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Psychology Prescribing Technical Review Committee c/o
Ron Briel, Program Manager
Licensure Unit, Division of Public Health
Nebraska Department of Health and Human Services

To the Members of the Psychology Prescribing Technical Review Committee:

As the founding director of the Master of Science Program in Clinical Psychopharmacology at Fairleigh Dickinson University, I have been asked to address misinformation that you may receive regarding the training model for prescribing psychologists. Opposition to prescribing psychologists typically comes from a small fringe group (Psychologists Opposed to Prescriptive Authority for Psychologists) and particular medical organizations that routinely battle against nonphysician groups seeking to expand their scope of practice. No doubt the review committee members in Nebraska will receive misleading information regarding the regulatory changes proposed by the Nebraska Psychological Association.

First, materials from critics demonstrate a basic misunderstanding of the training psychologists receive in preparation for prescribing. They claim the number of hours of additional training psychologists will receive in preparation for prescriptive authority (on top of their 5+ years of graduate work) are insufficient when compared to training by other medical professionals, but they completely ignore the fact that the role of the prescribing psychologist is very different. Physicians, physician assistants, and nurse practitioners are general medical providers first. When they prescribe, they can prescribe from the full 2000+ medications approved by the U.S. Food and Drug Administration. In addition, they are trained in a variety of medical procedures that are completely unrelated to prescribing. These include delivering babies, performing surgeries, and suturing a wound. In contrast, after completing the master's degree in clinical psychopharmacology the prescribing psychologist is only authorized to prescribe the approximately 100 medications associated with the treatment of mental disorders, and to order and interpret tests relevant to those medications. It is difficult to see how the current training model is insufficient to cover the entire portion of the medical school curriculum relevant to prescribing those medications, and to prepare the student to prescribe related medications in the future. In fact, POPPP's materials do not even attempt to do so, they just assume it is insufficient. The truth is that the master's degree in clinical psychopharmacology provides more formal training on these medications than medical school provides on all medications combined.

Let me provide you with a couple of pieces of information to support the claim that the training is sufficient. The attached Table 1 provides a comparison of content domains in the training of the prescribing psychologist and the psychiatrist. What this comparison suggests is that every topic relevant to prescribing for the psychiatrist is covered in the prescribing psychologist's training. Topics in the curriculum for psychiatrists not covered in the psychologist's training are topics such as anesthesiology that are completely irrelevant to the job of a psychiatrist, and would therefore just make the training less cost-efficient. Finally, the attached Table 2 demonstrates that every topic covered in the board examination for psychiatrists is covered in the two licensing examinations psychologists must pass before they are authorized to prescribe.

Second, the critics object to the use of online training. They fail to note that the U.S. Department of Education has found online teaching is actually slightly superior to face-to-face classes for learning (www2.ed.gov/rschstat/eval/tech/evidence-based-practices/finalreport.pdf). When you consider that online material can be reviewed multiple times, that it can be studied at the student's convenience, and that learning is not affected by absence at appointed class times, this finding should make sense. Of course, we recognize that a good clinician is not created by classroom work alone, and the practicum experience that is required for licensure creates the opportunity to cement learning through face-to-face interaction with a supervisor. In fact, it is just this combination of online and face-to-face learning that the Department of Education found results in the best learning outcomes of all.

Third, the shortage of psychiatrists represents a growing crisis in the treatment of individuals with mental disorders. Research sponsored by the Health Resources and Services Administration of the U.S. Department of Health and Human Resources estimated we need 45,000 more psychiatrists across the country to meet the shortage (Konrad et al., 2009). Yet psychiatry is in fact shrinking. According to Dr. Tom Insel, the Director of the National Institute of Mental Health, psychiatry has more practitioners over the age of 55 (55%) of all the major medical specialties, and the number of new psychiatrists is still declining. What solutions do the critics offer for this emerging crisis?

- Collaboration between psychologists and physicians: The proposal you are considering requires that the prescribing psychologist engage in such collaboration. In contrast, physicians are not required by law to consult with the patient's psychologist, so the proposed bill mandates more collaboration than does POPPP's solution.
- Training psychologists as physicians, physician assistants, or nurse practitioners: I've already made the point that training in one of those professions is inefficient, because general medical training includes many topics that are completely irrelevant to prescribing for mental disorders. Those paths would result in less intensive training in those skills the psychologist needs to prescribe for mental disorders, and extensive training in topics they will never use again. In the context of a crisis, this is simply foolhardy.

- Encouraging mental health specialization among medical providers. However, the critics don't indicate who is to pay existing medical providers, most of whom have no interest in treating individuals with mental disorders, to receive additional training in mental health. Presumably that would be the responsibility of the legislature. In contrast, the additional training the psychologist receives to prescribe is self-funded, and therefore comes at no cost to the state.

Fourth, critics raise a great deal of concern over the safety of psychologists as prescribers. Note they offer no evidence that psychologists are unsafe prescribers; just that for some reason they can't imagine psychologists could be safe with the amount of training received. At this point, psychologists have been prescribing in the military for over 20 years, and in two states for over 10 years. Prescribing psychologists have been deployed to both Iraq and Afghanistan, work on several American Indian reservations where they are often the only mental health provider, and have been deployed to multiple emergency situations by the U.S. Public Health Service. Hundreds of thousands of prescriptions have been written by prescribing psychologists, and despite close scrutiny by opponents of prescriptive authority, there has not been a single complaint to a licensing board, malpractice suit, or a report of a serious adverse event. This is far more safety data than the FDA requires before a medication is approved for distribution to millions of Americans. In fact, the first study to be published on attitudes of medical providers to prescribing psychologists found 96% of respondents thought the prescribing psychologist improves patient care. Their main complaint was that they wanted more prescribing psychologists (Shearer et al., 2012).

In summary, I hope you will ignore the scare tactics of a small fringe group of individuals, or vested interests, who provide no evidence that psychologists in fact are unsafe prescribers or that the training is insufficient for its purposes, show little concern over the growing crisis of prescribers for individuals with mental disorders, and at best offer flimsy alternatives for dealing with that crisis.

Sincerely,

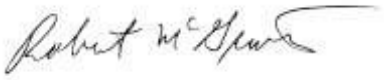

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Table 1. Comparison of Course Content

Content	Prescribing Psychology	Psychiatry
Ambulatory Care		Med School
Anatomy/Gross Anatomy	Master's program	Med School
Anesthesiology		Med School
Biochemistry	Master's program	Med School
Statistics	Doctoral program	Med School
Epidemiology/Public Health	Doctoral program	Med School
Cell Biology/Histology/Microanatomy	Master's program	Med School
Central Nervous System/Neuroanatomy/Neuroscience	Master's program	Med School
Cognitive/Emotional Bases of Behavior	Doctoral program	
Critical Care		Med School
Development	Doctoral program	Med School
Emergency Medicine		Med School
Ethics in Psychological/Psychiatric Practice	Doctoral/Master's program	Residency
Family/Community Medicine		Med School
Genetics	Master's program	Med School
Geriatrics	Master's program	Med School
Gerontology (Psychology of Aging)	Doctoral program	Residency
Immunology/Microbiology	Master's program	Med School
Internal Medicine	Master's program	Med School
Intro to Clinical Medicine/Intro to Ambulatory Care		Med School
Clinical Skills	Doctoral/Master's program	Med School/Residency
Neurology	Doctoral/Master's program	Med School/Residency
Nutrition		Med School
Obstetrics-Gynecology		Med School
Pathology	Master's program	Med School
Pathophysiology	Master's program	Med School
Pediatrics	Master's program	Med School
Personality, Normal	Doctoral program	Residency
Personality, Abnormal	Doctoral program	Residency
Pharmacology--General	Master's program	Med School
Pharmacology--Psychopharmacology	Master's program	Med School
Pharmacotherapy--Psychological/Psychiatric Disorders	Master's program	Med School/Residency
Physiology	Master's program	Med School/Residency
Primary Care	Master's program	Med School
Psychiatry	Doctoral/Master's program	Med School/Residency
Psychological Testing	Doctoral/Master's program	
Radiology		Med School
Research Methodology	Doctoral program	
Social Bases of Behavior	Doctoral program	
Surgery		Med School
Treatment Modalities: Psychological Therapies	Doctoral program	Residency

Prescribing Psychology covers doctoral training (Doctoral program) and courses in the psychopharmacology master's degree (Master's program). Psychiatry covers medical school (Med School) and psychiatric residency (Residency).

Table 2. Comparison of Licensing Exams

Content Area	Psychology	Psychopharm	Psychiatry
Biological Bases of Behavior	11%	8%	10%
Advanced Pharmacology		12%	10%
Clinical Psychopharmacology		13%	10%
Nervous System Pathology		9%	
Cognitive-Affective Basis of Behavior	13%		5%
Social and Multicultural Bases of Behavior	12%		5%
Growth and Life Span Development	13%		6%
Assessment and Diagnosis	14%	13%	39%
Treatment Intervention	16%		10%
Research Methods	6%		
Research Methods – Psychotropic Medications		4%	
Ethical/Legal/Professional Issues	15%		
Ethical/Legal Issues Specific To Pharmacotherapy		7%	5%
Integrating Psychopharmacology, Psychotherapy, & Assessment		15%	
Physiology and Pathophysiology		9%	
Assessment and Monitoring in Pharmacological Practice		10%	

Information about psychology licensing exams comes from the Association of State and Provincial Psychology Boards and the American Psychological Association. Information about the psychiatry licensing exam comes from the American Board of Psychiatry and Neurology.