OFFICE OF PROFESSIONAL REGULATION
VERMONT SECRETARY OF STATE

Psychologist Prescribing Sunrise Assessment

Vermont Office of Professional Regulation

January 2025

Executive Summary

By letter of May 28, 2021, the House Government Operations Committee asked the Office of Professional Regulation (OPR) to assess a proposal to expand doctoral psychologists' scope of practice. Today, psychologists in Vermont and most states are not authorized to prescribe medications. The proposed scope expansion, advanced by the Vermont Psychological Association (VPA or Applicant), would allow doctoral psychologists with enhanced training in psychopharmacology to qualify for a license specialty authorizing psychiatric prescribing.

Applying criteria set out in Vermont law, we find:

- Prescribing psychologists can contribute positively to the ranks of Vermont psychiatric clinicians. Prescribing psychologists may be specially equipped to pair psychotherapeutic and behavioral interventions with psychopharmacy in ways that incumbent prescribers rarely can.
- Applicant's proposed licensing requirements are less rigorous than those in most of the other seven states allowing psychologist prescribing, particularly around clinical education.
- If that shortcoming were corrected, the public can be reasonably assured that prescribing psychologists thus licensed are prepared to exercise independent prescribing judgment in most cases.
- Pediatric, geriatric, and medically complex cases, as well as in cases implicating controlled drugs and other drugs with complex risk profiles, should be either managed with active collaboration between the prescribing psychologist and a physician or otherwise prohibited.
- Though scope expansion is viable, access improvements are likely to be modest. Among the seven states to add prescribing to the scope of psychology practice, rollouts have been slow and uptake low.

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Summary of Proposal

Applicant's petition for a preliminary assessment of the proposed scope expansion summarizes the proposal as follows:

> If the scope of practice is amended, psychologist-doctorates with extensive additional education, training, [and] supervised practice, and [who have passed] a nation[al] exam may be issued a license to prescribe psychiatric medications for appropriately diagnosed psychological conditions. This will include consultation with other health practitioners, ordering lab tests, determining drug-drug and drug-disease interactions, frequent and sufficient follow up with individual patients, and emphasizing non-pharmacological approaches to improving overall health and mental health condition.[1]

The proposal is derived from model statutory language promulgated by the American Psychological Association (APA).[2]

[1] Rick Barnett, Vermont Psychological Association, Preliminary Assessment of Scope of Practice (Sept. 30, 2021) ("VPA Petition" or "Proposal").

[2] American Psychological Association, Model Legislation for Prescriptive Authority (Feb. 2019). Applicant's proposal also references and links to H.392 (2021 session), which had been introduced at the time this review was requested. For simplicity, and because H.392 is no longer pending in the General Assembly, this report refers solely to Applicant's proposal, with the understanding that some specifics are spelled out only in H.392 and incorporated by reference into Applicant's proposal.

Eligibility

Under Applicant's proposal,[3] to be eligible for the psychologist prescribing specialty,[4] a psychologist would need to:

(1) Be licensed in Vermont at the doctoral level;
(2) Hold "a postdoctoral master's degree in clinical psychopharmacology designated as meeting the necessary coursework requirements by the American Psychological Association or a comparable organization";[5]
(3) Pass a national examination testing prescribing competence;[6] and
(4) As part of the degree program, complete "100 patient consultations … in collaboration with and under the direction of a qualified practitioner,"[7] including a physician, an advanced practice registered nurse, or another prescribing psychologist with at least five years of experience.

The petition does not propose to alter the composition of the Board of Psychological Examiners or otherwise integrate oversight of prescribing psychologists by others experienced in prescribing.

To maintain the psychologist prescribing specialty, psychologists would need to complete eighteen hours of prescribing-related continuing education every two years.

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[3] Referencing H.392 § 2 (adding a 26 V.S.A. § 3019(a)).

[4] The petition uses the term "special psychologist prescribing certificate." In other professions, such an add-on state-issued credential is generally called a "specialty" or an "endorsement," with OPR preferring "specialty" to avoid confusion with out-of-state endorsement as a path to licensure. This report will refer to the proposed credential as a specialty, and OPR hopes that any future legislation will adopt the same term to reduce needless administrative complexity.

[5] American Psychological Association, Designation Criteria for Education and Training Programs in Psychopharmacology for Prescriptive Authority (Feb. 2019).

[6] Though not named directly in the proposal, the Psychopharmacology Examination for Psychologists (PEP) developed by the Association of State and Provincial Psychology Boards (ASPPB) is the exam proponents envision matching the language. Details available in ASPPB's PEP candidate handbook.

[7] H.392 § 2 (adding a 26 V.S.A. § 3019(b)).

Education

To be eligible for the proposed specialty, an applicant must have a postdoctoral master's degree in clinical psychopharmacology. The APA model postdoctoral master's degree in clinical psychopharmacology requires a 400 contact-hour program that includes the following coursework:

- Basic science
- Functional neuroscience
- Physical examination
- Interpretation of laboratory tests
- Pathological basis of disease
- Clinical medicine
- Clinical neurotherapeutics
- Capstone competency evaluation (separate from national examination)
- Pharmacology
- Clinical pharmacology
- Psychopharmacology
- Psychopharmacology research
- Professional, ethical, and legal issues
- Supervised clinical experience in physical assessment, involving care for at least 100 patients
- Systems of care

Consultation and Collaboration

Applicant's proposal would not restrict—by age, health status, or comorbidities—which patient populations a prescribing psychologist could serve. The proposal would require that patients have a primary care physician or psychiatrist of record, with whom a prescribing psychologist must "consult and collaborate … to obtain a concurrence prior to initiating, making changes to, or terminating a medication treatment plan."[8]

This collaboration requirement is confusing to construe. Were it read to require an existing prescriber's affirmative approval of all prescription choices, the scope expansion in question would be illusory, along with associated improvements to access to care. This preliminary analysis proceeds based on the understanding that Applicant intends for prescribing psychologists to have *independent* prescribing authority, that is, authority to prescribe medications independent of the opinion or guidance of the consulting primary care provider or psychiatrist of record. The proposal would leave details concerning consultation and collaboration to be specified in the Board's administrative rules.

[8] H.392 § 2 (adding a 26 V.S.A. § 3019(c)(2)).

The Preliminary Assessment Process

OPR is responsible for performing preliminary sunrise assessments to inform the General Assembly's consideration of proposals to expand a profession's scope of practice.[9] Sunrise reviews implement a State policy on professional licensing that favors openness, access, free competition, and regulatory minimalism.[10]

Professions requesting scope expansion are required to include the following in their petitions:

(1) A description of the practices and activities that the profession or occupation would be permitted to engage in if the scope of practice is amended.

(2) Public health, safety, or welfare benefits, including economic benefits that the requestor believes will be achieved if the request is implemented and, if applicable, any harm to public health if the request is implemented.

(3) The impact the amendment of the scope of practice will have on the public's access to occupational services.

(4) A description of the current laws and regulations, both federal and State, pertaining to the profession, including a description of the current education, training, and examination requirements and any relevant certification requirements applicable to the profession for which the amended scope of practice is being sought.

(5) The extent to which the public can be confident that a practitioner is competent to perform the activities and practices permitted under the amended scope of practice, including a description of the nature and duration of the education and training for performing these activities and practices, if any. ...

(6) A description of how the request relates to the profession's ability to practice to the full extent of the profession's education and training.

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[9] 26 V.S.A. § 3108(a)(1).

[10] Under Title 26, it "is the policy of the State of Vermont that regulation be imposed upon a profession or occupation solely for the purpose of protecting the public. ... [A]ll individuals should be permitted to enter into a profession or occupation unless there is a demonstrated need for the State to protect the interests of the public by restricting entry into the profession or occupation. ... If such a need is identified, the form of regulation adopted by the State shall be the least restrictive form of regulation necessary to protect the public interest." 26 V.S.A. § 3101.

(7) For health care professionals, a description of the impact an amendment to the scope of practice will have within the health care system, including:

a. the anticipated economic impact such an expansion will have for the system, for patients, and for other health care providers; and

b. identification of any health care professions that can reasonably be anticipated to be directly impacted by the request, the nature of the impact, and efforts made by the requestor to discuss the request with such health care professionals.

(8) A summary of the known scope of practice changes either requested or enacted in the State concerning the profession in the five-year period preceding the date of the current request.

(9) A summary of regional and national trends, legislation, laws, and regulations concerning licensure of the profession making the request, and a summary of relevant scope of practice provisions enacted in other states.

(10) How the standards of the profession or occupation will be maintained, including whether effective quality assurance standards pertaining to the activities and practices permitted under the proposed expanded scope of practice exist in the profession or occupation, such as legal requirements associated with specific programs that define or enforce standards.

(11) A profile of the practitioners in this State, including a list of associations, organizations, and other groups representing the practitioners and including an estimate of the number of practitioners in each group.[11]

Following review, OPR submits to the legislative committees of jurisdiction a preliminary assessment of the proposed scope expansion. OPR's recommendation is based on whether the proposed expansion is consistent with the policies and principles of Title 26, Chapter 57.

[11] 26 V.S.A. § 3108(b).

Means of Assessment

To prepare a preliminary assessment, OPR undertakes fact-finding and research. The Office reviews relevant literature and studies, engages in outreach to interested stakeholders, convenes public hearings, collects and compiles public comments, and reviews approaches in other jurisdictions.

To encourage awareness and participation among interested parties, the Office created a webpage dedicated to the review, emailed notice letters to professional associations and thousands of licensees in adjacent fields, invited emailed comments, and convened two virtual public hearings. Hearing times were staggered to improve compatibility with participants' work schedules. VPA's petition was posted online. Compiled commentary, including slide presentations by speakers, was shared with all participants who requested it.

OPR consulted throughout the review process with the Board of Psychological Examiners. VPA president Dr. Rick Barnett and government relations attorney Theo Kennedy visited the Board and shared information at multiple regular meetings. OPR also conferred with prominent critics of the legislation, represented by the Vermont Medical Society and affiliated associations of incumbent prescribers.

Finally, OPR sent electronic surveys to licensed psychologists to assess both their opinions on the proposal and the likely uptake of a prescribing specialty if one were created.[12]

[12] The compiled commentary, survey. and responses are available by request to sos.opr.comments@vermont.gov.

Current Scope of Psychology Licensure in Vermont

Vermont defines and regulates the practice of psychology through a system of licensure set out in Title 26.

> "Practice of psychology" means rendering or offering to render to individuals, groups, or organizations, for a consideration, any service involving the application of principles, methods, and procedures of understanding, predicting, and influencing behavior that are primarily drawn from the science of psychology. The science of psychology includes assessment, diagnosis, prevention, and amelioration of adjustment problems and emotional and mental disorders of individuals and groups.[13]

Like all other states, Vermont licenses psychologists with doctoral degrees. Vermont is among a minority of U.S. jurisdictions that also recognize and independently license master's-level psychologists.[14] To qualify for licensure in either degree category, one must complete a course of study focused on clinical practice—including diagnosis, assessment, and treatment of psychological disorders—and must complete at least 4,000 hours of supervised clinical practice, 2,000 of those after graduation. Vermont's five-member Board of Psychological Examiners oversees psychologist regulation and is among the fifty-odd professional credentialing programs within OPR.[15]

Vermont's actively licensed doctoral psychologists number 584, of whom 350 have addresses in the State. Actively licensed master's psychologists number 200, of whom 193 have addresses in the State.[16]

Like psychologists in most states, and consistent with the statutory definition above, Vermont psychologists not only diagnose and assess "adjustment problems and emotional and mental disorders," but also treat those disorders clinically.[17] Treatments may involve counseling therapy and behavioral interventions.

Current State law does not authorize psychologists to prescribe drugs. Prescribing falls within the legal definition of the practice of medicine. Title 26 specifically authorizes prescribing by allopathic physicians, osteopathic physicians, advanced

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[13] 26 V.S.A. § 3001(1).

[14] 26 V.S.A. § 3011a.

[15] 26 V.S.A. § 3006.

[16] Based on OPR's January 202 licensing data.

[17] 26 V.S.A. § 3001(1).

practice registered nurses[18] (APRNs), physician assistants, optometrists, dentists, veterinarians, and some naturopaths.[19]

Current specialist mental-health prescribers are psychiatrists, who are subset of medical doctors, and psychiatric nurse practitioners, who are a subset of APRNs. Primary care providers are also authorized to prescribe for psychiatric purposes.

History and Implementation Elsewhere

Vermont is not the first jurisdiction to consider expanding the scope of psychologists to include prescribing.

Federal Scope Expansion

Psychologist prescribing began, as many health-profession scope expansions do, in the military. Military regulatory practices on federal facilities are generally unconstrained by state licensing laws. In 1991, the United States Department of Defense (DOD) launched a Psychopharmacology Demonstration Program to experiment with extending psychologist scope of practice into prescribing. By 1998, the program had produced ten graduates, who were posted at Air Force, Army, and Navy facilities throughout the United States. An external evaluation by the American College of Neuropsychopharmacology (ACNP), published in 1998, concluded that "a 2-year program—one-year didactic, one-year clinical practicum that includes at least a 6-month inpatient rotation—can transform licensed clinical psychologists into prescribing psychologists who can function effectively and safely in the military setting ."[20]

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[18] "Nurse practitioner," "Advanced Practice Registered Nurse," and "APRN" are synonyms referring to a person licensed under 26 V.S.A. § 1611. Psychiatric nurse practitioners specialize in the treatment of mental health disorders, including by prescribing psychopharmaceuticals.

[19] Dentists', optometrists', and veterinarians' prescriptive authority is limited to purposes relating to their scopes of practice.

[20] American College of Neuropsychopharmacology (ACNP), "DoD Prescribing Psychologists: External Analysis, Monitoring, and Evaluation of the Program and Its Participants (May 1998), at 6. Less developed pilot projects also have been attempted within the Public Health Service and the Indian Health Service. *See* Shearer, David S., PhD; Moore, Bret A., PsyD; and Peck, Amy, PhD, "Establishing Uniform Requirements for Privileging Psychologists to Prescribe in Federal Service," *The Tablet* (April 2015), 34–37.

The DOD project is rightly credited as a seminal development of psychologist prescribing, but we believe it offers limited insight to state regulators of the civilian world. Specifically, evaluators of the military programs noted that (a) the military program required more education and training than proposed civilian programs, and (b) the military program integrated prescribing psychologists into a team of care providers, which differs from an independent psychology practice setting in the civilian context.[21] The DOD project also featured restrictions that Applicant's proposal does not. For example, DOD patients were all 18–65 years old, and prescribing psychologists were not free to prescribe all psychotropic drugs, but instead restricted to formularies.

The ANCP noted that not a single adverse event was detected in the course of the DOD project, and that is something, but we must also consider that the project graduated only ten providers, working in a military setting very different from rural, civilian Vermont.

Scope Expansions among the States

Seven states have implemented legislation authorizing psychologist prescribing: New Mexico, Louisiana, Illinois, Iowa, Idaho, Colorado, and Utah. Salient characteristics are summarized below, with nuances omitted. The summary may not reflect very recent statutory and regulatory changes and relies on inconsistent sources for some metrics. Numbers of licensees were provided by the American Psychological Association's Office of Professional Legal & Regulatory Affairs.

[21] ACNP noted "discussion at many sites about political pressures in the civilian sector for prescription privileges for psychologists. Virtually all graduates of the PDP considered the 'short-cut' programs proposed in various quarters to be ill-advised. … **Most said an intensive full-time year of clinical experience, particularly with inpatients, was indispensable.** … 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." ACNP, fn. 20 above, at 3–4 (emphasis added).

	New Mexico	Louisiana	Illinois	Iowa	Idaho	Colorado	Utah
Enacted	2002	2004	2014	2016	2017	2023	2024
Degree	Two-board approval, >450 credit hrs.	Post-doctoral APA-designated M.S. or equivalent	Post-doctoral M.S. with specified content and 18 rotations	Post-doctoral APA-designated M.S.		APA-designated M.S. or equivalent	M.S. with specified content
Exam	State approved, "national"	State approved, "national"; PEP named	Separate clinical competency exam	State approved, "national"; PEP named	PEP named in regulation	PEP	PEP or equivalent if named in rule
Supervised Practice	> 400 hrs. supervised practice; Conditional until 2 yrs. supervised	3 yrs w/ recommendation of 2 physicians	18 clinical rotations	2 years; 400-hr. practicum (100 in a psychiatric setting)	2 years	750 hours over 12-24 months	4,000 hours over at least 2 years
Pts. Consulted	100	100		600		150	
Supervision and Collaboration	General collaboration w/ PCP 24-hr notice of an Rx	General collaboration w/ PCP	Supervising physician delegates prescribing authority	General collaboration w/ physician	PCP must approve all medication		General collaboration w/ physician / psychiatric APRN
No. Licensed	63	181	21	7	12	7	0 (new program)

	New Mexico	Louisiana	Illinois	Iowa	Idaho	Colorado	Utah
Prohibited Populations			Pediatric, geriatric, pregnant, medically complex		Pediatric, geriatric require enhanced supervision	Pediatric, geriatric require relevant supervised practice	
Prohibited Drugs			Narcotics and benzodiazepines prohibited	Off-label; narcotics	Formulary prohibits opioids and CI narcotics	Narcotics	Non- SSRIs unless allowed by rule; narcotics; controlled substances
Legislation	NMOS § 61-9-17 et seq.	La. R.S., Title 27, § 1360.51 *et seq.*	225 ILCS 15/4.3	SF2188; Iowa Code, Ch. 154B	54 Id. Stat. §§ 54-2316–54-2320	12 Colo. Stat. Ann. 245-309	58 Utah Code Ann. 61-304
Rules	N.M.A.C. § 16.22.1 et seq.	La. Admin. Code, T. 46, Pt. XLV; Subpt. 2; Ch. 39	68 Ill. Code 1400	IAC 645.244	IDAPA 24.12.01	3 C.C.R. § 721-1.24	R. 156-61
Joint Oversight	w/ Medical Board	w/ Medical Advisory Committee		w/ Medical Board		w/ Medical Board	w/ Medical Board
Liability Insurance	Required			Required		Required	Required
CME (annual)	20 hrs.	20 hrs.	By rule	> 20 hrs.		20 hrs.	24 hrs.

Some lessons are clear. First, every state to implement psychologist prescribing has required more rigorous supervised clinical practice than the Applicants propose. Second, several have expressly required training in inpatient settings similar to the early Department of Defense pilot programs.[22] Third, programs require considerable time and resources to develop strikingly few practitioners. New Mexico, which enacted its program over two decades ago, has a prescribing psychologist population in the double digits, despite a population triple Vermont's. Eleven years after enacting its program, Illinois has seen twenty-one psychologists obtain credentials. If Vermont credentialed prescribing psychologists at the same rate, based on population, we would have one prescribing psychologist after offering the credential for ten years.

For a sense of relative size, consider that the number of APRNs actively licensed by the Vermont Board of Nursing is approximately nine times the number of prescribing psychologists practicing in the entire United States. There are more *psychiatric* APRNs—those specialized in psychiatric prescribing and treatment—with active Vermont licenses than there are prescribing psychologists anywhere.[23]

Recent Analyses Comparable to this Sunrise Review

Over the years, States have generated analyses relevant to this one in their efforts to improve access to care. Three bear particular attention: similar scope evaluations conducted in Washington and Nebraska and the comprehensive recommendations of Vermont's own Rural Health Services Task Force. Neither Washington nor Nebraska has moved forward on expanding the scope of practice for psychologists.

Washington State

The Washington State Department of Health in 2020 conducted a sunrise review of psychologist prescribing, applying statutory criteria that mirror Vermont's.[24] The Washington analysis concluded that the proposed education and training were insufficient "to train psychologists to prescribe controlled substances safely."[25] The Department felt that such training should match that required of nurse practitioners

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[22] See fn. 21, above.

[23] As of January 2025, there are 2,671 APRNs actively licensed in Vermont, of whom 366 are psychiatric APRNs.

[24] Sherry Thomas, Washington State Department of Health, Report to the Legislature: Sunrise Review Psychology Scope of Practice – Prescriptive Authority (Dec. 2020).

[25] *Id*. at 22.

and physician assistants.[26] The Department noted that psychologists' arguments for prescribing privileges focused on the scarcity of psychiatrists, but ignored the availability of many other existing prescribers. Finally, the Department questioned whether regulatory expertise was available, how a psychologist prescribing program could be self-supporting, and how many incumbent psychologists would actually invest the time and money needed to qualify.[27]

To date, Washington State has not authorized psychologist prescribing.

Nebraska

In 2017, Nebraska saw a similar analysis, presented by a seven-member Psychology Prescribing Technical Review Committee to that State's relevant policymakers.[28] The Committee published an extensive compendium of commentary related to six statutory criteria.

The Committee generally favored the idea of psychologist prescribing, agreeing that such expansion "would benefit the health, safety, or welfare of the public," which was "inadequately addressed by the present scope" of psychologist' practice; that psychologist prescribing would not significantly endanger the public; that there are appropriate post-professional programs available to assure competence; and that "there are adequate measures to assess" practitioners' competence and to address incompetent practice.[29]

However, the Committee found that "the current education and training" for psychologists did not adequately prepare them to prescribe. To date, Nebraska has not authorized psychologist prescribing.

Vermont's Rural Health Services Task Force

Vermont policymakers have expended considerable resources studying means of improving access to care. Act 26 of 2019 created a Rural Health Services Task Force, assisted by the Agency of Human Services and the Green Mountain Care Board, and

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[26] *Id*. at 21–22.

[27] *Id*. at 21. The Department priced entry at approximately $36,000.

[28] See Nebraska Department of Health and Human Services, Division of Public Health, Psychology Prescribing Technical Review Committee, "Report of Recommendations and Findings" (Aug. 2017).

[29] *Id*. at 48–50.

instructed the Task Force to "evaluate the current state of rural health care in Vermont and identify ways to sustain the system and to ensure it provides access to affordable, high-quality health care services." The 14-member Task Force met ten times in 2020 and included Dr. Richard Barnett, who authored Applicant's proposal.

The Task Force's recommendations regarding mental health care included re-opening the University of Vermont's Psychiatric-Mental Health Nurse Practitioner Program; capitalizing on telehealth to expand access to care; and considering participation in the interstate licensing compact for psychologists. Vermont has since expanded opportunities for telehealth licensure and joined the psychology interjurisdictional compact.[30] Notably, the Task Force's many recommendations did not include a recommendation to expand psychologist prescribing.

Substantial Arguments For and Against Scope Expansion

The proposal requires that policymakers consider the need for access against the need to ensure competence through provider exclusivity. The substantial statutory criteria are: (1) "[t]he extent to which the public can be confident that a practitioner is competent to perform" the expanded practices,[31] and (2) the "[p]ublic health, safety, or welfare benefits … the requestor believes will be achieved."[32]

As we assess both the availability of care and the training gradient between provider groups, it is helpful to note that psychiatric prescribing is available through generalist primary-care providers of many types—family and internal medicine physicians, physician assistants, nurse practitioners, and naturopaths—almost all with less psychiatry training than a psychiatrist and less psychology training than a psychologist.

Access to Care

Applicant's most compelling argument for psychologist prescribing is that Vermont is staring down a "massive national shortage of psychiatrists," leaving people unable to access vital mental health care. Citing a series of workforce studies, Applicant argues

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[30] The Vermont Legislature has since implemented two of these three recommendations, creating a low-cost, telehealth-specific license effective 2023 and joining the psychologist licensing compact effective 2024. 26 V.S.A. ch. 56, ch. 55 subch. 2; Act 37 (2023).

[31] 26 V.S.A. § 3108(b)(5).

[32] 26 V.S.A. § 3108(b)(2).

that doctoral psychologists, being skilled in psychological diagnosis, assessment, and treatment and much more numerous than psychiatrists, could, with supplemental training, meaningfully help to meet demand for medication-based therapy.[33] Consistent with VPA's data, hearing participants from the clinical counseling fields, as well as written comments from counselors, reported extraordinary difficulty connecting clients in need with psychiatrists. That said, slow rollouts and limited provider uptake in other states make us pessimistic that prescribing psychologists will appear in any significant numbers.

Though the urgent challenges delivering mental health care to our rural state are very real, readers may be surprised—as we were—at authoritative research demonstrating that the per-capita supply of psychiatrists, psychologists, and psychiatric nurse practitioners is better in Vermont than almost anywhere else in rural America. An exhaustive 2018 overview of provider distribution, found that Vermont and other New England states have the country's highest per capita supply of psychiatrists, psychologists, and psychiatric nurse practitioners.[34]

Value Added by Psychology Training

Proponents of scope expansion argue that to the extent prescribing psychologists will lack orientation to the biomedical aspects of psychiatric care, they will have vastly more training in psychology than other prescribers. Combining talk therapy with pharmacotherapy tends to deliver better outcomes than pharmacotherapy alone. Psychologists note that they are uniquely situated to offer bimodal care, which rarely is possible in a primary-care setting. Citing concerns within the medical community about the overuse of psychopharmaceuticals, pharmaceutical cascades, and limited oversight of medication tapering, psychologists argue that their training will tend to generate a more conservative prescribing practitioner, better able to titrate medications, follow patients across time, and assist with deprescribing. In this telling, critics concerned that prescribing psychologists lack medical training should be equally concerned that incumbent psychiatric prescribers lack psychological

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[33] *See* Application, pp. 3–4 (merging two studies to estimate that Vermont has only "one FTE psychiatrist for every 30,000 Vermonters," but "one FTE psychologist-doctorate for every 2600 Vermonters.")

[34] Andrilla, C. Holly A., et al., "Geographic Variation in the Supply of Selected Behavioral Health Providers," 54 Am. J. Prev. Med. S199–S207 (2018). Readers aware of the extraordinary challenges of accessing behavioral health care may object that minimizing provider shortages by observing they are worse elsewhere is like saying one is only a little bit on fire. Even so, the researchers' findings, based on NPI data, are sharply at odds with prevailing narratives that tend to localize workforce challenges.

training since few if any non-psychiatrist prescribers offer talk therapy as part of their practice.

Potential to Attract Clinicians

If the task at hand is winning a competition among the states, and particularly the rural states, to attract prescribing mental-health clinicians from a finite national pool, Applicant argues that it is beneficial to be an early adopter. Better, the thinking goes, to compete in a field of eight than of fifty-plus. Unfortunately, national numbers of prescribing psychologists remain bracingly small, even in states that have operated programs for some time. Proponents assert that we are on the cusp of exponential growth in the national pool of qualified prescribing psychologists, because hundreds of psychologists are in psychopharmacology training. It is hard to know what enrollment in out-of-state psychopharmacology M.S. programs might mean for a state like ours, since we have limited psychiatric facilities to train in and the nearest M.S. program is in New Jersey.

Adequacy of Medical Training

The most common and keen criticism of psychologist prescribing is that the psychopharmacology master's programs are insufficient to ensure appropriate clinical training.[35] Preparatory master's programs typically include two years of didactic instruction and a degree of attention to psychopharmacology that likely exceeds that attained by generalist prescribers.

We are instructed, however, to consider "whether the educational requirement includes a substantial amount of supervised practical experience."[36] The biomedical training under the APA model, particularly the required supervised clinical experience, may be insufficient to ensure independent prescribing competence in complex or unusual cases. The programs are principally offered online, and because none is located in Vermont, online learning would be the only practical means by which Vermont residents could access this special training. It is not clear where clinical sites would be found or how many viable clinical sites, if any, exist in Vermont.

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[35] The Vermont Medical Society, a prominent opponent of the proposal, offered a side-by-side tabular comparison of training among relevant providers. Although the comparison disregards psychologists' training in psychology, which is of considerable relevance to their net psychopharmacology preparation, it is an otherwise concise and accurate summary.

[36] 26 V.S.A. § 3108(b)(5)(A).

The training path for doctoral psychologists imparts formidable expertise in diagnosis, assessment, and treatment of mental disorders—more and better training in psychological diagnosis than is offered to most primary-care providers—but it includes no particular biomedical training. Consequently, under the Applicants' proposal, a psychologist's medical training to prescribe begins and substantially ends with a special master's psychopharmacology program and one hundred patient consultations under the supervision of a licensed prescriber. Nine annual hours of continuing medical education would be required to maintain the prescribing credential.

Although the proposal nods at requiring a diversity of experience within the 100 required consultations, OPR's experience with similar supervision expectations is that they are difficult to apply objectively, verify, or enforce. This leaves universities and credentialing authorities to rely on the good faith and conscientiousness of supervisors who are typically under social and professional pressure to move things along. The training in question could be appropriate to prepare a psychologist to prescribe drugs with favorable risk profiles to fundamentally healthy adults, but primary-care providers from nurse practitioners to physician assistants already are authorized to do that, and it is not what is proposed. What is proposed is unrestricted prescribing of all drugs, including those bearing black-box warnings or having significant abuse potential, to all populations, including children, the elderly, and those with comorbidities.

Availability of Qualifying Psychopharmacology Master's Programs

The anticipated access improvements from psychologist prescribing are constrained by limited sources of training. We are directed by statute to consider "whether educational programs exist in this State."[37] No Vermont college or university offers a qualifying degree. Applicants expressed hope that the Albany College of Pharmacy and Health Sciences in Colchester would develop a program to match future legislation, but that campus closed in June 2021.

Six graduate programs have attained APA designation as qualifying preparatory programs for psychologist prescribing, in California (two programs), New Jersey, Iowa, Idaho, and New Mexico. The programs do, however, draw from throughout the United States, inasmuch as courses are offered online and often via recorded lectures.

[37] 26 V.S.A. § 3108(b)(5)(C).

Vermont Board of Psychological Examiners Position

Vermont psychologists are divided as to whether psychologist prescribing is desirable.[38] The Board of Psychological Examiners voted against supporting H.392, a 2021 bill that mirrored Applicant's proposal, out of concern about insufficient pharmacology education. The Board made the following statement:

> The Board opposes [the bill] as currently drafted, but believes legislative efforts in Iowa and Illinois, which include enhanced educational requirements, enhanced supervision requirements, and population limits, offer benefits to the public that justify associated risks. The Board is also concerned that establishing laws distinguishing the scopes of practice of masters and doctoral level licensees undermines the original legislative intent that these licensees have the same scope of practice. Should the legislation be amended, the Board would appreciate the opportunity to review it again and offer its perspective.[39]

Additionally, the Board expressed concern that the pressures to find quick fixes, bill for services, and treat many clients will result in a shift away from the provision of essential psychology services to solely providing medical, pharmaceutical treatment.

Board members also questioned the adequacy of the medical education proposed to qualify a doctoral psychologist to prescribe. Opposition from that perspective tended to dovetail with skepticism about the necessity of the proposal.

Finally, the Board expressed concern that psychologist prescribing could undermine Vermont's longstanding policy of recognizing master's psychologists as peers. Despite the distinct licenses, the scopes of practice for master's-level and doctoral-level psychologists are the same. This was an intentional and deliberate legislative decision. The proposal to create a prescribing specialty for doctoral-level licensees only would be the first time the scopes of practice would be distinguished.

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[38] Only 7% of Vermont-licensed doctoral psychologists responded to an online survey conducted by OPR. Of those who responded, 80% supported psychologist prescribing. Only one respondent, who also authored Applicant's petition, reported having the necessary psychopharmacology degree. Just under half of respondents indicated interest in pursuing a psychopharmacology degree if prescribing were an option; however, the low response rate combines with inherent motivation bias of opt-in surveys to limit the utility of the survey findings.

[39] To the extent the Board's statement conveys a desire that master's psychologists be included as potential prescribers, this analysis disagrees. The additional years of training denoted by doctoral training involve advanced research methodology, statistics, and other skills vital to critical evaluation and interpretation of published research.

Administrative and Political Challenges

Finally, scope expansion would result in some administrative complications. No complication is insurmountable, but each bears consideration when balancing costs and benefits.

Suitability of Regulatory Location

First, any new program needs a regulatory home. The commonsense home for the program proposed is the Board of Psychological Examiners. The Board would be expected to oversee psychologist prescribing by writing administrative rules for prescribing, conducting investigations, and adjudicating disciplinary hearings. However, no sitting member has any experience in prescribing and, because prescribing has not heretofore been permitted, it will be difficult to find someone for this role. A transition plan would be necessary to ensure appropriate oversight. We suggest, if the proposal moves forward, that the General Assembly consider modeling such a plan on the statutorily created APRN subcommittee under the Board of Nursing, which features a visiting member from the Board of Medical Practice and specialist members from the professional community.[40] In time, the membership structure of the Board could include prescribing psychologists. In these ways, the Board of Psychological Examiners could be structured to appropriately oversee prescribing from the inception. The present legislation makes no such provision.

Funding

Second, the program would be unable to fund itself from licensing fees for prescribing psychologists. A longstanding principle of professional self-regulation in Vermont, enshrined in Chapter 57, is that a regulatory program shall be able to pay its own way. By any calculation, the legal and administrative expenses associated with standing up a psychologist prescribing credential, divided by the number of doctoral psychologists likely to take up the credential in the near term, will deliver a biennial licensing fee in the many thousands of dollars. This is untenable. If implementation and ongoing costs were shared by all of the State's incumbent psychologist licensees without distinguishing those with the prescribing specialty, psychologists ineligible for the new prescribing credential would be paying for its development and maintenance. At this point, this inequity is the best solution unless OPR receives a General Fund appropriation.

[40] 26 V.S.A. § 1615a.

Coordination and Integration

Third, if the General Assembly were to pursue scope expansion for psychologists, some degree of outreach and coordination would be necessary for payers and counterpart providers, such as pharmacists. The proposed legislation features periodic reports by the Board of Psychological Examiners to the Board of Pharmacy, but these will be unnecessary in our State, where both boards exist under OPR's umbrella and data relevant to each are readily available to the other.

The Slippery Slope

Psychologists are not the only regulated professionals in Vermont with doctoral-level training in diagnosis, assessment, and treatment of mental health disorders. In principle, there is no reason why the master's degrees that allow access to psychologist prescribing could not also be obtained by independent clinical social workers with doctoral (DSW) degrees, or by other clinical counselors with non-medical doctoral training.

Alternative Means of Improved Integration and Access

There is no question that psychologists, especially those with additional psychopharmacology training, can and should be more closely integrated in the clinical management of underserved patients. However, intermediate measures could be tried at lower expense and risk, plausibly to the benefit of both groups.

Collaborative Practice Agreements Without Direct Prescribing

The State's incumbent doctoral psychologists clearly have surpassing training in the diagnosis, assessment, and non-pharmaceutical treatment of mental health and behavioral disorders. Equally clear is that psychiatrists do not do most of the psychiatric prescribing in our healthcare system; the vast majority of which is done by primary-care providers such as physician assistants, advanced practice registered nurses, and physicians trained in family or internal medicine. The quality of psychiatric care offered by those generalists may be improved by organized collaboration between existing prescribers and psychologists. The Administrative Rules of the Board of Psychological Examiners expressly authorize exactly this kind of collaboration, allowing that a psychologist

> may offer a medication recommendation to the prescribing provider about a patient the psychologist has evaluated when such recommendation is an informed opinion based on the psychologist's

> education, training, and professional experience. The psychologist's opinion may inform the physician's medication decision.[41]

There appears to be ample opportunity under existing law to improve the integration of psychologists in diagnostic consultation and follow-up care.

Focusing on Psychiatrist Development

Representatives from the Board of Medical Practice testified that the shortage of psychiatrists derives from residency bottlenecks that have recently been relieved. The expansion of residencies—by approximately 1,000, reportedly—represents a step in the right direction. By population, however, Vermont might expect to pick up two of those 1,000—not a promising solution in the near term.

Focusing on Psychiatric APRN Development

A specific recommendation of the Rural Health Services Task force, discussed above, is to revive in-state training of psychiatric nurse practitioners at the University of Vermont. Notably, the Task Force did not recommend psychologist prescribing as a means of improving access to care. Though the two alternative approaches to improving access are in no sense mutually exclusive, the Task Force's choice to recommend the former and not the latter may be instructive in terms of priorities. The population of registered nurses who could credibly be persuaded to pursue psychiatric APRN training is far larger than the population of doctoral psychologists who could credibly be persuaded to pursue a prescribing credential.

Academic Bridge Programs from Ph.D. Psychology to Psych APRN

Some critics of the Applicant's proposal argued that psychologists who wish to prescribe should simply go to medical or nursing school. The option is available in theory but rarely taken in practice; few people who have completed approximately eight-plus years of postsecondary education to earn a doctorate would be willing to return to college for the core math and science training required for admission to conventional graduate programs. The leap backward would also fail to recognize and capitalize on psychologists' considerable training in a closely related field. Programs bridging doctoral psychology practice with psychiatric nurse practitioner roles,[42] with some element of advanced standing, could offer a more efficient and realistic alternative. Though psychology-to-psychiatric-APRN programs would be highly desirable from a policy perspective, such programs would come from pilots at one or more large universities—a challenging thing to legislate.

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[41] Administrative Rules for the Board of Psychological Examiners, Rule 6.5.

[42] All APRNs must be RNs, so the path must include core nursing training.

Final Recommendations

We cannot recommend scope expansion in precisely the form sought. The clinical, medical component of the training proposed does not compare favorably to that required of other master's-level behavioral-health prescribers, which stands as the consensus baseline for assurance of clinical competence to prescribe psychotropics. However, that deficiency could be remedied by adding more rigorous clinical experience requirements on the front end and commonsense limitations on the back. The states of Iowa and Illinois have taken these approaches, for example, by adding rigor and specificity to clinical experience requirements and by restricting narcotics prescribing. Both the Office and the Board—a body not natively enthusiastic about pharmacotherapeutics—believe the Iowa and Illinois models, rather than the APA model, bear consideration by the General Assembly.

We recommend the following enhancements to Applicant's proposal:

- Juvenile, elderly, pregnant, and medically and psychiatrically complex patients should be treated by prescribing psychologists under enhanced supervision and collaboration with a medical doctor.
- Expand scope to prescribing only, without reaching administration, distribution, or dispensing, thereby ensuring pharmacist oversight through a drug utilization review.
- Require a post-degree, fourteen-month clinical rotation in a variety of practice settings, consistent with Illinois's supervised practice requirement.
- The Commissioner of Health, in consultation with the Boards of Psychological Examiners and Pharmacy, should be authorized to restrict psychologists from prescribing specific high-risk drugs or classes of drugs.
- The Board and OPR should coordinate with prescribing clinicians from other professions to ensure competent investigation, prosecution, and adjudication of disciplinary cases concerning prescribing practice.

Lastly, turning to the "[p]ublic health, safety, and welfare benefits," we find that the competent addition of prescribing psychologists to the ranks of mental health providers offers two favorable impacts. First, prescribing psychologists may improve the integration of psychopharmacology and counseling psychology—therapies that are known to work in synergy, yet still remain an either/or solution for many Vermonters. Second, prescribing psychologists may supplement the number of eligible psychiatric providers while creating a needed bridge from primary care to psychopharmacology-focused care.

Psychologist prescribing offers modest returns in the near term. In *relative* terms, Vermont is not a desert in which qualified providers are waiting to flow: Our State and region are better supplied with behavioral health professionals than most. The reserve pool of prescribing psychologists is limited: Though scope-expansion proponents assert that hundreds of psychologists in the psychopharmacology-degree pipeline will soon graduate, our survey of actively licensed Vermont psychologists found only one licensee with a qualifying psychopharmacology degree.

Notwithstanding those caveats, we believe Illinois and Iowa have developed prescribing psychologist models that respond appropriately to critics' concerns, and we commend those models to legislators interested in advancing psychologist prescribing in Vermont.

STATE OF VERMONT
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