



Montana Psychiatric Association

A District Branch of the American Psychiatric Association

March 21, 2011

EXHIBIT 14
DATE 3/21/2011
HB SB 272

BEFORE YOU SUPPORT SB 272, BE SURE THESE QUESTIONS ARE ANSWERED TO YOUR SATISFACTION:

1. Is prescribing psychotropic medications practicing medicine?

Psychotropic medications are some of the most powerful medications available, and as such, have the potential for great good and great harm. To be able to independently prescribe any medication, physicians are required to undergo a minimum of 4000 hours of training. SB 272 would allow psychologist to prescribe with 444 hours of biomedical training and supervised treatment of 100 patients. Prescribing psychotropic medications is practicing medicine as psychotropic medications impact every organ in the body. This disparity in training should at least give you pause to consider the adequacy of training outlined in SB 272.

2. Does Montana need more "prescribers"?

At a minimum, Montana has 2259 physicians, 610 nurse practitioners, and 397 Physician Assistants for a total of 3,266 professionals with prescriptive authority to prescribe psychotropic medications. There is already a sufficient number of "prescribers" in Montana, but they are not evenly distributed, a problem that exists throughout rural and poor America.

3. If psychologists are allowed to prescribe psychotropic medications, is there any reason social workers, licensed professional counselors, and marriage and family counselors should not be given the same opportunity?

No. Social workers, licensed professional counselors, and marriage and family counselors have extensive amounts of training and experience in the social sciences (like psychologists) and if psychologists are allowed to prescribe, there is no logical barrier to these behavioral experts prescribing as well.

4. What is the evidence that psychologists will solve the "access to care" problem?

Rural areas in the United States have had longstanding "access to care" problems, and Montana is no exception. However, there is no data to suggest that prescribing psychologists will practice in areas where physicians or psychiatrists do not practice. "Access to care" is also a problem for people unable to pay for care. Again, psychologists are not likely to provide more uncompensated care than are physicians or psychiatrists.

In the two states (New Mexico and Louisiana) where psychologists have prescriptive authority, they have not solved the problem of "access to care." In New Mexico, there are reportedly 22 licensed prescribing psychologists. Of those: 2 had Illinois addresses, 9 practice in metropolitan areas of more than 250,000, and 2 practice in a town with a population less than 20,000. In Louisiana, there are reportedly 60 psychologists with "medical psychologist" designation. Of these: 8 did not have a Louisiana address, 75+% are located in the eight largest cities, and 1 practices in a town of less than 20,000.

5. What is the evidence that psychiatrists are opposing SB 272 because of "turf" issues?

Montana psychiatrists have high case loads. There are no trends indicating a lessening of need for psychiatric care into the foreseeable future. Any talk of "turf" issues ignores the day-to-day realities of Montana's practicing psychiatrists.

6. How accurate is the fiscal note attached to SB 272?

The Board of Psychologists estimates a one-time cost of \$6,148 for SB 272. If psychologists plan to ease the "access to care" issue with their prescriptive authority, they will likely be writing prescriptions for Medicaid clients. According to the 2010 Kaiser Commission on Medicaid and the Uninsured, Montana was one of five states with the highest rate of growth of Medicaid enrollment for children from June 2009 to June 2010 (>18%) and one of six states with the highest rate of growth of Medicaid enrollment for adults over the same period (>15%). In view of these figures and the psychologists' goal of solving "access to care" in Montana, it is rather disingenuous to imply that SB 272 will only add a one-time cost of \$6,148.

7. Why is it okay that the person who treats your brain can have 444 didactic hours + supervision of 100 patients, and the person who treats your heart (cardiologist) needs 16,000 hours of training?

It is obviously not okay, and no one would argue that the brain is less complicated than the heart. The fact that we would consider granting non-medically trained professionals the authority to prescribe for the brain again speaks to the ill-conceived nature of SB 272.

8. Does SB 272 have similar training and supervision requirements to New Mexico's psychology prescribing law?

It does not. Psychologists promoting SB 272 have implied that this bill mirrors the New Mexico psychology prescribing bill. New Mexico's psychology prescribing law requires more intensive training and supervision of psychologists who eventually obtain independent prescriptive authority, compared to the training and supervision requirements listed in SB 272. In spite of the increased requirements of the New Mexico psychology prescribing law, it is still not considered adequate to assure the safe prescribing of powerful psychotropic medications. For your reference, the specifics of New Mexico's psychology prescribing bill are detailed below.

The New Mexico psychology prescribing bill requires that a doctorate-level psychologist who wants prescribing privileges must attend 450 hours of classroom training in pharmacology, neuroscience, physiology, pathophysiology, and clinical pharmacotherapeutics. These training courses require approval by both the New Mexico Board of Medical Examiners and the New Mexico Board of Psychologist Examiners. Following completion of this classroom training, the psychologist-prescribing candidate must spend 400 hours treating people with mental disorders under the supervision of a psychiatrist or other physician. Each psychologist-prescribing candidate must treat at least 100 people. Once these requirements are fulfilled, psychologists can then apply for a "conditional prescription certificate." If granted, this would allow them to begin a two-year period in which they may prescribe psychoactive medications, defined as "a controlled substance or dangerous drug" requiring prescription, administered for the treatment of mental disorders, and "listed as a psychotherapeutic agent in *Drug Facts and Comparisons* or in the *American Hospital Formulary Service*." For the first

two years, all prescriptions must be written under the supervision of a licensed physician whose name must be reported to the state medical and psychology boards overseeing the program. Once the board is satisfied that a psychologist has successfully completed the two-year conditional period, it will issue a prescription certificate permitting the psychologist to prescribe without a physician's oversight with the proviso that the psychologist must participate in 20 hours of continuing education each year. The physician who supervised the conditional period must certify that the prescribing psychologist "successfully completed two years of prescribing psychotropic medications." The prescribing psychologist must also "maintain an ongoing collaborate relationship with the health care practitioner who oversees the patient's general medical care to ensure that necessary medical examinations are conducted, the psychotropic medication is appropriate for the patient's medical condition, and significant changes in the patient's medical or psychological condition are discussed."

9. How many other states have passed laws allowing psychologists prescriptive authority?

Despite countless legislative battles in California, Connecticut, Florida, Georgia, Hawaii, Illinois, Louisiana, Mississippi, Missouri, Montana (1995, 2007, 2009), New Hampshire, New Mexico, North Dakota, Oregon, Tennessee, Texas, Utah, and Wyoming, only Louisiana and New Mexico have psychology prescribing laws. Utah just defeated a psychology prescribing bill. In May, 2010, Oregon's Governor vetoed a psychology prescribing bill stating "a policy change of this significance requires more safeguard, further study, and greater public input."

10. What will be the composition of the Board of Psychology who will be changed with setting standards and monitoring prescribing psychologists?

According to SB 272, the Board of Psychology "shall certify prescribing psychologists to prescribe and dispense drugs or medicine in accordance with applicable state and federal Law." There is no requirement that a physician or psychiatrist, or anyone with recognized biomedical training and expertise in the management of psychotropic medications, be a part of the Board of Psychology. In contrast to New Mexico's psychology prescribing law, there is no mention that Montana's Board of Medical Examiners be involved in the training or supervision of psychologists seeking to prescribe psychotropic medications. Such an oversight is consistent with the tenor of SB 272: to gain prescriptive authority by legislation rather than education.

Respectfully Submitted,

Virginia Hill, M.D.
Secretary
Montana Psychiatric Association

March 21, 2011

David B. Carlson M.D.
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Dear Representative:

I am writing with much concern about the course of Senate Bill 272 which legalizes an inadequately trained and inadequately supervised group of mental health professionals - Psychologists - to prescribe medication. The problems with this bill are numerous and I hope you might have the time to review at least a couple of the concerns that I have.

Let me first review my background: I am a Board Certified Psychiatrist and have practiced in Montana since 1986. I worked at the Yellowstone Mental Health Center and the Billings Clinic for 20 years, and currently run one of the units at the Montana State Hospital (Warm Springs). I have been the Medical Director (Chief) of Psychiatry at the Billings Clinic, and have been intimately involved in trying to address Montana's shortage of mental health providers.

I fear the Montana Psychological Association has tried to "poison the well," and dismiss the concerns of myself (and those of my colleagues, the National Alliance for Mental Illness groups in Montana, The Montana Medical Association, and others) as a "Turf War." I assure you it may be so on the part of the Psychologists (as insurers are reimbursing them less and less), but not on the part of the Montana Psychiatric Association. If this would work we would support it as we feel the need most intensely of any providers involved. Our concerns are that this solves NO problems and will certainly create others. We see no financial benefits to ourselves by stopping this legislation, but you should be able to see the financial incentive of every proponent of this legislation - the Psychologists and those running the schools who come before you.

I have been very distressed by the politics of this situation. It has been repeatedly brought to the Montana Legislature (1995, 2007, 2009). It has been presented to and rejected by a number of committees, including finance and health committees. In my opinion, it has historically been brought to committees most "loaded" to support it. The duration of the proponent testimony at the Senate Business, Labor, and Economic Affairs Committee (Committee) exhausted the Committee, many of whom left prior to considering the opposition. The venue was inadequate, with seating for only a fraction of the interested parties. In short, I thought the deck was stacked.

Montana is currently a "target" for the American Psychological Association's national effort for this type of legislation. They have spent tens of thousands of dollars in Montana just on their 2011 effort. They have 4 lobbyists while we (Montana Psychiatric Association) have just 1.5 lobbyists. Psychologists are usually much more persuasive than Psychiatrists. After all, they studied the social science of human behavior and relationships, whereas Psychiatrists start out as Medical Doctors who, in addition to a high level of training in the structure and functioning of the whole human body, have focused on human behavior and the function of the brain. We have to trust that the truth will prevail over the money in this instance. I'll try to be succinct in describing my objections to this proposal:

- 1) Psychologists have no undergraduate and very little postgraduate education in chemistry,

anatomy, biology, or physiology. As a consequence, they have no foundation to learn the biochemistry, neuroanatomy, or advanced physiology that is the foundation for pharmacology. Psychology training programs show high inconsistencies in their focus and curriculum. The exposure to scientific medical information varies from little to none, even at the PhD level.

- 2) Psychologists have little to no experience with serious mental illness - Schizophrenia, Acute Bipolar Disorder, Major Depression - are not usually very responsive to talk therapy and patients are not involved with Psychologists until the major symptoms and risks are controlled in a hospital setting. Most Psychologists - close to all of them - have never even worked in a community hospital much less a State Hospital. We have 1 or 2 psychology students from the University of Montana PhD program at Montana State Hospital every year. They are within months of graduation with their doctorate, but they are clearly shocked by what they see here and have obviously not been prepared by their training for dealing with serious mental illness. I have tried to teach some of them some pharmacology but they have no background on which to formulate a common language to facilitate their learning. These are the disorders that generate much of the violence and suicidality that Psychologists claim they can recognize and treat.
- 3) Psychologists claim that a similar program halved the suicide rate in New Mexico. This is patently not true. We have twice now publicly confronted them with the facts and they keep using the same information (quieter this go-around). The presented suicide statistics were released in 2009. The numbers showed a decreased rate in New Mexico from #50 (worst) to #48 while Montana went to #50. It turns out this is not change beyond the level of chance variability (and they know that too). More important is that the data was collected from the years BEFORE psychology prescribing went into effect in New Mexico - it takes a few years to gather, confirm, and sort the information. Call them or their lobbyist and ask them please. They tried to use the same argument this year and I have been shocked by their brazen and blatant persistence with this fabrication - pushed not only in our face but in yours.
- 4) The Montana Psychological Association presents Psychologist prescribing as having "no problems" in other states. This is a word game. What do they mean by the word "problem"? I am considered an expert in the field of Psychopharmacology and have lectured in hundreds of teaching situations as well as having involvement in researching several different medications. In spite of this background and experience, I still have patients with serious reactions and side-effects to medications. The truth here is there is no information and no effort to collect information on the part of the Psychologists on possible "problems."
- 5) The one prescribing Psychologist in the state testified at the Senate Business, Labor, and Economic Affairs Committee. He revealed with no embarrassment or concern that he was prescribing for children! You need to know that even Adult Psychiatrists are reluctant to prescribe for children. Current recommendations are for Pediatricians to at least consult with a Child Psychiatrist before or in the early stages of treatment. We just don't know enough about the long-term effects of these medications in children to be so

casual about this. The fact that he and his supervisor did not know this and still do not appreciate it is truly frightening.

Another concern with the one prescribing Psychologist was that his "supervision" to complete his training was by a Family Practice doctor. Don't get me wrong. I admire and value Family Practice physicians - they know a little bit about everything - but they are not qualified to supervise the training the Psychologists need and claim they will get. Mainstream medical care - Nurses, Physician Assistants, Nurse Practitioners, and Medical Doctors do not use Family Practice to teach anyone a specialty practice - or even aspects of a specialty. Family Practice training itself involves time training with specialists! They train with a Surgeon, an Ob-Gyn, a Pediatrician, a Cardiologist, etc. They integrate this knowledge with a Family Practice Faculty but are not viewed as having the depth of knowledge to train or supervise a specialist. Most Family Practice training programs have not spent time on a psychiatric inpatient unit, much less a child or adolescent unit. Formal child and adolescent psychiatric training is also not offered in Medical School.

- 6) Psychologists misrepresent their training, repeating the phrase "2 years." To try to understand what this really means, we should try to translate that into credits or hours. Medical training is highly standardized from school to school. I had more hours of training in the first 2 months of my 4 year medical school than their entire program. And that was after completing undergraduate requirements of biology, chemistry, physics, calculus, and genetics. This was then followed by 4 years of 60 plus hour weeks with direct supervision, and only gradual reduction of intensity of supervision during my psychiatric residency. There is no part of my training that a degree in a social science would have exempted me from - that contention on the part of the Psychologists is plain and simple hubris.
- 7) In addition, this bill provides for Psychologists to train Psychologists to prescribe! They try to compare themselves to being "like Physician Assistants or Nurse Practitioners - only better at Mental Health." One obvious and important difference is they are the only group training themselves OUTSIDE of the medical system. True, they have more training in the social science aspects of mental health than the other groups, but far less training (in both hours and the severity of illness addressed) than the full-time 2 year Physician Assistant programs (and P.A.s are not independent practitioners) and the 6 plus full-time years (not including the required nursing experience before going on in training) of a Nurse Practitioner. Nurse Practitioners with psychiatric qualifications are also required to train with Psychiatrists. Why is this type of training important? It speaks to the need for vigilance of the medical and long term side-effects of medications. The ability to recognize and "clean up" a mess you might have made rather than dump the patient on an emergency room or competent practitioner.
- 8) Psychologists have enlisted the support of Native Americans and, in my opinion, exploited the tragedy of their situation in a cynical effort to get privileges to prescribe all across Montana because of a problem in an area where they already have this privilege. The distribution of Psychiatrists and Psychologists is almost the same around the State of

PLEASE OPPOSE SB 272

Montana. In fact the Psychologists most involved in pushing this are from the major cities. They don't plan to move to a rural area. One excuse is along the lines of it would be easier to get training/licensure. Really? Do they plan to open a school to train Psychologists in Montana and expect a faculty to move here? Why can't they be "bothered" to pass an examination where they did their training? One more weekend trip when they have already taken so many to train? Doesn't make sense to me.

Let me be frank - I've worked with many Native American patients. It may not be politically correct, but I believe the major issues related to the high suicide rate on the reservations are drugs and alcohol. Combined with poverty, these issues have resulted in many generations of severe family dysfunction that reinforces the cycle. Native Americans do not have a suicide rate higher than other populations because of a higher prevalence of "mental illness genes." The rates are similar to other races, including Caucasians, in similar socio-economic situations. Now drug and alcohol problems and family dysfunction don't change with any prescription. No psychiatric medication can help much, if at all, with these problems. They are in fact the domain and expertise of the Psychologists! Rather than blaming the Psychiatrists for not being available, I think we should look at the FAILURE of Psychologists to do Psychology on the reservations. Of course they are no more geographically available there than the Psychiatrists.

In reality, if granted prescriptive authority, these practitioners are going to continue in solo practice in the 7 major towns of Montana and will provide medications to high functioning (insured) patients with situational and personality problems. This is not the population overwhelming Montana, and will have no effect on the crisis. They will either (correctly) bail out on the seriously mentally ill patients, or (dangerously) try more dangerous medications that they or their Family Practice Supervisor may have seen used once or twice before, and end up aggravating the problem. It's not just speculation - I've seen it before with Physicians who thought they knew what they were doing - but actually didn't know enough to realize they didn't know enough. But at least the Physicians had backup (hospital, coverage, supportive consultation, and referral relationships) to temporize and stabilize the problem until more resources could be organized. That will not happen here with the vast majority of the Psychologists.

- 9) As written this Senate Bill 272 allows Psychologists to prescribe ANY medication. Do we want people who have received the least amount of training (outside the Medical mainstream) in the use of only certain medications to be able to legally prescribe any medication? I won't be dramatic as I expect most of these practitioners would not do this - but some may or could.
- 10) Psychologists are going to supervise this training and practice. Really? A Board that has not been trained in this area is going to referee a group that is just starting this. How do we expect that to go? Will they participate in the Medical-Legal Panel? What is their malpractice coverage?
- 11) Most psychologists are not participants in the mental health system in Montana. This has already become an excessively fragmented system due to Montana's efforts to "privatize"

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a money losing proposition. Costs have gone up with less care available as a result. Most Psychologists do not have any association with a Mental Health Center and almost none with a community hospital even with a psychiatric unit. Few have any experience with an emergency room or have the 24 x 7 coverage that is MANDATORY when responsible for putting powerful chemicals in the body of another person. I fear these patients will end up being "dumped" on an already overtaxed and already cobbled-together emergency system.

- 12) The proponents describe this bill as like the Department of Defense (DOD) experiment to train Psychologists to prescribe which was terminated several years ago. They present that program as "a success," as indeed it was declared so by the DOD. I would contend this is similar to the U.S. declaration of "victory" when we left Viet Nam. The program cost several million dollars to train (by Psychiatrists) a few specially selected PhDs. As of my last investigation, it appears only a couple of these are still even seeing patients and none are with the military. This bill is not like the New Mexico legislation which was far more detailed about the training expected and involves some level of participation by the Medical Licensing Board - not just a license from Business and Industry.

There is much more, but I hope that is enough to cause you some disturbance about Senate Bill 272. If you read this far, I appreciate your time and patience. I hope the above will be considered in your vote. As I said in my testimony before the Senate Business, Labor, and Economic Affairs Committee, I had hoped for more openness and less politics here in Montana. I am very distressed by the misrepresentations and half-truths being repeated by the proponents of this dangerous bill.

Giving prescriptive authority to psychologists has been recently rejected in Oregon and Utah. In fact it has been rejected over 60 times in multiple state legislatures. This idea has been rejected by the Montana Legislature on three previous occasions. I do not think the Montana Legislature should be treated like a slot machine where one keeps pulling the handle until one wins. This time I fear that politics and the big out of state money could win and the citizens of Montana could lose. If you are at all moved by this information, please share or discuss this with your colleagues - or even opponents. If you have any questions or feedback, please do not hesitate to contact me (at the above) or the Montana Psychiatric Association. Ask the proponents the questions I have posed.

You have spent much of this session dealing with a huge problem created by the voters of Montana when they legalized Medical Marijuana without the involvement of medical science. Please do not legislate into practice a treatment that Psychologists have not obtained by training. If Montana approves this, we may as well put Prozac in the water supply - that is the level of judgment I expect from this group and their proposed training. Thank you for your consideration and hopeful assistance.

Sincerely,

David B. Carlson, M.D.

March 18, 2011

To the House Health and Human Services Committee

SB 272 will be heard by the House Health and Human Services Committee this coming Monday March 21st at 3:00 pm. This bill would allow psychologists to prescribe medications without attending medical or nursing school. Please oppose this bill.

I am Michael Silverglat. I have practiced medicine in Missoula for 26 years. Although board-certified in psychiatry, geriatric psychiatry, and sleep medicine, I currently practice only sleep medicine.

1. Proponents of this measure have attempted to frame it as a "turf battle" between psychologists and physicians. This is absurd. Physicians do not oppose prescribing by non-physicians **with adequate training**. Montana has at least 1,100 actively practicing physician assistants (PAs) and nurse practitioners (NPs) Most of them work closely with physicians. Their required 6-8 years of training and experience is constantly infused with medical sciences, making them valuable members of the health care team.
2. Psychologists, on the other hand, are trained in individual, family, and social topics including thinking, mood, personality, and behavior. Very few have any depth of biomedical training. (True story: I was once asked by a psychologist whether it was true that women had colons but men did not.) SB 272 would permit psychologists to take home-based courses intended to graft medical training on to their nonmedical degrees.
3. The medications used to treat mental illnesses are among the most powerful available to modern medicine. These medications have potentially disabling and deadly side effects. Even when properly prescribed and monitored, they can cause convulsions, cardiac arrhythmia, diabetes, severe high or low blood pressure, coma, stroke or even disability or death. (I have personally observed every one of these reactions in my practice.) These adverse drug reactions have little to do with the skill of the prescriber. They are inherent in all medications.
4. In addition, 50% of patients requiring psychotropic medications have other serious medical conditions like hypertension or diabetes. Their illnesses and their non psychotropic medications can and do interact (sometimes dangerously) with psychotropic medications.
5. Symptoms that appear to derive from mental illness may actually be symptoms of infection, cancer, or other serious medical problem. I have seen a woman admitted to the psychiatric hospital because a bladder infection made her delirious. One dose of sulfa completely cured her "mental illness." I have seen a man with depression that would not get better because it was caused by pancreatic cancer. If you don't know about these diseases, how can you recognize what is wrong?

Senate Bill 272: Permitting Psychologists to Practice Medicine

QUALITY OF CARE: Prescribing potentially dangerous psychotropic medicines is medical care, and the responsibility for patients' medical care must rest with professionals who have medical training and experience (physicians, nurse practitioners and physician assistants). To allow non-medically trained persons to provide direct medical care without any medical supervision or medical training is a risky gamble with the mental and physical health of Montana citizens.

Proper diagnosis of mental illness first requires evaluation for non-psychiatric medical illness. A high proportion of patients suffering from mental illness also suffer from medical illness. Symptoms that appear to derive from mental illness may actually be symptoms of infection or cancer.

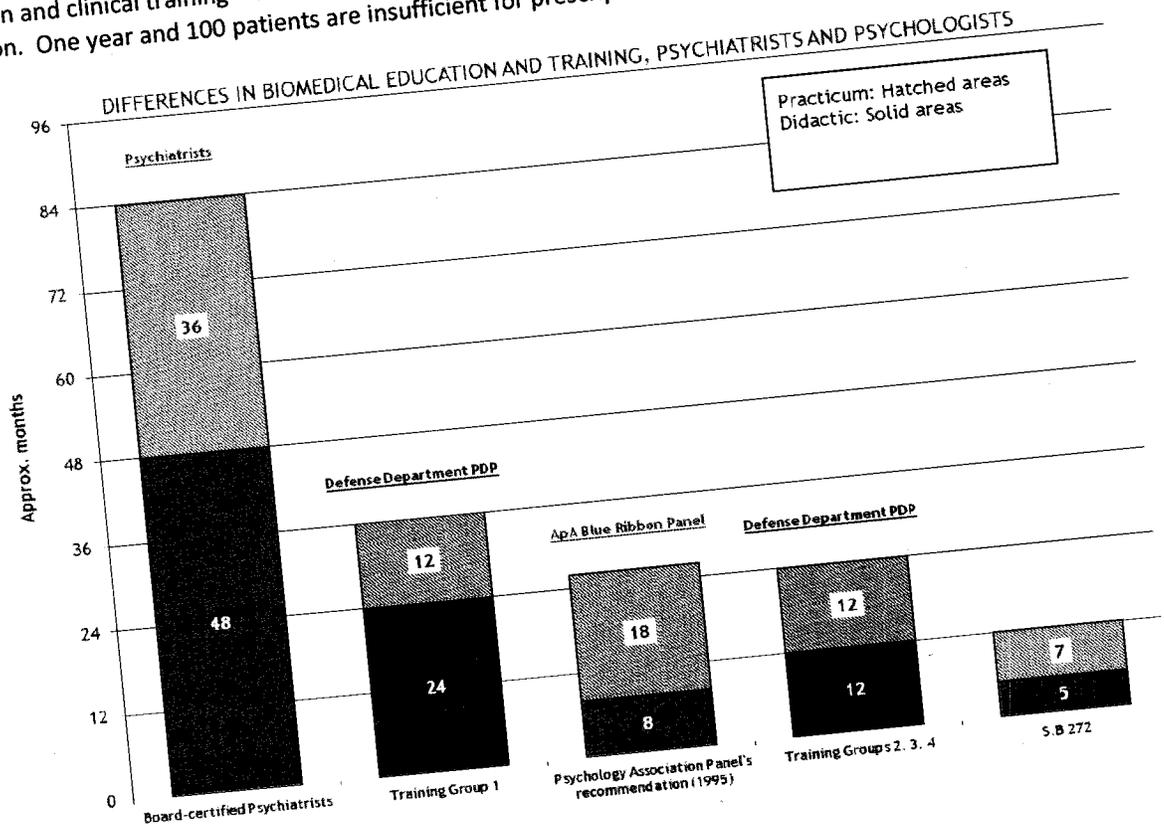
Since psychologists are trained in human development and behavior, and not medicine, their approach to psychiatric diagnosis is psychosocial, not medical. Psychologists have a significant deficit in basic sciences, from chemistry to biology to anatomy. Under S.B. 272, psychologists would be able to prescribe some of the most potent medications for complex patients who have co-morbid medical conditions.

Montana's patients deserve the highest quality psychiatric health care; Montana's patients would not be satisfied or well-served by a lower standard of care.

EDUCATION AND TRAINING:

S.B. 272 would allow psychologists to prescribe potentially dangerous psychotropic medications under vague training requirements, and would be overseen by a board which has no medically-trained members.

There is no recognized national standard for a "master's degree in psychopharmacology." It exists only among proponents and owners of psychology prescribing programs. The training language in S.B. 272 describes topics of study, but not the extent of that study. Even if we accept its advocates' description of a total of 444 hours of training, that is basically 7 weeks of a first year psychiatric residency. And the recommended practicum to actually see patients is only 1 year with 100 patients. Physicians have 4,000 hours of medical school education and experience, followed by more than 10,000 hours of residency education. One year and 100 patients are insufficient for prescriptive authority by any measure.



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From California Psychiatric Association

**SUMMARY/KEY POINTS,
June 2000 Report of the American College of
Neuropsychopharmacology (ACNP)* on the
Department of Defense Psychopharmacology Demonstration Project**

Key Notes: There is **no evidence** that anyone, other than one who was authorized to prescribe Adderall, has had any authority to prescribe any Schedule 2 medications such as **Ritalin**, Adderall and Dexedrin, commonly used to treat ADHD, and no evidence any are authorized to prescribe Clozaril.

Most of the medications they prescribe are the newer antidepressants, and individual graduates have either very limited, or no, experience with the medications used to treat bipolar disorder (manic-depression) or psychosis. The ones who are allowed to prescribe those medications often also have a requirement that they must consult with a psychiatrist before doing so and/or were closely proctored on their treatment of the patients on these medications.

–**All have physician backup**, and for all but the one in Iceland, that physician is a psychiatrist.

–None of them have treated long-term seriously mentally ill patients (those folks are sent to VA).

–**Apparently there is no patient outcome data**, because the supervisor of one of the psychologists (see page 18) suggested that any future programs “ought to collect patient outcome data (distress scales, hospitalization rates, suicide incidents, improvement rates, etc.) That would enable systematic comparisons of prescribing psychologists with relevant contrast groups.”

KEY POINTS FROM EXECUTIVE SUMMARY

“There was essentially unanimous agreement that the graduates were weaker medically than psychiatrists. ...In a few quarters, the criterion for ‘medical safety’ was equated with the knowledge and experience acquired from completing medical school and residency, and, of course, no graduate of the PDP could meet such a test.” (Page 6, point 2)

“The Evaluation Panel heard much skepticism from psychiatrists, [other] physicians, and some of the graduates about whether prescribing psychologists could safely and effectively work as independent practitioners in the civilian sector. The usual argument was that the team practice that characterized military medicine was an essential ingredient in the success of the PDP that could not be duplicated in the civilian world.” (Point 4, page 7)

“Each had an expert proctor who was available by phone, page, and e-mail,...they were doing excellent work by all accounts, the Evaluation Panel believed as a matter of principle that they would benefit more from the experience of closer daily liaison with an expert practitioner.”
(Point 5, page 7)

“Scope of practice and formulary: The practice of pharmacotherapy was restricted to adults age 18-65 for all graduates. ...One graduate who was completing a third of proctorship could not prescribe lithium or a number of new agents. Another prescribing psychologist [the only one stationed in California] was the most restricted of all graduates. He could treat only active duty patients even though dependents and retirees attended his clinic, and he could not prescribe lithium, depakote [both are used to treat bipolar disorder (manic-depression)] and some newer antipsychotics. The MAOIs [used to treat depression] were the most common exclusions, being included on only one graduate’s formulary.” (page 7)

Nature of patients: 3 treated 90 to 100% active duty military, 2 treated 60 to 80% dependents, 3 saw no retirees, one had 75% retirees and spouses. Most treated primarily or exclusively persons who had adjustment disorders [behavioral symptoms that develop in response to an identifiable stressor, typically including anxiety and depressed mood], anxiety disorders [panic disorder, phobias, obsessive-compulsive disorder, posttraumatic stress disorder], or depression. Most of the medications they used were the new antidepressants and anti-anxiety medications. (P 8)

Few of them had even limited experience with the medications used to treat bipolar disorder (manic-depression) or psychosis.

“Ward psychiatrists, civilian attendings, and the PDP Training Director (all psychiatrists) supervised the fellows. For medical and legal reasons, the fellows had to have medication orders, laboratory and radiology requests, restart orders, and admission and discharge summaries co-signed by the supervising psychiatrists.” (P. 13)

“The most common concern cited by most of the psychiatrist supervisors in one form or another was that the fellows knew too little medicine to prescribe psychotropic drugs safely. They worried about the lack of medical sophistication. These concerns applied more strongly to two graduates but were ascribed to a lesser extent to all fellows at the point of graduation. Nevertheless, most of the psychiatrist supervisors also said that the fellows knew very well when they were medically over their heads and when they needed consultation.”

INDIVIDUAL PRACTICE PROFILES ON EACH OF THE 10

Graduate AB (on east coast, page 17)

–64% of patients were medically-healthy active duty airmen, 23% dependents, 9% retirees, 4% retiree dependents.

–62% were depression or mood disorders, 19% anxiety disorders, 17% adjustment disorders.

--Mostly prescribed SSRIs [selective serotonin reuptake inhibitors such as Prozac, Paxil, Zoloft and Celexa].

He prescribed 2 antipsychotics in the past year, and he first discussed both with his supervising psychiatrist. He prescribed no MAOIs or stimulants.

Graduate AC: (page 19, in southeast U.S.)

- Treated 30% active duty, 35% dependents, and 35% retirees. There is no list of their diagnoses.
- There were no "persons with unstable medical conditions."
- he has "independent status", with its standard 10% of medication chart review each month.
- His formulary excluded MAOIs.

Graduate DC: (page 20, in the southeast)

- Treated 80% young, active duty airmen.
- Orders were physician countersigned
- The typical patient he or she saw was a homesick young airman who "spoke suicidal notions."
- The supervising psychiatrist countersigned admission and discharge orders and orders for medications not on his formulary.
- Disorders treated were 34% adjustment disorders, 27% major depression, and 12% bipolar disorder.
- 90% of his prescriptions were for Zoloft, Wellbutrin, Prozac, Deseryl, and Effexor (all are newer antidepressants).
- He was described as a "great team player."

Graduate CC: (p. 22, in the Southwest)

- treated only active duty
- typical cases were "young, physically healthy men who were acutely unhappy with the service or distressed by relationships."
- No more than 25% of patients got medications.
- almost all the patients were depression and anxiety disorders, only one schizoaffective disorder, and only one patient was prescribed an antipsychotic.

Graduate AD (p. 24) (in Columbus, Georgia)

- Scope of practice specifically limited to those "without unstable medical conditions."
- he had the broadest formulary and was the only graduate allowed to use MAOIs.
- He had a clear, detailed proctoring agreement.
- Treated 25% active duty, 23% retirees, and 52% dependents.
- Almost all medications he used were antidepressants and antianxiety medications. He gave 9 patients lithium and no antipsychotics.

Diagnoses were: 49% depressive and mood disorders, 22% anxiety disorders, 12% schizophrenia and dementia [yet he prescribed no antipsychotics], 8% adjustment disorders, and 6% alcohol and substance abuse.

-All patients were medically screened by physicians. The supervising psychiatrist thought he was great but "doubted how much one could extrapolate to the civilian world."

Graduate BD: (page 26, in the southwest)

- In a family care center.

- Most patients were dependents who had been pre-screened for medical conditions, 20% were active duty military.
- Most diagnoses were affective, anxiety, or adjustment disorders.
- His scope excluded patients with "unstable medical conditions." It also contained specific guidelines for supervision.
- all patients he placed on mood stabilizers [medications for manic-depression] or neuroleptics [antipsychotics] had to be proctored. His supervising psychiatrist and he discussed patients who might need mood stabilizers or antipsychotics and patients with medical problems before treatment was started.
- 30 to 40% of his patients were given medications.
- "Physicians were near-at-hand...to help prescribing psychologists compensate for any medical weaknesses."
- No information on his formulary.

Graduate AA: (p. 29, at East coast, then Iceland)

- Had a formulary of specific drugs.
- 60% of patients active duty, 40% retirees and dependents.
- Most patients were referred by primary care docs
- Most prescriptions were SSRIs.
- Did not do physical exams, but could order laboratory tests.
- Still in proctored status.
- Was being transferred to Iceland to a post with 9 M.D.s.
- He treated medically-uncomplicated patients, mostly depression, anxiety, and adjustment disorders.

Graduate BA: (page 31, stationed at Portsmouth, VA, then Camp Pendleton)

-This is the only one in California

- Still on proctored status.
- could admit patients to inpatient unit, but not treat them.
- "He had limited privileges and a restricted formulary."
- Formulary listed 36 specific drugs, excluding the newer antipsychotics.
- Could prescribe only for active duty personnel.
- could not initiate or discontinue lithium or depakote [used for manic-depression], only order refills. Ritalin was removed from his formulary.
- Most of the patients he saw were depression, anxiety, and adjustment disorders.
- Mostly used SSRI antidepressants and antianxiety agents.
- Only 13% of his patients received medications.
- 2 supervising psychiatrists reported on 2 incidents of what they considered "mistakenly managed patients" where the supervising psychiatrist had to intervene and transfer the patient to another provider.
- he treated a moderate number of patients with "a narrow range of relatively mild pathology. He rarely prescribed medication. When he did it was mostly SSRIs."

Graduate BC : (P. 33, in Bremerton WA)

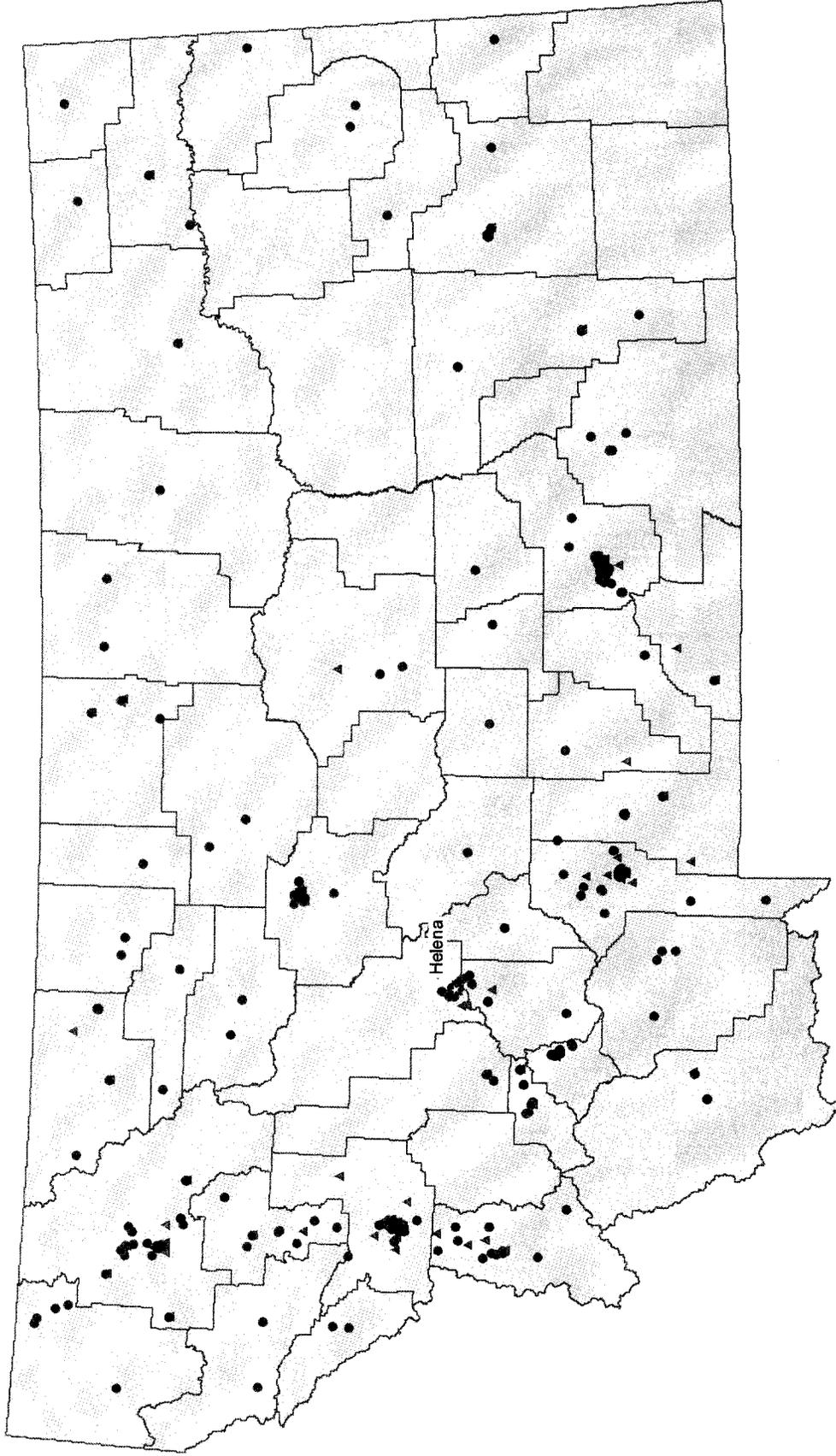
- Works with 3 psychiatrists and 2 psychologists
- Formulary is by drug class.
- Is under 10% chart review, ie., "independent privileges."
- practices interactively with psychiatrists and psychologists
- Is privileged to do physical exams, but does not do them.
- Has hospital admitting privileges and on-call duty in the ER
- He estimates 25% of his practice involves pharmacotherapy
- Uses mostly SSRIs and buspirone ([BuSpar, an antianxiety medication].
- Could start and stop medications with sailors, but had to consult before doing either with dependents. He was "also expected to discuss concomitant medical conditions with the supervisor."
- Was supervised about 90 minutes weekly.
- "-He reported his concern about granting prescription privileges to clinical psychologists in the general community. He regarded them as generally naive about medical and biological matters, and he feared that without rigorous training there would be problems."
- His supervising psychiatrist, who supported him and the program, thought that these psychologists can work well as collaborators and complements to psychiatrists in the military, but this would not work in the civilian world and would probably be dangerous. Other supervisors had similar views.

Graduate CD: (at Portsmouth, VA., going to medical school, page 34)

- Proctored by a psychiatrist, with review of 10% of his medication charts, and required to consult with her before initiating lithium or an antipsychotic
- Formulary is 40 specific medications, and specifically excludes carbamazepine [Tegretol, used to treat manic-depression], Clozaril [an antipsychotic] and MAOI antidepressants. Is authorized to prescribe Adderall [the only stimulant mentioned for any of the graduates, probably because he has more ADD patients than the others].
- 90% of patients are active duty, 80% of those are under 40, and 2/3 are male. The patients are young and have no, or only minor, medical problems.
- 2/3 of his prescriptions are for newer antidepressants, and 10-15% are for anxiolytics [the benzodiazepines used to treat anxiety, such as Xanax, Valium and Librium].
- Does not do physicals, take night call, and has almost no ER interaction.
- Has used Risperdal [a newer antipsychotic] once.
- Dr. Stewart viewed both of the psychologists she had supervised as having third-year medical student knowledge and 2d to 3d-year psychiatry resident knowledge of psychopharmacology.

*ACNP is an organization of clinicians, scientists, and educators, which includes both psychiatrists and psychologists. ACNP contracted with the federal government to evaluate the project.

Montana Psychiatrist and Primary Care Physician to Psychologist Distribution Comparison

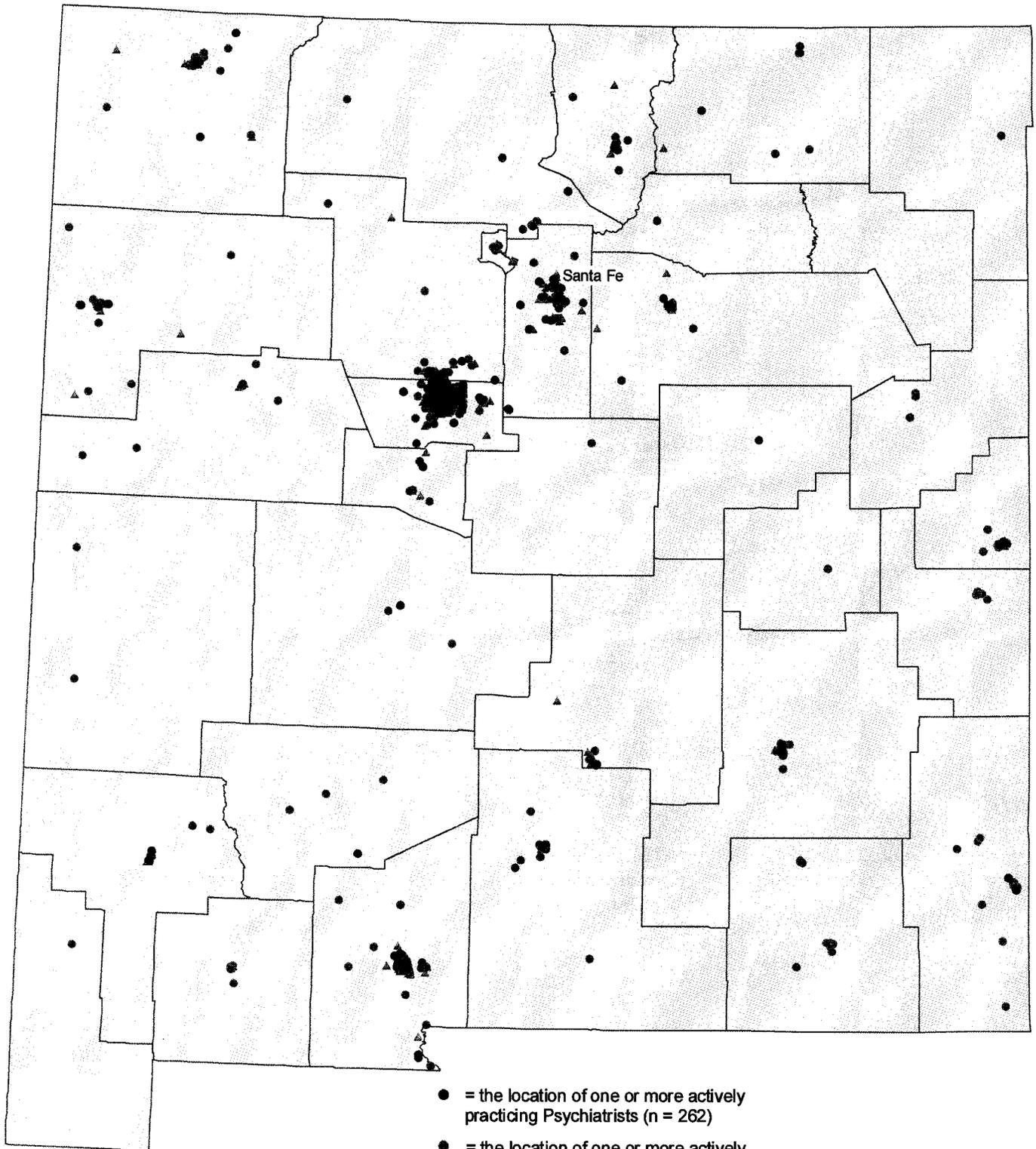


- = the location of one or more actively practicing Psychiatrists (n = 85)
- ▲ = the location of one or more actively practicing Primary Care Physicians (n = 795)
- = the location of one or more actively practicing Psychologists (n = 196)

Data Source: American Medical Association, American Osteopathic Association (2008) and the Montana Board of Medical Examiners (May 2008)



New Mexico Psychiatrist and Primary Care Physician to Psychologist Distribution Comparison



- = the location of one or more actively practicing Psychiatrists (n = 262)
- = the location of one or more actively practicing Primary Care Physicians (n = 1,607)
- ▲ = the location of one or more actively practicing Psychologists (n = 524)

Data Source: American Medical Association, American Osteopathic Association (2008) and the New Mexico Board of Examiners in Psychology (June 2008)



National Center for the Analysis of Healthcare Data (2008)