BEHAVIORAL MEDICINE ASSOCIATES LLC

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Members of the Prescribing Psychologist Permit Technical Review Committee
c/o Ron Briel, Program Manager, Credentialing Review Program
Licensure Unit, Division of Public Health
P.O. Box 95026
Lincoln, NE 68509

Dear Members of the Prescribing Psychologist Permit Technical Review Committee,

I am writing in support for prescriptive authority for psychologists with postdoctoral training in psychopharmacology as proposed by the Nebraska Psychological Association. As a clinical psychologist in southwest Nebraska for the past ten years, I can certainly attest to the critical shortage of prescribing professionals in this area. It has been estimated that approximately one third of our state's overall population reside in rural areas, many of whom go unserved on account of their distance from mental healthcare resources. In 2015, only one county in the State of Nebraska was not federally designated as shortage areas in area of psychiatry. Resultantly, there are multiple access barriers inherent to the current service delivery structure that may be addressed by permitting psychologists with additional formal training to prescribe psychotropic medication given that we already independently evaluate and treat major mental illness.

I can speak about aspects of barriers to mental health care in rural Nebraska not only as a psychologist, but as a member of a family-owned cattle ranching operation with extensive experience working with individuals within the agricultural sector. Consideration of factors related to availability, accessibility, and acceptability of services are imperative as there is much less value on specifics related to providers' degrees and much more emphasis on pragmatic utility in working with this population. There is often confusion about what differentiates psychologists, psychiatrists, and other primary care providers with respect to prescriptive authority and therefore patients often present with an assumption that medication will be provided onsite. Given that patients commonly travel considerable distances for services (60+ miles), it is often a difficult task to coordinate additional appointments to correspond on the same day of service without burdening patients in terms of additional drive time and missed work (especially for those in the farming/ranching industry). The stigma and cultural values tied to mental health renders it frequently challenging for patients to discuss their difficulties at all as the process of seeking help is often discrepant from self-reliant rural ideology. It is not uncommon for patients to prefer to maintain their privacy with a single provider related to their mental health and to request medication management by their psychologists. As such, psychologists may offer a parsimonious and efficient means of providing more comprehensive and convenient services among these demographic strata in particular. Moreover, the wait-time for patients to see a psychiatrist is often substantial (1-3 months), which can result in further symptomatic deterioration and concomitant functional degradation. As a result, Primary Care Physicians, Pediatricians, Physician Assistants, Advanced Practice Registered Nurses, and Specialty Clinics have in essence become the de facto prescribing mental health care system in rural Nebraska. Fortunately, many providers refer to us for psychological consultations and evaluations for diagnostic clarification to direct services. Although multi-disciplinary consultation and

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collaboration is certainly appreciated, enjoyable, and beneficial from a continuity of care perspective, this step also may add to the cumulative patient burden load with regards to having multiple appointments with providers over great distances. With utmost respect for our local general medical providers, some also acknowledge less interest, background, or confidence in the area of psychiatry. In an understandable effort to enhance efficiency based on their limited time, high patient demand, and attempts to meet patient requests for medications at the time of appointment, the added step of a psychological consultation or testing is sometimes skipped, which can inadvertently result in misdiagnoses, both over and under treatment, and less follow-up to determine response to treatment. Unfortunately, the resources are even more limited within the realm of child and adolescent psychiatry. Historically, I am not aware of any psychiatrists within 100 miles that have treated children or pre-adolescents over the course of my career to date. In the past, a local seasoned Pediatrician took great interest and effort in obtaining specialized training in the area, including coordinating a clinic with our office for several years, but has since retired, which resulted in the distribution of his caseload to several other Pediatricians. Furthermore, while our area is equipped with an older adolescent and adult inpatient psychiatric program within our local regional medical center, there are no inpatient/residential prescribing resources for children or younger adolescents. Last Sunday, I received a call from a Physician's Assistant in the Emergency Room in a community approximately 40 miles away who was treating a young adolescent who had overdosed. In an effort to coordinate a psychological evaluation, testing, and clarification with regards to medication recommendations, she was seen in our office on the following day by a clinical psychologist in our office that specializes in working with children and adolescents. Fortunately the patient had previously been seen in our office unbeknownst to the referring provider, which also streamlined her care. Optimally, with additional proper training, we would have also been able to provide either collaborative medical input or medication management either during her hospital admission or the following day as well. Please note that this truly reflects the best case scenario currently, as these services are often provided weeks subsequent to inpatient admissions or after patients have "given up" waiting for a psychiatric appointment. Efforts to establish psychiatric telehealth services have been made as well, but appear to be met with mixed responses in the experiences that have been shared by my patients and their families.

Arguments about prescription privileges for psychologists have routinely highlighted safety concerns, which although valid, to my knowledge, have been solidly disputed by impressive outcome data based on positive reports from both federal agencies (Department of Defense the Indian Health Service, and the US Public Health Services) and states who have already passed laws allowing psychologists to prescribe including New Mexico (2002) and Louisiana (2004), Illinois (2014), and Iowa (2016). In fact, as far as I am aware, there have been no complaints against psychologists with prescriptive authority for their use of medications in more than 20 years of prescribing, which is a testimony to several factors including the extensive post-doctoral training requirements. There are national training standards that have been developed by interdisciplinary advisory groups over the many years as well as national competency examination. Furthermore, the licensing regulations in the states and federal agencies have the prescribing psychologists providing integrated care by working with the patient's primary care provider. As noted above, collaboration with a patient's primary care provider is a typical standard of practice in our rural area anyways and would be a natural segue of care. Similarly, with regards to safety, it is also important to consider the investment in patient care in rural Nebraska as these individuals are often known to us as members of our communities, businesses, schools, and organizations and therefore carry an added layer

of care and accountability. I think that there would be interest and effort among fellow providers to pursue the necessary training, pending official legislation potentially enacting Nebraska as the 5th state to permit prescriptive authority for sufficiently trained clinical psychologists. Personally, additional training in this area would not only enhance our practice and benefit patients, but build on my training in health psychology, research in the area of medical psychology/behavioral medicine, and psychiatric mentorship. Also from a rural healthcare provider vantage, offering clinicians the opportunity to train to prescribe medication may bolster efforts to recruit and retain psychologists in underserved communities that may not otherwise have ties to the area.

Overall, I am pleased to offer support for the proposal and am looking forward to further discussion about this issue because it just makes sense, patients are already asking for it, and I believe that it is our responsibility to address identified barriers to access in rural Nebraska by well-trained and collaborative means.

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