2009 HOUSE HUMAN SERVICES

HB 1488

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1488

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 27, 2009

Recorder Job Number: 7849

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz called the hearing to order on HB 1488.

Rep. Nancy Johnson from District 37 sponsored and introduced the bill: Testified in support. **See Testimony #1.**

Chairman Weisz: Are you aware of any psychologist in this state would qualify now?

Rep. Johnson: Don't know of any, but maybe someone else does.

Rep. Frantsvog: When you described the points of legislation, Section 7 you talked about kinds of drugs prescribed. Is there a specific list?

Rep. Johnson: I don't know the medication list.

Rep. Conrad, sponsor of bill: Testified in support. Talked about personal experience with son and his depression problem.

Dr. Michael Tilus: testified as a non-partisan citizen: **See Testimony #2.**

Chairman Weisz: Is there currently a medical psychologist practicing in (inaudible)?

Dr. Michael Tilus: I know there are 6 in the state that have completed all the academic requirements like myself.

Rep. Holman: Are there any ramifications for insurance coverage or (inaudible) coverage, or Medicare?

Dr. Michael Tilus: I think there will be. In New Mexico history is that BC/BS had to be nugged along to do payment.

Brenda King PhD, clinical psychologist in private practice: Testified in support. This bill has the potential to do good in ND. We have more patients and not all getting care. We can determine if medication would be appropriate for patient and their specific problem.

OPPOSITION.

Bruce Levi, representing both ND Psychiatric Society and Medical Association:

Testified in opposition. **See Testimony #3.**

Dr. Andrew McLean, clinical professor of Neuroscience and psychiatrist:

Testified in opposition: **See Testimony #4.**

Rep. Potter: With psychiatric issues, you discussed type of drugs used for these issues. Does family practitioner prescribe those?

Dr. McLean: Correct.

Rep. Potter: With prescriptive powers of general practice physician, with education background of prescriptive drugs, is it greater than the psychologists be having?

Dr. McLean: They are allowed to prescribe the same medications. Some family practitioners are comfortable and some are not doing that.

Rep. Potter: For psychologist and general practitioners would their hours comparable then.

Dr. McLean: Yes. Primary care does not have the same background in mental health diagnosis that psychology does.

Dr. Kevin Dahmen, child psychiatrist: Testified in opposition. It is a matter of training. There are very few medications that don't interact with other medications. My concern is that psychologist won't know this. There are many psychiatrists to cover this state.

Rep. Holman: If a youth meets with a psychologist and it is determined they have some form of depression. How do you work together with the psychologist if the patient needs meds?

Dr. Dahmen: We try to go no medication route with children. I would work with pediatrician.

Paul Kolstoe PhD, ND Clinical Psychologist and President of ND Psychological Association: Testified in opposition. **See Testimony #5.**

Dr. Alan Fehr, Clinical Psychologist and President of ND State Board of Psychologist Examiners: Handed in written testimony in support of bill. See Testimony #6.

Chairman Weisz closed the hearing.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1488

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 11, 2009

Recorder Job Number: 9271

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Let's take up HB 1488.

Rep. Porter: We are looking at this, if we are having problems with access. Would like to hear from both sides about access to patient care.

Kevin (Inaudible) from psychiatric society: We all agree that access is the major issue. Our standpoint is is that from a patient's safety, it would be best to come from the medical community side. There are number of mid level prescribers who are well versed in mental health issues. Medical community is committed to work on the access issue from both psychiatry from consultation to primary care providers.

Rep. Conrad: (Inaudible) practicing right now, where are you (inaudible) telepsychiatry.

Kevin (?): Telepsychiatry is actually being done all over the state.

Rep. Conrad: What is your (inaudible) to increase the (inaudible).

Kevin (?): I personally have a meeting with (inaudible) world health this month to work on that.

Kevin Dahmen, child psychiatrist: In the Dickinson area, we are doing telepsychiatry. The key difference between the other program and ours is the medical basis of it. In need to have someone who is medically trained to do this. One hundred and forty hours cannot possible absorb all that it takes years to do. What helped out our program dramatically was, they had

more therapists there and transport was provided. They'd get patient from house to clinic and back again.

Rep. Conrad: We need to know how we will address this throughout the state.

Kevin Dahmen: There are people to provide services.

Rep. Potter: Describe how that works? Like it clarified.

Kevin Dahmen: It is a very high speed system. A TV screen and sound system and we could see and hear each other. Nurse or social worker would be in the background too. We can do this through the Williston Hospital.

Chairman Weisz: A clinical nurse could prescribe (inaudible) can a psychologist do that?

Kevin Dahmen: We are asking (clinical nurse) to treat them medically.

Rep. Potter: The nurse that would be working with you is she a nurse practitioner?

Kevin Dahmen: They go by different titles.

Rep. Potter: A nurse specialist is a particular type of nurse practitioner?

Kevin Dahmen: Nurse practitioner is a general term like they would have the general knowledge of general practice physician. Know a little bit about everything. Specialists, there area of specialty is specifically in that area.

Rep. Potter: The training that this clinical nurse specialist, how is it significantly better than a psychologist?

Kevin Dahmen: The nurses come from a medical arena and have the medical knowledge versus 4-9 years in psychology. In 450 hours we try to make them a doctor?

Rep. Conklin: The way you make it sound is that psychologists don't have any training in (inaudible) people.

Kevin Dahmen: They are highly trained as far as therapy. That is different from treating patient medically.

Rep. Holman: How does the 450 hours of specialized training compare to other medical specialties as far as the year or two years. The 450 would be about a year.

Kevin Dahmen: Say I don't want to be a psychiatrist anymore and I want to be a surgeon. I would have to go back to training for 5 years.

Rep. Holman: If you were already a medical doctor and wanted to specialize in the field of psychiatry, how does that compare.

Kevin Dahmen: It's variable, but it's less than 3 years.

Rep. Conrad: How many hours does a nurse practitioner have to take to do mental health and psychological evaluations.

Kevin Dahmen: Two year training process.

Rep. Porter: Motion for a DO NOT PASS.

Rep. Potter: Second.

Rep. Porter: This idea had merit access across ND. Specialties and subspecialties are always going to be issues. Profession has responded by using the technologies of today with telemedicine and mid level practitioners to make sure that there is enough access out there. The association from the psychologists are neutral on this issue.

Rep. Potter: Two concerns. With information I handed out it goes to 2007. Are some states working on this type of legislation and I want to know where they are going. Talked to psychologist in Grand Forks and she is concerned about this legislation. Felt more comfortable working under physician. Maybe we can work in that direction down the line.

Rep. Conklin: I think we should pass this. Need to give western ND help.

Rep. Frantsvog: The bill seems to answer the response to a problem. But, I think before we get involved in this, the medical field and the psychologist should get together and come up with a plan themselves that they can present unified to us.

Rep. Conrad: This area is the first time to come in front of legislation. I think that doctors should give some respect to the psychologists when it comes to evaluations and kind of information they can give.

Roll Call for a DO NOT PASS: 6 yes, 7 no, 0 absent.

MOTION FAILED.

Rep. Conrad: Motion for a DO PASS.

Rep. Conklin: Second.

Roll Call Vote for a DO PASS: 7 yes, 6 no, 0 absent.

MOTION CARRIED ON A DO PASS.

BILL CARRIER: Rep. Holman.

Date: 2-11-09

Roll Call Vote #: 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1488

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☐ Do Pass ☒ Do Not Pass ☐ Amended

Motion Made By Rep. Porter Seconded By Rep. Potter

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	✓		REP. TOM CONKLIN		✓
VICE-CHAIR VONNIE PIETSCH		✓	REP. KARI L CONRAD		✓
REP. CHUCK DAMSCHEN		✓	REP. RICHARD HOLMAN		✓
REP. ROBERT FRANTSVOG	✓		REP. ROBERT KILICHOWSKI	✓	
REP. CURT HOFSTAD		✓	REP. LOUISE POTTER	✓	
REP. MICHAEL R. NATHE	✓				
REP. TODD PORTER	✓				
REP. GERRY UGLEM		✓			

Total (Yes) 6 No 7

Absent 0

Bill Carrier _____

If the vote is on an amendment, briefly indicate intent:

failed

Date: 2-11-09

Roll Call Vote #: 2

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1488

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. Conrad Seconded By Rep. Conklin

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ		✓	REP. TOM CONKLIN	✓	
VICE-CHAIR VONNIE PIETSCH	✓		REP. KARI L CONRAD	✓	
REP. CHUCK DAMSCHEN	✓		REP. RICHARD HOLMAN	✓	
REP. ROBERT FRANTSVOG		✓	REP. ROBERT KILICHOWSKI		✓
REP. CURT HOFSTAD	✓		REP. LOUISE POTTER		✓
REP. MICHAEL R. NATHE		✓			
REP. TODD PORTER		✓			
REP. GERRY UGLEM	✓				

Total (Yes) 7 No 6

Absent 0

Bill Carrier Rep. Holman

If the vote is on an amendment, briefly indicate intent:

Motion carried on DO PASS

REPORT OF STANDING COMMITTEE

HB 1488: Human Services Committee (Rep. Weisz, Chairman) recommends **DO PASS** (7 YEAS, 6 NAYS, 0 ABSENT AND NOT VOTING). HB 1488 was placed on the Eleventh order on the calendar.

2009 TESTIMONY

HB 1488

#1

Testimony in Support of HB 1488
House Human Services Committee
January 27, 2009
Representative Nancy Johnson

Good morning Chairman Weisz and members of the House Human Services Committee.
For the record my name is Nancy Johnson. I'm a state representative from District #37 – Dickinson.

In a nutshell, HB 1488 would allow doctoral-level psychologists with advanced training and certification to prescribe psychotropic drugs for their patients. These individuals would be called Medical Psychologists.

First, three definitions; we all know what a medical doctor is. That individual has a license to practice medicine. A psychiatrist has a medical degree plus education in the treating of mental diseases. A psychologist has a degree in the science of the mind and mental states and processes but does not have a medical degree.

I have to admit that when I first heard about medical (or prescribing) psychologists I didn't understand what it meant and was a bit skeptical. But as I have done research I have become convinced that this is a viable and positive option for providing mental health services to citizens in our state, particularly in the rural areas.

I have included several letters sent to me from medical doctors, prescribing psychologists and educators of prescribing psychologists. I sincerely hope you take the time to read them. There is a lot of good information in them.

There is a nationwide shortage of psychiatrists, and a critical shortage in North Dakota. In the letter from Dr. Robert McGrath, and I quote, "On average, there are less than 4 psychiatrists per 100,000 residents in rural parts of the country, versus an average of 15 psychologists (Hartley, Bird, & Dempsey, 1999). The shortage of psychiatric care means that about 3/4 of people with mental disorders are treated by non-psychiatric physicians (Pincus et al., 1998). Most non-psychiatric physicians have had no more than 6 weeks of formal training in the study of diagnosing and treating mental disorders. They are poorly equipped to diagnose mental disorders, and have little or no training in treatment alternatives to medication. As a

result, they rely heavily on multiple medications when one medication fails, even though there is little evidence that combining medications works for mental disorders. If ¾ of cardiac or cancer patients were being treated by family physicians and pediatricians, it would be called a healthcare crisis, and the country would mobilize to rectify the problem. The fact that this state of affairs is allowed to continue is simply a travesty."

Because of our citizens' inability to have access to mental health workers, they are receiving sub-standard care. Psychologists are already trained and licensed to diagnose and treat mental illnesses, and a group of them has completed post-licensure training to prescribe. I just recently learned that there are 10 North Dakota and South Dakota psychologists working for Indian Health Services who have started the training this month. Without this legislation they would be restricted to providing this service through Indian Health Services only.

Psychologists have been safely prescribing for the past **15 years without even one negative complaint**. Active duty psychologists are prescribing in the military. Civilian trained prescribing psychologists work at military installations and in the public health service.

I'd like to share some comments from the letter sent by Dr. Mario Marquez, a prescribing psychologist in New Mexico. His third point is especially important. I quote, "The right to prescribe is also the right not to prescribe." He continues to comment that he takes individuals off drugs too. How much better it must be to work with an individual who has mental issues when they are able to discuss their difficulties rather than being in a medicated fog.

You may hear from the medical community that prescribing psychologists are not medically trained and would do harm to their patients. I've highlighted a portion of Dr. Marquez's reply to that. "Opponents of prescriptive authority for psychologists will argue that we are not properly trained - quite the contrary. The fact is psychologists have more training than any of the other behavioral health care providers who specialize in mental disorders. Only doctoral level North Dakota licensed psychologists who undergo rigorous post-doctoral training in psychopharmacology will be allowed to apply for prescriptive authority. The post-doctoral training generally consists of an additional masters degree specifically in psychopharmacology with approximately 450 academic hours in

psychopharmacology, and 400 hours clinical practice in psychopharmacology under the supervision of a physician. The post-doctoral training usually takes an additional 2-3 years of study, for a total of approximately 12-13 years of post secondary education, 7-8 years at the graduate level. In addition, a comprehensive national licensing examination must be approved by the Psychology Board, and must be passed before prescriptive authority will be granted. Once certified to prescribe, prescriptions written by psychologists will occur in collaboration with the patients' primary care health provider."

HB 1488 is not a mandate on any psychologist. It is an option for those who wish to invest their own dollars, time and energy into the advanced training. Currently, New Mexico and Louisiana have laws similar to this. The Department of Defense allows it.

In my testimony I've included a letter addressed to California Senator Sheila Kuehl from Dr. David Kipper. He sent the letter to me and gave me his permission to share it. Dr. Kipper is an internist. And again I quote "As an internist, I have the responsibility of treating a variety of conditions. To ignore the psychological impact of any disease on a patient's care is naïve. None of us are immune to mental health disorders. No family escapes from depression, anxiety, insomnia, or addiction. It is therefore imperative that practitioners address these issues while treating heart disease, cancer, diabetes, or any chronic illness. Significant data exists to support the detrimental impact of these psychological factors on all diseases. In order for me to address the medical conditions that come into my office I am required to acknowledge this relationship. And here is the obvious problem that this bill will address. For me to optimize the care I can provide I must take the time to deal with these issues. In any busy practice this is almost impossible. I must therefore rely on professionals that treat the psychological problems that contribute to the illness. In our current health care system there are not enough of these professionals to provide this care. Psychiatrists are a limited resource. When they are available, they are usually out of reach for the average patient due to financial limitations or time constraints. I must therefore look beyond to trained professionals that understand and treat the psychological components of the illness I see in my office." And further on, "The amount of hours and training is more than any general medical doctor ever receives and the success of the program in other states validates the threshold of these requirements. It is ludicrous to assume that most doctors can provide this level of care without this support."...

"Less than one percent of all physicians in the United States treat addiction and only ten percent of all medical schools offer training in addiction. Yet addiction is the most prevalent health care crisis we have in this country."

Committee members, that has been some background on this bill. Now I'd like to walk you through the legislation.

Section 1 is in the motor vehicle Chapter and allows the director to use information from a medical psychologist in regard to the issuance, renewal, suspension, revocation or cancellation of driver's licenses. This section was included by Legislative Council.

Section 2 is in the Pharmacist's Chapter and allows medical psychologists to do injections.

Section 3 is again in the Pharmacist's Chapter on record keeping. It changes persons to individual. A person can refer to on organization or business. It also changes physician to "prescriber" to include other individuals who may prescribe that are not medical doctors.

Section 4 does the same as section 3.

Section 5 is in the Psychologist's Chapter on licensure again stating who may and who may not prescribe drugs.

Section 6 allows for the exemption for Medical Psychologists and reiterates that a psychologist may not administer or prescribe drugs.

Section 7 is a new Chapter and is the meat of the bill. The beginning section gives definitions. "Medical psychologist" is the name Legislative Council has given for prescribing psychologists. I'd like to point out number 6: "Medicine has the same meaning...**to the extent the medicine is customarily used in or related to the diagnosis or treatment of a mental, behavioral, cognitive, or emotional disorder."** In number 8 – Prescriptive authority- that language is also used. I want to make it clear that not all medications and drugs are included. Medical psychologists do not intend to treat cancer, heart disease or diabetes. The drugs they would be permitted to prescribe relate to mental illnesses only!

Section 8 identifies that the North Dakota state Board of Psychologist Examiners would issue the certificates; develop and implement the procedures that individual would have to meet, including the qualifications set forth in the legislation; the prescribing practices requirements; controlled records requirements; and the powers and duties the board has to oversee Medical Psychologists.

In your packets you will also find a letter from Steven Tulkin. Dr. Tulkin is the Director of the Postdoctoral Master of Science Program in Clinical Psychopharmacology at the California School of Professional Psychology at Alliant International University. He sent me a letter explaining their program and accreditation. On the second page he states that he has been working with interested psychologists in our state and has "been in contact with Ms. Debra Huber from the North Dakota Department of Career and Technical Education" (the North Dakota University System). "She indicated that there is no problem with Alliant International University offering this program immediately to North Dakota psychologists."

With his letter I've included information about this program.

Mr. Chairman and committee members, do I think this will answer all the mental health needs in our state? No, but I think it is one component of the picture that can be of great benefit. New psychologists in school currently may continue with their education to become Medical Psychologists.

You will probably hear some opposition, but please remember that medical psychologists have been prescribing in 2 other state and through the Department of Defense for several years without any problems. Change is difficult and we all have a tendency to protect our turf. But please have an open mind to the possibility of providing better mental health services to all regions of our state. I urge you to give HB 1488 a strong Do Pass recommendation.

Fairleigh Dickinson University

School of Psychology
Teaneck-Hackensack Campus

Florham-Madison, NJ • Teaneck-Hackensack, NJ • Vancouver, BC • Wroxton, EN

Dear Representative Johnson,

I am writing you in support of House Bill 1488. I am a former president of Division 55 (American Society for the Advancement of Pharmacotherapy) of the American Psychological Association. Division 55 is dedicated to supporting efforts by psychologists around the country to seek legislative authority for psychologists to prescribe medications appropriate to the practice of psychology. I am also Training Director of the Master of Science Program in Clinical Psychopharmacology at Fairleigh Dickinson University, Teaneck NJ. Ours is one of five master's programs in the country preparing licensed psychologists in the use of medications. It is also a distance-based program, allowing psychologists in isolated settings such as apply to many areas of your state to complete their training in preparation to prescribe.

At one time I was not a supporter of prescriptive authority for psychologists. Over time, though, I have come to believe it is in the best interests of the patients we serve that psychologists receive prescriptive authority. In this letter I will outline why I now believe this to be the case.

There are two conditions that must be met before it would be justified awarding psychologists prescriptive authority. The first is that doing so will enhance the treatment of patients with mental disorders. The second is that doing so will not threaten patient safety. Regarding the first point, the mental health system in this country is in crisis. On average, there are less than 4 psychiatrists per 100,000 residents in rural parts of the country, versus an average of 15 psychologists (Hartley, Bird, & Dempsey, 1999). The shortage of psychiatric care means that about 3/4 of people with mental disorders are treated by non-psychiatric physicians (Pincus et al., 1998). Most non-psychiatric physicians have had no more than 6 weeks of formal training in the study of diagnosing and treating mental disorders. They are poorly equipped to diagnose mental disorders, and have little or no training in treatment alternatives to medication. As a result, they rely heavily on multiple medications when one medication fails, even though there is little evidence that combining medications works for mental disorders. If ¾ of cardiac or cancer patients were being treated by family physicians and pediatricians, it would be called a healthcare crisis, and the country would mobilize to rectify the problem. The fact that this state of affairs is allowed to continue is simply a travesty.

Psychologists trained to prescribe have at least seven years of training in diagnosis, assessment, and treatment of mental disorders. This training prepares them to identify the appropriate treatments, and to choose between drug and non-drug treatments in a way that no other mental health professional is able to do. Psychologists who prescribe in other states wear it as a badge of honor that they prescribe fewer medications than physicians do. It is also noteworthy that their preparation as prescribers comes at no cost to governmental bodies: psychologists pay for their own training.

Speaking of psychologists who prescribe, they are our best source of data on the second issue, that of safety. Psychologists have now been prescribing in the military for more than 10 years. In some cases they are working with seriously disturbed individuals, including servicemen with severe stress reactions to combat conditions in Iraq. To date, not one serious adverse event has resulted from a psychologist' prescribing practices, and not one complaint has ever been made against a prescribing psychologist. To the contrary, both the Navy and Air Force specifically identify prescribing psychologists in their healthcare regulations, and both the Army and Navy have deployed prescribing psychologists to active duty in Iraq.

Similarly, psychologists in Louisiana and New Mexico, the two states that allow psychologists to prescribe, have now written hundreds of thousands of prescriptions without one serious adverse event, and without one complaint lodged against them. In the 5 years psychologists have been allowed to prescribe in those states, they have become essential professionals in emergency rooms, in community mental health centers, on Indian reservations, and in psychiatric hospitals. In New Mexico psychologists are now training primary care residents in the use of psychotropic medications. It is a remarkable record of performance, and speaks volumes about the professionalism with which psychologists approach the sobering task of serving as a prescribing practitioner.

You will have opponents of this bill claim that psychologists will harm patients. Physicians have made these same claims every time another profession has tried to expand their scope of practice, whether it was prescriptive authority for nurse practitioners and optometrists, the power to practice psychotherapy for psychologists and social workers, even when nurses tried to get authority to use blood pressure cuffs in the early days of the 20th century. None of these claims have proven true. You will have opponents claim psychologists are opposed to prescriptive authority. While it is true a small minority of psychologists remain opposed, the profession has overwhelmingly recognized it is in the best interests of the public for psychologists to prescribe. The opponents will say that if psychologists want to practice medicine they should go to medical school, ignoring the fact that many other professions besides physicians have the authority to prescribe. Opponents will say that telemedicine will solve the problem, but ask them what they have done to make telemedicine a reality, and who will pay for the infrastructure to make such a solution possible. They will even claim the status quo is just fine, and this is the most serious misrepresentation of all. I expect you will hear all these claims, because I have heard them in other legislative hearings in many other states. None of them are true. What is true is that individuals with mental disorders are receiving substandard care. You have the power to help rectify that deplorable gap. Please vote in favor of House Bill 1488.

Sincerely,

Robert E. McGrath, Ph.D.
Professor, School of Psychology
Director, M.S. Program in Clinical Psychopharmacology
Director, Ph.D. Program in Clinical Psychology
Former President, APA Division 55

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January 24, 2009

The Honorable Nancy Johnson
North Dakota House of Representatives
State Capitol
Bismarck, North Dakota

RE: HB 1488 – Psychologists' Prescriptive Authority

Dear Representative Johnson:

I am writing to thank you for sponsoring HB 1488. This progressive and sorely needed legislation would allow appropriately trained North Dakota psychologists to prescribe and un-prescribe psychotropic medication within the scope of practice of psychology as defined in the bill. I am a prescribing psychologist in New Mexico and work with children and adolescents. Thank you for this opportunity to share my reasons for asking support of this bill from you and your colleagues.

1. There are approximately 75 appropriately trained psychologists in the U.S. with prescriptive authority in the United States Military and the states of New Mexico and Louisiana. During the past 15 years, psychologists have written hundreds of thousands of prescriptions for mental health medications. Of these, not a single negative complaint has been registered against any of the psychologists involved. Please take note that this is a remarkable accomplishment and amazing track record of safety that should put to rest any false accusations of prescribing, or medical psychologists posing a danger to the public. We are not a public health hazard and we have the evidence to prove it. Civilian trained psychologists are being credentialed to prescribe in the United States Army, Navy, and Air Force, in addition to the states mentioned. The U.S. Public Health Service Commissioned Corps has partnered with the Department of Defense in a Mental Health Initiative project, regarding prescribing psychologists. The Indian Health Services Behavioral Health Division Aberdeen Area is actively recruiting prescribing psychologists to fill their vacancies. Recently, two national employment agencies, InGenesis-Arora Joint Venture and Inamax Medical sent out notices recruiting psychologists who are licensed to prescribe.

2. These enlightening facts and critical pieces of information do not begin to explain all of the accomplishments of psychologists with prescriptive authority including treating thousands of people who otherwise may not have been treated, making care and access more readily available to more underserved and disenfranchised populations, especially now in these hard economic times, decreasing waiting times for patients to see providers with prescriptive authority, taking children, the elderly, and others off unnecessary over-

prescribed drugs, and providing better quality behavioral health care to patients.

3. The right to prescribe is also the right not to prescribe. Furthermore, it is the right to un-prescribe when appropriate. This understanding has helped me immensely in treating my patients. I am very pleased to tell you that I take children off drugs when appropriate. I can assure you the psychopharmacology-trained psychologists in North Dakota adhere to this same philosophy. The over-prescribing of psychotropics, particularly to children and the elderly is a national tragedy and has become a sensitive issue to psychologists trained in prescriptive authority. Many of us have come to believe that we now have become embattled in a moral obligation to provide appropriate high quality behavioral health treatment to those who need it most and receive it least.

4. Research has clearly shown it is much more effective to treat mental illness with a combination of therapy and medicine. For psychologists, prescriptive authority is another tool in our approaches of interventions utilized to combat mental and emotional illness and distress. We attempt to use medications as a last resort. Individual, group, family psychotherapy, cognitive, behavioral and social interventions are more effective, in most instances.

5. The education and training that prescribing and medical psychologists receive provide psychologists with the core knowledge in medicine and psychopharmacology they will need to prescribe psychotropic medications safely and effectively. The training is post-doctoral and the costs will be covered by the individual psychologists, not the state of North Dakota. Opponents of prescriptive authority for psychologists will argue that we are not properly trained - quite the contrary. The fact is psychologists have more training than any of the other behavioral health care providers who specialize in mental disorders. Only doctoral level North Dakota licensed psychologists who undergo rigorous post-doctoral training in psychopharmacology will be allowed to apply for prescriptive authority. The post-doctoral training generally consists of an additional masters degree specifically in psychopharmacology with approximately 450 academic hours in psychopharmacology, and 400 hours clinical practice in psychopharmacology under the supervision of a physician. The post-doctoral training usually takes an additional 2-3 years of study, for a total of approximately 12-13 years of post secondary education, 7-8 years at the graduate level. In addition, a comprehensive national licensing examination must be approved by the Psychology Board, and must be passed before prescriptive authority will be granted. Once certified to prescribe, prescriptions written by psychologists will occur in collaboration with the patients' primary care health provider.

6. Psychologists in North Dakota are trained experts in psychological approaches and will continue to utilize these techniques as a first line method. Medication will be used as an adjunct to these primary procedures. Psychotropics should be used cautiously, conservatively, and in many cases temporarily, especially with children and the elderly. Psychologists are trained to be empirical and systematic in their treatment approaches, and have shown to be more judicious in their use of medication.

7. We do not adhere to the 10-minute med check. We believe in doing the hard work of psychotherapy in treating our patients. This is what creates more long lasting change. The medical model assumes the physician is the expert. He evaluates the patient, makes the diagnosis, and prescribes the treatment. The patient is the passive recipient of the care. This works well for physical ailments; however, psychological care requires a more comprehensive approach, a therapeutic relationship with the doctor, and close collaboration with the patient to obtain the best outcome.

8. Psychiatry's arguments against psychologists prescribing are the same arguments the medical guild has been using for decades against other health care providers when they too attempt to increase their scopes of practice. "If you want to prescribe go to medical school." The organizers of the psychiatry guild disregard the overwhelming evidence that belies their position. Many of the non-medical school trained practitioners with legal authority to prescribe including for example, dentists, podiatrists, advanced nurse practitioners, optometrists, physician assistants, and psychiatric nurses, in addition to psychologists have proven unequivocally that one need not have had to attend medical school to learn how to prescribe safely and effectively in each of their areas of expertise. No one person or any profession has a monopoly on knowledge.

9. The shortage of psychiatrists is a serious problem and is getting worse. It is most disheartening that psychiatrists are not always available to prescribe medications, even for renewals or refills. Waiting times to see a psychiatrist ranges from weeks to months. This heightens the level of anxiety and emotional distress that some patients are already experiencing. A psychologist with prescriptive authority would minimize these situations.

Thank you for supporting prescriptive authority for appropriately trained psychologists. This idea whose time has come should not be about turf, it is about the people of North Dakota who are suffering emotional and psychological pain and not receiving adequate treatment, and in many cases, no treatment at all. Psychologists are taking a proactive approach to the behavioral health crises in North Dakota and across the country. The enduring shortage of psychiatrists and poor quality of medication management has forced psychology to take on this challenge. What is occurring in the military, in New Mexico and in Louisiana attests to the fact that citizens are receiving the safe and effective care they require and deserve. Thank you.

Sincerely,

E. Mario Marquez

E. Mario Marquez, PhD, ABMP
Prescribing Psychologist
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April 9, 2008

The Honorable Sheila Kuehl
Chair Person, Senate Health Committee
Sacramento, California

RE: BILL SB 1427

Dear Senator Kuehl;

I am writing in support of Bill SB 1427. I am an internist in Los Angeles and have practiced in this community for over thirty years. I cannot emphasize how important I feel this legislation is to our health care system. My experience as a general practitioner has convinced me that optimal health care depends on an understanding of the interaction between the physical and psychological factors that define an illness. To practice medicine without this awareness is malpractice. Throughout my career I have depended upon a paradigm of integrative care.

As an internist, I have the responsibility of treating a variety of conditions. To ignore the psychological impact of any disease on a patient's care is naïve. None of us are immune to mental health disorders. No family escapes from depression, anxiety, insomnia, or addiction. It is therefore imperative that practitioners address these issues while treating heart disease, cancer, diabetes, or any chronic illness. Significant data exists to support the detrimental impact of these psychological factors on all of these diseases. In order for me to address the medical conditions that come into my office I am required to acknowledge this relationship. And here is the obvious problem that this Bill will address. For me to optimize the care I can provide I must take the time to deal with these issues. In any busy practice this is almost impossible. I must therefore rely on professionals that treat the psychological problems that contribute to the illness. In our current health care system there are not enough of these professionals to provide this care. Psychiatrists are a limited resource. When they are available, they are usually out of reach for the average patient due to financial limitations or time constraints. I must therefore look beyond to trained professionals that understand and treat the psychological components of the illness I see in my office.

I therefore regularly depend on psychologists to help me manage my patients. Understanding the pharmacology appropriate in treating these conditions requires a level of expertise that most physicians to not have, and I cannot take the time with every

patient to adequately treat this part of the illness. This bill would allow me and countless other doctors to optimize the treatment outcomes of their patients.

I reviewed the requirements of the Bill that would allow psychologists to be licensed to prescribe psychotropic medication. The amount of hours and training is more than any general medical doctor ever receives and the success of the programs in other states validates the threshold of these requirements. It is ludicrous to assume that most doctors can provide this level of care without this support.

I have treated addiction for over twenty years as one more disease entity facing my internal medicine practice. I am a member of the California Society of Addiction Medicine and the American Society of Addiction Medicine and participate in an ongoing training program involving conferences, literature review, and seminars. Treating this disease absolutely depends on an integration of medical and psychological care. Pharmacotherapy is at the core of treating this disease. Less than one percent of all physicians in the United States treat addiction and only ten percent of all medical schools offer training in addiction. Yet addiction is the most prevalent health care crisis we have in this country. Allowing psychologists to participate in this treatment is critically important if we are to succeed in dealing with this cancer in our society.

I strongly urge the legislature to consider this very timely and important Bill. Without the support of well-trained professionals we will continue to offer suboptimal health care. There is no rationale for not allowing the trained psychologist to participate in our efforts to maximize the caring for our patients.

Sincerely_____

David A. Kipper, M.D.

DAK/cah

I have a faxed copy with his signature.
njohnson

CSPP CALIFORNIA SCHOOL OF PROFESSIONAL PSYCHOLOGY
ALLIANT INTERNATIONAL UNIVERSITY

ONE BEACH STREET SAN FRANCISCO, CA 94133

The Hon. Nancy Johnson
District 37
House of Representatives
North Dakota State Legislature
Bismarck, ND 58502-0222

Re: HB 1488

January 23, 2009

Dear Representative Johnson,

I am writing in support of HB 1488 that has been introduced in the North Dakota House of Representatives.

I am the Director of the Postdoctoral Master of Science Program in Clinical Psychopharmacology at the California School of Professional Psychology at Alliant International University. Our Program in Clinical Psychopharmacology has graduated over 300 licensed psychologists in 32 states, with over 50 of these graduates now qualifying to prescribe in the states of Louisiana and New Mexico, and in the United States Military. I would like to tell you something about our University and our Program.

Alliant International University is accredited by the Western Association of Schools and Colleges, which has also reviewed and approved the Postdoctoral Program in Clinical Psychopharmacology. Our University's PhD and PsyD programs have been accredited by the American Psychological Association. In 1997, the faculty approved the Postdoctoral Master of Science Program in Clinical Psychopharmacology, in part, because of "the documented shortage of mental health professionals trained to meet the needs of rural and underserved populations." Faculty reviews are conducted on each faculty member and on the content of each course in the Program. Our faculty includes physicians (including psychiatrists), neuropsychologists, prescribing medical psychologists, pharmacologists, and other health care professionals. I am also attaching a brief summary of my professional training and experience.

The purpose of the program is to educate practicing psychologists "in the scientific foundations and clinical applications of pharmacological management of mental disorders." Courses include Clinical Biochemistry, Neuroanatomy, Neurophysiology, Neurochemistry, Clinical Medicine, Physical Assessment and Laboratory Examinations, Pharmacology and Clinical Pharmacology, Psychopharmacology, Special Populations (Gender and Ethnic Issues, Child and Geriatric

Psychopharmacology, Chemical Dependency and Chronic Pain), Legal and Ethical Issues, and Research. Examinations are held in every class. The program has over 450 hours of instruction.

Our University and our Psychopharmacology Program, in particular, cooperate closely with states that are working to bring better access to comprehensive mental health care to rural and underserved populations. Our program has been approved in the states of Montana, Wyoming, Utah, Idaho, and Oregon—in addition to California, Louisiana, and Maryland. I have been in contact with Ms. Debra Huber from the North Dakota Department of Career and Technical Education. She indicated that there is no problem with Alliant International University offering this program immediately to North Dakota psychologists.

We have already been working closely with interested psychologists in North Dakota, South Dakota, and Montana, and are currently beginning a new cohort into our Postdoctoral Psychopharmacology Program this week. These doctoral level psychologists are already serving in some of the most isolated, remote, and medically underserved populations of the upper plains. Our program is uniquely designed to assist such primary behavioral health professionals in advancing their clinical knowledge, skill, and abilities

Our Dean, Dr. Morgan Sammons has agreed to support late entry for any North Dakota psychologists who might choose to attend the program after the passage of legislation. We will send DVDs of the missed classes to students, and arrange for them to take examinations with local proctors. We will do whatever we can to train the psychologists needed in North Dakota as quickly and efficiently as possible.

We welcome any questions that you or your colleagues have. We applaud your vision in pursuing this legislation.

Sincerely,

Steve R. Talbott, Ph.D.

Professor and Director,
Postdoctoral Master of Science Program in
Clinical Psychopharmacology

Kevin M. McGuinness, PhD, MS, ABPP

Clinical Psychology, Clinical Health Psychology

Elaine S. LeVine, Ph.D., ABMP
eslevine@hotmail.com
Martin G. Greer, Ph.D.
Martha S. Foschini, Ph.D.
Kevin M. McGuinness, Ph.D., M.S., ABPP

kevinmcg@gwmail.gwu.edu
Marlin Hoover, Ph.D., M.S., ABPP
Margaret Swaim, LPCC
Verna Pearl Hagen, LMHC, MA. Ed

January 22, 2009

Dear Representatives and Senators of the Great State of North Dakota,

I am writing to support House Bill 1488 (A BILL for an Act to create and enact chapter 43-32.1 of the North Dakota Century Code, relating to authorizing medical psychologists to prescribe drugs...). I write to you as a licensed medical psychologist, a private practitioner, and a senior Commissioned Officer of the United States Public Health Service (USPHS) who has fought for decades to improve access to quality health care for all Americans.

I am the Chairman of the USPHS Mental Health Functional Group Advisory Committee (MHFAC). The Mental Health Functional Group (MHFG) includes all commissioned mental health officers of the U.S. Public Health Service. I also serve as a disaster responder and commander of one of five mental health disaster response teams of the U.S. Department of Health and Human Services. As a commissioned officer I have served in Community Health Centers across our Nation. I have served in urban and rural centers providing care to Americans of all racial, ethnic, and cultural backgrounds. I have done the same as a disaster responder. I can say with certainty that my capacity to meet the mental health needs of underserved populations has benefited from not only from my ability to assess, diagnose, and provide psychotherapy to my patients, but also from my ability to safely prescribe medications when needed and to UN-prescribe them when necessary.

As a medical psychologist, I work with and lead a team of psychologists, psychiatrists, physicians, nurses and social workers. Most recently our team was detailed to provide mental health services to Native American patients in South Dakota. I was specifically requested to support the Behavioral Health Department of an Indian Health Service Hospital because of my legal authority to obtain full psychotropic prescription privileges as a medical psychologist. The need was great, not just to prescribe, but to adjust post-hospital-discharge medication in a community that had no clinical psychopharmacology practitioners. Unfortunately, when I left the Reservation, there was no one to continue in my place.

Please vote to PASS House Bill 1488 in this Legislative Session. Lives can be saved and suffering reduced if our Nation, through its States, provides the authority for properly educated doctors of psychology to obtain prescriptive authority.

Sincerely,

Kevin M. McGuinness

1395 MISSOURI AVENUE, LAS CRUCES, NEW MEXICO 88001

January 22, 2009

Dear Legislator,

I am writing you in support of House Bill 1488. I am a clinical psychologist and live in Williston, North Dakota. As a clinical psychologist and graduate of a postdoctoral M.S. program in Clinical Psychopharmacology working in a rural healthcare setting, I believe that I have a unique perspective on why granting prescriptive authority to appropriately trained psychologists is an important step in improving healthcare services to rural and underserved populations in North Dakota. In this letter I will outline why I believe this to be the case.

There are two conditions that must be met before it would be justified awarding psychologists prescriptive authority. The first is that doing so will enhance the treatment of patients with mental disorders. The second is that doing so will not threaten patient safety. Regarding the first point, the mental health system in this country is in crisis. On average, there are less than 4 psychiatrists per 100,000 residents in rural parts of the country, versus an average of 15 psychologists (Hartley, Bird, & Dempsey, 1999). The shortage of psychiatric care means that about 3/4 of people with mental disorders are treated by non-psychiatric physicians (Pincus et al., 1998). Most non-psychiatric physicians have had no more than 6 weeks of formal training in the study of diagnosing and treating mental disorders. They are poorly equipped to diagnose mental disorders, and have little or no training in treatment alternatives to medication. As a result, they rely heavily on multiple medications when one medication fails, even though in many cases there is little evidence that combining medications works for mental disorders. If three fourths of cardiac or cancer patients were being treated by family physicians and pediatricians, it would be called a healthcare crisis, and the country would mobilize to rectify the problem. The fact that this state of affairs is allowed to continue is simply a travesty.

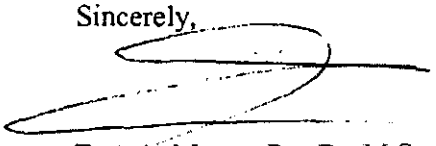
Psychologists trained to be prescribing psychologists have at least seven years of training in diagnosis, assessment, and treatment of mental disorders. This training prepares them to identify the appropriate treatments, and to choose between drug and non-drug treatments in a way that no other mental health professional is able to do. Psychologists who prescribe in other states wear it as a badge of honor that they prescribe fewer medications than physicians do.

Speaking of psychologists who prescribe, they are our best source of data on the second issue, that of safety. Psychologists have now been prescribing in the military for more than 10 years. In some cases they are working with seriously disturbed individuals, including service members returning from Iraq and Afghanistan with severe conditions such as posttraumatic stress disorder. As a former Army Clinical Psychologist that spent nearly 27 months in Iraq taking care of service members, I can attest to the incredible job that prescribing psychologists perform in Iraq. To date, no complaints have resulted from the prescribing practices of a psychologist. Similarly, psychologists in Louisiana have documented that they have written over 100,000 prescriptions without any complaints as well. This is a remarkable record of performance, and speaks volumes about the professionalism with which psychologists approach the sobering task of serving as a prescribing practitioner.

You will have opponents of this bill claim that psychologists will harm patients. Physicians have made these same claims every time another profession has tried to expand their scope of practice, whether it was prescriptive authority for nurse practitioners and optometrists, the power to

practice psychotherapy for psychologists and social workers, even when nurses tried to get authority to use blood pressure cuffs in the early days of the 20th century. None of these claims have proven true. You will have opponents claim psychologists are opposed to prescriptive authority. While it is true a small minority of psychologists remain opposed, the profession has overwhelmingly recognized it is in the best interests of the public for psychologists to prescribe. The opponents will say that if psychologists want to practice medicine they should go to medical school, ignoring the fact that many other professions besides physicians have the authority to prescribe. What is true is that individuals with mental disorders are receiving substandard care, particularly in rural states like North Dakota. You have the power to help rectify that deplorable gap. Please vote in favor of House Bill 1488.

Sincerely,



Bret A. Moore, Psy.D., M.S., ABPP
Board-Certified Clinical Psychologist

January 22, 2009

Dear Legislator,

I am writing to you in support of House Bill 1488. I am a physician and work in a very rural setting providing services to an underserved population. As a physician with over 18 years of experience utilizing psychotropic medications with patients suffering from psychiatric illness, I have a profound appreciation for the need to increase competent psychiatric care in rural communities. In my opinion, there is an immense shortage of psychiatrists and other appropriately trained psychiatric prescribers in North Dakota. I strongly believe that prescribing psychologists can fill this service gap and will help meet the increasing need for competent psychiatric care.

I currently work with two clinical psychologists that have received postdoctoral M.S. degrees in clinical psychopharmacology. I am amazed at the comprehensive level of training that these individuals have obtained as well as the breadth and depth of knowledge they possess on issues related to psychiatric disorders, pharmacotherapy, and conceptualizing a patient from a bio-psycho-social approach. I consult with these two doctors on a daily basis regarding both routine and complex psychiatric cases. I find their knowledge about psychotropic medications, psychiatric disorders, and treatment options other than psychotropic medications to be equal that of many psychiatrists that I have worked with in the past. Related to the latter, I find their ability to utilize non-pharmacological treatment methods to be one of their greatest assets. All too often, patients are given medication when cognitive and behavioral based methods may be more appropriate. This is an area that few psychiatric physicians, psychiatric nurse practitioners, and physician assistants have training in. They are an invaluable asset in rural health settings.

I strongly encourage you to pass House Bill 1488. Individuals with mental disorders are receiving substandard care, particularly in rural states like North Dakota. You have the ability to make a huge impact on the quality of life of many thousands of your constituents.

Sincerely,

Rafael A. Ortiz Graulau, M. D.
General Practitioner

January 22, 2009

Dear Legislator,

I am writing to you in support of House Bill 1488. I am a physician and work in a very rural setting providing services to an underserved population. As a physician with several years of experience utilizing psychotropic medications with patients suffering from psychiatric illness, I have a profound appreciation for the need to increase competent psychiatric care in rural communities. In my opinion, there is an immense shortage of psychiatrists and other appropriately trained psychiatric prescribers in North Dakota. I strongly believe that prescribing psychologists can fill this service gap and will help meet the increasing need for competent psychiatric care.

I currently work with two clinical psychologists that have received postdoctoral M.S. degrees in clinical psychopharmacology. I am amazed at the comprehensive level of training that these individuals have obtained as well as the breadth and depth of knowledge they possess on issues related to psychiatric disorders, pharmacotherapy, and conceptualizing a patient from a bio-psycho-social approach. I consult with these two doctors on a daily basis regarding both routine and complex psychiatric cases. I find their knowledge about psychotropic medications, psychiatric disorders, and treatment options other than psychotropic medications to be equal that of many psychiatrists that I have worked with in the past. Related to the latter, I find their ability to utilize non-pharmacological treatment methods to be one of their greatest assets. All too often, patients are given medication when cognitive and behavioral based methods may be more appropriate. This is an area that few psychiatric physicians, psychiatric nurse practitioners, and physician assistants have training in. They are an invaluable asset in rural health settings.

I strongly encourage you to pass House Bill 1488. Individuals with mental disorders are receiving substandard care, particularly in rural states like North Dakota. You have the ability to make a huge impact on the quality of life of many thousands of your constituents.

Sincerely,

Kevin Younger, M. D.

http://www.apapractice.org/apo/insider/leg/rxp/education/apatalking.html#

Reasons to Grant Prescriptive Authority to Appropriately Trained Psychologists

by APA Practice Organization

1. There is a critical need for appropriate and effective psychoactive medication, but access to this type of care is limited and decreasing.

- 20% of all Americans suffer from mental illness at any given time.
- Studies show that a combination of talk therapy and drug therapy is often the most effective treatment.
- Medical students in psychiatric residencies decreased 12% between 1988 and 1994. Interest in psychiatric residencies among medical students in the United States has decreased to the point that about half of the residency slots are being filled by graduates from medical schools in other countries.
- The majority of all psychotropic medications are prescribed by non-psychiatric health care providers who have limited exposure to diagnosing mental illnesses.
- In the United States there are at least 444 counties that have no psychiatrists but do have psychologists.

2. Psychologists are highly trained specialists in mental health who can and are being trained to prescribe psychoactive medications.

- Psychologists have an average of seven years of doctoral training in the diagnosis, assessment and treatment of mental and emotional disorders.
- Psychologists interested in obtaining prescriptive authority receive specialized post-doctoral training.
- Psychologists all over the United States are already seeking postdoctoral training in psychopharmacolgy.
- Psychologists in many professional settings are already collaborating with physicians on patients medication issues.
- Ten military psychologists have been trained to prescribe, and an independent study of this group shows them to be safe and effective prescribers.

- Most states have granted other non-physician providers, such as dentists, podiatrists, physician-assistants, nurse practitioners, and pharmacists, some degree of prescriptive authority, and many prescribe independently.

3. Prescriptive authority for psychologists increases continuity of care.

- It is time consuming for patients to see multiple health care providers for the same problem. Prescribing psychologists, because of their mental health expertise, will be able to provide patients with assessment, diagnosis, and therapy, as well as psychotropics and medication management.
- Psychologists trained to prescribe will provide integrated psychological and pharmacological care.

WHAT DO PSYCHOLOGISTS THINK ABOUT RxP?

A 1990 survey of APA members revealed that the majority of psychologists support the idea of training psychologists to prescribe. This survey showed that 70% of clinicians and 64% of non-clinicians support legislation to authorize RxP. The RxP movement has been gaining momentum over the last decade. The increasing support for RxP by APA members partially stems from deliberate efforts to educate psychologists about the myths and realities surrounding RxP. Some of the main points prompting continued education efforts are articulated below.

CRITICAL ARGUMENTS THAT SUPPORT RxP

1. Many non-psychiatric physicians and other health care providers are prescribing psychotropic medications for their patients and actually prefer to refer those individuals to psychologists for treatment, including assessment, possible psychotropic medication prescription, and treatment.

a. The number of visits to general physicians in which psychotropic medications were prescribed increased from 32.7M to 45.6M from 1985 to 1994. (The proportion of such visits increased from 5.1% to 6.5%). Should general physicians prescribe in this way? Do they have adequate training to diagnose mental illness? Are they spending sufficient time with patients who present with psychological distress?

b. The federal government, aided by medicine and the pharmaceutical industry, has been advocating for medicating as the primary treatment for mental and emotional disorders by primary care physicians. These physicians have little or no formal training in empirically-based mental health treatments, with the exception of continuing medical education about depression that is usually provided by drug companies.

c. By the year 2020, depression with psychological etiology will be the second leading cause of the non-fatal disabling effects of disease. (Depression currently accounts for 47% of the effects of physical disease and injury.)

2. Individuals usually seek help from primary care physicians when experiencing physical, social, or emotional changes and/or discomfort. Primary care physicians have limited training in psychiatric diagnosis and little training in modern psychological treatment strategies and techniques. Many are uncomfortable making psychiatric diagnoses and tend to ignore or minimize symptoms of mental distress. It is not uncommon for them to attempt to explain symptoms as being solely due to a physical problem.

3. Psychologists have extensive training in biopsychosocial assessment, standardized diagnostic procedures and a wide variety of techniques and skills for the treatment of mental and emotional disorders. Psychologists have learned these fundamentals for providing effective services through an intensive graduate program leading to a doctorate in psychology, as well as an internship and post-graduate experience. The depth and scope of training for psychologists in the mental health and the psychological aspects of disease exceeds that of other health professions.

4. Training in the physiological aspects of mental and behavioral disorders is a part of doctoral-degree programs in psychology; APA accreditation and the psychology state licensure examination require demonstrated baseline competence in the biological, psychological and social bases of behavior.

5. A 1992 survey of hospital-affiliated psychologists indicated that 64% of the respondents already collaborate with physicians regarding psychotropic medication dose, type or toxicity and 41% provide follow-up documentation on the efficacy of the psychotropic medications.

6. Many other non-physician providers who have the legal authority to prescribe include, for example, dentists, podiatrists, advanced nurse practitioners, nurse midwives, optometrists, and physician assistants. In 1997, there were over 160,000 Advanced Nurse Practitioners who were either prescribing or utilizing psychotropic medications in their practices in all 50 states. Psychologists are already prescribing in certain federal programs. They are prescribing informally in other non-governmental settings. This shows that one does not have to attend medical school to learn how to prescribe competently and successfully.

7. Because psychologists will have the *ability* to prescribe medication does not mean that medications will *always* be prescribed for their patients. The psychologist may determine that other treatments are more appropriate after she or he is able to complete a comprehensive assessment. Physicians, on the other hand, use medication therapy as their customary and primary treatment intervention. Therefore, if a depressed patient visits a primary care physician, they are likely to be prescribed an antidepressant. If this same patient visits a prescribing psychologist, other equally viable treatment options excluding, or in addition to, antidepressant therapy will be considered. It is important to remember thatthe authority to prescribe is also the authority NOT to prescribe.

8. Psychologists in health care are already practiced in recommending and monitoring psychotropic drugs and serve as an important resource for primary care physicians in their prescribing practices. It is logical to progress to the next level and train psychologists to prescribe independently.

CRITICAL ARGUMENTS AGAINST RxP

Many of the compelling arguments for the aggressive pursuit of RxP have been offered. Several arguments opposing RxP have also been advanced and they are detailed below. These opposing arguments have not been ignored or dismissed. Listed below are some of the common sentiments that have been expressed against RxP, as well as counterpoints to supplement the pro-RxP arguments already outlined in this document.

Argument #1:
"If psychologists want to prescribe medication, they should go to medical school."
Counterpoints:

A. Psychologists are highly trained specialists in mental health who can be trained to prescribe psychotropic medications, thus utilizing the psychologist's ability to deliver services that span the full range of mental health services.

B. Psychologists obtain a high level of competency through an extensive education and training process. This normally entails an average of seven years of education beyond the undergraduate degree in a comprehensive academic program that includes practical training experiences and didactics.

C. Almost all states require 1 to 2 years of supervised post-doctoral experience for the granting of licensure.

D. Clinical psychology students receive extensive training in the physiological aspects of mental disorders. In fact, APA accreditation standards require coursework and demonstrated competence in physiological bases of mental disease.

E. The Association of State and Provincial Psychology Boards, which monitors and oversees all state licensure examinations, requires knowledge of common physical disease symptoms and psychophysiology, as well as the effects of major psychotropic drugs and other commonly prescribed drugs on behavior and cognition.

F. Psychology's recognized competence in the medical and psychological aspects of illness is exemplified by the fact that over 3,000 psychologists are employed on medical school faculties where they participate in a range of health psychology activities, including teaching psychopharmacology courses!

Argument #2:
"Psychologists will become greedy pill-pushers. Prescribing will change the nature of the profession, causing psychologists to quickly write prescriptions and abandon our important psychological model of treatment."
Counterpoints:

A. Many psychologists are currently informally prescribing medications when they consult with physicians and psychiatrists about the treatment regimens of mutual patients, which includes the use and effects of psychotropic medication.

B. Psychologists have demonstrated that their expertise in treatment allows patients to regain functioning with fewer medications and lower dosages of medication, thus dispelling the fear that psychologists will "forget their skills" and become "pill-pushers."

C. Training in RxP is reserved for licensed psychologists who have been practicing for

a minimum of 5 years after the granting of their degree and license. This is to ensure that the new psychologist has sufficiently solidified their professional identity, operating from a well-developed psychological model of intervention.

D. RxP clearly supports a psychological model of prescribing, not a medical model of prescribing. Practice and prescribing according to these two models is philosophically and fundamentally distinct. Psychology views the individual and prescribing from a biopsychosocial framework, whereas medical practice and prescribing focuses on identifying disease and eradicating it.

E. Psychology has a strong identity and it can withstand and flourish with this additional tool for practice.

Argument #3:
"Liability insurance premiums will increase drastically and those who do not prescribe will have to pay higher rates to compensate for those who do prescribe. Doesn't the likelihood of mis-prescribing increase when psychologists, not physicians, prescribe?"
Counterpoints:

A. Over 70% of psychotropic medication in the United States is currently prescribed by non-psychiatric physicians who have minimal training in the detection and management of mental and emotional problems. Psychologists are much better trained and equipped to accurately diagnose and treat mental disorders.

B. Insurance premiums are rated based upon experience. The prescribing experience of Optometrists, Advanced Nurse Practitioners and Physician Assistants demonstrates that non-physician prescribers are as safe as physicians. Therefore, their premiums have not increased and are currently less expensive than the present liability rates for psychologists. Psychologists who oppose RxP fear substantial increases in liability insurance premiums. When medication is prescribed judiciously, as Optometrists and other non-physician prescribers have shown, there is no significant increase in premiums.

Argument #4:
"The education community has not been sufficiently consulted about the RxP scope of practice expansion. Are there going to be mandates to change core psychology curricula to adjust for RxP? Will the fundamentals of graduate psychology training suffer, or will more core courses be added, thus extending the duration of doctoral education?"
Counterpoints:

A. The following education/training constituency groups have provided specific input in the development of the RxP movement: Board of Educational Affairs, Board of Scientific Affairs, Division 12 (Clinical), Division 22 (Rehabilitation), Board of Professional Affairs, Committee for the Advancement of Professional Practice, Board of the Advancement of Psychology in the Public Interest, National College of Professional Psychology, APA Council of Representatives, and the APA Board of Directors. Additionally, RxP issues have been included on several cross-cutting agenda items during many sessions of consolidated meetings where several APA constituency groups gather simultaneously to conduct their business meetings.

B. The overall quality of current education of psychology students is valued, important and will not be compromised. However, in some academic settings, the training is dated and practitioner students are not being adequately trained to thrive in the current marketplace. Education should evolve as the field evolves, while preserving the

fundamentals of psychology education.

Argument #5:
"Are we just adding RxP because we fear that psychology is losing its distinctive identity to master's trained individuals? Why should psychologists prescribe if we already have a good relationship with, and accessibility to, psychiatrists and physicians? Will the field begin to devalue psychologists who do not prescribe, thus phasing these psychologists out of the field?"
Counterpoints:

A. RxP is an additional tool for psychologists use and it is not intended to replace the unique services that psychologists already deliver.

B. Psychologists already specialize with different populations, diagnoses and treatment approaches, and each specialty area is a respected sub-field of psychology.

C. Certification, not licensure, for RxP extends the current scope of psychological practice. It does not replace it.

D. Psychiatry has historically attempted to obstruct the evolution of psychology. For example, between 1950 - 1970 psychiatrists argued that it was unsafe to permit psychologists to practice outpatient psychotherapy without medical referral or medical supervision. Psychiatry also attempted to prevent psychologists from access to specialized training in psychoanalysis. They also opposed the psychologists' ability to treat patients in hospital settings and Skilled Nursing Facilities. And, psychiatrists unsuccessfully fought to defeat measures that now allow the elderly direct access to psychological care under the Medicare program (OBRA).

RECENT RxP ACTIVITIES
Note: RxP activities are constantly evolving and developing. Thus, this list of activities may not reflect the most current gains in the RxP movement.

1. RxP legislation has been introduced in nine states: AK, CA, FL, IL, GA, HI, LA, MO and MT (although the MT bill was not supported). Of these, Louisiana has made the most progress toward winning RxP. Their advocacy efforts have been effective in transferring their bill out of the Committee in both the House and the Senate.

2. The Indiana legislature enacted a public law with the express provision authorizing psychologists participating in a federal government sponsored training or treatment program to prescribe, although this provision has not been implemented to date.

3. Approximately one-half of all the State Psychological Associations have developed a task force to address RxP issues in their respective states. Other states without a specific RxP task force or committee discuss RxP issues as part of their Professional Affairs or Professional Development committees.

4. Level 3 training programs have been introduced or is being held in 12 states: FL (3 programs), KS, LA, GA, HI, IL, NH, NM, NY, OK TX and CA. Florida has two training programs and other states and regions are in varying stages of developing RxP training programs.

5. In addition to important victories in South Africa leading toward RxP, Guam recently won RxP for psychologists working in collaboration with physicians.

6. Licensure boards in 9 states (CA, CT, DC, FL, IL, MA, OK, TX and UT) have formally ruled that consulting on psychopharmacologic drug use for patients is *within the scope of practice* for psychologists.

7. An APA presidential initiative of Pat DeLeon, Ph.D. involves furthering the efforts to win RxP for psychologists.

8. Recent data shows that 75% of United States psychologists are in favor of RxP. This statistic is up 30% from 10 years ago.

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David Presti, PhD, Psychologist and Molecular Biologist
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- Asterisked courses may be taken for stand-alone Continuing Education and if exams are taken and passed, may be applied toward degree requirements.

Course Title	Hours	Current Instructors (subject to change)
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Neurosciences	84	
Neurochemistry*	(24 hrs.)	Presti
Neurophysiology	(24 hrs.)	Bolter
Neuroanatomy/Neuropathology	(36 hrs.)	Bolter
Clinical Medicine/Pathophysiology	60	TBD
Physical Assessment and Laboratory Evaluation	36	TBD
Clinical Pharmacology	60	Gutierrez
Advanced Psychopharmacology	48	
Depressive Disorders	(12 hrs.)	Preston
Anxiety Disorders	(12 hrs.)	Gutierrez
Psychotic Disorders	(12 hrs.)	Gutierrez
Bipolar Disorder/Drug-Drug Interactions	(12 hrs.)	Gutierrez
Special Populations in Psychopharmacology I	36	
Gender	(12 hrs.)	Mantel
Pediatric	(12 hrs.)	Brady
Chronic Pain/Geriatric	(12 hrs.)	Reeves/Hargrave
Special Populations in Psychopharmacology II	24	
Ethnicity	(12 hrs.)	TBD
Chronic Illness	(6 hrs.)	Tackett
PTSD and Borderline Personality Disorder	(6 hrs.)	Tackett
Chemical Dependence	12	Presti
Case Seminar	12	TBD
Pharmacotherapeutics	36	
Psychotherapy & Psychopharmacology	(12 hrs.)	Sammons
Legal/Ethics	(12 hrs.)	Brady
Research and Online Resources	(12 hrs.)	Comaty/Advokat
Total Didactic Hours	**432**	-
PEP Preparation Course	18	home study
Total hours	**450**	-

Administration/Staff:

Steven R. Tulkin, PhD, MSCP	Program Director	stulkin@alliant.edu
Wendy Stock, PhD, MSCP	Associate Program Director	wstock@alliant.edu
Michael Newman, MA	Executive Assistant	mnewman@alliant.edu

Johnson, Nancy

From: Larry J. Bernhardt [45berl@nd.gov]
Sent: Sunday, January 25, 2009 4:55 PM
To: Johnson, Nancy
Cc: Weisz, Robin L.; Pietsch, Vonnie A.; Damschen, Charles D.; Frantsvog, Robert; Hofstad, Curt L.; mnathe@nd.vog; Porter, Tim C.; Uglem, Gerald P.; Conrad, Kari L.; Holman, Richard G.; Potter, Louise S.; Conklin, Tom; Kilichowski, Robert J.
Subject: HB1488

Dear Representative Johnson:

I regret that I won't be able to attend the House Appropriations Committee Hearing on Tuesday and support HB1488, however I will be out of state - otherwise I would be there.

Allow me to make the primary point of why I support this bill. In rural North Dakota, our accesability to health and mental health care providers is much more limited than in the major urban areas of the state. By allowing this new responsibility for "medical psychologists", it expands the availability of those services to more of North Dakota and the people in need of those services.

I write this letter on behalf of the "SouthWest Area Healthy8 Network", which represents health care providers in all 8 of the Counties in S.W.
North Dakota and to let you know they have taken official action to support HB1488.

I also write this letter on behalf of Stark County Social Services, who also supports HB1498.

Thank you.

Larry Bernhardt, Director
Stark County Social Services
664 12th Street West
Dickinson, No. Dak. 58601
701-456-7675 (work)
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(52.55) 5264.2187

The Hon. Nancy Johnson
District 37
House of Representatives
North Dakota State Legislature
Bismark, ND 58502-0222

Via telefax: 701-328-1271

January 23, 2009

Dear Representative Johnson:

Thank you for your sponsorship of HB 1488, a bill that would allow appropriately trained psychologists the right to prescribe psychotropic medications.

I am one of the first prescribing psychologists in the nation, having graduated from the Department of Defense's Psychopharmacology Demonstration Project (PDP) in 1994. I acted as a prescribing psychologist until my departure from active duty one year ago (unfortunately the state of California, my current home, does not have legislation enabling psychologists to prescribe). While on active duty in the Navy, I served as the Navy clinical Psychology specialty leader, or the chief psychologist for the Navy, and I have also served as the US Navy Surgeon General's special assistant for Mental Health and Traumatic Brain Injury.

I currently serve as the Dean of the California School of Professional Psychology – one of the largest and oldest schools of professional psychology in US. CSPP has been training psychologists to prescribe since 1998. We have over 350 students who've received a postdoctoral master's in psychopharmacology after completing a rigorous 28 month curriculum.

In upcoming testimony, you are likely to hear that the PDP was a costly failure. In fact, the PDP, before being terminated by political pressure, succeed in training a group of highly skilled prescribing psychologists. In fact, prescribing psychologist continue to be used in all branches of the service, both in uniform and as civilians. We have now granted credentials to prescribing psychologists trained in civilian programs within the Defense Department and graduates of civilian training programs are being employed by the Public Health service.

You will hear that training psychologists to prescribe is unnecessary. In fact, documented shortages of psychiatrists existed within the DOD when I was being trained and continue to persist today, a fact noted in the 2007 Department of Defense's Mental Health Task Force Report that examined mental health service provision to returning veterans and their families. Post-traumatic stress disorder and traumatic brain injury have been called the signature injuries of the conflict in Iraq and Afghanistan. The need was, and continues to be, real. As an Operation Iraqi Freedom veteran, I remain concerned about our ability to provide comprehensive mental health services to veterans, particularly in rural or underserved areas.

You will hear that psychologists, if given prescriptive authority, will present a public health hazard. Historically, in any instance when physician health care providers have sought to expand their scope of practice into areas previously limited to physicians it has been argued that the public health would be harmed. In fact, these predictions have always been proven false. Just as is the case with nurse practitioners, optometrists, podiatrists, and other professions whose scope of practice has expanded, there is no evidence that these practitioners provide services that are of lower quality or endanger the health of the citizenry.

Psychologists are highly trained in comprehensive mental health services, including biological bases of behavior and mechanisms of mental disease, in their doctoral training long before they enter postdoctoral training to prescribe. They have demonstrated that they are eminently capable of acquiring the requisite knowledge to safely incorporate medications, when needed, into a mental health treatment plan. Psychologists who have already achieved the right to prescribe have convincingly demonstrated that they can do so safely and effectively, to the benefit of numerous patients and their families with mental health needs.

Thank you again for your support of this important legislation. If I can be of any assistance to you in your efforts to pass this bill, please do not hesitate to call on me.

Very truly yours,

Morgan T. Sammons, PhD, ABPP
CAPT, USN (ret)
Dean, California School of Professional Psychology

To the Human Services Committee,

I have been working in public health in southwestern North Dakota for nearly 22 years. During that time, I have seen the populations in our small towns dwindle further and further. Once vibrant main streets are now home to fewer and fewer businesses. While the population decreases, the average age of those that remain continues to rise. As we all know, when retirement age gets nearer, the need for health services increases as well. I have been tracking the prevalence of disease in southwestern North Dakota for over 20 years and one of the trends that I have seen develop in recent years is the incidence of mental health diseases. Alzheimer's disease and dementia have become increasingly evident in our aging population during the past few years. Our families struggle to take care of those loved ones inflicted with these diseases and often become frustrated when adequate or even minimal care is difficult to access. As a member of the Healthy 8 Community Health Network as well as its Executive Committee, I have been in communication with community agencies serving those in need of mental health services. Based on their concerns and observations, it is clear that a change is needed to more adequately provide the services and medications to those whose lives would clearly benefit from such a change.

Demand for psychiatric treatment has increased significantly over the past decade. The number of psychiatrists in the United States will not be able to keep up with the need for their services. The availability and costs of mental health services have been limiting factors in enabling those who need mental health treatment to receive those services. This is a great concern for publicly financed and managed health care plans. Increased administrative burdens, decreased fees and limitations on treatment options can result in decreased participation by psychiatrists. As a result, access to their services becomes greatly diminished especially in rural areas. Over the past few years, mental health care services have been increasingly more difficult to obtain in southwestern North Dakota. The looming difficult economic times facing many of our residents will translate into a certain increase in depression, anxiety and other mental health problems. House Bill 1488 will allow our citizens increased access to professionals qualified to provide them with the medications that they need. Under current law, these people may have to travel hundreds of miles to access those services. If this be the case, many of these individuals will simply not obtain proper treatment resulting in increased mental and medical health concerns as well as a greater strain and burden for their families. I feel that HB 1488 contains the necessary language ensuring that only properly trained, qualified and certified medical psychologists can prescribe these important medications in a safe and responsible manner. That is why I strongly support and urge passage of HB 1488.

As much of rural North Dakota becomes increasingly isolated, we need to continue to enable ourselves to be able to take care of our citizens without having to watch them have to leave our small towns and cities because they cannot access the care that they need. Passage of House Bill 1488 would be another small step forward in achieving that purpose. Your support would be greatly appreciated. Thank you for your consideration.

Kevin Pavlish
Environmental Health Practitioner- Southwestern District Health Unit
Healthy 8 Community Health Network

Johnson, Nancy

From: Jon Frantsvog [jon.frantsvog@bhshealth.org]
Sent: Monday, January 26, 2009 12:53 PM
To: Weisz, Robin L.
Cc: Pietsch, Vonnie A.; Conklin, Tom; Conrad, Kari L.; Damschen, Charles D.; Frantsvog, Robert; Hofstad, Curt L.; Holman, Richard G.; Kilichowski, Robert J.; Nathe, Mike R.; Porter, Todd K.; Potter, Louise S.; Uglem, Gerald P.; Johnson, Nancy
Subject: HB1488

Dear Representative Weisz:

As a member of *Healthy 8* - a coalition of human services providers, representing a broad array of health issues facing SW North Dakota, it is my pleasure to offer my encouragement to you, and your House Human Services Committee members, to support HB 1488. *Healthy 8* worked alongside Representative Nancy Johnson to consider what should be in this important piece of legislation. As ND sees a decreasing availability of mental health providers, HB 1488 opens the door for medical psychologists to help pick up the burden left behind for patients left without a caregiver. The recent retirement of Dickinson's two psychiatrists, and subsequent closing of the Dickinson's St. Joseph's Hospital and Health Center's mental health unit, has made very real, the impact of not having adequate numbers of psych providers, able to combat psychiatric and dementia related disease with medication. We're thankful to Representative Nancy Johnson for bringing HB 1488 forward to help to resolve that issue. I strongly urge you to send HB1488 to the full house with a "do pass" recommendation.

Do not hesitate to call on me if I can be of any help on this, or any other issue that you face during this sessions. And - thank you so much for being willing to take on the tough challenges that always face our legislators!

Sincerely,

Jon Frantsvog (yep - related to "Uncle Bob" Frantsvog!)

Jon Frantsvog, Administrator/CEO
St. Benedict's Health Center & Benedict Court
851 4th Avenue East
Dickinson, ND 58601
701 456 7242
701 456 7250(f)

Johnson, Nancy

From: colleen stebbins [cmstebbins@yahoo.com]
Sent: Monday, January 26, 2009 2:34 PM
To: Johnson, Nancy
Subject: HB 1488

Dear Nancy,

I, too, support HB 1488. I have been working in SW North Dakota as a Public Health nurse for 27 years. It is very evident that mental health services in rural ND are lacking if not in some cases almost absent. Our aging population has the problems that often times present with growing older, such as, dementia, Alzheimer's disease, loss of spouse, loss of independence, depression, etc.
The problems of the young and middle age are depression, suicide, alcohol and drug abuse, all of which can be treated if there are adequate facilities and professionals to help them. Many times this is a low income population and it is quite unreasonable to think that they can travel for 3 or more hours to receive any type of treatment. The problem increases because these visits are not one time visits but rather regular scheduled visits, optimally with the practitioner that has built some rapport with the patient.
Mental health issues are difficult, in that the patient often times cannot take the initiative to seek out help. They need services that are easily accessible and affordable.
I hope this is in some way helpful to you. It is a problem that needs to be addressed.

Colleen Stebbins, RN,CHN
Public Health Nurse
Bowman County
Southwestern District Health Unit

#2

1/25/2009

I am writing in support of House Bill 1488.

1. Introduction:

- My name is Dr. Michael R. Tilus. I am here today, on personal annual leave, representing my personal opinion as a private, non-partisan citizen. My opinions do not necessarily reflect the opinions of the Indian Health Service or the US Public Health Service.
- Currently assigned to Spirit Lake Health Center, as the Director of Mental Health and Social Services. I am a Commissioned Officer in the US Public Health Service at the rank of Lieutenant Commander. I serve on a rapid deployment Disaster Mental Health Response Team #4, having deployed to Florida for hurricane response, multiple tribal adolescent cluster suicide response, and other smaller disaster missions. I serve as the Sub-Chair for Prescribing Psychology on the Psychology Professional Advisory Group.
- I am a licensed psychologist in ND, AZ, CA, NM, and formally WA. I am also a licensed Marriage and Family Therapist in CA, and a board certified Pastoral Counselor with the American Association of Pastoral Counselors. I have been an ordained minister of 30 plus years, to include 12 years as an ecclesiastically endorsed Army Veteran Chaplain serving in the first Gulf war, followed by chaplaincy service in the ND Army National Guard and CA Army Reserve Corps. I currently have served 7 years in the Special Divisions Chaplaincy of my endorsing church.
- Completed a Postdoctoral Master of Science degree from Alliant International University in Clinical Psychopharmacology and am working to complete the clinical medical practicum and preceptorship requirements for additional certification as a Prescribing Psychologist or Medical Psychologist.

2. Current Requirements for Licensing as a Clinical Psychologist

- Doctoral degree from an accredited program, averaging 5 – 7 years.
- One year clinical pre-doctoral internship.
- One to two year post-doctoral supervision.
- Two years of supervised practice minimum.
- State Board exam that may include oral exam, as well as legal and ethics.
- National Board exam.

3. Current Requirements for Prescriptive Authority Training and Certification

- Completion of a Post-Doctoral Master of Science in Clinical Psychopharmacology
- Content Areas Include
    1. Clinical Biochemistry (24 hours)
    2. Neurosciences (84 hours), includes-
        -Neurochemistry (24 hrs)
        -Neurophysiology (24 hrs)
        -Neuroanatomy/Neuropathology (36 hrs)

3. Clinical Medicine/Pathophysiology (60 hrs)
4. Physical Assessment (36 hrs)
5. Pharmacology and Clinical Pharmacology (60 hrs)
6. Psychopharmacology (48 total hrs), includes-
   -Antidepressants (12 hrs)
   -Anxiolytics (12 hrs)
   -Antipsychotics (12 hrs)
   -Mood Stabilizers and Drug/Drug Interactions (12 hrs)
7. Special Populations in Psychopharmacology (60 total hrs), includes-
   -Child/Adolescent Psychopharmacology (12 hrs)
   -Gender Issues (12 hrs)
   --Geriatric psychopharmacology/Chronic Pain (12 hrs)
   -PTSD/Borderline Pers D/O/Chronic Medical Conditions (12 hrs)
   -Ethnopsychopharmacology (12 hrs)
8. Chemical Dependence (12 hrs)
9. Pharmacotherapeutics (36 total hrs), includes-
   -Research Issues in Psychopharmacology (12 hrs)
   -Professional, Ethical and Legal Issues (12 hrs)
   -Integrating Psychotherapy and Pharmacotherapy (12 hrs)
10. Case Seminar (12 hrs)
11. Review Course for the Psychopharmacology Examination for Psychologists (PEP)* [Students receive Continuing Education Credit but no academic credit is given for this course]

- Pass National Board Exam in Psychopharmacology
- Complete Supervised Medical Practicum of minimum 80 hours.
- Complete Supervised Practicum of Medication Management for a minimum of 100 patients for no less than 6 months to no more than 2 years by currently licensed medical provider
- Summary: stringent, arduous, respecialization!

4. How does it work in practice?

- Patient mental health care is integrated with medical care as a planned, intentional, collaborative effort.
- All patients are required to have an updated physical, appropriate lab, baseline ECG, MedTox to rule out any organic cause, illicit substance, or alcohol induced cause to their psychiatric symptoms.
- Patients and family members are interviewed to gather full biopsychosocial history, to include appropriate cultural and religious/spiritual variables.
- Psychotropic recommendations are only submitted to primary care physicians when the behavioral health treatment plan warrants their use as adjunct agents of change.
- Weekly, or bi-monthly psychotherapy, or family therapy, is always the backbone of the treatment plan. No psychotropics are recommended for patients unwilling to commit to psychotherapy.
- No pills without skills!

- The therapeutic relationship of seeing clients weekly is significantly different than the standard 10-minute psychiatric med check, or the 12 minute family practice visit.
- Drug-Drug effect and Adverse Drug Reactions are monitored on a weekly basis. This allows for significantly better diagnosis, dosing, and the ongoing use of psychosocial, cultural, and religious/spiritual interventions.
- Over prescribing and under dosing are common clinical problems; the authority to "un-prescribe" is a significant benefit of this kind of integrated, primary behavioral health provider role- medical psychologist.
- Psychopharmacological agents are only one of a number of tools that a medical psychologist can consider. Pills don't solve everything.
- This expanded scope of practice provides both psychotherapeutic and psychopharmacological services in a one stop fashion, to the underserved, the elderly, the chronically mentally ill, and minority populations.
- Without my more intimate knowledge of the relationship between psyche and soma, between mental/emotional illness and disease, between psychopharmacology and physiology, I would not be able to provide the same level of clinical services to my patients.
- This level of training for psychologists provides a more integrated and holistic view of mental and emotional disturbances in the assessment, diagnosis, and treatment of patients and families.
- Collaboration with primary care physicians often leads to better psychotropic medication trials, since the joint ability to evaluate a patient from a biomedical and psychological perspective allows me to understand how they view their psychiatric problems, their bodies, an dhow their psychological defensive strategies operate together to produce both physical and emotional stress.
- From my psychoanalytic psychodynamic perspective, why a patient refuses to follow treatment plan, resists a medical providers instructions to his diabetes control, or continues to use illicit drugs or alcohol to sooth their mind are all critical dynamics that affect the treatment outcome.
- Given the marvelous nature of our creation and how our body, mind, and soul are inexplicitly connected, the greater the understanding the medical psychologist of these, the greater the options for effective diagnosis and treatment.
- A critical and extensive knowledge and discomfort with the biomedical world also allows a more scientifically critical and informed review of medical research, psychopharmacological data, and its efficacy and treatment utility.

5. Safety of Patient:

- Inherent in this expansion of scope of practice is the now proven evidence that from a platform of appropriately chosen biomedical, basic science, and clinically specific coursework the clinical medical psychologist would have sufficient knowledge and training necessary to competently and safely prescribe psychotropic medication and diagnose, treat, and manage emotional disorders without first completing a medical degree and without medical supervision.
- The legislative efforts of doctoral level psychologists to create a new professional license/certification, with a scope of practice including the prescribing of

psychotropic medications without medical supervision, encountered many of the same roadblocks nonphysician health care professionals are experiencing today.

- The opposition from medical-psychiatric communities concerns over inadequate knowledge and clinical training, issues of patient safety, questions of actual need for additional prescribing personnel for underserved populations, and other opposing arguments existed then, and has continued on. Specifically, physicians have argued these points, and lost, against optometrists, advance nurse practitioners, podiatrists, and clinical pharmacists.
- There is nothing magical about medical school. The real error in this argument is the presumption that ONLY medical schools can train adequate prescribers. The same curriculum can be taught and learned outside of medical faculties. In fact, this is an arguable point for the innovate methods of accredited teaching organizations like Alliant International University and Farleigh Dickinson University who offer their MS degree to any out of state psychologist- a necessity if we are to fill gaps in access to care.
- "The argument that "if psychologists want to prescribe they should attend medical school"-that dog won't hunt! First, it subverts a principal justification for seeking prescriptive authority for psychologists, which is to substantially increase the number of appropriately trained, prescribers of psychotropic medication in order to fill gaps in access to care. Furthermore, it is an inefficient route since much of medical school training (or nursing training for psychiatric nurse practitioner) is irrelevant to the practice of psychopharmacology. Medical psychologists aren't seeking authority to prescribe all medication or do all medical procedures- only those that are usual and customary to the treatment of emotional, mental, or behavioral disorders.
- Postdoctoral Master of Science in Clinical Psychopharmacology often use the same books and qualified instructors as medical schools.
- The majority of non-psychiatric physicians receive only minimal training in diagnosing and treating mental health (maybe 6 weeks) and psychotropics (one semester in pharmacology and 1 week in psychotropic drugs). They are doing the best they can with what training they have.
- Yet some research suggests that as much as 80% of all visits to a general health provider involve significant behavioral health issues.
- The lack of refined differential diagnoses, the underutilization of psychosocial approaches and the over reliance on prescribing has led to suboptimum care when the medical model is exclusively applied in the treatment of the majority of mental health patients.
- An over reliance on pharmacotherapy as the primary therapeutic modality for emotional symptoms treated in medical practice has significantly increased in the recent years, with some estimates of the percentage of patients receiving medication for depression and other emotional symptoms reaching 90%, even when evidence indicates that many patients prefer psychotherapy to medication.
- In stark contrast to "a medical education", the psychologist with a postdoctoral specialization in clinical psychopharmacology brings multiple treatment approaches to bear in the evaluation and treatment of the patient, family, or couple.

- Furthermore, research provides no evidence that the competence of physicians as prescribers is superior to that of non-physician prescribers. Research has demonstrated that nurse practitioners and other non-physician prescribers offer more educational and counseling services than physicians, and that outcomes are equivalent to those physicians. In addition, research shows that patients acceptance of non-physician prescribers was generally higher than physicians.
- If in fact a full medical degree is unnecessary to achieve competence as prescribers as the research suggests, if it is actually an inefficient path for increasing access to safe and effective care, the real question becomes whether psychologists are adequately trained to prescribe.
- In comparing psychopharmacologically trained psychologists with those other professions that are currently authorized to prescribe (i.e., dentists, nurse practitioners, optometrists, physicians, podiatrists), and are, ipso facto, considered to be adequately trained, the following can be supported:
- Psychologists with a postdoctoral specialization in clinical psychopharmacology are among the most highly educated of all health care providers with prescriptive authority.
- Medical psychologists undergo more training than any other health care professional, including physicians holding an M.D. or D.O. degree before they are eligible to prescribe.
- In terms of specific content domains relevant to prescribing, the number of graduate contact hours dedicated to pharmacology and to biochemistry compare well to those of their prescribing colleagues in dentistry, optometry, podiatry, and nursing.
- A marked difference occurs in the number of hours devoted to research methodology, demonstrating the scientific critical value the psychologist carries to his work. This also begs the question of whether physicians are optimally qualified to evaluate the research base for the efficacy of the products that they prescribe, or to critically evaluate arguments from drug representatives about the efficacy and safety of the drugs that they prescribe.
- Similarly, psychologists' unique training in assessment and measurements sets them apart from any of the other paths towards prescribing. This correlates highly with a growing concern over misdiagnosis and over-diagnosis in mental health that leads at times to overmedicating.
- The far more extensive training psychologists receive in all aspects of mental health theory, formulation, and management assures that medication will be viewed in a larger context rather than as the treatment of choice in all circumstances.
- In contrast with the primary care physician or psychiatrist, the medical psychologist is in a better position to maintain current in the spectrum of treatment options available for mental disorders, a necessary condition for the implementation of evidence-based medicine.

6. Summary:

- In summary, one does not have to go to medical school to be a well informed, safe and effective prescribed. In fact, the medical school model has limitations,

in terms of cost and efficiency, and cannot be held out to be the sole option for serious, rigorous, professional training in psychopharmacology.

- Dr. Mario Marquez, outgoing President of the APA Division 55 "American Society for the Advancement of Pharmacotherapy" recently said "In New Mexico we are nearing two-dozen prescribing psychologists, and in Louisiana there are approximately 45 medical psychologists who are prescribing. In Guam where the Collaborative Practices Act passed in 1999, overriding a gubernatorial veto, two of our colleagues are completing training. Approximately 14 of our military psychologists, including some of the original Department of Defense, are prescribing as active duty, contractors or on reserve in NM, FL, LA, WA, HI, DC, and Afghanistan, Iraq, and other outside continental war zones, as of last count.
- Fact is, over 75 appropriately trained psychologists have been prescribing and un-prescribing for over 15 years in a safe and effective manner. Hundreds of thousands of prescriptions have been written. Moreover, not a single negative complaint has been registered against any of the psychologists. Truly, this is a remarkable and noteworthy accomplishment. Please make note, this is no small achievement and completely puts to rest any false arguments or accusations that prescribing psychologists are a public health hazard. Indeed we have said all along that psychologists will be much more cautious, objective, and systematic in our use of behavioral health medicines.
- At the federal level, in addition to the DoD trained prescribing psychologists, civilian trained prescribing psychologists are being credentialed to prescribe in the United States Army, Navy, and Air Force. The U S Public Health Service Commissioned Corps has partnered with the Department of Defense in the Mental Health Initiative project that includes the active recruitment of medical psychologists. The Indian Health Services Behavioral Health Division in Aberdeen Area is actively recruiting prescribing psychologists to fill their vacancies, as is the Montana Area Indian Health Service.
- In 2009 a record number of RxP bills are expected to be introduced in state legislatures all across the country. As a result, we must increase our efforts to what some of our leaders are now referring to as a moral responsibility to provide quality behavioral health care to the underserved, particularly, the poor, the abandoned, and the oppressed of our society. You have heard it many times before- it is the right thing to do, and if we don't quit, we will prevail. "
- It's safe enough for more than 3 million Department of Defense active and reserve duty Army, Navy, and Air Force sons and daughters. Not including their family members.
- It's safe enough for nearly 2 million residents in New Mexico.
- It's safe enough for nearly 4.3 million residents in Louisiana.
- It's safe enough for 173 thousand residents in the Territory of Guam.
- It's safe enough for 3.3 million American Indian/Alaska Natives.
- Let's make it safe enough for 636 thousand North Dakotans.

I respectfully request the North Dakota Legislators and Governor pass House Bill #1488. It's a good bill! And, it's the right thing to do!

Sincerely submitted,

Michael R. Tilus, PsyD, MSCP
Licensed Psychologist (ND #422)

#3

NORTH DAKOTA MEDICAL ASSOCIATION

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Testimony in Opposition to HB 1488
House Human Services Committee

North Dakota Psychiatric Society
North Dakota Medical Association
January 27, 2009

Good morning Chairman Weisz and Committee Members. I'm Bruce Levi and I represent both the North Dakota Psychiatric Society and the North Dakota Medical Association.

Both physician organizations oppose HB 1488, which would allow a "medical psychologist" to prescribe medications "customarily used in the diagnosis, treatment, and management of an individual with a psychiatric, a mental, a cognitive, a nervous, an emotional, or a behavioral disorder." Psychologist prescribing bills have been defeated in a large number of states over the past years. The North Dakota Psychiatric Society and the North Dakota Medical Association oppose permiting psychologists – who are not medically trained and who are not physicians – to prescribe psychotropic medications.

With me today is Dr. Andrew McLean, a psychiatrist who is here to testify on behalf of both the ND Psychiatric Society and the North Dakota Medical Association.

WHO IS INVOLVED?

Representatives from the Community
AARP Community Council
Badlands Human Service Center
Coalition for Horticulture & Human Wellbeing
Community Action and Development Program, Inc.
Dakota West Region Retired & Senior Volunteer Program (RSVP)
Dickinson Clinic
Dickinson Police Department
Dickinson Public Schools
DSU Department of Nursing
LoAnn's Marketing
Domestic Violence & Rape Crisis Center
Elder Care
Evergreen Inn
Great Plains Clinic, PC
NDSU Extension Service
Region VIII Children's Services Coordinating Committee
Sacred Heart Monastery
St. Benedict's Health Center
St. John's Lutheran Church
St. Joseph's Hospital and Health Center
St. Luke's Home/Park Avenue Villa
Southwest Coalition of Safe Communities/Prevention
Southwest Mental Health Association
Southwestern District Health Unit
Stark County Social Services
Trinity Catholic Schools System
West Dakota Parent & Family Resource Center
West River Regional Medical Center
Western Wellness Foundation
Westwind Consulting Center
Women's Way

HEALTHY 8 COMMUNITIES NETWORK

30 West Seventh Street
Dickinson, ND 58601-4399
Phone: 701-264-4274
Fax: 701-264-4801

HB 1488

HEALTHY 8 COMMUNITIES NETWORK

Assuring a Healthy Community for the People of Southwestern North Dakota

Tel: 701-264-4274

WHAT IS THE HEALTHY 8 COMMUNITIES NETWORK?

The Healthy 8 Communities Network was established to assure a healthy community for all people by empowering the community to take responsibility for health through on-going assessment, education, advocacy, intervention, prevention, cooperation, and collaboration.

HOW WILL THIS BE ACCOMPLISHED?

Members of the Healthy 8 Network identify, promote, and coordinate community-based programs that encourage healthy lifestyles for southwest North Dakota. Specifically, the following health priorities have been identified and assigned to committees:

- Cancer;
- Physical Activity, Fitness & Nutrition;
- Mental Health and Mental Disorders

MEMBERSHIP

The Healthy 8 Network is representative of any individual or organization who supports and encourages promoting healthy communities.

Membership is open to anyone who possesses:

- a commitment to improving the health of residents in southwest North Dakota,
- knowledge of southwest North Dakota and its people,
- a broad perspective in identifying and planning programs,
- enthusiasm,
- resourcefulness,
- and a team oriented approach.

Executive Committee Membership

The Healthy 8 Executive Committee shall be comprised of the Chairperson, Facilitator, and one (1) representative from each of the following groups: support service providers, human service providers, hospitals, long-term/basic care, private health care practitioners, and community-at-large.

The Healthy 8 Network Chairperson shall meet the following criteria:

- Qualifications of a member listed above.
- A leader in the community.
- Group facilitation skills.

Task Force Membership

Each Healthy 8 Network member will participate on a minimum of one task force. A chair and/or co-chair will be volunteer positions from the task force membership.

Responsibilities of Members and Executive Committee

Members will be responsible to:

- attend network meetings.
- serve as a member of a task force.
- participate in the identification, selection, and promotion of innovative healthy lifestyle activities.
- help assess community needs and identify existing resources.
- develop plans of action to carry out the mission.
- strive to coordinate programs and resources to maximize impact.
- develop a mechanism for evaluating and monitoring the strategies.
- recruit and retain membership and encourage participation.

AMERICAN PSYCHIATRIC ASSOCIATION
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Talking Points in Opposition to Psychologists' Practicing Medicine

States should reject psychology's attempts to gain prescribing privileges because psychologists do not have the medical background necessary to safely prescribe brain medications for patients.

Organized psychology is seeking the authority to prescribe psychotropic medications for mental illnesses.

- Only two states, New Mexico and Louisiana, have legislatively granted psychologists prescribing privileges. Rules were put in place in January 2005 to implement the programs. There is no "track record" demonstrating the safety of psychologists prescribing in either state yet.

- Psychologists' prescribing bills have been consistently defeated in more than 20 states since 1985.

The psychotropic medications used to treat mental illnesses are among the most powerful available to modern medicine.

- Psychotropic medications have potential disabling and deadly side effects. When not properly prescribed, they can cause convulsions, epilepsy, heart arrhythmia, blood diseases, seizures, severe high or low blood pressure, coma, stroke or even permanent disability or death. (For example, many antidepressant medications can cause a stroke, coma, seizures and tremors.)

- Fifty percent of the patients that require brain medications have other serious medical conditions requiring medications. All medications circulate in the same blood stream, perfuse the brain and every other body organ and interact with every other medication that a patient might be taking. Safe patient care requires that the treatment of other illnesses and the effects of other medications be integrated with the use of brain medication.

- Effective use of medications to treat brain disorders requires medical training, with a thorough understanding of physiology, chemistry, drug interactions and medical problems that masquerade as or cause brain malfunctions. Diagnosing and using medications to treat mental illnesses such as clinical depression and schizophrenia requires the same level of medical skill and knowledge as diagnosing and treating heart disease or diabetes. It is as important to know when not to prescribe as it is to know when to prescribe.

Psychologists are not qualified to prescribe medication.

- Psychologists, who can earn their Ph.D. by taking only a single course in the biological basis of behavior, are trained in the social and behavioral sciences and provide services that do not physically invade the body cavity, such as psychological assessment and psychotherapy. During their training, they do not observe the treatment of patients with medical illnesses other than mental disorders.

- Psychiatrists are medical doctors who specialize in the diagnosis and treatment of mental disorders and substance abuse disorders. Like other physicians, psychiatrists spend 12 or more years in medical school, internship and residency (learning, for example, anatomy, biology, chemistry, physiology, pathology, medical technology, neurology and pharmacology) and complete 10,000 hours of training. During their training, which occurs in a hospital setting under the supervision of senior physicians, a psychiatrist manages the care of 200-300 patients with a range of physical and emotional illnesses, performs examinations, renders medical diagnoses, provides medication or other treatment and monitors the effects of treatment.

The prescribing training programs proposed by organized psychology will not provide psychologists with the medical training necessary to safely prescribe psychotropic medications.

- The American Psychological Association's model curriculum for training psychologists to prescribe, a two year program of evening, weekend or home study courses, requires only 300 hours of didactic instruction and a clinical practicum involving 100 patients

- A cosmetology certificate requires twice as many hours of study (600) as psychologists propose in order to prescribe brain altering chemicals.

An unsuccessful Department of Defense (DoD) pilot program to train psychologists to prescribe was terminated by Congress in 1996.

- The program was not sought by the DoD but was initiated by a U.S. Senator staffed by a psychologist associated with organized psychology.

- In six years, only 10 psychologists graduated from the program, at a cost to taxpayers of $610,000 each.

- A 1997 General Accounting Office (GAO) report condemned the psychologist prescribing program, finding that "psychologists are not qualified to prescribe medication."

Non-physician professionals who do prescribe have medical training.

- Nurse practitioners and physicians' assistants, who have substantial training in the medical model, are better suited to be limited prescribers than are psychologists. In many states, nurses and physicians' assistants are authorized to dispense limited kinds of medications under the supervision of a physician. (They generally prescribe birth control pills, antibiotics, decongestants and topical skin medications.) Podiatrists and dentists, whose prescribing privileges are limited to the foot and the mouth, are also trained in the medical model.

- Some psychologists do prescribe as licensed nurse practitioners or physician assistants. This avenue to earn prescribing privileges through medical education has long been – and remains open to them.

The issue of psychologists' prescribing is divisive within the profession of psychology.

- Many psychologists, both practitioners and academicians, as well as the American Association of Applied and Preventive Psychology (the American Psychological Association's clinical affiliate) and the Society for the Science of Clinical Psychology (a division of the American Psychological Association) oppose prescription privileges for psychologists.

- Prescribing would change the nature of clinical psychologists' practice and training at the undergraduate, graduate, post-doctoral and continuing education levels. Many psychologists do not want their profession to be legislatively redefined.

- Prescription authority, when sought by other non-physicians such as nurses, was not controversial within the profession because their training was already medical in nature.

There is no societal need to grant psychologists prescription privileges.

- There is no shortage of prescribing professionals, nor is there consumer demand for additional prescribers. Training psychologists to prescribe unnecessarily duplicates health care services already provided by medical professionals.

- Psychologists are not geographically better situated to serve rural populations, as they are generally located in the same areas as psychiatrists. The needs of underserved areas can best be met by improving the mental health training of general physicians and other medically trained practitioners, who are more widely distributed than psychologists. (In some states, such as Montana, access to mental health care is being improved through outreach clinics, telemedicine, focused psychiatric recruitment and education of primary care physicians.)

- Granting psychologists prescription authority will increase health care costs. Psychologists' liability insurance would rise dramatically and additional training and regulatory resources would be needed. These costs would be passed on to patients and taxpayers.

Giving psychologists the prescription pad would be bad medicine for patients.

- High quality and cost effective treatment for mental health consumers can be provided by collaboration between psychologists and medical professionals. This type of collaboration has worked well for many years and is commonly practiced consistent with the established disciplines and in best interests of patients.

- The responsibility for patients' medical care should rest with those professionals who have medical training and experience.

Testimony

House Bill 1488

House –Human Services Committee

Representative Weisz, Chairman

January 27, 2009

Chairman Weisz, members of the House Human Services Committee, I am Dr. Andrew McLean. I am a Clinical Professor of Neuroscience, a psychiatrist. And while I wear many hats, I wish to be clear that I am here representing the North Dakota Medical Association, North Dakota Psychiatric Society, North Dakota Board of Medical Examiners, and no other agencies. I am here today to provide testimony in opposition of House Bill 1488, which allows a "medical psychologist" to prescribe medications "customarily used in the diagnosis, treatment, and management of an individual with a psychiatric, a mental, a cognitive, a nervous, an emotional, or a behavioral disorder."

I am actually appreciative of the Bill coming forward, as it challenges us all to discuss the important issue of mental health care access. My psychology colleagues are well trained to provide certain mental health care services. It is not about who is smart enough or cares enough. It is not about guild. It is about patient care and safety. And psychologist prescribing is the wrong solution to the problem.

There are many reasons why the issue of psychologist prescribing continues to be brought forward in states. What you will hear or have heard is this:

That access to psychiatric care is limited, particularly in rural areas. That the majority of prescribers of psychotropic meds are not psychiatrists, and

that mental health issues, including that of suicide, are too great not to allow psychologists to prescribe.

Our premise is this: 1) There are adequate numbers of prescribers currently in the state of North Dakota. 2) We need to develop programs for assisting those medically trained prescribers in the recognition and treatment of mental illnesses. 3) We need to acknowledge and support the current scope of practice of our psychologists and other mental health care providers.

In the past 12 years, 2 states and one territory have passed such bills (and the program in the territory Guam, started by the department of defense, is now defunct.)

Meanwhile, 20 states have defeated such bills. And under current law in North Dakota and 47 other states psychologists are prohibited from prescribing medications. Why? Because it is a patient safety issue. The bill's qualifications for prescriptive authority are vague- "...an appropriate number of hours". There is no medical involvement or oversight in this legislation. Here is an example of one of the two states that have passed such bills:

Since July 2002, New Mexico psychologists in their program are allowed prescribing privileges after 450 hours in core courses. They also must then spend 400 hours treating at least 100 patients under the supervision of either a psychiatrist or "other physician".

Compare that to a typical medical student graduate, who prior to even starting residency would have completed 4000 hours of similar study, then, depending on the residency, such as psychiatry, would have 15,000 hours of supervised medical school and advanced training, or 15 times the hours required by a psychologist asking for prescribing privileges.

In New Mexico, using data from 2008, 3 psychologists had reached the level of independent prescribing, and 10 supervised prescribing. In the entire state, 2 psychologists were doing almost 75% of the psychologist prescribing to the same percent of patients, and the vast majority of prescribers were not in shortage and rural areas, but urban. (Please see the attached ND map indicating practicing psychologist and physician locations throughout the state.)

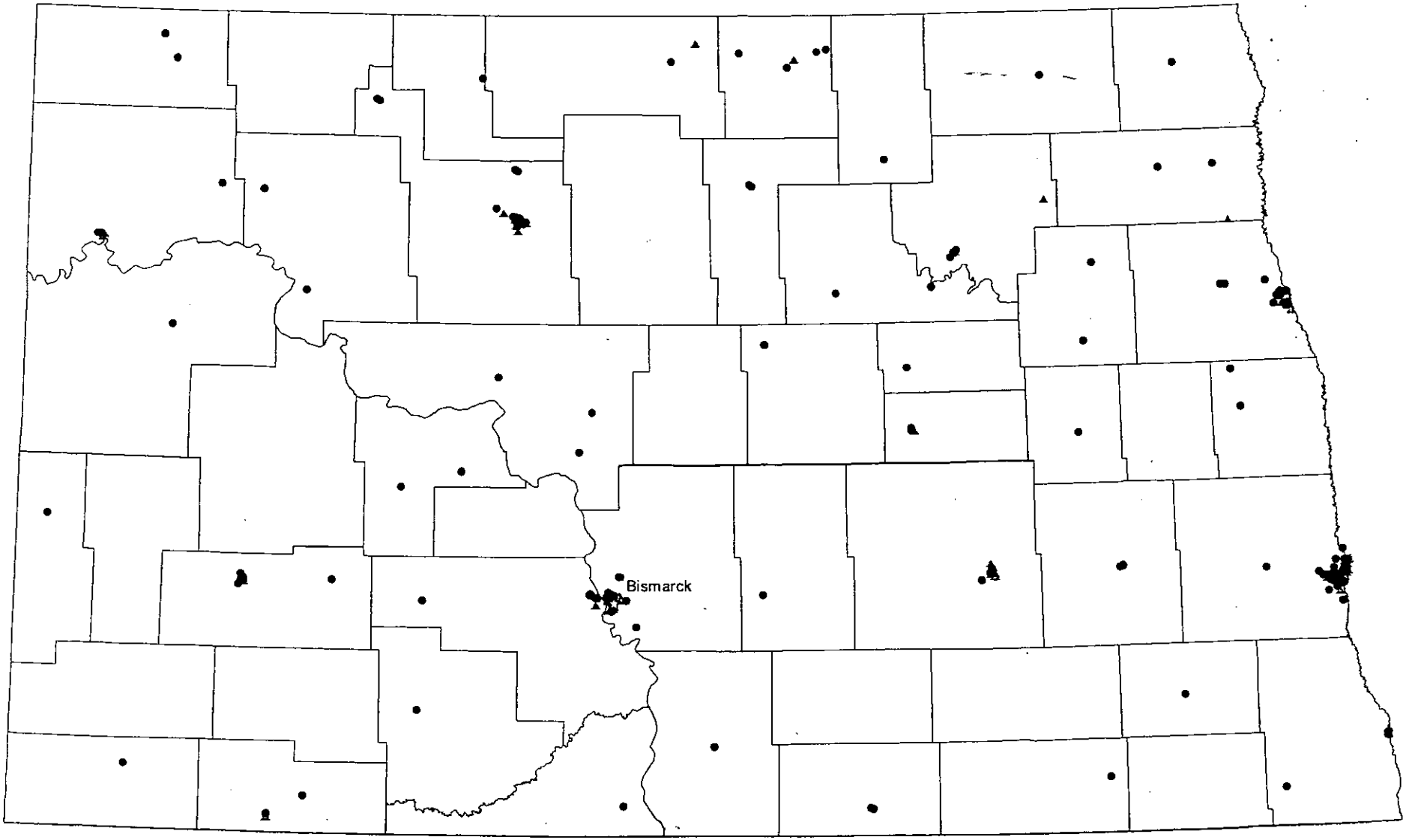
It is well recognized that those mental illnesses which require medical treatment are brain-based diseases. 50% of individuals requiring psychiatric care have medical co-morbidities. This means requiring not only the knowledge of potential drug-drug interactions, but medical knowledge of other illnesses. Every psychotropic medication I prescribe, even the so called "simple ones" have medical risks and potential interactions. And many of the current psychiatric treatments are almost analogous to "chemotherapy". Psychology prescribing programs permit the use of all of these medications. Over the years I have supervised many non-medical mental health professionals as well as medical students, residents, nurses, nurse practitioners, physician assistants, physicians, etc... I am still amazed that after all the years of medical and psychiatric training there are still gaps in knowledge and still learning to be done. But it is much better to build from a solid medical base than attempt to scaffold one from a non-medical background. Diagnosing illness and prescribing medication to treat it is based on a medical model of care. This demands full-time, thorough, medical education and training in order to practice safely and effectively. To propose part-time, shortcut training based on vague standards and requirements does a disservice to persons who need treatment for mental illnesses and substance use disorders. It is interesting that in this initiative is the implicit opposition to participating in established educational programs

such as Clinical Nurse Specialist, Nurse Practitioner or Physician Assistant programs, which include medical curricula and training.
General educational curricula for clinical psychologists deal minimally with human anatomy, physiology or biological principles. However, could a person with limited medical training safely prescribe *a* particular medication in *a* particular psychiatric case? Probably so. Could a person with much less hours of training than are currently required, fly a commercial plane and land it safely? Probably so. But as we've seen by the recent U.S. Airways flight into the Hudson, professional standards of training and experience are in place for a reason. It is the consistent training and practice over years which has been shown to lead to safe clinical care. The medical psychologist bill does not afford for that. Psychiatric prescribing is getting more complicated, not less. Serious psychiatric illnesses are associated more frequently with medical problems, not less.

So, what are the solutions? To develop programs for psychiatric access and consultation to current medically trained prescribers. To continue to develop tele-psychiatry, which is expanding in North Dakota. To continue to ensure collaboration among all mental health and primary care providers.
And finally, to build incentives and opportunities for those in medical training to pursue mental health practices. And as an editorial, we need more psychologists and behavioral analysts to assist in the non-medical behavioral care of individuals in our state, and they need to be adequately compensated for their services.
Again, to codify a substandard level of care as legally permissible in North Dakota would be a disservice to its citizens. We respectfully urge you to vote "No" on HB 1488

Thank you for your time. I would be happy to answer any questions.

North Dakota Psychiatrist and Primary Care Physician to Psychologist Distribution Comparison



● = the location of one or more actively practicing Psychiatrists (n = 85)

● = the location of one or more actively practicing Primary Care Physicians (n = 558)

▲ = the location of one of more actively practicing Psychologists (n = 180)

Data Source: American Medical Association, American Osteopathic Association (2008) and the North Dakota Board of Psychologist Examiners (July 2008)

AMA AMERICAN MEDICAL ASSOCIATION

National Center for the Analysis of Healthcare Data (2008)

House Human Services Committee
ND Psychological Association Regarding HB 1488
Provided by Paul Kolstoe
President of North Dakota Psychological Association

Chairman Weisz, Members of the Human Services Committee. My name is Paul Kolstoe, North Dakota Clinical Psychologist License Number 333 and President of the North Dakota Psychological Association. I appear today to present the position of the North Dakota Psychological Association on the matter of Medical Psychologists.

The NDPA wants to clearly recognize and support Rep. Nancy Johnson in bringing forward the needs of her community in their difficulty recruiting and retaining psychiatrists. This is a problem that is a challenge throughout North Dakota and, frankly, nationally as well. Through HB 1488 she and her constituents are attempting to address the shortage of appropriately trained mental health practitioners able to appropriately diagnose, prescribe medications, and monitor those medications. While other medical roles may legally prescribe medications, none but psychiatrists have been specifically trained for the mental health issues presented by patients. The legislature is the appropriate setting to consider alternatives and seek solutions to these increasingly unmet needs for appropriately trained mental health prescribers.

The official position of the North Dakota Psychological Association is neutral to the outcome of this bill. At this time our members are mixed in their support of HB 1488, but because it relates to the licensure of Psychology in North Dakota we feel obligated to let the legislature know of our Association's position.

Members appear to be in three categories. First - frankly, some psychologists are not interested in the additional effort and expense to attain Medical Psychologist status if it were available at this point in their career and are comfortable with their current practice. Second - another group of psychologists have no strong feelings on the matter, while recognizing that this is likely the future of psychology as society seeks appropriately trained mental health prescribers. Finally, there are some psychologists who are very enthusiastic and have already achieved preliminary training.

Again – as an Association we take no active role except to explain why we are neutral. Over the years the members of the North Dakota Psychological Association have been gradually shifting towards neutral or enthusiastic support of the Medical Psychologist role. However, while it involves the practice of Psychology at this time our membership has given us no mandate on the issue.

In summary,

- The ND Psychological Association (NDPA) is neutral to the overarching issue of the creation of the Medical Psychologist because our members' support is mixed. Opinions are diverse - while we have members who have obtained the preliminary training to be ready, others do not feel they want to assume this role.
- NDPA recognizes and is supportive of Rep. Nancy Johnson bringing forward the needs of her community. NDPA welcomes the full vetting of the matter through the legislative process.
- Finally, NDPA recognizes that North Dakota is severely challenged to recruit and retain appropriately trained Mental Health Prescribers, and this is a growing national problem that has reached critical status in rural areas.

Thank you for considering the points the North Dakota Psychological Association presents today. Addressing North Dakota's unmet needs of appropriately trained Mental Health Prescribers will not be easy and promises to be filled with strong emotions. It is a problem that the people of North Dakota need addressed, whether through this Medical Psychologist provision or through some other equally effective mechanism. I appreciate this opportunity to testify before you and would be happy to answer any questions.

ND STATE BOARD OF PSYCHOLOGIST EXAMINERS

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Testimony on HB 1488

Chariman Weisz and members of the Human Services Committee:

I am Dr Alan Fehr, clinical psychologist and president of the North Dakota State Board of Psychologist Examiners. We are a volunteer board, under appointment by the governor to regulate the profession of psychology in North Dakota.

Thank you for the opportunity to represent the Board of Psychologist Examiners' views regarding HB 1488.

We support HB 1488.

We do so with the understanding that approval of this bill will require considerable work for us as a board and involve additional expense. Although all psychologists in North Dakota are subject to application and renewal fees for licensure, this additional expense for certification of medical psychologists should be addressed through an additional application and renewal fee.

We recommend that Section 7 of HB 1488 include application and renewal fees for medical psychologists. In 43-32.1-03 we recommend inclusion of an application fee that

we could establish by rule to cover the application process and examinations, both oral and written. We recommend inclusion of an annual renewal fee in 43-32.1-04.

Currently, applicants for licensure as psychologists in North Dakota must have completed a doctoral degree in psychology, two years of supervised practice, and must have demonstrated competency by passing a national written exam and an oral exam with our board.

Medical psychologists would complete this licensure process and complete the additional regimen of training, supervised practice, and examination to be issued a certificate granting prescriptive authority.

We support this bill because we are concerned that citizens of North Dakota have access to the highest quality of mental health services, especially in less populated areas of the state. Currently, most citizens with mental disorders do not seek treatment, especially for the most common disorders, such as anxiety and depression. Those who do seek treatment tend to seek medical treatment from their primary care physicians, not treatment from mental health professionals. Research shows that, overall, the best treatments combine psychotherapy with closely monitored medical intervention.

By creating a new class of professional in ND – medical psychologists – there will potentially be an opportunity for citizens to have access to professionals who are highly

skilled in psychotherapy but also have the competency to responsibly provide treatment and monitoring of psychoactive medications.

As a regulating board, we are very aware of the implications to us, if this bill is approved. If this bill is approved, we will work to implement this bill through our administrative code to clarify the training requirements, supervision requirements, and collaboration with primary care physicians to ensure that medical psychologists operate safely and effectively for the citizens of North Dakota. To do so, we will draw upon model legislation from national organizations and the experience in jurisdictions that already allow for medical psychologists. We will hold hearings to gain input from medical professionals, psychologists, and the public.

We do not expect this process to be quick, nor do we expect a large number of psychologists to seek this training and credential. In fact, most established psychologists in North Dakota will probably not be interested in this training and credential. (For example, we have been told that the North Dakota Psychological Association is neutral to this bill.) We expect this credential to be of interest primarily to two groups of psychologists: psychologists from other states who already have gone through the additional training, and early career psychologists who are interested in undertaking the additional training. This credential should therefore attract professionals from other states, which we believe could serve the public well. As a board, we are committed to ensuring that these professionals have the training and experience to practice competently in our state, should this bill be passed.

I welcome your questions and look forward to an opportunity to testify in person.

Respectfully,

Dr Alan Fehr