Statement of

Daniel Ulrich, M.D.
President
Hawaii Council of Child and Adolescent Psychiatry

Senate Committee on Health
Hawaii State Legislature

S.B. 597: Prescriptive Authority; Psychologists

February 16, 2011
Chairman Green and Members of the Committee, thank you for the opportunity to submit testimony on S.B. 597, which would grant medication prescription privileges to certain psychologists in Hawaii. I am a child and adolescent psychiatric physician with more than 10 years of practice in Hawaii. I am also a pediatrician and certified by the American Board of Psychiatry and Neurology. I am a member of the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, and current President of the Hawaii Council of Child and Adolescent Psychiatry.

I am pleased to offer testimony on behalf of the Hawaii Council of Child and Adolescent Psychiatry (HCCAP). HCCAP represents more than 50 child and adolescent psychiatric physicians who actively research, diagnose and treat psychiatric disorders affecting children, adolescents and their families in Hawaii.

Currently, 48 states, including Hawaii, prohibit psychologists from prescribing. In the United States, only New Mexico (2004) and Louisiana (2006) have passed laws granting prescriptive authority to psychologists, but there have been no formal studies of impact.

S.B. 597 would authorize licensed psychologists that practice at federally qualified health centers to prescribe psychotropic medication for the treatment of mental illness. While psychologists are a valuable and critical part of our state’s mental health system, they are not medical doctors like child and adolescent psychiatrists and therefore do not have the necessary training or expertise to prescribe. As a physician, I can tell you that S.B. 597 would not improve access to high quality mental health care, and it will only compromise the safety of patients in Hawaii, particularly children and adolescents.

S.B. 597 Risks the Safety of Children and Adolescents with Mental Illnesses
Psychotropic medications used to treat mental illness affect all parts of the body, not only the brain. If improperly prescribed, they can have dangerous side effects, such as convulsions, epilepsy, heart arrhythmia, blood disease, seizures, coma, stroke and even death. Prior to their prescription, a comprehensive medical history should be obtained and a targeted medical evaluation completed. A psychologist does not have the training required to do such medical evaluations.

When dealing with children and adolescents, prescribing psychotropic medication becomes more complicated and the risks even greater. Children’s bodies metabolize medications differently than adults. Additionally, children and adolescents with severe mental illness are sometimes on more than one medication. The management of these conditions is complicated due to the need to consider the effect the medications will have on one another. Whether these are for a medical and psychiatric illness or just for a psychiatric illness, knowledge of these drug-to-drug interactions is critical to the child’s safety.

A medical evaluation and history, followed by an accurate treatment plan is particularly important for children. The wrong treatment plan can cause serious setbacks to a child’s emotional and physical development. Prescribing psychotropic medication for this age group requires the
judgment of a physician. As written, S.B. 597 has no regard for the complexities and risks of prescribing to children, putting them at great risk if the legislation is passed.

**Medical vs. Medication Training**

Child and adolescent psychiatrists are physicians with ten years of medical training, including a minimum of 10,000 – 12,000 hours of training in pharmacology. Consequently, I know first-hand the training necessary to understand a patient’s complete medical history, perform or interpret a physician’s exam, prescribe the appropriate medication at a safe dosage level, and avoid potentially fatal drug interactions.

S.B. 597 requires a master’s degree in psychopharmacology, as well as a modest amount of clinical experience that requires only 400 hours of treating patients. Under no circumstances do these training requirements provide adequate preparation to prescribe psychotropic medications, especially for children. Both the didactic and clinical requirements focus on medication training, not medical training.

*Medical* training involves scientific coursework in biology, anatomy, and chemistry, as well as significant clinical experience in real life settings. Competence is measured by multiple evaluation methods, including real world observation, to assure one can practice safely. *Medication* training, on the other hand, involves learning to identify and distinguish between medication types and categories, NOT the biological basis of medical conditions. Competence is measured by written exams and does not include real world observation.

The vast differences between these types of trainings become quite clear when distinguishing between some physical and mental illnesses. Physical illnesses can often mimic mental illnesses. Even with additional psychopharmacological training, a psychologist is not trained to discern the difference. For example, a patient who reports they are lethargic and gaining weight presents symptoms that are common in someone suffering from depression. But what if they actually have hypothyroidism? Will a psychologist identify this, or will the patient be misdiagnosed and given an unnecessary antidepressant?

S.B. 597 states that the Hawaii legislature has previously authorized prescription privileges to other professionals, such as advanced practice registered nurses, dentists, and physician assistants. However, this is misleading. Each of these professionals requires a form of medical, not only medication, training before granting prescription privileges. The training requirements proposed in S.B. 597 are significantly less rigorous and comprehensive than those required by the other disciplines.

**S.B. 597 Will Not Improve Access to Mental Health Care**

While it is certainly true that our state has a shortage of professionals, including child and adolescent psychiatrists, to care for those with mental illness, there is no evidence to suggest that allowing psychologists to prescribe medications will improve access to quality mental health care. Research has shown that psychologists are located in the same geographic areas as physicians and psychiatrists, which will not alleviate the shortage of mental health providers in underserved areas.
Hawaii should learn from the lessons of other states. In New Mexico and Louisiana, the only two states that allow psychologists to prescribe, few psychologists have actually completed training and become licensed to do so. The vast majority of these prescribing psychologists practice live in metro areas, not in the most underserved areas in the states.

**Depart of Defense Psychopharmacological Demonstration Project**

S.B. 597 also cites the United States Department of Defense Psychopharmacological Demonstration Project as evidence in support of granting psychologists prescription privileges. In actuality, this demonstration project was terminated in 1996 after only four years due to a United States General Accounting Office (GAO) investigation that found the program to be too expensive and unneeded. The project trained only 10 psychologists to prescribe, costing more than $610,000 per psychologist and a total of $6 million. Additionally, psychologists in the project were only allowed to treat active military personnel between 18-65 with uncomplicated cases, and only after patients received full medical evaluation. They were NOT authorized to treat children or the elderly. In conclusion, the GAO report recommended that the program be discontinued unless the prescribing psychologists practiced under a psychiatrist’s supervision.

**Real Solutions that Improve Access to Care**

Rather than granting psychologists prescription privileges, which risks patient safety and has not been shown to increase access to care, I urge you to invest in alternative solutions. For example, other states, including Massachusetts, Arkansas, and Washington, have improved access to mental health care by implementing collaborative programs between psychiatrists and primary care physicians, who are often the first professionals to see children with mental illness. These collaborative programs have increased primary care physicians’ capacity to serve children with mental illnesses and helped to alleviate the shortage of child and adolescent psychiatrists.

Additionally, the legislature can invest in initiatives to increase the child and adolescent psychiatric workforce by providing incentives for medical students to go into child and adolescent psychiatry, providing funding to child psychiatry training programs to fund additional residents, and by providing funding for the creation of post-pediatric training programs. Such initiatives will encourage more physicians to pursue the specialty, enable training programs to fund and enroll additional residents, and strengthen our state’s mental health workforce.

In conclusion, I urge you to reject S.B. 597 and similar legislation that would grant prescriptive authority to psychologists. Such legislation risks patient care and will not address the greater public health issue of access to quality mental health care.

Thank you for the opportunity to submit testimony. I would be pleased to answer any further questions and work with you on other ways to improve care for children and adolescents with mental illnesses.