Report to the Legislature

Sunrise Review

Psychology Scope of Practice – Prescriptive Authority

December 2020
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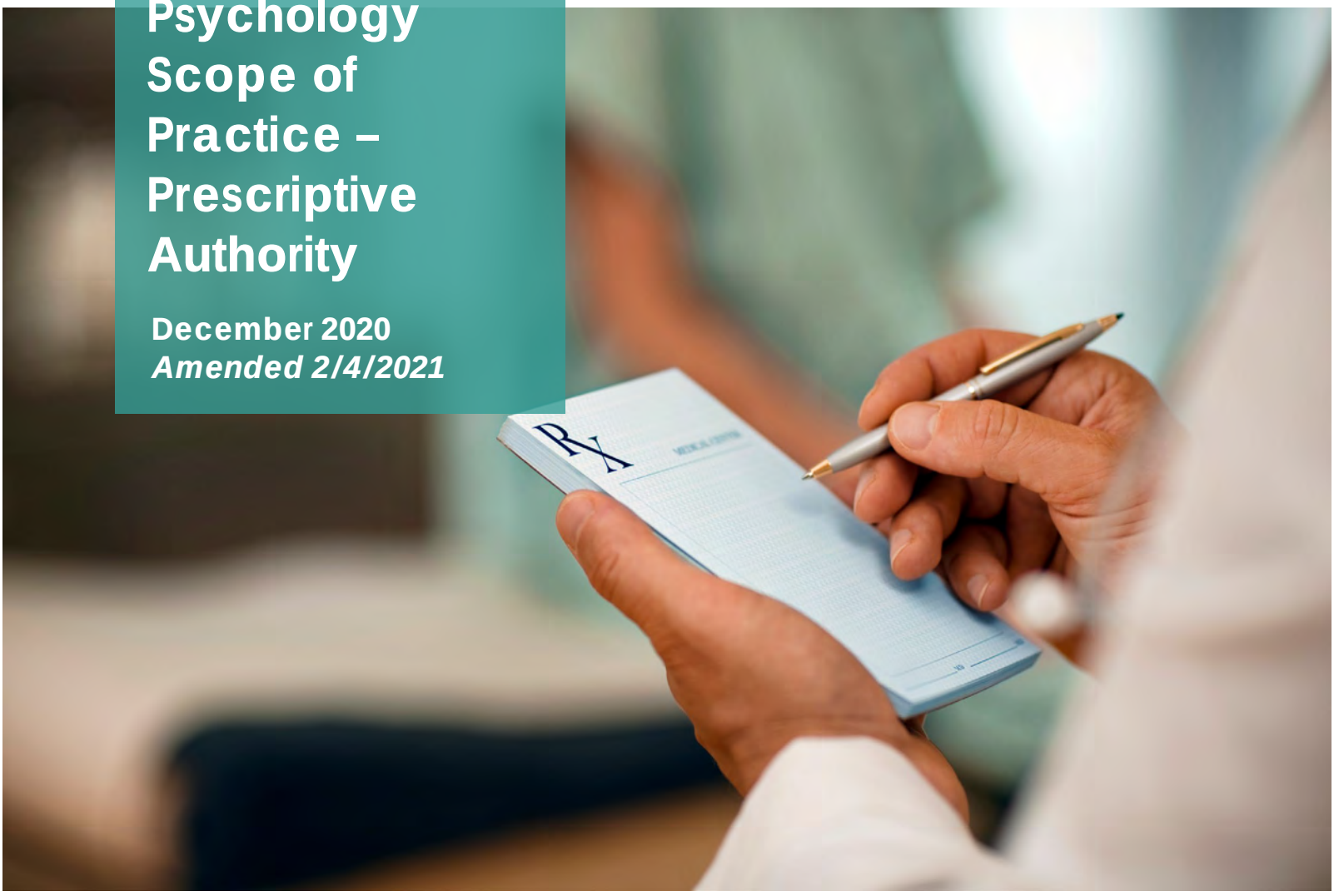

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Executive Summary

The House Health Care and Wellness Committee requested the department review a proposal under the sunrise law (chapter 18.120 RCW) to grant prescriptive authority for psychologists who obtain additional training. House Bill 2967 would grant authority to prescribe, administer, discontinue, and distribute controlled substances for psychiatric, mental, cognitive, nervous, emotional, developmental, or behavioral health disorders. This includes ordering necessary laboratory tests and diagnostic examinations. The Washington State Psychological Association (applicant) provided the applicant report, which explains how House Bill 2967 meets the sunrise criteria (See Appendix B).

The applicant report and stakeholders in support of the proposal assert it addresses the inability of patients to access psychiatrists, especially in rural areas, by creating capacity in the mental health system. They further state prescribing psychologists will not pose an increased risk to the public because their training is comparable to that of other prescribers such as psychiatrists and psychiatric nurse practitioners, and psychologists have been safely prescribing in other states.

Stakeholders opposed to the proposal assert it will not increase access to care because psychologists do not work in rural or underserved areas, and there is no evidence granting prescriptive authority would change this. In addition, they argue the proposed training is not sufficient to protect the public because psychotropic medications have significant effects on multiple organ systems, and often have side effects that require broad medical knowledge and experience to recognize and manage. They state psychologist doctoral programs do not provide training in general medicine and basic sciences needed to prescribe, and the proposed training does not include sufficient additional training in general medicine or adequate clinical experience.

Recommendation: The department does not support House Bill 2967 as written because it does not meet the sunrise criteria. Briefly, the criteria state that unregulated practice can clearly harm or endanger public health; the public needs and are expected to benefit from an assurance of professional ability; and the public cannot be protected in a more cost-beneficial manner.

Rationale:

- The applicant did not provide sufficient evidence the proposed education and training are adequate to train psychologists to prescribe controlled substances;
- The definition of "prescriptive authority" in House Bill 2967 is problematic because it does not include appropriate safeguards such as physician or other prescriber collaboration; has lack of clarity about which controlled substances can be prescribed, including opioids; and does not include non-controlled legend drugs, which omits many classes of medications to treat mental health conditions;[1] and
- The psychology board does not have the expertise to establish education and practice standards or evaluate potential prescribing violations. Although the applicant suggests adding prescribers to the board, the proposed legislation did not include this language.

[1] The applicant has stated they intend to address these issues in amendments to the proposed legislation. However, the department is required to evaluate the proposed legislation as submitted.

Summary of Information

Legislative Request

On April 23, 2020, Representative Cody, chair of the House Health Care and Wellness Committee, requested the department review a proposal under the sunrise law (chapter 18.120 RCW) to change the scope of practice for psychologists to grant prescriptive authority for those with additional training specified in the bill. The Washington State Psychological Association (applicant) submitted the applicant report on April 24, 2020 explaining how House Bill 2967 meets the sunrise criteria (See Appendix B).

House Bill 2967 would grant authority to "prescribe, administer, discontinue, and distribute controlled substances recognized or customarily used in the diagnosis, treatment, and management of individuals with psychiatric, mental, cognitive, nervous, emotional, developmental, or behavioral health disorders." The bill defines the term "prescriptive authority" to include "ordering necessary laboratory tests and diagnostic examinations."

Proposed requirements for certification as a prescribing psychologist include:

- Current license as a psychologist;
- Doctoral degree from an integrated program of graduate study in psychology;
- Master's degree of didactic education to include specific topics and consist of "an appropriate number of didactic hours to assure acquisition of the necessary knowledge and skills to prescribe in a safe and effective manner;"
- Successful completion of a postdoctoral prescribing psychology fellowship defined by the psychology board; and
- Passage of an examination developed by a nationally recognized organization and approved by the psychology board.

Background

Psychologists are regulated under chapters 18.83 RCW and 246-924 WAC. The practice of psychology is defined as "the observation, evaluation, interpretation, and modification of human behavior by the application of psychological principles, methods, and procedures for the purposes of preventing or eliminating symptomatic or maladaptive behavior and promoting mental and behavioral health. It includes, but is not limited to, providing the following services to individuals, families, groups, organizations, and the public, whether or not payment is received for services rendered:

> (a) Psychological measurement, assessment, and evaluation by means of psychological, neuropsychological, and psychoeducational testing;
>
> (b) Diagnosis and treatment of mental, emotional, and behavioral disorders, and psychological aspects of illness, injury, and disability; and

(c) Counseling and guidance, psychotherapeutic techniques, remediation, health promotion, and consultation within the context of established psychological principles and theories.

The psychology board, which consists of seven psychologists and two public members, is responsible for licensing and discipline of psychologists in Washington.

Requirements for licensure are a doctoral degree from a regionally accredited institution, no fewer than two years of supervised experience, and passing an examination. The doctoral degree program must include specific content areas listed in WAC 246-924-046 to address psychological diagnosis and intervention topics such as bases of behavior, psychopathology, human development, statistics and psychometrics, theories of diagnosis, and psychological interventions. Psychopharmacology is one of the required topics.

Admission to psychology doctoral programs typically requires a bachelor's degree, but no specific coursework, and does not typically include prerequisites basic sciences, such as anatomy and physiology, biology, or pathophysiology.

Applicant Report

RCW 18.120.030 requires the applicant group to explain a number of factors about the proposed legislation, including the problem it is attempting to fix, how it ensures competence of practitioners, and how it is in the public interest. The department refers to this as the "applicant report." The applicant report is intended to supplement the proposed legislation to help the department determine if the proposed change in scope of practice meets the criteria in RCW 18.120.010(2). Once the department receives the proposed bill and applicant report, it then solicits public comments. Next it shares a draft report for additional comments before finalizing the report for the legislature.

This section describes the arguments for the proposal made in the applicant report, which the Washington State Psychological Association (applicant) submitted on April 24, 2020. It states the problem the proposal addresses is the inability of patients to access psychiatrists because of a shortage of providers, especially in rural areas. The applicant report states "psychologists play a critical role in delivering mental health care … Adding prescriptive authority for psychologists with additional training will create much needed capacity in a significantly overburdened mental health and primary care system, while ensuring the health and safety of the public."

The applicant report provides data on mental health workforce shortages, stating only physicians, psychiatrists, and nurse practitioners[2] may prescribe medication for treating mental health issues. The evidence cited of a shortage of prescribers focuses mainly on psychiatrists, stating there were only 570 in Washington in 2018.[3] The report includes a 2014 U.S. Health Resources and Services Administration (HRSA) map of mental health professional shortage

[2] Please note that nurse practitioner and advanced registered nurse practitioner (ARNP) are used interchangeably in this report. ARNP is Washington's credential.
[3] Citing the Bureau of Labor Statistics, https://www.bls.gov/oes/2018/may/oes291066.htm.

areas (MHPSA) showing at least 10 counties in Washington without a psychiatrist, and the number of psychologists who live in these counties. The applicant states there is also a shortage of primary care physicians and that only about 2 percent of nurse practitioners obtain psychiatric specialization. Comments submitted by ARNPs United stated that the correct percentage of Washington nurse practitioners working in these settings is closer to 14. The applicant accepted this correction in its follow-up comments.

In its comments on the draft report, the applicant added the following information related to how it believes the proposal will increase access. It shared a 2019 statewide survey of Washington licensed psychologists where 53 percent of respondents were "interested to very interested" in obtaining the prescribing credential. They added that many psychologists live and practice in rural areas, but the question of where psychologists are located is less pertinent with the increase in the provision of telehealth services. They added this would make it easier for prescribing psychologists and other providers to provide treatment in underserved areas.

According to the applicant report, prescribing psychologists will not pose increased risk to the public because the training is comparable to that of other prescribers such as psychiatrists and psychiatric nurse practitioners. As evidence, the report includes a table on page 11 comparing training for prescribing psychoactive medications between psychiatric nurse practitioners, physicians, and pharmacologically trained psychologists. This comparison table was from a study, "Training Comparison Among Three Professions Prescribing Psychoactive Medications: Psychiatric Nurse Practitioners, Physicians, and Pharmacologically Trained Psychologists."[4]

The basis for the training comparison used by applicant is the American Psychological Association's (APA) Model Legislation for Prescriptive Authority and Designation Criteria for Education and Training Programs in Psychopharmacology for Prescriptive Authority. Under the APA model, certification is "contingent upon completing the basic science prerequisites, a two-year post-doctoral master's degree in clinical psychopharmacology from an accredited university, completion of a supervised practicum, and passing a national certification examination administered by the Association of State and Provincial Psychology Boards (ASPPB)." Designation is described as a public recognition of education and training programs that meet published standards for prescriptive authority for psychologists.

The applicant later clarified that training programs have traditionally "woven" the basic sciences in with the rest of the curriculum, but this is rapidly changing. The APA Model Curriculum states that programs that choose to offer preparation for clinical training in psychopharmacology will initially offer foundational coursework leading to competency in human anatomy, human physiology, biochemistry, and genetics.

[4] Muse, M., McGrath, R. (2010). Training Comparison Among Three Professions Prescribing Psychoactive Medications: Psychiatric Nurse Practitioners, Physicians, and Pharmacologically Trained Psychologists. *Journal of Clinical Psychology*, 66(1), 96-103.

According to the applicant, the APA has designated three education and training programs (Alliant International University, Fairleigh Dickenson, and New Mexico State University) and a fourth (Antioch University, Seattle) is in the process of establishing a program.

As evidence that trained psychologists can safely prescribe psychotropic medications, the applicant report cites the Department of Defense (DOD) Psychopharmacology Demonstration Project (PDP). The DOD program was the first in the country to train prescribing psychologists, with 10 graduates who went on to prescribe for mental health conditions. The applicant report cites evaluations from the U.S. General Accounting Office on the Department of Defense (DOD) Demonstration Project[5] and the American College of Neuropsychopharmacology[6] stating the DOD psychologists were safe prescribers.

The applicant also provides the following as evidence of the safety record of prescribing psychologists:

- Two peer-reviewed journal articles (one by Shearer et al.[7] and the other by Linda and McGrath[8]) detailing results from surveys of medical providers who rate the competence and safety of prescribing psychologists;
- Copies of letters of support for bills in other states from:
    - A medical psychologist practicing in Louisiana who serves on the medical committee that assists in regulating medical psychologists,
    - A psychiatrist in New Mexico stating there have been no actions taken against a prescribing psychologist for unsafe practice,
    - A retired physician with a Ph.D. in pharmacology in Oregon, and
    - Katherine Nordal, Ph.D., executive director for professional practice at the APA;
- A presentation to the Behavioral Health Subcommittee of the New Mexico Legislature showing no complaints were associated with the prescription certificate, and that New Mexico has added many new prescriptive providers to meet demand in rural and metropolitan areas; and

The applicant submitted comments in response to the draft report that additional evidence of safety is in the low malpractice insurance costs for the addition of prescription privileges. They said the average additional amount these psychologists pay is about $100 per year. Malpractice

[5] Government Accountability Office (1997). Defense health care need: Need for more prescribing psychologists is not adequately justified (GAO/HEHS-97-83).
[6] American College of Neuropsychopharmacology (1998). DOD prescribing psychologists: External analysis, monitoring, and evaluation of the program and its participants.
[7] Shearer, D.S., et. al. (2012). The primary care prescribing psychologist model: Medical provider ratings of the safety, impact and utility of prescribing psychologist in primary care settings, *Journal of Clinical Psychology in Medical Settings.* 19(4), 420-429.
[8] Linda W.P., McGrath R.E. (2017). The Current Status of Prescribing Psychologists: Practice Patterns and Medical Professional Evaluations. *Professional Psychology: Research and Practice*, 48, 38-45.

insurers use actuarial data to determine likely risk, which in the case of prescribing psychologists appears to be exceptionally low.

For consultation in matters limited to prescribing psychologists, the applicant report suggests the psychology board may add a prescribing psychologist as a member, or as a member of an "advisory group," as well as a physician and/or pharmacist at its discretion. House Bill 2967 does not include language regarding the addition of members, but in follow-up the applicants indicated it is their intent to include an additional board member in the bill. They state that they left "physician" broad so the psychology board could determine the best expert for the position, which could be a psychiatrist.

The department also followed up with the applicant to inquire why House Bill 2967 would not require collaboration among prescribing psychologists and primary care providers as do the other states that allow prescriptive authority. They responded that was their intent, but they believe it is more appropriate to put this collaboration in rule, rather than statute. They stated collaboration should require, at a minimum, written or verbal confirmation from the primary care physician, with an opportunity for them to ask questions, make comments, or make alternative plans with the psychologist.

House Bill 2967 authorizes certified psychologists to prescribe "controlled substances recognized or customarily used in the diagnosis, treatment, and management of individuals with psychiatric, mental, cognitive, nervous, emotional, developmental, or behavioral disorders." It does not include non-controlled legend drugs, under which many medications used to treat mental health conditions fall, such as Zoloft or Prozac.

APA Designation and Model Curriculum

The American Psychology Association (APA) has a designation process for postdoctoral education programs in psychopharmacology.[9] The model curriculum[10] states a minimum of 400 contact hours of didactic study should be required in basic science, functional neuroscience, physical examination, clinical neurotherapeutics, systems of care, pharmacology and psychopharmacology, research, and professional, ethical, and legal issues. The model curriculum does not specify a minimum number of hours in any topic area.

The model curriculum also includes supervised clinical experience in physical assessment and a prescribing psychology fellowship intended to be intensive and closely supervised. The model curriculum states this experience must include a sufficient range and number of patients to "demonstrate threshold performance levels for each competency area." It states that a sufficient number of supervised patient contact hours must be completed with a minimum of 100 patients, to include representatives of all stages of psychopharmacological treatment from initiation and

[9] American Psychological Association. (2019). Designation Criteria for Education and Training Programs in Psychopharmacology for prescriptive authority. https://www.apa.org/education/grad/rxp-designation-criteria.pdf, accessed June 22, 2020.

[10] American Psychological Association (2019). Model Education and Training Program in Psychopharmacology for Prescriptive Authority, p. 6. https://www.apa.org/about/policy/rxp-model-curriculum.pdf, accessed June 22, 2020.

maintenance through termination of treatment. No minimum number of supervised experience hours is included in the model curriculum.

Existing Educational Programs

The APA has designated the following programs as meeting their guidelines for postdoctoral education programs in psychopharmacology:

New Mexico

New Mexico State University's M.S. in clinical psychopharmacology program includes 459 hours of didactic instruction, a 480-hour supervised practicum, and a final capstone examination.

Fairleigh Dickinson University

Fairleigh Dickinson University's M.S. in clinical psychopharmacology program is about 450 hours (30 credits) of didactic instruction. The program is five semesters over the course of two years and also includes an optional clinical laboratory course for students who plan to enroll in the clinical practicum elective. The program requires a cumulative "capstone" examination for graduation. A nurse practitioner, neuroscientist, clinical psychologist, pharmacist, and two prescribing psychologists teach the courses.[11]

Alliant International University

Alliant International University's M.S. in clinical psychopharmacology program is described as a three-year master's program. A review of the curriculum shows it is about 450 hours of didactic instruction followed by an 80-hour physical assessment practicum.[12] Comments received in support of the proposal from the director of the master of science in clinical psychopharmacology states that students are trained by psychiatrists, physicians, nurse practitioners, pharmacists, neuroscientists, and prescribing psychologists.

In addition, the applicant added in their response to the department's draft report that Antioch University's MS in psychopharmacology program under development in Seattle is establishing rigorous education and training requirements. This program will be very similar to the highest level of nurse practitioner training, address concerns regarding adequacy of training, and require the same science courses as nursing students.

[11] Submitted by Derek C. Phillips, PsyD, MSCP, director, MS Program in Clinical Psychopharmacology School of Psychology and Counseling, Fairleigh Dickinson University. Dr. Phillips also noted two newer programs currently under review for APA-designation, the Chicago School of Professional Psychology and Idaho State University, which were not included in the applicant's proposal.

[12] According to follow up provided by Judi Steinman, PhD, program director of the MS in Clinical Psychopharmacology program.

States with Psychologist Prescriptive Authority

All states that have added prescriptive authority for psychologists require a license to practice psychology in the state where the psychologist is applying, a doctorate in psychology, and passage of an approved examination. Below is more information on each state along with specific requirements for their certifications.

New Mexico

New Mexico in 2006 passed the first law (Chapter 61, Article 9) allowing psychologists with additional education and training to prescribe. The law allows a licensed psychologist holding a *conditional prescription certificate* to prescribe psychotropic medication[13] under the supervision of a supervising clinician, and a psychologist holding a *prescription certificate* to practice without physician supervision, pursuant to the Professional Psychologist Act.

The psychology board (board) and New Mexico medical board must adopt guidelines on the collaborative relationship to ensure optimal patient care. A committee comprising members of the board and the New Mexico medical board was established to evaluate complaints, and to report its findings and recommendations to each board for appropriate action.

Additional requirements for the certificate include:

- Successful completion of pharmacological training from an institution of higher education approved by the board and the New Mexico medical board;
- Successful completion of an 80-hour practicum in clinical assessment and pathophysiology; and
- Maintenance of an ongoing collaborative relationship with the health care practitioner who oversees the patient's general medical care to ensure necessary examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition, and significant changes in the patient's medical or psychological condition are discussed.

After two years of practice under a *conditional prescription certificate*, the psychologist is eligible to apply for a *prescription certificate* after they have successfully undergone peer review by the board and the New Mexico Medical Board, and meet any other requirements determined by the board in rule. This requires collaboration with, but not supervision by, a physician.

Louisiana

Louisiana's Medical Psychology Practice Act (L.A.R.S. chapter 1360), enacted in 2009, authorizes a medical psychologist to administer, prescribe, and distribute drugs. Requirements for a

[13] Definition of psychotropic medicine states "a controlled substance or dangerous drug that may not be dispensed or administered without a prescription and whose primary indication for use has been approved by the federal Food and Drug Administration for the treatment of mental disorders…"

medical psychologist license are equal to the APA guidelines, with the additional requirement to maintain basic life support certification.

Louisiana has established a five-member Medical Psychologist Advisory Committee that includes a physician with a psychiatry specialty certification and four members who are medical psychologists. This committee is responsible for reviewing and recommending action on applications for licensure; educational requirements for other medical activities provided by medical psychologists; and changes in statutes and rules.

Medical psychologists may prescribe only in consultation and collaboration with the patient's primary care physician and with the physician's concurrence. The medical psychologists may not prescribe for a patient who does not have a primary or attending physician.

Louisiana has a second level of licensure for prescribing, the certificate of advanced practice, which requires three years of experience practicing as a medical psychologist; treatment of 100 patients; the recommendation of two collaborating physicians and the Medical Psychology Advisory Committee; and completion of 100 hours of continuing education.

Patients receiving care from a medical psychologist with a certificate of advanced practice are required to have an established primary care physician who must evaluate the patient for medical conditions and risk factors present (unless the patient was referred by this physician). A medical psychologist with the advanced certificate is required to provide the physician a summary of the treatment plan at initiation of treatment, follow-up reports, and a summary of the patient's condition and treatment no less than annually.

Illinois

The Illinois Clinical Psychologist Licensing Act (225 ILCS 15), enacted in 2015, authorizes a prescribing psychologist to prescribe medications through a written collaborative agreement with a physician. The collaborative agreement may include only medications for the treatment of mental health conditions that the collaborating physician generally provides to patients in the normal course of their clinical practice. It may not include benzodiazepine schedule III controlled substances. A prescribing psychologist may not prescribe to patients under 17 or over 65, those who are pregnant, or those with serious medical conditions, such as heart disease, cancer, stroke, seizures, or developmental or intellectual disabilities.

Two licensed prescribing psychologists and two physicians who generally prescribe medications for the treatment of mental health disease or illness were added to the Illinois State Board of Psychologist Examiners when the law was implemented.

Specific requirements for the credential include:

- Undergraduate biomedical prerequisite coursework;
- 60 credit hours of didactic coursework, including, but not limited to: pharmacology; clinical psychopharmacology; clinical anatomy and integrated science; patient evaluation; advanced physical assessment; research methods; advanced pathophysiology; diagnostic methods; problem-based learning; and clinical and procedural skills; and

- A full-time practicum of 14 months supervised clinical training.

The clinical training should include a research project, as well as clinical rotations in specific departments and instructional settings, such as hospitals, medical centers, hospital outpatient clinics, and community mental health clinics. The clinical training must meet the standards for physician assistant, advanced practice nurse education, or physician education.

Iowa

The Iowa Psychology Act (Iowa code, chapter 154B), enacted in 2016, authorizes psychologists to obtain a *conditional prescription certificate* to prescribe psychotropic medications under the supervision of a licensed physician. Iowa defines psychotropic medication as "a medicine that shall not be dispensed or administered without a prescription and that has been explicitly approved by the federal Food and Drug Administration for the treatment of a mental disorder, as defined by the most recent version of the diagnostic and statistical manual of mental disorders published by the American psychiatric association or the most recent version of the international classification of diseases. 'Psychotropic medication' does not include narcotics."

Iowa law requires the board of psychology (board), in consultation with the board of medicine, to adopt rules for prescribing psychologists. In addition, the board must establish a prescribing psychologist rules subcommittee. Members include a psychologist appointed by the board, a physician appointed by the board of medicine, and a member of the public appointed by the director of public health to develop rules for consideration by the board.

The board and the board of medicine must adopt joint rules on education and training standards. The rules must also establish specific minimum standards for the terms, conditions, and framework governing collaborative practice agreements, as well as the limitations on the prescriptions prescribed and eligible populations a prescribing psychologist may treat.

Additional requirements include completion of pharmacological training from an institution or continuing education provider approved by the board of psychology and the board of medicine, certification from the applicant's supervising physician as having successfully completed a supervised and relevant clinical experience in clinical assessment and pathophysiology, and an additional supervised practicum treating patients with mental disorders. A trained physician must supervise the practicum.

A psychologist may apply for a *prescription certificate*, which authorizes prescribing under a collaborative practice agreement with a licensed physician. The psychologist must possess a *conditional prescription certificate* and successfully complete two years of prescribing psychotropic medication as certified by the supervising licensed physician. There are additional requirements for specializing in the care of children, elderly, or people with comorbid conditions.

The prescribing psychologist or the psychologist with a *prescription certificate* must maintain an ongoing collaborative relationship with the licensed physician. The physician oversees the patient's general medical care to ensure necessary medical examinations are conducted, the

psychotropic medication is appropriate for the patient's medical condition, and significant changes in the patient's medical or psychological condition are discussed.

Idaho

The Idaho Psychologist Act (Idaho code, Title 54), passed in 2017, is the most recent law to authorize prescriptive authority for psychologists. Idaho issues a *conditional certification of prescriptive authority* and a *certification of prescriptive authority* to prescribe. Both require collaboration with the patient's licensed medical provider.

The psychology board must establish an advisory panel to review and advise on proposed prescriptive authority rules, including a formulary or limited formulary, and sufficient education and training. The board may also consult the advisory panel on complaints regarding prescriptive authority. The panel must consist of a psychiatrist, pediatric psychiatrist, or pediatrician recommended by the board of medicine; a pharmacist holding a doctoral-level degree recommended by the board of pharmacy; and two psychologists licensed in Idaho.

Additional requirements for the credential include:

- A master's degree in psychopharmacology awarded by an accredited program with a U.S. Department of Education-approved, regionally accredited institution of higher learning;
- At least two years of full-time education that is substantially equivalent to the education of an advanced practice psychiatric nurse practitioner in Idaho;
- Completion of prerequisites including sufficient biomedical education to ensure the necessary knowledge and skills to safely prescribe psychotropic medications;
- Clinical experience sufficient to attain competency in psychopharmacological treatment of a diverse patient population under the direction of a qualified practitioner (licensed physicians and prescribing psychologists as determined by the institution offering the clinical degree), and
- Supervision agreements with board-certified psychiatrists, neurologists or other physicians with specialized training and experience managing psychotropic medication.

Psychologists holding a *conditional certification of prescriptive authority* may prescribe only under direct supervision of a physician. Psychologists are qualified to receive a *certification of prescriptive authority*, which authorizes prescribing without direct supervision, after successfully completing two years of satisfactory prescribing as attested by the supervising physician or physicians. A psychologist who seeks to prescribe for pediatric or geriatric patients must complete at least one year of prescribing to such patient populations.

Prescriptive authority is limited to only those drugs or controlled substances recognized in or customarily used in the diagnosis, treatment and management of people with psychiatric, mental, cognitive, nervous, emotional or behavioral disorders; relevant to the practice of psychology or directly related procedures; and within the scope of the psychologist's license and certification of prescriptive authority.

Consideration of Prescriptive Authority in Other States

Proposals to add prescriptive authority for psychologists have been proposed in at least 23 states, but many have not passed.[14] Two Oregon governors have vetoed bills, citing lack of evidence the bills would improve access or quality of care, insufficient regulatory structure to prevent over-prescribing, and flaws with the proposals that prevent safe implementation. The five states the department reviewed that have enacted prescriptive authority have all imposed much more stringent regulations than those included in the proposal.

Stakeholder Engagement

As part of the sunrise review process, the department solicited comments from the public and stakeholders on the applicant's initial applicant report and on questions posed by the department. It received about 460 comments. This section provides a high-level summary of all comments received. (A more detailed summary is included in Appendix D.)

Comments in Support

The department received 55 comments from individuals and three comments from associations in support of the applicant's proposal to create a certificate of a prescribing psychologist. The associations were the American Society for the Advancement of Pharmacotherapy, California Association of Psychology Providers (CAPP), and Division 31 Executive Board American Psychological Association. Many of the comments in support of the proposal echoed those in the applicant report.

Those who commented in support of the applicant's proposal argue that providing psychologists the ability to prescribe will increase access to care to patients in rural areas and underserved populations, as well as in communities of color where psychologists are able to provide culturally competent treatment. This would also allow psychologists to provide holistic care in which they can treat patients with both medication and behavioral interventions, conjoining medication and psychotherapy to mitigate the severity of mental health symptoms.

This group of commenters stated psychologists have the most experience of all mental health professionals in mental health diagnosis and treatment. People currently receive psychotropic medications from general practitioner physicians, who generally have little training in psychology, and who are unable to provide frequent enough visits to monitor patients and to provide appropriate care.

Washington licensed psychologists, on the other hand, have a doctoral level of education and training in understanding brain-behavioral relationships. The proponents contend that the additional training referenced in the applicant report will provide for comparable amounts of education and supervised practice in pharmacology and psychotropic medicine as other prescribing credentials. Training would include working with psychiatrists, physicians, nurse

[14] Map provided by Psychologists Opposed to Prescription Privileges for Psychologists, data current as of July 23, 2013.

practitioners, pharmacists and neuroscientists. There would be an emphasis on integrated medical practice, and students would be trained in all medical disciplines.

Finally, proponents of the proposal argue that gaining access to medication can cause an undue financial and emotional burden on patients. Providers have discretion when it comes to accepting patients and will often not accept patients who are suicidal and in crisis, especially since the Volk decision.[15]

Comments in Opposition

The department received 308 comments in opposition to the applicant's proposal. Two-thirds (68 percent) of the comments were Washington State Medical Association (WSMA) members agreeing with WSMA's comments. The department also received comments from the following organizations: Kaiser Foundation Health Plan of Washington Options/Kaiser Permanente, Northwest Washington Medical Society, Psychologists Opposed to Prescription Privileges for Psychologists, Washington Academy of Eye Physicians and Surgeons, Washington Academy of Physician Assistants, Washington Chapter of American Academy of Pediatrics, Washington Medical Commission, Washington State Psychiatric Association, Whatcom and San Juan County Medical Society, and Yakima County Medical Society.

Opponents to the applicant's proposal assert that although psychologists have comprehensive training in diagnosing mental health disorders and providing psychotherapy, they do not receive the training in general medicine necessary to prescribe. In addition to pharmacology, training is also necessary in physiology, chemistry, biochemistry, physics, and other sciences to achieve the competency required to prescribe psychiatric medications. These medications can have significant effects on multiple organ systems, and can cause side effects that require broad medical knowledge and experience to be able to recognize and manage.

This group of commenters argued that allowing psychologists to prescribe would be dangerous, put patients at risk, and compound the problem of overprescribing. They noted that the proposal does not appear to exclude opioids, which is problematic in light of the current opioid crisis. Eighteen of the 30 most commonly prescribed psychotropic medications carry "black box warnings" due to their serious side effects. Psychotropics also carry a high risk of abuse. Opponents claim that it is impossible to define what is and is not a psychiatric medication, and there is no easy way to carve out just "psychiatric" prescribing privileges.

Opponents to the proposal argue that prescribing medications goes beyond psychologists' competence, even if they obtain the additional training. They point out that the proposed education is substantially less rigorous and comprehensive than the training required for all

[15] Commenter(s) are likely referring to Volk v. DeMeerleer, 187 Wash.2d 241 (2016) which holds, in part, "once a mental health professional and his or her outpatient form a special relationship that satisfies the requirements of Restatement § 315, the mental health professional is under a duty of reasonable care to act consistent with the standards of the mental health profession and to protect the foreseeable victims of his or her patient."

other prescribing disciplines. It is also less rigorous than the training the 10 psychologists obtained in the DOD program.

According to those opposed to the proposal, physicians spend years learning differential diagnoses and pharmacology, and honing their medical skills. This includes thousands of hours of residency after medical school. Medications affect every system in the body, and those who prescribe must have full education and training of the body and all its systems. Physicians also learn to recognize and diagnose physical diseases that can mimic or significantly contribute to mental illness. For example, migraines often mimic epilepsy, stroke, gastrointestinal disease, and psychiatric illness. Vitamin B12 deficiency can mimic dementia, schizophrenia, and depression.

Opponents pointed out that the proposal does not include a requirement to follow up with the patient's primary care provider to ensure consistent and appropriate medication therapy to avoid negative drug interactions.

While opponents acknowledge problems of access to care, they believe that allowing psychologists to prescribe will not increase access. Psychologists do not work in rural or underserved areas, and there is no reason to think gaining prescriptive authority would cause them to move to those areas. Opponents state psychologists are also some of the lowest insurance-accepting mental health therapists, and this legislation does nothing to guarantee they will accept Medicaid. Medicare does not reimburse for pharmacologic management by prescribing psychologists. Noting that there are psychologists who oppose this expansion of scope, the opponents suggest that fewer psychologists will choose to enter into prescribing than the applicant believes.

Opponents to the proposal believe access to care is better addressed by expanding telehealth, increasing availability of medical residencies, instituting collaborative care models, expanding Medicaid coverage so psychiatric care can be provided in primary care settings, creating incentives to encourage providers to serve in rural or underserved areas, and increasing training slots for psychiatrists.

Opponents of the proposal urge the department to consider the following when making recommendations on the proposal:

- The requirements of who can be a qualified supervisor need to be more stringent.
- Prescribing psychologists should be required to pass the same exam as a psychiatric nurse practitioner.
- Regulation does not ensure competency, and the psychology board does not have the expertise to adequately oversee prescribing.
- Consider Louisiana's program, which created a separate degree (medical psychologist) under the Board of Medicine.
- Illinois set new and more appropriate standards that limit the medications and the populations psychologists can treat, require training similar to physician assistants, and do not allow for online medical training.

Neutral or Other

The department received six comments from individuals, two from associations, three from government entities, and one from a continuing education provider that were neither in support nor opposed but provided additional information or clarifying questions or comments. The associations were ARNPs United of Washington State (ARNPs United) and the Washington State Hospital Association (WSHA). The government entities were the Office of the Insurance Commissioner (OIC), the Health Care Authority (HCA), and the Pharmacy Quality Assurance Commission (commission).

This group of commenters pointed out that the proposed bill has a major issue in the definition of prescriptive authority in RCW 18.83.010. As written, it includes controlled substances only but not legend drugs, which would exclude most antidepressants and antipsychotics, among other classes.

They questioned whether the department would adopt the APA guidelines as a base for defining qualified psychologists and how it would identify prescribing psychologists. This plays a particular role in hospital administrative processes, specifically related to privileges and admitting abilities.

This group argued that the legislation should require the prescribing psychologist to identify the patient's primary care provider and communicate all medication changes. They also stated there should be an interim period that includes collaborative prescribing, where a psychologist writes the order but a primary care provider reviews and approves it.

ARNPs United clarified that physician assistants and naturopathic physicians also have prescriptive authority for medication to treat mental disorders (naturopaths may prescribe only two controlled substances, codeine and testosterone). They also pointed out that a 2018 survey showed 13 percent of nurse practitioners are certified to practice in psychiatry. The Nursing Care Quality Assurance Commission estimates 14 percent of nurse practitioners in Washington work in psychiatric, mental health, and substance abuse treatment settings. This information appears to contradict the statement in the applicant report that 2 percent of nurse practitioner students choose to specialize in psychiatry.

The applicants stated a qualified supervisor would include a doctoral level psychiatric nurse practitioner (DNP); however, this would exclude many currently practicing psychiatric ARNPs because currently only 13 percent hold a DNP. There is no differentiation between those with a master's or doctoral degree, and a psychiatric ARNP would be a valuable addition to the board of psychology in the proposed bill. Continuing education for ARNPs, which include psychopharmacology, should be included as potential continuing education options.

The WSHA did not oppose the proposal but commented that collaboration with the primary care provider would be helpful. WSHA also posed questions for the department to consider:

- How will the board establish minimum education and training requirements without the requisite clinical expertise?

- Will the national examination meet the same requirements and core competencies for other providers licensed to prescribe psychotropic medications?
- What additional safeguards and oversight would be in place to ensure appropriate education to provide safe patient care?
- How will authorizing psychologists to prescribe increase access to care?

OIC noted that although the proposal would not create a new mandated benefit, it could have significant benefits for consumers due to the low availability of psychiatrists. Most clients currently get care through a psychologist and medications through a primary care provider.

HCA noted this proposal would significantly change the scope of practice for a psychologist. The effects on clients could be improved access in underserved areas. Access to pharmacology may increase for those covered under Apple Health, Public Employees Benefits Board and School Employees Benefits Board. Some concerns noted regarding the proposal were the comprehensiveness of the training, and lack of a requirement in the proposal for collaboration with the primary care provider. HCA argued that prescribing to children and the elderly may require a specialist in addition to a primary care provider. This would require use of the Second Opinion Networks.

The Pharmacy Quality Assurance Commission (commission) had additional concerns and suggestions. These were:

- The commission advised removing the requirement for the Examining Board of Psychology to transmit a list of prescribing psychologists to the commission because it would require additional support from staff and add undue strain on the commission's existing resources. Pharmacies can already verify a prescriber is authorized through the provider's United States Drug Enforcement Administration (DEA) numbers.
- The commission stated the formulary should be limited to legend drugs and to specific therapeutics essential in the treatment of behavioral health disorders, similar to professions like naturopaths or optometrists. They stated a majority of therapeutic agents effective in treating mental and behavioral health disorders are non-controlled legend drugs, which carry much lower risks for abuse, misuse, and risk to patients.
- The bill would also need to amend the Legend Drug Act, RCW 69.41.030(1) and 69.41.010(17)(a), to grant the proposed prescriptive authority.
- The national examination should meet similar requirements and core competencies of other providers with prescriptive authority for psychotropic therapies, such as psychiatric nurse practitioners.
- If controlled substances are included, the psychology board should require every licensee to register with the Prescription Monitoring Program (PMP).

Comments on draft report and department responses

As part of the sunrise review process, the department solicited comments from the applicant and stakeholders on a draft report shared in September. The department received about 130 comments. This section summarizes the key points made by the applicant and the department's response to each, followed by comments from other stakeholders.

Applicant Comments

The applicant submitted a number of comments to the draft report. The department summarized the applicant's key comments and our responses according to the following:

- Responses to department statements; and
- Responses to stakeholder comments (summarized in the Stakeholder Engagement section).

Responses to department statements

1. **Evidence of safe practice**

   Comment: The applicant responded to the department's assertion in the recommendation section, "The applicant report pointed to other states that have passed prescriptive authority for psychologists as evidence of safe practice. However, all states that have made this policy change have instituted more rigorous education and training requirements…."

   The applicant's response was that Antioch University's MS in psychopharmacology program currently under development in Seattle[16] is establishing rigorous education requirements very similar to the highest level of nurse practitioner training. They stated the Antioch program takes into account new information and concerns from literature, new state laws, other training programs, and input from the community and colleagues about the adequacy of current training. It also requires students to take the same science courses as Washington nursing students (including those admitted to Seattle University School of Nursing).

   In addition, the applicant stated that concerns about the "perceived" lack of prerequisite science training are unfounded because, though training programs have traditionally "woven" the basic sciences in with the rest of the curriculum, this is rapidly changing through new state laws and the current mandate from the APA.

   Department response: The department appreciates this new information; however, it is required to evaluate and make recommendations on the proposed legislation referred to it by the house health and wellness committee, and the chair of the house healthcare

[16] Expected to start accepting students in the fall of 2021.

and wellness committee has not provided draft amendment language for the department to evaluate. The department also cannot make recommendations on a program that is still under development. The department added brief information about Antioch's program under the Existing Educational Programs section (page 7), but did not make any other changes in the final report.

2. **Training should be equivalent to that of other prescribing professions, such as ARNPs**

   Comment: The applicant responded to the department's assertions that the requirements should be at least equal to those of advanced registered nurse practitioners or physician assistants.[17] The applicant detailed efforts to align the training under development at Antioch University with that of the training of family psychiatric mental health nurse practitioners and with a doctor of nursing practice at Seattle University School of Nursing. They stated this program will include the same number of prerequisite basic science courses, credit hours of psychopharmacology, and hours of supervision in the practice of prescribing psychiatric medications.

   Department response: The department did not make any changes to the draft report in response to these comments because it is required to make recommendations on the proposed legislation. In addition, it cannot make recommendations on a program that is still under development.

3. **Safe prescribing**

   Comment: The applicant also responded to the department's assertion "The applicants have not provided sufficient evidence the proposed education is sufficient to ensure safe prescribing by psychologist." They reiterated the training components included in the applicant report and added they have clarified several times that collaboration between a primary care provider and the prescribing psychologist will be a required component of practice.

   Department response: The department is required to make recommendations on the proposed legislation and cannot evaluate planned amendments. The department did not make any changes to the draft report in response to this comment.

4. **Absence of significant adverse events is evidence of safe prescribing in other states**

   Comment: The applicant stated it is surprising and concerning that the department does not consider the absence of significant adverse events from inappropriate prescribing by psychologists as evidence of safe practice. They stated if there were instances of harm

[17] The applicant was also responding to similar comments made by stakeholders.

caused by inappropriate psychologist prescribing, it would probably be considered evidence and been cited in this draft report.

Department response: The draft report noted this is insufficient evidence because all states that have made this policy change have instituted more stringent requirements than the proposal, or the legislation passed too recently to demonstrate experience with the new prescribers. The department did not make any changes to the draft report in response to this comment.

5. **Low malpractice costs**

Comment: The applicant added that the low malpractice insurance costs for the addition of prescription privileges for psychologists is further evidence of the safety of the proposal. The average amount these psychologists pay, in addition to their underlying malpractice coverage, amounts to about $100 per year. Malpractice insurers use actuarial data to determine likely risk, which, in the case of prescribing psychologists, appears to be exceptionally low.

Department response: The department agrees malpractice claim rates and cost of insurance are good indicators of risk. However, these indicators are not pertinent to the proposal under review because the states with psychologist prescriptive authority have stricter regulations than the proposal under review that may have an effect on malpractice insurance rates.[18] Because this was new information provided by the applicant, the department added a brief statement to the Applicant Report section (page 5), and addressed it in the Department Assessment of Proposal/ Safety of Psychologist Prescribing section (page 28).

6. **Increased Access (especially in rural and underserved areas)**

Comment: The applicant responded to the department's assertion they have not provided sufficient evidence the proposal would increase access to behavioral health care. The applicant stated the following in response:

- It is unclear how the department can assert that adding more prescribers would not increase access;
- A 2019 statewide survey of Washington licensed psychologists where 53 percent of responders were "interested to very interested" in obtaining the prescribing credential; and

[18] Please note the department did not confirm this information because it does not pertain directly to the proposal reviewed in the sunrise review.

- Focusing on the location of providers is much less meaningful given changes in the provision of telehealth services. They added this would make it easier for prescribing psychologists and other providers to provide services in underserved areas.

Department response: After obtaining and reviewing the referenced 2019 survey data,[19] the department agrees this provides some evidence granting prescriptive authority for psychologists could increase access to care by adding prescribers to the mental health system. The department made changes to the draft report regarding this issue in the Executive Summary (page 1), Department Assessment of Proposal (page 26), Review of Proposal Using Sunrise Criteria (page 31), and Recommendation (page 33) sections.

The department also agrees increased use of telehealth makes the issue of whether psychologists would work in rural areas less relevant. In response to these comments, the department removed the statement that the applicant "provided no evidence psychologists will choose to practice in rural or underserved areas" from the assessment of sunrise criterion two (page 31).

7. **Defining Prescriptive Authority**

Comment: The applicant responded to the draft report's assertion, "The definition of prescriptive of authority is problematic because it does not include sufficient safeguards like physician or other prescriber collaboration."

The applicant responded their original intent was to leave this issue to the psychology board to address in rule. However, after hearing the department say the proposed bill should address this issue, they are adding in an amended bill collaboration similar to what is required in New Mexico. They also said they intend to add language stating that a prescribing psychologist may not treat a patient who does not have an identifiable primary care provider on record.

Department response: As stated earlier, the department is required to make recommendations on the proposed legislation and cannot evaluate planned amendments. However, the department added a brief statement of this intent in the Recommendation section (page 33).

8. **Exclusion of Opioids**

[19] 223 Washington psychologists responded to the survey (127 were WSPA members and 96 were non-members) and the result. http://wapsych-news.org/rxp-2019survey-results/, accessed September 22, 2020.

Comment: The applicant responded to the department's assertion that the proposal does not appear to exclude opioids. They stated they are not seeking authority to prescribe opioids and though they believe the proposed bill implicitly excluded opioids, they intend to include an explicit exclusion in an amended bill for clarity.[20]

Department response: The department added the applicant's intent in the Department Assessment of Proposal (page 30).

9. **Inclusion of Legend Drugs**

Comment: The applicant responded to the statement in the draft report that the proposal is problematic because it does not include non-controlled legend drugs, which omits many classes of medications used to treat mental health conditions. The applicant stated they appreciate the opportunity to clarify this misunderstanding and intend to address this issue by amending the bill to correctly include legend drugs.

Department response: The department did not make any changes to the draft report in response to this comment because it is required to evaluate the proposed legislation, rather than planned amendments.

10. **Regulatory Board Oversight**

Comment: The applicant agreed with the department's assertion that the proposed legislation does not address the need for new expertise on the psychology board to provide oversight of prescribing providers. They stated they wanted to leave these decisions to the psychology board. However, they intend to amend the proposed bill to add more expertise through things such as requiring the psychology board to consult with medical boards; establishing a joint medical/psychology subcommittee; and adding more members to the board to include prescribing psychologists, physicians, psychiatric nurse practitioners and/or pharmacists.

Department response: The department did not make any changes in response to these comments because it is required to evaluate the proposed legislation as submitted.

11. **Number of Psychiatrists and Other Psychiatric Providers in Washington**

Comment: The applicant responded to statements in the draft report that the applicant report focuses mainly on psychiatrists, rather than on all providers who can prescribe for mental health conditions. They acknowledged that psychiatric ARNPs and psychiatric physician assistants have made a positive and meaningful contribution to improving psychiatric medication management, and have helped to fill the gap in prescribers.

The applicant continued by citing the Office of the Insurance Commissioner's comments that stated the proposal could have significant benefits for consumers due to the low

[20] Since also made similar comments in the draft report, we respond to this comment under…

availability of psychiatrists, and that most clients currently get care through a psychologist and medications through a primary care provider.

Department response: The department added the Office of the Insurance Commissioner's comment in the Department Assessment of Proposal/Provider Shortages and Access to Care section (page 26).

The applicant also responded to a number of comments submitted by stakeholders. Please see Appendix F, beginning on page A-149, to see the applicant responses.

Stakeholder Comments

Correction to Draft Report

Comment: The director of the in clinical psychopharmacology program at Fairleigh Dickinson University submitted corrections and clarifications to the report's description of the program, such as that it is 450 didactic hours of instruction, rather than 400, and that it is five semesters over the course of two years.

Department response: The department made the requested corrections and clarifications in the Existing Educational Programs section (page 7).

Comments opposing draft recommendations

1. **Comments:** The department received comments regarding challenges with recruiting and retaining psychiatrists, especially in rural and underserved populations. They also reiterated challenges to accessing prescribers willing to take patients on Medicaid.

   Department response: The department did not make changes to the draft report in response to these comments. The draft report acknowledged these challenges and stated that expanding the range of providers with prescriptive authority for mental health disorders could increase access to care.

2. **Comment:** The department received comments continuing to make the arguments that the proposed training is comparable to that of other prescribers.

   Department response: The department did not make changes to the draft report in response to these comments because it already noted a number of reasons the applicant did not prove the proposed education is comparable to other prescribers.

3. **Comment:** The department received comments continuing to make the argument that the safety records of psychologists in states that have granted prescriptive authority demonstrate the proposed training is adequate.

Department response: The draft report noted this is insufficient evidence because all states that have made this policy change have instituted more stringent requirements than the proposal. In addition, all states except New Mexico and Louisiana passed the legislation too recently to have experience with their new prescribers.

4. **Comment:** The department received comments continuing to make the argument the proposal would increase access to care without providing additional evidence.

   Department response: The department did not make any changes to the draft report in response to these stakeholder comments. However, because the department received additional evidence from the applicant that this could potentially increase access to care, it made changes to the draft report to acknowledge this additional information.

5. **Comment:** In addressing the shortage of psychiatrists to prescribe, one commenter stated the department should note that 40 percent of psychiatrists have cash-only practices (Staffcare, 2019), and the low number of psychiatrists accepting Medicaid, 35 percent (JAMA, 2019). Both these factors further constrict access, so prescribing psychologists can have a much greater effect.

   Department response: The department confirmed these statistics and added an acknowledgment of these challenges to the Department Assessment of Proposal/Provider Shortages and Access to Care section (page 26).

6. **Comment:** The department received a few comments stating malpractice insurance for psychologists is inexpensive to add prescribing, which is an objective measure of risk.

   Department response: The department did not make any changes to the draft report in response to these comments. Though these are good indicators of risk, the department again argues that states with psychologist prescriptive authority have stricter regulations than the proposal that may have an effect on these indicators.[21]

7. **Comment:** The department received comments from one organization questioning its motives in not supporting the proposal and stating that the evaluation was biased. They stated "…it is a FACT that psychologists have been safely prescribing now for a decade or so in several states, in the military and in the Public Health Services. It is troubling that the DOH is unwilling to acknowledge FACTS, although getting the facts correct seems to be an epidemic in some government administrations."

   Department response: The department based its recommendation on an impartial evaluation of the proposal against the criteria in the sunrise law. The department did not make any changes to the draft report in response to these comments.

[21] Please note the department did not confirm this information because it does not pertain directly to the proposal submitted in the sunrise review.

8. **Comment:** The Washington Academy of Physician Assistants changed their final position on the proposal, stating they support improved access to behavioral health care and expanding telehealth services for rural and underserved populations, however they are opposed to the proposal as written. They have concerns that physician assistants are not included as qualified supervisors despite their extensive education and clinical experience. They also indicated concerns with the broad formulary, stating though they believe prescribing psychologists would prescribe within their scope of practice and expertise, granting broad prescriptive authority to a new group of prescribers during the opioid epidemic may not be the best way to improve behavioral health care.

   Department response: The department updated their position to indicate they are opposed to the proposal and why.

Comments supporting draft recommendations

The department received five comments in support of the draft recommendations. The department did not make any changes to the draft report in response to these comments.

Comments supporting original proposal but not addressing draft report

The department received 26 comments supporting the original proposal. Because this comment period was to address the draft report, these comments are not included in the final report.

Department Assessment of Proposal

Provider Shortages and Access to Care

The applicant asserts psychologists will "create much needed capacity in a significantly overburdened mental health and primary care system, while ensuring the health and safety of the public." The applicant provided some evidence to support that the proposal could increase the number of prescribers. They provided an estimate of the number of psychologists who may choose to take the additional training and apply for the credential based on experience in two states and experience with ARNP prescriptive authority. They also referenced a 2019 APA survey of Washington psychologists that indicated 53 percent of respondents (223 responded to the survey) were "interested to very interested" in obtaining a prescriptive authority credential.[22]

[22] 127 respondents were WSPA members and 96 were non-members, http://wapsych-news.org/rxp-2019survey-results/, accessed September 22, 2020.

The 2014 shortage area map showing counties without a psychiatrist provided in the applicant report does not give a true picture of prescribers in Washington for a number of reasons. First, nearly half of the counties without a psychiatrist do not have a psychologist either. Second, thousands of practitioners authorized to prescribe in Washington (physicians, ARNPs, and physician assistants) are not included in the shortage area map, and are practicing in counties without a psychiatrist.[23] Finally, the number of licensed allopathic physician psychiatrists is 961, higher than the applicant report suggests.[24]

The Office of the Insurance Commissioner submitted comments expressing that the proposal could have significant benefits for consumers due to the low availability of psychiatrists, and that most clients currently get care through a psychologist and medications through a primary care provider.

Board of Psychology Expertise

The proposed legislation did not include any changes or additions to the psychology board for establishing and evaluating education and training requirements, setting practice standards, or evaluating potential prescribing violations. The applicant report stated it was their intent to include authority for the board to add a prescribing psychologist member and possibly a physician and/or pharmacist member. The department is concerned the proposed legislation does not address this gap in expertise.

The states that have enacted prescribing psychologist certifications have gone much further to ensure the regulatory body for psychologists has the necessary expertise to protect the public. These include requiring the psychology board to consult with medical boards, establishing joint medical/psychology subcommittees to write rules and evaluate complaints, establishing an advisory committee to recommend action to the psychology board, and adding more members to the psychology board to include prescribing psychologists and physicians.

Safety of Psychologist Prescribing

Controlled substances are tightly regulated because they have a higher potential for abuse, misuse, risk to public health, and physiological or physical dependence.[25] These medications require an understanding of the patient's overall health and underlying medical conditions. Because of potential side effects or interactions with other medications, prescribing controlled substances also requires knowledge of medications that treat medical conditions, in addition to those intended to treat mental health disorders. Controlled substances used to treat mental

[23] HRSA map and Department of Health licensing data using licensee count by county.
[24] Department licensing data. Specialty information is not collected for osteopathic physicians.
[25] United States Drug Enforcement Administration, Drugs of Abuse: A DEA Resources Guide 2017 Edition, https://www.dea.gov/sites/default/files/drug_of_abuse.pdf. Accessed August 13, 2020.

and behavioral health disorders include classes such as benzodiazepines (e.g., Lorazepam) and stimulants (e.g., Adderall).

Though not included in the proposal, many classes of drugs to treat mental health conditions are non-controlled legend drugs. These medications have a lower risk of abuse, misuse, or dependence. Examples include antipsychotics, antidepressants, a majority of mood stabilizers, and sleep medications. Some non-controlled legend medications are used off-label in mental health treatment. For example, Propranolol is approved to treat blood pressure but is used off-label to treat anxiety.

Use of these medications may significantly affect other organ systems, other therapies prescribed for patients with multiple comorbidities, or cause serious side effects. A significant number of patients requiring psychotropic drugs are also using other medications, with some studies showing this number may be as high as 50 percent.[26] Of the 30 most commonly prescribed psychotropic medications, 18 carry a "black box warning," which is the most stringent warning of potential serious side effects.

The applicant report asserts a lack of disciplinary action relating to prescribing in New Mexico and Louisiana, and the external evaluations of the DOD program, are evidence psychologists can safely prescribe in Washington. The department does not find this to be strong evidence because:

- There are fewer than 200 total prescribers in all of the states with psychologist prescriptive authority and no studies on their prescribing practices to demonstrate aspects of prescribing like the medications they are prescribing, what populations they are treating with medications, and when they are referring to other practitioners;
- The New Mexico and Louisiana laws regulating prescribing psychologists include more intensive education and additional safeguards, such as physician supervision or collaboration, parameters around what psychologists can prescribe, and to which populations of patients; and
- The DOD program findings may not apply to civilian psychologists because the proposed education and training are not as rigorous, the sample size was very small (10 participants), and it is unlikely psychologists in Washington would work in the same type of controlled, team-based environments as the DOD graduates.

The applicant also asserts that the cost of malpractice insurance for psychologists who prescribe is low, demonstrating the safety of expending prescribing authority to this profession. However, the states with prescriptive authority have stricter regulations than the proposal, which may impact malpractice rates.

[26] Comments submitted by Kaiser Permanente.

Practitioners with broad prescriptive authority in Washington for legend drugs and controlled substances used to treat mental health disorders include:[27]

- Physicians (allopathic and osteopathic physicians)
- ARNPs – independent practice
- Physician assistants – under a practice agreement and supervision

The department reviewed the underlying journal article[28] cited in the applicant report to show "prescribing psychology training is similar and favorably compared to the training of other psychopharmacologically trained providers." It then conducted a literature search and found a number of additional articles, many contradicting the Muse and McGrath findings. The department then reviewed submissions from stakeholders and medical curricula from educational institutions to ground itself in the underlying training for physicians, nurse practitioners and physician assistants.

The department did not find evidence the training proposed for prescribing psychologists is equal to or greater than that of physicians, nurse practitioners, (or also physician assistants, which weren't included in their referenced study but are applicable). The Muse and McGrath study cited by the applicants did not include undergraduate prerequisites in the basic sciences, nor additional foundational sciences physicians, nurse practitioners, or physician assistants obtain. For example, nurse practitioner master's programs typically require a bachelor's of science in nursing for admission, which requires on average 45 contact hours each of biology, physics, and inorganic chemistry, and 15 of organic chemistry.[29]

The department also found that the existing training programs for prescribing psychologists do not include an equivalent level of education in pathophysiology as received by other prescribing professions. For example, a 2019 study estimates physician assistants obtain an average of 250 hours in pathophysiology and family practice nurse practitioners obtain around 450 contact hours, but prescribing psychologists receive an average of only 57 hours.[30]

Lastly, nurse practitioner and physician assistant programs require clinical experience before entering their master's programs, as well as clinical rotations throughout their training, which would include clinical practice needed to hone skills in prescribing controlled substances.

The applicant report also cited studies of safe practice they say prove the education is adequate. These included a study by Linda and McGrath of perceptions of psychologist

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[27] Naturopathic physicians may prescribe legend drugs that include psychotropics but not controlled substances. Other prescribers, such as dentists and optometrists, have limited prescriptive authority, and are not included in this comparison.

[28] Muse and McGrath 2010

[29] Heiby, E. M. (2010). Concerns about substandard training for prescription privileges for psychologists. *Journal of Clinical Psychology*,66(1), 104–111. https ://doi.org/10.1002/jclp.20650, and independent research on nursing programs.

[30] Robiner W.N. , Tompkins T.L. et. al. (2019). Prescriptive authority: Psychologists' abridged training relative to other professions' training. *Clinical Psychology Science Practice,*27:e12309.

prescribing and practice patterns[31] and a study of medical provider ratings of safety of a psychologist in a primary care setting.[32] However, these studies relied on small sample sizes, practitioner self-assessments, or had other limitations.

The Linda and McGrath study acknowledged "These findings suggest the real issue is how to define the minimum training for psychologists that can generate safe and effective prescribers of psychotropic medications, not how that training compares to other professions with different roles in health care."[33] However, absent evidence these abbreviated education models are sufficient to protect patient safety, the department believes any new prescribers should meet the minimum education required in Washington to prescribe legend drugs and controlled substances. This would be equivalent to a nurse practitioner or physician assistant (before specializing).

Definition of Prescriptive Authority

The department finds the definition of prescriptive authority in House Bill 2967 problematic as it does not include non-controlled legend drugs, which include several classes of medications used to treat mental health disorders, such as antipsychotics and antidepressants such as Zoloft or Prozac.

The department also found the bill does not include sufficient protections around prescribing controlled substances, such as collaboration or consultation with a physician or other prescriber, and clear limitations on medications appropriate for treating mental health issues. For example, Iowa's definition includes "a medicine that… has been explicitly approved by the federal Food and Drug Administration for the treatment of a mental disorder, as defined by the most recent version of the diagnostic and statistical manual of mental disorders published by the American psychiatric association or the most recent version of the international classification of diseases."

Finally, it is unclear whether treatment of chronic pain with opioids could fall under controlled substances recognized or customarily used in the treatment and management of people with psychiatric, mental, cognitive, nervous, emotional, developmental, or behavioral disorders. Due to the opioid public health crisis, there are strict regulations for current prescribers around prescribing opioids, such as requirements around patient evaluation and treatment records, and a requirement to register with the Prescription Monitoring Program and perform a query before prescribing an opioid or benzodiazepine. The applicant stated in follow-up comments that it was not their intent to include opioids and the proposed bill implicitly excludes them.

[31] Linda and McGrath 2017
[32] Shearer et. al. 2012
[33] Linda and McGrath 2017

REVIEW OF PROPOSAL USING SUNRISE CRITERIA

The Sunrise Act, in RCW 18.120.010, states that a health care profession should be regulated or the scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

First Criterion: Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public.

The proposal does not meet this criterion. Psychologists are currently a thoroughly regulated profession with substantial training in treating mental health conditions. The proposal adds authority for psychologists to prescribe controlled substances without providing evidence the proposed education and training are adequate to protect the public. Prescribing is already regulated under a number of other professions' scopes of practice.

The applicant did not provide evidence the proposed education and training are sufficient to train psychologists to prescribe controlled substances safely. Absent a body of scientific evidence showing the minimum didactic and clinical education and experience necessary to safely prescribe controlled substances, the requirements should be at least equal to those of advanced registered nurse practitioners or physician assistants.

In addition, the psychology board does not have the expertise to determine appropriate education and prescribing practices. The proposal does not address this gap.

Second Criterion: The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability.

The proposal may partially meet this criterion. The department acknowledges the need to increase access to behavioral healthcare in Washington and believes the public may benefit from having a wider array of prescribers. The applicant provided some evidence the proposal could improve access to care. They estimated how many psychologists may choose to apply for the proposed prescriptive authority based on the experience in New Mexico and Louisiana, and on a 2019 survey of Washington psychologists showing about 50 percent of respondents were interested in this authority.

Currently, adequate protections are in place to assure the public of psychologists' initial and continued professional ability to practice safely within their current scope of practice. The proposal does not contain similar protections of public safety for prescribing

psychologists because the training and education requirements are not comparable to other prescribing professions; it lacks a requirement for collaboration with other providers; and does not contain necessary professional expertise on the Examining Board of Psychology.

Third Criterion: The public cannot be effectively protected by other, more cost-beneficial means.

The proposed legislation does not meet this criterion. The absence of prescribing expertise on the psychology board may drive up expert witness costs for disciplinary cases involving prescribing. State law, RCW 43.70.250, requires all professions to be self-supporting, so these expenses would be passed on to licensed psychologists.

This proposal is also costly for psychologists wishing to pursue prescriptive authority, with average costs projected by the applicants of nearly $36,000 for the additional education and supervised experience. It is unclear whether psychologists would want to devote the additional time or funds to pursue prescriptive authority certification. However, the applicant has provided some evidence of interest in this credential.

Recommendation

The department does not support the applicant's proposal as written to add prescriptive authority to the psychologist scope of practice. It does not meet the sunrise criteria for increasing a profession's scope of practice.

Rationale:

- The applicant has not provided evidence the proposed education and training are sufficient to train psychologists to prescribe controlled substances safely;
- The definition of "prescriptive authority" in House Bill 2967 is problematic because it does not include sufficient safeguards like physician or other prescriber collaboration; is unclear whether opioids would be included; and does not include non-controlled legend drugs, which omits many classes of medications to treat mental health conditions; and
- The psychology board does not have the expertise to establish education and practice standards or evaluate potential prescribing violations. Although the applicant suggests adding prescribers to the board, the proposed legislation did not include this language.

The applicant report pointed to other states that have passed prescriptive authority for psychologists as evidence of safe practice. However, all states that have made this policy change have instituted more rigorous education and training requirements, additional safeguards such as physician collaboration or supervision, limited formularies, age restrictions, and additional expertise in their regulatory structures to evaluate education, training, and complaints against providers.

In response to the draft report, the applicant indicated they intend to amend the proposed bill to address issues identified above. However, the department is required to review the proposed legislation submitted by the chair of the House Health Care and Wellness Committee and cannot make recommendations based on the applicant's intended amendments.

Appendix A

The Honorable Eileen Cody
303 John L. O'Brien Building
Olympia, WA 98504

April 23, 2020

The Honorable John Wiesman
Secretary of Health
Washington State Department of Health
P.O. Box 47890
Olympia, Washington 98504-7890

Dear Secretary Wiesman,

I am requesting that the Department of Health consider a Sunrise Review application for a proposal that would change the scope of practice for psychologists, namely giving this profession prescriptive authority for those with appropriate training.

A copy of the proposal is attached for HB 2967 (2020). The House Health Care & Wellness Committee would be interested in an assessment of whether the proposal meets the sunrise criteria for expanding the scope of practice for a regulated health profession in Washington.

I appreciate your consideration of this application and I look forward to receiving your report. Please contact my office if you have any questions.

Sincerely,

Eileen Cody

Representative Eileen Cody, RN
Chair, House Health Care & Wellness Committee
34th Legislative District

Cc: Kelly Cooper, Washington State Department of Health
Melanie Smith, Washington State Psychological Association
Representative Nicole Macri, 43rd Legislative District

Appendix B

H-3313.2

HOUSE BILL 2967

State of Washington 66th Legislature 2020 Regular Session

By Representative Macri

AN ACT Relating to the prescriptive authority of psychologists; amending RCW 18.83.010, 18.83.050, 18.83.080, and 18.83.090; reenacting and amending RCW 18.64.011, 18.79.260, and 69.50.101; and adding new sections to chapter 18.83 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 18.83.010 and 1994 c 35 s 1 are each amended to read as follows:

((~~When used in this chapter:~~)) The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) ((~~The~~)) "Board" means the examining board of psychology.

(2) "Clinical experience" means a period of supervised clinical training and practice in which clinical diagnoses and interventions are learned and which is conducted and supervised as part of the training program.

(3) "Controlled substance" has the same meaning as in RCW 69.50.101.

(4) "Department" means the department of health.

(5) "Practice of psychology" means the observation, evaluation, interpretation, and modification of human behavior by the application of psychological principles, methods, and procedures for the purposes

of preventing or eliminating symptomatic or maladaptive behavior and promoting mental and behavioral health. It includes, but is not limited to, providing the following services to individuals, families, groups, organizations, and the public, whether or not payment is received for services rendered:

(a) Psychological measurement, assessment, and evaluation by means of psychological, neuropsychological, and psychoeducational testing;

(b) Diagnosis and treatment of mental, emotional, and behavioral disorders, and psychological aspects of illness, injury, and disability; and

(c) Counseling and guidance, psychotherapeutic techniques, remediation, health promotion, and consultation within the context of established psychological principles and theories.

This definition does not include the teaching of principles of psychology for accredited educational institutions, or the conduct of research in problems of human or animal behavior.

((~~Nothing in this definition shall be construed as permitting the administration or prescribing of drugs or in any way infringing upon the practice of medicine and surgery as defined in chapter 18.71 RCW.~~

~~(2)~~)) (6) "Prescribing psychologist" means a person who holds an active license to practice psychology under this chapter and holds an active certificate to exercise prescriptive authority under the standards of section 2 of this act.

(7) "Prescription" has the same meaning as in RCW 18.64.011.

(8) "Prescriptive authority" means the authority of a prescribing psychologist to prescribe, administer, discontinue, and distribute controlled substances recognized or customarily used in the diagnosis, treatment, and management of individuals with psychiatric, mental, cognitive, nervous, emotional, developmental, or behavioral disorders. The term includes ordering necessary laboratory tests and diagnostic examinations, procedures necessary to obtain laboratory tests and diagnostic examinations, procedures which are relevant to the practice of psychology, and other directly related procedures within the scope of the practice of psychology in accordance with rules adopted by the board.

(9) "Secretary" means the secretary of health.

((~~(3) "Board" means the examining board of psychology.~~

~~(4) "Department" means the department of health.~~))

NEW SECTION. **Sec. 2.** A new section is added to chapter 18.83 RCW to read as follows:

(1) A psychologist who is licensed under this chapter may apply for certification as a prescribing psychologist to allow the psychologist to exercise prescriptive authority.

(2) The board shall certify an applicant as a prescribing psychologist if the applicant demonstrates to the board, by official transcript or other official evidence satisfactory to the board, that the applicant:

(a) Holds a current license as a psychologist;

(b) Holds a doctorate degree obtained from an integrated program of graduate study in psychology, as defined by rules of the board;

(c)(i) Has successfully completed an organized sequence of study in a master's degree offering intensive didactic education, and including the following core areas of instruction:

(A) Basic science;

(B) Functional neurosciences;

(C) Physical examination;

(D) Interpretation of laboratory tests;

(E) Pathological basis of disease;

(F) Clinical medicine;

(G) Clinical neurotherapeutics;

(H) Systems of care;

(I) Pharmacology;

(J) Clinical pharmacology;

(K) Psychopharmacology;

(L) Psychopharmacology research; and

(M) Professional, ethical, and legal issues;

(ii) The didactic portion of the education must consist of an appropriate number of didactic hours to assure acquisition of the necessary knowledge and skills to prescribe in a safe and effective manner;

(d) Has successfully completed a postdoctoral prescribing psychology fellowship defined by the board to obtain clinical experience sufficient to attain competency in the psychopharmacological treatment of a diverse patient population under the direction of qualified practitioners, as determined by the board; and

(e) Has passed an examination relevant to establishing competence for prescribing as developed by a nationally recognized organization and approved by the board.

(3) The board may waive certain requirements for applicants who have obtained relevant training and experience including:

(a) Psychologists who are dually licensed as physicians, nurse practitioners, or another health profession with comparable prescriptive authority in Washington; or

(b) Psychologists who have completed the United States department of defense psychopharmacology demonstration project.

(4) A certificate issued under this section may be renewed in accordance with RCW 18.83.090.

NEW SECTION. **Sec. 3.** A new section is added to chapter 18.83 RCW to read as follows:

(1) Prescribing psychologists may exercise prescriptive authority as provided in this chapter.

(2) A psychologist may not exercise prescriptive authority unless the psychologist holds a valid certificate of prescriptive authority under section 2 of this act.

(3) Each prescription issued by a prescribing psychologist must:

(a) Comply with all applicable state and federal laws and regulations; and

(b) Be identified as written by the prescribing psychologist in a manner determined by the board.

(4) A record of all prescriptions must be maintained in the patient's record.

(5) A prescribing psychologist may not delegate the authority to prescribe drugs and controlled substances to any other person.

(6) A prescribing psychologist who is authorized to prescribe controlled substances must submit to the board, in a timely manner, the prescribing psychologist's drug enforcement agency registration number.

(7) The board shall maintain a current list of every prescribing psychologist, the psychologists' license and certificate of prescribing authority numbers, and the drug enforcement agency registration and number.

(8)(a) The board shall transmit to the pharmacy quality assurance commission an initial list of prescribing psychologists. The list must contain:

(i) The name of each prescribing psychologist;

(ii) Each prescribing psychologist's identification number assigned by the board; and

(iii) The effective date of each prescribing psychologist's certificate of prescriptive authority.

(b) The board shall promptly notify the pharmacy quality assurance commission of:

(i) Any additions to the initial list as new prescribing psychologists are certified; and

(ii) The termination, suspension, or reinstatement of any prescribing psychologist's certification.

Sec. 4. RCW 18.83.050 and 2004 c 262 s 8 are each amended to read as follows:

(1) The board shall adopt such rules as it deems necessary to carry out its functions.

(2) The board shall examine the qualifications of applicants for licensing under this chapter, to determine which applicants are eligible for licensing under this chapter and shall forward to the secretary the names of applicants so eligible.

(3) The board shall:

(a) Develop and implement procedures for reviewing education and training credentials of applicants for certificates of prescriptive authority;

(b) Certify an applicant as a prescribing psychologist if the applicant meets the qualifications of section 2 of this act; and

(c) Adopt rules for denying, modifying, suspending, or revoking certification of a prescribing psychologist. The board may require remediation of any deficiencies in the training or practice pattern of the prescribing psychologist when, in the judgment of the board, such deficiencies could reasonably be expected to jeopardize the health, safety, or welfare of the public.

(4) The board shall administer examinations to qualified applicants on at least an annual basis. The board shall determine the subject matter and scope of the examination, except as provided in RCW 18.83.170. The board may allow applicants to take the examination upon the granting of their doctoral degree before completion of their internship for supervised experience.

((~~(4)~~)) (5) The board shall keep a complete record of its own proceedings, of the questions given in examinations, of the names and

qualifications of all applicants, and the names and addresses of all licensed psychologists. The examination paper of such applicant shall be kept on file for a period of at least one year after examination.

((~~(5)~~)) (6) The board shall, by rule, adopt a code of ethics for psychologists which is designed to protect the public interest.

((~~(6)~~)) (7) The board may require that persons licensed under this chapter as psychologists obtain and maintain professional liability insurance in amounts determined by the board to be practicable and reasonably available.

Sec. 5. RCW 18.83.080 and 1996 c 191 s 66 are each amended to read as follows:

The board shall forward to the secretary the name of each applicant entitled to a license under this chapter. The secretary shall promptly issue to such applicant a license authorizing such applicant to use the title "psychologist". Each licensed psychologist shall keep his or her license and certificate of prescriptive authority, if applicable, displayed in a conspicuous place in his or her principal place of business.

Sec. 6. RCW 18.83.090 and 2009 c 492 s 6 are each amended to read as follows:

(1) The board shall establish rules governing mandatory continuing education requirements which shall be met by any psychologist applying for a license renewal or renewal of a certificate of prescriptive authority.

(2) The office of crime victims advocacy shall supply the board with information on methods of recognizing victims of human trafficking, what services are available for these victims, and where to report potential trafficking situations. The information supplied must be culturally sensitive and must include information relating to minor victims. The board shall disseminate this information to licensees by: Providing the information on the board's web site; including the information in newsletters; holding trainings at meetings attended by organization members; or ((~~through~~)) another distribution method determined by the board. The board shall report to the office of crime victims advocacy on the method or methods it uses to distribute information under this subsection.

(3) Administrative procedures, administrative requirements, and fees for renewal and reissue of licenses shall be established as provided in RCW 43.70.250 and 43.70.280.

(4)(a) The board shall establish rules for the renewal of a certificate of prescriptive authority issued under section 2 of this act at the time of the renewal of the psychologist's license to practice psychology.

(b) Each applicant for renewal of a certificate of prescriptive authority shall present satisfactory evidence to the board demonstrating the completion of continuing education instruction relevant to prescriptive authority during the previous three-year renewal period.

Sec. 7. RCW 18.64.011 and 2016 c 148 s 1 are each reenacted and amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Administer" means the direct application of a drug or device, whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject.

(2) "Business licensing system" means the mechanism established by chapter 19.02 RCW by which business licenses, endorsed for individual state-issued licenses, are issued and renewed utilizing a business license application and a business license expiration date common to each renewable license endorsement.

(3) "Chart order" means a lawful order for a drug or device entered on the chart or medical record of an inpatient or resident of an institutional facility by a practitioner or his or her designated agent.

(4) "Closed door long-term care pharmacy" means a pharmacy that provides pharmaceutical care to a defined and exclusive group of patients who have access to the services of the pharmacy because they are treated by or have an affiliation with a long-term care facility or hospice program, and that is not a retailer of goods to the general public.

(5) "Commission" means the pharmacy quality assurance commission.

(6) "Compounding" means the act of combining two or more ingredients in the preparation of a prescription.

(7) "Controlled substance" means a drug or substance, or an immediate precursor of such drug or substance, so designated under or pursuant to the provisions of chapter 69.50 RCW.

(8) "Deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a drug or device, whether or not there is an agency relationship.

(9) "Department" means the department of health.

(10) "Device" means instruments, apparatus, and contrivances, including their components, parts, and accessories, intended (a) for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings or other animals, or (b) to affect the structure or any function of the body of human beings or other animals.

(11) "Dispense" means the interpretation of a prescription or order for a drug, biological, or device and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

(12) "Distribute" means the delivery of a drug or device other than by administering or dispensing.

(13) "Drug" and "devices" do not include surgical or dental instruments or laboratory materials, gas and oxygen, therapy equipment, X-ray apparatus or therapeutic equipment, their component parts or accessories, or equipment, instruments, apparatus, or contrivances used to render such articles effective in medical, surgical, or dental treatment, or for use or consumption in or for mechanical, industrial, manufacturing, or scientific applications or purposes. "Drug" also does not include any article or mixture covered by the Washington pesticide control act (chapter 15.58 RCW), as enacted or hereafter amended, nor medicated feed intended for and used exclusively as a feed for animals other than human beings.

(14) "Drugs" means:

(a) Articles recognized in the official United States pharmacopoeia or the official homeopathic pharmacopoeia of the United States;

(b) Substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings or other animals;

(c) Substances (other than food) intended to affect the structure or any function of the body of human beings or other animals; or

(d) Substances intended for use as a component of any substances specified in (a), (b), or (c) of this subsection, but not including devices or their component parts or accessories.

(15) "Health care entity" means an organization that provides health care services in a setting that is not otherwise licensed by the state to acquire or possess legend drugs. Health care entity includes a freestanding outpatient surgery center, a residential treatment facility, and a freestanding cardiac care center. "Health care entity" does not include an individual practitioner's office or a multipractitioner clinic, regardless of ownership, unless the owner elects licensure as a health care entity. "Health care entity" also does not include an individual practitioner's office or multipractitioner clinic identified by a hospital on a pharmacy application or renewal pursuant to RCW 18.64.043.

(16) "Hospice program" means a hospice program certified or paid by medicare under Title XVIII of the federal social security act, or a hospice program licensed under chapter 70.127 RCW.

(17) "Institutional facility" means any organization whose primary purpose is to provide a physical environment for patients to obtain health care services including, but not limited to, services in a hospital, long-term care facility, hospice program, mental health facility, drug abuse treatment center, residential habilitation center, or a local, state, or federal correction facility.

(18) "Labeling" means the process of preparing and affixing a label to any drug or device container. The label must include all information required by current federal and state law and pharmacy rules.

(19) "Legend drugs" means any drugs which are required by any applicable federal or state law or regulation to be dispensed on prescription only or are restricted to use by practitioners only.

(20) "Long-term care facility" means a nursing home licensed under chapter 18.51 RCW, an assisted living facility licensed under chapter 18.20 RCW, or an adult family home licensed under chapter 70.128 RCW.

(21) "Manufacture" means the production, preparation, propagation, compounding, or processing of a drug or other substance or device or the packaging or repackaging of such substance or device, or the labeling or relabeling of the commercial container of such substance or device, but does not include the activities of a

practitioner who, as an incident to his or her administration or dispensing such substance or device in the course of his or her professional practice, personally prepares, compounds, packages, or labels such substance or device. "Manufacture" includes the distribution of a licensed pharmacy compounded drug product to other state licensed persons or commercial entities for subsequent resale or distribution, unless a specific product item has approval of the commission. The term does not include:

(a) The activities of a licensed pharmacy that compounds a product on or in anticipation of an order of a licensed practitioner for use in the course of their professional practice to administer to patients, either personally or under their direct supervision;

(b) The practice of a licensed pharmacy when repackaging commercially available medication in small, reasonable quantities for a practitioner legally authorized to prescribe the medication for office use only;

(c) The distribution of a drug product that has been compounded by a licensed pharmacy to other appropriately licensed entities under common ownership or control of the facility in which the compounding takes place; or

(d) The delivery of finished and appropriately labeled compounded products dispensed pursuant to a valid prescription to alternate delivery locations, other than the patient's residence, when requested by the patient, or the prescriber to administer to the patient, or to another licensed pharmacy to dispense to the patient.

(22) "Manufacturer" means a person, corporation, or other entity engaged in the manufacture of drugs or devices.

(23) "Nonlegend" or "nonprescription" drugs means any drugs which may be lawfully sold without a prescription.

(24) "Person" means an individual, corporation, government, governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

(25) "Pharmacist" means a person duly licensed by the commission to engage in the practice of pharmacy.

(26) "Pharmacy" means every place properly licensed by the commission where the practice of pharmacy is conducted.

(27) "Poison" does not include any article or mixture covered by the Washington pesticide control act (chapter 15.58 RCW), as enacted or hereafter amended.

(28) "Practice of pharmacy" includes the practice of and responsibility for: Interpreting prescription orders; the compounding, dispensing, labeling, administering, and distributing of drugs and devices; the monitoring of drug therapy and use; the initiating or modifying of drug therapy in accordance with written guidelines or protocols previously established and approved for his or her practice by a practitioner authorized to prescribe drugs; the participating in drug utilization reviews and drug product selection; the proper and safe storing and distributing of drugs and devices and maintenance of proper records thereof; the providing of information on legend drugs which may include, but is not limited to, the advising of therapeutic values, hazards, and the uses of drugs and devices.

(29) "Practitioner" means a physician, dentist, veterinarian, nurse, prescribing psychologist, or other person duly authorized by law or rule in the state of Washington to prescribe drugs.

(30) "Prescription" means an order for drugs or devices issued by a practitioner duly authorized by law or rule in the state of Washington to prescribe drugs or devices in the course of his or her professional practice for a legitimate medical purpose.

(31) "Secretary" means the secretary of health or the secretary's designee.

(32) "Shared pharmacy services" means a system that allows a participating pharmacist or pharmacy pursuant to a request from another participating pharmacist or pharmacy to process or fill a prescription or drug order, which may include but is not necessarily limited to preparing, packaging, labeling, data entry, compounding for specific patients, dispensing, performing drug utilization reviews, conducting claims adjudication, obtaining refill authorizations, reviewing therapeutic interventions, or reviewing chart orders.

(33) "Wholesaler" means a corporation, individual, or other entity which buys drugs or devices for resale and distribution to corporations, individuals, or entities other than consumers.

Sec. 8. RCW 18.79.260 and 2012 c 164 s 407, 2012 c 13 s 3, and 2012 c 10 s 37 are each reenacted and amended to read as follows:

(1) A registered nurse under his or her license may perform for compensation nursing care, as that term is usually understood, to individuals with illnesses, injuries, or disabilities.

(2) A registered nurse may, at or under the general direction of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, naturopathic physician, optometrist, podiatric physician and surgeon, physician assistant, prescribing psychologist, osteopathic physician assistant, advanced registered nurse practitioner, or midwife acting within the scope of his or her license, administer medications, treatments, tests, and inoculations, whether or not the severing or penetrating of tissues is involved and whether or not a degree of independent judgment and skill is required. Such direction must be for acts which are within the scope of registered nursing practice.

(3) A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient.

(a) The delegating nurse shall:

(i) Determine the competency of the individual to perform the tasks;

(ii) Evaluate the appropriateness of the delegation;

(iii) Supervise the actions of the person performing the delegated task; and

(iv) Delegate only those tasks that are within the registered nurse's scope of practice.

(b) A registered nurse, working for a home health or hospice agency regulated under chapter 70.127 RCW, may delegate the application, instillation, or insertion of medications to a registered or certified nursing assistant under a plan of care.

(c) Except as authorized in (b) or (e) of this subsection, a registered nurse may not delegate the administration of medications. Except as authorized in (e) of this subsection, a registered nurse may not delegate acts requiring substantial skill, and may not delegate piercing or severing of tissues. Acts that require nursing judgment shall not be delegated.

(d) No person may coerce a nurse into compromising patient safety by requiring the nurse to delegate if the nurse determines that it is inappropriate to do so. Nurses shall not be subject to any employer reprisal or disciplinary action by the nursing care quality assurance commission for refusing to delegate tasks or refusing to provide the required training for delegation if the nurse determines delegation may compromise patient safety.

(e) For delegation in community-based care settings or in-home care settings, a registered nurse may delegate nursing care tasks only to registered or certified nursing assistants or home care aides certified under chapter 18.88B RCW. Simple care tasks such as blood pressure monitoring, personal care service, diabetic insulin device set up, verbal verification of insulin dosage for sight-impaired individuals, or other tasks as defined by the nursing care quality assurance commission are exempted from this requirement.

(i) "Community-based care settings" includes: Community residential programs for people with developmental disabilities, certified by the department of social and health services under chapter 71A.12 RCW; adult family homes licensed under chapter 70.128 RCW; and assisted living facilities licensed under chapter 18.20 RCW. Community-based care settings do not include acute care or skilled nursing facilities.

(ii) "In-home care settings" include an individual's place of temporary or permanent residence, but does not include acute care or skilled nursing facilities, and does not include community-based care settings as defined in (e)(i) of this subsection.

(iii) Delegation of nursing care tasks in community-based care settings and in-home care settings is only allowed for individuals who have a stable and predictable condition. "Stable and predictable condition" means a situation in which the individual's clinical and behavioral status is known and does not require the frequent presence and evaluation of a registered nurse.

(iv) The determination of the appropriateness of delegation of a nursing task is at the discretion of the registered nurse. Other than delegation of the administration of insulin by injection for the purpose of caring for individuals with diabetes, the administration of medications by injection, sterile procedures, and central line maintenance may never be delegated.

(v) When delegating insulin injections under this section, the registered nurse delegator must instruct the individual regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate the individual performing the delegated task weekly during the first four weeks of delegation of insulin injections. If the registered nurse delegator determines that the individual is competent to perform the injection properly and safely, supervision and evaluation shall occur at least every ninety days thereafter.

(vi)(A) The registered nurse shall verify that the nursing assistant or home care aide, as the case may be, has completed the required core nurse delegation training required in chapter 18.88A or 18.88B RCW prior to authorizing delegation.

(B) Before commencing any specific nursing tasks authorized to be delegated in this section, a home care aide must be certified pursuant to chapter 18.88B RCW and must comply with RCW 18.88B.070.

(vii) The nurse is accountable for his or her own individual actions in the delegation process. Nurses acting within the protocols of their delegation authority are immune from liability for any action performed in the course of their delegation duties.

(viii) Nursing task delegation protocols are not intended to regulate the settings in which delegation may occur, but are intended to ensure that nursing care services have a consistent standard of practice upon which the public and the profession may rely, and to safeguard the authority of the nurse to make independent professional decisions regarding the delegation of a task.

(f) The nursing care quality assurance commission may adopt rules to implement this section.

(4) Only a person licensed as a registered nurse may instruct nurses in technical subjects pertaining to nursing.

(5) Only a person licensed as a registered nurse may hold herself or himself out to the public or designate herself or himself as a registered nurse.

Sec. 9. RCW 69.50.101 and 2019 c 394 s 9, 2019 c 158 s 12, and 2019 c 55 s 11 are each reenacted and amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(a) "Administer" means to apply a controlled substance, whether by injection, inhalation, ingestion, or any other means, directly to the body of a patient or research subject by:

(1) a practitioner authorized to prescribe (or, by the practitioner's authorized agent); or

(2) the patient or research subject at the direction and in the presence of the practitioner.

(b) "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser. It does not include a common or contract carrier, public warehouseperson, or employee of the carrier or warehouseperson.

(c) "Board" means the Washington state liquor and cannabis board.

(d) "CBD concentration" has the meaning provided in RCW 69.51A.010.

(e) "CBD product" means any product containing or consisting of cannabidiol.

(f) "Commission" means the pharmacy quality assurance commission.

(g) "Controlled substance" means a drug, substance, or immediate precursor included in Schedules I through V as set forth in federal or state laws, or federal or commission rules, but does not include hemp or industrial hemp as defined in RCW 15.140.020.

(h)(1) "Controlled substance analog" means a substance the chemical structure of which is substantially similar to the chemical structure of a controlled substance in Schedule I or II and:

(i) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system substantially similar to the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance included in Schedule I or II; or

(ii) with respect to a particular individual, that the individual represents or intends to have a stimulant, depressant, or hallucinogenic effect on the central nervous system substantially similar to the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance included in Schedule I or II.

(2) The term does not include:

(i) a controlled substance;

(ii) a substance for which there is an approved new drug application;

(iii) a substance with respect to which an exemption is in effect for investigational use by a particular person under Section 505 of the federal food, drug, and cosmetic act, 21 U.S.C. Sec. 355, or chapter 69.77 RCW to the extent conduct with respect to the substance is pursuant to the exemption; or

(iv) any substance to the extent not intended for human consumption before an exemption takes effect with respect to the substance.

(i) "Deliver" or "delivery" means the actual or constructive transfer from one person to another of a substance, whether or not there is an agency relationship.

(j) "Department" means the department of health.

(k) "Designated provider" has the meaning provided in RCW 69.51A.010.

(l) "Dispense" means the interpretation of a prescription or order for a controlled substance and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

(m) "Dispenser" means a practitioner who dispenses.

(n) "Distribute" means to deliver other than by administering or dispensing a controlled substance.

(o) "Distributor" means a person who distributes.

(p) "Drug" means (1) a controlled substance recognized as a drug in the official United States pharmacopoeia/national formulary or the official homeopathic pharmacopoeia of the United States, or any supplement to them; (2) controlled substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in individuals or animals; (3) controlled substances (other than food) intended to affect the structure or any function of the body of individuals or animals; and (4) controlled substances intended for use as a component of any article specified in (1), (2), or (3) of this subsection. The term does not include devices or their components, parts, or accessories.

(q) "Drug enforcement administration" means the drug enforcement administration in the United States Department of Justice, or its successor agency.

(r) "Electronic communication of prescription information" means the transmission of a prescription or refill authorization for a drug of a practitioner using computer systems. The term does not include a prescription or refill authorization verbally transmitted by telephone nor a facsimile manually signed by the practitioner.

(s) "Immature plant or clone" means a plant or clone that has no flowers, is less than twelve inches in height, and is less than twelve inches in diameter.

(t) "Immediate precursor" means a substance:

(1) that the commission has found to be and by rule designates as being the principal compound commonly used, or produced primarily for use, in the manufacture of a controlled substance;

(2) that is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled substance; and

(3) the control of which is necessary to prevent, curtail, or limit the manufacture of the controlled substance.

(u) "Isomer" means an optical isomer, but in subsection (gg)(5) of this section, RCW 69.50.204(a) (12) and (34), and 69.50.206(b)(4), the term includes any geometrical isomer; in RCW 69.50.204(a) (8) and (42), and 69.50.210(c) the term includes any positional isomer; and in RCW 69.50.204(a)(35), 69.50.204(c), and 69.50.208(a) the term includes any positional or geometric isomer.

(v) "Lot" means a definite quantity of marijuana, marijuana concentrates, useable marijuana, or marijuana-infused product identified by a lot number, every portion or package of which is uniform within recognized tolerances for the factors that appear in the labeling.

(w) "Lot number" must identify the licensee by business or trade name and Washington state unified business identifier number, and the date of harvest or processing for each lot of marijuana, marijuana concentrates, useable marijuana, or marijuana-infused product.

(x) "Manufacture" means the production, preparation, propagation, compounding, conversion, or processing of a controlled substance, either directly or indirectly or by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling of its container. The term does not include the preparation, compounding, packaging, repackaging, labeling, or relabeling of a controlled substance:

(1) by a practitioner as an incident to the practitioner's administering or dispensing of a controlled substance in the course of the practitioner's professional practice; or

(2) by a practitioner, or by the practitioner's authorized agent under the practitioner's supervision, for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale.

(y) "Marijuana" or "marihuana" means all parts of the plant *Cannabis*, whether growing or not, with a THC concentration greater than 0.3 percent on a dry weight basis; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin. The term does not include:

(1) The mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination; or

(2) Hemp or industrial hemp as defined in RCW 15.140.020, seeds used for licensed hemp production under chapter 15.140 RCW.

(z) "Marijuana concentrates" means products consisting wholly or in part of the resin extracted from any part of the plant *Cannabis* and having a THC concentration greater than ten percent.

(aa) "Marijuana processor" means a person licensed by the state liquor and cannabis board to process marijuana into marijuana concentrates, useable marijuana, and marijuana-infused products, package and label marijuana concentrates, useable marijuana, and marijuana-infused products for sale in retail outlets, and sell marijuana concentrates, useable marijuana, and marijuana-infused products at wholesale to marijuana retailers.

(bb) "Marijuana producer" means a person licensed by the state liquor and cannabis board to produce and sell marijuana at wholesale to marijuana processors and other marijuana producers.

(cc) "Marijuana products" means useable marijuana, marijuana concentrates, and marijuana-infused products as defined in this section.

(dd) "Marijuana researcher" means a person licensed by the state liquor and cannabis board to produce, process, and possess marijuana for the purposes of conducting research on marijuana and marijuana-derived drug products.

(ee) "Marijuana retailer" means a person licensed by the state liquor and cannabis board to sell marijuana concentrates, useable marijuana, and marijuana-infused products in a retail outlet.

(ff) "Marijuana-infused products" means products that contain marijuana or marijuana extracts, are intended for human use, are derived from marijuana as defined in subsection (y) of this section, and have a THC concentration no greater than ten percent. The term "marijuana-infused products" does not include either useable marijuana or marijuana concentrates.

(gg) "Narcotic drug" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable

origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium, opium derivative, and any derivative of opium or opium derivative, including their salts, isomers, and salts of isomers, whenever the existence of the salts, isomers, and salts of isomers is possible within the specific chemical designation. The term does not include the isoquinoline alkaloids of opium.

(2) Synthetic opiate and any derivative of synthetic opiate, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, and salts is possible within the specific chemical designation.

(3) Poppy straw and concentrate of poppy straw.

(4) Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives or ecgonine or their salts have been removed.

(5) Cocaine, or any salt, isomer, or salt of isomer thereof.

(6) Cocaine base.

(7) Ecgonine, or any derivative, salt, isomer, or salt of isomer thereof.

(8) Any compound, mixture, or preparation containing any quantity of any substance referred to in ((~~subparagraphs~~)) (1) through (7) <u>of this subsection</u>.

(hh) "Opiate" means any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. The term includes opium, substances derived from opium (opium derivatives), and synthetic opiates. The term does not include, unless specifically designated as controlled under RCW 69.50.201, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). The term includes the racemic and levorotatory forms of dextromethorphan.

(ii) "Opium poppy" means the plant of the species Papaver somniferum L., except its seeds.

(jj) "Person" means individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

(kk) "Plant" has the meaning provided in RCW 69.51A.010.

(ll) "Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

(mm) "Practitioner" means:

(1) A physician under chapter 18.71 RCW; a physician assistant under chapter 18.71A RCW; an osteopathic physician and surgeon under chapter 18.57 RCW; an osteopathic physician assistant under chapter 18.57A RCW who is licensed under RCW 18.57A.020 subject to any limitations in RCW 18.57A.040; an optometrist licensed under chapter 18.53 RCW who is certified by the optometry board under RCW 18.53.010 subject to any limitations in RCW 18.53.010; a dentist under chapter 18.32 RCW; a podiatric physician and surgeon under chapter 18.22 RCW; a veterinarian under chapter 18.92 RCW; a registered nurse, advanced registered nurse practitioner, or licensed practical nurse under chapter 18.79 RCW; a naturopathic physician under chapter 18.36A RCW who is licensed under RCW 18.36A.030 subject to any limitations in RCW 18.36A.040; a psychologist licensed under chapter 18.83 RCW and certified as a prescribing psychologist under section 2 of this act; a pharmacist under chapter 18.64 RCW or a scientific investigator under this chapter, licensed, registered or otherwise permitted insofar as is consistent with those licensing laws to distribute, dispense, conduct research with respect to or administer a controlled substance in the course of their professional practice or research in this state.

(2) A pharmacy, hospital or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in this state.

(3) A physician licensed to practice medicine and surgery, a physician licensed to practice osteopathic medicine and surgery, a dentist licensed to practice dentistry, a podiatric physician and surgeon licensed to practice podiatric medicine and surgery, a licensed physician assistant or a licensed osteopathic physician assistant specifically approved to prescribe controlled substances by his or her state's medical commission or equivalent and his or her supervising physician, an advanced registered nurse practitioner licensed to prescribe controlled substances, or a veterinarian licensed to practice veterinary medicine in any state of the United States.

(nn) "Prescription" means an order for controlled substances issued by a practitioner duly authorized by law or rule in the state

of Washington to prescribe controlled substances within the scope of his or her professional practice for a legitimate medical purpose.

(oo) "Production" includes the manufacturing, planting, cultivating, growing, or harvesting of a controlled substance.

(pp) "Qualifying patient" has the meaning provided in RCW 69.51A.010.

(qq) "Recognition card" has the meaning provided in RCW 69.51A.010.

(rr) "Retail outlet" means a location licensed by the state liquor and cannabis board for the retail sale of marijuana concentrates, useable marijuana, and marijuana-infused products.

(ss) "Secretary" means the secretary of health or the secretary's designee.

(tt) "State," unless the context otherwise requires, means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(uu) "THC concentration" means percent of delta-9 tetrahydrocannabinol content per dry weight of any part of the plant *Cannabis*, or per volume or weight of marijuana product, or the combined percent of delta-9 tetrahydrocannabinol and tetrahydrocannabinolic acid in any part of the plant *Cannabis* regardless of moisture content.

(vv) "Ultimate user" means an individual who lawfully possesses a controlled substance for the individual's own use or for the use of a member of the individual's household or for administering to an animal owned by the individual or by a member of the individual's household.

(ww) "Useable marijuana" means dried marijuana flowers. The term "useable marijuana" does not include either marijuana-infused products or marijuana concentrates.

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Appendix C

*Applicant Report Cover Sheet and Outline

Washington State Department of Health Sunrise Review Application for Scope of Practice Change

COVER SHEET
Legislative proposal being reviewed under the sunrise process: HB 2967 introduced by Representative Macri 03/13/2020, with letter from Representative Cody to John Wiseman, Sec. of Health.

Name and title of profession the applicant seeks to credential/institute change in scope of practice: Chapter 18.83 RCW - Psychologists

Applicant's organization:
Washington State Psychological Association
Contact person:
Washington State Psychological Association:
2020 President – Julia Mackaronis, Ph.D julia.mackaronis@gmail.com
WSPA Lobbyist – Melanie Smith smith.melaniej@gmail.com

Address:
Washington State Psychological Association
9 S. Washington Street, Suite 201
Spokane, WA 99201

Telephone number: Phone:206/547-4220

Number of members in the organization: Number: 512
Approximate number of individuals practicing in Washington: 3110

Name(s) and address(es) of national organization(s) with which the state organization is affiliated:
American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
(800) 374-2721

Name(s) of other state organizations representing the profession:
None.

Introduction

This applicant report is submitted to the Department of Health (DOH) in compliance with RCW 48.47.030 on behalf of the Washington State Psychological Association (WSPA) hereinafter identified as "Applicant.". This report is based on a draft bill (Appendix A) which amends RCW 18.83.010, 18.83.050, 18.83.080, and 18.83.090; reenacting and amending RCW 18.64.011, 18.79.260, and 69.50.101; and adding new sections to Chapter 18.83 RCW. These amendments and additions will expand licensed psychologists' scope of practice to include prescriptive authority.

(1). A definition of the problem and why regulation is necessary

Since 1957 psychologists in Washington State have been licensed and regulated by the state under Chapter 18.83 RCW. Psychologists play a critical role in the delivery of mental health services in Washington State. However, their current scope of practice does not include the authority to prescribe medications for the treatment and management of mental disorders. Adding prescriptive authority to the scope of practice for those eligible psychologists in this state who have successfully completed additional education and training in clinical psychopharmacology will create much needed capacity in a significantly overburdened mental health and primary care system, while ensuring the health and safety of the public.

(1)(a) The nature of the potential harm to the public if the health profession is not regulated, and the extent to which there is a threat to public health and safety;

Washington State is ranked 45th in the United States on measures of mental illness prevalence and access to car (Mental Health America, 2020). Research reviewed by the Center for Disease Control (CDC) suggests that half of all adults in the United States will experience one or more episodes of a mental disorder in their lifetimes (Kessler et al., 2007). Approximately 1 in 5 children will experience a seriously debilitating mental illness (Merikangas et al, 2010). Untreated mental disorders not only negatively impact individuals and their family's lives, but also adds significantly to the economic burden of our society. The World Health Organization (WHO) estimates that 14% of the global economic burden of disease is attributed to mental disorders, but most people affected do not receive treatment (WHO, 2019).

In Washington State access to appropriate and effective mental health services remains a significant problem for men, women, and children of all ethnicities and social groups. Passage of state mandated mental health parity laws and the federal Patient Protection and Affordable Care Act (PPACA, 2010) have strengthened the legal right to treatment benefits. However, our current workforce shortage makes it difficult for many individuals to find a qualified provider and access those benefits.

Access to evaluations for medications for mental disorders are limited, because only a small subset of providers can prescribe. Currently only physicians, psychiatrists and Advance Practice nurses (ARNP) may prescribe medication for the treatment of mental disorders.

Psychiatrists scope of practice includes prescription authority. But many individuals are unable to find a psychiatrist who will treat them. In 2018, as established by the US Bureau of Labor

Statistics, there were only 570 psychiatrists in Washington State (https://www.bls.gov/oes/2018/may/oes291066.htm). Many psychiatrists will not take insurance and even fewer accept Medicaid. Requiring patients to privately pay for services makes access extremely difficult for low- and middle-income patients, and many psychiatrists have long waiting lists. Additionally, psychiatrists are retiring nationwide in large numbers, and are currently not being replaced by younger physicians choosing psychiatry as a specialty. More than half of all psychiatrists are age 55 and over (Satiani et al, 2018). Therefore, current barriers to psychiatric care will be further exacerbated as a significant percentage of psychiatrists in Washington are likely to retire within the next ten years. If patients experience difficulty finding a psychiatrist now, the problem will only worsen.

Dr. Daniel Carlat, associate professor of psychiatry at Tufts University School of Medicine and author of the article "45,000 More Psychiatrists Anyone" (Carlat, 2010), estimated the need for psychiatrists at that time at approximately 26 per 100,000 citizens. Washington state currently has approximately 8 psychiatrists per 100,000 residents, a severe shortage.

Rural areas in Washington have even less access. A 2014 U.S. Health Resources and Services Administration (HRSA) map of licensed clinical psychologist and mental health professional shortage areas (MHPSAs) indicates that at least 10 counties in Washington State are without a psychiatrist, the shortages being most significant in eastern and southwest Washington**. (**See Licensed Clinical Psychologists and Mental Health Professional Shortage Areas [MHPSA] by County and Congressional District, Appendix B).

Primary care physicians and ARNPS also prescribe medications to treat mental disorders. However, there is a shortage of primary care physicians. While ARNPs also provide psychiatric services, only an estimated 2% of all ARNP students choose to become psychiatric ARNPs (AANP website). Finally, primary care providers are often overburdened with responsibility for prescribing psychotropic medications in the absence of providers who specialize in psychopharmacology.

(1)(b) The extent to which consumers need and will benefit from a method of regulation, identifying competent practitioners, indicating typical employers, if any, of practitioners in the health profession; and

Regulation of health providers in Washington State exists to provide the public with protection from unethical, unprofessional and incompetent care. Licensure of all health professionals sets the standard of competence, including education, training and expertise. Regulation provides legal definitions of competent practice, a place for patients to submit complaints of unprofessional practice and the ability of the state to investigate and discipline health professionals accused and found guilty of unprofessional conduct. As is shown by empirical evidence from other jurisdictions, licensed prescribing psychologists will create no more nor less risk than currently exists for other prescribers.

(1)(c) The extent of autonomy a practitioner has, as indicated by: (i) The extent to which the health profession calls for independent judgment and the extent of skill or experience

required in making the independent judgment; and (ii) The extent to which practitioners are or would be supervised

The Examining Board of Psychology (EBOP) both licenses and disciplines psychologists under RCW 18.83. The EBOP establishes state requirements for level of education, training and supervision, continuing education and standards of practice for the profession. The draft bill (Appendix A) adds an additional certification to the license of any currently licensed psychologist who successfully meets the education, training and supervision requirements as defined in the legislation. Certification will indicate that the licensed psychologist is a prescribing psychologist.

Rules for ethical conduct of psychologists are in WAC 246-924-351 including the requirement that psychologists not practice beyond areas of competence. In addition, all psychologists are regulated by the state Uniform Disciplinary Act (RCW 18.130) and adhere to the American Psychological Association (APA) Code of Ethics (APA, 2011)**.** Licensure as a psychologist is a prerequisite to certification as a prescribing psychologist.

(2). The efforts made to address the problem: (a) Voluntary efforts, if any, by members of the health profession to: (i) Establish a code of ethics; or (ii) Help resolve disputes between health practitioners and consumers; and b) Recourse to and the extent of use of applicable law and whether it could be strengthened to control the problem;

Prescribing psychologists have been credentialed by the Department of Defense for many years. The first program to train and deploy prescribing psychologists was the Department of Defense (DOD) Military Health System (MHS) Psychopharmacology Demonstration Project (PDP) (Newman et al., 2000; GAO, 1997, 1999).

Background on the DOD Military Health System Psychopharmacology Demonstration Project (PDP):

A total of 10 Armed Forces psychologists completed the PDP program. They served in multiple positions of authority in the military and treated a variety of patients and mental disorders. They have utilized comprehensive formularies and have carried caseloads similar to psychiatrists and colleague psychologists. Overall, GAO/HHS (Health & Human Services department) examiners learned from supervisors, other providers and officials that (GAO, 1997, 1999; ACNP, 1998; Vector Research, 1996**)**:

- PDP graduates were fully integrated into the Military Health System (MHS);
- All but two of the original graduates were granted independent status to prescribe;
- They were held in high professional esteem by the military (examples: one became Chief of an Army mental health program; another Commander of an Air Force mental health program; and a third, Chief of a Navy hospital mental health department.)

The GAO report concluded that prescribing psychologists "- by reducing the time patients must wait and by increasing the number of personnel and dependents who can be treated for

illnesses requiring psychotropic medication – have enhanced the peacetime readiness of the locations where they are serving." (Page 4, GAO, 1999). Ultimately, the PDP was discontinued due to costs and opposition to psychologists prescribing. However, by the time the PDP had shuttered its doors the program had demonstrated the viability of training psychologists to safely and effectively prescribe psychotropic medication.

Subsequent evaluations independent of the GAO report were completed by contract to the DOD. The American College of Neuropsychopharmacology (ACNP, 1998) composed of psychologists and psychiatrists conducted six annual assessments of the PDP program concluding in 1998. The evaluations determined that the psychologists in PDP were safe prescribers and noted the absence of a single significant adverse event among patients treated by PDP psychologists, including licensing board complaints or personal injury lawsuits.

Since the conclusion of the PDP program, multiple states and entities have passed legislation adding prescriptive authority to the scope of practice of appropriately trained psychologists. They are: Louisiana; New Mexico; Illinois; Iowa; Idaho; the US Public Health Service; the Indian Health Service; the US military; and the US Protectorate of Guam. The first two states to regulate prescribing psychologists, Louisiana and New Mexico, together currently regulate over 176 prescribing psychologists.

(3)(a) Regulation of business employers or practitioners rather than employee practitioners;
Not applicable.

(3)(b) Regulation of the program or service rather than the individual practitioners;
The service of prescriptive authority for psychotropic medications is already regulated for related professions including psychiatry, psychiatric nurse practitioners, and psychiatric physician assistants. Regulation of the proposed change in scope of practice for clinical psychologists is necessary to protect the public interest by increasing access to qualified prescribers of psychotropic medications.

(3)(c) Registration of all practitioners;
Registration of all clinical psychologists would not be appropriate because the prescription of psychotropic medications by clinical psychologists requires specialized training. This specialized training is above and beyond the doctoral education and clinical training established by state and national standards for the licensure of clinical psychologists.

(3)(d) Certification of all practitioners;
Certification of all clinical psychologists is not applicable per response to 3.c above.

(3)(e) Why the use of the alternatives specified in this subsection would not be adequate to protect the public interest; alternatives in the subsection would not be adequate to protect the public from harm or ensure the health, safety, or welfare of the public.

Expansion of the scope of practice of appropriately trained clinical psychologists to include prescribing psychotropic medication will require specialized training, certification, assurance of initial and ongoing ability to practice safely which can only be reliably regulated by the state.

(3)(f) Why licensing would serve to protect the public interest;
The prescription of psychotropic medications has a clear potential for harm if conducted by unqualified health providers. Public safety and welfare requires that prescribers of psychotropic medications are appropriately trained and must establish initial and continuing competence. Regulating prescribing psychology as a health profession protects the public interest from potentially harmful practices and is the most cost-effective way of affording public protection.

(4) The benefit to the public if regulation is granted:
Licensed clinical psychologists are experts in the assessment, diagnosis and psychotherapeutic treatment of a broad range of chronic and acute psychological conditions. Clinical psychologists who can also prescribe psychotropic medication can provide one location with a single provider who can enlist both psychotherapy as well as medication treatments for behavioral health disorders. The public will be assured of the same protections they have now and that they have come to trust and expect.

Consumers will benefit from the updated standards now being proposed as these standards will allow the clinical psychologists to offer a broader range of treatment services. These consolidated services will:

- Improve access to care for consumers of all ages
- Provide a wider range of treatment options by consolidating care to a single mental health provider
- Decrease cost to the consumer

(4)(a) The extent to which the incidence of specific problems present in the unregulated health profession can reasonably be expected to be reduced by regulation;
High standards of training, licensing, and professional conduct for licensed clinical psychologists already exists in Washington State. The proposed amendments to clinical psychology regulations for the expanded scope of practice will further assure the public has continued access to safe psychological interventions, including therapy, as well as pharmacological treatment and therapies by licensed psychologists who also prescribe medication for the treatment and management of mental health disorders.

(4)(b) Whether the public can identify qualified practitioners;
The Department of Health (DOH) has an easily navigable and searchable website that lists all practitioners by name and license number so the public can identify qualified practitioners. All information regarding a practitioner's current licensing status or issues involving licensure is clearly marked and available for public record. This website could show which psychologists had been certified to prescribe medication.

(4)(c) The extent to which the public can be confident that qualified practitioners are competent:
All prescribing psychologists must meet the high standards of advanced coursework and educational requirements for certification as established by the American Psychological Association's Model Legislation for Prescriptive Authority (APA, 2019) and the Designation Criteria for Education and Training Programs in Psychopharmacology for Prescriptive Authority (APA, 2019). Certification is contingent upon completing the basic science pre-requisites, a two-year post-doctoral masters' degree in clinical psychopharmacology from an accredited university, completion of a supervised practicum, and passing a national certification examination administered by the Association of State and Provincial Psychology Boards (ASPPB).

(4)(c)(i) Whether the proposed regulatory entity would be a board composed of members of the profession and public members, or a state agency, or both, and, if appropriate, their respective responsibilities in administering the system of registration, certification, or licensure, including the composition of the board and the number of public members, if any; the powers and duties of the board or state agency regarding examinations and for cause revocation, suspension, and nonrenewal of registrations, certificates, or licenses; the promulgation of rules and canons of ethics; the conduct of inspections; the receipt of complaints and disciplinary action taken against practitioners;
Licensed psychologists are governed by RCW 18.83. The regulatory entity for prescribing psychologists would be same as the regulatory entity for all other psychologists in the state; the Examining Board of Psychology (EBOP). For consultation in matters limited to prescribing psychologists, the Board may include a prescribing psychologist as a member and/or an advisory group. A physician and/or pharmacist may be added to the Board at its discretion. The state agency will retain the powers and duties regarding examinations and for cause revocation, suspension, and nonrenewal of registrations, certificates, or licenses; the promulgation of rules; the conduct of inspections; the receipt of complaints and disciplinary action taken against practitioners.

(4)(c)(ii) If there is a grandfather clause, whether such practitioners will be required to meet the prerequisite qualifications established by the regulatory entity at a later date;
Not applicable.

(4)(c)(iii) The nature of the standards proposed for registration, certification, or licensure as compared with the standards of other jurisdictions;
The standards proposed are consistent with the standards of other states including: New Mexico, Louisiana, Idaho, and Iowa.

(4)(c)(iv) Whether the regulatory entity would be authorized to enter into reciprocity agreements with other jurisdictions;
Licensed clinical psychologists certified as prescribing psychologists in other jurisdictions who have met the educational, training and supervision criteria as established in the currently proposed regulations, may be credentialed for prescriptive authority in Washington State.

(4)(c)(v) The nature and duration of any training including, but not limited to: · Whether the training includes a substantial amount of supervised field experience; · Whether training programs exist in this state; · If there will be an experience requirement; · Whether the experience must be acquired under a registered, certificated, or licensed practitioner; · Whether there are alternative routes of entry or methods of meeting the prerequisite qualifications; · Whether all applicants will be required to pass an examination; and, · If an examination is required, by whom it will be developed and how the costs of development will be met.

To be certified as a prescribing psychologist, the following qualifications must be met:

- Hold a current license at the doctoral level to provide health care services as a psychologist in Washington.

- Complete a two-year post-doctoral Master's degree in clinical psychopharmacology from a program designated by the American Psychological Association (APA) providing psychopharmacological education and training for clinical psychologists that includes the following core areas of instruction:

    - basic science,
    - functional neurosciences,
    - physical examination,
    - interpretation of laboratory tests,
    - pathological basis of disease,
    - clinical medicine,
    - clinical neurotherapeutics,
    - systems of care,
    - pharmacology,
    - clinical pharmacology,
    - psychopharmacology,
    - psychopharmacology research,
    - professional, ethical, and legal issues.

- Complete advanced coursework that includes education to ensure acquisition of the necessary knowledge and skills to prescribe in a safe and effective manner.

- Complete a post-doctoral prescribing psychology fellowship sufficient to attain competency in the psychopharmacological treatment of a diverse patient population under the direction of qualified practitioners as determined by the state board of psychology. Such fellowships in other jurisdictions have met a minimum of 100 diverse patients, comprising 400 contact hours, during the course of no less than one year, supervised by a licensed provider with established expertise in psychopharmacology.

- Pass an examination developed by a nationally recognized body (e.g., the Psychopharmacology Examination for Psychologists [PEP] offered by the Association of State and Provincial Psychology Boards [ASPPB] and approved by the state Examining Board of Psychology). As the PEP has already been developed there are no costs to the State for the development or administration of the examination.

The American Psychological Association has designated several psychopharmacology programs that offer high-quality distance learning including as part of the training model:

- Alliant International University (California)
- Fairleigh Dickenson (New Jersey)
- New Mexico State University (New Mexico)

Additionally, Antioch University in Seattle is in negotiations to start a psychopharmacology masters' degree that would meet APA criteria and provide a hybrid brick-and-mortar and online program.

The American Psychological Association has established a process for designating postdoctoral education and training programs in psychopharmacology. This is a public recognition of education and training programs that meet published standards for prescriptive authority for psychologists. The designation criteria require programs to meet many standards such as whether the program has sufficient resources to support the training mission, qualified administrators, sufficient and qualified faculty and clinical supervisors, quality assurance procedures, essential course curriculum, clinical competencies for supervised clinical experience, and capstone competency evaluation. Approximately eight hundred psychologists have graduated thus far from the designated programs.

A complete description of the designation process is located on the following website: http://www.apa.org/education/grad/psychopharmacology.aspx

With the exception of PDP trained prescribing psychologists, there are no other alternative routes of entry or methods of meeting the prerequisite qualifications.

(4)(c)(vi) What additional training programs are anticipated to be necessary to assure training accessible statewide; the anticipated time required to establish the additional training programs; the types of institutions capable of providing the training; a description of how training programs will meet the needs of the expected workforce, including reentry workers, minorities, place-bound students, and others;
The American Psychological Association (APA) has designated several academic institutions to provide this training on-line. Only academic institutions that have been designated by the APA for the education of clinical psychologists in psychopharmacology would be permitted to provide the training. The online nature of the current programs discussed in 5(v) will allow

access to clinical psychologists seeking the training in all areas of the state and will not restrict access to minorities, alternative students, placebound or other student populations.

(4)(d) Assurance of the public that practitioners have maintained their competence:
Prescribing psychologists will be required to complete continuing education requirements on the same schedule as non-prescribing clinical psychologists in the State. The content of the continuing education for prescribing psychologists will include both the areas of clinical psychology and psychopharmacology. Therefore, the content of continuing education will be expanded beyond that expected of non-prescribing clinical psychologists. The amount of continuing education credits required will be determined by the Board, but will be no less that that required for non-prescribing clinical psychologists. The competence of licensed psychologists can currently be accessed through the Department of Health website or the Department of Health directly. The certification of prescribing psychologists would also be readily accessible through Department of Health resources.

(4)(d)(i) Whether the registration, certification, or licensure will carry an expiration date; and
The proposed expansion of scope of practice for prescribing psychologists would carry an expiration date with renewal requiring certification of completed continuing education. The certificate to prescribe will be separate from the license to practice psychology. The license to practice psychology in the State will be a pre-requisite for applying for a prescription certificate. The certification will carry an expiration date not in excess of two years.

(4)(d)(ii) Whether renewal will be based only upon payment of a fee, or whether renewal will involve reexamination, peer review, or other enforcement;
Renewal will be based certification of completed continuing education and the appropriate licensing fee.

(5) The extent to which regulation might harm the public.
Prescribing psychology will not pose an increased risk of harm to the public. First, prescribing psychology training is similar and favorably comparable to the training of other psychopharmacologically trained providers such as psychiatrists and psychiatric nurse practitioners. This can be seen when prescribing psychology training is compared to medical school training and nurse practitioner programs (see table from Muse & McGrath, 2010, p 99).

Table 1
Comparison of Entry-Level Training Models Leading to Prescriptive Authority

Profession	Minimum years post-baccalaureate	Graduate contact hours mean (and standard deviation)						
		Biochemistry-neuroscience	Pharmacology	Clinical practicum	Research-statistics	Behavioral assessment/diagnosis & psychometrics	Psychosocial interventions-psychotherapy	Other mental health/psychology course work
Psychiatric nurse practitioner[a]	2.5	48 (7)	56 (7)	146 (33)	99 (41)	30 (23)	32 (29)	128 (77)
Medicine[b]	4	216 (20)	59 (28)	855 (101)	33 (20)	18 (25)	9 (20)	15 (21)
Psychology[c]	6.5	161 (43)	288 (63)	680 (83)	225 (64)	267 (61)	255 (161)	351 (152)

Note. Values were computed equating one academic credit with 15 contact hours.
[a]Based on nurse practitioner master's degree programs at the Medical University of North Carolina, St. Joseph's College, University of Virginia, Vanderbilt University, and Yale University.
[b]Based on M.D. or D.O. programs, without further specialization residency, at the Mayo College of Medicine, Yale University, Tufts University, Stanford University, and A.T. Still University.
[c]Based on Ph.D., Ed.D., or Psy.D. programs plus the postdoctoral M.S. program at Alliant University, Fairleigh Dickinson University, the Massachusetts School of Professional Psychology, New Mexico State University, and NOVA Southeastern University.

Secondly, prospective prescribing psychologists must pass a rigorous examination developed by a nationally recognized body (e.g., the Psychopharmacology Examination for Psychologists [PEP] offered by the Association of State and Provincial Psychology Boards) and approved by the state board of psychology. The PEP covers the following content areas:

- Integrating clinical psychopharmacology with the practice of psychology
- Neuroscience
- Nervous system pathology
- Physiology and Pathophysiology
- Biopsychosocial and Pharmacologic Assessment and Monitoring
- Differential Diagnosis
- Pharmacology
- Clinical Psychopharmacology
- Research
- Professional, legal, ethical, and interprofessional issues

There is an extensive record demonstrating the safety to the public of prescribing psychologists as listed below

- The safety record of prescribing psychologists in New Mexico and Louisiana is detailed in results from surveys of medical providers who rated the competence and safety of prescribing psychologists (Shearer et al., 2012; Linda and McGrath, 2017).

- Letters of support (Appendix C).

- An evaluation report from the US General Accounting Office, “Overwhelmingly, the officials with whom we spoke, including each of the graduates’ clinical supervisors and an outside panel of psychiatrists and psychologists who evaluated each of the graduates, rated the graduates’ quality of care as good to excellent.” In addition, the GAO report stated, “we found no evidence of quality problems in the graduates’ credential files.” (GAO, 1999, p 8).

- Demonstrated safety and effectiveness in New Mexico:

  New Mexico recently completed a 10-year sunset report on the psychology licensing act reviewed the ten-year experience with prescriptive authority for psychologists. The review was conducted in 2015 by the Board of Psychologist Examiners (Appendix D). None of the complaints investigated listed in the report were associated with the prescription certificate. The report also included the following reference to prescribing psychologists about meeting the needs of the public.

  > "Our board has also continued to license psychologists who are training for prescriptive authority on a provisional basis and on an unrestricted basis following the completion of the requirements set out by the board's rules and statutes. In the process, our state has added many new prescriptive providers to meet the demand for mental health services across rural and metropolitan areas of the state."

- Dr. Donald Fineberg, a psychiatrist with extensive regulatory experience licensing New Mexico prescribing psychologists, made the following statement in a May 6, 2016 letter: "The New Mexico law has served our state well. In 14 years, there have been about 55 psychologists who have been licensed and there has not been a single action taken against psychologists for unsafe practices." (Appendix C).

- Evidence of safety for prescribing medical psychologists from Louisiana.
  Letter of support for the State of Nebraska's prescribing psychology proposed bill from Dr. Glenn Ally, who serves on the medical committee that assists in regulating the medical psychologist and advanced medical psychologist licenses in Louisiana (Appendix C)

- The American College of Neuropsychopharmacology (ACNP, 1998), composed of psychiatrists and psychologists, was contracted to perform an analysis of the Department of Defense project to train psychologists to prescribe medications for mental disorders. Their evaluation judged the psychologists with specialized training to be safe prescribers and assumed positions as chiefs of mental health clinics. The report noted the absence of a single significant adverse event among patients treated by the prescribing psychologists.

(5)(a) The extent to which regulation will restrict entry into the health profession: (i) Whether the proposed standards are more restrictive than necessary to insure safe and effective performance.

The proposed standards for expanded scope of practice do not restrict entry into the profession. The proposed standards ensure that required education, training, and supervised experience are completed for prescribing psychologists practicing in the State.

(5)(a)(ii) Whether the proposed legislation requires registered, certificated, or licensed practitioners in other jurisdictions who migrate to this state to qualify in the same manner as

state applicants for registration, certification, and licensure when the other jurisdiction has substantially equivalent requirements for registration, certification, or licensure as those in this state.
The proposed updates to the scope of practice do not alter the requirements that currently exist in statute related to practitioners who migrated to this state to qualify for licensure. Psychologists who pursue the prescribing psychologist certificate in the State must meet the same requirement as resident state applicants.

(5)(b) Whether there are similar professions to that of the applicant group which should be included in, or portions of the applicant group which should be excluded from, the proposed legislation.
There are no professions that should be included in the proposed expansion of scope of practice for psychologists. There are no subgroups of licensed psychologists which should be excluded from the proposed expansion of practice; seeking the certificate to be a prescribing psychologist shall be available to any licensed psychologist.

(6) The maintenance of standards:

(6)(a) Whether effective quality assurance standards exist in the health profession, such as legal requirements associated with specific programs that define or enforce standards, or a code of ethics; and
Current law requires that psychologists licensed under RCW 18.83 must comply with the Uniform Disciplinary Act to maintain professional conduct and they must meet the qualification requirements under 18.83.070, Applications for examination — Qualifications. The proposed standards do not change these requirements but do add additional requirements for qualifications as a prescribing psychologist.

(6)(b) How the proposed legislation will assure quality:

(6)(b)(i) The extent to which a code of ethics, if any, will be adopted;
Additional rules will be adopted by the Licensing Board for Psychology to implement the statutory authority conveyed by the legislature and signed by the Governor.

(6)(b)(ii) The grounds for suspension or revocation of registration, certification, or licensure;
The proposed standards do not change or alter current licensing requirements. Currently there is a code of ethics 18.83.050. The proposed updates to scope of practice do not change this. Current law requires that psychologists licensed under 18.83 must comply with the Uniform Disciplinary Act to maintain professional conduct and they must meet the qualification requirements under 18.83.070, Applications for examination — Qualifications. The proposed standards do not change these requirements.

(7) Coversheet - See initial page

(8) The expected costs of regulation:
We expect that there will be some costs associated with rulemaking activities. We anticipate additional revenue to the state by the fees for prescription applications and certificates.

(8)(a) The impact registration, certification, or licensing will have on the costs of the services to the public.
The current costs for licensing are not prohibitive, so we expect that the costs for certification will also not be prohibitive.

(8)(b) The cost to the state and to the general public of implementing the proposed legislation.
This financial information will be provided by the Department of Health.

The cost to members of the group proposed for regulation for the required education, including projected tuition and expenses, and expected increases in training programs staffing and enrollments at state training institutions.
Educational requirements expected are: academic coursework (approximately 2 years), clinical training including physical assessment (approximately 80 hours), and supervised prescribing experience. Based on the Idaho State University Psychopharmacology Program (https://isu.edu/pharmacy/prospective-students/clinical-psychopharmacology-program/) established for the training of prescribing psychologists, estimated tuition and expense projections are:

- Full-time Graduate Tuition - $4,962.98 per semester @ 4 semesters = $19,851.92
- Expenses and Supervisor Time - $6,000-$8,000 per year @ 2 years = $12,000-16,000
- Total projected cost per applicant- $31,851.92 -$35,851.92

Appendix A: Draft Proposal

H-3313.2

HOUSE BILL 2967

State of Washington 66th Legislature 2020 Regular Session

By Representative Macri

AN ACT Relating to the prescriptive authority of psychologists; amending RCW 18.83.010, 18.83.050, 18.83.080, and 18.83.090; reenacting and amending RCW 18.64.011, 18.79.260, and 69.50.101; and adding new sections to chapter 18.83 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 18.83.010 and 1994 c 35 s 1 are each amended to read as follows:

((~~When used in this chapter:~~)) The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) ((~~The~~)) "Board" means the examining board of psychology.

(2) "Clinical experience" means a period of supervised clinical training and practice in which clinical diagnoses and interventions are learned and which is conducted and supervised as part of the training program.

(3) "Controlled substance" has the same meaning as in RCW 69.50.101.

(4) "Department" means the department of health.

(5) "Practice of psychology" means the observation, evaluation, interpretation, and modification of human behavior by the application of psychological principles, methods, and procedures for the purposes

of preventing or eliminating symptomatic or maladaptive behavior and promoting mental and behavioral health. It includes, but is not limited to, providing the following services to individuals, families, groups, organizations, and the public, whether or not payment is received for services rendered:

(a) Psychological measurement, assessment, and evaluation by means of psychological, neuropsychological, and psychoeducational testing;

(b) Diagnosis and treatment of mental, emotional, and behavioral disorders, and psychological aspects of illness, injury, and disability; and

(c) Counseling and guidance, psychotherapeutic techniques, remediation, health promotion, and consultation within the context of established psychological principles and theories.

This definition does not include the teaching of principles of psychology for accredited educational institutions, or the conduct of research in problems of human or animal behavior.

((~~Nothing in this definition shall be construed as permitting the administration or prescribing of drugs or in any way infringing upon the practice of medicine and surgery as defined in chapter 18.71 RCW.~~

~~(2)~~)) (6) "Prescribing psychologist" means a person who holds an active license to practice psychology under this chapter and holds an active certificate to exercise prescriptive authority under the standards of section 2 of this act.

(7) "Prescription" has the same meaning as in RCW 18.64.011.

(8) "Prescriptive authority" means the authority of a prescribing psychologist to prescribe, administer, discontinue, and distribute controlled substances recognized or customarily used in the diagnosis, treatment, and management of individuals with psychiatric, mental, cognitive, nervous, emotional, developmental, or behavioral disorders. The term includes ordering necessary laboratory tests and diagnostic examinations, procedures necessary to obtain laboratory tests and diagnostic examinations, procedures which are relevant to the practice of psychology, and other directly related procedures within the scope of the practice of psychology in accordance with rules adopted by the board.

(9) "Secretary" means the secretary of health.

((~~(3) "Board" means the examining board of psychology.~~

~~(4) "Department" means the department of health.~~))

NEW SECTION. **Sec. 2.** A new section is added to chapter 18.83 RCW to read as follows:

(1) A psychologist who is licensed under this chapter may apply for certification as a prescribing psychologist to allow the psychologist to exercise prescriptive authority.

(2) The board shall certify an applicant as a prescribing psychologist if the applicant demonstrates to the board, by official transcript or other official evidence satisfactory to the board, that the applicant:

(a) Holds a current license as a psychologist;

(b) Holds a doctorate degree obtained from an integrated program of graduate study in psychology, as defined by rules of the board;

(c)(i) Has successfully completed an organized sequence of study in a master's degree offering intensive didactic education, and including the following core areas of instruction:

(A) Basic science;

(B) Functional neurosciences;

(C) Physical examination;

(D) Interpretation of laboratory tests;

(E) Pathological basis of disease;

(F) Clinical medicine;

(G) Clinical neurotherapeutics;

(H) Systems of care;

(I) Pharmacology;

(J) Clinical pharmacology;

(K) Psychopharmacology;

(L) Psychopharmacology research; and

(M) Professional, ethical, and legal issues;

(ii) The didactic portion of the education must consist of an appropriate number of didactic hours to assure acquisition of the necessary knowledge and skills to prescribe in a safe and effective manner;

(d) Has successfully completed a postdoctoral prescribing psychology fellowship defined by the board to obtain clinical experience sufficient to attain competency in the psychopharmacological treatment of a diverse patient population under the direction of qualified practitioners, as determined by the board; and

(e) Has passed an examination relevant to establishing competence for prescribing as developed by a nationally recognized organization and approved by the board.

(3) The board may waive certain requirements for applicants who have obtained relevant training and experience including:

(a) Psychologists who are dually licensed as physicians, nurse practitioners, or another health profession with comparable prescriptive authority in Washington; or

(b) Psychologists who have completed the United States department of defense psychopharmacology demonstration project.

(4) A certificate issued under this section may be renewed in accordance with RCW 18.83.090.

NEW SECTION. **Sec. 3.** A new section is added to chapter 18.83 RCW to read as follows:

(1) Prescribing psychologists may exercise prescriptive authority as provided in this chapter.

(2) A psychologist may not exercise prescriptive authority unless the psychologist holds a valid certificate of prescriptive authority under section 2 of this act.

(3) Each prescription issued by a prescribing psychologist must:

(a) Comply with all applicable state and federal laws and regulations; and

(b) Be identified as written by the prescribing psychologist in a manner determined by the board.

(4) A record of all prescriptions must be maintained in the patient's record.

(5) A prescribing psychologist may not delegate the authority to prescribe drugs and controlled substances to any other person.

(6) A prescribing psychologist who is authorized to prescribe controlled substances must submit to the board, in a timely manner, the prescribing psychologist's drug enforcement agency registration number.

(7) The board shall maintain a current list of every prescribing psychologist, the psychologists' license and certificate of prescribing authority numbers, and the drug enforcement agency registration and number.

(8)(a) The board shall transmit to the pharmacy quality assurance commission an initial list of prescribing psychologists. The list must contain:

(i) The name of each prescribing psychologist;

(ii) Each prescribing psychologist's identification number assigned by the board; and

(iii) The effective date of each prescribing psychologist's certificate of prescriptive authority.

(b) The board shall promptly notify the pharmacy quality assurance commission of:

(i) Any additions to the initial list as new prescribing psychologists are certified; and

(ii) The termination, suspension, or reinstatement of any prescribing psychologist's certification.

Sec. 4. RCW 18.83.050 and 2004 c 262 s 8 are each amended to read as follows:

(1) The board shall adopt such rules as it deems necessary to carry out its functions.

(2) The board shall examine the qualifications of applicants for licensing under this chapter, to determine which applicants are eligible for licensing under this chapter and shall forward to the secretary the names of applicants so eligible.

(3) The board shall:

(a) Develop and implement procedures for reviewing education and training credentials of applicants for certificates of prescriptive authority;

(b) Certify an applicant as a prescribing psychologist if the applicant meets the qualifications of section 2 of this act; and

(c) Adopt rules for denying, modifying, suspending, or revoking certification of a prescribing psychologist. The board may require remediation of any deficiencies in the training or practice pattern of the prescribing psychologist when, in the judgment of the board, such deficiencies could reasonably be expected to jeopardize the health, safety, or welfare of the public.

(4) The board shall administer examinations to qualified applicants on at least an annual basis. The board shall determine the subject matter and scope of the examination, except as provided in RCW 18.83.170. The board may allow applicants to take the examination upon the granting of their doctoral degree before completion of their internship for supervised experience.

((~~(4)~~)) (5) The board shall keep a complete record of its own proceedings, of the questions given in examinations, of the names and

qualifications of all applicants, and the names and addresses of all licensed psychologists. The examination paper of such applicant shall be kept on file for a period of at least one year after examination.

((~~(5)~~)) (6) The board shall, by rule, adopt a code of ethics for psychologists which is designed to protect the public interest.

((~~(6)~~)) (7) The board may require that persons licensed under this chapter as psychologists obtain and maintain professional liability insurance in amounts determined by the board to be practicable and reasonably available.

Sec. 5. RCW 18.83.080 and 1996 c 191 s 66 are each amended to read as follows:

The board shall forward to the secretary the name of each applicant entitled to a license under this chapter. The secretary shall promptly issue to such applicant a license authorizing such applicant to use the title "psychologist". Each licensed psychologist shall keep his or her license and certificate of prescriptive authority, if applicable, displayed in a conspicuous place in his or her principal place of business.

Sec. 6. RCW 18.83.090 and 2009 c 492 s 6 are each amended to read as follows:

(1) The board shall establish rules governing mandatory continuing education requirements which shall be met by any psychologist applying for a license renewal or renewal of a certificate of prescriptive authority.

(2) The office of crime victims advocacy shall supply the board with information on methods of recognizing victims of human trafficking, what services are available for these victims, and where to report potential trafficking situations. The information supplied must be culturally sensitive and must include information relating to minor victims. The board shall disseminate this information to licensees by: Providing the information on the board's web site; including the information in newsletters; holding trainings at meetings attended by organization members; or ((~~through~~)) another distribution method determined by the board. The board shall report to the office of crime victims advocacy on the method or methods it uses to distribute information under this subsection.

(3) Administrative procedures, administrative requirements, and fees for renewal and reissue of licenses shall be established as provided in RCW 43.70.250 and 43.70.280.

(4)(a) The board shall establish rules for the renewal of a certificate of prescriptive authority issued under section 2 of this act at the time of the renewal of the psychologist's license to practice psychology.

(b) Each applicant for renewal of a certificate of prescriptive authority shall present satisfactory evidence to the board demonstrating the completion of continuing education instruction relevant to prescriptive authority during the previous three-year renewal period.

Sec. 7. RCW 18.64.011 and 2016 c 148 s 1 are each reenacted and amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Administer" means the direct application of a drug or device, whether by injection, inhalation, ingestion, or any other means, to the body of a patient or research subject.

(2) "Business licensing system" means the mechanism established by chapter 19.02 RCW by which business licenses, endorsed for individual state-issued licenses, are issued and renewed utilizing a business license application and a business license expiration date common to each renewable license endorsement.

(3) "Chart order" means a lawful order for a drug or device entered on the chart or medical record of an inpatient or resident of an institutional facility by a practitioner or his or her designated agent.

(4) "Closed door long-term care pharmacy" means a pharmacy that provides pharmaceutical care to a defined and exclusive group of patients who have access to the services of the pharmacy because they are treated by or have an affiliation with a long-term care facility or hospice program, and that is not a retailer of goods to the general public.

(5) "Commission" means the pharmacy quality assurance commission.

(6) "Compounding" means the act of combining two or more ingredients in the preparation of a prescription.

(7) "Controlled substance" means a drug or substance, or an immediate precursor of such drug or substance, so designated under or pursuant to the provisions of chapter 69.50 RCW.

(8) "Deliver" or "delivery" means the actual, constructive, or attempted transfer from one person to another of a drug or device, whether or not there is an agency relationship.

(9) "Department" means the department of health.

(10) "Device" means instruments, apparatus, and contrivances, including their components, parts, and accessories, intended (a) for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings or other animals, or (b) to affect the structure or any function of the body of human beings or other animals.

(11) "Dispense" means the interpretation of a prescription or order for a drug, biological, or device and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

(12) "Distribute" means the delivery of a drug or device other than by administering or dispensing.

(13) "Drug" and "devices" do not include surgical or dental instruments or laboratory materials, gas and oxygen, therapy equipment, X-ray apparatus or therapeutic equipment, their component parts or accessories, or equipment, instruments, apparatus, or contrivances used to render such articles effective in medical, surgical, or dental treatment, or for use or consumption in or for mechanical, industrial, manufacturing, or scientific applications or purposes. "Drug" also does not include any article or mixture covered by the Washington pesticide control act (chapter 15.58 RCW), as enacted or hereafter amended, nor medicated feed intended for and used exclusively as a feed for animals other than human beings.

(14) "Drugs" means:

(a) Articles recognized in the official United States pharmacopoeia or the official homeopathic pharmacopoeia of the United States;

(b) Substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings or other animals;

(c) Substances (other than food) intended to affect the structure or any function of the body of human beings or other animals; or

(d) Substances intended for use as a component of any substances specified in (a), (b), or (c) of this subsection, but not including devices or their component parts or accessories.

(15) "Health care entity" means an organization that provides health care services in a setting that is not otherwise licensed by the state to acquire or possess legend drugs. Health care entity includes a freestanding outpatient surgery center, a residential treatment facility, and a freestanding cardiac care center. "Health care entity" does not include an individual practitioner's office or a multipractitioner clinic, regardless of ownership, unless the owner elects licensure as a health care entity. "Health care entity" also does not include an individual practitioner's office or multipractitioner clinic identified by a hospital on a pharmacy application or renewal pursuant to RCW 18.64.043.

(16) "Hospice program" means a hospice program certified or paid by medicare under Title XVIII of the federal social security act, or a hospice program licensed under chapter 70.127 RCW.

(17) "Institutional facility" means any organization whose primary purpose is to provide a physical environment for patients to obtain health care services including, but not limited to, services in a hospital, long-term care facility, hospice program, mental health facility, drug abuse treatment center, residential habilitation center, or a local, state, or federal correction facility.

(18) "Labeling" means the process of preparing and affixing a label to any drug or device container. The label must include all information required by current federal and state law and pharmacy rules.

(19) "Legend drugs" means any drugs which are required by any applicable federal or state law or regulation to be dispensed on prescription only or are restricted to use by practitioners only.

(20) "Long-term care facility" means a nursing home licensed under chapter 18.51 RCW, an assisted living facility licensed under chapter 18.20 RCW, or an adult family home licensed under chapter 70.128 RCW.

(21) "Manufacture" means the production, preparation, propagation, compounding, or processing of a drug or other substance or device or the packaging or repackaging of such substance or device, or the labeling or relabeling of the commercial container of such substance or device, but does not include the activities of a

practitioner who, as an incident to his or her administration or dispensing such substance or device in the course of his or her professional practice, personally prepares, compounds, packages, or labels such substance or device. "Manufacture" includes the distribution of a licensed pharmacy compounded drug product to other state licensed persons or commercial entities for subsequent resale or distribution, unless a specific product item has approval of the commission. The term does not include:

(a) The activities of a licensed pharmacy that compounds a product on or in anticipation of an order of a licensed practitioner for use in the course of their professional practice to administer to patients, either personally or under their direct supervision;

(b) The practice of a licensed pharmacy when repackaging commercially available medication in small, reasonable quantities for a practitioner legally authorized to prescribe the medication for office use only;

(c) The distribution of a drug product that has been compounded by a licensed pharmacy to other appropriately licensed entities under common ownership or control of the facility in which the compounding takes place; or

(d) The delivery of finished and appropriately labeled compounded products dispensed pursuant to a valid prescription to alternate delivery locations, other than the patient's residence, when requested by the patient, or the prescriber to administer to the patient, or to another licensed pharmacy to dispense to the patient.

(22) "Manufacturer" means a person, corporation, or other entity engaged in the manufacture of drugs or devices.

(23) "Nonlegend" or "nonprescription" drugs means any drugs which may be lawfully sold without a prescription.

(24) "Person" means an individual, corporation, government, governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

(25) "Pharmacist" means a person duly licensed by the commission to engage in the practice of pharmacy.

(26) "Pharmacy" means every place properly licensed by the commission where the practice of pharmacy is conducted.

(27) "Poison" does not include any article or mixture covered by the Washington pesticide control act (chapter 15.58 RCW), as enacted or hereafter amended.

(28) "Practice of pharmacy" includes the practice of and responsibility for: Interpreting prescription orders; the compounding, dispensing, labeling, administering, and distributing of drugs and devices; the monitoring of drug therapy and use; the initiating or modifying of drug therapy in accordance with written guidelines or protocols previously established and approved for his or her practice by a practitioner authorized to prescribe drugs; the participating in drug utilization reviews and drug product selection; the proper and safe storing and distributing of drugs and devices and maintenance of proper records thereof; the providing of information on legend drugs which may include, but is not limited to, the advising of therapeutic values, hazards, and the uses of drugs and devices.

(29) "Practitioner" means a physician, dentist, veterinarian, nurse, prescribing psychologist, or other person duly authorized by law or rule in the state of Washington to prescribe drugs.

(30) "Prescription" means an order for drugs or devices issued by a practitioner duly authorized by law or rule in the state of Washington to prescribe drugs or devices in the course of his or her professional practice for a legitimate medical purpose.

(31) "Secretary" means the secretary of health or the secretary's designee.

(32) "Shared pharmacy services" means a system that allows a participating pharmacist or pharmacy pursuant to a request from another participating pharmacist or pharmacy to process or fill a prescription or drug order, which may include but is not necessarily limited to preparing, packaging, labeling, data entry, compounding for specific patients, dispensing, performing drug utilization reviews, conducting claims adjudication, obtaining refill authorizations, reviewing therapeutic interventions, or reviewing chart orders.

(33) "Wholesaler" means a corporation, individual, or other entity which buys drugs or devices for resale and distribution to corporations, individuals, or entities other than consumers.

Sec. 8. RCW 18.79.260 and 2012 c 164 s 407, 2012 c 13 s 3, and 2012 c 10 s 37 are each reenacted and amended to read as follows:

(1) A registered nurse under his or her license may perform for compensation nursing care, as that term is usually understood, to individuals with illnesses, injuries, or disabilities.

(2) A registered nurse may, at or under the general direction of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, naturopathic physician, optometrist, podiatric physician and surgeon, physician assistant, prescribing psychologist, osteopathic physician assistant, advanced registered nurse practitioner, or midwife acting within the scope of his or her license, administer medications, treatments, tests, and inoculations, whether or not the severing or penetrating of tissues is involved and whether or not a degree of independent judgment and skill is required. Such direction must be for acts which are within the scope of registered nursing practice.

(3) A registered nurse may delegate tasks of nursing care to other individuals where the registered nurse determines that it is in the best interest of the patient.

(a) The delegating nurse shall:

(i) Determine the competency of the individual to perform the tasks;

(ii) Evaluate the appropriateness of the delegation;

(iii) Supervise the actions of the person performing the delegated task; and

(iv) Delegate only those tasks that are within the registered nurse's scope of practice.

(b) A registered nurse, working for a home health or hospice agency regulated under chapter 70.127 RCW, may delegate the application, instillation, or insertion of medications to a registered or certified nursing assistant under a plan of care.

(c) Except as authorized in (b) or (e) of this subsection, a registered nurse may not delegate the administration of medications. Except as authorized in (e) of this subsection, a registered nurse may not delegate acts requiring substantial skill, and may not delegate piercing or severing of tissues. Acts that require nursing judgment shall not be delegated.

(d) No person may coerce a nurse into compromising patient safety by requiring the nurse to delegate if the nurse determines that it is inappropriate to do so. Nurses shall not be subject to any employer reprisal or disciplinary action by the nursing care quality assurance commission for refusing to delegate tasks or refusing to provide the required training for delegation if the nurse determines delegation may compromise patient safety.

(e) For delegation in community-based care settings or in-home care settings, a registered nurse may delegate nursing care tasks only to registered or certified nursing assistants or home care aides certified under chapter 18.88B RCW. Simple care tasks such as blood pressure monitoring, personal care service, diabetic insulin device set up, verbal verification of insulin dosage for sight-impaired individuals, or other tasks as defined by the nursing care quality assurance commission are exempted from this requirement.

(i) "Community-based care settings" includes: Community residential programs for people with developmental disabilities, certified by the department of social and health services under chapter 71A.12 RCW; adult family homes licensed under chapter 70.128 RCW; and assisted living facilities licensed under chapter 18.20 RCW. Community-based care settings do not include acute care or skilled nursing facilities.

(ii) "In-home care settings" include an individual's place of temporary or permanent residence, but does not include acute care or skilled nursing facilities, and does not include community-based care settings as defined in (e)(i) of this subsection.

(iii) Delegation of nursing care tasks in community-based care settings and in-home care settings is only allowed for individuals who have a stable and predictable condition. "Stable and predictable condition" means a situation in which the individual's clinical and behavioral status is known and does not require the frequent presence and evaluation of a registered nurse.

(iv) The determination of the appropriateness of delegation of a nursing task is at the discretion of the registered nurse. Other than delegation of the administration of insulin by injection for the purpose of caring for individuals with diabetes, the administration of medications by injection, sterile procedures, and central line maintenance may never be delegated.

(v) When delegating insulin injections under this section, the registered nurse delegator must instruct the individual regarding proper injection procedures and the use of insulin, demonstrate proper injection procedures, and must supervise and evaluate the individual performing the delegated task weekly during the first four weeks of delegation of insulin injections. If the registered nurse delegator determines that the individual is competent to perform the injection properly and safely, supervision and evaluation shall occur at least every ninety days thereafter.

(vi)(A) The registered nurse shall verify that the nursing assistant or home care aide, as the case may be, has completed the required core nurse delegation training required in chapter 18.88A or 18.88B RCW prior to authorizing delegation.

(B) Before commencing any specific nursing tasks authorized to be delegated in this section, a home care aide must be certified pursuant to chapter 18.88B RCW and must comply with RCW 18.88B.070.

(vii) The nurse is accountable for his or her own individual actions in the delegation process. Nurses acting within the protocols of their delegation authority are immune from liability for any action performed in the course of their delegation duties.

(viii) Nursing task delegation protocols are not intended to regulate the settings in which delegation may occur, but are intended to ensure that nursing care services have a consistent standard of practice upon which the public and the profession may rely, and to safeguard the authority of the nurse to make independent professional decisions regarding the delegation of a task.

(f) The nursing care quality assurance commission may adopt rules to implement this section.

(4) Only a person licensed as a registered nurse may instruct nurses in technical subjects pertaining to nursing.

(5) Only a person licensed as a registered nurse may hold herself or himself out to the public or designate herself or himself as a registered nurse.

Sec. 9. RCW 69.50.101 and 2019 c 394 s 9, 2019 c 158 s 12, and 2019 c 55 s 11 are each reenacted and amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(a) "Administer" means to apply a controlled substance, whether by injection, inhalation, ingestion, or any other means, directly to the body of a patient or research subject by:

(1) a practitioner authorized to prescribe (or, by the practitioner's authorized agent); or

(2) the patient or research subject at the direction and in the presence of the practitioner.

(b) "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, or dispenser. It does not include a common or contract carrier, public warehouseperson, or employee of the carrier or warehouseperson.

(c) "Board" means the Washington state liquor and cannabis board.

(d) "CBD concentration" has the meaning provided in RCW 69.51A.010.

(e) "CBD product" means any product containing or consisting of cannabidiol.

(f) "Commission" means the pharmacy quality assurance commission.

(g) "Controlled substance" means a drug, substance, or immediate precursor included in Schedules I through V as set forth in federal or state laws, or federal or commission rules, but does not include hemp or industrial hemp as defined in RCW 15.140.020.

(h)(1) "Controlled substance analog" means a substance the chemical structure of which is substantially similar to the chemical structure of a controlled substance in Schedule I or II and:

(i) that has a stimulant, depressant, or hallucinogenic effect on the central nervous system substantially similar to the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance included in Schedule I or II; or

(ii) with respect to a particular individual, that the individual represents or intends to have a stimulant, depressant, or hallucinogenic effect on the central nervous system substantially similar to the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance included in Schedule I or II.

(2) The term does not include:

(i) a controlled substance;

(ii) a substance for which there is an approved new drug application;

(iii) a substance with respect to which an exemption is in effect for investigational use by a particular person under Section 505 of the federal food, drug, and cosmetic act, 21 U.S.C. Sec. 355, or chapter 69.77 RCW to the extent conduct with respect to the substance is pursuant to the exemption; or

(iv) any substance to the extent not intended for human consumption before an exemption takes effect with respect to the substance.

(i) "Deliver" or "delivery" means the actual or constructive transfer from one person to another of a substance, whether or not there is an agency relationship.

(j) "Department" means the department of health.

(k) "Designated provider" has the meaning provided in RCW 69.51A.010.

(l) "Dispense" means the interpretation of a prescription or order for a controlled substance and, pursuant to that prescription or order, the proper selection, measuring, compounding, labeling, or packaging necessary to prepare that prescription or order for delivery.

(m) "Dispenser" means a practitioner who dispenses.

(n) "Distribute" means to deliver other than by administering or dispensing a controlled substance.

(o) "Distributor" means a person who distributes.

(p) "Drug" means (1) a controlled substance recognized as a drug in the official United States pharmacopoeia/national formulary or the official homeopathic pharmacopoeia of the United States, or any supplement to them; (2) controlled substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in individuals or animals; (3) controlled substances (other than food) intended to affect the structure or any function of the body of individuals or animals; and (4) controlled substances intended for use as a component of any article specified in (1), (2), or (3) of this subsection. The term does not include devices or their components, parts, or accessories.

(q) "Drug enforcement administration" means the drug enforcement administration in the United States Department of Justice, or its successor agency.

(r) "Electronic communication of prescription information" means the transmission of a prescription or refill authorization for a drug of a practitioner using computer systems. The term does not include a prescription or refill authorization verbally transmitted by telephone nor a facsimile manually signed by the practitioner.

(s) "Immature plant or clone" means a plant or clone that has no flowers, is less than twelve inches in height, and is less than twelve inches in diameter.

(t) "Immediate precursor" means a substance:

(1) that the commission has found to be and by rule designates as being the principal compound commonly used, or produced primarily for use, in the manufacture of a controlled substance;

(2) that is an immediate chemical intermediary used or likely to be used in the manufacture of a controlled substance; and

(3) the control of which is necessary to prevent, curtail, or limit the manufacture of the controlled substance.

(u) "Isomer" means an optical isomer, but in subsection (gg)(5) of this section, RCW 69.50.204(a) (12) and (34), and 69.50.206(b)(4), the term includes any geometrical isomer; in RCW 69.50.204(a) (8) and (42), and 69.50.210(c) the term includes any positional isomer; and in RCW 69.50.204(a)(35), 69.50.204(c), and 69.50.208(a) the term includes any positional or geometric isomer.

(v) "Lot" means a definite quantity of marijuana, marijuana concentrates, useable marijuana, or marijuana-infused product identified by a lot number, every portion or package of which is uniform within recognized tolerances for the factors that appear in the labeling.

(w) "Lot number" must identify the licensee by business or trade name and Washington state unified business identifier number, and the date of harvest or processing for each lot of marijuana, marijuana concentrates, useable marijuana, or marijuana-infused product.

(x) "Manufacture" means the production, preparation, propagation, compounding, conversion, or processing of a controlled substance, either directly or indirectly or by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling or relabeling of its container. The term does not include the preparation, compounding, packaging, repackaging, labeling, or relabeling of a controlled substance:

(1) by a practitioner as an incident to the practitioner's administering or dispensing of a controlled substance in the course of the practitioner's professional practice; or

(2) by a practitioner, or by the practitioner's authorized agent under the practitioner's supervision, for the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale.

(y) "Marijuana" or "marihuana" means all parts of the plant *Cannabis*, whether growing or not, with a THC concentration greater than 0.3 percent on a dry weight basis; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin. The term does not include:

(1) The mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination; or

(2) Hemp or industrial hemp as defined in RCW 15.140.020, seeds used for licensed hemp production under chapter 15.140 RCW.

(z) "Marijuana concentrates" means products consisting wholly or in part of the resin extracted from any part of the plant *Cannabis* and having a THC concentration greater than ten percent.

(aa) "Marijuana processor" means a person licensed by the state liquor and cannabis board to process marijuana into marijuana concentrates, useable marijuana, and marijuana-infused products, package and label marijuana concentrates, useable marijuana, and marijuana-infused products for sale in retail outlets, and sell marijuana concentrates, useable marijuana, and marijuana-infused products at wholesale to marijuana retailers.

(bb) "Marijuana producer" means a person licensed by the state liquor and cannabis board to produce and sell marijuana at wholesale to marijuana processors and other marijuana producers.

(cc) "Marijuana products" means useable marijuana, marijuana concentrates, and marijuana-infused products as defined in this section.

(dd) "Marijuana researcher" means a person licensed by the state liquor and cannabis board to produce, process, and possess marijuana for the purposes of conducting research on marijuana and marijuana-derived drug products.

(ee) "Marijuana retailer" means a person licensed by the state liquor and cannabis board to sell marijuana concentrates, useable marijuana, and marijuana-infused products in a retail outlet.

(ff) "Marijuana-infused products" means products that contain marijuana or marijuana extracts, are intended for human use, are derived from marijuana as defined in subsection (y) of this section, and have a THC concentration no greater than ten percent. The term "marijuana-infused products" does not include either useable marijuana or marijuana concentrates.

(gg) "Narcotic drug" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable

origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium, opium derivative, and any derivative of opium or opium derivative, including their salts, isomers, and salts of isomers, whenever the existence of the salts, isomers, and salts of isomers is possible within the specific chemical designation. The term does not include the isoquinoline alkaloids of opium.

(2) Synthetic opiate and any derivative of synthetic opiate, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of the isomers, esters, ethers, and salts is possible within the specific chemical designation.

(3) Poppy straw and concentrate of poppy straw.

(4) Coca leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives or ecgonine or their salts have been removed.

(5) Cocaine, or any salt, isomer, or salt of isomer thereof.

(6) Cocaine base.

(7) Ecgonine, or any derivative, salt, isomer, or salt of isomer thereof.

(8) Any compound, mixture, or preparation containing any quantity of any substance referred to in ((~~subparagraphs~~)) (1) through (7) of this subsection.

(hh) "Opiate" means any substance having an addiction-forming or addiction-sustaining liability similar to morphine or being capable of conversion into a drug having addiction-forming or addiction-sustaining liability. The term includes opium, substances derived from opium (opium derivatives), and synthetic opiates. The term does not include, unless specifically designated as controlled under RCW 69.50.201, the dextrorotatory isomer of 3-methoxy-n-methylmorphinan and its salts (dextromethorphan). The term includes the racemic and levorotatory forms of dextromethorphan.

(ii) "Opium poppy" means the plant of the species Papaver somniferum L., except its seeds.

(jj) "Person" means individual, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

(kk) "Plant" has the meaning provided in RCW 69.51A.010.

(ll) "Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

(mm) "Practitioner" means:

(1) A physician under chapter 18.71 RCW; a physician assistant under chapter 18.71A RCW; an osteopathic physician and surgeon under chapter 18.57 RCW; an osteopathic physician assistant under chapter 18.57A RCW who is licensed under RCW 18.57A.020 subject to any limitations in RCW 18.57A.040; an optometrist licensed under chapter 18.53 RCW who is certified by the optometry board under RCW 18.53.010 subject to any limitations in RCW 18.53.010; a dentist under chapter 18.32 RCW; a podiatric physician and surgeon under chapter 18.22 RCW; a veterinarian under chapter 18.92 RCW; a registered nurse, advanced registered nurse practitioner, or licensed practical nurse under chapter 18.79 RCW; a naturopathic physician under chapter 18.36A RCW who is licensed under RCW 18.36A.030 subject to any limitations in RCW 18.36A.040; a psychologist licensed under chapter 18.83 RCW and certified as a prescribing psychologist under section 2 of this act; a pharmacist under chapter 18.64 RCW or a scientific investigator under this chapter, licensed, registered or otherwise permitted insofar as is consistent with those licensing laws to distribute, dispense, conduct research with respect to or administer a controlled substance in the course of their professional practice or research in this state.

(2) A pharmacy, hospital or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to or to administer a controlled substance in the course of professional practice or research in this state.

(3) A physician licensed to practice medicine and surgery, a physician licensed to practice osteopathic medicine and surgery, a dentist licensed to practice dentistry, a podiatric physician and surgeon licensed to practice podiatric medicine and surgery, a licensed physician assistant or a licensed osteopathic physician assistant specifically approved to prescribe controlled substances by his or her state's medical commission or equivalent and his or her supervising physician, an advanced registered nurse practitioner licensed to prescribe controlled substances, or a veterinarian licensed to practice veterinary medicine in any state of the United States.

(nn) "Prescription" means an order for controlled substances issued by a practitioner duly authorized by law or rule in the state

of Washington to prescribe controlled substances within the scope of his or her professional practice for a legitimate medical purpose.

(oo) "Production" includes the manufacturing, planting, cultivating, growing, or harvesting of a controlled substance.

(pp) "Qualifying patient" has the meaning provided in RCW 69.51A.010.

(qq) "Recognition card" has the meaning provided in RCW 69.51A.010.

(rr) "Retail outlet" means a location licensed by the state liquor and cannabis board for the retail sale of marijuana concentrates, useable marijuana, and marijuana-infused products.

(ss) "Secretary" means the secretary of health or the secretary's designee.

(tt) "State," unless the context otherwise requires, means a state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(uu) "THC concentration" means percent of delta-9 tetrahydrocannabinol content per dry weight of any part of the plant *Cannabis*, or per volume or weight of marijuana product, or the combined percent of delta-9 tetrahydrocannabinol and tetrahydrocannabinolic acid in any part of the plant *Cannabis* regardless of moisture content.

(vv) "Ultimate user" means an individual who lawfully possesses a controlled substance for the individual's own use or for the use of a member of the individual's household or for administering to an animal owned by the individual or by a member of the individual's household.

(ww) "Useable marijuana" means dried marijuana flowers. The term "useable marijuana" does not include either marijuana-infused products or marijuana concentrates.

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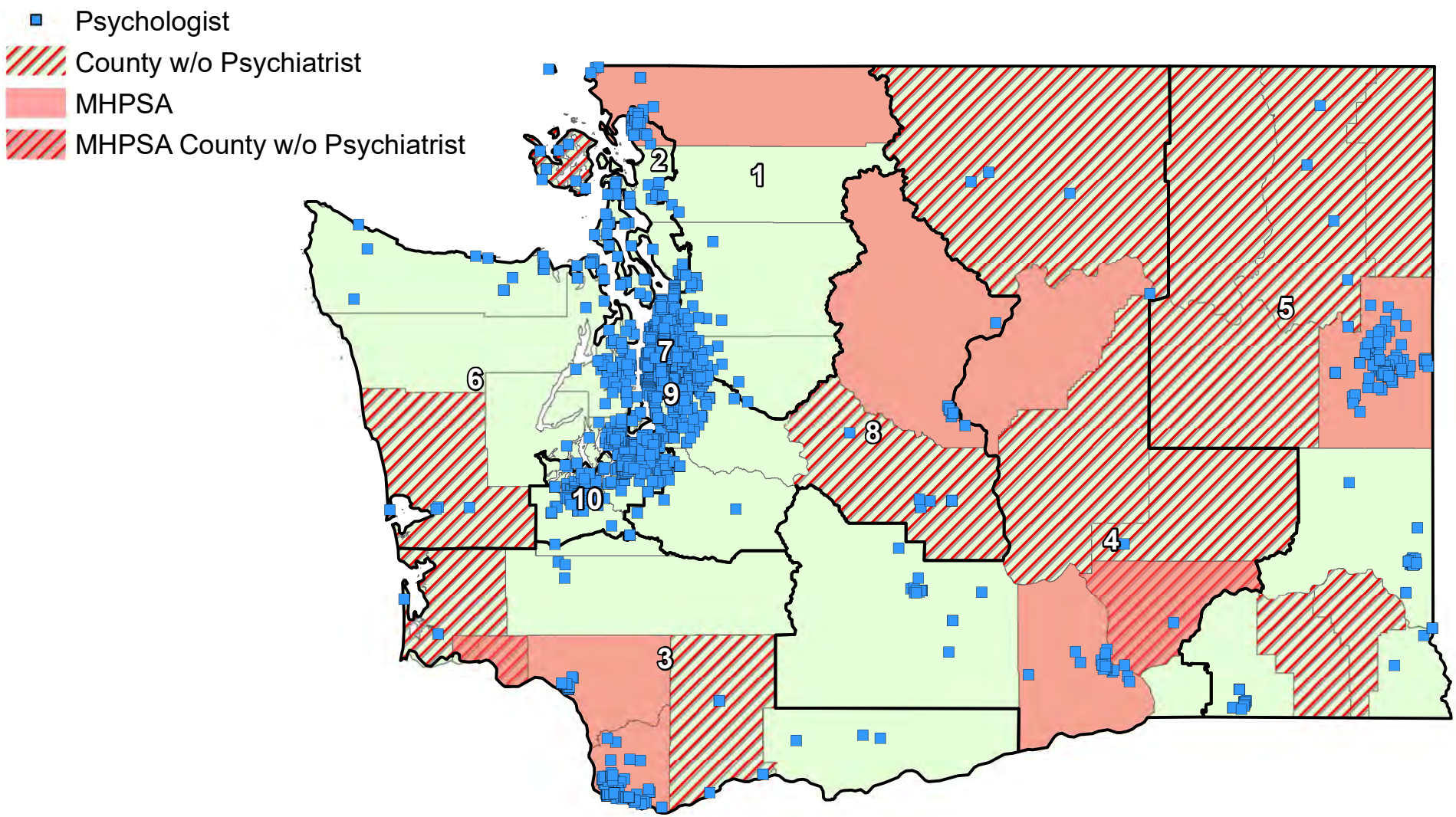
Appendix B: Licensed Clinical Psychologists and Mental Health Professional Shortage Areas (MHPSA) by County and Congressional District

AMERICAN PSYCHOLOGICAL ASSOCIATION PRACTICE ORGANIZATION

Washington

Licensed Clinical Psychologists and Mental Health Professional Shortage Areas (MHPSAs) by County and Congressional District



Data sources: U.S. Health Resources and Services Administration (HRSA), 2014; Washington Examining Board of Psychology; Washington Medical Commision

American Psychological Association Practice Organization, 750 First Street NE, Washington DC 20002-4242 | 202-336-5889 | www.apapracticecentral.org

Congressional District	Psychologist Count	Psychiatrist Count	Ratio of Psychologists to Psychiatrists	Total Population	Medicare Enrollees	% of Medicare Enrollees in Mental Health Professional Shortage Areas
01	179	51	3.5	684,234	136,458	13.7%
02	189	49	3.9	678,741	89,378	21.0%
03	132	28	4.7	679,270	150,913	62.7%
04	44	18	2.4	682,322	112,206	36.3%
05	233	63	3.7	676,586	125,494	69.7%
06	246	64	3.8	677,416	135,358	0.0%
07	695	232	3.0	686,251	104,971	0.0%
08	108	15	7.2	687,373	127,761	14.6%
09	323	149	2.2	682,076	102,037	0.0%
10	243	65	3.7	685,310	62,895	0.0%
WA Total:	**2392**	**734**	**3.3**	**6,819,579**	**1,147,470**	**24.3%**

Data sources: U.S. Health Resources and Services Administration (HRSA), 2014
Washington Examining Board of Psychology; Washington Medical Commision
US Census 2013 ACS 5yr Est.; US Census 113th Congressional Districts by County
American Psychological Association Practice Organization, 750 First Street NE, Washington DC 20002-4242
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Appendix C: Letters of Support

Letter 1:
Katherine Nordal, PhD
Executive Director for Professional Practice
American Psychological Association
March 15, 2017
Letter of support for prescriptive authority for psychologists addressed to Nebraska legislature

Letter 2:
Donald Fineberg, MD, Psychiatrist
New Mexico Private Practice
May 6, 2016
Letter of support for prescriptive authority for psychologists from a psychiatrist who has worked closely with prescribing psychologists in New Mexico

Letter 3:
Glenn Ally, PhD
Advanced Practice Medical Psychologist in New Mexico
Member of the Medical Psychology Advisory Committee to the Louisiana State Board of Medical Examiners
Jan 2, 2017
Letter of support for prescriptive authority for psychologists to Nebraska legislature detailing the success of prescribing psychology in Louisiana.

Letter 4:
Robert Julien, MD, PhD
Retired Anesthesiologist
Doctorate in Psychopharmacology
Renown author of books on psychopharmacology
Letter in response to criticism of prescriptive authority for psychologists
Feb 28, 2010

March 15, 2017

Ron Briel, Program Manager
Matthew Gelvin, Administrator
Credentialing Review (407) Program
Nebraska Department of Health and Human Services

Re: Proposed Prescribing Psychologist Credential submitted by the Nebraska Psychological Association

Dear Mr. Briel and Mr. Gelvin,

On behalf of the American Psychological Association (APA), I am writing in support of the proposal recently submitted by the Nebraska Psychological Association, which would allow licensed Nebraska psychologists who have completed additional specialized training in psychopharmacology to prescribe psychotropic medications under Nebraska law. APA is the leading scientific and professional society representing psychologists in the United States and is the world's largest association of psychologists, with more than 115,700 researchers, educators, clinicians, consultants and students as its members. Through its 54 divisions in subfields of psychology, including psychopharmacology, and its affiliations with 60 state, provincial and territorial psychological associations, APA works to advance psychology as a science, as a profession, and as a means of promoting health and human welfare.

The APA supports this proposal for the following reasons, which are discussed in further detail below:

- There is a critical need in Nebraska for improved access to safe, effective and comprehensive mental health care services. Psychologists with additional post-doctoral training in psychopharmacology are skilled in both the diagnosis and treatment of mental conditions and the use of psychotropic medications. They can provide urgently needed psychological interventions and psychopharmacological treatment services to the underserved populations of Nebraska.

- Psychologists can prescribe psychotropic medications safely and effectively. The U.S. Department of Defense Psychopharmacology Defense Project (PDP) clearly confirmed that. And appropriately trained psychologists in Louisiana, New Mexico, Indian Health Service, the U.S. Public Health Service and the U.S. military are safely and effectively prescribing for their patients. Recently, Illinois and Iowa enacted legislation granting prescriptive authority to appropriately trained psychologists.

- The current education and training recommendations for already licensed psychologists in clinical psychopharmacology are based on core competencies and contact hours jointly identified in collaboration with physicians and other health care providers dating back to the

early 1990s when the Department of Defense convened a blue ribbon panel to develop an education and training curriculum for the PDP.

- Organized psychiatry's opposition to psychology's' efforts to evolve its profession is not new.

This proposal would increase access to care by allowing psychologists with appropriate training in psychopharmacology to provide comprehensive mental health care.

A significant percentage of Americans suffer from a mental or emotional condition at some time in their lives, but their needs are not being met by the current health care delivery system. One such unmet need is in the area of psychopharmacological treatment. The vast majority of Americans who receive medications for the treatment of mental disorders do not obtain them from psychiatrists. In fact, studies have found that nearly 3/5 of psychotropic medications are prescribed by primary care providers for patients with no documented psychiatric diagnosis.[1] Many Americans go without treatment altogether, in part, because many lack access to a psychiatrist. Allowing licensed psychologists who have completed post-doctoral training in psychopharmacology to prescribe psychotropic medications would help remedy this access problem.

There is clearly a significant shortage of psychiatrists – both general psychiatrists and child and adolescent psychiatrists - to meet the mental health care needs in the U.S due to increased demand for mental health services, the aging baby boomer generation, and the increased lifespan of patients with chronic and co-occurring disorders. Not only are there not enough graduates from psychiatric residency programs to maintain the current number of psychiatrists, more than half of all psychiatrists are age 55 or older. Moreover, psychiatrists are the least likely to accept insurance or Medicaid compared to other medical specialties.[2]

[1] Mechanic D. *More People Than Ever Before Are Receiving Behavioral Health Care in the United States But Gaps and Challenges Remain,* Health Affairs 2014, 33(8) 1418-19. doi: 10.1377/hlthaff.2014.0504.
Mojtabai R, Olfson M. *Proportion of Antidepressants Prescribed without a Psychiatric Diagnosis is Growing*, Health Affairs 2011, 30(8): 1434. doi: 10.1377/hlthaff.2010.1024.
Mark TL, Levit KR, Buck JA. *Psychotropic Drug Prescriptions by Medical Specialty*, Psychiatric Services, September 2009, 60(9): 1167. doi: 10.1176/ps.2009.60.9.1167.

[2] Bishop TF, Press MJ, Keyhani S, Pincus HA. *Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care*, JAMA Psychiatry 2014, 71(2):176-181. doi:10.1001/jamapsychiatry.2013.2862.
Faulkner L, Juul D, Andrade N, et al. *Recent trends in American Board of Psychiatry and Neurology psychiatric subspecialties*. Acad. Psychiatry 2011; 35: 35-39.
The Center for Health Workforce Studies, *Trends in Demand for New Physicians, 2005-2010: A Summary of Demand Indicators for 35 Physician Specialties*. September 2011. http://chws.albany.edu/.

As a result of this shortage, patients' mental health issues often fall to their primary care or family physicians for diagnosis and treatment. But non-psychiatric physicians, who are not necessarily trained to diagnose and treat mental health disorders, do not have the time to effectively manage their patients' mental health problems nor are they trained to provide psychotherapy or other psychological interventions. Therefore, it is not surprising that often primary care physicians do not have the resources to engage in regular follow-ups or closely monitor treatment adherence for their patients' mental health problems. [3]

By comparison, psychologists are trained in the diagnosis and treatment of mental health disorders. Those psychologists who complete additional post-doctoral education and training in psychopharmacology can offer comprehensive treatment - both psychological and pharmacological treatment - to their patients. Numerous studies show that a combination of psychotherapy and pharmacotherapy is usually the most effective treatment for many mental health disorders.[4] In fact, many prescribing psychologists in New Mexico, Louisiana, and in the federal system have reported reducing or eliminating medications for a significant percentage of their patients.

Evidence shows that appropriately trained psychologists can prescribe psychotropic medications safely and effectively.

Granting psychologists prescribing authority is not a new concept. New Mexico and Louisiana have already enacted prescriptive authority laws for appropriately trained psychologists. There are now over 165 credentialed psychologists in New Mexico and Louisiana who have been prescribing since February 2005 without any adverse incident reported. Also, psychologists in the US military, the US Public Health Service and Indian Health Service, who have been credentialed to prescribe in those federal systems, demonstrate that psychologists can be trained to prescribe psychotropic medications safely and effectively thereby increasing access to much-needed mental health care services. And more recently, in June 2014, Illinois enacted prescriptive authority legislation for appropriately trained psychologists. Iowa followed suit in June 2016, passing its prescriptive authority bill for psychologists with specialized training.

[3] Association of American Family Physicians, *Mental Health Care Services by Family Physicians (Position Paper),* 2011, http://www.aafp.org/online/en/home/policy/policies/m/mentalhealthcareservices.

[4] Manber R, Kraemer H C, Arnow, B A, et al, *Faster Remission of Chronic Depression With Combined Psychotherapy and Medication Than With Each Therapy Alone*, Journal of Consulting and Clinical Psychology, 2008, 76(3) 459-467.
Blanco C, Heimberg RG, Schneier FR et al, *A Placebo-Controlled Trial of Phenelzine, Cognitive Behavioral Group Therapy, and Their Combination for Social Anxiety Disorder*, Arch Gen Psychiatry. 2010, 67:286-295.
Blom MBJ, Jonker K, Dusseldorp E, et al; *Combination Treatment for Acute Depression Is Superior Only when Psychotherapy Is Added to Medication*, Psychother Psychosom 2007,76:289-297.

The Department of Defense (DoD) Psychopharmacology Demonstration Project (PDP) demonstrated that psychologists can be trained to safely and effectively prescribe medications. The PDP was a highly scrutinized program and evaluations by external organizations confirmed that the PDP psychologists had performed safely and effectively as prescribing psychologists without any adverse outcomes. Each psychologist's quality of care was rated as good to excellent – by both their supervisors and an outside evaluation panel.

Development of APA Designation system and Model Curriculum Recommendations based on long history of interdisciplinary collaboration.

Since the PDP, several post-doctoral master's degree programs in clinical psychopharmacology have been established, training already licensed psychologists around the country for prescriptive authority. APA has established a designation system to evaluate those programs. The purpose of the designation system is to provide public recognition of education and training programs that meet certain threshold standards and published criteria. APA has already designated four postdoctoral psychopharmacology programs as meeting those standards. Establishment of this quality assurance system demonstrates further advancement in psychology's efforts to assure that prescribing psychologists receive comprehensive and standardized levels of training.

This designation system was premised on the principles and core competencies as recommended in APA's Recommended Education and Training in Psychopharmacology for Prescriptive Authority. The model curriculum document was the result of decades-long collaboration with other disciplines in developing a core curriculum to train already-licensed psychologists in clinical psychopharmacology in order to prescribe (or unprescribe) medications typically used for mental health.

In early 1990, the then Army Surgeon General formed a Blue Ribbon panel consisting of representatives from the three services' Surgeons General, the Office of the Assistant Secretary of Defense for Health Affairs, the American Psychiatric Association, the American Psychological Association), the American College of Neuropsychopharmacology, and other physicians, to determine the best training model and methods for the PDP. In 1993, the California Psychological Association convened a blue ribbon panel to develop core competencies and contact hours for training prescribing psychologists. That panel included 4 physicians, 1 clinical pharmacist, and 1 RN as well as one of the psychologists who was going through psychopharmacology training in the PDP. This panel developed recommendations about core competencies and contact hours. These interdisciplinary efforts were the starting point for the evolution of the APA's policies on psychopharmacology education/training and prescriptive authority. The current recommended curriculum is the culmination of the past 26+ years of developing, updating and refining those recommendations.

Psychiatry's opposition to psychology's efforts to advance the profession is not new.

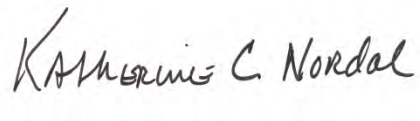
Organized psychiatry has a history of opposing the expansion of psychology as a profession. So its current opposition to psychology seeking to expand its practice to include prescriptive authority is neither surprising nor new. Psychiatry joined the American Medical Association and other specialty medical organizations to form the Scope of Practice Partnership (SOPP) – a well-funded initiative designed to combat any scope of practice expansions by non-physician health care providers. Blocking legislation granting prescriptive authority for appropriately trained psychologists has been identified as one of the SOPP initiative's top priorities.

At present, there are a number of non-physician health professionals who have obtained prescription privileges. For example, today, optometrists have obtained independent prescription privileges in all 50 states. It took almost 30 years since the first state granted privileges in 1971 for optometry to obtain this result. Podiatrists, advanced practice nurses and physician assistants have also achieved prescriptive authority in the majority of states. Clinical pharmacists also prescribe and administer medications.

In those 30 years, two patterns clearly emerged. First, organized medicine unsuccessfully opposed the granting of privileges in every state. Secondly, and most importantly, organized medicine's warnings about the danger to patients have proven to be unfounded. The patient safety issue asserted by the psychiatric community is the same issue that organized medicine has repeatedly cited in its attempts to limit other non-physician providers.

On behalf of the APA, we appreciate your diligent consideration of this important issue. We believe that prescribing psychologists can and will help to address the critical need for care experienced by many citizens in your state with mental health needs, just as other prescribing non-physician healthcare providers already do. New Mexico, Louisiana, Illinois and Iowa as well as a number of federal agencies have already granted prescriptive authority to psychologists for similar reasons. Please feel free to contact us if we can be of any assistance as you consider this issue.

Sincerely,



Katherine Nordal, Ph.D.
Executive Director for Professional Practice

Donald E. Fineberg, M.D.
200 West De Vargas St. -- Suite 5
Santa Fe, NM 87505

Tel: (505) 983-5387 e-mail: donfineberg@mac.com

May 6, 2016

Re: Endorsing Prescriptive Authority for Psychologists

This letter will hopefully provide you with information, from a Psychiatrist in practice sine 1978, based on 14 years of working with psychologists with prescriptive authority in New Mexico. The experience has been positive for both New Mexicans and for my professional practice. By way of full disclosure, psychologists have NEVER paid me for my opinion on this matter and I have been appointed to the New Mexico State board overseeing the licensing process. I serve without pay.

In New Mexico, we have had a Psychologist Prescriptive Authority law since 2002. It has been a great boon for the people of New Mexico. They have had increased access to quality psychological care, with the use of psychotropic medication when indicated. Even in Santa Fe and Albuquerque, where most of the state's psychiatrists practice, it was difficult to get an accurate psychological assessment and treatment with medication. Wait times were long and access was limited. In rural New Mexico, the problem was even greater.

The New Mexico law has served our state well. In 14 years, there have been about 55 psychologists who have been licensed and there has not been a single action taken against psychologists for unsafe practices. None. We need more psychologists with their degree of competence and dedication. Our state's mental health needs are still not met. Fears of being "overrun" by psychologists as well as fears of undertrained psychologists hurting patients have been shown to be completely without foundation. This is true for patients in general, as well as special populations, such as children and the elderly. Psychologists consult regularly with other professionals, especially doctors, for the management of medical conditions beyond their specialty. Psychologists have proven themselves to be team players in serving the mental health needs our state.

Every study of psychotropic medication prescribing demonstrates that the majority of these medications are prescribed non-psychiatrist physicians, such as internists or family practice doctors. Psychologists bring diagnostic and therapeutic expertise to the community. When looking at the additional training for prescriptive authority for psychologist, it is important to remember this training occurs in addition to the many years of psychological education that makes psychologists experts in accurate diagnosing, the true basis for effective prescribing.

Over the years, many doctors, especially in family practice have shared with me their experiences. One aspect stood out: Even before the law passed, they consulted psychologists in their community for diagnostic advice about their patients, and even recommendations for medications. The psychologists were de facto managing the care and the overworked doctors were writing the prescriptions. The law authorized psychologists to manage these patients, including medications, when indicated. Rather than competing with doctors, psychologists continued to be a part of an effective team of care providers. This is true today. Hard working doctors who care about their patients expressed gratitude for psychologists as prescribing colleagues. Even psychiatrists, who back in 2002, complained because of their fears of the competition from and inadequate training of psychologists with prescriptive authority have calmed down. These psychiatrists admit that they are busier than ever and psychologists provide high quality care.

Our governor at the time the law passed, Gary Johnson, a Republican, found support on both sides of the aisle from legislators. Ultimately, serving the well-being of the people of New Mexico won the day when he signed the bill into law. It was politics at its best in service to our state.

Please feel free to contact me, if I can offer any additional information or clarification.

Sincerely,

Donald E. Fineberg, M.D.

Glenn A. Ally, Ph.D., M.P.
(A Professional Psychology Corporation)
Clinical Neuropsychologist
Advanced Practice Medical Psychologist
155 Hospital Drive, Suite 200
Lafayette, Louisiana
70503

(337) 235-8304

January 2, 2017

Dear Technical Review Committee Members:

It is my honor and pleasure to submit a letter in support of the proposal recently submitted by the Nebraska Psychological Association to grant prescriptive authority to specially trained psychologists. In addition to offering my strong support for this proposal I would like to take this opportunity to provide information to the Committee on the history and progress of prescriptive authority for specially trained psychologists in Louisiana.

At this point, I am sure the Committee is aware that psychologists with prescriptive authority have been prescribing psychotropic medications in the US military for more than 20 years now and in New Mexico and Louisiana for more than 11 years. Illinois passed legislation in 2014 allowing specially trained psychologists to prescribe, however, the Illinois model differs from past experience in credentialing prescribing (medical) psychologists so it is early to reach conclusions. Just this past year, Iowa also passed enabling legislation to allow specially trained psychologist to secure prescriptive authority, and their statute closely models the successful approach taken in New Mexico.

By way of introduction, I am a Medical Psychologist in Louisiana and have had prescriptive authority to the past 11 years. Prior to having prescriptive authority, my specialty was and continues to be neuropsychology. I have had a private practice for approximately 36 years. In addition, I have had a hospital practice for approximately the same amount of time. In that hospital practice, I provide services throughout the hospital and particularly on the physical medicine and rehabilitation unit. In that regard, I have had the opportunity to work with medically compromised patients. Since gaining prescriptive authority I continued in that capacity, albeit now devoting only one day a week to my private practice. After gaining prescriptive authority, I have provided, and continue to provide, services to our Community Mental Health Center and services to a large cancer center affiliated with our 350 bed community non-profit hospital. So, in all settings I continue to provide services to patients with co-morbid medical conditions and medically compromised patients. From the ICU to outpatient mental health clinic, I and other medical psychologists have been comfortable providing mental health services, and, most importantly, our physician colleagues have become extremely comfortable relying

on the care that medical psychologists provide. Finally, I am a past member of the Louisiana State Board of Examiners of Psychologists (psychology licensing board), and I am currently a member of the Medical Psychology Advisory Committee to the Louisiana State Board of Medical Examiners (medical licensing board).

In May of 2004, Louisiana passed it's first statute granting authority to specially trained psychologists. This statute allowed the psychology board to grant a "Certificate of Prescriptive Authority" to Medical Psychologists, similar to what is currently being considered in Nebraska. Medical Psychologists were authorized to prescribe all medications normally used in the pharmacologic treatment of mental illness and to prescribe medications that are generally used for routine side effects. Additionally, Medical Psychologists were authorized to order tests necessary for diagnosis and/or monitoring the effects of the medications prescribed. In exercising that prescriptive authority, Medical Psychologists were mandated to "consultation, collaboration" with, and "concurrence" of the patient's primary care physician prior to writing the prescription. This safeguard was thought to be not only a good safety measure, but simply good practice. However, our experience taught us that this was cumbersome for primary care physicians, Medical Psychologists, and patients to have this occur before prescriptions were written. This was especially true on an inpatient basis. Typically what we heard by physicians when attempting to reach them for concurrence was, "That's why I consulted you to prescribe the best medication…no need to call me."

In 2009, the Louisiana legislature passed Act 251 that transferred regulatory authority for Medical Psychologists to the medical board. This statute provided for several factors. First, it eliminated the Certificate of Prescriptive Authority and legislated the establishment of a new, hybrid profession, the Medical Psychologist. The Medical Psychologist is now a licensed professional, a psychologist that has the expertise to not only prescribe psychotropic medications but to manage the mental health care of patients requiring such care. Secondly, Act 251 established two tiers of Medical Psychologists; those who are newly licensed and who must continue to provide prior "consultation, collaboration, and concurrence" as before and Advanced Practice Medical Psychologists who function more independently. Collaboration with the patient's primary care physician is still mandated, but that collaboration can take place during the normal course of provider interaction rather than being mandated before a prescription can be written for the patient needing psychotropic medication. The requirements for both Medical Psychologists and Advanced Practice Medical Psychologists are spelled out in statute and I am sure the Committee has been informed of those requirements.

Opposition to Medical Psychologists had taken the now familiar approaches that I am sure this Committee has heard multiple times. I will briefly address those common points of opposition.

Need: The opposition has suggested that there is no need for another prescriber. Perhaps Nebraska has found the means to provide all the quality mental health care that the State requires. If you have then I need go no further. Having psychologists with prescriptive authority will not be THE answer, but they will be quality help in the right direction for

Nebraska. At present, there are 96 Medical Psychologists in Louisiana and we are adding more each year. We are not only adding Medical Psychologists from within Louisiana. We have Medical Psychologists licensed in Louisiana who are currently prescribing in the US military and the US Public Health Service. We have had psychologists with appropriate training move from surrounding states in order to be licensed in Louisiana as Medical Psychologists. Our Medical Psychologists are in a variety of settings, inpatient and outpatient, public sector and private sector, solo practices, group practices, and integrate health practices, in both rural and urban communities.

Access: Perhaps this has been the most persuasive argument FOR psychologists with prescriptive authority. All parties concerned have acknowledged that there is an access problem for those needing mental health services. There are far too few psychiatrists and nurse practitioners to provide sufficient, quality services, and the number of psychiatrists in training is becoming smaller, not greater. There is certainly an access problem to those who are indigent and in rural communities. However, those who are in urban areas often experience access problems in the form of excessive wait times for new patient appointments or increasingly fewer providers accepting certain insurances.

The impact by Medical Psychologists on access in Louisiana has been significant. For those who are in private practice exclusively, access to these practitioners may not have increased a great deal. There are only so many hours in a day and the practitioner can only see so many people, regardless if the practitioner prescribes or does not prescribe. So, if you are in private practice and work 8 hours a day, you probably will not see more patients simply because you prescribe...although some have. Some have moved to half hour appointments for those who may be stable on medications, etc. In Louisiana, psychologists are not eligible for outpatient Medicaid reimbursement. Consequently, unless the psychologist works in a facility where the facility bills for services, and pays the psychologist in some manner, Louisiana psychologists are not likely to accept Medicaid outpatients. Where the greatest increase in access has been realized with Medical Psychologists is in the public sector...Community Mental Health Centers, State hospitals and clinics. While psychologists worked at these facilities previously, they were there mostly to do a limited amount of psychological testing. Most of the "psychotherapy" was being performed by social workers and Licensed Professional Counselors that the State can hire much more cheaply. Psychiatrists have been traditionally the medication managers. While there are psychiatrists at these facilities, there have been numerous vacancies for psychiatrists that remain unfilled. Louisiana has attempted to fill these vacancies with retired internal medicine physicians, but that has not always worked out. Some of the vacancies had been available for more than 5-10 years. Medical Psychologists began filling this void and increasing access to many indigent patients in the State system. My partner and I were the first in Louisiana to take such positions at our regional Community Mental Health Center. We split the hours of a full-time psychiatrist position at our Community Mental Health Center. Soon, other CMHCs began contracting with Medical Psychologists, and at least a few have been hired full-time. Likewise, Medical Psychologists have been contracted and hired in the State hospital system. We have a couple of Medical Psychologists at VA centers, but they are not yet allowed to prescribe in the VA system.

Rural Access: Another criticism by the opposition has been that psychologists are essentially in no greater numbers in rural areas than psychiatrists. While it may be true in some states that the physical location or residence for many tend to be in more populated areas, that does not mean that Medical Psychologists in Louisiana do not serve rural populations. For example, the CMHC where I work covers a seven parish (county) area. That area includes significant rural areas with satellite clinics, etc. So, we do see a large number of indigent and patients from rural areas at the main center and in the satellite clinics. And, as mentioned above, there have been shortages of psychiatrists willing to serve in these State facilities, particularly in more rural areas. New Orleans, Baton Rouge, and Shreveport tend to have an abundance of psychiatrists because the medical schools are located there, and New Orleans has a psychiatric residency program. But, outside of those areas, psychiatrists are just not filling such positions. Psychiatry has proposed "telepsychiatry" in lieu of prescriptive authority for specially trained psychologists. We have been hearing about the benefits to access by telepsychiatry for more than 10 years in Louisiana. That promise of increased access simply has not been realized. Instead, there are fewer psychiatrists who provide less access as more and more are abandoning general hospital practice so they do not have to "take call" and accept indigent or "no pay" patients in their practices. And, more psychiatrists seem to be abandoning those patients with managed care insurance coverage.

Keep in mind, Medical Psychologists are trained as psychologists first and have the skills and expertise to provide a variety of psychotherapies in addition to psychopharmacology. Most psychiatrists have limited their expertise to psychopharmacology only. It only makes sense to provide the treatment modality that best fits patients' needs rather than trying to force patients' needs into the only treatment modality that one profession may have. The Medical Psychologist is perhaps the only doctoral level professional that can provide both modalities.

Safety: Recognize that this issue, safety, has been an all too familiar cry by those in the medical community opposed to any expansion in scope of practice. Many years ago, physicians held that only physicians could use "needles" to puncture the body. Reluctantly and citing safety as an issue, only physicians and then Registered Nurses were allowed to puncture a vein to start an IV. Now, someone with a high school education and three months of training as a phlebotomist is allowed to puncture a vein with a needle and draw blood. Such "turf" issues are frequent and "safety" is almost always cited as the primary reason to deny expansion of scope of practice for disciplines other than physicians.

At this point, the argument against psychologists with special training having prescriptive authority that cites "safety" as the reason is simply a fear tactic to protect turf. There is now a 20 year history of psychologists prescribing in the US military and a 10 year history of medical psychologists prescribing SAFELY in two states. In more than 20 years of prescribing, there have been no complaints against psychologists with prescriptive authority for their use of medications. Again, I have served on the State psychology board and on the Medical Psychology Advisory Committee and am quite familiar with this data. When this issue is brought up by the opposition, and it will, the Committee should ask two questions of the opposition. First, "What evidence or data do

you have that psychologists with prescriptive authority are indeed not safe prescribers?" While opponents often come up with anecdotal, often fabricated, stories of safety issues, they cannot provide any data whatsoever, because it does not exist…this, in light of the extensive history of psychologists prescribing safely. A second question should be asked, "Would you provide evidence of any 10-20 year time period in your profession without complaint regarding prescribing medications?" Medical psychologists have been, and continue, prescribing safely for patients in need of medication for mental health issues. In fact, in 2009, when Louisiana passed Act 251, the Executive Director of the medical board testified in favor of the bill, and in doing so, he said, "We recognize that they (Medical Psychologists) are very safe prescribers."

Finally, I would like to briefly address another advantage of psychologists with prescriptive authority that is not generally discussed. Medical Psychologists are more likely to work in integrated health care settings. There are few, if any psychiatrists in Louisiana involved in the integrated care model. As I noted previously, I have worked at a large cancer center and provided my services there two days a week. I had a physical office in the cancer center and assisted six (6) oncologists and five (5) nurse practitioners in providing for the mental health needs and psychotropic medications for their cancer patients. The oncologists and their nurse practitioners certainly welcomed the help. I regularly met with the oncologists and nurse practitioners both formally and informally. In addition to scheduled appointments with our cancer patients, I often got the "hallway handoff" of patient and family who may have just been diagnosed with cancer. By the same token, I was able to provide group therapy to patients with breast cancer and other groups of cancer. There is a tremendous need for mental health care with cancer patients and their families, the patients welcome the opportunity to avail themselves of my services while in the same facility and in my private practice. There are other Medical Psychologists in integrated care settings who are providing not only additional expertise to our physician colleagues, but also greater access to patients who probably would not have gotten such services were it not for the working relationship between Medical Psychologists and physicians that is typically not seen with psychiatry. Psychologists with prescriptive authority are proving to be valuable members of integrated health care teams that seek to address the mental health care needs of their patients.

Thank you for allowing me the opportunity to provide information about the advantages of having psychologists with prescriptive authority. There are currently approximately 96 medical psychologists in Louisiana who are adding access to the full range of quality mental health services in our State, and they are doing so in a safe and effective manner. I would encourage you to consider the proposal offered by the Nebraska Psychological Association in the most positive manner. If I can be of any further assistance to this Committee, please do not hesitate to contact me. I would be happy to address and questions or concerns that the Committee may have regarding our experiences in Louisiana.

Sincerely,

Glenn A. Ally, PhD, MP
Advanced Practice Medical Psychologist
Clinical Neuropsychologist

ROBERT M. JULIEN, MD. PH.D.

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February 28, 2010

Dear Ms. Nielsen:

I have read your editorial in this morning's Sunday Oregonian. I am compelled to write not only because your facts are wrong, but you appear to be heavily influenced by persons or organizations exerting self-interest concerns. I am a retired physician (25 years of Anesthesiology in Portland) as well as a PhD in Psychopharmacology. I have no axe to grind in this matter, and I have no self-interests. For 35 years I have authored 11 editions of a widely used textbook of Psychopharmacology (*A Primer of Drug Action)*. In addition, I present psychopharmacology lectures throughout the United States; I have trained nurse anesthetists, medical students, and graduate physicians. I educate, through psychopharmacology seminars, other prescribers including Naturopathic Physicians, mental health Nurse Prescribers, Clinical Psychologists and other mental health professionals. I am familiar with prescribing psychologists in Louisiana, and I meet monthly with a study group of Psychologists here in Oregon.

It is beyond question that Psychiatrists, if they adhered to the ideals of psychiatry training, would best serve all the mentally ill of Oregon. This, of course, would presume that we have sufficient numbers and that they would utilize 50 minutes per patient and utilize their psychotherapeutic skills. This does not happen; our few psychiatrists have become 10-15 minute medication managers as have our other physician prescribers. It is also a fact that over 90% of mental health prescriptions are written by persons with little or no training in assessment, testing, and provision of physiological therapies. These prescribers, more often than not, fail to utilize the "experts" in assessment, testing, and provision of physiological therapies. These are our doctoral-level Clinical Psychologists.

All objective data indicate that the "gold standard" of mental health treatment lies in the combination of psychological therapy plus medication. In Oregon this is not being done. Merely writing prescriptions for mental health medications (as TV adds promote) does not achieve this; nor does psychological therapy provided in isolation. We must develop a system to provide, in a cost-effective manner, this combination of medication plus non-medication therapy. We are blessed in Oregon that a few doctoral-level Clinical Psychologists have gone beyond their Doctorate to obtain a Master's degree in Psychopharmacology and undertook several years additional supervised training in the clinical use of these medications.

Clinical psychologists, based on their Doctoral training, are uniquely trained in assessment and diagnosis of mental health disorder in persons of all ages. These are skills beyond those possessed by family practice physicians, mental health nurse prescribers, or naturopathic physicians. These specialized Clinical Psychologists who possess a Master's Degree in psychopharmacology add to their psychology skills the education and competency to prescribe medication as part of their psychology practice. Their training in Clinical Psychopharmacology does not differ significantly from (and may even be superior to) that taught mental health nurse practitioners, physician's assistants, or Naturopathic Physicians, all of whom have much less training in psychological treatments and in the integration of psychological and pharmacological interventions. Here, one specialized group is prepared to deliver this integrative care efficiently and in a cost-effective manner. I therefore am an Oregon Physician who strongly supports prescription privileges for Psychologists with advanced training in Clinical Psychopharmacology.

Robert M. Julien, MD, PhD
Lake Oswego, OR 97035

Appendix D: Sunset Review of the New Mexico Prescription Privilege Law

Presentation to the Behavioral Health Subcommittee State of New Mexico Legislature

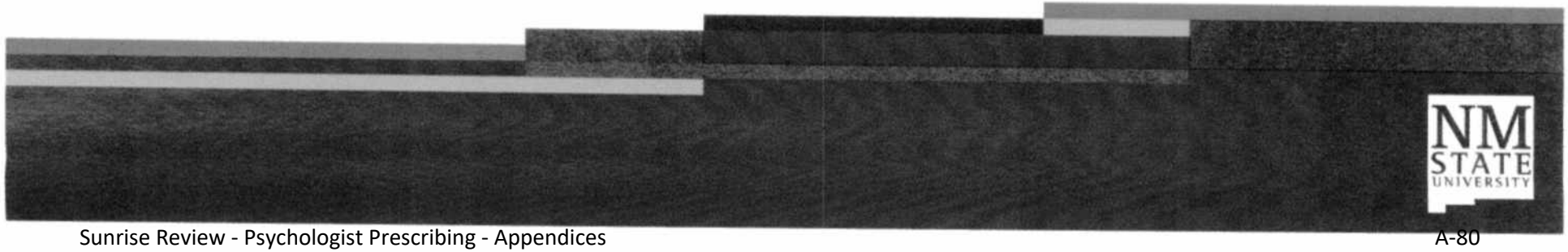
- Senator Mary Kay Papen
- Presiding Chair

December 2, 2011
Santa Fe, New Mexico

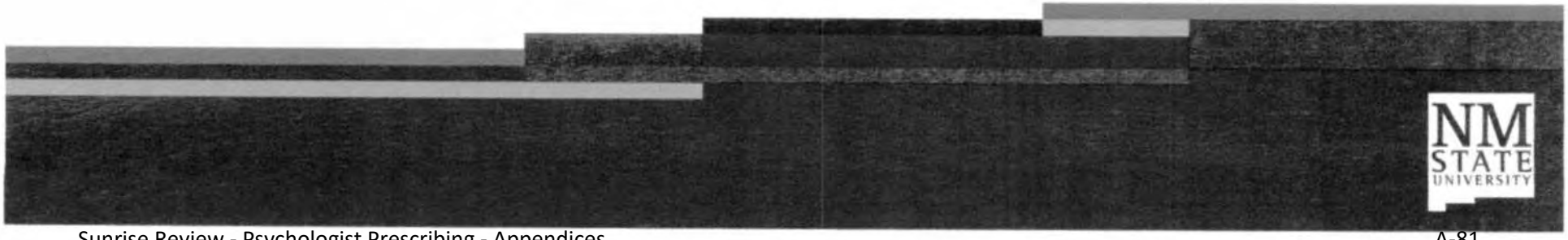
Presenter
Elaine S. LeVine, Ph.D., ABPP

Discussants:
Jonathan Schwartz, Ph.D.
Chair, Department of Counseling and Educational Psychology
New Mexico State University

Mario Marquez, Ph.D.
Evaluator of RxP Candidates for the New Mexico Board of Psychologist Examiners



Need for Prescribing Psychologists

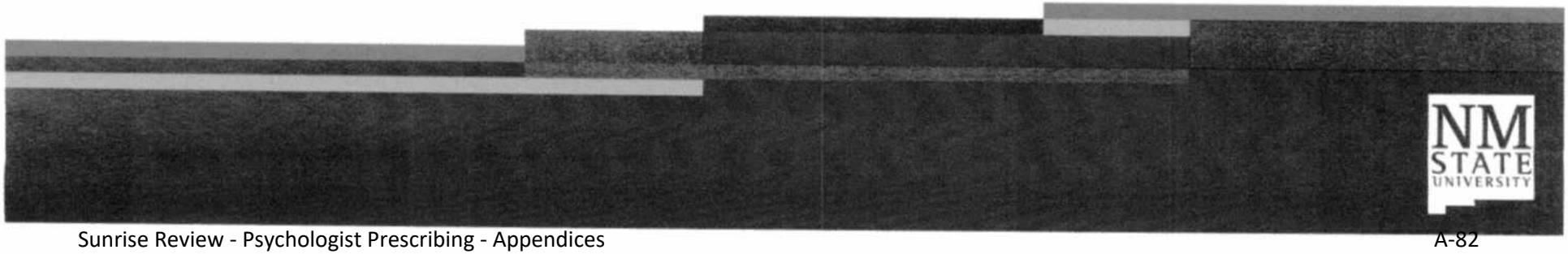


The Lack of Access to Mental Health Care is Particularly Critical in Rural New Mexico

Density Data:

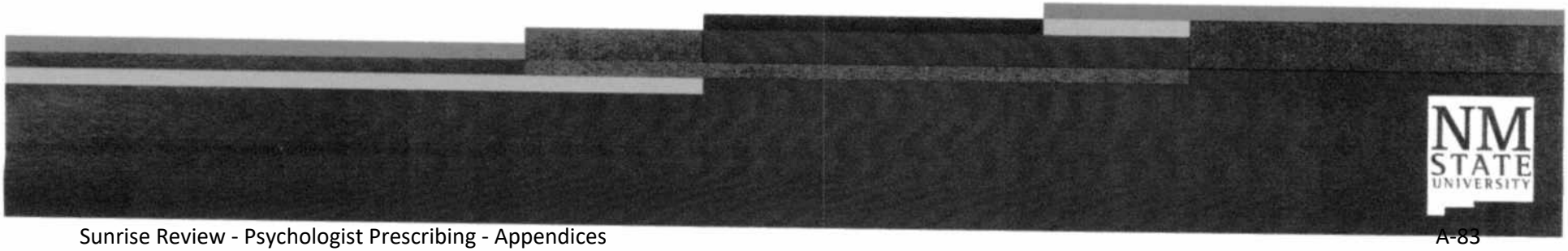
United States	**Psychologists**	**34.3/100,000**
	Psychiatrists	**14.3/100,000**
Metropolitan New Mexico	**Psychologists**	**41.0/100,000**
	Psychiatrists	**21.0/100,000**
Non Metro New Mexico	**Psychologists**	**13.0/100,000**
	Psychiatrists	**5.8/100,000**

American Psychological Association Practice Organization,
Psychologist and Psychiatrist Density Ratio Project, October 5, 2007,
prepared by The Center for Health Policy, Planning and Research.

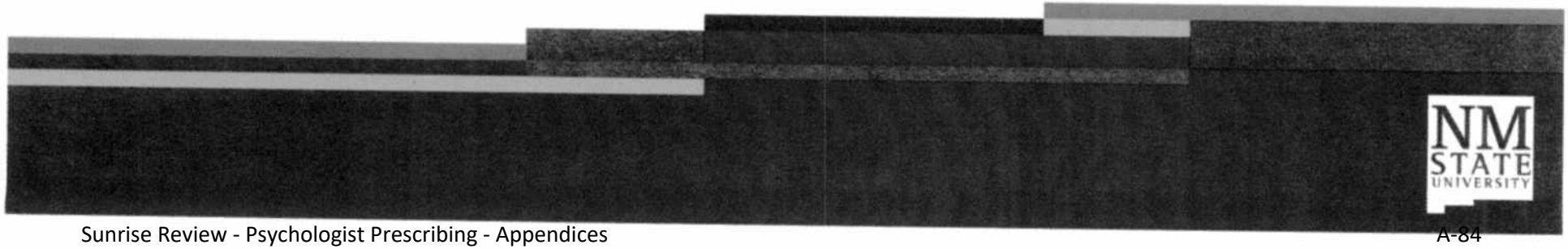


In a 2001 survey, we located **95** psychiatrists in New Mexico. Most are located in Albuquerque and Santa Fe, and many work at the Medical School of the University of New Mexico.

There are now **33** psychologists licensed to prescribe psychotropic medications under the New Mexico Law. **25** are prescribing in New Mexico. These prescribing psychologists have increased those available to provide psychopharmacological/psychotherapeutic care by **25%!**



In Addition to Easing the Overall Burden of Availability of Psychopharmacological Care in New Mexico, New Mexico's 31 Prescribing Psychologists Are Helping to Meet the Needs of the Underserved



Location of New Mexico Psychologists Licensed to Prescribe

Practicing in New Mexico

Albuquerque	7 1/5*
Alamogordo	1/5*
Chaparral	1/5*
Farmington	1
Grants	1
Hobbs	1 1/5*
Las Cruces6	
Las Vegas	1
Mescalero (1/5)*	
Roswell	1
Santa Fe	2 1/5*
Taos & North	1

Licensed in New Mexico/ Prescribing Out of State

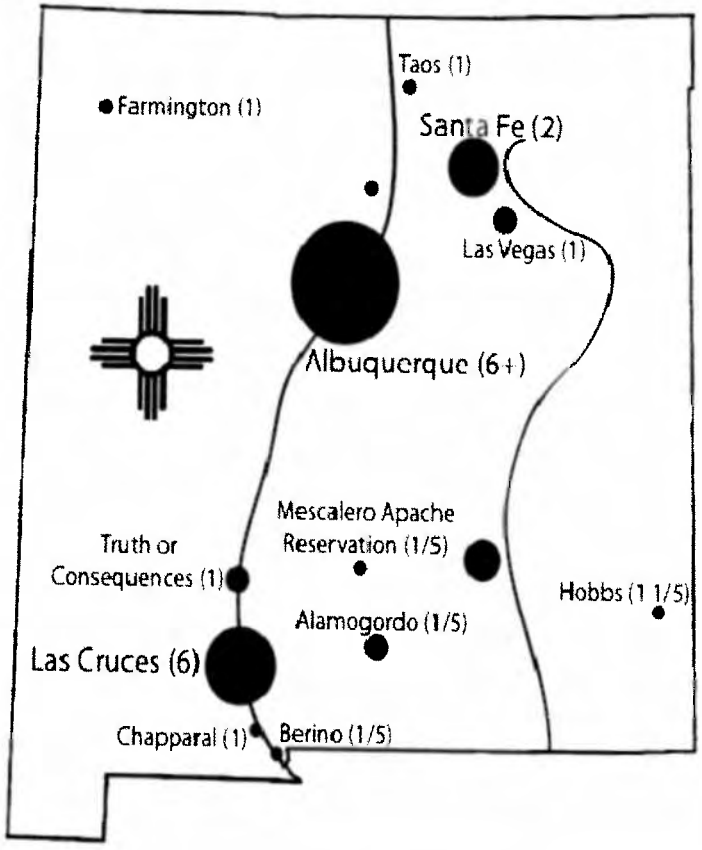
North Dakota IHS	1
Montana IHS	1
Washington Military Contractor	1
Texas Military Contractors	2

Licensed in New Mexico/ Consulting Out of State

Washington, D.C./California	1
Minnesota	1
(she was IHS New Mexico)	
Pennsylvania (New Mexico)	1
Illinois	1

*1/5 = consulting weekly

Prescribing Psychologists are Servicing Rural Communities



Other States with Practicing Prescribing Psychologists Licensed Through NM:

Montana (1)
North Dakota (1)
Texas (2)
Washington (1)

Legend

(x) Number of FTE prescribers

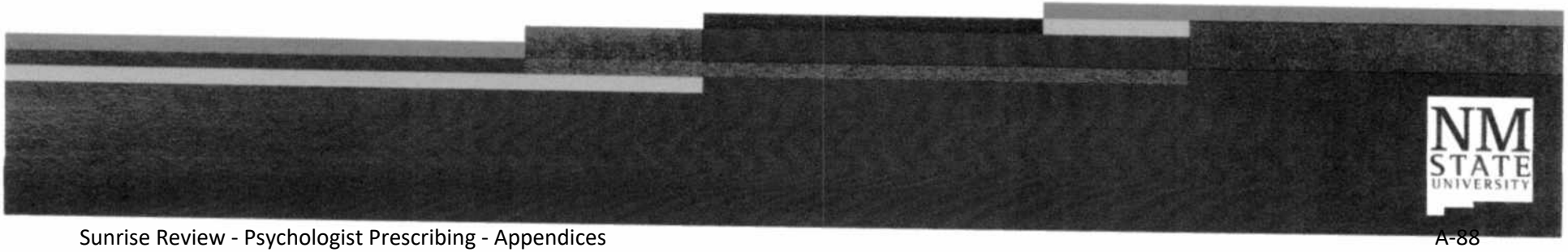
● Size of dot proportional to population density

1/5 = weekly to monthly consultation

Examples of Sites Where Prescribing Psychologists Complete Their Internships (offering free service) and are Employed

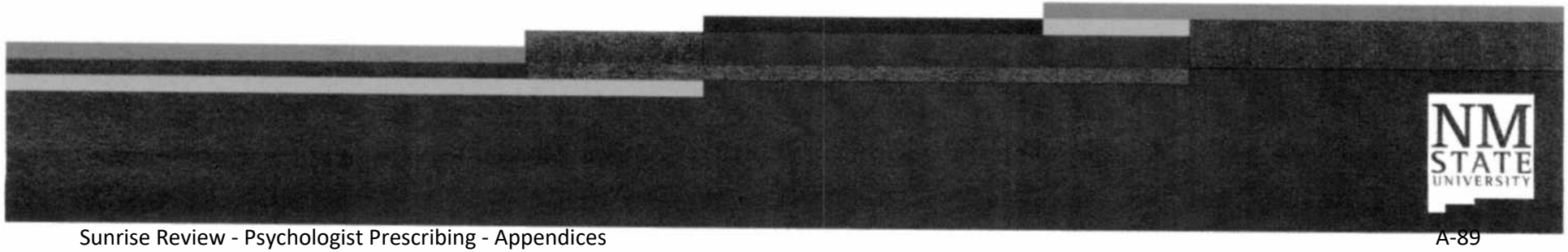
- Presbyterian Clinic in Gallup
- School-Based Health Clinic in Gadsden
- School-Based Health Clinic in Las Cruces
- General Hospital in Roswell
- Federally Qualified Health Clinics in Taos
- Federally Qualified Health Clinic in Espanola
- Federally Qualified Health Clinic in Truth or Consequences
- Mental Health Clinic in Taos
- General Hospital in Farmington
- Family Practice Residency Center in Las Cruces
- Memorial Medical Hospital in Las Cruces
- Taos-Picarus Indian Health Service
- Lovelace Outpatient Clinic in Albuquerque
- Private Clinics throughout the State including Albuquerque, Roswell
- Mental Health Clinic in Berino
- Federally Qualified Health Center in Chaparral
- Drug Treatment Centers in Albuquerque and Santa Fe
- Las Vegas State Hospital
- Director of Substance Abuse Clinic in Albuquerque

Overview of Training to become a Prescribing Psychologist



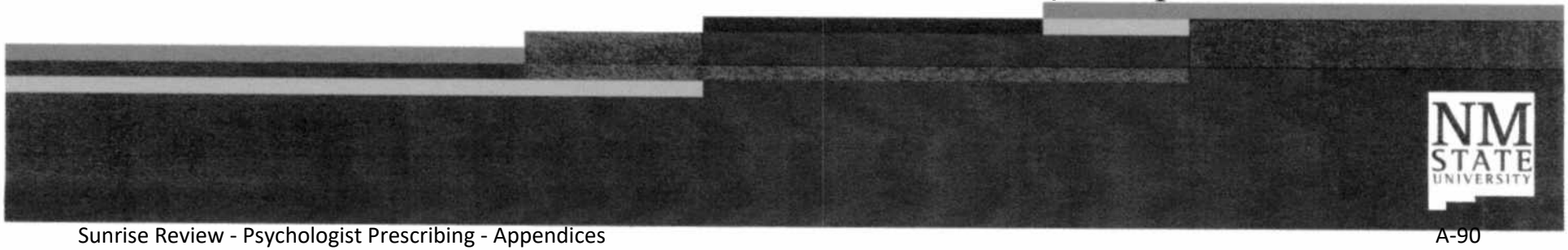
Training of Prescribing Psychologists

- Must have a doctoral degree and license as a psychologist in good standing to be accepted into the SIAP/NMSU program
- Must complete a post-doctoral Interdisciplinary Masters in Psychopharmacology which includes
  - 36 academic hours
  - 80 hour practicum with primary care physician
  - 400 hour/ 100 patient practicum in diagnosis and treatment of mental disorder
- Must pass a nationally standardized test, Psychopharmacology for Psychologists (the PEP).
- Then can obtain a conditional license to prescribe
- With conditional license, must see 50 patients over two years under supervision
- After review of records by New Mexico Board of Psychologist Examiners, conditional psychologists can obtain an unrestricted license to prescribe psychotropic medications



Rights and Responsibilities of Prescribing Psychologists

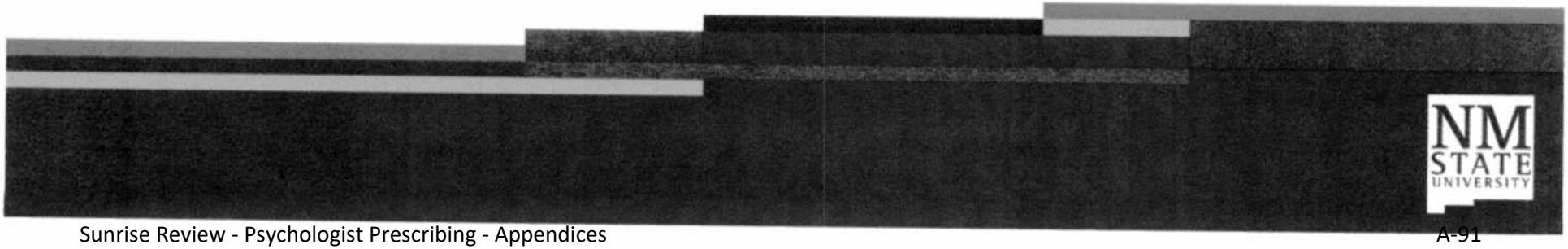
- Remain in a consultative relationship with a Primary Care Physician
- Formulary is limited to psychotropic medications
- Must order appropriate lab tests to be a safe prescriber
- Must practice within area of specialization of the psychology license and with appropriate post-doctoral supervision
  - Those with hospital practices and privileges can prescribe at hospitals for their patients
  - Child psychologists with prescriptive authority and appropriate post-doctoral supervision can prescribe for children
  - Must also have appropriate background and specialized supervision to work with geriatric populations
- Prescribing psychologists can bill for Medicaid and most private insurances at a rate approximately $10 higher per hour than other psychologists
  - Medicare does not yet recognize prescribing psychologists
- Prescribing psychologists offer the state great cost savings as they provide psychotherapy, psychological testing and assessment, and psychopharmacological intervention in each session by one provider



From the New Mexico Board of Psychologist Examiners' Perspective

"In the five years that psychologists have been prescribing in New Mexico, there have been no complaints at all to the State Board of Psychologist Examiners of patients having been harmed by prescribing psychologists. None. Also, there have been no allegations of improper or inappropriate prescribing which have been verified after review by the State Board of Pharmacy."

Robert Sherrill, Ph.D.
Chair
New Mexico Board of Psychologist Examiners

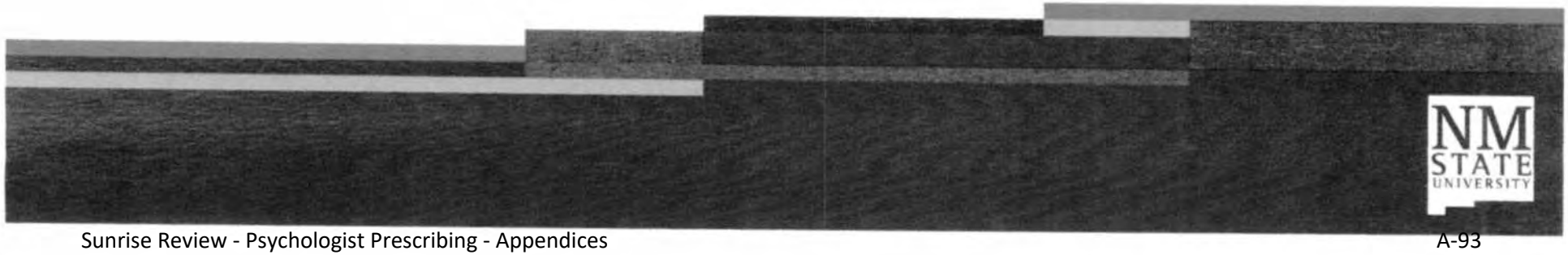


Prescriptive Authority for Psychologists Can Be a Vital Link in the Medical Home/Integrated Health Care Movement

Vector 1: Pressures on Primary Care Physicians

- Increasingly, primary care physicians are faced with helping patients with emotional problems.
- They have neither the time nor extensive training to deal with these issues in depth.
- They often respond to these pressures by prescribing psychotropic medications.
- In fact, over 80% of psychotropic medications are prescribed by primary care doctors.
- Yet, meta-analyses reveal that often these emotional needs could be addressed as effectively, or more effectively, by psychotherapy.
- Moreover, psychotherapy plus medication is often more effective than medication alone.

(In LeVine & Foster, 2010, Integration of Psychotherapy and Pharmacotherapy by Prescribing Psychologists: A psychobiosocial model of care. In R. McGrath & B. Moore, Therapy for Psychologists: Prescribing Collaborative Roles. Washington, DC: American Psychological Association)

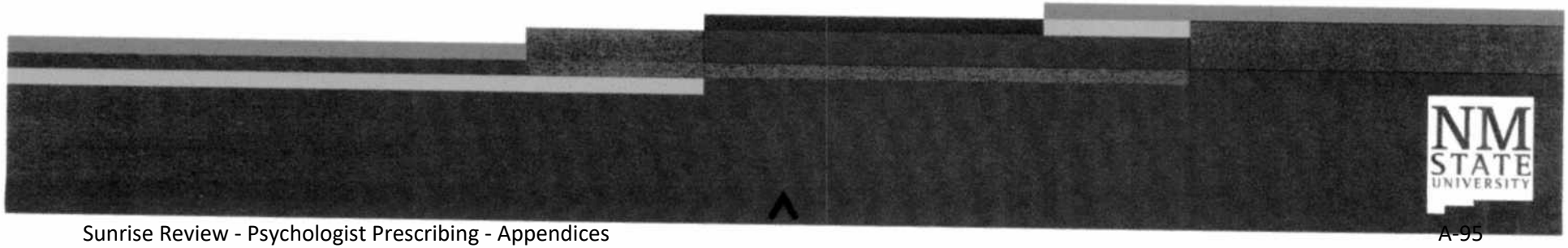


Vector 2: Pressures on Psychologists

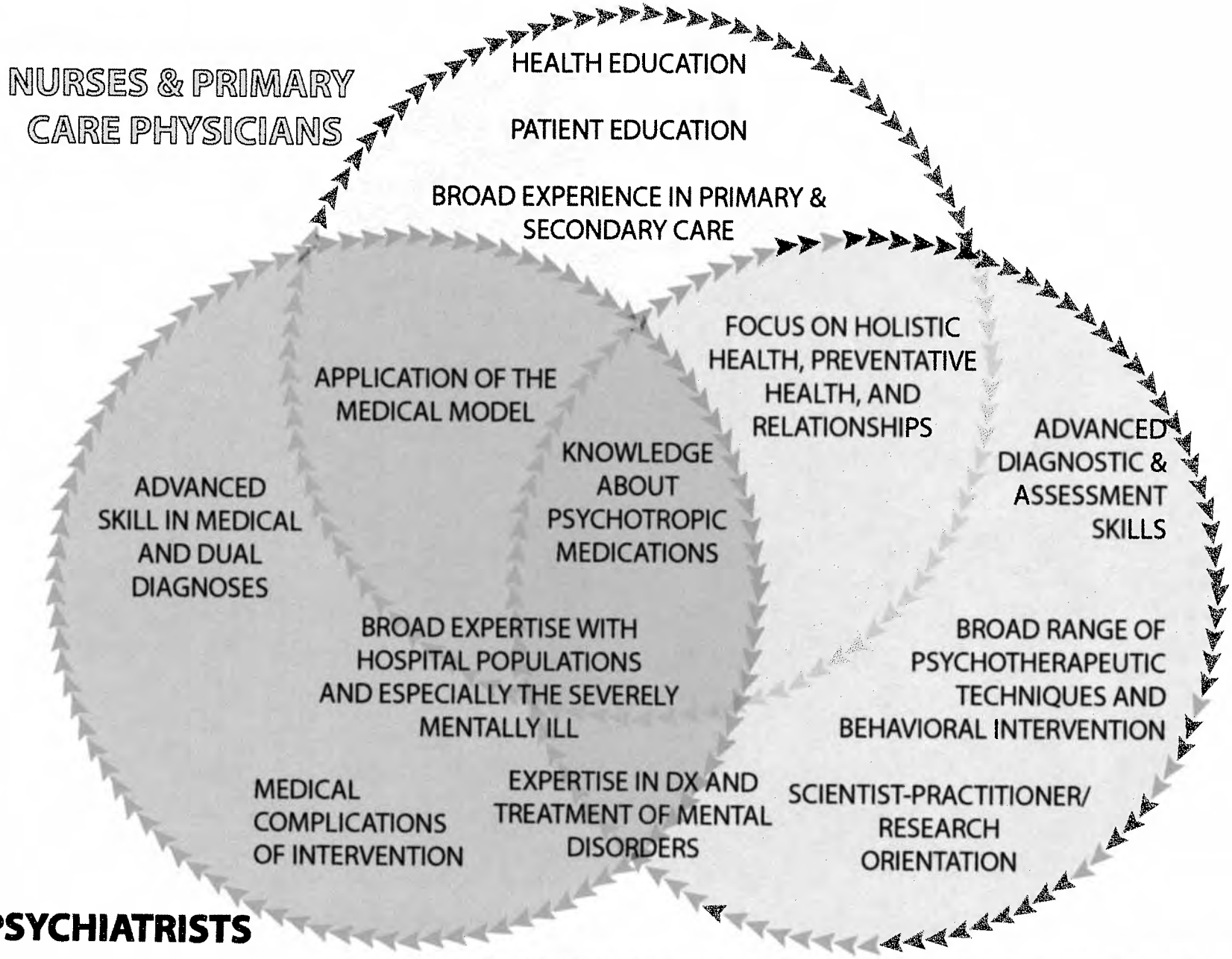
- It is increasingly difficult to maintain a private practice
  - Limited insurance reimbursement
  - Endless paperwork
  - It can take young graduates years to be accepted on insurance panels
  - New graduates need jobs in which they can quickly pay back huge college loans
- Many psychologists report more barriers to triage in our fragmented care system
- New positions are available in primary care centers, spurred by federal funding streams that require behavioral specialists in the centers
- The behavior specialists are being asked to adopt a biopsychosocial model of care (George Engel, 1981) as they triage with medical colleagues in these settings
- Their expertise must include: health psychology, knowledge of psychopharmacology, and knowledge about the dynamics of primary health care settings

Vector 3: Enter Prescribing Psychologists

- Prescribing psychologists, by law, must maintain a collaborative relationship with primary care physicians
- Many are working in medical settings
- Many report increasing referrals from physicians
- They also note increasing referrals for
  - Dual diagnoses patients
  - Severely mentally ill
    - LeVine, Wiggins, & Masse, 2011
- They are adopting a different model which includes the following:
  - Less use of multiple medications
  - A trend to take some patients off medications in favor of psychotherapy
  - Extensive informed consent



Psychiatrists, Nurse Practitioners, Primary Care Physicians and Psychologists Trained in Psychopharmacology and Primary Care Bring Overlapping Skills and Differing Strengths to Patient Care



An Example of the Integrated Practice of Behavioral Psychologists Trained in Prescriptive Authority and Physicians at the Family Practice Residency Program Center in Las Cruces

- The Family Practice Center employs three prescribing psychologists
  - Full-time RxP psychologists work side by side with physicians to assess and treat patients
  - Full-time RxP psychologists train the medical residents in psychopharmacology
  - The RxP psychologists supervise doctoral students from the American Psychological Association accredited Counseling Psychology program of New Mexico State University in principles of health psychology and primary health care psychology
  - The doctoral level psychology interns provide therapy and lifestyle intervention (weight loss, stop smoking clinics, etc.) under RxP psychologists as supervisors
  - A third part-time RxP psychologist provides a Balint group, a support group for the residents in which they can confidentially express their concerns about patients, their personal stresses as physicians and hone their communication skills

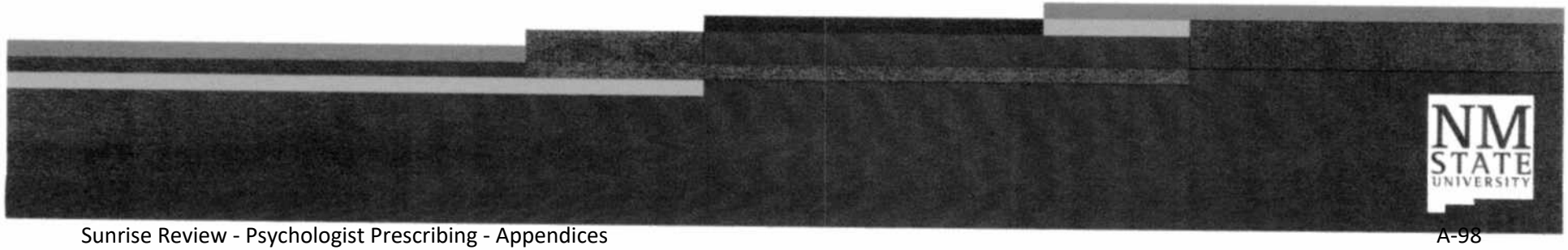
- In turn, the Family Practice Medical Staff and Residents
  - Provide medical consultation on all patients seen by the RxP psychologists and doctoral psychology interns
  - Teach courses in pathophysiology for the NMSU post-doctoral psychopharmacology program
  - Provide supervision of RxP psychologists completing their preceptorships

Summary

The prescribing psychologists of New Mexico express their deep gratitude to the New Mexico Legislature for its far-sighted support of our efforts.

We will continue to do our best to:

- Provide quality care to the mentally ill
- Increase access to care for all New Mexican citizens
- Become a formative part of Integrated Health Care Models with particular emphasis on underserved populations in rural settings



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Appendix D

Psychology Prescriptive Authority Sunrise
Applicant Responses to follow up questions on applicant report

1. **All of the states referenced in the applicant report that currently allow prescriptive authority for psychologists require some level of supervision, consultation, and/or collaboration with a physician. Why did you not include this type of provision in your proposal?**

   It is our intent to require collaboration between the prescribing psychologist and each patients' primary care provider (PCM) for all prescribing psychologists credentialed under this proposal. Such collaboration would require, at a minimum, a written or verbal confirmation from the PCM. Further, it would provide the PCM an opportunity to ask questions, make comments or make alternative plans with the prescribing psychologist. This collaboration is required because it reflects best practice and increases patient safety.

   We believed that it was more appropriate to have this collaboration detailed in the WAC rather than in RCW. It was an oversight on the part of the Applicant to not more clearly state that collaboration with primary care providers would be a required component of practice.

2. **Your applicant report suggests addition of a prescribing psychologist, physician, and/or pharmacist to the board for consultation on matters relating to prescribing.**

a. **Was your intent for suggesting a physician that it be a board-certified psychiatrist?**

   The category "physician" automatically includes psychiatrists. We left physician broadly defined so that the Board could determine the best expert in psychopharmacology for the position. It might be a psychiatrist, but other physicians might also meet the Board's required criteria. For example, Dr. Robert Julien, a prominent author on psychopharmacology, is an anesthesiologist as well as an expert on psychopharmacology.

b. **If not, why would one not be considered?**

   A psychiatrist would be a very reasonable and practical selection by the Board.

c. **Why wasn't an additional board member included in House Bill 2967?**

   We made this improvement after the bill was drafted and introduced.

3. **The department has heard of challenges from applicants for mental health professions requiring supervised hours for licensure in finding a supervisor. Have you studied whether applicants for prescriptive authority will be able to find a "qualified supervisor" willing to provide this service?**

   We proactively address to issue by broadly defining supervisors as "qualified practitioners, as determined by the Board" in Section 2(2)(d). Supervisors could include:

   - Licensed psychiatrists
   - Licensed physicians with expertise in psychopharmacology
   - Prescribing psychologists
   - Doctoral level licensed psychiatric nurse practitioners

By allowing the Board to consider a broad array of possible qualified supervisors, applicants should be able to find a supervisor. Additionally, the Washington State Psychological Association (WSPA) would curate a list of potential supervisors to assist trainees in meeting this requirement.

4. **Do you have an estimate of how many psychologists may apply for prescriptive authority? Do you have current numbers on how many prescribing psychologists are practicing in each state?**

Prescribing Psychologists in Other States and Jurisdictions

State	All Active Psychologists	Active Prescribing Psychologists	Percent of All Active Psychologists
Louisiana	800	110	13.7%
New Mexico	785	68	8.6%

The Department of Defense, Public Health Service Corp, and Indian Health Service numbers are harder to locate due to the nature of those services, but conservative estimates are that there are 30 to 60 total prescribing psychologists in those services.

Illinois, Idaho, and Iowa are just beginning to credential prescribing psychologists and their numbers will be available in the next several years.

Psychologists are Already Completing RxP Training
According to the American Psychological Association, there are more than 900 graduates of post-doctoral Master's degree programs in clinical psychopharmacology countrywide, with more than 140 psychologists currently enrolled in accredited programs. Almost 500 psychologists have passed the Psychopharmacology Examination for Psychologists exam.

Training Will Be Available in Washington State
Antioch University in Seattle just approved the formation of a Master's degree program in psychopharmacology that will meet the American Psychological Association criteria as a designated program to train prescribing psychologists. We expect the first students to start the program in 2021.

Washington Estimate of Prescribing Psychologist Potential
A 2019 statewide survey of psychologists in Washington State showed 53% were "interested to very interested" in obtaining the prescribing credential. Factoring in the time commitment and cost, and looking at other states' experiences, we estimate that between 10-15% of Washington psychologists will complete the required education and training and apply to become prescribing psychologists.

References

New Mexico State Regulation and Licensing Department
http://www.rld.state.nm.us/boards/Look_Up_A_License.aspx

Louisiana State Board of Medical Examiners https://online.lasbme.org/#/verifylicense

Louisiana State Board of Examiners of Psychologists http://www.lsbep.org/

American Psychological Association, Petition for the designation of Clinical Psychopharmacology as a Specialty Area of Psychology https://www.apa.org/ed/graduate/specialize/clinical-psychopharmacology.pdf

5. **Do you have current information on disciplinary action relating to prescribing in all the states where psychologists have prescriptive authority?**

Based on a search of the New Mexico Regulation and Licensing Department website (http://www.rld.state.nm.us/boards/Psychologist_Examiners_Disciplinary_Actions.aspx) and the Louisiana State Board of Medical Examiners (https://www.lsbme.la.gov/), the following complaints and/or disciplinary actions have been identified against prescribing psychologists:

Louisiana:

a. There are currently no revoked or suspended licenses.

b. There are four Board actions related to disciplinary action:

i. Voluntary surrender of license for allegation of Medicare fraud unrelated to the practice of prescribing psychology (http://apps.lsbme.la.gov/disciplinary/DocViewer.aspx?decision=true&fID=115667).

ii. Fully reinstated and unrestricted license after two years of probation for allegations of authorizing office staff to make medical determination and issue prescriptions http://apps.lsbme.la.gov/disciplinary/DocViewer.aspx?decision=true&fID=115738).

iii. Fully reinstated and unrestricted license after two years of probation when the psychologist's application for advanced practice certification was noted to have a self-report of two previous DUIs http://apps.lsbme.la.gov/disciplinary/DocViewer.aspx?decision=true&fID=97661).

iv. Official reprimand following allegation of failing to consult or collaborate with a licensed physician as required. Five months later, the psychologist was granted an advanced practice certificate after meeting the requirements of the Board (http://apps.lsbme.la.gov/disciplinary/DocViewer.aspx?decision=true&fID=103035).

New Mexico:

b. There are currently no revoked or suspended licenses.

c. There are two Board actions related to disciplinary action:

i. The psychologist's license and prescribing psychologist credentials were revoked for failure to respond to the second Notice of Contemplated Action (NCA) from the Board for allegations of violating the Professional Psychologists Act. The allegations are not specified http://www.rld.state.nm.us/uploads/files/PSY-16-18-INC%20Allan%20Roberts.pdf).

ii. The psychologist voluntarily relinquished all unexpired licenses, including a credential to prescribe, following an allegation of prescribing a controlled substance not within their prescriptive authority http://www.rld.state.nm.us/uploads/files/PSY-18-7-COM%20PSY-18-16-COM%20PSY-18-17-COM%20Settlement%20Agreement.pdf

6. **Do you have information on the availability of continuing education related to pharmacology?**

Continuing education opportunities are numerous. Virtually all regional or state psychiatric conferences, psychopharmacology conferences, or accredited online programs that offer continuing medical education in psychopharmacology are appropriate for prescribing psychologists. This is currently the way that most prescribing psychologists earn their continuing education for prescriptive authority.

For example, the Washington State Psychiatric Association (WSPA) holds a Spring and Fall conference every year as does their national organization, the American Psychiatric Association. Additionally, many well-respected organizations offer online Continuing Medical Education (CME) credits in the area of psychiatry and psychopharmacology (e.g., Carlat Publishing at https://www.thecarlatreport.com/about/about-cme-center/, AudioDigest-Psychiatry at https://www.audio-digest.org/, and Neuroscience Education Institute at https://www.neiglobal.com/, to name just a few).

7. What is the intent behind Section 4(3)(c)? We have a number of questions regarding this section:

a. How would the board become aware of the "deficiencies" referenced? Through a formal complaint?

Yes, "deficiencies" would be identified via formal complaints. An existing system for handing formal complaints is operated by the Examining Board of Psychologists (EBOP); this system handles formal complaints well and would be continued.

b. Why is this section needed when the Uniform Disciplinary Act (chapter 18.130 RCW) already includes a broad range of sanctions the board can use?

This section was included at the recommendation of our parent organization, the American Psychological Association, in its Model Legislation for RxP. The intent was to ensure that there was protection for the public in place, not to replace an existing system that is operating well. This gives the board the option to adopt additional "…rules for denying, modifying, suspending, or revoking certification of a prescribing psychologist" in Section 4(3)(c) if the existing rules unreasonably limit the board's disciplinary options. If the board determines that the Uniform Disciplinary Act (chapter 18.130 RCW) as it exists is adequate to meet their responsibilities, they may opt to make no changes.

c. This section could limit the sanctions already available to the board for public safety concerns. Is this section intended to point out that remedial training can be imposed or to limit the board's disciplinary options for these cases?

There is no intent to limit the board's disciplinary options. In fact, the intent of the section was to allow the board to broaden its options if needed (see response to question 7b above). Remedial training may be imposed at the board's discretion, but the board would maintain the power to determine the most appropriate action on a case by case basis.

It may be that the most parsimonious way to ensure that the board retains the powers and options that it needs to address formal complaints and allegations is to continue Uniform Disciplinary Act (chapter 18.130 RCW) as it is currently written. If that is the case, the Applicant does not oppose making that change to the bill.

Appendix E

The Department received a total of 387 comments and hundreds of pages of attachments. We are summarizing them, rather than including them in their entirety.

Comments in Support

Individuals

The Department received 55 comments from individuals in support of the applicant's proposal to create a certificate of a prescribing psychologist. Many comments echoed the information provided in the applicant report. Comments are summarized below.

The Department of Defense, as well as several other states, have given psychologists the ability to prescribe and have done so safely. Prescribing psychologists have been safely providing psychotropic medications in New Mexico, Louisiana, Illinois, Iowa, Idaho, the US Military, the US Public Health Service and the Indian Health Service for 20 or more years with no reports of inappropriate prescribing.

Louisiana has the designation of medical psychologist. New Mexico has both a conditional prescribing license and an unrestricted license. New Mexico has 70 prescribing psychologists who work in all areas of the state. There are 170 prescribing psychologists in the United States. Idaho has recently granted prescriptive authority to psychologists, and received a grant for $680,000 to fund faculty and staff to run the Masters of Science program in Clinical Psychopharmacology at Idaho State University. A majority of other states have also issued formal statements indicating that the psychologist scope of practice can include some form of activity in prescriptive consultation. It is not uncommon for providers to prescribe through a collaborative agreement, similar to what pharmacists are able to do today.

Providing psychologists the ability to prescribe will increase access to care to patients in rural areas and underserved populations. This will also allow for psychologists to provide holistic care in which they can treat patients with both medication and behavioral interventions, conjoining medication and psychotherapy to mitigate the severity of mental health symptoms. This could lead to short term medical intervention and long term psychotherapy. By allowing for this holistic approach to care, there will be cost savings for patients as they will no longer need to see two different providers. Psychologists are experts in delivering non-psychotropic mental health care, and have formed collaborative, caring relationships with their patients. Psychologists will have the ability to provide quality medication management and will even be able to de-prescribe medications if they are not working. Psychologists have the most experience in mental health diagnosis and treatment of all mental health professionals.

Psychologists come from diverse backgrounds and they see diverse clients that need culturally competent people of color as mental health providers and prescribers in providing culturally appropriate comprehensive treatment.

Individuals currently receive psychotropic medications from general practitioners, who often have little training in psychology and are unable to provide frequent enough visits to monitor the patients and provide the appropriate care. Many families have told of challenges locating practitioners who can prescribe medical interventions. When a patient sees a second provider to access medication it can cause an undue financial and emotional burden on them having to explain their issues to someone who has no background in their care. Psychotropic medications are very important in managing the

behavioral and mood symptoms associated with this population. Psychologists are highly skilled in assessment and have doctoral level training in understanding brain- behavior relationships. Allowing psychologists who are interested in expanding their practice by completing additional and extensive medical training would provide increased access to evaluations for psychotropic medications and offer an opportunity for clients to consolidate their behavioral healthcare to a single provider, resulting in better and less expensive care.

That mentally ill patients are overwhelmingly left untreated is no longer a question. Some estimates suggest up to 50% of Americans with mental illness remain untreated. Estimates suggest the societal cost of untreated mental illness is $150 billion a year and rising. Adding highly trained and skilled psychologists as a resource to the millions being left untreated seems not only to be a great idea but a desperately needed one. The follow citations were attached to this comment:

- Leahy, R. (2010). The Cost of Depression. *The Huffington Post*. Retrieved November 21, 2013 from http://www.huffingtonpost.com/robert-leahy-phd/the-cost-of-depression_b_770805.html
- The Cost Of Depression
- www.huffingtonpost.com
- Greenberg, P, et al. (2003). The economic burden of depression in the United States: How did it change between 1990 and 2000? *Journal of Clinical Psychiatry*, *64*(12), 1465-1475.
- Rampell, C. (2013). The Half-Trillion-Dollar Depression. *New York Times*, MM14.

General access to care is limited, as there are not enough nurse practitioners or physicians to meet the needs of Washington, and this is only going to increase due to COVID19. This lack of access is going to continue as people retire and not enough students are going into the field to fill the gap. There are currently long wait times and limited access to these providers. They also do not serve in rural areas. Providers also have discretion when it comes to accepting patients, and often times providers will not accept patients who are suicidal and in crisis. Due to the Volk decisions providers have stopped seeing patients with suicidal and assaultive ideations.

Psychologists in Washington have a doctoral level of education and training in understanding brain-behavioral relationships. The additional training referenced in the application will provide for comparable amounts of education and supervised practice in pharmacology and psychotropic medicine as other prescribing credentials. Training will include working with psychiatrists, physicians, nurse practitioners, pharmacists and neuroscientists. There will be an emphasis on integrated medical practice and students will be trained in all medical disciplines.

Associations and Other Organizations

The department received four comments from associations in support of the applicant's proposal to create a certificate of a prescribing psychologist.

The California Association of Psychology Providers (CAPP) advocated in support of the proposal and provided background information on the legal battle which has taken place there. CAPP is best known for its precedent setting lawsuit CAPP v Rank, followed by the legislature mandating independent practice for clinical psychologists on staff of a hospital. Organized medication fought this to the California Supreme Court which affirmed the law. These details are provided to inform of the opposition others will bring against prescribing psychologists, even though psychologists have been safely prescribing in other states, the US Military, Public Health Service, and the Indian Health Services for years.

The Division 31 Executive Board American Psychological Association stated they encourage the collaborative practice of psychological and pharmacological treatment. They stated providers appreciate the ability to refer to prescribing psychologists who have considerable expertise in the treatment of mental health conditions. The education and training they must receive to become prescribing psychologists provides them with the most experience in mental health diagnosis and treatment out of all mental health professionals. Prescribing psychologists will provide for a one stop shop for patients to receive both medication and behavioral care. There is a 30 year history of psychologists prescribing with extremely positive outcomes.

The Washington Academy of Physician Assistants share their support of this proposal. They understand their colleagues oppose this but they believe this will improve access. Patients should have access to providers who know them well and can make collaborative decisions on their medical treatment.

The American Society for the Advancement of Pharmacotherapy provided comments on behalf of their Board of Directors and their membership. Allowing psychologists to prescribe patients will create access to collaborative practice of both psychological and pharmacological treatments. The mental health needs of the state are not being met, and there is a crisis in access to care. There is a shortage of psychiatrists that will continue to worsen as more retire. Sixty to eighty percent of psychiatric medications are prescribed by primary care providers, often with little to no training in mental health assessment, diagnosis, and treatment. The ability for psychologists to prescribe could potentially help decrease unnecessary medications.

Program director of the Antioch University Master of Science in Clinical Psychopharmacology wrote that the first program will begin in the summer of 2021 and that he will ensure quality training is provided. Added that we should follow the lead of other states, such as Idaho where a $680,000 grant funded a program at Idaho State University.

Comments neutral or other

Individuals

The Department received six comments from individuals that were neither in support or opposition but provided additional information or clarifying questions or comments. Those are summarized below.

Important additions are needed in the proposed bill. There is a key shortcoming in the proposed revision of RCW 18.83.010, in the new subsection (8), defining "prescriptive authority." As written, this section includes only "controlled substances," which are covered in RCW 69.50; it does not include "legend drugs," which are defined in RCW 69.41. As written, this would exclude most antidepressants and antipsychotics, among other classes. Failing to include "legend drugs" in this section will create an awkward conflict between RCW 18.83 and RCW 18.64.011. Furthermore, the addition of psychologists to RCW 69.50.011 (mm) (1) must be matched by a similar addition to RCW 69.41.010 (17)(a) to allow them to prescribe legend drugs.

There is clearly a need to increase access to mental health providers. States that have prescribing psychologist have not had any sustainable fall out from this.

There are questions regarding whether the state would be adopting the APA guidelines as a base for defining qualified psychologist and questioned how pharmacies and facilities will identify prescribing

psychologists. This plays a particular role in hospital administrative processes, specifically related to privileges and admitting abilities.

Education in physiology, biochemistry, pharmacology to understand how medications affect the body and relate to other diseases and safety should be required. This would be equal to training physicians or nurse practitioners undergo.

There are concerns about how a prescribing psychologist would ensure that a primary care provider is kept informed. It should be required to identify a primary care provider and communicate all medication changes. There should also be an interim period that includes collaborative prescribing, where a psychologist writes the order but it is reviewed and approved by a primary care provider.

The level of training should be more clearly defined and the diverse patient population requirement should be in the 400-600 range, not 100. This would make it more likely they will see enough diversity in patient conditions and medications.

There was a recommendation to have both a pharmacist and physician added to the board of psychology. There should be a family or internal medicine physician because those with mental health conditions are often seen in primary care, so they would have a unique perspective on caring for these types of patients.

There should be reports or official statements from the DEA noting the numbers of prescriptions of controlled substances prescribed by psychologists. That type of data should be used to determine whether there are concerns that would warrant potentially limiting quantities or doses of medications psychologists could prescribe.

Associations

PBI Education provides mostly remedial education in areas of ethics, boundaries, prescribing, recordkeeping, and communication. Remedial courses provide impactful learning and positive change. Remedial courses are customarily order after disciplinary action. These course exists currently for psychologist deficient in prescribing practices. Offer virtual classrooms to allow for prompt and timely access.

ARNP United of Washington State provided clarifications on the applicants report. The applicant stated that only physicians, psychiatrists and advance practice nurses may prescribe medications for the treatment of mental health disorders. However, physician assistants and naturopathic physicians have prescriptive authority for medication for treatment of mental disorders. Physician assistants have controlled substance prescribing authority while naturopathic physicians can only prescribe two controlled substances, codeine and testosterone.

The applicant refers to 2% of ARNP students choose to become psychiatric ARNP's, however 2018 survey showed 12.7% of NP's certified and practicing, 2018 data from NCQAC estimated 667 of 4,807 NP's in WA were in psychiatric/mental health/substance abuse settings, approximately 13.9%.

The applicant states that prescriptive authority for psychotropic medications is regulated for psychiatric nurse practitioners, but others like certified nurse midwives and clinical nurse specialists also have prescriptive authority for all drugs.

The applicant's response to department follow up questions stated that qualified supervisor would include a doctoral level psychiatric nurse practitioner, however this would exclude some currently

practicing psychiatric ARNP's because currently only 13% hold a doctorate degree and there is no differentiation between nurse practitioners with a doctoral verses a master's degree.

A psychiatric ARNP would be a valuable addition to the board. There are also numerous continuing education offerings for ARNP's which include psychopharmacology and these should be included as potential options.

The Washington State Hospital Association provided questions for the department to consider when reviewing this proposal and considering implementation.

- How will the board establish minimum education and training requirements without the requisite clinical expertise?
- National examination – does it meet the same requirements and core competencies for other providers who are licensed to prescribe psychotropic medications?
- What additional safeguards and oversight would be in place to ensure appropriate education to provide safe patient care? Collaboration with the primary care provider in the applicants response is helpful
- How will prescribing psychologist increase access?

Government Entities

Office of the Insurance Commissioner noted the proposal would not create a new mandated benefit. The proposal could provide significant benefits for consumers due to the low availability of psychiatrists. Individuals are currently getting care through a psychologist and medications through a primary care provider.

Health Care Authority noted that this proposal would significantly change the scope of practice for a psychologists. The effects on clients could be improved access in currently underserved areas. Access to pharmacology may increase for those covered under Apple Health, PEBB and SEBB. Some concerns regarding the proposal are the comprehensiveness of the training, and collaboration with the primary care provider. While collaboration is noted in the applicant report, it is not required as part of the legislation. It also needs to be considered that prescribing to children and the elderly may require a specialist in addition to a primary care provider. This will require use of the Second Opinion Networks which reviews and assesses appropriate drug use in children. This will likely increase the number of children exposed to doses above the guideline limits and require additional reviews and costs to the state. There is also the Beers Criteria Medication List of drugs that should be avoided by the elderly and their use requires specialized management to ensure benefits outweigh the risks. They recommend that legislation be updated to include protections to ensure prescribing is managed properly for both behavioral and physical health. Updates will need to be made to differentiate between a prescribing psychologist and a non-prescribing psychologist. The provider payment system would also need to be updated to capture certificate numbers and DEA numbers as well as adding a new National Uniform Claim Committee standard taxonomy for the new psychologist provider subspecialty. Finally, the expanded scope may lead to higher reimbursement rates.

Comments in Opposition

Individuals

The Department received 98 comments in opposition from individuals as well as an additional 210 comments mirroring the Washington State Medical Associations comments summarized in this section.

Prescribing medications is not the same as knowledge of and experience diagnosing and treating psychiatric symptoms and disorders. Psychiatric medications have significant effects on multiple organ systems and can cause side effects that require broad medical knowledge and experience to be able to recognize and manage. This includes metabolic syndrome, diabetes, impaired intestinal motility, neutropenia, hypertension, hypotension, anticholinergic symptoms, and cardiac arrhythmias. Current prescribers have extensive knowledge and education in general medicine before prescribing, giving them the ability to recognize and differentiate between mental health issues and physical health issues. Psychiatric illnesses are mimicked by other neurological, endocrine and metabolic disorders. If a psychologist misdiagnosis a physical illness as a mental illness and causes harm, will they be held at fault?

Safe prescribing of psychotropic medications involves being able to fully assess things like the increased risk of suicide, violence and homicide - https://www.bmj.com/content/358/bmj.j3697/rr-4, where ensuring dosages are monitored and keeping the patient under close supervision are critical. They also are not equipped to handle the potential consequences of withdrawal from antidepressants, as more than half of people experience withdrawal effects - https://www.sciencedirect.com/science/article/pii/S0306460318308347.

Studies show that psycho-pharmaceutical drugs have the potential for adverse reactions, such as akathisia (a state of agitation, distress, and restlessness) that may result in homicide - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3513220/ due to a genetic mutations. There are tests that can be performed to prevent this, but they are not included in the proposed bill. In addition, antidepressants are potentially linked to an increase risk of diabetes - https://www.theguardian.com/commentisfree/2010/aug/14/drug-companies-bury-negative-research.

Pharmacology is not the only science involved in prescribing medications. There is also training in physiology, chemistry, biochemistry, physics, microbiology, pathology, molecular biology, anatomy, genetics, embryology, and other hard sciences to achieve the competency required to prescribe an antidepressant.

Physicians asses the patients overall health before prescribing drugs. This includes ordering, administering and analyzing tests. This proposal provides for no testing requirements prior to prescribing to prevent prescribing medications that could have negative interactions with the body. This proposal could also reduce the availability of psychotherapeutic services & psychological testing.

Psychologists are excellent therapists with comprehensive training in diagnosing and applying appropriate treatment modalities of psychotherapy. They are valued colleagues, but they do not receive the training in general medicine necessary to prescribe. Insurers have also been pushing towards medicating, which has decreased the role of psychologists but isn't a good reason to allow them to prescribe.

Allowing psychologists to prescribe is dangerous and puts patients at risk. This would lead to overloading hospitals. There are already too many individuals who are over-prescribed and this would make it worse. There is also an opioid crisis, and this proposal does not limit this type of prescribing and could fuel the crisis. Psychologists do not take the Hippocratic Oath and could put patients at harm.

Antipsychotic medications require constant monitoring by qualified physicians. There are risks of suicide, violence and homicide as well as severe withdrawal effects that psychologists are not qualified

to recognize or handle. Most psychotropic medications carry a Black Box warning label. Primary care providers often refer to psychiatrists because these medications and conditions can be so complicated. Psychiatrists do much more: continuous evaluation, education and treatment implementation. Allowing psychologists to prescribe undervalues the work of psychiatrists.

Psychologists currently will refer patients to prescribers with suggested medications and often those are the incorrect medication. This lack of knowledge will also make psychologists a target for pharmaceutical marketing.

The state has allowed naturopaths to prescribe and are already seeing the dangerous outcome of this. If we allow psychologists to prescribe, physicians will be cleaning up their mess too. To allow psychologists to prescribe, due to a perceived shortage, is akin to letting nursing assistants become nurses where they can assess patients, give medications and IV's because there is a nursing shortage. Those with mental illness do not deserve a substandard level of care.

While there is a shortage of access to care, allowing psychologists to prescribe and put patients at risk is not the correct solution. This will also not increase access. Psychologists do not work in rural or underserved areas, and there is no reason to think that once they have prescriptive authority they will move to those areas. The answer to this shortage is not simply more prescribers, it is more physicians. Psychologists are some of the lowest insurance-accepting mental health therapists and this legislation does nothing to guarantee that they will accept Medicaid.

There are other solutions to address the shortage of access to mental healthcare. These include expansion of CMS coverage so psychiatric care can be provided in primary care settings. Psychologists could work collaboratively with medical doctors, similar to how physician assistants function, or they could play a role in a multidisciplinary team. Increasing access to and use of telepsychiatry would also help, as well as creating incentives to encourage providers to serve in rural or underserved areas. Increasing training slots for psychiatrists is another options. Psychologists could also take the necessary courses to become a nurse practitioner or physician assistant. These courses cover the same topics in the applicants report but in more depth, and the time and expense to achieve this credential would be similar in nature to that proposed. There are also already boards and commissions in place that have the appropriate knowledge and expertise to provide oversight of these professions.

The education required under this proposal is not adequate to allow for safe prescribing by a psychologist. There is no shortcut to medical expertise. Truncated courses in general medical subjects is not an adequate substitute. Training, especially online distance learning, cannot replace 8 years of medical school plus residency. Pharmacology is not the only type of education needed to prescribe, because they also need physiology and pathophysiology. Psychiatrists and other prescribers also get a base education in biology, psychics, chemistry and advanced mathematics, where psychologists do not. The supervision training hours are also not sufficient, nor the number of diverse patients a psychologist must see. Other prescribers must go through a full residency. Nursing has been successful in coming into this prescribing role because of its historical roots in the biological sciences and application of somatic therapies.

The American Psychological Association posted in article in June 2012 arguing the inappropriate risks of prescribing these drugs - https://www.apa.org/monitor/2012/06/prescribing.

If this proposal were to be enacted, there are some things to consider. The requirements of who can be a qualified supervisor need to be more stringent. Prescribing psychologists should be required to pass

the same exam as a psychiatric nurse practitioner. Regulation does not ensure competency, and the psychology board does not have the expertise to adequately oversee unsafe or inappropriate prescribing practices. Louisiana has the safest program, which created a separate degree, known as a medical psychologist, and placed the individuals under the board of medicine. Illinois set new and more appropriate standards, limiting the medications and populations a psychologist can treat. They also require training similar to physician assistants and do not allow for online medical training.

This is not a "turf" issue. There are psychologists who oppose this expansion of scope as well. Psychologists in Oregon advocated for the governor to veto this legislation twice, under two different governors. The National Association on Mental Illness is opposed to prescribing psychologists. Proponents of prescriptive authority for psychologist spent over $500,000 in Louisiana. The association also attached two documents that are attached at the end of the summary of comments.

Additional points made were:

- There is virtually no evidence that reducing medical training to about 10% of that required for physicians and about 20% of that required for advanced practice nurses (advanced nurse practitioners) will protect the consumer (see also Robiner et al., 2019).
- 89.2% of members of the multi-disciplinary Association for Behavioral and Cognitive Therapies (ABCT) argue that medical training for psychologists to prescribe **should be equivalent to other non-physician prescribers** (*The Behavior Therapist,* September 2014).
- A survey of Illinois psychologists and Oregon psychologists yielded similar findings (78.6%; Baird, K. A. [2007]. A survey of clinical psychologists in Illinois regarding prescription privileges. *Professional Psychology: Research and Practice, 38*, 196-202. doi:10/1037/0735-7028.38.2.196; 69.2%; Tompkins & Johnson [2016]. What Oregon psychologists think and know about prescriptive authority: Divided views and data-driven change. *Journal of Applied Biobehavioral Research*).
- The 2014 ABCT survey found only 5.8% endorsed the effectiveness of online medical training, which is permitted in this bill and only 10.9% would refer a patient to a prescribing psychologist whose medical training is what is required in similar bills.
- Proponents claim that the lack of a reported death or serious harm by prescribing psychologists somehow provides evidence of safety. It does not! It only provides evidence that any harm done by these psychologists was not identified and reported by the psychologists themselves or their patients. A lack of evaluation of safety, and the absence of any credible, comprehensive system to identify problems, does not constitute evidence for safety. Psychologists' meager training to diagnose physical problems suggests that psychologists probably would not even know if their prescribing had caused medical problems. Lawsuits in Louisiana suggest the need for a more general survey of malpractice claims in these states to evaluate claims of "no adverse effects" (Robiner et al., 2019).
- The 2014 ABCT survey found that 88.7% of psychologists agreed that there should be a moratorium on bills like this one until there is objective evidence that the training involved adequately protects consumers.

Additional articles included with comments in opposition of proposal:

- Pollitt, B., (2003) Fool's Gold: Psychologists Using Disingenuous Reasoning to Mislead Legislatures into Granting Prescriptive Authority, American Journal of Law & Medicine, 489

- Robiner, W.N., Tumlin, T.R., Tompkins, T.L., (2013) Psychologists and Medications in the Era of Interprofessional Care: Collaboration Is Less Problematic and Costly Than Prescribing, Clin Psychol Sci Pract., 20: 489–507

- Position Statement, Response to Clinical Psychologists Prescribing Psychotropic Medications, International Society of Psychiatric-Mental Health Nurses (2001)

- Psychologists Opposed to Prescription Privileges for Psychologists, Annotated Bibliography of Articles and Readings That Raise Concerns About Prescription Privileges for Psychologists, http://www.poppp.org

- Robiner, W.N., Tompkins, T.L., Hathaway, K.M., (2019), Prescriptive Authority: Psychologists' abridged training relative to other professions' training, Clin Psychol Sci Pract. 2020;27:e12309.

- Robiner, W.N., et. al., (2003) Prescriptive Authority for Psychologists: Despite Deficits in Education and Knowledge?, *Journal of Clinical Psychology in Medical Settings*, 10, 3, pp. 211-222.

- Robiner, W.N., et. al., (2002) Prescriptive Authority for Psychologists: A Looming Health Hazard?, *Clin Psychol Psi Pract,* 9, pp. 231-248.

Associations

The department received eight comments from associations in opposition to the applicant's proposal to create a certificate of a prescribing psychologist.

The Washington State Medical Association and the Yakima County Medical Society, as well as 210 individuals provided the same comments. They stated that while psychologists are an important member of the health care team, allowing them to prescribe unnecessarily and unjustifiably compromises patient safety. Increasing access to pharmaceutical drugs is not tantamount to increasing access to care, nor will allowing psychologists to prescribe increase the number of psychologists or the number of patients they can see. Workforce assessments have found that psychologists are not practicing in rural areas and access to care remains a problem.

More than half the patients with mental illness also have physical comorbidities, and this can lead to serious drug interactions. Physical illness can also present as mental illness, and psychologists do not have the training to differentiate. Psychotropics are some of the most dangerous drugs a physicians can prescribe and there is a high risk of abuse. While the applicant focuses on psychotropic medications, the legislation is not limited to them.

The Department of Defense program the applicant references was a small sample size in a controlled environment, with 10 psychologist and only 8 made it through. In the end the program was found not to be cost effective and was discontinued.

The proposed educational and training requirements for psychologists are not equivalent to physicians and insufficient to ensure safe prescribing practices. Physicians study the entire human body and all of its systems – cardiovascular, endocrine, neuropsychiatric and more. A psychologist's education is highly variable and programs do not have equivalent, or consistent requirements. The proposal relies on programs that are promulgated by the American Psychological Association, without evidence that this training is adequate.

There are concerns with oversight as the psychology board does not currently have anyone with prescriptive authority. While the proposal states they may add a prescriber, there is no requirement

that they do so. The board does not have the expertise to oversee and regulate unsafe prescribing practices.

The National Association of Mental Illness is opposed to this legislation and states there needs to be more integration, not additional silos. Access to mental health care can be increased in other ways, specifically through telemedicine.

The Washington Chapter of American Academy of Pediatrics recognizes that psychologists play a critical role in the mental health delivery system as behavioral health professionals. However, psychologists have no required basic medical education or training that would qualify them as medical practitioners. They have not been trained to medically asses the entire person and to understand the effect of pharmaceutical and other medical treatments on diseases and conditions that afflict the systems of the body. The application includes a training requirement but the American Psychological Association sets the curriculum, accredits the programs, and proactively lobbies that these minimal standards amount to sufficient "medical" training. Psychology boards likely lack the necessary medical expertise to oversee and ensure safe practice and standards of care. Records show that in states that have chosen to allow unsafe psychologist prescribing, psychologists are prescribing their patients heart medications, muscle relaxants and cholesterol drugs, which have potentially dangerous side effects and interactions. The Department of Defense project referenced by the applicant noted substantial costs and questionable benefits. Urge the rejection of this proposal in favor of real reforms that improve access to safe, effective and integrated treatment for people with mental health needs.

The Washington Academy of Eye Physicians and Surgeons states it is irresponsible to grant access to providers lacking a comprehensive medical education. Psychologist education, even at the doctoral level, does not have the basic science, pharmacology, anatomy, physiology, nor integrated clinical experience required to safely prescribe systemic medications. While the applicant states that granting this authority will increase access to mental healthcare, increasing access to pharmacological therapies is not the same as increasing access to care. The proposal focuses on psychotropic medications but the legislation is not limited and could include opioid prescribing. Further the medications used to treat psychiatric disorders cause a wide variety of eye-related complications. The proposal fails to ensure appropriate parameters and oversight for the profession and will negatively impact patient safety.

Whatcom and San Juan County Medical Society – The Northwest Washington Medical Society recognizes that clinical psychologists serve a valued role in treating patients with mental or cognitive health conditions. However, the current and proposed education is no comparison to the required training of practicing clinicians. There are complex principles of human anatomy, chemistry, biochemistry, pharmacology are established in a physician's education and that education continues during their years of postgraduate training. The proposal focuses on psychotropic medications but the legislation is not limited and could include opioid prescribing. This proposal does not protect the public from harm and, quite frankly, does represent an increased risk of harm to the public. Enabling psychologists to prescribe does not increase patients' access to care.

Psychologist Opposed to Prescriptions Privileges for Psychologist (POPPP) states that allowing psychologists to prescribe poses unnecessary risks to the public and would be an inappropriate and inefficient mechanism of addressing mental health needs. Psychologists have provided major contributions to understanding human development throughout the life cycle and to a multitude of dimensions of human functioning. Despite these contributions, there are limits to the practice. Prescribing medications goes beyond psychologists' competence, even if they obtain the additional

training. Prescribed medications can be very positive, but there can be unintended adverse drug reactions that psychologists are not trained to recognize. Unlike the training of current prescribers in other professions, the doctoral training of psychologists historically does not equip them to prescribe and manage medications safely. The APA model is substantially less rigorous and comprehensive than the training required for all other prescribing disciplines. It also fails to meet the recommendations of APA's own experts in its Ad Hoc Task Force of Psychopharmacology. Furthermore, the APA training model is substantively less rigorous than the training that the DOD training, which was a small sample size and concluded that prescribing psychologists were weaker medically, and closer to students. Psychology regulatory boards lack the expertise to effectively regulate prescriptive practices. Allowing psychologists to prescribe does not increase access, as there is no reason to expect these individuals would move to rural areas. Collaboration should be the focus, not independent prescribing.

POPPP also submitted a petition in opposition to the proposal that was signed by approximately 200 psychologists, six from Washington. They attached a document, Psychologists Opposed to Prescription Privileges for Psychologists Annotated Bibliography of Articles and Readings That Raise Concerns About Prescription Privileges for Psychologists, which is attached at the end of this document.

The Washington State Psychiatric Association recognizes that psychologist are experts in behavioral interventions and highly valued members of the mental health care community, but prescriptive authority should not be expanded. This is also opposed by the American Academy of Child and Adolescent Psychiatry and WA Chapter of WA State Council of Child and Adolescent Psychiatry.

There is insufficient education and training. Psychologists have no medical training and psychology programs are highly variable. They lack training in the basic sciences (chemistry, biology, and physics, all of which are required for physicians prior to medical school) and general medicine (anatomy, physiology, pathology, pharmacology.) The proposed additional education is a mere 400-hour program (including coursework) that can be completed completely online and includes such courses as "basic science." This is not sufficient. The applicant report references the DOD program, which is not sufficient justification for the proposal because of the small number of participants, as well as the fact that the applicant's proposal "does not stipulate such intensity …nor clinical severity, setting, or care parameters" (cites Clinical Psychology Science and Practice journal (March 2019) entitled "Prescriptive authority: Psychologists' abridged training relative to other professions' training). They further stated the DOD program "became defunct shortly after a 1997 U.S. Government Accounting Office report entitled *Need for More Prescribing Psychologists Is Not Adequately Justified* showed that there were many weaknesses in the program, and that psychologists fared poorly on exams, especially compared with nurse practitioners and other clinicians with more training (cited Need for More Prescribing Psychologists Is Not Adequately Justified. HEHS-97-83: Published: Apr 1, 1997. Publicly Released: Apr 1, 1997. Accessed on 6/1/2020 at https://www.gao.gov/products/158441).

In comparison, physicians spend years learning differential diagnoses, pharmacology, and honing their medical skills. They perform differential diagnosis, looking at both the mind and body, because there can be comorbidities and the physician needs to determine how medications will interact. They learn to recognize and diagnose physical diseases that can mimic or significantly contribute to mental illness (provided examples 31 of psychical diseases that can manifest as mental illness.)

Physician education is highly regulated by the Accreditation Council for Graduate Medical Education (ACGME) and is widely recognized as the gold standard for medical training. After graduating medical school, doctors are not allowed to practice yet. Three to seven more years of intensive training is required in the form of residency. This includes 12,000 to 16,000 patient hours and managing the care

of 2,000 patients with a range of behavioral/physical disorders. It is crucial to have in-person and hands-on experience prescribing after spending years learning differential diagnoses. There is no easy or quick replacement for the years of clinical rotations and exposure to people with medical illness that is standard in physician training. Psychiatric disorders do not stop at the brain. Medications affect every system in the body, and those who prescribe must have full education and training of the body and all its systems. Washington licensed physicians must also complete two hundred hours of continuing education every four years, and specialty boards, including the American Board of Psychiatry and Neurology for psychiatrists, have their own requirements for continuing education to maintain certification in a specialty.

While there is agreement that there is a shortage of mental health care providers, the applicant incorrectly states who can prescribe and are missing at least a 3rd of the workforce (physician assistants). Giving psychologists prescriptive authority is not the solution to increasing access. The applicants own reporting shows there are also not sufficient numbers of psychologists in rural areas (cited Applicant Appendix - Data sources: U.S. Health Resources and Services Administration (HRSA), 2014; Washington Examining Board of Psychology; Washington Medical Commission American Psychological Association Practice Organization, 750 First Street NE, Washington DC 20002-4242 | 202-336-5889 | www.apapracticecentral.org).

This will not increase the net number of available providers. Psychologists do not practice in rural areas so this would not increase access. Access to care can be increased via other means, such as through telehealth, increasing availability of medical residencies, and the Collaborative Care Model. The National Association of Mental Illness's "Public Policy Position on Prescription Privileges for Psychologists, Workforce Shortages" further provides that there is not current evidence that expanding prescribing privileges to psychologist will address these shortage (cited https://www.nami.org/NAMI/media/NAMI-Media/downloads/Public-Policy-Platform_9-22-14.pdf).

There are five states that have granted psychologists prescriptive authority and only 177 total prescribers in the Unites States. Medicare does not reimburse for pharmacologic management by prescribing psychologists due to their lack of education and training.

The Department of Defense program only trained 10 psychologist to prescribe and the proposed training model falls short even compared to that training model. The U S. Government Accounting Office issued a report entitled *Need for More Prescribing Psychologists Is Not Adequately Justified* based on this program.

The applicant makes claims that are conclusory and unsubstantiated as it's not clear that the services provided by a psychologist would be more cost effective, nor does it preclude the dual utilization of a physician. Errors and risks in psychologist prescribing could actually continue the trend of dual utilization. The association also disagrees that this could be a cost saver, as patients may end up being over prescribed medications or have adverse effects from wrongly prescribed medications. Further, controlled substances can irreparably and irreversibly damage an individual's liver, kidneys, or other organs. We argue there will be no patient benefit but there is a potential for patient significant harm.

The applicant provides no evidence that regulation by the regulating bodies could well ensure qualifications, education, training, examinations, and maintenance of competency. The risks of psychologist prescribing outweigh the hypothetical benefits. Co-prescribing of these medications with other medications can be incredibly fraught and requires a holistic training and expertise to ensure patient safety and to avoid patient harm. Of the thirty most commonly prescribed psychotropic medications, 18 carry "black box warnings" (provided 12 examples of drugs and their side effects.) The

focus of the applicant's proposal is centered on the prescribing of mental health related medications, but it is not the full extent of the prescriptive authority applicants are seeking in the legislation. It is impossible to define what is and is not a psychiatric medication, and there is also no easy way to carve out just "psychiatric" prescribing privileges. Opioids appear to be contemplated by this proposal as well.

The association also recommended looking to the collaborative care model, where a primary care provider, a psychiatrist and a behavioral health care manager work together to provide mental health care to a much broader group of patients using innovative features such as telemedicine and measurement based care. The following articles were attached to their comments, as well as the document, Psychologists Opposed to Prescription Privileges for Psychologists Annotated Bibliography of Articles and Readings That Raise Concerns About Prescription Privileges for Psychologists, which is attached at the end of this document.

- Robiner, W.N., Tompkins, T.L., Hathaway, K.M., (2019), Prescriptive Authority: Psychologists' abridged training relative to other professions' training, Clin Psychol Sci Pract. 2020;27:e12309.
- Attached at end of comments document - Psychologists Opposed to Prescription Privileges for Psychologists Annotated Bibliography of Articles that Raise Concerns about Prescription Privileges for Psychologists.

Government Entity

The Washington Medical Commission states they proposal will not only fail to protect the public from harm, it will have the opposite effect of increasing risk of harm to the public. Psychiatric medications have significant effects on multiple organ systems. These effects not infrequently require management with other non-psychiatric medications. There is also the potential for serious drug interactions. Knowledge of human anatomy, physiology, biochemistry, plus general pharmacology, and experience in diagnosing and treating all types of medical disorders, is a prerequisite to being able to prescribe. A two year master's level degree and a fellowship with 100 patient encounters and 400 contact hour is not sufficient in any scenario. In comparison, family medicine physicians must complete a residency that requires 542 unique actual patient encounters per year for three years. Truncated courses in general medical subjects is not an adequate substitute for the education and training physicians and other prescribers receive. The DOD project referenced as evidence for this practice is outdated and was not rigorously studied.

They disagree that this will be a cost saver, but rather has the potential to increase the costs of medical care due to the need to treat adverse medical events. There is also increase in potential costs for trial and error prescribing due to lack of experience.

The applicant fails to county physician assistants among those practitioners that offer mental health services and prescriptive authority. The applicant also states psychiatrists do not take insurance and are private pay, but we could not find evidence supporting this claim.

Questions remain as to how the profession will be compliant with the Prescription Monitoring Program and whether the board would have legal standing to opine on and bring a legal case against a prescribing psychologist when the board, by definition, does not have that expertise.

Other

The Kaiser Foundation Health Plan of Washington Options/Kaiser Permanente agrees with the message from the Washington State Medical Association and provided additional comments. The proposal jeopardizes patient safety and fails to emphasize the need for collaborative care in the primary care setting. Psychologists lack the background and experience needed to safely prescribe and medical complex medications. Psychotropics present more complex drug interactions and adverse effects than any other class of drug. A significant number of patients requiring psychotropic drugs, with some studies indicating at least 50 percent, are using other medications. Psychiatrists spend thousands of hours managing the care of thousands of patients with an assortment of psychical and mental health conditions. The training in the proposal is insufficient and not comparable. Articles cited for these comments:

- James E. Long, Jr., Note, Power to Prescribe: The Debate over Prescription Privileges for Psychologists and the Legal Issues Implicated, 29 L. & PSYCHOL. REV. 243, 252 (2005).
- Julia Johnson, Whether States Should Create Prescription Power for Psychologists, 33 L. & PSYCHOL. REV. 167, 174 2009).

There is an issue with the lack of access to mental health care but this is not the solution. Instead there should be a focus on strengthening models that promote patient-centered care through collaboration. Increasing the number of prescribers does not equate to an increase in meaningful access to mental health care.

Articles attached to comments in opposition of the proposal:

- Robiner, W.N., Tompkins, T.L., Hathaway, K.M., (2019), Prescriptive Authority: Psychologists' abridged training relative to other professions' training, Clin Psychol Sci Pract. 2020;27:e12309.

- Tompkins, T.L, Johnson, J.D., (2016), What Oregon Psychologists Think and Know About Prescriptive Authority: Divided Views and Data-Driven Change, Journal of Applied Biobehavioral Research, 21, 3, pp. 126-161

- Psychologists Opposed to Prescription Privileges for Psychologists, Annotated Bibliography of Articles and Readings That Raise Concerns About Prescription Privileges for Psychologists (Attached at the end of these comments)

PSYCHOLOGISTS OPPOSED TO PRESCRIPTION PRIVILEGES FOR PSYCHOLOGISTS

Annotated Bibliography of Articles and Readings That Raise Concerns About Prescription Privileges for Psychologists

http://www.poppp.org

Contents

Revised January, 2009

Index to Issues Raised in the Prescription Privileges Debate

(*Numbers correspond to number of reference in the table of contents – not the page*)

Annotated Bibliography of Articles and Readings That Raise Concerns About Prescription Privileges for Psychologists

Overview: This annotated bibliography was created by Psychologists Opposed to Prescription Privileges for Psychologists (POPPP). It is intended to give the reader ready access to concerns that have been raised in the professional literature of Psychology, as well as more broadly in nursing and law. Some of the information is taken verbatim from the texts and abstracts. At times, editorial emphasis and commentary are provided by using bold print or by inserting text in brackets. The reader is encouraged to become more familiar with these concerns so as to consider key issues that raise questions about the prudence of granting psychologists prescription privileges. Follow the contents above is an index that may be used to address some specific issues that are part of this controversy.

1. American College of Neuropsychopharmacology (2000). DoD prescribing psychologists external analysis, monitoring, and evaluation of program and its final report. *American College of Neuropsychopharmacology Bulletin, 6*, Retrieved on January 15, 2007 from http://www.acnp.org/Docs/BulletinPdfFiles/vol6no3.pdf.

Reports an evaluation of the performance of 10 psychologists trained in a pilot project to prescribe in the military. Prescribing was limited to adults 18 to 65 years old who already have been medically cleared by a physician, and therefore may have less pathology than non-screened patients. The 2-year, full-time training program included 712 classroom hours on medical didactics and a year of supervised practice in a military hospital with routine physician back-up.

All 10 of the prescribing psychologists who were trained recommended *against* any reduction in required training. Most said an intensive full-time year of clinical experience, particularly with inpatients, was indispensable. They also favored a structured 2-year program, such as theirs *at a medical hospital* for training psychologists. The Evaluation Panel heard much skepticism from psychiatrists, physicians, and some of the graduates who participated in the program about whether prescribing psychologists could safely and effectively work as independent practitioners in the civilian sector. **[Despite such considerations, the APA model *in fact* decreased the training required to prescribe from that of the PDP, and effectively deleted the prerequisites.]**

The Final Report of the American College of Neuropsychopharmacology on the PDP assessed graduates ”for the most part highly esteemed, valued, and respected, there was essentially unanimous agreement that the **graduates were weaker medically than psychiatrists.”** Their medical knowledge was variously judged as on a level of students rather than physicians.

The report indicated that some graduates had limited formularies, and continued to have dependent prescriptive practice (i.e., supervised by a physician). PDP participants were

atypical of psychologists in that eight out of 10 had leadership positions. **[It would not be appropriate to assume that the experiences of a skewed population would be fully predictive of training for less accomplished psychologists].**

The report emphasized,

> "it will be ***essentia***l to select trainee psychologists **with an adequate background** for advanced training in psychopharmacology. Two areas are particularly important--a preparatory science background and competence in clinical nosology. In order to study pharmacology at the advanced level needed to manage pharmacotherapies, **trainees must have a background in chemistry, biology and mathematics.** Chemistry should include post-baccalaureate biochemistry and the necessary preparation for a course at this level. Typically, this would include undergraduate general and organic chemistry. Biology should include undergraduate level general biology, vertebrate and human anatomy, and other course work adequate for a post-baccalaureate level course in mammalian physiology. It would be important for the graduate physiology course to contain exposure to human pathophysiology. It would also be essential that trainees have an adequate background in the biological basis of behavior. Understanding of clinical pharmacokinetics and many relevant biochemical phenomena requires a background in mathematics, including at a minimum, college-level algebra."

[The APA model for training in psychopharmacology does not require the prerequisites or other aspects of the actual training that was recommended by this report.]

2. American Psychological Association (2008). *Guidelines and principles for accreditation of programs in professional psychology.* Washington DC: Author. http://www.apa.org/ed/accreditation/G&P0522.pdf

This document presents the standards for accreditation for doctoral level training in Psychology. Accreditation is "intended to protect the interests of students, benefit the public, and improve the quality of teaching, learning, research, and professional practice…. Accreditation is a voluntary, non-governmental process of self-study and external review intended to evaluate, enhance, and publicly recognize quality in institutions and in programs of higher education."

[The document does not cover *any* training in psychopharmacology. Indeed, the word "psychopharmacology" does not appear anywhere in this 43 page document. No coursework in psychopharmacology is required to obtain a doctoral degree in psychology. The training of doctoral level psychologists does *not* require that students obtain any education in "Psychopharmacology", "Chemistry" or any specific courses in human Biology other than a single course in the "biological aspects of behavior."

No programs for training psychologists in psychopharmacology have been accredited by the American Psychological Association as meeting APA accreditation standards for a postdoctoral residency or any other level of doctoral or postdoctoral training. Unlike other training in psychology, there is not an internal mechanism for accrediting training or supervised experiences in psychopharmacology. This is

in contrast to training mechanisms in prescribing disciplines as well]

3. Association of State and Provincial Psychology Boards (2001). *ASPPB Guidelines For Prescriptive Authority*. Montgomery, AL: Author. http://asppb.org/publications/guidelines/paq.aspx

The mission of the Association of State and Provincial Psychology Boards (ASPPB) is to assist member boards in their mission to protect the public. "**As a matter of policy, ASPPB neither endorses nor opposes the current movement within many professional organizations to promote prescription privileges for psychologists. "**

"These guidelines were prepared in an effort both to provide guidance to jurisdictions that have received, or are anticipating statutory approval of, prescription privileges for psychologists, and also to continue ASPPB's efforts to achieve greater uniformity of standards among jurisdictions when making changes to their acts and regulations. **There is not yet a standard for how boards of psychology should regulate prescriptive authority for psychologists if legislatures enact this authority through statutory change."**

"**The most appropriate standard of care for psychologists to meet in prescribing medications is a complex, weighty matter that is subject to controversy.** A potential advantage in establishing the standard of care as that of a "reasonably prudent psychologist who is trained to prescribe drugs" is that it affords direct comparisons between prescribing psychologists. On the other hand, **a standard of care that compares psychologist prescribers to physicians (i.e., psychiatrists, primary care physicians) might be argued to provide a higher level of public protection by setting a threshold standard that is equivalent to that which exists in current practice….** Some case law has established the standard of care of other health professions as needing to meet that of physicians, while other cases have not upheld this standard. In the event that dependent authority is granted in some jurisdictions, not only standards of care but also standards for supervision, may become complex issues for boards, legislatures, and the courts."

"As psychologists pursue prescriptive authority, it may be anticipated that there will be questions and challenges to regulatory models, standards, and procedures, as well as to the definition of the scope of practice, training models, and other requirements for prescriptive authority… **Thus far, there are no accreditation mechanisms in place for training programs for psychologists in clinical psychopharmacology**. It is highly desirable that psychopharmacology programs become accredited…c.learly it is in the public's interest for programs to undergo some type of external review, as is done in psychological doctoral programs and internships, psychiatric residencies, and other professional training programs. "

"Defining the qualifications of supervisors for the supervised applied training in psychopharmacology continues to be a challenge. As an emerging field in psychology, there are a limited number of psychologists who are qualified to serve as supervisors…The APA (1996b) recommendations for postdoctoral training… do[es] not

address the duration of supervised applied training in psychopharmacology" [and] do[es] not delineate specific qualifications or the basis for demonstrating skills in psychopharmacology….Currently, the profession has no accepted standards for supervisors' experience in prescribing psychoactive medications prior to serving as supervisors.

Further information is available through the ASPPB website. http://www.asppb.org.

4. Bush, J.W. (2002). Prescribing privileges: Grail for some practitioners, potential calamity for interprofessional collaboration in mental health. *Journal of Clinical Psychology, 58*, 681-696.

Focuses on the probable consequences of prescription privileges (RxP) upon collaboration between psychologists and physicians. The current state of collaboration between psychologists and medical professionals is reviewed. Data are presented from a small survey of clinical psychologists indicate consequences of RxP include: (1) psychiatrists and other medical professionals would receive fewer referrals from psychologists; (2) psychologists would receive fewer referrals for psychosocial services from medical professionals; (3) most psychologists anticipate an adverse effect upon collaboration with physicians; and (4) psychologists are at best divided over RxP.

5. DeNelsky, G. Y. (1996). The case against prescription privileges for psychologists. *American Psychologist, 51*, 207-212.

The authority to prescribe psychoactive medications could have major negative effects on the practice, education, and training of psychologists. Prescription authority also would have major changes how psychological services are marketed and on the public's perception of the profession. Although it is APA policy to pursue prescription privileges, APA cannot require that states actually change scope of practice laws their licensing laws.

6. Dozois, D. J. A., Dobson, K. S. (1995). Should Canadian psychologists follow the APA trend and seek prescription privileges? A Reexamination of the (R)evolution. *Canadian Psychology, 36*, 288-304.

This paper critically examines three key issues surrounding the prescription debate (quality of care, marketability, and psychology's heritage) and demonstrates that, with respect to professional psychology as a whole, obtaining prescription privileges may not be the optimal way to enhance its practice. A second purpose is to place these developments within the context of Canadian psychology. Although American "gains in professional autonomy have usually followed in (Canada" (Dohson el al., 1993), Canadian psychologists face far more impediments to seeking prescription privileges than their southern colleagues. Despite the fact that such obstacles do not preclude our profession from determining its own destiny and advocating for this privilege, we argue at both a practical and conceptual level; 1) **that the benefit is not worth the battle** and,

2) that obtaining prescription privileges may have austere ramifications for the basic identity and core philosophy of professional psychology in Canada.

7. Fowles, D. (2005). Prescription privileges for psychologists. *Clinical Science, 5,* 6, 7. [Electronic Version]. Retrieved November 25, 2007 from http://www.bsos.umd.edu/sscp/Fall_2005_Newsletter.pdf

The Society for the Science of Clinical Psychology, which is a Section of Division 12 (Clinical) of the APA, had posted on its website the results of a survey on prescription privileges. The results showed the membership was ***strongly opposed*** to prescription privileges. The author describes how APA leadership required the Section to remove any information from its website that suggests there is opposition to official APA policy or be thrown out of the organization. The Section elected to remove the information. However, the SSCP's Task Force statement on RxP is posted at http://www.mspp.net/SSCPscriptpriv.htm

8. Guiterrez, P. M., & Silk, K. R. (1998). Prescription Privileges for Psychologists: A review of the Psychological literature. *Professional Psychology: Research and Practice, 29*, 213-222.

The article provides a general overview of the prescription privileges debate and the related policy issues is presented. Various experiments with psychologists prescribing medications are then reviewed. Next, the survey data to date are summarized. Finally, position papers on both sides of the issue are reviewed. The authors attempt to review objectively both sides of the argument, to critique the existing data, and to assist readers in appreciating the breadth and scope of the prescription privileges debate. The purpose of this article was not to support either side but, rather, to provide a sufficient review of the literature, which will allow psychologists to form more informed opinions on where they stand on the issue.

"It should be possible to compare the psychology fellows to psychiatry residents working in similar settings …Existing data support the positions that clinical psychologists can be adequately trained to independently prescribe medication and that this is a cost-effective alternative, at least within the military health care system. These data must now be replicated in a variety of settings before an informed decision for or against prescription privileges can be made."

[The article provides an overview of the DOD, including General Accounting Office's report, which found that there is no need for prescribing psychologists in the military. They review previous surveys of psychologists, such Boswell & Litwin (1992), who found 49% of hospital-based psychologists were opposed to RxP.] Whereas several surveys indicate majorities of psychologists agree with the RxP agenda, many are not interested in pursuing it.]

9. Hayes, S.C. (1995, Spring). Using behavioral science to control guild excesses. *The Clinical Behavior Analyst*, 1, 17.

The author proposes ways for applied psychology to respond to capitated systems of health care. He argues prescription privileges do not address the profession's survival. Scientifically-oriented applied psychology can survive market pressures by advocating effective interventions to managed care because such treatments are cost effective and cheaper in the long run. Psychologists are also trained to develop and evaluate programs, train Masters level providers, and supervise.

10. Hayes, S. C., & Heiby, E. M. (Eds.). (1998). *Prescription Privileges for Psychologists: A Critical Appraisal.* Reno, NV: Context Press.

This authoritative book presents the first critical and comprehensive examination of the issue of prescription privileges for psychologists. The editors and authors review issues discussed at a conference sponsored by the American Association of Applied and Preventative Psychology (AAAPP), a professional organization of psychologists, that opposes prescription privileges for psychologists. The book includes both con and pro positions from experts in the field.

11. Hayes, S. C., & Heiby, E. M. (1996). Prescription privileges: Does psychology need a fix? *American Psychologist, 51*, 198-206.

The article identifies reasons some psychologists are seeking prescription privileges now. Reasons offered include: (1) Over-reliance on psychotherapy as a way to earn a living; (2) An oversupply of doctoral-level psychotherapists; (3) The rise of managed care and concerns about cost-effectiveness of services when Masters level providers are less expensive; (4) The hegemony of syndromal classifications (i.e., DSM); and (5) Medical guild and drug company interests. Offers ways applied psychologists readily can adapt to these five conditions without becoming medical specialists via prescription privileges.

12. Hayes, S.C., Walser, R.D., & Bach, P. (2002). Prescription privileges for psychologists: Constituencies and Conflicts. *Journal of Clinical Psychology, 58*, 697-708.

The pros and cons of training for prescription privileges within the discipline rather than through established avenues (such as nursing) vary from the point of view of constituencies involved. One constituency involves scientist-practitioners who tend to oppose prescription privileges. However, there has not been much organized opposition from the basic science organizations. A second constituency is the practice-based organizations that have been in support of prescription privileges. However, there is not much support from rank and file private practitioners. The resistance to prescription privileges can be understood in terms of what costs and benefits are valued. **Opposition is not arbitrary or unreasonable and is likely to continue.**

13. Hayes, S.C., Walser, R.D., & Follette, V.M. (1995). Psychology and the temptation of prescription privileges. *Canadian Psychology, 36*, 313-320.

The article describes the proposal to pursue prescription privileges (PP) as reflecting an identify crisis in psychology. It argues that psychology is a science in its own right and does not have the adequate bases for prescribing drugs. Notes **prescription privileges will harm training, and is unethical.** Reports on the Resolution Against Prescription Privileges passed by the American Association of Applied and Preventive Psychology in Jan. 1995.

14. Heiby, E. M. (2002a). Prescription privileges for psychologists: Can differing views be reconciled? *Journal of Clinical Psychology, 58,* 589-597.

The article summarizes six arguments made in testimony at state legislatures by psychologists who oppose prescription privileges bills. The main topics concern whether there is a societal need for psychologists to practice medicine, whether psychology as a discipline has evolved in this direction, how training would change the discipline, what the addition of medical training would cost financially, and whether the current collaborative model is adequate. The author concludes that the debate reflects a deep schism in the field of clinical psychology. The schism is seen as a divide between those primarily trained to be psychotherapists and those primarily trained to be scientist-practitioners. It is argued that the former type of clinical psychologists are more likely to support prescribing and are interested in the survival of professional schools. In contrast, the later type tends to oppose privileges and are interested in the survival of university departments of psychology. Suggestions are offered for the unification of the discipline. Since 1995, AAAPP official policy has been to oppose RxP based upon a survey indicating a majority of the membership opposes PPP.

> "It is probably fair to say that prescription privileges for psychologists…is one of the most controversial proposals debated by the discipline in many decades." (p. 589)

> "High quality and cost-effective mental health treatment is commonly accomplished through collaborations between psychologists and physicians and there is no reason this cannot continue when psychotropic medications are indicated" (p. 594)

15. Heiby, E.M. (2002b). It is Time for a moratorium on legislation enabling prescription privileges for psychologists. *Clinical Psychology: Science and Practice, 9,* 256-258.

The article argues that it is premature to pursue prescriptive authority. Psychologists have taken the debate over this issue to state legislatures and present as a house divided. Rather than seek a radical change in scope of practice by legislative fiat, changes to the field must evolve from within if the field of clinical psychology is to remain unified.

16. Heiby, E.M., Deleon, P.H., & Anderson, T. (2004). A debate on prescription privileges for psychologists. *Professional Psychology: Research and Practice, 35*, 336-344.

The article summarized a debate held at the 2002 convention of the APA. Pro and con positions were presented on the following topics: (1) Whether the science and practice of clinical psychology will benefit from prescription authority; (2) How the APA Training Model is justified given the evaluation of the DoD project and the amount of training required of other professions with prescribing authority; and (3) The impact of medical training upon university-based psychology departments in relation to curriculum, faculty staffing, and financial costs both to the university and students. Heiby argues that the science and practice of clinical psychology will be harmed given resources and time will be reallocated to medical training and practice. She asserts there is no evidence to support the APA Training Model, which would give psychology the dubious reputation of being a prescribing profession with the least amount of medical training. She notes that medical training in psychology departments at traditional universities would lead to fewer courses in psychology, fewer faculty with degrees in psychology, duplication of resources already available in nursing and medical schools. The cost of tuition would increase dramatically to cover these expenses. DeLeon argued there is a societal need for more psychoactive drugs, that expert opinion is sufficient to justify the APA Training Model, and that it does not matter if traditional universities are harmed.

17. International Society of Psychiatric-Mental Health Nurses Position Statement: Response to Clinical Psychologists Prescribing Psychotropic Medications: November 2001
http://www.ispn-psych.org/docs/11-01prescriptive-authority.pdf

It is the position of ISPN membership that nurses **have an ethical responsibility to oppose the extension of the psychologist's role into the prescription of medications.** This is not a turf issue or an attempt to limit a perceived competing profession. This belief is rooted in the ethical guidelines of our own profession. The professional standards for nursing require nurses who prescribe pharmacologic agents to have their prescriptive actions based on an awareness of pharmacological and physiological principles and knowledge (ANA, 1996, p. 14). We should expect the same from other professionals. The *Scope and Standards of Advanced Practice Registered Nursing* (ANA, 1996) mandates the advanced practice nurse to "contribute to resolving the ethical problems or dilemmas of individuals or systems" (p. 19). It would seem inappropriate and contrary to our profession, therefore, for nurses to assist clinical psychologists in the development of limited training modules for the sanctioning of prescriptive knowledge.

Clinical psychologists represent an important and effective profession that has a long and honored history of working with the mentally ill and facilitating the mental health of their patients. Clinical psychologists have a long and distinguished history of theory-based care practices, and their contributions have come from their unique perspective, which has historically not been somatically based. The current paradigm of psychology rejects the neurobiological basis of mental illness and this theoretical

perspective is reflected in traditional educational practices that limit the exposure to and knowledge of biological sciences.

Psychopharmacology is a critical aspect of today's treatments for mental illness. Safe and effective utilization of medications requires (a) an in-depth knowledge of the human body, and (b) the requisite knowledge to understand the impact of medications on the body, and the physiology of drug-drug and drug-food interactions. **Clinical psychologists do not possess this knowledge and receive little to no clinical supervision in this role. Therefore, they cannot safely prescribe medications to patients with complex, holistic health needs.**

The needs of the mentally ill are many. Limited access, limited availability of prescribers, and limited job positions for clinical psychologists cannot influence nurses to undertake inappropriate action. The desire to meet the needs of our patients is great, but this pressure cannot allow nurses to be drawn into behaviors that are ethically dangerous. The battle over prescriptive authority for clinical psychologists has been going on for many years. It is an issue that challenges nurses, and one around which nursing as a profession needs to respond. As advocates for our patients, we need to speak out against practices that may be harmful to patients. It is our ethical responsibility to speak out and for each nurse to uphold the standards of the profession.

[The above statement is one of only 9 position statements on the website of this organization of nurses. The others address diversity, cultural competence and access to mental health care, youth violence, the global burden of disease, restraint and seclusion, rights of children in treatment, palliative care, and alcohol withdrawal. This speaks to the importance of opposing prescription privileges on various grounds, including ethics, and reflects the concern of professionals who are in an excellent position to recognize the boundaries of professional competence.]

18. Kingsbury, S.J. (1992). Some effects of prescribing privileges. *Professional Psychology: Research and Practice, 23,* 3-5.

The author obtained his M.D. after practicing as a clinical psychologist, giving him a unique window on the debate. He indicates how medical practice consumes most of his professional time. He criticizes proponents of RxP for not mentioning (1) psychologists' possible selfish motivation, (2) the negative impact of RxP, or (3) the issues some psychologists raise in opposing prescribing privileges. He notes, "…it is clear to me that recent discussions of the advantages of psychologists having prescription privileges have been simplistic."

In describing the differences in the training for physicians and psychologists, he stated:

> **"Studying the effects of medications on the kidney, the heart, and so forth is important for the use of many medications. Managing these effects is often crucial and has more to do with biochemistry and physiology than with psychology. I was surprised to discover how little about medication use has to do with psychological principles and mow much of it is just medical"** (p. 6.)

In other words, preparation for prescribing has less to do with the types of activities psychologists are trained for and does require the scientific underpinnings more than some might think.

19. Kingsbury, S. J. (1987). Cognitive differences between clinical psychologists and psychiatrists. *American Psychologist, 42*, 152-156.

Differences in perspective about psychopathology and its treatment may create many of the difficulties in communication between clinical psychologists and psychiatrists. These differences, engendered by different training experiences, include how the professions view science, diagnosis, clinical experience, other disciplines, and the hierarchical nature of organizations. Some ways these differences may adversely affect communications between psychiatrists and clinical psychologists are explored.

The author describes significant differences between psychologists and physicians in their training, experiences, and thinking. For example he reports, **"In my first month of residency training in psychiatry at a psychiatry emergency service I believe I saw more patients individually than in my entire graduate [Psychology] training**." (p. 155) Often health professionals have little understanding of each others' training models and difference in perspectives and activities.

20. Lavoie, K. L., & Barone, S. (2006). Prescription privileges for Psychologists: A comprehensive review and critical analysis of current issues and controversies. *CNS Drugs, 20*, 51-66.

The debate over whether clinical psychologists should be granted the right to prescribe psychoactive medications has received considerable attention over the past 2 decades in North America and, more recently, in the UK. Proponents of granting prescription privileges to clinical psychologists argue that mental healthcare services are in crisis and that the mental health needs of society are not being met. They attribute this crisis primarily to the inappropriate prescribing practices of general practitioners and a persistent shortage of psychiatrists. It is believed that, as they would increase the scope of the practice of psychology, prescription privileges for psychologists would enhance mental health services by increasing professionals who are able to prescribe. The profession of psychology remains divided on the issue, and opponents have been equally outspoken in their arguments.

The purpose of the present article is to place the pursuit of prescription privileges for psychologists in context by discussing the historical antecedents and major forces driving the debate. The major arguments put forth for and against prescription privileges for psychologists are presented, followed by a critical analysis of the validity and coherence of those arguments. Through this analysis, the following question is addressed. Is there currently sufficient empirical support for the desirability, feasibility, safety and cost effectiveness of granting prescription privileges to psychologists?

Although proponents of granting prescription privileges to psychologists present several compelling arguments in favor of this practice, there remains a consistent lack of empirical evidence for the desirability, feasibility, safety and cost effectiveness of this proposal. More research is needed before we can conclude that prescription privileges for psychologists are a safe and logical solution to the problems facing the mental healthcare system.

> "The debate about whether psychologists should be granted prescription privileges is still in its infancy…**There does not appear to be compelling evidence of the desirability of granting prescription privileges for psychologists.** Pilot projects relating to the feasibility, safety, and cost effectiveness of prescription privileges for psychologists are either sparse or unavailable. Although proponents present several compelling arguments in favour of granting prescription privileges for psychologists, more research is needed before we can conclude that prescription privileges for psychologists are a safe and logical solution to the problems affecting the mental healthcare system.
>
> In the meantime, psychologists should concentrate their efforts on improving both the professional and public dissemination of the services they already provide. In particular, they could work on improving collaboration with GPs and psychiatrists to ensure that medicated patients are properly monitored and advised of available psychotherapy options. Psychologists need not go beyond the boundaries of psychological practice to expand into new treatment areas. There have already been important advances in the areas of health psychology and behavioural medicine, where psychologists have demonstrated success in improving treatment adherence, health behaviours and disease outcome in cancer patients,[107-109]obese patients,[110]coronary artery disease patients[111,112]and patients with HIV.[113]**Expanding the quality and scope of these interventions may represent a more desirable, feasible, safe and cost-effective goal than the pursuit of prescription privileges at this time."** (p. 66)

21. Pollitt, B. (2003). Fool's gold: Psychologists using disingenuous reasoning to mislead legislatures into granting psychologists prescriptive authority. *American Journal of Law & Medicine, 29*, 489-524.

This Article challenges the psychologists' arguments, favoring legislative approval that grants them prescriptive authority. The author provides a critique of each of the American Psychological Associations' reasons for attempting to convince legislatures to grant psychologists prescription privileges: 1) psychologists' education and clinical training better qualify them to diagnose and treat mental illness in comparison with primary care physicians; 2) the Department of Defense Psychopharmacology Demonstration Project ("PDP") demonstrated non-physician psychologists can prescribe psychotropic medications safely; 3) the recommended post-doctoral training requirements adequately prepare psychologists to prescribe safely psychotropic medications; 4) this privilege will increase availability of mental healthcare services, especially in rural areas; and 5) this privilege will result in an overall reduction in medical expenses, because patients will

visit only one healthcare provider instead of two-one for psychotherapy and one for medication. [The author persuasively counters these contentions, and others, such as that granting them prescriptive authority would significantly allay un-met mental health needs in rural areas, which he argues is also highly questionable.]

Psychologists seeking prescriptive authority assert that granting this privilege will increase patient access to psychotropic medication, especially in rural areas. Instead of working on collaborative models in which physicians prescribe medication and psychologists provide therapy, which is a highly workable model, proponents seek to supplant psychiatry and non-prescribing psychologists by creating a "new breed" of psychologist (a.k.a. pseudo-psychiatrist**). [This article, from outside of Psychology itself, also reflects that other stakeholders, beyond psychologists, have legitimate concerns about psychologist prescribing.]**

22. Robiner, W. N., Bearman, D. L., Berman, M., Grove, W. M., Colón, E., Armstrong, J., & Mareck, S. (2002). Prescriptive authority for psychologists: A looming health hazard? *Clinical Psychology: Science and Practice, 9,* 231-248.

Surveys of psychologists and trainees have yielded inconsistent estimates of psychologists' support of the notion of psychologists prescribing drugs and there has been considerable debate in the field about it. Ambivalence about the prescription privilege agenda raises questions about why psychologists have reservations about it. Although many psychologists are interested in pursuing prescription privileges, the historical training paradigm in psychology comprises limited education in the physical sciences that is directly relevant to prescribing medications. Issues related to prescriptive authority for psychologists, including training gaps, attitudes, and accreditation and regulation are discussed.

The authors' primary concern is the risk of suboptimal care if psychologists undertake prescribing that could arise from their limited breadth and depth of knowledge about human physiology, medicine, and related areas. This risk would be compounded by psychologists' limited supervised physical clinical training experiences. The authors review various concerns addressed in the literature. For example, In one survey, more than two thirds of psychologists in independent practice described their training related to psychopharmacological issues as "**poor**".

The American Psychological Association's Ad Hoc Task Force on Psychopharmacology, the group that provided the basic analysis of psychologists' potential activities and training related to psychoactive medications**,** noted that other health professions (e.g., nursing, allied health professions) **require** undergraduate preparation in anatomy, biology, inorganic and organic chemistry, pharmacology, human physiology, (and some require physics); undergraduate psychology degrees and **admission to psychology graduate school *do not.*** In fact, one study found **only 7% had completed the recommended undergraduate biology and chemistry prerequisites required for medical or nursing school.** Even though the APA's own Task Force recognized the importance of such relevant training, the APA's model for training psychologists to prescribe medications deleted the prerequisite coursework in the biological and physical sciences for such

training. This makes the APA training model for prescribing remarkably weaker than the training required for all other health professionals who are trained to prescribe.

Current proposals also fail to delineate clear requirements for several key aspects of supervised practical training and there has not been any external accreditation mechanism to even evaluate the quality of training. For example, the APA model failed to specify minimal criteria for: (a) the **breadth** of patients' mental health conditions; (b) the **duration** of treatment (i.e., to allow for adequate monitoring and feedback) or requirements for outpatient or inpatient experiences; (c) **exposure** to adverse medication effects; nor (d) **exposure** to patients with comorbid medical conditions and complex drug regimens. Also, the **qualifications** for supervisors are vague. The training advocated by the APA even fails to meet APA's own requirements for accreditation of psychology training. The existing psychology doctoral and internship programs generally lack the faculty capable of teaching courses and supervising practical experiences related to prescribing. Similarly, it is unclear how well psychology boards would be equipped to regulate this aspect of psychologists' practice.

The authors also note that proponents of psychologist prescribing tend to focus on certain charged and arguably disingenuous issues to promote their cause, rather than on the inadequacies noted above. Rather than addressing issues such as the potential benefits to patient care of increasing psychologists' collaborations with prescribes, they focus on underserved populations. For example, they decry the shortage of mental health services in rural areas without promoting other ways in which psychologists could better serve rural populations, such as collaborating better with other rural healthcare professionals. Moreover, they ignore the demographic fact that few psychologists practice in rural areas and that there is no reason to expect that if they were allowed to prescribe that they would resettle in rural areas.

The authors also recognize that certain populations, such as older adults might be at higher risk of adverse outcomes of psychologists prescribing given the foreseeable drug interactions and more complex issues that would likely complicate their care. Quality care is likely to require greater medical expertise than is likely to result from training psychologists to prescribe.

23. Robiner, W. N., Bearman, D. L., Berman, M., Grove, W. M., Colón, E., Armstrong, J., Mareck, S., Tanenbaum, R. (2003). Prescriptive authority for psychologists: Despite deficits in education and knowledge? *Journal of Clinical Psychology in Medical Settings, 10*, 211-222.

As some psychologists advocate for prescription privileges, the need for closer analysis of the differences between psychologists and psychiatrists grows. The authors' survey and test data reveal key statistically significant gaps in psychologists' training and their significant limitations in their knowledge pertaining to prescribing relative to psychiatrists. Attitudes toward prescribing and estimates of psychologists' competence in prescribing are presented. The authors believe that psychologists' deficits in training and pertinent knowledge constitute major hurdles to competent prescribing. They recommend that caution is warranted about expanding psychologists' scope of practice to include prescribing.

24. Sechrest, L. & Coan, J.A. (2002). Preparing psychologists to prescribe. *Journal of Clinical Psychology, 58,* 649-658.

This report is an investigation of the training received by professionals currently authorized to prescribe medications is considered as a step toward understanding what might be involved in preparing psychologists appropriately if prescription privileges for psychology were to be obtained. Information about admission and curriculum requirements was collected from medical schools, dental schools, physician assistant programs, nurse practitioner programs, and schools of optometry. Results suggest a high level of pharmacologically relevant coursework is required for admission to, and the completion of, programs that currently prepare their professionals to prescribe. It is argued that preparing psychologists to prescribe would likely entail similar training requirements in addition to, or instead of, those already in place, leaving clinical psychology dramatically and permanently altered.

The authors conclude the APA training model represents an experimental reduction in American standards for medical practice. The medical training in the model is less than that required for other prescribing professions, including physician assistants, advanced nurse practitioners, physicians, dentists, and optometrists (Sechrest & Coan, 2002). The author notes that only one psychology graduate program in the U.S. requires any background in the natural and life sciences for admission and that psychologists do not have the pre-requisites for medical training required of all other prescribing professions.

Only three (of 168) doctoral programs in psychology have specific physical or life science prerequisites. By contrast, Prescribing Professions have undergraduate prerequisites, generally in highly competitive classes.

Prerequisite Hours for Prescribing Professions

Prerequisite	*Medicine*	*Dentistry*	*Physician Assistant*	*Optometry*	*Nurse Practitioner*	*Psychology (Ph.D.)*
Biology	8.0	8.5	4.9	7.3	30	0
Physics	7.7	7.6	0.5	8.1	3.5	0
Inorganic Chemistry	7.8	8.2	6.8	8.1	3.1	0
Organic Chemistry	7.5	7.3	2.1	4.6	1.1	0

25. Smyer, M. A., Balster, R. L., Egli, D., Johnson, D. L., Kilbey, M. M., Leith, N. J., & Puente, A.E. Summary of the Report of the Ad Hoc Task Force on Psychopharmacology of the American Psychological Association. (1993). *Professional Psychology: Research and Practice, 24,* 394-403.

The American Psychological Association Board of Directors established an ad hoc task force on psychopharmacology to explore the desirability and feasibility of psychopharmacology prescription privileges for psychologists. In this context, the Task Force's charges were to determine the competence criteria necessary for training psychologists to provide service to patients receiving medications and to develop and evaluate the necessary curricular models. This article summarizes the Task Force's major recommendations and provides specific information regarding its training recommendations. It is hoped that this article will encourage broad discussion of psychology's most appropriate integration of psychopharmacology knowledge and its applications into its training programs and professional activities.

[The Task Force indicated the need for more stringent training than the APA model ultimately required, such as when APA abolished the scientific prerequisites for the psychopharmacology training. The APA has also never promoted the Level 2 type of training, which the Task Force discussed, would have promoted psychologists' *collaboration* with other health care professionals in terms of prescribing. It would have provided a mechanism for psychologists to obtain advanced training in psychopharmacology, but would not have resulted in their direct prescribing, so that their limited knowledge of relevant topics, such as pathophysiology and other central scientific areas would not put patients at unprecedented risk.]

Excerpts from the Task Force report include:

> "It is likely that only a small percentage of psychological service providers have a high degree of experience and expertise with pharmacological treatment and are actively working with physicians in assessing, selecting, and managing psychoactive medications…" (p. 396)
>
> "When APA Division 42 (Independent Practice) recently polled its members, the majority of the 440 participants described both their graduate training and opportunities for continuing education in psychopharmacology as inadequate. More than two thirds characterized their training for dealing with psychopharmacological issues as "poor," and 78% felt that continuing education opportunities were insufficient to allow them to expand their knowledge and skill base in drug therapy…this lack of training, coupled with current regulations, requires psychologists to defer to physicians on medication matters for their clients." (p. 396)
>
> "At the doctoral level…[only] 14% of private and 7% of public institutions require a psychopharmacology course." (p. 397)
>
> "When considering the training of psychologists in psychopharmacology and related sciences, it is useful to consider the science curricula for other health service professionals. Programs in such health professions as allied health, pharmacy, optometry, dentistry, nursing, medicine, and osteopathy differ in the length and intensity of their science training, but certain features are common to all. All of these professions require undergraduate preparation in general biology and chemistry. For the allied health professions (such as medical technology, dental hygiene, occupational therapy, and physical therapy) as well as nursing and pharmacy, where professional training typically occurs at the bachelor's-degree level, students also receive undergraduate preparation in human physiology and anatomy, and some programs require organic chemistry and physics as well. Nurses, pharmacists, and most allied health professionals also receive advanced undergraduate-level instruction in pharmacology.
>
> Entrance requirements for post-baccalaureate dental, medical, and osteopathic medical schools generally include course-work in organic chemistry, at least general biology, mathematics through college-level algebra, and physics. Most students admitted to these professional schools have had additional biology and chemistry

coursework. Doctoral-level training in dentistry, osteopathy, and medicine almost invariably includes advanced coursework in human anatomy and physiology, biochemistry, cellular biology, pharmacology, microbiology and immunology, and pathology. Most schools of dentistry, osteopathy, and medicine require 2 full years of intensive classroom training in these health sciences. Clinical pharmacists with Pharm.D. degrees have completed their bachelor's-level pharmacy degree and typically at least two additional years of advanced training in pharmacology.

A survey of 102 U. S. schools of medicine for 1989–1990 conducted by the Association for Medical School Pharmacology (1990) revealed that medical students received an average of 104 teaching hours in pharmacology." (p. 397)

"It is unlikely that this competence can be developed through continuing education, because approximately 2 years' full-time didactic training with additional supervised clinical experience in medication decision making is envisioned. **Retraining of practicing psychologists for prescription privileges would require careful selection criteria, focusing on those psychologists with the necessary science background… It would require students to have undergraduate science training similar to that required of other health service providers (e.g., nurses, pharmacists, allied health professionals, dentists, and/or physicians).** It would also require a postdoctoral period of supervised clinical experience. (p. 400)

"Undergraduate Prerequisites

A psychopharmacology track should recruit students with a strong background in the biological sciences. Some background in anatomy, physiology, and chemistry would be necessary to take the graduate-level courses that make up the proposed curriculum. This background could be obtained during undergraduate studies, as a post-baccalaureate student, or in some circumstances, during early years of the graduate program.

The Task Force believes the following areas of undergraduate instruction are needed.

Biology

A minimum of 12 to 15 semester hours in undergraduate biology is recommended. This would include courses in general biology, cellular and human genetics, vertebrate anatomy, and mammalian physiology. Ideally, some laboratory experience would accompany one or more of these courses. Prospective students also would be well advised to obtain undergraduate preparation in cell and molecular biology to prepare themselves for the advances in psychopharmacology being made using these approaches.

Chemistry

A minimum of 9 to 12 semester hours would be recommended. Students need sufficient preparation to take a graduate-level biochemistry course; typically this would require two semesters of general chemistry and at least one semester of organic chemistry.

Mathematics

College-level algebra would be a minimum. This would not typically be a problem for psychology graduate students, who usually have good quantitative backgrounds. Pharmacology and/or substance abuse

A number of colleges and universities offer undergraduate courses in pharmacology or a substance abuse course that covers the basic pharmacology of drugs of abuse. These courses would be desirable but not mandatory." (p. 400)

"It would be difficult, however, to provide Level 3 training through traditional continuing education mechanisms. It was assumed [for prescriptive authority] that

the medical management of the patient was being done by a physician (i.e., a general practitioner, pediatrician, or internist), and that **psychiatric management was restricted or not available.** (p. 401)

26. Society for a Science of Clinical Psychology (2001). Task force statement on prescribing privileges (RxP). http://www.mspp.net/SSCPscriptpriv.htm

The Task Force notes the vast majority of SSCP members strongly oppose RxP. The Task Force calls for a moratorium on APA's expenditure on RxP, a survey of the membership, and a balanced peer-reviewed mini-convention on the pro's and con's of RxP. **The Task Force presents the following 9 reasons to oppose APA's policy on RxP:**

"1. RxP would not fill unmet needs for service as claimed by proponents.

(a) The psychiatrically underserved population is not very large. Even in the aggregate, it is smaller than RxP advocates in APA's central office wish us to believe.

(b) The geographic distribution of psychologists largely follows that of psychiatrists. Thus little net gain in coverage is even possible.

© Few psychologists have chosen to practice in places like rural Montana or the South Bronx. There is no reason to think that RxP would make an appreciable difference.

(d) Organizations of consumers of mental health services (e.g., NAMI) have not come forth to endorse RxP. At the last RxP bill hearing in the Hawaii legislature, several consumers testified against RxP but none in favor.

2. No satisfactory precedents exist, either for designing suitable training programs, or for predicting psychologists' performance as prescribers.

(a) The definition of what would constitute adequate training remains highly speculative and controversial. APA's model program is far from being a final or even an authoritative statement of what would be needed.

(b) The Department of Defense program, with 10 graduates, was about twice as intensive as that envisioned by the APA model program. It cannot be reproduced on a broad scale. It is therefore not a meaningful precedent.

© Guam — small, remote, and atypical in other respects — requires medical oversight of its handful of prescribing psychologists. It is not a precedent for RxP in the form espoused by APA.

(d) APA's training model specifies three sequential levels. Current RxP training programs offer Level 3 (see section 3 below), but omit the prerequisite Levels 1 and 2. They also omit the undergraduate prerequisites in biology (12-15 semester hours), chemistry (9-12 hours) and algebra (one course).

(e) Some programs claiming to meet APA standards are conducted via distance learning — quite unlike the Defense Department program or those offered to

optometrists.

(f) In short, there is no existing program that meets even APA's scaled-down criteria.

3. Few existing psychologists would be able to complete any acceptable training program.

(a) The APA Level 3 model, skimpy as many believe it to be, entails 350 classroom/lab hours, plus one year of closely supervised practicum experience involving 100 patients. This is equal to approximately two years of full-time work.

(b) This time requirement does not include prerequisite undergraduate-level work (see section 2[d] above), some or all of which most prospective candidates would need.

© The cost of APA-model training — even when no undergraduate work is needed — is estimated at $20,000 to $30,000 per student if received in a university or professional school setting. This does not include income sacrificed in order to make time available for RxP training.

4. Graduate education in basic psychological science and psychosocial treatments would be severely diminished and distorted unless most or all biomedical coursework were at the post-doctoral level.

(a) Many currently practicing psychologists are already under-trained in psychological science and empirically supported treatments. Displacing traditional curriculum content in graduate schools with RxP-focused coursework would render this deficiency still worse.

(b) Making RxP training wholly post-doctoral would add two years and $20,000 to $30,000 — plus the cost of any undergraduate prerequisites needed and the years of earning ability forever lost — just as it would for existing psychologists.

© By changing the prerequisites for doctoral programs, RxP would attract a different population of applicants and further diminish the emphasis on psychosocial/behavioral treatments.

5. In addition to the direct costs of RxP training, there are a number of externalities — so far, not widely recognized — that argue strongly against RxP.

(a) Malpractice premiums would go up for those who elect to prescribe, and possibly for all licensed psychologists whether they prescribe or not.

(b) Should even a few malpractice suits against prescribing psychologists based on claims of inadequate medical training be successful, insurance coverage would become prohibitively expensive or disappear altogether. Legislatures that had previously authorized RxP would face an onslaught of pressures to rescind it, and those that had not yet authorized it would reject RxP bills out of hand. The damage that would be done to psychologists and to the profession is incalculable — much worse than the damage done to physicians and medicine

when they are sued.

© Student loan debt would increase sharply as a result of additional borrowings and years of delay in commencing repayment.

(d) Adding faculty to departments of psychology to teach the RxP curriculum would cost an estimated $800,000 to $1,000,000 annually. Only schools wholly supported by tuition could hope to recover these outlays. Universities relying on state funds and endowments would have to absorb a large share of additional faculty costs without recourse.

(e) RxP would widen the existing gap between university and professional-school programs, and in effect create two divergent spinoffs of clinical psychology. It would be only mildly facetious to say that we would come to be seen, at least by outsiders, as either underpaid psychiatrists or overpriced social workers. In the process, the cross-fertilization between psychological science and practice — psychology's trump card in the mental health field — would have been severed.

(f) If psychologists obtain RxP, master's-level social workers and counselors will almost certainly try to follow. (Pat DeLeon has in fact written in support of social workers seeking RxP.) Should they succeed, the market will be flooded with Rx-eligible personnel, and the competitive advantage sought by psychology's RxP advocates would quickly vanish.

6. Psychologists would be exposed to patients' demand for "pill fixes" and the blandishments of the pharmaceutical industry, just as psychiatric and other medical professionals already are.

(a) It is naïve to assume that psychologists' background in psychosocial treatments would significantly "inoculate" them against such powerful pressures.

(b) By de-specializing psychologists in psychosocial treatments and their scientific underpinnings, their commitment and competence in this area is likely to be further eroded.

7. Contrary to claims made by key people in APA's central office, psychology is not united behind RxP. A series of surveys over the past 10 years has shown sentiment to be about equally divided.

(a) APA's much-cited 1995 data, which showed a majority in favor of RxP, relied upon a single, highly biased questionnaire item in the context of an omnibus survey on membership issues. More objective studies suggest that a majority is actually opposed to RxP.

(b) Recent survey evidence suggests that many psychologists nominally classified as "favorable" to RxP are willing to endorse RxP simply out of an altruistic desire to help colleagues — while having little or no interest in pursuing such training themselves.

© There is reason to believe that few psychologists — even those who find the RxP idea attractive — are aware of and have given careful thought to the length and cost of any plausible training requirements. What their attitudes would be if they

were fully informed remains unknown.

8. **Organized psychiatry and medicine can be counted upon to oppose RxP in state legislatures far more vigorously and effectively than they have opposed previous expansions in our scope of practice.**

(a) They have the financial and political ability to turn the RxP campaign into a rout for psychology, and are fully prepared to do so if necessary.

(b) Faced with RxP bills in the legislatures, they are likely to seize the opportunity to roll back gains in our scope of practice that have been painstakingly eked out over decades.

© There is evidence from New York that medicine's sabotage of scope-of-practice legislation sought by NYSPA was intended as a shot across our bow to head off RxP.

(d) Fruitful collaboration between psychologists and medical professionals would be undermined — and possibly damaged quite seriously — by the battle over RxP.

(e) APA has spent over $800,000 pressing its RxP agenda, and has recently escalated its efforts still further. Yet all that it will take to defeat RxP bills in state legislatures is for psychologists opposed to RxP to expose its lack of solid support among psychologists. (This has already happened in Hawaii).

9. **RxP opponents fully recognize the need for psychologists to have education and experience relevant to biomedical treatments. But this does not imply a general need for prescribing authority. Good alternatives exist that have none of the drawbacks cited above.**

(a) For psychologists who want to prescribe drugs on their own, nurse practitioner (NP) training would prepare them far better than any RxP program that has been seriously proposed. It would provoke less opposition from the medical establishment. No new legislation — costly, time-consuming and dangerous to pursue — would be required. And it would probably be supported by the nursing profession, which as matters now stand is likely to join organized medicine in opposing RxP.

(b) For psychologists who do not want to prescribe, or who cannot afford the time and money to obtain the requisite training, well-designed CE offerings would enable them to participate collegially and knowledgeably in collaboration with medical professionals. A large percentage of psychologists are already so equipped, and they collaborate routinely and effectively with their medical colleagues.

© Training is particularly needed for collaboration with primary care physicians — who write about 75% of the prescriptions for psychoactive medications in this country, yet often have skimpy knowledge of the proper use of such drugs, and are even less well acquainted with the advantages of psychological treatments. Such collaboration would also do more than RxP to meet the needs of underserved areas and populations.

(d) APA can play a vigorous and constructive role in enhancing psychological practice via these alternatives. It can take the lead in arranging NP training at an affordable cost, and it can develop and promote modules to advance interprofessional collaboration. These things can be done at much less cost and risk than pursuing the present quixotic campaign for RxP — and they would do away with the divisive atmosphere that APA's unilateral promotion of RxP has needlessly brought upon our profession." (n.p.)"

27. Stuart, R. B., & Heiby, E. E. (2007). To prescribe or not to prescribe: Eleven exploratory questions. *Scientific Review of Mental Health Practice. 5*, 4-32.

Many psychologists believe that gaining prescription authority (RxP) would benefit them, their patients, and the field. Prescribing could extend the boundaries of psychological services, but doing it responsibly requires many changes in knowledge acquisition and clinical practice. Since organized psychology is firmly committed to this change, the 11 questions presented here are intended to help individual clinicians decide whether they should seek prescriptive authority. The questions address significant challenges in obtaining the necessary education about human biology; the ways in which organ systems are affected by drugs; methods of prescribing and monitoring treatment results; and preparing for a possible increased risk of malpractice actions. Those considering the pursuit of prescribing authority will also want to determine whether the few psychologists who can currently prescribe drugs have used their authority safely and effectively. In addition, it is important to realize that to meet high standards of care for psychological services, prescribers must both keep abreast of the evolving body of psychological theory and research and devote equal or greater time to maintaining the most current knowledge about the predictable effects of drugs. The latter task is difficult due to common flaws in drug research and flaws in the policies and procedures used by the FDA to regulate drugs. Psychologists should be prepared to adjust their practices to meet these and other challenges *before* they put pen to the prescription pad.

The authors review a variety of problems related to RxP and note that Psychology is in the awkward position of being a scientifically based profession that is seeking to expand its scope based on a small pilot program (i.e., the PDP) that reaches well beyond the parameters of the available data. The authors raise a series of questions to help students and psychologists weigh the costs and potential risks of prescribing against its hoped-for benefits, which will not necessarily be realized, including:

- ? How will you minimize the risk of a misdiagnosis that leads you to prescribe the wrong drug?
- ? How will you minimize the risk of making prescription errors that lead to adverse drug events?
- ? How accurately will you be able to predict the effects of the drugs that you prescribe?
- ? How will you find the accurate information needed for sound decisions about drugs?
- ? How will you avoid choosing a drug that is generally correct for the diagnosis but incorrect for a given patient?
- ? How will you gain access to the resources that you will need to adequately assess patients

before prescribing drugs, and then to monitor medication effects?
? How will you be able to resist the pressure to prescribe unnecessary drugs?
? Do you know enough to make a data-based decision about prescribing authority now?

28. Wagner, M.K. (2002). The high cost of prescription privileges. *Journal of Clinical Psychology, 58*, 677-680.

If the APA medical training model (APA 1996b) is adopted, the cost of the additional graduate training at a southern state university was estimated to be at least $155,000 for students, assuming the student lives on $20,000 per year. This estimated cost to the student does not include the additional costs involved in undergraduate pre-medical training or the higher tuition costs at private universities' graduate programs, including professional schools. Data are presented relative to the financial burden it will place on students, universities, internship sites, **and the consumers** of psychological Services, and the authors question who is going to pay for it?

29. Walker, K. (2002). An ethical dilemma: Clinical psychologists prescribing psychotherapeutic medications. *Issues in Mental Health Nursing, 23*, 17-29.

The use of psychotropic medication to treat psychiatric disorders has surged in recent years, and while commonly prescribed, the question of who should be allowed to prescribe such medication has become an increasingly important issue to nurses. Psychologist shave historically functioned in roles such as psychotherapy and psychological testing, but as standards of care for psychiatric disorders incorporate medication, reimbursement for psychotherapy is declining. Medication prescription and management have not been traditionally seen as the role of the psychologist, however, many clinical psychologists have begun to advocate for prescription authority as a legally sanctioned role for their profession. This article addresses the issues of clinical psychologists seeking prescriptive privilege. It is argued that the current paradigm of psychology rejects the neurobiological basis of mental illness and that **psychologists prescribing medication presents an ethical dilemma for nurses.** It is the contention of the author that nurses have an ethical responsibility to advocate against the extension of the psychologist's role into the prescription of medications. This article also reveals that other mental health professionals (i.e., not just physicians) have significant concerns about psychologists' proposed role in prescribing.

30. Walters, G.D. (2001). A meta-analysis of opinion data on the prescription privilege debate, *Canadian Psychology, 42*, pp. 119-125.

The author concludes psychologists are about evenly divided over whether the profession should pursue prescription privileges. Proponents of privileges ignore the divisiveness over this issue. The results, based on 17 samples, showed minimal consensus and a general split of opinion on the advisability of pursuing the prescription privilege agenda. These findings suggest that prescription privileges have the potential to confuse issues of

training and identity for future generations of psychologists. Although the difference is not statistically significant, **more psychologists than not believe that professional/ scientific organizations like APA should not be spearheading efforts to gain prescription privileges.** At the least, psychologists are evenly divided on this issue. Second, professional psychologists are more supportive of prescription privileges in principle than they are of obtaining the training necessary to prescribe medication.

31. Westra, H. A., Eastwood, J. D., Bouffard, B. B., & Gerritsen, C. J. (2006). Psychologist's pursuit of prescriptive authority: Would it meet the goals of Canadian health care reform? *Canadian Psychology, 47,* 77-95.

The authors seek to facilitate reflection on the important issue of prescriptive authority for Canadian psychologists. The paper contextualizes the discussion of prescriptive authority in the broader context of health care reform in Canada. More specifically, the authors review pharmacotherapy and psychological services in view of how effectively each of these currently meets three major challenges in health care reform: reducing costs, increasing treatment efficacy, and improving access to treatment.

The authors conclude that psychological services are less costly than pharmacotherapy. Prescription drugs clearly and vastly exceed spending on psychological services. In their view, there are very few valid arguments supporting the expansion of prescriptive authority to psychologists, when considering important indices on which future health care services will be judged. In contrast, on the basis of the present review and analysis, it seems to us that a fuller promotion of existing psychological expertise would more result in reduced health care costs, increase treatment efficacy, and improve access to treatment.

The authors believe that "the change that would appear to most benefit consumers, psychologists, other health care providers, and payers, is increased access to psychological services and fuller utilization of psychological expertise. **The best way to realize the benefits of pharmacotherapy may not be through having prescription authority ourselves, but rather through offering strongly desired and much needed complementary expertise grounded in psychological science** (e.g., knowledge of relationship and other psychosocial contextual factors, compliance enhancement, specific psychological treatments, psychoeducation, and so on). Stated differently, if you were a marketer with a choice as to which product to market – one that is widely available, incurs substantive costs, and is less preferred, or one that consumers want, is not currently widely available, is desirable to payers in terms of cost-reduction potential, and is highly effective which would you choose?"

Psychiatric Medications Affect All Body Systems

Safe, appropriate prescribing requires expert medical knowledge of all body systems.

Nervous

Medications affect the connection between brain and body, sometimes impairing alertness and reaction time. May cause seizures or stroke.

Skin

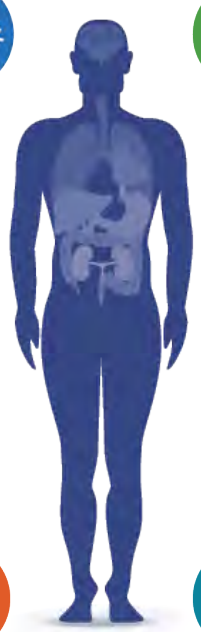
Medications may cause a potentially fatal rapid loss of skin (known as Stevens-Johnson syndrome).

Respiratory

Medications are known to affect a patient's ability to breathe and rate of breath. May cause respiratory failure.

Urinary

As part of the removal of waste, medications can impact one's kidneys, bladder and urinary tract. May cause kidney stones or failure.



Cardiovascular/Circulatory

The heart, arteries and veins are crucial to delivering oxygen and nutrients to organs and cells, and medications can alter their function. May cause cardiac arrest.

Reproductive

Fertility, sex drive, and maternal and infant health all may be at risk because of certain medications. May cause birth defects.

Endocrine

Medications may change a patient's hormone production, secretion and metabolism. May cause abnormal breast development and lactation in men and women.

Immune

Medications can affect or destroy immune and lymphatic systems, impacting the body's ability to defend against disease-causing agents or even cancer.

Musculoskeletal

Some medications can cause tremors or permanent involuntary movements. Others may affect calcium absorption, bone density and bone formation.

Digestive

Medications are often taken by mouth, metabolized by the liver and can affect the stomach, pancreas, gallbladder and intestines. May cause liver failure.

Cleveland Clinic Lerner College of Medicine of Case Western University and Psychiatric Residency	**Case Western Reserve University Clinical Psychology Track + Alliant University Psychopharmacology**

Curriculum Comparison

UNDERGRADUATE	**Pre-Med Undergraduate** **Bachelor's of Science Required** <u>Pre-Med Requirements</u> • Inorganic Chemistry (2 semesters, online not accepted) • Organic Chemistry (1 semester, online not accepted) • Biochemistry or Molecular Chemistry (1 semester, case-by-case online) • Writing/College English (1 semester, online not accepted) • Research Experience (more than one summer of hypothesis research) • <u>Pre-Med Recommended</u> Biology (2 semesters, online not accepted) • Physics (2 semesters, online not accepted) • Social Sciences (1 semester, online not accepted) • Behavioral Sciences (1 semester, online not accepted) • Biostatistics (1 semester, online not accepted)	**Pre-Psychology Requirements** Bachelor's Degree (any kind)	UNDERGRADUATE
MEDICAL SCHOOL	**<u>First Year</u>** • Basic and Translational Research • Cardiovascular & Respiratory Sciences 1 • Gastrointestinal System 1 • Advanced Research in Medicine 1 • Foundations of Clinical Medicine 1 • Art and Practice of Medicine 1 • Endocrinology & Reproductive Biology 1 • Renal Biology 1 • Musculoskeletal Sciences 1 • Neurosciences 1 • Hematology 1 • Immunology & Microbiology	**<u>First Year</u>** • Psychopathology • Psychological Assessment I • Assessment Practicum I • Clinical Interviewing • Research Design & Quantitative Analysis I • Research Clerkship • Measurement of Behavior OR Ethics & Professional Issues • Psychological Assessment II • Assessment Practicum II • Research Design & Quantitative Analysis II • Master's Research	MASTER'S DEGREE
MEDICAL SCHOOL	**<u>Second Year</u>** • Clinical Research (medical) • Musculoskeletal Sciences 2 • Neurosciences 2 • Behavioral Sciences • Endocrinology & Reproductive Biology 2 • Advanced Research in Medicine 2 • Foundations of Clinical Medicine 2 • Art and Practice of Medicine 2 • Cardiovascular & Respiratory Sciences 2 • Hematology 2 • Gastrointestinal System 2 • Renal Biology 2 ***USMLE PART I***	**<u>Second Year</u>** • Core Course(s) • Cognitive-Behavioral Psychotherapy Seminar & Practicum • Mini-Course • Field Placement • Master's Research • Cognitive-Behavioral Psychotherapy Seminar & Practicum II • Ethics & Professional Issues OR Measurement of Behavior • Master's Research / Specialty Exam Preparation	MASTER'S DEGREE
MEDICAL SCHOOL	**<u>Third Year</u>** • Medicine/Family Medicine/Aging (12 weeks) • Pediatrics/Obstetrics-Gynecology (12 weeks) • Neurology/Psychiatry (8 weeks) • Surgery/Emergent Care (8 weeks) • Acting Internships (8 weeks total): • Medicine, Pediatrics, Surgery, or Family Medicine	**<u>Third Year</u>** • Psychodynamic Seminar & Practicum I • Core Course(s) OR Elective(s) • Field Placement • Mini Course • Psychodynamic Seminar & Practicum II • Specialty Exams; preparation for Doctoral Research	MASTER'S DEGREE

MEDICAL SCHOOL	**Fourth Year** • Clinical Electives (MEDICAL clinical, minimum of 20 weeks) • Longitudinal Clinic (2 weeks) • Non-Clinical Electives (12 weeks) ***USMLE PART II Clinical Skills*** ***USMLE PART II Clinical Knowledge***	**Fourth Year** • Doctoral (non-medical) Research • Core OR Elective Course • Field Placement • Mini-Course	MASTER'S DEGREE/PhD
MEDICAL SCHOOL	**Fifth Year** • Capstone – Integrating Cases and Material (2 weeks) • Research Thesis (48 weeks)	**Fifth Year** • Non-medical internship Examination for Professional Practice in Psychology (EPPP): 225 multiple choice test	GRADUATE DEGREE/PhD
MEDICAL RESIDENCY	**MEDICAL RESIDENCY IN PSYCHIATRY** **Adult Psychiatry Residency Program – PGY1** *Clinical Rotations:* *MEDICINE* • Internal Medicine Inpatient (8 weeks) • Outpatient Family Practice (4 weeks) • Emergency Medicine (4 weeks) *NEUROLOGY* • Neurology Inpatient (4 weeks) • Neurology Consults (4 weeks) *PSYCHIATRY* • Adult Inpatient Psychiatry (20 weeks) • Inpatient Chemical Dependency (4 weeks) • Med-Psych Clinics (4 weeks) ***USMLE PART 3***	**Psychopharmacology Master's in Science Degree (Alliant University) Total Credit Units: 29.6, which equals 462 hours of classes, followed by optional 16-hour Review Course for the Psychopharmacology Examination for Psychologists (PEP)** **COMPLETELY ONLINE – PASS/FAIL** **First Year** • Clinical Biochemistry (1.6 units) • Neuroscience: Neuroanatomy/Neuropathy (2.4 units) • Neuroscience: Neurochemistry (1.6 units) • Neurophysiology and Clinical Medicine/Pathophysiology (5.6 units)	MASTER'S DEGREE
MEDICAL RESIDENCY	**Adult Psychiatry Residency Program – PGY2** • Psychosomatic Medicine (16 weeks) • Inpatient Child and Adolescent Psychiatry (8 weeks) • Outpatient CBT (4 weeks) • Inpatient Chemical Dependency (4 weeks) • Inpatient Forensics (4 weeks) • Emergency Psychiatry (4 weeks) • Chronic Pain (4 weeks) • ECT (4 weeks)	**COMPLETELY ONLINE – PASS/FAIL** **Second Year** • Pharmacology/Clinical Pharmacology (4 units) • Physical Assessment (2.4 units) • Special Populations (2.4 units) • Advanced Psychopharmacology (4 units)	MASTER'S DEGREE
MEDICAL RESIDENCY	**Adult Psychiatry Residency Program – PGY3** *Rotations -Longitudinal over 12 months* • Sleep, Mood Disorders Intensive Outpatient Program • Outpatient Continuity Clinic • Psychotherapy Clinic + Psychotherapy Supervision • Community Mental Health Clinic • Outpatient Clinic New Evaluations • Longitudinal or Modular Electives (including, but not limited to women's mental health, psycho-oncology, neuropsychiatry clinics, LGBT clinic, ethics, community mental health, HIV clinic, eating disorders) • Research	**COMPLETELY ONLINE – PASS/FAIL** **Third Year** • Special Populations 2: Gender, Ethnicity, Chemical Dependency (2.4 units) • Pharmacotherapeutics (2.4 units) • Case Seminar (0.8 units) • Practicum in Clinical Psychopharmacology (0 units) **Psychopharmacology Examination for Psychologists (PEP): 150 multiple choice questions**	MASTER'S DEGREE
MEDICAL RESIDENCY	**Adult Psychiatry Residency Program – PGY4** • Rotations on Inpatient Psychiatry Units at Lutheran Hospital in Junior-Attending Role • Neuropsychiatry Clinics (8 weeks) • Longitudinal or Modular Electives (including, but not limited to women's mental health, psycho-oncology, neuropsychiatry clinics, LGBT clinic, ethics, community mental health, HIV clinic, eating disorders) • Research Clinic ***ABPN CLINICAL SKILLS VERIFIED*** ***ABPN WRITTEN KNOWLEDGE EXAM***		

Appendix F

September 17, 2020

Washington State Psychological Association (WSPA) Response

Washington State Department of Health Draft Report of the Sunrise Review: Psychology Scope of Practice – Prescriptive Authority, December 2020.

Dear Ms. Thomas,
Thank you for sharing the draft Sunrise Review on Psychology Scope of Practice Prescriptive Authority and allowing the Washington State Psychological Association the opportunity to review and comment on the draft. We appreciate the complexity and nuance of this issue and we have provided what we hope will be some clarifying information for your consideration for inclusion in the final report. We focused most of our comments on the education requirements, and have included a number of exhibits to demonstrate that the educational requirements being proposed are consistent with other professions licensed to prescribe in Washington. Thank you for reviewing our submitted comments and please let us know if you have any questions.

Section 1: Addressing Statements from the Department of Health Recommendations in the Draft Report:

1. **Education and Training Requirements:** On page 22 of the Recommendation section, the Department of Health writes: "The applicant report pointed to other states that have passed prescriptive authority for psychologists as evidence of safe practice. However, all states that have made this policy change have instituted more rigorous education and training requirements…."

   Washington State will Establish Rigorous Education and Training Requirements

   Antioch University in Seattle has approved the formation of a postdoctoral master's degree in psychopharmacology to explicitly train psychologists seeking credentialing in prescribing psychology in Washington or other states, and so will directly mirror the educational requirements in other states. The model developed by Antioch will establish the education, including prerequisites, that will be used to define the education required in our amended bill. This section will explain how the training of psychologists with prescriptive authority (PsyD[1]/MSCP) in the State of Washington will ensure prescribing in a safe manner. This is done by comparing the training of psychologists with prescriptive authority with the advanced training of Advanced Registered Nurse Practitioners (ARNP) becoming Psychiatric Mental Health Nurse Practitioners (MHNP) with a Doctor in Nursing Practice (DNP). We will detail how the training of psychologists with prescriptive authority is very similar to the highest-level of nurse practitioner training.

   The Training of the Advanced Registered Nurse Practitioners (ARNP)

   For background, registered nurses (RN) who want to "assume primary responsibility and accountability for the care of patients" (WAC 246-840-300) must become licensed as advanced registered nurse practitioners (ARNP). To become a licensed ARNP in the State of Washington, the RN must complete a graduate degree with a concentration in advanced nursing practice.

[1] Licensed psychologists have either a PhD or PsyD. Some may also have EdD. We are using PsyD in this paper since Antioch University, Seattle offers the PsyD rather than the other two possible degrees.

The curriculum is specified in state law. The ARNP provides services within their training or "scope of practice." The Seattle University School of Nursing offers nursing training at both the undergraduate and graduate level. A popular program is the advanced practice nursing immersion (APNI) (https://www.seattleu.edu/nursing/dnp/apni/). This is open to students with an undergraduate degree in any field and with no health care experience. After completing this one-year intensive program, students are eligible for licensure as a Registered Nurse (RN). These newly trained RNs then become a PMHNP with a DNP by completing an additional 4-year training program. At the end of these studies, the student will have earned an RN, be licensed as an ARNP with a specialty in mental health (PMHNP), and a Doctor of Nursing Practice (DNP). This is the highest level of psychiatric nurse practitioner training available.

The Training of Psychologists with Prescriptive Authority

Psychologists with prescriptive authority in states which have legalized prescriptive authority for psychologists (RxP; e.g., Idaho) are required to be a licensed psychologist, earn a Master of Science in Clinical Psychopharmacology (MSCP), pass a national test in psychopharmacology (PEP), and complete other requirements as specified by state law. Psychologists with prescriptive authority operate in collaboration with a primary care provider, and prescribe a limited formulary of medicines (psychotropics) directly related to mental health difficulties. Psychologists with prescriptive authority continue to be independent practitioners when providing other psychological services (e.g., psychotherapy).

Antioch University, Seattle (AUS) will be starting a Master of Science in Clinical Psychopharmacology (MSCP) training program in the Fall 2021. The MSCP program will be housed within the Antioch University, Seattle Doctor of Psychology (PsyD) Clinical Psychology program (American Psychological Association [APA]- approved). Admission to the MSCP program will require licensure as a psychologist and employment in a health service capacity. Students enrolled in an APA-approved health service psychology program (e.g., clinical psychology) may be admitted as well. Students may start the MSCP program during doctoral training, but the completion of the required fellowship and capstone project may not be completed until psychologist licensure is obtained.

In creating the MSCP program at Antioch University, Seattle, the literature from 1984 to 2010 was reviewed, using a review by McGrath (2010) as a guide. A thorough literature review of the years from 2010 to 2020 was then conducted. This literature review revealed 35 peer-reviewed journal articles, a journal dedicated to RxP, and seven books. Twenty of the articles were written in favor of RxP, two articles were neutral, and thirteen articles were written clearly against RxP. All the books were in favor of RxP. No current professional books in opposition to RxP were located. Details about the results of this review, and recommendations for future RxP may be found at Curtis, Hoffman, and Sloan (2020).

The new APA model curriculum (APA, 2019) for psychopharmacology training was used to set the initial curriculum for future APA designation. The MSCP was further refined by taking into account information from the literature reviews, new state laws, other training programs, input from the community and colleagues, and concerns about training (both current and historical; e.g., Heiby, 2010). A visual representation of basic components of the MSCP program are provided in the references.

Concerns Addressed

One major concern of RxP training is the "perceived" lack of prerequisite science training (i.e., anatomy, physiology, or microbiology). For example, Robiner, Tomkins, & Hathaway (2019) reviewed programs of other prescribers (e.g., medical school and training of nurse practitioners) and determined that RxP training is insufficient. One reason given for this conclusion is that RxP does not require prerequisite science training as the other prescribing professions require. This may have been valid 10 years ago, but this conclusion is now is based on outdated information and is categorically untrue. Robiner and colleagues did not take into account new state laws and current mandates from the American Psychological Association (APA). RxP training programs have traditionally "woven" the basic sciences in with the rest of the curriculum, but this is rapidly changing. The three states that most recently passed RxP require specific courses in anatomy, physiology, and other sciences, depending on the state. In addition, the new APA model curriculum for psychopharmacology training (APA, 2019) states, "Programs that choose to offer preparation for clinical training in psychopharmacology will initially offer foundational coursework leading to competency in human anatomy, human physiology, biochemistry, and genetics…" (p. 2). In the Antioch MSCP curriculum, students will be required to the take the same Washington State science requirements of nursing students (WAC 246-840-541), including those admitted to our comparison school, Seattle University School of Nursing.

Other concerns related to training voiced by Robiner and colleagues (2019), and others (e.g., Heibe, 2010; Tomkins & Johnson, 2016) are that more training in prescribing ethics, differential diagnoses, and access issues are needed. These are valid concerns. The Antioch University, Seattle MSCP program will focus on populations marginalized from our current mental health system. Every syllabus will have literature and training for how to address issues related to individuals of diverse backgrounds, rural areas, and those with complex mental health issues. In addition, a course in social justice was added to have additional training in ethical prescribing. During the prescribing psychology seminars, case discussions involving differential diagnoses will take place. All courses will be taught by experts in the field. For example, a pharmacist will teach pharmacology. An MD, DO, or ARNP will teach the courses in physical assessment, pathophysiology, and clinical medicine.

Comparison of Training Programs

Those critical of RxP training have voiced repeatedly that training should be equivalent to the training of one of the other prescribing professions (e.g., ARNP). To address this criticism, we have made extraordinary efforts to align the MSCP training at Antioch University with that of the training of Family Psychiatric Mental Health Nurse Practitioners (PMHNP) and with a Doctor of Nursing Practice (DNP) at Seattle University School of Nursing. The program at Seattle University was chosen as a guide and comparison since this program is highly regarded around the state and across the nation. Attached, you will find a brief overview of the MSCP program at Antioch University, Seattle, a detailed program comparison review, and graphic summary of findings (Appendix I, II, and III).

The comparison of training between these two programs indicates that future psychologists with prescriptive authority in Washington State who trained in the MSCP program at Antioch University, will have more years of overall training than PMHNPs with a Doctor of Nursing Practice (DNP) trained in the Seattle University Nursing program. The psychologists with prescriptive authority will have more years in training related to psychology, mental health, and

clinical intervention. This is a similar finding of other researchers (Muse & McGrath, 2010; Robiner, Tompkins, & Hathaway, 2019). On the other hand, PMHNPs with a DNP have more experience working with patients in medical settings given their initial training as Registered Nurses (RNs). The psychologists with prescriptive authority and PMHNPs with a DNP will have the same number of prerequisite basic science courses, credit hours of psychopharmacology, and hours of supervision in the practice of prescribing psychiatric medications. The PMHNPs will have more credit hours of physical assessment, pathophysiology, and pharmacology. This make sense since prescribing psychologists with prescriptive authority need training in these areas, but not as much as a fully independently practicing PMHNP with a much broader formulary for prescribing (McGrath, 2020).

Conclusion

Psychologists with prescriptive authority, and PMHNPs with a DNP (as well as master's level ARNPs), are extremely well-trained clinicians with more expertise than most of the clinicians working in the field of mental health. Given the escape of psychiatrists to fee-for-service private practice settings, and the decline of physicians going into psychiatry, there will be a greater gap of care in the future. These two fairly new professions will help to fill the gap left behind. In fact, collaboration between psychologists with prescriptive authority, and ARNPs in general, will create an extremely effective team. The training of psychologists with prescriptive authority is very similar to the PMHNPs with a DNP, which leads to no cause for alarm about safety. The risk of psychologists with prescriptive authority is further lowered since the collaboration with primary care provider is mandated. The thorough training, and this safeguard, will ensure safety as found in other states.

American Psychological Association (2019). *Model education and training program in psychopharmacology for prescriptive authority*. Washington, DC: Author. Retrieved from https://www.apa.org/about/policy/rxp-model-curriculum.pdf

Curtis, S.E., Hoffman, S.B., & Sloan, M.O. (2020). *Prescriptive authority for psychologists: The next step*. Manuscript submitted for publication.

Heiby, E. M. (2010). Concerns about substandard training for prescription privileges for psychologists. *Journal of Clinical Psychology*, *66*(1), 104-111. https://doi.org/doi:10.1002/jclp.20650

McGrath, R. E. (2010). Prescriptive authority for psychologists. *Annual Review of Clinical Psychology*, 6, 21-47. https://doi.org/10.1146/annurev-clinpsy-090209-151448

McGrath, R. E. (2020). What is the right amount of training? Response to Robiner et al. *Clinical Psychology: Science and Practice*, *27*(1), 1-3. https://doi.org/10.1111/cpsp.12315

Muse, M., & McGrath, R. E (2010). Training comparison among three professions prescribing psychoactive medications: Psychiatric nurse practitioners, physicians, and pharmacologically trained psychologists. *Journal of Clinical Psychology*, 66 (1), 96-103. https://doi.org/10.1002/jclp.20623

Robiner, W. N., Tompkins. L., & Hathaway, K. M. (2019). Prescriptive authority: Psychologists' abridged training relative to other professions' training. *Clinical Psychology: Science and Practice*, *27*(1), 1-19. https://doi.org/10.1111/cpsp.12309

Tompkins, T. L., & Johnson, J. D. (2016). What Oregon psychologists think and know about prescriptive authority: Divided views and data-driven change. *Journal of Applied Behavioral Research*, *21*(3), pp. 126-161. https://doi.org/10.1111/jabr.12044

2. **Safe Prescribing:** "The applicants have not provided sufficient evidence the proposed education is sufficient to ensure safe prescribing by psychologist" (p. 1).

   The postdoctoral master's program, per the application, would include, at minimum, 400 hours of intensive didactic education in the following areas: anatomy and physiology; biochemistry; neurosciences to include neuroanatomy, neuropathology, neurophysiology, neurochemistry and neuroimaging; pharmacology; psychopharmacology; clinical medicine and pathophysiology; health assessment, including relevant physical and laboratory assessment; diversity and lifespan factors, special populations; and case reviews that cover a broad range of clinical psychopathologies, complicating medical conditions presenting as psychiatric illness, diagnostic questions, choice of medications, management of untoward side effects from medications, compliance problems, and the alternative treatment approaches. Additionally, the clinical practicum supervised by the physician (as proposed in the application) will ensure the applicant for a prescription certificate has demonstrated competency in assessing a significantly ill medical population, assessing vital signs, observing the progression of illness and continuity of care of individual patients, laboratory assessment, as well as physical health assessment techniques.

   The safety of patients is ensured by the thorough training and supervision in the postdoctoral master's program, and through the required integrated care between the prescribing psychologist and the primary health care practitioner. The applicant has clarified several times that collaboration between a primary care provider and the prescribing psychologist will be a *required* component of practice. When prescribing drugs for a patient, the prescribing psychologist shall maintain ongoing communication with the primary health care practitioner who oversees the patient's general medical care. The purpose of the communication includes ensuring that necessary medical examinations are conducted, and determining whether a drug prescribed by the prescribing psychologist is not contraindicated for the patient's medical condition.

   It is surprising and concerning to the applicants that the absence of significant adverse events caused by inappropriate prescribing by psychologists is not considered evidence. Conversely, we strongly suspect if there were instances of harm caused by inappropriate prescribing by prescribing psychologists this would be considered evidence and would have appropriately been cited in this draft report. The Department of Health cannot have it both ways. Either significant adverse events caused by harmful prescribing is a marker of (lack of) safety and skill or it is not.

   To emphasize the level of safety demonstrated by the lack of significant adverse events caused by harmful prescribing, consider the following. Assume for a moment that at a minimum, the 200 prescribing psychologists in Louisiana and New Mexico prescribe or renew 10 prescriptions per day (the actual number is probably much higher). Then presume that they work 48 weeks out of 52. That would amount to 48,000 prescriptions per year. If we consider just the past 10 years, that would be almost half a million prescriptions **without** significant adverse events caused by harmful prescribing.

Additionally, there is a baseline of prescribing that can be used for comparison. According to the findings of the 2019 Medscape Psychiatrist Malpractice Report, forty-one percent of U.S. psychiatrists have been sued for malpractice at least once. (https://www.medscape.com/viewarticle/924388).

Additionally, objective data supporting the safety of prescribing psychologists can be found in the low rates of malpractice insurance payments prescribing psychologists make for the addition of prescription privileges. The average amount that these psychologists pay in addition to their non-prescribing malpractice coverage amounts to about $100 per year. Insurance companies do not favor particular specialties. Rather they use actuarial data to determine likely risk, which in the case of prescribing psychologists, appears to be exceptionally low.

Yes, psychopharmacologic drugs have significant potential for harm if prescribed inappropriately. And clearly the data, or lack of data, shows that prescribing psychologists manage that risk very well. Additionally, prescribing psychologists, like other prescribers of psychotropic medication, are trained to follow Clinical Practice Guidelines (CPG). Following CPGs and other expert recommendations are just one additional way in which prescribing psychologists have managed to maintain their excellent safety record.

3. **Increased Access:** "…nor that the proposal would increase access to behavioral health care as they assert" (pg. 1).

   The applicants are not clear how the Department of Health can assert that adding more prescribers trained specifically in the practice of psychopharmacology would not increase access. Increasing the number of prescribers has been a goal of the State of Washington, including the rationale behind HB 1593 passed in 2019. This bill creates a new teaching behavioral health hospital at the University of Washington in part to address the workforce shortage. Additionally the Washington State Behavioral Health Workforce Taskforce report issued in 2017 included the recommendation to "4.b. Graduate more behavioral health professionals licensed as prescribers" (https://www.wtb.wa.gov/wp-content/uploads/2019/05/WA-Behavioral-Health-Workforce-Assessment-2016-17.pdf). These are two of the latest examples of efforts by Washington State to improve access by increasing the number of prescribers in Washington State.

   Additionally, other states that permit prescribing psychology have reported increased access. For example, prescribing psychologists in New Mexico met with the Behavioral Health Subcommittee of the State of New Mexico Legislature in 2011. Documents from that meeting showed there were no complaints associated with the prescription certificate, and that New Mexico has added many new prescriptive providers to meet demand in rural and metropolitan areas (documentation provided with application).

4. **Defining Prescriptive Authority:** "The definition of prescriptive of authority is problematic because it does not include sufficient safeguards like physician or other prescriber collaboration" (pg. 1).

   In Appendix D of the draft report the Applicant Responses to follow-up questions on the applicant report can be found.

   > **The Department of Health asked this question:** "All of the states referenced in the applicant report that currently allow prescriptive authority for psychologists require some

level of supervision, consultation, and/or collaboration with a physician. Why did you not include this type of provision in your proposal?

Our response: "It is our intent to require collaboration between the prescribing psychologist and each patients' primary care provider (PCM) for all prescribing psychologists credentialed under this proposal."

We had intended to detail the collaboration with physicians in the WAC rather than the RCW. We accept that the Department of Health believes this is better addressed in the bill. Our language requiring collaboration with a primary care provider will be the same or similar as that used by New Mexico. New Mexico was used as an example by the Department of Health of a clear definition of collaboration. That definition follows:

"Maintenance of an ongoing collaborative relationship with the health care practitioner who oversees the patient's general medical care to ensure necessary examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition, and significant changes in the patient's medical or psychological condition are discussed."

Additionally, we intend to add language that states that a prescribing psychologist may not treat a patient who does not have an identifiable primary care provider on record.

5. **Inclusion of Legend Drugs:** "…and does not include non-controlled legend drugs that are used to treat mental health conditions" (pg. 1).

   The applicant appreciates the opportunity to clarify this misunderstanding. We intend to use the same language other states that have passed prescribing psychology legislation to identify the formulary of prescribing psychologists. The correct wording does of course include legend drugs, as this is one of the most important roles of a prescribing psychologist. The amended language is below and the added wording is in bold.

   "Prescriptive authority" means the authority to prescribe, administer, discontinue, and/ or distribute without charge **drugs or** controlled substances recognized in or customarily used in the diagnosis, treatment, and management of individuals with psychiatric, mental, cognitive, nervous, emotional, developmental, or behavioral disorders; this includes the authority to order necessary laboratory tests, diagnostic examinations, and procedures necessary to obtain such laboratory tests or diagnostic examinations; or other procedures directly related thereto within the scope of practice of psychology in accordance with rules and regulations adopted by the regulatory board."

6. **Regulatory Board Oversight:** The proposal does not address the need for new expertise on the psychology board to provide oversight of prescribing providers nor investigate complaints regarding prescribing

   The applicant agrees that the proposal does not adequately define changes needed to the regulatory board. The intent was to leave the specific members to be added to the Examining Board of Psychology.

   On page 16 of the Department of Health draft report, the Department of Health states, "The states that have enacted prescribing psychologist certifications have gone much further to ensure the regulatory body for psychologists has the necessary expertise to protect the public.

These include requiring the psychology board to consult with medical boards, establishing joint medical/psychology subcommittees to write rules and evaluate complaints, establishing an advisory committee to recommend action to the psychology board, and adding more members to the psychology board to include prescribing psychologists, psychiatric nurse practitioners and physicians."

WSPA will amend the bill based on the Department of Health draft report feedback to:

- Require the EBoP to consult with medical boards
- Establish joint medical/psychology subcommittees to write rule and evaluate complaints
- Establish an advisory committee to recommend action to the psychology board
- Add more members to the board to include prescribing psychologists and physicians. The applicants also believe that psychiatric nurse practitioners and pharmacists would add great value to the board.

Section 2: Responses to Specific Statements in the Department of Health Draft Report:

1. **Number of Psychiatrists and Other Psychiatric Providers in Washington:** The Department of Health draft report stated on page 3: "The evidence cited of a shortage of prescribers focuses mainly on psychiatrists…"

   The applicants acknowledge that psychiatric ARNPs and psychiatric Physician Assistants (PA) have made a very positive and meaningful contribution to improving psychiatric medication management in the state. More than any other professions, the psychiatric ARNPs and psychiatric PAs have made the greatest impact on the dearth of specialty psychiatric prescribers in Washington.

   The access problem for patients needing to be seen by a prescriber of psychiatric medication is acknowledged in the Department of Health draft report. This problem with access is well known within the state and is reflected in a statement in the draft report by the Office of the Insurance Commissioner on page 15 (emphasis added): "OIC noted that although the proposal would not create a new mandated benefit, **it could have significant benefits for consumers due to the low availability of psychiatrists**. Most clients currently get care through a psychologist and medications through a primary care provider."

2. **Psychologists Work in Rural Areas:** The Department of Health draft report referred to an opposition claim on page 13: "Psychologists do not work in rural or underserved areas, and there is no reason to think gaining prescriptive authority would cause them to move to those areas."

   Attached is a list of the number of psychologists and psychiatrists working in every county in Washington courtesy of Dr. Steven Curtis (Appendix IV). The resources used to obtain this data are listed. A review of the list will show that psychologists well outnumber psychiatrists in rural counties. Some counties do not have either a psychologist or psychiatrist. Data for psychiatric nurse practitioners and psychiatric PAs was not included in this document and would further clarify areas of need. Psychologists are already living and working in rural areas in Washington state, therefore, there is no reason to convince them to move to rural areas.

   However, focusing on the location of providers is much less meaningful given the advent and changes in the provision of telehealth services. With advent of more secure and easier to use

telehealth systems, prescribing psychologists and other providers can better project their services to underserved areas. The Washington State Healthcare Authority has a new program (https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/request-zoom-license-connect) to ensure that providers can provide confidential services. This will dramatically increase access to rural communities for many providers. Adding more specialized providers in the provision of psychopharmacological interventions will only increase our ability to serve the underserved.

3. **Insurance and Medicaid:** The Department of Health draft report referred to an opposition claim on page 13: "Opponents state psychologists are also some of the lowest insurance-accepting mental health therapists, and this legislation does nothing to guarantee they will accept Medicaid"

   The Washington State Psychological Association is working on solutions for Medicaid beyond just a prescribing psychologist credential. It is worth remembering that for decades PhD credentials were preempted by Medicaid from offering out-patient services, and that has dramatically impacted psychologists' familiarity with Medicaid. And as recently as 2004, when Mental Health Parity was passed there was strong resistance to services provided by PhD's included in Medicaid. Psychologists shouldn't be faulted for not participating in a program they have historically been excluded from using.

   WSPA has been actively working with other advocates and stakeholders to increase access for those on Medicaid and do our part to resolve the barriers to psychologists accepting Medicaid, including participating the in the on-going Rates and Workforce subcommittee of the Children and Youth Behavioral Health Subcommittee. The challenges with low reimbursement rates, a duplicative and laborious Medicaid credentialing system, plus Medicaid restrictions on services provided by psychologists have made it difficult for many providers to accept Medicaid. The applicant believes that the accessibility of Medicaid is a critical issue, but shouldn't have bearing on the determination of the safety of prescribing psychologists. We believe that prescribing psychologists is safe for all patients, regardless of whether the patient is on Medicaid, using commercial insurance, or in an ERISA regulated plan.

   According to an article by Kugelmass (2016), "About 30 percent [of psychologists] appear to accept no insurance at all, according to the American Psychological Association, a trade group for psychologists." We acknowledge the barriers to psychologists serving individuals on Medicaid; however, this has no bearing on the safety of the services offered by prescribing psychologists.

   Kugelmass, H. (2016). "Sorry, I'm Not Accepting New Patients": An Audit Study of Access to Mental Health Care, Journal of Health and Social Behavior, 57(2): 168-183

4. **How Many Psychologists are Likely to become Credentialed as Prescribing Psychologists:** The Department of Health draft report referred to an opposition claim on page 13 in which the opposition states, "Noting that there are psychologists who oppose this expansion of scope, the opponents suggest that fewer psychologists will choose to enter into prescribing than the applicant believes."

   While the actual number of psychologists who will pursue a prescribing psychology certificate in Washington is unknown to either the applicant or the opposition, the applicant can explain how we used data to make our predictions. First, we took the average of the percentage of

psychologists in Louisiana and New Mexico who chose to become prescribing psychologists. Respectively, 8.6% and 13.7% of licensed psychologists in New Mexico and Louisiana became prescribing psychologists. The average is 11%. The second piece of data is from a 2019 statewide survey of psychologists in Washington State showing that 53% of responders were "interested to very interested" in obtaining the prescribing credential. Factoring in the time commitment and cost, and looking at other states' experiences, we estimate that between 10-15% of Washington psychologists will complete the required education and training and apply to become prescribing psychologists. Other researchers in this field have come up with a similar number of expected providers as well (McGrath, 2010). This is also similar to the percentage of nurses who become prescribers (APRNs) in the State of Washington. According to the Nursing Education Programs Annual School Report of the Washington Department of Health (Department of Health, 2020), as of May 31, 2019, there were a total of 110, 488 nurses statewide. Of these, 8,649 of these nurses have become Advanced Registered Nurse Practitioners. This represents 7.8 % of nurses become prescribers.

Department of Health (2020). Nursing education programs annual school report. Nursing Care Quality Commission of the Washington Department of Health. https://www.Department of Health.wa.gov/Portals/1/Documents/6000/669269.pdfNew Mexico State Regulation and Licensing Department

http://www.rld.state.nm.us/boards/Look_Up_A_License.aspx

Louisiana State Board of Medical Examiners https://online.lasbme.org/#/verifylicense

Louisiana State Board of Examiners of Psychologists http://www.lsbep.org/

Shearer, D.S. (2019, April 26). WSPA endorses RxP: Results of a statewide survey. Washington State Psychological Association (WSPA) News. http://wapsych-news.org/rxp-2019survey-results/

5. **Percentage of Psychiatric Nurse Practitioners in Washington:** The Department of Health draft report referred to a statement by the neutral ARNP United on page 14: "The Nursing Care Quality Assurance Commission estimates 14 percent of nurse practitioners in Washington work in psychiatric, mental health, and substance abuse treatment settings. This information appears to contradict the statement in the applicant report that two percent of nurse practitioner students choose to specialize in psychiatry."

   The applicant accessed this data from the American Association of Nurse Practitioners (AANP) website. The number was rounded up to 2%. See link below or Appendix V https://storage.aanp.org/www/documents/NPFacts__080420.pdf

   The applicant is pleased that psychiatric ARNPs are far exceeding the national average in Washington State and contributing greatly to improving access to psychiatric care in our state.

6. **Lack of Differentiation Between Master's and Doctoral Level ARNPs:** The Department of Health draft report referred to a statement by the neutral ARNP United on page 14: "The applicants stated a qualified supervisor would include a doctoral level psychiatric nurse practitioner (DNP), however this would exclude many currently practicing psychiatric ARNP's because currently only 13 percent hold a DNP There is no differentiation between those with a

masters or doctoral degree, and a psychiatric ARNP would be a valuable addition to the board of psychology in the proposed bill."

The applicant appreciates the information regarding the lack of differentiation between ARNPs with a masters or doctoral degree and will amend the bill to reflect this information. We agree that a psychiatric ARNP would be a valuable addition to the board of psychology, as well as the academic faculty at Antioch University, and this is reflected in our language above addressing amendments to the board.

7. **Exclusion of Opioids:** The opposition states that the proposal does not appear to exclude opioids (p. 12).

   Psychologists in Washington State categorically do not seek the authority to prescribe opioid medications. The exclusion of the authority to prescribe any opioid medication is implicit in the definition of "prescriptive authority" in the bill. However, for the purpose of clarity, the applicants will make this explicit by amending the bill to state that prescribing psychologists do not prescribe opiate medications.

8. **Defining Psychiatric Medications:** Opponents claim that it is impossible to define what is and is not a psychiatric medication, and there is no easy way to carve out just "psychiatric" prescribing privileges (p. 13).

   Entire text books and reference materials are devoted to only discussing medication used for psychiatric purposes. As the Department of Health draft report points out, five states have in fact defined what is, and is not, psychiatric medication. These definitions have met the rigorous demands in the process of developing and passing legislation permitting prescribing psychology in these five states.

   For example, this is the language used in Iowa's bill:

   Iowa defines psychotropic medication as "a medicine that shall not be dispensed or administered without a prescription and that has been explicitly approved by the federal food and drug administration for the treatment of a mental disorder, as defined by the most recent version of the diagnostic and statistical manual of mental disorders published by the American psychiatric association or the most recent version of the international classification of diseases. 'Psychotropic medication' does not include narcotics" ("narcotics" includes opioids).

   WSPA will amend the bill to clarify the definition of what is and is not a psychiatric medication.

9. **Online Training:** Throughout the opposition comments, there are many statements regarding the inadequacy of online training. A number of the prescribing psychology training programs, with the notable exception of training required for Illinois, offer online programs or a combination of in person and online training. The Antioch University psychopharmacology post-doctoral master's degree program will offer a combination of in person and online training.

   A search of the internet reveals that there are many ARNP programs online (e.g., Best Online Nurse Practitioner Programs: https://www.affordablecollegesonline.org/degrees/nursing-programs/nurse-practitioner/); as well as PA programs online, The Best Online Physician Assistant Master's Programs of 2020: https://www.bestcolleges.com/features/top-online-physician-assistant-masters-programs/). Some of the schools offering this online education for PAs include Yale University, Stony Brook University, and University of Wisconsin-Madison.

Online training has made huge strides in quality as reflected by the major universities now offering many courses in this format. Additionally, keep in mind only psychologists who have completed a doctoral degree, or who are in the process of obtaining a doctorate in psychology, will be admitted to the master's degree in psychopharmacology program. At this point in their careers they have mastered the ability to study and do well in high level graduate courses. Having an online portion of training also helps psychologists living in rural areas have access to training. These are some of the psychologists we most hope will pursue prescribing psychology and bring their expertise to underserved populations throughout our state.

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Appendix I: Master of Science in Psychopharmacology (MSCP) – Antioch University, Seattle

Master of Science in Psychopharmacology (MSCP) – Antioch University, Seattle

Title	Credits
(all of Pre-year)	15
Physical Assessment	3
Introduction to Prescribing Psychology (RxP) I (1- credit for 3 quarters)	3
Pathophysiology/Laboratory Measures	3
Clinical Medicine/Systems of Care	3
Psychopharmacology I and II	6
Pharmacology	3
Advanced Neuroscience//Clinical Neurotherapeutics	3
Social Justice Practice	3
Fellowship/Capstone	3
Total of 45 hours of Didactic Instruction	**30 credits plus pre-year -= 45 credits**

	Summer	Fall	Winter	Spring
Pre-Year	Chemistry[1]	Anatomy[2]	Physiology[2]	Microbiology[2]
Year #1	Physical Assessment[3] Practicum (80 hours)	Pathophysiology/ Laboratory Tests[4] Intro to RxP I	Clinical Medicine/ Systems of Care Intro to RxP I	Psychopharmacology – I/ Intro to RxP I
Year #2	Pharmacology	Advanced Neuroscience/ Clinical Neurotherapeutics	Psychopharmacology II	Social Justice of RxP Practice
Year #3	Fellowship (500 hours face-to-face)	Fellowship	Fellowship	Capstone[5]

[2] These courses will be taken during undergraduate training, during doctoral training, or upon admission and prior to the start of pathophysiology course. We will refer students to take these courses through the John Hopkins School of Nursing Online Prerequisite Courses for Health Professions program (https://nursing.jhu.edu/academics/programs/prerequisites/). Courses are accepted nationwide.

[3] In order to start the coursework in pathophysiology, completion of the pre-year courses and completion of the physical assessment instruction/practicum experience is required. For the physical assessment course, students will be required to spend the hands-on portion of the course on the Antioch University, Seattle campus. All remaining courses will be taught through distance learning. Students also complete an 80-hour physical assessment practicum simultaneously.

[4] Physical assessment, pathophysiology, laboratory tests, clinical medicine, and systems of care will be taught by an MD, DO, or ARNP. Pharmacology will be taught by a PharmD. Neuroscience and clinical neurotherapeutics will be taught by a neuropsychologist. Psychopharmacology I & II will be taught by a psychiatrist, psychiatric ARNP, or prescribing psychologist. All other courses taught by the program director or Antioch University PsyD faculty.

[5] Pre-Year and Years #1 and #2 may be started during doctoral studies by students in APA approved doctoral programs in health service psychology. Year #3 can only be completed after licensure as a psychologist. Upon completion of year #3, students are able to take the national psychopharmacology exam (PEP).

Appendix II: Training Curriculum Comparison of APRN and Prescribing Psychology, September 2020

Training Curriculum Comparison of APRN and Prescribing Psychology, September 2020

Doctoral of Psychology in Clinical Psychology (PSYD)[6] Master of Science in Clinical Psychopharmacology (MSCP)[7] Antioch University, Seattle		**Advanced Practice Nursing Immersion (APNI) Family Psychiatric Nurse Practitioner (PMHNP) College of Nursing Seattle University**	
Sources of Information PsyD Program Website (link below) https://www.antioch.edu/seattle/wp-content/uploads/sites/5/2019/05/clinical-psyd-five-year-degree-plan-2020.pdf MSCP Program Information Sheet (Attached) Washington Administrative Code		**Sources of Information** APNI/PMHNP website (link below: https://www.seattleu.edu/nursing/dnp/apni/apni-first-year-program-of-study/ Washington Administrative Code	
Psy.D. Program in Clinical Psychology 140 quarter credits 3,000 supervised clinical hours Full Time Only All courses taught by PhDs	**Admission** Prefer Psychology B.A. or B.S. Prerequisite coursework: Introduction to Psychology Developmental Psychology Abnormal Psychology Statistics Admission test? Yes - GRE	**Admission** Any type of undergraduate degree Prerequisite coursework: Algebra Introduction to Psychology Anatomy and Physiology 1 & 2 with lab Microbiology with Lab Psychology Growth and Development Statistics Chemistry, 1 year high school chem or 1 quarter of college Admission test? No Accept on-line prerequisites? Yes	**Advanced Practice Nursing Immersion (APNI)** Pre-licensure Coursework for APNI Students – path to Registered Nurse (RN) 71 quarter credit hours 600 supervised clinical hours Full Time
	1st Year Psychometrics Foundational Clinical Skills Writing Seminar Psychopathology 1&2 Social Justice & Cultural Competency 1 &2 Individual differences & Personality 1 & 2 Intelligence Assessment Lifespan Development - Child Personality Assessment Integrated Assessment	**1st year (APNI program begins)** Pathophysiology Foundational Concepts and Skills Pharmacology for Nursing Care Nursing Care of Children Promoting Population Health Care of Childbearing Family Leadership and Management Promoting Mental Health Nursing Care during Altered Health in Adults Nursing Theory & Critical Inquiry Ethical Care for Social Justice Population Role Synthesis Epidemiology Population Based Health	Ready for NCLEX-**RN** Exam upon completion of 1st year
	2nd Year Assessment Lab Interventions 1, 2, &3 Research Methods 1, 2, 3, & 4	**2nd year (PMHNP training begins)** Pharmacology for Registered Nurses Ethical Care for Social Justice Foundations of Nursing Knowledge	**Family Psychiatric Mental Health Nurse Practitioner**

[6] (American Psychological Association (APA) approved)

[7] to begin Fall 2021 – (APA Designation Submission once 1st cohort begins)

	Professional Seminar Learning Theory Lifespan Development – Adult Cognition & Affect	Health Care System Economic and Financial Analysis Epidemiology Advanced Pathophysiology Population-Based Health Care Advanced Health Assessment Lab Advanced Health Assessment Theory Nursing Theory and Critical Inquiry Differential Diagnosis Health Care Policy Advanced Pharmacology Quality Improvement Process	**(PMHNP) Doctor of Nursing Practice** **127 quarter credits** **500 face-to-face patient hours of supervision** **500 related patient hours under supervision** **Full Time** **Courses taught by ARNPs, MDs, and DOs**
	3rd Year Social Psychology Biological Basis of Behavior 1&2 Professional Issues Writing Seminar History and Systems Dissertation Seminar Advanced Ethics Psychopharmacology Community Psychology Consultation and Supervision	**3rd Year** Neurobiology of Psychiatric Disorders Psychotherapy and Health Promotion Health Informatics Clinical Practicum, Psychiatric I Advanced Psychiatric Diagnosis and Management Program Design and Evaluation Critical Inquiry II Psychopharmacology Clinical Practicum II	
	4th Year Clinical Neuropsychology Integrated Behavioral Health Dissertation Seminar	4th Year Global Health Clinical Practicum, Psychiatric III Assessment and Management of Substance Disorders and Addictions Advanced Practice Nursing Roles and Functions Leadership in Health Systems Psychopharmacology – II Cognitive Behavioral Therapy DNP Project Internship I, 2, &3 Transition to Professional Practice DNP Project Presentation	Eligible for licensure as ARNP after obtaining speciality designation which requires passing of specialty test Completion of DNP
Eligible for licensure as psychologist at end of 5th year and after passing national exam (EPPP)	**5th year** Internship – Full Time All Year Dissertation completion and defense		
Master of Science in Clinical Pharmacology (MSCP) 45 quarter credits 80-hour physical assessment practicum 500-hour fellowship	**Admission** Licensed Health Service Psychologist or doctoral student in health service psychology program approved by the APA Pre-Requisites prior to starting advanced coursework: Chemistry – if needed Anatomy & Physiology – 1 & 2 with lab Microbiology with lab Note: this may be completed in undergraduate training, during doctoral training, or upon admission and prior to starting advanced coursework		
	1st year of MSCP (6th year of training) Physical Assessment and Practicum Pathophysiology Laboratory Tests		

	Intro to RxP 1, 2, &3 Clinical Medicine Systems of Care Psychopharmacology 1		
	2nd year of MSCP (7th year of training) Pharmacology Intro to RxP 4, 5, and 6 Advanced Neuroscience Clinical Neurotherapeutics Psychopharmacology 2 Social Justice RxP Practices		
Basic eligibility as prescribing psychologist after passing PEP. There may be additional supervision hours required depending on state law.	**3rd year of MSCP (8th year of training)** Fellowship – 500 hours of prescribing to 100 patients of diverse backgrounds and issues		

Appendix III: Summary of Training Curriculum Comparison of APRN and Prescribing Psychology, September 2020

Summary of Training Comparison

	PsyD/MSCP	MHNP/DNP	Comparison
Years of Training	8 years	4 years	PsyD/MSCP spend 4 to 5 additional years in training
Total Quarter Credits	185	198	Similar credit hours
Supervision Hours Total	3000 – PsyD 580 – MSCP Total = 3580	600 1st year to RN 1000 to doctorate Total = 1600	PsyD/MSCP have far more supervision hours with direct patient/client contact
Supervision Hours Prescribing	500 – face-to-face	500 face-to-face 500 indirect	Essentially the Same
Science Prerequisites	15 quarter credits To be completed prior to advanced coursework	15 quarter credits To be completed upon admission	The Same Both require Anatomy/Physiology (2 courses with lab) and Microbiology with lab prior
Physical Assessment	3 quarter credits	4 quarter credits	PMHNP/DNP has more
Pathophysiology/Clinical Medicine	6 quarter credits	9 quarter credits	PMHNP/DNP has more
Differential Diagnoses	3 quarter credits	3 quarter credits	Same
Pharmacology	5 credit hours	10 quarter credits	PMHNP has 5 more hours of pharmacology
Neuroscience	3 quarter credits	3 quarter credits	Same
Psychopharmacology	6 quarter credits	6 quarter credits	Same
Advanced Science courses taught by MD, ARNP, DO, or Pharm D	100%	100%	The Same

Appendix IV: Psychologists and Psychiatrists in Washington by County

Psychologists and Psychiatrists in Washington by County

(For questions or comments contact Dr. Steven Curtis at scurtis@antioch.edu)

Data Sources:

1) Our gathering of licensed active psychiatrists in Washington State by City, County, and Behavioral Health: Administrative Services Organizations (BH-ASO)- current 4/20/2020
2) Licensed Psychologists data - 10/25/2019
3) US Census Bureau - Quick facts - 7/1/2019
4) Psychiatric ARNP Data -Washington State's Behavioral Workforce -10/2017 - by Service district and rate per 100,000
5) National ARNP website
6) Washington State's Physician Workforce in 2016- Center for Health and Workforce Studies - University of Washington

	Number State-Wide	Rate per 100000	Percent Urban[1]	Percent King County	# of Counties not Served
ARNP	530	7.4	40	DK	DK
Psychiatrists	881	11.57	80	66	17/39 = 43%
Psychologists	2584	33.9	75	49	8/39 = 20%

Counties not served by psychiatrists include the following: Adams, Asotin, Columbia, Douglas, Ferry, Franklin, Garfield, Kittitas, Klickitat, Lincoln, Okanogan, Pacific, Pend Orielle, Skamania, Stevens, Wahkiakum, and Whitman.

Counties not served by psychologists include the following: Asotin, Columbia, Garfield, Adams, Ferry, Lincoln, Pend Orielle, and Wahkiakum

In Douglas (4), Franklin {3), Kittitas {13), Okanogan (7), Pacific (2), Stevens (4), and Whitman (33) we have a total of 66 psychologists who work in the counties not served by psychiatrists. This represents a total of 347,023 people with increased services across these counties.

[1] Note - Urban is King County, Pierce County, and North Sound - others have more stricter definition of Urban.

Number of Psychiatrists and Psychologists by County

County	Psychiatrists	Psychologists	Population
Adams	0	0	19,983
Asotin	0	0	22,582
Benton	10	27	204,390
Chelan	6	16	77,200
Clallam	5	10	77,331
Clark	25	105	488,241
Columbia	0	0	3,985
Cowlitz	6	7	110,593
Douglas	0	4	43,429
Ferry	0	0	7,627
Franklin	0	3	95,222
Garfield	0	0	2,225
Grant	1	1	43,429
Grays Harbor	1	6	75,061
Island	5	22	85,141
Jefferson	3	21	32,221
King	589	1,269	2,252,782
Kitsap	12	65	271,473
Kittitas	0	13	47,935
Klickitat	0	3	22,425
Lewis	4	3	80,707
Lincoln	0	0	10,939
Mason	1	4	66,768
Okanogan	0	7	42,243
Pacific	0	2	22,471
Pend Oreille	0	0	13,724
Pierce	62	333	904,980
San Juan	1	7	17,582
Skagit	3	17	129,205
Skamania	0	6	12,083
Snohomish	29	176	822,083
Spokane	61	171	522,798
Stevens	0	4	45,723
Thurston	24	121	290,536
Wahkiakum	0	0	4,488
Walla Walla	2	15	60,760
Whatcom	17	89	229,247
Whitman	0	33	50,104
Yakima	14	34	250,873
Total	881	2,594	6,635,626

Appendix V: American Association of Nurse Practitioners: NP Facts

AANP | American Association of NURSE PRACTITIONERS®

NP Facts

The Voice of the Nurse Practitioner®

There are more than 290,000 nurse practitioners (NPs) licensed in the U.S. [1]

- More than 30,000 new NPs completed their academic programs in 2018–2019.[2]
- 89.7% of NPs are certified in an area of primary care, and 69.0% of all NPs deliver primary care.[3]
- 82.9% of full-time NPs are accepting Medicare patients and 80.2% are accepting Medicaid patients.[4]
- 41.7% of full-time NPs hold hospital privileges; 11.7% have long-term care privileges.[4]
- 95.7% of NPs prescribe medications, and those in full-time practice write an average of 20 prescriptions per day.[4]
- NPs hold prescriptive privileges, including controlled substances, in all 50 states and D.C.
- In 2019, the median base salary for full-time NPs was $110,000.[3]
- The majority of NPs (57.4%) see three or more patients per hour.[4]
- Malpractice rates remain low; only 1.1% have been named as primary defendant in a malpractice case.[4]
- NPs have been in practice an average of 10 years.[3]
- The average age of NPs is 47 years.[3]

Distribution by NP Certification [3]

Certification*	Percent of NPs
Family^	65.4
Adult^	12.6
Adult–Gerontology Primary Care^	7.8
Acute Care	5.5
Pediatrics–Primary Care^	3.7
Adult–Gerontology Acute Care	3.4
Women's Health^	2.8
Psychiatric/Mental Health–Family	1.8

Gerontology^	1.7
Hospice and Palliative Care	1.5

** NPs may be certified in more than one area*

^ Primary Care Focus

Updated August 2020

[1] AANP National Nurse Practitioner Database, 2020.

[2] American Association of Colleges of Nursing (AACN). (2020). *2019-2020 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington DC: AACN.

[3] 2019 AANP National Workforce Survey.

[4] 2018 AANP National Nurse Practitioner Sample Survey.

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