August 7, 2023

Hon. Frank Burns, Chair
Hon. Carl Walker Metzgar, Republican Chair
House Professional Licensure Committee
Pennsylvania House of Representatives
Harrisburg, PA 17120

Re: HB 1000—Prescription Privileges for Psychologists

Dear Chair Burns, Republican Chair Walker Metzgar, and Members of the Committee:

I appreciate the opportunity to submit information to this Committee, which is considering legislation to expand the scope of practice of licensed, doctorate-level clinical psychologists to grant them prescriptive authority.

I am a Senior Fellow at the Cato Institute, working in the Department of Health Policy Studies. In October 2022, the Cato Institute published my study, "Expand Access to Mental Health Care: Remove Barriers to Psychologists Prescribing Medications."[1]

I am also a general surgeon in private practice for over 40 years in Phoenix, AZ. Perhaps ironically, I can prescribe psychiatric meds to my patients even though it has been years since I received clinical psychopharmacology training or experience. In Arizona, as in most states, clinical psychologists with doctorate degrees must refer patients who need medication to assist with their therapy to licensed prescribers. These are usually psychiatrists. However, roughly 50 percent of psychiatrists nowadays don't accept insurance, and it can be difficult and costly for patients to see psychiatrists. Psychologists can also refer their patients to primary care practitioners to prescribe psych meds or, as previously mentioned, even to general surgeons like me if a psychiatrist is unavailable.

In any case, patients are subjected to the inconvenience and added cost—in time and money—of seeing two health care providers to receive medication-assisted psychotherapy. This can cause hardships for people suffering from mental health problems in rural and underserved areas.

As my paper describes, more than 30 years ago, the U.S. Department of Defense trained doctorate-level clinical psychologists to prescribe psych meds to increase the workforce of prescribing psychotherapists. The American College of Neuropsychopharmacology reviewed the program for the Department of Defense. It concluded, "It seems clear that a two-year program—one year didactic, one year clinical practicum that includes at least six months of inpatient rotation—can transform licensed clinical psychologists into prescribing psychologists who can function effectively and safely and expand the delivery of mental health treatment to a variety of patients in a cost-effective way." A Government Accounting Office review of the program concurred.

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Today, prescribing psychologists (or RxPs) practice in several federal agencies, including the military, the U.S., Public Health Service Commissioned Corps, and the Indian Health Service. They have been practicing in the territory of Guam since 1999, in New Mexico since 2002, and in the states of Louisiana (2004), Illinois (2014), Iowa (2016), Idaho (2017), and, this year, Colorado.[2]

As I point out in my paper, the evidence shows that prescribing psychologists prescribe as safely as, and possibly more conservatively than psychiatrists. They also tend to continue to talk psychotherapy with their patients, whereas recent research shows less than 11 percent of psychiatrists engage in talk therapy these days—most primarily practice pharmacotherapy.

Researchers publishing in the August 2023 issue of the journal *Health Policy* used data from the National Vital Statistics System of the National Center for Health Statistics from 1999–2015 to evaluate suicide rates before and after New Mexico and Louisiana expanded psychologists' scope of practice to include prescriptive authority.[3] The authors concluded:

Expanding the scope of practice of doctoral-level psychologists who have completed training in clinical psychopharmacology to include prescriptive authority is associated with a 5 to 7 pp [percentage point] decrease in suicides in New Mexico and Louisiana. The largest reductions in suicides are for male, white, married, single, and middle-aged sub-populations. The results are robust to several different additional specifications and frameworks.

And:

In the U.S., expanding scope of practice for specifically trained psychologists to include prescriptive authority may help address poor mental health care outcomes, such as suicides. Similar policy expansions may be useful for other countries where referral from a psychologist and prescription assignment from a psychiatrist are separated.

I encourage lawmakers to avoid making psychologists undergo unnecessary didactic or clinical training and to tailor requirements to what prescribing psychologists will face in their clinical practices. For example, in some states, representatives of the MD and DO professions have sought to make psychologists complete clinical rotations in surgery, internal medicine, obstetrics-gynecology, and even histology before they are granted prescriptive authority. Lawmakers should view such proposals as cynical attempts by entrenched incumbents to reduce competition by erecting barriers to psychologists seeking prescriptive authority.

It is also essential to make licensing criteria flexible enough to accommodate educational innovations that academics, politicians, and policymakers cannot foresee.

Some states grant provisional prescriptive authority to clinical psychologists, requiring them to practice in collaboration with a licensed prescriber for one or two years, after which the clinical psychologists' prescriptive authority becomes unrestricted. HB 1000 language states that a prescribing psychologist may not prescribe psych meds to a patient without the patient first seeing a primary care practitioner (who usually has less knowledge and experience in clinical psychopharmacology than a psychologist who has gone through the requisite training) *indefinitely. The* PCP must agree with the psychologist's plans to prescribe the meds and be available for collaboration *indefinitely*.

This provision defeats the primary purpose of granting prescriptive authority to psychologists: psychologists can already refer their patients to PCPs (including family physicians, nurse practitioners, and physician assistants) to get their patients medicated. The purpose of granting prescriptive authority is to minimize the number of providers (and the attendant costs in time and money) that mental health patients need to see to obtain medication-assisted psychotherapy, thus helping improve access to mental health services.

Pennsylvania lawmakers can help increase access to medication-assisted mental health services without expending taxpayer dollars by granting prescriptive authority to qualified clinical psychologists.

Respectfully submitted,

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[1] https://www.cato.org/briefing-paper/expand-access-mental-health-care-remove-barriers-psychologists-prescribing and https://www.cato.org/sites/cato.org/files/2022-10/BP_142_update.pdf

[2] https://www.cato.org/blog/colorado-poised-become-sixth-state-allow-patients-access-prescribing-psychologists

[3] https://www.sciencedirect.com/science/article/abs/pii/S0168851023001318#preview-section-introduction