Pennsylvania House Professional Licensure Committee
Informational Hearing on HB 1000
August 7, 2023

Testimony from the Pennsylvania Psychological Association

Good Afternoon Chairman Burns, Chairman Metzger and Members of the Professional Licensure Committee.

My name is Dr. Dan Waner and with me today is Dr. Krista Boyer and we are here today to testify on behalf of the Pennsylvania Psychological Association who represents over 3000 licensed psychologists and psychology students. As you know we are here today to discuss HB1000 and how it provides a solution to the psychotropic medication access crisis in Pennsylvania. I am a licensed clinical psychologist with a Ph.D. from Duquesne, and also a soon-to-be graduate of Fairleigh Dickinson's post-doctoral Masters of Science in Clinical Psychopharmacology (MSCP) program. Along with my colleague, Dr. Krista Boyer, we are going to provide a brief review of the psychotropic medication access crisis in Pennsylvania, and how HB 1000 provides a practical solution to this issue by granting psychologists prescriptive authority.

In 2020, right as the Covid-19 crisis was emerging, the Pennsylvania Joint State Commission produced a Mental Health Workforce Shortage report. It detailed that under all plausible scenarios, Pennsylvania was looking at a "growing shortfall" between our need for psychotropic medicines, and the available prescribing workforce. The report predicted an untenable gap of 730 psychiatrists in Pennsylvania to just reach baseline levels by 2030. This is after our state has spent a decade investing resources into various psychiatry led initiatives to boost our community psychiatrist population but producing no meaningful bump in access.

Covid-19 turned this shortfall into a full-blown crisis. There are multiple dynamics at play, but at its most basic level we are seeing both a decrease in available psychiatrists, and an increase in mental health needs. It is now common to hear of mentally ill people remaining in emergency rooms for upwards of a month, receiving no treatment, taking up spaces for people with physical health crises, simply waiting for an available psychiatrist to help manage the medications. It is now common to hear of physicians unable to find places to refer their patients with mental illness, holding onto cases they don't know how to treat or what to do with. This crisis is especially significant among children as there are not enough child psychiatrists to address their specific mental health needs.

A recent national survey found only 18% of psychiatrists are accepting new patients … that means more than 4 out of 5 psychiatrists are not. To see how Pennsylvania compares, PPA volunteer Katelyn Salva called a random assortment of psychiatry practices across Pennsylvania to see if she could get an appointment. She found a full 36% of psychiatry practices flat out said they are not accepting any new clients, and another 36% were only scheduling 6 to 8 weeks out. Only one practice was scheduling within a week – but that practice did not accept insurance.

HB 1000 would provide a means for psychologists to help fill this gap. Psychologists are an independent profession from psychiatry. Instead of attending medical school, we receive a doctorate degree in psychology (either a Ph.D., or Psy.D.) which includes intensive clinical experience through practicum, internship, and post-doctoral requirements. All along we learn and utilize evidence-based psychosocial interventions which are the backbone of the mental health care system. HB 1000 lays out the training and practicum requirements that take these already highly trained mental health experts, and equip them to become proper and safe prescribers.

It does this by mandating that prescribing psychologists obtain an extra masters degree known as the Masters of Science in Clinical Psychopharmacology (the MSCP). The MSCP is the standard post-doctoral, post-licensure degree that provides necessary background in physiology and neurology in order to become safe and helpful prescribers.

Further, HB 1000 includes expectations for a clinical preceptorship under the supervision of a physician or prescribing psychologist, ensuring psychologist prescribers obtain real world experience. Once finished with this means of study, psychologist prescribers possess well over a decade of clinical experience and are thus some of the most well-trained prescribers in the mental health space. They can then prescribe independently, but narrowly: limited only to psychotropic medications, and only with a collaborative agreement with a primary care provider.

Importantly: in allowing psychologists to prescribe medication, this legislation also allows psychologists to de-prescribe medication to patients. This is very important as there are some patients who remain on medications far longer than necessary and on dosages that exceed what is necessary to keep their condition under control. For instance, I was consulting with a patient recently who was continuing on antipsychotic medications prescribed from a period in his life when he was more acutely suicidal, but which were now making him feel dulled. With collaboration with his primary care physician and much rigmarole we were able to safely step this client down off of this medication that was once helpful, but now deleterious to this client's full mental health recovery. Were I to have the rights to prescribe, this experience would have been much faster, and easier for the patient.

Prescribing psychologists are already having a positive impact in the jurisdictions where they are allowed to practice. The U.S. Armed Services was the first organization to provide a pilot project for psychologist prescribers. It began in the 1980s, and since that time many states facing the same access gap to psychiatrists have provided similar means to what HB 1000 proposes. Research that is cited in the information we provided to you shows that these states have had positive mental health outcomes as a result of prescribing psychologists, most notably a decrease in mental health related deaths (See the letter from Phil Hughes of UNC for a summary of this important research).

With the passage of HB 1000, Pennsylvania would quickly start to see their prescribing gap filled. There are already about 50 psychologists with the appropriate training in our state, just waiting for the laws to change. Many of these psychologists travel to states that do allow them to prescribe, thus siphoning off resources we could use at home in Pennsylvania. Further, thanks to a survey of our PPA membership, we know that there are hundreds of psychologists who would undergo the training and become available here at home, if this legislation provided a

legal means and direction for them to make their psychology skills helpful in the way of prescribing.

Thus, I urge this committee to support this legislation and help psychologists make a more meaningful impact on Pennsylvania's mental health needs.

Chairman Burns, Chairman Metzger and Members of the House Professional Licensure Committee, thank you for giving me the opportunity to speak today. I am Krista Boyer, a licensed psychologist with a doctorate in counseling psychology from Carlow University. In addition to my doctoral degree, I recently completed my first semester of clinical pharmacology training at Fairleigh Dickinson University (FDU). It is significant to note that my graduate and doctoral studies included a biopsychosocial framework that supported the integration of biology, psychology and social-environmental factors, and that I took both masters and doctoral level courses in biopsychology and clinical pharmacology prior to starting the program at FDU, therefore I am well informed on the relationship between biological factors and behavioral functioning, and as a practice take a thorough medical history of all clients that I treat. I am here today in support of HB1000.

As part of my professional activities, I have worked in an outpatient mental health setting in a rural part of the state since I graduated. I also serve as an adjunct professor at both Carlow and Chatham Universities in their graduate psychology programs and provide contracted psychological evaluation services to several protective services organizations, including the Allegheny County Area Agency on Aging, therefore I have seen firsthand the vast impact that the shortage of access to psychiatric prescribers has had on many.

To begin with, I would like to detail the impact I have seen on my outpatient clientele, who were the catalyst for giving me the motivation to work tirelessly on the PPA RxP Committee supporting this legislation, and to undertake the additional master's degree in clinical psychopharmacology at FDU. The task to locate a psychiatrist that is accepting new patients is overwhelming. It takes multiple calls until you can get through to an office that is accepting new patients as Dr. Warner has mentioned, and once you do get through, the wait list is often 6-8 weeks long. The process is burdensome and taxing on people who are already grappling with panic attacks, sleepless nights, and energy levels that are so low that they are barely able to get out of bed. Additionally, this has caused overscheduled outpatient providers like myself to increase the frequency of our sessions with clients with high risk issues, such as suicidal ideation, so that we can buffer as best we can until a psychiatric visit is secured and medications are at a therapeutic level. I often find myself adding on time at the beginning or end of my day to accommodate such clients. I have sat with clients who have lost jobs, had relationships end, and suffered legal consequences due to mental health symptoms while waiting for psychiatric care. I have also had clients have to make the difficult choices between a session with me and a session with their psychiatrist due to not being able to afford the session cost or co-pays for both visits or being able to take time away from work for both their counseling session and medication management appointment. I have heard countless times, "why can't you just provide my medication? You know me best, and you spend the most time with me." HB1000 would allow for both psychotherapy and medication management services to occur in one visit making the process uncomplicated for mental health consumers.

In my role as adjunct professor, I have frequent contact with very bright and eager psychologists in training who are aware that there are six states that allow psychologists to become prescribers. They have made it known to me that if this is not an option in this state, they will not hesitate to relocate to states where this is an option because they are interested in integrating their therapeutic skills and medication management services. Given the mental health needs of the Commonwealth of Pennsylvania, we cannot afford to lose qualified providers to other states.

Finally, I would like to detail the starkest impact that the lack of psychiatric access has caused, and that has been in my role as an evaluator conducting capacity assessments for older adults through the Area Agency on Aging. In this position, I am called to determine if an adult meets the legal definition of an incapacitated person and for the appropriateness of an appointment of a guardian of person and estate. I generally go to the home of the individual to conduct these evaluations. I have countless examples of individuals who are experiencing psychosis including paranoia, hallucination, and delusions, who do not fully meet the legal definition of an incapacitated person, yet engage in behaviors that place strain on local police, fire, emergency response, and protective service departments. For psychosis, the frontline treatment is antipsychotic medication.

One of these cases involved an individual who called the fire department 16 times in a three-week period to report the hallucinations of smoke and flames in their apartment. Each time the fire department was called, an inspection revealed no smoke, flames, or evidence of fire damage. Frustrated firefighters would leave the scene feeling a loss for how to appropriately respond, not wanting to ignore calls, but also not wanting to tie up precious resources in the event that a true emergency would need them.

If I, as a psychologist, had prescriptive authority, medication for this individual could have been prescribed and coordinated upon my contact with this person. Instead, this individual went several months of continued 911 calls and the experience of terror, fear, and self-neglect due to the fire that he believed was in his apartment until he could be stabilized on an anti-psychotic medication. Additionally, his case remained open with protective service until a visit could be coordinated, causing the investigator to frequently monitor the case while she had an extensive caseload to begin with.

I would also like to highlight a case involving children. According to the American Association of Child and Adolescent Psychiatry, a full 97% of Pennsylvania counties do not have enough psychiatrists focusing on this population. With the rising trend in teen suicides, and the fact that these medications can be helpful for teens when used judiciously and carefully, we must understand that psychologist prescribers would be very helpful for impacting some of our most alarming public health trends for kids. As a psychologist evaluator in a rural county, I regularly met children who would benefit from a medication that were I prescriber I could address. Instead, I would find myself regularly referring for a medication assessment that was simply not possible because appointments were too rare. These children meanwhile experience all problems of mental illness from schooling to friends, when competent frontline prescribing on my part could have really made a difference.

Thank you for allowing us to testify at the hearing today. Once again we would like to urge you to support HB 1000 and vote it out of committee.

Respectfully submitted,

Dr. Dan Warner
225 Taylor St.
Pittsburgh, PA 15224

Dr. Krista Boyer
121 North Main St, Suite 200
Greensburg, PA 15601