February 4, 2026

Re: OPPOSITION to H237 that would expand practice to allow prescriptive authority for psychologists

Dear Legislators,

My testimony is informed from my experience as a doctoral-level trained clinical psychologist (UCLA). My experience includes being a Professor of Psychology at Linfield University since 2002 and conducting research on this issue to try to understand psychologists' knowledge and views of prescriptive authority as well as psychologists' likelihood of training to pursue prescriptive authority. My opinions do not represent the institution. My opinions are consistent with testimony submitted by Psychologists Opposed to Prescription Privileges for Psychologists (POPPP). I am on the Board of Advisors of POPPP. As my testimony and the POPPP petition suggest, this is not simply a "turf" issue. Opposition stems from serious concerns about the lack of data to support the efficacy and safety of short-cut training. Proponents advance prescriptive authority bills with the promise of increasing the number of prescribers as a solution to problems accessing high-quality empirically-supported treatments (ESTs). Equating mental health treatment to prescribing and overlooking data that suggest those with the greatest barriers to accessing care reside in underserved areas without access to *any* mental health providers does nothing to improve treatment access for residents in Vermont. Psychologists should be working with other health professionals and legislators to develop innovative solutions that address unmet needs in your state.

I am writing to request that you oppose H.237 and any future initiatives that would allow psychologists to prescribe medications in Vermont. I have been active in opposing legislation in Oregon and was a part of the team that convinced our Governor to veto a bill in 2010 that was pushed through both the house and senate in a short special session. I fought alongside consumers and colleagues from allied health and mental health disciplines in 2017 to again convince another Governor to veto another psychologist prescribing bill. Consumer protection, concerns about quality of training, and lack of evidence of improving care or access have been central to gubernatorial vetoes of RxP legislation in Hawaii (Lingle, 2007) and Oregon (Kulongoski, 2010; Brown, 2017).

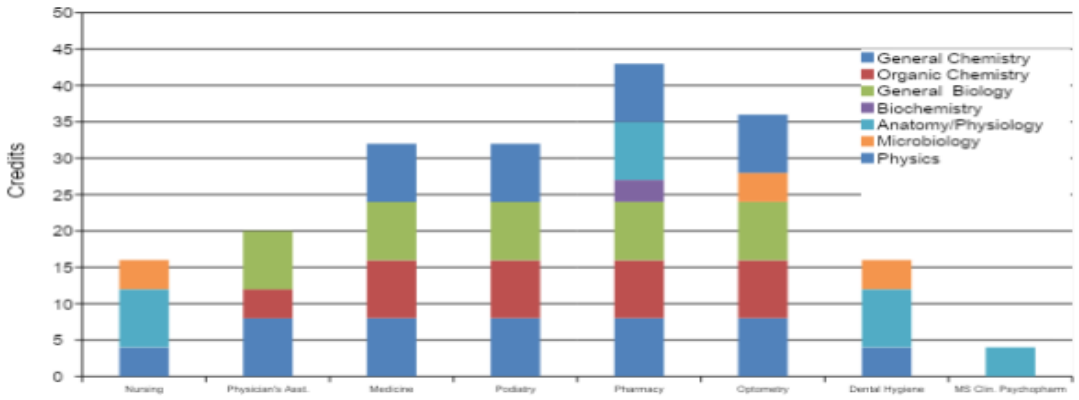
Below I detail my most serious concerns. I also reference several recent peer-reviewed articles as they contain figures demonstrating several key points of concern: failed efforts across many states that drain time and money away from finding real solutions to mental health challenges; vast discrepancy between psychologists' preparation relative to other non-physician prescribers; lack of evidence to support arguments of improved access; failure to provide data about prescriptive patterns that speak to outcomes, safety and access to ESTs, including therapy vs. medication. I strongly believe that the stigma that surrounds mental illness serves as a more formidable barrier to accessing care than any other factor and is one that would not be addressed by establishing a lesser-trained class of psychologist prescribers. However, the American Psychological Association (APA) continues to invest significant time and money in providing boiler plate legislative bills to state organizations who then replicate the same unsupported arguments and initiate the process of wrangling over the bare minimum training acceptable to medically treat the mentally ill. This race to

the bottom echoes the message that is acceptable to provide sub-standard care to folks who suffer from mental illness. It is not. They deserve better care.

Reasons for Opposition Involve Risk to the Consumer

- Training for a doctorate in clinical psychology does not include pre-medical or medical training (see Figure 1 from Robiner et al., 2013 - psychologists are not regularly prepared with even the most basic science courses prior to entering graduate school). There is no language in this bill requiring pre-requisites in the basic sciences. All but Illinois, which adopted more stringent standards aligning with PA programs in 2014, do not require prerequisites. Notably, Illinois has continued to try to weaken the standards set forward in that bill, which morphed into more stringent standards owing to pressure from opponents and some legislators who refused to compromise. They seem to be pushing to further expand practice and erode training and education requirements that were signed into law in 2014. The current bill seems to suggest that the training is equivalent across states. As noted in Robiner et al., 2020 this is clearly not the case. IF these were ***accredited*** postdoctoral training programs that assumption might be safe. However, NONE of these programs are accredited. Other post-doctoral training programs involve accreditation. Designation does not involve program or curriculum review, but instead appears to be updated by a small and insular APA committee every decade since the mid-1990s. Accreditation (vs. designation) also signals a higher bar regarding preparation to serve in a unique role – in this case practicing medicine. However, the preparation to pursue training related to practicing medicine is clearly not equivalent to other health professions (see Figure 1).

Figure 1
College Basic Science Prerequisite Courses for Admission to Health Science Programs



Note: Multiply credits by 10 for estimated hours of instruction. These 2013 data were derived by surveying admission requirements to the largest programs in New Jersey (e.g., Farleigh Dickinson University, University of Medicine and Dentistry of New Jersey, Rutgers University). Although there were no physical or health sciences prerequisites for entry into the Ph.D. programs in Clinical Psychology, both the FDU and Rutgers curriculum included one course in biopsychology or behavioral neuroscience.

- There is virtually no evidence that reducing medical training to about 10% of that required for physicians and about 20% of that required for advanced practice nurses (advanced nurse practitioners) will protect the consumer (see also Robiner et al., 2020). In fact, the proposed training disconcertingly includes less than half the training of the DoD's PDP, which is typically

cited as evidence for the effectiveness and safety of RxP, despite the striking differences in rigor and intensity. Concerns include: non-selective admission process (i.e., the PDP by contrast recruited exemplary officers with strong science backgrounds); abbreviated curriculum and training content and duration; lack of standardized training (i.e., unspecified faculty qualifications, range of clinical settings); no standards regarding limits to scope of practice (i.e., PDP psychologists treated adults aged 18 to 65, limited formulary; the current bill excludes RxP to children but it is unclear why the upper age limit is 80 and it leaves determination of limits on formulary to a board of psychologists to regulate this medical practice). The continued development of programs based on controversies about the adequacy of training remains concerning. Why, after all, should training to prescribe, which arguably entails greater safety risks for patients than other services rendered by psychologists, evade the quality mechanism of accreditation that governs all other post-baccalaureate psychology education and training in health service psychology?

- 89.2% of members of the multi-disciplinary Association for Behavioral and Cognitive Therapies (ABCT) argue that medical training for psychologists to prescribe **should be equivalent to other non-physician prescribers** (Deacon, 2014). A survey of Illinois psychologists (78.6%; Baird, 2007) and Oregon psychologists (69.2%; Tompkins & Johnson, 2016) yielded similar consensus

- The 2014 ABCT survey found only 5.8% endorsed the effectiveness of online medical training, which is not excluded in this bill and only 10.9% would refer a patient to a prescribing psychologist whose medical training is what is required in similar bills; it is unclear whether this to-be-developed training program will be online or in-person

- The current bill does include more rigorous training than past bills (increased breadth of training across settings, close collaboration with a physician). That being said, there are concerns that attempts to get *any* legislation passed is a *preliminary strategy* used in some states as a prelude to subsequent efforts to seek later legislative changes that erode initial safeguard requirements in attempts to expand scope of practice (e.g., in NM proponents proposed a bill to allow the use of long-term anti-psychotic injectables by prescribing psychologists. In Illinois proponents have attempted to remove provisions prohibiting prescribing psychologists from treating children/adolescents and individuals over the age of 65).

- The current bill expands **medical practice** to psychologists with broad discretion provided to the board of psychologists to determine specifics about licensing, continuing education, and oversight, the majority of whom may have no experience in prescribing. In medical settings, confidence is only weakly correlated with competence and overconfidence is more prevalent than under-confidence, especially at lower levels of competence (Jaspan et al., 2022). Given that lower levels of competence have been associated with overconfidence in other medical professionals, there are legitimate concerns about prescribing psychologists' bias and blind spots in recognizing bounds of competence

- Proponents claim that the lack of a reported death or serious harm by prescribing psychologists somehow provides evidence of safety. It does not! It only provides evidence

that any harm done by these psychologists was not identified and reported by the psychologists themselves or their patients. A lack of evaluation of safety, and the absence of any credible, comprehensive system to identify problems, does not constitute evidence for safety. Psychologists' meager training to diagnose physical problems suggests that psychologists probably would not even know if their prescribing had caused medical problems (in fact, at least one person submitted testimony regarding the adverse effects of a psychologist prescribing Vyvanse). Lawsuits in Louisiana suggest the need for a more general survey of malpractice claims in these states to evaluate claims of "no adverse effects" (Robiner et al., 2019). Proponents, Linda and McGrath (2017), in their small study also noted that participants reported adverse effects - one reported a patient being hospitalized or harmed by medication, and a medical colleague reported a psychologist prescribed two medications with antagonistic effects. Hughes et al. (2025), using private insurance claim data that are not readily available to other researchers, recently claimed that adverse drug events (ADEs) "were rare for both prescribing psychologists (1.5%) and psychiatrists (2.4%)", and that the rates were 24% lower among patients treated by prescribing psychologists vs. psychiatrists. However, in their published Table 1 reporting descriptive statistics the rates were reversed (2.4% of those treated by prescribing psychologists reported ADEs vs. 1.5% for psychiatrists). I mention this in that some of these statistically complex analytic papers have not been pre-registered and submitted to APA journals where it is unclear whether reviewers or editors have the expertise to evaluate the analytic decisions being made as well as the interpretations of those analyses. Perhaps this was a typo in Table 1, but it leads to concerns about the peer review process.

- The 2014 ABCT survey found that 88.7% of psychologists agreed that there should be a moratorium on bills like this one until there is objective evidence that the training involved adequately protects consumers. Proponents acknowledge that this training has, "the least overlap with traditional medical curricula'' (Fox et al., 2009, p. 258) and that the "public sector might also serve as an experimental laboratory for society as elected officials explored expanding a health profession's scope of clinical practice" (p. 263). Given the complexity and risks of prescribing, the fact that the evidence purportedly supporting prescribing psychologists' competence and impact, quality and safety is woefully inadequate in scope, quantity, and quality, as it relies on small convenience samples, poor response rates, and mostly self-report (Levine et al., 2011; Linda & McGrath, 2017; Peck et al., 2021) is deeply concerning. Across the limited published studies, prescribing psychologists reported increased income (Levine et al., 2011; Linda & McGrath, 2017) and treating individuals with more severe psychopathology. They also reported increased client load and income from their expanded practice, with over half reporting increased income owing to shifts in practice (i.e., discontinuing managed care in lieu of fee-for-service care and raising rates).

- Most prescribing psychologists reported prescribing medication to the majority of their patients, both as monotherapy and in combination with psychotherapy (Levine et al., 2011; Linda & McGrath, 2017; Peck et al., 2021). Also lacking is a broad perspective about how encouraging a new class of additional prescribers fails to curtail concerns about the dangers (Hampton et al., 2014; Gotzsche et al., 2015) and overuse of psychotropics (Olfson et al., 2012). Likewise, the magnitude of polypharmacy reported in the limited number of self-report studies is concerning given the dearth of evidence to support use and factors that contribute,

such as invalid assumptions about the efficacy of combined medication and limited awareness about metabolic and neurological adverse drug events (e.g., Zito et al., 2021). While Hughes and colleagues (2025) recently reported, among privately insured patients, that prescribing psychologists performed slightly better than psychiatrists in terms of polypharmacy (20% lower rate), they also found significantly higher rates (175%) of psychotropic polypharmacy relative to Primary Care Physicians. Overall, the self-reported advantages and disadvantages of expanding practice paint a problematic picture of professionally-interested factors driving expanded scope of practice, especially in light of the lack of evidence with regard to actual behavior or outcomes (i.e., chart review or insurance database review). Perceptions and complaints about practice also seem to signal low meta-cognition about the dangers inherent in the role (i.e., overprescribing, practicing outside bounds of competence, need for medical screening and collaboration). Changes to scope of practice should be made centering patient safety and outcome, not professional desire or financial gain

- Given proponents of prescriptive authority for psychologists (RxP) spent over $500,000 to pass a prescribing bill in Louisiana alone speaks to the availability of funds to conduct informative consumer safety studies for the amount of medical training required in this bill. How much funding did the Vermont Psychological Association receive from the APA? I am a psychologist, full professor, and educator who was trained at one of the top clinical psychology graduate programs in the U.S. I receive NO compensation for publicly opposing RxP and NO direct benefit from the work (e.g., having attained full professorship my publications about these concerns yield no additional career benefit). What drives my opposition is a strong belief in collaborative care grounded in ethics that respect bounds of competence. I agree that we need to improve access to mental health care. This is not equivalent to expanding access to prescribers.

  <u>The State of Illinois has set a new and more appropriate standard for prescription privileges for psychologists</u>

  - In 2014, the State of Illinois enacted a law to permit psychologists to prescribe some psychotropic medications (e.g., excluding narcotics and benzodiazepines) to a limited population (excluding youth, the elderly, pregnant women, the physically ill, and those with developmental disabilities). This bill does require clinical just over a few months of specialized training across five settings, but is leaving formulary-based restrictions up to a board of psychologists who are not medically trained.
  - The training requirement is similar to what is required of Physician Assistants, including completing undergraduate pre-medical science training before studying post-degree psychopharmacology. This training includes 7 undergraduate and 20 graduate courses along with a 14-month practicum in multiple medical rotations. The training program must be accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA).
  - No online medical training is acceptable.
  - The Illinois Psychological Association, Nursing and Medical associations, and POPPP support the Illinois law, as it requires, at minimum, the same medical training as other non-physician prescribers. This is more appropriate than the APA model in that it

meets an existing standard for healthcare providers, rather than establishing a new lower standard.

- HOWEVER, In the last several years, Illinois has been pushing to expand formulary (to include benzodiazepines and opioids), to relax restrictions to include both pediatric and geriatric populations with no substantial changes in training. They are likely to continue to introduce bills that will continue to erode the more stringent training standards that aligned most closely with other prescribers. Again, political wrangling and professional desire should not drive public mental health policy.

Alternative Solutions to Access to Psychoactive Drugs

The stated rationale for proposing such bills is to improve access. There is NO RELIABLE EVIDENCE to suggest that allowing psychologists to prescribe will improve access in any meaningful way. In our recent workforce study, psychologists in states that allow prescriptive authority represent only **0.23%** of the workforce of prescribers in those states. In a blog post accompanying the peer-reviewed article we demonstrate how other health professions have been filling gaps in psychiatric care. To underscore the potential underwhelming impact of RxP, In the two states (Louisiana and New Mexico) with the longest history of allowing psychologists to prescribe, the **ratio of prescribing psychologists to the population is approximately one one-hundredth of the rates for other prescribers.**

Several proponents have also suggested that prescribing psychologists have decreased suicide in states where they are allowed to practice. Drawing causal claims from correlational data is problematic. Failing to mention that anti-depressants come with black box warnings given heightened suicide risk among youth and young adults is also disturbing. Equally concerning is the fact that proponents ignore the fact that researchers found ELEVATED rates of suicide in females (increases of 8%) in their unpublished study (Choudhury & Plemmons, 2021), but reported favorable changes for reductions for males and no significant change for women in their peer-reviewed, published paper two years later (Choudhury & Plemmons, 2023). Again, pre-registration and commitment to open science reduces concerns over researcher decision making that biases conclusions drawn. Moreover, a critique accepted for publication (McKay, Rizvi, Atkins, & Kerr, in press) highlights important limitations of additional research (Hughes et al., 2023) that RxP proponents have suggested reveals decreased suicide rates in states that have enacted prescriptive authority for psychologists. McKay et al.'s article has not been published by an APA journal for over one year since it has been accepted, apparently awaiting invited commentary by Hughes and colleagues. In fact, Hughes et al. reported an initial decrease in suicide in NM with no subsequent annual changes, while no changes were found for Louisiana. The causal claims made by proponents about RxP reducing suicide are unwarranted and inaccurate.

There are many alternatives to psychologists prescribing that more appropriately enhance access to the prescription of psychoactive medications in those individuals who would benefit from them and expand access to mental health care.

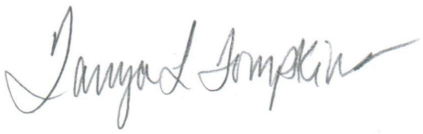
1. Collaboration between psychologists and physicians.
2. Completion of medical or nurse practitioner or physician assistant education by psychologists seeking to prescribe that do not abbreviate scientific and clinical training relative to these other fields. Encouraging medical schools and nurse practitioner training programs to offer

executive track programs for psychologists. Funding existing efforts to improve training related to psychoactive medications and expand the current prescribing professions.

3. Use of telepsychiatry, which is promoted by the Department of Veterans Affairs, the military, and the U.S. Bureau of Prisons, and rural health centers, is an effective means of transcending the challenges of distance between psychiatrists and patients for many patients. It is a mechanism for providing direct patient care by psychiatrists as well as a technology for providing primary care providers with appropriate consultation to develop appropriate treatment regimens, thereby extending the reach and impact of psychiatrists.
Encouraging all health professions to broaden their distribution to better serve rural areas.
The prescribing laws in New Mexico and Louisiana did not result in psychologists moving their practices to rural areas as they had declared would happen. For example, in an Oregon survey and consistent with prior studies (94% - Baird, 2007), the majority of psychologists sampled (96%) practiced in metropolitan areas and those practicing in non-metro areas were no more likely than urban psychologists to express an interest in pursuing prescriptive authority (see attached chart from Tompkins & Johnson, 2016; used with permission; no prescribing psychologists in Guam identified despite enabling legislation in 1999). Additionally, few (less than 7%) Oregon psychologists expressed an interest in pursuing training to become prescribers; in fact, results support prior survey results of both Oregon (Campbell et al., 2006) and Illinois (Baird, 2007) psychologists in suggesting that few have an interest in pursuing training and even fewer plan to prescribe. More recently, in proponents' recent simulation study evaluating millions of individuals receiving care Hughes and colleagues (2024) similarly found that individuals living in metro service areas "were more likely to see a prescribing psychologist, meaning a smaller proportion of their patients were from rural areas" (p. 13). Expanding mental health care demands innovative solutions to improve care for all Vermont residents.

I deeply appreciate your time and thoughtful consideration of this bill that warrants your opposition to it. If you have any questions that I can answer or would like for me to forward studies/data to you, please reach out.

Respectfully,



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