Dear Senators,

I am somewhat new to Vermont, moving here in July 2022, when I took a position as an Emergency Psychiatrist at UVMMC. Since then, I have become the Medical Director of Emergency Psychiatry.

It is only recently that a colleague alerted me to the H.237 “psychology prescribing bill”.

I do not want to me alarmist, but I have several reservations regarding this bill.

1. False sense of expanding access - it is my understanding that the number of psychologists who are actually interested in prescribing in this state is small. The handful of psychology colleagues I interact with all express similar sentiments: it is not why the pursued psychology, focus on medications may impact/cut-into their psychotherapy time with a patient, they are not interested in further training and/or requiring to have a supervising psychiatrist as part of their practice.
2. Improvements in the collaborative care model - it is also my understanding speaking with advocates on this matter that the landscape of outpatient care has shifted for the better since the first draft of this bill was proposed. I can say from experience that UVMMC and CHC have both been pro-active and dedicated to providing psychiatric prescribing consult to primary care providers.
3. Unintended consequences - Nontraditional psychiatric prescribing already exists in VT by nurse practitioners, physician assistants, and naturopaths. The level of training for these prescribers is not as rigorous as specialist MD/DO and this proposed bill similarly has an incredibly low requirement for training. I see the consequences of this on a daily basis with substandard care leading to mental health crises and/or mismanagement of mental health crises. Three examples from my last week of work alone:
    a. A physician assistant continued a potent domine-blocking antipsychotic agent on a patient who was diagnosed with Parkinsons Disease while also being prescribed a pro-dopamine agent by his neurologist. The patient has an affective disorder, not a psychotic one. This has led to worsening side effects and his presentation to the ED.
    b. A patient in their 30's with over six-months of worsening depression never had their initial anti-depressant dose increased, which was started at a sub-therapeutic level by an NP. At their most recent appointment instead of increasing the medication another anti-depressant was added-on, also at a sub-therapeutic level. They presented to the ED after writing a suicide note which thankfully

alarmed them and they told a friend who brought the patient to the ED. This was a patient who had never experienced a depressive episode previously. They were never counseled to seek psychotherapy by their outpatient NP.

c. A patient in their 40's who was on an anti-depressant for over 10 years (which can be problematic prescribing - but I digress), was told they by their NP could simply stop their medications as it was "safe". Withdrawal effects of antidepressants are known which can range from physical discomfort to neurological symptoms to suicidal ideation. The patient presented to the ED with all three.

While there are excellent colleagues, I have who are NPs and PAs, and I have no aversion to hiring similarly credential practitioners in the hospital (I have written letters of recommendation for two NPs and 1 PA). The supervision in the outpatient world is often not sufficient and expanding prescribing privileges to a profession that has even less exposure to medical training is troubling. The guardrails outlined in the bill likely are not sufficient and potentially too vague.

As outline above, I would not recommend passing H.237 as it will not significantly improve access to mental health care and will only expose patients to unintentional negative consequences.

Thank you for considering my experience and informed position on this matter.

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Resident of Essex (Town)