June 14, 2017

To: Sen. Rod Monroe, Co-Chair
Rep. Barbara Smith Warner, Co-Chair
Members of the Joint Ways and Means Committee on Education

From: Tanya Tompkins, Ph. D.
RE: Psychologist who OPPOSES HB 3355 authorizing psychologists to prescribe medication

My name is Tanya Tompkins. I am a resident of McMinnville, Oregon. I am here today to testify in opposition to HB 3355. 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.

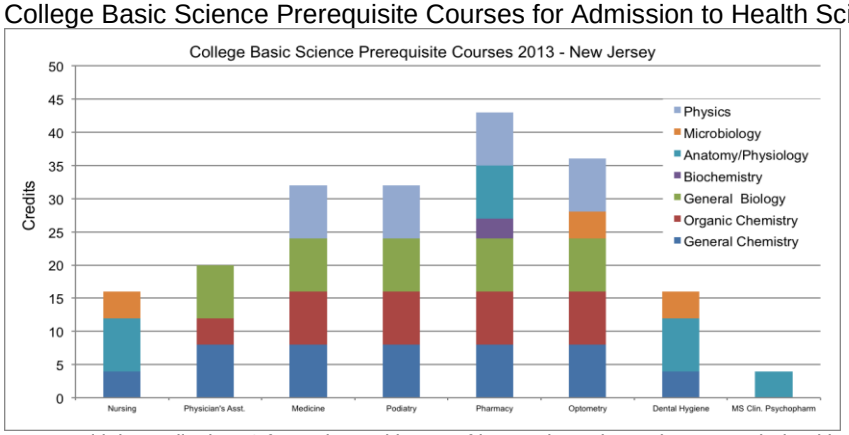
But as a researcher and educator, I have serious questions about whether this legislation addresses rural access in a way that is safe and cost-effective.

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 advance a bill that addresses none of the major concerns about the legislation.

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).

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.

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.

As an educator, I view someone who assumes, that with absolutely no background in the physical sciences, they can pursue advanced training in clinical psychopharmacology (that relies on distance education, open-book exams, limited material tailored to what is stipulated by law, and a final 150 question multiple choice exam whose "pass" rate fluctuates – but averages 70%) as adequately preparing them for clinical training as ethically suspect for not fully appreciating their bounds of competence. Oregon consumers deserve safe and high quality care, not that provided by minimally qualified practitioners.

- 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. The current bill provides NO provision for systematic evaluation of improved access, safety or competence. In fact, one proposed revision (HB 3355-A11) seems to weaken language (i.e., board "may" vs. "shall" report and seek consultation from the committee) surrounding the committee's oversight role. The practice of medicine should be overseen by the Oregon Medical Board, not a psychology board with no training or experience in prescribing.
- 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 **<u>any</u> 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

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*

| Code and description | Sample | | Populace | |
|---|---|---|---|---|
| | *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). Proponents suggest that we have a "critical shortage of well-trained professionals who can diagnose and effectively treat mental illness". The Health Resources and Services Administration designates any area with less than one psychiatrist per 30,000 people a mental-health-professional shortage area, so proponents are correct that 48% of the population of Oregon currently reside in a shortage area. However, if passing legislation to allow psychologists to prescribe addressed these shortages we would predict lower rates in both New Mexico (where legislation passed in 2002) and Louisiana (where legislation passed in 2004). While the shortage rates are lower in NM than Oregon (30% vs. 48%) there have consistently been fewer prescribing psychologists in NM relative to Louisiana (2 to 3 times as few). Thus, we would expect even lower shortage rates in Louisiana. These expectations don't match the facts, the shortage rates are double (60%) in Louisiana (and higher than in Oregon) despite having over 100 medical psychologists prescribing in the state. This begs the question of what the problem is and whether introducing a lesser-trained class of prescribers will help or hinder the problem. When one looks at the low numbers of psychologists interested in pursuing RxP from my survey in Oregon, the current distribution rates of physicians, psychiatrists, and psychologists in our state, as well as where prescribing psychologists in NM and Louisiana are practicing one has to realistically concede that this will not address access issues.
5. Expanding mental health training to prescribers (expanding project ECHO).

Thank you for your kind consideration of this opinion.

Respectfully,

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