Responses to Issues at the Public Hearing
Criteria 1-6

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Dear Members of the Psychology Prescribing Technical Review Committee:

Criteria 4-6

Would prescribing psychologists have enough training in psychopharmacology to prescribe as effectively as primary care physicians, PAs, or APRNs?

The application provided evidence of effective and safe prescribing for prescribing and medical psychologists that spans over twenty years. One part of the evidence comes from Dr. Donald Fineberg, New Mexico psychiatrist, who was appointed in 2002 by the then governor of the state to oversee the credentialing of prescribing psychologists. The following quote from Dr. Fineberg succinctly addresses the above question, and was already provided to the technical review committee via a recorded interview with Dr. Fineberg.

“You know to the skeptics I would say let’s look at our experience in New Mexico. In New Mexico since people started prescribing and those people being psychologists started prescribing, there have been no difficulties in terms of complaints of unsafe practices. I’m on the board; I can tell you there have been none. I’m not saying there have been one or two but we’ve taken care of it, or it’s been a minority, or it’s not been much of a problem. I’m not saying any of that. I’m saying none. I’m saying none as in zero. So to those critics I would say listen, I understand theoretically what your concerns might be but actually that’s not a problem.” Dr. Donald Fineberg, MD, psychiatrist, Santa Fe, New Mexico, May 7, 2016

Other data provided in the application also addresses the adequacy of the training, and also helps explain the stellar safety record, as described by Dr. Fineberg. Specifically, the postdoctoral
training programs for psychologists seeking prescriptive authority provide many more hours in pharmacology in contrast to institutions that train physicians or psychiatric nurse practitioners, based on a survey of the curriculum in major academic institutions (see page 29 of application and Appendix J). Appendix J provides a table comparing the entry-level training models for psychiatric nurse practitioners, physicians, and prescribing psychologists. This table contrasts training for the three professions in content areas that include biochemistry-neuroscience, pharmacology, clinical practicum, behavioral assessment/diagnosis & psychometrics, and psychosocial interventions. Data on graduate contact hours were obtained from institutions that include the Mayo College of Medicine, Yale University, Stanford University, and Vanderbilt University. The full article comparing the graduate training of the three professions can be found using the following link:  http://rxpsychology.fdu.edu/Resources/MuseMcGrath2010.pdf

In the area of pharmacology, the prescribing psychologists had an average of 288 hours of training, compared with 59 hours for physicians and 56 for psychiatric nurse practitioners.

In the area of behavioral assessment/diagnosis and psychometrics, the prescribing psychologists averaged 267 hours, compared with 9 hours for physicians, and 32 hours for psychiatric nurse practitioners.

To those who argue that psychiatry residents receive more training, it is important to note that the majority of psychotropic medications are prescribed by physicians in other specialties such as family medicine. The above comparison fits with psychotropic prescribing as it is done today, not some idealized notion of how it would look if all patients who received psychiatric medications were prescribed their medications by psychiatrists.

Dr. Donald Fineberg, after twelve years of experience in the regulation of prescribing psychologists in New Mexico, also made the following remark relevant to Criteria 4-6.

“You know at first, to be honest, as a physician and a psychiatrist I also had my doubts as to how such a program might be organized, but when I saw the curriculum and I saw how thorough it was, I saw how many bases it covered, and I saw the level and quality of the psychologists who became interested in the program, my fears were relieved and I became a part of it. So that when the time came to actually put the law into effect one of the requirements of the board that oversaw giving out the licenses for prescriptive authority to psychologists was that there be a physician member, and I was asked by the governor to be that physician. So I’ve had the chance to oversee the process both in terms of the training and as a clinician where I spend 95% of my time, and finally as a volunteer on the state board.” Dr. Donald Fineberg, MD, psychiatrist, Santa Fe, New Mexico, May 7, 2016

https://www.youtube.com/watch?v=6y9JmP-QxYQ&feature=youtu.be

Dr. Robert Julien, M.D., Ph.D. authored 11 editions of a widely used textbook in psychopharmacology (A primer of Drug Action). Dr. Julien is arguably one of the most respected experts in psychopharmacology. Please note the following excerpt from Dr. Julien’s letter to an
Oregon newspaper regarding credentialing qualified psychologists in Oregon to prescribe psychotropic medications.

“Clinical psychologists, based on their Doctoral training, are uniquely trained in assessment and diagnosis of mental health disorders 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, a 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.

http://www.nebpsych.org/resources/Documents/Robert%20Julien%20MD%20PhD%20RxP%20Ltr%2070731.pdf

Dr. Randall Tackett, a pharmacologist and toxicologist familiar with the training of prescribing psychologists, provided his expert opinion on the adequacy of RxP training (see Appendix N of the application). The following is an excerpt from Dr. Tackett’s opinion on the adequacy of the training of prescribing psychologist.

“I have over 34 years experience of teaching healthcare professionals either as students or in continuing education programs. The integration and specialization of the curriculum is unrivaled in my opinion. After teaching and interacting with several of the students after they have graduated, I feel that the students are well trained and they communicate and integrate well with other healthcare professionals. In fact, when teaching the Clinical Medicine and Clinical Pharmacology courses, the students are taught at the same level as I have taught medical students and pharmacy students. They have a limited formulary and are extremely well trained in pharmacology of the drugs on that formulary. The communication skills they bring to the table when combined with the psychopharmacological knowledge are an excellent base for diagnosing, prescribing and monitoring drug therapy.”

Leading authors of published books in psychopharmacology, Robert Julien, MD, Ph.D., and Stephen Stahl, MD, have co-authored books with prescribing psychologists. Why would experts of this stature collaborate with prescribing psychologists if the psychologists were unqualified in psychopharmacology?
There was substantial evidence provided in the application regarding the adequacy of training for the conditional prescription certificate and prescription certificate. Below is a set of questions for those who do not think the training is adequate per the 407 criteria.

- How can the postdoctoral training programs described in the application be inadequate when these same programs are accepted by the Louisiana Board of Medical Examiners, New Mexico licensing division, Indian Health Service, and Department of Defense (DoD), and have demonstrated effectiveness in training prescribers for over twelve years in the states?
- How can these postdoctoral training programs be inadequate given the impeccable safety record of prescribing and medical psychologists? As indicated in the application, the safety record includes 12 years of data from Louisiana and New Mexico where psychologists with authority have treated both general mental health patients and special populations such as children and seniors. Can those in opposition provide evidence of a 12 year period in their history of such safe prescribing?
- The postdoctoral training model described in the application is now accepted in Iowa and Idaho. How could the Nebraska application be fatally flawed when other states have adopted the same model of training that has been proven effective in New Mexico and Louisiana?
- How is the fear of prescriptive authority for psychologists with advanced training, as asserted by various medical organizations, any different from the same turf battles and fears leveled at advanced practice nurses (i.e., the training isn’t rigorous enough, it’s not nursing, safety hasn’t been demonstrated), during decades that nursing proposed an expanded scope of practice for nurses with advanced training?
- Where is the evidence that the only safe and effective model for training to prescribe medication is that used in medical schools? The training model for prescribing and medical psychologists is different from medicine and other medical professions in that the psychologist first gains expertise in applying psychosocial interventions when addressing the full range of behavioral disorders, and later adds expertise to utilize mental health medication(s) when indicated to improve outcomes. Psychologists are already licensed to diagnose and treat mental illnesses. Adding this skill set provides the already licensed psychologists with an additional treatment approach to consider when rendering mental health care. The other models are in reverse order, in that the professional tends to focus primarily on using biological interventions with behavioral health disorders, which can lead to over-prescribing of drugs. Psychologists are in a unique position to use the tool that best fits patients’ needs rather than forcing patients’ needs into the only tool other professionals may have. As the saying goes, “When all you have is a hammer everything looks like a nail.” As depicted repeatedly in the application and in evidence provided for the 407 review, the prescribing or medical psychologists have a broader set of tools in his/her tool kit for addressing behavioral health disorders, AND has the authority to unprescribe medications that are unneeded, unsafe, counter-productive, or can be replaced by assisting the
patient to learn skills and ways to coping that have a long lasting/permanent impact for the patient’s behavioral health.

- Why should patients be denied access to the expanded and less expensive model of psychological care that allows the patient to have his/her psychotherapy and mental health medications addressed during the same appointment, just because the training model is not politically dominant in the health care system?

**Criterion 3**

*What adjunctive medications would a prescribing psychologist be able to utilize, and under what conditions or limitations?*

There will be some instances in which a provider will utilize pharmaceutical intervention to alleviate side effects from an otherwise effective medication. Many individuals experience nausea or sexual side effects from SSRIs and SNRIs. When a patient feels that the primary condition is very well controlled and that a medication is having highly positive results, but produces a side effect that is not desirable, a pharmaceutical response can be helpful, such as adding to the regimen an antiemetic or a low dose of bupropion for the later. In addition some antipsychotic medicines carry a risk of EPS (extrapyramidal symptoms), which can be managed through the use of diphenhydramine, or benztropine, as well as other potential options.

Concerns about potential side effects, both common and rare, are addressed with the patient prior to beginning treatment with a pharmacological agent, throughout the course of treatment, and in real time as a patient may be struggling with the side effect of a medication. Many minor side effects will improve over time, but only if the patient continues to take the medicine. These potential issues would be addressed particularly well by prescribing psychologists, given how frequently they have contact with their patients. This allows an opportunity to discuss side effects with the patient and help determine if it is better to stop the medicine, wait for the side effects to resolve, or initiate an adjunct medicine to alleviate the side effect. Keep in mind that psychologists are licensed professionals who are already accustomed to referring to appropriate professionals when additional expertise is needed. The application and proposed regulatory language mandates collaboration with the patient’s primary medical provider. This approach ensures a higher level of safety for the patient given the coordination between prescribing professionals.

Adjunctive medications used by a prescribing psychologist would be limited to those with an evidence base for managing known side effects when there is a documented reason for not switching to another medication. Medications with an FDA indication or other standard-based practice for treating side effects would be the only medications considered. As indicated in the application, the applicant will have covered the management of drug side effects in the postdoctoral educational program, practica, and supervised experience with a provisional prescription certificate.

Any given practitioner is always limited in some way based on his/her training, experience, and competence. Nebraska regulations defining unprofessional conduct by a psychologist would apply to the psychologist with prescriptive authority, and these standards indicate,
“A psychologist shall not provide services or use techniques for which he or she is not trained and experienced.” These are legally binding standards. A prescribing psychologist would be subject to discipline for exceeding the boundaries of his/her competence in managing drug side effects.

Criterion 3

Would increasing the number of prescribers result in more instances of overdosing?

With an increase of any number of things, obviously the possibility of adverse events also increases. But this same argument would apply to increasing the number of psychiatrists or nurse practitioners, or primary care physicians.

However, data from states with extensive experience with prescribing and medical psychologists indicates the expected increase did not materialize. This reflects the high quality of training for this group and also other factors such as psychologists having other treatment tools and techniques and actively communicating with each patient’s primary medical care provider. This ensures a higher level of safety compared to business as usual, in which other medical providers have no regulatory requirement to communicate with the patient’s other prescribers. In practice, patients tend to see psychologists significantly more often than their primary care physicians or other specialists. Most patients have an on-going treatment relationship with their psychologists rather than a once-a-year wellness visit or visits only when there is an acute problem, and psychologists tend to spend more time with patients during visits. Dr. Donald Fineberg is quoted below regarding the value of the model of care provided by psychologists with advanced training and expanded scope of practice.

“Now in addition to officially working for giving licensure, I’ve had the opportunity to watch psychologists go from the training stage to the actual stage of clinical practice so they’ve gone from the stage of being trainees to actually being colleagues. So I’ve had the chance to work with at least a dozen of them over the years around the question of the best way to approach patients and at which point medicine would be helpful to be prescribed or often the case, not prescribed. One of the problems that people have in the field of psychotropic medicine is that many people who need it don’t get it, but many people who don’t need it have it prescribed. It’s a paradox, but one of the things that I’m really pleased about the training for the psychologists for prescriptive authority in New Mexico is that they work very hard about that difference. Because the prescriptive authority to be able to prescribe medicine also gives the authority not to give it when it’s not indicated. “ Dr. Donald Fineberg, MD, psychiatrist, Santa Fe, New Mexico, May 7, 2016
Criterion 2

Would psychologists taking the RxP training and practicing as prescribers concomitantly reduce the amount of time they spend providing therapy to patients?

The question about practice patterns of prescribing and medical psychologists was addressed empirically by Dr. Wendy Linda and Dr. Robert McGrath, with results published in 2017, and referenced in the application. The study did not find a bias towards the use of medications versus psychosocial interventions. Patients were seen for medication and psychotherapy, therapy alone, or medication alone. If the patient was seen for medication alone, frequently another mental health professional was providing the psychotherapy. On average, prescribing psychologists saw nine patients during the last full day of care, with an average session length of 39 minutes.

Please refer to the link below depicting interviews with prescribing and medical psychologists on how they meet the need of their patients. As you can see, they do not take a cookie cutter approach. Instead, the practitioner adjusts the interventions to the specific needs of each patient. The video starts with patients being asked what they want as a model of delivery of care, and this is followed by prescribing and medical psychologists describing how they work to meet the need.

https://www.youtube.com/watch?v=jKZoGxRkyCY&feature=youtu.be

As indicated in a prior response to this question, posted on the 407 website, psychologists pursuing the postdoctoral master’s degree spend their weekends and evenings studying and taking courses. It is not uncommon for psychologists to obtain postdoctoral training in other specialties, and psychologists typically pay for their own training so they do not stop seeing patients to engage in lifelong professional learning.

Psychologists going into the postdoctoral training in clinical psychopharmacology with less of a background in the basic sciences must spend more time studying during the first year in the program. However, by the second year the courses are far more focused on actual clinical work involving the utilization of psychotropic medications with current patients. This and the subsequent phases of the training overlap extensively with the current practice of the psychologist.

The advantage of the prescribing psychologist model of training is you are working with licensed professionals who live in Nebraska and provide care to Nebraskans. The psychologist’s patients soon begin to benefit from their psychologist’s participation in the clinical psychopharmacology training program, as the psychologist can speak with more authority regarding whether drugs would be of benefit or of harm.

In contrast, the other models of training are built from the undergraduate level up with individuals who are very limited in what clinical services they can provide until licensed in Nebraska. The other model HOPES that the trainees will stay in Nebraska after becoming license eligible.
The prescribing psychologist model starts with currently licensed psychologists who have established a home and professional roots in their communities. There is not a need to hope they will stay, unless of course they choose to move to Iowa or other state to function with an expanded scope of practice.

The question implies a loss of psychological services. This may be a true issue if the number of licensed psychologists in Nebraska was stagnant or even decreasing, as with psychiatry. As documented in the application, there was a 28% increase in the number of psychologists licensed in Nebraska between 2006 and 2016. Moreover, the pipeline is growing substantially in the field of psychology. For example, there was a 70% increase in master’s level psychologists over a ten year period, and many of these professionals go on to enter doctoral training. Nebraska is fortunate to have doctoral training programs in clinical, counseling, and school psychology. Additionally, there are 45 or more clinical internships in Nebraska, and many of these early career psychologists stay in Nebraska. If Nebraska enacts prescriptive authority in our state we could retain even more of these early career professionals vs. lose them to states that went beyond debating the value of prescriptive authority for qualified psychologists.

Criterion 3

Would it be acceptable to authorize prescriptive authority with the patient’s PCP having veto power over any prescription written by the prescribing psychologist?

Per the application, the prescribing psychologist is mandated to communicate the treatment plan to the PCP when drugs would be used to treat a mental disorder. The prescribing psychologist would defer to the PCP if he/she prefers to manage the psychotropics, or prefers to have another practitioner provide the psychotropic medication(s).

Criterion 3

Given the complexities of rapid organic and brain-structure changes in children, and the shortage of effective drugs for pediatric behavioral health issues, is it safe to allow prescribing psychologists to attend pediatric patients?

New Mexico and Louisiana have licensed prescribing and medical psychologists to treat children for around 12 years without a safety problem. These states do not prohibit qualified prescribing or medical psychologists from utilizing drugs to treat mental disorders in children when the psychologist has expertise in treating children. In other words, gaining prescriptive authority does not provide the licensed psychologist, who had previously treated adults exclusively, with the expertise to treat children, pharmacologically or otherwise.

The Nebraska proposal would require the applicant to complete a postdoctoral master’s degree that includes the following coursework:
i. anatomy and physiology;
ii. biochemistry;
iii. neurosciences to include neuroanatomy, neuropathology, neurophysiology, neurochemistry and neuroimaging;
iv. pharmacology;
v. psychopharmacology;
vi. clinical medicine and pathophysiology;
vii. health assessment, including relevant physical and laboratory assessment;
viii. diversity and lifespan factors, special populations;
ix. 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 alternative treatment approaches.

The practica described in the application requires the applicant be supervised in the assessment and treatment of children or other special populations, if appropriate to the current and anticipated practice of the trainee.

The proposal also requires the psychologist who specializes in the care of children, elderly, or other special populations shall complete at least one year of the minimum two years with a provisional prescription certificate, prescribing psychotropic medications to such populations, under the supervision of a physician.

As documented in the application, not only are the prescribing and medical psychologists safe prescribers, but they are skillful when it comes to treating special populations. It seems to be overlooked that licensed psychologists ALREADY work with special populations. Please see the quotes from various medical professionals from New Mexico who commented on psychologists’ ability to treat special populations.

“I think psychologists have the ability to prescribe all age groups, pediatric patients as well as elderly patients, geriatric patients. You know if the argument comes that the psychologist doesn’t have the experience to know what’s happening with the physiology of an individual during development and during the aging process. I mean that’s, that’s absolutely false given the fact that the psychologists typically have Ph.D.’s in neurodevelopment, etc. So you…I mean that understanding is part of the formal education and I think…I think it’s purely based on a misunderstanding or an ignorance of what psychologists brings to the table, and again, with an appropriate collaborative approach, I think it can be done very safely. Absolutely.”  
Dr. John Andazola, MD, Medical Director of the Southern New Mexico Family Medicine Residency Program, Las Cruces, November 9, 2015
“You know, just on a very human level you should know that the patients in New Mexico are very appreciative of the fact that their psychologist had gotten prescriptive authority and can prescribe for them. I’ve had the opportunity to consult by way of second opinions and by way of other family members that I’ve referred, like the spouse of, or the child of, to a psychologist, and what I hear again and again is that the same caring psychologist that does the psychotherapy, that does the psych testing, and that when the need came for medication they were able to prescribe, offered the family a tremendous amount of relief.” **Dr. Donald Fineberg, MD, psychiatrist, Santa Fe, New Mexico, May 7, 2016**

“Well my…my experience with children and elderly patients who are seeing a psychologist who is prescribing is that there’s great knowledge and respect for the problems that can happen, and I would say that the psychologists that I’ve worked with are even more cautious than perhaps a psychiatrist might be at times. I don’t want to make any generalizations that are overbroad, but there’s a good deal of concern for children and especially for elderly patients that if it involves a medical problem, needs medical, psychological coordination with their medical caregivers…and…I think the rule is caution on the part of the psychologists, and they have adequate training and knowledge to know when to be cautious, to know what the limits are, so I would refute, you know, the assertions from the opponents of psychologists prescribing, that it would be dangerous in elderly or in children. I just haven’t seen that at all.” **Dr. Joseph Ewing, MD, Family Practice Physician, Las Cruces, New Mexico, November 10, 2015**

“For psychologists who are uncertain about the whole subject of prescribing authority or someone opposed I would tell them that I happily use my initial training as a psychologist literally every day in terms of interviewing, talking about family dynamics, psych testing as necessary, working with families to set up behavior modification programs. Those are things that we all learned in our initial training which are very useful now and that’s the way I want to practice. I don’t want to do fifteen minute office med check visits. To me that is unfortunate and less than optimal care even though that’s the direction that the industrialization of medical care, including mental health, is pushing practitioners. I just don’t want to do it and you know I have my practice here in Farmington and I give myself to be old and cranky and do it the way I feel I want to. Which is to try to be humane, not just a pill prescriber.” **Dr. Robert Sherrill, Ph.D., Prescribing Psychologist, Farmington, New Mexico, November 13, 2015**
Criterion 3

Is there a danger in empowering individual prescribing psychologists, who practice in isolation, to use dangerous drugs to treat complex cases?

This question indicates a lack of knowledge about the contents of the application. The proposal mandates that the prescribing psychologist collaborate and communicate with each patient’s primary medical care provider who is overseeing the patient’s general medical care. One excerpt from the application, pertinent to the question, is copied below. In addition, there are several quotes below from medical practitioners who routinely work with prescribing or medical psychologists in New Mexico and Louisiana who commented on the teamwork approach taken by psychologists.

We suspect the “isolation” reference is in regards to psychologists who are in private practice. What is seen in reality was best described by Dr. Glenn Ally, Advanced Practice Medical Psychologist, who provided testimony to this Committee. Dr. Ally is in private practice; however, he has contracts with a large general hospital, community mental health center, and a cancer center. Members of the applicant group are in private practice and work in clinical facilities and go through credentialing and privileging as do other providers. As pointed out by Dr. Ally, in Louisiana the advent of medical psychology has resulted in many in private practice picking up contracts with behavioral and medical facilities because these facilities cannot keep or hire psychiatrists. As you may recall, Dr. Ally mentioned that he and fellow medical psychologists accepted contracts to provide services to their community mental health centers. And as he noted, there are other medical psychologists who have accepted positions at other state facilities – positions that have been vacated and unfilled by psychiatrists for years. This has provided greater access and shorter wait times to those patients within the state’s mental health system.

Per the application the following is a requirement for the psychologist with a conditional prescription certificate or prescription certificate.

“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 prescribing psychologist shall provide the primary health care practitioner a summary of the treatment plan and follow up reports as dictated by the patient’s condition. The purpose of the communication includes ensuring that necessary medical examinations are conducted, and determining whether a drug prescribed by the prescribing psychologist is contraindicated for the patient’s medical condition. If a patient does not have a primary health care practitioner the prescribing psychologist shall not prescribe to the patient. The Board shall develop regulations, in consultation with the Prescribing Psychologist Advisory Committee, relating to communication from the prescribing psychologist to the primary health care practitioner.”

Application for the Prescription Certificate, 2017
“You know, when I think about the kind of training that the psychologists have gotten here in New Mexico, two factors that stand out...one is that the training is extremely thorough. That the psychologists are quite capable on their own of caring for their patients in every dimension: psychologically, but also biologically when medication is indicated. The second factor that stands out to me when people criticize the training is the isolative fantasy they have about psychologists. The psychologists in New Mexico are team players. They’re part of an overall team that provides care for the patients in New Mexico. They work closely with doctors, with psychiatrists, with social workers. They make the care the best possible care that the patients can get. Dr. Donald Fineberg, MD, psychiatrist, New Mexico

“Another factor which I think is very important to understand, and this relates to something that we were talking about before, is psychologists work as part of a team. For example, one of the side effects certain medications might have might affect the heart and the vulnerable state of a person’s heart might affect the choice of medication. Psychologists who are trained in the program are very aware of that and they work with the internists and cardiologists involved before the medication is prescribed. What I’m always concerned about when objections are raised to psychologist’s ability to work with complex medical problems is this: psychiatrists don’t work with complex medical problems. They’re part of an integrated team of specialists. My license as a psychiatrist from the State of New Mexico says I’m a physician and surgeon. But I can tell you it’s been years since I’ve had anything to do with taking out an appendix and that hasn’t happened since medical school. So of course I work with other specialties, cardiologists, endocrinologists to deal with the best possible treatment for the patient. Psychologists do the same. If anything psychologists are especially and acutely aware of the differentiation between psychology and psychotropic medication and the interface of the use of that medication with other medical specialties.” Dr. Donald Fineberg, MD, psychiatrist, New Mexico

“You know when you think about safety issues for prescribing it’s possible to conjure up imaginary scenarios like a psychologist acting on their own, treating a patient with medical problems that somehow they would be unaware of and wouldn’t know how to treat. Now this imaginary scenario has never happened in New Mexico, but even if you thought this imaginary scenario might be a reality, I would ask you how many thousands of people do you want to go untreated because they can’t get an appointment with a competent practitioner to evaluate their situation, to relieve their depression? To relieve the incipient psychosis that would not otherwise be treated. How many of those people do you want to go on suffering just because there’s an imaginary person somewhere that might
have had been misdiagnosed and mistreated?” Dr. Donald Fineberg, MD, psychiatrist, New Mexico

“Actually no I have never encountered, in our specific practice, where our prescribing psychologists are prescribing inappropriately or ineffectively. In fact, I strongly believe that our prescribing psychologists here are very knowledgeable and if they fill the need to collaborate or gain knowledge from other professionals, they don’t hesitate to do that. So I have not had any negative experiences.” Dr. Davena Norris, Pharm.D, Clinical Pharmacist

“It makes me think about years ago when they didn’t think nurse practitioners shouldn’t treat some of those same populations, but we have special training to treat pediatrics, to treat geriatrics, and very obviously they have had the same. I have not come across, I have not had one patient have a bad outcome because of medications they prescribed, and all the kids at the schools, there are so many of those kids who have problems, it is so sad to say, and they, I can’t tell you enough about how they fill that gap.” Tammy Smith, APRN, Family Nurse Practitioner, Louisiana

Criterion 5

Have you approached medical schools in Nebraska to provide the training?

The applicant group is open to discussing involvement of Nebraska medical schools in training psychologists for prescriptive authority. We would recommend including the director of one of the current postdoctoral training programs with extensive experience training psychologists to prescribe safely and effectively in federal agencies, New Mexico, and Louisiana.

Nevertheless, please keep in mind there are huge political and financial disincentives for medical schools to be involved with training psychologists in prescriptive authority. The American Medical Association and American Psychiatric Association are opposed to prescriptive authority for psychologists. Would the medical schools risk alienating members of these two national organizations, especially if the medical school has a psychiatry residency program?

The training of psychiatrists is commonly supplemented, to a significant degree, by federal and state funding. The prescribing psychologist model is self-funded. What medical school would risk losing third party funding for medical students and residents to support training prescribing psychologists?

Medical schools don’t own medical knowledge. The current training programs for prescribing and medical psychologists hire the expertise to teach courses in pharmacy, physiology and pathophysiology, and health assessments. As noted by Dr. Tackett, Ph.D. in Pharmacy, the coursework presented to psychologists is the
same as other prescribing professions and that coursework is often taught by the same faculties who have taught or are teaching other prescribing professions.

**Criterion 1 and 2**

There is no need to expand the types of prescribers beyond physicians, nurse practitioners, and physician assistants to cover the behavioral health needs in Nebraska, especially with the expansion of telepsychiatry.

A theme running through the testimony of the opposition is “they’ve got this covered.” If this theme were actually the case, there would be no mental health provider shortages. But we know there are. If “we got this’ were actually the case then telepsychiatry, which has been promised to be the answer for the past twenty years, would have actually resolved the problem. Though telepsychiatry has been helpful, there continue to be shortages of psychiatrists and primary care physicians, who prescribe approximately 80% of psychotropic medications. As demonstrated in study after study, the current number of psychiatrists is insufficient, even in places where telepsychiatry is utilized. Data indicate there are fewer, not more; physicians entering psychiatry residences, thus the shortage will persist. If psychiatry is overburdened at present, how will adding telepsychiatry resolve that shortage? Even with primary care physicians taking on more of the burden for treating mental illness and even with the addition of nurse practitioners, there still exists a mental health services deficit in Nebraska.

In response to “we got this,” it is fitting that an open-minded and dedicated pediatrician from Beatrice gets the last word on the assertion. Dr. Reyes actually read letters of opposition, the application, and the response from the proponents to the content of the letters of opposition, and then wrote an informed letter to the technical review committee. Here is an excerpt from that letter relevant to the assertion that the opponents have things covered.

“Clinical psychologists have specialized training that as a medical doctor I did not get in my years of training. I have reviewed some of the opposing views of prescriptive privileges to psychologists and the primary theme is the lack of adequate training that they would receive. I have read the proposed curriculum and have seen the comparison of training for prescribing psychologists to psychiatric providers including psychiatric nurse practitioners and without a doubt they would be more than qualified. This is in addition to having medical provider supervision and ongoing collaboration with patients’ primary care providers. The proposed curriculum is well thought out and provides significant training in mental health. I would support supervising our clinical psychologist in her prescriptive training program.
“I respect my fellow medical providers but the fact remains is there is a shortage of qualified mental health providers in our country. There is not enough pediatric psychiatrists, pediatricians or family practice physicians that are willing to practice in small communities such as ours creating a deep void in mental health services. When there is an opportunity for dedicated psychologists to further extend their education and improve mental health for families they serve, this should be welcomed. There are a few states that are doing this now and are reaching more patients. We should learn from these examples and adjust them to fit our community’s needs.” **Dr. Marilou Reyes, MD, Pediatrician, Beatrice**