as good to excellent, noting there was no evidence of quality problems found in the graduates' credential files.[86] Several physicians reported that they relied on the graduates for information on psychotropic medications.[87]

To date, there have been no reported adverse incidents resulting from the prescriptive authority of PDP program graduates. Or, as a program graduate stated in 2003, "There is no published evidence that any of these psychologists do this in any way less safe or effective." Another noted that "Uniformly, we had positive patient outcomes. All the data showed that we worked well with other health-care professionals and that we provided safe and effective treatment to our patients."[88]

## Conclusion

Taken together, the various external evaluations clearly indicate that the PDP program was a success, demonstrating that "licensed military psychologists could be trained to provide an expanded range of mental health services that included psychopharmacology and psychotherapy." The evaluations found that "prescribing psychologists provide safe, high-quality care while simultaneously improving access to treatment."[89] Patient safety was not at risk. Although several evaluations recommended terminating the program, termination was not suggested because of any recognized failure of the program. Rather, termination was suggested because the military had sufficient psychiatrists and clinical psychologists on staff and had not

83. See 1997 GAO report, page 2.

84. See ACNP Final Report, page 3.

85. See ACNP Final Report, page 2.

86. See 1999 GAO report, page 8.

87. See 1999 GAO report, page 8.

88. *Psychology's first prescribers*, APA Online Monitor on Psychology, Volume 34, No. 2, February 2003.

89. See "A Retrospective Analysis," page 602.

demonstrated a need for prescribing psychologists to achieve medical readiness that justified the training expenditure.

# Chapter 3

# TRENDS RELATING TO PRESCRIBING PSYCHOLOGISTS IN OTHER JURISDICTIONS

Senate Concurrent Resolution No. 113, S.D. 1, requested the Legislative Reference Bureau to include in its study trends in other states relating to limited prescriptive authority for certain psychologists, including patient safety. Part I of this chapter reviews legislative actions in other jurisdictions regarding prescriptive authority for psychologists. Part II discuses patient safety issues in the three jurisdictions, Guam, New Mexico, and Louisiana, where psychologists have been granted prescriptive authority. Although only two states have granted prescriptive authority to certain clinical psychologists, another trend is reflected in the growing number of available postdoctoral psychopharmacology training programs. Part III discuses those training programs in comparison with the training required by the United States Department of Defense Psychopharmacology Demonstration Project and the training curriculum recommended by the American Psychological Association.

## Part I. Legislative Action in Other Jurisdictions

Psychologists in Hawaii and on the mainland have been seeking prescriptive authority for approximately twenty years. A number of states have seen legislation introduced to authorize psychologists to prescribe medication under certain circumstances, but only Guam, New Mexico, and Louisiana have statutorily established prescriptive authority for psychologists as of this writing. In New York, psychologists reportedly dropped their pursuit of prescription privileges in return for psychiatrists' support of legislation defining psychology and who may use the term in connection with their practice.

### Guam

In 1998, the Legislature of Guam unanimously overrode the governor's veto of B 695, to become the first jurisdiction to allow psychologists to prescribe medication. Guam's law authorized prescriptive authority for "allied health professionals," which includes clinical psychologists and physician assistants. It authorizes a clinical psychologist to prescribe drugs according to the terms of a collaborative practice agreement[1] with a physician, who must be always available. When the bill was passed, Guam had 160,000 residents and 1,000,000 tourists who were served by only five psychiatrists.

1. A collaborative practice agreement appears to be the agreement between a clinical psychologist and a Guam licensed physician that sets the terms and conditions of the drugs that the clinical psychologist may order and prescribe. The agreement also includes a scope of practice description. See 10 G.C. A. section 12827.

To qualify for prescriptive authority in Guam, the clinical psychologist must have:

(1) A valid Federal Drug Enforcement Administration (DEA) certification;

(2) A current Guam Controlled Substance Registration from Department of Public Health and Social Services;

(3) A written collaborative practice agreement[2] approved by the:

(a) Board of Allied Health Examiners

(b) Board of Allied Health Examiners; and

(c) Board of Medical Examiners;

(4) A physician who is available at all times; and

(5) Evidence of completion of a nationally and professionally accepted pharmaceutical curriculum.[3]

As of March 2002, there were apparently no psychologists in Guam[4] who have taken advantage of the law.

## New Mexico

On March 6, 2002, New Mexico became the first state to enact a law authorizing certain psychologists to prescribe medications. New Mexico's law provides for two levels of clinical psychologists with prescriptive authority: (1) conditional prescribing psychologists, who are supervised for a minimum of two years by a physician who is knowledgeable in psychotropic medications; and (2) prescribing psychologists, who are not supervised. The law was intended to "expand the pool of mental health care providers by providing additional training in medicine and pharmacology to psychologists who are already experienced clinicians with doctoral level

2. As part of the required collaborative practice agreement, the prescribing psychologist must submit a scope of practice and a list of drugs for approval by the Board of Allied Health Examiners, Board of Pharmacy, and Board of Medical Examiners. The collaborative practice agreement may not include any drugs that the clinical psychologist is not competent to prescribe or drugs that are not routinely administered within the applicant's scope of practice. See 10 G.C.A. section 12827.

3. A "nationally and professionally accepted pharmaceutical curriculum" is not defined in the Guam Code.

4. See Deborah Josefson, "Psychologists allowed to prescribe drugs for mental illness," *BMJ* 2002, 324;698 (23 March), www.bmj.com/cgi/content/full/324/7339/698/d.

training."[5] According to supporters, New Mexico's measure was based on the training program used by the United States Department of Defense's Psychopharmacology Demonstration Project[6] (PDP). The bill was supported by the New Mexico Medical Society and the New Mexico Psychological Society. Psychiatric opponents, however, argued that:

- Training would not qualify psychologists to prescribe safely;
- There is no medical school or school of pharmacy at New Mexico State University to host a psychopharmacology training program;
- The Department of Defense's PDP was not independently evaluated or proven safe;[7] and
- Psychologists are not more likely to practice in remote under served areas than psychiatrists.

A compelling factor in passing the prescriptive authority legislation in New Mexico was the difficulty experienced by a large number of state residents seeking psychiatric care. Approximately 28% of New Mexico's population lives in either Albuquerque or Santa Fe. Only 18 psychiatrists served the 72% of state residents who lived elsewhere, while 175 psychiatrists were available to provide psychiatric care for residents of Albuquerque or Santa Fe. Waiting times for an appointment with a psychiatrist in rural areas could be up to five months. The National Alliance of Mental Health noted that 75% of the mentally ill in New Mexico were not receiving appropriate psychotropic medications.[8]

Following passage of the law in 2002, the New Mexico state legislature established a committee tasked with developing recommendations for state regulations to implement the prescription privilege for psychologists. The committee's final report included recommendations and was written by a joint committee of physicians appointed by the New Mexico Medical Board and psychologists appointed by the New Mexico Board of Psychologist Examiners.[9] The

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5. See, "APA's Russ New Newman Testifies on Behalf of New Mexico's Important Step Toward Comprehensive Mental Health Care," APA Online, September 21, 2004, www.apa.org/releases/NMtestimony.html.

6. Although New Mexico's training program was reportedly "based on" the PDP program's training model, New Mexico's requirements are somewhat less stringent than the required classroom and clinical training of the PDP program.

7. A number of external evaluations contradict this argument. See "External Evaluations of the Psychopharmacology Demonstration Project," in Part II, Chapter 2 of this study.

8. See, Robert Ericson, "Prescription Privilege Based on Proven Model," February 9, 2002, www.aabjournal.com.

9. The law, HBO 170, directed the two state boards to produce implementing regulations and to report to the governor and legislature on progress made and problems encountered. The committee's tasks included the defining of a curriculum for the programs aimed at teaching psychologists to prescribe, details of the clinical practicum supervision, designation of national certification exam, adoption of a formulary, and potential limits on population to be treated. The final report included a minority and majority report. See "Final Report of the

regulations were a collaboration between the Psychologist Examiner's Board and the Medical Board and are reported to include extensive education and training requirements with numerous check points and safeguards. Three years after passage of the bill, the regulations relating to prescriptive authority for psychologists took effect on January 7, 2005.

### Conditional Prescribing Psychologist in New Mexico

In New Mexico, a psychologist must prescribe for two years as a conditional prescribing psychologist before applying to be an unsupervised prescribing psychologist. A conditional prescribing certificate authorizes a psychologist to prescribe psychotropic medications for a two year period under the supervision of a physician who is knowledgeable in psychotropic medications. To receive a conditional prescription certification, the applicant must establish that the applicant:

- Has completed a doctoral psychology program;
- Holds a current New Mexico license to practice psychology;
- Has successfully completed pharmacological training from an institution of higher education approved by the New Mexico State Board of Psychologist Examiners and the New Mexico Board of Medical Examiners;
- Has passed a national certification examination approved by the New Mexico State Board of Psychologist Examiners and the New Mexico Board of Medical Examiners that tests an applicant's knowledge of pharmacology in the diagnosis, care, and treatment of mental disorders;
- Within 5 years preceding the date of application, has successfully completed a minimum of 450 hours of class work,[10] 80-hour practicum in clinical assessment and pathophysiology, and a 400 hour/100 patient practicum under the supervision of a physician;
- Has sufficient malpractice insurance; and

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Joint Committee for HB 170: Prescriptive Authority to Psychologists Act of 2002," September 19, 2003, http://nmpsych.org/report_hb_170.htm.

10. The academic part of the training includes psychopharmacology, neuroanatomy, neurophysiology, clinical pharmacology, pathophysiology, pharmaco-therapeutics, pharmacoepidemiology (and physical and lab assessments). See 92 NMSA section 61-9-17.

- Meets all other requirements as determined by rule of the Board.[11]

In addition to the two years of supervision by a physician, a conditional prescribing psychologist is also required to maintain a collaborative relationship with a patient's primary treating health care practitioner. This collaboration requires the conditional prescribing psychologist to initiate contact with the patient's primary care physician when medication is warranted to treat the mental or emotional disorder. It also requires the physician to contact the patient's psychologist concerning a new medial diagnosis or changes in the patient's medical condition. The primary care physician must agree with the psychologist's recommended psychopharmacological treatment; if not, the psychologist shall not prescribe.[12]

**Prescribing Psychologist in New Mexico**

At the end of a two year supervised period of conditional prescription certification, a psychologist may apply for a prescription certificate if the applicant:

- Was granted a condition prescribing certificate and successfully completed 2 years of prescribing psychotropic medications as certified by the supervising licensed physician;
- Successfully underwent independent peer review;[13]
- Holds a current New Mexico license to practice psychology; and
- Has sufficient malpractice insurance.

A prescribing psychologist who holds a prescription certificate is not subject to supervision by a physician, although administrative rules require that prescribing psychologists establish a collaborative relationship with each patient's primary care physician in the same manner as a conditional prescribing psychologist.

11. Administrative rules require the applicant to submit a proposed supervisory plan signed by the applicant and supervising physician. The rules also require that the applicant hold a current certification in basic cardiac life support. See 16.22.25.8 NMAC.

12. Only in the case of an emergency that jeopardizes the patient's health or well being, may the psychologist prescribe without prior consultation with the primary health care physician. See 16.22.20.8 NMAC.

13. The peer review panel includes conditional prescribing psychologists, prescribing psychologists or licensed psychologists with psychopharmacology training and knowledge; licensed psychiatrists, physicians, nurse practitioners of physician assistants with training and experience in psychopharmacology; and pharmacists with training and experience in psychopharmacology. To receive a prescription certificate, an applicant must successfully complete the peer review process. See 16.22.25.9 NMAC.

As of September 20, 2006, there were four conditional prescribing psychologists in New Mexico. There were no prescribing psychologists.[14] There are reports that access to mental health care has increased for patients in rural and urban areas of New Mexico as a result of prescriptive authority for psychologists.[15]

## Louisiana

In 2004, Louisiana became the second state to authorize certain psychologists to prescribe medications. A psychologist who is authorized to prescribe drugs is referred to as a "medical psychologist."[16] At the time the law was passed, Louisiana had only one psychiatrist for every 9,000 residents; the state ranked 48th in social services. Because many psychiatrists opted out of the state's Medicare and Medicaid systems, waiting time for psychiatric care was approximately three months.[17] Low income individuals without health insurance had difficulty in getting mental health services. Prior to the bill's passage, a psychologist was required to suggest medication to each patient's primary care physician, who would then prescribe the drug or reject the psychologist's suggestion. This procedure required an additional doctor visit and a longer wait to receive prescriptions. Supporters claimed that prescriptive authority for psychologists would improve access to mental health care and provide cost savings. Psychiatrists opposed psychologists' efforts to "practice medicine without benefit of medical school and supervised medical residency."[18]

Louisiana adopted administrative rules to implement the prescriptive authority law in less than one year and the rules were effective early in 2005,[19] in contrast to the nearly three years that it took New Mexico to accomplish the same task.[20] Perhaps as a result, Louisiana's law and

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14. September 20, 2006, telephone interview with member of the New Mexico Board of Psychological Examiners. Additionally, the board member stated that there were only four conditional prescribing psychologists because psychologists were having difficulties finding the supervisory physician required to apply for a conditional prescribing certificate.

15. See Zak Stambor, "Psychology's prescribing pioneers," *Monitor on Psychology*, Volume 31, No. 7, July/August 2006.

16. A medical psychologist is a psychologist who has undergone specialized training in clinical psychopharmacology and has passed a national proficiency examination in psychopharmacology approved by the State Board of Examiners of Psychologists and who holds from the Board a current certificate of responsibility. See LA RS 37:2371.

17. November 30, 2006 telephone interview with John Bolter, PhD, MP, Chair of the Louisiana State Board of Examiners of Psychologists.

18. See May 6, 2004 News Release, American Psychiatric Association, Arlington, Va.

19. November 30, 2006 telephone interview with John Bolter, PhD, MP, Chair of the Louisiana State Board of Examiners of Psychologists.

20. Louisiana's rules process moved much faster because, unlike New Mexico's law, the prescriptive authority law in Louisiana did not require the state medical board or any other group representing physicians to approve the rules.

rules appear to be less specific than comparable law and rules in New Mexico. For example, there is no specific number of hours required for classroom and clinical training provided under Louisiana law. Rather, requirements are more generally stated; the required content areas of courses and the clinical training "opportunities" are listed, but without a specification of the hours required for each area. Clinical training "opportunities," for example, must provide an opportunity to review, present, and discuss case examples representing a broad range of clinical psychopathologies.[21] How many "opportunities" over what period of time is unclear.[22]

**Medical Psychologist in Louisiana**

An applicant for a certificate of prescriptive authority must:

- Hold a postdoctoral master's degree in clinical psychopharmacology;
- Pass a national proficiency exam in psychopharmacology approved by the State Board of Examiners of Psychologists; and
- Hold a current Louisiana license to practice psychology with an applied clinical specialty.[23]

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21. See L.A.C. section 403(3)(a) and (b). Classroom instruction is required in: anatomy and physiology; biochemistry; neurosciences; pharmacology; psychopharmacology; clinical medicine/pathophysiology; and health assessment, including relevant physical and laboratory assessment. Training must present opportunities to review, present, and discus case examples of a broad 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; and alternative treatments and treatment failures.

22. RS 37:2373 provides the requirements to receive a certificate of prescriptive authority:

    RS 37:2373. Certification; requirements

    The board shall issue a certificate of prescriptive authority to any psychologist who files an application upon a form and in such a manner as the board prescribes, and who furnishes satisfactory evidence to the board that the psychologist meets each of the following requirements:

    (1) Holds a current Louisiana license to practice psychology with an applied clinical speciality as defined by the board.

    (2) Has successfully graduated with a postdoctoral master's degree in clinical psychopharmacology from a regionally accredited institution or equivalent to the postdoctoral master's degree as approved by the board. The curriculum shall include instruction in anatomy and physiology, biochemistry, neurosciences, pharmacology, psychopharmacology, clinical medicine/pathophysiology and health assessment, including relevant physical and laboratory assessment.

23. See LA RS 37:2373 and 46 L.A.C. section 403.

Limitations on the scope of practice of medical psychologists provide that they may treat with medications only certain mental and emotional disorders and may prescribe only those drugs recognized and customarily used in the diagnosis and management of mental and emotional disorders.[24] Unlike conditional prescribing psychologists in New Mexico, there is no initial period of supervision by a psychiatrist or physician with knowledge of psychotropic drugs required for medical psychologists. Before the Louisiana law was implemented, there were discussions on whether to require physician supervision for medical psychologists. Apparently, the supervision issue focused on what area of a medical psychologist's practice might require supervision and what was the reason for requiring supervision.[25] Was a psychiatrist required to observe prescription writing? Or, was supervision required for the patient's safety by making known any possible complicating medical conditions the patient might have?

Ultimately, it was decided that the medical psychologist should be required to obtain all information concerning the patient's medical condition from the patient's primary care physician before prescribing any psychotropic medication. Consequently, supervision was deemed unnecessary. Instead, a collaborative relationship with the patient's primary care physician was required before a medical psychologist could start, stop, or change medication, similar to New Mexico's required collaboration.[26] The collaborative relationship was deemed more appropriate than supervision because collaboration with the patient's primary care physician would give the medical psychologist needed medical information. The collaborative arrangement was intended to provide optimal medical and mental health care for patients.[27] If a patient does not have a primary care physician, a medical psychologist shall not prescribe for that patient. Medical psychologists may not prescribe narcotics.

As of November 30, 2006, there were thirty-four medical psychologists in Louisiana. An additional five medical psychologists are expected to be licensed by the end of 2006.[28] Medical psychologists have reportedly issued more than 20,000 prescriptions as of this writing.[29] One medical psychologist in private practice in Louisiana claims that patients are saving time and

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24. A medical psychologist may prescribe medications for mental and emotional disorders that arise secondary to a primary medical condition only if the primary medical condition is treated by a primary care physician. See LA RS 37:2371 and 46 L.A.C. section 405.

25. November 30, 2006 telephone interview with John Bolter, PhD, MP, Chair of the Louisiana State Board of Examiners of Psychologists.

26. See LA RS 37:2375 and see 46 L.A.C. sections 407 and 409.

27. See 46 L.A.C. section 405. According to the Chair of the Louisiana State Board of Examiners of Psychologists, physicians have participated in the required collaboration without opposition. November 30, 2006, telephone interview with John Bolter, PhD, MP, Chair of the Louisiana State Board of Examiners of Psychologists.

28. November 30, 2006, telephone interview with John Bolter, PhD, MP, Chair of the Louisiana State Board of Examiners of Psychologists.

29. November 30, 2006, telephone interview with John Bolter, PhD, MP, Chair of the Louisiana State Board of Examiners of Psychologists.

money as a result of prescriptive authority for psychologists because of the new one-stop shop approach available from a medical psychologist.[30]

## New York

Although New York has the second largest population of psychologists in the country, until recently no state law statutorily defined the practice of psychology. For approximately four years, psychologists supported proposed legislation that, among other things, provided a definition of psychologist, thus determining who could use the title psychologist and authorized prescribing privileges.

In order to secure passage of legislation to define the practice of psychology, psychiatrists and psychologists reached a compromise. Psychologists gave up their pursuit of prescriptive authority in return for psychiatric support of legislation that, among other things, defined "psychology" and determines who qualified to use the title psychologist. In 2003, both psychiatrists and psychologists supported S 7727, which defines the practice of psychology and who can use the title psychologist in conjunction with their practice.[31] S 7727 specifically states that psychologists are "prohibited from prescribing or administering drugs as . . . a treatment, therapy, or professional service."

# Part II. Patient Safety Issues in New Mexico and Louisiana

Both New Mexico and Louisiana have taken certain precautions relating to patient safety in their laws that authorized prescriptive requirements. The New Mexico and Louisiana laws implementing prescriptive authority include the following patient safety related requirements:

- A collaboration with each patient's primary care physician before a prescription may be issued;
- Medications that may be prescribed are limited to those used to treat mental and emotional disorders;
- Passage of a national proficiency examination in psychopharmacology;
- Continuing education as a condition of certification renewal; and

30. See Zak Stambor, "Psychology's prescribing pioneers," *Monitor on Psychology*, Volume 31, No. 7, July/August 2006.

31. See Ken Hausman, "Psychologists Sacrifice Claim to Prescribing Privileges," *Psychiatric News*, Volume 38 Number 2, 2003. See pn.psychiatryonline.org/cgi/content/full/38/31/-a. The bill also provided for the licensing of mental health practitioners.

- Limitation on medical and emotional disorders that may be treated with medication.

In addition, New Mexico requires the successful completion of a two year period as a conditional prescribing psychologist under the supervision of a physician knowledgeable in psychotropic medication before a psychologist can apply for a certificate to prescribe independently. A successful peer review is also a part of the application for a certificate to prescribe independently in New Mexico. Unlike the federal Psychopharmacology Demonstration Project, neither state appears to have limited the scope of practice to patients between 18 and 65. In fact, as part of the required clinical practicum, New Mexico specifically requires an applicant to have treated a diverse patient population, "including adults, children/adolescents, and geriatrics."[32] Also in contrast to the PDP program, the prescribing psychologists in New Mexico and Louisiana are, apparently, in private practice in the civilian sector. They did not receive their clinical training in a military medical facility, with a team practice approach to medicine; and they currently are independent providers, unlike the collaborative practice of the military medical facilities to which PDP participants were initially assigned after completing the program.

Because prescriptive authority for psychologists has been in effect in New Mexico and Louisiana for a relatively short period of time, it does not appear that either program has been evaluated. Although there are only four conditional prescribing psychologists in New Mexico at this writing, no complaints have been reported against those individuals thus far.[33] Similarly, no complaints or adverse effects have been reported in Louisiana.[34] The Chair of the State Board of Examiners of Psychologists in Louisiana reports that the collaboration between medical psychologists and a patient's primary care or attending physician has, in fact, resulted in an improved level of care for the patient because the mental and medical care providers are working together to ensure the best course of treatment.[35] The thirty-four medical psychologists in Louisiana have issued, apparently safely, more than 20,000 prescriptions.[36] The number of prescriptions issued by the four conditional prescribing psychologists in New Mexico is unknown, although there are no records of complaints related to the drugs prescribed.

The Bureau has no independent information to confirm which psychopharmacology training program any of the four conditional prescribing psychologists of New Mexico or the thirty-four medical psychologists of Louisiana completed to satisfy the requirements for prescriptive authority in their respective state. Because neither state has classroom or clinical

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32. See 16.22.23.9 (F)(4)(b) NMAC.

33. September 20, 2006, telephone interview with member of the New Mexico Board of Psychological Examiner.

34 . November 30, 2006, telephone interview with John Bolter, PhD, MP, Chair of the Louisiana State Board of Examiners of Psychologists.

35. November 30, 2006, telephone interview with John Bolter, PhD, MP, Chair of the Louisiana State Board of Examiners of Psychologists.

36. See, Patrick DeLeon, "The 21st century is here," www.nevadapsychologists/org/messages/21cent.html.

training requirements as stringent as the PDP program training model, it can be assumed that the prescribing psychologists in both states completed psychopharmacology training programs less rigorous than the training required for PDP program graduates. These less rigorous training requirements may later prove significant, given that both states report that there have been no claims against the psychologists who prescribe in their state and no reports of adverse effects on their patients' safety. In addition, the prescribing psychologists in New Mexico and Louisiana did not have the benefits of the team practice of the military medical system in their clinical training or in their post-graduate practice. Although a collaborative relationship with a patient's primary care physician is required, the prescribing psychologists are practicing independently, without the safety net military medicine provides.

According to anecdotal information at least, the prescribing psychologists in New Mexico and Louisiana have apparently successfully issued prescriptions and treated their patients safely and effectively. However, because prescriptive authority was implemented in both states only recently, as of this writing, no external evaluation has been conducted on the effect of prescribing psychologists on access to mental health care or the adequacy of any psychopharmacology training program approved by either state. Because of the differences in training requirements and procedures, the newly authorized prescriptive authority for psychologists in New Mexico and Louisiana bears careful monitoring.

## Part III. Postdoctoral Psychopharmacology Training Programs

It is possible that the apparent success of the United States Department of Defense Psychopharmacology Demonstration Project (PDP program or program) has caused supporters of prescriptive authority to believe that it is only a matter of time until other states join New Mexico and Louisiana in granting prescriptive authority to certain clinical psychologists. Even before the PDP program was terminated, the American Psychological Association adopted a postdoctoral curriculum for practitioners who sought prescription privileges: Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges.[37] Whatever their origin, there are at least ten programs across the nation that currently offer postdoctoral training in psychopharmacology to clinical psychologists. A brief review of those programs indicates that the classroom training and the clinical training offered does not duplicate the training of the PDP program, one year of full time classroom training and one year of full time clinical training.

37. The recommended curriculum was approved by the APA Council of Representatives on August 12, 1996. In addition, in 2005, the Association of State and Provincial Psychology Boards (ASPPB) and the National Register of Health Service Providers jointly developed criteria and procedures for the designation of postdoctoral programs in clinical psychopharmacology. The criteria are to aid licensing boards and credentialing bodies to identify which *programs* meet established guidelines. See Brief Review of the Development of the Criteria for Approval of an ASPPB/National Register Designated Postdoctoral Program in Psychopharmacology, online at asppb.org/about/new.aspx. Earlier the ASPPB had adopted Guidelines for Prescriptive Authority to develop consistency in regulating prescriptive authority by their licensing boards. The 2000 recommendations are guidelines for writing regulations relating to certification of *individuals* for prescription privileges. See ASPPB Guidelines for Prescriptive Authority, online at asppb.org. Although they may prove helpful to the Legislature, the guidelines and criteria for training programs and certification of individuals developed by the ASPPB will not be discussed in this study.

The PDP program is the only program that has been evaluated several times and has been declared a success, with no adverse effects on patients reported.

## Training Program - Department of Defense Psychopharmacology Demonstration Project

The classroom and clinical training for the Psychopharmacology Demonstration Project is discussed at length in Chapter 2. In general, the first class of PDP program participants had 1,365 hours of classroom requirements, essentially the same first two years of the medical school curriculum taken by medical students at the Uniformed Services University of the Health Sciences. Subsequent classes of PDP participants had full time classroom training that was shortened and tailored to one year to their needs, resulting in 650 to 700 required classroom hours. All participants had one year of full time clinical experience, which was supervised by psychiatrists. The year of clinical training was approximately 2,000 hours long and included inpatient and outpatient experience.

## Recommended Postdoctoral Training in Psychopharmacology- American Psychological Association

In 1996, the American Psychological Association (APA) adopted the "Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges,"[38] which included:

*Classroom training:* minimum of 300 contact hours in:

| | |
|---|---|
| Neuroanatomy | 25 |
| Neurophysiology | 25 |
| Neurochemistry | 25 |
| Pharmacology | 30 |
| Clinical Pharmacology | 30 |
| Psychopharmacology | 45 |
| Developmental Psychopharmacology | 10 |
| Chemical dependency and chronic pain management | 16 |

38. The APA prerequisites to postdoctoral training in psychology include: a doctoral degree in psychology; a current state license as a psychologist; and practice as a "health services provider" psychologist. The APA further states that demonstrated knowledge of human biology, anatomy and physiology, biochemistry, neuroanatomy, and psychopharmacology is a necessary prerequisite for embarking on this postdoctoral training. See, Preamble, Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges, approved by the APA Council of Representatives on August 12, 1996.

| | |
|---|---|
| Pathophysiology | 60 |
| Introduction to Physical assessment and laboratory exams | 45 |
| Professional, ethical, legal issues | 15 |
| Psychotherapy/pharmacotherapy interactions | 10 |
| Computer based aids to practice | 5 |
| Pharmacoepidemiology | |

*Clinical practicum:* no length of time specified

- Minimum of 100 patients seen for medication
- Inpatient and outpatient placements
- Inclusion of appropriate classroom instruction
- Minimum of 2 hours weekly of individual supervision

The APA also stated that the provider of such a postdoctoral training program must be a regionally accredited institution of higher learning or another appropriately accredited provider of instruction and learning. It is unclear which facility qualifies as an "appropriately accredited provider of instruction and learning."

## Other Psychopharmacology Training Programs

Currently, there are approximately ten programs offering psychopharmacological training to psychologists. Classroom credits offered vary from 25.6 to 33 academic credits. Courses are described ranging from twenty to thirty six months. The number of hours per week required for classroom training varies: 2-6 hours; 6-12 hours; 5-15 hours; 10 weeks over 2 years, with 37.5 to 45 hours per week on campus; 1-6 hours; 3-12 hrs; and 10-15 hours. Unlike the on-campus classroom training of the PDP graduates, these programs are designed so that "practicing psychologists will have their professional life disrupted minimally." Four of the programs offer a postdoctoral Master of Science in Clinical Psychopharmacology. A chart that compares the various psychopharmacology training programs is attached as Appendix D.

For example, at Nova Southeastern University classes are held once a month on weekends for nine months. A number of programs provide class room training only on weekends. One program is described as "residential," comprised of ten six-day sessions to receive 3.15 academic credits. Another program allows students to attend classes via audio conference calls, accompanied by class handouts and videotapes of classes. One program is

entirely long distance learning. Online discussions and weekly chats also are part of many curriculum. For the clinical practicum, most programs state that they offer practicum documentation, and will assist with but do not guarantee practicum placement. The Farleigh Dickinson University program provides a postdoctoral clinical psychopharmacology MS, but the clinical training is elective.

In Honolulu, Argosy University offers a Postdoctoral Certificate in Psychopharmacology.[39] The Honolulu campus of Argosy University, a national for-profit university, is one of thirteen campuses and six extension sites in the U.S., offering undergraduate, graduates, and postgraduate degrees. Argosy University/Hawaii was founded in 1994 as The American School of Professional Psychology/Hawaii campus.[40] Argosy reports that the curriculum meets the requirements recommended by the American Psychological Association and has incorporated elements of the United States Department of Defense Psychopharmacology Demonstration Project. To enter the program, the only requirement is a doctoral degree in clinical psychology and a state license in psychology. There is no indication that applicants are held to high standards of selection for admission to the program, as recommended by evaluations of the PDP program. The program includes Level II, Level III, and a Clinical Field Practicum. Level II training is intended to certify a postdoctoral clinical psychologist to provide consultation in psychopharmacology, but not to prescribe independently. Level III training is the "standard for obtaining independent privileges."[41] To receive a certificate of completion of Level III, a student is required to complete 24 credit hours of classroom training and a one year clinical field practice of approximately 15 hours weekly, under the supervision of a board certified psychiatrist.

## Comparison and Analysis of Psychopharmacology Training Programs

Many of the existing training programs purporting to provide postdoctoral psychopharmacology training to postdoctoral clinical psychologists to qualify them for prescriptive authority claim that their program training meets or exceeds the recommended guidelines of the American Psychology Association. However, APA's recommended postdoctoral classroom training of 300 hundred hours and the clinical training of an unspecified duration do not measure up to the classroom and clinical training requirements of the PDP program, the only training program with demonstrated success. Consequently, whether or not each existing program meets the APA's recommended guidelines seems irrelevant since there has been no psychopharmacology training program based on the APA's recommended classroom and clinical training requirements that been evaluated and deemed a success. Accordingly, the Bureau did not attempt to analyze each program to confirm its claim in this regard. Applicants

39. See the website of Argosy University/Hawai‘i, The American School of Professional Psychology, http://www.argosyu.edu/honolulu/programs.asp?plid=57&xid=0.

40. See www.argosyu.edu/hawaii.

41. See Program Requirements, www.argosyu.edu/honolulu/programs.asp?plid=57&xid=23.

do not appear to be held to high selection standards; the only criteria is a postdoctoral degree in psychology and a state license to practice.

Any postdoctoral psychopharmacology training program with classroom training that is shorter than one year of full time classroom courses, that requires less than 650 hours, that allows distance learning, weekend courses, and online chats, combined with a clinical training program of less than one year of supervised full time inpatient and outpatient experiences, may or may not be sufficient or effective classroom and clinical training to guarantee safe prescription writing. A training model of one year of full time classroom training and one year of full time clinical training that includes inpatient and outpatient experiences, with supervision by a psychiatrist, was demonstrated to be effective by the apparent success of the PDP program. Additionally, it should be noted that PDP program training was provided at accredited educational facilities and at well recognized military medical centers: the Uniformed Services University of Health Systems, with an accredited medical school and graduate nursing program, and Walter Reed Medical Center or Malcolm Grow Medical Center. Most of the current postdoctoral psychopharmacology training programs are provided by for-profit professional schools and do not match the training requirements or facility credentials of the PDP classroom and clinical training program.

Only the training provided by the Psychopharmacology Demonstration Project has successfully produced prescribing psychologists who, according to several external evaluations, have demonstrated that they could safely prescribe psychotropic medications under prescribed circumstances.[42] Whether a training program with requirements less rigorous than the PDP classroom and clinical training would succeed has not been established by external evaluations, although anecdotal information reports there have been no patient safety issues related to prescribing psychologists in New Mexico and Louisiana. Because the success of a training program that does not at least duplicate the PDP program training requirements is uncertain, it is not known whether approving a psychopharmacology training program with less stringent classroom and clinical requirements would or would not put patient safety at risk.

## Summary

Despite more than twenty years of legislative efforts in a number of states, only two states and Guam have granted prescriptive authority to clinical psychologists: New Mexico and Louisiana. New Mexico authorized prescriptive authority for psychologists at least partly because most of the psychiatrists practiced in Santa Fe and Albuquerque, while 72% of the population lived elsewhere. In Hawaii, though, most of the psychiatrists practice where most of

42. When interviewed by the ACNP evaluation panel concerning the possibility of future military or civilian programs to train clinical psychologists to prescribe, PDP program graduates favored a two year training program much like their own PDP program, but perhaps more tailored to the needs and skills of clinical psychologists. At a minimum, a year of full time clinical training, with at least a six month inpatient rotation, was deemed indispensable by graduates. See ACNP Final Report, page 3.

the residents live, on Oahu. Residents in medically underserved areas of New Mexico and Hawaii both face long waits to receive psychiatric care.

The laws in New Mexico and Louisiana include certain requirements that address patient safety issues. Because prescriptive authority was authorized only recently, there apparently have been no external evaluations of the effect of prescriptive psychologists on patient safety or increased access to mental health care. Despite a growing number of programs purporting to offer postdoctoral training in psychopharmacology and the lack of safety issues related to prescribing psychologists in New Mexico and Louisiana thus far, only the classroom and clinical training of the Department of Defense's pilot program has been evaluated and determined a success. The Psychopharmacology Demonstration Project successfully trained ten clinical psychologists to prescribe psychotropic medications to treat generally nonserious mental health conditions of patients aged 18 to 65, when no complicated medical condition was present. Existing postdoctoral training programs in psychopharmacology appear to offer classroom and clinical training that is less rigorous than the PDP training, which logically suggests that the practices of prescribing psychologists in New Mexico and Louisiana, together with their requirements for licensing, should be closely monitored. The classroom and clinical training requirements of any program other than the PDP program have not been evaluated; patient safety has not been established relating to any program with training requirements less stringent than the PDP program.

# Chapter 4

# A REVIEW OF ARGUMENTS IN SUPPORT AND IN OPPOSITION TO PRESCRIPTIVE AUTHORITY FOR QUALIFIED CLINICAL PSYCHOLOGISTS

## Supporters

Generally speaking, the central claim of those who support prescriptive authority for qualified clinical psychologists is that prescribing psychologists would increase access to mental health care for our most underserved residents. Supporters point to the success of United States Department of Defense's Psychopharmacology Demonstration Project (PDP program or program) as evidence that clinical psychologists can be trained to prescribe psychotropic medications safely and effectively. Supporters note that twenty percent of Americans with mental illness have a critical need for available, appropriate, and effective psychoactive medication. In addition, supporters contend that prescriptive authority for qualified clinical psychologists would offer an alternative to the medical model of treating mental illness, noting that clinical psychologists have significant training in biopsychosocial assessment and standardized diagnostic procedures. They point to the success of numerous nonphysician health care providers who have prescriptive authority as evidence that nonphysicians can prescribe safely.

Individuals and organizations who testified in support of prescriptive authority for psychologists during 2006 include: the American Psychological Association; the Hawaii Psychological Association, Hawaii Primary Care, Hawaii Medical Service Association; numerous community health centers, the Louisiana Academy of Medical Psychologists; the Health Psychology Associates; a graduate of the United States Department of Defense Psychopharmacology Demonstration Project; a licensed conditional prescribing psychologist from New Mexico; numerous psychologists; and other individuals. During legislative hearings on prescriptive authority for psychologists, supporters raised the following points:

### Prescriptive Authority for Qualified Psychologists Would Improve Access to Mental Health Care

- Patients of federally qualified health centers, by definition, are a medically underserved population or reside in a medically underserved area;

- Mental health patients often wait weeks for an appointment with a psychiatrist; and

- Prescribing psychologists would provide a continuity of health care for certain mental health patients, eliminating the need to be seen by a physician to obtain medication.

**Clinical Psychologists Can Be Trained to Prescribe Safely and Effectively**

- The Psychopharmacology Demonstration Project trained postdoctoral clinical psychologists to prescribe psychotropic medications safely and effectively;

- External evaluations of the PDP program found that graduates' quality of care was rated by their psychiatrist supervisors as good to excellent, adding that no evidence of quality problems were found in the graduates' credential files;

- Under laws passed in New Mexico in 2002 and Louisiana in 2006 authorizing certain psychologists to prescribe, psychologists in those states apparently have prescribed drugs without incident;

- Clinical psychologists seek to prescribe only within their scope of practice, which includes less than one percent of medications;

- Patient safety concerns can be addressed through specialized classroom and clinical training requirements; and

- In some federally qualified health centers, clinical psychologists with psychopharmacology training are already collaborating successfully with physicians on patient medication issues.

**Critical Need**

- Twenty percent of Americans suffer from mental illness at any given time;

- Medical students in psychiatric residencies decreased by twelve percent between 1988 and 1994; half of the psychiatric residency slots are filled by students from other countries;

- The majority of psychotropic medications are prescribed by physicians with limited exposure to diagnosing and treating mental illness;

- Patients of general practitioners may be misdiagnosed and given drugs unnecessarily;

- In some instances, PDP program graduates discontinued apparently unnecessary medications, noting that the authority to prescribe includes the authority to not prescribe; and

- It is less disruptive to patients to have only one health care provider who can both prescribe medications and provide therapy.

**Alternative to Medical Model to Treat Mental Illness**

- The medical model has been described as diagnosing a "defect or disease" and using surgery or medication to remove the problem. Medical practitioners liken health to the absence of disease, assuming pharmaceutical intervention, if not surgery;

- Under the medical model, the "doctor knows best" and the patient plays a passive role in treatment;

- The psychological treatment model of prescribing psychologists would be a systems-oriented, holistic, and integrated approach that provides integrated psychological and pharmacological care;

- The psychological model equates health with "integrity of function and adaptability," and medication, when necessary, is but one aspect of treatment that would likely be used in combination with other interventions;

- Psychologists with authority to prescribe have used the authority to not prescribe; in contrast to physicians' use of drug therapy as the customary and primary treatment intervention;

- Patients would be more active in their own treatment in the psychological model because that model is more collaborative with and thus empowering to the patient; and

- Research has shown the best outcome for mental health disorders is a combination of psychotherapy and medication.

**Nonphysician Health Care Providers Have Prescribed Safely in Many States, Including Hawaii**

- Prescribing by nonphysician health care providers such as advanced practice nurse practitioners and physicians assistants has proved safe; and

- Insurance premiums have not increased for these health care providers.

**Clinical Psychologists Have Significant Training**

- Clinical psychologists' training in mental health and psychological aspects of medical conditions exceeds that of other health care professionals;

- Clinical psychologists have a high level of competency and expertise in the diagnosis, assessment, and treatment of mental and emotional disorders through many years of extensive education and training; and

- Psychologists' competence in medical and psychological aspects of medical conditions is reflected by the presence of 3,000 psychologists on various medical school faculties.

## Opponents

The central argument voiced by opponents of prescriptive authority for qualified clinical psychologists is that clinical psychologists do not have a medical background and, consequently, would be unable to prescribe medications safely or to recognize medical conditions that mimic mental illnesses. Opponents claim that because clinical psychologists have a social and behavioral science rather than medical background, they lack the education needed to understand the dangers of certain drugs and potentially dangerous interactions. They note that nonphysician health care providers who have prescriptive authority have a medical background and limited authority. They also contend that the crisis in access to mental health care is exaggerated and that prescribing psychologists would lead to an increase in health care costs. The apparent success of the Psychopharmacology Demonstration Project, opponents claim, can not be duplicated in the civilian sector.

Opponents of prescribing psychologists included: the Department of Health; the Department of Public Safety; the State Board of Psychology; the State Board of Medical Examiners; the American Psychiatric Association; the Hawaii Medical Association; the Hawaii Association of Osteopathic Physicians and Surgeons; the Hawaii Psychiatric Medical Association; the American Association of Applied and Preventive Psychology; the American Osteopathic Association; the National Alliance for the Mentally Ill Oahu; a professor of psychology; numerous psychiatrists; and other individuals. Opponents of prescriptive authority expressed the following concerns:

**Psychologists Do Not Have Medical Training or Scientific Background**

- Psychologists do not have training in basic organic chemistry, biochemistry, normal and abnormal physiology, and general pharmacology principles;

- Psychologists have inadequate experience in the care and treatment of seriously mentally ill patients who have dual medical and psychiatric illness;

- Psychologists have insufficient medical knowledge to recognize a physical disease that mimics mental illness or that contributes to psychiatric presentation; and

- Physicians, including psychiatrists, have a clinically focused education that emphasized physical sciences; they learned, under the supervision of a physician, how to evaluate and treat patients by a hands-on approach.

**Doctoral Degrees in Psychology are Based Upon Social and Behavioral Sciences**

- Doctoral degrees in psychology are not based upon a medical or scientific model; they do not require any biological or physical science courses; and there is no uniformity among required science courses in education and training requirements for clinical psychologists;

- Doctoral training in psychology is in a nonmedical setting; students do not observe or participate in treating patients with medical illnesses;

- Doctoral training in psychology does not prepare graduates to detect and treat concomitant nonmental illness or to understand and deal with the potential interaction of psychotropic drugs with other drugs; and

- Psychologists are trained only to do psychotherapy and psychological testing.

**Nonphysician Health Care Providers Have Medical Backgrounds and Prescriptive Authority is Limited**

- Advanced practice registered nurses, physicians' assistants, optometrists, and other nonphysicians who have prescriptive authority have a medical background that includes required courses in biological and physical sciences; and

- Nonphysicians who prescribe generally require physician supervision, are authorized to prescribe only limited types of medications, or both.

**The Crisis in Access to Mental Health Services is Exaggerated**

- There is no societal need to grant prescriptive authority to psychologists because there is no shortage of prescribing health care professionals and no consumer demand to have prescribing psychologists;

- Prescribing psychologists would be an unnecessary duplication of health care services already provided by medical professionals;

- The John A. Burns School of Medicine, the Hawaii Psychiatric Medical Association, the Department of Health, and other parties are working together to reduce system barriers to mental health services and are implementing programs to improve access to psychiatric services for mental health consumers; and

- Crises telephone lines with psychiatric backup have increased access to mental health services for all islands.

**Prescribing Psychologists Would Increase Health Care Costs**

- Psychologists' liability insurance would be likely to rise dramatically;

- Additional training and regulatory resources would be needed, increasing state regulatory costs that likely would be passed to patients and non-patient taxpayers;

- Because clinical psychologists have inadequate training to detect and treat most non-mental medical conditions, patients would also need a physician, at an additional cost; and

- Prescribing psychologists would be likely to raise fees to reflect new skills.

**Prescribing Psychologists Can Only Be Successful in Military Medical Facilities**

- Private sector patient population is significantly different from patients treated by PDP graduates in the military health care system;

- Patients with complicated medical conditions were "largely screened out" as patients to be treated by PDP graduates;

- PDP graduates relied on the supervision of psychiatrists and back up of physicians; and graduates treated only patients between 18 and 65;

- The occupational and health care teams of military medical facilities collaborate closely and military patients are "duty-bound" to cooperate in the treatment of their illnesses, unlike private sector medical care; and

- Success of prescribing psychologists in the military medical facilities is unlikely to be duplicated in the private sector health care market because of economic forces.

## Summary

Supporters of prescriptive authority for qualified clinical psychologists who work in federally qualified health centers claim that prescribing psychologists would increase access to critically needed mental health treatment, including medication, for our most underserved population. They point to the success of the Psychopharmacology Demonstration Project program to demonstrate that clinical psychologists can be trained to prescribe a limited formulary safely and effectively, with no adverse affects to patients. Supporters also note the success of nonphysician providers who have safely prescribed for a number of years as support for their position.

In contrast, opponents of prescribing psychologists claim that a medical background with training in biological and physical sciences is necessary to prescribe safely and recognize medical conditions that mimic mental illness. Opponents contend that the crisis in mental health care access is exaggerated and that the success of the Psychopharmacology Demonstration Project cannot be duplicated in the civilian sector.

# Chapter 5

## COMPARING CLINICAL PSYCHOLOGISTS AND PSYCHIATRISTS; AND NONPHYSICIAN HEALTH CARE PRESCRIBERS

In discussions of prescriptive authority for psychologists, the clinical psychologist's lack of a medical background and education in biological and neuroscience courses is most often stated by opponents as the main objection to authorizing prescriptive authority. Clearly, the classroom and clinical training requirements for clinical psychologists and psychiatrists have little similarity even though both professions diagnose and treat patients with mental illness. The differences are discussed in Part I below.

When clinical psychologists point out that various nonphysician health care providers have successfully held prescriptive authority for several years, opponents point out in return that those nonphysician providers have classroom and clinical training that is based in medicine, unlike clinical psychologists. The education and training requirements of nonphysician health care professionals who have prescriptive authority are discussed in Part II. A chart that illustrates the applicable level of supervision, the formulary that may be prescribed, licensing requirements, and the name of the licensing agency for nonphysician prescribers also is included at the end of this chapter.

Part III provides a brief summary of information from Part I and Part II. The degree requirements for a PhD[1] in clinical psychology, an MD in psychiatry, and a master's degree as an advance practice registered nurse are taken from the appropriate departmental web sites of the University of Hawaii at Manoa (UH), at www.hawaii.edu. The classroom and clinical training required for podiatrists, optometrists, and physician assistants are generally taken from the web site of the national professional association for each nonphysician prescriber, respectively. Licensing requirements for nonphysicians with prescribing authority are taken from the Hawaii Revised Statutes and the Hawaii Administrative Rules.

1. Doctoral programs in psychology grant either a PhD or a PsyD, depending on the program. In this study, a graduate of a doctoral program in psychology is referred to as a PhD for the sake of convenience. In terms of length of training, students in PhD programs take significantly longer, approximately 1 to 1.5 years longer, to complete their degrees than do PsyD students. Various interpretations are given to this difference, from PsyD training is more focused and efficient on one hand, to PhD training is more comprehensive and rigorous on the other. See John C. Norcross and Patricia H. Castle, "Appreciating the PsyD: The Facts," at www.psichi.org/pubs/articles/article_171.asp, web site of Psi Chi, The National Honor Society in Psychology.

# Part I. Clinical Psychologists and Psychiatrists

Although both clinical psychologists and psychiatrists are required to obtain an undergraduate bachelor's degree in college before entering graduate or medical school, the differences in their training is noticeable even beginning with the undergraduate courses required for each. Both professions require four years of college and a great deal of specialized classroom and clinical training at the graduate level. A doctoral degree in clinical psychology requires a minimum of four years of graduate school and one year of clinical internship, although it is common to take up to seven years to complete a PhD in psychology. In contrast, to receive an MD as a psychiatrist, a student must complete four years of medical school and a four year psychiatry residency, for a minimum of eight years of graduate education.

Although clinical psychologists and psychiatrists both treat patients with mental or emotional disorders, a clinical psychologist's treatment is based on behavioral sciences and psychiatric treatment is based on a medical model. Because the academic courses and clinical training required for clinical psychologists and psychiatrists have little similarity, the two fields have distinct differences in their approach to treatment of mental illnesses. Although a strong exposure to several areas in the field of psychology is required at all levels, it would be possible to complete a doctoral degree in clinical psychology without taking any biological or neuroscience based courses. In contrast, psychiatrists have biological and neuroscience based requirements that begin in undergraduate school and continue through medical school and psychiatric residency training. Both clinical psychologists and psychiatrists experience a significant amount of clinical training in undergraduate and graduate or medical school.

## Doctoral Degree in Clinical Psychology

A doctoral degree in clinical psychology requires four years of undergraduate work and four to seven years of graduate school that includes a one year clinical internship. Psychology is the study of the human mind and behavior.[2] The doctoral clinical studies program of the Psychology Department of the University of Hawaii is a scientist-practitioner model of training that seeks to integrate science and practice in classroom and clinical assessment, therapy, and research and training and to train culturally competent scientist-practitioners.[3]

### Prerequisites to Doctoral Degree in Psychology: 4 Years of College

To enter the doctoral clinical studies program in psychology at the University of Hawaii (UH), a student must have completed four years of college as an undergraduate.

2. See "Psychologists," Occupational Outlook Handbook, www.bls.gov/oco/ocos056.htm.

3. See www.psychology.hawaii.edu.

Doctoral program applicants must show a strong undergraduate background in psychology, including courses in statistics, methodology, abnormal psychology, and other basic areas such as physiological, cognitive, learning, behavioral, social, and developmental psychology. No courses in biological, chemistry, or physics are required for a B.A. in psychology.

**Requirements of a Psychology Doctoral Degree in Clinical Studies**

For doctoral candidates in the clinical studies graduate school program at UH, the core curriculum includes: clinical core courses;[4] statistics and research methodology; history and systems; basic areas of psychology; plus clinical and other elective courses.[5] Clinical core courses teach students basic interviewing skills; intellectual/cognitive and personality assessment; clinical report writing and case conceptualization; psychopathology; ethics of clinical practice; and an empirical/scientific orientation towards clinical practice.

As part of their graduate training, doctoral candidates in the clinical studies program must complete a minimum of four semesters of clinical therapy practicum training, with a minimum of fifteen hours weekly each semester, and a one year clinical internship. The clinical experiences are intended to strengthen a science-based clinical practice in a closely-supervised and supportive training environment.[6] A graduate of a psychology doctoral program in clinical studies at UH receives a PhD in clinical psychology.

In summary, a doctoral degree in clinical psychology requires four years of college as an undergraduate, and four to seven years of classroom and clinical training in graduate school, including a one year clinical internship. Graduate school course work

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4. Courses include: clinical psychology; assessment I, II, and II; behavioral assessment; child psychopathology; treatment research; adult psychopathology; child and/or adult practicum; child or adult treatment: cognitive behavioral therapy; and an internship in clinical psychology. See "Clinical Studies Program Manual," page 12, at www.psychology.hawaii.edu/pages/graduate_programs/clinical.html.

5, One doctoral program in clinical psychology lists electives often taken by doctoral candidates as child psychopathology, child psychotherapy, child assessment, family therapy, neuropsychological assessment, community psychology, cognitive behavior therapy, psychopharmacology, adolescence, and multivariate statistics. See the Psychology Department at Loyola University's "Detailed Description of the Clinical Psychology PhD Program," www.luc.edu/psychology/graduate/clinical/detaileddescriptionoft.shtml.

6. Clinical experiences must include: ongoing therapy contact with clients; an integration of assessment, treatment, program development, evaluation, and case formulation; a minimum of weekly supervision from facility and academic supervisors; on-site case conferences and seminars on clinical assessment and treatment; the integration of science and clinical practice; and study of current literature related to clinical activities. See "Clinical Studies Program Manual," page 15, at ww.psychology.hawaii.edu/pages/graduate_programs/clinical.html.

concentrates in courses in areas in the field of psychology. Courses in biological and neurosciences are not required in undergraduate or graduate school.

## Medical Degree in Psychiatry

To become a psychiatrist, a student must complete four years of undergraduate work and a minimum of eight years of graduate medical school and residency classroom and clinical training that includes four years of medical school and four years in a psychiatry residency program. Psychiatry is the investigation of the biological basis of mental illness, in contrast to the behavioral approach to diagnosis and treatment of mental illness in clinical psychology. The psychiatry residency program at John A. Burns School of Medicine at the University of Hawaii includes special training in the diagnosis and treatment of mental illness including disorders of emotions, thoughts, moods, perceptions, motivations, interpersonal relationships, work, sexuality, and socialization.

### Prerequisites to a Psychiatric Residency Program: College and Medical School

To enter a psychiatric residency program, a student must have completed four years of college and four years of medical school. Before entering medical school, an undergraduate student must complete premedical course work of 90 hours, including 26 credit hours in general biology, molecular and cellular biology, general chemistry, biochemistry, and general physics courses. Additional course work in biological and social sciences is strongly encouraged; for example classes in immunology, genetics, microbiology, human anatomy, physiology, psychology and sociology are highly desirable but not required.

Medical school is a four year program that examines disease from population, behavioral, biological, and clinical perspectives.[7] Medical students systematically study the entire human structure, function, and behavior around organ systems of the body. Themes include reproductive health, child and adolescent health, geriatric health, dermatology, and nutrition. The scientific background to understand medical problems relevant to the care of any patient in any clinical situation continues throughout all four years of medical school. During their clinical clerkships, medical students participate in the direct care of patients and the management of health and disease.[8] Clerkships rotate through family practice, surgery, obstetrics and gynecology, pediatrics, psychiatry, and internal medicine.[9]

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7. Medical school at UH includes 5 curricular units in the first two years, with possible electives units 2-5. Clinical clerkships take place in the final two years. Patient contact and clinical skill development starts in Unit 1 and increases each semester. See JABSOM MD Program, Curriculum, at jabsom.hawaii.edu/JABSOM/admissions/curriculum.php.

8. See JABSOM MD Program, Curriculum at jabsom.hawaii.edu/JABSOM.

9. See JABSOM MD Program, Curriculum, at jabsom.hawaii.edu/JABSOM/admissions/curriculum.php.

### Requirements of Psychiatry Residency Program

After completing four years of college as a premedical undergraduate and four years of medical school, a medical school graduate may enter the psychiatry residency program at UH. The psychiatry residency is a four year program that emphasizes psychiatry, neurology, and internal medicine in the first year and concentrated psychiatric training in years two through four. It is based on understanding human behavior on multiple levels and through integration of biological, psychological, and sociocultural dimensions. Psychiatry residents receive broad supervised clinical experience and structured teaching experience. The residency includes individual supervision, classroom seminars, medical rounds, and case conferences. A graduate of a psychiatry residency is a physician who specialized in psychiatry, an MD.

In summary, to become a psychiatrist, a student must complete four years of college that includes 26 hours in biology, chemistry, and physics courses as a premedical students. After college, the student must complete four years of medical school and thereafter an additional four years in a psychiatric residency program.

## Comparison of Classroom and Clinical Training for Clinical Psychologists and Psychiatrists

A doctoral clinical psychologist may take as long as seven years to complete graduate school requirements for classroom and clinical training.[10] A psychiatrist completes a minimum of eight years of classroom and clinical training: four years of medical school and four years of psychiatric residency.

Although both professions diagnose and treat mental illness, a comparison of the classroom and clinical requirements for a PhD in clinical psychology and an MD in psychiatry reflects the differences in the basis of the respective treatment models. There is little, if any, biological or neuroscience based coursework required to receive a PhD in clinical psychology. In contrast, as an undergraduate, a premedical student must complete 26 credit hours of science courses that include general biology, cellular and molecular biology, chemistry, biochemistry, and physics even before entering medical school. Additional science requirements continue through medical school and the psychiatry residency. Both professions require a significant amount of clinical training in college and graduate school.

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10. The UH Psychology Department notes that students often take 2 to 2½ yrs to complete a master's degree program. The Department also states that, after completing an MA in psychology, the PhD program requires an additional 2 to 4 years, and an internship.

A clinical psychologist's lack of a medical education, with its science based course requirements, is the strongest concern of those who oppose prescriptive authority for psychologists, most of whom are psychiatrists. To be proficient in prescribing psychotropic medications, it would seem reasonable to require significant additional postdoctoral classroom and clinical training for clinical psychologists to prescribe safely.

## Part II. Other Health Care Providers with Prescriptive Authority

Supporters of prescriptive authority for psychologists often point to nonphysician health care professionals who have safely prescribed medications for a number of years as a basis to support prescriptive authority for nonphysician clinical psychologists. These nonphysician prescribers include advanced practice nurses, physician assistants, podiatrists, and optometrists. Generally speaking, however, nonphysician health care providers with prescriptive authority have some degree of medical training that is similar, but less thorough, than the classroom and clinical requirements for an MD in psychiatry. Their classroom and clinical training requirements provide a limited medical education generally based in biology, chemistry, and physics courses and other sciences relevant to their respective professions. Consequently, opponents of prescriptive authority for clinical psychologists point out that nonphysicians with prescriptive authority have a medical background that clinical psychologists lack. Moreover, opponents point out that, even with their medical background, nonphysician prescribers nonetheless require supervision or are limited to a restrictive formulary of drugs that may be prescribed.

### Podiatrists

The American Association of Colleges of Podiatric Medicine states that a podiatrist is to the foot what a dentist is to the mouth, a doctor specializing in the prevention, diagnosis, and treatment of foot disorders resulting from injury or disease.[11] A podiatrist practices the medical, surgical, mechanical, manipulative, and electrical diagnosis and treatment of the foot, malleoli and soft tissue about the ankle, except for ankle fractures.[12] A doctor of podiatric medicine has a science based background, with classroom requirements and clinical trainings similar to the training of a physician who was trained in a traditional medical school.

11. See "Frequently Asked Questions, "at www.aacpm.org/html/careerzone/cz3_faqs.asp, web site of American Association of Colleges of Podiatric Medicine.

12. See "podiatric medicine" as defined in section 463E-1, Hawaii Revised Statutes (HRS).

### Prerequisites to Entering a Podiatric Medical School

Generally, a minimum of three years of college are required to enter a podiatric medical school.[13] Required college courses include biology, chemistry, organic chemistry, physics, and English.[14]

### Requirements of Podiatric Medical School Program

A podiatric medical school is a four year graduate level program. The first two years are classroom instruction and laboratory work in the basic medical sciences, such as anatomy, physiology, microbiology, biochemistry, pharmacology, and pathology. During the third and fourth years, students take courses in the clinical sciences, with experiences in the college clinics, community clinics, and accredited hospitals. Clinical courses include general diagnosis (history taking, physical examination, clinical laboratory procedures, and diagnostic radiology), therapeutics (pharmacology, physical medicine, orthotics, and prosthetics), surgery, anesthesia, and operative podiatric medicine.[15]

After completing four years of podiatric medical school, a residency of two to four years is required. A podiatric residency program provides medical and surgical experience that is competency based.[16] A graduate of a podiatric medical school is a DPM, a doctor of podiatric medicine.

In summary, to receive a DPM, a student must first complete a minimum of three years of college that includes chemistry, physics, and biology courses, then four years of podiatric medical school that includes medical and clinical science courses, and a residency of two to four years, for a total of six to eight years of graduate level medical school classroom and clinical training in podiatric medicine.

## Optometrists

Doctors of optometry are health care providers who examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures, and

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13. According to the American Association of Colleges of Podiatric Medicine, more than 90% of applicants to podiatric medical schools in 2005-2006 had a bachelor's degree or higher. www.aacpm.org/html/careerzone/cz3_faqs.asp.

14. See "Admission Requirements," at www.aacpm.org/html/careerzone/require.asp.

15. www.aacpm.org.

16. Board certified podiatric physicians must have two years of residency, with interdisciplinary experience in a variety of rotations. See Residency Training at www.aacpm.org/html/careerzone/career_training.asp. Web site of the American Association of Colleges of Podiatric Medicine.

related systemic conditions. In addition to prescribing glasses and contact lenses, optometrists also treat eye diseases such as glaucoma that require treatment with pharmaceutical agents. Although the practice of optometry is defined to include the use and prescription of pharmaceutical agents, as established by the board of examiners in optometry, only therapeutically certified optometrists are authorized to use and prescribe therapeutic pharmaceutical agents.[17]

### Prerequisites to Entry into a School or College of Optometry

Although optometry schools entry requirements vary, most students complete a four year undergraduate degree before entering an optometry program.[18] According to the Association of Schools and Colleges of Optometry, general requirements for all optometry schools include: at least a year of biology or zoology, general chemistry, general physics, English, and college mathematics.[19]

### Requirements of a Doctor of Optometry Program

An optometry program is a four year program, usually entered after completing four years of college. Classes in an optometry school or college include the basic health sciences (anatomy, physiology, pathology, biochemistry, pharmacology and public health), optics, and vision science, and extensive clinical experience that include taking case histories, performing examinations, learning diagnostic techniques, and discussing treatment services. A graduate of an optometry program is a doctor in optometry and holds an OD.

In summary, an optometrist is a doctor in optometry, who most often has completed four years of college and a minimum of four years of graduate school

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17. See section 459-1, HRS. The Board of Examiners in Optometry includes five licensed optometrists who have practiced optometry for at least five years and two public members. See section 459-3, HRS. The board licenses optometrists and recognizes therapeutically certified optometrists. See section 459-7 and section 459-7.4, HRS. Therapeutically certified optometrists are authorized to use and prescribe only therapeutic pharmaceutical agents to treat and manage conditions of the anterior segment of the eye, eyelids, and lacrimal system and to remove foreign objects from the eye. A therapeutic pharmaceutical agent means topical solutions, suspensions, and ointments applied to the surface of the eye or adjoining tissue. Certain over the counter topical or oral agents may be used or prescribed. Optometrists are authorized to use such drugs for topical ophthalmic use. See section 16-92-2, Hawaii Administrative Rules (HAR).

18. See "Student and Advisor Information," at www.opted.org/info_faq.cfm#9, web site of the Association of Schools and Colleges of Optometry.

19. Because admission to an optometry program requires a standardized Optometry Admission Test, other recommended courses include: quantitative reasoning, reading comprehension, general biology, general physics, general chemistry organic chemistry, calculus, statistics, microbiology, anatomy/physiology, and psychology. See www.opted.org/info_profile1.cfm.

classroom and clinical training in optometry that includes basic health sciences and science relevant to the diagnosis and treatment of eye problems.

## Advance Practice Registered Nurses

The UH School of Nursing master's program in nursing offers advance practice nursing options that specialize in primary care, psychiatric/mental health, or clinical systems management.[20] The Advance Practice Registered Nurses (APRN), psychiatric/mental health specialization focuses on psychosocial and biological knowledge for the core specialization, with practice in primary, acute, chronic, and population-based care.

### Prerequisites to Become an APRN with Prescriptive Authority

To become an APRN with prescriptive authority, a student must complete a minimum of four years in prenursing and nursing school to receive a BS in nursing.[21] Pre-nursing course requirements include English, symbolic reasoning, global and multicultural perspectives or social sciences, chemistry or biochemistry, microbiology, physiology, and pharmacology courses. A bachelor of science in nursing prepares a generalist professional nurse to deliver care in a variety of health care settings and to meet the state requirements for eligibility to take the national licensing examination and provides a basis for graduate study in nursing.

### Requirements for APRN with Prescriptive Authority

After receiving a BS in Nursing, a student must complete 36–58 graduate school of nursing credits to receive a master's degree in clinical nursing or nursing science to qualify as an APRN with prescriptive authority. A master's degree in nursing generally requires approximately two years of training in the graduate school of nursing after receiving a BS in nursing.

In summary, an APRN with prescriptive authority must complete a minimum of four years of college in prenursing and nursing school courses and clinical training to receive a BS in nursing and thereafter complete a minimum of two years in the graduate school of nursing to receive an MS in nursing.

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20. According to the UH School of Nursing's web site, an MS in Nurse Practitioner is offered in specialties that include adult nurse practitioner; family nurse practitioner; geriatric nurse practitioner, and pediatric nurse practitioner. A master's degree program is nursing administration and nursing education is available. In addition, master's degree programs also are offered in psychiatric mental health for adults and for children and adolescents. See www.nursing.hawaii.edu/Academics.html.

21. According to the School of Nursing at UH, the nursing curriculum requires completion of three years of nursing courses to receive a BS in nursing.

## Physician Assistant

Generally, a physician assistant is educated in the medical model of evaluation, diagnosis, and treatment. The profession was established to increase access to health care, often by extending primary care physician services to medically underserved areas. Education standards require clinical experiences in family medicine, general internal medicine, pediatrics, prenatal care and gynecology, general surgery, emergency medicine, psychiatry/behavioral medicine, and geriatrics. The programs are required to provide medical and surgical clinical practice experience. The national certifying examination, required by state law, tests medical and surgical knowledge. The degree awarded by each program is not uniform; degrees range from a certificate to a master's degree.[22] In Hawaii, a physician assistant is subject to medical education and training standards established by the Board of Medical Examiners.[23] Only one hundred eighty Physician Assistant certificates have been issued by the State.[24]

### Prerequisites to Physician Assistance Training Program

A minimum of two years of college courses in basic science and behavioral science are perquisites to beginning a physician assistance training program. Most physician assistants have a bachelor's degree and nearly three years of health care experience before entry into a physician assistant program.[25]

### Requirements for a Physician Assistant Program

A physician assistant program is most often a two year graduate level program, entered after completing four years of college and receiving a bachelor's degree. The first year of a physician assistant program includes classes in anatomy, physiology, biochemistry, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory sciences, behavioral sciences, and medical ethics. The second year is clinical training in inpatient and outpatient settings, averaging 2,000 hours of supervised clinical practice.

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22. See "For Applicants: What is a PA?" www.paeonline.org/applicantwhatpa.html, web site of Physicians Assistant Education Association.

23. See section 453-5.3, HRS.

24. See "About HAPA," www.hapahawaii.org/abouthapa.shtml.

25. See, Issue Brief, Physician Assistant Education Preparation for Excellence, American Academy of Physician Assistants, March 2006.

In summary, a physician assistant must complete a minimum of two years of college (although most individuals complete four years of college) and an additional two years of graduate level classroom and clinical training in a physician assistant program.

## Part III. Summary

Although clinical psychologists and psychiatrists both diagnose and treat patients who have mental illness, the differences in their treatments reflect the differences in the training model for each profession. Clinical psychologists are social scientists who study human behavior and mental processes related to that behavior. A psychiatrist is a medical doctor who has studied all of the body's systems and understands human behavior on several levels, integrating biological, psychological, and sociocultural aspects of behavior. As a physician, a psychiatrist is authorized to prescribe medications in treating patients. Given the lack of medical background, clinical psychologists in most jurisdictions are not authorized to prescribe medications in treating mental illness.[26]

While it is true that nonphysician health care providers have successfully held prescriptive authority for several years, the classroom and clinical training of these prescribers provide a medical background that clinical psychologists lack. In addition, most of the nonphysician providers are limited in their prescriptive authority: they may prescribe only under supervision or they may prescribe only a limited formulary of medications, generally only those medications related to treating patients in their individual health care specialties.

In determining whether to authorize prescriptive authority for clinical psychologists who practice in community health centers, legislators must be mindful of not only the significant differences in the classroom and clinical training of clinical psychologists and psychiatrists, but also the basic medical background of nonphysician health care prescribers. A clinical psychologist treats mental illness as a social scientist, from a behavioral perspective; a psychiatrist treats patients as a physician, from a medical model with additional special training in psychiatry. Although the need to increase access to mental health care in Hawaii is undeniable, particularly to residents who are medically underserved, patient safety must be the primary consideration.

26. With the previously discussed exceptions of certain licensed clinical psychologists in New Mexico and Louisiana and graduates of the federal Psychopharmacology Demonstration Program. See chapter 3 of this study.

NONPHYSICIAN PRESCRIBERS

| Prescriber | Supervision Level | Formulary | Licensing Requirements | Licensing Agency/Board |
|---|---|---|---|---|
| Podiatrist | Independent | Limited formulary: drugs used to treat the foot and soft tissue area. | Graduation from approved college of podiatric medicine; completion of an approved podiatric residency; demonstrated competency and professional knowledge;[1] pass written exams in basic sciences; clinical sciences; and clinical competency.[2] | Board of Medical Examiners[3] |
| Optometrist | Independent | Limited formulary of therapeutic pharmaceutical agents.[4] | Current Hawaii license; completed 100 board approved course in treatment and management of ocular diseases; passed national test; completed 100 hours of preceptorship under supervision of ophthalmologist.[5] | Board of Examiners in Optometry[6] |
| APRN | Within the terms of a collegial working relationship[7] with a physician.[8] | Limited by certain drugs or categories of drugs subject to an exclusionary formulary.[9] | Recognition as APRN by Board of Nursing; MS in clinical nursing or nursing science; current certification in nursing practice specialty; within 3 years prior to license application; 30 contact hrs of advanced pharmacology education; 1,000 of clinical experience as a APRN practitioner's in the nursing practice specialty; collegial working relationship agreement with a licensed physician; and payment of fee.[10] | State Board of Nursing[11] |
| Physician Assistant | Supervised by a physician[12] | Drugs that include schedule III through V medications, as designated by the supervising physician.[13] | Graduation from board approved training program; current national certification; federal disciplinary report; signed statement from licensed supervising physician; employer's name; other information required to investigate applicant's qualifications.[14] | Board of Medical Examiners[15] |

1. See section 463E-3 and section 463E-4, Hawaii Revised Statutes (HRS).
2. See section 463E-4, HRS.
3. See section 463E-2, HRS.
4. May use or prescribe steroidal agents; controlled substances may not be prescribed. See section 459-7.4, HRS and section 16-92-25.1, Hawaii Administrative Rules (HAR).
5. See section 459-7.4, HRS.
6. See section 459-3, HRS.
7. A collegial relationship between an APRN with prescriptive authority and a licensed physician requires that:
   - The physician is engaged in the same or related specialty practice and affiliated with the same institution;
   - The parties jointly acknowledge and accept responsibility that the relationship will have the interest and welfare of the patient foremost in mind;
   - The parties acknowledge that the APRN's prescriptive authority is governed by strict adherence to the exclusionary formulary; and

- The documentation shall include:
  - Name and area of practice of the APRN and the physician;
  - Any agreed upon limitations, including which party prevails when there is disagreement on a prescription;
  - Method of communication;
  - Name of institution where parties practice; and
  - Name of interim physician.

  See section 16-89C-10, HAR.

8. Despite the requirement of a collegial working relationship with a physician, state law or relevant administrative rules do not expressly require that an APRN is required to consult with a physician prior to prescribing a prescription drug not included in the exclusionary formulary.
9. It appears that the terms of the collegial working relationship may place additional limitations on drugs that the APRN may prescribe. See section 16-89C-10, HAR. Under the terms of the exclusionary formulary, substances in schedules I, II, III, IV, or V of chapter 329, HRS, may not be prescribed. See section 457-8.6, HRS, and section 16-89C-15, HAR, including Exhibit A to Chapter 89C of HAR. A joint formulary advisory committee was established to recommend the applicable formulary. The joint formulary advisory committee is composed of two licensed APRNs; two licensed physicians, three licensed pharmacists, a representative of the UH school of medicine and a representative of a school of nursing with an APRN program. In establishing the exclusionary formulary, the Board of Medical Examiners is required to consider the recommendations of the joint formulary advisory committee. See, section 457-8.6, HRS. See section 457-8.6, HRS, and section 16-89C-15, HAR, including Exhibit A to Chapter 89C of HAR.
10. See section 16-89C-9, HAR.
11. The State Board of Nursing is required to have one of its required six RN members be recognized as an APRN. See section 457-3 and section 457-8.6, HRS. The State Board of Nursing is required to designate the requirements for APRN related to prescriptive authority. See section 457-8.6, HRS.
12. See section 453-5.3, HRS. But see: "Supervision" shall not be construed as necessarily requiring the physical presence of the supervising physician at the time and place the services are rendered. See section 18-85-44.5, HAR.
13. A physician assistant may not prescribe Schedule II medications. See section 16-85-49(8) (B), HAR.
14. The Board of Medical Examiners is required to establish the medical educational and training standards for physician assistant. See section 16-85-46, HAR.
15. See section 453-5.3, HRS.

# Chapter 6

# FEDERALLY QUALIFIED HEALTH CENTERS: BARRIERS AND SOLUTIONS TO INCREASE ACCESS TO PSYCHIATRIC AND MENTAL HEALTH SERVICES

Senate Concurrent Resolution No. 113, S.D. 1, requests the Legislative Reference Bureau to review and describe the barriers, if any, to hiring psychiatrists at federally qualified health centers and offer possible solutions to increase access to mental health care for the medically underserved in Hawaii.

## Federally Qualified Health Centers

A "federally qualified health center" (FQHC) provides health services, including mental health services, to medically underserved individuals. By definition, a FQHC provides health services either to a federally designated "medically underserved population" or is located in a federally designated "medically underserved area." A "medically underserved population" is an urban or rural area designated by the federal government as having a shortage of personal health services and population groups who have either economic barriers (low-income or Medicaid-eligible population) or cultural and/or linguistic barriers to receiving primary care or who lack medical insurance.[1] Similarly, a "medically underserved area" is a federally designated geographic location that has a high proportion of the population who are 100 percent below the poverty level, are elderly, have high infant mortality rates, and have a relatively low ratio of primary care physicians per 1,000 population.[2]

Federally qualified health centers receive federal funding under section 330 of the Public Health Service Act[3] to provide comprehensive primary care services, including mental health services, to high risk populations who are medically underserved. Community health centers receive cost-based reimbursement for serving Medicare and Medicaid patients. As a public or private tax-exempt nonprofit entity, FQHCs may also qualify for federal grants to serve special populations. Facilities classified as FQHCs include community health centers, migrant health centers, health care for the homeless programs, public housing primary care programs, and urban Indian and tribal health centers. For purposes of convenience, this study uses the term "community health

1. Kauai, Maui, and the island of Hawaii, and the Kalihi Palama, Waikiki and Waimanalo areas of Oahu are federally designated as "medically underserved populations."

2. Hawaii, Molokai and Kalihi Valley, Koolau Loa, and Waianae on Oahu receive health care services as federally designated medically underserved areas.

3. See Public Health Services Act, as amended by the Health Centers Consolidated Act of 1996, P.L. 104-2999.

centers" to refer to federally qualified health centers. Community health centers must provide primary care services for all ages. Other services that must be provided directly or by arrangement with another provider include mental health and substance abuse services. There are no specific requirements for core staff at a community health center.

**Mental Health Care at Community Health Centers in Hawaii**

There are thirteen community health centers in Hawaii. They serve approximately 90,000 patients annually. Each island in the State has at least one community health center, except for Lanai, which is served by the Molokai community health center. According to the United States Department of Health and Human Services' Bureau of Primary Health Care, frequent diagnoses and therapies for FQHC patients in Hawaii include mental and behavioral health problems. In Hawaii, one in five residents has a diagnosable mental illness. In 2004, approximately 55,000 people with mental health issues received care from community health centers. At one community health center anxiety, depression, and adjustment disorders are the primary diagnoses for their patients.[4] The Hawaii Primary Care Association has reported that the waiting time for a psychiatric appointment ranges from six weeks to three months and is even worse on the neighbor islands where psychiatric services are sometimes not available at all.

In 2004, Hawaii community health centers reported that mental health treatment and counseling was available onsite at all facilities.[5] Out of all community health center staff of 876, only 47 are full time staff that are classified as mental health and substance abuse specialists.[6] This classification, however, includes psychiatrists, psychologists, and other licensed or credentialed behavioral health providers. These 47 staffers had nearly 41,000 patient visits in 2004. Depression and other mood disorders accounted for 15,108 visits by 2,888 patients; all mental health and substance abuse visits totaled 47,922, with no number of patients reported.

Only two of the community health centers in Hawaii have a psychiatrist on staff. Seven of the thirteen clinical psychologists who have completed the psychopharmacology component of the Tripler Army Medical Center Civilian Postdoctoral Fellowship program are currently working at community health centers in Hawaii. It is reported that these seven clinical psychologists are working collaboratively with the other health care professionals in their respective community health center and, to different degrees, are

4. See Beth Gesting, Executive Director of Hawaii Primary Care Association, "Prescription for better mental health care," Honolulu Star Bulletin, March 30, 2006.

5. Onsite was defined to include services from salaried employees, contracted providers, National Health Service Corps staff, volunteers, and others who provide service on behalf of the community health center. Services may also be provided through referrals. See "Percent of Health Centers Providing Select Services Onsite," Health Center Fact Sheet, Hawaii, 2004, National Association of Community Health Centers, Inc.

6. See Health Center Fact Sheet, Hawaii, 2004, National Association of Community Health Centers, Inc.

making drug recommendations to the physicians that have generally been well received by the physicians.[7] Community health center staff who have described the provision of medical and mental health services in Hawaii's FQHC's as a collaborative approach, similar to the collaborative nature of health care provided in military medical facilities. Regardless of the number of psychiatrists and clinical psychologists who currently are on staff or provide services to Hawaii's community health centers, there remains a shortage in community mental health services available to the medically underserved, particularly in the neighbor islands.[8]

## Barriers to Hiring Psychiatrists at Federally Qualified Health Centers

Community health centers nationally are said to face "substantial challenges" in recruiting physicians and other clinicians.[9] For example, a recent study noted that obstetrician-gynecologists and psychiatrists represent less than ten percent of the physician staff at health centers, but their vacancy rates were 20.8% and 22.6%, respectively.[10] Difficulties in attracting psychiatrists (as well as other clinicians) to federally qualified health centers can be attributed to a variety of issues. Community Health center officials are said to consider as factors: the declining interest in primary care among medical students and proposed cuts to federal primary care training programs.[11] Because FQHCs are required to serve a medically underserved population or to be located in a medically underserved area, community health centers are often located in areas that are geographically, economically, and culturally challenged, resulting in various problems, real or perceived, by clinicians considering an FQHC practice.

Barriers to hiring psychiatrists to practice in an FQHCs can include: the cost of housing; the cost of running a practice; a presumed or perceived lower quality of schools (for family members); employment opportunities for spouses or partners; cultural, educational, and recreational offerings; the economic condition of the community; available health care for the psychiatrist and family; professional and personal isolation; concerns about the available adequacy of support for psychiatric practice; and general relocation costs. Moreover, practice in medically underserved areas may be more costly because there may be greater demands due to lack of alternatives, resulting in longer

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7. See November 1, 2006, email correspondence with Jill Oliveira, PhD, Hawaii Psychological Association.

8. See "Mental Health," Hawaii Primary Care Association, www.hawaiipca.net/issues-detail.php?id=CO_23_10.

9. See Amy Snow Landa, "Health centers struggle to recruit clinicians," April 10, 2006, amednews.com, at www.ama-assn.org/amednews/site/free/gvsb0410.htm.

10. See Amy Snow Landa, "Health centers struggle to recruit clinicians," April 10, 2006, amednews.com, at www.ama-assn.org/amednews/site/free/gvsb0410.htm.

11. See Amy Snow Landa, "Health centers struggle to recruit clinicians," April 10, 2006, amednews.com, at www.ama-assn.org/amednews/site/free/gvsb0410.htm.

work hours. In more metropolitan communities, a similar practice may entail fewer hours and lower costs. Nevertheless, it would seem that these barriers to attracting psychiatrists to FQHCs would also be applicable to any other mental health professional who may consider relocating to provide mental health service in a FQHC, including, one would suspect, psychologists.

## State Health Planning and Development Agency Study on Increasing Access to Specialty Health Care on Neighbor Islands and Rural Areas

Although in this study the Bureau has identified potential barriers and suggested various approaches to increase access to mental health services in medically underserved areas, the State Health Planning and Development Agency was given two years to address similar health care issues. In 2005, the Legislature adopted Senate Concurrent Resolution No. 195, S.D. 1, H.D. 1, which requested the State Health Planning and Development Agency (SHPDA) to address similar, but broader, health care issues. Specifically, S.C.R. No. 195, S.D. 1, H.D. 1 requested the State Health Planning and Development Agency to identify and evaluate barriers to community-based access to specialty care, which would include psychiatrists and clinical psychologists, and to make recommendations to improve access to specialty care on the neighbor islands and in rural Oahu. SHPDA was requested to submit an interim report of its findings and recommendations to improve access to specialty care to the Legislature twenty days prior to the convening of the Regular Session of 2006 and a final report twenty days prior to the convening of the Regular Session of 2007.

In conducting the specialty care study, SHPDA was requested to consult with: the Department of Health; the Department of Human Services; the State Council on Developmental Disabilities; the Insurance Commissioner; the Hawaii Health Systems Corporation; representatives of health care plans including but not limited to Aloha Care, Hawaii Medical Service Association, and Kaiser Permanente; the John A. Burns School of Medicine of the University of Hawaii; the Office of Rural Health; Hawaii Primary Care Association; Healthcare Association of Hawaii; Hawaii Psychological Association; Hawaii Psychiatric Medical Association; Hawaii Disability Rights Centers; and other associations and stakeholder groups.

A telephone interview with David Sakamoto, Administrator, confirmed that SHPDA had identified problems related to hiring specialty health care and increasing access on neighbor islands and in rural areas, and that it was in the process of developing solutions to be included in its final report to be submitted to the 2007 legislature as required by S.C.R. No. 195, S.D. 1, H.D. 1.[12]

12. October 11, 2006, telephone interview with David Sakamoto, MD, MBA, Administrator, State Health Planning and Development Agency.

## Suggestions to Increase Access to Psychiatric Services and Mental Health Care at Federally Qualified Health Centers

During legislative hearings in 2006 on H.B. No. 2589, H.D. 2, S.D. 1, a bill granting prescriptive authority for certain psychologists who practiced in federally qualified health centers or licensed health clinics, opponents of the bill often referred to SHPDA's current directive under S.C.R. No. 195, S.D. 1, H.D. 1, and urged that no action be taken on granting prescriptive authority to psychologists until SHPDA submitted its final report in 2007. While their suggestion to wait for SHPDA's recommendations before granting prescriptive authority is not unreasonable, a number of interested groups are currently exploring other solutions to increasing access to specialized health care, including mental health services, in medically underserved areas.

For example, the Psychiatric Access Collaboration, which includes participants who represent the Hawaii Psychiatric Medical Association; the Hawaii Primary Care Association; the John A. Burns School of Medicine, Department of Psychiatry; and the Department of Health, and other interested parties have been meeting since summer of 2006 to identify and initiate immediate to intermediate-term actions to improve access to psychiatric services in the State, but particularly for MedQuest and uninsured patients in rural and isolated areas.[13] For example, a telepsychiatry program to serve Maui and Molokai was implemented in November 2006 by the John A. Burns School of Medicine at the University of Hawaii. The executive budget of the governor's administration for FY 2007 includes more than $3,000,000 to increase Medicaid reimbursement rates for psychiatric services that will include a $30 neighbor island differential. In addition, a nonprofit organization has contracted with the Department of Health to provide cultural and language translation services; a request to approve provision of these services for neighbor island residents has been submitted.[14]

Other more long range proposals include increased recruiting by the John A. Burns School of Medicine of students interested in rural practice; educating students at rural schools about mental health careers; and providing opportunities to learn culturally competent mental health care practices.

Additional suggestions to attract psychiatrists or increase access to psychiatric services were offered by the Hawaii Psychiatric Medical Association during the 2005 legislative session, including:

(1) The use of J-1 visa immigrant psychiatrists to work in rural or urban health care professional shortage areas (a J-1 is for foreign medical graduates who wish to pursue graduate medical training; a J-1 Visa Waiver allows a physician to stay in the United States to practice in a

13. See Minutes of Psychiatric Access Collaboration, Meeting #2, August 8, 2006; and November 21, 2006 interview with Lydia Hemmings, of the Hawaii Psychiatric Medical Association.

14. See Psychiatric Access Collaboration, Summary Report 2006.

federally designated health professional shortage or medical underserved area);

(2) Stipends for resident psychiatrists to travel to rural areas once or twice a month to see patients;

(3) Increased funding and expanded use of video teleconferencing or telemedicine for psychiatrists to consult with patients as well as physicians and clinical psychologists at FQHCs; and

(4) A legislative appropriation of funds to the Adult Mental Health Division to increase its staff.

In contrast, supporters of prescriptive authority for certain qualified psychologists point to prescribing psychologists as a viable way to increase access to mental health services to the medically underserved. The Bureau is not recommending for or against prescriptive authority for psychologists in this study; instead the study is intended to provide useful information relevant to a legislative decision on the issue.

### Other States' Solutions to Increase Health Care Access for the Medically Underserved

Not unsurprisingly, other states are working to increase access to health care to their medical underserved areas or populations. A Wisconsin program provides up to $50,000 in loan repayments for health care professionals who agree to practice in federally designated health professional shortage areas for three years. The Wisconsin Office of Rural Health also has a physician placement program that connects physicians to communities in need. The program makes community profiles available online and helps physicians' spouses find employment, among other services. The program had placed 325 physicians in nearly 120 communities across Wisconsin as of June, 2006.[15] North Carolina has a loan repayment program similar to Wisconsin. A four year commitment is required to receive loan repayments. These programs could be reproduced in Hawaii and made applicable to psychiatrists who provide services at FQHCs for an agreed upon time.

## Summary

In response to the Legislature's 2005 request to SHPDA in S.C.R. No. 195, SHPDA has identified the barriers to providing adequate specialty health care on the neighbor islands and rural Oahu and currently, is in the process of finalizing

15. State Health Notes. Volume 27, Issue 469, June 12, 2006.

recommendations to improve access.[16] A telephone interview with the Administrator of the State Health Planning and Director Assistance confirmed that SHPDA is expected to submit its final report no later than twenty days prior to the convening of Regular Session of 2007, as directed by S.C.R. No. 195, S.D. 1, H.D. 1.[17]

Although the Bureau has identified barriers to hiring psychiatrists and has offered solutions to increase access to mental health services that include psychiatric care in this chapter, the Bureau defers to the findings and recommendations of SHDPA, the State's health planning agency, in its final report in response to S.C.R. No. 195, S.D. 1, H.D. 1, on the issue of identifying the barriers to hiring health care specialists, including psychiatrists, and recommending solutions to increase access to mental health care on the neighbor islands and rural areas of Oahu and urges the Legislature to give SHPDA's final report careful consideration. In addition, the community health centers should be consulted to determine whether hiring a full time psychiatrist best fits the mental health needs of their respective community.

16. October 11, 2006, telephone conference with David Sakamoto, MD, MBA, Administrator, State Health Planning and Development Agency.

17. October 11, 2006, telephone conference with David Sakamoto, MD, MBA, Administrator, State Health Planning and Development Agency.

# Chapter 7

# FINDINGS AND SUMMARY

## Findings

### The Department of Defense Psychopharmacology Demonstration Project; Evaluations

The United States Department of Defense's Psychopharmacology Demonstration Project (PDP) program successfully trained ten clinical psychologists to safely prescribe psychotropic medications to treat certain patients with mental health conditions at military medical facilities. Panels that included psychiatrists, psychologists, and representatives of the American Association, of Medical Colleges, the Accreditation Council for Graduate Medical Education, the medical school of the Uniformed Services University of the Health Sciences, and the Walter Reed Medical Center were convened to determine the best training model and methods for the PDP program. Although selection criteria for candidates were not formally articulated, a candidate generally, was required to hold a doctorate in psychology, a state license in good standing, and be an officer in the armed services. Perhaps because all participants had post-doctorate clinical experience ranging from a few to more than ten years, one evaluation suggested that a minimum of two years of clinical experience should be required. The program's success led another evaluation to suggest that candidates for future psychopharmacology training programs, whether military or civilian, should be held to high selection standards.

Although the PDP program's training model went through several variations, all graduates received a minimum of one year of full time classroom training at the Uniformed Services University of the Health Sciences and one year of full time clinical training under the supervision of a psychiatrist at Walter Reed Medical Center or Malcolm Grow Medical Center. All classes except the initial class had outpatient and inpatient rotations in their clinical training; the first class did not have outpatient experiences as part of their clinical requirement.

After the initial PDP class graduated, an advisory council to the program was established to provide post-graduate recommendations or guidelines to the military medical facilities to which graduates were assigned to aid the facilities in appraising credentials, granting privileges, and setting formularies for program graduates. The guidelines:

- Suggested that a PDP graduate be allowed to conduct physical assessments before beginning drug therapy, monitor and manage drug treatment of patients with stable mental conditions, and adjust medications and dosages according to treatment plans under indirect supervision.

Direct supervision was recommended only to begin or terminate any medication in the prescribing psychologist's formulary;

- Recommended against allowing treatment of patients with concomitant, unstable medical conditions or outside the ages of 18 through 65;

- Suggested a formulary limited to psychoactive medications and adjunctive drugs; and

- Were intended to be flexible and adjustable according to differences in the graduates and needs of the assignment facility.

Several external evaluations of the PDP program were conducted, which agreed that the program successfully taught the graduates how to prescribe safely and effectively. One evaluation found that graduates filled critical needs and performed with excellence at their assigned military medical facilities. It also agreed that the PDP graduates were medically safe; their medical knowledge was on a level between third and fourth year medical students, with psychiatric knowledge between second or third year psychiatry residents. One evaluation reported that the program graduates' clinical supervisors, all of whom were psychiatrists, "overwhelmingly" evaluated the graduates' quality of care as good to excellent and noted further that no evidence of quality problems or adverse outcomes was found in the graduates' credential files.

In another evaluation, a discussion of possible replication of the PDP program revealed that graduates favored a two year training program similar to their own PDP training: one year of full time classroom training and one year of supervised full time clinical training that includes at least a six month inpatient rotation. Noting that the military health care system allows easy access to comprehensive treatment records and close collaboration with other treating health care providers, some military health services psychiatrists, physicians, and even some PDP program graduates were reported to be skeptical that prescribing psychologists could work as safely and effectively as independent practitioners in the civilian sector. They believed that the team practice characteristic of military medicine was an essential ingredient in the PDP program's success.

Evaluations indicate that PDP program graduates' formulary, or the medications that could be prescribed, and their scope of practice ultimately were determined by each graduate's assigned medical facility; and that all graduates were initially supervised by psychiatrists, but ultimately gained independent status. Evaluations commonly described the patients treated as: aged 18 to 65; either active duty personnel, dependents, retirees, or spouses; and medically healthy outpatients[1] suffering primarily from adjustment, anxiety, or depression disorders. Medicines prescribed by PDP program graduates were reported to be mostly newer antianxiety and antidepressant agents.

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1. Although one evaluation has stated that one graduate treated inpatients exclusively, a review of the evaluation fails to confirm this statement. At least two graduates, however, saw patients in *both* outpatient and inpatient settings. See ACNP Final Evaluation, pages 24 and 27.

The 1997 GAO evaluation acknowledged that the PDP program successfully trained military psychologists to prescribe psychotropic medications. It also recognized that prescribing psychologists enhanced peacetime medical readiness by increasing the number of mental health care providers and by reducing the psychiatry workload. In fact, the evaluation also observed that one article predicted that prescriptive authority for psychologists could be "particularly beneficial" if prescribing psychologists practiced in clinical settings that included *medically underserved areas*, in other words, in community health centers. However, the report supported terminating the PDP program because the training cost was not justified by a demonstrated need for prescribing psychologists. The military medical health system was found to have sufficient psychiatrists and clinical psychologists to meet medical readiness during wartime.

Similarly, the 1999 GAO evaluation described graduates as well-integrated into the military health system, noting that they held positions of responsibility, such as clinic or department head. The American College of Neuropsychopharmacology (ACNP) final report found that all graduates performed with excellence and filled different niches at their various assignments. It recognized the quality and achievement of the graduates, noting that the graduates provided an unexpected benefit as teachers. Their success led the final report to conclude that selection standards should be high for future candidates who seek admission to any similar psychopharmacology training program, whether military or civilian. The 1999 GAO report acknowledged that graduates enhanced peacetime medical readiness on several levels and that their quality of care was rated as good to excellent by their supervising psychiatrists and others, with no evidence of quality problems. The graduates' contribution to wartime medical readiness, however, was deemed minimal and costly.

If the Department of Defense should find prescribing psychologists to be necessary, the report recommended the Department should be required to:

- Clearly define the prescribing psychologists role and scope of practice ;
- Design a curriculum that is appropriate to the role and scope of practice of prescribing psychologists; and
- Determine the need for and level of supervision for prescribing psychologists.

## Trends in Other States Relating to Prescriptive Authority

Prescriptive authority for psychologists has been a legislative issue across America for approximately twenty years. In 1998, Guam became the first jurisdiction to allow psychologists to prescribe medication; a collaborative practice agreement with a Guam licensed physician is required. It has been reported, however, that no Guam psychologists have sought to prescribe. At this writing, only two states have authorized

prescriptive authority for certain clinical psychologists. Because both programs were implemented recently, there is little external data to establish their success or failure.

In 2002, New Mexico became the first state to authorize prescriptive authority for psychologists. Before prescribing independently, two successful years as a conditional prescribing psychologist under the supervision of a physician knowledgeable in psychotropic drugs must be completed. A collaborative relationship with each patient's primary care physician is required for all psychologists with prescriptive authority. Contact with the collaborating primary care physician is required prior to beginning or changing medications; without agreement of the primary care physician, no prescription may be written. As of September 2006, there were four conditional prescribing psychologists in New Mexico and no psychologists prescribing independently. It was reported that psychologists were experiencing difficulties finding psychiatrists willing to provide the required supervision for the initial two years of conditional prescribing.

In 2004, Louisiana became the second state to authorize certain psychologists, known as "medical psychologists" to prescribe. Although direct physician supervision is not required, a collaborative relationship with the patient's primary physician is required, similar to New Mexico's collaboration requirement. Medical psychologists may treat only certain medical and emotional disorders and prescribe only those drugs recognized and customarily used in the management of mental and emotional disorders. Narcotics may not be prescribed.

Although the required classroom and clinical training requirements for prescribing psychologists in New Mexico and Louisiana are less stringent than the PDP training model, as of this writing no adverse effect on patients safety has been reported and no complaints have been filed against the prescription psychologists in either state. Arguably then, the psychologists with prescriptive authority in New Mexico and Louisiana are prescribing safely and effectively, with less training than PDP graduates.

It should be noted, however, that unlike the PDP program, New Mexico and Louisiana did not prohibit treating patients younger than eighteen or older than sixty-five. In addition, the currently available postdoctoral psychopharmacology training programs do not appear to have any specialized education or training regarding the treatment of children or seniors. To allow prescribing psychologists to issue prescriptions to children and seniors without precise training relevant to the effect of medication on these two special populations would seem risky. Given the specialized additional training required to become a pediatrician, child psychiatrist, or even child psychologist, limiting the age of patients to be treated by PDP participants or graduates was not an unjustified restriction. Prescribing psychologists who treat children or seniors without additional training may put those patients at unnecessary risk.

In New York, psychologists dropped their quest for prescriptive authority in return for support of psychiatrists for legislation defining a psychologist and determining who may use that title. Ultimately, the bill provided that psychologists are prohibited from prescribing or administering drugs as a treatment, therapy, or professional service.

Although only two states have authorized prescribing psychologists, the American Psychological Association (APA) has adopted a recommended postdoctoral training program in psychopharmacology for clinical psychologists seeking prescription privileges. Currently, there are a number of programs that offer such training and claim to meet the APA's requirements. Some of the current programs allow online courses as part of the classroom training or offer clinical training as optional. Some programs grant a master's degree upon successful completion. The APA recommended training provides less rigorous classroom and clinical training than the training that PDP program graduates received.

Since the prescriptive authority requirements in New Mexico and Louisiana are not as stringent as the PDP training model, the apparent safe prescribing practices of psychologists in those states is likely to set off debates on the adequacy of psychopharmacology training programs that meet APA recommendations, but are less rigorous than PDP training. However, only the PDP training model has been externally evaluated and pronounced a success. Accordingly, the PDP program appears to establish the only training model with classroom and clinical training requirements that have been shown to successfully train postdoctoral clinical psychologists to prescribe safely. *No* training program, however, has been evaluated and found to have safely prescribed medications to children or seniors.

## Supporters and Opponents

Supporters contend that prescriptive authority for psychologists will: increase access to mental health care, particularly in underserved areas or populations; improve patient choice; and provide a continuity of health care. They point to health care providers such as physician assistants and nurses to establish that nonphysicians can prescribe safely. Supporters include psychologists and community health centers.

Opponents say that, since psychologists do not have a medical background, they would be unable to safely prescribe complex psychotropic medications, recognize medical conditions, and understand potential drug interaction. Opponents further maintain that such prescriptive authority would threaten the quality of mental health care and patient safety. Opponents also note that nonphysicians with prescriptive authority have a medical education that clinical psychologists lack and further, that nonphysician prescribers are subject to supervision or formulary limitations. Psychiatrists are the primary opponents.

## Increasing Access to Mental Health Care, Including Psychiatric Services, at Federally Qualified Health Care Centers

Federally qualified health care centers (FQHC), also known as community health centers (CHC), are required to provide health services to a federally designated medically

underserved population or to be located in a federally designated medically underserved area. Hawaii has federally designated medically underserved populations and medically underserved areas, as well as federally designated mental health professional shortage areas. There are thirteen community health centers in Hawaii, which serve approximately 90,000 medically underserved patients annually; there is at least one community health center on each island, except Lanai.

In theory, CHCs provide mental health services to individuals who are not seriously mentally ill; those individuals with serious mental illness receive mental health services from community mental health centers run by the state Department of Health. In reality, however, many CHC clients may have not only a serious mental illness, but also may need medical services for a complicated medical condition. Furthermore, CHC clients who need mental health care may include children and seniors. In contrast, it should be noted that PDP graduates for the most part treated only patients between ages 18 to 65, who were generally healthy medically and whose most frequent mental health disorders were adjustment, anxiety, and depression disorders.

Barriers to hiring psychiatrists to practice in CHCs purportedly relate to: housing costs; cost of running a practice; presumed or perceived lower quality of schools for family members; employment opportunities for spouses or partners; economic condition of the community; cultural, education, and recreational offerings; and professional and personal isolation. However, it would be logical to assume that these barriers may apply to any mental health professional considering a practice in a FQHC, including, perhaps, psychologists.

Pursuant to Senate Concurrent Resolution No. 195, S.D. 1, H.D. 1 adopted by the 2005 regular session of the Legislature, the State Health Planning and Development Agency (SHPDA) has conducted a two year study to identify barriers and suggest approaches to increase access to specialty health care, which includes psychiatric services, in medically underserved areas. SHPDA has indicated that a final report will be submitted to the 2007 legislature. The Legislative Reference Bureau defers to SHPDA's expertise as a health planning agency and urges careful consideration of SHPDA's findings and recommendations.

Access to mental health care in CHCs has been improved as a result of a Tripler Medical Center postdoctoral fellowship program in psychology that has produced thirteen graduates with postdoctoral training that includes psychopharmacology courses. It is reported that seven of the graduates are now practicing in community health centers in collaborative relationships with other health care providers and, in varying degrees, have made recommendations on psychotropic medications that have been well received by their physician colleagues.

Another approach to improving access to mental health care has focused on improving access to psychiatric services for the medically underserved, as identified by the Psychiatric Access Collaboration. The group, which includes psychiatrists, representatives of the Department of Health, the Department of Human Services, the

Hawaii Primary Care Association, the State Health Planning and Development agency, and the medical school at UH, and other interested parties, met several times in 2006 and identified several actions, particularly for rural and isolated areas. Some of the group's recommendations to improve psychiatric access for the medically underserved include a community liason psychiatrist pilot project, a provider database, and use of telepsychiatry. The John A. Burns School of Medicine's telepsychiatry program on Molokai and Maui already have been initiated.

Community health centers in Hawaii have indicated support for prescribing psychologists as a way to increase access to mental health services needed by their clients. Furthermore, some community health centers have indicated that their clients' mental health needs may be better served by hiring mental health care providers other than psychiatrists.

## Classroom and Clinical Training Requirements of Clinical Psychologists and Psychiatrists

A doctorate degree in clinical psychology requires successful completion of courses in social and behavioral sciences, including as much as seven years of classroom and clinical training at the graduate level. Clinical psychologists are trained in theories of human development and behavior, with a psychosocial approach to diagnosis and treatment of mental illness. No biological or neuroscience science courses are required to receive a PhD in psychology. In contrast, a psychiatrist must complete a medical degree that emphasizes biological and neurosciences before beginning a four year psychiatric residency program, for a minimum of eight years of medical school and clinical training at the graduate level. Psychiatrists are specialized physicians who treat patients' mental illness and behavioral disorders according to a medical model and can distinguish between mental conditions with an organic cause and organic conditions with symptoms that mimic a mental disorder.

## Nonphysician Prescriptive Authority

A number of nonphysician health care professionals have prescriptive authority, including advanced practice registered nurses; physician's assistants; optometrists; and podiatrists. Unlike clinical psychologists, nonphysician prescribers have substantial classroom and clinical training in the medical model. Nonphysician prescribers are frequently limited in the drugs they are authorized to prescribe or are required to be supervised by a physician, or both.

## Summary

A need to increase access to mental health services statewide, particularly for the medically underserved population, is acknowledged by clinical psychologists,

psychiatrists, community health centers, other health care providers, state agencies, and consumers. After a two year study, SHPDA will submit its final report to the 2007 regular session of the Legislature, identifying barriers and offering solutions to increase access to specialty health care, including mental health services, to those in medically underserved areas. Given SHPDA's expertise as the State's health planning agency, their suggestions to increase access to health care deserve serious consideration by the Legislature.

Whether prescriptive authority for certain qualified psychologists who practice in community health centers is an appropriate approach to increasing mental health services for medically underserved areas and populations is a policy decision for the Legislature. The Bureau makes no recommendation on the issue, but notes that only one training model has been evaluated and found to have successfully trained postdoctoral clinical psychologists to prescribe psychotropic drugs for patients with mental illness, the PDP program. The PDP program included the following requirements or factors:

- A one year full time classroom training at a university that included medical science courses and courses tailored to participants needs;

- A one year full time clinical training at a medical center that included inpatient and outpatient experience and supervision by psychiatrists, and a wide range of health care professionals, labs, and other equipment available in close proximity;

- All participants had doctoral degrees in psychology and at least some years of clinical experience before entering the PDP program;

- Development of the PDP training model and curriculum had input from psychologists, psychiatrists, representatives of American Association of Medical Colleges, the Accreditation Council for Graduate Medical Education, the medical school of the Uniformed Services University of Health Sciences, and the Walter Reed Army Medical Center;

- The success of PDP graduates suggested that candidates for any similar training program, whether military or civilian, should be held to high selection standards; several years of clinical experience was also suggested;

- Patients treated were generally limited to outpatients between the ages of 18 to 65, without serious medical conditions or serious mental illnesses;

- Drugs prescribed were limited to psychotropic medications and adjunctive drugs;

- Graduates received supervision by psychiatrists during their initial post-graduate medical facility assignment; and

- Health care in military medical facilities is reported to be an open, collaborative practice that permits ready access to patient information and consultation with other health care providers.

In addition, in any deliberation of whether to authorize prescriptive authority for qualified psychologists who practice in community health centers, legislators also should include consideration of the following caveats:

- Only two states have authorized certain psychologists to prescribe and little evaluative data from these states has been reported because those laws are very new;

- Prescribing psychologists in New Mexico and Louisiana are in private practice in the civilian sector which does not provide the collaborative approach to medicine in which PDP participants trained and practiced; patient safety has not been established for this type of practice for which there is no "safety net;"

- In contrast to patients treated by PDP graduates, clients who need mental health services at Hawaii community health centers include children and seniors and persons having both a serious mental illness and a serious medical condition;

- There is no program that authorizes psychologists to prescribe psychoactive medications for children or seniors that has been evaluated or determined to be safe;

- Unlike the development of the PDP training model and curriculum, the American Psychological Association training recommendations were developed solely by psychologists;

- Current psychopharmacology training programs that authorize online learning, weekend classes, and optional clinical experience are considerably less rigorous than the PDP training model, and there are significant variations between the various programs;

- No current psychopharmacology training programs appear to offer specialized training on the effects of medication on children and seniors;

- Admission into current postdoctoral psychopharmacology programs require only a doctoral degree in psychology and a current state license to practice psychology; these minimal requirements do not establish the high selection standards suggested by the ACNP evaluation panel or the minimum two year clinical experience recommended by the Advisory Council;

- In contrast to admission requirements for psychopharmacology training programs, an applicant to a psychiatry residency is subject to stricter scrutiny; a personal statement, recommendation letters, transcripts from undergraduate and medical school, and a personal interview are minimum requirements;

- The Advisory Council to the PDP program recommended that applicants to the program should have a minimum of 2 years experience as a clinical psychologist;

- No postdoctoral training program in psychopharmacology that meets the APA training recommendations has been externally evaluated and deemed successful; and

- There is no postdoctoral training in psychopharmacology for clinical psychologists in Hawaii that has high selection standards to choose participants or that meets the classroom and clinical training requirements of the PDP program.

If the Legislature deems it appropriate to authorize prescriptive authority for qualified clinical psychologists who practice in community health centers, the Legislature may wish to consider requiring a training model that requires minimum classroom and clinical training requirements no less rigorous than the PDP program training model and a scope of practice and formulary for graduates that is no broader than limitations applied to PDP program graduates.

Regardless of the approach or solutions adopted to increase access to mental health services for the medically underserved population, it is clear that patient safety cannot be compromised. Patient safety should guide the Legislature's decision on the issue of prescriptive authority for qualified clinical psychologists under limited circumstances.

THE SENATE
TWENTY-THIRD LEGISLATURE, 2006
STATE OF HAWAII

# S.C.R. NO. 113 S.D. 1

# SENATE CONCURRENT RESOLUTION

REQUESTING THE LEGISLATIVE REFERENCE BUREAU TO STUDY THE ISSUE OF AUTHORIZING PSYCHOLOGISTS WHO HAVE OBTAINED THE APPROPRIATE EDUCATION, TRAINING, AND EXPERIENCE TO PRESCRIBE A LIMITED FORMULARY OF PSYCHOTROPIC MEDICATIONS FOR THE TREATMENT OF MENTAL ILLNESS WHILE PRACTICING IN FEDERALLY QUALIFIED HEALTH CENTERS OR LICENSED HEALTH CLINICS LOCATE IN FEDERALLY DESIGNATED MEDICALLY UNDERSERVED AREAS OR IN MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS.

WHEREAS, it has been stated by proponents of legislation proposing to confer prescriptive authority on clinical psychologists that there are not enough psychiatrists available to serve patients at federally qualified health centers in the State; and

WHEREAS, at the same time, there appear to be certain barriers to the hiring of psychiatrists at these federally qualified health centers; and

WHEREAS, it has been suggested by proponents of legislation proposing to confer prescriptive authority on clinical psychologists that, under certain conditions relating to obtaining appropriate education, training, and experience, clinical psychologists may be qualified to prescribe medications; and

WHEREAS, this view is strongly contradicted by those who believe that prescriptive authority to treat mental illness carries with it many inherent dangers to the health, safety, and well being of the public if that prescriptive authority is not retained and exercised only by medically trained and qualified psychiatrists; and

WHEREAS, these competing views need to be carefully examined; and

WHEREAS, it is in the interest of the health, safety, and well-being of the State to examine the pros and cons of the debate regarding the appropriateness of conferring prescriptive authority on clinical psychologists to treat mental illness in the State; now, therefore,

BE IT RESOLVED by the Senate of the Twenty-third Legislature of the State of Hawaii, Regular Session of 2006, the House of Representatives concurring, that the Legislative Reference Bureau is requested to study the issue of authorizing psychologists who have obtained the appropriate education, training, and experience to prescribe a limited formulary of psychotropic medications for the treatment of mental illness, while practicing in federally qualified health centers or licensed health clinics located in federally designated medically underserved areas or in mental health professional shortage areas; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau is requested to include in its study:

(1) A comparison of requisite educational requirements of psychologists versus psychiatrists, advanced practice nurse practitioners at the prescriptive level, optometrists, podiatrists, and physicians' assistants for what prescriptive authority they have and what medications they are allowed to prescribe, if any, and under what supervision;

(2) Evidence of patient safety where psychologists prescribe psychotropic medications or are responsible for the management of patient care that includes psychotropic medications;

(3) Trends in other states concerning conferring limited prescriptive authority on certain psychologists;

(4) A review of the arguments in support and in opposition to conferring limited prescriptive authority on certain psychologists;

(5) A review and description of barriers or obstacles, if any, to the hiring of psychiatrists at federally qualified health centers, such as the number of

positions available, the funding available, the availability of psychiatrists to fill these positions, and the possible solutions to removing such barriers or obstacles; and

(6) A review of the program operated by the United States Department of Defense authorizing certain psychologists to prescribe a limited formulary of psychotropic medications, including a review of any evaluations for the program or statistics that might be available; and

BE IT FURTHER RESOLVED that the Hawaii Primary Care Association, the Hawaii Psychological Association, and the Hawaii Psychiatric Medical Association are requested to designate representatives authorized to speak on behalf of the organization who may be consulted by the Bureau with respect to the issues in this study, provided that the Bureau shall not be limited to consulting only with these representatives; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau is further requested to review experiences and studies in Hawaii and other states, including but not limited to Louisiana, New Mexico, and New York, that may have passed legislation allowing psychologists to prescribe, including problems relating to misdiagnosis and treatment of patients as a result of allowing psychologists to prescribe various medications; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau is requested to report its findings and recommendations to the Legislature not later than twenty days prior to the convening of the Regular Session of 2007; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Acting Director of the Legislative Reference Bureau, the Chairperson of the Board of Psychology, the Chairperson of the Board of Medical Examiners, the Director of Health, and the Executive Directors of the Hawaii Primary Care Association, the Hawaii Psychological Association, and the Hawaii Psychiatric Medical Association.

# Appendix B

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UNSERVED MENTAL HEALTH NEEDS AND PRESCRIPTIVE PRIVILEGES
FOR PSYCHOLOGISTS IN HAWAII

A Report On the Psychotropic Medications Roundtable

Submitted to the Sixteenth Legislature
in Response to
House Resolution 334-90
Fifteenth Legislature, 1990

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January 2, 1990

Center for Alternative Dispute Resolution
Ali'iolani Hale
Room 207
417 King Street
Honolulu, Hawaii 96813
*808/548-3080*

## III. IMPROVING MENTAL HEALTH SERVICES

Although participants in the Roundtable process continue to hold divergent views about the granting of prescriptive privileges to psychologists, the Roundtable surfaced some proposed improvements regarding the unserved/underserved needs of Hawaii's mentally ill. Members of the Roundtable, which included a cross-section of psychiatrists, psychologists, and other professionals, jointly offer the following suggestions for consideration by the Legislature.

1. The Legislature should consider inviting the members of the Roundtable, along with other interested and affected groups, to present their individual and organizational views on the various issues embedded in H.R. 334-90. During the course of the Roundtable's meetings, participants exchanged considerable amounts of information and data that might help public officials better understand the unmet needs of Hawaii's mentally ill and that might also help illuminate the issue of granting prescriptive privileges to psychologists. Since this report does not attempt to provide a comprehensive account on encapsulation of all of this information, Roundtable participants, to the extent they so desire, might be afforded additional opportunities to present pertinent data and the viewpoints that flow from such information.

2. The State should explore ways of creating inducements and

incentives to better insure the delivery of existing psychological and psychiatric services to the unserved and underserved.

(a) The State of Hawaii should increase the number (position counts) and amount of pay for psychiatrist and psychologist positions that are tied directly into services being provided to children, adolescents, the elderly, SDMI populations and possibly to pregnant mothers.

(b) In order to attract and keep professional services for those who work with the neediest populations (in particular, neighbor island children, elderly, and SDMI), the State should -- in addition to improving its basic outreach systems -- find creative incentives to increase service. Such inducements might include, in addition to higher pay:

- State-paid malpractice insurance;
- housing or housing subsidies;
- tax credits;
- more and/or better fee-for-service opportunities in other areas;
- free or low-rent office space for visiting physicians and psychologists; and stipends and grants-in-aid for psychiatrists and psychologists-in-training with paybacks in the form of service to underserved populations.

3. The State should examine ways to reduce the economic obstacles that prevent the delivery of needed psychiatric and psychological services to those groups most in need, i.e. children, the elderly, SDMI, and rural and low-income populations.

(a) Wherever possible, the State should continue to explore reasonable strategies of insurance reform and/or tort reform that might lead to the reduction of economic risk now assumed by psychologists and psychiatrists who work most closely with these populations.

(b) The State should consider legislating and enacting laws that would insure that:

- medication management provided by a physician does not count as a psychotherapy visit;
- psychological testing or consultation done by a psychologist does not count as a psychotherapy visit regardless of who the therapist is; and
- the minimum number of sessions which must be

provided as a benefit by an insurance carrier are increased to 20 sessions per year.

(c) The State should examine the SHPDA and certification process with the objective of reducing the high costs of securing permits. Such certifications might be modified or even eliminated for certain areas.

(d) HMSA, Champus, and other insurance providers should be encouraged to subsidize the services of student psychologists and psychiatrists for work in outlying areas.

4. The State of Hawaii should take the lead through its various departments, branches, offices, agencies, and schools to implement a more systematic and consistent philosophy of practice that emphasizes teamwork and collaboration between psychiatrists, psychologists, nurses, and other professionals. Psychologists and psychiatrists in particular should also, through their professional associations and through training programs, seek to enhance cross-training and inter-professional understandings.

(a) The Department of Health should recommend legislation to pilot and then fully establish a "homebuilder" program which utilizes teams of doctoral level providers and paraprofessionals which focuses on the evaluation and treatment of families and children.

(b) There is a need for psychologists, psychiatrists, and other mental health professionals to better understand each other's methodologies. A representative task group of all of these professionals should be created to identify a curriculum that accomplishes this. The local professional associations of both psychologists and psychiatrists should also establish a Joint Committee on Interprofessional Affairs or a local interdisciplinary council to address issues such as cross-training, diagnostic tests, and the improvement of training for all professionals on issues regarding appropriate uses of medications.

(c) Local professional associations of both psychologists and psychiatrists should arrange for an overlap of annual meetings with a structured agenda which includes the diagnosis and treatment of unserved and underserved groups. Both groups should also, through their respective associations, be encouraged to do more pro bono work with the unserved and underserved.

(d) The University of Hawaii should be urged to create additional courses, programs, and scholarships which might lead to interdisciplinary collaboration in areas of mental health practice related to unserved and underserved populations.

(e) The State should identify and fund promising projects and pilot programs that demonstrate collaborations between psychologists and psychiatrists, particularly for the elderly,

children, SDMI, and other unserved and underserved populations.

(f) The State should seek ways to encourage the improvement of medication monitoring for SDMI patients and, where there are insufficient psychiatrists, should consider a system in which general practitioners, under the general supervision of psychiatrists and operating on teams comprised of various mental health professionals, would take a greater role in diagnosis and the prescription of psychotropic medications.

Attachments

#1 - HR 334-90
#2 - Roundtable Participant Mailing List
#3 - Summary of Arguments for and Against Prescriptive Privileges for Psychologists

Attachment #3

# FACILITATOR'S SUMMARY OF ARGUMENTS FOR AND AGAINST GRANTING PRESCRIPTIVE PRIVILEGES TO PSYCHOLOGISTS

H.R. 334-90 posed four specific questions to the Roundtable regarding potential prescriptive privileges for psychologists. They were:

* Would allowing properly trained psychologists to prescribe certain medications address some of the unserved or underserved needs of Hawaii's mentally ill?

* What would the conditions be, if any, under which medications could be prescribed?

* If these conditions exist, what training (including training regarding the relationship between substance abuse and the prescription of medication to mentally ill individuals) should be required? and

* What procedures should the State adopt for establishing and maintaining a formulary of psychoactive agents that may be safely prescribed by psychologists?

Generally speaking, the psychiatrists and psychologists participating in the Roundtable held (and continue to hold) opposing views on the proposed granting of prescriptive privileges for psychologists. The facilitators structured a process for the Roundtable process to brainstorm and discuss these viewpoints. However, the Roundtable did not attempt to assess the validity of the various arguments and assumptions that lie behind the debate. The facilitators goal was to describe as simply as possible the details of the assertions and arguments both in favor and against this idea. The hope is to improve public understanding of the issues involved. In this context, arguments were raised, refined, and clarified throughout the discussions. The facilitators took notes which more circulated to the participants.

What follows is the facilitators' summary of these discussions. They should not be viewed as an authoritative or exhaustive discussion of these issues. They simply recite the positions articulated by Roundtable participants favoring or opposing the proposition to extend prescription privileges for a united formulary of psychotropic medication to specially trained psychologists.

1. Qualifications To Prescribe: Arguments For

(a) Some psychologists have formal education and extensive supervised clinical experience in both the biological and behavioral aspects of mental illness. With additional training and a limited formulary of drugs, some psychologists could be qualified to prescribe psychotropic medication.

(b) There are existing experimental training programs in psychopharmacology for psychologists (i.e., Department of Defense).

(c) Psychotropic drugs can be (and are) prescribed at this time by professionals without training in modern psychotropic drugs or the drug needs of the mentally ill. Some examples are: psychiatrists with out-of-date training, nurse practitioners, and non-psychiatrist M.D.s. The level of training actually required to safely prescribe psychotropic drugs is not known or agreed upon.

3. Qualifications To Prescribe: Arguments Against.

(a) The appropriate prescription of any drug occurs within a complex evaluation, diagnostic, and therapeutic process which is integral to the practice of medicine. It is dangerous to assume that prescribing drugs can be set apart from medical training and practice. No specialty in medicine has focused on medication treatment only. For example, there is no such things as a gynecologist whose training is limited to "gynepharmacology".

(b) Psychiatric training in psychopharmacology combines supervised clinical experienced and formal instruction. The training is built on a foundation of comprehensive medical training in biochemistry and physiology. Only students who have demonstrated competence in pre-medical subjects such as chemistry and physiology are admitted to medical school. Therefore it is unlikely that any training course which is short enough to be practical for the training or retraining of psychologists would provide an adequate foundation to safely warrant prescription privileges.

(c) The programs of training for non-MDs in prescribing drugs (eg., Department of Defense) requires a sophisticated understanding of the patient's entire system. Psychotropic medications impact the whole system and can interact with other conditions, medications, diet, alcohol, and drug use. This problem is much more common in the elderly and in other unserved populations.

(d) The costs to develop adequate training, supervision, monitoring, and regulation of psychologists with prescription privileges for even a limited formulary of psychotropic medications would far outweigh any potential benefits.

4. Quality of Care: Arguments For.

(a) If psychologists could prescribe psychotropic medications for their patients, their extensive training in behavioral and attitudinal interventions could result in a reduction of the overuse of these medications in the effective treatment of the mentally ill.

(b) While the ratio of psychiatrists to the population

of Hawaii falls within national norms, the distribution of their practice leaves some of the mentally ill population unserved or underserved. There are significant structural, professional, financial, and psychological disincentives for psychiatrists to work with the elderly, children. and SDMI populations, particularly those that reside in rural areas. The needs of these groups for diagnosis, medication, and medication monitoring are underserved. Psychologists are more available and accessible to monitor and treat these groups. Therefore, drug needs would be more adequately met and over-medication because of inadequate monitoring would be diminished.

(c) It is difficult for some psychologists to use psychiatrists as referrals to meet the potential medication needs of their patients. Either psychiatrists will not take the patients who do not have sufficient insurance coverage, or it is uneconomical for both to treat the same patient because of the low rate of total reimbursement, or the continuity of care is lost in the referral system, or the patient is taken over by the psychiatrist and the treatment gains from the psychologist are wasted. If psychologists could prescribe for the medication needs which are clearly indicated (eg., antidepressants), many of these problems could be eliminated.

(d) Some consumer groups (National Alliance for the Mentally Ill, for example) have endorsed the extension of prescription privileges to psychologists.

5. Quality of Care: Arguments Against.

(a) Psychologists do not have the clinical experience required to know of and recognize drug complications.

(b) The addition of another and potentially less qualified provider of medication to the spectrum of mental health services increases the danger to the public of taking ineffective or dangerous medications and increasing overall levels of drug use.

(c) The same disincentives that inhibit the availability of psychiatrists for the underserved would operate for psychologists. There is no evidence that psychologists would be more available to unserved and underserved populations than psychiatrists.

(d) Any barriers to the joint use of psychologists and psychiatrists for more comprehensive patient care should be approached directly as problems that might be solved by collaboration between the professions, changing reimbursement policies, or changing the organization of practice.

6. Economics: Arguments For

(a) Assuming that the overall volume of prescribed psychotropic medications remains constant and assuming the extra training and insurance coverage for psychologists do not involve

## Appendix C

HOUSE OF REPRESENTATIVES
TWENTY-THIRD LEGISLATURE, 2005
STATE OF HAWAII

# H.C.R. NO. 255 H.D. 2

# HOUSE CONCURRENT RESOLUTION

ESTABLISHING AN INTERIM TASK FORCE ON THE ACCESSIBILITY OF MENTAL HEALTH CARE TO CONSIDER THE FEASIBILITY OF THE STATE AUTHORIZING TRAINED AND SUPERVISED PSYCHOLOGISTS TO SAFELY PRESCRIBE PSYCHOTROPIC MEDICATIONS FOR THE TREATMENT OF MENTAL ILLNESS.

WHEREAS, there have been legislative proposals to give psychologists prescriptive authority; and

WHEREAS, there have been disputes as to the adequacy of training and education in order for psychologists to prescribe; and

WHEREAS, concerns have been expressed about the safety to patients; and

WHEREAS, the legislature desires to have both the psychiatrists and psychologists, through their respective associations, to commence meaningful discussions to explore solutions to some of the issues mentioned above; and

WHEREAS, timely, efficient and cost-effective treatment of mental illnesses in federally qualified health centers could avoid the significantly greater social, economic, and medical costs of non-treatment for these under-served populations; and

WHEREAS, crystal methamphetamine addiction and other related substance abuse issues have contributed significantly to an unprecedented demand for services from an already overtaxed mental health system; now, therefore,

BE IT RESOLVED by the House of Representatives of the Twenty-third Legislature of the State of Hawaii, Regular Session of 2005, the Senate concurring, an interim Task Force on the Accessibility of Mental Health Care (Task Force) is established to consider solutions to provide adequate quality mental health

care in medically under-served areas of Hawaii by mental health professionals which include psychiatrists and psychologists; and

BE IT FURTHER RESOLVED that the Task Force shall be six members in total to include only the following:

(1) Two designees of the Hawaii Psychiatric Medical Association;

(2) Two designees of the Hawaii Psychological Association;

(3) Chairperson of the House Committee on Health or the Chairperson's designee; and

(4) Chairperson of the Senate Committee on Health or the Chairperson's designee;

and

BE IT FURTHER RESOLVED that the Task Force submit a report of its discussions, and any findings and recommendations, to the Governor and the Legislature no later than 20 days prior to the convening of the Regular Session of 2006; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Speaker of the House of Representatives, President of the Senate, Executive Director of the Hawaii Psychiatric Medical Association, and Executive Director of the Hawaii Psychological Association.

## REPORT TO THE LEGISLATURE

### INTRODUCTION

House Concurrent Resolution No. 255 (HCR 255) was passed in 2005. HCR 255 established an interim task force to consider solutions to provide adequate quality mental healthcare in medically under-served areas of Hawaii by mental health professionals including psychiatrists and psychologists. The task force members met five times and are:

- Chair, Health - Senator Rosalyn Baker
- Vice-Chair, Health - Representative Josh Green
- Hawaii Psychiatric Medical Association (HPMA) – Jeffrey Akaka/Lili Kelly
- Hawaii Psychological Association (HPA) – Raymond Folen/Jill Oliviera

### BACKGROUND

The main purpose of the task force was to explore the accessibility of mental healthcare in Hawaii. Hawaii's rural areas, particularly on the neighbor islands, suffer a significant shortage of mental health providers and facilities capable of focusing exclusively on mental illness. The socio-economic status of an individual, such as the poor and/or uninsured, makes it substantially more difficult to gain access to healthcare. There are 13 federally qualified community health centers (CHC) throughout Hawaii. At each of these facilities, all people are afforded access to healthcare regardless of their insurance status or ability to pay. Patients who go to a CHC are often the most needy and most medically neglected, including untreated mental illness.

### TASK FORCE DISCUSSIONS

Central to the issue of mental healthcare access was for psychologists to prescribe medication at the CHC.

**Concerns Regarding Psychologists Prescribing Medications**

- Members of the HPMA felt that prescription privileges should be limited to those who have extensive clinical and instructional training, such as medical doctors, nurse practitioners, and physician assistants. HPMA members felt psychologists did not have the necessary medical background.

- HPMA members addressed concerns that if all 13 CHC hired the maximum of two psychologists able to prescribe medication, it would have a negative effect on the psychiatric discipline, although it would provide more significant mental healthcare to the state's most needy population.

- HPMA members recommended the following:

- Creating a comprehensive network of statewide tele-psychiatry to be initially used at a CHC pilot program, currently being prepared;

- Using and training psychiatrists in residency programs for positions in rural communities; and

- Encouraging psychiatrists to practice in under-served communities with incentives (loan repayments and/or medical malpractice breaks).

**Reasons for Psychologists to Prescribe Medications**

- The HPA pointed out that the number of psychiatrists serving Hawaii's Community Health Centers has not changed in decades. In 2004, there was an average of 5.63 psychiatrists serving three of the CHC, despite the overwhelming need for behavioral health services in all CHC. Psychologists are trained to work in the CHC primary care setting; providing psychological services as well as psychopharmacological consultation. In just four years, the number of psychologists have doubled, with 9.71 psychologists employed or contracted to provide services in nine of the thirteen CHC on O'ahu, Kaua'i, Moloka'i, Maui, and the Big Island.

- Over the last 20 years, psychiatrists have been unable to meet the need for psychoactive medications, an often critical component in mental healthcare.

- Psychologists have been prescribing medications since 1974. Several examples include psychologists in various state systems, the Indian Health Service, and the Department of Defense.

- Hawaii's CHC medical directors have observed first-hand the work of psychologists in their primary care settings and have endorsed legislative proposals for prescriptive authority for psychologists within the CHC.

- Members of the HPA were content to collaborate completely with physicians and other healthcare professionals to establish both the necessary curriculum and standardized testing criteria to allow for prescription rights.

## RECOMMENDATIONS

After careful consideration on both sides of the discussion regarding psychologists prescribing medications as a means to address the shortage of quality mental healthcare access, the legislators working on this Task Force recommended that:

- The Legislature establish training requirements for prescribing psychologists which should include a minimum of 500 hours of instructional training in Clinical Psychopharmacology and all necessary areas of medical science. The HPA program is a 450-hour, Post-Doctoral Masters Degree in Clinical Psychopharmacology which includes:

- A year-long 100 patient practicum supervised by a doctor licensed under Chapter 453, Hawaii Revised Statutes (medical doctor);

- A two-year conditional prescribing period where the psychologist must have agreement from a supervising medical doctor for every prescription written; and

- A requirement to pass the national Psychopharmacology Examination for Psychologists.

- The Legislature authorize appropriately trained psychologists, with a professional affiliation with a Federally Qualified Community Health Center, be able to prescribe psychoactive medications.

# Psychopharmacology Training Programs
## Comparison Chart

| | California School of Professional Psychology/Alliant International University | Fairleigh Dickinson University | Massachusetts School of Professional Psychology | Nova Southeastern University Center for Psychological Studies | Prescribing Psychologists' Register (PPR) | Southwestern Institute for the Advancement of Psychotherapy (A collaborative program with New Mexico State University) | The Psychopharmacology Institute |
|---|---|---|---|---|---|---|---|
| | | | | General Information | | | |
| Official Name of Program | Postdoctoral Master of Science in Clinical Psychopharmacology | Psychopharmacology Postdoctoral Training Program | Master of Science in Clinical Psychopharmacology | Postdoctoral Master of Science in Clinical Psychopharmacology | Prescription Privilege Preparation Training | Postdoctoral Training Program in Psychopharmacology | Postdoctoral Certificate in Psychopharmacology |
| Program Address | California School of Professional Psychology Alliant International University Alameda, CA 94501 | School of Psychology T-WH1-01 Fairleigh Dickinson University Teaneck, NJ 07666 | Massachusetts School of Professional Psychology Boston, MA 02132 | Nova Southeastern University Center for Psychological Studies Ft. Lauderdale, FL 33314 | PPR Miami, FL 33179-2229 | Southwestern Institute for the Advancement of Psychotherapy Las Cruces, NM 88001 | The Psychopharmacology Institute Lincoln, NE 68526 |
| | | | | Didactic Program | | | |
| Primary Model | Details | Details | Details | Details | Details | Details | Details |
| Outcome | Postdoctoral Master of Science in Clinical Psychopharmacology | Postdoctoral Master of Science in Clinical Psychopharmacology | Postdoctoral Master of Science in Clinical Psychopharmacology | Postdoctoral Master of Science in Clinical Psychopharmacology | Board Certified, Diplomate-Fellow in Psychopharmacology (FICPP) | Presently, professional development on NMSU transcript (working to become a Masters in Psychopharmacology) | Postdoctoral Certificate in Psychopharmacology -- credit transferable to two regionally accredited institutions for a Postdoctoral Masters Degree in Psychopharmacology |
| Credits | CE: 384 Academic: 25.6 | CE: 480 Academic: 30 | CE: 450 Academic: 37.5 | CE: Details Academic: 31.5 (Includes 200 hours of Practicum) | CE: 306 or 450 Academic: 34 | 42 credits | CE: 496 (corresponds with 33 academic credits) |
| Curriculum | Details | Details | Details | Details | Details | Details | Details |
| Approximate Length | 22 months | 20 months | 24 months (September-June) | 24 months | 24 months | 27 months | 24-36 months |
| Projected # Hours/Week | 2-6 hours, depending on prior coursework and experiences | 6-12 hours | 5-15 hours | 10 weeks over two years, 37.5 – 45 hrs per week on campus | 2-6 hours | 3-12 hours per week, depending on prior coursework, particular class and experiences | 10-15 hours per week |
| Cost | $8,900 | $12,000-13,000 | $11,500 | $11,200 | Starts at $3,400 | $8,200 | $7,700 |
| Other Expenses | Approx. $1,000 for books, travel to meetings | Approx. $700 for books, travel to five meetings | Approx. $1,000 for books, travel to meetings | Approx. $900 books, travel to 10 meetings | Travel expenses | Approx. $1,000 for books, stethoscope, travel to meetings | Approx. $700 for books – no travel required |
| | | | | Practicum/Clinical Experiences | | | |
| Practicum Model | Program offers practicum documentation; will assist with but does not guarantee practicum placement | Program offers practicum documentation; will assist with but does not guarantee practicum placement | Program offers practicum documentation, and offers 50 hrs of group supervision; will assist but does not guarantee practicum placement | Program offers practicum documentation; will assist with but does not guarantee practicum placement | PPR's Practicum (Preceptorship), requires a minimum of 100 patients, under an MD Preceptor, over a year's minimum period | The preceptorship is monitored by the collaborative program. It is a two-semester, six-hour course. | The preceptorship is done in collaboration with a local preceptor. All documentation and guidance provided by TPI following Academy of Medical Psychology (AMP) criteria. |
| Timing of Practicum | Upon completion of didactic program | Upon or near completion of didactic program | Upon completion of didactic program | 100 hour practicum usually completed at end of each year | Starting near completion of training program | Upon completion of didactic program | On or near completion of didactic program |
| Cost | $155 | $300 per semester | $2,250 | Cost included in tuition | None | $350 per three-credit semester | Included in tuition |
| Other Clinical Experiences | No | Weekly case conference/chat during didactic program | 6-day PEP review course available for $750 | Chat room, class email, WebCT for some courses, facilitators | None | Voluntary field trips, such as organ dissection at coroner's office | 80-hour pathophysiology practicum with internal medicine or family physician; web-based video streaming of physical examinations of 11 body systems |