State of Vermont
Office of the Secretary of State
128 State Street
Montpelier, VT 05633-1101
(802) 828-2363

Sarah Copeland Hanzas, Secretary of State
S. Lauren Hibbert, Deputy Secretary

Office of Professional Regulation
Michael Warren, Interim Director
Tara Grenier, Deputy Director

March 13, 2025

To: **Hon. Alyssa Black, Chair**
House Committee on Health Care

From: **S. Lauren Hibbert, Deputy Secretary of State**
Jen Colin, General Counsel, Office of Professional Regulation, Secretary of State

Re: **H.237, An act relating to prescribing by doctoral-level psychologists**

Dear Committee Members:

Thank you for the opportunity to testify about H.237. This past January, OPR completed an in-depth study of the 2021 proposal of the Vermont Psychological Association (VPA) to create a prescribing specialty for certain doctoral-level psychologists working with collaborating practitioners. As of January of this year, and as detailed in our report, seven states have adopted programs that allow specially trained doctorate psychologists to obtain prescribing authority.

While we did not recommend adopting VPA's proposal as drafted, we support a psychologist prescribing specialty if several improvements to VPA's proposal were incorporated.

This bill greatly improves upon the 2021 proposal and would adopt many of the recommendations from our report. At the same time, there are a few aspects of the bill that we would recommend changing in order for OPR to fully support the bill.

Qualifications for Prescribing Psychologists

In our report, we recommend the creation of a prescribing specialty for doctoral-level psychologists who completed an APA-designated postdoctoral psychopharmacology degree, passed a national exam, and completed substantial rotations. This is an example of the typical three-legged stool of professional qualification: education, examination, and experience.

- **Education.** The bill would require a postdoctoral program "accredited by the American Psychological Association or its successor." While technically the APA designates these programs, not accredits them, we agree with the substantive policy and recommend

simply changing "accredited" to "designated." With that small tweak, we support this aspect of the bill.

- **Examination**. The bill would give OPR rulemaking authority to determine an appropriate examination by rule, which we would do in consultation with the Board of Psychological Examiners and other professional boards with relevant expertise. We support his aspect of the bill.

- **Experience.** In our report, we recommend that prescribing psychologists be required to complete a post-degree 14-month clinical rotation in a variety of practice settings. This is a similar degree of hands-on experience to that undergone by nurse practitioners, who similarly obtain prescribing privileges based on (rigorous) master's-level medical education.

    - We modeled this recommendation on Illinois's psychologist prescribing statute, which was enacted over a decade ago. Illinois requires rotations in 9 practice settings over a total of 14 months, in psychiatry, pediatrics, geriatrics, family medicine, internal medicine, emergency medicine, obstetrics and gynecology, surgery, and one elective (with neurology recommended).

    - We feel this range of experience is necessary for psychologists to anticipate interactions, side effects, medical (as opposed to strictly psychological) comorbidities, and other complexities.

    - H.237, in contrast, requires "two years of supervised practice for not less than 20 hours per week in a clinical setting agreed upon by both the psychologist-doctorate and collaborating practitioner." H.237, page 5 at lines 1–3.

    - Confusingly, it also grants rulemaking authority related to "the length of clinical rotations [and] appropriate instructional settings." *Id.* page 3, lines 19–21. It is not clear to OPR if the two years of supervised practice meant to be the same as clinical rotations.

    - OPR has a strong preference for the qualifications to be established in statutory language as opposed to rules. Therefore we are asking that if this bill moves out of committee, the committee amend the qualifications to include a required clinical rotation within 9 practice settings over a total of 14 months, in psychiatry, pediatrics, geriatrics, family medicine, internal medicine, emergency medicine, obstetrics and gynecology, surgery, and one elective (with neurology recommended).

Scope of practice

It's important to define the scope of practice for this specialty—to make clear that a prescribing psychologist cannot prescribe, for example, antibiotics for strep throat. This seems to be the intention of the bill but there are a few areas OPR would like clarified in the language.

- **Which conditions?** The bill defines "drug" as "agent related to the diagnosis, treatment, or management of a mental, nervous, emotional, behavioral, cognitive, or substance misuse disorder." This language is somewhat outdated and could exclude ADHD and other disorders that are brain-related and within psychological scope of practice, but not "mental, nervous, emotional," etc. We recommend tying the scope of psychologist prescribing to conditions in the DSM and/or creating rulemaking authority to explore this in more depth than is practical in statute.
- **Which drugs?** Second, the bill would allow prescribing psychologists to prescribe only those prescription drugs "for the treatment of mental health conditions that the collaborating practitioner generally provides to patients in the normal course of practice." H.237 at page 5, lines 12–14. This is unenforceable. OPR will not know what drugs the collaborating practitioner generally prescribes. Privacy laws would protect the records of a patient of the collaborating practitioner; and even if they didn't, how would OPR's enforcement team establish what the collaborating practitioner "generally" does without broadly reviewing all of their patients' records? We recommend, instead, either requiring prescribable medications to be stated explicitly in the collaborating practice agreement or using a statutory definition tied to objectively knowable standards in the field. This is something OPR can develop further in rulemaking.
- **Rulemaking authority to forbid certain drug classes.** We also ask that the bill add rulemaking authority for OPR to restrict or forbid the use of certain classes of medications. The majority of states that allow psychologist prescribing, for example, forbid the prescribing of opioids and other narcotics, and some forbid the prescribing of controlled substances altogether; the only states that permit psychologists to prescribe opioids are the two that built their programs in the early 2000s, before widespread public awareness of the opioid crisis and changes in opioid prescribing across medicine. Vermont should not buck this trend.

Drafting Issue--License vs. Specialty

At OPR, we distinguish between licenses and specialties.

- A **license** is basic authorization to engage in a professional practice.
- A **specialty** is an add-on to that license that expands the scope of practice for holders of that specialty, who must show additional qualifications to obtain the specialty. Examples are the prescribing specialty for naturopathic physicians; the local anesthesia specialty for dental hygienists; and the firearm specialty for security guards. In older statutes, specialties are sometimes also called endorsements or privileges.

- The bill refers several times to a prescribing psychologist *license*. We do not recommend, and we do not think the bill's sponsors intend, to create a separate license for prescribing psychologists, who would then have either to maintain two separate licenses or give up their basic psychologist-doctorate licenses.
- We ask that the bill be revised to refer to the prescribing *specialty* which can be added to a psychologist-doctorate license.

Implementation timeline: too short

The bill would grant rulemaking authority effective 7/1/25 and require OPR to start issuing specialties 7/1/26.

- OPR anticipates introducing, in the 2026 session, a bill to broadly repeal and replace the licensing statutes for all of OPR's mental health professions, including psychologists. This would implement a multi-year Mental Health Licensing Study that the General Assembly requested and that was completed in December 2024. As such, we plan on engaging in rulemaking for all mental health professions, including psychology, after the 2026 session.
- Standing up this prescribing program by 7/1/26 would duplicate our efforts, since we anticipate overhauling the psychology rules in late 2026-2027.
- In addition, we have a substantial rulemaking backlog, with several other high-priority rules that in the public interest should come ahead of this new specialty.
- **We ask that the second effectiveness date in the bill, 7/1/26, be amended to 1/1/28 or 7/1/28.**

Final caveat: A high-cost, low-impact program

- While our report supported psychologist prescribing as possible to authorize safely, we cautioned that the number of psychologists who will obtain the specialty will likely be very small, with a correspondingly small impact on public access to care.
- This is based on numbers from other states that have adopted psychologist prescribing. If Vermont psychologists obtain the specialty at a rate similar to their peers in other states, it might be a decade or more before we have double digits of prescribing psychologists.
- OPR is funded by professional licensing fees. Therefore, staff time to develop and maintain this specialty would be funded by licensees who will never obtain the specialty—and, indirectly, by those licensees' patients.
- One solution to this unfairness would be a general fund allocation for the implementation of a psychologist-prescribing program.