SB384

Measure Title:	RELATING TO PRESCRIPTIVE AUTHORITY FOR CERTAIN CLINICAL PSYCHOLOGISTS.
Report Title:	Prescribing Psychologists; Clinical Psychologists; Prescriptive Authority Privilege; Board of Psychology
Description:	Authorizes and establishes procedures and criteria for prescriptive authority for clinical psychologists who meet specific education, training, and registration requirements, including requiring prescribing psychologists to adhere to all applicable statutory regulations. Requires the board of psychology to report to the legislature prior to the regular session of 2021. Effective July 1, 2018. Sunsets August 31, 2025.
Companion:	HB767
Package:	None
Current Referral:	CPH, JDL/WAM
Introducer(s):	BAKER, ENGLISH, ESPERO, GABBARD, KEITH-AGARAN, K. RHOADS, RUDERMAN, Harimoto, Ihara, Inouye, Kidani, Nishihara, Riviere

PRESENTATION OF THE
BOARD OF PSYCHOLOGY

TO THE SENATE COMMITTEE ON
COMMERCE, CONSUMER PROTECTION, AND HEALTH

TWENTY-NINTH LEGISLATURE
Regular Session of 2017

Thursday, February 9, 2017
9:00 a.m.

TESTIMONY ON SENATE BILL NO. 384, RELATING TO PRESCRIPTIVE AUTHORITY FOR CERTAIN CLINICAL PSYCHOLOGISTS.

TO THE HONORABLE ROSALYN H. BAKER, CHAIR,
AND MEMBERS OF THE COMMITTEE:

My name is May Ferrer, Executive Officer of the Hawaii Board of Psychology ("Board"). Thank you for the opportunity to provide comments on Senate Bill No. 384, Relating to Prescriptive Authority for Certain Clinical Psychologists.

The purpose of Senate Bill No. 384 is to authorize the Board to grant prescriptive authority to prescribing psychologists who meet specific education, training, and registration requirements.

While the Board has not yet reviewed Senate Bill No. 384, it was noted that the language in the bill closely mirrors House Bill No. 1072, H.D. 1, S.D. 1 from 2016, to which the Board expressed its support at its meeting on April 15, 2016.

The Board will discuss Senate Bill No. 384 at its next scheduled meeting on February 17, 2017.

Thank you for opportunity to provide comments regarding Senate Bill No. 384.

Hawai‘i Psychological Association

For a Healthy Hawai‘i

P.O. Box 833
Honolulu, HI 96808

www.hawaiipsychology.org

Email: hpaexec@gmail.com
Phone: (808) 521-8995

Testimony in Support of SB 384
Relating to Prescriptive Authority for Certain Clinical Psychologists
February 9, 2017

Honorable Chair Baker, Honorable Vice-Chair Nishihara, and Members of the Committee,

My name is Dr. Raymond Folen. I am the Executive Director of the Hawaii Psychological Association and I would like to provide testimony in strong support of SB 384 that will allow prescriptive authority for appropriately trained clinical psychologists:

1. There is a huge need for mental health services in rural and underserved areas in Hawaii. This need has now turned into a crisis.
2. For years, many community groups, community organizations and professional organizations have proposed a no-cost, safe and effective means to help address this pressing need. Providing appropriately trained psychologists, many of whom already live and work in underserved areas, the authority to prescribe will have a significant positive impact on these communities. This is the intent of SB 384.
3. The training requirements in SB 384 are consistent with current U. S. Navy, U. S. Air Force and U. S. Army standards for psychologists credentialed to prescribe. They are also consistent with training requirements in other states where psychologists prescribe. The training requirements that SB 384 proposes will insure patient safety and quality care. This has been documented, studied and clearly demonstrated in the practices of prescribing psychologists.
4. Clinical psychologists are licensed health professionals with an average of seven years of post-baccalaureate study and three thousand hours of post-graduate supervised practice. Prescribing psychologists will receive, at a minimum, an additional two years of training and supervised practice in an accredited program and they will be required to pass a national examination. The intensive didactic portion of their program includes instruction in anatomy and physiology, biochemistry, neuroanatomy, neurophysiology, neurochemistry, physical assessment and laboratory examinations, clinical medicine and pathophysiology, clinical and research pharmacology and psychopharmacology, clinical pharmacotherapeutics, research, and professional, ethical, and legal issues.
5. Unfortunately, organized psychiatry continues to distort the solid foundation and appropriateness of SB 384 and they continue to mischaracterize the extensive training requirements in the bill.
6. There are simply not enough psychiatrists to meet the overwhelming mental health needs in our state. Individuals in need are being forced to wait three months – a quarter of a year – to get an appointment. It is difficult to find an available psychiatrist in downtown Honolulu, let alone in rural communities on the neighbor islands.

Rather than relying on psychiatry to spread - even more thinly - their very limited resources, we are offering a solution based on demonstrated success. Hawaii's psychologists are well represented throughout the Islands and can provide the needed psychopharmacology services at no additional cost to the State. SB 384 will relieve many in desperate need from the needless suffering and damage that results when treatment is unnecessarily delayed for months. Please support your community in their efforts to improve access to mental health services and pass SB 384 so we can deliver the full range of mental health services to the people who need them.

Raymond A. Folen, Ph.D., ABPP
Executive Director

To: Senate Committee on Commerce, Consumer Protection, and Health
Senator Rosalyn H. Baker, Chair
Senator Clarence K. Nishihara, Vice Chair

From: Julienne O. Aulwes, M.D., Chair, Task Force on Improving Access to Psychiatric Care, Hawaii Psychiatric Medical Association

Jeffrey Akaka, M.D., Chair, Legislative Committee, Hawaii Psychiatric Medical Association - testifying

Hearing Date: February 9, 2017
Hearing Time: 9:00 AM

Re: SB 384 - Relating to Prescriptive Authority for Certain Clinical Psychologists

Position: **OPPOSED**

Dear Senate Committee on Commerce, Consumer Protection, and Health:

On behalf of the Hawaii Psychiatric Medical Association (HPMA), I am testifying today to ask the committee to please **vote NO on SB 384.**

Last session the prescriptive authority for psychologists' bill was defeated, but the legislature asked HPMA for help in addressing the difficulties patient's in rural areas have in accessing psychiatric care. In response, the Hawaii Psychiatric Medical Association, the American Psychiatric Association (APA), and the Hawaii Medical Association (HMA), have been working on multiple fronts to try to solve this problem – I will briefly cover them in my testimony today.

First off I would like to point out the proponents of psychologist prescribing and SB 384 have introduced the essentially the same bill that was defeated last session making no changes and bringing no additional feedback or solutions to the discussion. This legislation gives psychologists prescriptive authority not taking into account the new and innovative methods of bringing mental health care to our communities. There are several reasons why this bill should not be passed, including certain statements in the bill which appear to be less than 100% accurate.

The good news is since last session HPMA, HMA and others have been working to find viable solutions and we can now solve rural access to psychiatric care problems by methods proven to work, work safely in other states, and which we have started to implement those methods here.

The first of the three better alternatives we have been working on is HB 1272 (SB 1155), the Collaborative Care Model. Numerous evidence-based studies show that by keeping the psychiatric patients with mild to moderate psychiatric conditions in their family doctor's office, embedding a behavioral health care manager, and contracting with an off-site psychiatric consultant, the Collaborative Care Model results in better medical as well as psychiatric care for patients. It provides improved patient outcomes, better patient and provider satisfaction, and saves money up to $600-$1000/patient/year.

Instead of a psychiatrist taking care of only three-four patients in a morning, the Collaborative Care Model allows a psychiatrist to oversee the care of 10-15 patients in a morning – meaning an increase in access to care for our community. The data on this program has been so positive that Medicare started paying for Collaborative Care in January 2017. But we need your leadership as this proven solution is not covered by Medicaid. What we need is for Medicaid to cover the same service that Medicare started paying for – bringing a VIABLE solution to our state. This is why HPMA has worked with some of your colleagues on HB 1272 / SB 1155 to accomplish this. The time is now to abandon the same old so-called solutions and work to promote programs that move Hawaii healthcare in the direction of better medical (including psychiatric) care for more people at less cost.

Second, Network Adequacy is a major contributor to difficulties accessing psychiatrists, but this also has a potential solution in the network adequacy bills HB 914 / SB 387. HPMA and its members have been working with your colleagues to ensure when patients need mental health care, their insurers are providing trained medical professionals to help.

Finally, the Hawai‘i Project ECHO (Extension for Community Healthcare Outcomes), a partnership between the Hawai‘i State Rural Health Association and the University of Hawai‘i, helps primary care doctors get help on challenging cases through videoconferences with specialist physicians. It started in January 2016 with Psychiatry as the first specialty covered, and included members of HPMA holding faculty positions at the University Of Hawaii John A. Burn School Of Medicine's Department of Psychiatry. Current research shows this method improves the care of patients of participating rural primary care physicians up to the level of care at city academic medical centers.

Our critics will say that "nothing has been done" in the short 6 months but as you will see from my testimony today, HPMA has been actively pushing efforts in the community to bring increased mental health care access to the community. The entire healthcare field is moving in the direction of more collaborative, team-based, integrated care. HPMA is working hard to help Hawaii move forward in a way that provides better healthcare outcomes with better satisfaction at lower costs. There is no comparable valid evidence that a bill like SB 384 would accomplish this.

Therefore, I ask you to all hit pause on the same old so-called solutions to our issues and please vote **NO** on SB 384. The alternatives are here, growing, proven to work on large scales, and are far safer than SB 384.

HPMA and its members welcome this opportunity to inform you about them and ask for your support.

Aloha and mahalo,

Jeffrey Akaka, M.D.
Chair, Legislative Committee
Hawaii Psychiatric Medical Association

Julienne O. Aulwes, M.D.
Chair, Task Force on Improving Access to Psychiatric Care
Hawaii Psychiatric Medical Association

Mental Health America of Hawai`i

1124 Fort Street Mall, Suite 205
Honolulu, Hawaii 96813
P 808.521.1846 | **F** 808.533.6995
www.mentalhealthhawaii.org

Helping Hawai'i Live Well

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health
From: Trisha Kajimura, Executive Director

Re: **Testimony in support of SB 384**, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. We strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

Not everyone dealing with mental health issues needs medication, but when someone who needs it is not able to get it in a timely manner, they can end up in a crisis that could have been avoided. This type of crisis takes a terrible toll on the individual, their support system, and their overall health. Hawai'i has been dealing with a physician shortage for years and it is not getting better. Prescriptive authority for psychologists with advanced training is one of the solutions that will help to alleviate this dangerous prescriber shortage.

Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony. You can reach me at trisha@mentalhealthhawaii.org or (808)521-1846 if you have any questions.

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Government Relations

Testimony of
Jonathan Ching
Government Relations Specialist

Before:
Senate Committee on Commerce, Consumer Protection, and Health
The Honorable Rosalyn H. Baker, Chair
The Honorable Clarence K. Nishihara, Vice Chair

February 9, 2017
9:00 a.m.
Conference Room 229

Re: SB384 Relating to Prescriptive Authority for Certain Clinical Psychologists

Chair Baker, Vice Chair Nishihara, and committee members, thank you for this opportunity to provide testimony on SB384, which authorizes the board of psychology to grant prescriptive authority to prescribing psychologists who meet specific education, training, and registration requirements.

Kaiser Permanente Hawaii OPPOSES SB384.

We recognize that the purpose of this measure is to address the shortage of prescribing mental health care providers in the State and appreciate the sunset provision; however, Kaiser Permanente Hawaii finds the educational and clinical training requirements under SB384 are insufficient from both a safety and scope of practice perspective. We are not convinced that these requirements adequately prepare a psychologist to be able to prescribe psychotropic medications, which can cause serious harm to patients. Furthermore, Kaiser Permanente Hawaii notes that the complexities of the interaction between the mind and body cannot be adequately understood at the level of training currently required under SB384 for any psychologist seeking prescriptive authority.

During residency, psychiatrists must complete a minimum of 8,320 hours of clinical training in psychiatry/child psychiatry (four years). These clinical training hours, which involve seeing patients under supervision, do not include the additional four years of medical school, where psychiatrists learn anatomy, physiology, pharmacology, biochemistry, histology, neurology, neuroanatomy, and cell and molecular biology. These courses are also supplemented by two full years of clinical experience, which includes two months in each of the following areas: Internal Medicine, Obstetrics & Gynecology, Family Practice, General Surgery, and Pediatrics, Psychiatry, plus training in radiology, interpretation of EKGs, and understanding of labs and significance of those labs. This comprehensive training for psychiatrists allows them to determine when they need to look at a medical, pharmacological, or psychological cause of a patient's symptoms.

711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Office: (808) 432-5210
Facsimile: (808) 432-5906
Email: jonathan.l.ching@kp.org

In contrast, according to Alliant International University's Postdoctoral Master of Science Program in Clinical Psychopharmacology, which is one of the clinical pharmacology programs designated by the American Psychological Association,[1] a psychologist must complete 462 class hours.[2] If the minimum 400 clinical hours required under SB384 are also included, the minimum requirement to eligible for prescriptive authority is 862 hours, which is 10% of the hours a psychiatrist is required to complete just during their residency.[3] Kaiser Permanente Hawaii highlights this difference in hours because it holds that prescriptive authority requires appropriate interpretation of symptoms ***and*** the appropriate medical acumen and clinical knowledge, which can only be acquired through the completion of medical school and extensive clinical training.

As an alternative to SB384, Kaiser Permanente Hawaii suggests the committee consider exploring ways to address the shortages of specialty health providers in rural and remote areas of our State. One such approach is the funding of Project ECHO (Extension for Community Healthcare Outcomes), a partnership between the University of Hawai'i and the Hawai'i State Rural Health Association, which is a knowledge-on-demand model of telehealth care that educates, trains, and supports rural general practitioners and other available healthcare representatives on the best practice treatment protocols for complex diseases. Funding of SB1045, which makes an appropriation to the department of health to implement and administer an ECHO program, will help train primary care physicians and other healthcare representatives who live in rural and remote areas and who currently care for members of the public where there is the most need. This could include training of primary care providers in the areas of psychotic and substance abuse disorders, which can help better facilitate mental health care via telemedicine between a primary care provider and a psychiatrist.

Therefore, Kaiser Permanente Hawaii urges the committee to **HOLD** SB384. Mahalo for the opportunity to testify on this important measure.

[1] See http://www.apa.org/education/grad/designation.aspx.
[2] See http://catalog.alliant.edu/preview_program.php?catoid=28&poid=3703&returnto=1%20096.
[3] An psychologist seeking prescriptive authority under SB384 would be required to complete a minimum of 862 hours, which includes classroom and clinical hours versus a psychiatrists' 8,320 clinical hours required during a 4-year residency.

ROMAN CATHOLIC CHURCH IN THE STATE OF HAWAII

Hawaii Catholic Conference
The Public Policy Voice of the Roman Catholic Church in the State of Hawaii

SUBMITTED ONLINE: February 7, 2017

TO: Senate Committee on Commerce, Consumer Protection & Health
HEARING DATE: Thursday, February 9, 2017 in Room 229
SUBMITTED BY: Walter Yoshimitsu, Executive Director
POSITION: **Support for SB 384 Relating to Prescriptive Authority**

The Hawaii Catholic Conference is the official public policy voice for the Roman Catholic Church in the State of Hawaii. The above-referenced bill would authorize and establish procedures and criteria for prescriptive authority for clinical psychologists who meet specific education, training, and registration requirements, including requiring prescribing psychologists to adhere to all applicable statutory regulations.

We support SB 384 because it would significantly address the lack of professionals to serve patients with mental illness and drug abuse disorders. There is no doubt that there is a need for additional providers for mental health and addiction treatment as we seek more efficient integrated health care services.

According to Mental Health Hawaii website, our state "has a significant rate of youth who suffer from depression and manifest suicidal behavior, and of college students whose mental health problems are not being treated." Sadly, gaps in mental health services remain. In fact, Hawaii has no secure residential treatment facilities and only two psychiatric hospitals for teens, both on Oahu. This is a travesty to people in our community who need services.

The current opiate epidemic also makes it clear that we need more trained professionals who can assist young people and adults avoid addiction in the first place and recover if they have become addicted. This bill would add specialized psychologists with authority to prescribe medication for their patients who need them.

While we understand that there are some concerns expressed by the American Psychiatric Association, we simply want to address the need for mental health services in the rural areas – and we all acknowledge that the need is great! While we agree that caution should be exercised moving forward, it does make sense for Psychologists to be able to prescribe psychiatric medicines if they are properly trained and licensed to do so. This bill attempts to do just that and it is a step in the right direction.

Mahalo for the opportunity to testify.

6301 Pali Highway ◆ Kaneohe, Hawaii ◆ 96744-5224 ◆ Phone: (808) 203.6735
www.catholichawaii.org ◆ hcc@rcchawaii.org ◆ wyoshimitsu@rcchawaii.org

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, February 7, 2017 2:27 PM
To: CPH Testimony
Cc: pluta@maui.net
Subject: Submitted testimony for SB384 on Feb 9, 2017 09:00AM

SB384
Submitted on: 2/7/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Joseph D Pluta	WEST MAUI TAXPAYERS ASSOCIATION INC.	Support	No

Comments: My name is Joseph D Pluta, President Emeritus, V.P. and Treasurer, of the WMTA. On behalf of the Board of Directors of the West Maui Taxpayers Association INC, WMTA, we are submitting testimony in Strong Support of SB 384. As a founding director/member of the West Maui Taxpayers Association Inc, over 38 years ago, and having resided in West Maui all that time I am acutely aware of the absence of quality psychiatric care in West Maui. It's been decades of neglect while the challenges have increased dramatically with more demands and a homeless crisis. Psychologists have proven prescriptive authority and safeguards in the language of this measure are prudently in place. There is simply not any reason to continue to ignore the meaningful benefits to improving mental health in Hawaii found in this bill. Please pass this bill without delay. Malama Pono ame Mahalo, Joseph D Pluta,

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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February 9, 2017

The Honorable Rosalyn H. Baker, Chair
The Honorable Clarence K. Nishihara, Vice Chair
Senate Committee on Commerce, Consumer Protection
and Health

Re: SB 384 – Relating to Prescriptive Authority for Certain Clinical Psychologists

Dear Chair Baker, Vice Chair Nishihara, and Committee Members:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 384, which would provide prescriptive authority for qualified psychologists. HMSA supports this Bill.

HMSA is dedicated to ensuring that all of our members are able to access the care they need, when they need it. This not only includes services for their physical health and wellbeing, but their mental health as well.

We believe that the language contained within this measure will provide the necessary safeguards to ensure only those psychologists with the appropriate education, clinical training, and registration will be authorized to prescribe the medications our members need. This will afford our members greater and wider access to care.

Thank you for the opportunity to testify on this measure.

Sincerely,

Mark K. Oto
Director, Government Relations

Psychologists Opposed to Prescription Privileges for Psychologists
www.poppp.org

Petition-Testimony OPPOSE SB384

A REQUEST **FROM PSYCHOLOGISTS** TO **OPPOSE** LEGISLATION GRANTING PRESCRIPTION PRIVILEGES FOR PSYCHOLOGISTS through non-traditional and substandard means

2 February2017

We, the undersigned **psychologists** and all others concerned about quality healthcare **OPPOSE** any efforts to allow psychologists to prescribe medications through **non-traditional means and substandard training.**

We consider prescribing by psychologists to be controversial, even among psychologists. The movement for prescriptive privileges originated within the Psychology profession, rather than being championed by other stakeholders, such as patient advocacy or public health groups. As psychologists, we oppose this proposal because we believe that it poses unnecessary risks to the public and would be an inappropriate and inefficient mechanism of addressing mental health needs of the population. We are a diverse group of psychologists, including clinicians, educators, and researchers.

Psychologists have made major contributions to human health and wellbeing and will continue to do so. The profession of Psychology has made major contributions to understanding human development throughout the life cycle and to a multitude of dimensions of human functioning as individuals, groups, communities, societies and cultures. Despite these contributions, there are limits to the practices that psychologists can undertake responsibly as professionals. We believe that prescribing medications goes beyond psychologists' competence…even if they obtain the additional training advocated by the American Psychological Association.

Psychotropic drugs are medications that have multiple effects on the human body. These effects are complex and result from the interaction among patients' unique health status, their other prescribed medications, as well as their diets, lifestyles, and other factors. Although the therapeutic effects of prescribed medications can be very positive, unintended adverse drug reactions are common. To minimize the risk of potential adverse effects, that can even have life-threatening consequences, we believe that medications should be prescribed only by professionals who have undergone suitable

medical training that prepared them to manage these medications within the context of patients' overall health conditions. Patients have a right to expect that their medications will be managed by professionals whose education adequately trains them to understand their health history, and assess their current health status, and the potential broad systemic effects of their medications. 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.

Unfortunately, the American Psychological Association's (APA) model for training doctoral psychologists to obtain limited training in psychopharmacology, after they complete graduate school, does not match the levels required of other prescribing professionals (e.g., physicians, nurse practitioners, physician's assistants, optometrists) in terms of their overall training in matters directly related to managing medications. **The APA model is substantially less rigorous and comprehensive than the training required for all other prescribing disciplines.** Whereas the training of psychologists in certain professional activities, such as psychotherapy and psychological assessment, is generally more comprehensive than that of practitioners in other fields, this is not the case for training in clinical psychopharmacology**. The APA training model for prescribing even fails to meet the recommendations of APA's own experts** in its Ad Hoc Task Force of Psychopharmacology (e.g., in terms of undergraduate prerequisites in biology and other sciences) and has other inadequacies (e.g., lack of explicit requirements for supervision; no accreditation of programs).

It is noteworthy that the APA training model is substantively less rigorous than the training that the 10 psychologists undertook in the experimental program of the Department of Defense (DoD). Despite the alarmingly small sample of that pilot program, which precludes generalizing from it, the fact that the current training model is far less comprehensive, and the fact that inadequacies were noted in some of the graduates of the DoD program, proponents of psychologist prescribing make the dubious claim that the DoD program justifies prescribing by psychologists. It does not! In fact, the final report on the DoD project revealed that the psychologists were "**weaker medically"** than psychiatrists and compared their medical knowledge to students rather than physicians. We oppose psychologist prescribing because citizens who require medication deserve to be treated by fully trained and qualified health professionals rather than by individuals whose expertise and qualifications have been independently and objectively assessed to be at the student level. At this point, the training is less rigorous, with most of the training occurring online.

Proponents of psychologist prescribing also have misleadingly invoked a range of unrelated issues to advocate for their agenda. An article in the *American Journal of Law & Medicine* entitled, "Fool's Gold: Psychologists Using Disingenuous Reasoning To Mislead Legislatures Into Granting Psychologists Prescriptive Authority" critiques the rationales that advocates of prescription privileges use to promote their cause. Proponents point to problems in the healthcare system, such as the rural and other populations that are underserved. Whereas such problems are indeed serious and warrant changes in the healthcare system, allowing psychologists to prescribe is neither an appropriate nor an effective response. Permitting relatively marginally trained providers to provide services is not an acceptable way to increase access to healthcare services where high quality health care is needed. Rather than relying on under-trained psychologists to prescribe, it would be much more sensible to develop mechanisms to facilitate psychologists' providing those services that they are highly qualified to provide (e.g., counseling) to those populations and to innovate other approaches for medically-qualified providers (for example, collaboration, telehealth) to leverage available services. It should be noted that most psychologists practice in urban and suburban areas: There is no reason to expect that prescribing psychologists would have a significant impact on compensating for the shortages of psychiatrists in rural and economically disadvantaged areas, where relatively few actually work. Other remedies are needed to address such problems that would not compromise the quality of care.

Other health professionals, including nurses and physicians, are also concerned about psychologist prescribing. However, this should not be seen as a simple turf battle: It is because of legitimate concerns that the proposals for training psychologists to prescribe are too narrow and abbreviated. The International Society of Psychiatric-Mental Health Nurses position statement asserts, “nurses have an ***ethical responsibility*** to oppose the extension of the psychologist's role into the prescription of medications'” due to concern about psychologists' inadequate preparation, even if they were to get *some* additional training, in accordance with the APA model. When it comes to prescribing psychoactive medications that have a range of potential therapeutic and adverse effects on the human body, including interactions with other medications, shortcuts to training are ill advised. Some psychoactive drugs come with black box warnings about their potential risks.

Another concern is the limited expertise of psychology regulatory boards to effectively regulate prescriptive practicing. Given the similar limits in medication-related training of most psychologists who serve on these boards to that of other psychologists, and the fact that psychology boards historically have not overseen prescribing, we question whether regulatory boards have the expertise, resources and systems to provide effective oversight of psychologist prescribing.

Before supporting this controversial cause, we urge legislators, the media, and all concerned with the public health to take a closer look at this issue. Rather than permitting psychologists to prescribe medications, we advocate enhancement of currently available collaborative models in the delivery of mental health care, in which licensed psychologists work collaboratively with fully qualified prescribers to provide safe and effective services for those individuals who may benefit from psychoactive medications.

There are better and safer alternatives to psychologists prescribing that we believe will have a greater positive impact on mental health services. A more promising means for enhancing the mental health services available to all citizens than to allow psychologists to prescribe would be to dedicate efforts to better integrating mental health professionals, including psychologists, into the healthcare system, such as in primary care settings, where they could collaborate with other providers (who are prescribers) in the care of people who may need medications and psychological services. The barriers to such care have been detailed in a recent report by the U. S. Department of Health and Human Services, *Reimbursement of Mental Health Services in Primary Care Settings*. Overcoming the barriers to such care is an objective upon which psychologists agree with each other, and with other health professionals, and is clearly in the public interest. It would improve the quality of mental health care available in urban and rural areas.

We respectfully request that you OPPOSE SB384 that would allow psychologists to prescribe through non-traditional and substandard means.

Al Galves, Ph,D.	International Society for Ethical Psychology and Psychiatry	agalves2003@comcast.net
Alex Williams	University of Kansas	alexwilliams123@gmail.com
Alexandra Solovey	Minnesota School of Professional Psychology	sandrazas@gmail.com
Alix Timko, Ph.D.	Towson University	ctimko@towson.edu
Alan E. Fruzzetti, Ph.D.	University of Nevada, Reno	aef@unr.edu
Andrew M. Sherrill, M.A.	Northern Illinois University	andrew.sherrill@gmail.com
Andrew Whitmont, Ph.D.	dba Yakima Psychological Services	yakpsyche@yahoo.com
Anne Marie Albano, Ph.D., A.B.P.P.	Columbia University College of Physicians and Surgeons	aa2289@columbia.edu
Arlyne J. Gutmann, Ph.D.	Private Practice	ajgutmann@aol.com
Barry Dauphin, Ph.D.	Private Practice	barrydauphin@mac.com

Beth Hartman McGilley, PhD	Univ. of Kansas School of Medicine	bmcgilley@psychology.kscoxmail.com
Braden Berkey, Psy.D.	Prairie Psychological Services	braden.berkey@sbcglobal.net
Brandon Gaudiano, Ph.D.	Butler Hospital/Brown University	brandon_gaudiano@brown.edu
Brett Deacon, Ph.D.	University of Wollongong	bdeacon@uow.edu.au
Brian Chu, Ph.D.	Rutgers University	brianchu@rci.rutgers.edu
Bruce L. Baker, Ph.D.	UCLA	baker@psych.ucla.edu
Bruce Gale, Ph.D.	BehaviorTech Solutions, Inc	bruce@bgalephd.com
Carolina Clancy, Ph.D.	Durham VA Medical Center	carolina.clancy@va.gov
Carolyn A. Weyand, Ph.D	Private Practice	cweyand@copper.net
Carolyn Black Becker, Ph.D.	Trinity University	cbecker@trinity.edu
Catherine A. Fiorello, Ph.D., A.B.P.P.	Temple University	catherine.fiorello@temple.edu
Cheryl Carmin, Ph.D.	University of Illinois at Chicago	ccarmin@psych.uic.edu
Cynthia Spanier, Ph.D.	Psychological Health & Behavioral Medicine	cyndiespanier@aol.com
Dana Fox, Ph.D.	Private Practice	decfox@aol.com
Daniel J. Burbach, Ph.D., A.B.P.P.	Lakeview Psychological Associates, S.C.	dbgc@tds.net
David Fresco, Ph.D.	Kent State University	fresco@kent.edu
David Marcus, Ph.D.	Washington State University	david.marcus@wsu.edu
David S. Schwartz, M.A.		DSchwa68@aol.com
David Valentiner, Ph.D.	Northern Illinois University	dvalentiner@niu.edu
David L. Van Brunt, Ph.D.	Private Practice	dlvanbrunt@gmail.com
Dawn Birk, Ph.D.	Indian Health Services Behavioral Health (MT)	dawn.birk@ihs.gov
Dean McKay, Ph.D.	Fordham University	mckay@fordham.edu
Deanna Barch, Ph.D.	Washington University	dbarch@artsci.wustl.edu
Diana S. Rosenstein, Ph.D.	Private practice	drosenstein@juno.com
Diane L. Bearman, Ph.D.	University of Minnesota Medical School	bearm003@umn.edu
Dianna L. Kucera, M.A.	Private Practice	DKucera21@yahoo.com
Don Benson, Psy.D.	Park Ridge Behavioral Health Care	donbenpsyd@yahoo.com
Douglas A. MacDonald, Ph.D.	University of Detroit Mercy, Dept of Psychology	macdonda@udmercy.edu
Drew A. Anderson, Ph.D.	University at Albany-SUNY	drewa@albany.edu
E. David Klonsky, Ph.D.	University of British Columbia	edklonsky@gmail.com
Edward Katkin, Ph.D.	SUNY at Stony Brook	edward.katkin@sunysb.edu
Elaine Heiby, Ph.D.	University of Hawaii at Manoa	heiby@hawaii.edu
G Neffinger, Ph.D., A.B.P.P.	Private Practice	ggneff@earthlink.net
Gail Margoshes, Psy.D.	Private Practice	margoshes@aol.com
Gary Schoener, M. Eq.	Gary R. Schoener Consulting	grschoener@aol.com
Geoffrey L. Thorpe, Ph.D., A.B.P.P.	University of Maine	geoffrey.thorpe@umit.maine.edu
Gerald C. Davison, Ph.D.	University of Southern California	gdaviso@usc.edu
Gerald Rosen, Ph.D.	University of Washington	grosen@uw.edu
Gregory Stuart, Ph.D.	University of Tennessee Health Science Center	gstuart@utk.edu
Howard Eisman, Ph.D.	New York Institute for Cognitive and Behavioral Therapy	howardeisman@verizon.net
Howard N. Garb, Ph.D.	Lackland Air Force Base	howard.garb@lackland.af.mil
Ian Douglas Rushlau, Psy.D.	Belmont Center for Comprehensive Treatment	RushlauI@einstein.edu
Ian R. Sharp, Ph.D.	Private Practice	is@medavante.net
Ilyssa Lund, Psy.D.	Argosy University	ilyssa.lund@gmail.com
James C. Megas, Ph.D., L.P.	Private Practice	jmegas@cal.berkeley.edu
James Carson, Ph.D.	Oregon Health Science University	carsonja@ohsu.edu
James Coan, Ph.D.	University of Virginia	jcoan@virginia.edu
James D. Herbert, Ph.D.	Drexel University	james.herbert@drexel.edu
James G. Murphy, Ph.D.	University of Memphis	jgmurphy@memphis.edu
James Overholser, Ph.D., A.B.P.P.	Case Western Reserve University	overholser@case.edu
James Schroeder, Ph.D.	St. Mary's Center for Children	jschroeder@stmarys.org
Jan Willer, Ph.D.	Private Practice	jan@drwiller.com
Jane E. Fisher, Ph.D.	University of Nevada, Reno	jefisher6@yahoo.com
Jeff R. Temple	University of Texas Medical Branch, Galveston	jetemple@utmb.edu
Jeffrey M. Lohr, Ph.D.	University of Arkansas	jlohr@uark.edu

Jeffrey M. Zacks, Ph.D.	Washington University	jzacks@artsci.wustl.edu
John A. Yozwiak, Ph.D.	University of Kentucky	jayozwiak@uky.edu
John Allen, Ph.D.	University of Arizona	jallen@u.arizona.edu
John Breeding, Ph.D.	Private Practice	wildcolt@austin.rr.com
John B. Hertenberger, PhD	Rockdale Juvenile Justice Center	johnh@rrjjc.com
John C. Hunziker, Ph.D.	Private Practice	JCHunziker@msn.com
John P. Hatch, Ph.D.	University of Texas Health Science Center at San Antonio	hatch@uthscsa.edu
John T. Moore, Ph.D.	Richmond State Hospital	moorejohnt@gmail.com
Jon Elhai, Ph.D.	University of Toledo	jonelhai@gmail.com
Jonathan Abramowitz, Ph.D.	University of North Carolina at Chapel Hill	jabramowitz@unc.edu
Jordan Bell, Ph.D.	New Mexico Veterans Affairs Health Care System	jordan.bell@va.gov
Jorge Cuevas, Ph.D.	Advocate Illinois Masonic Medical Center Behavioral Health Services	Jorge.Cuevas@advocatehealth.com
Joseph Hatcher, Ph.D., A.B.P.P.	Nationwide Children's Hospital	Joseph.Hatcher@NationwideChildrens.org
Julie Anne Holmes, Ph.D.		jholmes@hawaii.edu
Julie Larrieu, Ph.D.	Tulane University School of Medicine	jlarrie@tulane.edu
K. Anthony Edwards, Ph.D.	Private Practice	kanth86@hotmail.com
David L. Van Brunt, Ph.D.	Private Practice	dlvanbrunt@gmail.com
Karen B. Wasserman, PsyD, RN	Private Practice	drkarenb@columbus.rr.com
Katherine Kainz, Ph.D.	Olmsted Medical Center	kkainz@olmmed.org
Kathleen Palm, Ph.D.	Clark University	kpalm@clarku.edu
Kathleen Palm, Ph.D.	Clark University	kpalm@clarku.edu
Kelly G. Wilson, Ph.D.	University of Mississippi	kwilson@olemiss.edu
Kenneth D. Cole, Ph.D.	VA Long Beach Healthcare System	kenneth.cole@va.gov
Kenneth Feiner, Psy.D.	Private Practice	kenfeiner@aol.com
Kenneth L. Grizzle, Ph.D.	Medical College of Wisconsin	kgrizzle@mcw.edu
Kristin Kuntz, Ph.D.	The Ohio State University Medical Center	kristin.kuntz@osumc.edu
Kristy Dalrymple, Ph.D.	Brown University/Rhode Island Hospital	kristy_dalrymple@brown.edu
Latha Soorya, Ph.D.	Mount Sinai School of Medicine	latha.soorya@mssm.edu
Leonardo Bobadilla, Ph.D.	Western Carolina University	lbobadilla@wcu.edu
LeRoy A. Stone, Ph.D., A.B.P.P.	Private Practice	lastone2@earthlink.net
Lewis Schlosser, Ph.D.	Seton Hall University	lewis.schlosser@shu.edu
Lisa Hoffman-Konn, Ph.D.	Minneapolis VAMC	lisa.hoffman-konn@va.gov
Lisette Wright, M.A.	Private Practice	lwrightpsy1@earthlink.net
Marc Atkins, Ph.D.	University of Illinois at Chicago	atkins@uic.edu
Marc Kessler, Ph.D.	University of Vermont	mkessler@uvm.edu
Marion Rollings, Ph.D.	Private Practice	Drmarionrollings@gmail.com
Marion Rudin Frank, Ed.D.	Private Practice	mjfrank@comcast.net
Mark D. Popper, Ph.D.	Sequoia Psychotherapy Center, Inc.	mdpphd@comcast.net
Mark Zipper, Ph.D.	Allina Medical Clinic	Mark.Zipper@allina.com
Marlys Johnson, M.A.	University of Minnesota	marlysjohn@aol.com
Martha Josephine Barham, Ph.D.	Private Practice	marti@drbarham.com
Martin Keller, Ed.D., A.B.P.P.	Private Practice	martykeller@cox.net
Mary A. Fristad, Ph.D., A.B.P.P.	The Ohio State University	mary.fristad@osumc.edu
Mary Gail Frawley-O'Dea, Ph.D.	Private Practice	mgfod@aol.com
Mary Lamia, Ph.D.	Private Practice	drlamia@aol.com
Mary Pharis, Ph.D., ABPP	Private Practice	marypharis@mail.utexas.edu
Matthew Fanetti, Ph.D.	Missouri State University	mfanetti@missouristate.edu
Matthew Jarrett, Ph.D.	University of Alabama	majarrett@ua.edu
Matthew K. Nock, Ph.D.	Harvard University	nock@wjh.harvard.edu
Michael Aisenberg, Psy.D.	Private Practice	Dr.A@yourAgame.com
Michael Handwerk, Ph.D.	Harrisburg Medical Center	handwerkm@yahoo.com
Michael J. Rohrbaugh, Ph.D.	University of Arizona	michaelr@u.arizona.edu
Michael Myslobodsky, Ph.D.	Howard University	mmyslobodsky@gmail.com
Michael P. Twohig, Ph.D.	Utah State University	michael.twohig@usu.edu
Michael Thompson, Psy.D.	Private Practice	info@drmichaelthompson.com
Michaele P. Dunlap, Psy.D.	Mentor Professional Corporation	talkdoc@comcast.net

Michelle James, Ph.D., A.B.P.P.	Private Practice	mjames@oakton.edu
Mike Parent, M.A.	University of Akron	michael.parent@ufl.edu
Milton E. Strauss, Ph.D.	University of New Mexico/Case Western Reserve University	Milton.Strauss@gmail.com
Molly S. Clark, Ph.D.	University of Mississippi Medical Center	mclark@umc.edu
Monte Bobele, Ph.D., A.B.P.P.	Our Lady of The Lake	bobem@lake.ollusa.edu
Nandi Haryadi	PT. Mekar Armada Jaya	n4ndie@gmail.com
Nathan Weed, Ph.D.	Central Michigan University	nathanweed@charter.net
Nathan Weed, Ph.D.	Central Michigan University	nathanweed@charter.net
Nicholas Greco, M.A.		gandggroup@yahoo.com
Nicki Moore, Ph.D.	University of Oklahoma	nmoore@ou.edu
Patricia J Aletky, Ph.D.	Private Practice	aletk001@umn.edu
Patricia K. Kerig, Ph.D.	University of Utah	p.kerig@utah.edu
Patricia McKenna, Ph.D.	Private Practice	mail@patriciamckenna.com
Patrick L. Kerr, Ph.D.	West Virginia University School of Medicine	pkerr@hsc.wvu.edu
Paul Arbisi, Ph.D., A.B.P.P.	Minneapolis VA Medical Center	arbis001@umn.edu
Paul M. Brinich, Ph.D.	Private Practice	brinich@unc.edu
Paul Springstead, Ph.D., A.B.P.P.	Northern Pines MHC	pspringstead@npmh.org
Paula D. Zeanah, Ph.D.	Tulane University	pzeanah@tulane.edu
Paula MacKenzie, Psy.D.	Private Practice	paula_mackenzie_126@comcast.net
Peter H. Lewis, Psy.D.	James A. Lovell Federal Health Care Center	peter.lewis@va.gov
R C Intrieri	Western Illinois University	mfrci@wiu.edu
Ralph J. Tobias, Ph.D.		Tobiasrj@sbcglobal.net,
Reid K Hester, Ph.D.	Private Practice	reidhester@behaviortherapy.com
Renate H. Rosenthal, Ph.D.	University of Tennessee Health Science Center	rrosenthal@uthsc.edu
Richard B. Stuart, D.S.W., A.B.P.P.	University of Washington	rstuart@seanet.com
Richard H. Schulte, Ph.D.	Private Practice	rickschulte@cox.net
Richard Sethre, Psy.D.	Private Practice	rsethre@gmail.com
Robert Bloom, Ph.D.	Chicago School of Professional Psychology	bobloom@ameritech.net
Robert Henry, Ph.D.	Center for Problem-Solving Therapy	earthy.psychologist@doctor.com
Robert H. Moore, Ph.D.		moorebob@juno.com
Robert Parker, Ph.D.	Private Practice	bob@focusreframed.com
Robert Klepac, Ph.D.	University of Texas Health Science Center – San Antonio	bobappic@aol.com
Karl Schmitt, Psy.D.		ksschmitt@gmail.com
Richard Schweickert, Ph.D.	Purdue University	swike@psych.purdue.edu
Robert L. Sokolove, Ph.D.	Boston University School of Medicine	sokolove@bu.edu
Robin MacFarlane, Ph.D.	Private Practice	MacFarlane.testing@gmail.com
Roland Moses, Ed.D., A.B.P.P.	Private Practice	rolandgmoses@msn.com
Ron Acierno, Ph.D.	Medical University of South Carolina	acierno@musc.edu
Ronald Glaus, Ph.D.	Oregon State Hospital (ret.)	rag7@comcast.net
Sam R. Hamburg, Ph.D.	Sam R. Hamburg, Ph.D.	Sam R. Hamburg, Ph.D.
Samantha Kettle, Psy.D.	VA Medical Center, Durham	samantha.kettle@va.gov
Samuel B. Tobler, Ph.D.	Private Practice	samuel.tobler@mountainhome.af.mil
Sandra Georgescu, Psy.D.	Chicago School of Professional Psych	sgeorgescu@sbcglobal.net
Scott F. Coffey, Ph.D.	University of Mississippi Medical Center	scoffey@psychiatry.umsmed.edu
Scott J. Hunter, Ph.D.	University of Chicago	shunter@yoda.bsd.uchicago.edu
Scott Lilienfeld, Ph.D.	Emory University	slilien@emory.edu
Seth J. Gillihan, Ph.D.	Haverford College	mail@sethgillihan.com
Shireen L. Rizvi, Ph.D.	New School for Social Research	RizviS@newschool.edu
Sophia K. Bray, Ph.D.	Private Practice	sk-bray@comcast.net
Stephen Benning, Ph.D.	Vanderbilt University	s.benning@vanderbilt.edu
Stephen E. Finn, Ph.D.	Center for Therapeutic Assessment	sefinn@mail.utexas.edu
Stephen Labbie, Ph.D.	Private Practice	labbiephd@comcast.net
Stephen Soldz, Ph.D.	Boston Graduate School of Psychoanalysis	ssoldz@bgsp.edu
Steven B. Gordon, Ph. D., A.B.P.P	Steven B. Gordon, Ph. D., A.B.P.P	sgordon@behaviortherapyassociates.com
Steven C. Hayes, Ph.D.	University of Nevada	stevenchayes@gmail.com

Steven M. Ross, Ph.D.	University of Utah	steve.ross@utah.edu
Stewart Shankman, Ph.D.	University of Illinois at Chicago	stewarts@uic.edu
Stuart Quirk, Ph.D.	Central Michigan University	Stuart.Quirk@gmail.com
Susan M. Flynn Ph.D.		flynnphd@comcast.net
Susan E. Hickman, Ph.D.	Oregon Health & Science University	hickmans@ohsu.edu
Susan Wenze, Ph.D.	Brown University Medical School	susan_wenze@brown.edu
Suzann P. Heron, M.A.	Private Practice	spheron8@aol.com
Tanya Tompkins, Ph.D.	Linfield College	tatompki@linfield.edu
Teri Hull, Ph.D.	Rush University Medical Center	Teri_Hull@rush.edu
Terry Unumb, Ph.D.	Private Practice	drtunumb@aol.com
Terry Wilson, Ph.D.	Rutgers University	tewilson@rci.rutgers.edu
Thomas C. Hamburgen, Ph.D.	Consultants in Anxiety and Related Disorders	thamburgen@charter.net
Thomas Gustavsson, M.A.	Psychology Partners	Thomas.gustavsson@psykologpartners.se
Thyra Fossum, Ph.D.	University of Minnesota	tafossum@umn.edu
Tim Carey, Ph.D.	University of Canberra	Tim.Carey@canberra.edu.au
Timothy A. Post, Psy.D	Whiteman Air Force Base	timothy.post@whiteman.af.mil
Timothy E. Spruill	Florida Hospital	timothy.spruill.edd@flhosp.org
Timothy Tumlin, Ph.D.	Clinical & Health Psychologists, Ltd.	tumlintr@comcast.net
Todd Finnerty, Psy.D.	Private Practice	toddfinnerty@toddfinnerty.com
Toni Heineman, D.M.H.	A Home Within	theineman@ahomewithin.org
Tony Papa, Ph.D.	University of New Mexico	apapa@unr.edu
Tracy A Knight, Ph.D.	Western Illinois University	TA-Knight@wiu.edu
Tracy L. Morris, Ph.D.	West Virginia University	tracy.morris@mail.wvu.edu
Wayne B. Kinzie, Ph.D., A.B.P.P.	Grand Valley Status University	kinziew@gvsu.edu
Wendy Nilsen, Ph.D.	University of Rochester School of Medicine	Wendy_Nilsen@URMC.Rochester.edu
William Douglas Tynan, Ph.D., A.B.P.P.	Nemours Health & Prevention Services	dtynan@nemours.org
William Robiner, Ph.D., A.B.P.P.	University of Minnesota Medical School	robin005@umn.edu
Yessenia Castro, Ph.D.	UT Austin	ycastro1@mdanderson.org
Zeeshan Butt, Ph.D.	Northwestern University	z-butt@northwestern.edu
Frank Floyd	University of Hawaii at Manoa	ffloyd@hawaii.edu

PHOCUSED

PROTECTING HAWAII'S OHANA, CHILDREN, UNDER SERVED, ELDERLY AND DISABLED

February 09, 2017

TO: Senator Rosalyn H. Baker, Chair
Senator Clarence K. Nishihara, Vice Chair
Members of the Senate Committee on Commerce, Consumer Protection, and Health

FROM: Natalie Okeson, Interim Executive Director, PHOCUSED

SUBJECT: Testimony in Support of SB384, RELATING TO PRESCRIPTIVE AUTHORITY

Hearing: February 09, 2017 at 9:00am
Conference Room 229

PHOCUSED is a nonprofit, nonpartisan organization dedicated to increasing the safety for, visibility of, and investment in the children and adults in Hawaii who are marginalized, impoverished, and under-served. PHOCUSED remains extremely concerned by our state's lack of access to psychiatrists and the medications they are able to prescribe to their patients, especially on the Neighbor Islands. The passage of SB348 will give properly trained and approved psychologists the ability to help consumers who would be otherwise unable to access the medication they need.

Our organization fully supports granting prescriptive authority to those psychologists who have fulfilled a number of additional qualifications, ensuring such professionals can responsibly and safely work to meet the mental health needs of our state's population.

1822 Keeamoku Street, Ulu Center Honolulu, HI 96822 P: 808.521.7459
www.phocused-hawaii.org admin@phocused-hawaii.org

Among others, those additional qualifications include completing a post-doctoral Master of Science degree in Clinical Psychopharmacology or an equivalent, which follows a model curriculum as determined the American Psychological Association.

As an active community partner in the effort to address the homelessness issue, PHOCUSED understands the close ties between certain individuals experiencing homelessness and mental health problems. Although prescribing psychologists will only be able to prescribe only for patients with a primary care physician, this increased access to proper treatment and care could prove to be crucial in helping prevent homelessness among certain at-risk individuals.

Thank you for the opportunity to submit testimony in support of SB384.

1822 Keeamoku Street, Ulu Center Honolulu, HI 96822 P: 808.521.7459
www.phocused-hawaii.org admin@phocused-hawaii.org

From: Peter Smith
To: CPH Testimony
Subject: Hawaii"s SB 384
Date: Wednesday, February 8, 2017 5:56:04 AM

Peter Smith Psy.D. - Maryland Academy of Medical Psychologists

Re: Testimony in strong support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 7th at 9:00 am in State Capitol conference room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

Psychologists have had prescriptive authority since 1990's through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists. Malpractice insurance through the APA Insurance Trust is only a few hundred dollars more for Prescribing Psychologists, which says a lot about the safe care Prescribing Psychologists offer.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

Peter Smith PsyD - President MAMP
Marla Sanzone Ph.D. MP - Dean MAMP
Samuel Dutton Ph.D. MP - Provost MAMP

Senate Committee on Commerce, Consumer Protection, and Health

Senator Rosalyn H. Baker, Chair,

Senator Clarence K. Nishihara, Vice Chair

Thursday, February 9, 2017, 9:00 am, Conference Room 229

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Aloha Senator Baker,

I have lived and worked as a psychologist on the island of Kaua'i for the past 17 years. I am very aware of the needs of our community. I have served on the board of the Hawai'i Psychological Association most recently as Past President and currently am co-chairing the Kaua'i Mental Health Care Consortium. We simply do not have enough psychiatrists to serve our people. Please support SB384 and help us help the communities we serve.

As you well know, SB 384, authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

Marie Terry-Bivens, Psy.D.

Clinical Psychologist

2975 Haleko Rd, Suite 307

Lihue, HI 96766

drmarieterry@gmail.com

From: mailinglist@capitol.hawaii.gov
Sent: Monday, February 6, 2017 4:51 PM
To: CPH Testimony
Cc: mpoirier808@gmail.com
Subject: Submitted testimony for SB384 on Feb 9, 2017 09:00AM

SB384
Submitted on: 2/6/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Marion Poirier	Individual	Oppose	No

Comments: Dear Senator Baker and Members, I oppose prescriptive authority for psychologists because of safety, logistical, and practicality reasons. Instead, we need to make a concerted effort to attract physicians, APRN's, Physicians Assistant to underserved areas. Primary care physicians can also be better trained to serve persons sufffering from anxiety and depressive disorders which would take a big load off the other existing providers. Telemedicine has not begun to be properly utilized. Let us not subject our citizens to what over 45 states do not do. Thank you for listening, and please HOLD this measure. Marion Poirier, M.A., R.N.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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From: mailinglist@capitol.hawaii.gov
Sent: Monday, February 6, 2017 3:09 PM
To: CPH Testimony
Cc: val@jesusanswers.com
Subject: Submitted testimony for SB384 on Feb 9, 2017 09:00AM

SB384
Submitted on: 2/6/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Valerie Willman	Individual	Support	No

Comments: To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health From: Dr. Valerie Willman, Ph.D. Psychologist Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229 Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care. Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists. The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications. Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384. Thank you for the opportunity to submit this testimony. Sincerely, Valerie Willman

From: mailinglist@capitol.hawaii.gov
Sent: Monday, February 6, 2017 11:49 AM
To: CPH Testimony
Cc: dshoup@iolalahui.org
Subject: Submitted testimony for SB384 on Feb 9, 2017 09:00AM

SB384
Submitted on: 2/6/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
David Shoup	Individual	Comments Only	No

Comments: To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health From: (your name and organization) Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229 Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care particularly on remote islands where there are few prescribers with mental health training. Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists. The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications. Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384. Thank you for the opportunity to submit this testimony. David Shoup

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

From: mailinglist@capitol.hawaii.gov
Sent: Monday, February 6, 2017 11:31 AM
To: CPH Testimony
Cc: theatk@gmail.com
Subject: Submitted testimony for SB384 on Feb 9, 2017 09:00AM

SB384
Submitted on: 2/6/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Adrian Kerwin	Individual	Support	No

Comments: As someone who works with children on a regular basis, I believe this bill will allow for a safe and appropriate method of getting necessary prescription medication to those who will benefit.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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To the Hawai‘i State Legislature:

For several years now, there has been a reticence on behalf of medical doctors to admit that other professionals can perform many of the same functions as physicians, including taking a history, performing a medical examination, ordering diagnostic testing, and prescribing medication.

However, despite that, other practitioners have been allowed to slowly expand their prescriptive powers and medical treatment and are now considered licensed professionals in the medical community with full abilities thereof.

Nurse practitioners are now allowed to practice independently in the state.

Certified Nurse Anesthetists are standard in most operating rooms.

Naturopathic physicians have prescribing abilities for medications, despite their alternative educational background which is now considered to be enough knowledge to know how to effectively and appropriately treat mental illness.

It is time to recognize that the mental health care of Hawai‘i’s citizens is in critical need of appropriate prescribing psychologists to assist with their care.

The facts are clearly delineated as below:

- There is a defined shortage of mental health providers as documented in the bill.

- There is advanced training required to be allowed to have prescriptive privileges, including obtaining a masters degree level of education in psychopharmacology.

- Medical doctors who undergo training in allopathic medical schools have broad prescribing powers despite having a minimal exposure to psychopharmacology. The only specialty that does have advanced training is psychiatrists. However, any doctor with a license can prescribe medication, with no restrictions. An ophthalmologist can prescribe Zoloft. But a PhD trained psychologist can not.

It is time to acknowledge that there is no further need for a territorial restriction on the ability to prescribe medication by trained psychologists who have achieved a level of competence in their use of medication greater than that of most medical doctors.

Other advanced practitioners have greater abilities to do so, even with less educational requirements than the proposed bill in front of the legislature.

I am in complete support of this bill, and all of the requirements therein, to allow psychologists to prescribe medication for patients independently.

Sincerely,

Dr. Kathleen Kozak
Board Certified Internal Medicine Physician
Honolulu, Hawaii

From: mailinglist@capitol.hawaii.gov
Sent: Friday, February 3, 2017 11:49 AM
To: CPH Testimony
Cc: rontthi@gmail.com
Subject: *Submitted testimony for SB384 on Feb 9, 2017 09:00AM*

SB384
Submitted on: 2/3/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Ronald Taniguchi, Pharm.D.	Individual	Support	No

Comments:

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From: mailinglist@capitol.hawaii.gov
Sent: Friday, February 3, 2017 7:09 AM
To: CPH Testimony
Cc: milton.strauss@gmail.com
Subject: Submitted testimony for SB384 on Feb 9, 2017 09:00AM

SB384
Submitted on: 2/3/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
milton strauss	Individual	Oppose	No

Comments: Dear Senators: I am a clinical psychologist recently retired from a 40+ year professional career and am strongly opposed to prescription privileges for psychologists. The training proposed and rational for the health of the public being served by such privileges are both seriously flawed. Turning to the matter of training first: The post-doctoral master's degree in clinical psychopharmacology that is proposed requires no previous education in life sciences at either the bachelor's or graduate level other than the 1-semester course in biological bases of behavior required of all graduates of APA-approved doctoral programs in health service psychology. This limited background, together with a curriculum that requires less than half the education required of psychiatric nurse practitioners ill-prepares anyone to prescribe psychotropic medications that can have serious and complex side effects. As you may know, Illinois approved a psychologist prescribing law two years ago. It has not yet been implemented, perhaps in part because of the lack of support by psychologists who wish to prescribe. This makes the reasonable requirement that prescribing privileges for psychologists should be as stringent as that for master's level nurse practitioners. This, in my professional opinion should be the requirement in any state that wishes to license psychologists to prescribe psychotropic medication. A second major rationale for psychologist prescription privileges is the expansion of services to underserved populations. This rationale is without any empirical support. It is clear from the experience of others states that have approved psychologist prescribing privileges that those psychologists practice in the same geographic areas as medical professionals, and so do not increase the availability of mental health services for underserved citizens. The patterns of practice locations of psychologists do not differ from those of psychiatrists in any state in which this has been studied. Underserved populations will not be better served by prescribing psychologists than they would be by expanding the training of psychiatric clinical nurse specialists. Your colleague, Richard Creagan, MD, has written cogently about why such prescription privileges are not sound in the following, which I am pleased to bring to your attention.
http://www.civilbeat.org/2016/04/hb-1072-would-endanger-mental-health-patients/
Thank you for considering my testimony.

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Elaine M. Heiby, Ph.D.
Licensed Psychologist and Professor Emerita of Psychology
2542 Date St., Apt. 702, Honolulu, HI 96826
Phone: (808) 497-0929 Email: heiby@hawaii.edu

2 February 2017

Hawaii State Legislature Senate Health Committee

Re: OPPOSITION to SB384 Relating to prescription privileges for psychologists

Dear Honorable Senators:

This is individual testimony that is informed from my experience as a doctoral level psychologist since 1980. My experience includes being a Professor of Psychology at the University of Hawaii at Manoa from 1981 to 2014, a Hawaii Licensed Psychologist since 1982, and a former member of the Board of Psychology. My opinions do not represent the University or the Board. My opinions are consistent with testimony submitted by Psychologists Opposed to Prescriptions Privileges for Psychologists (POPPP) and I am on the Board of Advisors of POPPP (https://www.poppp.org).

Purpose of HB767

This bill aims to expand the scope of practice of psychologists to that of psychiatrists based on only 10% of the medical training completed by psychiatrists. This expansion of scope of practice crosses disciplinary boundaries. It is not accurate to compare this expansion of scope of practice to permitting other health professionals, such as dentists and nurses, to prescribe as the training of these other allied health professionals is already premedical and medical in nature. In contrast, the training of psychologists is not related to the practice of medicine. Therefore, **this bill proposes a radical reduction of required medical training in order to practice medicine in Hawaii**.

Cost Implications

Some will have testified that this is a no-cost bill. This is not true. In order to offer the substandard medical training specified in this bill, it would cost the University of Hawaii-Hilo College of Pharmacy at least $250,000 per year (http://www.hawaii.edu/offices/app/aa/cms/MSCP_proposal_5-12-11_final_rev3.pdf).

Reasons for Opposition involve Risk to the Consumer

- Since 1996, bills similar to this one have been rejected at least 193 times in 26 states owing to substandard medical training (see 2016 map attached)

- Training for a doctorate in clinical psychology does not include pre-medical or medical training. Therefore, as stated above, comparison to expansion of scope of practice for dentists and nurses is erroneous because the training of these other professionals is already medical in nature.

- 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. This bill suggests there is solid evidence that licensing requirements for physicians and nurses is extremely excessive. Yet no such evidence exists and no bills to reduce the training required for physicians and nurses are being entertained.

- 89.2% of about 1000 members of the psychological Association for Behavioral and Cognitive Therapies (ABCT) argue the medical training for psychologists to prescribe should be equivalent to other non-physician prescribers (*the Behavior Therapist, September 2014)*. A survey of Illinois psychologist 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).

- Only 5.8% endorsed the effectiveness of online medical training, which is permitted in this bill (ABCT survey)

- Only 10.9% would refer a patient to a prescribing psychologist whose medical training is what is required in this bill (ABCT survey).

- 88.7% agreed that there should be a moratorium on bills like this one until there is objective evidence that the training involved protects the consumer (ABCT survey).

- The impact of prescribing privileges in New Mexico and Louisiana should be objectively evaluated for consumer safety before this experiment is repeated in Hawaii. Consumer safety outcome in the military is difficult to evaluate owing to the Feres Doctrine (barring lawsuits involving injuries to members of the armed forces) and the small number of prescribing psychologists (e.g., 2 in the Navy and 4 in the Air Force).

- 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 evidence of safety does not constitute evidence for safety.**

- There have been malpractice lawsuits filed against prescribing psychologists in New Mexico and Louisiana, so some problems in their practice have been asserted.

- Given proponents spent over $500,000 to pass a prescribing bill in Louisiana alone speaks to the availability of funds to conduct such a consumer safety study for the amount of medical training required in this bill.

- The choice by the APA to not conduct a consumer safety outcome study suggests a lack of concern about consumer safety. There has been erosion in the ethics of the APA in the past decades. The ethics of the APA has changed from professional ethics designed to protect the consumer to guild ethics, designed to increase the income of psychologists regardless of the impact upon the consumer (http://kspope.com/PsychologyEthics.php#contentarea).

- Evidence of this erosion is apparent in the disregard for consumer safety in prescribing and in other areas, such as the APA's explicit support of doing harm by endorsing psychologists to conduct torture and the APA's admitted deception of the membership by presenting voluntary contributions as mandatory.

  The State of Illinois has set the standard for prescription privileges for psychologists

  - Illinois Model for psychologists prescribing is not controversial

  - 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). http://ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1294&ChapAct=225%26nbsp%3BILCS%26nbsp%3B15%2F&ChapterID=24&ChapterName=PROFESSIONS+AND+OCCUPATIONS&ActName=Clinical+Psychologist+Licensing+Act%2E

  - The training requirement is similar to what is required of Physician Assistants, including undergraduate pre-medical training. This training includes 7 undergraduate and 20 graduate courses along with a 14-month practicum in multiple medical rotations.

- The Illinois Psychological Association and Nursing and Medical associations supported the Illinois law, as it requires the same medical training as other non-physician prescribers. Psychologists Opposed to Prescription Privileges for Psychologists (POPPP) does not oppose the Illinois Model because of the standard medical training required.

Solutions to access to psychoactive drugs while protecting the consumer

1. Collaboration between psychologists and physicians. The University of Hawaii-Hilo's College of Pharmacy provides training for such collaboration if needed (http://hilo.hawaii.edu/catalog/ms-clinincal-psychopharmacology.html).

2. Completion of medical or nursing school by psychologists. Encouraging medical and nursing schools to offer executive track programs for psychologists and social workers.

3. Use of Tele-psychiatry, which is promoted by the Department of Veterans Affairs and the U.S. Bureau of Prisons and **enabled by HB1272**

4. Modify this bill to meet the required training and scope of practice limitations in the Illinois law enabling psychologists to prescribe.

5. 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 attached chart; Source: Prof. T. Tompkins, 2010; used with permission; no prescribing psychologists in Guam identified despite enabling legislation in 1999).

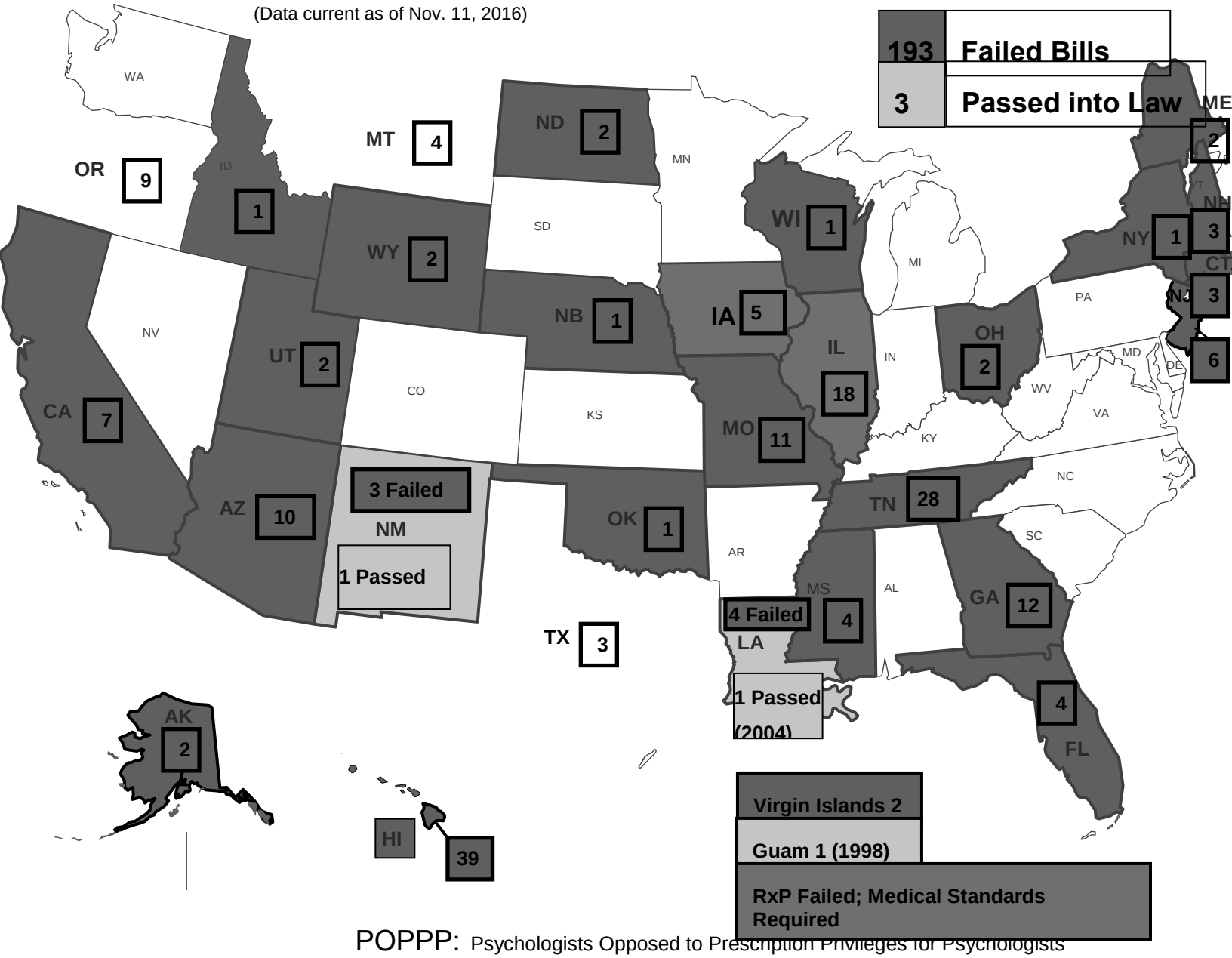
Thank you for your kind consideration of this opinion.

Respectfully,

Elaine M. Heiby, Ph.D.
Psychologist (HI license 242)
Professor Emerita of Psychology, UH-Manoa

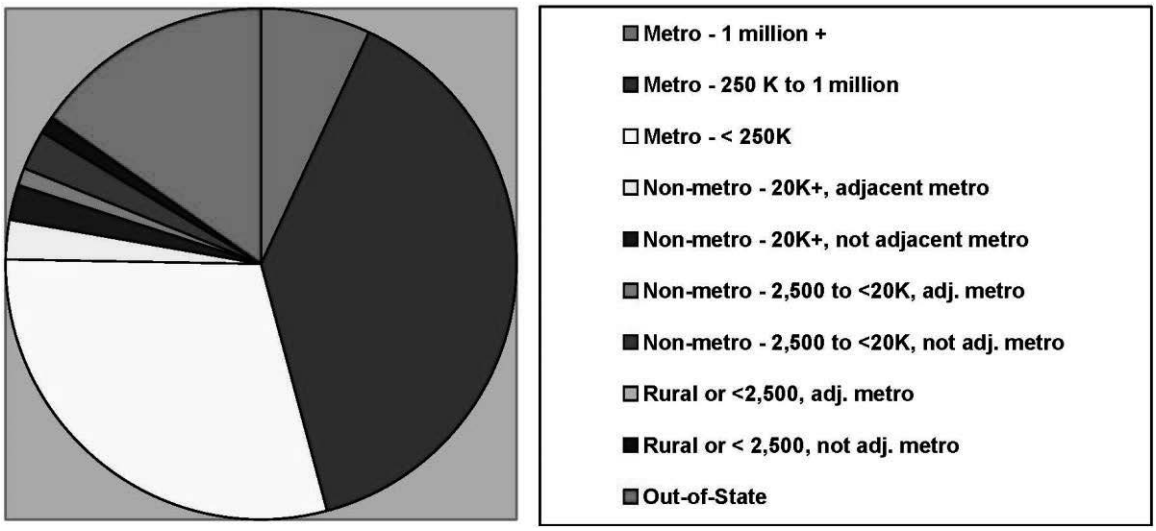
Psychologist Prescriptive Authority Legislative Bills 1995-2016

(Data current as of Nov. 11, 2016)



POPPP: Psychologists Opposed to Prescription Privileges for Psychologists

Combined Distribution of Psychologists Authorized to Prescribe Medications in NM, LA, and Guam



From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 2, 2017 5:45 PM
To: CPH Testimony
Cc: lenora@hawaii.edu
Subject: Submitted testimony for SB384 on Feb 9, 2017 09:00AM

SB384
Submitted on: 2/2/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Dr. Lenora Lorenzo	Individual	Support	No

Comments: I speak in support of SB 384 regarding Psychologists Prescribing Authority. Our ohana in our islands, particularly the neighbor islands and rural areas are unable to see psychiatric prescribers due to insufficient psychiatrist providers and or psychiatrist who do not accept Medicaid/Quest insurance. This is very problematic access issue. The trained and educated psychologist can help us to meet this access issue in a safe, cost effective and timely manner. The American Psychological Association has developed model curriculum includes education, and training leads to the certificating examination. I believe a supervisory period with the primary care provider (PCP) or psychiatric specialist (physician or APRN) and an ongoing collaborative agreement with primary care provider will support our psychologist to deliver both the psycho therapy and pharmacology therapy safely and effectively. Health care is changing such that all health care providers should be collaborating and working together for best practice and best outcomes. I believe an ongoing collaborative or collegial agreement with the PCP is imperative to support the prescribing psychologist and ensure best practice care for our ohana. Mahalo for your support of this important measure, O au me ka ha`a (I am humbly yours), Lenora Lorenzo DNP, APRN, BC FNP, GNP, ADM, CDE, FAANP University of Hawai'i SONDH Faculty Hawai'i Association of Professional Nurses Treasurer American Association of Nurse Practitioners Hawai'i State

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From: mailinglist@capitol.hawaii.gov
Sent: Thursday, February 2, 2017 5:22 PM
To: CPH Testimony
Cc: mendezj@hawaii.edu
Subject: *Submitted testimony for SB384 on Feb 9, 2017 09:00AM*

SB384
Submitted on: 2/2/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Javier Mendez-Alvarez	Individual	Support	No

Comments:

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From: Dr. Kelly Harnick <kcharnick@icloud.com>
Sent: Tuesday, February 7, 2017 4:45 AM
To: CPH Testimony
Subject: Fwd: Submitted testimony for SB384 on Feb 9, 2017 09:00AM

Aloha, Last week my testimony submitted through the Capitol website online for the house version of this bill did not seem to go through correctly, although I got this same confirmation. Just forwarding to make sure that it gets received by the committee and I look forward to testifying in person on Thursday morning. Thank you for the opportunity to address the committee in strong support. Mahalo Nui,

Dr. Kelly Harnick
Maui

Sent from my iPhone

Begin forwarded message:

> **From:** mailinglist@capitol.hawaii.gov
> **Date:** February 7, 2017 at 4:30:54 AM HST
> **To:** CPHtestimony@capitol.hawaii.gov
> **Cc:** kcharnick@icloud.com
> **Subject: Submitted testimony for SB384 on Feb 9, 2017 09:00AM**
>
> **SB384**
> Submitted on: 2/7/2017
> Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Kelly Harnick	Individual	Support	Yes

> Comments: I will be flying over from Maui, and providing my testimony in strong support in person to the committee, Mahalo for the opportunity to speak.
>
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To: Senate Committee on Commerce, Consumer Protection, and Health

From: Amber Lea Rohner Sakuda, MD

Subject: **SB 384, Relating to Prescriptive Authority for Certain Psychologists**

Hearing Date: Thursday 2/9/17, 9:00 AM

Position: **OPPOSED FROM MAUI**

Aloha Senator Baker & Members of the Committee on Commerce, Consumer Protection, and Health,

Mahalo for this opportunity to testify in opposition to SB 384. I am a medical doctor specializing in adult psychiatry with 2 years of sub-specialty training in child & adolescent psychiatry. This is my 6th year back home on Maui practicing psychiatry since I finished my 13 years of supervised training on thousands of patients. I'm very concerned about the lack of safety in HB 767 which would allow psychologists with no medical background to do substantially less training (400 hours over 1-4 years on 100 patients) to be able to prescribe many of the same medications I do. That means they could potentially prescribe addicting substances for ADHD like Desoxyn (methamphetamine) & Adderall (amphetamine salts) with minimal training & supervision.

I continue to be heavily involved in mental health integration/collaborative care efforts on Maui, helped with a case on Kauaʻi, & formerly helped on the Big Island as well, to train primary care physicians (PCPs) to manage psychiatric conditions better, which seems a much safer & cost effective way to improve access to mental health treatment. It would require a significant amount of time & money, and new legislation, to train a psychologist with absolutely no medical background how to try to function as a medical doctor specializing in psychiatry.

If your parent or child was depressed & suicidal & in need of medication, would you want them to see a psychiatrist with 12+ years of medical training, or a psychologist with 1-4 years of medical training? Let's do what is pono & protect patient safety.

Please support patient safety & **VOTE NO on HB 767**!

Mahalo nui loa for your consideration of my testimony.

Much Aloha,

Amber Lea Rohner Sakuda, MD

(808) 870-1093

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, February 8, 2017 5:35 AM
To: CPH Testimony
Cc: hwanddw@aol.com
Subject: Submitted testimony for SB384 on Feb 9, 2017 09:00AM

SB384
Submitted on: 2/8/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
David Wittenberg	Individual	Comments Only	No

Comments: I support SB384. We have a desperate need for more professionals to prescribe psychotropic medications on Maui. We have a shortage of prescribers and we cannot help many people in crisis. I help run the crisis team on Maui, Molokai and Lanai and we would welcome a prescribing psychologist to help with our shortage. Psychologists would help meet the need and have the necessary training to do it. Please pass this measure, we desperately want psychologist to help with our shortage. Their training is excellent. Thanks, Dr. David Wittenberg

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D. DOUGLAS SMITH, M.D.
229 Aiokoa Street
Kailua, Hawaii 96734

February 9, 2016 at 9:00 AM
Room 229

To: COMMITTEE ON COMMERCE, CONSUMER PROTECTION & HEALTH
Senator Rosalyn H. Baker, Chair
Senator Clarence K. Nishihara, Vice Chair

From: D. Douglas Smith, M.D.

Re: SB 384, Relating to Prescriptive Authority for Certain Psychologists

IN OPPOSITION

I would like to thank Chair Baker, Vice Chair Nishihara, and members of the Senate Committee on Commerce, Consumer Protection and Health for the opportunity to submit comments on SB384.

I am a physician who specializes in psychiatry and have spent my career practicing in Hawaii. For 11 years I was on the faculty of the JABSOM department of psychiatry and much of that time I coordinated psychopharmacology training for resident physicians.
I am opposed to this bill, and urge you to either overhaul it with extensive amendments to include all reasonable safeguards, or to vote to defer this bill.

There are several reasons why this bill, however well-intended, would be bad law. Few doubt that Hawaii's health plan networks lack adequate access to psychologists, psychiatric physicians, primary care doctors, specialists and other health professionals in rural and under-served communities across the state. This has limited access to safe and effective care, particularly on the outer islands. The purpose of SB384 is to help fix this.

Unfortunately, this bill's primary impact would be on Oahu, not the neighbor islands. The bill's low training standards are unsafe given the broad formulary and scope of practice it would allow. For over 20 years, psychologists seeking to prescribe have refused to adopt reasonable medical education and training standards, such as those comparable to APRN's. This bill would place considerable logistical and liability burdens on the Department of Health, exposing the State to foreseeably large claims. The bill is dismissive of the extensive medical education and training of psychiatric physicians. Its passage would demoralize this critical part of the healthcare workforce, making it harder to recruit and retain psychiatrists in Hawaii. SB384 would disrupt, distract and divide the mental health community at a time when teamwork and collaboration are desperately needed to adopt proven solutions to improving access to safe mental health care. The controversial nature of SB384 poses significant political risks if those who vote for its passage are later held to account for any failure to fix the access to care problem, for any new problems it creates, for any harms to patients and for any liabilities to the state or other entities.

For committee members hoping to be better informed about these matters, I have expanded upon this testimony at length, and attached relevant reports and documentation.

1. SB384 IS NOT A NEIGHBOR ISLAND BILL

Supporters have downplayed the fact that HB1072 is primarily about Honolulu county, not the outer islands. Star Advertiser reporter, Kevin Dayton, has described this proposal as "a measure that will allow specially trained psychologists to prescribe certain medications for people with mental illnesses on the neighbor islands." This reflects a false narrative about which communities will be most affected by this bill. The bill is not in any way limited to the neighbor islands, and all available evidence indicates that its primary impact will be on urban Oahu, where most eligible psychologists live and work. This is also the case in Louisiana, where between 91% and 97% of the 78 prescribing psychologists practice in urban and suburban areas. The same pattern is seen in New Mexico, the only other state with experience of prescribing psychologists. Even though supporters admit there is no shortage of psychiatric physicians on Oahu, this is where this bill will have the greatest impacts, for better or worse.

2. SB384 IS NOT A SAFE SOLUTION

The small number of influential psychologists who have been supporting this bill have made misleading claims about safety. First, they have long argued that since a Department of Defense (DoD) pilot program was found to be safe in the 1990's, what is being proposed will be safe too. Second, they have grossly misrepresented the proposed training as rigorous, high quality and on par with other prescribers such as APRN's. Third, they have repeatedly claimed that there have been no adverse events or complaints against the psychologists who have prescribed drugs in Louisiana and New Mexico. The first two claims are misleading, and the third claim is clearly false.

The first misleading safety claim is that the training model allowed under SB384 would be safe because "the DoD-PDP training model and standards were studied and shown to be safe and effective". This safety claim provides a superficial veneer of legitimacy by failing to point out that SB384 lacks the DoD-PDP program's limits on formulary and scope of practice, as well as its required minimum classroom and clinical training requirements and rigor. These DoD-PDP standards and safeguards are well documented in data published about the program. Concerns have been raised for over ten years about the repeated omission of these important standards and safeguards from crash course prescribing bills. For example, after the Legislative Reference Bureau's extensive review of this issue in 2007, the LRB's 104 page report concluded (see attachment):

> *If the Legislature deems it appropriate to authorize prescriptive authority for qualified clinical psychologists who practice in community health centers, the Legislature may wish to consider requiring a training model that requires minimum classroom and clinical training requirements no less rigorous than the PDP program training model and a scope of practice and formulary for graduates that is no broader than limitations applied to PDP program graduates.*
>
> *Regardless of the approach or solutions adopted to increase access to mental health services for the medically underserved population, it is clear that patient safety cannot be compromised. Patient safety should guide the Legislature's decision on the issue of prescriptive authority for qualified clinical psychologists under limited circumstances.*

By any objective measure, SB384 and 39 similar bills over the years in Hawaii have not met the LRB's common-sense safety standard, nor its more detailed recommendations. Consider that under SB384, psychologists would be approved by the State of Hawaii to prescribe potent, and often risky drugs after only 400 hours of clinical experience doing so. Compare this with the 10,000 hours (5 years full-time) of supervised experience the Hawaii legislature requires for journeyman plumbers and electricians:

> *HRS 448E-5 Minimum requirements.*
>
> *Journey worker electrician: To be eligible for the journey worker electrician examination, an applicant shall be at least eighteen years of age and shall provide satisfactory evidence of experience in residential or commercial wiring of at least* ***five years full-time*** *or its equivalent, but not less than* ***ten thousand hours****, in the trade* ***under the supervision*** *of a journey worker or supervising electrician;*
>
> *Journey worker plumber: To be eligible for the journey worker plumber examination, an applicant shall provide satisfactory evidence of experience of at least* ***five years' full-time*** *or its equivalent, but not less than* ***ten thousand hours****, as a journey worker's or master plumber's helper.*

SB384's required 400 hours of clinical experience, supervision of 100 patients, and 2 hours per week of supervision is NOT required to include the use of the broad range of psychotropic drugs and drug classes or the treatment of significant numbers of higher risk groups, such as children, the elderly, pregnant women, medically ill and severely mentally ill individuals. For example, SB384 would allow psychologists with no clinical experience evaluating or treating children with psychological or pharmacologic interventions to prescribe drugs to children. The same goes for prescribing drugs to teens, elderly, the medically-ill, pregnant women and the severely mentally-ill without required medical education, clinical training or supervised experience in caring for these high risk groups.

SB384 hides behind the fig leaf requirement for "clinical psychopharmacology programs designated by the American Psychological Association, or the equivalent of a post doctoral master's degree", while failing to point out that these low-quality programs are not required to have any significant training or supervised experience in the treatment of these higher risk populations with psychiatric drugs.

But it gets worse. Under Hawaii law, the five years of supervised experience required for prospective plumbers and electricians must consist of plumbing or electrical work. SB384 defies this common sense standard and is so carelessly written that there is no requirement that the 400 hours of clinical experience involve any supervised use of psychotropic medications at all. Psychologists would be able to satisfy SB384's clinical experience standard just by providing 400 hours of talk therapy!

The bill's omission of so many common-sense safeguards is of such great concern that it has been referred to as "crash course prescribing". Last session, the Hawaii House Committee on Health draft of a similar bill included more rigorous training standards, but the Senate simply removed them after crossover. One thing is clear at this point; it is not fair, modest or accurate to gloss over the omission of critical standards and safeguards in comparing the sketchy requirements of SB384 to those of the more rigorous and cautious DoD-PDP program.

The second safety claim in SB384 is that the training model it endorses for psychologists would be on par with other prescribers such as APRN's with prescriptive authority. This is not true because SB384 allows a broader formulary than for APRN-Rx, and because its required minimum classroom and clinical training requirements are much less rigorous. Compared to the APRN-Rx standards for faculty, admission requirements, curriculum, and supervision, MSCP programs fall woefully short (see attachment for details).

For example, consider the Basic Science and Preclinical Science curriculum of 9 semester hours that SB384 would allow for a prescribing psychologist vs 27 semester hours required for an APRN-Rx. MSCP psychologists at UH Hilo were provided just 6 semester-hours of recorded lectures on biochemistry and a 3 semester-hour taped class on human anatomy and physiology combined with microbiology ('1' = one semester-hour):

111111111 – MSCP psychologist (9)

111111111111111111111 – BSN-RN (21 non-prescribing)

111111111111111111111111111 – APRN-Rx (27)

111111111111111111111111111111111111111111111 – MD (45)

In terms of the proposed formulary, APRN-Rx are prohibited from prescribing controlled drugs that SB384 would allow psychologists to prescribe, including amphetamines and other stimulants for the treatment of attention deficit hyperactivity disorder (ADHD).

The third false claim is perhaps the boldest of all, and it's right there in the preamble of SB384, "There are approximately one hundred thirty psychologists with prescriptive authority in Louisiana and New Mexico. Furthermore, there have been no adverse events or complaints brought against any of these prescribing psychologists regarding their practice."

This is a startling claim to make for any medical provider who has prescribed medications for any length of time, especially psychiatric drugs that carry significant risks for side-effects and serious adverse events even in the best of hands. It is baffling that psychologists would spread such a rosy sounding falsehood. This suggests either a worrisome naivete and lack of clinical experience with these drugs, or a conscious desire to mislead the public about the risks and complexities of psychopharmacology.

Psychopharmacology is more challenging than most people realize. This is one of the reasons that even primary care physicians, who have completed extensive medical training, are sometimes uncomfortable using these medications. Generally, their reluctance is not because they are uncomfortable with psychiatric symptoms or diagnosis. It has to do with the complexity of how psychiatric medications are selected, the dosages and schedule of

administration, the effects on underlying medical conditions, and the interactions between psychiatric drugs and other medications. Properly identifying and managing side-effects can be challenging, particularly neurologic and psychiatric side-effects that can easily be misattributed as symptoms of the patient's illness.

Some psychiatric medications have low toxicity. These are the medicines that primary care physicians tend to be very comfortable using. In fact they are the largest prescribers of these widely used medications. However, most psychiatric medications can have significant medical or psychiatric side effects. Many of these carry warnings about the serious risks, such as heart arrythmias, seizures or suicidal thinking.

An example of a middle-risk medication is Vyvance, which is from a class of stimulant medications specifically mentioned in this bill as being allowed. Vyvanse is an amphetamine that is commonly used to treat Attention Deficit Hyperactivity Disorder. This drug can have significant medical side effects such as cardiac arrhythmias, seizures or even sudden death. It can also have significant psychiatric side effects, ranging from anxiety, insomnia and panic attacks to paranoia, hallucinations and delusions. It can cause aggression. Amphetamines and other stimulants such as Vyvance can have significant interactions with other drugs, such as the stimulating antidepressant Wellbutrin which itself and that carries some of these same risks. I have attached detailed FDA information about Vyvance to this testimony because this is where the rubber actually meets the road with this bill. I encourage committee members to look it over to better understand the types of medical and psychiatric risks that psychologists will commonly encounter if this SB384 is passed into law.

Some psychiatric medications carry major medical risks and complex medical risks that, frankly, can challenging even for psychiatric physicians to manage safely. An example of medication with such a high risks profile is Clozaril, used in the treatment of schizophrenia. To help the committee get a sense of the serious and complex medical risks that some psychiatric medications have, I have also attached information about Clozaril to this testimony. Another medication that could be placed in the high-risk category is Lithium, commonly used to treat Bipolar Disorder, as well as treatment resistant Depression. SB384 would also permit psychologists to use these high-risk psychiatric medications, and they will have to manage them safely. Frankly, I find this very unwise.

The point I'm trying to make, and which I encourage policy-makers and advocates to clearly understand, is that the use of psychiatric medications is not a low risk endeavor. It is not simple. These medications have potent effects on mind and body. If not prescribed and managed properly, people will get hurt. Many folks are not aware of these risks, and those of us who know better wish this wasn't the case. 12 years of doctoral training in psychology does nothing to reduce the medical risks of these drugs. Once in the body, these chemicals will do what they are going to do. We may wish all of the psychiatric medications were safe and easy to use, but that is just the way it is. Wishing won't change the facts.

So what about the claim that in New Mexico and Lousiana, the two states that have allowed psychologists to prescribe for several years, there have been no have been no adverse events such as those described above? Could this possibly be true?

No, of course not. Undoubtedly, there have been many, many adverse outcomes and complaints, many more than get reported formally. Those who are mentally vulnerable and often unable to advocate for themselves. However, absent a reasonable study of the matter, it is impossible to quantify the number and severity of these incidents. There have, however, been anecdotal reports of severe incidents, including lawsuits against prescribing psychologists and a 2014 firearm tragedy that made national news.

When first I heard about the FSU shooting, I looked into it. It turns out this incident and its aftermath were covered in depth by the press. Investigative reports, witness statements, autopsy reports and police reports are posted online. This mass shooting on a college campus appears to have resulted from a New Mexico psychologist giving a combination of the antidpressant Wellbutrin and the amphetamine Vyvanse to a young assistant district attorney back in the summer of 2014 when he sought help to focus better at work. Over the next few months, this unfortunate man, with no significant psychiatric history and a promising law career ahead of him, began to slowly unravel. He soon developed anxiety, insomnia and panic attacks, and later hallucinations and delusions of persecution. On several occasions, these problems were brought to the attention of his psychologist, but the medications were not managed properly. When this assistant DA's mental health crisis became unmistakable, it was not recognized and managed by his psychologist in a safe manner. His life ended tragically in November 2014 when he was killed after shooting 3 people because he believed he was the target of a conspiracy. His autopsy showed that the Amphetamine in his blood and urine at the time (see attachment).

3. SB384 WOULD PUT THE DEPARTMENT OF HEALTH AT RISK

The main "safeguards" in bill is that psychologists granted prescriptive authority would have to work in collaboration and consultation with licensed physicians, and with employed psychiatric physicians at the Department of Health for patients who are forensically encumbered or diagnosed with serious mental illness. These tend to be the most complex, most vulnerable and highest risk patients in the state.

The fact is, collaborating physicians, employers, health facilities, credentialing bodies and health plans would shoulder the burden of ensuring that prescribing psychologists have had sufficient education, training and supervised clinical experience for their practice activities. This is likely to increase medical liability and malpractice costs for these collaborating physicians and entities. If any of them fails to perform its due diligence in providing clinical oversight or in reviewing a prescribing psychologist's qualifications for the practice being approved, facilitated or permitted, they will be liable for any harms.

Under SB384, DOH would be responsible for "protocols" and the DOH psychiatrists required to collaborate with these psychologists would also be considered "treating psychiatrists". The way SB384 is written, this would include collaborating with any non-DOH psychologists practicing in the community who treat a patient with "Serious Mental Illness" (bipolar I disorder, bipolar II disorder, delusional disorder, major depressive disorder with psychotic features, psychosis secondary to substance use, schizophrenia, schizophreniform disorder, and schizoaffective disorder).

This committee just passed another bill, SB899, that is very relevant to the proposal to make psychiatric physicians within DOH responsible for entering into collaboration agreements and protocols with poorly-trained psychologists. Under this bill, the State will be liable "for injury or loss of property, or personal injury or death, arising or resulting from the negligent or wrongful act or omission of any professionally licensed or certified employee of the State while acting within the scope of the employee's office or employment."

Imagine if there is a situation like the FSU shooting? You can bet that Honolulu's aggressive plaintiff's attorneys will be eager to expose these low training standards and any errors in collaborative oversight. State taxpayers would be on the hook for any judgments in these cases. There are also political risks to any administrators at DOH and any politicians who are found to have allowed vulnerable and high-risk patients to be harmed by poorly trained psychologists. Few would want to expose themselves to scrutiny.

Another difficulty with SB384's reliance on collaboration with the DOH would be the fact that psychiatric diagnoses often change. Patients with Depression who are started on antidepressants can develop develop hypomania/mania or can develop psychosis. Patients who use illegal drugs, or even prescription stimulants or high-potency medicinal cannabis preparations, can develop psychosis. And when this happens, how would the prescribing psychologist manage these now "serious" cases?

If psychologists are not qualified to continue providing pharmacologic care for these "serious conditions" independent of DOH, would patients be placed at risk by interruption of medication and withdrawal symptoms? What would be the role of DOH be in such high-risk cases? Can it refuse to provide immediate care? Would there be liability issues with abandonment?

There can be disagreement about diagnoses as well, so for the purposes of this law, who's opinion will prevail, DOH or the psychologist or others? Again, keep in mind that these will be the more serious, higher risk cases that generally require urgent treatment and continuity of care to prevent bad outcomes.

For all of these foreseeable difficulties and risks, the combination of SB384 and SB889 is worrisome for Department of Health operations and the State's limited budget. The lack of safeguards in SB384, and its reliance on collaboration to make up for its broad formulary, its unlimited scope of patients and its low standards for education, training and clinical supervision, would create a ticking risk-management time-bomb for the state's budget and reputation. The State's assumption of this shared risk with community practitioners would be an unprecedented arrangement, creating a risk-management minefield in which DOH physicians would be expected to collaborate with these poorly trained psychologists in the care of the highest risk patients and to guard both patient and public safety. It will expose the deep pockets of the self-indemnified DOH (i.e. taxpayers of Hawaii) to any plaintiff with severe mental illness who is harmed under SB384's reckless scheme. Last year alone, the legislature had to approve $11 million to resolve claims against the state. Just think what one tragedy like the FSU shooting could cost.

The only way to reduce these risks to amend SB384 to include higher training standards, a narrower drug list and a limited range of patients similar to the Department of Defense

program, as recommended by the Hawaii Legislative Reference Bureau back in 2007 (see attachment). Failing to do so would be reckless in light of these foreseeable risks and liabilities.

Supporters of psychologist prescribing in Hawaii have had 10 years to adopt the LRB's common-sense safeguards, but have failed to do so. After all these years of having the crash course training rejected by our legislature (39 failed bills?), why haven't the psychologists who want to prescribe been willing to agree to adopt these reasonable safeguards? Why do they refuse proposals for more training? Why did they insist on removing such safeguards that the House Committee on Health had put into last session's bill? The answer appears to be that these few influential psychologists are not really concerned about ensuring patient safety.

4. SB384 WOULD MAKE IT HARDER TO RECRUIT AND RETAIN WELL-TRAINED PSYCHIATRIC PHYSICIANS IN HAWAII

Rather than responding to the many genuine concerns about their reckless proposal with reason and facts, the few Hawaii psychologists pushing for crash course prescribing have focused primarily on discrediting and marginalizing opponents. Over many years, detailed criticisms and inconvenient facts about this reckless proposal have been repeatedly brought to their attention, and they have have doubled down with the misleading claims that "organized medicine (has) conjured up as many misleading and false arguments as possible to block this proven initiative."

Putting blame on psychiatric physicians for the repeated failure of crash course psychologist prescribing and for the failure to implement safe and effective reforms to improve access to care has tended to marginalize them further. This is seen in the way some lawmakers, state agencies, private organizations, committees and task forces focused on improving access fail to reached out and partner with our state psychiatric association and community psychiatrists. This stigma is demoralizing to many psychiatric physicians, especially when "organized psychiatry" is painted as responsible for solving the access problem and for failing to do so.

We do have a shortage of psychiatric physicians and need to make Hawaii attractive for psychiatrist as a place to come to practice, and a place where their education, training and expertise are valued and respected. We want encourage local medical students to choose careers in Psychiatry, and to choose to practice here. We should also find ways for our Psychiatry residents here in Hawaii to have more experiences in rural and neighbor island areas in order to encourage them to live and work there.

It is my understanding that from 2000 to 2014 the Department of Psychology at Tripler Army Medical Center obtained substantial Federal funds for similar purposes, in terms of rural experiences and training local psychologists. Reportedly the Tripler psychology program received approximately $1 million per year for this purpose. During this time, the Tripler psychology department also contracted with Argosy University to train Tripler psychologists in psychopharmacology using Federal funds.

After learning about this successful initiative, I decided to ask Dr. Ray Folen about it. He has been one of the top psychologists at TAMC for many years, and one of the leaders in

the department. He was also listed as the Director of the psychopharmacology program at Argosy University during this time, so I figured he would have detailed knowledge of how these programs operated and were funded.

Dr. Folen did not return my calls to his workplace or the messages I left last year. Fortunately, I ran into him at the legislature last March.

I asked Dr. Folen how the psychologists at Tripler had managed to get these programs off the ground and where the funding came from. He told me that he knew nothing about the funding, and that he knew nothing about the Argosy psychopharmacology program. I told him that I was surprised by this because he was listed as being the program director at Argosy for several years. He again insisted he had nothing to do with it. So I asked him who was in charge of the program. He said he had no idea.

I found this surprising given that for many years Dr. Folen has pushed hard for psychologist prescribing in Hawaii, indeed it has been one of his top priorities. I pointed out that since he had been the chief of psychology at Tripler during this time, he might have known something about these matters. Dr. Folen became defensive. He admitted that he had taught at Argosy in the late 1990's, but reiterated firmly that he had no idea who was in charge of running the program or where the funding came from. I did not find him to be credible, and the available evidence about his professional affiliations contradicts what he told me (see attachment).

I have also written and left messages for Dr. Robin Miyamoto, who trained at Argosy and Tripler, and who also became one of the Tripler training directors during this time. I received no response. It is hoped that the psychologists involved in the Tripler and Argosy programs will one day be willing to share information that could help with the recruitment and retention of more psychiatric physicians in under-served areas of the state.

While I have no power to compel Drs. Folen or Miyamoto to share information, members of the committee might want to ask them about potential sources of funding and other ways of allowing Tripler or JABSOM psychiatry residents to travel to rural and outer island communities and provide the type of quality care, consultation and collaboration that we're all looking for.

There is also concern that Dr. Folen and those few psychologists who favor of crash course prescribing are not eager to see Hawaii recruit and retain more psychiatric physicians even while they bemoan the psychiatrist shortage in rural areas. They have repeatedly insisted that psychiatric physicians are responsible to for the failure to improve access to care over the years. They have disparaged psychiatric physicians as dishonest and unconcerned about patient suffering. It may be good political strategy to blame psychiatrists while misleading legislators, concerned advocates and the general public with demonstrably false and inaccurate claims, and while ignoring valid concerns about crash course prescribing, but it has been damaging and divisive to our mental health community over the past 30 years. It should be pointed out that such conduct is strictly prohibited under Hawaii Law:

> *Modesty, scientific caution, and due regard for the limits of present knowledge shall characterize all statements of psychologists who supply information to the public, either directly or indirectly. Psychologists who interpret the science of psychology or the services of psychologists to clients or to the general public have an obligation to*

report fairly and accurately. Exaggeration, sensationalism, superficiality, and other kinds of misrepresentation shall be avoided.
(Hawaii Administrative Rules TITLE 16 - CHAPTER 98 - PSYCHOLOGISTS).

The fact is, "organized psychiatry" is not the problem. The psychiatric Association has been working on and advocating for laws and policies to improve access to care, and they continue to do so. Meanwhile, hundreds of dedicated psychiatric physicians are working hard every day helping individuals across the state who struggle with our most complex and challenging biopsychosocial problems.

SB384 would communicate to these psychiatric physicians, loud and clear, that their years of medical education, training, and supervised practice are not respected or valued here in Hawaii. It is possible that the net impact of SB384 on qualified prescribers will be negative by discouraging psychiatrists from choosing to practice in Hawaii, by discouraging medical students from choosing to specialize in psychiatry, and by pushing older psychiatric physicians to retire early. Continuing to alienate, marginalize and exclude the state's largest and most qualified resource when we are facing a "shortage of prescribers" is not a winning strategy. SB384 would drive a permanent wedge between psychologists and psychiatrists when their cooperation is needed more than ever.

Programs and facilities that would require psychiatric physicians to "collaborate" with poorly trained prescribing psychologists may have a hard time recruiting and retaining them. The department of health's support for SB384 is baffling in this regard. With trouble filling its openings for psychiatrists to treat the state's most complex and highest risk patients, why would DOH support burdening them with responsibility for the medication decisions of psychologists with poor medical training? This should be reconsidered.

5. SB384 DISRUPTS & DISTRACTS FROM SAFE AND EFFECTIVE SOLUTIONS

The supporters of psychologist prescribing have convinced some lawmakers and advocates that "organized psychiatry" has shirked its duty to fix the access to care problem. As the state psychological association's executive director, Ray Folen, said last year:

> *Organized psychiatry has promised - primarily in years when a psychology prescribing bill is introduced in the legislature - to address the access to care problem in Hawai'i's rural, medically underserved areas, but they have ignored their promises or have come up with short-lived solutions that have ended in failure.*

It is misleading to claim that Hawaii's psychiatric physicians, beyond their own clinical practice, are responsible for adopting needed mental health system reforms and for providing the necessary funding, oversight, enforcement to implement them. Let's be clear: psychiatric physicians have never received special funding or legal authority to make the types of system reforms necessary to improve access to care.

The fact is, within our fragmented, privatized healthcare system, neither doctors, patients, nor lawmakers have the responsibility, resources or authority to ensuring access to care in underserved areas. The important question is, "Is there anyone who is responsible for fixing the access problem?" The answer is yes.

Hawaii's regulated health plans are legally responsible for maintaining adequate provider networks, and for the apparent failure to do so. These plans have the sophisticated statewide systems of command and control, expertise in health care operations necessary to improve access to care, and ample resources to do so, including combined revenues in excess of $6 billion per year.

For example, Optum-UnitedHealthCare and Ohana-Wellcare, for-profit corporations based in Minnesota and Florida, took in over $177 million more in combined annual revenue here in Hawaii than claims paid in 2013. This could have paid for over 800 more psychiatrists for Hawaii, more than four times the number currently in practice, and that is for just two of our Medicaid plans.

To be clear about who is responsible for ensuring access to mental health care in Hawaii, lets consider what the law says. All health plans in the state have made legal promises to provide an adequate network of clinicians to properly care for all members assigned to them and for whom they have received and accepted payments – including members with mental health needs in rural and underserved areas. For example, all MedQuest plans are required to provide access to behavioral health care:

> HAR 17-1735.2-4 (b)
>
> *[MedQuest plans shall include] development and maintenance of a sufficient network of health care providers to ensure the provision of required health services are provide to an eligible individual in a timely manner.*
>
> RFP–MQD–2014-005
>
> *The health plan shall have an established provider network that meets the requirements of this RFP at the time of proposal submission for all primary care, acute care, behavioral health and long-term care services including nursing facilities and home and community-based services providers. The health plan is solely responsible for ensuring it: (1) has the network capacity to serve the expected enrollment in the service area; (2) offers an appropriate range of services and access to preventive, primary, acute,* ***behavioral health****, and long-term services and supports (LTSS); and (3) maintains a sufficient number, mix, and geographic distribution of providers of covered services.*

Similar requirements are also present in other State and Federal laws governing commercial health plans and Medicare Advantage plans (HRS 432-F(2), 42 C.F.R. 438.206, CMS Medicare Managed Care Manual, etc...)

Managed health care plans in Hawaii can greatly improve the adequacy of their provider networks, including psychiatric physicians and psychiatric APRNs. There are numerous opportunities to increase participation rates, to recruit and retain qualified providers, to properly train more providers, to improve the efficiency of care, to improve member health, and to reduce unnecessary demand for services (see attachment). Unlike SB384, most of these approaches will not just improve access to psychiatric medications, but also to primary and other medical specialty care.

The common-sense policy solution to the lack of access problem is to compel our health plans to finally dedicate themselves to meeting their obligations rather than blaming others and making excuses. To make this happen, advocates and officials need to stop turning a blind eye to the problem and to start insisting on proper monitoring and enforcement of existing laws and contracts.

There are two Network Adequacy bills before the legislature this year (HB914 and SB387) that promise to help Hawaii better focus on who is responsible and what needs to be done to improve access to mental health care.

There are also two other legislative options seeking to ensure that rural patients with chronic diseases get same level of healthcare as can be obtained in an urban setting. Both involve educating, training, and supporting rural primary care practices. HB1272 would expand Medicare's recent support for Psychiatric Collaborative Care to include the state's MedQuest program. SB1045 would allow the department of health to implement and administer an ECHO program, which is being championed by U.S. Senator Brian Schatz.

We need to pass these measures rather than blaming "organized psychiatry" and being distracted by risky, divisive and inadequate proposals.

RECOMMENDATIONS

Lawmakers can reduce these five areas of risk by avoiding taking sides on this controversy and by minimizing future harms to public health and the state budget:

1. Insist that SB384 be amended to adopt the LRB's recommended safeguards from the best studied prescribing psychologist regime – the DoD-PDP (see attachment). If this is not agreeable to supporters, the bill should be deferred.
2. Commit to support the monitoring and enforcement of legal standards for health plan network adequacy so that health plans are compelled to begin using their massive resources to implement safe, effective and sustainable strategies to improve access to care.
3. Support collaborative approaches that are non-divisive and that have been proven to be safe in published studies.

Thank you for allowing me to testify on HB 767, and your consideration of these concerns is appreciated. Please contact me if I can be of any assistance to the committee.

Sincerely,

D. Douglas Smith, M.D.

PRESCRIPTIVE AUTHORITY FOR PSYCHOLOGISTS: ISSUES AND CONSIDERATIONS

LYNN MERRICK
Research Attorney

Report No. 2, 2007

Legislative Reference Bureau
State Capitol
Honolulu, Hawaii 96813

http://www.hawaii.gov/lrb/

FINDINGS AND SUMMARY

A need to increase access to mental health services statewide, particularly for the medically underserved population, is acknowledged by clinical psychologists, psychiatrists, community health centers, other health care providers, state agencies, and consumers. After a two year study, SHPDA will submit its final report to the 2007 regular session of the Legislature, identifying barriers and offering solutions to increase access to specialty health care, including mental health services, to those in medically underserved areas. Given SHPDA's expertise as the State's health planning agency, their suggestions to increase access to health care deserve serious consideration by the Legislature.

Whether prescriptive authority for certain qualified psychologists who practice in community health centers is an appropriate approach to increasing mental health services for medically underserved areas and populations is a policy decision for the Legislature. The Bureau makes no recommendation on the issue, but notes that only one training model has been evaluated and found to have successfully trained postdoctoral clinical psychologists to prescribe psychotropic drugs for patients with mental illness, the PDP program. The PDP program included the following requirements or factors:

1. A one year full time classroom training at a university that included medical science courses and courses tailored to participants needs;
2. A one year full time clinical training at a medical center that included inpatient and outpatient experience and supervision by psychiatrists, and a wide range of health care professionals, labs, and other equipment available in close proximity;
3. All participants had doctoral degrees in psychology and at least some years of clinical experience before entering the PDP program;
4. Development of the PDP training model and curriculum had input from psychologists, psychiatrists, representatives of American Association of Medical Colleges, the Accreditation Council for Graduate Medical Education, the medical school of the Uniformed Services University of Health Sciences, and the Walter Reed Army Medical Center;
5. The success of PDP graduates suggested that candidates for any similar training program, whether military or civilian, should be held to high selection standards; several years of clinical experience was also suggested;
6. Patients treated were generally limited to outpatients between the ages of 18 to 65, without serious medical conditions or serious mental illnesses;
7. Drugs prescribed were limited to psychotropic medications and adjunctive drugs;
8. Graduates received supervision by psychiatrists during their initial postgraduate medical facility assignment; and
9. Health care in military medical facilities is reported to be an open, collaborative practice that permits ready access to patient information and consultation with other health care providers.

In addition, in any deliberation of whether to authorize prescriptive authority for qualified psychologists who practice in community health centers, legislators also should include consideration of the following caveats:

10. Only two states have authorized certain psychologists to prescribe and little evaluative data from these states has been reported because those laws are very new;
11. Prescribing psychologists in New Mexico and Louisiana are in private practice in the civilian sector which does not provide the collaborative approach to medicine in which PDP participants trained and practiced; patient safety has not been established for this type of practice for which there is no "safety net;"
12. In contrast to patients treated by PDP graduates, clients who need mental health services at Hawaii community health centers include children and seniors and persons having both a serious mental illness and a serious medical condition;
13. There is no program that authorizes psychologists to prescribe psychoactive medications for children or seniors that has been evaluated or determined to be safe;
14. Unlike the development of the PDP training model and curriculum, the American Psychological Association training recommendations were developed solely by psychologists;
15. Current psychopharmacology training programs that authorize online learning, weekend classes, and optional clinical experience are considerably less rigorous than the PDP training model, and there are significant variations between the various programs;
16. No current psychopharmacology training programs appear to offer specialized training on the effects of medication on children and seniors;
17. Admission into current postdoctoral psychopharmacology programs require only a doctoral degree in psychology and a current state license to practice psychology; these minimal requirements do not establish the high selection standards suggested by the ACNP evaluation panel or the minimum two year clinical experience recommended by the Advisory Council;
18. In contrast to admission requirements for psychopharmacology training programs, an applicant to a psychiatry residency is subject to stricter scrutiny; a personal statement, recommendation letters, transcripts from undergraduate and medical school, and a personal interview are minimum requirements;
19. The Advisory Council to the PDP program recommended that applicants to the program should have a minimum of 2 years experience as a clinical psychologist;
20. No postdoctoral training program in psychopharmacology that meets the APA training recommendations has been externally evaluated and deemed successful; and

21. There is no postdoctoral training in psychopharmacology for clinical psychologists in Hawaii that has high selection standards to choose participants or that meets the classroom and clinical training requirements of the PDP program.

If the Legislature deems it appropriate to authorize prescriptive authority for qualified clinical psychologists who practice in community health centers, the Legislature may wish to consider requiring a training model that requires minimum classroom and clinical training requirements no less rigorous than the PDP program training model and a scope of practice and formulary for graduates that is no broader than limitations applied to PDP program graduates.

Regardless of the approach or solutions adopted to increase access to mental health services for the medically underserved population, it is clear that patient safety cannot be compromised. Patient safety should guide the Legislature's decision on the issue of prescriptive authority for qualified clinical psychologists under limited circumstances.

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Argosy University/Honolulu

Academic Catalog Addendum 2004–2005

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ARGOSY UNIVERSITY

Thomás Cummings Ph.D.
Colorado State University
Faculty in Graduate Psychology
Dr. Cummings has been at the school since September 2000. His areas of interest include cross-cultural assessment, neuropsychology, anger management, post-traumatic stress disorder, sexual dysfunction, Taoist/Buddhist meditation, and the incorporation of religious and spiritual beliefs in the psychotherapeutic process. He is a health research specialist with the National Center for Post-Traumatic Stress Disorder Research, Veterans Administration, Honolulu, Hawaii. He is a consultant for the Primary School Adjustment Project and has a small private practice. He teaches the assessment I course, psychopathology, and group therapy.

Raymond A. Folen, Ph.D., ABPP
University of Hawai'i at Manoa
Director of the Postdoctoral Program in Clinical Psychopharmacology
Dr. Folen has been teaching at the school since it opened and serves as director of the postdoctoral program in clinical psychopharmacology. Dr. Folen is also chief of the Behavioral Medicine and Health Psychology Service at Tripler Army Medical Center and has over 23 years of postdoctoral experience in clinical practice, research, and training. He has published extensively in the areas of behavioral medicine, biofeedback, telehealth, psychopharmacology, and professional issues in psychology. Dr. Folen is Board Certified in Clinical Psychology, is past-president of the Hawaii Psychological Association, and is a fellow of the American Psychological Association. He is one of 150 psychologists in the country recognized as a Distinguished Practitioner by the National Academies of Practice. His current courses include personality assessment, assessment integration, and diversity issues in health psychology.

Claudette H. Ozoa, Ph.D.
University of Nebraska-Lincoln
Faculty in Graduate Psychology
Dr. Ozoa has held appointments as staff psychologist at the Stratton Veterans Administration Medical Center, New York where she specialized in psycho-oncology/hospice and geriatrics, and Memorial Hospital, Albany, New York where she gained extensive experience working with multidisciplinary teams. Dr. Ozoa was a principal partner, Capital Psychological Associates, Albany, New York and founded OnePinkRibbon.com. Her clinical work has focused on women's health issues; in particular breast cancer and the impact psychoeducational and coaching techniques have on women's response to treatment and recovery. Additionally, she has clinical interests in post-traumatic stress disorder, sexual abuse, and relationship issues. Currently, Dr. Ozoa maintains a part-time private practice primarily focused on pain management and behavioral medicine with a special focus on how psychological well-being impacts recovery from and coping physical illness. Dr. Ozoa teaches courses in group therapy, child and family therapy, assessment I, developmental psychology, and leads practicum seminars.

Louise Penkman, Ph.D., C.Psych.
University of Victoria
Faculty in Graduate Psychology.
Dr. Penkman has interests in pediatric oncology which is implicated through her active involvement in research such as: developing educational and rehabilitative interventions for children with neurological dysfunction, creating links for professionals working with understudied populations, and a focus on psychosocial programs for children with cancer and their families. Prior to joining Argosy University/Honolulu, she was an adjunct assistant professor at the University of Calgary's Department of Oncology. Her areas of interests are in educational and rehabilitative interventions for children with neurological dysfunctions and children with cancer and their families. She has clinical experience working with indigenous youth and their families on Canada's west coast.

HB767 - ANALYSIS OF PROPOSED STANDARDS & SAFEGUARDS

In 2006-2007, the Hawaii Legislative Reference Bureau (LRB) conducted an impartial review of the psychologist prescribing issue. The LRB's detailed 100 page report made no recommendation on the final question, but noted that only one training model has been evaluated and found to have successfully trained postdoctoral clinical psychologists to prescribe psychotropic drugs for patients with mental illness, the 1990-1997 Department of Defense PDP program (DoD-PDP). The Bureau's final recommendation was:

> If the Legislature deems it appropriate to authorize prescriptive authority for qualified clinical psychologists who practice in community health centers, the Legislature may wish to consider requiring a training model that requires minimum classroom and clinical training requirements no less rigorous than the PDP program training model and a scope of practice and formulary for graduates that is no broader than limitations applied to PDP program graduates.
>
> Regardless of the approach or solutions adopted to increase access to mental health services for the medically underserved population, it is clear that patient safety cannot be compromised. Patient safety should guide the Legislature's decision on the issue of prescriptive authority for qualified clinical psychologists under limited circumstances.

The primary question for policy makers should be, "How close does the process proposed under HB767 come to meeting the LRB's recommended requirements for (A) clinical training, (B) scope of practice, (C) medication formulary and (D) patient safety?" Another question of importance is (E) "Does HB767 have any budgetary implications or other risks?"

A. PROPOSED TRAINING AND SUPERVISION REQUIREMENTS ARE INADEQUATE

The LRB recommended that the Legislature require a training model with minimum classroom and clinical training requirements no less rigorous than the PDP program training model. How close does the process proposed under HB767 come to meeting the LRB's recommended requirements for clinical training?

As noted by the LRB, the Department of Defense PDP training program included the following four requirements or factors:

1. Curriculum: PDP students had one to two full-time years of classroom training in the basic and preclinical biomedical sciences, and one year of full-time clinical training at a medical center that included inpatient and outpatient experience. This totaled 2-3 calendar years of full-time study. The PDP training model and curriculum was designed and approved not just by psychologists, but also by psychiatric physicians, representatives of American Association of Medical Colleges, the Accreditation Council for Graduate Medical Education, the medical school of the Uniformed Services University of Health Sciences, and the Walter Reed Army Medical Center.

Graduates of the apparently defunct University of Hawaii at Hilo Masters of Science in Clinical Psychopharmacology (UHH-MSCP) and Argosy University MSCP programs did not require applicants to demonstrate passing grades in any of the usual prerequisite courses or labs in basic foundational sciences, and instead claimed to provide students with equivalent basic science and preclinical biomedical education in a fraction of the time. At the UHH-MSCP program, listening to recorded lectures was the primary teaching method. The program told applicants, "As a distance learning online program, we offer flexible scheduling to ensure that your education does not impair your current work schedule."

In terms of biomedical science, UHH-MSCP applicants were not required to have completed any of the standard courses or labs for science majors. Instead, the psychologists were provided 6 semester-hours of recorded lectures on biochemistry, as opposed to the standard 21 semester-hours of general, organic and biochemistry required for other students at the College of Pharmacy. The psychologists received just a 3 semester-hour taped class combining human anatomy & physiology and microbiology, material that normally spans 24 semester-hours for other students at the University of Hawaii. Taken together, the basic and preclinical science provided to MSCP psychologists totaled just 9 credit-hours, compared to 21 credit-hours for non-prescribing nursing students, at least 27 credit-hours for APRN students, and 46 credit-hours for pharmacists and physicians. The following represents the amount of required basic and preclinical coursework ('1' = one semester-hour):

11111111 – MSCP psychologist at UHH (9)
1111111111111111111 – BSN-RN (non-prescribing) at UHH (21)
111111111111111111111111 –APRN at UH Manoa (27)
111111111111111111111111111111111111111111111 – Pharmacist at UHH (46)
111111111111111111111111111111111111111111111 – MD at JABSOM (46)

UHH-MSCP program provided a total of 33 credit-hours education. This is equivalent to a one year, two semester graduate program, though it is spread over 6 semesters with a 1/4 - 1/3 time student schedule. The Argosy University MSCP program offered graduates only a 22 semester credit hour curriculum. For comparison, nursing students enrolled in the U.H. Hilo Bachelor of Science in Nursing program (BSN) receive a total of 123 credit-hours over 4 years, and APRN's with prescriptive authority receive even more.

As the LRB concluded, "Current psychopharmacology training programs that authorize online learning, weekend classes, and optional clinical experience are considerably less rigorous than the PDP training model." HB767 permits these low standards and lacks reasonable safeguards regarding quality and duration of the DoD-PDP curriculum.

2. Selective Admission: The PDP had a selective admission process and the LRB concluded that "candidates for any similar training program, whether military or civilian, should be held to high selection standards; several years of clinical experience was also suggested… The Advisory Council to the PDP program recommended that applicants to the program should have a minimum of 2 years experience as a licensed clinical psychologist."

There is no evidence that the criteria used by the UHH-MSCP program to select applicants recognized the challenges of its accelerated curriculum. It required no entrance examination or other evidence to ensure that its psychologists were sufficiently gifted or exceptionally qualified to allow them to safely bypass so much of the standard biomedical science coursework. In fact, its program coordinator admitted that her students were often "scared by biochemistry". The program did not require applicants to have 2 years or more of experience as a licensed clinical psychologist. The MSCP student selection process basically takes all comers.

Advising against this, the LRB cautioned, "Admission into current postdoctoral psychopharmacology programs require only a doctoral degree in psychology and a current state license to practice psychology; these minimal requirements do not establish the high selection standards suggested by the ACNP evaluation panel or the minimum two year clinical experience recommended by the Advisory Council." HB767 lacks these reasonable safeguards regarding the quality and experience of MSCP applicants.

3. Expert Clinical Supervision: PDP students were supervised by physicians specialized in psychiatry, and a wide range of health care professionals, labs, and other equipment available in close proximity.

The UHH-MSCP program's first director was a pharmacist with no experience treating patients with psychiatric drugs, or even on the pharmacy aspects of psychiatric drugs. This is also the case for the next program director, Supakit Wongwiwatthananukit, PharmD, a veterinary pharmacist whose main contribution since transferring to the School of Pharmacy from the U.H. Cancer Center, was designing a curriculum for pharmacy students to treat animals. As he described this, "The curriculum was designed to expose students to a veterinary clinical setting."

The basic science portion of the UHH-MSCP curriculum was not taught by qualified faculty with relevant degrees in these respective fields. Chemistry material was not taught by chemists. Biology material was not taught by biologists. This does not even meet community college standards.

According to current program listings, the only UHH-MSCP faculty who were trained to prescribe medications are Allen Novak, APRN-Rx and Kristine McCoy, MD, a family doctor. Both were listed as "guest lecturers".

The UHH-MSCP program had no other faculty or clinical training sites to provide the necessary supervised clinical experience. Instead, students were required to find their own clinical training sites and volunteer supervisors. Generally this meant a primary care doctors at a community health center. It is notable that even though the program's director advocated for psychologist prescribing by insisting that primary care doctors are not qualified to treat mental illness, the program relied on these same doctors as the primary supervisors for its psychologist trainees.

HB767 lacks reasonable safeguards regarding the quality of program faculty and clinical supervisors.

4. Post-graduate Collaboration: PDP graduates received close supervision by psychiatric physicians during their initial postgraduate medical facility assignment, and an ongoing open, collaborative practice that permitted ready access consultation with physicians who were on-site or readily available.

The process proposed under HB767 requires psychologists to maintain documented "collaborative agreements" and "treatment protocols" with DOH psychiatrists for patients with serious mental illness, and with the primary care physician for all other patients. These required collaborations, protocols and

agreements would be the primary safeguards in the bill, but it is difficult to assess exactly what they would entail, how they will be meaningful, and their medico-legal implications. One thing is clear, these are likely to be the primary focus of scrutiny in event of adverse outcomes.

B. PROPOSED SCOPE OF PRACTICE LACKS SAFEGUARDS

How close does the process proposed under HB767 come to meeting the LRB's recommended requirements for scope of practice?

The LRB recommended that the Legislature require a scope of practice that is no broader than limitations applied to PDP program graduates. It also noted:

> There is no program that authorizes psychologists to prescribe psychoactive medications for children or seniors that has been evaluated or determined to be safe.

The PDP scope of practice was limited to outpatients between the ages of 18 to 65, without serious medical conditions or serious mental illnesses. HB767 does not have this safeguard, would allow psychologists to prescribe risky drugs to children, teens, elderly, the medically-ill and the severely mentally-ill. Most people don't understand that there are no requirements for adequate supervised clinical experience for each of these specialized areas of practice, either during MSCP training or even in psychology doctorate programs.

HB767 does not require psychologists to meet the usual standards American Psychological Association (APA) for specialized training in child psychology or for proficiency in assessment and treatment of serious mental illness before prescribing drugs to in these higher risk cases. There is no evidence that any MSCP program offers the specialized biomedical, clinical and psychopharmacologic training required to safely treat children, seniors and other higher risk patient populations with drugs.

This bears repeating, HB767 would allow psychologists who have no clinical experience evaluating or treated children with psychological or pharmacologic interventions to prescribe drugs to children. The same goes for prescribing drugs to teens, elderly, the medically-ill and the severely mentally-ill. The bill's lack of such a common-sense safeguard is of great concern.

C. PROPOSED MEDICATION FORMULARY LACKS SAFEGUARDS

The LRB recommended that the Legislature require a formulary that is no broader than the limitations applied to PDP program graduates. How close does the process proposed under HB767 come to meeting the LRB's recommended requirements for the medication formulary?

Because PDP psychologists did not treat patients with severe mental illness, their medication formulary was limited to the lower risk drugs prescribed for less serious conditions. HB767 lacks this reasonable safeguard, and would permit psychologists use all psychiatric medications, a formulary that is nearly equivalent to that used by psychiatric physicians.

D. HB767 LACKS MULTIPLE DoD-PDP SAFEGUARDS

The LRB recommended that patient safety should guide the Legislature's decision on the issue of prescriptive authority for clinical psychologists. All agree that psychiatric drugs are no less complex and no less risky when prescribed by a Hawaii psychologist than by others. Once they are in someone's body, the chemicals will do what they do. Nevertheless, HB767 lacks many of the common-sense safeguards of the PDP, that could be described as "someone allowed to provide a medical service, should first have the substantial and relevant education, training and supervised experience for that speficic service". Consider the following comparison of safeguards:

- 2-3 years of quality, full-time biomedical training? *PDP -yes, HB767–no*
- Selective applicant process? *PDP -yes, HB767–no*
- Qualified preclinical and clinical faculty? *PDP -yes, HB767–no*
- Supervisors expert in the use of psychiatric drugs? *PDP -yes, HB767-no*
- Limited to the lowest risk medications? *PDP -yes, HB767–no*
- Videotaped lectures as primary teaching method? *PDP-no, HB767-yes*
- Prescribe drugs to children? *PDP-no, HB767-yes*
- Prescribe drugs to teens? *PDP-no, HB767-yes*
- Prescribe drugs to pregnant women? *PDP-no, HB767-yes*
- Prescribe drugs to the elderly? *PDP-no, HB767-yes*
- Prescribe drugs to the medically-ill? *PDP-no, HB767-yes*
- Prescribe drugs for severe mental illness? *PDP-no, HB767-yes*
- Psychology training in treating children? *PDP-n/a, HB767-no*
- Psychology training in treating teens? *PDP-n/a, HB767-no*

- Psychology training in treating pregnant women? *PDP-n/a, HB767-no*
- Psychology training in treating the elderly? *PDP-n/a, HB767-no*
- Psychology training in treating the medically-ill? *PDP-n/a, HB767-no*
- Psychology training in treating severe mental illness? *PDP-n/a, HB767-no*
- Medical training in treating children with drugs? *PDP-n/a, HB767-no*
- Medical training in treating teens with drugs? *PDP-n/a, HB767-no*
- Medical training in treating children with drugs? *PDP-n/a, HB767-no*
- Medical training in treating pregnant women with drugs? *PDP-n/a, HB767-no*
- Medical training in treating the elderly with drugs? *PDP-n/a, HB767-no*
- Medical training in treating severe mental illness with drugs? *PDP-n/a, HB767-no*
- Does HB767 mention any of this in its preamble? *No.*

SUMMARY

The available evidence continues to support the LRB's conclusion that, "There is no postdoctoral training in psychopharmacology for clinical psychologists in Hawaii that has high selection standards to choose participants or that meets the classroom and clinical training requirements of the PDP program."

The PDP only allowed psychologists to prescribe only after a 2-3 year, full-time biomedical training program, taught and supervised by qualified medical school faculty at Walter Reed. When finished, these military psychologists were only allowed to use a limited list of the safest psychiatric drugs to treat healthy adults aged 18-65, but not children, teens, elderly, the medically-ill or the severely mentally-ill.

HB767 does not compare favorably to an objective examination of the PDP training program safeguards for the admission process, curriculum and training content, duration, faculty and supervisor qualifications, and required clinical settings. This is alarming given that the bill also fails to require and the important PDP safeguards of a narrow scope of practice and limited formulary. This risk is compounded by the fact that neither conventional clinical psychology training nor MSCP programs require any significant education or supervised clinical experience for children, seniors or other specialized patient populations.

Another safeguard missing from HB767 involves psychologists who may have completed MSCP training years ago, perhaps 10-15 years ago or more, and who have no evidence of substantial relevant prescriptive practice or continuing education since then. Allowing these individuals to begin prescribing after such a long gap, especially given the sketchy quality of the training being considered, is yet another concern.

It is clear, according to the LRB's independent and objective analysis of this controversial issue, that HB767 does not require adequate education and training and poses significant risks to patient safety. The bill's primary safeguard, consultation and collaboration with physicians, will push these risks down to the level of those responsible for oversight the prescribing psychologists. For the highest risk cases, this would include department of health psychiatrists. Any future claims of inadequate training and negligent supervision would be very difficult to defend given the findings of the LRB and other independent experts.

All of these risks and costs can be avoided by voting against HB767, and instead implementing initiatives that are safe and proven to work.

Assistant District Attorney killed in shootout after being prescribed Antidepressants and Stimulants by New Mexico psychologist

On November 20, 2014, 31-year-old New Mexico attorney Myron May opened fire on students and employees in and around Strozier Library at Florida State University (FSU) before being shot and killed by police. His autopsy showed that he had Amphetamine in his blood and urine, likely the Amphetamine prescribed for him by his psychologist for several months.

Myron May was a popular student at his alma mater, having been elected as a student senator at FSU. After graduating from FSU with honors, May attended Texas Tech law school, where he obtained his juris doctorate.

At first recruited into at a national law firm, May later opted to join a smaller firm in Houston, representing employees instead of management. Leaving behind employment law and Houston, he moved to Las Cruces, New Mexico in January 2014, where he worked first as a Public Defender and then as an Assistant District Attorney in Dona Ana county. In New Mexico, May first practiced under a "limited license" before passing that state's Bar exam and being sworn in May 2014. He was well liked and respected.

With a heavier case load as a prosecutor, May sought help over the summer from a prescribing psychologist to focus better at work. The psychologist prescribed him Wellbutrin, an antidepressant, and Vyvanse, an amphetamine drug approved for Attention Deficit Hyperactivity Disorder (ADHD). New Mexico was one of only three states in the U.S. that allowed some psychologists to prescribe medications.

After taking these drugs for three weeks, May suffered a panic attack at work. After a second panic attack, May returned to the prescribing psychologist for an adjustment to his medications. At one point, he also went to a hospital emergency room due to panic and anxiety.

May reportedly became increasingly paranoid and delusional, believing that he was being targeted by a secret government program. On September 7, May's girlfriend called the police. May told the officers that someone was watching him through a camera hidden in his apartment, and the police laughed at him, according to a witness. He complained of hearing voices coming in through the walls as he bathed. He complained that he wasn't sleeping because of his neighbors' constant spying and that their voices kept him up. May said he wanted to buy a gun and take revenge on his neighbors. At one point, May documented these psychotic experiences on YouTube and his belief he was the target of a far-flung and intricate government conspiracy. (See: www.youtube.com/watch?v=a1vIkUZjRl4)

The 2008 FDA-approved label for Vyvanse (lisdexamfetamine) warns of treatment emergent or worsening psychosis, mania, hallucinations and delusional thinking. An FDA review of pediatric postmarketing adverse events involving Vyvanse further revealed that the drug regulatory agency has received other reports of homicidal ideation in children, an unlabeled event.

(See: www.accessdata.fda.gov/drugsatfda_docs/label/2008/021977s001lbl.pdf)

Frightened and concerned about his medications, May's friends contacted his prescribing psychologist who reportedly met with May and declared him to be fine. Within a few days, May had voluntarily checked himself into Mesilla Valley Hospital, a mental health center. He was released four days later to the care of his prescribing psychologist.

On October 5, May drove to Denver and back, making frantic phone calls to his friends from the road. He reportedly said that the police were on to him, that his hotel room was bugged, that he was being followed, and that he would be a millionaire when he brought justice to the crooked cops who were persecuting him. Unable to get help from his prescribing psychologist, May's friends contacted the facility he had been to the month before, Mesilla Valley Hospital, but were told he would have to come there voluntarily, be brought by the police or committed by his psychologist.

Two days later, May went to the County sheriff's office because he couldn't take it anymore and was going to turn himself in. He was turned away. That evening, May's girlfriend called police when he came to her home and appeared floridly delusional. He had left before they arrived. It is not clear why his prescribing psychologist did not intervene.

(See: www.scribd.com/document/252093571/Myron-May-Police-Report-Oct-7)

One month after abruptly quitting his job with the District Attorney's office, May walked into Florida State University's Strozier Library with a gun, shot and wounded three students, and was gunned down by police. Nathan Scott and Farhan "Ronny" Ahmed were hospitalized after being shot by May. Mr. Scott recovered, but Mr. Ahmed was paralyzed. The tragedy could have been much worse. Student Jason Derfuss, who found a bullet in his backpack upon returning home, was saved by his books and a high-impact plastic water bottle. Bullets also reportedly grazed or narrowly missed students Elijay Velez and Robert Cohen. May's gun also malfunctioned as he attempted to shoot library security employee Paige McPhadden.

Toxicology results showed that assistant District Attorney May had amphetamine in his system at the time of his death, likely the Vyvance given to him from his prescribing psychologist.

(See: page 16 www.scribd.com/document/252095421/Myron-May-s-autopsy-report)

HOW CAN HEALTH PLANS CREATE ADEQUATE PROVIDER NETWORKS

A`ohe hana nui ka alu`ia

No task is too big when done together.

Over the long run, and often in the short run as well, the most effective and affordable way to improve access to safe, quality care is to strengthen our health care workforce with adequate numbers of committed, culturally competent and well-trained doctors, and to maximize community health through prevention and early detection, thereby reducing need for medical and other health care. Some visionary leaders have planted seeds for these changes that can grow into long term solutions if the conditions are favorable. So, let's roll up our sleeves and start to help out, because cultivating those conditions will not be easy at the outset. Throughout our healthcare community, many will have to re-prioritize, restructure or retrain to be able to fully contribute to a better way of keeping as many of our people healthy, and wisely caring for those who become ill. Make no mistake - given the direct-care manpower demands, we all need to do our part.

Many already realize that we must head in this direction; they see the destination in their mind's eye or have been lucky enough to get glimpses of it taking place. What is less clear is which policy initiatives will help move all of Hawai`i over to the health care Promised Land. In policy debates thus far, it has been said that no single entity can fix what ails the system, nor can one organization solely address the widespread change needed. This conclusion should be examined.

While it is true that no one person or entity can fix things, it is worth considering, "Is there is an organization, or group of organizations, that has the primary authority, ability and responsibility for ensuring that the necessary widespread change is effectively carried out?"

If there is a top candidate group for this leadership role, it is the health plans doing business in Hawai`i. These health plans operate in all of our communities, and the insurance companies that run them have over $6 billion of combined annual revenue. They are the only entities with the authority, expertise and resources to select, design and implement reforms on the scale necessary to be successful.

There is debate about whether or not health plans are responsible for more than token preventive and wellness activities, and they have largely kept provider recruitment and retention at arms length. Plans may avoid involvement in such activities for fear that the interventions are too nonspecific, or have no clear endpoints. How do you know when someone has enough health? Should every beneficiary be given their own personal coach, trainer and chef?

A. Supply and Demand

Under the traditional insurance model, health plans are only responsible for providing "medically-necessary" services once illness occurs, but not before. Technically and legally this is correct, and if plans choose to stop there it seems they can. Under this model, health plans have devoted resources to such tools and practices as utilization management (UM), quality improvement, and claims scrutiny, even though this has weakened provider relations and their ability to maintain adequate provider networks.

Some health plans may be less interested in initiatives to increase the overall supply of providers (though they should) and more with the practice mix (how many of specific specialties vs primary care), geographic distribution and plan participation levels of doctors. If there is a statewide shortage, but a particular plan has enough of the right kind of doctors in the right places who are willing to see enough members, maybe it doesn't matter what is happening with other plans.

Health plan network adequacy regulations require that the supply of providers is equal or greater than members needs for necessary services. This can be expressed as: Supply ≥ Demand. Unfortunately, health plans are able to give the appearance of adequate provider networks by a combination of:

- Inflating provider directories (false Supply ≥ Demand).
- Hiding complaints and other evidence of lack of access (Supply ≥ false Demand).

Across the country, there is growing awareness that proper regulation is necessary to ensure a supply of providers equal or greater than members' needs for necessary services: true Supply ≥ true Demand. The remedies for inadequate provider networks include some combination of:

- Increased provider Supply by recruitment, retention and workforce development.
- Increased Efficiency by coordinated care and reduced utilization management.
- Reduced beneficiary Demand by prevention, wellness, and early illness detection.

Policy makers and State regulators must realize that health plans remain legally responsible for adequate provider networks, and that the primary focus of health plan regulation should be authentic network adequacy. Plans should otherwise be given as much freedom as possible to choose themselves from the many tested strategies available to improve specialty and primary care provider network recruitment and retention.

Before considering these specific strategies available to health plans to improve access to care, let's take a moment to acknowledge one of the challenges of sustaining a system of adequate health plan provider networks. Once plans achieve adequate provider networks, the notorious "free rider" or "carpetbagger" problem emerges. A "free rider" health plan could then be able to achieve an adequate provider network without doing much at all,

and profit from the efforts and investments of the other plans. This would be particularly true for late-comers, and for-profit insurance companies. Compared to the current situation, this would be a welcomed problem - one that policy-makers may have to find a solution for through innovative contracting, legislation or enforcement. Hawai`i health plans have a shared interest in increasing overall supply and distribution of our providers, as well in reducing service demands through prevention, primary care and wellness. Efforts should be made to encourage cooperation and to discourage opportunistic selfish profiting. Plans should keep this in mind as they consider their options.

B. Increasing Supply: Provider Recruitment and Retention and Training

1. Traditional Recruitment Efforts – the Quick Fix:

- Marketing.
- "Head hunters".
- Locum Tenens.
- Relocation assistance.
- Help with practice start-up expenses.
- Retention challenges (distorted expectations, do not adjust to our culture, lack deep social ties, less committed to staying in Hawai`i).

2. Strengthen Hawai'i-based incentives and supports – the Long Game:

- Local students and residents have family and friends here, are culturally sophisticated regarding our people and more committed to their communities over the long haul - retention is high.
- The Native Hawai`ian Health Scholarship Program (NHHSP) tuition for tuition, books, other educational costs, and a monthly stipend.
- Targeted training exposure - rural medical student rotations.
- 'Imi Ho'ōla helps 12 college seniors from disadvantaged backgrounds to JABSOM.
- JABSOM summer programs for high school students.
- Visits by doctors and medical school students to high school classrooms, career fairs.
- Neighbor Island Residency Training (Hilo Family Residency Program established in 2014 with health plan funding).
- Rural, Recruitment and Retention Network (3R Net) for posting jobs in Hawai`i.
- The Department of Health's Office of Primary Care and Rural Health (OPCRH).
- The Hawai`i Primary Care Office (PCO).
- Expansion of the Hawai`i /Pacific Basin Area Health Education Center (AHEC).

3. Increase use of National Health Service Corps (NHSC) incentives by CHC's:

- The Hawai`i Loan Repayment Program (HLRP) up to $40,000 a year.
- NHSC Students to Service Loan Repayment Program (S2S LRP) up to $120,000.
- NHSC Loan Repayment Program (NHSC LRP) up to $50,000.
- NHSC Faculty Loan Repayment Program, up to $40,000.
- Conrad 30 (J-1 Visa) program for foreign medical graduates who trained in the U.S.
- NHSC Medical Students Scholarship Program, tuition, fees, other educational costs, and provides a living stipend.

4. Payment Reforms and other Incentives and Assistance:

- Pay bonuses to PCPs to meet care targets (quality, wellness, prevention).
- Pay providers higher rates for services delivered in rural and underserved areas.
- General Excise Tax breaks for services delivered in rural and underserved areas.
- Coordinate with our congressional delegation to secure a fair increase in the Hawai`i Medicare provider payment Geographic Adjustment Factor (1.003 = average) based on our high taxes and living costs (172% above average).
- Seek to prohibit non-compete clauses in provider employment contracts.
- Reduce risk and cost of part-time practice to retain competent older doctors
    - Medical fraud enforcement reform.
    - Malpractice and disciplinary reform (Hawai`i rate of 3.53 severe disciplinary actions per 1000 physicians is well above average).
    - Make unnecessary technical changes optional (electronic medical records).
    - Keep maintenance of certification (MOC) voluntary.

5. Improve Communication – the Cornerstone of Provider Relations:

- Written information about changes to administrative procedures, clinical break-throughs, quality measures, and legal updates.
- Provider relations shift from the telephone to in-person meetings at provider offices.
- Placed representatives in the communities that they serve.
- Routine provider site visits, with the frequency of such visits depending on member volume (monthly at sites with 500 or more members, every six weeks or once per quarter for those with less).
- For downloads that replace direct mailings (newsletters), send email with the newsletter in the body or a link that takes the user to the desired information.
- Conduct annual provider satisfaction surveys and share the results and the Plan's cor-

rective actions.

- Mixed-mode survey (mail survey, e-mail reminders and Web-based option) higher response rates.
- Survey announcement letter or an e-mail about the upcoming survey, estimated timeline for arrival and deadline, when and how results will be made available, and encouraging participation.
- Supplement written or online satisfaction surveys, interview providers and take notes.
- For identified areas of poor performance, use provider focus groups to gain further information and insight and to hear about specific scenarios and examples of provider issues.
- Target areas needing performance improvement, determine interventions, implement and re-measure provider satisfaction at a later date.

6. Improve the Provider Recognition Practices:

- Highlight local examples of provider best practices in office administration, clinical practices, and quality measures in its provider newsletter and public forums.
- Recognize providers with dedication, expertise to encourage and retain them and as models for others.
- Thank network providers who provide uncompensated care to the uninsured in addition to care of plan members.
- Thank providers with personal letters from the medical director, newspaper radio and television spots.
- Annual county provider dinner with Quality awards (trophy and gift) to the most outstanding provider.

7. Strengthen the Provider Outreach Practices:

- Identify potential recruits by tracking claims submitted by nonparticipating specialists, and encourage them to join the network.
- Ask their contracted PCPs in rural communities to identify which specialists accepted their referrals based on informal collegial relations.

C. Increasing Efficiency: Help Doctors Focus on Patient Care not Paperwork

1. New Models of Care: Coordination and Technology

- Increased use of available AV technology for telehealth (Zoom) for direct care.
- Increased use of AV technology for collaborative care and consultation between primary care providers and specialists.
- Reimbursement and support for collaborative and team-based care models.

- Initiatives that educate, train, and support rural general practitioners or other available healthcare representatives on the best practice treatment protocols for complex diseases (project ECHO).

2. Improve UM practices and Reduce Administrative Burdens:

- Improve in UM customer service.
- Use technology tools to facilitate authorizations and referrals.
- Web-based search engines so that providers can search by diagnosis code for conditions that require authorization.
- No referral/authorization requirements for office-based services of in-network specialists.
- No referral/authorization requirements for services that have a high approval rate.
- No authorizations that specialists are required to obtain from PCPs.
- Replace authorizations based on dollar thresholds or number of visits, with more meaningful categories like:
    - Serious or complex medical conditions.
    - High-cost conditions.
    - Conditions with a history of overutilization or inappropriate utilization.
    - Conditions with corresponding legal requirements (e.g., hysterectomies and sterilizations).
- Have knowledgeable representatives, available to providers during regular Hawai`i working hours.
- Identify and evaluate outlier provider participation (high or low volume) assess for quality and reasons for participation rates, and incorporate into QI process.
- Correct errors in provider directories.

3. Simplify the Health Care Encounter Data Submission Process:

- Contract with a central clearinghouse, (e.g., WebMD) for providers to submit encounter data,
- Offer providers a coach to review current coding methods and teach strategies that could improve encounter data accuracy and reimbursement levels.

4. Simplify the Process for Verifying Member Eligibility:

- Medicaid status changes frequently for members.
- Contracting providers require a simple and dependable access to member eligibility status.
- Online lookup system through a secure Web application.

- Interactive voice response (IVR) option that verifies eligibility by telephone.
- Card swipe system can help high-volume practices to verify eligibility.
- Facilitate printing verification of eligibility, and honor claims for retroactively terminated members.

5. Simplifying the Provider Credentialing Process:

- Reduce the amount of documentation that providers must submit.
- Enabling electronic submission of credentialing documents.
- Extend re-credentialing from every two to every three years.
- Contract with a central clearinghouse to reduce submissions to multiple health plans (Council for Quality Affordable Health Care).
- Implement fair use of "board certification" and educate members about this.

6. Assist with Practice Operations (enabling service practices):

- Support use of Telemedicine in areas with shortages of health care professionals and services.
- Case management and other services aimed at patients who have trouble keeping appointments.
- Address the social barriers that may prevent or interfere with members' ability to receive medical services:
    - Transportation services.
    - Child care arrangements.
    - Interpreter services.
    - Cell phones so case managers can contact them.
- Private practice education and outreach of residents, non-participating area doctors.
- Assist with CME, MOC, credentialing with focus on plan priorities, population needs.
- Providing practical assistance to providers interested in starting a private practice.
- Provide access to free, open source, user friendly and certified electronic medical record billing and prescribing software that is interoperable with plan systems.

D. Reducing Demand: Focus on Wellness, Prevention, and Early Detection

Providers and Health Plans should increasingly focus on helping members become healthier and avoid getting sick or injured in the first place. Network Adequacy will benefit from a multi-pronged campaign that provides advocacy materials focused alcohol, obesity, public safety, safe vaccination, tobacco use, and wellness and prevention. Some

plans might choose to adjust premiums or use other incentives for healthy behaviors. With their expertise in designing and implementing effective strategies to modify human behavior, Health Psychologists will be central to these efforts.

1. Advocate for Healthy choices, Habits and Behaviors:

- Getting 7-8 hours of sleep each day.
- Avoiding intake of tobacco, alcohol and other intoxicants, and excessive caffeine
- Learning proper Mindfulness based Stress Reduction.
- Regular physical activity, gentle movement throughout the day and periodic exercise.
- Avoiding prolonged sedentary activities.
- Avoid excessive "screen time".
- Paying attention to posture, body position and movement.
- Adequate intake of fresh water, avoiding drinks with sugar and caffeine.
- Good bowel habits, with adequate fiber intake.
- Eating fresh whole fruits, vegetables, starches and fish – culturally and geographically appropriate.
- Involvement with fishing, gardening or community supported agriculture.
- Avoid intake of processed foods with high content of fats, oils, sugars and simple starches.
- Regular kindness with each other, including physical touch when appropriate.
- Wearing helmets and safety belts and following work place safety rules.
- Avoiding risky sexual behaviors.
- Washing hands, and practicing good hygiene.
- Properly preparing and storing food.
- Recognizing the value of good health and making it a top priority.
- Practicing water safety.
- Take steps in youth activities to reduce and detect concussions and head injury.

2. Individual and Organization Health Measurement:

Gallup-Healthways Well-Being 5: Validated survey instrument measures, tracks and reports on the well-being of individuals and organizations.

- Physical - having good health and enough energy to get things done daily.
- Community - liking where you live, feeling safe and having pride in your community.
- Financial - managing your economic life to reduce stress and increase security.

- Social - having supportive relationships and love in your life.
- Purpose - liking what you do each day and being motivated to achieve your goals.

3. Other Health Plan Wellness and Prevention Initiatives:

- Facilitate participation from online consumer support communities.
- Assist members seeking to make healthy lifestyle changes (HMSA365 Discounts costs for gym memberships, yoga classes, healthy food and vitamins, health books and magazines, discounts on hearing aids, eye exams, frames, lenses, LASIK, non-emergency medical transportation, acupuncture, hypnotherapy, massage…).
- Health Education Workshops for members teaching about aspects of health and well-being.
- Support community wellness initiatives (Blue Zones).
- Provide coverage for evidence-based wellness services (Ornish Institute, ‘Ekahi health).

4. Health Coaching for improving well-being and managing diseases:

- Hawai`i-based Coaching Team includes registered nurses, exercise physiologists, health educators, registered dietitians, and other health care professionals.
- Teach strategies for dealing with unhealthy impulses, habits and situations.
- Guidance and support in setting realistic goals.
- Member chooses how to get support and how often, over the phone or online.
- Examples: asthma and obstructive pulmonary disease; heart failure and coronary artery disease; diabetes; and stress, depression, substance abuse, smoking (QuitNet® tobacco cessation program).
- Provides referrals to other services that might help with diet, exercise, and nutrition.

5. CE Focus for Providers, Nurses, Health Psychologists and other counselors:

- Providing motivation and encouragement for healthy lifestyle changes.
- Providing education to all age groups, especially young adults how to stay healthy, in a form they can understand, and based on needs and interests.
- Improve Motivational Interviewing skills.
- Provide preventive services such as cancer screenings, preventive visits and vaccinations.
- Providing family planning to prevent early and unplanned pregnancy.
- Programs to effectively prevent violence, sexual assault and bullying.
- Providing housing support to individuals who are homeless or at risk.

- Providing those recovering from chronic illness with jobs and volunteer opportunities.
- Providing counseling to support prudent financial decisions and money management.
- Providing representative payee services when necessary.
- Providing transportation or outreach services when necessary.
- Prescribing use of lowest effective doses of medications in all age groups, especially kupuna.
- Improve communication about end of life care and use of advance directives and hospice (Having the Conversation).
- Minimize use of narcotic analgesics outside of hospice-palliative care.

E. Summary

The 18 approaches and 137 practices listed above are just some of the many available to health plans for reducing unnecessary demands on provider networks and increasing their supply of participating providers. Our large state-wide and national insurance companies are best able to implement coherent plans to achieve and maintain adequate provider networks. Insurers may choose to cooperate on shared initiatives with one another, with provider groups and individual doctors, and/or with state officials and policy makers. Several of these strategies have already been implemented by Hawai`i health plans and been proven to work here in the islands.

Medications Frequently Used for Psychiatric Indications

The classification of psychotropic medication is fairly standard but medications can be used for treatment of illnesses that would be considered listed under a different classification. For example, some medications listed under antipsychotics maybe used as a mood stabilizer.

Antidepressants
amitriptyline (Elavil)
amoxapine (Asendin)
bupropion (Wellbutrin, Wellbutrin SR)
bupropion (Wellbutrin XL)
citalopram (Celexa)
desipramine (Norpramin)
desvenlafaxine (Pristiq, Khedezla)
doxepin (Sinequan)
duloxetine (Cymbalta)
escitalopram (Lexapro)
fluoxetine (Prozac)
imipramine (Tofranil)
levomilnacipran (Fetzima)
maprotiline (Ludiomil)
mirtazapine (Remeron, Remeron SolTab)
nefazodone (Serzone)
nortriptyline (Pamelor, Aventyl)
paroxetine (Paxil, Paxil CR)
protriptyline (Vivactil)
sertraline (Zoloft)
trazodone (Desyrel)
trimipramine (Surmontil)
venlafaxine (Effexor, Effexor XR)
vilazodone (Viibryd)
vortioxetine (Brintellix)

Anxiolytics/Sedatives/Hypnotics
alprazolam (Xanax, Xanax XR)
buspirone (BuSpar)
chlordiazepoxide (Librium)
clonazepam (Klonopin)
clorazepate (Tranxene)
diazepam (Valium)
diphenhydramine (Benadryl)
eszopiclone (Lunesta)
flurazepam (Dalmane)
hydroxyzine (Atarax, Vistaril)
lorazepam (Ativan)
oxazepam (Serax)
pentobarbital (Nembutal)
ramelteon (Rozerem)
suvorexant (Belsomra)

temazepam (Restoril)
triazolam (Halcion)
zaleplon (Sonata)
zolpidem (Ambien)
zolpidem (Ambien CR)

Antipsychotics
aripiprazole (Abilify, Abilify Discmelt)
aripiprazole (Abilify Maintena)
Aripiprazole lauroxil (Aristada)
asenapine (Saphris)
brexpiprazole (Rexulti®)
chlorpromazine (Thorazine)
clozapine (Clozaril, Fazaclo, Versacloz) **** see sample toxicity profile (below)***
droperidol (Inapsine)
fluphenazine (Prolixin)
fluphenazine decanoate (Prolixin D)
haloperidol (Haldol)
haloperidol decanoate (Haldol D)
iloperidone (Fanapt)
loxapine (Loxitane)
loxapine inhalant (Adasuve)
lurasidone (Latuda)
molindone
olanzapine (Zyprexa, Zyprexa Zydis)
olanzapine pamoate (Zyprexa Relprevv)
paliperidone (Invega)
paliperidone palmitate (Invega Sustenna)
paliperidone palmitate (Invega Trinza)
perphenazine (Trilafon)
pimozide (Orap)
quetiapine (Seroquel)
quetiapine (Seroquel XR)
risperidone (Risperdal, Risperdal M-Tab)
risperidone (Risperdal Consta)
thioridazine (Mellaril)
thiothixene (Navane)
trifluoperazine (Stelazine)
ziprasidone (Geodon)

Chemical Dependency Adjuncts
acamprosate (Campral)
disulfiram (Antabuse)
naltrexone (ReVia, Vivitrol)
topiramate (Topamax)

Monoamine Oxidase Inhibitors
isocarboxazid (Marplan)
phenelzine (Nardil)

selegiline (Emsam)
tranylcypromine (Parnate)

Mood Stabilizers
carbamazepine (Tegretol, Tegretol XR, Carbatrol, Equetro)
divaiproex sodium (Depakote, Depakote ER, Depakote Sprinkles)
lithium (Eskalith, Eskalith CR, Lithobid)
valproic acid (Depakene)
oxcarbazepine (Trileptal)
lamotrigine (Lamictal)

Stimulants
amphetamine/dextroamphetamine mixture (Adderall, Adderall XR)
dexmethylphenidate (Focalin, Focalin XR)
dextroamphetamine (Dexedrine, Dexedrine ER-)
lisdexamfetamine (Vyvanse)
methamphetamine (Desoxyn)
methylphenidate (Ritalin, Ritalin SR, Concerta, Metadate, Metadate CD)
methylphenidate patch (Daytrana)
methylphenidate solution (Quillivant XR)

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use Vyvanse safely and effectively. See full prescribing information for Vyvanse.

Vyvanse (lisdexamfetamine dimesylate) Capsules, CII

Initial U.S. Approval: 2007

WARNING: POTENTIAL FOR ABUSE
See full prescribing information for complete boxed warning

- Amphetamines have a high potential for abuse; prolonged administration may lead to dependence (9)
- Misuse of amphetamines may cause sudden death and serious cardiovascular adverse events

-----RECENT MAJOR CHANGES-----

Indications and Usage, Adult (1.1)	04/2008
Dosage and Administration, Adult (2)	04/2008

-----INDICATIONS AND USAGE-----

Vyvanse is a prodrug of dextroamphetamine, a stimulant, and is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). (1)

-----DOSAGE AND ADMINISTRATION-----

- Recommended dose: Adults and pediatric patients ages 6-12; 30 mg once daily in the morning (2)
- Maximum dose: 70 mg once daily in the morning (2)

-----DOSAGE FORM AND STRENGTHS-----

- Capsules: 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg (3)

-----CONTRAINDICATIONS-----

- Advanced arteriosclerosis (4)
- Symptomatic cardiovascular disease (4)
- Moderate to severe hypertension (4)
- Hyperthyroidism (4)
- Known hypersensitivity or idiosyncrasy to sympathomimetic amines (4)
- Glaucoma (4)
- Agitated states (4)
- History of drug abuse (4)
- During or within 14 days following the administration of monoamine oxidase inhibitors (MAOI) (4, 7.2)

-----WARNINGS AND PRECAUTIONS-----

- Serious Cardiovascular Events: Sudden death has been reported in association with CNS stimulant treatment at usual doses in children and adolescents with structural cardiac abnormalities or other serious heart problems. Sudden death, stroke and myocardial infarction have been reported in adults taking stimulant drugs at usual doses for ADHD. Stimulant products generally should not be used in patients with known structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, coronary artery disease or other serious heart problems. (5.1)
- Increase in Blood Pressure: Monitor blood pressure and pulse at appropriate intervals in patients taking Vyvanse. Use with caution in patients for whom blood pressure increases may be problematic. (5.1)
- Psychiatric Adverse Events: Use of stimulants may cause treatment-emergent psychotic or manic symptoms in patients with no prior history, or exacerbation of symptoms in patients with pre-existing psychosis. Clinical evaluation for bipolar disorder is recommended prior to stimulant use. Monitor for aggressive behavior. (5.2)
- Seizures: may lower the convulsive threshold, and in the presence of seizures, should be discontinued. (5.3)
- Visual Disturbance: difficulties with accommodation and blurring of vision have been reported with stimulant treatment. (5.4)
- Tics: may exacerbate tics. Clinical evaluation for tics and Tourette's syndrome is recommended prior to stimulant administration. (5.5)
- Long-Term Suppression of Growth: monitor height and weight at appropriate intervals in pediatric patients taking Vyvanse. (5.6)

-----ADVERSE REACTIONS-----

- Children ages 6 to 12: Most common adverse reactions (incidence ≥5% and at a rate at least twice placebo) were decreased appetite, dizziness, dry mouth, irritability, insomnia, upper abdominal pain, nausea, vomiting and decreased weight. (6.2)
- Adults: Most common adverse reactions (incidence ≥5% and at a rate at least twice placebo) were upper abdominal pain, diarrhea, nausea, fatigue, feeling jittery, irritability, anorexia, decreased appetite, headaches, anxiety, and insomnia. (6.2)

To report SUSPECTED ADVERSE REACTIONS, contact Shire US Inc. at 1-800-828-2088 or FDA at 1-800-FDA-1088 or www.fda.gov./medwatch

-----DRUG INTERACTIONS-----

- Urinary acidifying agents may reduce blood levels of amphetamine. (7.1)
- Urinary alkalinizing agents may increase blood levels of amphetamine. (7.2)
- MAOI antidepressants are contraindicated. (4; 7.2)
- The effects of adrenergic blockers, antihistamines, antihypertensives, phenobarbital, and phenytoin may be reduced by amphetamines. (7.3)
- The effects of tricyclic antidepressants, meperidine, phenobarbital and phenytoin may be potentiated by amphetamines. (7.4)
- Norepinephrine may potentiate the effects of amphetamines. (7.6)

-----USE IN SPECIFIC POPULATIONS-----

- Pregnancy: Use only if the potential benefit justifies the potential risk to the fetus. Based on animal data, may cause fetal harm. (8.1)
- Nursing Mothers: should refrain from breastfeeding. (8.3)
- Pediatric Use: has not been studied in children under 6 years of age or in adolescents over 12 years of age. (8.4)
- Geriatric Use: has not been studied in geriatric patients. (8.5)

See 17 for PATIENT COUNSELING INFORMATION and Medication Guide.

Revised: XX/2008

FULL PRESCRIBING INFORMATION: CONTENTS*

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*Sections or subsections omitted from full prescribing information are not listed.

FULL PRESCRIBING INFORMATION

WARNING: POTENTIAL FOR ABUSE

AMPHETAMINES HAVE A HIGH POTENTIAL FOR ABUSE. ADMINISTRATION OF AMPHETAMINES FOR PROLONGED PERIODS OF TIME MAY LEAD TO DRUG DEPENDENCE. PARTICULAR ATTENTION SHOULD BE PAID TO THE POSSIBILITY OF SUBJECTS OBTAINING AMPHETAMINES FOR NON-THERAPEUTIC USE OR DISTRIBUTION TO OTHERS AND THE DRUGS SHOULD BE PRESCRIBED OR DISPENSED SPARINGLY.

MISUSE OF AMPHETAMINES MAY CAUSE SUDDEN DEATH AND SERIOUS CARDIOVASCULAR ADVERSE EVENTS.

1 INDICATIONS AND USAGE

1.1 Attention Deficit Hyperactivity Disorder

Vyvanse™ is indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

The efficacy of Vyvanse in the treatment of ADHD was established on the basis of two controlled trials in children aged 6 to 12 and one controlled trial in adults who met DSM-IV-TR®) criteria for ADHD *[see CLINICAL STUDIES (14)]*.

A diagnosis of Attention Deficit Hyperactivity Disorder (ADHD; DSM-IV®) implies the presence of hyperactive-impulsive and/or inattentive symptoms that cause impairment and were present before the age of 7 years. The symptoms must cause clinically significant impairment, e.g. in social, academic, or occupational functioning, and be present in two or more settings, e.g. school (or work) and at home. The symptoms must not be better accounted for by another mental disorder. For the Inattentive Type, at least 6 of the following symptoms must have persisted for at least 6 months: lack of attention to details/careless mistakes; lack of sustained attention; poor listener; failure to follow through on tasks; poor organization; avoids tasks requiring sustained mental effort; loses things; easily distracted; forgetful. For the Hyperactive-Impulsive Type, at least 6 of the following symptoms (or adult equivalent symptoms) must have persisted for at least 6 months: fidgeting/squirming; leaving seat; inappropriate running/climbing; difficulty with quiet activities; “on the go”; excessive talking; blurting answers; can’t wait turn; intrusive. The Combined Type requires both inattentive and hyperactive-impulsive criteria to be met.

Special Diagnostic Considerations

Specific etiology of this syndrome is unknown, and there is no single diagnostic test. Adequate diagnosis requires the use not only of medical but also of special psychological, educational, and social resources. Learning may or may not be impaired. The diagnosis must be based upon a complete history and evaluation of the patient and not solely on the presence of the required number of DSM-IV characteristics.

Need for Comprehensive Treatment Program

Vyvanse is indicated as an integral part of a total treatment program for ADHD that may include other measures (psychological, educational, social) for patients with this syndrome. Drug treatment may not be indicated for all patients with this syndrome. Stimulants are not intended for use in patients who exhibit symptoms secondary to environmental factors and/or other primary psychiatric disorders, including psychosis. Appropriate educational/vocational placement is essential and psychosocial intervention is often helpful. When remedial measures alone are insufficient, the decision to prescribe stimulant medication will depend upon the physician's assessment of the chronicity and severity of the patient's symptoms and on the level of functional impairment.

Long-Term Use

The effectiveness of Vyvanse for long-term use, i.e., for more than 4 weeks, has not been systematically evaluated in controlled trials. Therefore, the physician who elects to use Vyvanse for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

2 DOSAGE AND ADMINISTRATION

Dosage should be individualized according to the therapeutic needs and response of the patient. Vyvanse should be administered at the lowest effective dosage.

In children 6 to12 years of age or adults who are either starting treatment for the first time or switching from another medication, 30 mg once daily in the morning is the recommended dose. If the decision is made in the judgment of the clinician to increase the dose beyond 30 mg/day, daily dosage may be adjusted in increments of 10 mg or 20 mg at approximately weekly intervals. The maximum recommended dose is 70 mg/day; doses greater than 70 mg/day of Vyvanse have not been studied. Amphetamines are not recommended for children under 3 years of age. Vyvanse has not been studied in children under 6 years of age or over 12 years of age.

Vyvanse should be taken in the morning. Afternoon doses should be avoided because of the potential for insomnia.

Vyvanse may be taken with or without food.

Vyvanse capsules may be taken whole, or the capsule may be opened and the entire contents dissolved in a glass of water. The solution should be consumed immediately and should not be stored. The dose of a single capsule should not be divided. The contents of the entire capsule should be taken, and patients should not take anything less than one capsule per day.

Where possible, drug administration should be interrupted occasionally to determine if there is a recurrence of behavioral symptoms sufficient to require continued treatment.

3 DOSAGE FORM AND STRENGTHS

Vyvanse capsules 20 mg: ivory body/ivory cap (imprinted NRP104 20 mg)

Vyvanse capsules 30 mg: white body/orange cap (imprinted NRP104 30 mg)

Vyvanse capsules 40 mg: white body/blue green cap (imprinted NRP104 40 mg)

Vyvanse capsules 50 mg: white body/blue cap (imprinted NRP104 50 mg)

Vyvanse capsules 60 mg: aqua blue body/aqua blue cap (imprinted NRP104 60 mg)

Vyvanse capsules 70 mg: blue body/orange cap (imprinted NRP104 70 mg)

4 CONTRAINDICATIONS

- Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity or idiosyncratic reaction to sympathomimetic amines, glaucoma
- Agitated states
- Patients with a history of drug abuse
- During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result)*[See Drug Interactions (7.2)]*

5 WARNINGS AND PRECAUTIONS

5.1 Serious Cardiovascular Events

Sudden Death and Pre-existing Structural Cardiac Abnormalities or Other Serious Heart Problems

Children and Adolescents

Sudden death has been reported in association with CNS stimulant treatment at usual doses in children and adolescents with structural cardiac abnormalities or other serious heart problems. Although some serious heart problems alone carry an increased risk of sudden death, stimulant products generally should not be used in children or adolescents with known serious structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, or other serious cardiac problems that may place them at increased vulnerability to the sympathomimetic effects of a stimulant drug *[see CONTRAINDICATIONS (4)]*.

Adults

Sudden death, stroke, and myocardial infarction have been reported in adults taking stimulant drugs at usual doses for ADHD. Although the role of stimulants in these adult cases is unknown, adults have a greater likelihood than children of having serious structural cardiac abnormalities, cardiomyopathy, serious heart rhythm abnormalities, coronary artery disease, or other serious cardiac problems. Adults with such abnormalities should also generally not be treated with stimulant drugs *[see CONTRAINDICATIONS (4)]*.

Hypertension and Other Cardiovascular Conditions

Stimulant medications cause a modest increase in average blood pressure (about 2-4 mm Hg) and average heart rate (about 3-6 bpm) and individuals may have larger increases. While the mean changes alone would not be expected to have short-term consequences, all patients should be monitored for larger changes in heart rate and blood pressure. Caution is indicated in treating patients whose underlying medical conditions might be compromised by increases in blood pressure or heart rate, e.g. those with pre-existing hypertension, heart failure, recent myocardial infarction, or ventricular arrhythmia *[see CONTRAINDICATIONS 4)]*.

Assessing Cardiovascular Status in Patients Being Treated with Stimulant Medications

Children, adolescents, or adults who are being considered for treatment with stimulant medications should have a careful history (including assessment for a family history of sudden death or ventricular arrhythmia) and physical exam to assess for the presence of cardiac disease, and should receive further cardiac evaluation if findings suggest such disease (e.g. electrocardiogram and echocardiogram). Patients who develop symptoms such as exertional chest pain, unexplained syncope, or other symptoms suggestive of cardiac disease during stimulant treatment should undergo a prompt cardiac evaluation.

5.2 Psychiatric Adverse Events

Pre-existing Psychosis

Administration of stimulants may exacerbate symptoms of behavior disturbance and thought disorder in patients with a pre-existing psychotic disorder.

Bipolar Illness

Particular care should be taken in using stimulants to treat ADHD in patients with comorbid bipolar disorder because of concern for possible induction of a mixed/manic episode in such patients. Prior to initiating treatment with a stimulant, patients with comorbid depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder. Such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder and depression.

Emergence of New Psychotic or Manic Symptoms

Treatment-emergent psychotic or manic symptoms, e.g. hallucinations, delusional thinking, or mania in children and adolescents without a prior history of psychotic illness or mania can be caused by stimulants at usual doses. If such symptoms occur consideration should be given to a possible causal role of the stimulant, and discontinuation of treatment may be appropriate. In a pooled analysis of multiple short-term, placebo-controlled studies, such symptoms occurred in about 0.1% (4 patients with events out of 3482 exposed to methylphenidate or amphetamine for several weeks at usual doses) of stimulant-treated patients compared to 0 in placebo-treated patients.

Aggression

Aggressive behavior or hostility is often observed in children and adolescents with ADHD, and has been reported in clinical trials and the post marketing experience of some medications indicated for the treatment of ADHD. Although there is no systematic evidence that stimulants cause aggressive behavior or hostility, patients beginning treatment of ADHD should be monitored for the appearance of, or worsening of, aggressive behavior or hostility.

5.3 Seizures

There is some clinical evidence that stimulants may lower the convulsive threshold in patients with prior history of seizures, in patients with prior EEG abnormalities in absence of seizures, and, very rarely, in patients without a history of seizures and no prior EEG evidence of seizures. In the presence of seizures, the drug should be discontinued.

5.4 Visual Disturbance

Difficulties with accommodation and blurring of vision have been reported with stimulant treatment.

5.5 Tics

Amphetamines have been reported to exacerbate motor and phonic tics and Tourette's syndrome. Therefore, clinical evaluation for tics and Tourette's syndrome should precede use of stimulant medications.

5.6 Long-Term Suppression of Growth

Careful follow-up of weight and height in children ages 7 to 10 years who were randomized to either methylphenidate or non-medication treatment groups over 14 months, as well as in naturalistic subgroups of newly methylphenidate-treated and non-medication treated children over 36 months (to the ages of 10 to 13 years), suggests that consistently medicated children (i.e. treatment for 7 days per week throughout the year) have a temporary slowing in growth rate (on average, a total of about 2 cm less growth in height and 2.7 kg less growth in weight over 3 years), without evidence of growth rebound during this period of development. In a controlled trial of amphetamine (d- to l-enantiomer ratio of 3:1) in adolescents, mean weight change from baseline within the initial 4 weeks of therapy was –1.1 lbs. and –2.8 lbs., respectively, for patients receiving 10 mg and 20 mg of amphetamine. Higher doses were associated with greater weight loss within the initial 4 weeks of treatment. In a controlled trial of Vyvanse in children ages 6 to 12 years, mean weight loss from baseline after 4 weeks of therapy was -0.9, -1.9, and -2.5 lb, respectively, for patients receiving 30 mg, 50 mg, and 70 mg of Vyvanse, compared to a 1 lb weight gain for patients receiving placebo. Higher doses were associated with greater weight loss with 4 weeks of treatment. Careful follow-up for weight in children ages 6 to 12 years who received Vyvanse over 12 months suggests that consistently medicated children (i.e. treatment for 7 days per week throughout the year) have a slowing in growth rate, measured by body weight as demonstrated by an age- and sex-normalized mean change from baseline in percentile, of -13.4 over 1 year (average percentiles at baseline and 12 months, were 60.6 and 47.2, respectively). Therefore growth should be monitored during treatment with stimulants, and patients who are not growing or gaining weight as expected may need to have their treatment interrupted.

5.7 Prescribing and Dispensing

The least amount of amphetamine feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Vyvanse should be used with caution in patients who use other sympathomimetic drugs.

6 ADVERSE REACTIONS

6.1 Clinical Studies Experience

The premarketing development program for Vyvanse included exposures in a total of 762 participants in clinical trials (348 pediatric patients, 358 adult patients and 56 healthy adult subjects). Of these, 348 pediatric (aged 6 to 12) patients were evaluated in two controlled clinical studies (one parallel-group and one crossover), one open-label extension study, one single-dose clinical pharmacology study, and 358 adult patients were evaluated in one controlled clinical study and one open-label extension study. The information included in this section is based on data from the 4-week parallel-group controlled clinical studies in pediatric and adult patients with ADHD. Adverse reactions were assessed by collecting adverse events, results of physical examinations, vital signs, weights, laboratory analyses, and ECGs.

Adverse reactions during exposure were obtained primarily by general inquiry and recorded by clinical investigators using terminology of their own choosing. Consequently, it is not possible to provide a meaningful estimate of the proportion of individuals experiencing adverse reactions without first grouping similar types of reactions into a smaller number of standardized reactions categories. In the tables and listings that follow, MedDRA terminology has been used to classify reported adverse reactions.

The stated frequencies of adverse reactions represent the proportion of individuals who experienced a treatment-emergent adverse reaction of the type listed at least once.

<u>Adverse Reactions Associated with Discontinuation of Treatment in Clinical Trials</u>

In the controlled pediatric (aged 6 to 12) trial, 10% (21/218) of Vyvanse-treated patients discontinued due to adverse reactions compared to 1% (1/72) who received placebo. The most frequent adverse events leading to discontinuation and considered to be drug-related (i.e. leading to discontinuation in at least 1% of Vyvanse-treated patients and at a rate at least twice that of placebo) were ECG voltage criteria for ventricular hypertrophy, tic, vomiting, psychomotor hyperactivity, insomnia, and rash (2/218 each; 1%).

In the controlled adult trial, 6% (21/358) of Vyvanse-treated patients discontinued due to adverse events compared to 2% (1/62) who received placebo. The most frequent adverse events leading to discontinuation and considered to be drug-related (i.e. leading to discontinuation in at least 1% of Vyvanse-treated patients and at a rate at least twice that of placebo) were insomnia (8/358; 2%), tachycardia (3/358; 1%), irritability (2/358; 1%), hypertension (4/358; 1%), headache (2/358; 1%), anxiety (2/358; 1%), and dyspnea (3/358; 1%).

Adverse Reactions Occurring at an Incidence of 2% or more Among Vyvanse Treated Patients in Clinical Trials

Adverse reactions reported in the controlled trials in pediatric and adult patients treated with Vyvanse or placebo are presented in the Tables 1 and 2 below. The prescriber should be aware that these figures cannot be used to predict the incidence of adverse reactions in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatment uses and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse reaction incidence rate in the population studied.

Pediatric

Table 1 Adverse Reactions Reported by 2% or More of Pediatric Patients Taking Vyvanse in a 4-Week Clinical Trial

Body System	Preferred Term	Vyvanse (n=218)	Placebo (n=72)
Gastrointestinal Disorders	Abdominal Pain Upper	12%	6%
	Vomiting	9%	4%
	Nausea	6%	3%
	Dry Mouth	5%	0%
General Disorder and Administration Site Conditions	Pyrexia	2%	1%
Investigations	Weight Decreased	9%	1%
Metabolism and Nutrition	Decreased Appetite	39%	4%
Nervous System Disorders	Dizziness	5%	0%
	Somnolence	2%	1%
Psychiatric Disorders	Insomnia	19%	3%
	Irritability	10%	0%
	Initial Insomnia	4%	0%
	Affect lability	3%	0%
	Tic	2%	0%
Skin and Subcutaneous Tissue Disorders	Rash	3%	0%

Note: This table includes those reactions for which the incidence in patients taking Vyvanse is at least twice the incidence in patients taking placebo.

Adult

Table 2 Adverse Reactions Reported by 2% or More of Adult Patients Taking Vyvanse in a 4-Week Clinical Trial

Body System	Preferred Term	Vyvanse (n=358)	Placebo (n=62)
Gastrointestinal Disorders	Dry Mouth	26%	3%
	Diarrhea	7%	0%
	Nausea	7%	0%

Table 2 Adverse Reactions Reported by 2% or More of Adult Patients Taking Vyvanse in a 4-Week Clinical Trial

Body System	Preferred Term	Vyvanse (n=358)	Placebo (n=62)
General Disorder and Administration Site Conditions	Feeling Jittery	4%	0%
Investigations	Blood Pressure Increased	3%	0%
	Heart Rate Increased	2%	0%
Metabolism and Nutrition Disorders	Anorexia	5%	0%
	Decreased Appetite	27%	3%
Nervous System Disorders	Tremor	2%	0%
Psychiatric Disorders	Insomnia	27%	8%
	Anxiety	6%	0%
	Agitation	3%	0%
	Restlessness	3%	0%
Respiratory Thoracic and Mediastinal Disorders	Dyspnea	2%	0%
Skin and Subcutaneous Tissue Disorders	Hyperhidrosis	3%	0%

Note: This table includes those events for which the incidence in patients taking Vyvanse is at least twice the incidence in patients taking placebo.

Vital Signs

Weight Loss – In the controlled adult trial, mean weight loss after 4 weeks of therapy was 2.8 lbs, 3.1 lbs, 4.3 lbs, for patients receiving final doses of 30 mg, 50 mg and 70 mg of Vyvanse, respectively, compared to a mean weight gain of 0.5 lbs for patients receiving placebo.

6.2 Adverse Reactions Associated with the Use of Amphetamine

Cardiovascular

Palpitations, tachycardia, elevation of blood pressure, sudden death, myocardial infarction. There have been isolated reports of cardiomyopathy associated with chronic amphetamine use.

Central Nervous System

Psychotic episodes at recommended doses, overstimulation, restlessness, dizziness, insomnia, euphoria, dyskinesia, dysphoria, depression, tremor, headache, exacerbation of motor and phonic tics and Tourette's syndrome, seizures, stroke.

Gastrointestinal

Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.

Allergic

Urticaria, rashes, and hypersensitivity reactions, including angioedema and anaphylaxis. Serious skin reactions, including Stevens Johnson Syndrome and Toxic Epidermal Necrolysis have been reported.

Endocrine

Impotence, changes in libido.

7 DRUG INTERACTIONS

7.1 Agents that Lower Blood Levels of Amphetamines

Urinary Acidifying Agents
These agents (ammonium chloride, sodium acid phosphate, etc.) increase the concentration of the ionized species of the amphetamine molecule, thereby increasing urinary excretion.

Methenamine Therapy
Urinary excretion of amphetamines is increased, and efficacy is reduced, by acidifying agents used in methenamine therapy.

7.2 Agents that Increase Blood Levels of Amphetamines

Urinary Alkalinizing Agents
These agents (acetazolamide, some thiazides) increase the concentration of the non-ionized species of the amphetamine molecule, thereby decreasing urinary excretion.

Monoamine Oxidase Inhibitors
MAOI antidepressants, as well as a metabolite of furazolidone, slow amphetamine metabolism. This slowing potentiates amphetamines, increasing their effect on the release of norepinephrine and other monoamines from adrenergic nerve endings; this can cause headaches and other signs of hypertensive crisis. A variety of toxic neurological effects and malignant hyperpyrexia can occur, sometimes with fatal results.

7.3 Agents Whose Effects May be Reduced by Amphetamines

Adrenergic Blockers
Adrenergic blockers are inhibited by amphetamines.

Antihistamines
Amphetamines may counteract the sedative effect of antihistamines.

Antihypertensives
Amphetamines may antagonize the hypotensive effects of antihypertensives.

Veratrum Alkaloids
Amphetamines inhibit the hypotensive effect of veratrum alkaloids.

Ethosuximide
Amphetamines may delay intestinal absorption of ethosuximide.

7.4 Agents Whose Effects May be Potentiated by Amphetamines

Antidepressants, Tricyclic
Amphetamines may enhance the activity of tricyclic antidepressants or sympathomimetic agents; d-amphetamine with desipramine or protriptyline and possibly other tricyclics cause striking and sustained increases in the concentration of d-amphetamine in the brain; cardiovascular effects can be potentiated.

Meperidine
Amphetamines potentiate the analgesic effect of meperidine.

Phenobarbital
Amphetamines may delay intestinal absorption of phenobarbital; co-administration of phenobarbital may produce a synergistic anticonvulsant action.

Phenytoin
Amphetamines may delay intestinal absorption of phenytoin; co-administration of phenytoin may produce a synergistic anticonvulsant action.

7.5 Agents that May Reduce the Effects of Amphetamines

Chlorpromazine
Chlorpromazine blocks dopamine and norepinephrine receptors, thus inhibiting the central stimulant effects of amphetamines, and can be used to treat amphetamine poisoning.

Haloperidol
Haloperidol blocks dopamine receptors, thus inhibiting the central stimulant effects of amphetamines.

Lithium Carbonate
The anorectic and stimulatory effects of amphetamines may be inhibited by lithium carbonate.

7.6 Agents that May Potentiate the Effects of Amphetamines

Norepinephrine
Amphetamines enhance the adrenergic effect of norepinephrine.

Propoxyphene Overdosage
In cases of propoxyphene overdosage, amphetamine CNS stimulation is potentiated and fatal convulsions can occur.

7.7 Drug/Laboratory Test Interactions

Amphetamines can cause a significant elevation in plasma corticosteroid levels. This increase is greatest in the evening. Amphetamine may interfere with urinary steroid determinations.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Animal reproduction studies of lisdexamfetamine dimesylate have not been performed. Studies have been performed with the active metabolite of lisdexamfetamine, d-amphetamine, either alone or in combination with l-amphetamine, as noted below.

Teratogenic Effects

Pregnancy Category C

Amphetamine (d- to l-enantiomer ratio of 3:1) had no apparent effects on embryofetal morphological development or survival when orally administered to pregnant rats and rabbits throughout the period of organogenesis at doses of up to 6 and 16 mg/kg/day, respectively. Fetal malformations and death have been reported in mice following parenteral administration of d-amphetamine doses of 50 mg/kg/day or greater to pregnant animals. Administration of these doses was also associated with severe maternal toxicity.

A number of studies in rodents indicate that prenatal or early postnatal exposure to amphetamine (d- or d,l-) at doses similar to those used clinically can result in long term neurochemical and behavioral alterations. Reported behavioral effects include learning and memory deficits, altered locomotor activity, and changes in sexual function.

There are no adequate and well-controlled studies in pregnant women. There has been one report of severe congenital bony deformity, tracheo-esophageal fistula, and anal atresia (vater association) in a baby born to a woman who took dextroamphetamine sulfate with lovastatin during the first trimester of pregnancy. Amphetamines should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nonteratogenic Effects

Infants born to mothers dependent on amphetamines have an increased risk of premature delivery and low birth weight. Also, these infants may experience symptoms of withdrawal as demonstrated by dysphoria, including agitation, and significant lassitude.

8.2 Labor and Delivery

The effects of Vyvanse on labor and delivery in humans is unknown.

8.3 Nursing Mothers

Amphetamines are excreted into human milk. Mothers taking amphetamines should be advised to refrain from nursing.

8.4 Pediatric Use

Vyvanse is indicated for use in children with ADHD aged 6 to 12 years. Vyvanse has not been studied in children under 6 years of age or adolescents. Long-term effects of

amphetamines in children have not been well established. Amphetamines are not recommended for use in children under 3 years of age.

A study was conducted in which juvenile rats received oral doses of 4, 10, or 40 mg/kg/day of lisdexamfetamine dimesylate from day 7 to day 63 of age. These doses are approximately 0.3, 0.7, and 3 times the maximum recommended human daily dose of 70 mg on a mg/m^2 basis. Dose-related decreases in food consumption, bodyweight gain, and crown-rump length were seen; after a four week drug-free recovery period bodyweights and crown-rump lengths had significantly recovered in females but were still substantially reduced in males. Time to vaginal opening was delayed in females at the highest dose, but there were no drug effects on fertility when the animals were mated beginning on day 85 of age.

In a study in which juvenile dogs received lisdexamfetamine dimesylate for 6 months beginning at 10 weeks of age, decreased bodyweight gain was seen at all doses tested (2, 5, and 12 mg/kg/day, which are approximately 0.5, 1, and 3 times the maximum recommended human daily dose on a mg/m^2 basis). This effect partially or fully reversed during a four week drug-free recovery period.

8.5 Geriatric Use

Vyvanse has not been studied in the geriatric population.

9 DRUG ABUSE AND DEPENDENCE

9.1 Controlled Substance

Vyvanse is classified as a Schedule II controlled substance.

9.2 Abuse and Dependence

Amphetamines have been extensively abused. Tolerance, extreme psychological dependence, and severe social disability have occurred. There are reports of patients who have increased the dosage to levels many times higher than recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with amphetamines may include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

Human Studies

In a human abuse liability study, when equivalent oral doses of 100 mg lisdexamfetamine dimesylate and 40 mg immediate release d-amphetamine sulfate were administered to individuals with a history of drug abuse, lisdexamfetamine dimesylate 100 mg produced subjective responses on a scale of “Drug Liking Effects” "Amphetamine Effects", and "Stimulant Effects" that were significantly less than d-amphetamine immediate release 40 mg. However, oral administration of 150 mg lisdexamfetamine dimesylate produced increases in positive subjective responses on these scales that were statistically indistinguishable from the positive subjective responses produced by 40 mg of oral immediate-release d-amphetamine and 200 mg of diethylpropion (C-IV).

Intravenous administration of 50 mg lisdexamfetamine dimesylate to individuals with a history of drug abuse produced positive subjective responses on scales measuring "Drug Liking", "Euphoria", "Amphetamine Effects", and "Benzedrine Effects" that were greater than placebo but less than those produced by an equivalent dose (20 mg) of intravenous d-amphetamine.

Animal Studies

In animal studies, lisdexamfetamine dimesylate produced behavioral effects qualitatively similar to those of the CNS stimulant d-amphetamine. In monkeys trained to self-administer cocaine, intravenous lisdexamfetamine dimesylate maintained self-administration at a rate that was statistically less than that for cocaine, but greater than that of placebo.

10 OVERDOSAGE

Individual patient response to amphetamines varies widely. Toxic symptoms may occur idiosyncratically at low doses.

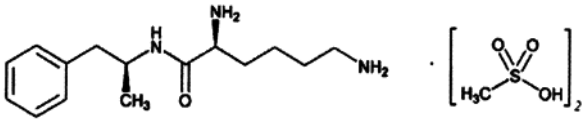
Symptoms: Manifestations of acute overdosage with amphetamines include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states, hyperpyrexia, and rhabdomyolysis. Fatigue and depression usually follow the central nervous system stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension, and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning is usually preceded by convulsions and coma.

Treatment: Consult with a Certified Poison Control Center for up-to-date guidance and advice. Management of acute amphetamine intoxication is largely symptomatic and includes gastric lavage, administration of activated charcoal, administration of a cathartic, and sedation. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Acidification of the urine increases amphetamine excretion but is believed to increase risk of acute renal failure if myoglobinuria is present. If acute severe hypertension complicates amphetamine overdosage, administration of intravenous phentolamine has been suggested. However, a gradual drop in blood pressure will usually result when sufficient sedation has been achieved. Chlorpromazine antagonizes the central stimulant effects of amphetamines and can be used to treat amphetamine intoxication.

The prolonged release of Vyvanse in the body should be considered when treating patients with overdose.

11 DESCRIPTION

Vyvanse (lisdexamfetamine dimesylate) is designed as a capsule for once-a-day oral administration. The chemical designation for lisdexamfetamine dimesylate is (2S)-2,6-diamino-*N*-[(1*S*)-1-methyl-2-phenylethyl] hexanamide dimethanesulfonate. The molecular formula is $C_{15}H_{25}N_3O\bullet(CH_4O_3S)_2$, which corresponds to a molecular weight of 455.60. The chemical structure is:



Lisdexamfetamine dimesylate is a white to off-white powder that is soluble in water (792 mg/ml). Vyvanse capsules contain 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, and 70 mg of lisdexamfetamine dimesylate and the following inactive ingredients: microcrystalline cellulose, croscarmellose sodium, and magnesium stearate. The capsule shells contain gelatin, titanium dioxide, and one or more of the following: D&C Red #28, D&C Yellow #10, FD&C Blue #1, FD&C Green #3, and FD&C Red #40.

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action

Lisdexamfetamine is a prodrug of dextroamphetamine. After oral administration, lisdexamfetamine is rapidly absorbed from the gastrointestinal tract and converted to dextroamphetamine, which is responsible for the drug's activity. Amphetamines are non-catecholamine sympathomimetic amines with CNS stimulant activity. The mode of therapeutic action in Attention Deficit Hyperactivity Disorder (ADHD) is not known. Amphetamines are thought to block the reuptake of norepinephrine and dopamine into the presynaptic neuron and increase the release of these monoamines into the extraneuronal space. The parent drug, lisdexamfetamine, does not bind to the sites responsible for the reuptake of norepinephrine and dopamine *in vitro*.

12.3 Pharmacokinetics

Pharmacokinetic studies of dextroamphetamine after oral administration of lisdexamfetamine have been conducted in healthy adult and pediatric (aged 6 to 12) patients with ADHD.

In 18 pediatric patients (aged 6 to 12) with ADHD, the T_{max} of dextroamphetamine was approximately 3.5 hours following single-dose oral administration of lisdexamfetamine dimesylate either 30 mg, 50 mg, or 70 mg after an 8-hour overnight fast. The T_{max} of lisdexamfetamine was approximately 1 hour. Linear pharmacokinetics of dextroamphetamine after single-dose oral administration of lisdexamfetamine dimesylate was established over the dose range of 30 mg to 70 mg in children aged 6 to 12 years.

There is no unexpected accumulation of dextroamphetamine AUC at steady state in healthy adults and no accumulation of lisdexamfetamine after once-daily dosing for 7 consecutive days.

Food does not affect the observed AUC and C_{max} of dextroamphetamine in healthy adults after single-dose oral administration of 70 mg of Vyvanse capsules but prolongs T_{max} by approximately 1 hour (from 3.8 hrs at fasted state to 4.7 hrs after a high fat meal). After an 8-hour fast, the AUC for dextroamphetamine following oral administration of lisdexamfetamine dimesylate in solution and as intact capsules were equivalent.

Weight/Dose normalized AUC and C_{max} were 22% and 12% lower, respectively, in adult females than in males on day 7 following a 70 mg/day dose of lisdexamfetamine dimesylate

for 7 days. Weight/Dose normalized AUC and C_{max} values were the same in girls and boys following single doses of 30-70 mg.

Metabolism and Excretion

After oral administration, lisdexamfetamine is rapidly absorbed from the gastrointestinal tract. Lisdexamfetamine is converted to dextroamphetamine and l-lysine, which is believed to occur by first-pass intestinal and/or hepatic metabolism. Lisdexamfetamine is not metabolized by cytochrome P450 enzymes. Following the oral administration of a 70 mg dose of radiolabeled lisdexamfetamine dimesylate to 6 healthy subjects, approximately 96% of the oral dose radioactivity was recovered in the urine and only 0.3% recovered in the feces over a period of 120 hours. Of the radioactivity recovered in the urine 42% of the dose was related to amphetamine, 25% to hippuric acid, and 2% intact lisdexamfetamine. Plasma concentrations of unconverted lisdexamfetamine are low and transient, generally becoming non-quantifiable by 8 hours after administration. The plasma elimination half-life of lisdexamfetamine typically averaged less than one hour in studies of lisdexamfetamine dimesylate in volunteers.

Dextroamphetamine is known to inhibit monoamine oxidase. The ability of dextroamphetamine and its metabolites to inhibit various P450 isozymes and other enzymes has not been adequately elucidated. *In vitro* experiments with human microsomes indicate minor inhibition of CYP2D6 by amphetamine and minor inhibition of CYP1A2, 2D6, and 3A4 by one or more metabolites, but there are no *in vivo* studies of p450 enzyme inhibition.

Special Populations

Age

The pharmacokinetics of dextroamphetamine is similar in pediatric (aged 6 to 12) and adolescent (aged 13 to 17) ADHD patients, and healthy adult volunteers. Any differences in kinetics seen after oral administration are a result of differences in mg/kg dosing.

Gender

Systemic exposure to dextroamphetamine is similar for men and women given the same mg/kg dose.

Race

Formal pharmacokinetic studies for race have not been conducted.

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis/ Mutagenesis and Impairment of Fertility

Carcinogenicity studies of lisdexamfetamine dimesylate have not been performed.

No evidence of carcinogenicity was found in studies in which d-, l-amphetamine (enantiomer ratio of 1:1) was administered to mice and rats in the diet for 2 years at doses of up to 30

mg/kg/day in male mice, 19 mg/kg/day in female mice, and 5 mg/kg/day in male and female rats.

Lisdexamfetamine dimesylate was not clastogenic in the mouse bone marrow micronucleus test *in vivo* and was negative when tested in the *E. coli* and *S. typhimurium* components of the Ames test and in the L5178Y/TK^{+-} mouse lymphoma assay *in vitro*.

Amphetamine (d- to l-enantiomer ratio of 3:1) did not adversely affect fertility or early embryonic development in the rat at doses of up to 20 mg/kg/day.

13.2 Animal Toxicology

Acute administration of high doses of amphetamine (d- or d,l-) has been shown to produce long-lasting neurotoxic effects, including irreversible nerve fiber damage, in rodents. The significance of these findings to humans is unknown.

14 CLINICAL STUDIES

The efficacy of Vyvanse in the treatment of ADHD was established on the basis of two controlled trials in children aged 6 to 12 and one controlled trial in adults who met Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR) criteria for ADHD *[see INDICATIONS AND USAGE (1)]*.

Pediatric

A double-blind, randomized, placebo-controlled, parallel-group study was conducted in children aged 6 to12 (N=290) who met DSM-IV criteria for ADHD (either the combined type or the hyperactive-impulsive type). Patients were randomized to fixed dose treatment groups receiving final doses of 30, 50, or 70 mg of Vyvanse or placebo once daily in the morning for four weeks. All subjects receiving Vyvanse were initiated on 30 mg for the first week of treatment. Subjects assigned to the 50 and 70 mg dose groups were titrated by 20 mg per week until they achieved their assigned dose. Significant improvements in ADHD symptoms, based upon investigator ratings on the ADHD Rating Scale (ADHD-RS), were observed at endpoint for all Vyvanse™doses compared to patients who received placebo. Mean effects at all doses were fairly similar, although the highest dose (70 mg/day) was numerically superior to both lower doses (30 and 50 mg/day). The effects were maintained throughout the day based on parent ratings (Conner's Parent Rating Scale) in the morning (approximately 10 am), afternoon (approximately 2 pm), and early evening (approximately 6 pm).

A double-blind, placebo-controlled, randomized, crossover design, analog classroom study was conducted in children aged 6 to 12 (N=52) who met DSM-IV criteria for ADHD (either the combined type or the hyperactive-impulsive type). Following a 3-week open-label dose titration with Adderall XR®, patients were randomly assigned to continue the same dose of Adderall XR (10, 20, or 30 mg), Vyvanse (30, 50, and 70 mg), or placebo once daily in the morning for 1 week each treatment. A significant difference in patient behavior, based upon the average of investigator ratings on the Swanson, Kotkin, Agler, M.Flynn and Pelham (SKAMP)-Deportment scores across the 8 sessions of a 12 hour treatment day, was observed between patients who received Vyvanse compared to patients who received placebo. The drug effect was similar for all 8 sessions.

Adult

A double-blind, randomized, placebo-controlled, parallel-group, study was conducted in adults (N=420) who met DSM-IV criteria for ADHD. In this four-week study, patients were randomized to fixed dose treatment groups receiving final doses of 30, 50, or 70 mg of Vyvanse or placebo. All subjects receiving Vyvanse were initiated on 30 mg for the first week of treatment. Subjects assigned to the 50 and 70 mg dose groups were titrated by 20 mg per week until they achieved their assigned dose. Significant improvements in ADHD symptoms, based upon investigator ratings on the ADHD Rating Scale (ADHD-RS), were observed at end point for all Vyvanse doses compared to placebo.

16 HOW SUPPLIED/STORAGE AND HANDLING

Vyvanse capsules 20 mg: ivory body/ivory cap (imprinted NRP104 20 mg), bottles of 100, NDC 59417-102-10

Vyvanse capsules 30 mg: white body/orange cap (imprinted NRP104 30 mg), bottles of 100, NDC 59417-103-10

Vyvanse capsules 40 mg: white body/blue green cap (imprinted NRP104 40 mg), bottles of 100, NDC 59417-104-10

Vyvanse capsules 50 mg: white body/blue cap (imprinted NRP104 50 mg), bottles of 100, NDC 59417-105-10

Vyvanse capsules 60 mg: aqua blue body/aqua blue cap (imprinted NRP104 60 mg), bottles of 100, NDC 59417-106-10

Vyvanse capsules 70 mg: blue body/orange cap (imprinted NRP104 70 mg), bottles of 100, NDC 59417-107-10

Dispense in a tight, light-resistant container as defined in the USP.

Store at 25º C (77º F). Excursions permitted to 15-30º C (59-86º F) [see USP Controlled Room Temperature]

17 PATIENT COUNSELING INFORMATION

See Medication Guide

17.1 Information on Medication Guide

Prescribers or other health professionals should inform patients, their families, and their caregivers about the benefits and risks associated with treatment with Vyvanse and should counsel them in its appropriate use. A patient Medication Guide is available for Vyvanse. The prescriber or health professional should instruct patients, their families, and their caregivers to read the Medication Guide and should assist them in understanding its contents. Patients should be given the opportunity to discuss the contents of the Medication Guide and to obtain answers to any questions they may have. The complete text of the Medication Guide is attached to the package insert.

17.2 Controlled Substance Status/Potential for Abuse, Misuse, and Dependence

Patients should be advised that Vyvanse is a federally controlled substance because it can be abused or lead to dependence. Additionally, it should be emphasized that Vyvanse should be stored in a safe place to prevent misuse and/or abuse. Patient history (including family history) of abuse or dependence on alcohol, prescription medicines, or illicit drugs should be evaluated *[See Drug Abuse and Dependence (9)]*.

17.3 Serious Cardiovascular Risks

Patients should be advised of serious cardiovascular risk (including sudden death, myocardial infarction, stroke and hypertension) with Vyvanse. Patients who develop symptoms such as exertional chest pain, unexplained syncope, or other symptoms suggestive of cardiac disease during treatment should undergo a prompt cardiac evaluation *[See Warning and Precautions (5.1)]*.

17.4 Psychiatric Risks

Prior to initiating treatment with a stimulant, patients with comorbid depressive symptoms should be adequately screened to determine if they are at risk for bipolar disorder. Such screening should include a detailed psychiatric history, including a family history of suicide, bipolar disorder, and/or depression. Additionally, stimulant therapy at usual doses may cause treatment-emergent psychotic or manic symptoms in patients without prior history of psychotic symptoms or mania *[See Warnings and Precautions (5.2)]*.

17.5 Growth

Growth should be monitored during treatment with stimulants, and patients who are not growing or gaining weight as expected may need to have their treatment interrupted. *[See Warnings and Precautions (5.6)]*.

17.6 Pregnancy

Patients should be advised to notify their physicians if they become pregnant or intend to become pregnant during treatment *[see Dosage and Administration (2) and Use in Specific Populations (8.1)]*.

17.7 Nursing

Patients should be advised not to breast feed if they are taking Vyvanse *[see Use in Specific Populations (8.3)]*.

17.8 Impairment in Ability to Operate Machinery or Vehicles

Amphetamines may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or vehicles; the patient should therefore be cautioned accordingly.

Pharmacist: Medication Guide to be dispensed to patients

Manufactured for: Shire US Inc., Wayne, PA 19087

Made in USA

For more information call 1-800-828-2088

Vyvanse is a trademark of Shire LLC

Last Modified: mm/dd/2008

MEDICATION GUIDE
VYVANSE™
(lisdexamfetamine dimesylate) CII

Read the Medication Guide that comes with Vyvanse before you or your child starts taking it and each time you get a refill. There may be new information. This Medication Guide does not take the place of talking to your doctor about you or your child's treatment with Vyvanse.

What is the most important information I should know about Vyvanse?

Vyvanse is a stimulant medicine. The following have been reported with use of stimulant medicines.

1. Heart-related problems:

- **sudden death in patients who have heart problems or heart defects**
- **stroke and heart attack in adults**
- **increased blood pressure and heart rate**

Tell your doctor if you or your child have any heart problems, heart defects, high blood pressure, or a family history of these problems.

Your doctor should check you or your child carefully for heart problems before starting Vyvanse.

Your doctor should check you or your child's blood pressure and heart rate regularly during treatment with Vyvanse.

Call your doctor right away if you or your child has any signs of heart problems such as chest pain, shortness of breath, or fainting while taking Vyvanse.

2. Mental (Psychiatric) problems:

All Patients

- **new or worse behavior and thought problems**
- **new or worse bipolar illness**
- **new or worse aggressive behavior or hostility**

Children and Teenagers

- **new psychotic symptoms (such as hearing voices, believing things that are not true, are suspicious) or new manic symptoms**

Tell your doctor about any mental problems you or your child have, or about a family history of suicide, bipolar illness, or depression.

Call your doctor right away if you or your child have any new or worsening mental symptoms or problems while taking Vyvanse, especially seeing or hearing things that are not real, believing things that are not real, or are suspicious.

What Is Vyvanse?

Vyvanse is a central nervous system stimulant prescription medicine. **It is used for the treatment of Attention-Deficit Hyperactivity Disorder (ADHD).** Vyvanse may help increase attention and decrease impulsiveness and hyperactivity in patients with ADHD.

Vyvanse should be used as a part of a total treatment program for ADHD that may include counseling or other therapies.

Vyvanse is a federally controlled substance (CII) because it can be abused or lead to dependence. Keep Vyvanse in a safe place to prevent misuse and abuse. Selling or giving away Vyvanse may harm others, and is against the law.

Tell your doctor if you or your child have (or have a family history of) ever abused or been dependent on alcohol, prescription medicines or street drugs.

Who should not take Vyvanse?

Vyvanse should not be taken if you or your child:

- have heart disease or hardening of the arteries
- have moderate to severe high blood pressure
- have hyperthyroidism
- have an eye problem called glaucoma
- are very anxious, tense, or agitated
- have a history of drug abuse
- are taking or have taken within the past 14 days an anti-depression medicine called a monoamine oxidase inhibitor or MAOI.
- is sensitive to, allergic to, or had a reaction to other stimulant medicines

Vyvanse has not been studied in children less than 6 years old. Vyvanse is not recommended for use in children less than 3 years old.

Vyvanse may not be right for you or your child. Before starting Vyvanse tell your or your child's doctor about all health conditions (or a family history of) including:

- heart problems, heart defects, high blood pressure
- mental problems including psychosis, mania, bipolar illness, or depression
- tics or Tourette's syndrome
- liver or kidney problems
- thyroid problems
- seizures or have had an abnormal brain wave test (EEG)

Tell your doctor if you or your child is pregnant, planning to become pregnant, or breastfeeding.

Can Vyvanse be taken with other medicines?

Tell your doctor about all of the medicines that you or your child take including prescription and nonprescription medicines, vitamins, and herbal supplements. Vyvanse and some medicines may interact with each other and cause serious side effects. Sometimes the doses of other medicines will need to be adjusted while taking Vyvanse.

Your doctor will decide whether Vyvanse can be taken with other medicines.

Especially tell your doctor if you or your child takes:

- anti-depression medicines including MAOIs
- anti-psychotic medicines
- lithium
- blood pressure medicines
- seizure medicines
- narcotic pain medicines

Know the medicines that you or your child takes. Keep a list of your medicines with you to show your doctor and pharmacist.

Do not start any new medicine while taking Vyvanse without talking to your doctor first.

How should Vyvanse be taken?

- **Take Vyvanse exactly as prescribed.** Vyvanse comes in 6 different strength capsules. Your doctor may adjust the dose until it is right for you or your child.
- Take Vyvanse once a day in the morning.
- Vyvanse can be taken with or without food.
- From time to time, your doctor may stop Vyvanse treatment for awhile to check ADHD symptoms.
- Your doctor may do regular checks of the blood, heart, and blood pressure while taking Vyvanse. Children should have their height and weight checked often while taking Vyvanse. Vyvanse treatment may be stopped if a problem is found during these check-ups.
- **If you or your child takes too much Vyvanse or overdoses, call your doctor or poison control center right away, or get emergency treatment.**

What are possible side effects of Vyvanse?

See **"What is the most important information I should know about Vyvanse?"** for information on reported heart and mental problems.

Other serious side effects include:

- slowing of growth (height and weight) in children
- seizures, mainly in patients with a history of seizures
- eyesight changes or blurred vision

Common side effects include:

- upper belly pain
- decreased appetite
- dizziness
- dry mouth
- irritability
- trouble sleeping
- nausea
- vomiting
- weight loss

Vyvanse may affect your or your child's ability to drive or do other dangerous activities.

Talk to your doctor if you or your child has side effects that are bothersome or do not go away.

This is not a complete list of possible side effects. Ask your doctor or pharmacist for more information

How should I store Vyvanse?

- Store Vyvanse in a safe place at room temperature, 59 to 86° F (15 to 30° C). Protect from light.
- **Keep Vyvanse and all medicines out of the reach of children.**

General information about Vyvanse

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. Do not use Vyvanse for a condition for which it was not prescribed. Do not give Vyvanse to other people, even if they have the same condition. It may harm them and it is against the law.

This Medication Guide summarizes the most important information about Vyvanse. If you would like more information, talk with your doctor. You can ask your doctor or pharmacist for information about Vyvanse that was written for healthcare professionals. For more information about Vyvanse, please contact Shire US Inc. at 1-800-828-2088.

What are the ingredients in Vyvanse?

Active Ingredient: lisdexamfetamine dimesylate
Inactive Ingredients: microcrystalline cellulose, croscarmellose sodium, and magnesium stearate. The capsule shells contain gelatin, titanium dioxide, and one or more of the following: D&C Red #28, D&C Yellow #10, FD&C Blue #1, FD&C Green #3, and FD&C Red #40.

This Medication Guide has been approved by the U.S. Food and Drug Administration.

Last Modified: 04/dd/2008

CLOZAPINE ORAL

Clozapine is used for the symptomatic management of psychotic disorders. Drug therapy is integral to the management of acute psychotic episodes and accompanying violent behavior in patients with schizophrenia and generally is required for long-term stabilization to improve symptoms between episodes and to minimize the risk of recurrent acute episodes. Antipsychotic agents are the principal class of drugs used for the management of all phases of schizophrenia and generally are effective in all subtypes of the disorder and subgroups of patients. Patient response and tolerance to antipsychotic agents are variable, and patients who do not respond to or tolerate one drug may be successfully treated with an agent from a different class or with a different adverse effect profile.

Labeled Uses
SCHIZOPHRENIA, NOS

Uses DI™
Psychotic Disorders

CLOZAPINE
Adverse Effects List

Incidence more frequent
CARDIOVASCULAR EFFECTS
FEVER
HYPOTENSION
ORTHOSTATIC HYPOTENSION
TACHYCARDIA
CONSTIPATION
DIZZINESS
HEADACHE
HYPERSALIVATION
NAUSEA
VOMITING
WEIGHT GAIN

Incidence less frequent
AGITATED STATES
AKATHISIA
BLURRED VISION
CONFUSION, DRUG INDUCED
EKG CHANGES
FAINTING

HYPERTENSION
DRY MOUTH
GI IRRITATION
HEARTBURN
HYPERHIDROSIS
AGRANULOCYTOSIS
BLOOD DYSCRASIAS
DEPRESSION
DIFFICULT URINATION
EOSINOPHILIA
EXTRAPYRAMIDAL EFFECTS
GRANULOCYTOPENIA
IMPOTENCE
INSOMNIA
LEUKOPENIA
MUSCLE RIGIDITY
NEUROLEPTIC MALIGNANT SYNDROME
SEIZURES
TARDIVE DYSKINESIA
THROMBOCYTOPENIA
TREMORS

CLOZAPINE
Precautions

Label Warnings from First DataBank:

May cause drowsiness. Alcohol may intensify this effect. Use care when operating a car or dangerous machines.
It is very important that you take or use this exactly as directed. Do not skip doses or discontinue unless directed by your doctor.
Obtain medical advice before taking non-prescription drugs as some may affect the action of this medication.

Drug Disease Contraindications from First DataBank:

Most Significant
For these conditions, action to reduce the risk of adverse interaction is usually required

AGRANULOCYTOSIS
APLASTIC ANEMIA
BLOOD DYSCRASIAS
BONE MARROW DEPRESSION
NEUROLEPTIC MALIGNANT SYNDROME
SEVERE CNS DEPRESSION

Significant
For these conditions, assess risk to patient and take action as needed

NARROW ANGLE GLAUCOMA
PROSTATIC HYPERTROPHY
SEIZURE DISORDER

Possibly Significant
For these conditions, conservative measures are recommended until more is known.

CARDIOVASCULAR DISEASE
GASTROINTESTINAL DISORDERS
HEPATIC FUNCTION IMPAIRMENT
RENAL FUNCTION IMPAIRMENT

Fever:

Fever or transient temperature elevations exceeding 38°C generally have been reported in 5% or more of patients receiving clozapine. The peak incidence of fever occurs within the first 3 weeks of therapy, usually between days 5—20 of treatment. Fever generally is benign and self-limiting and usually diminishes within a few (4—8) days despite continued clozapine therapy; however, it may necessitate discontinuance of the drug. Fever occasionally may be associated with an increase or decrease in leukocyte count, in which case patients should be evaluated for underlying infection or development of agranulocytosis. (See Cautions: Hematologic Effects.) In the presence of high fever, the possibility of neuroleptic malignant syndrome also must be considered. (See Extrapyramidal Reactions under Cautions: Nervous System Effects.)

The mechanism of clozapine-induced fever (other than that occurring secondary to some other factor such as infection) is not yet known. It may result from the drug's pronounced anticholinergic activity (see Anticholinergic Effects under Pharmacology: Nervous System Effects) or a direct effect on the hypothalamic thermoregulatory center. Clozapine-induced hyperthermia may be a hypersensitivity reaction, a common mechanism underlying drug fevers. It has been suggested that decreasing the dosage of clozapine and then gradually increasing it to the previous level may reverse the hyperthermia and not be accompanied by a recurrence of elevated temperature; however, recurrence is possible despite such dosage adjustment.

Precautions and Contraindications:

Clozapine shares many of the toxic potentials of other antipsychotic agents (e.g., phenothiazines), and the usual precautions associated with therapy with these agents should be observed. (See Cautions, in the Phenothiazines General Statement 28:16.08.)

Because of the substantial risk of agranulocytosis and seizures, both of which present a continuing risk over time, extended treatment of patients failing to respond adequately to clozapine generally should be avoided. (See Uses: Schizophrenia.) In addition, the need for continued treatment in patients exhibiting a beneficial clinical response to clozapine should be reevaluated periodically. Patients receiving clozapine should be warned about the substantial risk of developing agranulocytosis andinformed that frequent, regular blood tests are required to monitor for the occurrence of this effect; the manufacturer currently recommends weekly monitoring. Patients should be advised to report immediately the development of lethargy, malaise, weakness, fever, sore throat, mucous membrane ulceration, or any other potential manifestation of infection. Particular attention should be paid to any flu-like symptoms or other complaints that might suggest infection. Patients who develop agranulocytosis or severe leukopenia/granulocytopenia (leukocyte less than 2000/mm3 and ANC less than 1000/mm3) while receiving clozapine should not be rechallenged with the drug. Although it is not known whether the risk of agranulocytosis is increased, clozapine generally should be avoided or used with caution in patients with a history of agranulocytosis induced by other drugs.

Patients in whom clozapine therapy has been abruptly discontinued (e.g., because of leukopenia or agranulocytosis) should be observed carefully for recurrence of psychotic manifestations. (See Other Nervous System Effects under Cautions: Nervous SystemEffects.)

Clozapine should be administered with extreme caution to patients having a history of seizure disorder or other factors possibly predisposing to seizure (e.g., abnormal EEG without a history of epilepsy, preexisting CNS pathology, history of electroconvulsive therapy or of perinatal or birth difficulties, family history of seizure or febrile convulsion). Generalized tonic-clonic (grand mal) seizures have occurred in patients receiving clozapine, particularly in patients receiving high dosages (greater than 600 mg daily) and/or in whom plasma clozapine concentrations were elevated. (See Seizures under Cautions: Nervous System Effects.) Because of the substantial risk of seizures associated with clozapine use, patients should be advised not to engage in any activity where sudden loss of consciousness could cause serious risk to themselves or others (e.g., operating heavy machinery, driving an automobile, swimming, climbing).

Clozapine should be used with caution in patients with cardiovascular disorders because the drug may cause tachycardia, hypotension, and cardiac and/or respiratory arrest. Patients receiving clozapine should be advised of the risk of orthostatic hypotension, especially during the period of initial dosage titration. (See Cautions: Cardiovascular Effects.) In patients with known cardiovascular disease, the recommendation for gradual dosage titration following a low initial dose should be observed carefully. (See Dosage and Administration: Dosage.) Occasionally, severe hypotension or orthostatic collapse may necessitate a temporary reduction in dose or interruption of therapy. Severe hypotensive effects may be alleviated with standard measures (e.g., IV fluids, placing patient in Trendelenburg's position) and, if required, by the administration of norepinephrine or phenylephrine; epinephrine should not be used since a further lowering

of blood pressure may occur. (See Drug Interactions: Other Drugs.) Patients should be informed of the risk of orthostatic hypotension associated with use of clozapine, especially during the period of initial dosage titration. In addition, if clozapine therapy has been discontinued for more than 2 days, patientsshould be advised to contact their clinician for dosing instructions. (See Cautions: Cardiovascular Effects.)

Because of the likelihood that a proportion of patients receiving long-term therapy with an antipsychotic agent will develop tardive dyskinesia, patients in whom long-term clozapine therapy is considered and/or their family or guardians should be fully informed, if possible, about the potential risk of developing this syndrome. The manner in which the patient and/or their family or guardians are informed should take into account the clinical circumstances and the competency of the patient to understand the information. The manufacturer states that, because of the potential risk of tardive dyskinesia, long-term clozapine therapy generally should be reserved for patients whose disorder is responsive to the drug; in addition, clozapine shouldbe prescribed in a manner that is most likely to minimize the occurrence of tardive dyskinesia.As with any antipsychotic agent, the smallest effective dosage and shortest duration of therapy producing an adequate clinical response should be employed. Patients receiving clozapine should be evaluated periodically to determine whether maintenance dosage could be decreased or the drug discontinued. If manifestations of tardive dyskinesia appear in a patient receiving clozapine, drug discontinuance should be considered. However, some patients may require treatment with clozapine despite the presence of the syndrome.

During clozapine therapy, patients may experience transient temperature elevations exceeding 38°C, with the peak incidence within the first 3 weeks of therapy. (See Cautions: Fever.) While this fever generally is benign and self-limiting, it may necessitate discontinuance of therapy. Occasionally, there may be an associated increase or decrease in leukocyte count, and patients with fever should be carefully monitored to rule out the possibility of infection or the development of agranulocytosis. In the presence of high fever, the possibility of neuroleptic malignant syndrome also must be considered.(See Extrapyramidal Reactions under Cautions: Nervous System Effects.)

Fatal pulmonary embolism has been reported with clozapine therapy. The possibility of pulmonary embolism should be considered in patients presenting with deep-vein thrombosis, acute dyspnea, chest pain, or other respiratory signs and symptoms.

Since clozapine has potent anticholinergic activity, the drug should be used with caution in individuals whose condition may be aggravated by anticholinergic effects (e.g., patients with prostatic hypertrophy, ileus, urinary retention, angle-closure [obstructive, narrow-angle] glaucoma). In addition, clozapine therapy has been associated with varying degrees of impairment of intestinal peristalsis, ranging from constipation to intestinal obstruction, fecal impaction, and paralytic ileus, that rarely have been fatal. The manufacturers state that constipation may be treated initially by maintaining adequate hydration and by using bulk-forming laxatives. Consultation with a gastroenterologist may be necessary in more severe cases.

Severe hyperglycemia, sometimes leading to ketoacidosis, has been reported in patients without a prior history of hyperglycemia who received clozapine therapy. The possibility of impaired glucose tolerance should be considered in patients presentingwith symptoms of hyperglycemia, including polydipsia, polyuria, polyphagia, and weakness. The manufacturers state that discontinuance of therapy should be considered in patients who develop severe hyperglycemia.

Because there have been reports of hepatic dysfunction, including hepatitis, in patients receiving clozapine, the drug should be used with caution in patients with preexisting liver disease. Liver function tests should be performed immediately in patients who develop nausea, vomiting, and/or anorexia during clozapine therapy. The manufacturers state that clozapine therapy should be discontinued in patients with marked elevations in serum aminotransferase concentrations or in those presenting with manifestations of jaundice.

Patients should be warned that clozapine may impair their ability to perform activities requiring mental alertness or physical coordination (e.g., operating machinery, driving a motor vehicle), especially during the first few days of therapy. The recommendation for gradual dosage escalation should be closely followed. Although some clinicians recommend that clozapine not be prescribed on an outpatient basis until the patient has developed tolerance to the drug's sedative effects, others state thattherapy with the drug can be started in many patients on an outpatient basis. Patients receiving clozapine should notify their physician if they are taking, or plan to take, any nonprescription or prescription medication or alcohol-containing beverage or product.

Because of the adverse CNS effects associated with clozapine therapy, the manufacturers state that an anesthesiologist should be consulted regarding continuation of clozapine therapy in patients undergoing surgery involving general anesthesia.

Clinical experience with clozapine in patients with concomitant systemic diseases is limited. Therefore, the manufacturer states that caution is advisable if the drug is used in patients with hepatic, renal, or cardiac disease.

Clozapine is contraindicated in patients with myeloproliferative disorders, uncontrolled epilepsy, preexisting bone marrow depression, or a history of clozapine-induced agranulocytosis or severe granulocytopenia. The drug also is contraindicated in patients receiving other agents that may cause agranulocytosis or suppress bone marrow function and in those with severe CNS depression or comatose states from any cause. Although the manufacturer does not mention it as a specific contraindication toclozapine therapy, the American Psychiatric Association recommends that clozapine therapy be avoided in schizophrenic patients who are unable or unwilling to comply with the close monitoring that is necessary to detect possible adverse hematologic effects associated with the drug.

Clozapine is contraindicated in patients with a history of hypersensitivity to the drug or any ingredient in the formulation.

Pediatric Precautions:

Safety and efficacy of clozapine in pediatric patients in children younger than 16 years of age have not been established.

Geriatric Precautions:

Clinical studies of clozapine did not include sufficient numbers of patients 65 years of age and older to determine whether geriatric patients respond differently than younger patients. Because geriatric patients may be at increased risk for certaincardiovascular (e.g., orthostatic hypotension, tachycardia) and anticholinergic effects of the drug (e.g., constipation, urinary retention in the presence of prostatic hypertrophy, extrapyramidal manifestations), clozapine should be used cautiously in this age group. In addition, geriatric patients generally are more sensitive than younger patients to drugs that affect the CNS; data from clinical studies indicate that the incidence of tardive dyskinesia appears to be highest among geriatric patients, especially women. In general, dosage should be titrated carefully in geriatric patients, usually initiating therapy at the low end of the dosage range; the greater frequency of decreased hepatic, renal, and/or cardiac function and of concomitant disease and drug therapy observed in the elderly also should be considered.

Pregnancy, Fertility, and Lactation:

Reproduction studies in rats and rabbits using clozapine dosages approximately 2—4 times the usual human dosage have not revealed evidence of harm to the fetus or impaired fertility. There are no adequate and controlled studies to date using clozapine in pregnant women, and the drug should be used during pregnancy only when clearly needed. Patients receiving clozapine should notify their physician if they become or plan to become pregnant during therapy.

Studies in animals suggest that clozapine may be distributed into milk. Because of the potential for serious adverse reactions to clozapine in nursing infants, a decision should be made whether to discontinue nursing or the drug, taking into accountthe importance of the drug to the woman.

Clozapine Adverse Effects Discussion

Hematologic Effects:

Granulocytopenia and Agranulocytosis

Agranulocytosis, defined as an absolute neutrophil count (ANC) less than 500/mm3 and characterized by leukopenia (leukocyte count less than 2000/mm3) and relative lymphopenia, has an estimated cumulative incidence of 1—2% after 1 year of clozapine therapy, as compared with an estimated incidence of 0.1—1% for phenothiazine-induced agranulocytosis. The rate of clozapine-induced agranulocytosis is based on the occurrence of 15 cases out of 1743 patients who received clozapine during clinical trials in the US. Some evidence suggests that the incidence of clozapine-induced agranulocytosis is at least 10 times greater than that of other antipsychotic agents, although it also has been suggested that the incidence of clozapine-induced agranulocytosis may be no higher than that associated with phenothiazines. ***Of the 149 cases of clozapine-induced agranulocytosis reported worldwide as of December 31, 1989, 32% were fatal.*** Few of these fatalities have occurred since 1977 when the knowledge of clozapine-induced agranulocytosis became widespread and close monitoring of leukocyte count became widely practiced. In the US, under a weekly leukocyte monitoring system in premarketing studies and in postmarketing experience with clozapine, 585 cases of agranulocytosis, including 19 fatalities, had occurred as of August 21, 1997; one patient receiving concomitant therapy with carbamazepine and clozapine died following development of an unusual hypoplastic anemia with agranulocytosis, a pancytopenic condition not usually characteristic of clozapine-induced hematologic effects. Based on analysis of data pooled from a confidential National master file of information (the Clozaril® National Registry), the incidence of agranulocytosis appears to rise steeply during the first 2 months of therapy and peaks in the third month. The incidence gradually declines with continued therapy and reaches a rate of 3 per 1000 person-years by 6 months of therapy. After 6 months, the incidence of agranulocytosis declines still further. However, the manufacturer cautions that a reduction in the frequency of leukocyte monitoring may result in an increase in incidence of agranulocytosis.

The precise mechanism by which clozapine induces agranulocytosis is not known, but both immunologic and toxic mechanisms (including a direct myelotoxic effect) have been implicated. Some evidence suggests that granulocyte antibodies may be involved. Except for the evidence of marked bone marrow depression during initial clozapine therapy and a disproportionate number of females, there are no established risk factors, based on worldwide experience, for developing clozapine-induced agranulocytosis.However, a disproportionate number of US cases have occurred in patients of Eastern European Jewish heritage compared with the overall proportion of such patients exposed to clozapine during domestic trials. Results of genetic typing indicate that genetic factors marked by a major histocompatibility complex haplotype (HLA-B38, DR4, DQw3) may be associated with the susceptibility of certain Jewish patients with schizophrenia to

develop agranulocytosis when treated with clozapine; the incidence of some phenotypes common among Ashkenazi Jews has been found to be greatly increased in patients with clozapine-induced agranulocytosis.

Most cases of clozapine-induced agranulocytosis in the US have occurred within 4—16 weeks of exposure to the drug. Although no patient characteristics predictive of an increased risk of agranulocytosis with clozapine have been identified conclusively, agranulocytosis associated with the use of other antipsychotic agents has been reported to occur more frequently in women, geriatric patients, and patients who are cachectic or have serious underlying medical conditions (e.g., immunocompromised patients, patients with human immunodeficiency virus [HIV] infection); such patients also may be at increased risk for developing agranulocytosis with clozapine therapy.

Investigation of 16 cases of clozapine-associated granulocytopenia occurring within a 2-month period in 1975 in southwest Finland, including 13 cases of agranulocytosis, revealed characteristics similar to those of phenothiazine-induced agranulocytosis. In all of these cases, the reaction occurred during first exposure to the drug and followed a latent period of 17—109 days at a cumulative dose of 4.5—42 g; reduced values for hemoglobin and peripheral erythrocyte and thrombocyte counts were foundinfrequently, and granulopoiesis in sternal marrow usually was severely depressed or absent. Erythropoiesis was below normal in only one case, and thrombopoiesis was normal or even increased. Hematologic values returned to baseline within 1—3 weeks after withdrawal of clozapine. All fatalities were attributed to secondary infection in patients in whom granulocytopenia was not diagnosed early or clozapine discontinued promptly. In patients who died, the clinical course typically consisted of fever with tonsillitis, which progressed to pneumonia and septicemia; the immediate cause of death usually was renal or cardiac failure. The frequency of clozapine-induced agranulocytosis or granulocytopenia in the Finnish experience was 7.1 per thousand—approximately 21 times higher than that reported in other countries. Although it has been suggested that a local genetic or environmental factor or factors may have been involved in the Finnish cases, the existence of such a factor has not been documented.

The most likely time of occurrence of granulocytopenia appears to be 4—16 weeks after initiation of treatment with clozapine. However, neither dose nor duration of therapy is a reliable predictor of agranulocytosis. Most patients develop agranulocytosis within the first 10 weeks of therapy, but a latent period of up to 1 year or longer also has been reported. Within the first 18 weeks of therapy, 77—90% of all cases of granulocytopenia and agranulocytosis have been reported and 85% of fatalities secondary to agranulocytosis have occurred. The latent period between the fall in leukocyte count and the development of a secondary infection usually is moderately long. Leukocyte count usually declines gradually (e.g., over a period of weeks), but italso may decline precipitously. Patients receiving clozapine may have a transient and benign reduction in leukocyte count without progression to agranulocytosis, and may or may not develop manifestations of infection (e.g., fever, sore throat).

Patients in whom granulocytopenia is diagnosed and clozapine therapy discontinued before the occurrence of infection generally have a favorable prognosis. Early diagnosis of granulocytopenia and appropriate medical management can forestall serious consequences and reduce morbidity and mortality substantially since the condition generally is reversible if clozapine is discontinued promptly. In contrast, agranulocytosis is more likely to be fatal in patients in whom clozapine therapy is not halted before the development of infection.

Because of the substantial, persistent risk of agranulocytosis associated with clozapine use, patients must have a leukocyte count performed before initiation of therapy with the drug. Clozapine therapy should not be initiated if the baseline leukocyte count is less than 3500/mm3. While some clinicians suggest that leukocyte counts be done weekly during the first 4—12 months of therapy and then less frequently (e.g., every 2 weeks or monthly) thereafter, most clinicians state that patients must have weekly leukocyte counts for the duration of therapy. However, the manufacturers suggest that the frequency of monitoring depends in part on the duration of therapy, adherence to therapy, and development of adverse hematologic effects. The manufacturers state that patients must have leukocyte counts done at least weekly for the first 6 months of continuous treatment and then every other week thereafter if leukocyte counts remain acceptable (leukocyte equal to or exceeding 3000/mm3, ANC equal toor exceeding 1500/mm3). Less frequent (i.e., every other week) of leukocyte counts also may be considered in patients who had a brief interruption in therapy (i.e., 1 month or less) before completion of 6 months, exhibited no adverse hematologic effects,and continued weekly leukocyte counts upon reinstitution of therapy. In patients receiving therapy for more than 6 months without adverse hematologic effects who have had an interruption in therapy of 1 year or less, monitoring of leukocyte counts also can be done every other week when therapy is reinstituted. However, in patients receiving therapy for less than 6 months who had an interruption in therapy for more than 1 month and exhibited no adverse hematologic effects, weekly leukocyte counts should be continued for an additional 6 months before reducing the frequency to every other week. In addition, leukocyte counts must be monitored weekly for an additional 6 months before reducing monitoring to every other week in all patients in whom the leukocyte count has fallen below acceptable limits (leukocyte less than 3000/mm3, ANC less than 1500/mm3), but who remain rechallengeable (i.e., leukocyte equal to or exceeding 2000/mm3 and ANC equal to or exceeding 1000/mm3) 1500/mm3). In addition, patients must have weekly leukocyte counts for at least 4 weeks following discontinuance of the drug. The manufacturer states that the distribution of clozapine is contingent upon the results of the required blood tests.

Although some clinicians suggest that body temperature be measured at least once daily for the first 18 weeks of clozapine therapy, others state that such monitoring is not an adequate means of assessing infection in clozapine-treated patients because of the drug's pharmacologic potential for causing temperature elevation. Patients should be advised to report immediately the appearance of lethargy, weakness, fever, sore throat, or any other potential manifestation of infection. The leukocyte count and differential should be repeated if, after initial clozapine therapy, the leukocyte count decreases to less than

3500/mm3; if it decreases by a substantial amount (defined as a single decrease of 3000 or more in the leukocyte count or a cumulative decrease of 3000 or more within 3 weeks) from baseline (even if it remains greater than 3500/mm3); or if immature leukocytes are present. If subsequent determinations of leukocyte count and differential reveal a total leukocyte count between 3000—3500/mm3 (mild leukopenia) and an ANC exceeding 1500/mm3, such determinations should be performed twice weekly.

If the total leukocyte count falls to less than 3000/mm3 or the ANC to less than 1500/mm3, clozapine therapy should be interrupted, leukocyte count and differential should be performed daily, and the patient should be monitored for flu-like symptomsor other manifestations of infection. Therapy may be resumed if symptoms of infection do not develop and if the leukocyte and ANC exceed 3000 and 1500/mm3, respectively. However, twice-weekly leukocyte and differential counts should then be performed until the leukocyte count exceeds 3500/mm3. If the leukocyte count decreases to less than 2000/mm3 or the ANC to less than 1000/mm3 (i.e., agranulocytosis), bone marrow aspiration should be considered to determine granulopoietic status. Protective isolation of the patient with close observation may be indicated if granulopoiesis is determined to be deficient. leukocyte and differential counts should be monitored daily or every other day until these values return to normal, which usually takes about 2 weeks. If infection develops, appropriate cultures should be performed and anti-infective regimens instituted, and the patient should be monitored closely. Supportive therapy with biosynthetic hematopoietic agents, including filgrastim, a recombinant human granulocyte colony-stimulating factor (G-CSF), and sargramostim, a recombinant human granulocyte-macrophage colony-stimulating factor (GM-CSF), has been effective in a limited number of patients with clozapine-induced neutropenia and agranulocytosis. Consultation with a hematologist and infectious disease expert is recommended.

During recovery, when the patient no longer has signs of infection and has a leukocyte count exceeding 4000/mm3 and an ANC exceeding 2000/mm3, determinations of leukocyte count with differential should be performed weekly until results show 4 consecutive weeks of normal values.

When granulocytopenia is diagnosed and clozapine therapy is discontinued, patients usually recover in 7—28 days. Most of these patients require further antipsychotic therapy because of a recurrence of psychotic symptoms. (See Other Nervous System Effects under Cautions: Nervous System Effects.) Since there appears to be no cross-sensitivity between clozapine and other antipsychotics in terms of hematologic toxicity, other antipsychotic drugs generally may be used without causing further hematologic complications in patients who develop clozapine-induced agranulocytosis. However, patients who develop clozapine-induced agranulocytosis (or those in whom the total leukocyte and ANC decrease to less than 2000/mm3 and less than 1000/mm3, respectively) should not be rechallenged with clozapine. Patients in whom clozapine therapy has been discontinued due to substantial leukocyte suppression have been found to develop agranulocytosis upon rechallenge with the drug, often with a shorter latency on reexposure. To reduce the chance of rechallenge in patients who have experienced

substantial bone marrow suppression with clozapine therapy, the manufacturer maintains a confidential national master file of information (the Clozaril® National Registry) on all such patients.

Eosinophilia
Eosinophilia has been reported in approximately 1% of patients who received clozapine therapy in clinical trials. The manufacturers state that if the total eosinophil count exceeds 4000/mm3, clozapine therapy should be temporarily discontinued untilthe count falls below 3000/mm3.

Other Hematologic Effects
Other hematologic effects reported with clozapine therapy include leukopenia, neutropenia, and thrombocytopenia, which have been reported in 1—3% of patients. Anemia, leukocytosis, and increased platelet count have been reported in less than 1% of patients receiving clozapine. Other clozapine-induced hematologic effects reportedly include basophilia, a substantial reduction in B cells, and an increase in hemoglobin concentration. Elevated erythrocyte sedimentation rate (ESR) and sepsis have been reported in patients receiving clozapine during postmarketing surveillance; however, a causal relationship to the drug has not been established.

Nervous System Effects:

Seizures
Clozapine lowers the seizure threshold, and ***seizures reportedly occurred in approximately 3.5% of patients*** exposed to the drug during clinical trials in the US (cumulative annual incidence of approximately 5%). In contrast, a seizure incidence of approximately 1% has been reported in patients treated with other antipsychotic agents. The risk of seizures with clozapine therapy appears to be related to dosage and/or plasma concentrations of the drug, with a reported incidence of approximately 0.6—2% at dosages less than 300 mg daily, 1.4—5% at 300—600 mg daily, and 5—14% at high dosages (600—900 mg daily). Clozapine-induced seizures may be associated with rapid dosage escalations or the influence of drugs or disease on clozapine metabolism, which maylead to increased plasma concentrations of the drug.

One patient receiving clozapine experienced a generalized tonic-clonic (grand mal) seizure following accidental ingestion of an extra dose (total dose ingested within 24 hours: 1050 mg); the same patient had another seizure several weeks later, 2 hours after a usual 450-mg morning dose. Results of plasma clozapine determinations obtained at the time of the seizures revealed plasma clozapine concentrations of approximately 2000 ng/mL in each case. Another patient who had been taking clozapine for 27months had a generalized tonic-clonic seizure following an apparent intentional overdosage (total dose ingested within 24 hours: approximately 3 g), after which the patient made an uneventful recovery. One hour after the seizure, the patient’s plasma clozapine concentration was 1313 ng/mL.

Discontinuance of clozapine therapy, at least temporarily, should be seriously considered in patients who experience seizures while receiving the drug; however, some clinicians state that reduced clozapine dosage and/or, occasionally, addition of anticonvulsant therapy may adequately ameliorate this effect. If clozapine therapy is to be continued in such patients, many clinicians recommend obtaining additional informed consent from the patient. In patients in whom clozapine is withheld, it has been suggested that therapy with the drug can be reinitiated at one-half the previous dosage. Clozapine dosage may then be increased gradually, if clinically indicated, and the need for concomitant anticonvulsant therapy should be considered. Some clinicians recommend that patients who have experienced a clozapine-induced seizure not be given clozapine dosages exceeding 600 mg daily unless the results of an EEG performed prior to the anticipated dosage increase are normal; others suggest addition of anticonvulsant therapy and/or consultation with a neurologist in managing such patients. In patients with preexisting seizure disorders who are treated concomitantly with certain anticonvulsants and clozapine, the anticonvulsant dosage may need to be increased. However, clozapine should not be used concomitantly with anticonvulsants (e.g., carbamazepine) or other drugs that potentially may cause bone marrow suppression. (See Drug Interactions: Myelosuppressive Agents.)

Extrapyramidal Reactions

In contrast to other antipsychotic agents, clozapine has a low potential for causing certain acute extrapyramidal effects (e.g., dystonias). Such effects, when they occur, have been limited principally to tremor, restlessness, rigidity, and akathisia; these manifestations generally are milder and less persistent than those produced by other antipsychotic drugs. In addition, marked or total remission of such manifestations induced by other antipsychotics has occurred during treatment with clozapine in some patients.

Neuroleptic malignant syndrome (NMS), a ***potentially fatal symptom complex****,* has been reported in patients receiving phenothiazines or other antipsychotic therapy. NMS attributable to clozapine therapy alone has been reported in a few patients, and there also have been several reports of NMS in patients treated concomitantly with clozapine and lithium or other CNS drugs; some clinicians suggest that NMS may be more likely to occur when clozapine or other antipsychotic agents are used concomitantly with lithium. Manifestations of NMS (e.g., muscle rigidity, hyperpyrexia, tachycardia, increased serum creatine kinase [CK, creatine phosphokinase, CPK], diaphoresis, somnolence), all of which may not occur in all patients with the condition, have occurred in a few patients treated with clozapine alone or combined with lithium or carbamazepine; resolution of the syndrome occurred following discontinuance of clozapine. However, clozapine also has been used successfully and apparently without recurrence of NMS in at least one patient who developed the syndrome while receiving chlorpromazine.

For additional information on NMS, see Extrapyramidal Reactions in Cautions: Nervous System Effects, in the Phenothiazines General Statement 28:16.08.

Tardive Dyskinesia

A syndrome consisting of potentially ***irreversible, involuntary, dyskinetic movements*** may develop in patients treated with antipsychotic agents. However, results of clinical trials in which clozapine was used have demonstrated a virtual absence of acute extrapyramidal reactions (e.g., dystonia), and there reportedly have been no confirmed cases of tardive dyskinesia associated with clozapine therapy alone. Nevertheless, a few cases of tardive dyskinesia have been reported in patients receiving clozapine who had been treated previously with other antipsychotic agents. Although current evidence suggests that clozapine may be less likely than other antipsychotic agents to cause tardive dyskinesia, it cannot yet be concluded, based on current limited experience, that the drug is incapable of causing this syndrome. The possibility of clozapine-induced tardive dyskinesia should be considered in patients receiving long-term therapy with the drug or in those starting clozapine therapy after discontinuance of other antipsychotic agents.

For additional information on tardive dyskinesia, see Tardive Dyskinesia in Cautions: Nervous System Effects in the Phenothiazines General Statement 28:16.08.

Other Nervous System Effects

Drowsiness and/or sedation occur frequently in patients receiving clozapine. (See Effects on Sleep under Pharmacology: Nervous System Effects.) The sedative-hypnotic effect of clozapine is most pronounced initially, diminishes after 1—4 weeks, and thengenerally, but not always, disappears during continued therapy. Daytime sleepiness may be minimized by administration of clozapine at bedtime. (See Dosage and Administration: Dosage.)

Dizziness and vertigo, headache, syncope, disturbed sleep (e.g., insomnia) or nightmares, hypokinesia or akinesia, and agitation have been reported with clozapine therapy. Clozapine also may cause confusion or delirium, which may be related to centralanticholinergic effects, and has been ameliorated in some cases by IV administration of physostigmine. Depression, fatigue, hyperkinesia, weakness or lethargy, and slurred speech also have been reported. Other adverse nervous system effects associated with clozapine therapy include ***ataxia, epileptiform movements or myoclonic jerks, and anxiety***.

Adverse nervous system effects reported in less than 1% of clozapine-treated patients include ***loss of speech, amentia (deterioration in cognitive function), tics, poor coordination, delusions or hallucinations, stuttering, dysarthria, amnesia, histrionic movements, increased or decreased libido, paranoia, shakiness, parkinsonian syndrome, and irritability.*** Difficulty in writing, residual daytime effects such as impairment of mental performance, and periodic cataplexy, which is characterized by sudden episodes of dropping objects and may or may not be accompanied by knee buckling, also have been reported infrequently with clozapine therapy**.** ***Exacerbation of psychosis, myoclonus, paresthesia, and status epilepticus*** have been reported in patients receiving clozapine during postmarketing surveillance; however, a causal relationship to the drug has not been established.

Abrupt discontinuance of clozapine (e.g., because of leukopenia or agranulocytosis) may result in recurrence of psychotic symptoms or behavior, including autism, auditory hallucinations, suicide attempts, development of parkinsonian symptoms, anxiety,insomnia, delusions, and violent behavior. It has been suggested that this "rebound psychosis" may result, at least in part, from clozapine-induced supersensitivity of mesolimbic dopamine receptors (see Behavioral Effects in Animals under Pharmacology:Nervous System Effects) and that the essential feature of this phenomenon appears to be recurrence of positive symptoms of schizophrenia. Patients who develop rebound psychosis following discontinuance of clozapine may improve with initiation of other antipsychotic therapy; however, clozapine should not be reinstituted in patients in whom severe leukopenia/granulocytopenia or agranulocytosis has occurred.(See Cautions: Hematologic Effects.)

Fever:

Fever or transient temperature elevations exceeding 38°C generally have been reported in 5% or more of patients receiving clozapine. The peak incidence of fever occurs within the first 3 weeks of therapy, usually between days 5—20 of treatment. Fever generally is benign and self-limiting and usually diminishes within a few (4—8) days despite continued clozapine therapy; however, it may necessitate discontinuance of the drug. ***Fever occasionally may be associated with an increase or decrease in leukocyte count, in which case patients should be evaluated for underlying infection or development of agranulocytosis.*** (See Cautions: Hematologic Effects.) In the presence of high fever, the possibility of neuroleptic malignant syndrome also must be considered. (See Extrapyramidal Reactions under Cautions: Nervous System Effects.)

The mechanism of clozapine-induced fever (other than that occurring secondary to some other factor such as infection) is not yet known. It may result from the drug's pronounced anticholinergic activity (see Anticholinergic Effects under Pharmacology: Nervous System Effects) or a direct effect on the hypothalamic thermoregulatory center. Clozapine-induced hyperthermia may be a hypersensitivity reaction, a common mechanism underlying drug fevers. It has been suggested that decreasing the dosage of clozapine and then gradually increasing it to the previous level may reverse the hyperthermia and not be accompanied by a recurrence of elevated temperature; however, recurrence is possible despite such dosage adjustment.

Cardiovascular Effects:

Hypotension and hypertension reportedly occur in less than 10% of patients receiving clozapine. When they occur, changes in blood pressure, principally reductions in systolic pressure, appear soon after initiation of clozapine therapy and may be associated with rapid dosage increases. A decrease in arterial blood pressure below 90 mm Hg was reported in 18% of male patients and 33% of female patients receiving clozapine in one retrospective study. Hypotension may result from clozapine's antiadrenergic effects (see

Adrenergic Effects under Pharmacology: Nervous System Effects) and may pose a serious risk for individuals with compromised cardiac function. However, tolerance to the hypotensive effects of clozapine often develops with continued therapy.

Orthostatic hypotension, with or without syncope, has been reported, particularly during initial titration or rapid escalation of clozapine dosage; however, this effect may represent a continuing risk in some patients. Rarely (approximately 1 case per 3000 patients), ***orthostatic hypotension has been accompanied by profound collapse and respiratory and/or cardiac arrest*** in patients receiving initial doses as low as 12.5 mg. If clozapine therapy is temporarily discontinued (i.e., for 2 or more days),the manufacturers recommend that the drug be reinitiated at a lower dosage (12.5 mg once or twice daily). In some cases when collapse and cardiac and/or respiratory arrest developed during initial therapy, benzodiazepines or other psychotropic agents were used concomitantly, suggesting a possible adverse interaction between clozapine and these agents. (See Drug Interactions: Benzodiazepines.) Although the clinical importance of this interaction has not been fully established, the manufacturers state that clozapine should be initiated with caution in patients receiving benzodiazepines or other psychotropic agents. Collapse and respiratory and/or cardiac arrest also have been reported in patients receiving initial therapy with clozapine alone. The risk of orthostatic hypotension may be reduced by initiating therapy at lower dosages, followed by only gradual, modest increases as necessary.(See Dosage and Administration: Dosage.) In some cases, withholding the drug for 24 hours and then restarting at a lower dosage has been accomplished without recurrence of orthostatic hypotension.

Tachycardia, which may persist throughout therapy in some cases, reportedly has been observed in 25% of patients receiving clozapine. Patients who experience clozapine-induced tachycardia demonstrate an average increase in pulse rate of 10—15 beats per minute (bpm); with aggressive dosage increases, the mean increase in heart rate ranges from 20—25 bpm. Persistent tachycardia associated with clozapine therapy is not simply a reflex response to hypotension and is present in all positions monitored. Although this effect may lessen once a plateau dosage level is reached, ***tachycardia may pose a serious risk for individuals with compromised cardiac function.***

Some clozapine-treated patients experience ECG repolarization changes, including ST-segment depression, shortening of the PQ interval, and/or flattening, depression, or inversion of T waves. These changes usually normalize after discontinuance of clozapine and are similar to those seen with other antipsychotic agents. The clinical importance of these changes currently is unclear, but some clinicians suggest that they occur infrequently and usually are not serious.

In clinical trials of clozapine, ***some patients experienced serious cardiovascular events, including ischemic changes, chest pain and angina, hypertension, myocardial infarction, nonfatal arrhythmias, or sudden, unexplained death.*** Causality assessment was difficult because of serious preexisting cardiac disease in many of the patients and plausible alternative causes.

Congestive heart failure and myocarditis (with or without eosinophilia), and pericarditis/pericardial effusions reportedly have occurred in clozapine-treated patients. Postexercise decreases in left ventricular output, which may indicate left ventricular failure, also have been reported in patients receiving the drug. Edema, palpitation, phlebitis or thrombophlebitis, cyanosis, ventricular premature complexes, and bradycardia have been reported in less than 1% of clozapine-treated patients. Although a causal relationship has not been established, atrial or ventricular fibrillation also has been reported in patients receiving the drug.

Deep-vein thrombosis and pulmonary embolism have been reported in patients receiving clozapine during postmarketing surveillance. As of December 31, 1993, 18 cases of fatal pulmonary embolism were reported in patients 10—54 years of age receiving clozapine therapy. Based on the extent of use observed in the Clozaril National Registry, the mortality rate associated with pulmonary embolism were 1 death per 3450 person-years of use; this incidence is approximately 27.5 times higher than that in thegeneral population. Although a causal relationship between clozapine and these adverse cardiovascular effects has not been established, the possibility of pulmonary embolism should be considered in patients presenting with deep-vein thrombosis or respiratory symptomatology. (See Cautions: Precautions and Contraindications.)

Rare instances of sudden, unexplained death have been reported in psychiatric patients, with or without associated antipsychotic drug treatment, and the relationship between sudden death and antipsychotic drug use is unknown. Some autopsy results have suggested that clozapine-treated patients have died from cardiac arrest and uncompensated cardiac disease, or from other causes such as renal insufficiency or severe alcohol abuse. A causal relationship between clozapine use and sudden death has not been established.

Autonomic Nervous System Effects:

Adverse autonomic nervous system effects occur in more than 5% of patients receiving clozapine. Dry mouth occurs frequently, but hypersalivation, an apparently paradoxical effect considering the drug's potent anticholinergic activity, is more common. (See Cautions: GI Effects.)

Other autonomic nervous system effects of clozapine include ***hyperhidrosis, decreased sweating, visual disturbances, nasal congestion, and pallor. Numbness, polydipsia, hot flushes (flashes), dry throat, and mydriasis*** have been reported in less than 1%of clozapine-treated patients.

Hepatic Effects:

Transient increases in liver function test results, including serum aminotransferases (transaminases), LDH, and alkaline phosphatase, may occur with clozapine therapy,

usually with no accompanying physical signs or symptoms. Clozapine-induced changes in liver function test results may be more pronounced than those with other tricyclic antipsychotic agents. Clozapine causes slight ***liver hyperplasia*** in rats; hyperplasia was reversible and no histologic changes were detectable. Clozapine occasionally causes slight elevations of bilirubin concentration. ***Cholestasis, hepatitis, and jaundice have been reported in patients receiving clozapine*** during postmarketing surveillance; however, a causal relationship to the drug has not been established.

Endocrine and Metabolic Effects:

Clozapine causes only a brief, transient ***elevation of prolactin concentration***. (See Pharmacology: Neuroendocrine Effects.) Because the drug's effects on prolactin are only minor, prolactin-dependent effects such as galactorrhea and amenorrhea usually are not associated with clozapine therapy. Breast pain or discomfort has been reported in less than 1% of clozapine-treated patients.

Clozapine may cause increased appetite, polyphagia, and weight gain in a substantial proportion (approximately one-third) of patients. Some clinicians suggest that the potential for weight gain with clozapine therapy may be similar to that with other antipsychotic therapy; others state that they have observed greater weight gain with clozapine in some patients. Some clozapine-treated patients reportedly have gained up to 1 kg weekly for 6 weeks. Weight gain may result from the drug's serotonergic-, histaminergic-, and adrenergic-blocking properties. Weight gain has been reported to be a problem for some patients during long-term therapy with clozapine and may be a major cause of outpatient noncompliance. Some clinicians suggest using exerciseand active measures (e.g., dietary counseling) to control dietary intake in clozapine-treated patients.

Severe hyperglycemia, sometimes leading to ketoacidosis, has been reported in patients without a prior history of hyperglycemia who received clozapine therapy. While a causal relationship to clozapine has not been established, blood glucose concentrations reportedly returned to normal following discontinuance of the drug in most patients but recurred in at least one patient upon subsequent rechallenge with clozapine. The effect of clozapine on glucose metabolism in patients with diabetes mellitus has not been studied.

Hyperuricemia, hyponatremia, weight loss, and decreased serum cholesterol concentrations also have been reported in patients receiving clozapine, although a causal relationship to the drug has not been established.

Small ***decreases in protein-bound iodine or thyroxine concentrations*** have been reported in some patients receiving clozapine, but these values remained within normal limits.

GI Effects:

Increased salivation may occur in approximately one-third of patients receiving clozapine; in some studies, hypersalivation was reported in up to 75—85% of clozapine-treated patients. Salivation may be profuse, very fluid, and particularly troublesome during sleep because of decreased swallowing. Since clozapine exhibits intrinsic anticholinergic properties, hypersalivation is an unexpected paradoxical effect. A muscle-relaxant effect of the drug may contribute to hypersalivation, but the cause has not been fully elucidated. Difficulty in swallowing has been reported in a few clozapine-treated patients, and it has been suggested that the drug may cause esophageal dysfunction, which may contribute to or exacerbate the nocturnal hypersalivation associated with clozapine therapy. Some clozapine-treated patients develop tolerance to increased salivation within a few weeks. Occasionally, hypersalivation may be ameliorated by reduction of clozapine dosage or cautious use of a peripherally acting anticholinergic drug; however, some clinicians generally advise against the use of anticholinergic therapy for this adverse effect because of possible potentiation of clozapine's anticholinergic activity.

Other GI effects associated with clozapine therapy include ***constipation, diarrhea, nausea and vomiting, heartburn, abdominal discomfort, and anorexia***; some of these effects have been reported in more than 5% of patients. Although some clinicians advocate the use of metoclopramide (e.g., in doses less than 30 mg daily) for the treatment of clozapine-induced nausea, other clinicians suggest that metoclopramide or other dopamine antagonists not be used or be used with extreme caution for the treatment of clozapine-induced nausea because of their potential for causing parkinsonian manifestations and tardive dyskinesia.

Abdominal distention, gastroenteritis, rectal bleeding, nervous stomach, abnormal stools, hematemesis, gastric ulcer, bitter taste, and eructation have been reported in less than 1% of patients receiving clozapine. Although a causal relationship to the drug has not been established, salivary gland swelling and paralytic ileus also have been reported in patients receiving clozapine.

Genitourinary Effects:

Genitourinary effects reported with clozapine therapy include ***polyuria, incontinence, urinary urgency or frequency, urinary retention, or other urinary abnormalities; enuresis; impotence; abnormal ejaculation; dysmenorrhea; and vaginal itch or infection. Priapism and acute interstitial nephritis also have been reported with clozapine therapy***, although a causal relationship to the drug has not been established.

Respiratory Effects:

Clozapine-induced respiratory effects include ***throat discomfort, dyspnea or shortness of breath, coughing, pneumonia or pneumonia-like symptoms, rhinorrhea,***

hyperventilation, wheezing, bronchitis, laryngitis, and sneezing. Although a causal relationship to the drug has not been established, aspiration and pleural effusion also have been reported with clozapine therapy during postmarketing surveillance.

Respiratory depression or failure, including arrest requiring resuscitation, also has been reported in patients receiving clozapine, usually at initiation of therapy and particularly in patients receiving concomitant benzodiazepine therapy or in those with a history of recent benzodiazepine use. Some evidence indicates that the incidence of respiratory arrest and vascular collapse is about 1—2% of patients receiving clozapine concomitantly with a benzodiazepine. For additional precautionary information about this potential effect, see Drug Interactions: Benzodiazepines.

Dermatologic and Sensitivity Reactions:

Rash has been reported in 2% of patients receiving clozapine. ***Pruritus, eczema, erythema, bruising, dermatitis, petechiae, and urticaria have occurred*** in less than 1% of patients.

Hypersensitivity reactions, including photosensitivity, vasculitis, erythema multiforme, and Stevens-Johnson syndrome, have been reported with clozapine during postmarketing surveillance; however, a causal relationship to the drug has not been established.

Musculoskeletal Effects:

Adverse musculoskeletal effects reported in 1% of clozapine-treated patients include ***muscular weakness (myasthenic syndrome); back, neck, and leg pain; and muscle ache or spasm. Muscle twitching and joint pain have been reported less frequently. Rhabdomyolysis has been reported with clozapine*** during postmarketing surveillance; however, a causal relationship to the drug has not been established.

Other Adverse Effects:

Numb or sore tongue, chills (with or without fever), malaise, ear or eyelid disorder, ocular hyperemia, epistaxis, and nystagmus have been reported in 1% or less of patients receiving clozapine. ***Periorbital edema*** also has been reported in clozapine-treated patients, although a causal relationship to the drug has not been established.

Mutagenicity and Carcinogenicity:

Clozapine did not exhibit carcinogenic potential in long-term studies in mice and rats receiving dosages approximately 7 times (on a mg/kg basis) the usual human dosage. Clozapine also did not exhibit genotoxic or mutagenic effects when assayed in appropriate bacterial and mammalian tests.

CLOZAPINE
Drug Interactions

Drug-Drug Interactions from First DataBank

These drug interactions are reviewed by an editorial panel at First DataBank and determined to be clinically significant.The list does not include every interaction ever reported.

Contraindicated
RITONAVIR/CLOZAPINE

Severe
CLOZAPINE/CARBAMAZEPINE

Moderate
CLOZAPINE/SELECT SSRI'S

Drug Interactions:

The manufacturer states that the potential risks of using clozapine in combination with other drugs have not been evaluated systematically. However, clinical experience and/or theoretical considerations indicate that certain potential drug interactions exist.

Myelosuppressive Agents
The mechanism of clozapine-induced agranulocytosis is unknown; however, the possibility that causative factors may interact synergistically to increase the risk and/or severity of bone marrow suppression warrants consideration. (See Cautions: Hematologic Effects.) Therefore, clozapine should not be used with other agents having a well-known potential to suppress bone marrow function. That clozapine may be directly myelotoxic has been suggested by in vitro study of the serum and bone marrow of a patient who died during multidrug therapy that included clozapine and carbamazepine.

Drugs Affecting the Seizure Threshold
Clozapine may lower the seizure threshold and has caused seizures in some patients (see Seizures under Cautions: Nervous System Effects); therefore, concomitant therapy with other agents that lower the seizure threshold generally should be avoided if possible. If such combined therapy is required, caution should be exercised (e.g., using low initial dosages of clozapine with slow upward titration) and the possible need for anticonvulsant therapy considered.

Benzodiazepines
Severe hypotension (including absence of measurable blood pressure), respiratory or cardiac arrest, and loss of consciousness have been reported in several patients who received clozapine concomitantly with or following benzodiazepine (i.e., flurazepam, lorazepam, diazepam) therapy. Such effects occurred following administration of 12.5—150 mg of clozapine concurrently with or within 24 hours of the benzodiazepine, but patients generally have recovered within a few minutes to hours, usually spontaneously; the reactions usually developed on the first or second day of clozapine therapy. Although a causal relationship has not definitely been established and such effects also have been observed in clozapine-treated patients who were not receiving abenzodiazepine concomitantly (see Cautions: Cardiovascular Effects), death resulting from respiratory arrest reportedly has occurred in at least one patient receiving clozapine concomitantly with a benzodiazepine. An increased incidence of dizziness and sedation and greater increases in liver enzyme test results also have been reported with this drug combination.

The manufacturer of clozapine recommends caution when the drug is initiated in patients receiving benzodiazepine therapy. However, some clinicians advise that, pending further accumulation of data, greater precaution should be exercised. These clinicians recommend that since initial titration of clozapine may cause respiratory arrest requiring resuscitation, which may be potentiated by recent benzodiazepine therapy, these latter drugs should be discontinued for at least 1 week prior to initiating clozapine therapy. In addition, these clinicians recommend that clozapine therapy be initiated in a setting where facilities for resuscitation are immediately available for the first few hours after administration of the first dose. Other clinicians, however, state that institutional initiation of clozapine therapy may not be necessary or practical, although they recommend slow and cautious initiation of the drug at low dosages.

Other CNS Depressants
Clozapine may be additive with, or may potentiate the action of, other CNS depressants such as opiates or other analgesics, barbiturates or other sedative/hypnotics, general anesthetics, or alcohol. When clozapine is used concomitantly with other CNS-depressant drugs, caution should be exercised to avoid excessive sedation.

Other CNS-active Agents
Although a causal relationship has not been established, at least one death has been reported with concomitant clozapine and haloperidol therapy. A 31-year-old woman with schizophrenia developed respiratory arrest, became comatose, and died 4 days after receiving 10 mg of haloperidol orally and a single 100-mg dose of clozapine IM. The patient had been maintained on oral clozapine 200 mg daily for 2 years and also had received smaller doses of haloperidol concomitantly with clozapine therapy without unusual adverse effect.

Neuroleptic malignant syndrome has been reported rarely with clozapine therapy alone and during concomitant therapy with clozapine and carbamazepine, lithium, or other

CNS-active agents. (See Extrapyramidal Reactions under Cautions: Nervous System Effects.)

Orthostatic hypotension, sometimes accompanied by profound collapse and respiratory and/or cardiac arrest, has been reported rarely with clozapine therapy alone and during concomitant therapy with other psychotropic agents. Although the clinical importance of this interaction has not been fully established, the manufacturers of clozapine state that the drug should be initiated with caution in patients receiving other psychotropic agents.

Drugs Undergoing Hepatic Metabolism or Affecting Hepatic Microsomal Enzymes
Metabolism of clozapine is mediated by the cytochrome P-450 (CYP) microsomal enzyme system, mainly by the isoenzyme 1A2 (CYP1A2), and possibly by other isoenzymes (e.g., CYP2D6). Concomitant use of clozapine with drugs that inhibit the CYP enzyme system (e.g., cimetidine, erythromycin, quinidine, certain antidepressants, phenothiazines, type 1C antiarrhythmics [e.g., propafenone, flecainide, encainide]) may result in increased plasma concentrations of clozapine. Conversely, concomitant use of clozapine with drugs that induce the CYP enzyme system (e.g., carbamazepine, phenytoin) may result in decreased plasma concentrations of clozapine. Caution should be observed if clozapine is used concomitantly with these drugs. Dosage adjustments of clozapine and/or other drugs may be necessary in patients receiving concomitant therapy with drugs that inhibit or induce the CYP enzyme system.

Phenytoin
Substantial reductions in plasma clozapine concentrations and exacerbation of psychosis have been reported in patients receiving concomitant therapy with clozapine and phenytoin, and an increase in clozapine dosage may be required to reestablish antipsychotic efficacy in patients receiving such combined therapy. In 2 patients stabilized for 1—2 weeks on a given dosage of clozapine, addition of phenytoin for prevention of clozapine-induced seizures resulted in a 65—85% decrease in steady-state plasma clozapine concentrations. Control of psychotic manifestations was regained in both patients by gradually increasing clozapine dosage. Although the mechanism of this potential interaction has not been established, it has been suggested that phenytoin may increase clozapine metabolism via stimulation of the hepatic cytochrome P-450 (microsomal) enzyme system and/or displacement of clozapine from protein binding sites, or that phenytoin may decrease absorption of clozapine from the GI tract. Pending further study, clozapine-treated patients in whom phenytoin therapy is initiated should be monitored carefully for reemergence of psychotic manifestations and clozapine dosage adjusted accordingly.

Carbamazepine
Concomitant use of clozapine and carbamazepine has been shown to decrease clozapine concentrations by about 40—50%. In addition, neuroleptic malignant syndrome has been reported rarely with clozapine therapy alone and during concomitant therapy with carbamazepine. (See Extrapyramidal Reactions under Cautions: Nervous System Effects.) Therefore, the manufacturers of clozapine state that concomitant use of these

agents generally is not recommended. However, if clozapine and carbamazepine are used concomitantly, it should be considered that discontinuance of carbamazepine may result in increased plasma concentrations of clozapine.

Selective Serotonin-reuptake Inhibitors
Concomitant use of clozapine with certain selective serotonin-reuptake inhibitors (SSRIs) can increase plasma concentrations of clozapine and enhance clozapine's pharmacologic effects secondary to suspected inhibition of clozapine metabolism by SSRIs. Modest (less than twofold) elevations in plasma clozapine concentrations have been reported in patients receiving clozapine concomitantly with certain SSRIs (i.e., fluoxetine, paroxetine, sertraline), although substantial (threefold) increases in trough plasma clozapine concentrations have occurred in patients receiving concomitant therapy with clozapine and fluvoxamine. The manufacturers of clozapine state that caution should be exercised and patients should be closely monitored when clozapine is used in patients receiving SSRIs, and a reduction in clozapine dosage should be considered.

Protein-bound Drugs
Because clozapine is highly protein bound, it theoretically could be displaced from binding sites by, or it could displace from binding sites, other protein-bound drugs such as oral anticoagulants (e.g., warfarin). Although no clinically important drug interactions have been reported to date, patients receiving clozapine with drugs that are highly protein bound should be observed closely for adverse effects.

Other Drugs
Clozapine has potent anticholinergic effects and may potentiate the actions of other drugs possessing such activity (e.g., antimuscarinics).

Clozapine may be additive with or potentiate the actions of hypotensive agents. In addition, the administration of epinephrine should be avoided in the treatment of clozapine-induced hypotension because of a possible reversal of epinephrine's vasopressor effects and subsequent further lowering of blood pressure.

Smoking
Some evidence indicates that cigarette smoking may substantially reduce plasma clozapine concentrations. Limited data indicate that average plasma clozapine concentrations following a given dose in smokers average 60—82% of those in nonsmokers. Changes in liver enzyme activity and/or the GI tract induced by nicotine or other substances present in cigarette smoke may explain these reduced concentrations. These effects should be considered when adjusting clozapine dosage in patients who smoke cigarettes.

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CLOZAPINE
Overdose & Toxicity

Chronic Toxicity:

Physical and/or psychological dependence have not been reported in patients receiving clozapine.

Chronic toxicity studies in mice, rats, dogs, and monkeys have revealed no specific organ toxicity. After 1 year of treatment with clozapine, a brown discoloration caused by increased lipopigment was observed in various organs in rats; this change normally appears with increasing age. Discoloration was noted in the thyroid, brain, liver, kidney, heart, spleen, and skeletal muscle of rats, but such increased pigmentation was not associated with deleterious changes. The liver did show slight, dose-dependent changes, including centrolobular vacuolation, hepatocyte swelling, and increased weight.

Acute Toxicity:

Pathogenesis
Acute toxicity studies in animals revealed that the LD50s for clozapine administered orally, IV, or intraperitoneally are approximately 145—325, 58—61, and 90 mg/kg, respectively.

Although the acute lethal dose of clozapine in humans remains to be established, fatal overdoses with the drug generally have been associated with doses exceeding 2.5 g. However, there also have been reports of patients surviving overdoses that substantially exceeded 4 g of the drug.

Manifestations
In general, overdosage of clozapine may be expected to produce effects that are extensions of pharmacologic and adverse effects. The most commonly reported signs and symptoms of clozapine overdosage have been altered states of consciousness and CNS depression (e.g., drowsiness, delirium, coma), tachycardia, cardiac arrhythmias, hypotension, respiratory depression or failure, aspiration pneumonia, and hypersalivation. Seizures have occurred with overdosage in some patients. (See Seizures under Cautions: Nervous System Effects.)

A 24-year-old woman who ingested 2 g in excess of her prescribed daily dosage (i.e., total ingestion approximately 3 g within a 24-hour period) had a tonic-clonic (grand mal) seizure; her plasma clozapine concentration 1 hour after the seizure (1313 ng/mL) was 500 ng/mL higher than usual, but she recovered uneventfully. In a 50-year-old woman who ingested 1 g of clozapine, the only manifestations were confusion and hallucinations lasting about 48 hours. A 26-year-old man who ingested approximately 3 g of clozapine became drowsy, agitated, and disoriented; he also had visual hallucinations, dysarthria, tachycardia, and hypersalivation. The patient was treated with gastric lavage and also received diazepam, digitalis, and anti-infectives, but continued to exhibit manifestations of severe central anticholinergic toxicity. Administration of physostigmine salicylate 2 mg by slow IV injection resulted in improvement in the patient's mental status within minutes; however, symptoms recurred after approximately 1 hour. Symptoms finally remitted 18—24 hours later with no further treatment.

Treatment

Treatment of clozapine overdosage generally requires symptomatic and supportive care, including monitoring of cardiac and vital signs. There is no specific antidote for the management of clozapine overdosage.

The manufacturer recommends establishing and maintaining an airway and ensuring adequate ventilation and oxygenation. Activated charcoal, which may be used with sorbitol, may be as or more effective than emesis or gastric lavage and should be considered in the treatment of clozapine overdosage. Electrolyte and acid-base balance should be monitored and adjusted accordingly. Peritoneal dialysis or hemodialysis is of limited value in the treatment of clozapine overdosage because the drug is almosttotally bound to serum protein. Forced diuresis, hemoperfusion, and exchange transfusion also are unlikely to be of benefit. While physostigmine salicylate may be useful as adjunctive treatment if severe anticholinergic toxicity is present, the drugshould not be used routinely because of its potential adverse effects.

Epinephrine should not be used for treating clozapine-induced hypotension, since clozapine can reverse epinephrine's vasopressor effects and cause a further lowering of blood pressure. Because of potential additive anticholinergic effects, quinidine or procainamide should be avoided when treating clozapine-induced arrhythmias. Surveillance of the patient should be continued for several days following overdosage because of the risk of delayed effects. In managing clozapine overdosage, the clinician should consider the possibility of multiple drug involvement.

CLOZAPINE
Pharmacology & Chemistry

Chemistry and Stability:

Chemistry
Clozapine is a dibenzodiazepine-derivative antipsychotic agent. The drug is a piperazine-substituted tricyclic antipsychotic agent that is structurally similar to loxapine but that differs pharmacologically from this and other currently available antipsychotic agents (e.g., phenothiazines, butyrophenones). Because of these pharmacologic differences, clozapine is considered an atypical antipsychotic agent.

While the structure-activity relationships of phenothiazine antipsychotic agents have been well described, these relationships for heterocyclic antipsychotic agents, including clozapine, have not been as fully characterized. Generally, the unsubstituted benzene ring seems to be important for interactions at dopamine receptors, while the chloro-substituted benzene ring seems more important for action at muscarinic receptors. In addition, an open carbon side chain replacing the piperazine moietyof clozapine generally leads to loss of activity.

Clozapine differs structurally from most currently available antipsychotic agents by the presence of a seven- rather than a six-membered central ring and the spatial relationship between the piperazine moiety and the chloro-substituted benzene ring.The core tricyclic ring system of clozapine is nonplanar and allows the piperazine moiety limited freedom of rotation.

Clozapine differs structurally from loxapine by the presence of a diazepine rather than an oxazepine central ring in the tricyclic nucleus and by the presence of a chlorine atom at position 8 rather than 2 of the tricyclic nucleus. The presence of a chlorine atom at position 8 of the tricyclic nucleus of clozapine appears to be associated with its distinct pharmacologic profile and may be responsible for the drug's antimuscarinic activity.

Clozapine occurs as a yellow, crystalline powder and is very slightly soluble in water.

Stability
Commercially available clozapine tablets should be stored in tight containers at a temperature not exceeding 30°C.

Pharmacology:

Clozapine is a dibenzodiazepine-derivative antipsychotic agent. While clozapine shares some of the pharmacologic actions of other antipsychotic agents, the drug has been described as an atypical antipsychotic agent since many of its CNS effects differ from

those of typical agents (e.g., butyrophenones, phenothiazines). In fact, these apparent differences in actions on neostriatal dopaminergic receptors have led some investigators to question the importance of the dopaminergic system in mediatingthe therapeutic effects of neuroleptic drugs. The exact mechanism of antipsychotic action of clozapine has not been fully elucidated but appears to be more complex than that of other antipsychotic agents and may involve serotonergic, adrenergic, and cholinergic neurotransmitter systems in addition to more selective, regionally specific effects on the mesolimbic dopaminergic system. Because of differences in the neurologic effects of clozapine, the drug is not considered a classic neuroleptic agent.

Nervous System Effects

Although the precise mechanism of action of antipsychotic drugs has not been fully elucidated, current data suggest that the therapeutic effects of these agents involve antagonism of dopaminergic systems in the CNS. In animals, classic neuroleptic agents increase muscle tone or induce postural abnormalities (catalepsy), antagonize stereotyped behaviors induced by the dopamine agonists apomorphine and amphetamine, accelerate dopamine turnover in various areas of the brain, increase serum prolactinconcentrations, and produce dopamine receptor hypersensitivity on repeated administration. These effects, many of which have been attributed to blockade of dopamine receptors in the neostriatum, form the basis for the hypothesis that idiopathic psychoses result from overactivity of dopamine in neostriatal and mesolimbic systems.

Unlike typical antipsychotic agents, clozapine exerts relatively weak antidopaminergic action within the neostriatum and has a low propensity to produce extrapyramidal effects or stimulate prolactin secretion. While some studies have demonstrated that relatively high doses of clozapine suppress the conditioned avoidance response in animals, which is a characteristic of typical antipsychotic agents, this response is not completely blocked by clozapine, and tolerance to this effect develops rapidly with repeated dosing, suggesting that it is not specifically related to clozapine's antipsychotic action. Further research is needed to elucidate fully clozapine's antipsychotic action in terms of the drug's serotonergic, adrenergic, muscarinic, and peptidergic effects and their influences on functional alterations in dopamine receptor systems.

Antidopaminergic Effects

The therapeutic effects of antipsychotic drugs are thought to be mediated by dopaminergic blockade in the mesolimbic and mesocortical areas of the CNS, while antidopaminergic effects in the neostriatum appear to be associated with extrapyramidal effects. Several (at least 5) different types or subtypes of dopamine receptors have been identified in animals and humans. The relative densities of these receptors and their distribution and function vary for different neuroanatomical regions, and clozapine's unique effects may be secondary to regionally specific receptor interactions and/or other effects on dopaminergic neurons. Results obtained from receptor binding, behavioral, metabolic, and electrophysiologic studies of clozapine as well as theapparently low incidence of extrapyramidal effects associated with clozapine therapy suggest that the drug is more active in the mesolimbic than the neostriatal dopaminergic system. Results

of some studies suggest that clozapine is more effective inincreasing dopamine turnover and release in the nucleus accumbens or olfactory tubercle than in the neostriatum with acute administration and that it reduces dopamine release in the accumbens but not in the neostriatum during prolonged administration, which suggests preferential effects on dopaminergic function in the limbic system. However, conflicting data (i.e., no preferential limbic effects) also have been reported with both acute and repeated administration of the drug, which may reflect differences in analytical techniques, regional differences in drug distribution or receptor affinity, or other variables.

Some evidence suggests that the effects of clozapine on dopamine metabolism in the neostriatum are dose related; unlike typical antipsychotic drugs, clozapine appears to increase striatal dopamine turnover only at supratherapeutic doses. Single highdoses (80 mg/kg intraperitoneally) of clozapine in rats interfere with dopaminergic transmission by blocking postsynaptic dopamine receptors and causing a compensatory increase in dopaminergic neuronal firing, while lower doses retard dopamine release. Clozapine appears to increase striatal dopamine content when given either in single high doses or repeated low doses, and low doses of the drug reportedly decrease the degradation of dopamine to 3-methoxy-4-hydroxyphenylacetic acid (homovanillic acid, HVA) in the neostriatum. In a rodent model of tardive dyskinesia, single low doses (up to 1.2 mg/kg intraperitoneally) of clozapine suppressed ketamine-induced linguopharyngeal movements, which resemble symptoms of tardive dyskinesia (e.g., tongue protrusions, retrusions, and swallows), by 15—75% compared with baseline measures. At clozapine doses of 4.8 mg/kg or higher, clozapine caused total suppression of these movements, and duration of suppression became dose dependent. Since suppression of abnormal linguopharyngeal movements occurred at doses substantially lower than those reported to alter dopamine turnover, it has been suggested that doses of the drug lower than those required for antipsychotic activity may be useful for treating antipsychotic-induced tardive dyskinesia. (See Uses: Other Uses.)

Current evidence suggests that the clinical potency and antipsychotic efficacy of both typical and atypical antipsychotic drugs generally are related to their affinity for and blockade of central dopamine D2 receptors; however, antagonism at D2 receptors does not appear to account fully for the antipsychotic effects of clozapine.

In in vitro studies, clozapine is a comparatively weak antagonist at D2 receptors. Clozapine's affinity for the D2 receptor on a weight basis reportedly is approximately one-third (33%) that of loxapine, one-tenth (10%) that of chlorpromazine, and one-fiftieth (2%) that of haloperidol. In oral dosages of 300 mg daily, clozapine produces a 40—65% occupancy of D1 and D2 receptors. During long-term clozapine therapy, the relative occupancy of D1 receptors may become greater than that of D2 receptors, or the long-term effects of the drug on D2 receptors may be antagonized by its nondopaminergic properties. Although the in vitro affinity of clozapine for D1 and D2 receptors in brain tissue of animals appears to be similar, the drug's in vivo effects in many animals resemble those of D1 receptor-specific antagonists. Compared with typical antipsychotic agents, clozapine shows greater affinity for and appears to produce greater

blockade of neostriatal dopamine D1 receptors; other data suggest that clozapine preferentially but not selectively antagonizes D1 receptor-mediated functions. At clinically effective dosages, however, the drug produces comparable blockade of D1 and D2 receptors and less D2 blockade than typical antipsychotic drugs. Long-term administration of clozapine leads to a 35—50% "up-regulation" of D1 receptors, which is comparable to that observed with administration of selective D1 antagonists; however, the number of D2 receptors is not changed, possibly because the proportionof occupied receptors required to elicit a response is less for D1 than for D2 receptors. Limited evidence suggests that D1 receptors may exist either coupled to adenylate cyclase or in uncoupled form. Clozapine appears to be a potent, competitive inhibitor of dopamine-stimulated adenylate cyclase in vitro, and the adenylate cyclase-coupled state of the D1 receptor binds clozapine with high affinity; in contrast, typical antipsychotic agents bind preferentially to the uncoupled D1 receptor.

Although their role in eliciting the pharmacologic effects of antipsychotic agents remains to be fully elucidated, dopamine D3, D4, and D5 receptors also have been identified; clozapine appears to have a much higher affinity for the D4 receptor thanfor D2 or D3 receptors. Current information on D3-receptor affinity for antipsychotic drugs suggests that most antipsychotics probably bind to both D2 and D3 receptors, although with higher affinity to D2 receptors; however, the magnitude of the difference in D3- versus D2-receptor binding is much less with atypical antipsychotics such as clozapine, suggesting that effects on D3 receptors may play a more important role in the pharmacologic actions of atypical versus typical antipsychotic drugs.The high affinity of the D4 receptor for clozapine and its preferential distribution in cortical and limbic areas in animals may explain, in part, the relative lack of tardive dyskinesia and extrapyramidal effects during clozapine therapy. The cloning of a gene for a neuron-specific dopamine D5 receptor, which binds antipsychotic drugs with similar affinity as the D1 receptor but has a tenfold higher affinity for dopamine, also has been reported.

Clozapine's clinical potency appears to be twice that of chlorpromazine on a weight basis, although the drug demonstrates considerably weaker D2-receptor binding affinity than chlorpromazine and appears to be much less potent in elevating dopamine metabolite concentrations in the brain. Clozapine produces a more potent blockade of central serotonergic, adrenergic, histamine H1, and muscarinic receptors than typical antipsychotic agents; also, long-term administration of clozapine enhances striatal D1-receptor function in animals and results in "down-regulation" of cortical, type 2 serotonergic (5-HT2) receptors, suggesting that an interaction between these central neurotransmitter systems may be important for the drug's antipsychotic efficacy. Antagonism at cholinergic and alpha1-adrenergic receptors in the mesolimbic system, compensating for dopaminergic blockade in the neostriatum, may explain the apparent selectivity and low incidence of extrapyramidal effects seen with clozapine. The amygdala also may be a site of action for clozapine, since repeated administration of the drug selectively induces supersensitivity to locally applied dopamine in the amygdala, and amygdaloid neurons are excited by clozapine but generally unresponsive to other antipsychotic agents (e.g., haloperidol).

Further studies are needed to elucidate the mechanism of clozapine's antipsychotic effects in various areas of the CNS.

Neurophysiologic Effects

In vitro and in vivo electrophysiologic studies in animals demonstrate different sensitivities of various brain areas to clozapine-mediated postsynaptic receptor blockade. While clozapine increases firing rates of both nigrostriatal (A9 pathway) and mesolimbic (A10 pathway) dopaminergic neurons after acute administration, only mesolimbic dopaminergic neurons exhibit prolonged depolarization blockade following repeated exposure to the drug. Repeated administration of typical antipsychotic agents (e.g., haloperidol) concomitantly with an anticholinergic agent (trihexyphenidyl) or an alpha1-adrenergic blocking drug (prazosin) mimicked these selective effects of clozapine on mesolimbic versus nigrostriatal dopaminergic neurons, suggesting that alpha1-adrenergic blocking and/or anticholinergic effects may be responsible, in part, for the differential effects of clozapine in these midbrain areas. Some evidence suggests that the nucleus accumbens has greater sensitivity for clozapine than do other regions, which may explain why the drug appears to produce depolarization blockade of dopaminergic neurons only in the mesolimbic area. However, some studies have shown that neurons in the neostriatum also may be responsive to clozapine. Clozapine reportedly produces an increase in dopamine metabolites in the neostriatum comparable to or even greater than that in the nucleus accumbens. Demonstrable dopamine-receptor supersensitivity in both striatal and limbic forebrain regions also has been reported with prolonged clozapine administration. Therefore, it has been suggested that there may be a dissociation between the effects of clozapine on synthesis and metabolism of dopamine within nigrostriatal neurons and the drug's effects on neuronal firing rate and dopamine release.

Adrenergic Effects

Clozapine has adrenergic-blocking activity, which may be partially responsible for the sedation, muscle relaxation, and cardiac effects observed in patients receiving the drug. (See Cautions: Cardiovascular Effects.) Although the drug appears to have relatively weak alpha-adrenergic blocking effects compared with typical antipsychotic drugs such as chlorpromazine, clozapine's in vitro affinity (relative to dopamine D2-receptor affinity) for alpha1- and alpha2-adrenergic receptors is much higher than that of other antipsychotics, including chlorpromazine, haloperidol, loxapine, and thioridazine. Clozapine increases the number and sensitivity of alpha1-adrenergic, but not dopamine D2, receptors. The turnover rate of epinephrine and norepinephrine also may be increased by clozapine, but to a lesser extent than that of dopamine. Substantial increases in plasma norepinephrine concentrations, which decreased following discontinuance of the drug but remained above basal levels, have been noted in both schizophrenic and healthy individuals receiving clozapine; such increases may be the result of feedback mechanisms activated by adrenergic blockade.

Clozapine's central alpha1-adrenergic blocking activity also may be responsible for the dose-related hypothermia observed in mice given the drug. Clozapine also induces ataxia

and blocks amphetamine-induced hyperactivity in mice, although repeated administration of the drug results in almost complete tolerance to these effects. It has been suggested that clozapine's alpha1-adrenergic blocking properties may, in part, mediate its differential effects on midbrain dopamine receptors and be responsible for itsrelative lack of extrapyramidal effects. However, the clinical importance of the drug's alpha1-adrenergic effects has not been fully elucidated.

Anticholinergic Effects

Clozapine possesses potent anticholinergic activity in vitro; the drug's affinity for muscarinic receptors substantially exceeds that of other antipsychotic agents (e.g., 39—50 times greater than that of chlorpromazine and 100 times that of loxapine) and may be similar to that of tricyclic antidepressants and antimuscarinic antiparkinsonian agents (e.g., benztropine, trihexyphenidyl). It has been suggested that clozapine's anticholinergic effects may be more potent centrally than peripherally and thatadverse anticholinergic effects generally are not dose limiting; however, peripheral anticholinergic effects such as dry mouth are common and may be troublesome. Clozapine-induced delirium, which reportedly has occurred with rapid dosage escalation,has been reversed by physostigmine; this suggests that clozapine has central antimuscarinic activity. Some evidence also suggests that clozapine's anticholinergic properties may counteract the effects of dopamine receptor blockade in the neostriatum and thus prevent extrapyramidal reactions. Limited data suggest that the propensity of antipsychotic drugs to cause extrapyramidal effects varies inversely with anticholinergic potency and antimuscarinic activity; however, the relatively potent anticholinergic activity of clozapine does not appear to account adequately for its atypical actions.

Serotonergic Effects

It has been suggested that schizophrenia may involve a dysregulation of serotonin- and dopamine-mediated neurotransmission, and clozapine may at least partially restore a normal balance of neurotransmitter function, possibly through serotonergic regulation of dopaminergic tone. Clozapine blocks central type 2 serotonergic (5-HT2) receptors; the drug also antagonizes central and peripheral type 3 serotonergic (5-HT3) receptors. Long-termand acute administration of clozapine has produced down-regulation of 5-HT2 receptors in the frontal cortex and neostriatum of male rats; single or repeated daily injections of clozapine also reduced the number of cortical 5-HT2 receptors but did not change receptor affinity. In contrast to effects caused by typical antipsychotic agents, an increase in brain tryptophan, serotonin, and 5-hydroxyindoleacetic acid (5-HIAA) concentrations generally has been reported with clozapine administration in animals. It has been suggested that these effects might contribute to the pronounced sedative effects of clozapine, although increases in blood serotonin concentrations occurring during clozapine treatment in humans have been inconsistent and variable. (See Effects on Sleep under Pharmacology: Nervous System Effects.) Clozapine's serotonergic effects also reportedly may contribute to the drug's efficacy against negative symptoms of schizophrenia and to the weight gain observed during clozapine therapy. (See Cautions: Endocrine and Metabolic Effects.)

Effects on Other Central Neurotransmitters
Clozapine appears to have important activity on the metabolism of Gamma-aminobutyric acid (GABA), which has inhibitory effects on dopaminergic neurons. In contrast to the effects of typical antipsychotic drugs, clozapine apparently augments GABA turnover in both the neostriatum and nucleus accumbens. Increases in neostriatal GABA turnover and release may attenuate extrapyramidal reactions, while a similar action in the nucleus accumbens may be related to antipsychotic efficacy.

Clozapine appears to have central histamine H1-receptor blocking activity; such activity reportedly may be associated with sedation, hypotension, and weight gain. The drug's affinity (relative to dopamine D2-receptor affinity) for histamine H1-receptors is approximately 30 times that of chlorpromazine and 4 times that of loxapine.

Behavioral Effects in Animals
Studies of the effects of clozapine on animal behavior routinely used to detect antipsychotic activity support its classification as an atypical antipsychotic drug. Such studies suggest that the neostriatum is relatively unresponsive to clozapine. Since the drug does not induce catalepsy or inhibit apomorphine-induced stereotypy, which are thought to be mediated principally by the nigrostriatal dopamine system, clozapine's antipsychotic activity appears to result from the drug's activity in otherareas. Clozapine also does not block amphetamine-induced hyperactivity or apomorphine-induced emesis in animals as the typical antipsychotic agents do. Long-term administration of clozapine causes supersensitization of behaviors mediated by mesolimbic dopaminergic pathways (e.g., dopamine-induced locomotion) but not those mediated via neostriatal systems (e.g., dopamine-induced stereotypy). Long-term administration of clozapine in male rats caused a marked supersensitivity (of the same magnitude andduration as that of haloperidol) in the mesolimbic but not the nigrostriatal system. It has been suggested that supersensitivity of mesolimbic dopamine receptors may be associated with the apparent rebound psychosis that has been reported following clozapine therapy. (See Cautions: Other Nervous System Effects.)

EEG Effects
Clozapine may produce dose-related changes in the EEG, including increased discharge patterns similar to those associated with seizure disorders, and may lower the seizure threshold; seizures have occurred in patients receiving the drug, particularly with high dosages (greater than 600 mg daily), rapid dosage increases, and/or in the presence of high plasma concentrations. (See Seizures in Cautions: Nervous System Effects.) Some EEG changes associated with clozapine administration are atypical of those generally seen with other antipsychotic agents, resembling more closely those produced by antidepressants. Like other drugs with antipsychotic activity, clozapine increases beta-, delta-, and theta-band amplitudes and slows dominant alpha frequencies in clinical EEG studies. However, in patients with severe, treatment-resistant schizophrenia, increases in delta and theta band frequencies are more pronounced with clozapine than with haloperidol or chlorpromazine therapy, a finding that appears to parallel the drugs' relative antiserotonergic, antihistaminic, and anticholinergic activities. Enhanced EEG

synchronization, paroxysmal sharp-wave activity, and spike and wave complexes also may develop during clozapine therapy. Clozapine-induced EEG changes generally appear soon after initiation of the drug and return to baseline upon cessation of therapy.In one study, the EEG showed slight general changes or slight diffuse slowing in 75% of patients receiving clozapine; in another study, clozapine caused marked EEG changes, including a slowing of basal activity, in 5% of patients.

Effects on Sleep

Clozapine causes a shift in the sleep-wake pattern toward dozing in animals, with marked reductions in both slow-wave and paradoxical sleep times. However, tolerance to the drug's sedative effect usually occurs, although slowly in some patients, during continuous administration of clozapine. In a controlled study of short-term (3-day) administration in healthy young men, clozapine in dosages of 25 mg nightly substantially increased total sleep time on the first night of administration, but the duration of sleep returned to baseline by the third night. Clozapine did not substantially affect the time spent in stage 1, 2, 3, or slow-wave sleep, nor did it affect latency to the rapid eye movement (REM) period or the percentage of time spent in REM sleep. However, the percentage of time spent in stage 4 sleep was reduced substantially on the second and third nights of drug administration, while a variety of REM indices were increased on the third night of the study.

In a few patients receiving clozapine dosages of 150—800 mg daily, REM sleep increased to 85—100% of total sleep time after several days of drug therapy, with the onset of REM sleep occurring almost immediately after patients fell asleep. Intensification of dream activity also has been reported during clozapine therapy. Some clinicians have suggested that a correlation may exist between increases in body temperature and REM sleep and clozapine-induced improvement in psychosis. Cataplexy has been reported in some patients receiving clozapine.

Neuroendocrine Effects

In contrast to typical antipsychotic drugs, clozapine therapy in usual dosages generally produces little or no elevation of prolactin concentration in humans. Administration of clozapine to rats has produced a transient, dose-related increase in prolactin concentrations that is of much shorter duration than that caused by other antipsychotic agents. Prolactin normally is inhibited by dopamine released from tuberoinfundibular (TIDA) neurons into the pituitary portal circulation. In rats, clozapineacutely increases the activity of TIDA neurons, which inhibit the release of prolactin; activation of TIDA neurons may be mediated by an enhanced release of neurotensin. Clozapine's effect on prolactin appears to be transient, possibly because the drug appears to dissociate from dopamine receptors more rapidly than typical antipsychotic agents and is therefore eliminated from the brain more rapidly.

Clozapine has an effect on corticotropin (ACTH) and corticosterone, possibly through its effects on dopamine metabolism in the hypothalamus. Short-term administration of clozapine (cumulative dose: 200 mg) to a few patients with schizophrenia resulted in

marked inhibition of apomorphine-induced somatotropin (growth hormone) response, suggesting that clozapine may block the dopamine receptors responsible for eliciting this response. In contrast to typical antipsychotic agents, clozapine decreases or has no effect on basal cortisol levels. Clozapine markedly increases corticosterone concentrations in a dose-dependent fashion; other antipsychotic agents appear to increase corticosterone concentrations only at doses producing substantial D2-receptorblockade. Clozapine-induced stimulation of corticosterone secretion may result from stimulation, rather than blockade, of dopamine receptors, but the exact mechanism has not been fully elucidated.

Other Effects
Clozapine produced a dose-dependent delay in initiation of copulation in male rats, which may be related to blockade of mesolimbic dopamine receptors; however, the drug had no effect on copulatory behavior once the behavior had started. Fertility inmale and female rats reportedly is not adversely affected by clozapine. (See Cautions: Pregnancy, Fertility, and Lactation.)

In animals, even small oral doses of clozapine cause ptosis, relaxation, and a reduction in spontaneous activity, effects that are consistent with the drug's sedative activity. Inhibition of locomotor activity induced by clozapine diminishes with repeated administration. With increasing doses of the drug, reactions to acoustic and tactile stimuli decline, and disturbances in equilibrium have been reported. Clozapine also inhibits isolation-induced aggression in mice at doses lower than those affecting motor function, suggesting a specific antiaggressive effect.

Studies in animals suggest that clozapine has a weak and variable diuretic effect; the clinical importance of this effect has not been established. In both rats and dogs, low doses of clozapine tend to increase the elimination of water and electrolytes, while higher doses are associated with increases in potassium excretion and sodium retention.

Pharmacokinetics:

Absorption
Clozapine is rapidly and almost completely absorbed following oral administration. However, because of extensive hepatic first-pass metabolism, only about 27—50% of an orally administered dose reaches systemic circulation unchanged. Some, but not all, evidence suggests that clozapine may exhibit nonlinear, dose-dependent pharmacokinetics, with oral bioavailability being approximately 30% less following a single 75-mg dose than at steady state following multiple dosing. GI absorption appears to occur principally in the small intestine and is approximately 90—95% complete within 3.5 hours after an oral dose. Food does not appear to affect the rate or extent of GI absorption of the drug. The relative oral bioavailability of commercially available 25- and 100-mg clozapine tablets reportedly is equivalent, as is the relative oral bioavailability of tablets and capsules of the drug.

Following oral administration of a single 25- or 100-mg oral dose of clozapine as tablets in healthy adults, the drug is detectable in plasma within 25 minutes, and peak plasma clozapine concentrations occur at about 1.5 hours. Peak plasma concentrations may be delayed with higher single doses and with multiple dosing of the drug. In one multiple-dose study, peak plasma clozapine concentrations at steady state averaged 319 ng/mL (range: 102—771 ng/mL) and occurred on average at 2.5 hours (range: 1—6hours) after a dose with 100 mg twice daily as tablets in healthy adults; minimum plasma concentrations at steady state averaged 122 ng/mL (range: 41—343 ng/mL). Steady-state plasma concentrations ranging from 200—600 ng/mL generally are achieved with oral dosages of 300 mg daily, and steady-state peak plasma concentrations generally occur within 2—4 hours after a dose. Steady-state plasma concentrations of clozapine are achieved after 7—10 days of continuous dosing.

Considerable interindividual variation in plasma clozapine concentrations has been observed in patients receiving the drug, and some patients may exhibit either extremely high or extremely low plasma concentrations with a given dosage. Such variability may be particularly likely at relatively high dosages (e.g., 400 mg daily) of the drug. In one study, a sixfold interindividual variation in steady-state plasma clozapine concentration was observed in patients receiving such dosages. In addition, considerable intraindividual variation, particularly from week to week, may occur in some patients. However, substantial intraindividual variations in pharmacokinetic parameters typically are not observed from day to day. Although the interindividual variability in plasma clozapine concentrations is consistent with that reported for other antipsychotic drugs and may be secondary to differences in absorption, distribution, metabolism, or clearance of the drug, further study is needed to clarify whether such variation results principally from variable pharmacokinetics or other variables.

There is some evidence that interindividual differences in pharmacokinetic parameters for clozapine may result, at least in part, from nonlinear, dose- dependent pharmacokinetics of the drug. However, a linear dose-concentration relationship also has been reported. Results of a study in patients with chronic schizophrenia revealed a correlation between oral clozapine dosages of 100—800 mg daily and steady-state plasma concentrations of the drug. In addition, linearly dose-proportional changes inarea under the plasma concentration-time curve (AUC) and in peak and trough plasma concentrations have been observed with oral dosages of 37.5, 75, and 150 mg twice daily in other studies.

Smokers appear to achieve plasma clozapine concentrations that are approximately 60—80% of those achieved by nonsmokers following oral administration of the drug, possibly because of alterations in hepatic metabolism and/or GI absorption of the drug caused by nicotine or other substances (e.g., polycyclic aromatic hydrocarbons) present in cigarette smoke. (See Drug Interactions: Smoking.) There also is limited evidence that gender may affect plasma clozapine concentrations, with concentrations beingsomewhat reduced, perhaps by as much as 20—30%, in males compared with females. In addition, smoking has a greater effect on clozapine plasma concentrations in men than in women, although this difference could result simply from gender differences insmoking behavior. Plasma

concentrations may be increased in geriatric individuals compared with relatively young (e.g., 18—35 years old) individuals, possibly secondary to age-related decreases in hepatic elimination of clozapine.

Pharmacologic effects of clozapine (e.g., sedation) reportedly are apparent within 15 minutes and become clinically important within 1—6 hours. The duration of action of clozapine reportedly ranges from 4—12 hours following a single oral dose. In one study in patients with schizophrenia, the sedative effect was apparent within hours of the first dose of the drug and was maximal within 7 days. (See Effects on Sleep under Pharmacology: Nervous System Effects.) However, antipsychotic activity generally is delayed for one to several weeks after initiation of clozapine therapy, and maximal activity may require several months of therapy with the drug.

Correlations between steady-state plasma concentrations of clozapine and therapeutic efficacy have not been established, and some evidence suggests that the degree of clinical improvement is independent of plasma concentrations ranging from 100—800 ng/mL. However, it also has been suggested that serum clozapine concentrations less than 600 ng/mL may be adequate for therapeutic effect in most patients. Results of one study of 29 patients treated with clozapine 400 mg daily for 4 weeks showed thatpatients were most likely to respond to therapy when their plasma clozapine concentrations were at least 350 ng/mL and/or when plasma concentrations of clozapine plus norclozapine (an active metabolite) totaled at least 450 ng/mL. Further study is needed to determine whether nonresponding patients with plasma clozapine concentrations less than 350 ng/mL will benefit from increasing their dosage in an attempt to achieve higher concentrations.

Although a relationship between clozapine plasma concentrations and the risk of seizures has been suggested (see Seizures under Cautions: Nervous System Effects), most clinicians believe that a relationship between plasma concentrations of the drug and the risk of adverse effects has not been established.

Distribution

Distribution of clozapine into human body tissues is rapid and extensive; distribution of metabolites of the drug also appears to be extensive. In mice and rats, clozapine distributes principally into the lung, spleen, liver, kidney, gallbladder, and brain, achieving concentrations in these tissues up to 50 times those in blood. At 8 hours after IV injection, clozapine was still detectable in these organs but not in blood. There is limited evidence in animals that clozapine and its metabolitesmay be preferentially retained in the lungs by an energy-dependent, carrier-mediated process and by cellular binding. Evidence in animals also suggests that competition between clozapine and other drugs (e.g., chlorpromazine, imipramine, certain tetracycline antibiotics) for pulmonary binding sites may potentially affect plasma and tissue concentrations of clozapine, but the clinical importance, if any, of such an effect has not been established.

The volume of distribution of clozapine has been reported to be approximately 4.65 L/kg. In one study, the volume of distribution at steady state averaged 1.6 L/kg (range: 0.4—

3.6 L/kg) in schizophrenic patients. Because the volume of distribution of clozapine is smaller than that of other antipsychotic agents, it has been suggested that clozapine is less sequestered in tissues than the other drugs. Clozapine is approximately 97% bound to serum proteins.

Results of receptor-binding studies in monkeys indicate that clozapine rapidly crosses the blood-brain barrier following IV injection. The highest brain uptake of the drug was in the striatum in these animals; lesser concentrations were achieved in the thalamus and mesencephalon, although they exceeded those in the cerebellum. The pharmacokinetic characteristics of the drug in the CNS paralleled those in plasma in these monkeys, with an elimination half-life from CNS of about 5 hours. Evidence from other animal studies indicates that CNS concentrations of the drug exceed those in blood. Distribution of the drug into the CNS in humans has not been characterized.

Clozapine reportedly is present in low concentrations in the placenta in animals; information on placental transfer of the drug in humans currently is unavailable. Results of animal studies indicate that clozapine distributes into milk. (See Cautions: Pregnancy, Fertility, and Lactation.)

Elimination

The decline of plasma clozapine concentrations in humans is biphasic. The elimination half-life of clozapine following a single 75-mg oral dose reportedly averages 8 hours (range: 4—12 hours); that after a 100-mg oral dose appears to be similar. The elimination half-life of clozapine at steady state following administration of 100 mg twice daily reportedly averages 12 hours (range: 4—66 hours). The rapid elimination phase may represent redistribution and is followed by a slower apparent mean terminal elimination half-life of 10.3—38 hours. Although a study comparing single and multiple dosing of clozapine demonstrated an increase in elimination half-life with multiple dosing, other evidence suggests this finding is not attributable to concentration-dependent pharmacokinetics.

Clozapine is metabolized in the liver prior to excretion. Clozapine may undergo N-demethylation, N-oxidation, 3-carbon oxidation, epoxidation of the chlorine-containing aromatic ring, substitution of chlorine by hydroxyl or thiomethyl groups, and sulfur oxidation. A glucuronide metabolite, tentatively identified as a quaternary ammoniumN-glucuronide of clozapine, also has been identified. Metabolism of clozapine may occur by one or more of these routes.

The rate of formation and biologic activity of clozapine metabolites have not been fully elucidated. The desmethyl metabolite of clozapine (norclozapine) has limited activity while the hydroxylated and N-oxide derivatives are inactive. The N-oxide anddesmethyl derivatives are found in urine and plasma of humans in a proportion of 2:1.

Approximately 32% of a single oral dose of clozapine is found in plasma as the parent compound after 3 hours, 20% in 8 hours, and 10% up to 48 hours following the dose.

Only limited amounts (approximately 2—5%) of unchanged drug are detected in urine and feces. Approximately 50% of an administered dose is excreted in urine and 30% in feces; maximum fecal excretion has been estimated at 38%.Approximately 46% of an oral dose of clozapine is excreted in urine within 120 hours.

Total plasma and blood clearance of clozapine reportedly average 217 and 250 mL/minute, respectively, but show considerable interindividual variation.

June W. J. Ching, Ph.D., ABPP
Board Certified Clinical Psychologist
American Board of Professional Psychology
Pacific Business News Building
1833 Kalakaua Avenue, Suite 800
Honolulu, Hawaii 96815

Direct Line: (808) 949-9502
Secretary: (808) 955-7372
Fax: (808) 951-9282

February 7, 2017

Vote YES SB 384: Prescriptive Authority Legislation

Dear Senator:

Your support for greater mental health access to care is critical. SB 384 can and will make a difference to help provide care to those in dire need when it's most necessary. Providing prescriptive authority to advance trained prescribing psychologists will increase the resources of our local residents facing serious mental illnesses. This can lead to a reduction in suicide rates, prevention of homelessness due to mental illness, and reduction of healthcare costs.

Hawaii has a profound shortage of psychiatrists, especially on the Neighbor Islands. According to the Mental Health in American Survey (2012-2013), 66% of adults with mental Health illness and 70.9% of youth with major depressive disorder, did not receive treatment in Hawaii.

It is disheartening to me when my own relatives turn to me for viable options out of desperation because they have exhausted the list of psychiatrists who have turned them down as new patients for medication evaluations. Imagine the frustration and suffering experienced when you contact 6 to 9 psychiatrists in a row and they will not accept a cared one for psychiatric care because their schedules are full or are not providers for their medical insurance.

It is a fact that other states have successfully implemented prescriptive authority for psychologists. New Mexico, Louisiana, Illinois, Iowa, Guam, the Military, Public Health Service and Indian Health Service grant prescriptive authority to trained psychologists. There have been no adverse outcomes reported, no malpractice claims and no charges brought by any state licensing board for improper use of medications.

We humbly ask for you to hear and pass SB 384 and make a difference in Hawaii that will save lives of those in our community!

Sincerely,
June W. J. Ching, Ph.D., ABPP
Board Certified Clinical Psychologist
Licensed Hawaii

To: Committee on Commerce, Consumer Protection, and Health

Chair Rosalyn H. Baker

Vice Chair Clarence K Nishihara

From: Brian R. Schultz, M.D., Ph.D.

Re: SB384 Relating to Prescriptive Authority for Certain Clinical Psychologists

IN OPPOSITION

Thank you to Chair Baker, Vice Chair Nishihara, and the members of the Senate Committee on Commerce, Consumer Protection, and Health.

I am psychiatrist practicing in Hawaii. I applaud efforts to expand access to safe mental health care in the State of Hawaii. However, I am very concerned that SB384, in its current form, does not ensure an adequate level of training for prescriptive privileges. I was taught in my residency, as a future instructor of medical students and psychiatry residents in training, that we owe it to our trainees' future patients to prepare the trainees well and to evaluate them critically. Similarly, we owe it to the future patients in our population that we have trained their providers adequately. As the Committee responsible for Consumer Protection and Health, I encourage you to consider the **lack of consumer protection this bill offers** through its vague and minimal training requirements, and the health risks it subjects to our population. Moreover, there are other safer and effective methods by which to expand mental health care coverage. Particularly, the collaborative care model and telehealth solutions have proven to expand coverage in a safe manner, with care delivered by adequately trained practitioners. Please **VOTE NO** on SB384, which is unlikely to result in its stated goals. Please act positively on other legislative items in consideration this session that are based on proven methods of expanding access to safe mental health care.

Sincerely,

Brian R. Schultz, M.D., Ph.D.

Linda Hufano, Ph.D.
Executive Director & Licensed Psychologist
Alaka'i Na Keiki, Inc.,
1100 Alakea St, Suite 900
Honolulu, Hawaii 96813
(808) 523-7771

February 6, 2017

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Linda Hufano, Ph.D., Executive Director and Licensed Psychologist, Alaka'i Na Keiki, Inc.

Re: Testimony in Support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists
Hearing: Thursday, February 9, 2017, 9:00 a.m., Conference Room 229

My name is Linda Hufano. For over 30 years, I have worked as a psychologist in Hawaii. I was employed with the state departments of health and education for 10 years. I worked as a private practice psychologist in Honolulu and Leeward areas for 15 years. And, for the past 20 years, I have directed a behavioral health agency whose mission has included providing services for individuals who have difficulty accessing services because of the nature of their disability and/or because they live in rural, underserved areas.

Despite recruitment efforts, pay incentives, and the like, it has been an accepted "a fact of life" that there are not enough psychiatrists to meet the needs of our citizenry. As a psychologist, I am immensely proud of my colleagues who are no longer willing to be complacent about the needs for timely services, including psychiatric medication, and are willing to lend their hand by advocating for this bill, and when passed, being willing to pursue the demanding, rigorous training that will equip them to help address the needs for psychiatric medication of our Hawaii residents with mental health issues.

As I understand it, this bill as written provides the necessary safeguards to ensure that only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications. Psychologists in other states, including New Mexico, Louisiana, Illinois and Iowa have had prescriptive authority for years, and through the Department of Defense since 1974, and there have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

I hope that you will support this bill. Thank you for your consideration of my testimony.

Linda Hufano, Ph.D.
Executive Director and Licensed Psychologist
Alaka'i Na Keiki, Inc.

Richard J. Kravetz, Ph.D.
President & Licensed Psychologist
Alaka'i Na Keiki, Inc.,
1100 Alakea St, Suite 900
Honolulu, Hawaii 96813
(808) 523-7771

February 7, 2017

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

Re: Testimony in Support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 a.m., Conference Room 229

I have been a licensed psychologist in Hawaii for over thirty years. There has always been a shortage of psychiatrists, and individuals needing psychiatric medication have had difficulty accessing these services, especially those living in rural areas of our state.

The state's efforts, including pay incentives, have not changed the fact that there are not enough psychiatrists to meet the needs of Hawaii residents who need psychiatric medication.

It is imperative that the state do more – which means providing consumers with access to needed by professionals who are trained and qualified to provide the care needed.

This bill as written provides the necessary safeguards to ensure that only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications. Psychologists in other states, including New Mexico, Louisiana, Illinois and Iowa have had prescriptive authority for years, and through the Department of Defense since 1974, and there have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

I urge your support in passing SB 384 on behalf of individuals who would be adversely affected by not having access to timely care from qualified professionals.

Thank you for the opportunity to provide testimony.

Richard J. Kravetz, Ph.D.
President and Licensed Psychologist
Alaka'i Na Keiki, Inc.

THE TWENTY-NINTH LEGISLATURE
REGULAR SESSION OF 2017

TO: **COMMITTEE ON COMMERCE, CONSUMER PROTECTION, AND HEALTH**
Senator Rosalyn H. Baker, Chair
Senator Clarence K. Nishihara, Vice Chair

FROM: **Jill Oliveira Gray, Ph.D.**
Hawaii Licensed Clinical Psychologist

HEARING: Thursday, February 9, 2017 at 9:00 am, Room 229

RE: **TESTIMONY IN SUPPORT OF SB 384**
RELATING TO PRESCRIPTIVE AUTHORITY FOR CERTAIN CLINICAL PSYCHOLOGISTS

Honorable Chairs, Vice-Chairs and members of the Committee on Commerce, Consumer Protection, and Health, my name is Dr. Jill Oliveira Gray and I am a licensed Clinical Psychologist who has worked in rural, medically underserved areas for the past 16 years to include Hana, Maui, Molokai, and Waimānalo. I am also a past President of the Hawai'i Psychological Association and current Training Director at I Ola Lāhui, an American Psychological Association accredited pre-doctoral internship and post-doctoral fellowship that has trained and placed psychologists in rural, medically underserved areas across our state since 2007. Because of my years of clinical experience serving rural, medically underserved areas, and first hand knowledge of what the severe needs of these communities are and the profound impact that mental health provider shortages have on the psychological well being of these communities, **I would like to submit this testimony in strong support of SB 384.**

The mental health needs of individuals across our state continue to outweigh the capacity of our mental health system. I have been advocating in support of this measure for 14 years and during this time have not witnessed significant improvements in patients being able to access timely psychiatric care, particularly in rural areas of our state, but also on O'ahu where repeated referrals to multiple psychiatrists are made due to many who do not accept new patients and/or Medicaid/Medicare patients. The psychiatrists that I do know who have made themselves available in rural areas are ***severely overbooked*** and unable to provide patients the attention and connectedness they need and require in order to benefit from their services.

According to a Report on Findings from the Hawai'i Physician Workforce Assessment Project (December, 2014), physician shortages, including psychiatry, are highest in Hawai'i's rural areas. Across the different counties, in ranking order, the greatest shortage of psychiatrists is found on Maui at 41.2%, followed by Hawai'i island 39.2%, and, Kaua'i at 29.5%. According to this report, there is a 0% shortage for psychiatry on O'ahu but this doesn't take into account other aspects of accessibility including, availability (i.e., how soon and how often can a patient be seen?) and acceptability (i.e., quality of the relationship). I have witnessed all too often the suffering that persists due to individuals not being able to receive adequate psychiatric care on an outpatient basis. Psychiatrists practice in various types of health care settings, to include hospitals and residential treatment programs where the larger portion of our population does not require care, however, they do face access difficulties to receive appropriate outpatient medication management in order to maintain functioning and prevent worsening of psychological problems.

THE TWENTY-NINTH LEGISLATURE
REGULAR SESSION OF 2017

Prescriptive authority for advanced trained clinical psychologists is a *long term*, *no-cost solution* to addressing the mental health provider shortages in our state. In Hawai'i, more people die from suicides than from motor vehicle accidents, drownings, falls, poisonings, suffocations, and homicides. From 2008-2012, there was an increasing trend in number of suicides and attempts in Hawai'i with an average of 170 deaths and 852 attempts per year. The highest reported number of deaths in a 21-year period was a mere 5 years ago in 2010 with 195 deaths (Hawai'i State Department of Health, Hawai'i Injury Prevention Plan, 2012-2017). According to this report, the most common negative life events that precede suicide are relationship issues (34%) (i.e., break up or divorce), or serious illness or medical issues (26%). Many studies show that people who commit suicide receive little or no treatment for their mental health problems due to the multiple barriers that exist (i.e., access, availability, acceptability, cost). It is not to be taken lightly that despite a 0% documented shortage of psychiatrists on O'ahu, "…65% of the O'ahu [suicide] victims had a documented history of mental illness" (Hawai'i State Department of Health, Hawai'i Injury Prevention Plan, 2012-2017, p. 34). Something does not add up here. We need any and all solutions to address the problems of accessing timely, accessible, and acceptable care across our State.

The basic argument from those who oppose this measure is that patient safety will be seriously compromised by allowing psychologists to prescribe—but after 20 years of psychologists' prescribing, this has not proven to be true. Psychologists have been prescribing in the Indian Health Service and Department of Defense for the past 2 decades. There are now **130** prescribing psychologists licensed through New Mexico and Louisiana, many of whom are serving in rural, medically underserved areas and medically underserved populations. For example, the prescribing psychologists in New Mexico have increased the number of doctoral-level trained prescribers by 100%, and increased access to care among Medicaid patients by 60%. Via personal communication with a prescribing Medical Psychologist (MP) in Louisiana, after 10 years of practice, there have been NO complaints against MP's regarding prescribing and one of the benefits of MP's is that they are able to fill in positions that have been left vacant by psychiatrists for years.

The post-doctoral, master's level clinical psychopharmacology (MSCP) training sequence proposed in SB 384 is equivalent to that of the American Psychological Association's recommendations for obtaining the requisite sequence of training and certification specific to the practice of prescribing psychotropic medication.

There are multiple safeguards imbedded in this legislation to include:

- 2 years of course work culminating in a master's degree that covers content areas essential to prescribing psychotropic medication; 400 supervised (2 hours/week), direct face-to-face hours treating a diverse population of no less than 100 patients in either inpatient or outpatient settings;
- Passing a rigorous national exam, the Psychopharmacology Exam for Psychologists (PEP);
- Required to obtain Federal DEA license;
- Required to maintain malpractice insurance;

- Required to prescribe only in consultation and collaboration with a patient's physician of record and only after a written collaborative agreement has been signed; will not be allowed to prescribe for any patient who does not have a primary or attending physician;
- For forensically encumbered or severely mentally ill patients, a prescribing psychologist must work with the department of health psychiatrist and/or enter into a collaborative agreement with the department of health;
- Exclusionary formulary prohibiting the prescribing of schedule I-III drugs to include opiates and narcotics and no off-label prescribing for patients 17 years of age and younger; and,
- Annual continuing education requirements specific to psychopharmacology and in addition to the existing continuation requirements for licensed clinical psychologists.

For all these reasons, and most importantly, to improve the health care system for Hawaii's medically underserved areas and most vulnerable populations, I humbly ask for your support of SB 384.

Respectfully submitted,

Jill Oliveira Gray, Ph.D.
Licensed Clinical Psychologist
Direct of Training
I Ola Lāhui, Inc

Senator Rosalyn H. Baker, Chair
Senator Clarence K. Nishihara, Vice Chair

SB 384
Relating to Prescriptive Authority for Certain Clinical Psychologists

Thursday, February 9, 2017
9:00 am
Conference Room 229

To Senate Committee on Commerce, Consumer Protection, and Health Chair, Vice Chair and Committee Members:

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I **strongly support this measure** because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. **Please help us improve mental health in Hawaii by passing SB 384.**

Thank you for the opportunity to submit this testimony.

Sincerely,

Michelle Kawasaki, Ph.D.
Licensed Clinical Psychologist
94-970 Lumiauau Street, #B101
Waipahu, HI 96797
(808) 256-7031

2/7/17

I am testifying against SB384. This attempt to increase access to mental healthcare is bad solution to a complex problem. I have practiced pediatrics and psychiatry in Hawaii since beginning my training her in 1997. In that time I have served patients on every island except Niihau. The way to improve access to care is by changing the economy that drives healthcare delivery. If mental health providers were able to provide telehealth care for a reasonable reimbursement it would happen more often. Currently Medicaid and Medicare prevent us from doing this and commercial reimbursement for mental health care is not keeping pace with the cost of doing business in Hawaii.

Instead of allowing a few psychologists to expand their scope of practice, find a way to let psychiatrists, advance practice registered nurses, and physician assistants do our jobs with available technology and at a reasonable reimbursement. Allow Adam Smith's "invisible hand" of supply and demand correct an imbalance in care distribution caused by current restrictions and decades of poor reimbursements for mental health treatment.

Thanks for opposing SB384.

David E. Roth MD, FAAP, FAPA
Board Certified Child & Adolescent Psychiatrist, Adult Psychiatrist and Neurologist, and General Pediatrician
President
Mind & Body Works, Inc.

TO: Committee of Commerce, Consumer Protection, and Health
Rep. Rosalyn Baker (Chair)
Rep. Clarence Nishihara (Vice Chair)

HEARING: Thursday, February 9, 2017. 9:00 AM
Conference Room 229

FROM: Alannah Collat

RE: SB384 Relating to Prescriptive Authority for Certain Clinical Psychologists

To the members of the Committee of Commerce, Consumer Protection and Health,

Thank you for this opportunity to testify in **strong support** of SB384, which aims to authorize the board of psychology to grant prescriptive authority to prescribing psychologists who meet specific education, training, and registration requirements.

As someone who advocates on behalf of mentally ill adolescents in the state of Hawai'i, it is clear to me that many of Hawaii's residents, particularly in rural communities, are unable to access comprehensive and affordable mental health care that they need. Through working with one of my clients, I have seen how lacking access to mental health services can have devastating effects on an entire family. Providing advanced training in psychopharmacology to certain clinical psychologists who wish to become prescribing psychologists will help to maintain healthy individuals, families and communities.

I urge you to pass SB384 so that we may allow rural communities increased access to mental health care. Thank you for your consideration and for the opportunity to testify in support of this measure.

Sincerely,

Alannah Collat

IN OPPOSITION OF SENATE BILL 384 (Psychologist Prescribing)

ALOHA, Honorable Members of the Senate:

I am a practicing adult and geriatric psychiatrist in Honolulu who works in both a clinic setting and in a nursing home, and I would urge you to vote NO against the proposed bill allowing psychologists prescribing privileges. I would stress that I have heard from my own patients over the years and from members of the community in rural community Q&A sessions on the outer islands their concern about the safety of such a proposal given the complexity of medication prescribing in their own or their family members' experiences with mental health care. The issue of concern, I believe, is ACCESS TO CARE, and this is NEITHER a viable nor a safe solution. Additionally, some, in fact, many patients MAY NOT be candidates for medications and may be helped by psychotherapy "talk therapy."

The prescription of medications requires, at the least, medical training because medications impact the brain, heart, lungs, kidneys, endocrinologic, hematologic, musculoskeletal, and neurologic systems, among others, and involves a complex decision making process after a thorough medical assessment.
Without this, an appropriate diagnosis cannot be made (ruling out other medical causes or conditions resulting in a psychiatric presentation), the decision to medicate cannot be arrived at, nor can medications be safely managed in the context of medical conditions (medical monitoring) due to the sensitive process of adjusting and fine-tuning doses of medications. Children, pregnant women, and elders are particularly vulnerable populations.

I am concerned we could affect the welfare of our patients, the very ones we are trying to help. There is NO replacement for a medical training, I would stress.

I would urge you to CONSIDER VIABLE MEANS OF IMPROVING ACCESS TO CARE, some of which I am already myself actively training in currently, collaborative care. I would urge you to review the valid and proven measures of improving access to care via the collaborative care models now being used on the US Mainland in which PCPs collaborate with psychiatrists to increase numbers of patients who can access care, often three-fold in a given day. Telepsychiatry is yet another powerful modality that can safely provide and improve access to patients who otherwise may struggle to find a provider for mental health care services.
Please vote NO, in the name of protecting the health and welfare of our community and explore other, much safer means to improve access to mental health care.

Thank you for your time on this matter.
Mahalo and sincerely,
Rika Suzuki MD
Adult and geriatric psychiatry

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Dr. Robert Mayfield, Ph. D; ABMP; Prescribing Psychologist; Neuropsychologist.

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

Dr. Robert Mayfield, Ph. D; ABMP
Licensed Psychologist
Prescribing Psychologist
Neuropsychologist

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, February 8, 2017 8:58 AM
To: CPH Testimony
Cc: drscomatyadvokat@gmail.com
Subject: Submitted testimony for SB384 on Feb 9, 2017 09:00AM

SB384
Submitted on: 2/8/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Joseph E. Comaty, Ph.D., M.P.	Individual	Support	No

Comments: To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health From: Joseph E. Comaty, PhD, MP Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229 Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care. A recent article supports the effectiveness of prescribing psychologists; that they fulfill the aims of increasing access to care, especially for more indigent patients; and that they provide quality care and are recognized by their medical colleagues as being safe and effective prescribers (Linda and McGrath (2017): Professional Psychology: Research and Practice, Vol. 48, No. 1, 38–45). Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists. I know this is true since I am a Medical (i.e., Prescribing) Psychologist in LA. I am aware of the lack of any complaints or malpractice actions against any LA Medical Psychologist. The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications. Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384. Thank you for the opportunity to submit this testimony. Contact: drscomatyadvokat@gmail.com

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to

the committee prior to the convening of the public hearing.

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Dear Madam Chair Baker and all of the Members of the House Committee,

Mahalo for allowing me to give testimony with the people of Hawaii in mind.

My name is Raissa Tanqueco and I am a Psychiatrist in training. It took a long time to get to where I am at. Four years of undergraduate degree in Biology, four years of medical school and another four years of residency for me to complete my training in Psychiatry. But I would never change a thing, because that's what it takes to keep our patients safe. Learning medical terminology is like learning a new language. It cannot be mastered by an online course alone, it has to be practiced with others who speak the same language and understand the subtleties and art of medicine for many years. My concern with SB 384 is that it will be our most vulnerable patients, those who may not know what the difference in training between doctors in Psychology or Psychiatry is, who will be at highest risk. Granted that psychologists are trained to understand behavior, our bodies are made of many organ systems that influence that. Medications do not stop at the brain. There can be potentially very serious injuries to the heart, lungs, stomach, liver, kidneys, and blood.

I URGE YOU TO PLEASE VOTE NO ON SB 384.

I end with hope, because there are safer solutions to improve access to care. Please strongly consider Collaborative care between/among physicians, Project ECHO and network adequacy. I stand in full support of my testimony.

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Katie Arfa, I Ola Lāhui Behavioral Health Services

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

Although psychologists in many states have had prescriptive authority for decades without consumer complaint, arguments have been made that psychologists lack adequate understanding about the complexities of biological systems as a means of dismantling this measure. However, I urge you to consider how this is a biased and flawed argument for the following reason: Unless specializing in psychiatry, generalist physicians have an extensive amount of knowledge in the area of physiological illnesses, but very little education and training on the brain and mood…and yet they have prescriptive rights for psychotropic medications, which primarily affect brain functioning. Psychologists' education is the inverse: it *centers* on brain functioning while physiological systems are less emphasized. By the same rationale that allows generalist physicians to prescribe psychotropics, why then shouldn't psychologists, who *specialize* in brain functioning and have undergone advanced pharmacology training, have the same rights in order to provide the best care for their patients?

I am a psychology intern, meaning I will be sitting for the board of psychology licensing exam in the next year. I work in a primary care setting, alongside amazing physicians and other medical staff. I would like to point out that as wonderful as my colleagues are, it is common for our primary care physicians to consult with myself and other psychology staff—many of us trainees to obtain pharmacologic recommendations and advice to treat patients with mental health disorders. In the vast majority of instances, exactly what we recommend is what is eventually prescribed.

As psychologists, we are also uniquely equipped to help our patients monitor adherence, side effects, dosage, and interactions with other medications, since we spend significantly more time with them than most psychiatrists do during monthly check-ins. Unfortunately, it is a common complaint of my patients that though they saw a psychiatrist for a medication evaluation, they felt rushed and unheard. When

prescribing mood-altering drugs to patients with mental health complications, is it not better for patients to be closely and frequently monitored—and who better than by the psychologist who sees them weekly and knows them best?

It's easy to forget that this issue directly affects the lives of countless individuals. Severely depressed or suicidal patients are facing 2-3 month wait times to see a psychiatrist or turning to primary health care when they *could* be working with their primary mental health professional, their psychologist, who has received ample education and hands-on training in prescribing psychotropic medications.

As such, I urge you to consider helping us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Kyla Stueber, Doctoral Student at the Hawaii School of Professional Psychology at Argosy University

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

From: mailinglist@capitol.hawaii.gov
Sent: Wednesday, February 8, 2017 10:57 AM
To: CPH Testimony
Cc: rkailianu57@gmail.com
Subject: *Submitted testimony for SB384 on Feb 9, 2017 09:00AM*

SB384
Submitted on: 2/8/2017
Testimony for CPH on Feb 9, 2017 09:00AM in Conference Room 229

Submitted By	Organization	Testifier Position	Present at Hearing
Rachel L. Kailianu	Individual	Support	Yes

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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COMMITTEE ON COMMERCE, CONSUMER PROTECTION, AND HEALTH
Senator Rosalyn Baker, Chair
Senator Clarence Nishihara, Vice Chair

NOTICE OF HEARING
Thursday, February 9, 2017 at 9:00 AM
Conference Room 229
State Capitol
415 South Beretania Street

TESTIMONY IN SUPPORT OF SB 384
RELATING TO PRESCRIPTIVE AUTHORITY FOR CERTAIN CLINICAL PSYCHOLOGISTS

Honorable Chair Baker, Vice-Chair Nishihara and members of the Committee on Health, I am Robin Miyamoto, a Clinical Psychologist and Assistant Professor with the Departments of Native Hawaiian Health and Family Medicine and Community Health at the John A. Burns School of Medicine. I serve the Medicare/Medicaid community of Wahiawa and Mililani and I wish to submit this testimony in strong support of SB 384. This bill would allow advanced trained medical psychologists to prescribe and dispense medication within the scope of practice of psychology as defined by Hawai‘i Law.

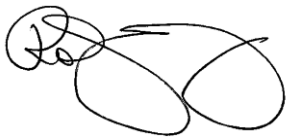
I support this bill for numerous reasons:

- In Hawai‘i, there is a substantial gap in mental health care that can be safely filled by granting prescription privileges to medical psychologists with advanced training in clinical psychopharmacology.
- Psychologists have been prescribing medications since 1974. They have done so in state systems, in the Indian Health Service, and in the Department of Defense.
- The education and training outlined in this bill, based in part on the already proven training of the U.S. Department of Defense Psychopharmacology Demonstration Project, and consistent with the American Psychological Association's Recommended Post-Doctoral Training in Psychopharmacology for Prescription Privileges, will provide psychologists with the core knowledge in medicine and psychopharmacology they will need to prescribe psychotropic medications safely and effectively.
- The training is part of a Post-Doctoral degree, the cost of which would be covered by the individual psychologist. These programs do not cost the state a single penny.

Psychiatry's arguments are the same ones that have been used for decades against nurses, podiatrists, optometrists, dentists and doctors of osteopathy. The organizers of the psychiatry guild disregard the overwhelming evidence that belies their position and they continue to distort and mislead. It is most disheartening that, for psychiatry, the goal is to keep us from prescribing even at the cost of the communities we serve.

What is the motivation behind our efforts? If you look at testimony provided over the years, psychology's message is consistent: to provide a full range of mental health services to those unserved and underserved communities. SB 384 will expand on our ability to do exactly that.

Thank you for your consideration.



Respectfully submitted by,
Robin E. S. Miyamoto, Psy.D.
677 Ala Moana Blvd. 1016
Honolulu, Hawaii 96813
Office: 808-692-1012
Fax: 808-587-8576
robinemi@hawaii.edu

From:	Edward Korber
To:	CPH Testimony
Subject:	Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists
Date:	Wednesday, February 8, 2017 2:02:31 AM

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Edward J. Korber, PhD.

Licensed Psychologist,

NYS office of Mental Health, Creedmoor Psychiatric Center

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

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Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

Respectfully,

Edward J. Korber, PhD

From: J. Blair Cano
To: CPH Testimony
Subject: Hawaii SB 384
Date: Wednesday, February 8, 2017 4:47:14 AM

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: J. Blair Cano, PsyD @ Neurofeedback Colorado Springs

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

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Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

--

J. Blair Cano, PsyD
Licensed Psychologist
Pediatric & Adult Neuropsychology
Colorado & Hawaii
719.964.8953

Neurofeedback Colorado Springs, Inc.
2906 Beacon St.
Colorado Springs, Co 80907

From: Shrinkart@aol.com
To: CPH Testimony
Subject: Re: Testimony in support of SB 384
Date: Wednesday, February 8, 2017 5:57:54 AM

February 8, 2017

Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health:

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Dear Senator Baker:

I am writing to ask for your support of SB 384, the bill to permit properly trained psychologists to prescribe psychotropic medications in Hawaii.

I write from a public health standpoint, and because I believe in the importance of the issue. I have nothing to gain financially, but am aware of the potential benefits of such a law because of my own career practicing as a clinical psychologist in a federal prison. There I saw the need for competent providers of clinical psychopharmacology services in correctional facilities, where so many citizens with serious mental illness are now housed, partly because they lack adequate treatment resources in the community.

You may already be aware that the military permits psychologists who have completed a clinical psychopharmacology curriculum to prescribe for men and women on active duty. Perhaps you also know that New Mexico, Louisiana, Illinois, Iowa, and Guam have already passed prescriptive authority laws of the type currently under consideration in Hawaii. The Indian Health Service has begun authorizing prescribing psychologists, reflecting the desperate need on that agency's part for high quality care of this sort. This is also true for the Public Health Service.

Prescribing psychologists have shown that they can provide this service safely and effectively. I believe the passage of the prescriptive authority bill, SB 384, would be a great benefit to the people of Hawaii, as similar authorization already has been for patients in the military, those receiving care from Indian Health Service and Public Health Service providers, and residents of New Mexico and Louisiana. In particular, it would benefit many of those citizens needing mental health care who, for various reasons, have the least access to treatment. I wish we had such a progressive law here in Virginia.

Thank you for your attention to my concern.

Sincerely yours,

Robert K. Ax, Ph.D.
Licensed Clinical Psychologist
Federal Bureau of Prisons (Retired)

5610 Chatmoss Road
Midlothian, VA 23112

Look for this notification to ensure that this is a valid e-mail sent by Bob Ax

From:	Elizabeth Schilling
To:	CPH Testimony
Subject:	Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists
Date:	Monday, February 6, 2017 4:05:30 PM

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Elizabeth C. Schilling, MFT
Behavioral Health Specialist V
State of Hawaii / Department of Education

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.
Elizabeth C. Schilling, MFT

Linda Hufano, Ph.D.
Executive Director & Licensed Psychologist
Alaka'i Na Keiki, Inc.,
1100 Alakea St, Suite 900
Honolulu, Hawaii 96813
(808) 523-7771

February 6, 2017

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Linda Hufano, Ph.D., Executive Director and Licensed Psychologist, Alaka'i Na Keiki, Inc.

Re: Testimony in Support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists
Hearing: Thursday, February 9, 2017, 9:00 a.m., Conference Room 229

My name is Linda Hufano. For over 30 years, I have worked as a psychologist in Hawaii. I was employed with the state departments of health and education for 10 years. I worked as a private practice psychologist in Honolulu and Leeward areas for 15 years. And, for the past 20 years, I have directed a behavioral health agency whose mission has included providing services for individuals who have difficulty accessing services because of the nature of their disability and/or because they live in rural, underserved areas.

Despite recruitment efforts, pay incentives, and the like, it has been an accepted "a fact of life" that there are not enough psychiatrists to meet the needs of our citizenry. As a psychologist, I am immensely proud of my colleagues who are no longer willing to be complacent about the needs for timely services, including psychiatric medication, and are willing to lend their hand by advocating for this bill, and when passed, being willing to pursue the demanding, rigorous training that will equip them to help address the needs for psychiatric medication of our Hawaii residents with mental health issues.

As I understand it, this bill as written provides the necessary safeguards to ensure that only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications. Psychologists in other states, including New Mexico, Louisiana, Illinois and Iowa have had prescriptive authority for years, and through the Department of Defense since 1974, and there have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

I hope that you will support this bill. Thank you for your consideration of my testimony.

Linda Hufano, Ph.D.
Executive Director and Licensed Psychologist
Alaka'i Na Keiki, Inc.

From: Allison Seales
To: CPH Testimony
Subject: SB 384
Date: Monday, February 6, 2017 9:23:53 AM

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Allison Seales

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care. I served on Molokai and the North Shore of Oahu for several years as a Licensed Clinical Psychologist and many of my patients were unable to get the medications and psychiatric care they needed.

Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

Allison Seales, Ph.D.
Licensed Clinical Psychologist

From: kathleen iannitello
To: CPH Testimony
Subject: No prescribing authority for psychologists
Date: Monday, February 6, 2017 6:21:00 PM

It is not safe or necessary for psychologists to prescribe medications . They do not have the necessary training and education in anatomy and physiology to competently prescribe and malpractice liability would be enormous . There are plenty of psychiatrists . Patients need better access to them and insurance coverage . I cover lanai , my colleague covers Molokai , no problem there. Plenty of docs on Maui and Oahu and people on Kauai that seek treatment can get it . Partnering with psychiatric residency programs would provide a safer more rational alternative . Not just giving prescribing power to unqualified psychologists . I vote AGAINST giving psychologists prescribing authority

Sent from my iPhone

From:	Adrienne Kadooka
To:	CPH Testimony
Subject:	Testimony in support of SB 384
Date:	Wednesday, February 8, 2017 8:59:57 AM

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: (your name and organization)

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

From:	George Wang
To:	CPH Testimony
Subject:	Testimony in support of SB 384
Date:	Tuesday, February 7, 2017 2:28:15 PM

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: George Wang, resident of Honolulu

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements.

I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

From:	Alexander Bivens
To:	CPH Testimony
Subject:	Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists
Date:	Tuesday, February 7, 2017 7:57:33 AM

Aloha trusted senators,

Thank you for hearing SB 384, which would grant prescriptive privileges to properly trained psychologists. Obtaining psychopharmaceutical prescriptions takes a very long time on Kauai due to the very small number of prescribing psychiatrists who work here. A 4-week wait is typical, 6 weeks is not unusual. It is embarrassing for Kauai, and it makes me feel like I am living somewhere other than the USA where we should have ready access to modern medical care.

Prescriptive authority has been granted to psychologists in other areas of the US, and there have been no reported adverse outcomes. and There are no discernible safety reasons for not increasing the number of prescribers who can serve the people of Kauai and other neighbor islands (I am less familiar with the circumstances on Oahu, so I will reserve comment about that region of the state).

I am satisfied that SB 384 ensures that prescribing psychologists will have all the training and experience necessary to safely benefit our community. Please vote to assist suffering persons in rural Hawaii by passing SB 384.

With sincerity and gratitude,

Alex Bivens, Ph.D.
Clinical Psychologist
Pacific Psychology Partners, Inc.
P.O. Box 321
Anahola, HI 96703
v. (808) 332-7190
f. (808) 443-0068

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Ciara Kahahane, Student at the William S. Richardson School of Law

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

The shortage of psychiatrists is strongly felt in Hawai‘i, particularly on neighbor islands. Rural communities have incredible trouble accessing psychiatric care. That means that many people who suffer from mental health conditions and may benefit from medication are unable to get the treatment they need.

Passing SB 384 will give properly trained and approved psychologists the ability to help such consumers, who should have a right to access medication. This bill has the chance to substantially increase the availability of medication to low-income and minority groups. It is certainly a step in the right direction for our state’s legislature.

For a reminder of how the availability of mental healthcare will benefit the community at large, I need only point to the connection between mental illness and homelessness, the latter being a problem that the state government has agonized over for years.

Please help us improve mental health in Hawaii by passing SB 384. Thank you for the opportunity to submit this testimony.

Sincerely,
Ciara Kahahane

From:	Mary Heaney
To:	CPH Testimony
Subject:	Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists
Date:	Monday, February 6, 2017 10:33:33 AM

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Mary Heaney MSN, CNM

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

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Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Mahalo for the opportunity to submit this testimony.

Mary

--

“Patriotism is supporting your country all the time and your government when it deserves it.”
— **Mark Twain**

From: Julie Y Takishima-Lacasa, PhD
To: CPH Testimony
Subject: Testimony in SUPPORT of SB 384
Date: Monday, February 6, 2017 8:47:31 PM

Testimony in SUPPORT of SB 384
RELATING TO PRESCRIPTIVE AUTHORITY FOR CERTAIN CLINICAL PSYCHOLOGISTS

SENATOR ROSALYN H. BAKER, CHAIR
SENATOR CLARENCE K. NISHIHARA, VICE CHAIR
SENATE COMMITTEE ON COMMERCE, CONSUMER PROTECTION, AND HEALTH

Hearing Date:
Thursday February 9, 2017, 9:00 a.m. Conference Room 229

2/6/17

I am writing in SUPPORT of SB 384. As a clinical psychologist who has worked in various rural communities across Hawai'i, I have experienced first-hand the devastating consequences of the lack of basic access to psychiatric services on my patients – the suffering of your constituents caused by this crisis is very real.

As such, we need all solutions being put forth to address this critical and growing problem, not just one or two solutions, or only those that will spread thin an already severely limited pool of psychiatrists serving those in need in our state. Across all of our islands psychologists outnumber psychiatrists by approximately 20% and therefore offer a substantial potential pool of prescribing providers. This represents one significant solution to address this access to care crisis that should not be overlooked.

Thank you for the opportunity to submit this testimony.
Respectfully submitted,

Julie Takishima-Lacasa

Julie Y. Takishima-Lacasa, Ph.D.
Licensed Clinical Psychologist
Chair, Legislative Committee, Hawai'i Psychological Association

From:	Sharon K. Usagawa
To:	CPH Testimony
Subject:	Testimony SB 384
Date:	Tuesday, February 7, 2017 11:38:59 PM

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Sharon Usagawa LCSW

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Hawaii has long been struggling in providing good mental health care for our most vulnerable and at-risk population who are dealing with mental health issues that can be overwhelming for them. This is one step in alleviating the shortage of psychiatric care and supporting those that need it the most.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

From: Venus Masselam
To: CPH Testimony
Subject: please support Bill 384
Date: Wednesday, February 8, 2017 3:10:35 AM

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Venus S. Masselam PHD, Maryland Psychological Association (MPA)#2637

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

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Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.
Thank you for the opportunity to submit this testimony.

Venus S Masselam PHD

Sincerely,

Venus Masselam, PHD
8705 Burning Tree Road
Bethesda, MD 20817
(301) 365-3948

Susana A. Galle, Ph.D., M.S.C.P., A.B.M.P.
The Body-Mind Center
1325 18th St., N.W. Suite 212
Washington, D.C. 20036
(202) 362-3837
Active Licenses: DC # 814; NM # 1038; NM Rx License 0028

February 8, 2017
To:
State of Hawaii Senators
Honorable Ladies and Gentlemen,

As a Psychologist with prescription privileges in New Mexico (NM), I offer my unqualified endorsement for passage of the law **authorizing prescriptive authority for appropriately-trained psychologists in Hawaii.** First and foremost, that law will **increase access to competent mental health services in a parsimonious way.** Furthermore, my experience in NM, based on extensive collaboration with medical doctors of various specialties, enables us all to offer best practices through integrated treatment. Thus, prescribing psychologists can also help upgrade the levels of practice, and create a highly competitive professional market.

The Hawaii RxP Law would allow appropriately trained psychologists to prescribe medication for the treatment of mental illness. The training required for psychologists who prescribe would be a doctoral degree, internship, licensure, completion of two to two and a half years additional post-doctoral education in Psychopharmacology, completion of a supervised residency (Clinical Medicine rotation, and Psychopharmacology practicum), and passing a national examination in clinical psychopharmacology (PEP). The curriculum preparing psychologists for prescriptive competencies includes core science courses, pharmacology, psychopharmacology, and advanced medical training in relevant areas. Most Psychopharmacology training programs for psychologists now grant an M.S. post doc degree in Clinical Psychopharmacology (M.S.C.P.) at graduation.

The acute shortages of psychiatrists has resulted in over 80% of psychotropic medication being prescribed by general practitioners (non-psychiatrists) who typically are able to spend only a few minutes with each patient before writing a prescription. While multiple studies have demonstrated that a combination of psychotherapy and drug therapy is the most effective treatment for most mental health problems, many patients in Utah are not getting this level of care. A recent study found that **two-thirds of the children who are prescribed medication for mental health disorders by their family doctor never saw a mental health specialist.** A prescribing psychologist would be able to determine if medication is needed for the child or if other treatments would represent a better option.

It is incumbent upon the State of Hawaii to search for innovative solutions, and allow new professionals who can provide both psychological and medication services competently. Waiting times for appointments with psychiatrists are weeks or, very often, months. The state and local public sectors are in an uncontrolled spending contest to find psychiatrists who are not available. Because of the shortages of psychiatrists, many psychiatrists will not accept insurance and charge hundreds of dollars just to see a new patient. Most patients need services sooner and cannot afford the cost.

Psychologists in Hawaii currently treat patients with all mental disorders at all levels of severity who are hospitalized or are outpatients. For over 50 years, the existing practice of psychologists has included making a differential diagnosis which distinguishes a mental disorder from medical conditions that are referred to a general practice physician. The existing practice also includes assessing patients for the need

for medications and for treating patients who often have had prescriptions ordered for their mental disorder. In the latter case, the psychologist assesses the medication's effects and side effects and the patient's response to them.

Prescribing psychologists in other states (New Mexico and Louisiana), in the military, and in the Indian Health Services have an unblemished record of prescribing medications safely and effectively. Opponents of the law have no evidence to support any claim about problems with safety. The psychologists within the Department of Defense have seen close to 200,000 patients with NO DEATHS and NO ADVERSE OUTCOMES. Government and outside evaluators have concluded that the Department of Defense psychologists were indeed trained to provide patients safe pharmacological care. Prescribing psychologists in Louisiana and New Mexico have written over 45,000 prescriptions WITH NO DEATHS AND NO ADVERSE OUTCOMES.

Hawaii prescribing psychologists will receive the same level of advanced education as prescribing psychologists in other parts of the country. Experience has shown that **prescribing psychologists employ concurrent psychological treatment modalities when they prescribe medications**. As a result, **prescribing psychologists prescribe medications only when they are needed**. They do not pull out the prescription pad when other treatments represent a better choice. As a result, prescribing psychologists represent a new, important choice for people in Hawaii who may want a balanced assessment when medications are considered so that they feel more comfortable that medication is really needed when it is prescribed.

Properly trained Hawaii psychologists with prescription privileges will bring about an unprecedented solution to the problem of inadequate services and high costs. This solution does not involve increasing taxes or increasing insurance premiums. Neither does it involve deciding which patients will not be served in order to decrease costs. The proposed law will increase the available services and curb the soaring cost increases for taxpayer supported services as well as for services in the private sector. The shortages of psychiatrists, the crisis in state facilities, and the proven track record of prescribing psychologists make passage that law more critical than ever. Psychologists have once again come through as a helping profession, with the highest level of responsibility and care for the mental health and wellbeing of their communities: they have gone back to school after being licensed as psychologists, learned while also working, and have acquired the competencies necessary to practice with prescriptive authority. **I urge your support of this law.** Thank you for your prompt attention to this matter.

Sincerely,

Dr. Susana A. Galle
Director, The Body-Mind Center
Washington, D.C.
Active Licenses in DC and NM; inactive in CA & MD
Medical and Prescribing Psychologist
Albuquerque, NM
Diplomate, American Board of Medical Psychology (AMP)
Science Editor, Archives of Medical Psychology
Board of Directors, AMP
Faculty Member, CSPP)
Alliant International University
San Diego, CA
M.S. post doc program in Clinical Psychopharmacology

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Sid Hermosura, Psy.D.

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care. As a psychologist working in rural communities, I have seen many patients suffer because they are not able to get an appointment with a psychiatrist. Prescribing psychologists with the proper training could fill this gap in care.

Psychologists have had prescriptive authority since 1974 through the Department of Defense, and later in the Public Health Service, Indian Health Service, Guam, New Mexico, Louisiana, Illinois, and Iowa. There have been no reported adverse outcomes or malpractice complaints related to prescriptive authority for psychologists.

The language in this measure will provide the necessary safeguards to ensure only those psychologists with appropriate education, clinical training and registration will be authorized to prescribe from a limited formulary of psychiatric medications.

Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

Sid Hermosura, Psy.D.
Licensed Clinical Psychologist

CPH Testimony

From: Michael Hand <mphand@msn.com>
Sent: Wednesday, February 8, 2017 1:48 PM
To: CPH Testimony
Subject: Prescriptive Authority for Specially Trained Psychologists

To: Senator Rosalyn H. Baker, Chair, Senator Clarence K. Nishihara, Vice Chair, and members of the Senate Committee on Commerce, Consumer Protection, and Health

From: Michael Hand, Ph.D., Psychologist in Private Practice

Re: Testimony in support of SB 384, Relating to Prescriptive Authority for Certain Clinical Psychologists

Hearing: Thursday, February 9, 2017, 9:00 am, Conference Room 229

Thank you for hearing SB 384, which authorizes the Board of Psychology to grant prescriptive authority to psychologists who meet specific education, training, and registration requirements. I strongly support this measure because it will help to alleviate the difficulty that people suffering from mental health problems have in accessing proper treatment and care.

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Passing SB 384 will give properly trained and approved psychologists the ability to help consumers that otherwise would be unable to access the medication they need and should have a right to access. Please help us improve mental health in Hawaii by passing SB 384.

Thank you for the opportunity to submit this testimony.

Respectfully,

Michael Hand, Ph.D.

600 Sunland Park Drive,

Blldg 6, Ste 100, El Paso, Texas 79912

Sent from my iPhone

From: Ray Terry
To: CPH Testimony
Subject: Psychologists Prezcriptons
Date: Wednesday, February 8, 2017 6:18:46 AM

I support the captioned legislation as in the best interest of needy patients.

Ray Terry
Memphis, TN

Ray Terry

Dear The Hawaii State House, The Hawaii State Senate, and Governor David Ige,

We are pleased to present you with this petition affirming this statement:

"Please pass legislation allowing Medical Psychologists with advanced training to prescribe psychotropic medications in the state of Hawaii. Our communities are suffering because of the lack of access to timely psychiatric care.

"

Attached is a list of individuals who have added their names to this petition, as well as additional comments written by the petition signers themselves.

Sincerely,
Don Lane

Gabriela Layi
Kailua, HI 96734
Feb 6, 2017

Conrad Moreno
Honolulu, HI 96815
Feb 6, 2017

Kiran Syed, Psy D.
Honolulu, HI 96826
Feb 5, 2017

This would be a great opportunity for Hawaii to attract medical psychologist to your state to help provide services for the citizens of Hawaii. Please pass this bill!

Larry Thomas, Ph.D.
Brenham, TX 77833
Feb 4, 2017

We have seen the benefit of RxP being able to consult with the patient's PCP in order to help with the continuity of care. In addition, many NP's and PCPs are asking what our RxPs would suggest for a Rx considering we work with the patient more intensely and are able to provide a thorough evaluation. The RxPs are needed to help provide ultimate care and fill the gaps where psychiatrists are few and far between.

Temperance Johnson
TX, TX 79925
Feb 3, 2017

Billy James
Comfort, TX 78013
Feb 3, 2017

Laura Avila, PhD
Dublin, CA 94568
Feb 3, 2017

Due to the lack of psychiatrist nationwide ,it is very important psychologist with advanced training in psychopharmacology be allowed to prescribe in Hawaii Patients need the care. Thank you.

Jennifer Darakjy
El paso, TX 79922
Feb 3, 2017

Gregory Simonsen
Dallas, TX 75219
Feb 3, 2017

Carol Grothues
Dripping Springs, TX 78620
Feb 3, 2017

Levi Armstrong
Wylie, TX 75098
Feb 3, 2017

Stephen Gary McClure Ph.D.
Roseville, CA 95661
Feb 2, 2017

Lucensed in Colorado & Hawaii

J. Blair Cano, PsyD
Colorado Springs, CO 80907
Feb 2, 2017

As a Past-President of the American Psychological Association I have found multiple research article that support the use of psychotropic medications by psychologists trained in their use for the prevention of suicide, unnecessary psychiatric hospitalizations and increased productivity in the work place. I strongly urge the enactment of SB 384 and HB 1072. I worked with Senator Inouye to get such legislation adopted in 1985. This unmet need still exists and needs your support. Dr Jack G. Wiggins

Dr Jack G Wiggins
Fountain Hills, AZ 85268
Feb 1, 2017

Zac Sluyter
Honolulu, HI 96826
Jan 18, 2017

Paige Sluyter
Honolulu, HI 96826
Jan 18, 2017

Beth Pasternak
Kihei, HI 96753
Jan 15, 2017

Michelle Tuipulotu
Lahaina, HI 96761
Jan 15, 2017

Please support mental health in Hawaii

Ivan Gonzalez
Puyallup, WA 98374

Jan 13, 2017

Kaipu Seales
Kaunakakai, HI 96748
Jan 13, 2017

No reason that after advanced training in psychopharamcology, Clinical Psychologists should not be allowed to prescribe.

Christopher Harkins
Honolulu, HI 96815
Jan 13, 2017

Daniel Pacheco
Waianae, HI 96792
Jan 13, 2017

One of the reason for homelessness is the lack of medication that can help these people. Example is the "sundowner syndrome" that elderly suddenly acquire.

Barbara Zachary
Honolulu, HI 96822
Dec 30, 2016

Karen M Rosner
Honolulu, HI 96815
Dec 24, 2016

We lack enough psychiatrists to treat low income people. They are hurting and conditions worsen without access to appropriate medications due to the lack of enough psychiatrists able to take these patients. Please help. We don't want people who are seeking help to become homeless due to lack of access to prescriptions for meds. Tx for listening.

Betty Lou Larson
HOnolulu, HI 96822
Dec 24, 2016

Many MSCP psychologists would galdly relocate to HI if this bill passes.

Jeff C Rose
Chico, CA 95973
Nov 6, 2016

Amber Nicole Rowe
Rapid City, SD 57702
Nov 6, 2016

Alysa lavoie
Honaunau, HI 96726

Oct 16, 2016

Barnypok
New York, Syria
Aug 12, 2016

Megan Jones
Lahaina, HI 96761
Jun 7, 2016

Patrick Mason
Oklahoma City, OK 73120
Jun 3, 2016

Aiona Rose
Wailuku, HI 96793
May 4, 2016

Please pass House Bill 1072, which would allow Psychologists in Hawaii to prescribe medications. On Maui, if you have Quest insurance, it takes frequently over 3 months to meet with a psychiatrist. If you have commercial insurance, it often can also take a very long time. I know because I manage 3 of the 8 psychiatrists that work on Maui. We desperately need psychologists prescribing. Prescribing psychologists also have been prescribing safely and effectively for the past 20 years in the military and on Native American reservations without any negative consequences for patients. A survey of family physicians who refer patients to prescribing psychologists in the Army Medical Command's Western Region found that 87 percent believe prescribing psychologists (RxP) have improved care. Safety would be ensured because it would requires all prescriptions written by prescribing psychologists to be approved by a psychiatrist or physician. Limiting prescribing to psychiatrists or other physicians ignores the obvious shortage of all health care providers here. Those who exist, such as family practice physicians, lack the training and experience in mental health and psycho-pharmacology that is essential to effective treatment. Critics bemoan the quality of training that clinical psychologists receive in order to write prescriptions for their patients, and secondarily, minimize similar education for physician assistants and nurse practitioners. Students enrolled in postdoctoral programs such as the master of science in clinical psychopharmacology at the University of Hawaii-Hilo's Daniel K. Inouye College of Pharmacy already have extensive training from Psy.D. or Ph.D. degree programs. The masters curriculum gives clinical psychologists further specialization that can improve treatment. An extensive practicum training with oversight by a psychiatrist or physician is required in HB 1072 and the UH-Hilo masters program. The qualifying national certification examination is written with input from psychologists, nurses, pharmacologists, pharmacists, physicians and psychiatrists (http://dhhs.ne.gov/publichealth/licensure/documents/PEPApplication.pdf). Another objection is that psychologists are not trained to be physicians, but that misses a critical aspect of prescribing psychology. Psychologists are not being trained to replace physicians; they are being educated to hone their excellent diagnostic and therapeutic training to improve integrated patient care. It is time for residents of Hawaii to receive the access to care that they deserve.

David Wittenberg
Makawao, HI 96768
Apr 27, 2016

Michele Hondo
Wailuku, HI 96793
Apr 27, 2016

Tracy Dossett
Baton Rouge, LA 70817
Apr 21, 2016

Cameron
Aiea, HI 96701
Apr 19, 2016

Katrina Edwards
Abilene, TX 79601
Apr 19, 2016

John Reardon
Albququerque, NM 87123
Apr 18, 2016

Angeline Dickson
Kailua, HI 96734
Apr 17, 2016

David Zuccolotto PhD
Folsom, CA 95630
Apr 17, 2016

Angela Mitchell
Chula Vista, CA 91914
Apr 13, 2016

Martha Dell
Hood River, OR 97031
Apr 13, 2016

Anne Farrar-Anton
Maywood, NJ 07607
Apr 12, 2016

Ike Nelson
Littleton, CO 80123
Apr 12, 2016

Please Vote yes on House bill 1072 realted to prescriptive authority fir advanced trained psychologists. Thank you!

Jennifer Darakjy
El paso, TX 79922
Apr 11, 2016

Much needed. Please support this.

Susan Wyche
Kihei, HI 96753
Apr 10, 2016

Aubriana Teeley
Kenmore, WA 98028
Apr 8, 2016

lisa
haiku, HI 96708
Apr 7, 2016

Erin
San Diego, CA 92123
Apr 5, 2016

Michelle Taylor
Mercer island, WA 98040
Apr 2, 2016

I feel proper medical care to everyone should be considered a basic human right. There should be as little resistance and few steps to complete care as possible. Mental health is just as vital as physical well-being, if not more so. One would not ignore a broken bone, therefore any mental health issue that prohibits healthy function should be considered just as important to the pursuit of happiness. Thank you for your consideration for improving the lives of so many Hawaiians.

Aigne Sponaugle
Imperial Beach, CA 91932
Apr 1, 2016

Patrick Davis
Missoula, MT 59803
Apr 1, 2016

Life Member of APA; licensed in HI, inactive; in CA inactive as I am retired. Past training and experience: adjunct Professor of UCI Med School as well as adjunct professor of several Doctor of Psychology programs. I have developed an APA-approved internship program. Have over 30 plus years in clinical, health and forensic psychology experience. Was longstanding member of the Adelberg Medical Group. Trained at Children's Hospital with fellowship in the Special Neurology Clinic; appointed by CA Gov. Brown to oversee the clinical programs of a major state hospital. While in Hawaii I worked with Betty Ann Rocha at the Liliuokalani Children's Center and worked closely with many of the MDs in the State. I agree entirely that prescribing privileges for psychologists with special psychotropic medication training is in the best interest of under-served populations as well as the entire population of Hawaii. This is especially important because many mainland psychiatrists have little or no understanding of the unique needs of Hawaii's multicultural and varied ethnic populations. --Sent with aloha to all of my psychologist friends including Dr. Bill T. whose friendship and support I still treasure.

Richard M Deatherage Ph.D.
Latrobe, CA 95682
Apr 1, 2016

Angela Miller
Ravenna, OH 44266
Apr 1, 2016

This legislation serves those in most need. We are a profession that is trained to serve.

Joan B. Read PhD
ATLANTA, GA 30324-3169
Mar 31, 2016

Kendra Nickerson
Pasadena, CA 91106
Mar 31, 2016

Please consider following the groundbreaking decisions of NM, LA, Guam, and IL who have successfully implemented prescribing privileges for psychologists. It allows for significant improvement in the lives of your underserved populations who have mental illness and limited access to quality care.

Amanda MacKinnon
Fairbanks, AK 99701
Mar 31, 2016

Ken Fogel, Psy.D.
Park Ridge, IL 60068
Mar 31, 2016

Kiana Amoncio
Lahaina, HI 96761
Mar 31, 2016

Kanaan Amoncio
Lahaina, HI 96761
Mar 31, 2016

Robert Marshall
Lahaina, HI 96761
Mar 31, 2016

Tina Marshall
Lahaina, HI 96761
Mar 31, 2016

I support the passing of this bill!

Brandi baker
Lahaina, HI 96761
Mar 31, 2016

Margaret Bencomo-Rivera
San Antonio, TX 78223
Mar 31, 2016

Claire Corey
St. Louis Park, MN 55416
Mar 31, 2016

In Louisiana, specially trained psychologists have been prescribing safely for more than 10 years...no catastrophies, the sky has not fallen, but access to quality mental health care has improved. Please help the citizens of Hawaii by passing this bill.

Glenn A. Ally, PhD, MP
Lafayette, LA 70503
Mar 31, 2016

Hawaii is ready for this.

Warren R. Littleford
Chandler, AZ 85286
Mar 31, 2016

John King
Albuquerque, NM 87110
Mar 31, 2016

Closing Mental Health gaps and improving continuity of care. What else needs to be said. Please set an example for the rest of the country to legislation can be furthered in other states.

Casey
Bemidji, MN 56601
Mar 31, 2016

Danny Wedding
Berkeley, CA 94707
Mar 31, 2016

Speaking as one of the professors of the next generation of psychologists, the mental health access for our citizens will be greatly enhanced by having prescribing privileges available to licensed psychologists. We already have many current psychologists prepared to safely and competently prescribe.

Dr. Stephen E. Berger
Orange, CA 92868
Mar 31, 2016

I fully support prescriptive privilege for psychologists. Passage of this would allow for enhanced emotional wellbeing to many who are underserved at present. Thank you!

Brian Seavey
Colorado Springs, CO 80906
Mar 31, 2016

Pete Welcome
Haiku, HI 96708
Mar 31, 2016

Doug MacKenzie
Haiku, HI 96708
Mar 31, 2016

Pamela Malefyt
Corona del Mar, CA 92625
Mar 31, 2016

Lorenzo Provencio
Imperial Beach, CA 91932
Mar 31, 2016

Michael C Smith
Imperial Beach, CA 91932
Mar 31, 2016

Harlan Hughes
Kula, HI 96790
Mar 31, 2016

melyssa souza
Makawao, HI 96768
Mar 31, 2016

Annette Gorospe
Kualapuu, HI 96757
Mar 31, 2016

David Duty
San Diego, CA 92103
Mar 31, 2016

Dylan Franco
yuma, AZ 85365
Mar 30, 2016

Linda Smith
Imperial Beach, CA 91932
Mar 30, 2016

Shelby Kaiman
San Diego, CA 92106
Mar 30, 2016

Please pass legislation allowing Medical Psychologists with advanced training to prescribe psychotropic medications in the state of Hawaii. Our communities are suffering because of the lack of access to timely psychiatric care.

chris enomoto
Honolulu, HI 96813
Mar 30, 2016

We need to do everything we can to help those in need. With the influx of those individuals moving to Hawaii, we need to have the infrastructure to help our new kama'ainas.

Suzanne Antounian
Kihei, HI 96753
Mar 30, 2016

Robert Cornelia
San Diego, CA 92103
Mar 30, 2016

Christen Aiguier
Edmonds, WA 98026
Mar 29, 2016

Claire
San Diego, CA 92101
Mar 29, 2016

Linda
Waipahu, HI 96797
Mar 29, 2016

Psychologists can and have been SAFELY and SUCCESSFULLY providing comprehensive mental health treatments for years in many settings. Let's move FORWARD!

Dr. Lesajean M. Jennings
Houston, TX 77003
Mar 29, 2016

Lorien Ramirez
Spring Valley, CA 91978
Mar 29, 2016

Meghan ALCH Au
Kaneohe, HI 96744
Mar 29, 2016

Patricia Lovette
Myrtle Beach, SC 29579

Mar 29, 2016

Ala Jaarah
Staten Island, NY 10301
Mar 29, 2016

Should have been done years ago.

Bill Jenkins
Gold Canyon, AZ 85118
Mar 29, 2016

Gregory Syrios
La Jolla, CA 92037
Mar 29, 2016

Good work

Joanne foxxe
Lahaina, HI 96761
Mar 29, 2016

Lilian Hodges
Coronado, CA 92118
Mar 29, 2016

Please pass legislation to help mental health patients get the treatment they deserve.

Pilar
West Palm Beach, FL 33415
Mar 29, 2016

Maira Horta
San diego, CA 92123
Mar 29, 2016

Lauren au
Kailua, HI 96734
Mar 29, 2016

Cynthia Winters
Seattle, WA 98178
Mar 29, 2016

Kirsten Robertson
Seattle, WA 98102
Mar 29, 2016

Ryan Barletta
Alpine, CA 91901-1461
Mar 29, 2016

Joseph Reid
SAN DIEGO, CA 92163
Mar 29, 2016

Cindy Hodges
St Helena, CA 94574
Mar 28, 2016

Trevor Mork
Kihei, HI 96753
Mar 28, 2016

Mary Malik, PhD
San Luis Obispo, CA 93401
Mar 28, 2016

Laurie Chapman
San Diego, CA 92103
Mar 28, 2016

Doreen A. Samelson
Stockton, CA 95219
Mar 28, 2016

sharon tawfilis
encinitas, CA 92024
Mar 27, 2016

Marie Wolf
Phoenix, AZ 85021
Mar 27, 2016

Oliver Kempter
Munich, Germany
Mar 27, 2016

Erik Jul
Honolulu, HI 96822
Mar 27, 2016

Timothy Stillman
Makawao, HI 96768
Mar 27, 2016

Benita Young
Calabasas, CA 91302
Mar 27, 2016

Grace Walsh
United States 97769
Mar 26, 2016

As a psychologist who has lived in many rural areas, this bill is a necessity that need not be feared. With proper training psychologists in other states have proven this a successful move. Mahalo for approving! Dr. Dara

Dr. Dara Rampersad
Kihei, HI 96753
Mar 26, 2016

Sylvia Law
Kailua, HI 96734
Mar 26, 2016

Katrina Ginter
Kihei, HI 96753
Mar 26, 2016

Danielle Nahas
San Diego, CA 92101
Mar 26, 2016

Thomas Delaney, PhD
San Dimas, CA 91773
Mar 26, 2016

Howard S Rubin
Los Angeles, CA 90036
Mar 25, 2016

Psychologists have demonstrated for over 30 years that they can prescribe safeland effectively without risk to public safety. Psychologists are far more qualified to effectively prescribe psychotropic medications that are nurse practitioners, who are already prescribing psychotropic medications in many states. Many patients are not receiving adequate mental health care due to a shortage of psychiatrists. Support prescriptive authority for psychologists to improve public access to quality mental health care.

Keith Valone
Pasadena, CA 91105
Mar 25, 2016

Laura Austin
Apo, AE 09126

Mar 25, 2016

Excellent News!

Stacy Johnstone, Psy.D.,M.S.C.P.
Camarillo, CA 93010
Mar 25, 2016

Stephanie Abel, Ph.D.
San Diego, CA 92104
Mar 25, 2016

Nicole Randall
Vallejo, CA 94591
Mar 25, 2016

Brandon Freiberg
Camarillo, CA 93010
Mar 25, 2016

Sharna Wood, PhD
Cleburne, TX 76033
Mar 25, 2016

Francine johansen
Kula, HI 96790
Mar 25, 2016

Juliet Langley
Kailua, HI 96734
Mar 24, 2016

Trying to help a client find a psychiatrist or APRN to get medicated quickly and effectively, we are in a state of crisis here on Maui. We have only half the number of psychiatrists we need on Maui - and many of those we have will not take Quest clients. This is crucial to support the people we serve.

Kristi Ishikawa
Kahului, HI 96732
Mar 24, 2016

Dr Daniel A Thomas Jr
Alpharetta, GA 30005-4465
Mar 24, 2016

Angie Rumaldo
Bronx, NY 10463
Mar 24, 2016

Lyndsay
Oakland, CA 94611
Mar 24, 2016

Deborah Christensen
Draper, UT 84020
Mar 24, 2016

Robin Knox
Kihei, HI 96753
Mar 24, 2016

I am a psychologist who works with the Army and I travel across the country doing support for Department of Defense mental health training. Make no mistake, there is a huge gap in service when it comes to medication access for VA and DoD members. Hawaii approving prescription privledges will help ease this problem in the long run. It is a complex problem with no easy solution, yet this will be a step in the right direction.

Michael Jones
Puyallup, WA 98374
Mar 24, 2016

Amy Stewart
Taylor Ridge, IL 61284
Mar 24, 2016

Alicia Rivera
Alhambra, CA 91801
Mar 24, 2016

Kaimen Slay
Forest City, IA 50436
Mar 24, 2016

I support prescription privileges in Hawaii.

Sharon
Moline, IL 61266
Mar 24, 2016

Dene
kaneohe, HI 96744
Mar 24, 2016

Jessica Tomsen
Kula, HI 96790
Mar 24, 2016

In support

Dion Mesta
Honolulu, HI 96822
Mar 24, 2016

Lauren Wilson
Makawao, HI 96768-8613
Mar 24, 2016

Carrie Kennedy
Stafford, VA 22556
Mar 24, 2016

Martin Fino
Oxford, MS 38655
Mar 24, 2016

William Johnson
Twentynine Palms, CA 92277
Mar 24, 2016

Todd Deneen, Psy.D.
Springfield, MO 65810
Mar 24, 2016

Justin Baker
Jacksonville, NC 28547
Mar 24, 2016

Move this bill forward for the sake of mental health patients in hawaii

Pagehaviland
Eagle, ID 83616
Mar 24, 2016

Ivan Gonzalez
Stickney, IL 60402
Mar 23, 2016

Nathan Moon
Beaufort, SC 29902
Mar 23, 2016

Chris Heath
Providence, RI 02906
Mar 23, 2016

Caroline Williams
Santa Fe, NM 87507
Mar 23, 2016

The public needs the care of properly trained prescribing psychologists.

Rob Woodman, Ph.D.
Davis, CA 95616
Mar 23, 2016

I was trained and lived in Hawaii prior to getting my PhD in Psychology. This would be great for the State of Hawaii and the field of psychology.

John Gruenewald
Ventura, CA 93003
Mar 23, 2016

Dr. Russell Crouse
Germantown, TN 38138
Mar 23, 2016

Prescribing psychologists have rigorous training requirements meeting and exceeding that of other medication prescribers

Dr. William July, PhD
Austin, TX 78701
Mar 23, 2016

Dr Pat Gehr
Camarillo, CA 93012
Mar 23, 2016

Lynn
Baton Rouge, LA 70816
Mar 23, 2016

Lorena Vazquez
Guayama, PR 00785
Mar 23, 2016

Psychologist can provide the necessary treatment for patients, including medication. Why wait !!!!

Chi chang
Cerritos, CA 90703
Mar 23, 2016

Susanne
Laveen, AZ 85339

Mar 23, 2016

Thank you for your work on this critically important issue.

Daniel Banken
Puyallup, WA 98374
Mar 23, 2016

Rural folks need access to quality comprehensive mental health care.

Dr. Robert J. Resnick
Glen Allen, VA 23060
Mar 23, 2016

I am a veteran. This bill would allow greater access for underserved individuals like myself. It takes a month or more to get an appointment with psychiatry at the VA.

Brian Gross
Aiea, HI 96701
Mar 23, 2016

Rachel Passmore
San Diego, CA 92103
Mar 23, 2016

Though I don't live in Hawaii, I know that access to a psychiatrist can be just as difficult, as it is in California. I support appropriately trained psychologists prescribing psychoactive medication.

Janet Kraemer
San Jose, CA 95125
Mar 23, 2016

As a prescribing psychologist in Indian country (Prairie states) I can attest to the need in underserved areas. and the value that will be added with legislation to allow Medical Psychologists prescribing rights.

Johna Hartnell
Fort Yates, ND 58538
Mar 23, 2016

Rachael Kishner Wehl
Salt Lake city, UT 84111
Mar 23, 2016

Dr Jennifer Rousch
Pasadena, CA 91107
Mar 23, 2016

Damon LaBarbera
Panama City, FL 32401

Mar 23, 2016

Jada Cade
Coronado, CA 92118
Mar 23, 2016

Chris Wehl
Salt Lake City, UT 84111
Mar 23, 2016

Daryl Tawata
Honolulu, HI 96816
Mar 23, 2016

I support this petition whole heartedly.

Robert Maiden, Ph.D.
Alfred, NY 14895
Mar 23, 2016

James Childerston
Hagerstown, MD 21740
Mar 23, 2016

Jed Savard
Issaquah, WA 98027
Mar 23, 2016

Dr. Nanci Klein
Salt Lake City, UT 84111
Mar 23, 2016

Ann Altoonian
Rochester, NY 14609
Mar 23, 2016

Antonio Puente
Wilmington, NC 28405
Mar 23, 2016

Dr. G. Norman West
Sewanee, TN 37375-4050
Mar 23, 2016

Morgan Sammons
Ashland, OR 97520
Mar 23, 2016

Pili Kaninau
Wailuku, HI 96793
Mar 23, 2016

In memory of Senator Daniel K. Inouye.

Randolph Hack
Honolulu, HI 96816-3244
Mar 23, 2016

Monica Tatekawa-Chen
Aiea, HI 96701
Mar 23, 2016

Please Pass HB 1072! Neighbor islands and rural areas are underserved and need your support! Mahalo!

Marie
Kalaheo, HI 96741
Mar 19, 2016

Jamie Gomes
Kailua kona, HI 96745
Mar 19, 2016

Allow more access to psychotropic medications. Psychologists w/requisite training should be allowed t o prescribe.

Alexander Bricken
Honolulu, HI 96817
Mar 19, 2016

Kacey Purdy
Mililani, HI 96789
Mar 19, 2016

Having prescribing psychologist in rural communities will greatly benefit Hawaii's people with mental illnes.

Sonny Ferreira
Ewa Beach, HI 96706
Mar 19, 2016

This is a viable way to mitigate mental health shortages in rural areas and with underserved populations

Leia Twigg-Smith
Honolulu, HI 96822
Mar 19, 2016

cris caleffi
Honolulu, HI 96837-0962
Mar 16, 2016

Lawrence Kim
Honolulu, HI 96821
Mar 8, 2016

Daniel Kaplin, PhD
Staten Island, NY 10314
Mar 3, 2016

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lylian young
Media, PA 19063
Feb 26, 2016

I am an advanced practice medical psychologist in Louisiana. My experience with prescribing has been very positive. My general medical colleagues refer liberally to me because they value the expertise of medical psychologists. A vote for Hawaii medical psychology is a vote to increase patient access to doctoral level experts in mental health.

David Williams
Monroe, LA 71201
Feb 23, 2016

Michael J. Cole
Kailua, HI 96734
Feb 22, 2016

As a psychologist, I have patients who cannot get appointments with a psychiatrist for 2-3 months or who are unable because of Medicaid or Quest. With advanced training, psychologists will help bridge this gap.

Brenda Lovette
Kailua, HI 96734
Feb 22, 2016

Terry Lamb
Waialua, HI 96791
Feb 17, 2016

Alexandra Love
Honolulu, HI 96813
Feb 16, 2016

Michael Stilwell
Kihei, HI 96753
Feb 16, 2016

Thomas Flach
Ewa Beach, HI 96706
Feb 15, 2016

Morgan Flach
Ewa Beach, HI 96706
Feb 15, 2016

Satchel Pratt
Gulfport, MS 39503
Feb 14, 2016

The lack of sufficient psychiatric resources on our rural island of Kauai has been an ongoing issue for decades. I fully endorse this legislation as a means to improve access to mental health care in Hawaii!

Barbara Johnson
Kapaa, HI 96746
Feb 13, 2016

Please pass the RxP bill

Scott Shiroma
Kaneohe, HI 96744
Feb 9, 2016

Gina Sanzone
cuy fls, OH 44221
Feb 9, 2016

Mark Muse
Rockville, MD 20850
Feb 8, 2016

We need better access to mental health care

Christine Shiroma
Aiea, HI 96701
Feb 8, 2016

As a neuropsychologist practicing in New Mexico, a state with prescription privileges for psychologists, I want to voice my support for this bill (RxP Hawaii). We in New Mexico have a similar problem with access to mental health care as Hawaii does, and while RxP in New Mexico has not totally alleviated this issue, it has gone a long way in increasing access to care and reducing suffering. With that being said, please think of your citizens when you consider this bill. They are in desperate need of improved access to mental health resources and, as has been demonstrated through other states, psychologists with the appropriate training can provide that care.

R Brock Frost, PhD
Albuquerque, NM 87108
Feb 8, 2016

Psychologists are capable and should be offered the opportunity to do more in the community and this is one way that can happen. Please make this happen soonest!

Una Starr
Honolulu, HI 96818
Feb 8, 2016

Please address this critical need for the citizens of the Beloved State of Hawaii.

Nancy M Vrechek
Jupiter, FL 33458
Feb 7, 2016

Mayona Kealoha
Honolulu, HI 96818
Feb 5, 2016

We need to pass the bill. It will help everyone.

Adelia Butac
Mililani, HI 96701
Feb 5, 2016

Isaiah Moreno
Honolulu, HI 96817
Feb 5, 2016

Nathan heid
haleiwa, HI 96712
Feb 5, 2016

Bernadette Heid
Haleiwa, HI 96712
Feb 5, 2016

T. Crabb

Kailua, HI 96734
Feb 5, 2016

Cecilia Gay
Honolulu, HI 98312
Feb 5, 2016

This has been a long time coming!

Kevan Kamisato
Honolulu, HI 96822
Feb 5, 2016

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pass the bill

thomas roeske
aiea, HI 96701
Feb 5, 2016

Please pass the bill to allow psychologists to prescribe psychotropic medication to increase mental health services and assistance to those who find it difficult to see psychiatrists and/or obtain access and help to reduce physical, psychological and cognitive symptoms of mental health disorders. Please pass this bill, your help is greatly needed. Thank you!

Madelyn Butac-Roeske
Aiea, HI 96701
Feb 5, 2016

Christina Uemura
Honolulu, HI 96816
Feb 4, 2016

Alistair Taylor
Haleiwa, HI 96712
Feb 4, 2016

Kyla Stueber
Honolulu, HI 96821
Feb 4, 2016

Cassandra Moon
Honolulu, HI 96822
Feb 4, 2016

Henri-Lee Stalk
Honolulu, HI 96815
Feb 4, 2016

Franklin Foote
Miami, FL 33176
Feb 1, 2016

As a current Psychopharmacologist who works as such at a local hospital in CA, I experience on a daily basis the need for these services. Daily I hear how thankful the attending physicians are of my consult services as we get to discuss medical concerns together with psychiatric issues. Please pass legislation to allow medical psychologists/Psychopharmacologists to prescribe as our training is as severe, intense, and efficient to safely practice medicine. My colleague physicians are witnesses of my medical training and the patients benefit from my services.

Manuel Fernandez
Concord, CA 94520
Jan 30, 2016

Elaine Archambeau
Kapaa, HI 96746
Jan 30, 2016

The cost to not passing this legislation is to the patient.

Elizabeth Richeson
El pasi, TX 79912
Jan 29, 2016

Julie Barnes
New York, NY 10011
Jan 29, 2016

Thomas Kessey
Fallon, NV 89406
Jan 29, 2016

Please pass Medical Psychology legislation. Please pass legislation allowing Medical Psychologists with advanced training to prescribe psychotropic medications in the state of Hawaii. Our communities are suffering because of the lack of access to timely psychiatric care.

Stephen Bloomfield
Jacksonville, FL 32217
Jan 29, 2016

Lorri Reynard
OSSINING, NY 10562-3813
Jan 29, 2016

A much needed step for the people of Hawaii to get service they need.

Gabrielle toloza
Kailua, HI 96734
Jan 28, 2016

Elliot
Woodmere, NY 11598
Jan 28, 2016

Karen Banes
Aiea, HI 96701
Jan 28, 2016

Marian matthaey
Great Neck, NY 11021
Jan 28, 2016

Please support access to comprehensive psychological services including medical psychology...Hawaii was one the first states to start this needed legislation. IT's time to get it passed!

Keith Westerfield
New York, NY 10040
Jan 28, 2016

Hawai’i can lead America to create a better future for all of its people's please support access to comprehensive psychological services including medical psychology...

Edward Korber
Lynbrook, NY 11563
Jan 28, 2016

Kelsie Okamura
Waipahu, HI 96797
Jan 28, 2016

Kimberly Mizo
Honolulu, HI 96817
Jan 27, 2016

Greed is the only reason this bill does not pass. Time to stop the suffering and do the right thing.

Shirley Suder
Kihei, HI 96753
Jan 27, 2016

My brother in law needs this Bill to pass, so I back it for him and others in need - with all my heart!

Gill McBarnet
Kula, HI 96790
Jan 27, 2016

Roberta Murtagh
Woodbury, CT 06798
Jan 27, 2016

Chris Gamby
Kapaa, HI 96746
Jan 27, 2016

Tanya Gamby
Kapaa, HI 96746
Jan 26, 2016

Kathy Collins
Wailuku, HI 96793
Jan 26, 2016

Cori Takesue
Lanai City, HI 96763
Jan 26, 2016

Johny Double
Lahaina, HI 96761
Jan 23, 2016

Michelle Collins
Hamden, CT 06517-4019
Jan 15, 2016

Justin Matsuura
Honolulu, HI 96825
Dec 31, 2015

SHAUNA GRANER
HONOLULU, HI 96813
Dec 29, 2015

Stephanie Espiritu
Lahaina, HI 96761
Dec 21, 2015

Lisa Stilwell
Kihei, HI 96753

Dec 20, 2015

This is an extremely important bill to pass that will elevate the level of mental health care in our state: something sorely needed.

Lorraine Fay
Lahaina, HI 96761
Dec 19, 2015

Barbara Lewis
Ocean View, HI 96737
Dec 18, 2015

Leslie Lang
Pepeekeo, HI 96783
Dec 17, 2015

Jesse Lambert
St. Amant, LA 70774
Dec 16, 2015

It's for a good cause! Mahalo for doing this.

Priscilla May
Kailua, HI 96734
Dec 8, 2015

Hana Choi
Minneapolis, MN 55407
Nov 27, 2015

Todd Bell
Columbus, GA 31909
Nov 27, 2015

I believe that this legislation will improve access to behavioral health pharmacological treatment that otherwise is unavailable in rural areas particularly.

Wayne Law
Kapaa, HI 96746
Nov 19, 2015

Lisa Darcy
Haiku, HI 96708
Nov 9, 2015

Terrie Eliker
Kula, HI 96790
Nov 9, 2015

Lisa Ambrosino Ho
Honolulu, HI 96816
Nov 8, 2015

Michelle James
Honolulu, HI 96817
Nov 6, 2015

I am a licensed mental health provider who is also a doctoral student in psychology. Upon graduation, I plan to get advanced training in a 2 year postgraduate program to be able to prescribe psychotropic medication. Currently there are only three states that I can prescribe. Lets make Hawaii number 4. Allowing psychologists to prescribe will bring more providers to Hawaii. Psychiatrists oppose this because it effects their bottom line. The military has had prescribing psychologists for years now!

S. Kyle Cardwell
Fairbanks, AK 99707
Oct 27, 2015

Lauren Ampolos
Kahului, HI 96732
Oct 12, 2015

Shana
Pukalani, HI 96768
Sep 29, 2015

Lauren Glamb
Honolulu, HI 96814
Sep 21, 2015

This will undoubted save lives. As a nurse, and a sister who's beloved brother has severe mental illness, I humbly ask you to pass this legislation.

catherine
Wailuku, HI 96792
Sep 20, 2015

Sanni Tharp
Kihei, HI 96753
Sep 20, 2015

cornelia soberano
wailuku, HI 96793
Sep 20, 2015

Joseph D Pluta

JOSEPH D PLUTA
Lahaina, HI 96761
Sep 20, 2015

Rayann Obet
Wailuku, HI 96793
Sep 20, 2015

Linda Norrington
Kihei, HI 96753
Sep 20, 2015

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stacey krenelka
kihei, HI 96753
Sep 20, 2015

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joy Gorman
makawao, HI 96768
Sep 20, 2015

We need this service now!

Beverly Bose
kahului, HI 96733
Sep 20, 2015

Diane oregan
Wailuku, HI 96793
Sep 20, 2015

Jonathan B Drechsler
Wailuku, HI 96793
Sep 20, 2015

Go for it!!!

Debbie sutton
Wailuku, HI 96793
Sep 20, 2015

Medical psychologists with advanced training are critically needed to support the work of physicians to address the mental health crisis. They have prescribed for many years in two states, the military, the Indian Health Service, and the Public Health Service without problems. Recently, medical psychologists with specialized training gained prescriptive authority in Illinois.

Dr. Sharon Murphy
Hinsdale, IL 60521
Aug 14, 2015

Teresa Martins
Rio de Janeiro, Brazil
Aug 3, 2015

I agree that Medical psychologists with advanced training in clinical psychopharmacology should be legally authorized to prescribe psychoactive medications. For many years now, medical psychologists have been safely prescribing without incident in two states, one U.S. Territory, the military and the Indian Health service without incident. Psychiatry's argument that medical psychologists would put public safety at risk is fallacious and politically motivated only serving the needs of the psychiatry profession without regard for meeting the public's needs.

Arnold Blumenfeld
Newhall, CA 91321-2521
Jul 12, 2015

Please pass this important Bill to address Hawaii's shortage of knowledgable providers. The Bill's education & clinical requirements will ensure a higher standard of care.

DC Minogue
Makawao, HI 96768
Jul 8, 2015

Help provide access to mental health care for all.

Julia Myers
San Diego, CA 92106
Jul 8, 2015

Jeremiah redins
Kihei, HI 96753
Jul 5, 2015

Corey Suda
Kihei, HI 96753
Jul 5, 2015

Bernard Wazlavek
El Paso, TX 79934
Jul 4, 2015

This is a much-needed service which has been shown to help underserved patients who lack access to prescription care.

James Grubman PhD
Turners Falls, MA 01376
Jun 26, 2015

Lesley A. Slavin

Kailua, HI 96734
Jun 25, 2015

Marie Terry-Bivens, Psy.D.
Anahola, HI 96754
Jun 24, 2015

Rachel
Tiffin, OH 44883
Jun 24, 2015

Kari
Lahaina, HI 96761
Jun 23, 2015

Aris Banaag
Kahului, HI 96732
Jun 19, 2015

Fernando Rocha Beserra
Rio de Janeiro, Brazil
Jun 16, 2015

Adolfo retuya
Beverly hills, CA 90212
Jun 16, 2015

EGINA KERR RETUYA
beverly hills, CA 90212
Jun 14, 2015

Allan Roberts
Los Angeles, CA 90035
Jun 14, 2015

Rural communities are suffering because of a lack of service. Also, there are too many who are receiving too much medication and not enough of other treatments which are more effective and less toxic.

Santo Triolo
Kihei, HI 96753
Jun 10, 2015

Sean Hodges, Ph.D., MSCP
Coronado, CA 92118
Jun 7, 2015

Don W. Hume,PhD
LasCruces,, NM 88001
Jun 2, 2015

Susan
Staunton, VA 24401
Jun 2, 2015

Brian Gotterer
Newport Beach, CA 92660
Jun 2, 2015

Catherine C Brodeur, PsyD
Westford, MA 01886
Jun 2, 2015

Vincent Morello
Phoenixville, PA 19460
Jun 2, 2015

I HAVE BEEN PRESCRIBING IN NEW MEXICO SINCE 2011.IT IS WONDERFUL TO BE A FULL SERVICE MENTAL HEALTH PROFESSIONAL FOR MY PATIENTS.THEY ARE GRATEFUL!

DAVID F. O'CONNELL,Ph.D.
WOMELSDORF, PA 19567
Jun 2, 2015

Dr sj soter
Santa fe, NM 87505
Jun 1, 2015

Michael R Plumeri
Mt. Laurel, NJ 08054
Jun 1, 2015

Dr. Leo J Burke III
Philadelphia, PA 19107
Jun 1, 2015

Please support the mental health of the community and the advanced training of these medical psychologists.

Dr. Paul Colte
Salt Lake City, UT 84113
Jun 1, 2015

Nadia Webb, PsyD, MP
Portland, OR 97232
Jun 1, 2015

Dr. Robert Rinaldi
Wheaton, IL 60189
Jun 1, 2015

A real need in rural America.

Mark muse
Edinburg, VA 22824
Jun 1, 2015

This bill is critically needed. Prescribers will be required to complete a full additional masters degree plus supervised training.

Steven Tulkin
San Mateo, CA 94503
Jun 1, 2015

Alexander Patterson
Puyallup, WA 98374
Jun 1, 2015

Elizabeth Toole
Pasadena, CA 91101
Jun 1, 2015

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carl b ihli
ANNAPOLIS, MD 21401
May 31, 2015

Donna Aucoin
Lafayette, LA 70508
May 31, 2015

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safely prescribing for 8 years at 8 different clinics with n=5000 plus patients stable and/or improved and 0 deaths due to psychotropic Meds or med errors.

Victoria Witt MP AP
slidell, LA 70458
May 30, 2015

I am a prescribing medical psychologist in Louisiana.

Dr. Jen Chandler
New Orleans, LA 70115
May 30, 2015

I am in favor of this Bill, HB 1072, because it will allow the underserved healthcare eligible population of Hawaii to have the opportunity to receive much needed mental health treatment.

Rick Wilson, PhD, MP
Kihei, Maui, CA 96753
May 30, 2015

Priscilla Roth-Wall, Ph.D. MSCP
Hernando, MS 38632
May 30, 2015

Colleen Brandt
North Caldwell, NJ 07006
May 30, 2015

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i am a medical psychologist and am mmaking a difference inpeoples lives in mo thanks you

susan
cleveland, MO 64734
May 30, 2015

I am very much in favor of psychologists acquiring prescription privileges. Psychologists are the most trained in the mental health professions.

Rosalyn M. Laudati
Corona del Mar, CA 92625
May 30, 2015

Until we start taking care of our own we are no better than the Third World country and worse in some ways because we actually have the resources

Stephen Cheshire
Los Lunas, NM 87031
May 30, 2015

Lynn
Port Washington, NY 11050
May 29, 2015

Anthony Ragusea
Key West, FL 33040
May 29, 2015

Elizabeth Nielson PhD
Woodstock, NY 12498
May 29, 2015

I was the chair of the New Mexico Board of Psychologist Examiners from 2006-2012, and during that time we had no complaints at all that a prescribing psychologist had harmed a patient.

Robert Sherrill, Jr.
Farmington, NM 87401
May 29, 2015

CASTILLE
BATON ROUGE, LA 70808
May 29, 2015

Ron L. Cohorn, Ph.D.
Hot Springs, AR 71913
May 29, 2015

Thomas Fain
Baton Rouge, LA 70810
May 29, 2015

John Teal
Jackson, MS 39206
May 29, 2015

As a psychologist trained to prescribe and having done so for 7 years (I'm the 7th Rx Psychologist in New Mexico) I can attest to the importance of having more providers for underserved populations.

Marlin C Hoover PhD MS
FLOSSMOOR, IL 60422-1358
May 29, 2015

Mike Westbrook
Hobbs, NM 88240
May 29, 2015

Medical psychologists are providing a much needed service to the people of Louisiana.

Tony R. Young. PhD MP
Monroe, LA 71201
May 29, 2015

Best service best quality practice

Robert Mayfield
Las Cruce, NM 88011
May 29, 2015

Michael Hansen
covinton, LA 70433
May 29, 2015

Sumer
Gonzales, LA 70737
May 29, 2015

Stephen Colmant
Las Cruces, NM 88007
May 29, 2015

Kelly Ray, PhD, MP
Baton Rouge, LA 70809
May 29, 2015

K. Chris Rachal PhD MP
Thibodaux, LA 70301
May 29, 2015

I am a Medical Psychologist licensed under the Louisiana Board of Medical Examiners.

Mayling Walker
New Orleans, LA 70114
May 29, 2015

I've been a Medical Psychologist since 2005 and an Advanced Practice Medical Psychologist since 2012.

Curtis Vincent
Baton Rouge, LA 70806
May 29, 2015

E. H. BAKER, PhD, MP
MONROE, LA 71203
May 29, 2015

The reason why prescribing is an issue is spelled M O N E Y.

William K. Hunt, Ph.D
Albuquerque, NM 87110
May 29, 2015

John Fidanza
Zachary, LA 70791
May 29, 2015

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citizens deserve access to mental health services. Specially trained medical psychologist provide prescribing services to the under served population safely and effectively. We have had a positive effect on mental health care.

Lynette Heslet, PhD, MP
Picayune, MS 39466
May 29, 2015

I support RxP Hawaii

Peter Smith PsyD
ALBuquerque, NM 87104
May 29, 2015

Tiffany Jennings
Natchitoches, LA 71458
May 29, 2015

I am an Advanced Practice, Medical Psychologist who has safely prescribed in both the Army and private practice for years without incident, providing much needed care to active duty service members, dependent spouses and children; as well as to the community. I hope Hawaii joins NM, LA, and IL in allowing properly training Psychologists to provide pharmacotherapy.

Joseph J. Sesta
Apollo Beach, FL 33572
May 29, 2015

I am a prescribing psychologist in New Mexico since 2005. I can personally attest to the significant impact we have made in both states.

John courtney
Socorro, NM 87801
May 29, 2015

Kelly Coleman
bellevue, WA 98006
May 22, 2015

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becky paschoal
kihei, HI 96753
May 22, 2015

Christine Hamilton
Tomah, WI 54660
May 21, 2015

Donald lANNON
Wailuku, HI 96793
May 21, 2015

Luke Bitton
Castle Rock, CO 80109
May 10, 2015

Mark Phillipson
Kunia, HI 96815

May 5, 2015

Kressa Olguin
Kihei, HI 93753
Apr 30, 2015

Asher
Baltimore, MD 21239
Apr 17, 2015

MICHAEL CALIRI
kailua, HI 96734
Apr 16, 2015

I've completed training and now work in a military health climic were physcians and nurse practioners now rely on my knowledge daily. This legislation can help thousands in Hawaii.

Gilbert O. Sanders, EdD
Choctaw, OK 73020
Apr 15, 2015

Helen Chen
San Francisco, CA 94116
Apr 14, 2015

Barbara Stroud
Palo Alto, CA 94303
Apr 14, 2015

Sally Palafox
Honolulu, HI 96824
Apr 14, 2015

Siobhan donnelly
Brooklyn, NY 11222
Apr 14, 2015

Taletha Derrington
HALF MOON BAY, CA 94019
Apr 13, 2015

Sita Gonzales
Hilo, HI 96720
Apr 13, 2015

Kimmie Ha
Rosemead, CA 91770
Apr 13, 2015

This will help your constut

Andrew Griffin
Mexia, TX 76667
Apr 13, 2015

William RYAN, PH.D.
Belgrade, MT 59714
Apr 13, 2015

I hope this passes, so that the undeserved can be served well qualified treating psychologists.

Jeff Schanowitz
San Diego, CA 92108
Apr 13, 2015

Marisa Brown
Eagar, AZ 85925
Apr 12, 2015

Ivan irie
Honolulu, HI 96815
Apr 12, 2015

Pamela pritchett
Waikoloa, HI 96738
Apr 12, 2015

Natasha Mroczek
Memphis, TN 38103
Apr 12, 2015

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peter sotiriou
Manhattan Beach, CA 90266
Apr 12, 2015

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joel bass
atlanta, GA 30319
Apr 12, 2015

Laura Kroeten-Bue
Minneapolis, MN 55408
Apr 12, 2015

Sarah Fraser
Astoria, NY 11103
Apr 12, 2015

Dr. Jane Storrie
Burlington, Canada
Apr 12, 2015

Meg rauen
Brooklyn, NY 11215
Apr 12, 2015

Anthony Marks
Kennewick, WA 99337
Apr 12, 2015

Jerelenn Medeiros
Honolulu, HI 96826
Apr 12, 2015

Geney
san jose, CA 95123
Apr 11, 2015

Rose Marie Pilarca
Ewa Beach, HI 96706
Apr 11, 2015

Samantha Scott
Salisbury, MD 21801
Apr 11, 2015

As a medical psychologist who is prescribing in Louisiana in a rural area otherwise with no psychiatric specialists, I want to give my whole-hearted support to this legislation!

Robert M. Nevels, Ph.D. , M.P.
New Roads, LA 70760
Apr 10, 2015

Ashley Strauss
Seattle, WA 98121
Apr 10, 2015

We need this to happen.

Cedric Alonzo
Kaunakakai, HI 96748
Apr 10, 2015

Agatha Akai
Kaunakakai, HI 96748
Apr 10, 2015

Lauren
Muttontown, NY 11545
Apr 10, 2015

Jason Stingel
Dresden, OH 43821
Apr 10, 2015

I live and work on Molokai in the Medical arena. Passing this legislation is the right thing to do for our community and state. I strongly support this bill.

Jane Woolsey
Hoolehua, HI 96729
Apr 10, 2015

Azita
Kailua, HI 96734
Apr 10, 2015

Psychologists are best choice to prescribe for mentally ill!

Leslie Roberson
Evans, GA 30809
Apr 10, 2015

MICHAEL ZAKARAS
GULFPORT, MS 39505-2341
Apr 10, 2015

Cherise Imai
kaneohe, HI 96744
Apr 10, 2015

James Spira
Kailua, HI 96734
Apr 10, 2015

Shannon Uilani Lima
Kaunakakai, HI 96748
Apr 9, 2015

Jay Land
Syracuse, NY 13224
Apr 9, 2015

Robin Miyamoto
Honolulu, HI 96821
Apr 9, 2015

Rosie F Davis
Kaunakakai, HI 96748
Apr 9, 2015

This something that has been neded for a very long time.

Steve
Aiea, HI 96701
Apr 9, 2015

Please help mentally ill folks access medical support efficiently

Darcy
Tacoma, WA, WA 98405
Apr 9, 2015

Kendra Sherwood
Aurora, CO 80013
Apr 9, 2015

Dr. Cherie B. Ruben
Derby, NY 14047
Apr 9, 2015

Jo Ann Takushi
Aiea, HI 96701
Apr 9, 2015

Jeff Pilarca
Honolulu, HI 96706
Apr 9, 2015

Sherrie Takushi
Pearl City, HI 96782
Apr 9, 2015

Diana Caro-Salvador
Ewa Beach, HI 96706
Apr 9, 2015

Lila
Kailua, HI 96734
Apr 9, 2015

Susan Cobbs
Kapolei, HI 96707
Apr 9, 2015

Sandra Conway
haiku, HI 96708
Apr 9, 2015

Please help those who can't help them selves alone..

Mary Bahe
Fresno, CA 93710
Apr 9, 2015

Elvira Ellazar
kaneohe, HI 96744
Apr 9, 2015

John Covey
Marianna, AR 72360
Apr 9, 2015

William Moore
SURGOINSVILLE, TN 37873-6301
Apr 9, 2015

Psychologists with the additional training, because of their extensive education, and primary treatment modality of psychotherapy are well-equipped to truly choose the best treatment options for pts. The idea that psychologists with 6-8 years of doctoral training and a subsequent 2-3 years of specialized psychopharmacology training, cannot master prescribing, and that Nurse Practitioners with two years of training in treating psychological disorders can, is absurd. I have completed the training and am often appalled at the level of skill that many prescribers have. This is purely a political issue, not one of effective treatment of suffering individuals. Please pass this bill.

Linda A. Garrone, PhD
Carver, MA 02330-1322
Apr 9, 2015

Many patients are unable to find a provider qualified to prescribe psychotropic medications. By passing this legislation, you will enable qualified psychologists to meet the treatment needs of the mentally ill.

Lisa Harrell-DeLamater
Syracuse, NY 13210
Apr 9, 2015

This is an important bill to pass. Those who will benefit are the Hawaiian people who need the services of highly qualified psychologists with advanced practice credentials.

Kenneth Larsen
Rowley, MA 01969
Apr 9, 2015

Gabriel TAN
Singapore, Singapore
Apr 9, 2015

Jerry F Ledesma
Kaunakakai, HI 96748
Apr 9, 2015

Lily Pimentel
Makawao, HI 96768
Apr 9, 2015

Allan Yozawitz
Fayetteville, NY 13066
Apr 9, 2015

Elyse Kaplan
Baltimore, MD 21218
Apr 9, 2015

Peggy
Fort Mitchell, AL 36856
Apr 9, 2015

I fully support RxP

Lewis J. Malgieri,Ph.D.
Camillus, NY 13031
Apr 9, 2015

Strongly support prescribing psychologist. Am American Indian on Reservation without a prescribing Psychiatrist or Psychiatric NP or PA.

Dan Foster
Rosebud, SD 57570
Apr 9, 2015

H G sanchez
san luis obispo, CA 93406
Apr 9, 2015

Tiffanie Fennell
Seattle, WA 98116
Apr 9, 2015

The Psychologists with Advanced MS in Psychopharmacology have more knowledge and training than other professionals that are allow to prescribe. Please pass the law that allows Psychologists to Prescribe Independently. Thank you, Dr. Maria Rosa (Rosie) Buse Canada

Dr. Rosie Buse
North York, Canada
Apr 9, 2015

Fellows Arthur Rolland
Austin, TX 78759-8659
Apr 9, 2015

Greg Febbraro, Ph.D.
West Des Moines, IA 50265
Apr 8, 2015

Barry Rufenacht
Berlin, VT 05602
Apr 8, 2015

Greg
Longmont, CO 80504
Apr 8, 2015

Herbert Gupton
Kailua, HI 96734
Apr 8, 2015

Rick Cannon
Tracy, CA 95377
Apr 8, 2015

Michael Smith
Yakima, WA 98902
Apr 8, 2015

Mike
Pearl City, HI 96782
Apr 8, 2015

Please pass legislation allowing Medical Psychologists with advanced training to prescribe psychotropic medications in the state of Hawaii. Our communities are suffering because of the lack of access to timely psychiatric care.

Kim Arredondo
Bryan, TX 77803
Apr 8, 2015

Please pass this bill, we need more prescribing psychologists

Anne T Molloy
Silver Spring, MD 20904
Apr 8, 2015

Dr Rick McGraw
San Angelo, TX 76904
Apr 8, 2015

Tiffany Garner
Towson, MD 21286
Apr 8, 2015

Jessica
East Syracuse, NY 13057
Apr 8, 2015

Rafael A. Salas
Ruidoso, NM 88345
Apr 8, 2015

Albert Chiu
Oakland, CO 94611
Apr 8, 2015

Dana OBrien
Rockville, MD 20852
Apr 8, 2015

SUPPORT IT BECAUSE IT IS THE RIGHT THING TO DO.

SHELDON D. WEINSTOCK
BALTIMORE, MD 21201
Apr 8, 2015

Please help support this effort on behalf of those who need mental health assistance in the population.

Michael A. Baer, PhD
Bradenton FL. 34202, FL 34202
Apr 8, 2015

Julie B
Rockville, MD 20852
Apr 8, 2015

Tamara Knox
London, KY 40741

Apr 8, 2015

Jeffrey Shein
Los Angeles, CA 90045
Apr 8, 2015

Lee Livingston, PsyD, ABPP-RP
San Antonio, TX 78259
Apr 8, 2015

Deborah Gambles
Fort Washington, MD 20744
Apr 8, 2015

Andrea Fiscus
Billings, MT 59102
Apr 8, 2015

Sandra L. Smith
Jamesville, NY 13078
Apr 8, 2015

Carrie Singer
Boyds, MD 20841
Apr 8, 2015

Dr. Melissa Joseph
Clinton, NY 13323
Apr 8, 2015

Kathryn Berk, Ph.D.
Burlington, VT 05401
Apr 8, 2015

There is a huge shortage of psychiatric prescribers and many patients simply go without their medications. This legislation would help thousands of people get the medications they need along with the as-important psychotherapy to help them make more long term recovery.

Nora K Marks
Kennewick, WA 99336
Apr 8, 2015

Anen Morton
Dallas, TX 75219
Apr 8, 2015

Daisy Porter
Eldon, IA 52554
Apr 8, 2015

licensed psychologist HI #1312

leah wingeart
Henderson, NV 89044
Apr 8, 2015

As a community provider, I know all too well the struggles of clients not having timely access to psychiatry. Most of these clients end up hospitalized for suicidal thoughts. Please consider passing this important piece of legislation to support your communities!

Alicia Meyer
Rockville, MD 20853
Apr 8, 2015

Martha Viglietta
Manlius, NY 13104
Apr 8, 2015

This is a must.

Sayuli Wong
Yuba City, CA 95993
Apr 8, 2015

Sandra Aguilar
Pico Rivera, CA 90660
Apr 8, 2015

Gayla Heape
Marshfield, MO 65706
Apr 8, 2015

Please approve this important public health solution.

Maria F. McGuinness
El Paso, TX 79912
Apr 8, 2015

Jack L Houk PhD
LaFayette, NY 13084
Apr 8, 2015

Loretta Lobbia
Liverpool, NY 13090
Apr 8, 2015

Please support prescription privileges for properly trained psychologists. Your citizens need greater access to medical evaluation and treatment.

Thomas Kremer
Austin, TX 78745
Apr 8, 2015

Dan Roberts
Round Rock, TX 78681
Apr 8, 2015

Amy Provan
Towson, MD 21204
Apr 8, 2015

Stephen Gary McClure Ph.D.
Roseville, CA 95661
Apr 8, 2015

Mary Jones
Tiburon, CA 94920
Apr 8, 2015

I went to the U. of Hawaii and visit regularly. Hawaii residents need more access to high quality mental health care and psychopharmacology. Appropriately trained psychologists can provide this. James H Bray, PhD 2009 President, American Psychological Association

James H Bray, PhD
Houston, TX 77098
Apr 8, 2015

Joseph Cautilli
Philaelphia, PA 19147
Apr 8, 2015

Ginger Capps Sample
Amarillo, TX 79102
Apr 8, 2015

Melissa Bagwell
Santa Fe, NM 87508
Apr 8, 2015

PLEASE PASS THIS BILL!

keith petrosky
West Chester, PA 19382
Apr 8, 2015

As a Licensed Psychologist Hawaii #416 and California PSY 8536 I ask you to support legislation allowing Medical Psychologists with advanced training to Rx psychotropic medications in the State of Hawaii.

Dean Haddock
Bakersfield, CA 93380
Apr 8, 2015

Gwendolyn M. Lawson
Marshfield, MO 65706
Apr 8, 2015

Deborah Christensen
Draper, UT 84020
Apr 8, 2015

Tom pedigo
Savannah, GA 31406
Apr 8, 2015

Ann Rost
Marshfield, MO 65706
Apr 8, 2015

I have a time share in Kauai and I can see the need for Medical Psychologist to be able to prescribe. The people of Kauai are severally underserved for psychological services.

Dr. Frank Lucchetti
Sonoma, CA 95476
Apr 8, 2015

Julie Barnes
New York, NY 10011
Apr 8, 2015

K V Davis
Casper, WY 82601
Apr 8, 2015

Denis Zavodny
Smyrna, GA 30303
Apr 8, 2015

Michael G. McBride Ph.D.
Port Angeles, WA 98362
Apr 8, 2015

James Maxson, Psy.D
Helena, MT 59602

Apr 8, 2015

Karen J. Kietzman, Psy.D.
Billings, MT 59102
Apr 8, 2015

Stephen Ross
Windsor, CO 80550
Apr 8, 2015

Lorilee Schoenbeck
Burlington, VT 05401
Apr 8, 2015

Do the right thing for the people of HI!

Dr. Scott Wylie
Loveland, CO 80538
Apr 8, 2015

Doug Andrews
Rutland, VT 05701
Apr 8, 2015

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please bring this bill to the Senate floor for a vote. There is a clear need for integrated care, and prescribing psychologist provide integrated care, therapy and medication management, making access to care easier.

Jon Bos, Psy.D., MSCP
Indianapolis, IN 46290
Apr 8, 2015

Dr. Bob Hemmerr, Psy.D
Manchester, VT 05254
Apr 8, 2015

I support HB1072. FROM CA PSYCHOLOVGIST PSY5108.

Dr. Darius K. Fanibanda
los gatos, CA 95032
Apr 8, 2015

Paul W. Bagwell, Psy.D., MA, ABMP
Las Vegas, NM 87701
Apr 8, 2015

Bradford K.W. Chang, PhD
Bellevue, WA 98006
Apr 8, 2015

Peter M. Oppenheimer
Barrington, RI 02806
Apr 8, 2015

please help us serve those whose access to care is limited.

deirdre rainer
Kailua, HI 96734
Apr 8, 2015

Michele Fouts
New Haven, VT 05472
Apr 8, 2015

Psychologists can fill a large hole in the care of people who need medications. Please consider this bill carefully. Thank You

Donald Hunt
St. Johnsbury, VT 05819
Apr 8, 2015

Psychologists educated in psychopharmacology are the most apprporiate persons to prescribe for mental illness. They see their patients for 45 minutes to an hour every week as ppposed to psychiatrists or PCPs who see their patients for 15 to 30 minutes every 6 weeks to 3 months

Frances Griffis
Shelburne, VT 05482
Apr 8, 2015

Karen D. Sanders
Germantown, TN 38138
Apr 8, 2015

Dr. Richard L. Luscomb
Germantown, TN 38138
Apr 8, 2015

Please do not deny needed services to those in your state who need them the most

Steven Tulkin
San Mateo, CA 94403
Apr 8, 2015

Suzanne Sitkowski
Norwich, VT 05055
Apr 8, 2015

Hawaii was the first state to recognize the value of prescribing psychologists. Please make it the next to realize that vision for Hawaiians.

Joshua C. McGuinness
El Paso, TX 79912
Apr 8, 2015

Although I was originally against this idea in the '90s; the American Psychological Association and those working on this matter have created a sound training program and national exam to ensure client safety. Since then I have written articles in support of it as well as participated in presentations to support this initiative. What is more, psychologists with advanced training have been prescribing now for decades in the Armed Services and since in other states safely. Please be sure to hear the whole of the situation, not just scare tactics proffered by the American Medical Association and its affiliates.

Michael R. Bütz, Ph.D.
Billings, MT 59102
Apr 8, 2015

Michael Mason
Seattle, WA 98103
Apr 8, 2015

Jonathan Rich, Ph.D.
Long Beach, CA 90802
Apr 8, 2015

David Hartman
Highland Park, IL 60035
Apr 8, 2015

As a frequent visitor to Waikoloa on the Big Island and future property owner, I long for enhanced access and the careful care that Medical Psychologists provide. Thank you for your support of this legislation.

Douglas Marlow
Lake Oswego, OR 97034
Apr 8, 2015

Richard elghammer
Danville, IL 61832
Apr 8, 2015

Craig Vander maas
Grand rapids, MI 49503
Apr 8, 2015

Victor Ashear
Sheridan, WY 82801
Apr 8, 2015

I support prescription privileges for psychologists who have medical psychology training.

Dr. Robert North
Shelbyville, TN 37160
Apr 8, 2015

Jessica M Mason, PsyD
Seattle, WA 98103
Apr 8, 2015

This measure will greatly improve menal health service provision and treatment compliance, as well as save money for the state. It's time to pass this legislation.

Lisa E. Harris, PhD
New York, NY 10016
Apr 8, 2015

John P. Thorn, Ph.D.
Victor, ID 83455-0633
Apr 8, 2015

Hi, Psychologists with advanced training in psychopharmacology have been prescribing safely for decades without incident in other states and the military, and it's time for Hawaii to pass a law that will help it's people. That's why I signed a petition to The Hawaii State House, The Hawaii State Senate, and Governor David Ige, which says: "Please pass legislation allowing Medical Psychologists with advanced training to prescribe psychotropic medications in the state of Hawaii. Our communities are suffering because of the lack of access to timely psychiatric care. Dr. Lawson

Ward M. Lawson, PhD, ABPP, ABMP
Marshfield, MO 65706
Apr 8, 2015

Aloha, good luck Hawaii!

Bryan Mickelson
Worland, WY 82401
Apr 8, 2015

Geoffrey Sherman, Ph.D.
Buffalo, WY 82834
Apr 8, 2015

Please allow the people more services, rather than keep the AMA monopoly that doesn't serve enough

Christine Winter Ph.D.
Newcastle, WY 82701
Apr 8, 2015

Louise Miglionico
Jericho, VT 05465
Apr 8, 2015

La Keita Carter, PsyD
Baltimore, MD 21212
Apr 8, 2015

Dr Connie Kaplan, PsyD
New York, NY 10003
Apr 8, 2015

Ann Altoonian, PsyD
Rochester, NY 14609
Apr 8, 2015

Lack of access to psychiatry is a huge problem in my state and this needs to happen in Vermont as well.

Kirke McVay
Shaftsbury, VT 05262
Apr 8, 2015

Martha Stretton
Chester, VT 05143
Apr 8, 2015

Janyna Mercado
San Antonio, TX 78258
Apr 8, 2015

Access to high quality mental healthcare is a civil right.

Karen Postal, Ph.D., ABPP-CN
Andover, MA 01810
Apr 8, 2015

Dorcia Tucker, PsyD
Annapolis, MD 21404
Apr 8, 2015

Rebecca
New Orleans, LA 70118
Apr 8, 2015

Lynn Pinkham
Port Washington, NY 11050
Apr 8, 2015

I fully support this bill

konstantin lukin
hoboken, NJ 07030
Apr 8, 2015

Please support prescription privileges for specially trained psychologists.

Paul Custer
South Pasadena, CA 91030
Apr 8, 2015

Urania T. Poulis
Yonkers, NY 10701
Apr 8, 2015

I strongly support RxP for properly trained clinical psychologists in every state of the union

Laurence Perotti, Ph.D/
San Antonio, TX 78217
Apr 8, 2015

Jonna Fries
Los Angeles, CA 91024
Apr 8, 2015

Lorri Ovryn
New Rochelle, NY 10801
Apr 8, 2015

Gabrielle Stutman
Dobbs Ferry, NY 10522
Apr 8, 2015

We have visited Hawaii many times and have friends who are long time residents and busuness owners in on Kona.

A Eugene Shapiro, Ph.D, Psy.D.
Boynton Beach, FL 33437, FL 33437
Apr 8, 2015

I fully support perscription privileges for psychologist!

Gary B Kelley, PhD
Solon, OH 44139
Apr 8, 2015

Jeffrey Zimmerman
Katonah, NY 10536
Apr 8, 2015

Dr. Doug Gerardi
Philadelphia, PA 19106-2515
Apr 8, 2015

Dr. Brenda Payne
Iowa City, IA 52245
Apr 8, 2015

Dr. Erin Sisk
saratoga springs, NY 12866
Apr 8, 2015

Dr. Fernando Obledo
San Antonio, TX 78230
Apr 8, 2015

I support

Cal Robinson
Newport News, VA 23606
Apr 8, 2015

Julie
Studio City, CA 91604
Apr 8, 2015

Athena Howard
Los Angeles, CA 90066
Apr 8, 2015

This legislation will facilitate access to behavioral healthcare by psychologists with advanced training in psychopharmacology. It's the right thing to do for our community.

June Ching
Honolulu, HI 96821
Apr 8, 2015

George H.
Valley Village, CA 91607
Apr 8, 2015

Dr. Heather Wittenberg
Wailuku, HI 96793
Apr 8, 2015

Tonya Miles
Overland Park, KS 66210
Apr 8, 2015

Please allow psychologists with the appropriate advanced education and training in the field of psychopharmacology to be prescibers in so gravely needed service and in light of shortage of psychiatrists. Thank you.

Lawrence Howard, MS, PhD
Los Angeles, CA 90066
Apr 8, 2015

Monika Mentes
Bethalto, IL 62010
Apr 8, 2015

Peter Claydon
Santa Barbara, CA 93101
Apr 8, 2015

Tina Panteleakos
Santa Barbara, CA 93101
Apr 8, 2015

Lisa Taylor
Richboro, PA 18954
Apr 8, 2015

Joram Lanzar
honolulu, hi, HI 79912
Apr 8, 2015

The need for comprehensive mental health services (psychotherapy and psychopharmacology) is overwhelming and I urge legislators to pass this legislation. George L. Lynn, Psy.D. ABPP

d
Lyme, CT 06371
Apr 8, 2015

John Kluczynski
Riverside, IL 60546
Apr 8, 2015

Angela Davis, M.A., NCSP
Monrovia, CA 91016
Apr 8, 2015

Allows the vote

Tibor Jukelevics
Rancho Palos Verdes, CA 90275
Apr 8, 2015

Please support the petition!

Steven M Brown
Portland, OR 97202
Apr 8, 2015

This legislation is essential to the residence of Hawaii

Jack G. Wiggins, Ph.D.
Fountain Hills, AZ 85268
Apr 8, 2015

Jared Skillings, PhD, ABPP
Grandville, MI 49418
Apr 8, 2015

â€‹I managed the medications for many Hawaiian Activated Reserves who were deployed and re-deployed at Ft. Hood, and treated them as well in Iraq. Most of these Soldiers would have had NO psychotropic medication â€‹if I had not been available and licensed by two States which DID pass their RxP bills on through committee to a fair vote. Because HI has not passed this critically needed bill, OTHERS have to provide medical care such as this to your Citizen Soldiers

MAJ (R) Hopewell
Fort Worth, TX 76133
Apr 8, 2015

Gregory Coe
Pahoa, HI 96778
Apr 7, 2015

We are having the same situation in Texas - can not find a psyciatrist to meet the needs of my Hispanic patients!!

jorge carrillo
houston, TX 77040
Apr 7, 2015

Roy Wilensky
Fairfax, VA 22033
Apr 7, 2015

Lorraine

Lahaina, HI 96761
Apr 7, 2015

Catherine Kosora
Kurtistown, HI 96760
Apr 7, 2015

Beatriz C Trabing
Lahaina, HI 96761
Apr 7, 2015

James Wilson
Trabuco Canyon, CA 92679
Apr 7, 2015

Very important to help the big island people in need

Kim Krell
Kurtistown, HI 96760
Apr 7, 2015

Jose Figueroa
Staten Island, NY 10301
Apr 7, 2015

Katherine
kailua Kona, HI 96740
Apr 7, 2015

Psychologists with prescription privileges have been serving communities with situations similar to Hawaii (low practitioner to high demand) for some time and with great outcomes. Hawaii would benefit from increased access to competent clinicians who can prescribe medications.

Matthew Zemba
Nottingham, MD 21236
Apr 7, 2015

Steven Peltz
Vienna, VA 22180
Apr 7, 2015

Who is blocking this legislation geared specifically towards helping the poor of Hawaii??

Paul McMahon, Ph.D.
Fontana, CA 92336
Apr 6, 2015

John W Johnson PhD
Highland, CA 92346

Apr 6, 2015

Bret Moore
San Antonio, TX 78260
Apr 6, 2015

Jessica Lazaro
Issaquah, WA 98027
Apr 6, 2015

Jobel M.
Kapolei, HI 96707
Apr 6, 2015

Lasar Hurd-McCabe
Aiea, HI 96701
Apr 6, 2015

Seema Buksh
Coquitlam, Canada
Apr 6, 2015

Kristen
Honolulu, HI 96825
Apr 6, 2015

Robin Kumabe
Honolulu, HI 96820
Apr 6, 2015

Aulii Mafi
Honolulu, HI 96825
Apr 6, 2015

Damon
El Paso, TX 79922
Apr 6, 2015

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kanoelani kanoho
kapolei, HI 96707
Apr 6, 2015

Patrick Connelly
Southport, NC 28461
Apr 6, 2015

Robert S. Meier, Ph.D.
Beaumont, TX 77706
Apr 6, 2015

Ralph Casazza
Houston, TX 77042
Apr 6, 2015

Mariah Arnold
Hanover, MD 21076
Apr 6, 2015

Rebecca Buller
Coronado, CA 92118
Apr 6, 2015

Dana Turnbull
Euless, TX 76040
Apr 6, 2015

There is no reason medical psychologists with advanced training should not be allowed to prescribe! They are well prepared to take on this responsibility!

Jane Curtis
Bainbridge Island, WA 98110
Apr 6, 2015

James K Childerston
Hagerstown, MD 21740
Apr 6, 2015

Leslie Dozzo
Albq, NM 87109
Apr 6, 2015

For the legislation allowing Psychologist to prescribe.

Leo Hruska, Ph.D.
Annapolis, MD 21401
Apr 6, 2015

Dr Sanzone
Annapolis, MD 21032
Apr 6, 2015

David Berger
Harbor Beach, MI 48441
Apr 6, 2015

Laila Spina
Honolulu, HI 96812
Apr 6, 2015

Jeen Chu
Aiea, HI 96701
Apr 6, 2015

Mary Jean Romano
Kaneohe, HI 96744
Apr 6, 2015

Carol A Dickson
Honolulu, HI 96822
Apr 6, 2015

I am in support of this bill and encourage the HI legislature to pass it. Your state needs the added services to your population that trained psychologists can provide.

Blake F. White, Ph.D.
Albuquerque, NM 87111-8076
Apr 6, 2015

I ask for your professonal support, pass the bill to benefit those most in need of Medical Psychologists' services.

Elizaabeth Delgado-Torres
El Paso, TX 79911
Apr 6, 2015

LEIGH KADOOKA
AIEA, HI 96701
Apr 6, 2015

Please pass the bill.

Nancy Chou
Cerritos, CA 90703
Apr 6, 2015

May Wu
DIAMOND BAR, CA 91765
Apr 6, 2015

I urge you to pass this bill to benefit the people of Hawaii.

Fred Lin
Cupertino, CA 95014
Apr 6, 2015

I strongly support this bill.

Janet Wu
Cupertino, CA 95014
Apr 6, 2015

Mariah Shaver
Aiea, HI 96701
Apr 6, 2015

Kapua Beyer
Honolulu, HI 96821
Apr 6, 2015

Donna Glatzel
Honolulu, HI 96821
Apr 6, 2015

Robert Chang, Ph.D., M.S.C.P.
Mescalero, NM 88340
Apr 6, 2015

Mario Marquez PhD
Albuquerque, NM 87109
Apr 6, 2015

I am VERY supportive of this petition.

Mitchel Perlman
San Diego, CA 92106
Apr 6, 2015

Please pass this legislation

venus masselam
Bethesda, MD 20817
Apr 6, 2015

Properly trained psychologists are safe prescribers - in Louisiana for over 10 years prescribing psychologists have had a great safety record!

Dr. Samuel Dutton
Severna Park, MD 21146-2732
Apr 6, 2015

Jeanne Knight
Albuquerque, NM 87196-0131
Apr 6, 2015

Patients need the care and the advanced training is thorough and solid.

Jennifer darakjy
El Paso, TX 79922
Apr 6, 2015

Support prescription privileges for psychologists for the people who would benefit from increased access to this type of care.

Treven
Henrico, VA 23238
Apr 6, 2015

Gloria Frigola
Rockville MD, MD 20850
Apr 6, 2015

Mark Muse
Rockville, MD 20850
Apr 6, 2015

Sara Ocasio
Miami, FL 33177
Apr 5, 2015

Elizabeth Berger
Harbor Beach, MI 48441
Apr 5, 2015

Carol Fahy
Kaneohe, HI 96744
Apr 5, 2015

Please pass this bill. It should be about providing better access for those who need it rather than the political issue it is for some.

Marianne Westbrook
Hobbs, NM 88240
Apr 5, 2015

Herbert Wilkins
Grants, NM 87020
Apr 5, 2015

Camille Taylor
Lahaina, HI 96761
Apr 5, 2015

Do the right thing and promote access to care.

Jeffrey Stern
Honolulu, HI 96819
Apr 5, 2015

Robert Surber
Keaau, HI 96749
Apr 5, 2015

Sheri Short
Lahaina, HI 96761
Apr 5, 2015

Denise Durant-Wilson
Mission Viejo, CA 92690
Apr 5, 2015

Dr. Efrain A. Gonzalez
Miami, FL 33173
Apr 5, 2015

Stephanie Bunin
Morrisville, PA 19067
Apr 5, 2015

Anthony LoPresti M.S.
Baltimore, MD 21230
Apr 4, 2015

Nina Barry
Apple Valley, MN 55124
Apr 4, 2015

Michael G Sawyer
Baltimore, MD 21212
Apr 4, 2015

Jeremy
honolulu, HI 96813
Apr 4, 2015

RUTH Roa-Navarrete
APO, AE 09464
Apr 4, 2015

Helen L Young
Papaaloa, HI 96780

Apr 4, 2015

Catherine Ogawa
Honolulu, HI 96822
Apr 3, 2015

ANGELIQUE SNYDER
Baltimore, MD 21218
Apr 3, 2015

Kate Cunningham
Baltimore, MD 21209
Apr 3, 2015

John Sawyer
Baltimore, MD 21212
Apr 3, 2015

I strongly encourage you to pass this legislation. I have been a prescribing psychologist for 7 years working the federal government.

David Shearer, PhD
Gig Harbor, WA 98335
Apr 3, 2015

Karen Lesniak
Fife, WA 98424
Apr 3, 2015

Morgan Kamerdze
Baltimore, MD 21210
Apr 3, 2015

Jessica Batinjane
Baltimore, MD 21209
Apr 3, 2015

Corey Molzon
Sea bright, NJ 07760
Apr 3, 2015

Good luck Hawaii!

Cheryl Hall
Lubbock, TX 79410
Apr 3, 2015

I strongly support Hawaii psychologists appropriately trained in psychopharmocology be given the authority to prescribe medications for the residents of Hawaii. Alumni and former football player at the University of Hawaii

James H Bray, PhD
Houston, TX 77021
Apr 3, 2015

Lauren Palazzolo
Baltimore, MD 21210
Apr 3, 2015

There is such a shortage of qualified psychiatrists. Licensed Psychologists with advanced psychopharmacology training are well positioned to fill this gap and meet the treatment needs of our neediest, most vulnerable, and often most distressed citizens There is ample evidence of the success and safety of appropriately trained psychologists providing these much needed services. Jeffrey E. Barnett, Psy.D., ABPP

Jeffrey Barnett
Baltimore, MD 21210
Apr 3, 2015

Jessica Rothstein
Nottingham, MD 21236
Apr 3, 2015

There are significant gap in services for low income and rural hard to fill communities with little to no access to adequate psychiatric care due to lack of provider shortage. Allowing trained and highly qualified medical psychologist to prescribe would fill this gap for both psychotherapy and psychotropic medications standpoint, ultimately best serving one of the most vulnerable population siginificantly in need of this medical services!!!

Amy Park
Olympia, WA 98506
Apr 2, 2015

Sarah Santos
Hilo, HI 96720
Apr 2, 2015

Leah Goodman
Kailua-Kona, HI 96740
Apr 2, 2015

Allow medical psychologists with advanced training to prescribe psychotropic medication in Hawaii. Communities are suffering because of the lack of access to timely psychiatric care.

Jennifer Green
Boone, NC 28607
Apr 2, 2015

Robert Measel Jr
Keaau, HI 96749
Apr 2, 2015

I am a prescribing psychologist, proud to be serving the underserved in Indian Country.

Marie Greenspan
Crow Agency, MT 59022
Apr 2, 2015

Sonja Lund Pedicini
Saratoga, CA 95070
Apr 2, 2015

I am a NM Prescribing Psychologist. After 6 years prescribing I know it can work.

Christina Vento
Albuquerque, NM 87114
Apr 2, 2015

Michael Yee
Kailua Kona, HI 96740
Apr 2, 2015

Myriam Etchegoin
Corona Del Mar, HI 92625
Apr 1, 2015

On behalf of a family member, and resident of Hawaii, who has not been well-served by the state's psychology safety net.

Paul Klarin
SALEM, OR 97302
Apr 1, 2015

Elizabeth Brumm
Bodega, CA 94922
Apr 1, 2015

Michelle Matusek
Kailua Kona, HI 96745
Apr 1, 2015

Dawn Hall
Haiku, HI 96708
Apr 1, 2015

Jenny Bell
San Diego, CA 92107
Apr 1, 2015

Bailey
Kamuela, HI 96743
Apr 1, 2015

Kevin Cronin
Los Angeles, CA 90038
Apr 1, 2015

Paul Kozak
Kamuela, HI 96743
Apr 1, 2015

i lost my Aunt because of the lack of Psychological help available.

Ana Ramos
Hayward, CA 94644
Apr 1, 2015

Marisa Kagan
Kilauea, HI 96754
Apr 1, 2015

This is very important for the welfare of our citizens

Valentin Atienza
Palm Beach, FL 33480
Apr 1, 2015

Maria B Estrada
Las Vegas, NV 89123
Apr 1, 2015

Pamela Hurley
Kailua Kona, HI 96745
Apr 1, 2015

I fully support the RxP movement to help the healthcare crisis for undeserved populations.

Christina Mentes
Santa Barbara, CA 93101
Apr 1, 2015

Katie Kolman
Henderson, NV 89014

Apr 1, 2015

Cathy Mascarenas
Orange, CA 92867
Apr 1, 2015

I lost my wife and my 5 year old and 3 year old lost their mother to suicide. She was on a waiting list for a year. The doctors office never called. We need more doctors in every state. Please help us by making laws that give us more doctors to keep our family whole.

Reynaldo Ramos
las cruces, NM 88011
Apr 1, 2015

Eve Ducati
San Marcos, CA 92078
Apr 1, 2015

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mitchell cooke
sleepy hollow, NY 10591
Apr 1, 2015

I fully support this petition.

Stephen R Yerian
Washington Court House, OH 43160
Apr 1, 2015

Teddie LaPierre
Long Beach, NY 11561
Apr 1, 2015

Les Shirwindt
las vegas, NV 89123
Apr 1, 2015

Robert Stroozas
Fort Lauderdale, FL 33305
Apr 1, 2015

Edward Good
Centereach, NY 11720
Apr 1, 2015

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kenya
waikoloa, HI 96738
Apr 1, 2015

dr barbara kapetanakes
sleepy hollow, NY 10591
Apr 1, 2015

Please for the sake of mankind. Pass this please. We need peace of mind. Thank you.

Michele
Miami, FL 33176
Apr 1, 2015

Anthony Trent
Brentwood, CA 94513
Apr 1, 2015

My nephew lives on the big Island and suffers from mental illness. We need legislation to hlp in their treeatment.

Barbara Plasschaert
Santa Clarita, CA 91390
Apr 1, 2015

Kathleen Pfendler
Haiku, HI 96708
Mar 31, 2015

David C. Wiesner, Ph.D.
Raleigh, NC 27604
Mar 31, 2015

I am also a medical/prescribing psychologist in Albuquerque, NM, and have seen the major positive impact on mental health services from having RxP legislation in that state.

Susana A. Galle
Washincgton, DC 20015
Mar 31, 2015

Dr Harv simon
weston, CT 06883
Mar 31, 2015

Lindsay Higgins
Montreat, NC 28757
Mar 31, 2015

Kim Bishop
waikoloa, HI 96738
Mar 31, 2015

Earl B Sutherland Jr Ph.D.
Hardin, MT 59034
Mar 31, 2015

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i have been living with Mental Illness for ten years. This Bill will help me and countless others get the help we need!

Robinson Klarin
waikoloa, HI 96738
Mar 31, 2015

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this is an issue that is long overdue! Pass this Bill today!

Robert Klarin
Waikoloa, HI 96738
Mar 31, 2015

I have been a medical psychologist for three years in NM practicing safely and effectively. Currently, I am the only behavioral health prescriber in a town of 11,000 and county of 25,000 which is considered frontier. I am working full-time and have a long waiting list due to lack of behavioral health providers in general in our area. I know many other medcal psychologists in NM who are doing the same thing I am in filling a huge gap in quality services in severely underserved areas. Please bring these badly needed services to your constituents and bring this to a vote.

Renee H Wilkins, Psy.D., MP
Grants, NM 87020
Mar 31, 2015

Patricia Butts
Las vegas, NV 88123
Mar 31, 2015

Stephanie Stowman
Las vegas, NV 89141
Mar 31, 2015

Stephanie Hall Morin
Hilo, HI 96720
Mar 31, 2015

It's time for Hawaii to pass this bill into law!

Beth Rom-Rymer
Chicago, IL 60611
Mar 31, 2015

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dian jonus
Laguna Beach, CA 92651

Mar 31, 2015

Ginette Perrin
Temecula, CA 92590-2724
Mar 31, 2015

As a Psychologist who is pursing this advanced training, passing this legislation would not only aid in care for those who are undeserved, it can aid as a recruitment tool for those who want to use their advanced training.

Peter Smith
Towson, MD 21204
Mar 31, 2015

Liz Campbell, Ph.D.
Orlando, FL 32825
Mar 31, 2015

Julie Schmidt
lahaina, HI 96761
Mar 31, 2015

Charlene Van Cott
Oak Harbor, WA 98277
Mar 31, 2015

Hawaii's population is vastly underserved in mental health coverage, especially re. access to prescribers of needed psychoactive meds. Trained psychologists can do this safely and competently.

Wendy Stock
Berkeley, CA 94708
Mar 31, 2015

Stephanie Espiritu
lahaina, HI 96761
Mar 31, 2015

Please pass legislation.

Dawn Lewis
Lahaina, HI 96761
Mar 31, 2015

Raymond Folen
Honolulu, HI 96822
Mar 31, 2015

Sheina
Las vegas, NV 89122
Mar 31, 2015

Dr Robert Rottschafer
Monument, CO 80132
Mar 31, 2015

Jill
Lone tree, CO 80124
Mar 31, 2015

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dana kiesel
Beverly Hills, CA 90210
Mar 31, 2015

Please pass this critical legislation allowing Medical Psychologists with advanced training to prescribe psychotropic medications in the state of Hawaii. Mental health is vital to your citizens who are suffering because of lack of access to timely psychiatric care. Thank you!

Dr. M. H. Wright
Cranfills Gap, TX 76637
Mar 31, 2015

Brittney simonelli
henderson, NV 89014
Mar 31, 2015

Nicole Meadows Kashner
Waikoloa, HI 96738
Mar 31, 2015

Cathy Frey
Pahoa, HI 96778
Mar 31, 2015

Duke
eaw beach, HI 96797
Mar 31, 2015

Brittany Klarin
Waikoloa, HI 96738
Mar 31, 2015

Mental health care is too important to ignore!

David Walling
Huntington Beach, CA 92648
Mar 31, 2015

Dr Christina shook
Enola, PA 17025

Mar 31, 2015

Shaynna Herrera
Totowa, NJ 07512
Mar 31, 2015

Christine Jones
Los Angeles, CA 90010
Mar 30, 2015

Kimberly Bulava
Naples, FL 34120
Mar 30, 2015

Christine Bierdrager-Salley
San Bernardino, CA 92405
Mar 30, 2015

Dr. Larry Brooks
Hollywood, FL 33021
Mar 30, 2015

The island community of Guam shares the same need as the island community of HI. Our citizens suffer because there is a lack of timely access to good prescribing specialists in the area of mental health.

Jaylene Kent, Ph.D.
Tamuning, GU
Mar 30, 2015

Enzo Young Sa
Weston, MA 02493
Mar 30, 2015

Amy F Guevara
Las Vegas, NV 89135
Mar 30, 2015

Dr. Efrain A. Gonzalez
Miami, FL 33173
Mar 30, 2015

Gary Wautier
Marquette, MI 49855
Mar 30, 2015

Andrew Scherbarth
Jacksonville, FL 32216
Mar 30, 2015

People with mental illness need be taken care of,they are just sick. Not crazy, and they need also lots of love!

Myrna Castaneda
Henderson, NV 89012
Mar 30, 2015

Andrew Hicks
Saint Petersburg, FL 33704
Mar 30, 2015

Mary Shea
Orlando, FL 32832
Mar 30, 2015

Psychologists with prescription privileges will help solve the problem of a paucity of psychiatrists nationwide for better more timely service to the community. please pass this bill.

Raul Martinez
San Antonio, TX 78207-1641
Mar 30, 2015

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jayne braden
Sycamore, IL 60178
Mar 30, 2015

Mark Kamena, PhD, ABPP
NOVATO, CA 94947
Mar 30, 2015

Steve bloomfield
Jacksonville, FL 32217
Mar 30, 2015

Diane J. Willis, PhD
Norman, OK 73072
Mar 30, 2015

John Skidmore
Pahoa, HI 96778
Mar 30, 2015

Even here in Bethesda, Maryland "inside the Beltway", the need for prescribing psychologists is significant - children may need to wait 3 to 4 weeks for a new patient appointment with a child psychiatrist. I also have a part time practice in a Rural Health Clinic in West Virginia. The nearest child psychiatrist is 90 minutes by car and one of my new patients has bee on a waiting list for more than 3 months. This child is coming to me now as the parents secured an agreement with their family physician to prescribe what I recommend if I am following the case. I have a post-doctoral masters degree in clinical psychopharmacology and completed my 1000 hour preceptorship in that particular Rural Health Clinic , so the physicians there know and trust my pharmacotherapy skill-set. I strongly encourage bringing HB 1072 forward for a vote. Thank you.

Neal Morris, EdD, MS, CBSM, ABPP-CL
Bethesda, MD 20814
Mar 30, 2015

Debbie HOLDER
LAWRENCEBURG, IN 47025
Mar 30, 2015

Alexander Kraft
el paso, TX 79913
Mar 30, 2015

Psychologists with advanced training have a long, significant and safe history of prescribing psych medication in other states. Hawaii offers advanced training and with appropriately trained prescribing psychologists the people of Hawaii will have increased access to necessary care.

Jo Velasquez
Las Cruces, NM 88003
Mar 30, 2015

Mary noonan
Minnetonka, MN 55305
Mar 30, 2015

Yaron G Rabinowitz, PhD, ABPP
Hampstead, NC 28443
Mar 30, 2015

In the Midwest we are also experiencing severe shortages in psychiatric care, especially those with psychotropic medication and monitoring. Prescribing psychologists are a safe and progressive alternative to this nationwide crisis.

Harlan Gilbertson MS PsyD MSCP LP
Mora, MN 55051
Mar 30, 2015

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william samek
Miami, FL 33143
Mar 30, 2015

Allowing psychologists to prescribe a limited formulary of medications for mental disorders is a win for all the underserved citizens of Hawaii.

David S. Greenfield, Ph.D.
Seminole, FL 33776
Mar 30, 2015

Jeff Matranga
Waterville, ME 04901
Mar 30, 2015

Anthony Podraza
Winterport, ME 04496
Mar 30, 2015

Mikhail Bogomaz
Jacksonville, FL 32207
Mar 30, 2015

It's the right thing to do.

Brian Bigelow
Wannapitae, Canada
Mar 30, 2015

Nadine Case
Saranac Lake, NY 12983
Mar 30, 2015

Michael Brunner
Austin, MN 55912
Mar 30, 2015

Please Pass the medical psychology bill. Many Hawaiians are not getting the medical care they need due to a lack of timely psychiatric care.

Kimberly Kinsler
Tampa, FL 33613
Mar 30, 2015

Tony Kreuch
Albuquerque, NM 87199
Mar 30, 2015

Anthony Rinaldi
Iowa City, IA 52240
Mar 30, 2015

Daniel Ullman
Lincoln, NE 68506
Mar 30, 2015

Robin Henderson
Bend, OR 97701
Mar 30, 2015

March 30, 2015 To Gov. Ige and to the Members of the Hawaii Legislature: I am writing about something which I believe is of great importance to the people of Hawaii, and to citizens all across our country. I ask your support of HB 1072, the bill to permit properly trained psychologists to prescribe psychotropic medications. I write from a public health standpoint, and because I believe in the importance of the issue. I have nothing to gain financially. I am a psychologist who is retired from the federal prison system, where I worked with many individuals with serious and persistent mental illness. It was difficult to find and keep qualified psychiatrists, even though the prison where I practiced was located near Richmond, Virginia, where there is a large medical school. Based on my direct experience and those of colleagues in other institutions and agencies, I became convinced of the need for prescribing psychologists in correctional institutions. Further, there are many mental health care â€œconsumersâ€ in other settings â€“ community mental health centers, on Indian reservations, and in rural areas, for instance â€“ who could benefit from properly trained psychologistsâ€™ authorization to prescribe psychotropic medications. You may already be aware that the military permits psychologists who have completed a clinical psychopharmacology curriculum to prescribe for men and women on active duty. Perhaps you also know that New Mexico, Louisiana, and Illinois have already passed prescriptive authority laws of the type currently under consideration in Hawaii. The Indian Health Service has begun authorizing prescribing psychologists, reflecting the desperate need on that agencyâ€™s part for high quality care of this sort. Prescribing psychologists have shown that they can provide this service safely and effectively. I believe the passage of a prescriptive authority bill, HB 1072, would be a great benefit to the people of Hawaii, as similar authorization already has been for patients in the military, New Mexico, and Louisiana, and will soon be to patients in Illinois. I wish we had such a progressive law here in Virginia. Thank you for your attention to this request. Sincerely yours, Robert K. Ax, Ph.D. Federal Bureau of Prisons (Retired) 5610 Chatmoss Road Midlothian, VA 23112

Robert K. Ax
Midlothian, VA 23112
Mar 30, 2015

Dr. Derek Phillips
Lakeland, FL 33803
Mar 30, 2015

I strongly support the passing of legislation allowing properly trained psychologists to bridge the access gap by prescribing psychotropic medications.

Mary Sa
Isanti, MN 55040
Mar 30, 2015

Over 20 years of psychologists prescribing demonstrates how improving this access can be safe and effective.

Robert Younger
Alexandria, VA 22304
Mar 30, 2015

This is needed and long overdue

Dr. Dennis P. Girard
Waban, MA 02468
Mar 30, 2015

Please support the prescriptive authority bill for psychologists. I have been teaching Psychopharm for 10 years now. Psychologists are by far some of my best students -- understanding the need to protect their patients.

Perry Buffington
Orlando, FL 32811
Mar 30, 2015

As a colleague of many psychologists and other mental health providers in HI, I understand the difficulty that Hawai'ians often encounter getting access to quality mental health care. This bill will definitely expand access, I strongly support it.

Morgan Sammons
Ashland, OR 97520
Mar 30, 2015

Please pass legislation allowing Medical Psychologists with advanced training to prescribe psychotropic medications in the state of Hawaii. This is part of a constructive, national effort to provide timely psychiatric care. Thank you for considering this petition.

Linda R. Jeffrey
Pilesgrove, NJ 08098
Mar 30, 2015

As a clinical psychologist in Guam where there are limited providers competent in the prescription of psychotropic medications, I know the importance of this bill. Consumers deserve to have services in a timely manner and psychologists who obtain the advanced training can deliver these services in a safe and effective way. Please pass this legislation. It is for the good of the consumers and their families.

Lyndsey Miller
Tamuning, GU 97931
Mar 30, 2015

The training for psychologists to prescribe psychotropic medications is rigorous. It is years beyond getting both their doctoral degree and license. Please pass this important legislation.

Thomas DeAntonio, Ph.D, MS
Canoga Park, CA 91436
Mar 30, 2015

This is an urgent need, and I ask your full support.

Terri Erwin
Wailuku, HI 96793
Mar 30, 2015

Robert Edward Hsia
Honolulu, HI 96816
Mar 30, 2015

Joe Etherage
Apo, AE 09705
Mar 30, 2015

Please pass legislation allowing Medical Psychologists with advanced training to prescribe psychotropic medications in the state of Hawaii. Our communities are suffering because of the lack of access to timely psychiatric care.

Walter W. Windisch
Towson, MD 21204
Mar 30, 2015

Yosef Geshuri, PhD, JD, MP
Porterville, CO 92537
Mar 30, 2015

Geraldine Barton
Fair Oaks Ranch, TX 78015
Mar 30, 2015

Passing this bill is vital to the mental and overall physical health of countless individuals. Please pass this legislation quickly and without further delay. It should be passed in all the States of this great Country! Shelley Slapion-Foote, Ph.D. - Licensed Psychologist in Florida

Michelle Slapion-Foote
Miami, FL 33176
Mar 30, 2015

Our work in NM is helping to meet needs in rural and urban undeserved areas among those with many risk factors and needs. I have been prescribing since 2005. I recently retired from a rural hospital in one of the poorest counties in NM. Thomas C Thompson, PhD, MP, ABN, ABMP Medical Psychology and Neuropsychology-Prescribing Diplomate American Board of Professional Neuropsychology Diplomate American Board of Medical Psychology

Thomas C Thompson Ph.D.
Las Cruces, NM 88005
Mar 30, 2015

Joseph E. Comaty, Ph.D., M.P.
Baton Rouge, LA 70808
Mar 30, 2015

J H
Palmetto, FL 34221
Mar 30, 2015

Patients benefit greatly, who are able to receive integrated care by having the same Provider perform both the counseling and medication management. Too often, patients with mental health needs have fragmented care in which the counselor is not actively collaborating with the medication management provider. Prescribing psychologists have the expertise to provide both.

Lia Billington
Littleton, CO 80127
Mar 30, 2015

For the benefit of millions of patients please pass this important legislation. Mental Health Care is a shambles and this is one step towards fixing it.

Pam Van Allen
Stockton, CA 95219
Mar 30, 2015

Theresa Faulkner, Ph.D.
Buffalo, WY 82834
Mar 30, 2015

Please pass this important legislation for the underserved citizens of Hawaii

Kathleen M McNamara
Kula, HI 96790
Mar 30, 2015

Let's do the right thing for the American people.

George Zaki
Port St. Lucie, FL 34984
Mar 30, 2015

Please support the reconsideration of the RxP Bill in Hawaii. Thank you, T U Ketterson, PhD Licensed Psychologist -Florida

Timothy Ketterson, Ph.D.
Gainesville, FL 32608
Mar 30, 2015

I support psychologist obtaining prescription authority in Hawaii because there is a need for this expertise and service to be provided to the community to be provided in a kind, patient and compassionate way.

Tibor Jukelevics.
Torrance, CA 90505
Mar 30, 2015

Please help the citizens of Hawaii obtain appropriate psychological care.

John Gavazzi
Mechanicsburg, PA 17050
Mar 30, 2015

Prescribing psychologists have been an enormous aid to the underserved of Bee Mexico

Elaine KeVine, Ph.d.
Las Cruces, NM 88001
Mar 30, 2015

Mary Evers
Durham, NC 27713
Mar 30, 2015

As a psychologist trained in prescribing, and former resident of the Big Island, I strongly encourage allowing this bill to move forward. If I were able to practice my full trade as I do in the DoD, I would return to the land of Aloha. Mahalo for your kind consideration.

Michael Connor
Orange Park, FL 32067
Mar 30, 2015

Please allow the prescription bill for psychologists to move forward. It will help hundreds who need this service in Hawaii.

Susan Frank
Louisville, KY 40207
Mar 30, 2015

I've visited Hawaii several times and would like to have a prescribing psychologist available next time I visit.

S A Ragusea
Key West, FL 33040
Mar 30, 2015

Rick Barnett
Stowe, VT 05672
Mar 30, 2015

Monroe Weil, Ph.D.
Great Neck, NY 11021
Mar 30, 2015

David B Kazar
Helotes, TX 78023-2973
Mar 30, 2015

This is very important for improving accessible mental health care for underserved Hawaiians.

Andris Skuja
Oakland, CA 94611
Mar 30, 2015

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please pass the Psychologist Prescription Privledge Bill allowing our citizens to have access to much needed mental health care.

Nancy Vrechek
Honolulu, HI 96813
Mar 30, 2015

This bill will help the citizens of California. Properly trained psychologists prescribe safely in the Military, in the Indian Health Service, in the Public Health Service and in two other states. Anyone who claims that psychologists prescribing is unsafe either doesn't know the facts or is purposefully lying.

Steve Berger
Lake Forest, CA 92630
Mar 29, 2015

Please respectfully move the psychologist rxp bill.

Mike kim
Gold River, CA 95670
Mar 29, 2015

Psychologists with advanced training in clinical psychopharmacology will aid in filling the gap of service providers who can treat mental health disorders.

Dr. Michael Lucido
Eastport, MI 49627
Mar 29, 2015

Please allow democracy to work and bring the bill to allow psychologists with advanced training in pharmacology to practice in Hawaii. It is a sorry day when you allow vested interests prevent highly trained medical psychologists from working in your state... If they can care for the brave members of our armed forces they can care for the rest of us... NP, pa and Md's with less training than medical psychologists can why not someone with even more training ?

Edward Korber
Lynbrook, NY 11563
Mar 29, 2015

K Lamb
Lutz, FL 33558
Mar 29, 2015

Please support prescriptive authority for appropriately trained psychologists as it will greatly, and safely, expand services to those who need it and often cannot receive it. Thank you

Michael Hand, PhD
El Paso, TX 79912
Mar 29, 2015

Please allow the Senate to review and vote on this important bill

Robert C Rinaldi
Wheaton, IL 60189
Mar 29, 2015

Please pass legislation allowing Medical Psychologists with advanced training to prescribe psychotropic medications in the state of Hawaii. Our communities are suffering because of the lack of access to timely psychiatric care.

Gary howell
Tampa, FL 33603
Mar 29, 2015

Please support HB1072.

Kevin McGuinness
Rockville, MD 20850
Mar 29, 2015

Robert McGrath
Warwick, NY 10990-3202
Mar 29, 2015

As a license medical psychologist in Louisiana, I know of the tremendous service medical psychologists provide. Hawaii needs this tremendous service for their citizens.

Dr Keith Westerfield
New YOrk, NY 10040
Mar 29, 2015

In memory of Sen. Inouye, with whom I had the pleasure of meeting at an MSC dinner while an intern at WRAMC in Washington.

David K. Jackson
Covington, LA 70435
Mar 29, 2015

Many patients in Hawaii need psychiatric care, however, they are not getting the treatment that they need. Psychologists can fill in the gaps pertaining to medication treatment and provide the most comprehensive interventions. I urge you to pass the law this year.

Dr. Tony Wu
Diamond Bar, CA 91765
Mar 29, 2015

Dr. Deepan Chatterjee
Ellicott City, MD 21042
Mar 29, 2015

Prescribing psychologist are highly trained and increase public access to services and safety.

David Wade
Hood river, OR 97031
Mar 29, 2015

I was born in Hawaii and serve the nation's military personnel and veterans through APA's mental health policy work. RxP for psychologists will break down yet another barrier to high-quality, effective healthcare. Please move and pass this bill.

Heather O'Beirne
Alexandria, VA 22304
Mar 29, 2015

Dr. Anthony Ragusea
Key West, FL 33040
Mar 29, 2015

Psychiatry, despite its claims, has not been able to handle the burden for years, Hawaii citizens in need of psychopharmacological services are not receiving the care they deserve, and we, as Psychologists, have been bringing this to the attention of the legislature since the mid-1980's. It is time to structure public policy to provide this much needed resource with the confidence that Psychologists have been successfully and safely prescribing in other venues, both Federal and State for 20 years. Thank you, Thomas Evans, Ph.D., ABPP M.S. Clinicalpsychopharmacology Kahului, HI 96733 808-551-0490

Thomas Evans
Kahului, HI 96733
Mar 29, 2015

Improve mental health delivery services; support prescriptive authority for appropriately trained psychologists. Dr. Robert J. Resnick, Former President APA.

Dr. Robert J. Resnick
Glen Allen, VA 23060
Mar 29, 2015

Medical Psychologists are "Mission-Multipliers" who enhance the widest and most evidence-based delivery of psychological and pharmacological services in collaboration with our medical colleagues. Underserved populations have the right to expect this kind of integrated care for their highest well being and balance!

Dr. Michael R. Tilus
Crow Agency, MT 59022
Mar 29, 2015

Mark Yates
Pasadena, CA 91101
Mar 29, 2015

Justin
honolulu, HI 96819
Mar 28, 2015

Nieda Saoit
Honolulu, HI 96819
Mar 28, 2015

Katrina
Mililani, HI 96789
Mar 28, 2015

Michael Christopher
Honolulu, HI 96816
Mar 28, 2015

Lyndee Taketa
Santa rosa, CA 95409
Mar 27, 2015

Shoko Burkett
Honolulu, HI 96816
Mar 27, 2015

Bridgit Williams
Ewa Beach, HI 96706
Mar 27, 2015

Rachel Linhares
san francisco, CA 94121
Mar 27, 2015

Christy chang
Wailuku, HI 96793
Mar 27, 2015

Francis Choi
Wailuku, HI 96793
Mar 27, 2015

Hayley Porter
Lutherville, MD 21093
Mar 27, 2015

Justin Maeda
Honolulu, HI 96813
Mar 27, 2015

Connie Paguirigan
Honolulu, HI 96819
Mar 27, 2015

Gary Robello
Honolulu, HI 96818
Mar 27, 2015

Marie Robello
Honolulu, HI 96818
Mar 27, 2015

Francis Aurellano
Honolulu, HI 96821
Mar 27, 2015

Nicole Robello
honolulu, HI 96818
Mar 27, 2015

Lana Choi
Wailuku, HI 96793
Mar 26, 2015

Lynell Paguirigan
Honolulu, HI 96819
Mar 26, 2015

Glenda Saoit
Pearl City, HI 96872
Mar 26, 2015

Jolinda Yamamoto
honlulu, HI 96825
Mar 26, 2015

People suffering from Mental Health disorders need access to necessary medication interventions to decrease further suffering. Please do not deny them this access.

Julie Greenberg
Corte Madera, CA 94925
Mar 26, 2015

Stefanie Escontrias
San Antonio, TX 78222
Mar 26, 2015

Haunani Iao
Kula, HI 96790
Mar 26, 2015

I cannot believe this has not already happened here in Hawaii. When psychiatrists are so scarce, who better to prescribe psychotropic medications than a training medical psychologist?

Nicolette Rittenhouse-Young
kailua, HI 07076
Mar 26, 2015

Michael Shintaku
Hilo, HI 96720
Mar 25, 2015

Charles Lasker
Kalaheo, HI 96741
Mar 25, 2015

I support this bill!

Molly Berman
Honolulu, HI 96815
Mar 25, 2015

Jon S. Muramoto
Pearl City, HI 96782
Mar 25, 2015

Karli Lum
Honolulu, HI 96818
Mar 24, 2015

Charlene Nakagawa
Honolulu, HI 96817
Mar 24, 2015

Crystal Ann Rambayon
Honolulu, HI 96822
Mar 24, 2015

Robyn McNichols
Honolulu, HI 96819
Mar 24, 2015

Jennifer Hamada
Honolulu, HI 96815
Mar 24, 2015

Brandon McNichols
Honolulu, HI 96819
Mar 24, 2015

Judy Luu
Mansfield, TX 76063
Mar 24, 2015

Cynthia Mancione
Eastchester, NY 10709
Mar 24, 2015

lori narimasu-hirayasu
honolulu, HI 96821
Mar 24, 2015

gerardo peredia
stockton, CA 95215
Mar 24, 2015

Sandra R Wexler
Kailua Kona, HI 96745
Mar 24, 2015

Valerie Koenig
Honolulu, HI 96816
Mar 24, 2015

Rodel
Honolulu, HI 96819
Mar 23, 2015

I want to make a difference!!!

Gabriel Valenzuela
Los Angeles, CA 90047

Mar 23, 2015

Roy Ogawa
Honolulu, HI 96821
Mar 23, 2015

Warren Young
Honolulu, HI 96819
Mar 23, 2015

Barbara Valenzuela
Los Angeles, CA 90047
Mar 23, 2015

Susan Young
Aiea, HI 96701
Mar 23, 2015

Glenn Ogawa
Kaneohe, HI 96744
Mar 23, 2015

MARISA FRITKIN
LONG BEACH, CA 90808
Mar 23, 2015

Nathan
HNL, HI 96815
Mar 23, 2015

Erin Yoshioka
honolulu, HI 96813
Mar 23, 2015

Nancy Kowardy
Papaaloa, HI 96780
Mar 23, 2015

Ernalene Padunan
Honolulu, HI 96818
Mar 23, 2015

John Ray Saoit
Honolulu, HI 96819
Mar 23, 2015

Please support this bill!!! It's about increasing access to health care in Hawaii, especially in rural areas.

Richard Saoit
Honolulu, HI 96819
Mar 23, 2015

Keliann Nagamine
Honolulu, HI 96825
Mar 23, 2015

Cheryl Andaya
honolulu, HI 96813
Mar 23, 2015

JANET THOMAS
HONOLULU, HI 96818
Mar 23, 2015

I Have personally experienced the expertise and benefits of utilizing medical psychologists.

Lisa garcia
Kapolei, HI 96707
Mar 23, 2015

Erin Ogawa
honolulu, HI 96821
Mar 23, 2015

Steven Curtis
Bainbridge Island, WA 98110
Mar 22, 2015

Adrienne Kadooka
Aiea, HI 96701
Mar 22, 2015

Melissa Belanger
Kailua, HI 96734
Mar 21, 2015

It's time to make rational decisions based on science and allow qualified clinicians to prescribe, increasing access to quality care.

Martin Johnson
Honolulu, HI 96813
Mar 21, 2015

Jan Arakawa
Kula, HI 96790
Mar 21, 2015

It's time to increase access to care!

Jeffrey D Stern
Honolulu, HI 96819
Mar 20, 2015

Good work Don...keep pushing!

ananda harris
makawao, HI 96768
Mar 20, 2015

We need our Psychologists to prescribe psychotropic medications. We are short handed and need the extra expertice.

Deborah Shannon-Ryken
Hakalau, HI 96710
Mar 20, 2015

Having just moved from Hawai'i after living in Aiea for 22 years, I can attest to the great need for prescribers given the varied mental health needs across the population of Hawai'i. Advanced masters level training in psychopharmacology, which exceeds the training of many other prescribers in mental health disorders, builds upon the foundation of psychologists' doctoral training in diagnosis, assessment and treatment.

Kathleen Brown
Fort Myers, FL 33916
Mar 20, 2015

Please expand access to mental health services. As psychologists are trained to prescribe safely, community safety increases through access to mental health.

David Narang
Encino, CA 91316
Mar 19, 2015

Tamara Lester
Makawao, HI 96768
Mar 17, 2015

Petia Maximova
sofia, Bulgaria
Mar 14, 2015

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angie young

Haiku, HI 96708
Mar 14, 2015

Nancy Jaqua Dein
Kihei, HI 96753
Mar 13, 2015

Cathy Paxton-Haines
Pukalani, HI 96768
Mar 13, 2015

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julie baker
kula, HI 96790
Mar 13, 2015

Gill McBarnet
Kula, HI 96790
Mar 13, 2015

Nancy Bly
Downers Grove, IL 60515
Mar 13, 2015

Candis Cornell
mililani, HI 96789
Mar 13, 2015

Tolly Amaxopoulos
Honolulu, HI 96822
Mar 13, 2015

Sarah Alethea
waimanalo, HI 96795
Mar 13, 2015

Rhea Nekota
Mililani, HI 96789
Mar 13, 2015

Danielle Gleason
Honolulu, HI 33141
Mar 13, 2015

approve this bill. It's long over due. It's about providing appropriate mental health services for anyone that has the need in Hawaii. Stop allowing this to be a turf war issues. Medical psychologists will be required to have additional, extensive traing, supervision, experience, AND pass a national licensure exam. This is in addition to 8-10 years of college, internships, and passing a national exam as a clinical psychologist. Please make the right decision, for OUR community.

Dr Daniel Lane, PhD, MSC
kula, HI 96790
Mar 13, 2015

Leslie Chen
lahaina, HI 96761
Mar 12, 2015

Ray Terry
Memphis, TN 38104
Mar 12, 2015

Dawn Olsen
kalaheo, HI 96741
Mar 11, 2015

Kathleen Terry-Sharp
Memphis, TN 38104
Mar 11, 2015

Teal Jorgenson
Owings Mills, MD 21117
Mar 11, 2015

Patrick Turns
Franklin, TN 38103
Mar 11, 2015

Louise B Terry
Memphis, TN 38104
Mar 11, 2015

We need this on Kauai!

Judith White
Kapaa, HI 96746
Mar 11, 2015

Stacey Machorek
Kalaheo, HI 96741
Mar 11, 2015

Our rural communities need access to care. Please pass the RxP bill for psychologists to prescribe.

Marie terry-Bivens
Anahola, HI 96703
Mar 11, 2015

Maxine
Kaneohe, HI 96744
Mar 9, 2015

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janet Montgomery
kailua, HI 96734
Mar 6, 2015

Susan M. Schultz
Kaneohe, HI 96744
Mar 6, 2015

Margaret Romano
The villages, FL 32162
Mar 6, 2015

Cynthia M Sottnick
New York, NY 10011
Mar 6, 2015

Please pass this law; it is important for the well being of people with mental illness and will also protect public safety and reduce other social and economic costs associated with untreated mental illness

Kathleen Sands
Honolulu, HI 96825
Mar 6, 2015

Catherine Cooke
Honolulu, HI 96816
Mar 6, 2015

Please help us improve health care and lower disparity rates . Aloha

Chris Conybeare
Honolulu, HI 96813
Mar 5, 2015

Ryan Suda
kihei, HI 96753
Mar 4, 2015

Dave McLeod
Wailuku, HI 96793
Mar 4, 2015

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bradney hickle
kihei, HI 96753
Mar 3, 2015

Chris Foster
Kihei, HI 96753
Mar 3, 2015

Linda Smith
Pahoa, HI 96778
Mar 3, 2015

Kristin Rajala
Honolulu, HI 96826
Feb 28, 2015

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lisa dillon
kaunakakai, HI 96748
Feb 26, 2015

Please help our communities!

Anne Steinke
Kualapuu, HI 96757
Feb 25, 2015

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lisa norris
kualapuu, HI 96757
Feb 25, 2015

Jennifer L Napoli
Kaunakakai, HI 96748
Feb 25, 2015

Sabrina Bianchi
Snohomish, WA 98290
Feb 22, 2015

Caroline Fay
Lahaina, HI 96761
Feb 22, 2015

Lance Murphy
kihei, HI 96753

Feb 12, 2015

Darryl Salvador
Ewa Beach, HI 96706
Feb 12, 2015

I operate an intensive outpatient program on Maui and struggle to find someone to help my patients pharmacologically.

Debra Bayer
Kihei, HI 96753
Feb 10, 2015

Elsa
Port Washington, NY 11050
Feb 10, 2015

Traci Martino
Baltimore, MD 21286
Feb 10, 2015

Barbara Hernandez
Opalocka, FL 33054
Feb 8, 2015

Melanie Manon
Margate, FL 33063
Feb 8, 2015

Kristine M.
Kahului, HI 96732
Feb 8, 2015

Lea Godfrey
Wailuku, HI 96793
Feb 8, 2015

Robin
Makawao, HI 97668
Feb 7, 2015

Michael Muench
Hawaii National Park, HI 96718
Feb 5, 2015

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leslie gullo
buffalo, NY 14220
Feb 4, 2015

Bernadine Fernandez
Las Vegas, NV 89169
Feb 4, 2015

As a Internist I fully support Medical Psychologists in Hawaii. We nned them with us in covering the expanding mental health need.

Alexander Sy MD
New York, NY 10025
Feb 3, 2015

I am an LCSW and my clients have poor access to psychiatrists. While this is a very needed service, I am not sure that psychologists prescribing psych meds will make a permanent change in this issue. Many psychologists on Maui do not take Quest patients. How do we address the needs of these people who desperately need access to psych meds and the time intensive adjusting of meds to find the maximum therapeutic dosage?

Noreen Erony
Pukalani, HI 96768
Feb 3, 2015

The people of Hawaii need access to these experts - both in therapy and medication - a comprehensive treatment that only a prescribing Psychologist can provicd.

Dr Keith Westerfield
New York, NY 10024
Feb 3, 2015

Tina A Boteilho
Makawao, HI 96768
Feb 3, 2015

Michelle James
Honolulu, HI 96817
Feb 3, 2015

Rochelle
Kahului, HI 96732
Feb 3, 2015

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rochelle dunning
kihei, HI 96753
Feb 3, 2015

Barbara Hanger
Kula, HI 96790
Feb 3, 2015

Kathryn Snyder
Lahaina, HI 96761
Feb 2, 2015

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noncy manning
makawao, HI 96768
Feb 2, 2015

I have done research on this topic and highly support these psyxhologists!

Mirette Misak
Staten island, NY 10312
Feb 2, 2015

Adrianna Flavin, PhD
Pukalani, HI 96768
Feb 2, 2015

Lorraine Fay
Lahaina, HI 96762
Jan 30, 2015

Cheyenne Fox
Fairfield, OH 45014
Jan 20, 2015

Eric Watan
Captain Cook, HI 96704
Jan 17, 2015

This is a very important bill covering a very critical issue. As a provider of mental/behavioral health services in a rural area, I strongly support this legislation that would bring much-needed services to areas that experience serious disparities in health outcomes, which are in large part due to poor access to health care.

Julie Takishima-Lacasa
Honolulu, HI 96821
Jan 17, 2015

Making lives better for those who needs medical care.

Thelma Widmaier
Arlington, TX 76017
Jan 16, 2015

Ellen Kilbey
Hauula, HI 96717
Jan 16, 2015

Jill Oliveira Gray
Honolulu, HI 96813
Jan 16, 2015

Aileen Preston
Hauula, HI 96717
Jan 16, 2015

Today is the day this Bill should and will move forward. Our island residents are suffering from lack of care and resources. My family has been and is affected by the lack of Mental Health care in our Islands. As an advocate for my own son and thousands Of others I ask you to move forward with this HB today!

Cathy Klarin
Waikoloa, HI 96737
Jan 13, 2015

Judi Steinman
Laupahoehoe, HI 96764
Jan 13, 2015

Elizabeth Murph
Honolulu, HI 96819
Jan 12, 2015

Priscilla Kahele
Hauula, HI 96717
Jan 10, 2015

Maelani Valentine
Laie, HI 96762
Jan 10, 2015

Deborah Michiko Fried
Hilo, HI 96720
Jan 10, 2015

HANNAH K PRESTON-PITA
Keaau, HI 96749
Jan 10, 2015

Emily Bankhead
lahaina, HI 96761
Jan 9, 2015

Kimber Williams
Waller, TX 77484
Jan 9, 2015

B. Fay
Lahaina, HI 96761
Jan 4, 2015

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claudia Micco
Lahaina, HI 96761
Jan 4, 2015

Tracey Novy
lahaina, HI 96761
Jan 4, 2015

URGENT TO PASS THIS ONE

CAROLE PLUTA
Lahaina, HI 96761
Jan 4, 2015

Cherie Dasmacci
Kihei, HI 96753
Jan 4, 2015

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ray thomas
temecula, CA 92590
Jan 2, 2015

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jennifer tardibuono
lahaina, HI 96761
Jan 2, 2015

Michele Liberty
Wailuku, HI 96793
Dec 22, 2014

Leah
lahaina, HI 96761
Dec 22, 2014

Erik Blair
Kahului, HI 96732
Dec 22, 2014

The psychologists should be the ones determining what is best for their patients. Not politicians.

Priscilla Goldman
Palm Harbor, FL 34684
Dec 21, 2014

Sylvia Ching
Honolulu, HI 96813
Dec 18, 2014

I am a Hawaii Certified Peer Specialist. I support this petition. Mele Kalikimaka and Aloha

Cynthia Wicks
Chandler, AZ 85286
Dec 17, 2014

My patients inform me that they have difficulty in obtaining medication evaluations and monitoring from the limited number of psychiatrists on Maui.

Virginia Cantorna, PsyD
Wailuku, HI 96793
Dec 17, 2014

As a psychologist practicing on Maui, I fully support legislation that will improve my patients' access to quality Rx mental health care here!

Linda Sattler, PsyD
Lahaina, HI 96761
Dec 17, 2014

Michelle Griess
Wailuku, HI 96793
Dec 12, 2014

Naomi crozier
pukalani, HI 96768
Dec 11, 2014

MacKenzie Yamamoto-Lane
kula, HI 96790
Dec 11, 2014

Our rural communities need more professionals who prescribe.

Virginia Shaw
Kahului, HI 96733-6300
Dec 10, 2014

Scott Lau
kapaau, HI 96755
Dec 10, 2014

Carol Preston
Lahaina, HI 96761

Dec 10, 2014

I am a family practice doctor licensed in both California and Hawaii and see every day the tremendous need for behavioral health services in coordination with primary care. There is a severe shortage and I believe psychologists with advanced training would help fill this tremendous gap.

traci stevenson
Sonoma, CA 95476
Dec 9, 2014

Farran Rossetti
Kula, HI 96790
Dec 8, 2014

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bill
Honokaa, HI 96727
Dec 7, 2014

Steven Dutcher
Honolulu, HI 96813
Dec 7, 2014

Noenoe Barney-Campbell
honolulu, HI 96813-1379
Dec 6, 2014

Michelangelo Salmoiraghi
Kapaau, HI 96755
Dec 6, 2014

Shaun Campbell
Honolulu, HI 96815
Dec 6, 2014

Lou Ann Barcai
Kihei, HI 96753
Dec 6, 2014

AaronHarnick
kahului, HI 96732
Dec 6, 2014

Jeff Gishkin
Wailuku, HI 96793
Dec 5, 2014

Getting an apppt.to see your psychiatrist is anywhere from4 to 6 weeks...all they do is ask how you are doing and give you refills.

Patricia McGrath
Kihei, HI 96753
Dec 5, 2014

Kawika Kaikala
Makawao, HI 96768
Dec 5, 2014

Kelly Sueoka
Bellevue, WA 98006
Dec 5, 2014

I am all for this. If they have that extra traning it should be helpful & less costly for most. That means more people will be able to afford help.

Sherry Lane
Valparaiso, FL 32580-1224
Dec 5, 2014

Val sexton
valparaiso, FL 32578
Dec 5, 2014

SUSAN C KING
WAILUKU, HI 96793
Dec 5, 2014

Sachiko Yamamoto-Lane
Kula, HI 96790
Dec 5, 2014

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do the right thing and please pass this bill!

Daniel Lane
kula, HI 96790
Dec 5, 2014

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passage of this bill would be a great help to rural areas like Molokai

Stephanie Napoli
kaunakakai, HI 96748
Dec 4, 2014

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jamie Lee
Kihei, HI 96753

Dec 4, 2014

Marilyn McIntosh
Kealakekua, HI 96750
Dec 4, 2014

Allison Seales
Kaunakakai, HI 96817
Dec 4, 2014

Please support RxP. People are suffering without access to psychiatric care.

Kelly Harnick
Lahaina, HI 96761
Dec 3, 2014

Don Lane
Wailuku, HI 96793
Dec 3, 2014