AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

February 24, 2019

Senate Committee on Judiciary
Senate Committee on Ways and Means
Hawaii State Capitol
415 South Beretania Street
Honolulu, HI 96813

Dear Chair Rhoads and members of the Senate Committee on Judiciary, and Chair Dela Cruz and members of the Senate Committee on Ways and Means,

On behalf of the American Psychiatric Association, a national medical specialty society representing more than 37,800 psychiatric physicians, as well as their patients and families, we urge you to oppose SB 819 which would authorize clinical psychologists to prescribe powerful psychotropic drugs to Hawaii patients. While psychologists are experts in important behavioral interventions, they have no medical training. Giving them permission to prescribe to would put the health and safety of Hawaii patients at risk.

There is often confusion about the difference between psychiatrists and psychologists. While psychologists are valuable mental health professionals and respected colleagues, only psychiatrists are medical doctors specializing in the diagnosis and treatment of mental disorders and substance abuse disorders. Just like surgeons or internists, psychiatrists are physicians who attend medical school (4 years), and then specialize through a medical residency. Psychiatrists complete a rigorous four-year medical residency in psychiatry after they complete medical school. This is over 12,000 hours of training specializing in medical treatment of mental health, including substance use disorders. Psychiatrists focus on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders. Through their vast medical training, psychiatrists are able to conduct psychotherapy and prescribe medications and other medical treatments.

Psychologists treat mental disorders with psychotherapy and other behavioral interventions. A psychologist has an advanced degree, usually a Ph.D. in psychology or Doctor of Psychology (Psy.D.). Psychologists often have extensive training in research or clinical practice and in psychological testing and evaluation, but they **do not** have medical training.

SB 819 would authorize psychologists to obtain a license to independently prescribe after completing as few as 400 clinical hours (including course work) and a one-year period of "clinical supervision." This course work can be done completely online.

Physicians spend years learning differential diagnoses, pharmacology, and honing their medical skills. This cannot be replicated in a 400-hour training period. SB 819 would grant a psychologist prescriptive authority once they pass a 150-question multiple choice Psychopharmacology Exam for Psychologists (PEP). PEP is a product provided and administered by the American Psychological Association. **No** medical doctor's license and ability to prescribe was based solely on a multiple-choice exam, nor could their course work be completed online. Additionally, testing of physicians is performed by medical boards that are separate from professional medical associations in order to prevent conflicts of interest.

While we realize this legislation was intended to increase access to needed mental health care, prescriptive authority for psychologists has not solved the mental health needs of the rural communities in the very few states that have implemented such laws. We would instead encourage evidence-based solutions to address access to care such as Collaborative Care, where primary care providers and psychiatrists work together to provide mental health care to a much broader group of patients. Additionally, telehealth, where providers can harness the power of technology to safely treat patients, is another proven way to safely address access to care.

Patient safety must be paramount when considering the change of any law, and SB 819 puts some of Hawaii's most vulnerable patients at risk. Powerful psychotropic medications do not stop at the patient's brain; they affect many systems of the body such as the heart, lungs, stomach, and kidneys. There can be seriously disabling or deadly side-effects of the medications if improperly prescribed and managed. Patients needing more than one drug at a time for other physical conditions, such as both heart disease or diabetes and mental illness, are at risk for potentially serious drug interactions. More than half of all patients who have a mental disorder also have one or more physical ailments. In short, psychotropic medications should only be prescribed by clinicians with significant medical training and broad understanding of all systems of the body.

We urge you to oppose SB 819 and would welcome the opportunity to work with you through our partners – the Hawaii Psychiatric Medical Association and the Hawaii Medical Association – to facilitate evidence-based, proven programs that can truly assist Hawaii patients with mental illness, including substance use disorders. Thank you for the opportunity to share our concerns. If you have any questions regarding this information, please contact Erin Philp, Director of State Government Relations, at ephilp@psych.org.

Sincerely,

Saul Levin, M.D., M.P.A.
C.E.O. and Medical Director
American Psychiatric Association

Hawai‘i Psychological Association

For a Healthy Hawai‘i

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COMMITTEE ON JUDICIARY
Senator Karl Rhoads, Chair
Senator Glenn Wakai, Vice Chair

COMMITTEE ON WAYS AND MEANS
Senator Donovan M. Dela Cruz, Chair
Senator Gilbert S.C. Keith-Agaran, Vice Chair

HEARING: TUESDAY, FEBRUARY 26, 2019, 10:00 AM, ROOM 211

Testimony in **STRONG SUPPORT** of SB819 SD1
RELATING TO PRESCRIPTIVE AUTHORITY FOR
CERTAIN CLINICAL PSYCHOLOGISTS

The Hawai‘i Psychological Association (HPA) is in STRONG support of SB819 SD1. 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.

The nationally recognized Psychopharmacology Examination for Psychologists is no longer developed or administered by the American Psychological Association's Practice Organization's College of Professional Psychology. It is now developed and administered by the **Association of State and Provincial Psychology Boards (ASPPB).** Therefore, we request that section (4) of *§465- Prescriptive authority privilege; requirements* be amended as follows (page 12, lines 3-19):

(4) The applicant has successfully passed the nationally recognized Psychopharmacology Examination for Psychologists developed by the ~~American Psychological Association's Practice Organization's College of Professional Psychology~~ Association of State and Provincial Psychology Boards, or other authority, relevant to establish competence across the following content areas: neuroscience, nervous system pathology, physiology and pathophysiology, biopsychosocial and pharmacologic assessment and monitoring, differential diagnosis, pharmacology, clinical psychopharmacology, research, integrating clinical psychopharmacology with the practice of psychology, diversity factors, and professional, legal, ethical, and interprofessional issues; provided that the passing score shall be determined by the American Psychological Association's Practice Organization's College of Professional Psychology or other authority, as applicable.

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SB819 SD1 will expand our ability to provide a full range of mental health services to the most underserved communities of Hawai‘i, and therefore we respectfully ask that you consider a “YES” vote on this bill.

Sincerely,

Julie Takishima-Lacasa, PhD
Chair, HPA Legislative Action Committee
HPA President-Elect

Testimony of the Board of Psychology

Before the
Senate Committee on Judiciary
and
Senate Committee on Ways and Means
Tuesday, February 26, 2019
10:00 a.m.
State Capitol, Conference Room 229

On the following measure:
S.B. 819, S.D. 1, RELATING TO THE PRESCRIPTIVE AUTHORITY FOR CERTAIN CLINICAL PSYCHOLOGISTS

Chair Rhoads, Chair Dela Cruz, and Members of the Committees:

My name is Christopher Fernandez, and I am the Executive Officer of the Board of Psychology (Board). The Board supports this bill and offers amendments.

The purposes of this bill are to: (1) authorize and establish procedures and criteria for prescriptive authority for clinical psychologists who meet specific education, training, and registration requirements; (2) require the Board to submit a report to the Legislature, prior to the Regular Session of 2021, on the authorization of prescriptive authority to prescribing psychologists who meet specific education, training, and registration pursuant to this bill, if enacted; and (3) repeal the prescriptive authority for clinical psychologists on August 31, 2025.

The Board acknowledges that S.D. 1 adopts several of the Board's recommended amendments. In addition, the Board requests additional clarifying language in paragraph (3) on page 10, line 20 to page 12, line 2, which sets forth the clinical experience requirement, as it remains unclear whether the 800 hours of clinical prescribing practicum includes subparagraphs (B), (C), (D), (E), and (F). The Board believes that in the Regular Session of 2017, when it suggested the increase from 400 hours to 800 hours in clinical prescribing practicum for similar measure S.B. 384, the 800 hours would include the: 8 week rotation; 100 patients' supervision requirement; minimum 80 hours of physical assessment practicum in a primary care setting; 100 hours of community service; and 2 hours per week of supervision by a primary care provider or a prescribing psychologist. To clarify S.D. 1's clinical experience

requirement, the Board proposes the following amendment to subparagraph (3): "The applicant has clinical experience that includes [~~:~~

~~(A) A~~] a minimum of eight hundred hours completed in a clinical prescribing practicum, including geriatric, pediatric, and pregnant patients, completed in no less than twelve months and no more than fifty-six months[~~;~~], and consists of:

Thank you for the opportunity to testify on this bill.

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TO:
SENATE COMMITTEE ON THE JUDICIARY
Sen. Karl Rhodes, Chair
Sen. Glenn Wakai, Vice Chair

SENATE COMMITTEE ON WAYS AND MEANS
Sen. Donovan Dela Cruz, Chair
Sen. Gilbert SC Keith-Agaran, Vice Chair

DATE: February 26, 2019
TIME: 10:00 am
PLACE: Conference Room 211

FROM: Hawaii Medical Association
Jerry Van Meter, MD, President
Christopher Flanders, DO, Executive Director

Re: SB 819 SD 1: Relating to Prescriptive Authority for Certain Clinical Psychologists

Position: **Oppose**

Chairs Rhodes and Dela Cruz, Vice Chairs Wakai and Keith-Agaran, and all members of the Senate Judiciary and Ways and Means Committies:

This legislation is a proposal that puts the health and safety of the citizens of Hawaii with mental illness, including substance use disorders, in serious jeopardy. SB 819 SD1 proposes to allow clinical psychologists, who are experts in important behavioral interventions but who have no medical training, the permission to prescribe extremely powerful psychotropic drugs for patients with psychiatric disorders. While we understand the intention of this legislation is to increase access to needed mental health care, SB 819 puts Hawaii's most vulnerable patients at risk while failing to promote *available evidence-based solutions* to mental health access challenges. We urge you to look at safer models already up and functioning in Hawaii, as there are better alternatives to supporting patients with mental health needs.

These alternatives include:

Project Echo: A program Hawaii began in 2017 that is helping deliver **quality** mental health care to patients in rural areas of the state. To go along with this, Congress also overwhelmingly passed the Expanding Capacity for Health Outcomes Act (Public Law No. 114-270). The legislation, sponsored by Hawaii Senator Brian Schatz, will help

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better integrate the Project ECHO model originating out of the University of New Mexico into health systems across the country. Senator Schatz's legislation directs the federal Secretary of Health and Human Services to prioritize analysis of the model and examine its impact on addressing mental health and substance use disorders.

Collaborative Care: A specific type of integrated care that improves access to evidence based mental health care for primary care patients. Working with a patient's primary care provider and a "care managers", a medically trained psychiatric consultant" (i.e. psychiatrist, nurse practitioner, or clinical nurse specialist or physician assistant with psychiatric training with psychiatric training) deliver care to a population of patients needing care. This "care team" shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.

As you know, SB 819 would permit psychologists to obtain a prescription pad by acquiring a master's degree in psychopharmacology or "equivalent", as determined by the Hawaii Board of Psychology - a professional regulatory group that has no specific medical expertise or medical background. SB 819 would require little clinical experience to prescribe medications including controlled substances, antipsychotics, and an almost unlimited range of non-psychotropic medications. Under SB 819, only 400 contact hours with 100 patients is required as part of this training. Consider for a moment that psychiatric resident physicians, who complete a four-year medical residency program following graduation from medical school, **will generally see 100 patients in just two weeks.**

SB 819 would require passage of an exam created and administered by the same national organization that accredits these haphazard postdoctoral degree programs and that stands to directly benefit from this new certification. No other voluntary, dues-paying membership organization in any medical specialty (e.g., cardiology, obstetrics and gynecology, psychiatry) has created such an exam – nor do national professional advocacy associations for nurses and physician assistants accredit their graduate programs. These dangerously low and inadequate requirements must be taken into consideration, and any proposed training standards must be compared to the 12 or more years of medical education and training psychiatrists and other physicians receive to be able to safely care for any patient that is suffering physical, mental, or substance use disorders.

As you review SB 819, please consider the following:

- Proponents of SB 819 state that this will increase access to mental health care

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in Hawaii and cite both Louisiana and New Mexico as examples. The facts in New Mexico and Louisiana illustrate that psychologists' claims about increased access have not materialized. Specifically, after having gained prescriptive privileges, few psychologists in either New Mexico or Louisiana have become certified to prescribe psychotropic drugs, let alone practice in a rural or underserved area.

- Prescriptive authority for psychologists has not solved the mental health needs of the rural communities in those very few states that implemented such laws. Despite promises made in New Mexico and Louisiana, psychologists did not and do not move their practices to serve the rural communities.

- Fragmentation of Hawaii's health care system will increase by limiting the availability of behavioral therapy that integrated mental health care teams have come to rely on from psychologists. Coordinated, team-based care in which every member is relied on for their training and expertise is the model of practice and reimbursement the nation is moving toward. We would be happy to serve as a resource to this Committee on programs like Project Echo and collaborative care models already underway in Hawaii and in other states that would be more sustainable alternatives to solving significant access problems. HB 1566 would seriously undermine this movement.

In summary, the practice of medicine is a serious responsibility that requires years of thorough and relevant medical education and training. Allowing psychologists to prescribe after dramatically short-cutting the medical education and training necessary presents a serious and avoidable danger to Hawaii's most vulnerable patients. Again, we urge you to vote No on SB 819 and would welcome the opportunity to work with you to facilitate evidence-based, proven programs that can truly assist citizens of Hawaii suffering from mental illness, including substance use disorders.

LATE

SB-819-SD-1
Submitted on: 2/25/2019 10:27:26 AM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Deborah Baker	Testifying for American Psychological Association	Support	No

Comments:

Attached please find written testimony from the American Psychological Association in support of Hawaii's SB 819 for consideration by the members of the Hawaii Senate Judiciary and Ways & Means Committees. Please let us know if we can be of any assistance.

Deborah C. Baker, JD
Director, Legal and Regulatory Policy, Practice Directorate

American Psychological Association

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Helping Hawai'i Live Well

To: Senator Karl Rhoads, Chair, Senator Glenn Wakai, Vice Chair, Members, Senate Committee on Judiciary

To: Senator Donovan Dela Cruz, Chair, Senator Gilbert Keith-Agaran, Vice Chair, Members, Senate Committee on Ways and Means

From: Trisha Kajimura, Executive Director

Re: TESTIMONY IN SUPPORT OF SB 819 SD1 RELATING TO PRESCRIPTIVE AUTHORITY FOR CERTAIN CLINICAL PSYCHOLOGISTS

Hearing: THURSDAY February 26, 2019, 10:00 am, CR 211

Thank you for hearing SB 819 SD1, 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.

Mental Health America of Hawaii is a 501(c)3 organization founded in Hawai'i 77 years ago, that serves the community by promoting mental health through advocacy, education and service.

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 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.

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 819 SD1will 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 819 SD1.***

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

THE THIRTIETH LEGISLATURE
REGULAR SESSION OF 2019

TO: **SENATE COMMITTEE ON JUDICIARY**
Senator Karl Rhoads, Chair
Senator Glenn Wakai, Vice Chair

SENATE COMMITTEE ON WAYS AND MEANS
Senator Donovan M. Dela Cruz, Chair
Senator Gilbert S.C. Keith-Agaran, Vice Chair

FROM: **Jill Oliveira Gray, Ph.D.**
Hawaii Licensed Clinical Psychologist

RE: **TESTIMONY IN SUPPORT OF SB 819 SD 1**
RELATING TO PRESCRIPTIVE AUTHORITY FOR CERTAIN CLINICAL PSYCHOLOGISTS

Honorable Chairs, Vice-Chairs and members of the Senate Committees on Judiciary and Ways and Means, 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 18 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 819 SD 1.**

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 16 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 have to be made due to many who do not accept new patients and/or Medicaid/Medicare patients. Individuals on O'ahu are having to wait weeks to months before they are able to get appointments. 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. We simply don't have enough psychiatric resources in our state.

According to the most recent Report on Findings from the Hawai'i Physician Workforce Assessment Project (December, 2018), 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 36.91%, followed by Kaua'i county at 33.3%, and Hawai'i county at 32.95%. This annual report continues to indicate 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 receiving appropriate outpatient medication management in order to maintain functioning and prevent worsening of psychological problems.

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 compromised by allowing psychologists to prescribe—but after 22 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 **178** prescribing psychologists licensed through New Mexico, Louisiana, and Illinois, many of whom are serving in rural, medically underserved areas and medically underserved populations. Recently, Idaho and Iowa also passed legislation to allow prescriptive authority for advanced trained clinical psychologists. 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.

SB 819 SD 1 contains increases in training requirements and supervised clinical experiences and additional setting and population specifications such as obtaining 80 hours in a physical assessment practicum in a primary care, family practice, community or internal medicine setting and 100 hours of supervised community service that will include homeless, veteran and low-income populations. Supervised clinical experiences will include no less than 2 hours per week of supervision by a licensed physician or osteopathic physician, an APRN-Rx, or a prescribing psychologist.

SB 819 SD 1 also contains multiple safeguards imbedded in this legislation to include:

- 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 access to quality mental health care for Hawaii's medically underserved areas and most vulnerable populations, I humbly ask for your support of SB 819 SD 1.

Respectfully submitted,

Jill Oliveira Gray, Ph.D.
Licensed Clinical Psychologist
Direct of Training
I Ola Lāhui, Inc

SB-819-SD-1
Submitted on: 2/24/2019 10:54:21 PM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Vivek Datta MD MPH	Individual	Oppose	No

Comments:

I am a physician board certified in psychiatry and forensic psychiatry who is involved in the training of medical students, psychology interns, psychiatry residents, internal medicine residents, neurology residents and pharmacy residents and I oppose this legislation. I work closely with clinical psychologists in addition to training clinical psychology predoctoral interns. Psychologists serve an important role in the evaluation and treatment of mental disorders. They are skilled in providing individual, group, and family psychotherapy, in psychological testing, clinical supervision, and organizational and administrative roles. They are not psychiatrists who undergo a minimum of 8 years' medical training and postdoctoral residency training in psychiatry, and legislation allowing psychologists to prescribe constitutes a threat to public safety and risks limiting access to talk therapies.

1. We do not need psychologists prescribing drugs, we need greater availability of psychotherapy.

Although psychiatric medications have their place in the treatment of mental disorders, and for some serious conditions such as schizophrenia and bipolar disorders, are first-line treatments, these medications have become vastly overprescribed. One of the reasons for this is because of the lack of availability of psychotherapies. Allowing psychologists to prescribe will only worsen the shortage of available therapists. Psychotherapies are the first-line treatment for depression, phobias, generalized anxiety disorder, panic disorder, posttraumatic stress disorder, obsessive compulsive disorder, anorexia nervosa, bulimia nervosa, medically unexplained physical symptoms, and are an important part of the treatment of bipolar disorder, psychotic disorders, and substance use disorders. Psychological interventions can also be helpful in treating patients with dementia and traumatic brain injuries.

The overprescribing of psychotropic medications is costly, leads to unnecessary adverse effects, and may lead to the worsening of the course of mental disorders including depression and psychotic illnesses. They may undermine the natural capacity for individuals to cope with adversity, to respond with resilence, and instead communicate harmfully and falsely that their problems are beyond their control and due to "chemical imbalances" which can only be remedied by drugs.

2. Some psychotropic medications have abuse potential, are addictive, and carry a risk of diversion

Benzodiazepines such as Valium and Xanax can be effective in the short-term treatment of anxiety and insomnia, but they can be addictive, are subject to abuse, and maybe sold by patients illegally. Similarly, stimulant drugs such as Adderall and Vyvanse used to treat ADHD can be addictive and abused. When not prescribed judiciously such drugs can create an epidemic of drug abuse and addiction. This is a situation that will only be worsened by granting prescribing privileges to psychologists.

3. Psychiatric medications can have harmful effects of the body.

Psychotropic medications include some "heavy duty" medications such as Clozapine, lithium, and haldol. Psychologists do not have the necessary background in medicine in order to be able to assess the risks including serotonin toxicity, neuroleptic malignant syndrome, metabolic syndrome, nephrogenic diabetes insipidus, toxic epidermal necrolysis, Stevens-Johnson Syndrome, hemophagocytic lymphohistiocytosis, and other potentally life-threatening complications of psychiatric medications.

4. There are hundreds of thousands of medical conditions that can present with psychiatric symptoms.

As physicians, psychiatrists are attuned to the fact that patients presenting with neuropsychiatric symptoms may have another neurological or medical condition underlying their maladies. These range from a urinary tract infection causing delirium, or hypothyroidism causing to depression to the large number of causes of psychosis including autoimmune limbic encephalitis, metachromatic leukodystrophy, Wilson's disease, Lewy Body Dementia, mitochondrial disease, behavioral variant frontotemporal dementia, systemic lupus erythematosus, cerebral amyloid angiopathy and so on. Psychologists do not have the requisite medical training to be able to diagnose and detect neuropsychiatric symptoms secondary to other medical conditions. Missing potential treatable diseases or fatal conditions, could be disastrous.

5. Medical training and specialized skill is required to work with special populations.

Prescribing medications to children, to pregnant or breastfeeding women, and to the elderly, has significant consequences. This is why psychiatrists typically do further training in child and adolescent psychiatry if they wish to focus on psychiatric disorders in young people. The effects of psychotropic drugs on the developing brain is understudied, and should not be done lightly. Antipsychotics are already overprescribed, particularly to children from minority backgrounds, the poor and those in custodial care. Similarly, while there is growing data about the possible effects of psychiatric drugs on the developing fetus and for breastfeeding mothers, this requires an understanding of embryology, developmental biology, obstetrics, and careful risk/benefit analysis, which requires a sound foundation in medical sciences.

Furthermore, individuals over the age of 65 tend to have multiple comorbidities, tend to be on multiple medications, and are more sensitive to the effects of medications. Psychologists lack the requisite expertise to consider the effects of psychotropic drugs in the geriatric population. The current legislation would give prescribing psychologists the ability to prescribe drugs to high risk populations - children, expectant mothers, the elderly - with no checks and balances, or safeguarding.

6. Vulnerable populations deserve a minimum standard of care

Incarcerated populations, the homeless, victims of interpersonal violence, patients with HIV/AIDS, and those with co-occuring mental health and substance use disorders are vulnerable populations who are often marginalized, disenfranchised, and have high levels of psychosocial and medical complexity. Psychologists are typically trained to work with individuals who have a lower level of complexity and illness severity, and a cadre of poorly trained prescribing psychologists with little oversight should not be foisted onto vulnerable populations who often require a much higher level of skill and experience to work with.

7. Most psychologists have little experience working with individuals with severe mental illness.

The vast majority of psychologists have little to no experience working with patients with schizophrenia, bipolar I disorder, refractory depression, psychotic crises, delusional disorder, catatonia and so on. These are the individuals who are most likely to need treatment with psychiatfi medications, and in particular antipsychotic medications. Beyond the particulars of prescribing medications that can cause diabetes, strokes, abnormal movement disorders, and in some cases fatal blood clots and heart disease, working with this population requires significant experience in the evaluation and diagnoses of psychoses, including excluding other medical causes of the presentation, substance use disorders, co-existing medical problems, and risk assessment focusing on the potential dangerousness of individuals to themselves or others.

8. Prescribing does not occur in a vacuum.

The notion that psychologists can learn to prescribe medications through a substandard mostly online masters' program is fallacious. The notion of prescribing drugs as simply another bow in the string of the therapeutic armamentarium of the psychologist is dangerous. Prescribing medication occurs in the context of their response to other therapies, their diagnosis, exclusion of other causes of the patient's psychiatric symptoms, consideration of co-occuring medical condition, consideration of co-occuring substance use disorders, consideration of drug-drug interactions, and special circumstances (e.g. heart disease, kidney disease, liver disease, pregnancy), ethical issues (such as the financial incentive for a psychologist to prescribe whether indicated or not), the psychological meaning of prescribing (e.g. failure of the psychologist to be an effective therapist), as the well the legal, spiritual, and cultural implications of doing so. Psychologists do not have the ability to learn from psychiatrists in these training

programs and thus do not have the opportunity to consider the multiple facets of prescribing and how it fits into a psychologist's clinical practice.

9. Other alternatives to expanding care exist.

Successful approaches to upscaling the need for psychiatric intervention without adversely impacting availability to psychotherapy including collaborative care, use of telepsychiatry, use of access lines, training primary care physicians in primary care psychiatry and expanding psychiatry residency positions. Collaborative care is a population-based, measurement-based, evidence-based intervention that provides psychiatric consultation in primary care and other settings with the use of care managers in order to enhance mental health care in different settings. Telepsychiatry allows psychiatrists to dial in remotely and provide access to underserved area. Psychiatric access lines provide telephone consultation to healthcare providers to provide them with advice on how to manage common psychiatric disorders and use medications appropriately in particularly populations including children and adolescents and pregnant women. Funded fellowships in primary care psychiatry train a cadre of physicians to effectively treat patients with common mental disorders in the primary care setting. Finally, there has been an uptick in the popularity of psychiatry as a medical specialty, meaning there is now sufficient interest to further expand psychiatry residency positions to create a workforce to serve the next generation. As psychiatrists are most likely to practice where they trained, training more psychiatrists locally is the most effective way to expand the local psychiatric workforce and providing the minimum standard of mental health care the public deserves.

LATE

SB-819-SD-1
Submitted on: 2/26/2019 7:16:40 AM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Melodie Aduja	Testifying for O`ahu County Committee on Legislative Priorities of the Democratic Party of Hawai`i	Support	No

Comments:

Dear Chair Rhoads, Chair Dela Cruz and members of the Senate Committees on the Judiciary and Ways and Means,

Please vote NO on any version of SB819 including SB819SD1.

There are no valid studies showing such a measure would be safe nor improve access (there is a SHORTAGE OF PSYCHOLOGISTS in rural areas practicing what they have actually been trained to do, specific psychotherapies which often can work better than pills), and better, safer alternatives to SB819SD1 in Hawaii already exist and should be expanded including:

Telemedicine

APRN-RX

Project ECHO

Collaborative Care

Below please find an analysis of the study done by Hawaii's own 2006-2007 Legislative Reference Bureau on the only highly scrutinized experiment to train psychologists to prescribe in history, the Department of Defense Psychopharmacology Demonstration Project (DOD-PDP), and how simple but wrong solution bills such as SB819SD1 would fall woefully short of even this highly controversial and ultimately terminated, program. (The DOD-PDP cost taxpayers $6 Million to train 10 psychologists. At least one dropped out – in order to go to medical school).

Please vote NO on SB819SD1.

Thank you.

Jeffrey Akaka, MD

SB819 - 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 SB819SD1 (for brevity SB819SD1 will be referred to below as SB819) 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 SB819 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 SB819 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):
111111111 – MSCP psychologist at UHH (9)
11111111111111111111 – BSN-RN (non-prescribing) at UHH (21)
111111111111111111111111111 –APRN at UH Manoa (27)
1111111111111111111111111111111111111111111111 – Pharmacist at UHH (46)
11111111111111111111111111111111111111111111111 – 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." SB819 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.”
SB819 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 past program listings, the only UHH-MSCP faculty who were trained to prescribe medications were 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 doctor 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. SB819 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 onsite or readily available.
The process proposed under SB819 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 SB819 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. SB819 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. SB819 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, **SB819 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 SB819 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. SB819 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. SB819 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, SB819 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 specific service". Consider the following comparison of safeguards:

- 2-3 years of quality, full-time biomedical training? PDP -yes, SB819–no
- Selective applicant process? PDP -yes, SB819–no
- Qualified preclinical and clinical faculty? PDP -yes, SB819–no
- Supervisors expert in the use of psychiatric drugs? PDP -yes, SB819-no
- Limited to the lowest risk medications? PDP -yes, SB819–no
- Videotaped lectures as primary teaching method? PDP-no, SB819-yes
- Prescribe drugs to children? PDP-no, SB819-yes
- Prescribe drugs to teens? PDP-no, SB819-yes
- Prescribe drugs to pregnant women? PDP-no, SB819-yes
- Prescribe drugs to the elderly? PDP-no, SB819-yes
- Prescribe drugs to the medically-ill? PDP-no, SB819-yes
- Prescribe drugs for severe mental illness? PDP-no, SB819-yes

 Psychology training in treating children? PDP-n/a, SB819-no
 Psychology training in treating teens? PDP-n/a, SB819-no
 Psychology training in treating pregnant women? PDP-n/a, SB819-no
 Psychology training in treating the elderly? PDP-n/a, SB819-no
 Psychology training in treating the medically-ill? PDP-n/a, SB819-no
 Psychology training in treating severe mental illness? PDP-n/a, SB819-no
 Medical training in treating children with drugs? PDP-n/a, SB819-no
 Medical training in treating teens with drugs? PDP-n/a, SB819-no
 Medical training in treating children with drugs? PDP-n/a, SB819-no
 Medical training in treating pregnant women with drugs? PDP-n/a, SB819-no
 Medical training in treating the elderly with drugs? PDP-n/a, SB819-no
 Medical training in treating severe mental illness with drugs? PDP-n/a, SB819-no
 Does SB819 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. SB819 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 SB819 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 SB819 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 SB819, and instead implementing initiatives that are safe and proven to work, like Telemedicine, Project ECHO, training more APRN-Rxs, and Collaborative Care.

Please vote NO on SB819SD1.

To: Chair Sen Rhoads, Chair Sen Dela Cruz and members of the Senate Committees on the Judiciary and Ways and Means

Re Hearing February 26, 2019, Room 229 at 9:30 am

Re: SB 819 Relating to Prescriptive Authority for Certain Clinical Psychologists

Position: **OPPOSED**

Please vote NO on SB 819

SB 819 would authorize psychologists on the Psychology Board to tell other psychologists that they can practice medicine. Medical doctors and nurses have biological training and work together in hospitals. Our watchword is “First, do no harm” because we know that we have tremendous power to harm as well as to heal. Psychologists are valuable but they don’t come from that **culture** and you can’t learn it from a book.

Thank you for listening to my concerns.

Aloha,

Leslie Gise MD
Psychiatrist on Maui and Molokai x 24 years
Clinical Professor, Department of Psychiatry, John A Burns School of Medicine
Staff physician, Maui Health System (formerly Maui Memorial)

SB-819-SD-1
Submitted on: 2/22/2019 7:55:39 AM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Ethan Pien	Individual	Oppose	No

Comments:

2/26/2019

To Whom It May Concern,

This is regards to my support of Senate Bill: Relating to Prescriptive Authority for Certain Psychologists.

Here in Hawaii we strive to provide accessible health care and the delivery of care to many of Hawaii's underserved population. We acknowledge that in Hawaii we do have a shortage of health care providers. Within the "medical field" we have come to accept nurse practitioners as fully independent practitioners and the use of physician assistants as extenders of medical care. Physician assistants have prescriptive authority based on their training and scope of work.

However, we still have not acknowledged that we do have a shortage of health care providers with prescriptive authority within the "psychiatric field". We do need to have psychiatric extenders: i.e., psychologists to have prescriptive authority based on their training and scope of work. Many of the underserved population are homeless and suffer from mental illnesses. With the lack of funding in the 1980's for institutionalized care and the change in reimbursements, many of those patients with mental illnesses were discharged to the streets. During that change in funding, social workers in the hospital would recommend continued hospitalization because of "unsafe discharge." However, because the hospitals could not afford to keep those patient who were homeless (and with mental illnesses) discharge from the hospital was then seen as appropriate since it will be a "discharge to previous living situation." IE: Homeless.

We have programs in the "medical field" to initiate HIV treatment on a same day basis if a patient is thought to have been exposed to HIV: Post exposure Prophylaxis and / or if found to be HIV positive that day with a rapid (same day) test for HIV. We also initiate patients on pre exposure prophylaxis: PrEP: treatment on the same day if they are in a "high exposure" group and their rapid (same day) HIV test is negative. We do this to prevent the spread of HIV since studies have shown that there is a lack of follow up / taking medications and the risk of spreading HIV if there is a delay between diagnosis and the initiation of treatment. Previously newly diagnosed HIV patients would have to be notified then scheduled with a "medical provider" in order to initiate treatment.

For those with mental illnesses, it may take longer than 3- 4 months in order to obtain an appointment with a psychiatrist just to be initially seen. Many of the vulnerable homeless population with mental illnesses are not able to see a psychiatrist since they are on QUEST. Many patients on QUEST who need psychiatric care are given a list of participating providers by their insurance company and told that they: the patient: will need to call the psychiatrist on their own to locate a psychiatrist who will accept them as a patient. This is the same vulnerable population that have no access to cell phones.

For these reasons, I do ask that Senate Bill: be passed to allow Prescriptive Authority for Certain Psychologists based on training and scope of work.

Hiram Young MD

Hiram Young MD

SB-819-SD-1
Submitted on: 2/24/2019 3:32:04 PM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Naomi Bikle	Individual	Oppose	No

Comments:

To: Chair Rhoads and members of the Senate Committee on Judiciary, and Chair Dela Cruz and members of the Senate Committee on Ways and Means

RE: SB819 SD1

POSITION: OPPOSED

“For fools rush in where angels fear to tread.” ~Alexander Pope, 1711. This alludes to inexperienced or rash people attempting things that more experienced people avoid. Prescribing psychologists will put patients in danger. The culture of medical education emphasizes our power to harm as well as to heal, and part of our oath is “do no harm.”

Prescribing psychiatric medicines looks easy, but it’s not. You can die from a rash from a mood stabilizer, or from a shot of pain medicine if you are also taking an antidepressant. New side effects and drug interactions are discovered every day. To prescribe psychiatric medications, you need medical education.

Data from CMS/Medicare reveal that psychologists prescribing in other states are prescribing medications that are not commonly prescribed by psychiatrists (antibiotics, blood thinners, anti-HIV, diabetes and high blood pressure medications). This is not safe! These medications’ risks and complications require management from internists or other specialists.

I work closely with primary care providers, psychologists, and social workers at West Hawaii Community Health Center through the Collaborative Care Model, use of which is steadily increasing. The psychologists are an integral part of the team, but best serve patients within their scope of expertise – diagnostic assessments and psychotherapy interventions. They have significantly limited clinical experience with medications compared to MDs, DOs, and, to an extent, Physician Assistants and Advanced Practice Registered Nurses with prescriptive authority. Psychiatric patients deserve to receive the same quality healthcare as others.

We have a shortage of primary care physicians who prescribe most psychotropic drugs, so increasing the number of primary care physicians with support through

telepsychiatry, collaborative care and/or Project ECHO would increase patients' access to psychiatric medications.

The bill talks about “collaborative” practice, but it is not “collaborative;” it is independent practice.

What I think would help is funding state mental health services so that they could successfully recruit more psychiatrists, expanding the diagnoses covered by state mental health, which has been cut back over the years, as well as increase funding and insurance reimbursements to further develop and promote evidence based models such as collaborative care.

Thank you for your consideration of my testimony.

Naomi Bikle, MD | psychiatrist

Kailua Kona, HI

SB-819-SD-1
Submitted on: 2/24/2019 4:17:12 PM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Sunita	Individual	Oppose	No

Comments:

Please do not give poorly trained nurse practitioners/ psychologists independent practice rights. I have seen life threatening mismanagement by some NPs. I don't want people to die. As a physician who spent THOUSANDS of hours in training, I fear the damage wrought by NPs who go to an online school and shadow for a few hundred hours. I didn't spend nights, weekends, being on call every 4th night, and years of my life learning medicine to be fine with undertrained nurses trying to do what I do. It's a travesty that will hurt patients. I don't want to clean up their messes when the patients make their way to me. I would prefer the mess isn't made in the first place, because these are human lives in the balance. Do not allow this to happen.

SB-819-SD-1
Submitted on: 2/24/2019 7:01:42 PM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
naz	Individual	Oppose	No

Comments:

It is a travesty that you want to allow a non physician to prescribe any medicine. Medicines can be dangerous. Psychologists are no more qualified to prescribe medications then the patients themselves! This is not access to care this is access to harm! Vote NO!

SB-819-SD-1
Submitted on: 2/24/2019 11:26:51 PM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Christopher Knightsbridge	Individual	Support	No

Comments:

The mental health crisis in Hawaii. impacts every facet of our society and if you are against this bill but are unable to fully explain why, please be open to reaching out for information or abstaining as there truly are too many lives at risk.

Hawaii has an estimated 11.35 psychiatrists for every 100,000 of our people. Approximately 2 percent of the population lives with schizophrenia disorder, which also happens to be one of the severe mental illnesses that is most respondent to medication and psychotherapy when combined.

Hawaii is currently home to the nations largest population of homeless individuals. According to one of the most extensive surveys on homelessness taken, in 2015,

"It found 564,708 people were homeless on a given night in the United States. Depending on the age group in question, and how homelessness is defined, **the consensus estimate as of 2014 was that, at a minimum, 25 percent of the American homeless**—140,000 individuals—**were *seriously* mentally ill** at any given point in time."

"Forty-five percent of the homeless—250,000 individuals—had *any* mental illness. More would be labeled homeless if these were annual counts rather than point-in-time counts."

Give psychologists the opportunity to undergo the advanced training, licensure, and Masters degree in Psychopharmacology and you will have given our state another weapon to fight our mental health crisis.

Thank you,

Chris

SB-819-SD-1
Submitted on: 2/25/2019 8:57:38 AM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Leanne Fox	Individual	Support	No

Comments:

Our communities are suffering because of the lack of access to comprehensive mental health care. Some of our most vulnerable citizens are unable to obtain the care needed to live healthy and functional lives. Often times, this leads to serious consequences such as drug overdose, suicide, and homelessness. The homelessness issue is a concern on every island and Psychologists are ready and willing to help. We already provide more access to care to Medicaid and Medicare patients than other prescribing mental health professionals, and are part of the coalition to address homelessness, and provide care alongside of our colleagues and community partners.

Prescriptive Authority for advanced practice Psychologists is a safe and already utilized option in five other states, in Federally Qualified Health Centers, on Indian Reservations and in the military. More and more, prescriptive authority is being authorized by states for specially trained advance practice psychologists to use as a tool in providing comprehensive, and integrative mental health care.

SB819 SD1 will provide the foundation to explore the suitability of Prescriptive Authority for advanced practice Psychologists to be able to support psychotherapy with psychopharmacological support, and I am in full support of this effort.

Prescribing Psychologists have been successfully prescribing since the 1990s in the US military, the Public Health service, the Indian Health Service, Louisiana, New Mexico, Guam, and most recently have the opportunity to do so in Illinois, Iowa, and Idaho.

Please vote YES on SB819 SD1 to allow greater access to care for those most in need.

SB-819-SD-1
Submitted on: 2/25/2019 9:39:09 AM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Simrun Kalra	Individual	Oppose	No

Comments:

There is a reason why medical school and 4 years of residency is required

LATE

SB-819-SD-1
Submitted on: 2/25/2019 10:20:10 AM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
rika suzuki	Individual	Oppose	No

Comments:

RIKA SUZUKI M.D.

TO: Chair Rhoads and members of the Senate Committee on Judiciary and Chair Dela Cruz and members of the Senate Committee on Ways and Means

DATE: February 25, 2019

HB 3105 RELATING TO PSYCHOLOGISTS PRESCRIBING

POSITION: **OPPOSE**

My testimony is submitted in opposition to **SB819SD1** relating to psychologists prescribing.

I am opposed to this measure because the needs of medically underserved populations must be met as safely, consistently, and responsibly as any other population. The patient populations of the medically underserved are particularly vulnerable. Access to mental health care does not equate to the need for medications. Increasing the number of prescribers is not the solution to improving access. Even suicidal patients are not always in need of medications but rather intensive supportive counseling and psychosocial supports and interventions, and triage. The triage process to identify

danger and acuity, and immediate needs can be carried out by a variety of mental health professionals.

In treating the underserved populations with medications, however, especially the young, the old and the sick, it is even more imperative that comprehensive medical training of brain and organ systems take place before safely identifying those patients who may benefit from medications. In prescribing, the medical model must be adhered to, as in any other treatment population. To expedite services to underserved populations, we are now actively exploring and putting to use integrative and collaborative care models between primary care providers and mental health providers. This kind of collaboration improves the efficiency of delivery of care, increases the numbers serviced, and decreases the time to access care.

Please help protect and advocate for the welfare of our underserved populations by your consideration to HOLD **SB819SD1** in committee.

Thank you,

Rika Suzuki M.D., Adult and Geriatric Psychiatry

From: juliaf1979@gmail.com
To: JDCTestimony
Subject: Testimony in SUPPORT of SB819 SD1
Date: Monday, February 25, 2019 1:28:44 PM

Julia Fox
2457 Auhuhu St
Pearl City, HI 96782-1044

February 25, 2019

Karl Rhoads
Chair, Senate Committee on Judiciary

Dear Senator Rhoads:

SENATE
THE THIRTIETH LEGISLATURE
REGULAR SESSION OF 2019

COMMITTEE ON JUDICIARY
Senator Karl Rhoads, Chair
Senator Glenn Wakai, Vice Chair

COMMITTEE ON WAYS AND MEANS
Senator Donovan M. Dela Cruz, Chair
Senator Gilbert S.C. Keith-Agaran, Vice Chair

HEARING: TUESDAY, FEBRUARY 26, 2019, 10:00 AM, ROOM 211

Testimony in SUPPORT of SB819 SD1
RELATING TO PRESCRIPTIVE AUTHORITY FOR CERTAIN CLINICAL PSYCHOLOGISTS

Our communities are suffering because of the lack of access to comprehensive mental health care. Some of our most vulnerable citizens are unable to obtain the care needed to live healthy and functional lives. Often times, this leads to serious consequences such as drug overdose, suicide, and homelessness. The homelessness issue is a concern on every island and Psychologists are ready and willing to help. We already provide more access to care to Medicaid and Medicare patients than other prescribing mental health professionals, and are part of the coalition to address homelessness, and provide care alongside of our colleagues and community partners.

Prescriptive Authority for advanced practice Psychologists is a safe and already utilized option in five other states, in Federally Qualified Health Centers, on Indian Reservations and in the military. More and more, prescriptive authority is being authorized by states for specially trained advance practice psychologists to use as a tool in providing comprehensive, and integrative mental health care.

SB819 SD1 will provide the foundation to explore the suitability of

Prescriptive Authority for advanced practice Psychologists to be able to support psychotherapy with psychopharmacological support, and I am in full support of this effort.

Prescribing Psychologists have been successfully prescribing since the 1990s in the US military, the Public Health service, the Indian Health Service, Louisiana, New Mexico, Guam, and most recently have the opportunity to do so in Illinois, Iowa, and Idaho.

Please vote YES on SB819 SD1 to allow greater access to care for those most in need.

Sincerely,

Julia Fox

On Time Testimony	Late Testimony
1. Priscilla Roth-Wall, Ph.D.	1. Gerardo Rodriguez-Menendez
2. Nancy Sidun	2. Joseph Comaty
3. Charles Lepkowsky	3. Ivan Gonzalez
4. Victoria Liou-Johnson	4. Marlin Hoover
5. Jean Adair-Leland	5. Casey McDougall
6. Marie Terry-Bivens	6. Thomas Thompson
7. Robin Miyamoto	7. Steve Curtis
8. Bracken Gott	8. Katrina Obleada
9. Eric Larsen	9. Judi Steinman
10. Ivan Irie	10. Marla Sanzone
11. William Trushima	11. Edward Korber
12. Judith White	12. Lesley A. Slavin
13. Christina Uemura	13. Lyle Herman
14. Greta Kugler	
15. Annie Nguyen	
16. Richard Kim	
17. June W J Ching PhD	
18. Darin Arsenault	
19. Bradley McConnell	
20. Lucas Morgan	
21. Anthony Arellano	
22. Judith Rocap	
23. Debra Yamashita	
24. Tanecia Blue	
25. Kaili Taylor	
26. Linda Hufano	
27. Nozanin Yusufbekova	
28. Kathleen McNamara	
29. William Hicks	
30. Sean Scanlan	
31. Marian Miller	

LATE

SB-819-SD-1
Submitted on: 2/25/2019 12:44:24 PM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Roman Acierto	Individual	Oppose	No

Comments:

LATE

SB-819-SD-1
Submitted on: 2/25/2019 2:22:33 PM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
Steve Ward	Individual	Support	No

Comments:

Aloha,

I am a 35 plus year resident of the Big Island, and I support the bill.

Our communities are suffering because of the lack of access to comprehensive mental health care. Some of our most vulnerable citizens are unable to obtain the care needed to live healthy and functional lives. Often times, this leads to serious consequences such as drug overdose, suicide, and homelessness. The homelessness issue is a concern on every island and Psychologists are ready and willing to help. We already provide more access to care to Medicaid and Medicare patients than other prescribing mental health professionals, and are part of the coalition to address homelessness, and provide care alongside of our colleagues and community partners.

Prescriptive Authority for advanced practice Psychologists is a safe and already utilized option in five other states, in Federally Qualified Health Centers, on Indian Reservations and in the military. More and more, prescriptive authority is being authorized by states for specially trained advance practice psychologists to use as a tool in providing comprehensive, and integrative mental health care.

SB819 SD1 will provide the foundation to explore the suitability of Prescriptive Authority for advanced practice Psychologists to be able to support psychotherapy with psychopharmacological support, and I am in full support of this effort.

Prescribing Psychologists have been successfully prescribing since the 1990s in the US military, the Public Health service, the Indian Health Service, Louisiana, New Mexico, Guam, and most recently have the opportunity to do so in Illinois, Iowa, and Idaho.

Please vote YES on SB819 SD1 to allow greater access to care for those most in need.

With aloha,

Steven Ward

From: lucas.morgan@gmail.com
To: JDCTestimony
Subject: Testimony in SUPPORT of SB819 SD1
Date: Sunday, February 24, 2019 1:08:30 AM

Lucas Morgan
609 Kumukahi Pl.
Honolulu, HI 96825-1116

February 24, 2019

Karl Rhoads
Chair, Senate Committee on Judiciary

Dear Senator Rhoads:

SENATE
THE THIRTIETH LEGISLATURE
REGULAR SESSION OF 2019

COMMITTEE ON JUDICIARY
Senator Karl Rhoads, Chair
Senator Glenn Wakai, Vice Chair

COMMITTEE ON WAYS AND MEANS
Senator Donovan M. Dela Cruz, Chair
Senator Gilbert S.C. Keith-Agaran, Vice Chair

HEARING: TUESDAY, FEBRUARY 26, 2019, 10:00 AM, ROOM 211

Testimony in SUPPORT of SB819 SD1
RELATING TO PRESCRIPTIVE AUTHORITY FOR CERTAIN CLINICAL PSYCHOLOGISTS

Our communities are suffering because of the lack of access to comprehensive mental health care. Some of our most vulnerable citizens are unable to obtain the care needed to live healthy and functional lives. Often times, this leads to serious consequences such as drug overdose, suicide, and homelessness. The homelessness issue is a concern on every island and Psychologists are ready and willing to help. We already provide more access to care to Medicaid and Medicare patients than other prescribing mental health professionals, and are part of the coalition to address homelessness, and provide care alongside of our colleagues and community partners.

Prescriptive Authority for advanced practice Psychologists is a safe and already utilized option in five other states, in Federally Qualified Health Centers, on Indian Reservations and in the military. More and more, prescriptive authority is being authorized by states for specially trained advance practice psychologists to use as a tool in providing comprehensive, and integrative mental health care.

SB819 SD1 will provide the foundation to explore the suitability of

Prescriptive Authority for advanced practice Psychologists to be able to support psychotherapy with psychopharmacological support, and I am in full support of this effort.

Prescribing Psychologists have been successfully prescribing since the 1990s in the US military, the Public Health service, the Indian Health Service, Louisiana, New Mexico, Guam, and most recently have the opportunity to do so in Illinois, Iowa, and Idaho.

Please vote YES on SB819 SD1 to allow greater access to care for those most in need.

Sincerely,

Lucas Morgan
8082822564

SB-819-SD-1
Submitted on: 2/26/2019 5:53:37 AM
Testimony for JDC on 2/26/2019 10:00:00 AM

LATE

Submitted By	Organization	Testifier Position	Present at Hearing
David Shearer, PhD	Individual	Support	No

Comments:

THE SENATE

THE THIRTIETH LEGISLATURE

REGULAR SESSION OF 2019

To: COMMITTEE ON WAYS AND MEANS/COMMITTEE ON JUDICIARY

SEN KARL RHOADS

SEN GLENN WAKAI

SEN DONOVAN M. DELA CRUZ

SEN GILBERT S.C. KEITH-AGARAN

HEARING: Tuesday, February 26, 2019 at 10:00am, Conference Room 211

RE: Testimony in **SUPPORT** of SB819 SD1: RELATING TO PRESCRIPTIVE AUTHORITY FOR CERTAIN CLINICAL PSYCHOLOGISTS.

I am writing to you as a prescribing and clinical psychologist who works in a federally qualified health center in Washington State. I have worked collaboratively for almost 10 years with primary care physicians, nurse practitioners, psychiatrists, and physician's assistants in behavior health and primary care medical settings as a prescribing

psychologist. It has been my personal and professional experience that the demand for mental health professionals who can appropriately prescribe psychotropic medications far exceeds the capabilities of the existing mental health care system. Providing prescriptive authority to psychologists, who elect to complete extensive additional training and clinical work, in addition to the traditional doctoral degree, internships, and fellowships, will provide a meaningful answer to this problem. I can personally attest to the safety and efficacy of enlisting prescribing psychologists to expand behavioral health care to underserved and deserving patients.

Prescriptive Authority for specially trained advanced practice Psychologists is not only safe, but is already utilized option in five other states, in Federally Qualified Health Centers, on Indian Reservations and in the military. More and more, prescriptive authority is being authorized by states for specially trained advance practice psychologists to use as a tool in providing comprehensive, and integrative mental health care.

Prescribing Medical psychologists have been successfully prescribing since the 1990s in the US military, the Public Health service, the Indian Health Service, Louisiana, New Mexico, Guam, and most recently have the opportunity to do so in Illinois, Iowa, and Idaho.

Please vote **YES** on SB819 SD1 to allow greater access to care for those most in need.

Respectfully submitted,

David Shearer, PhD, MS

Prescribing and Clinical Psychologist

3714 30th Ave Ct NW

Gig Harbor, WA 98335

253.365.1595

LATE

SB-819-SD-1
Submitted on: 2/26/2019 6:05:05 AM
Testimony for JDC on 2/26/2019 10:00:00 AM

Submitted By	Organization	Testifier Position	Present at Hearing
R Kona	Individual	Oppose	No

Comments:

Psychologists do not have ANY comprehensive medical training and allowing them to prescribe psychiatric medications, many of which are DEA controlled substances due to potential for abuse and misuse places patients and the profession of psychology/psychiatry at greater risk. Psychopharmacology is a specialized skillset, partly due to the significant medication interactions and consideration of non-psychiatric disease/illness that is often co-morbid and complicates treatment plans. Psychologists don't have the inpatient/outpatient expertise needed to successfully manage complex medical patients who have psychiatric needs without placing everyone in danger. Thank you.