

SB272

Presentation to Senate Committee:
Business, Labor, and Economic Affairs

This bill having been referred to the Business, Labor, and Economic Affairs Committee could be perceived as involving a "turf battle." That definitely is not the position of those in opposition to the bill. The Montana Psychiatric Association (MPA), the Montana Medical Association (MMA), the National Alliance on Mental Illness (NAMI) and the Psychologists Opposed to Prescription Privileges for Psychologists) POPPP are concerned regarding safety for patients. Members of the MPA and the MMA are already busy working with patients so there is no desire to be busier. Certainly NAMI and POPPP have no reason to be in a "turf battle."

Psychotropic medications are very potent with potential for serious side effects involving all systems in the body, not only the brain. The proposed two years Masters Degree in clinical psychopharmacology includes many subjects similar in name to medical school courses. The two years of clinical experience do not compare with education and training of physicians. Even back in the old days after I graduated from medical school there were four more years of supervised training in psychiatry and neurology followed by two years in clinical practice before being eligible to take the board examination. Patient safety relies on that much experience.

Previous concerns have been expressed regarding the opportunity for Prescribing Psychologists to occupy locations where psychiatrists are not readily accessible. The development of telemedicine in Montana is already helping to resolve that. Material prepared for the Committee reveals how scarcely that has been achieved in New Mexico and Louisiana, the two states that have allowed Prescribing Psychologists.

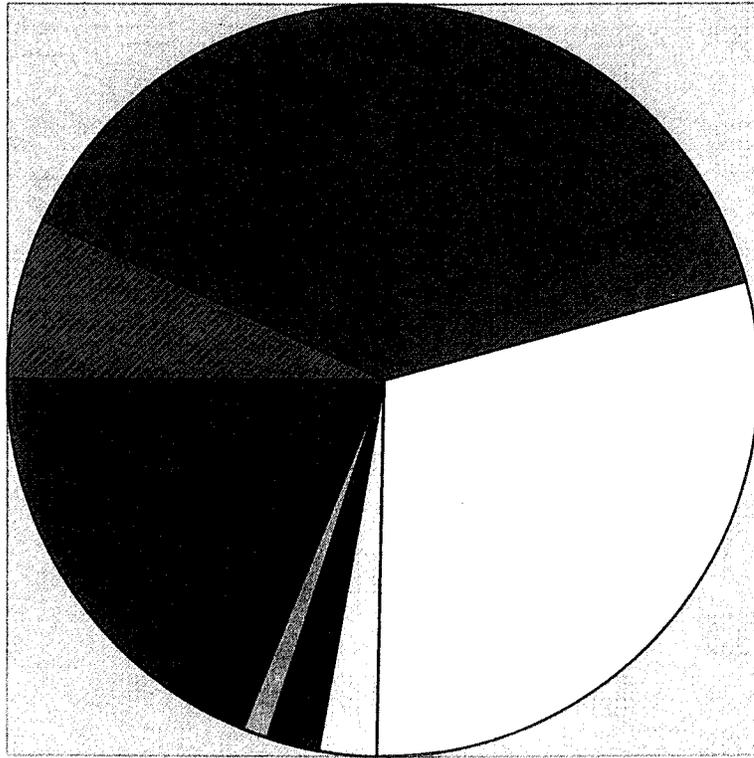
Understandably the Indian Health Service has a concern for those living on reservations. However, being a federal agency there are ways already demonstrated to approach that problem without requiring a Montana Statute to allow Prescribing Psychologists.

The Montana Psychiatric Association and the Montana Medical Association join the National Alliance on Mental Illness and the Psychologists Opposed to Prescription Privileges for Psychologists in requesting a do not pass on SB272.

Thank you,

Donald Harr, M.D.

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



- Metro - 1 million +
- Metro - 250 K to 1 million
- Metro - < 250K
- Non-metro - 20K+, adjacent metro
- Non-metro - 20K+, not adjacent metro
- Non-metro - 2,500 to <20K, adj. metro
- Non-metro - 2,500 to <20K, not adj. metro
- Rural or <2,500, adj. metro
- Rural or < 2,500, not adj. metro
- Out-of-State

*Note: There are no prescribing psychologists practicing in Guam despite legislation being passed granting prescriptive authority to psychologists in 1999.

Distribution of psychologists authorized to prescribe medications in Louisiana

Rural-Continuum Codes	La	Percent	Populace	Percent
1 = County in metro area with 1 million population or more	6	9.7%	1,316,510	29.5%
2 = County in metro area of 250,000 to 1 million	24	38.7%	1,081,938	24.2%
3 = County in metro area with fewer than 250,000	20	32.3%	942,219	21.1%
4 = Nonmetro county with 20,000 or more, adjacent to metro area	2	3.2%	522,762	11.7%
5 = Nonmetro county with 20,000 or more, not adjacent to metro area	0	0%	0	0%
6 = Nonmetro county with population 2,500-19,999, adjacent to metro area	1	1.6%	483,625	10.8%
7 = Nonmetro county with population 2,500-19,999, not adjacent to metro area	0	0%	81,510	1.8%
8 = Nonmetro county completely rural or less than 2,500, adjacent to metro area	0	0%	10,560	0.2%
9 = Nonmetro county completely rural or less than 2,500, not adjacent to metro area	0	0%	29,852	0.7%
Out-of-State*	9**	14.5%		
TOTAL	62		4,468,976	

*Out-of-State means they are licensed in Louisiana but are no longer practicing in the state

**One medical psychologist in Louisiana is "out-of-state" but also licensed as a prescriber in NM; this psychologists' information regarding practice can be found in the NM data; thus, there are actually 61 medical psychologists licensed in Louisiana

Distribution of psychologists authorized to prescribe medications in New Mexico

Rural-Continuum Codes	NM	Percent	Populace	Percent
1 = County in metro area with 1 million population or more	0	0%	0	0%
2 = County in metro area of 250,000 to 1 million	9	37.5%	729,649	40.2%
3 = County in metro area with fewer than 250,000	5	20.8%	417,775	23.0%
4 = Nonmetro county with 20,000 or more, adjacent to metro area	0	0%	137,096	7.6%
5 = Nonmetro county with 20,000 or more, not adjacent to metro area	2	8.3%	213,595	11.8%
6 = Nonmetro county with population 2,500-19,999, adjacent to metro area	0	0%	171,618	9.5%
7 = Nonmetro county with population 2,500-19,999, not adjacent to metro area	2	8.3%	133,366	7.4%
8 = Nonmetro county completely rural or less than 2,500, adjacent to metro area	0	0%	5,180	0.3%
9 = Nonmetro county completely rural or less than 2,500, not adjacent to metro area	1	4.2%	3,543	0.2%
Out-of-State*	5	20.8%		
TOTAL	24**		1,814,872	

*Out-of-State means they are licensed in NM but are no longer practicing in the state

**Two New Mexico psychologists have 2 practices in different areas (one in 2 and 3; the other in 7 and 9); thus the actual number of NM psychologists is actually 22

S&D Harr

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Sent: Thursday, March 17, 2011 2:13 PM
Subject: FW: Psychologist Opposing SB 272 - Clarifying the Issue of Suicide

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Subject: Psychologist Opposing SB 272 - Clarifying the Issue of Suicide

Dear Honorable Representatives,

The Health and Human Services Committee will soon be considering SB 272. As a psychologist I strongly oppose this bill, which is deeply flawed and dangerous for several reasons. Please allow me to address one issue frequently cited by the bill's advocates: That the risk of letting online-trained psychologists prescribe powerful drugs is necessary to reduce the rate of suicides in Montana. I hope to show you that these claims are wrong and misleading. This bill is neither necessary nor would it be effective in addressing the issue of suicide in Montana.

1. Advocates of SB 272 say Montana's suicide rate is second in the nation. The 2006 statistics by the American Foundation for Suicide Prevention do rank Montana as Number 2. However ... data taken from the National Center for Health Statistics and Bureau of Census make the issue clearer: When the numbers are adjusted for age, then Montana was NOT 2, but instead fell to 48th in the nation. Furthermore, these statistics show that Montana is ranked No. 32 in America in the prevalence of depression. These numbers make the real problem clear: Montana has more residents who are more likely to commit suicide because of their age group, not because of depression or a shortage of prescribers. Adding dangerously undertrained prescribers will not change the demographics of Montana.

2. The same figures cited by advocates of SB 272 show that right behind Montana, the state with the third highest suicide rate is New Mexico. As you may know, New Mexico is one of two states that allowed psychologists to prescribe, in 2002. Not only was that legislation ineffective in lowering New Mexico's ranking, it actually grew worse after psychologists received prescribing privileges, moving up from No. 5 to No. 3 in 2006. This is evidence that such risky changes in mental health care are ineffective in addressing important public health problems. Again, the numbers say the problem was NOT a shortage of prescribing psychologists.

3. The same thing happened in Louisiana, which is the other state that has allowed psychologists to prescribe. That state showed a higher rate of suicide, moving up one place in 2006 as well. Again, this indicates that such legislation is not effective.

4. An article from the psychiatric press, provided in a link below, shows that either medication OR psychotherapy will reduce the number of suicide attempts. Psychologists are obviously already trained to provide psychotherapy, which will reduce suicides. Adding drugs prescribed by undertrained psychologists, who already can reduce suicide attempts with counseling, is unnecessary.

<http://pn.psychiatryonline.org/content/42/15/1.2.full>

5. The same article notes that primary care physicians prescribing medications are as effective as psychiatrists in preventing suicide attempts. There are in fact 1,258 medical providers trained and authorized to prescribe psychoactive medication. Putting a prescription pad in a few undertrained psychologists' hands is not necessary, but it is dangerous.

Thus, the demographics of Montana's population is the principal reason for its suicide rate, not because Montanans are more depressed than other Americans (they are less depressed) or they need more drugs by undertrained prescribers. May I suggest Montana needs collaboration between psychologists and medical providers, each adding their own special expertise.

If you would like to discuss this or wish other information, I would be glad to stay in touch by email or through the telephone.

Respectfully,

Tim Tumlin, Ph.D.

Timothy R. Tumlin, Ph.D.
Darien, IL

S&D Harr

From: "S&D Harr" <ssurelyl@Q.com>
To: <taylor@northernbroadcasting.com>
Sent: Friday, February 18, 2011 8:46 AM
Subject: Fw: Psychology scope of practice

----- Original Message -----

From: Michael Silverglat
Subject: Psychology scope of practice

What I would like the legislature to know

1. Since 1995, measures to authorize psychologists to prescribe medicine have been introduced in 24 states, including Montana. The measure has been rejected by the legislature in 22 states, including three times in Montana.
2. Only two states have approved psychologist prescribing, despite years of intense activity funded and encouraged by the American Psychological Association. Louisiana and New Mexico approved it in 2004 and 2002, respectively. Consequently, there is almost no track record (except from the psychologists themselves) that shows that psychologists can prescribe potent brain medications safely and effectively to patients with serious psychiatric illnesses.
3. Persons without medical training should not be permitted to prescribe medicines. Physicians, physician assistants, and nurse practitioners have medical training and are qualified. Psychologists do not have medical training. A correspondence course "master's degree in psychopharmacology" would not change that fact. When the prescription is written, the prescriber must be aware of the status of the patient's metabolism, heart, blood pressure, nervous system, kidney function, liver function, chronic illnesses, and other medications. How can a psychologist evaluate all of that without having studied those systems in detail?
4. These risks are not theoretical. Here is a single example: Quetiapine is widely used for treatment of schizophrenia and bipolar disorder. The manufacturer's prescribing information for this drug warns that it may cause syncope, dystonia, neuroleptic malignant syndrome, diabetes mellitus, QT prolongation, agranulocytosis, and Stevens-Johnson syndrome, among others. How can a person who is not familiar with those conditions ever recognize them if they occur? The answer is that they cannot. When they occur, the patient will go to an emergency room or primary care clinic, not to the psychologist.
5. Here are some real examples from my practice:
 - o High blood level of ammonia, causing encephalopathy and resulting in hospital admission (Depakote)
 - o A seizure in a brain-injured woman, one week after starting Wellbutrin
 - o Optic neuritis caused by Tegretol and resulting in permanent blindness in one eye
 - o Tardive dystonia caused by Zoloft, remitted slowly after the drug was stopped.
 - o A stroke in a 69 year old bipolar patient, 4 weeks after starting Abilify
 - o Sudden cardiac death 24 hours after starting a small dose of amitriptyline.
6. Every one of these events has occurred in my practice and some of the time, even the primary care physician did not think of the possibility of an adverse reaction to the patient's "mental" drug. Would a psychologist who is only superficially trained in physiology have seen what is happening?
7. What is really shocking and scary is a statement made at the legislative committee hearing the last time this topic came up for debate. A psychologist speaking in favor of it stated "Since psychologists have been prescribing in New Mexico, five thousand prescriptions

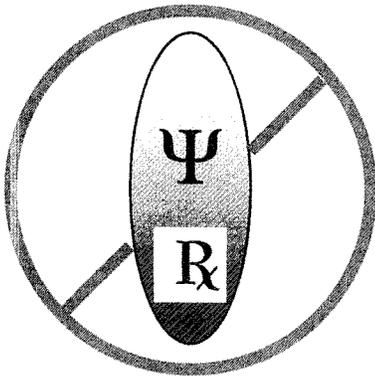
have been written without a single adverse effect." Any physician, pharmacist, or nurse could tell you that it is quite impossible to write FIVE prescriptions without an adverse effect, as it has little to do with the skill of the prescriber. Well trained, responsible prescribers know that adverse drug reactions are a certainty. Someone who does not know medicine will never know the harm they are doing.

Michael Silverglat

Postscripts:

1. It is to be expected that psychologists would try to style this effort as a turf battle. It is nothing of the kind. Every psychiatrist I know is busier than they want to be. We will never run out of patients, regardless how many other persons are writing prescriptions. We are not defending "territory". If we have the most active voice, it is because we know more about the risks and benefits of these drugs than do most others.
2. I know it is a picky point, but the idea that a master's degree in psychopharmacology would qualify someone to prescribe drugs for mental illness is way off track. We all studied pharmacology in medical school. It is one of the basic sciences, like histology, biochemistry, and physiology. Academically important, especially if you want to do research, but not a preparation for clinical practice. (My anatomy course certainly did not make a surgeon of me!)

MS



Petition

A REQUEST TO OPPOSE LEGISLATION GRANTING PRESCRIPTION PRIVILEGES FOR PSYCHOLOGISTS (SB 272)

We, the undersigned psychologists, petition the members of the House of Representatives of the State of Montana to OPPOSE any efforts to allow psychologists to prescribe medications. We consider prescribing by psychologists to be controversial, even among psychologists. The movement for prescriptive privileges originated within the Psychology profession, rather than being championed by other stakeholders, such as patient advocacy or public health groups. As psychologists, we oppose this proposal because we believe that it poses unnecessary risks to the public and would be an inappropriate and inefficient mechanism of addressing mental health needs of the population.

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

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

only by professionals who have undergone suitable medical training that prepared them to manage these medications within the context of patients' overall health conditions. Patients have a right to expect that their medications will be managed by professionals whose education adequately trains them to understand their health history, and assess their current health status, and the potential broad systemic effects of their medications. Unlike the training of current prescribers in other professions, the doctoral training of psychologists historically does not equip them to prescribe and manage medications safely.

Unfortunately, the American Psychological Association's (APA) model for training doctoral psychologists to obtain limited training in psychopharmacology, after they complete graduate school, does not match the levels required of other prescribing professionals (e.g., physicians, nurse practitioners, physician's assistants, optometrists) in terms of their overall training in matters directly related to managing medications. **The APA model is substantially less rigorous and comprehensive than the training required for all other prescribing disciplines.** Whereas the training of psychologists in certain professional activities, such as psychotherapy and psychological assessment, is generally more comprehensive than that of practitioners in other fields, this is not the case for training in clinical psychopharmacology. **The APA training model for prescribing even fails to meet the recommendations of APA's own experts** in its Ad Hoc Task Force of Psychopharmacology (e.g., in terms of undergraduate prerequisites in biology and other sciences) and has other inadequacies (e.g., lack of explicit requirements for supervision; accreditation of programs).

It is noteworthy that the APA training model is substantively less rigorous than the training that the 10 psychologists undertook in the experimental program of the Department of Defense (DoD). Despite the alarmingly small sample of that pilot program, which precludes generalizing from it, the fact that the current training model is far less comprehensive, and the fact that inadequacies were noted in some of the graduates of the DoD program, proponents of psychologist prescribing make the dubious claim that the DoD program justifies prescribing by psychologists. It does not! In fact, the final report on the DoD project revealed that the psychologists were "**weaker medically**" than psychiatrists and compared their medical knowledge to **students** rather than physicians.

Proponents of psychologist prescribing also have misleadingly invoked a range of unrelated issues to advocate for their agenda. An article in the *American Journal of Law & Medicine* entitled, "Fool's Gold: Psychologists Using Disingenuous Reasoning To Mislead Legislatures Into Granting Psychologists Prescriptive Authority" critiques the rationales that advocates of prescription privileges use to promote their cause. Proponents point to problems in the healthcare system, such as the rural and other populations that are underserved. Whereas such problems are indeed serious and warrant changes in the healthcare system, allowing psychologists to prescribe is neither an appropriate

nor an effective response. Permitting relatively marginally trained providers to provide services is not an acceptable way to increase access to healthcare services where high quality health care is needed. Rather than relying on under-trained psychologists to prescribe, it would be much more sensible to develop mechanisms to facilitate psychologists' providing those services that they are highly qualified to provide (e.g., counseling) to those populations and to innovate other approaches for medically-qualified providers (for example, collaboration, telehealth) to leverage available services. It should be noted that most psychologists practice in urban and suburban areas: There is no reason to expect that prescribing psychologists would have a significant impact on compensating for the shortages of psychiatrists in rural and economically disadvantaged areas, where relatively few actually work. Other remedies are needed to address such problems that would not compromise the quality of care.

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

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

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

There are alternatives to psychologists prescribing that we believe will have a greater positive impact on mental health services. A more promising means for enhancing the mental health services available to all citizens than to allow psychologists to prescribe would be to dedicate efforts to better integrating mental health professionals, including psychologists, into the healthcare system,

such as in primary care settings, where they could collaborate with other providers (who are prescribers) in the care of people who may need medications and psychological services. The barriers to such care have been detailed in a recent report by the U. S. Department of Health and Human Services, *Reimbursement of Mental Health Services in Primary Care Settings*. Overcoming the barriers to such care is an objective upon which psychologists agree with each other, and with other health professionals, and is clearly in the public interest. It would improve the quality of mental health care available in urban and rural areas.

We respectfully request that you oppose legislation that would allow psychologists to prescribe.

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