TESTIMONY OF MEREDITH ZEBROWSKI
HB 1000 Prescription Privileges for Psychologists in PA

Good afternoon, Chairman Burns, Chairman Metzgar, and Members of the Licensure committee, thank you for giving me the opportunity to speak today. My name is Meredith Zebrowski, I am a PA Licensed Psychologist and Certified School Psychologist. I have the privilege of working as a psychologist at Wesley Family Services, a non-profit mental health agency in Pittsburgh, serving children and adolescents with significant mental health needs across a variety of settings including our Partial Hospitalization Program, Kindergarten Readiness Program, Acute Partial Hospital and Outpatient Center. I come here concerned about the current state of access to quality and comprehensive mental health care, which in many, if not most, of my clients cases includes the need for prescriptive healthcare, which were problematic prior to the pandemic but now feel dire in my day to day practice. I want to discuss several client's cases that I have worked on over the last several years which I believe, highlight the dire state of access to prescriptive healthcare services which could be ameliorated through prescriptive authority for psychologists in improving and expanding access to quality, comprehensive mental health care.

This past year I worked with a 6 year old client named "Kaden" (*Note: name redacted, pseudoname used*). The nature of my role with Kaden was rather unique and comprehensive within our agencies model; I completed a neuropsychological evaluation which informed implementation of a specific treatment plan through ongoing consultation with his team. Kaden experienced chronic abuse, neglect and pathogenic parenting while in the care of his biological parents and was eventually adopted into a loving home. His adoptive parents are dedicated to Kaden's success but are overwhelmed, as his biological siblings were also adopted into their home. His behavioral needs, self-management skills, directed and sustained attention skills as well as ability to inhibit motor impulses and elevated activity levels were significant within the classroom; through my evaluation, Kaden was diagnosed with an Attention Deficit Hyperactivity Disorder, Combined Presentation in addition to a Traumatic Stress Disorder. During my feedback session with the family and Kaden's treatment team, I discussed the findings of my neuropsychological testing, classroom observations, teacher and parent ratings, all of which triangulated towards the diagnosis of AD/HD along with a traumatic stress disorder; in my feedback I discussed the biopsychosocial framework of AD/HD including differences in frontal lobe developmental and structure along with differences in availability of the neurotransmitters, leading to my recommendation of psychotropic intervention to tandem our implementation of behavioral management strategies and therapeutic intervention for Kaden. The family is relieved to have an answer to Kaden's emotional and behavioral struggles and attempt to get scheduled with his PCP to begin psychotropic management. Unfortunately, they receive word from his PCP that they do not prescribe stimulant medications and that Kaden will need to be seen by a child psychiatrist. The treatment team then assisted the family in making referrals to child psychiatrists; the waitlists were staggering and Kaden would not be seen for approximately five months to receive the care he urgently needed. In this time, we were able implement appropriate interventions and support for Kaden to assist in self-management and attention skills within the classroom and we develop a therapeutic treatment plan targeting his needs; however, he still struggles immensely and we feel the missing piece in

his treatment is medication management, yet feel helpless. Five months pass, and Kaden is finally scheduled for his intake with a psychiatrist; who agrees with my findings that Kaden would benefit from psychotropic stimulant medication. Kaden begins his medication management plan, and in tandem with our interventions already in place he begins to thrive. Kaden's case highlights several points which are crucial to children's mental and behavioral health needs in Pennsylvania and unfortunately, his case is more so the norm than the exception, in my experience. Firstly, there exists a monumental barrier in concerns for equality of access to receiving prescriptive services due to the extensive waitlists for child psychiatrists in Pennsylvania. Had Kaden been seen immediately for the recommendation of medication management, through someone like myself, his gains in development could have been paced forward approximately 5 months. For the developing brain of a child, these timelines are crucial. For Kaden, the ability to direct and sustain his attention and inhibit his impulses within the classroom, which are a neurologically compromised skills for him, meant another five month period with less opportunity for gains in academic, social and emotional instruction. I will also argue that Kaden's case also highlights a difference in the *quality* of such services which could be addressed by myself, his psychologist, having the ability to undergo additional training and supervised experience to provide prescriptive healthcare. Part of my role in his care is ongoing monitoring of data in regards to his treatment progress. Therefore, I am making ongoing data based decisions for Kaden to modify, or continue plans anchored in specific data points. Adding the ability to integrate his psychotropic management into the mental and behavioral health treatment plan I already oversee would ensure that Kaden's mental health care is truly an *integrative* model.

I want to discuss another client's case who illustrates a different perspective on prescription privileges for psychologists, through a 15 year old client named "Megan" (*Note: name redacted, pseudoname used*). Megan was referred to my outpatient office for a comprehensive diagnostic evaluation. When Megan presented for our intake, she appeared extremely lethargic, with ongoing feelings of sadness and hopelessness. She appeared disheveled and did not appear to be adequately addressing her hygiene. An important piece of information is that at my initial meeting with Megan, she is already being treated by her psychiatrist for a diagnosis of Major Depressive Disorder and Generalized Anxiety Disorder. As such, she is prescribed several psychotropic medications related to these conditions. I grow further concerned for Megan's case as she discusses her daily sleeping habits, hygiene habits, eating habits, and her lack of a movement or exercise routine. Megan was spending approximately 8 hours daily in consuming electronic content, either through playing video games, watching television or YouTube. She was not showering, brushing her teeth or engaging in other hygiene tasks on a regular basis; further, her diet was poor and was restricted to mostly high-carbohydrate meals. Megan was an adolescent for whom an Autism Spectrum Disorder had been overlooked for years by different professionals; however, it was one of the missing pieces in her treatment needs. Following my diagnosis, I formulate a plan for Megan and her parents to follow in regards to all of the other aspects of her mental health, beyond her psychotropic treatment, that were barriers in her well-being. These included beginning weekly individual therapy, a participation in a therapeutic social skills group, establishing a healthy sleep routine, restricting electronic access for more socialization and community involvement, and developing a slow increase of introduction of new foods to be added to her diet. With a more holistic plan in place for Megan she has made extensive

gains in her social and emotional development over the last two years since our first meeting. Psychotropic management, for Megan, without all of the aforementioned factors being addressed did not provide the quality and comprehensive care she needed and her mental health was declining. Psychologists are in a unique role to take a multifaceted view of psychotropic management with our strong foundation in psychological training, which at a minimum, involves five to six years of doctoral level study, training, and supervised practice. Thus, I believe we are in a position to improve the quality of medication utilization by ensuring that other biopsychosocial aspects of treatment are incorporated into each client's treatment regime. Psychotropic management would serve as one piece in a comprehensive treatment plan for each of our clients.

We are in the middle of a mental health crisis and it is time for our system to respond to the growing number of client needs. I believe that the future of mental health care in Pennsylvania is ensuring that adequate resources for care becomes readily available to individuals who are in desperate need. It is not acceptable for clients to wait 6 months or longer for quality, comprehensive mental health care. Further, Psychologists are in a unique position to close the gap in health disparities across Pennsylvania by providing high quality, integrative healthcare with the opportunity for further training and supervised practice. I am confident that by obtaining prescriptive authority, our profession will ultimately make the healthcare system in Pennsylvania significantly better. Therefore, I urge for your support for HB 1000. Thank you for your time and consideration.

Respectfully submitted by:

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