April 4, 2017

Oregon State Legislature
HOUSE HEALTH CARE COMMITTEE
Re: Psychologist who OPPOSES HB 3355 authorizing psychologists to prescribe medication

Chair Greenlick and honorable members of the committee. My name is Tanya Tompkins. I am a resident of McMinnville, Oregon. I am here today to testify in opposition to HB 3355. I am a clinical psychologist by training. I hold a Ph.D. in clinical psychology with a minor in measurement and psychometrics from UCLA. I trained at the Resnick Neuropsychiatric Hospital at UCLA. I have been a Professor of Psychology at Linfield College since 2002. I recently conducted a study of Oregon psychologists to try to understand what they knew and thought about the issue of prescriptive authority. Our results were published in a peer-reviewed journal this past fall.

I am an educator and I am one of a large number of psychology professionals who have serious concerns about this kind of legislation as it has advanced in a handful of states around the country. As a board member of Psychologists Opposed to Prescription Privileges for Psychologists (POPPP), I have also submitted separate testimony on behalf of POPPP.

As a community preventionist who spearheaded efforts to adopt and evaluate suicide prevention gatekeeper training in our local community (and 6 colleges/universities around the state) I share the concerns of the proponents of this legislation about the importance of increasing access to mental health services to rural parts of the state.

But as a researcher and educator, I have serious questions about whether this legislation addresses rural access in a way that is safe and cost-effective.

This legislation is substantially similar to legislation that was vetoed by Governor Kulongoski in 2010. It contains none of the recommendations that were proposed by the Late Senator, Dr. Alan Bates, which would have addressed all of the substantive concerns that I (and hundreds of other psychologists) have about this legislation. It is very disappointing that instead of addressing legitimate concerns that reflect a broad division within the psychology community, proponents have instead chosen to propose a bill that addresses none of the major concerns about the legislation.

Although my testimony will focus on two main concerns – the risk that this legislation proposes to consumers and its failure to address rural access to mental health care – I first wanted to point out a structural flaw in the composition of the oversight committee whose decision-making will ultimately determine the degree to which concerns about competency and safety may be minimized or amplified (formulary, residency programs, standards/exams/continuing education, etc.).

These important decisions, the outcomes of which will be largely unknown until after the legislation is signed into law, will be made based on majority rule and the committee is imbalanced, 4-3, in favor of psychologists. No other state has taken a similar approach, and it is unacceptable given the public health implications of this policy.

With that, I'd like to tackle the two main concerns that I have about the bill:

1. This legislation has far lower standards of preparation and training for psychologists than for other non-medical prescribers and poses a risk to consumers.
2. There is no evidence to support arguments that expanding prescriptive authority to psychologists will expand access to mental health services in rural communities based on where most prescribing psychologists reside and practice.

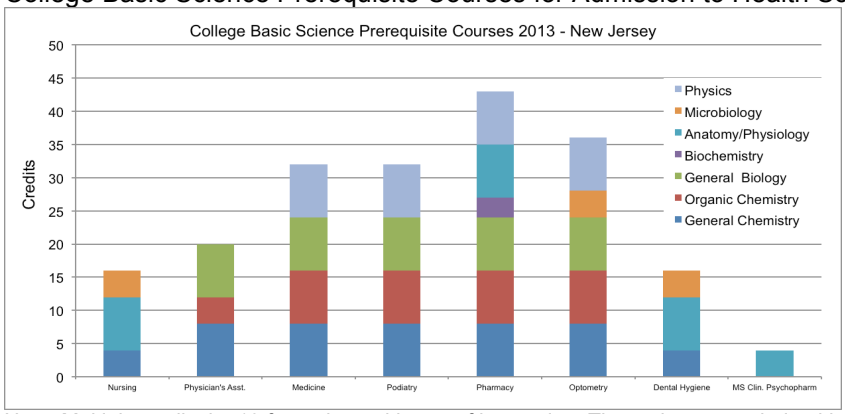
CONCERN #1: Unnecessary Risk to the Consumer

Psychologists' training in the biopsychosocial basis of behavior does not provide an adequate foundation for the practice of medicine. Earning a doctorate in clinical psychology does not require taking a single biology class (see Figure 1 from Robiner et al., 2013 - psychologists are not prepared with even the most basic science courses prior to entering graduate school).

Despite the fact that the original APA Task Force (1992), argued that "retraining of practicing psychologists for prescription privileges would need to carefully consider selection criteria, focusing on those psychologists with the necessary science background," (p. 66), **entry into the MS psychopharmacology programs requires NO prerequisites in science, nor does the current bill select for individuals with a strong grounding or foundation in science.** Although the proposed two-year residency training appears to be more rigorous than in other states (and prior bills proposed in Oregon) there are no stipulations about the number of hours of patient care to be required. Is this a full-time two-year residency requirement? Part-time? Would an afternoon, once per week for two years be deemed sufficient to meet the requirement?

This bill would allow psychologists with far less preparatory training and background in practicing medicine than any other non-physician prescribers (i.e., nurse practitioners, physician assistants) who have taken the equivalent of 7 distance education 4-credit courses (graded credit/no credit) from a non-medical school out of the state to prescribe medication. These "designated" programs are not accredited. Designation is a less stringent process than accreditation. It should be noted that the programs do not meet the APA's standards for the accreditation of postdoctoral fellowships or residencies (and are not accredited like other prescribers' clinical training requirements). Oregon consumers deserve safe and high quality care, not that provided by minimally qualified practitioners.

Figure 1
College Basic Science Prerequisite Courses for Admission to Health Science Programs



Note: Multiply credits by 10 for estimated hours of instruction. These data were derived by 2013 survey of admission requirements to the largest programs in New Jersey (e.g., Farleigh Dickinson University, University of Medicine and Dentistry of New Jersey, Rutgers University). Although there were no physical or health sciences prerequisites for entry into the Ph.D. programs in Clinical Psychology, both the FDU and Rutgers curriculum included one course in biopsychology or behavioral neuroscience.

- The vast majority of psychologists, in Oregon and across the U.S., argue that medical training for psychologists to prescribe **should be equivalent to other non-physician prescribers** (Baird, 2007; Deacon, 2014; Tompkins & Johnson, 2016).
- Deacon's (2014) survey found only 5.8% of psychologists 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 (or errors are caught by supervising physicians). A lack of evaluation of safety, and the absence of any credible, comprehensive system to identify problems, does not constitute evidence for safety.
- Recent data from the Part D Prescriber Public Use File (PUF) from the Centers for Medicare and Medicaid Service (CMS) suggests that some medical psychologists from Louisiana and prescribing psychologists from New Mexico have been prescribing beyond the legislative bounds of their licenses. For example, not only have they been prescribing powerful psychotropic medications (e.g., antipsychotics), but also anti-Parkinsonian agents like benztropine mesylate, likely to help control extrapyramidal disorders associated with anti-psychotic use. In addition, prescribing psychologists used several classes of drugs used to treat medical problems (e.g., Hytrin – anti-hypertensive, Plavix – anti-coagulant, Zenaflex – muscle relaxant) that reflect prescribing practices well beyond their competence of training (and in some cases the statutory limits of the prescribing license). Given that these data are only available for two years (2013, 2014) and only include prescriptions provided to approximately 70% of all Medicare beneficiaries it is unclear to what degree these instances of inappropriate prescribing may reflect more widespread problems with prescribing psychologists prescribing outside their bounds of competence. Recent disciplinary action in Louisiana (see attached) suggests some prescribers' inappropriate prescribing practices are being detected. Lawsuits filed in Louisiana suggest that patients of medical psychologists have suffered serious harm at the hands of these prescribers (e.g., life-threatening reaction to fibromyalgia drug Savella; acute myocardial infarction stemming from Pristiq and Ritalin when it was not safe or medically advisable to prescribe; overdose of Tenex in a 4-year-old with prior history of myoclonic seizures which required hospitalization and worsened his seizure disorder).
- The impact of prescribing privileges in New Mexico and Louisiana should be objectively evaluated for consumer safety before any experiment in psychologist prescribing is allowed in Oregon.
- Research touting evidence of "safety" and "competence" are limited in their extremely small samples that are also prone to response bias (Levine et al., 2011 – n = 17 which was less than 30% of all prescribing psychologists; Linda & McGrath, 2017 – n = 24 which was less than 15% of all prescribing psychologist) and their reliance on self-reported behaviors (rather than actual prescribing practices). Shearer et al. (2012) surveyed 47 primary care prescribers and residents about their views of prescribing psychologists and concluded that his research provided evidence that prescribing psychologists "practice safely and effectively" (p. 428), the study participants were reporting about their experience with ONE prescribing psychologist (who was also the lead author of the study) in a primary care setting in the Army.
- The limits of self-report are underscored by a study that demonstrated while 9 errors were self-reported using the institutional incident reporting process in 31 psychiatric inpatients, an independent multidisciplinary review team found 2,194 errors (19% low risk of harm, 23%

moderate risk of harm, 58% high risk of harm) for the same 31 patients and episodes of care. It would be generous to suggest there is **any evidence** supporting competency and safety of prescribing psychologists and recent court cases and CMS data suggest serious cause for concern.

The State of Illinois has set a new and more appropriate standard for prescription privileges for psychologists

- In 2014, the State of Illinois enacted a law to permit psychologists to prescribe some psychotropic medications (e.g., excluding narcotics and benzodiazepines) to a limited population (excluding youth, the elderly, pregnant women, the physically ill, and those with developmental disabilities).
- The training requirement is similar to what is required of Physician Assistants, including completing undergraduate pre-medical science training before studying post-degree psychopharmacology. This training includes 7 undergraduate and 20 graduate courses along with a 14-month practicum in multiple medical rotations. The training program must be accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).
- No online medical training is acceptable.
- The Illinois Psychological Association, Nursing and Medical associations, and POPPP support the Illinois law, as it requires, at minimum, the same medical training as other non-physician prescribers. This is more appropriate than the APA model in that it meets an existing standard for healthcare providers, rather than establishing a new lower standard.

CONCERN #2: We need MEANINGFUL Solutions to Address Access Issues

Proponents vastly overstate the number of prescribing psychologists. Currently there are no prescribing psychologists in Illinois, Iowa or Guam, so claims about safety and access based on those states are false. Peer-reviewed research (Campbell et al., 2006; Tompkins & Johnson, 2016) seriously calls into questions claims about improving access in the remaining states. There is no evidence to suggest that prescribing and medical psychologists in New Mexico and Louisiana have significantly addressed rural access issues with less than 7% of prescribers practicing in non-metro areas across both states (see Tables from Tompkins & Johnson, 2016).

Distribution of psychologists authorized to prescribe medications in Louisiana

Rural continuum codes	Louisiana	Percentage	Populace	Percentage
1 = County in metro area with 1 million population or more	6	9.7%	1,316,510	29.5%
2 = County in metro area of 250,000 to 1 million	24	38.7%	1,081,938	24.2%
3 = County in metro area with fewer than 250,000	20	32.3%	942,219	21.1%
4 = Non-metro county with 20,000 or more, adjacent to metro area	2	3.2%	522,762	11.7%
5 = Non-metro county with 20,000 or more, not adjacent to metro area	0	0%	0	0%
6 = Non-metro county with population 2,500–19,999, adjacent to metro area	1	1.6%	483,625	10.8%
7 = Non-metro county with population 2,500–19,999, not adjacent to metro area	0	0%	81,510	1.8%
8 = Non-metro county completely rural or less than 2,500, adjacent to metro area	0	0%	10,560	0.2%
9 = Non-metro county completely rural or less than 2,500, not adjacent to metro area	0	0%	29,852	0.7%
Out of state*	9**	14.5%		
Total	62		4,468,976	

*Out of state means they are licensed in Louisiana but are no longer practicing in the state.
**One medical psychologist in Louisiana is "out of state" but also licensed as a prescriber in New Mexico; this psychologists' information regarding practice can be found in the New Mexico data; thus, there are actually 61 medical psychologists licensed in Louisiana.

Distribution of psychologists authorized to prescribe medications in New Mexico

Rural continuum codes	New Mexico	Percentage	Populace	Percentage
1 = County in metro area with 1 million population or more	0	0%	0	0%
2 = County in metro area of 250,000 to 1 million	9	37.5%	729,649	40.2%
3 = County in metro area with fewer than 250,000	5	20.8%	417,775	23.0%
4 = Non-metro county with 20,000 or more, adjacent to metro area	0	0%	137,096	7.6%
5 = Non-metro county with 20,000 or more, not adjacent to metro area	2	8.3%	213,595	11.8%
6 = Non-metro county with population 2,500–19,999, adjacent to metro area	0	0%	171,618	9.5%
7 = Non-metro county with population 2,500–19,999, not adjacent to metro area	2	8.3%	133,366	7.4%
8 = Non-metro county completely rural or less than 2,500, adjacent to metro area	0	0%	5,180	0.3%
9 = Non-metro county completely rural or less than 2,500, not adjacent to metro area	1	4.2%	3,543	0.2%
Out of state*	5	20.8%		
Total	24**		1,814,872	

*Out of state means they are licensed in New Mexico but are no longer practicing in the state.
**Two New Mexico psychologists have two practices in different areas (one in 2 and 3; the other in 7 and 9); thus the actual number of New Mexico psychologists is actually 22.
Combined Distribution of Psychologists Authorized to Prescribe Medications in New Mexico, Louisiana, and Guam
*Note: There are no prescribing psychologists practicing in Guam despite legislation being passed granting prescriptive authority to psychologists in 1999.

A representative sample of nearly 400 Oregon psychologists revealed that 96% were practicing in metro areas. Of the limited number (< 7%) who expressed interest in pursuing training and becoming a prescribers, the vast majority were currently practicing in metro areas. As you can see from the attached distribution maps, psychologists, psychiatrists and family physicians tend to be clustered around the same regions. Without an incentive to serve rural areas, passing HB 3355 will not likely increase access to these populations.

Table 3

Participant and General Population Information According to Oregon Rural-Urban Continuum Codes

	Sample		Populace	
Code and description	*n*	%	*n*	%
1. County in metro area with 1 million population or more	253	63.89	1,789,580	46.71
2. County in metro area of 250,000 to 1 million	80	20.20	742,453	19.38
3. County in metro area with fewer than 250,000	43	10.86	645,903	16.86
4. Non-metro with urban population of 20,000 or more, adjacent to metro area	4	1.01	220,595	5.76
5. Non-metro with urban population of 20,000 or more; not adjacent to metro area	2	0.51	175,457	4.58
6. Non-metro with urban population of 2,500 to 19,999, adjacent to metro area	6	1.52	157,993	4.12
7. Non-metro with urban population of 2,500 to 19,999, not adjacent to metro area	3	0.76	79,563	2.08
8. Non-metro with completely rural or less than 2,500 urban population; adjacent to a metro area	0	0	0	0
9. Non-metro with completely rural or less than 2,500 urban population; not adjacent to a metro area	0	0	19,530	0.51

<u>There are many alternatives to psychologists prescribing that more appropriately enhance access to the prescription of psychoactive medications in those individuals who would benefit from them.</u>

This radical expansion of scope of practice has not stemmed from a careful community mapping of consumer access to medication management. Access problems are indeed serious and warrant changes, but so are clear patterns of overprescribing. Adding marginally trained psychologists to the workforce is not an appropriate or effective response.

More sensible is increasing access to psychotherapy, which psychologists are highly qualified to provide, to underserved populations. In fact, a disconcerting pattern of increasing medication use at the expense of psychotherapy utilization has occurred over the past two decades despite a growing body of literature justifying the use of psychosocial interventions as first-line treatments and a clear consumer preference for psychotherapy. There is no evidence to suggest the prescribing psychologists won't succumb to the same pressures to prescribe, rather than provide evidence-based psychotherapies given that it is more lucrative to do so. In fact, Linda & McGrath (2017) found that among prescribers surveyed in New Mexico and Louisiana, nearly 2/3 reported increased income. Instead of looking to short-cut training models to increase the number of prescribers we should be working to address systemic factors that limit access to effective non-pharmacological treatments, while at the same time strengthening innovative and collaborative models of care that ensure those who need medication have access to quality care.

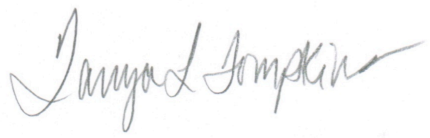
1. Collaboration between psychologists and physicians, building on the unique skills that psychologists bring to the setting (i.e., screening tools that inform stepped care models that use

low-cost, low resource-intensive programs as first-line interventions, when warranted, while conserving in-person services for those most in need of either individual psychotherapy and/or medications).

2. Completion of medical or nurse practitioner or physician assistant education by psychologists. Encouraging medical and nursing schools to offer executive track programs for psychologists.
3. Use of tele-psychiatry, which is promoted by the Department of Veterans Affairs, the military, and the U.S. Bureau of Prisons, and rural health centers, is an effective means of transcending distance between psychiatrists and patients. It is a mechanism for providing direct patient care by psychiatrists as well as a technology for providing primary care providers with appropriate consultation to develop appropriate treatment regimens, thereby extending the reach and impact of psychiatrists. There is evidence of efficacy of the OPAL-K program here in Oregon.
4. Encouraging all professionals to serve rural areas. The prescribing laws in New Mexico and Louisiana did not result in psychologists moving their practices to rural areas as they had declared would happen (see above tables from Tompkins & Johnson, 2016; used with permission).
5. Expanding mental health training to prescribers (expanding project ECHO).

Thank you for your kind consideration of this opinion.

Respectfully,



Tanya L. Tompkins, Ph.D.
Professor of Psychology
Linfield College