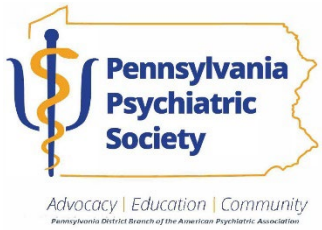

WRITTEN COMMENTS OF THE PENNSYLVANIA PSYCHIATRIC SOCIETY

BEFORE THE HOUSE PROFESSIONAL LICENSURE COMMITTEE

ON PSYCHOLOGIST PRESCRIBING

AUGUST 7, 2023

Good afternoon, Chairman Burns, Chairman Metzger and members of the Committee. I am testifying on behalf of the Pennsylvania Psychiatric Society (Society), a district branch of the American Psychiatric Association (APA), representing nearly 1,500 physicians across the commonwealth who practice the medical specialty of psychiatry. We appreciate the opportunity to provide written comments on the best approach to addressing the crisis in access to mental health services. We hope you will agree that extending prescribing privileges to individuals without a medical background is not safe, will not increase access to mental health care, and discriminates against a very vulnerable patient population.

My name is Mary Anne Albaugh, MD. I am a member of the Society's government relations committee, and have served on its council for over twenty years. On the national level, I serve as a member of the executive committee of the APA Assembly. I am a child and adolescent psychiatrist from Erie Pennsylvania, and work closely with the Erie County Office of Mental Health and Intellectual Disability.

We agree with Representative Frankel that there is a problem with accessing mental health care. Where we strongly disagree is that it can be helped in any way by adding prescriptive authority to the impressive skills of our psychologist colleagues. And it can do harm.

We need more providers of mental health care.
The crisis in access is not a crisis in access to medication; it is a crisis in access to care. The skills which psychologists bring to the teams we work in are invaluable. We need more of them. The scarcity in access to care cannot be solved by an already overstretched group.

Prescribing medication requires a knowledge of the whole body, every organ system, fundamentals of cardiac conduction, immunology, electrolyte balance and many other things. This cannot be achieved in an abbreviated course. The training psychiatrists receive starts in college, with rigorous science classes. It continues through many months of classroom instruction and lab sessions learning the science behind treatment. Then there is supervised clinical work on all of the clinical services—obstetrics, surgery, neurology, internal medicine, family medicine, pediatrics, neurology, anesthesiology, orthopedics—prior to graduation from medical school (four full years.) Residency is another four year endeavor (at least five for those of us in child and adolescent psychiatry) with again rotations on neurology, emergency medicine and internal medicine. This is all done to provide the experience needed to responsibly care for individuals with mental illness.

Persons with mental illness deserve the highest protection the state can provide. One of the purposes of committees such as this is to make sure that the public is protected, that those who desire to provide services in the commonwealth are up to the task. The public at large can be expected to judge for themselves which providers of services they can trust once endorsed by the legislature. For those suffering with serious mental illness, and those that love them, this is especially important; they need our most highly skilled practitioners.

There are better ways to expand access to sophisticated psychopharmacology. Better access to behavioral health care can be achieved by the expansion of the Collaborative Care Model, which was included in HB 849 introduced by Representative Schlossberg. In this model, a fully

trained psychiatrist consults with a primary care office team, which includes an embedded behavioral health care worker and a medical record with evidence-based metrics. This has proven to be cost effective, timely, and convenient for patients following the principle of taking care of the whole person. I would direct you to a link which I provide describing this approach which has already been adopted by many of the large health care systems in the commonwealth, but which needs additional funding to help adoption in smaller practices in more rural areas. Link: https://youtu.be/zXZTgq3GyPw

In states and jurisdictions where this has been tried, there has been no increased access demonstrated. Prescribing psychologists have been in existence for more than twenty years, in one pilot form or another. There have been fewer than 300 licensed in this way. Most psychologists find that their current skills are much in demand and have not chosen to add this different mechanism of treatment, which they cannot hope to master as well as others with a medical background. Licensing authorities are difficult and expensive to set up without any real justification in numbers.

Our profession is dedicated to the care of those with mental illness. Much of what we do does not include medication treatment, though we assess everyone to see whether we believe this will be of benefit. With our knowledge and experience, we advise and prescribe when appropriate. We are very concerned that this difficult task might be undertaken by anyone with far less knowledge and experience.

Please do not advance this any further.

I am attaching a letter our organization sent in April in response to the co-sponsorship memorandum.

I am ready to answer any questions you might have. I thank you for your time.

Sincerely,

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Pennsylvania Psychiatric Society

Advocacy | Education | Community
Pennsylvania District Branch of the American Psychiatric Association

April 11, 2023

Dear Representative:

The Pennsylvania Psychiatric Society represents nearly 1500 Pennsylvania physicians who specialize in the treatment of mental illness. We are writing in response to the co-sponsorship memorandum circulated by Representative Dan Frankel, which proposes extending prescribing privileges to psychologists. We believe this is the wrong approach to the problem of access to mental health services.

The crisis in mental health access is real; the solution must be to use all members of the behavioral health team applying their important skills to provide care. The expertise of our psychologist colleagues is valuable and appreciated; it is needed to address the psychological needs of patients with mental illness. But it is important to recognize what training and skills different members of the team bring to the table.

The difference between psychiatrists and psychologists is fundamental, despite the similar names. Psychiatrists graduate from college and attend medical school and receive an MD or DO. Psychologists attend graduate school and receive a PhD or Psy.D. Medical schools and graduate schools in psychology are quite different places.

The decision to specialize in psychiatry for most does not occur until after didactic and hands-on education in each of the medical specialties: surgery, internal medicine, obstetrics/gynecology, pediatrics, emergency medicine, neurology, and others. This breadth of medical training does not stop; after graduation, psychiatrists complete four years of residency training in teaching hospitals. This involves at least six months of training on general medical services, caring for patients with every illness that comes our way. All of this postgraduate training takes place under the supervision of seasoned clinicians, with gradually increasing independence of practice. Medical schools and residency training programs are overseen by independent boards which ensure that they adhere to rigorous standards.

Training in psychology also requires several years beyond the bachelor's degree, with different programs emphasizing distinct aspects of the science. Following graduation psychologists can choose careers in a variety of settings. Working clinically requires licensure, achieved by a one-year internship and satisfying the requirements of a state board. None of the mandated education or training requires any knowledge of clinical medicine.

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The lack of access to behavioral health services includes recognized psychological practices of psychotherapy, cognitive behavioral therapy, psychological testing, and others. Extending prescriptive authority to psychologists does nothing to address these needed services, which they are well trained to provide. There is an enormous unmet need for all sorts of psychological therapy services in the Commonwealth, with long waiting lists for well-trained and skilled therapists. Addressing this need is one which needs careful attention, and which may be harmed by unwise attempted medicalization of psychology.

Psychologists and psychiatrists practice in the same places; rural access is not increased by expanding scope. There are a few states which have adopted training programs to try to train psychologists to prescribe, in hopes that it will solve some of the rural access problems. This has not been demonstrated by years of follow-up studies. There have been very few psychologists who have decided to take the path to prescriptive authority, fewer than 300 exist. Most psychologists recognize that they already possess an impressive array of skills which are vitally needed

Other professionals with limited prescriptive authority are based on a significant foundation of medical knowledge and experience. Problems with access to medical care of all stripes had led to an expansion of scope of practice, including limited prescriptive authority under collaborative care agreements, for nurse practitioners and physicians' assistants. These members of the health care team have had extensive education on how the body works, how medications can be used to influence that working, what sorts of problems with medication use one must be on the lookout for, and how to address them. Importantly, each of these has worked closely with physicians throughout training and beyond and know when and how to use the skills of the physician team lead to help avoid trouble. This team approach to care has been successful in extending the reach of physicians; it is not a model with which many of our psychologist colleagues have easy familiarity.

Patients with mental illness are a vulnerable group who deserve the best protection for their care. It can be difficult for anyone to judge the quality of care they are receiving from their health care team. This difficulty is often amplified by mental illnesses which can impair judgement and perception of reality. It is disturbing for those of us who dedicate our lives to caring for such individuals, to think that our patients may be receiving pharmacologic treatment from those without a medical background. Such a two-tiered system does not serve Pennsylvania well.

Prescribing psychoactive medication is complex and requires a knowledge of the whole body and its different systems. Many of the medications we use can have serious, sometimes fatal side effects on blood pressure, heart rhythm, balance, blood chemistry, anemia, diabetes, digestive function and other systems. They can cause the sometimes-irreversible neurological impairment of tardive dyskinesia. It is important to recognize these side effects and initiate appropriate testing and treatment. Interactions with drugs being used to treat other conditions must also be considered and weighed carefully. All of our training is geared to making sure that our interventions **“first do no harm”** as we swear with our Hippocratic oath.

Any piece of legislation must be judged by asking what the problem is it is designed to solve, and then whether this is the way to solve it. The problem of access to mental health care is very real. Medication is only one part of the care that we in behavioral health provide, however. Our psychologist colleagues

are an important part of the solution to the problem of access, but not by extending prescriptive authority to them. We believe this must be retained by those with the necessary medical education and training.

We urge you not to cosponsor this proposed legislation.

Sincerely,

Hope S. Selarnick, MD, DLFAPA
PaPS President

Kenneth Certa, MD, DLFAPA
Co-Chair, PaPS Government Relations Committee

P.S. A better solution to providing access to behavioral health care is the expansion of the Collaborative Care Model, which is being put forward in separate bills this session (as it was last session by Wendi Thomas.) This model, in which a behavioral health worker is embedded in a primary care office, and a psychiatrist consults with the primary care provider on a regular basis, has been shown to be an effective way to reduce patient distress in a timely and cost-saving way.