My name is Eric Silk, PhD, MSCP. I serve as Training Director for the Master of Science in Clinical Psychopharmacology (MSCP) program at Idaho State University and as a member of the Idaho Board of Psychologist Examiners. I write in support of H 237 in my individual capacity.

For the past several years, I have closely followed Vermont's deliberations regarding prescriptive authority for psychologists. Much of the opposition has centered on concerns about safety and the alleged inadequacy of clinical training. Safety is precisely why modern prescribing psychology statutes require rigorous postdoctoral medical education, supervised clinical prescribing experience, national examination, and structured collaboration. Psychiatric medications can indeed be dangerous. They can also be lifesaving. The responsible response to that reality is not prohibition - it is high-level training, structured oversight, and careful scope design. That is exactly what states such as New Mexico, Louisiana, Illinois, Iowa, Idaho, and Colorado have implemented.

In fact, during earlier phases of Vermont's debate, a psychiatrist publicly expressed concern about insufficient clinical training in MSCP programs. I reached out directly and provided detailed curricular materials outlining our coursework at ISU in pathophysiology, pharmacology, physical assessment, laboratory interpretation, differential diagnosis, and supervised prescribing. The response was immediate and unequivocal: *"Thank you so much for sending this. Your program sounds fabulous, much more comprehensive."* I subsequently invited interested clinicians to observe our students' live clinical case presentations. The concern was rooted not in data, but in unfamiliarity with the rigor of the actual training. I continue to see gross misrepresentation of the actual training standards, specifically in opposition to this very bill. Our MSCP students in Idaho are literally training in the same facilities, with the same professors, as our medical, PA, nursing, pharmacy, and other health professions.

Idaho provides a useful comparison to Vermont. Both are largely rural states with workforce shortages and geographic barriers to psychiatric care. Idaho now has **1**4 licensed prescribing psychologists, with additional graduates completing MSCP training each year. That number may sound modest, but Idaho has only roughly 100 psychiatrists statewide - many employed in federal or institutional settings and therefore inaccessible to much of the general public. Even incremental increases in well-trained prescribers meaningfully improve access, reduce wait times, and strengthen integrated behavioral health services.

Prescribing psychologists are not intended to replace psychiatrists. They are doctoral-level clinicians with extensive training in assessment and psychotherapy who complete substantial additional post-doctoral medical education specifically focused on psychopharmacology. In my professional judgment, there is no clinician better positioned to integrate psychotherapy and medication management thoughtfully and conservatively than a properly trained prescribing psychologist. We have options beyond medication, and that breadth strengthens - not weakens - clinical decision-making. The irony is that much of the opposition to H 237 comes from models of care that rely primarily on medication management alone.

For the people of Vermont, this is ultimately about safety, access, and efficacy. Two decades of implementation in other states demonstrate that structured prescriptive authority can be safe, carefully regulated, and beneficial to patients. I respectfully urge you to support H 237.