VERMONT

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Agency of Human Services

November 23, 2021

Gabe Gilman, Esq.
General Counsel, Office of Professional Regulation
Vermont Secretary of State
89 Main Street, 3rd Floor
Montpelier, VT 05602

Re: Preliminary Assessment of Application to Expand the Scope of Practice of Psychologists

Dear Mr. Gilman:

On Wednesday, November 3rd the Vermont Board of Medical Practice considered the application from the Vermont Psychological Association to expand the scope of practice of certain doctoral-level psychologists to allow them to prescribe psychiatric drugs to patients with psychiatric, cognitive, nervous, emotion, or behavioral disorders. The Board unanimously voted to oppose such an expansion, with one member abstaining.

The Board concluded Vermonters would not be well served by the requested action. Quite simply, members concluded that the risks to patient safety are not warranted. The various factors underlying that conclusion follow.

1. Psychiatrists are not psychologists with prescribing rights. Psychiatrists, like all physicians,[1] must complete a medical school curriculum designed to ensure mastery of all the following[2]:
    a. Biomedical, Behavioral, and Social Sciences, including how these are applied to the health of individuals and populations.

[1] The Board licenses allopathic physicians, who are commonly referred to as MDs. Osteopathic physicians, known as Doctors of Osteopathy (DO) also practice psychiatry. Comments here are based on MD educational, training, and examination requirements, but DO requirements for education, training, and examination are similarly rigorous.

[2] US Medical schools are accredited by the Liaison Committee on Medical Education. The curriculum requirements listed here summarize the content of Standard 7 of the October 2021 version of the LCME publication *Standards for Accreditation of Medical Education Programs Leading to the MD Degree*, which is available online at: https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Flcme.org%2Fwp-content%2Fuploads%2Ffilebase%2Fstandards%2F2022-23_Functions-and-Structure_2021-10-28.docx&wdOrigin=BROWSELINK.

b. Classroom and clinical training about organ systems, life cycle, prevention, symptoms, signs, differential diagnosis, treatment planning, and continuity of care as they all relate to preventive, acute, chronic, rehabilitative, and end-of-life care.
c. Scientific method, clinical research, and translational research, including how to conduct, evaluate, and explain research to patients, as well as apply it to patient care.
d. Critical judgment and problem-solving skills.
e. Instruction in diagnosis, prevention, appropriate reporting, and treatment of medical consequences associated with common societal problems.
f. Cultural competence and recognition of disparities in health care.
g. Medical ethics.
h. Communication skills.
i. Interprofessional collaboration skills.

While the above knowledge and skills reflected in that list are generally covered in the didactic portions of the medical school curriculum, it is a total of 4,000 or more hours of supervised clinical training across the spectrum of medical practice in clinical rotations that ensure physicians have a foundation to practice safely during the next step, residency training. Training requirements vary from state-to-state, but typically residency training requirements to become licensed to practice independently ensure that physicians have a minimum of 5,000 to 7,000 additional hours of supervised clinical practice. Most physicians have more. Another element of the pathway to become a physician is examinations. MDs must pass an intensive series of examinations taken at different points during medical school and residency training that is known as the United States Medical Licensing Examination, or USMLE. Finally, a very large majority of physicians go on to become certified by one of the certifying boards that administers exams focused on a medical specialty. At one time board certification was enduring, but now most specialty board certifications are limited to approximately ten years, with a requirement for ongoing education and reexamination required to maintain certification.

2. What this means for patient safety in the context of prescribing for psychiatric needs.

There can be no debate that psychologists are highly educated and trained in their field, but that field is not medicine. The difference in medical education and clinical medical training between any physician and a psychologist who has completed a psychologist's pharmacology program as proposed in the application cannot be understated. One of the programs mentioned in the application, the Idaho State University MS in Clinical Psychopharmacology, describes itself in this way[3]:

> *The program is available in a hy-flex model with either in-person or distance learning options. For distance learning, campus visits are required during the program. In person instruction is offered at Idaho State University-Meridian*

[3] https://www.isu.edu/pharmacy/prospective-students/clinical-psychopharmacology-program/

Sam and Aline Skaggs Health Science Center. The two-year program combines traditional classroom coursework with supervised clinical experience during the summer semesters.

A non-traditional, part-time route is also available for current practitioners. If a non-traditional route is desired, students should contact the program training director to determine an appropriate schedule to complete requirements, keeping in mind prerequisites and co-requisites.

Another of the four programs offered to teach pharmacology to psychologists, New Mexico State University, describes its Postdoctoral M.S. in Clinical Psychopharmacology Degree program as follows[4]:

The NMSU advanced postdoctoral MSCP degree can be completed in approximately 2 years. Two supervised clinical fieldwork experiences are embedded during coursework. Students are authorized to begin an 80 hr. physical assessment practica AFTER completion of the pathophysiology and physical examination sequence. Then later, trainees are eligible to begin their 100 patient, 400 hour prescribing psychologist fellowship by class #18.

Additional details about the program are found in "Program Highlights[5]," which disclose additional information.

Fits Your Schedule

The MSCP degree program is a hybrid format, offering online and in-person classes with flexible class schedules and outside self-paced learning. Live instruction is offered in Las Cruces, NM, where the master's in clinical psychopharmacology degree program is based. Students also can participate in live classes from their home computers and review archived classes through learning management systems. All instruction is provided on the weekends. Over the course of didactic clinical psychologist training, students are exposed to more than 450 hours of classroom contact.

Hands-On Facilities

Over the years, the MSCP degree program has developed other partners to offer students exemplary hands-on training in pathophysiology and physical assessment. Currently, the clinical psychopharmacology program is partnering with Arrowhead Medical Academy, NMSU School of Nursing and St. Ambrose University for access to simulations labs, mock exam rooms, medical instrumentation and training facilities.

Medical school graduates must have a minimum of six to seven years of medical education and training, and a large majority have more. At a minimum they must have

[4] https://cep.nmsu.edu/academic-programs/clinical-psychopharmacology/
[5] https://online.nmsu.edu/degree-programs/Masters/ms-clinical-psychopharmacology.html

about 9,000 hours of supervised clinical training and most typically have thousands more hours of clinical experience when first licensed and able to independently prescribe medications. The demanding path of education and training required to become a physician is not simply to exclude others who would like to provide medical care. It is because decades of experience have shown that more training means better outcomes and safer care. A 2017 academic article studied the relationship between having fewer years of residency training and being sanctioned by a medical board for unprofessional conduct. *Training Matters: A Retrospective Study of Physician Disciplinary Actions by the Louisiana State Board of Medical Examiners, 1990–2010.* Journal of Medical Regulation, Vol. 102, No. 4, Dec. 2017, Allen, Marier, Mouton, and Shankar.[6] The data showed a significant variance between physicians who had completed at least three years of residency and those with less than three years. 13% of physicians with fewer than three years of residency had been sanctioned at least once; 4% of physicians with at least three years had ever been sanctioned. At the top of the list of offenses by the less-trained group was improper prescribing (36%). Other leading problems were failure to meet standards of practice (27%) and incompetence (19%). It seems self-evident that more training would make for better medical practice – the study confirmed that is the case.

At the first public hearing on this issue psychiatrists spoke about how important their medical school training is to their being able to safely prescribe. One psychiatrist described how knowing when not to prescribe is critical, and how much he relies on those years of medical school classes and rotations, and the broad training across specialties during the first (internship) year of residency is to him for being able to identify non-psychiatric conditions that may manifest themselves through symptoms that seem to be psychiatric symptoms. General medical knowledge is also critical for understanding drug interactions and how treatment for non-psychiatric conditions may impact psychiatric care, and how other conditions may impact prescribing decisions for psychiatric conditions.

The bottom line is that prescribers who've had a small fraction of the relevant education and an even smaller fraction of the supervised clinical medical experience of a physician simply cannot be expected to do as well prescribing. 500 hours of clinical exposure is not the same as 10,000 hours or more training that prepares physicians for practice. Proponents of psychologist prescribing tried to suggest that there's little evidence of problems. There are three points to keep in mind regarding that.

First, there are five states in total that allow psychologists to prescribe, and in three of those states psychologists have been able to prescribe for only a very short time (Idaho 2019, Iowa 2019, and Illinois 2018). The two remaining passed laws allowing it only 2004 (Louisiana) and New Mexico (2002). Searches of the Louisiana and New Mexico boards that license psychologists show that there are 114 "medical psychologists" in

[6] Available online at: https://www.lsbme.la.gov/sites/default/files/documents/Healthcare%20Resources%20for%20the%20Practitioner/Training%20Matters.pdf.

Louisiana and 57 psychologists with prescribing privileges in New Mexico. There simply is very little experience with how this experiment might work.

Second, lack of recognition of problems does not mean there have been no problems. Ask physicians who sign death certificates how likely it is that it would be discovered that a patient who died from a coronary problem actually had an arrythmia that caused the problem brought on by inappropriate prescribing of a psychiatric medication for which arrythmia is a known side effect. Also keep in mind that, for example, patients who are being prescribed benzodiazepines for mood disorders rarely complain about those who are prescribing the controlled substances. It defies logic to suggest that psychologists who have much, much less medical training than physicians have somehow been immune from making clinical errors in prescribing and monitoring patients.

3. Why would a state take on the risk of allowing psychologists to prescribe?

Perhaps if conditions in Vermont resembled conditions in Idaho, it might be argued that it would make sense for a state to take on the risk of allowing psychologists to prescribe controlled substances despite the great disparity in medical education and clinical medical training. It appears that there is an across-the-board crisis in mental health care in Idaho, as show in data collected by a leading mental health organization. Mental Health America is an independent, non-profit organization committed to promoting mental health and access to mental health services. They issue an annual report of findings about access in every state. The overall access to mental health care ranking of Idaho[7] for 2022 is 42. Vermont's ranking for 2022 for overall access to mental health care is 1. That means they found that the data shows the best access to mental health care is in Vermont, while Idaho was near the bottom. Similarly, the related ranking for mental health workforce availability in 2022 shows Vermont with the 6th best ranking, while Idaho is 33rd. It is a similar story in Iowa, with Iowa ranking 45th on mental health workforce availability. New Mexico is recognized as having significant access to care problems related to its large size and the problem of extreme isolation in large swaths of very rural areas. New Mexico's area is 121,590 square miles, compared to Vermont at 9,616 square miles. Each of the states that has gambled on the wisdom of having psychologists prescribe has its own access issues. Illinois seems to have a relatively high population density, but with much of the population concentrated in the Chicago area, Illinois too has large rural areas with significant access challenges. Illinois's area is 57,915 square miles and, despite large numbers of metal health care providers in its large urban areas, the state ranks 28th for mental health care workforce availability.

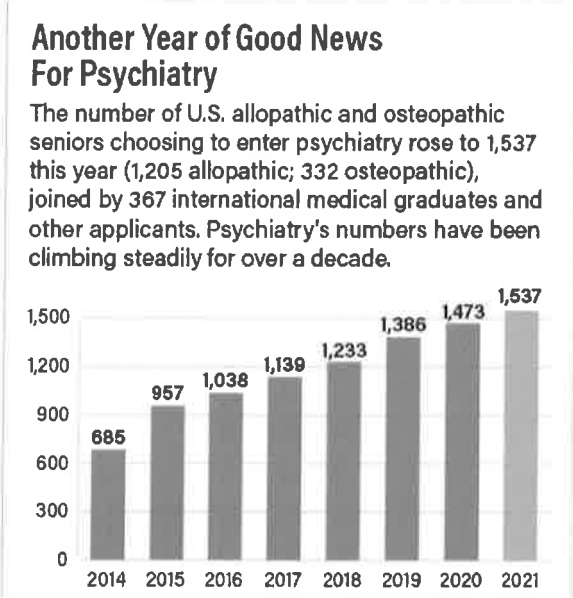
Vermont is not Idaho, nor is it New Mexico. There is no doubt that there have been some access to care challenges and that there are anecdotes to back up those assertions. Certainly, the stresses of the pandemic have highlighted access issues. However, the data cannot be disputed. Vermont is among the very top ranked states for access to care in

[7] Excerpts from Mental Health America's report for 2022 are attached. The full report is available online at: https://mhanational.org/issues/state-mental-health-america.

general and mental health care specifically. The circumstances in Vermont are quite different from those in the states that have risked extending the right to prescribe controlled substances to those who have so much less medical training.

4. But what about the numbers of psychiatrists?

   Another important factor to consider is the availability of psychiatrists. Access to psychiatry care declined across the nation over the past two decades as many psychiatrists reached retirement age and the number of psychiatry residents fell. However, there is good news about the prospects for psychiatry. The total number of US medical and osteopathic school graduates beginning psychiatry residency programs in 2014 was just 685[8]. By 2021, the number had risen to 1537. An additional 367 physicians who trained internationally also entered psychiatry, for a total of over 1,900 new psychiatrists beginning training this year. The numbers of psychiatry residents has been climbing steadily for several years and the much larger supply of psychiatrists completing training should result in a noticeable increase in access to psychiatric care in the very near future.



The significant rebound in the number of medical school graduates entering psychiatry residency programs is one factor in addressing patients' needs for psychiatric medications. Another is primary care physicians. While we are waiting to see the full

[8] Data cited here is from *Psychiatry Residency Match Numbers Climb Again After Unprecedented Year in Medical Education,* American Psychiatric Association, *Psychiatric News,* April 21, 2021. Copy attached and online at: https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2021.5.27.

impacts of the increasing number of psychiatrists, primary care providers are working to meet patient needs. One study reported in 2010 that primary care providers are prescribing psychiatric medications for 30 percent of their patients.[9] During the second public hearing on this issue the Director of the UVMMC Family Medicine residency program explained how the program has recognized the role of primary care physicians in meeting the need for psychiatry care and thus expanded the program's focus on mental health issues. Primary car e physicians have been safely and adequately meeting many of their patients' mental health care needs without immediately sending them to psychiatrists. Their capacity to do so is increasing with the increasing numbers of patients receiving such care and the expanded attention mental health needs receive in training programs. Care within the medical home is not undesirable; when appropriate it is advantageous and a goal of Vermont healthcare policy.

The surge in newly trained psychiatrists is a reality that is supported by data, and that promises to improve access to psychiatry care in Vermont. Prescribing for mental health care needs by primary care providers is also meeting the need, and the capacity of primary care providers to do so is expanding.

On the other hand, the proposal to allow psychologists to prescribe controlled substances cannot be seen as a solution to the current need for psychiatric care. During discussion of proposals to expand telehealth, there has been much said about a crisis of access to psychology care. How many psychologists have the time to devote to a pharmacology program? If some psychologists were to take on additional education and training, and then add this new aspect of practice, would that not just further exacerbate the challenges of access to psychology services? Perhaps that is why almost 20 years after the experiment began in New Mexico and Louisiana there are so few psychologists licensed to prescribe.[10] Furthermore, even if there was an excess capacity for psychology services in Vermont, at best the proposal would have only long-range potential to help. If this were adopted in the 2022 legislative session it would be years before a handful of psychologists might be educated, trained, and licensed to prescribe. This proposal has little true potential to improve access to care, and certainly not in the next several years. Given the surge in psychiatry residents being trained in recent years, it would appear that by that time access to care by psychiatrists will be significantly improved.

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[9] *Understanding the expanding role of primary care physicians (PCPs) to primary psychiatric care physicians (PPCPs): enhancing the assessment and treatment of psychiatric conditions*, Mental Health in Family Medicine, March 2010, available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2925161/

[10] With a population of 4.67 million at the 2020 census, or 7.2 times Vermont's population of approximately 643,000, Louisiana licenses only 114 "medical psychologists," and many of those have addresses outside the state, which raises questions about whether they actually are in practice there and prescribing. New Mexico's population was 2.12 million, or approximately 3.3 times Vermont's, yet they have only 57 psychologists licensed to prescribe.

For all the above reasons, the Board of Medical Practice urges OPR to find in its preliminary assessment that the scope of practice amendment is not consistent with the principles and standards set forth in Chapter 57 of Title 26, Vermont Statutes Annotated. Opening up prescribing of controlled substances to an additional profession that has much less training than the professions that currently have this authority is contrary to the principle of protecting the public. The prescribing of controlled drugs is a professional activity that carries the highest level of risk. The risks are not limited to patients who would be prescribed drugs, but also extend to anyone who might encounter the patient, or those who might come into possession of the drugs. Fifty-four states and the District of Columbia have not chosen to experiment with this expansion of psychology practice, while only five states have done so. Vermont should not gamble with the safety of those seeking mental health care in this state.

Do not hesitate to contact me if you have questions about this submission or need anything else.

Sincerely,

David K. Herlihy
Executive Director

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