# SB 597, SD 1

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| **Measure Title:** | **RELATING TO PSYCHOLOGISTS.** |
| **Report Title:** | **Prescriptive Authority; Psychologists** |
| **Description:** | **Authorizes limited prescriptive authority for qualified psychologists who practice at a federally qualified health center. Effective 7/1/2050. (SD1)** |
| **Companion:** | |
| **Package:** | **None** |
| **Current Referral:** | **HTH, CPN** |

**PRESENTATION OF THE**
**BOARD OF PSYCHOLOGY**

TO THE SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION

TWENTY-SIXTH LEGISLATURE
Regular Session of 2011

Tuesday, March 1, 2011
9:30 a.m.

**WRITTEN COMMENTS**

**TESTIMONY ON SENATE BILL NO. 597, S.D.1, RELATING TO PSYCHOLOGISTS.**

TO THE HONORABLE ROSALYN H. BAKER,
AND MEMBERS OF THE COMMITTEE:

My name is Ahlani K. Quiogue, and I am the Executive Officer of the Board of Psychology ("Board"). The purpose of this bill is to authorize appropriately trained and supervised licensed psychologists to prescribe antidepressant medications for the treatment of mental illness.

As written, the Board opposes this bill for the following reasons:

**Scope of Practice**

- The proposed scope of practice allows psychologists to prescribe antidepressant medications to patients of all ages, including patients who have medical illnesses in addition to mental conditions. Unlike the Department of Defenses' Psychopharmacology Demonstration Project ("PDP"), the model upon which this bill is purportedly based, this bill does not restrict psychologists to prescribe antidepressant medication to a certain age group. The Board believes that the unlimited authority to prescribe antidepressant medication to the general population poses a great risk to the public. The Board's position is that many antidepressant

medications should not be prescribed to children, and that antidepressant medication may have different effects when used by patients who are over the age of sixty-five (65). Further, the Board believes that in general, antidepressant medication may produce serious harm to patients, with side effects either from the medication itself or from an interaction between other medications that the patient is taking. Thus, the Board supports limiting the prescriptive authority to patients between the ages of eighteen (18) and sixty-five (65) to better ensure public safety.

**§465-B Conditional prescription certificate; application.**

- Subsection (2)(B): *"Relevant clinical experience sufficient to attain competency in the psychopharmacological treatment of a diverse patient population under the direction of a supervising physician,* ***which consists of not less than one year,*** *involving four hundred hours treating a diverse population of no fewer than one hundred patients with mental disorders* ***including at least two hours of weekly supervision****..."*

  This provision appears to conflict with §465-D of the bill, which states a psychologist who applies for a prescription certificate shall demonstrate, in addition to other requirements, that the psychologist has been issued a "conditional prescription certificate, which includes **successful completion of two years of prescribing antidepressant medication** ..." Given this information, it appears that the requirements for a *conditional certificate* falls short of what is required to obtain a *prescription certificate.*

Additionally, with regard to the supervision requirement, the Board prefers that the two hours of weekly supervision be on-site supervision.

The Board suggests amending subsection (2)(B) to read:

*"Relevant clinical experience sufficient to attain competency in the psychopharmacological treatment of a diverse patient population under the direction of a supervising physician, which consists of at least **two years**, involving four hundred hours treating a diverse population of no fewer than one hundred patients with mental disorders including at least two hours of **on-site** weekly supervision..."*

**§465-C Conditional prescription certificate; powers, duties, and responsibilities.**

- Subsection (a)(2): *"Inform the board of the name of the supervising physician under whose supervision the psychologist will prescribe antidepressant medication..."*

  The Board is concerned that, while this provision requires the prescribing psychologist to inform the Board of the supervising physician's name, there is no explicit requirement that a prescribing psychologist be supervised by a physician. As currently drafted, the bill only implies that a prescribing psychologist be supervised by a physician.

- Subsection (b): *"...The authorization shall be limited to services provided to patients under the care of the psychologist and who are enrolled at the federally qualified health center **identified by the board**."*

The Board believes that its jurisdiction does not extend to identifying federally qualified health center ("FQHC") sites. Therefore, the Board recommends deleting the language "*identified by the board*".

**§465-D Prescription certificate.**

- The Board is extremely concerned that the bill, as currently drafted, allows a psychologist with a prescription certificate to prescribe outside of a FQHC. The Board recommends that language similar to §465-B(7) of the bill be inserted within §465-D.
- Subsection (a)(1): *"A conditional prescription certificate, which includes successful completion of two years of prescribing antidepressant medication as certified by a supervising physician."*

  The language above is inconsistent with the requirements set forth in §465-B(2)(B) of the bill which requires not less than one year of relevant clinical experience.
- Subsection (a)(2): *"Successful completion of a process of independent peer review approved by the department of commerce and consumer affairs."*

  The Board questioned the purpose of having the psychologist undergo an independent peer review. Additionally, the Board questioned how the information provided from an independent peer review would assist in determining the qualifications of obtaining a prescription certificate.
- Subsection (c)(2): *"Annually satisfies the continuing education requirements for prescribing psychologists, as set by the board, which*

*shall be no fewer than twenty hours each year, at least half of which shall be in pharmacology or psychopharmacology."*

Before continuing education is implemented for any board or commission of the Department of Commerce and Consumer Affairs, the Professional and Vocational Licensing Division's Continuing Education Guidelines – Checklist ("Checklist") must be completed to demonstrate a need for the continuing education requirement. Given the fact that the Checklist has not been completed, the Board recommends deleting this provision in its entirety.

- Subsection (d): *"The prescription certificate shall be immediately relinquished by the psychologist if the psychologist no longer meets the requirements of subsection (a)."*

  The Board questioned whether subsection (c) should be referenced instead of subsection (a).

**§465-E Administration.**

- Not withstanding the delayed implementation date of July 1, 2050, the Board is concerned that while the bill specifies some of the requirements that must be completed for a psychologist to obtain the conditional certificate and the prescription certificate, it is silent on many issues that are directly related to the effective implementation of this bill. For example, the Board must promulgate rules to: 1) establish which proficiency examination may be used to test an applicant's knowledge in the area of psychopharmacology; 2) identify the amount of malpractice

insurance a psychologist must maintain for both the conditional prescription certificate and prescription certificate; 3) clarify the procedures to renew a conditional prescription certificate and prescription certificate; 4) specify the grounds for denial, suspension, or revocation of a conditional prescription certificate and prescription certificate, including provisions for the suspension or revocation of the license to practice psychology upon the suspension or revocation of a conditional prescription certificate or prescription certificate; and 5) establish procedures for peer review. The Board understands the urgency to have the bill become law after years of debate on this issue. However, as currently drafted, the bill does not provide the Board sufficient fiscal and staff resources to carry out many elements of the bill.

Thank you for the opportunity to provide written comments, respectfully in opposition to Senate Bill No. 597, S.D. 1.

HMSA

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March 1, 2011

The Honorable Rosalyn H. Baker, Chair
The Honorable Brian T. Taniguchi, Vice Chair

Senate Committee on Commerce and Consumer Protection

**Re: SB 597 SD1 – Relating to Psychologists**

Dear Chair Baker, Vice Chair Taniguchi and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify in support of SB 597 SD1 which would authorize limited prescriptive authority for qualified psychologists who practice at a Federally Qualified Health Center (FQHC).

HMSA is dedicated to ensuring that all of our members are able to access the care they need, when they need it. This includes services not just for an individual's physical health but for their mental health as well. We support initiatives to increase the ability of individuals with mental illness who are in underserved areas to access appropriate services.

We believe that the language contained within this measure will allow psychologists to provide much-needed services within the FQHC setting. The limited scope of the program, the military's support and the likely increase in access to mental health services, are all reasons to support the passage of SB 597 SD1.

We would respectfully request the Committee see fit to pass this measure today. Thank you for the opportunity to testify today.

Sincerely,

Jennifer Diesman
Vice President
Government Relations

TO: Senate Committee on Commerce and Consumer Protection
The Hon. Rosalyn Baker, Chair
The Hon. Brian Taniguchi, Vice Chair

FROM: David Liu, Medical director, Moloka'i Community Health Center

SUBJECT: **Support of SB 597 Relating to Psychologists**

I am writing this testimony in strong support of SB597, which would allow appropriately trained psychologists who work in federally designated medically underserved areas, to prescribe and dispense medication within the scope of practice of psychology as defined by Hawaii Law.

I support this bill for numerous reasons:

- In Hawaii there is a substantial gap in mental health care that can be safely filled by granting prescription privileges to appropriately trained psychologists.
- Psychologists have been prescribing medications since 1974. They have done so in state systems, in the Indian Health Service, and in the Department of Defense. Most recently, prescriptive authority was passed in New Mexico and Louisiana.
- The U.S. Department of Defense Psychopharmacology Demonstration Project (PDP) and safety data from Louisiana and New Mexico clearly demonstrate that appropriately trained psychologists can safely and effectively prescribe psychotropic medications.
- The education and training outlined in this bill, based in part on the already proven training of the PDP, and consistent with the American Psychological Association (APA) Recommended Post-Doctoral Training in Psychopharmacology for Prescription Privileges, will provide psychologists with the core knowledge in medicine and psychopharmacology they will need to prescribe psychotropic medications safely and effectively. The training is part of a Post-Doctoral Master's degree, the cost of which would be covered by the individual psychologist. These programs do not cost the state a single penny.

Moreover, the federal government subjects community health centers to strict standards of quality assurance—among the strictest of any health care entity—a fact which contributes substantially to the safety of their services. Finally, federally qualified health centers (FQHCs) employ a team approach to health care, integrating physicians, nurse practitioners, and physician's assistants into the program of care, an approach that ensures substantial support and advice to prescribing psychologists.

This measure is particularly attractive at this time: The Native Hawaiian Health Scholarship Program is training new culturally-competent psychologists who have an obligation to serve Native Hawaiians and other underserved populations within appropriate agencies, including community health centers. This is a wonderful opportunity to match community needs with resources.

Thank you for your consideration.

Respectfully submitted by,

David Liu

AMERICAN
PSYCHOLOGICAL
ASSOCIATION
PRACTICE ORGANIZATION

February 28, 2011

The Honorable Rosalyn H. Baker, Chair
The Honorable Brian T. Taniguchi, Vice Chair
Committee Members
Senate Committee on Commerce and Consumer Protection
State Capitol Building
415 South Beretania Street, Room 229
Honolulu, HI 96813

**Re: Support for SB 597, Relating to Prescriptive Authority for Psychologists**

Dear Senators Baker, Taniguchi, and Distinguished Committee Members:

I am writing on behalf of the American Psychological Association (APA) in support of SB 597, which would allow appropriately trained psychologists in federally qualified health centers (FQHCs) to prescribe psychotropic medications within the scope of practice of psychology as defined by Hawaii law. APA is the leading scientific and professional society representing psychologists in the United States and is the world's largest association of psychologists, with more than 150,000 members and affiliates. Through its 54 divisions in subfields of psychology, including psychopharmacology, and its affiliations with 60 state, provincial and territorial psychological associations, APA works to advance psychology as a science, as a profession, and as a means of promoting health and human welfare.

The APA supports SB 597 – without the Senate Health Committee's amendment limiting the formulary to antidepressant medications only -- for the following reasons, which are expanded upon below:

- There is a critical need in Hawaii for improved access to safe and effective psychoactive medication treatment delivered by providers who are skilled in both the diagnosis and treatment of mental conditions and the use of psychotropic medications. Appropriately trained prescribing psychologists can provide urgently needed psychological interventions and psychopharmacological treatment service to the underserved populations of Hawaii.
- The evidence shows that appropriately trained psychologists can prescribe psychotropic medications safely and effectively. The U.S. Department of Defense Psychopharmacology Defense Project (PDP) clearly demonstrated that appropriately trained psychologists can safely and effectively prescribe psychotropic medications. And appropriately trained psychologists in Louisiana, New Mexico, Indian Health Service, and the U.S. military have written over 200,000 prescriptions without adverse incident and are effectively addressing and responding to the need for mental health services in those states and programs.
- Opposition by organized psychiatry to psychologists' efforts is not new to our profession when any change to scope of practice is proposed.

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*Executive Director*

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**1) There is a critical need for appropriate and effective psychoactive medication, but access to psychopharmacological care is being impeded.**

There is a clear need for increased access to care in Hawaii. For example, the data indicates that there are insufficient mental health services available to meet the needs of Hawaii's citizens. The federal government has recognized that native Hawaiians have the highest rate of untreated medical and psychological concerns, including significant substance abuse issues, in Hawaii and higher rates than other indigenous and minority individuals within the U.S.[1] According to the President's New Freedom Commission on Mental Health[2], the lack of access to the full range of mental health services is especially pronounced for rural Americans, including many citizens of Hawaii.

One reason for the inadequate access to mental health care is the shortage of psychiatrists. According to a 1999 survey conducted by the Public Health Research Group, at least 444 U.S. counties had licensed psychologists, but no psychiatrists. Figures from recent various U.S. health workforce studies indicate that the average number of psychologists per 100,000 of the Hawaiian population is 42.5 as compared to an average of 9.8 psychiatrists per 100,000. The number of psychiatrists is expected to decline further. The Physicians Foundation acknowledged that the projected shortage of psychiatrists is particularly acute and that "[t]he number of psychiatrists being trained is wholly insufficient to replace those who will soon retire."[3] And the U.S. Bureau of Health Professions projected that between 1995 and 2020, demand for psychiatrists will increase by 100% for child and adolescent psychiatrists and by 19% for generalists.[4] This bill would allow psychologists to help address this gap in service provision caused in part by the shortage of psychiatrists.

In addition to addressing this critical shortage, SB 597 would improve the quality of care for those who could benefit from psychoactive medication. The key to effective use of psychotropic medications is the accurate diagnosis and treatment of the mental condition at issue. Due to the extreme shortage of psychiatrists, the majority of psychotropic medications are currently prescribed by non-psychiatric physicians, who are not necessarily trained to diagnose and treat mental health disorders.[5] SB 597 would authorize psychologists in FQHCs to perform this valuable service, thereby affording patients the benefit of psychologists' specialized knowledge and training.

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[1] *See* Native Hawaiian Health Care Act of 1988 a/k/a Native Hawaiian Health Care Improvement Act, 42 USC § 11701 (2005). *See also* MENTAL HEALTH: CULTURE, RACE AND ETHNICITY – A Supplement to Mental Health: A Report of the Surgeon General (U.S. Department of Health and Human Services [DHHS], 2001) http://www.surgeongeneral.gov/library/mentalhealth/cre/.

[2] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003 www.mentalhealthcommission.gov.

[3] *See Health Reform and the Decline of Private Physician Practice: A White Paper Examining the Effects of the Patient Protection and Affordable Care Act on Physician Practices in the United States*, prepared by Merritt Hawkins on behalf of The Physicians Foundation (2010)

[4] Kim, WJ Child and adolescent psychiatry workforce: a critical shortage and national challenge. *Acad Psychiatry.* Winter 2003; 27(4): 277-82.

[5] Pincus, H. A., Tanielian, T. L., Marcus, S. C., Olfson, M., Zarin, D. A., Thompson, J., & Zito, J. M. (1998). Prescribing trends in psychotropic medications: Primary care, psychiatry, and other medical specialties. *JAMA, 279,* 526-531.

Under SB 597, psychologists would also improve quality by integrating two key mental health treatment approaches– therapy and medication management. Numerous studies, including a 2008 study published in the Journal of the American Medical Association and a 2007 study published in the American Journal of Psychiatry, demonstrate that a combination of psychotherapy and pharmacotherapy is usually the most effective treatment for many mental health disorders. Yet most psychiatrists focus solely on medication management while no longer providing therapy, and most primary care physicians are not trained to provide psychotherapy.

In contrast, psychologists who are trained to prescribe medication offer both psychotherapy and pharmacotherapy. The psychological model of prescribing is a systems-oriented, holistic and integrative approach wherein treatment involves an active, problem-solving role by the patient and collaboration between the psychologist and patient. For psychologists, medication is only one of a number of psychological interventions at their disposal and they are more likely to use medication in combination with other interventions/treatment methods, such as psychotherapy. As a result, a number of prescribing psychologists in New Mexico and Louisiana, the U.S. military and Indian Health Service have reduced or eliminated medications for a significant percentage of their patients.

**2) Evidence shows that appropriately trained psychologists can prescribe psychotropic medications safely and effectively.**

Granting psychologists prescribing authority is not a new concept. New Mexico and Louisiana have already enacted prescriptive authority laws for appropriately trained psychologists. There are now over 80 appropriately trained psychologists in New Mexico and Louisiana who are certified to prescribe and who have written over 200,000 (here is that number again) prescriptions since February 2005 without any adverse incident reported. Psychologists in the military and Indian Health Service, who have been credentialed to prescribe in those federal systems, also demonstrate that psychologists can be trained to prescribe psychotropic medications safely and effectively.

APA's support for the prescriptive authority issue is not taken lightly, nor has it come quickly. It has evolved from years of examination of the need for such service, intense scrutiny of the potential for successfully training psychologists to prescribe safely and effectively, and development of the best model for such training. One example of APA's commitment to this issue is our support for the Department of Defense (DoD) Psychopharmacology Demonstration Project (PDP), which proved that psychologists can be trained to prescribe safely and effectively.

In 1991, ten psychologists participated in the PDP, which was designed to train and use psychologists to prescribe psychotropic medications. APA committed to seeing the PDP completed in order to answer the question of whether already licensed clinical psychologists can be trained to safely and effectively prescribe medications. The ten prescribing psychologists treated a wide variety of patients, including active duty military, their dependents, and military retirees, with ages ranging from 18 to 65.

The PDP was a highly scrutinized program. The American College of Neuropsychopharmacology (ACNP) conducted its own independent, external review of the PDP and in 1998, presented its final report to the Defense Department. Likewise, the General Accounting Office (GAO) – since renamed the Government Accountability Office -- issued its report on the PDP program to the U.S. Senate Armed Services Committee. Both reports repeatedly stressed how well the PDP psychologists had performed. Both the ANCP and the GAO had interviewed each of the PDP psychologists' clinical

supervisors. Both reports found that every single supervisor – each one of them a psychiatrist – praised the psychologists' quality of care. According to the 1999 GAO Report, "an outside panel of psychiatrists and psychologists who evaluated each of the graduates rated the graduates' quality of care as good to excellent." The 1998 ACNP review stated that the PDP psychologists "had performed safely and effectively as prescribing psychologists, and that no adverse outcomes had been associated with their performance." Several physicians told the GAO that they came to rely on the PDP psychologists for information about psychotropic medications.

The most recent example of APA's commitment to this issue is the creation of a designation system to evaluate postdoctoral education and training programs in psychopharmacology for prescriptive authority. The purpose of the designation system is to provide public recognition of education and training programs that meet certain threshold standards and published criteria. APA has already designated two postdoctoral psychopharmacology training programs as meeting those standards. Establishment of such a system demonstrates further advancement in psychology's efforts to assure that prescribing psychologists receive comprehensive and standardized levels of training.

**3) Psychiatry's opposition to psychologists' efforts to advance their profession is not new.**

Psychology's movement towards prescription privileges did not occur in a vacuum, but rather, in the context of a similar movement by other health professionals. At present, there are a number of non-physician health professionals who have obtained prescription privileges. For example, today, optometrists have obtained independent prescription privileges in all 50 states. It took almost 30 years since the first state granted privileges in 1971 for optometry to obtain this result. Podiatrists, advanced nurse practitioners and physician assistants have also achieved prescriptive authority in the majority of states. In those 30 years, two patterns clearly emerged. First, organized medicine unsuccessfully opposed the granting of privileges in every state. Secondly, and most importantly, organized medicine's warnings about the danger to patients have never been substantiated.

The January 31, 2005 issue of U.S. News & World Report, which includes a number of articles about the current state of health care, chronicled the ongoing prescription battle between medicine and non-physicians, dating back to the late 1960s and 1970s when doctors of osteopathy sought prescription privileges. Medicine raised claims of patient safety again in the early 1980s when optometrists began seeking prescriptive authority as well as in the early 1990s when physician assistants and nurse practitioners began to push for prescription privileges. Organized medicine opposed these advances, always arguing that only through attendance at medical school can one safely prescribe. Nevertheless, the article noted that experience "has shown that many non-physician providers perform safely, or at least as safely as physicians do, in their expanded role."

Not surprisingly, organized psychiatry has a history of opposing any expansion of the scope of practice of psychology as a profession. From the 1950s through the 1970s, psychiatrists argued that it was not safe to permit psychologists to practice outpatient psychotherapy without medical referral or supervision. Despite this opposition, all 50 states plus the District of Columbia now license psychologists for the independent practice of psychotherapy. The use of psychological testimony in court was delayed for years by the efforts of psychiatric groups to discount its significance. Psychiatrists tried for decades to prevent psychologists from diagnosing mental disorders, claiming that diagnosis was exclusively a medical function.

Psychiatry has also opposed psychologists' ability to treat patients in hospital settings. This position has been clearly rejected by the California Supreme Court, which held that a hospital may permit clinical psychologists on its staff "to provide psychological services within the legal scope of their licensure, without physician supervision and without discriminatory restrictions." (CAPP v. Rank, 1990). Psychiatry's current opposition to psychology seeking to expand its scope of practice to include prescriptive authority is neither surprising nor new. And the patient safety issue asserted by the psychiatric community is the same issue that organized medicine has repeatedly cited in its attempts to limit other non-physician providers.

In conclusion, I would like to reiterate the critical points for your legislature to keep in mind while considering this legislation:

- Hawaii has an immediate and critical need for improved access to safe and effective psychoactive medication treatment delivered by providers skilled in both the diagnosis and treatment of mental conditions and in the use of psychotropic medications.

- Psychologists are highly trained mental health specialists, many of whom have acquired this additional post-doctoral training in psychopharmacology in order to collaborate with physicians about their patients' medications. Other non-physician providers safely prescribe medications in Hawaii and in fact, psychologists in New Mexico, Louisiana, IHS, and the military, who have been certified to prescribe, have already demonstrated their ability to prescribe safely and effectively.

- Psychiatry's concerns regarding prescribing psychologists are without merit, and their opposition to this legislation highly suspect considering its decades-long opposition to any proposed change in the scope of practice for professional psychology.

On behalf of the APA, we appreciate your diligent consideration of this important issue. We believe that prescribing psychologists can and will help to address the critical need for care experienced by many Hawaiians with mental health needs, just as other prescribing non-physician healthcare providers serve the citizens of Hawaii. The states of New Mexico and Louisiana have already enacted psychologist prescribing laws for similar reasons. We urge your passage of SB 597 but we strongly encourage that the current amendment limiting the formulary to antidepressant medications be replaced with the original full formulary provision.

Sincerely,

Katherine Nordal

Katherine Nordal, Ph.D.
Executive Director for Professional Practice

# PSYCHOLOGICAL RESOURCES HAWAII

3577 Pinao Street Honolulu, Hawaii 96822 (808) 988-7655

Testimony in Support of SB 597 SD1 Relating to Psychologists
March 1, 2011

Honorable Chair Baker, Vice-Chair Taniguchi, and Members of the Committee,

My name is Dr. Raymond Folen. I would like to provide testimony in strong support of SB 597 that will allow prescriptive authority for appropriately trained psychologists practicing at federally qualified health centers (FQHCs):

1. There is a huge need for mental health services in rural and underserved areas in Hawaii. With recent cuts in mental health funding, this need has turned into a crisis.
2. For years, the Hawaii Psychological Association, the Hawaii Primary Care Association, HMSA, Kokua Kalihi Valley, Na Pu'uwai Native Hawaiian Health Care System, Waimanalo Health Center, staff from the University of Hawaii at Hilo College of Pharmacy, and many other community groups have proposed a no-cost, safe and effective means to help address this pressing need. Providing appropriately trained psychologists, who already live and serve in these underserved areas, the authority to prescribe will have a significant positive impact on these communities. This is the intent of SB 597.
3. The training requirements in SB 597 are consistent with current U. S. Navy, U. S. Air Force and U. S. Army standards for psychologists credentialed to prescribe. They are also consistent with training requirements in other states where psychologists prescribe. The training requirements that SB 597 proposes will insure patient safety and quality care. This has been documented, studied and clearly demonstrated in the practices of prescribing psychologists.
4. Unfortunately, organized psychiatry continues to distort the solid foundation and appropriateness of SB 597 and they continue to mischaracterize the extensive training requirements in the bill.
5. There are simply not enough psychiatrists to meet the overwhelming mental health needs in our state. It is no secret that psychiatry residencies are difficult to fill. 40% of these positions have to be filled by foreign graduates or otherwise go vacant. The University of Hawaii graduates a very small number of psychiatry residents per year, a mere drop in the bucket when viewed in light of the tremendous need. It is difficult to find an available psychiatrist in downtown Honolulu, let alone in rural communities on the neighbor islands.
6. Rather than relying on psychiatry to spread - even more thinly - their very limited resources, we are offering a solution based on demonstrated success. Hawaii's psychologists are well represented in the rural communities and can provide the needed psychopharmacology services at no cost to the State. Please pass SB 597 so we can deliver a full range of mental health services to the people who need them.

Raymond A. Folen, Ph.D., ABPP
Licensed Psychologist

# Hawai'i Primary Care Association

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To: **The Senate Committee on Commerce & Consumer Protection**
The Hon. Rosalyn H. Baker, Chair
The Hon. Brian T. Taniguchi, Vice Chair

## Testimony in Support of Senate Bill 597, SD 1
## Relating to Psychologists
### Submitted by Beth Giesting, CEO
### March 1, 2011, 9:30 a.m. agenda, Room 229

The Hawai'i Primary Care Association strongly endorses this bill, which addresses prescriptive authority for certain psychologists. We believe that the requirements outlined in this bill regarding psychopharmacological training, supervised practice, standardized testing, board review and authorization, and practice only within a Federally-Qualified Health Center setting will ensure that patients will be well-served and protected. Moreover, we feel this bill, which costs the State nothing, is imperative to meet escalating needs and shrinking mental health resources. It must be emphasized that ONLY the patients who are cared for by FQHCs and ONLY the psychologists appropriately trained, supervised, and working with a FQHC will be affected by this legislation.

This bill is crucial to enabling FQHCs to implement a model of behavioral health care for their patients that is integrated with primary medical care and provided by a team of medical and behavioral health professionals. It is notable that one of the major recommendations of the State Mental Health Transformation grant was to integrate primary health care and behavioral health care. Moreover, this model is highly recommended by the federal Healthcare Resources & Services Administration, which mandates that FQHCs provide mental health care. By "integration" we mean that medical and behavioral health clinicians work from a common set of protocols and refer patients back and forth as appropriate to the needs of the patient, and freely communicate with each other about their care and management. Ideally, the integrated team should be supported by consultation with a psychiatrist on treatment decisions who would also be available to provide direct clinical care to referred patients who are seriously mentally ill.

Why do we think this is the best behavioral health model for Federally Qualified Health Centers in Hawai'i?

- Significant needs. Hawai'i's 14 nonprofit community health centers on six islands care for 130,000 people who are at risk for not getting the health care they need because of poverty, lack of insurance, language and cultural gaps, or just because they live in rural areas where few doctors practice. Increasingly, FQHCs – both in rural and urban areas – are the providers of behavioral health care in underserved communities because their patients, who typically have a number of co-occurring social, educational, economic, and health problems, are more susceptible even than the norm to depression, anxiety, and other mental disorders. Some studies suggest that 40% of FQHC patients are in need of behavioral health care. At the same time, FQHC patients are increasingly less likely to have access to any behavioral health care providers other than those who work at a FQHC, in part, because of cutbacks in state funding for mental health services.
- Training fits needs. The psychologists who would be affected by this bill go through a thoroughly vetted training program to prescribe the drugs that are included in a limited formulary. The psychologists are also trained to be part of the primary care treatment team at FQHCs. As such, they understand the

needs and circumstances of the patients, the resources of the health center, and their role as part of the clinical team.

- Workforce availability. While this legislation affects a relatively small number of psychologists, their number and availability to Federally Qualified Health Centers is roughly equivalent to the demand for their services. As there is a shortage of psychiatrists available even to serve privately insured patients living in urban areas, the availability of psychiatrists to FQHCs and to rural Hawai'i is questionable.
- Appropriate to needs. Psychologists are well-suited both to the needs of Federally Qualified Health Centers and to their financial resources. Psychiatrists are scarce, command high salaries, and are necessary to health centers primarily as consulting specialists on a limited basis. It makes a lot more sense to us to get the most from our psychologists.

Opponents of this bill, largely psychiatrists, argue against it because of patient safety and the purported dangers of establishing a two-tier system. We firmly reject that position. We have a "one tier" system now and it completely neglects the needs of tens of thousands of people. Not only is the care that will be provided of the highest quality but to continue to do nothing - to allow our underserved communities to be without help because psychiatrists do not serve them - is to endanger the patients and the communities that Legislators and Federally Qualified Health Centers care about.

Thank you for the opportunity to support this measure.

**HAWAII MEDICAL ASSOCIATION**
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Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net

**Tuesday, March 1, 2011 9:30 a.m. Conference Room 229**

To: COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Rosalyn H. Baker, Chair
Senator Brian Taniguchi, Vice Chair

From: Hawaii Medical Association
Dr. Morris Mitsunaga, MD, President
Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: SB 597 Relating to Psychologists

Chairs & Committee Members:

About half of health care is not straightforward. Many patients have atypical symptoms and don't fit the classic "textbook" picture of a diagnosis, and often the diagnosis is unclear. Many have multiple, interacting conditions. Many have side effects to medications, or symptoms that could be side effects, or maybe coincidence, or maybe a new independent condition. Many have drug interactions. Many have symptoms that are complicated by psychosocial factors. Drugs are distributed throughout the entire body, and may cause side effects or allergic reactions affecting *any* organ system. A prescribing practitioner must be able to sort these things out, prioritize them, and weight their significance in order to make informed decisions about prescribing medications and in order to appropriately manage side effects and complications.

None of these things can be safely and appropriately taught by reading a textbook or from classroom derived knowledge. Due to the complexity of real-world health care, in many cases prescription of medications cannot be done safely by simply applying standardized recommendations, guidelines, or "best practices." Safe and appropriate prescription of medications requires extensive training that includes supervised clinical experience *in the decision making role,* as is provided in medical school and specialty residency training.

Non-medical practitioners such as psychologists do not receive this kind of training, and if it were added to their normal training it would have to approximate medical school and residency. The training provided in schools of naturopathy is even less appropriate to safe prescription of drugs and pharmaceuticals. If we

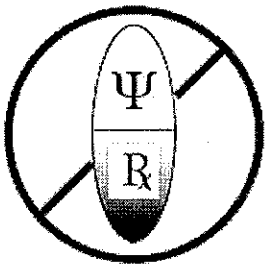
need more doctors, and if individuals who started their training in pharmacy school or psychology graduate school want to be doctors, then we should train them as doctors and send them to medical school.

The reasons we have access to care problems are in large part related to the escalation in administrative complexity and cost for the practice of medicine, and this is especially true for shortage primary care specialties and psychiatry. For high-risk specialties such as obstetrics, orthopedic surgery, and neurosurgery, malpractice costs are also a significant factor in access to care problems. These problems have also been compounded by changes in the way the State of Hawaii administers Medicaid. These problems will require constructive and creative improvements in how we finance and organize health care, and will not be solved simply by giving prescriptive privileges to unqualified and inappropriately trained disciplines like psychology, and naturopathy.

The legislature is responsible to the citizens of Hawaii to ensure that the health care they receive is provided by appropriately trained and qualified practitioners, and not by those with inappropriate training and qualifications. This is a matter that should be determined by *appropriate training*, not by "effective lobbying."

This is what consumer protection is all about.

Thank you for the opportunity to provide this testimony.




**PSYCHOLOGISTS OPPOSED TO PRESCRIPTION PRIVILEGES FOR PSYCHOLOGISTS**

POPPP
P.O. Box 337
Edmonds, WA 98020
(425) 771-4548
Email: responses@poppp.org
Website: http://psychologistsopposedtoprescribingbypsychologists.org/

21 February 2011

RE: **OPPOSE** SB 597 Relating to prescription privileges for psychologists

Dear Honorable Senators:

We are a group of psychologists who OPPOSE this bill because it is designed to allow psychologists to prescribe medication *with less than half of the medical training required of all other prescribing professionals in Hawaii.*

This bill would create a *substandard* medical profession that places the consumer at unknown risk. There has never been an objective evaluation of the effects such a drastic reduction in medical training upon consumer safety.

Proponents could conduct a systematic evaluation of the effects on consumer safety, but have chosen not to do so. Instead, they explicitly state a desire to use the public sector as unwitting subjects in an experiment. (Fox et al., 2009, Am. Psychologist, 64)

Because of the risk to consumers, bills like this one have been rejected about 100 times in 24 states.

Alternatives to this bill include collaboration between psychologists and physicians or other medically trained prescribers.

We believe that psychologists have made major contributions to human health and well-being and will continue to do so. The profession of psychology has made major contributions to understanding human development throughout the life cycle and to a multitude of dimensions of human functioning as individuals, groups, communities, societies and cultures. Despite these contributions, there are limits to the practices that psychologists can undertake responsibly as professionals. We believe that prescribing medications goes beyond psychologists' competence.

Our opposition is based on the following more detailed considerations:

**1. Psychologists are divided about obtaining prescription privileges.**

Only about half of surveyed psychologists support prescription privileges. (Walters, G.D., 2001, A meta-analysis of opinion data on the prescription privilege debate, Canadian Psychology, 42, pp. 119-125).

Psychologists who do support prescription privileges also support training requirements equivalent to other non-physician prescribers, such as advanced practice nurses (Baird, K.A., 2007, Professional Psychology: Research and Practice, 38, 196-202).

When allied medical professions such as optometrists have sought an expansion of scope of practice in the form of prescription privileges, doing so originated by members of the profession and was not controversial. This is not the case within psychology. Instead, the pursuit of prescription privileges became a policy of the American Psychological Association without input from the membership (DeNelsky, 2001, The National Psychologist, 10 [4], p.5) Psychologists who support prescription privileges have been shown to provide legislatures with unsubstantiated reasons for expanding scope of practice to the field of medicine (Pollitt, B. 2003, Fools Gold: Psychologists Using Disingenuous Reasoning to Mislead Legislatures into Granting Psychologists Prescriptive Authority, American Journal of Law and Medicine, 29)

**2. Risk to the consumer**

As psychologists, we oppose this proposal because we believe that it poses unnecessary risks to the public and would be an inappropriate and inefficient mechanism of addressing mental health needs of the population.

Psychotropic drugs are medications that have multiple effects on the human body. These effects are complex and result from the interaction among patients' unique health status, their other prescribed medications, as well as their diets, lifestyles, and other factors. Although the therapeutic effects of prescribed medications can be very positive, unintended adverse drug reactions are common. To minimize the risk of potential adverse effects, that can even have life-threatening consequences, we believe that only professionals who have undergone suitable medical training that prepared them to manage these medications within the context of patients' overall health conditions should prescribe medications. Patients have a right to expect that their medications will be managed by professionals whose education adequately trains them to understand their health history, and assess their current health status, and the potential broad systemic effects of their medications. Unlike the training of current prescribers in other professions, the doctoral training of psychologists historically does *not* equip them to

prescribe and manage medications safely.

Because of consumer safety concerns, prescribing medication by psychologists has not been supported by patient advocacy groups (e.g., NAMI) and has been explicitly opposed by the International Society of Psychiatric Mental Health Nurses because the training is inadequate (Response to Clinical Psychologists Prescribing Psychotropic Medications Position Statement, 2001).

**3. Inadequate medical training**

Unfortunately, the American Psychological Association's (APA) model for training doctoral psychologists to obtain prescription privileges does *not* match the levels required of other prescribing professionals (e.g., physicians, nurse practitioners, physician's assistants, optometrists) in terms of their overall training in matters directly related to managing medications.

The APA model is *substantially less rigorous and comprehensive than the training required for all other prescribing disciplines.* Whereas the training of psychologists in certain professional activities, such as psychotherapy and psychological assessment, is generally more comprehensive than that of practitioners in other fields, this is *not* the case for training in the practice of medicine.

The APA training model for prescribing even fails to meet the recommendations of APA's own experts in its Ad Hoc Task Force of Psychopharmacology (e.g., in terms of undergraduate prerequisites in biology and other sciences) and has other inadequacies (e.g., lack of explicit requirements for supervision; accreditation of programs).

It is noteworthy that the APA training model is substantively *less rigorous* than the training that the 10 psychologists undertook in the experimental program of the Department of Defense (DoD). Despite the alarmingly small sample of that pilot program, which precludes generalizing from it, the fact that the current training model is *far less comprehensive*, and the fact that inadequacies were noted in some of the graduates of the DoD program, proponents of psychologist prescribing make the dubious claim that the DoD program justifies prescribing by psychologists. It does not!

**4. Psychology regulatory boards are not prepared to monitor the practice of medicine**

Psychology regulatory boards have limited expertise to effectively regulate prescriptive practicing. Given the similar limits in medication-related training of most psychologists who serve on these boards to that of other psychologists, and the fact that psychology boards historically have *not* overseen prescribing, we question whether regulatory boards have the resources and systems to provide effective oversight of psychologist prescribing.

This inadequacy of a board of psychologists to oversee the practice of medicine has been acknowledged by prescribing psychologists in Louisiana. They have stated that they are practicing medicine and that *for moral considerations*; they must be viewed as a new

profession. Therefore, they now operate under the auspices of the state's *board of medicine*, not the board of psychology.

**5. Integrative care is a viable solution to providing psychoactive medication**

Proponents of psychologist prescribing also have misleadingly invoked a range of unrelated issues to advocate for their agenda. For example, they point to problems in the healthcare system, such as the rural and other populations that are underserved. Whereas such problems are indeed serious and warrant changes in the healthcare system, allowing psychologists to prescribe is neither an appropriate nor an effective response. Permitting relatively marginally trained providers to provide services is not an acceptable way to increase access to healthcare services where high quality health care is needed. Rather than relying on under-trained psychologists to prescribe, it would be much more sensible to develop mechanisms to facilitate psychologists' providing those services that they *are* highly qualified to provide (e.g., counseling) to those populations and to innovate other approaches for medically-qualified providers (for example, collaboration, telehealth) to leverage available services. It should be noted that most psychologists practice in urban and suburban areas:

There is no reason to expect that prescribing psychologists would have a significant impact on compensating for the shortages of psychiatrists in rural and economically disadvantaged areas, where relatively few actually work. Other remedies are needed to address such problems that would not compromise the quality of care.

Rather than permitting psychologists to prescribe medications, we advocate enhancement of currently available *collaborative* models in the delivery of mental health care, in which licensed psychologists work collaboratively with fully qualified prescribers to provide safe and effective services for those individuals who may benefit from psychoactive medications.

Thank you for your kind consideration of our opinion.

Sincerely,

Richard Stuart
Board of Advisors
Psychologists Opposed to Prescription Privileges for Psychologists

TO: Senate Committee on Commerce and Consumer Protection
The Hon. Rosalyn H. Baker, Chair
The Hon. Brian T. Taniguchi, Vice Chair

**Testimony in Support of Senate Bill 597 SD1**
**Relating to Psychologists**
**Submitted by Melissa Pavlicek, Executive Director, Hawaii Psychological Association**
**March 1, 2011, 9:30 a.m., Conference Room 229**

The Hawaii Psychological Association ("HPA") strongly endorses this legislation that would enable prescriptive authority for psychologists who serve in federally qualified health centers in medically underserved areas in the State of Hawaii.

**Prescriptive authority for appropriately trained psychologists is a no-cost solution to significantly improve and increase access to sorely needed comprehensive mental health services, particularly in rural, medically underserved areas.**

**Psychologists have been prescribing in the Department of Defense, Indian Health Service for over 10 years, and in both New Mexico and Louisiana since 2004 and 2006, respectively.** As of October 2010 there are an estimated 51 and 26 psychologists certified to prescribe in Louisiana and New Mexico, respectively.

**Despite recent efforts by the state and psychiatrists to improve mental health provider shortages in rural, medically underserved areas, there still remains significant need, particularly from a preventative and ongoing care standpoint.** We need multiple efforts from all mental health providers **over a consistent and extended period of time** before mental health needs across our state will be adequately met.

S.B. 597 SD1 provides another effective means whereby highly trained mental health providers will be maximally utilized to conduct quality patient care.

For all these reasons, and most importantly, to improve the health care system for Hawaii's medically underserved areas, HPA humbly asks for your support of S.B. 597 SD1.

TO: Senate Committee on Commerce and Consumer Protection
The Hon. Rosalyn H. Baker, Chair
The Hon. Brian T. Taniguchi, Vice Chair

**Testimony in Support of Senate Bill 597 SD1**
**Relating to Psychologists**
**Submitted by President of Hawai'i Psychological Association**
**March 1, 2011, 9:30 a.m., Conference Room 229**

I strongly endorse this legislation that would enable prescriptive authority for psychologists who serve in federally qualified health centers in medically underserved areas in the State of Hawaii.

**Prescriptive authority for appropriately trained psychologists is a no-cost solution to significantly improve and increase access to sorely needed comprehensive mental health services, particularly in rural, medically underserved areas.**

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For all these reasons, and most importantly, to improve the health care system for Hawaii's medically underserved areas, I humbly ask for your support of S.B. 597 SD1.

Respectfully submitted

Barbara Higa Rogers, MPH, LCSW, PsyD.
Licensed Psychologist
Clinical Manager KCPC Big Island
President Hawai'i Psychological Association

TO: Senate Committee on Commerce and Consumer Protection
The Hon. Rosalyn Baker, Chair
The Hon. Brian Taniguchi, Vice Chair

**Testimony in Support of Senate Bill 597 SD1**
**Relating to Psychologists**
**Submitted by Haunani Iao, Psy.D- Hui No Ke Ola Pono, Inc. and Mālama I Ke Ola Health Center**
**March 1, 2011, 9:30 a.m., Conference Room 229**

I am writing to urge you to support SB 597, which would allow appropriately trained psychologists who work in federally designated medically underserved areas, to prescribe and dispense medication within the scope of practice of psychology as defined by Hawaii Law.

This bill will increase access to quality care for Hawaii's residents for numerous reasons:

- In Hawaii there is a substantial gap in mental health care that can be safely filled by granting prescription privileges to appropriately trained psychologists.

- Psychologists have been prescribing medications since 1974. They have done so in state systems, in the Indian Health Service, and in the Department of Defense. Most recently, prescriptive authority was passed in New Mexico and Louisiana.

- The U.S. Department of Defense Psychopharmacology Demonstration Project (PDP) and the safety data from Louisiana and New Mexico clearly demonstrate that appropriately trained psychologists can safely and effectively prescribe psychotropic medications.

- The education and training outlined in this bill, based in part on the already proven training of the PDP, and consistent with the American Psychological Association (APA) Recommended Post-Doctoral Training in Psychopharmacology for Prescription Privileges, will provide psychologists with the core knowledge in medicine and psychopharmacology they will need to prescribe psychotropic medications safely and effectively. The training is part of a Post-Doctoral Master's degree, the cost of which would be covered by the individual psychologist. These programs do not cost the state a single penny.

Psychiatry's arguments are the same ones that have been used for decades against nurses, podiatrists, optometrists, dentists and doctors of osteopathy. It is most disheartening that, for psychiatry, the goal is to keep us from prescribing even at the cost of the communities

we serve.

What is the motivation behind our efforts? If you look at testimony provided over the years, psychology's message is consistent: to provide a full range of mental health services to unserved and underserved communities. SB 597 will expand on our ability to do exactly that.

Thank you for your consideration.

Sincerely,
Haunani Iao

Senator Rozalyn Baker, Chairperson
Senate Consumer Protection Committee

February 19, 2011

The Honorable Senator Baker and Committee members;

W would like to go on record in strong support of SB-597, SD-1 allowing limited prescribing privileges to clinically trained psychologists.

I have been a primary care provider for more than 35 years. A few years ago, while working at an FQHC in Hawaii, I had the privilege of working with clinically trained psychologists with the pharmacologic skills described in this bill. These professionals not only had the ability to provide therapy and counseling to their clients, they were able to provide consultation to the other clinicians (physicians, PAs, APRNs) on the medical management of those clients as well. They were the professionals we all relied on to help monitor a patient's response to medical therapy, yet, ironically, THEY THEMSELVES COULD NOT PRESCRIBE !!?

SB-597 could solve that problem at Hawaii's FQHCs where a team approach to patient care and management is typically in place. Even if Hawaii's mental health programming were not so dismally short of providers, this would still be an innovative idea; therapists who could also prescribe working hand-in-hand with primary care clinicians as a part of a team effort to help Hawaii's people achieve an optimal quality of life. Let Hawai'i join the other states in extending prescribing privileges to psychologists, giving service and access to care the highest priority.

Thank you for this opportunity to provide supportive testimony for SB-597,SD-1.

Dan Domizio PA,MPH
Clinical Programs Director
Puna Community Medical Center
Pahoa, Hawaii

# Waimānalo Health Center

Ola Hāloa
The Sustaining of Life

TO: Senate Committee on Commerce and Consumer Protection
The Hon. Rosalyn H. Baker, Chair
The Hon. Brian T. Taniguchi, Vice-Chair

**Testimony in Support of Senate Bill 597, SD1**
**Relating to Psychologists**
**Submitted by May Akamine, RN, MS, Executive Director**
**March 1, 2011, 9:30 a.m. Agenda, Room 229**

Waimānalo Health Center strongly endorses this bill, which addresses prescriptive authority for specific psychologists. This bill would broaden the scope of services so badly needed by Hawai'i's Federally Qualified Health Centers' (FQHCs) – like Waimānalo Health Center's – ability to serve the myriad of patients who need behavioral and mental health services. Approximately 8% of our patients have a mental health or substance abuse condition. We realize that this measure is a 3-year pilot starting in Waianae. We are confident that the initial phase will prove successful so our Waimānalo community will benefit in the future with psychologists with prescriptive authority.

FQHCs are the most ideal venue for diagnosing and treating patients needing behavioral and mental health services because integration of these vital services with primary care is critical in treating our patients' needs with a holistic approach. By serving them in a "one-stop shop" setting, we can have the greatest impact on their medical, mental and behavioral health outcomes.

We need to be able to offer as many options to our patients as possible and allowing prescriptive authority for trained psychologists is one of the most cost-effective and efficient ways to deliver care to those with virtually no options for mental health treatment requiring medications. Our primary care providers face dilemmas every single day trying to make mental health referrals for our patients with conditions that require psychiatric medications knowing that our patients won't improve without such needed services, yet they do the best they can. Our patients need these services. Our primary care providers need and deserve the back-up and support that psychologists with prescriptive authority can provide. We believe that this measure would create a model of care that would have the greatest impact on the mental health of our patients in underserved communities like Waimānalo.

Mahalo nui loa for the opportunity to provide our testimony in support of this bill.

TO: Senate Commerce and Consumer Protection Committee
The Hon. Rosalyn H. Baker, Chair
The Hon. Brian T. Taniguchi, Vice-Chair

**Testimony in Support of Senate Bill 597, SD1**
**Relating to Psychologists**
**March 1, 2011, 9:30 a.m., Agenda, Room 229**

The Waimānalo Health Center fully supports this bill in order to broaden the scope of services so badly needed by Hawai'i's Community Health Centers' ability to serve the myriad of patients who present to our centers needing mental health services. Four our health center approximately 8% of the clients we serve have a mental health or substance abuse condition.

It goes without saying that health centers are the perfect venue for diagnosing and treating patients needing mental health services whoa re already accessing other services within our centers. By serving them in a one-stop shop capacity we can have the greatest opportunity to impact their clinical and mental health outcomes. We desperately need to be able to offer as many options to our patients as possible and providing prescriptive authority for trained psychologists ahs the potential to serve as one of the most cost effective and efficient ways to deliver care to those with virtually tno options for mental health treatment requiring medications. Our practitioners face day-to-day dilemmas in knowing that their patients' medical and metnal health conditions won't improve without such needed services, yet they do the best they can. Practitioners who work in our centers deserve theis type of back up and support. We believe that thismeasure could create a model that can have the greatest impact on the mental health of underserved communities.

Thank you for the opportunity to testify on this bill.

Respectfully submitted,

Christina K. Lee, M.D.
Medical Director
Waimānalo Health Center

*Kokua Kalihi Valley Comprehensive Family Services*
2239 N. School Street Honolulu, Hawai'i 96819 tel: 808-791-9400 fax: 808-848-0979 www.kkv.net

Senator Rosalyn H. Baker, Chair
Senator Brian T. Taniguchi, Vice Chair

# Testimony in support of Senate Bill 597 SD1

**Relating to Psychologists**

**Submitted by David Derauf MD MPH**
**Executive Director**
**Kokua Kalihi Valley**

**Tuesday March 1, 2011, 930 A.M., Room 229**

Kokua Kalihi Valley (KKV) is supportive of this measure, which would allow appropriately trained psychologists to prescribe medications within the recognized scope of the profession within the setting of Federally Qualified Health Centers.

It remains our opinion that the key question to be entertained in deliberating on this law is: Will it assist under-served communities in Hawaii to increase access to safe and effective mental health care services? It is our opinion that the answer to that question is in the affirmative!

A continually growing body of research shows that a large percentage of individuals (upwards of 70% in some studies) seeking medical care in community clinics have important underlying behavioral health issues. We see that to be true in our health center every day with patients of all ages and ethnicities. But today, thanks to new models of care, in which psychologists are co-located with medical providers, effective therapy can be delivered to more and more patients. Thanks to this model, many people suffering from a wide variety of behavioral health issues, ranging from medication adherence, gaining motivation to begin exercise programs, dealing with chronic pain, or treating anxiety and depression, now have access to the help of trained professionals.

Hawaii's experience with Nurse Practitioners over the past years gaining prescriptive authority may be instructive. Fears and allegations from the medical community that they would not be able to prescribe safely have been shown over the ensuing years to be misplaced. However, the same charge is now leveled against Psychologists . But the existing scientific evidence that exists on the question is that PhD level psychologists with adequate training and ongoing training can, just like Nurse Practitioners, also learn to prescribe safely.

All other avenues towards increasing access to mental health services to Hawaii's under-served should of course continue to be explored, but it is unreasonable to imagine that Hawaii in the near future will have enough psychiatrists to serve the mental health needs of its population, especially the under-served and most especially the under-served in rural areas.

Granting prescriptive authority to psychologists practicing in federally Qualified Health Centers should help to continue to develop the promising move towards expanded behavioral services for Hawaii's under-served populations in a safe manner.

Thank you.

TO: Senate Committee on Commerce and Consumer Protection
The Hon. Rosalyn Baker, Chair
The Hon. Brian Taniguchi, Vice Chair

**Testimony in Support of Senate Bill 597 SD1**
**Relating to Psychologists**
**Submitted by Kelly C. Doty, Psy.D., Molokai Community Health Center**
**March 1, 2011, 9:30 a.m., Conference Room 229**

I am writing to urge you to support SB 597, which would allow appropriately trained psychologists who work in federally designated medically underserved areas, to prescribe and dispense medication within the scope of practice of psychology as defined by Hawaii Law.

I am a Clinical Psychologist currently serving at Molokai Community Health Center (MCHC). Before recently joining MCHC, I served at Hana Community Health Center, as the only full-time, Licensed Psychologist serving East Maui for the past two and a half years. I can personally attest to the challenges facing our rural communities with poor or no access to specialized care regarding psychotropic medication management. It remains a very difficult challenge to find patients a referral to psychiatry without undue hardship on them financially and emotionally. For Hana patients, they are required to drive 2 hours each way on the Hana Highway to see a psychiatrist. For our patients on Molokai, psychiatric services are limited. This results in primary care physicians having to take on the care of these patients, without specialized training in psychotropic medication management.

This bill will increase access to quality care for Hawaii's residents for numerous reasons:

- In Hawaii there is a substantial gap in mental health care that can be safely filled by granting prescription privileges to appropriately trained psychologists.

- Psychologists have been prescribing medications since 1974. They have done so in state systems, in the Indian Health Service, and in the Department of Defense. Most recently, prescriptive authority was passed in New Mexico and Louisiana.

- The U.S. Department of Defense Psychopharmacology Demonstration Project (PDP) and the safety data from Louisiana and New Mexico clearly demonstrate that appropriately trained psychologists can safely and effectively prescribe psychotropic medications.

- The education and training outlined in this bill, based in part on the already proven training of the PDP, and consistent with the American

Psychological Association (APA) Recommended Post-Doctoral Training in Psychopharmacology for Prescription Privileges, will provide psychologists with the core knowledge in medicine and psychopharmacology they will need to prescribe psychotropic medications safely and effectively. The training is part of a Post-Doctoral Master's degree, the cost of which would be covered by the individual psychologist. These programs do not cost the state a single penny.

Psychiatry's arguments are the same ones that have been used for decades against nurses, podiatrists, optometrists, dentists and doctors of osteopathy. It is most disheartening that, for psychiatry, the goal is to keep us from prescribing even at the cost of the communities we serve. I, as a psychologist, look forward to working together with all other disciplines, including psychiatry, which provides the best standard of care and benefit to our patients.

What is the motivation behind our efforts? If you look at testimony provided over the years, psychology's message is consistent: to provide a full range of mental health services to unserved and underserved communities. SB 597 will expand on our ability to do exactly that.

Thank you for your consideration.

Sincerely,

Kelly C. Doty, Psy.D.
Clinical Psychologist

# Molokai Community Health Center Testimony

The community has benefited from the Molokai community health center since the beginning when their doors open in 2004. They are the only integrated Health Center on the entire island of Molokai. A few services they have are primary health care, dental hygiene care, who serves not only the adults but also the children as well; they have behavioral health care and have outreach services. They are partnership cooperation's and collaborate with the Na pu'u wai centers, the Molokai Drug Store and the High School; these are just some of the partners that merge in incorporating the Molokai community health center. Dr Darryl Salvador behavioral health director also serves as the residency administer director for students majoring in psychology from the University of Argosy, under the direction of the Tripler Army Medical Center.

The Molokai Community Health Center serves more than one third of our island population. Clinical statistics have estimated that the Molokai Community Health center single handily serves a population of about 3000 Molokai residence. The (MCHC) recently received a federal government grant. They have purchased real estate land at the old Pau Hana Inn site. The new site will serve, as the future home of the Molokai community health center. They are planning to offer up 15 new health care positions. This will definitely ease up the high unemployment rate on Molokai. They are looking to utilize these additional workers in different specialized integrated health programs. The renovation on the site has already started, and the (MCHC) is still waiting to hear about the release of funds from Governor Lingle, to help in the cost of building the center. The amount not yet allotted by the governor to the (MCHC) totals up to one million dollars.

Now that I gave you a little history of what I know about the Molokai Community Health Center, let me give you ,my own personal experiences with the (MCHC).Many Of you know me in the past of suffering from mental Illness, which lately has been in good and stable recovery. Since the first appointment I made with the Molokai Community Health Center, I was not required to go through any screenings of any sorts. I was not required to have any insurance, although I had my disability insurance. I had office visits with the primary doctors, which also included Dr Darryl Salvador the behavioral, health director many times without any problems. They were always friendly and nice to me and treated me as if I were family. Sometimes when I use to wait in the waiting room for my appointments, I glanced to see all the different people served by the Molokai community health center. People came from all lifestyles and ranged from ages to one-day-old babies to an elderly handicap quadriplegic individual, sitting in a wheel chair, in the waiting room, waiting to be serve by the Molokai community health center, no client were ever denied services, and every patient possible were treated .

The Molokai Community Health Center has been open for six gratifying years. They have helped so much of the people here on Molokai. The young and old as well, the keiki's and the kapuna community never experienced discrimination with the Molokai community Health Center, whether they qualified to see a doctor or if they had insurance coverage. They treated everyone of us with equality and with tender loving care. They have changed so many lives in the process of their services in the community, including mine. They continue to serve, literally the whole community of Molokai. They foresee in the near future a modern vision of health care, in taking the next step towards innovative streamline health care in extending their health services to the community of Molokai.

The services would reach out with the latest technology in health care that would bring more up to date intergraded services, as well as specializing in services that the island of Molokai absolutely needs to have better health care for them. They also need to be able to have the legal right to dispense psychotropic drugs presumably because off the lack of licensed psychiatrist on island, and the need for versatility on such an under deserved area. I look forward to the (MCHC) theme to sound something like this, for patients to be "mentally healthy" and "psychically fit". Please help and assist the needs of the Molokai Community center in extending your Aloha in any way possible, we need to work as a community. In addition, as special, as this Aina is that we live on and call home. We as the kamaaina's who have the privilege to live on this sacred grounds, should have the understanding of working together towards unity, in health and longevity, not for the covetous cause of self interest and greed, but as a community which is inclusive of understanding one another, and knowing where we came from, a special place we call Molokai.

Peter D. Gonzalez (HCPS)

Hawaii Certified Peer Specialist

**Testimony in Support of SB 597 SD1**
**Relating to Psychologists**
March 1, 2011
Senate Committee on Commerce and Consumer Protection
9:30am, Conference Room 229

Honorable Chair Rosalyn Baker, Vice-Chair David Ige, and members of the Senate Commerce and Consumer Protection Committee, my name is Dr. Darryl Salvador. I am a licensed clinical psychologist and Director for Behavioral Health Services at the Molokai Community Health Center. I would like to submit testimony **In Support** of Senate Bill 597 SD1 that would allow appropriately trained psychologists to prescribe psychotropic medications in federally qualified health centers in medically underserved areas.

**There is a critical need for appropriate and effective psychotropic medication, but access to this type of care is limited and decreasing.**

- The mental health needs of Hawaii's rural, poor, and underserved areas are severe. The last two decades have not seen an appreciable change in this condition. Psychiatrists have been coming to Molokai but their time is significantly limited in addressing our rural population on Molokai. They have been only able to come 1 - 3 times per month and their wait list to see patients in need of psychiatric services are often 2 – 3 months.
- It is evident that the federally qualified Community Health Centers (CHCs) serve as the medical and behavioral health care "safety net" for the majority of Hawaii's medically underserved populations.
- 85% of all psychotropic medications are prescribed by non-psychiatric health care providers who have limited exposure to diagnosing mental illnesses.

**Appropriately trained psychologists are the best choice to fill a crucial gap in our system.**

- Psychologists are highly trained specialists in mental health who can and are being trained to prescribe psychoactive medication, as well as, have an average of seven years of doctoral training in the diagnosis, assessment and treatment of mental and emotional disorders.
- Psychologists interested in obtaining prescriptive authority receive 2 years of psychopharmacology coursework, a 1-year practicum and 2 years of supervised training.
- RxP clearly supports a psychological model of prescribing, not a medical model of prescribing. Practice and prescribing according to these two models is philosophically and fundamentally distinct. Psychology views the individual and prescribing from a biopsychosocial framework, whereas medical practice and prescribing focuses on identifying disease and eradicating it.
- Ten military psychologists have been trained to prescribe, and an independent study of the graduates' quality of care was, without exception, "good to excellent" and that "It is more cost effective to train psychologists to prescribe than to use a combination of psychologists and psychiatrists to provide the same mental health care". Safety data from New Mexico and Louisiana supports that prescribing psychologists are safe and economical.
- Prescriptive authority for appropriately trained psychologist provides a no-cost solution to improve and increase access to much needed comprehensive healthcare in rural, medically underserved areas.

We need your help, legislators and constituents both, to close this large and critical gap in healthcare in our state, a gap that delays access to effective integrated care, overburdens primary care physicians and leads to out-of control pharmacy costs. With a concerted, unified effort, we can create the change that gets patients the help they need more quickly, more efficiently and more cost effectively.
Thank you for considering this testimony in support of SB 597 SD1.

Respectfully submitted,

***Darryl S. Salvador, Psy.D.***
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**TESTIMONY IN SUPPORT OF SB 597 SD1 RELATING TO PSYCHOLOGISTS**

FROM: **Dr. Allison Hu Seales, Licensed Clinical Psychologist**

DATE: February 27, 2011

Honorable Chair Baker, Vice-Chair Taniguchi, and Members of the committee, my name is Dr. Allison Hu Seales and I am a Licensed Clinical Psychologist who has worked and lived on the island of Moloka'i for three years at Na Pu'uwai Native Hawaiian Health Care System. I am also a clinical supervisor for Clinical Psychology Postdoctoral Fellows on the island of Lana'i.

**I would like to submit this testimony in strong support of Senate Bill 597.** Because Moloka'i is my home and because of my work experiences on Moloka'i and Lana'i, I have firsthand experience of the mental health needs of these communities and the negative effects of these unmet needs on all residents.

Because of recent cuts to mental health services in the State of Hawai'i and because of the rural nature of our communities, there are not enough psychiatrists who serve on our islands. Lana'i residents especially must wait for psychiatric services (if they qualify for AMHD services) or must fly off island because the psychiatrist is only on the island once per month.

I firmly believe that the passage of this bill is long overdue. It has multiple safeguards built into it, and a more than 14 year record of safety to stand on to include DoD, New Mexico, and Louisiana prescribing psychologists, and finally, is a solution in this time of economic crisis to provide comprehensive mental health services at no extra cost to the state.

Thank you for considering my testimony in support SB 597.

Respectfully submitted,
Dr. Allison Hu Seales

**March 1, 2011**

**TO: The Hon. Rosalyn H. Baker, Chair, Senate Commerce and Consumer Protection Committee**
**The Hon. Brian T. Taniguchi, Vice Chair, Senate Commerce and Consumer Protection Committee**

**TESTIMONY IN SUPPORT OF S.B. 597, S.D. 1**
**RELATING TO PSYCHOLOGISTS**
**Submitted by Dr. Jill Oliveira Gray**
**March 1, 2011, 9:30 am Agenda, Room 229**

Honorable Chair Baker, Vice-Chair Taniguchi, and Members of the Senate Health Committee, my name is Dr. Jill Oliveira Gray and I am a Licensed Clinical Psychologist who has worked in rural, medically underserved areas for the past 10 years. I worked on the island of Moloka□i for 8 years and have been on staff at the Waimānalo Health Center since 2008. I am also the immediate past President of the Hawai□i Psychological Association. Because of my years of clinical experience serving rural, medically underserved areas, and having the first hand knowledge of what the severe needs of these communities are, as well as, the profound impact that mental health provider shortages have on the psychological well being of these communities, **I would like to submit this testimony in strong support of Senate Bill 597.**

**The mental health needs of individuals across our state have significantly worsened in recent years.** State budget cutbacks over the past 4 years have further reduced accessibility to timely mental health care for under- and uninsured populations, and the problem is particularly more acute and severe in rural areas. In areas such as West Hawai□i, Wai□anae, Kaneohe, and Moloka'i, the Adult Mental Health Division has undergone such severe cut backs that clinics in these areas have been forced to either significantly reduce their services or close their doors entirely, leaving hundreds of patients with severe and persistent mental illness without adequate medication management and overall treatment. It has occurred on more than one occasion in Waimānalo that referral appointments to psychiatrists in the community often take weeks to months, if at all, to obtain. In one case, 15 different psychiatrists were contacted for a patient and not one of them could take the individual either because they were not taking new patients or were not accepting the type of insurance the patient had.

**The basic argument from those who oppose this measure is that patient safety will be seriously compromised by allowing psychologists to prescribe—but after 15 years of psychologists' prescribing, this has not proven to be true.** Psychologists have been prescribing in the Indian Health Service and Department of Defense (DoD) for the past 2 decades. Updated information on prescribing psychologists indicate there are now 29 prescribing psychologists licensed through New Mexico and approximately thirty more in the pipeline. They are located throughout New Mexico in many underserved communities in integrated health settings, as well as in behavioral clinics. In Louisiana there are now 50 prescribing psychologists. A letter from the chair of the state Board of Psychologist Examiners stated that "over the past five years there have been no complaints at all to the Board of Psychologist Examiners of

patients being harmed by prescribing psychologists. None. Also, there have been no allegations of improper or inappropriate prescribing which have been verified after review by the state Board of Pharmacy."

**The post-doctoral, psychopharmacological training sequence proposed in S.B. 597, S.D. 1 is equivalent to that of the American Psychological Association's recommendations for obtaining the requisite sequence of training and certification specific to the practice of prescribing psychotropic medication and the final curriculum of the DoD Psychopharmacology Demonstration Project (PDP).** Post-doctoral psychopharmacological training programs have been available in Hawai'i since 2001 beginning at Tripler, Argosy University, and since January 2011, at the University of Hawai'i Hilo, College of Pharmacy. There are multiple safeguards imbedded in this legislation to include:

- 2 years of course work culminating in master's degree that covers content areas essential to prescribing psychotropic medication; 3 years of supervised clinical experience under direct supervision of a licensed physician (1 year as part of master's program; 2 years during conditional prescribing phase)
- Required to obtain Federal DEA license
- Required to maintain malpractice insurance
- Practice of prescribing limited to Federally Qualified Health Centers
- Maintain ongoing collaborative relationship with physician who oversees patients general medical care
- Undergo process of independent peer review as approved by DCCA
- Annual continuing education requirement of 20 hours, ½ of which must be in pharmacology or psychopharmacology

**Psychologists are already employed in 10 of the 14 FQHCs (as well as 3 of the 5 Native Hawaiian Health Care System clinics),** making recommendations regarding psychotropic medications while working collaboratively with primary care physicians. These psychologists are poised to maintain this presence and continue to expand via existing training programs that are already up and running. One such psychology training program, called, I Ola Lāhui was established in 2007 to train psychologists at the practicum, intern and post-doctoral levels. Collaborative arrangements have been forged over the past four years between I Ola Lahui and six FQHCs and 3 Native Hawaiian Health Care Systems to increase the behavioral health workforce capacity available in rural, medically underserved areas.

Thank you for the opportunity to testify in strong support of S.B. 597, S.D.1

Respectfully submitted,
Dr. Jill Oliveira Gray

ARGOSY UNIVERSITY
Hawai'i Campus

# Certificate in Psychopharmacology

Accepting applications for spring 2007
Classes begin in January!

## Description of Program

**The Certificate in Psychopharmacology is a 32-hour credit program for postdoctoral psychologists with practicum. It is designed to build upon the clinical psychology training and experience and give the appropriate education and experience to prescribe psychotropic medications independently, effectively, appropriately, and safely. It is also designed to train psychologists to work collaboratively with physicians, nurses, and other health care providers in order to coordinate care.**

## Program Learning Outcomes

- **When presented with a patient in a primary care setting, graduates will be able to accurately assess, diagnose, design and implement an appropriate treatment plan, using psychopharmacological agents and psychological interventions effectively and safely to the**
- **When working in a primary care setting, graduates will be capable of professional collaboration and consultation with other health-care providers ethically, professionally, and appropriately.**

**The program will seek to prepare graduates to pass the Psychopharmacology Exam for Psychologists.**

## Program Outline

1. **Foundations in Human Anatomy, Physiology, Biochemistry & Organic Chemistry (3 credit hours)**
2. **Pathophysiology (4 credit hours)**
3. **Physical and Lab Science (3 credit hours)**
4. **Neuroanatomy (2 credit hours)**
5. **Neurophysiology (2 credit hours)**
6. **Neurochemistry (2 credit hours)**
7. **Pharmacology (2 credit hours)**
8. **Clinical Pharmacology (2 credit hours)**
9. **Special Issues: Developmental, Chemical Dependency, and Pain Management (2 credit hours)**
10. **Psychopharmacology (3 credit hours)**
11. **Pharmacotherapeutics (2 credit hours)**
12. **Professional and Legal Issues (1 credit hours)**
13. **Practicum (1 credit hour per semester)**

Admission Requirements

- **Completed Application for Admission Form**
- **$50 Application Fee (non-refundable, except in California)**
- **Official transcript from the university that awarded the doctoral degree**
- **Must be a licensed psychologist (Tripler Army Medical Center (TAMC) fellows are exempt)**
- **Submit license number and state(s) where licensed**
- **Immunization records**
    - **Proof of two doses of Measles vaccine are required with at least one of the two being Measles-Mumps-Rubella (MMR) vaccine**
    - **A Certificate of Tuberculosis (TB) Examination confirming that the PPD skin test was given within 12 months before first attending school**

2006-2007 Tuition & Fees

- **$546 per credit**

| | |
|---|---|
| • **Student Activity Fee (annual) 1** | **50.00** |
| • **Technology Fee (per credit)** | **10.00** |
| • **Graduation Fee 2** | **150.00** |
| • **Add/Drop Fee 3** | **50.00** |
| • **Installment Plan Fee (per semester)** | **35.00** |
| • **Late Registration** | **50.00** |
| • **Late Payment** | **25.00** |
| • **Returned Check Fee** | **35.00** |
| • **Transcript Fee** | **No Charge** |
| • **Express Transcript 4** | **20.00** |

*1. Students enrolled in no greater than one credit each term are exempt from the Student Activity Fee. Activity fees are charged at $25.00 in the Fall and $25.00 in the Spring.*

*2. A Graduation Fee is assessed to all degree seeking students upon completion of their program of study and prior to the receipt of their diploma.*

*3. Students who elect to change their schedule after registration may do so by completing a Course Add/Drop Request Form. The Course Add/Drop Fee is assessed for each request form submitted to the Student Services Office. Multiple changes may be submitted on one form.*

*4. An Express Transcript Fee is charged for transcripts requested to be sent via an overnight carrier.*

Tuition and Fees include a 4% Hawaii General Excise Tax.

# 2006-07 Argosy University Psychopharmacology Course Descriptions

**Psychopharmacology Foundations (45 contact hours)**
This course is designed to provide students the necessary background in basic human anatomy, physiology, organic chemistry and biochemistry necessary to successfully complete the other courses in the psychopharmacology program.

**Pathophysiology (60 contact hours)**
The objective of this course is to provide a basic understanding of human physiology and pathology, including normal anatomy and physiological processes, variability in response due to age, gender, disability, and ethnic differences, medical conditions affecting biodisposition, side effects, including contraindications, as well as pathological states emphasizing how alterations in normal physiology affect bioavailability and biodisposition of pharmacological agents. This course examines the pathophysiologic mechanisms of common clinical disorders such as coronary artery disease, heart failure, hypertension, etc. In addition, content area reflects issues regarding pathophysiological adaptation, responses, and common therapeutic interventions.

**Neuroanatomy (30 contact hours)**
The objective of this course is to provide a foundation in human neuroanatomy. This course exposes the student to functional aspects of the brain and spinal cord from a systemic perspective including sympathetic and parasympathetic systems. Aspects covered include CNS topography, sensory systems, neurochemistry, motor systems and the functions of the structures within the brain. The course will also integrate an understanding of the interactions of pharmacological agents on the nervous system and neuropathology.

**Introduction to Physical and Laboratory Assessment (45 contact hours)**
The objective of this course is to provide a well-grounded foundation in medical history taking and physical diagnosis as well as a basic understanding of laboratory analysis. Topics covered are medical history taking, complete physical exam, and systems examination, such as cardiovascular system, pulmonary system, and neurological system. Includes familiarity with medical charts, physical exams, laboratory and radiological examinations.

**Pharmacotherapeutics (30 hours)**
The objective of this course is to provide a well-grounded foundation in the study of the therapeutic uses and effects of drugs in mental health. The course includes pharmacotherapeutic interactions, psychotherapy/ pharmacotherapy interactions, drug interactions, compliance maintenance programs, computer-based aids to practice, and pharmacoepidemiology.

**Neurophysiology (30 contact hours)**
The objective of this course is to provide a clinically oriented survey of the human nervous system and provide an understanding of the peripheral and central nervous system including cellular neurophysiology, functioning of the brain, the role of neurotransmitters, receptors, plasticity and related concepts. The course will also provide information on the structure and functioning of specific systems throughout the brain and provide students with an integration of diagnostic tools.

**Neurochemistry (30 contact hours)**
The educational objective of this course is an understanding of the molecular, chemical, and cellular biology of the nervous system. The study of neurotransmitters, steroids, and peptides is emphasized; other aspects of medical neurochemistry and behavioral neurochemistry are also addressed. It will seek to describe and characterize in molecular terms, interaction, signaling in sensory and cognitive processes and in more long-term processes such as synaptogenesis, neuronal plasticity and degeneration. Different approaches will be discussed from organic and peptide synthesis to molecular and cellular biology. The course will focus on cell-cell interactions, adhesion molecules and extracellular matrices, intracellular traficking, cytosol-nuclear communication, nerve growth and regeneration, exitoxicity, apoptosis, drug addiction and prion diseases.

**Pharmacology (30 contact hours)**
This course introduces students to the general principles of drug action and dynamics, toxicities, and therapeutic uses. Material to be presented includes the effects of adrenergic drugs, antipsychotic duress, antianxiety agents, and drugs of abuse. Basic understanding of drug interaction is also presented.

**Professional and legal issues (15 hours)**
The objective of this course is to provide a background in the professional, ethical, and legal issues associated with the use of pharmacological agents.

**Clinical pharmacology (60 contact hours)**
The focus of this course is on the clinical aspects of adverse drug reactions and drug data basis. Topics to be covered are pharmacokinetics, pharmacoepidemiology, drug-induced disease, adverse drug reactions, and pharmacology of the aging process.

**Psychopharmacology (45 hours)**
This course provides a solid background in the principles and practice of psychopharmacology. Topics to include the study of disease and a more detailed review of neurotransmitters such as seretonin,nonoamines, acetylcholine, GABA, and glutamate. Additional topics include presentation of the clinical pharmacology of antipsychotic, antidepressant, and antianxiety drugs, as well as drug interactions and psychopharmacology in special populations such as children and older adults.

**Special Issues in Pharmacology (30 hours)**
The objective of this course is to provide an overview of pharmacology across the age span and in special circumstances. Specific issues covered include drug interactions and toxicities encountered during the early life of the child, evaluation of drug responses in the elderly and age-related changes in pharmacological management, pharmacological pain management, and the use of pharmacological agents in chemical dependency.

## Faculty for the Argosy Certificate in Psychopharmacology program have included:

James Westphal, MD (Psychiatrist)

Louis Melomadroma, MD, Ph.D. (Psychiatrist)

Barry Cole, MD (Psychiatrist)

Peter Collori, MD (Psychiatrist)

Frederick Merciar, Ph.D.

Kimberly Finney, Ph.D. (Air Force Credentialed Psychologist

Daniel S. Janik, MD

Anne Leake, Ph.D., APRN-Rx

Shelley Silverman, APRN-Rx, MSN, PFN

**Master's Degree in** Clinical Psychopharmacology
**Argosy University at Honolulu Campus**
**.32 Credits**

Psychopharmacology Foundations: **This course is designed to provide students the necessary background in basic human anatomy, physiology, organic chemistry, and biochemistry.**

Neuroanatomy: **This course covers basic human neuroanatomy and neuropathology. An emphasis is on categorization of tracts by neurotransmitter systems. Categorizations by neurotransmitter function will allow an early introduction to pharmacological agents and how they interact with the various anatomical pathways. The anatomy of the brain, spinal cord, and sympathetic and parasympathetic nervous systems will be important to the study of psychopharmacology. Brain regions studied will include the cerebral cortex, frontal cortex, hippocampus, basal ganglia, thalamus and hypothalamus, and brain stem (with particular attention to locus coeruleus and dorsal raphae nuclei). Involvement of particular anatomical regions in certain mental illnesses and relevant neurological illnesses will be introduced. Neuropathology content will include nervous system pathology. Basic neurodiagnostic markers of pathology and mechanisms of extrapyramidal dysfunction will be included, as well as a discussion of the hypothesized neuropathological basis of psychological disorders.**

Pathophysiology: **All major anatomical systems and physiological processes involved in illnesses that prescribers must be aware of are covered. Diseases of the cardiovascular, hepatic, renal, endocrine, and gastrointestinal systems are discussed in detail. Major illnesses that can disguise as psychological disorders receive particular attention. All of the above are considered in terms of the relationship to their response to medications. There will be a discussion of the way in which medical conditions impact an individual's psychological status, and the ways in which psychological conditions impact an individual's medical status. Interactions of drugs used to treat pathophysiological conditions with those commonly used psychopharmacological practice will be discussed. Effects of general medical conditions on drug pharmacokinetics and pharmacodynamics as well as effects of age, sex, and ethnicity will also be included.**

Introduction to Physical Assessment and Laboratory Exams: **This course will introduce the topics of basic history and physical examination, as they are pertinent to prescribing of medication. The goal of this course will be to allow the practitioner to gain the knowledge necessary to interpret reports of medical histories, physical examinations, and laboratory studies. Laboratory studies will include basic blood chemistry panels, complete blood counts, thyroid and other endocrinological tests, urinalysis, basis radiological studies, computerized tomography scans, magnetic resonance imaging studies of the brain, electrocardiogram reports, and electroencephalogram reports. The monitoring of psychotropic medications with blood levels where appropriate and required concomitant general laboratory tests (e.g., liver function tests with Depakote, thyroid function tests with lithium, etc.) will be emphasized. The ability to distinguish between side effects of medication versus signs and symptoms of general medical conditions, as they are manifested in the history, physical exam, and laboratory studies, will be emphasized.**

Neurophysiology: **This course covers physiological concepts underlying central and peripheral nervous system function. Cellular neurophysiology concepts such as the resting potential, action potential, and basic ion channel kinetics will be introduced. An integrated view of the electrical functioning of the brain, with an introduction to electroencephalographic concepts, will be introduced. Neurotransmitter receptor function, second messengers, and neural plasticity with an introduction to cellular theories underlying learning will also be included.**

Neurochemistry: **This course will emphasize the various neurotransmitter systems relevant to modern psychopharmacological practice. These include, but are not limited to, serotonin, norepinephrine, dopamine, acetylcholine, glutamate, GABA, opioids, and Substance P. The**

**interaction of these neurotransmitters and their receptors will be emphasized, as will the mechanism of action of the various receptor systems. The biochemical mechanisms of action of prototypical drugs used in modern psychopharmacological practice will be introduced in this course.**

Pharmacology: **This core course will cover basic scientific and clinical concepts fundamental to the subject of general pharmacology. General principles, such as pharmacodynamics and pharmacokinetics, will be introduced and expanded upon in all of the pharmacology and psychopharmacology courses, and will provide students with knowledge of the common pharmacological agents used in general medical practice. Also introduced is the important concept of drug interactions, which will be reemphasized throughout later coursework. General pharmacodynamic principles, including mechanisms of drug action, drug-receptor, and drug-enzyme models will be presented. The sympathetic and parasympathetic nervous systems and drug actions on these systems will be emphasized. The pharmacokinetic principles of routes of administration, absorption, distribution, metabolism, half-life, protein-binding, lipid solubility, elimination and the blood-brain barrier, will be included.**

Clinical Pharmacology: **This course will expand upon and continue the discussions regarding the pharmacodynamic and pharmacokinetic characteristics of certain medications that will include agents affecting the central nervous system, antibiotics, cardiovascular agents, analgesics, and drugs affecting the renal, pulmonary, gastrointestinal, and urological systems. In addition, it presents drug-drug interactions of all major medication groups: cardiac, antibiotics, opioid, antifungal, and psychotropic medications. Specific attention is paid to the interaction of differing agents, contraindications, side effect profiles, drug-disease interactions and over the counter interactions. Common adverse effects and potential drug-drug and drug-food interactions will be emphasized in each section.**

Psychopharmacology: **This core course will cover basic scientific and clinical concepts fundamental to the subject of general pharmacology. General principles, such as pharmacodynamics and pharmacokinetics are expanded upon in all of the pharmacology and psychopharmacology courses, and will provide students with knowledge of the common pharmacological agents used in general medical practice. In addition, the concept of drug interactions will be reemphasized throughout coursework. General pharmacodynamic principles, including mechanisms of drug action, drug-receptor, and drug-enzyme models will be presented. The sympathetic and parasympathetic nervous systems and drug actions on these systems will be emphasized. The pharmacokinetic principles of routes of administration, absorption, distribution, metabolism, half-life, protein-binding, lipid solubility, elimination and the blood-brain barrier, will be included. This course also will include discussions regarding antipsychotics (first and second generation agents), anxiolytics, antidepressants, and special topics related to treating the psychotic disorders, depressive disorders, and anxiety disorders. Mechanism of action, drug interactions, dosing, adverse effects, and the pertinent aspects of differential diagnosis will be covered. Possible psychiatric presentations of general medical conditions, with particular attention to the detection and treatment of drug-induced psychiatric, neurologic, and cognitive impairments will be presented.**

Pharmacotherapeutics: **Focus of this course is on the use of psychotropic medications in clinical practice. Topics covered include appropriateness of psychotropic use, assessment protocols, risks and benefits when using psychotropics, controlling and preventing adverse events, psychotherapy, and medications, and terminating psychotropic treatment. It also reviews the interaction of psychological treatments and psychopharmacological treatments for the varying disorders found in the day-today practice of a clinical psychologist as defined by the International Classification of Diseases (Current Edition).**

Special Issues in Pharmacology: **This course will supplement the general psychopharmacology course by emphasizing the treatment of disorders of childhood and old age. Disorders in children**

will include ADHD, anxiety disorders, depression, and others. Differences between the treatment of these disorders in children and adults will be emphasized. Treatment of co-morbid conditions in children with conduct disorder, mental retardation, and learning disabilities will be discussed. In the geriatric population, treatment of dementia and delirium will be emphasized. Common medical conditions presenting with psychiatric manifestations, and the treatment of depression, psychosis, anxiety, and insomnia in the elderly will be topics of discussion. This course will also cover substance abuse and its treatment. Major classes of substance of abuse, including alcohol, cocaine, marijuana, opiates, hallucinogens, stimulants, caffeine, and nicotine will be discussed. Diagnosis, evaluation, and treatment of intoxication and withdrawal states will be emphasized. Abuse of commonly prescribed psychotropics and drugs used to treat pain will be topics for discussion. The treatment of chronic pain and opiates, antidepressants, mood stabilizers, and other adjunctive treatments will be discussed.

Legal, Ethical, and Professional Issues: This course will examine the single practitioner model, in which one practitioner provides therapy and medication prescription services versus a split-treatment model in which these functions are divided between two practitioners. Literature studies of synergistic interactions between psychotherapy and pharmacotherapy will be introduced.

This course will also cover the use of computer databases for literature searches such as Medline. Online resources such as the National Library of Medicine database and drug interaction databases will be introduced. Computer networks used to receive laboratory and radiology reports and to communicate with pharmacies will be covered.

Further, it will examine the literature relating to treatment of various disorders with psychotropic medication. For example, the literature on maintenance and discontinuation of antidepressant medication and abuse of prescribed and illicit drugs will be included.

Moreover, it covers the ethical relationships of psychopharmacological principles and agents typically encountered in clinical practice. Finally, it integrates and builds on the psychologist's prior knowledge of research issues but applied this to pharmacological agents. Students will learn how to evaluate new drug research and gain knowledge of the pitfalls of clinical trials.

Psychopharmacology Practicum: The student will complete an eight-hour per week year-long practicum in a designated setting supervised by a prescribing psychologist (military only) or psychiatrist.

Psychopharmacology Seminar: This seminar is offered by a prescribing clinical psychologist from the Department of Psychology. Student completing the psychopharmacology practicum are expected to attend this seminar. Students are required to present cases seen during the practicum.

| Didactic Curriculum for PDP: | Iteration 1 (Group A, N=2)) | | Iteration 2 (Group B, N = 1) | | Iteration 3 (Group C and D, N = 7)) | |
|---|---|---|---|---|---|---|
| **YEAR 1** | **Course** | **(hours)** | **Course** | **(hours)** | **Course** | **(hours)** |
| Medical School | Anatomy I-IV | (341) | Survey of Human Anatomy | (54) | Anatomy | (48) |
| | Medical Physiology | (198) | Survey of Biochemistry | (54) | Biochemistry | (57) |
| | | | Physiology | (39) | Neurosciences | (54) |
| | Biochemistry | (160) | Neuroanatomy-Neurophysiology | (42) | Physiology | (39) |
| | Clinical Medicine I | (86) | Psychopharmacology | (21) | Pathophysiology | (60) |
| | | | | | Clinical Medicine | (121) |
| Modified Med Sch | | | Pathology I and II | (102) | Clinical Concepts | (100) |
| | | | Clinical Concepts | (100) | Pharmacology | (83) |
| | | | Pharmacology | (83) | Clinical Pharmacology | (21) |
| | | | Clinical Pharmacology | (21) | Psychopharmacology | (21) |
| | | | Intro to Clinical Medicine | (135) | Introduction to Primary Care | (56) |
| Grad Sch Nursing Seminars | Clin Psychopharm | | | | | |
| **YEAR 2 (Group A only)** | | | | | | |
| Medical School | Pathology | (215) | | | | |
| | Pharmacology | (86) | | | | |
| | Clinical Medicine II | (132) | | | | |
| | Clinical Concepts | (100) | | | | |
| | Clinical Pharmacology | (47) | | | | |
| Seminar Series | Behavioral Pharmacology | | | | | |
| | Human Genetics | | | | | |
| | Immunology | | | | | |
| **TOTAL HOURS** | | **1,365** | | **651** | | **660** |

**Excerpt taken from the American College of Neuropsychopharmacology (ACNP, 1998) Evaluation Report:**

**"Observation, consideration, and evaluation of Group A's performance and the necessity to confine the didactic curriculum to one year led to a number of changes for subsequent groups. For example, the level of detail in Anatomy, Histology, Microscopic Pathology, Biochemistry, and Endocrinology to which Group A was exposed did not appear appropriate to the proposed role of prescribing psychologists. Such considerations led to a number of decisions that resulted in** *shortening and tailoring these and other courses (or components of courses) to the specific needs of potentialprescribing psychologists" (ACNP, Final Report, p. 12)*

**Course & hours comparisons between Iteration 3 of PDP, DoD current requirements, Argosy University, and UH Hilo College of Pharmacy**

| Iteration 3 (Group C and D, N = 7) | | DoD CURRENT Requirements | | Argosy University | | UHH Coll of Pharmacy | |
|---|---|---|---|---|---|---|---|
| **Course** | **(hours)** | **Course** | **(hours)** | **Course** | **(hours)** | **Course** | **(hours)** |
| Anatomy | (48) | Neuroanatomy | (25) | Psychopharmacology Foundations* | (45) | Physiology | (45) |
| Biochemistry | (57) | Neurophysiology | (25) | Pathophysiology | (60) | Biochemistry: Biomolecules | (45) |
| Neurosciences | (54) | Neurochemistry | (25) | Neuroanatomy | (30) | Biochemistry: Metabolism | (45) |
| Physiology | (39) | Pharmacology | (30) | Intro to Physical and Laboratory Assessment | (45) | | |
| Pathophysiology | (60) | Clinical Pharmacology | (30) | Pharmacotherapeutics | (30) | | |
| Clinical Medicine | (121) | Psychopharmacology | (45) | Neurophysiology | (30) | Integrated Pharmacotherapy I* | (105) |
| Clinical Concepts | (100) | Developmental Psychopharm | (10) | Neurochemistry | (30) | | |
| Pharmacology | (83) | Chemical Dependency & Chronic Pain | (15) | Pharmacology | (30) | Integrated Pharmacotherapy II | (105) |
| Clinical Pharmacology | (21) | Pathophysiology | (60) | Professional & Legal Issues | (15) | Integrated Pharmacotherapy III | (105) |
| Psychopharmacology | (21) | | | Clinical Pharmacology | (60) | Advanced CNS Therapeutics | (45) |
| Introduction to Primary Care | (56) | Physical & Lab Assessment | (45) | Psychopharmacology | (45) | | |
| | | Professional, ethical and legal Issues | (15) | Special Issues in Pharmacology | (30) | | |
| | | Psychotherapy/pharmaco-therapy interactions | (10) | | | | |
| | | Computer-based aids to practice | (5) | *Provides necessary background in basic human anatomy, physiology, organic chemistry and biochemistry necessary to successfully complete the other courses in the psychopharmacology program | | *Integrated pharmacotherapy I, II, and III will include lectures and seminars on pharmacokinetics (25h), clinically relevant pathophysiology (45h), pharmacology (90h), substances of abuse and addiction (30h), therapeutics (35), and weekly seminar (90) | |
| | | Pharmacoepidemiology | (10) | | | | |
| **TOTAL HOURS:** | **660** | | **350** | | **450** | | **495** |

BOTTOM LINE: Training program curricula may vary (as they do for any other discipline), however, all legislation and DoD practice regulations require passing a standardized national examination: the Psychopharmacology Examination for Psychologists. The test, rather than the exact curricula, is what is held up as the gold standard for demonstrating competency—the same is true for any other licensing process.

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HONOLULU, HI 96817
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Testimony in Support of SB 597 SD1, Relating to Psychologists

March 1, 2011

Honorable Chair Baker, Vice Chair Taniguchi and members of the committee, my name is Dr. Robin Miyamoto. I am a Clinical Psychologist working at Hawaii Medical Center, Director of Training for I Ola Lāhui, a psychology training program that sends trainees to Hawaii's rural areas, and Past-President of Hawai'i Psychological Association. I would like to provide testimony in strong support of SB 597 that would allow prescriptive authority for appropriately trained psychologists practicing at federally qualified health centers (FQHCs).

As you know, this is not a new issue, in 2007, SB 1004 passed through the State Legislature, allowing appropriately trained psychologists working in Federally Qualified Community Health Centers (FQHCs) and Medically Underserved Areas (MUAs) to prescribe psychotropic medications. However, on July 10, 2007 Governor Lingle vetoed the measure. Since then, the demand for such legislation has increased because the needs have not been met; in fact they have grown exponentially, because of the problematic economy, the recent cuts to the Adult Mental Health Division, and decrease in funding to social service agencies. In that same period of time, psychologists are now in 11 of the 14 FQHCs and the health centers are convinced this is the best way to service their patients. This coupled with 4 more years of data from other states and the military demonstrating the safety profile of prescribing psychologists, suggests this is a no-cost safe solution to an overburdened system.

In the 4 years that have passed since the veto, the State of Hawai'i's need for mental health services has only increased:

• In a 6-month period in 2008, there were 6 Domestic Violence murders (3 of them murder-suicides), a 50% increase over previous years.

• In 2006, 1435 residents were involuntarily taken to emergency rooms for psychiatric evaluation and treatment.

• In the first 4 months of 2007, HPD responded to 404 calls to assist in psychological crisis. Based on a review of records, 54% of these calls resulted from inadequate medication management.

• A recent report by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that only 40.4% of the population currently diagnosed with severe and persistent mental illness received services by the DOH, AMHD. In 2007, 14,276 out of a total of 52,064 adults with SMI received services through AMHD, indicating that approximately 37,788 individuals may not have received services. These numbers do not include other individuals with diagnoses such as substance abuse post-traumatic stress disorder, or a prior experience with domestic violence.

• The Department of Health's Adult Mental Health Division (AMHD) cut $25 million dollars from their 2009 budget, cut another 20% cut in 2010, and now only provides services to patients with Medicaid or no insurance. These cuts mean thousands more will go without services.

• While Psychiatry has made attempts to service rural areas, we have seen no increase in services on the 4 major islands. Efforts to increase services to Moloka'i have resulted in a total of 8 in-person service days per month, and 1 day per month via VTC. 6 of these days are only available to patients in the AMHD or DOE system. Additionally, the recipients of the services are primarily Caucasian and do not reflect the ethic distribution of the island, namely 68% Native Hawaiian. The island's Native Hawaiian population continues to seek services at the CHC or Na Pu'uwai Native Hawaiian Health Care System.

I believe that SB 597 would help to alleviate access issues, relieve an overburdened mental health system, and begin to decrease the tremendous health disparities existing for ethnic minorities and the poor. Thank you for your attention and consideration.

Thank you for considering my testimony in support SB 597.

Respectfully Submitted,
Robin E. S. Miyamoto, Psy.D.
Clinical Psychologist
Past-President, Hawai'i Psychological Association

SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
SENATOR ROSALYN H. BAKER, CHAIR
SENATOR BRIAN T. TANIGUCHI, VICE CHAIR
Tuesday, March 1, 2011
9:30 A.M. Conference Room 229

Jeffrey D. Stern, Ph.D.
Licensed Clinical Psychologist
1833 Kalakaua Ave. Suite 503
Honolulu, HI 96815

In regards to SB597 SD1 relating to limited prescriptive authority for appropriately trained and licensed clinical psychologists, I am in favor of a 5-year pilot program with appropriate outcome measures to assess it's success.

I am a psychologist who was raised here in Honolulu and I was recently elected President Elect of the Hawaii Psychological Association. Like you, I am in a position where I represent not myself, but many others whose opinions I must consider. Historically, I was opposed to psychologists having prescriptive authority because I was a student of one of the biggest opponents of this while I attended University of Hawaii and, at the time, her arguments made sense to me. She pointed out that the field is growing exponentially and there isn't enough time in a day to keep up with the demands of a practice and keep up with the demands of a prescriptive practice with all the content and growth/change that occur in that field, simultaneously. However, I have watched our profession handle technological advances, which are even more considerable, with enthusiasm and competence (e.g., Tripler's Telehealth program, HMSA's online care connection). I have watched a number of psychologists on the mainland United States successfully prescribe a limited number of medications with competence for more than 10 years. I have seen the majority of my colleagues delve rather selflessly into careers involving rural healthcare and underserved populations, and it strikes me as rather narrow-minded to see their efforts to promote prescriptive authority as a manipulative attempt to gain market share rather than as means of addressing a need among their patients. We psychologists have worked hard to help define the issue as one of access to care and not of "turf" and it gives me no small measure of satisfaction to see that most people finally see it as such. As a graduate of the University of Hawaii at Manoa, a "land grant" University, I understand it is my responsibility to give back to Hawaii and one way our profession gives back is to provide high quality services in rural areas to underserved populations.

In my practice, I see children and families. With this group, most of them Medicare/Medicaid and working class families with children with disabilities, it seems quite justifiable to see patients on Saturdays so that kids don't have to miss school to see me. It just makes sense. What kind of child and family psychologist would I be if I regularly asked parents to pull their children out of school to come see me? Along a similar line of reasoning, it seems quite justified for properly trained and certified psychologists to provide patients in need, access to appropriate treatments at times that work for them. It makes little sense to me to assume that a bipolar adult slipping into a manic phase can wait a week or several to get to see a psychiatrist. In that time, he or she could be out of a job or worse.

Our "seamless" system of care should provide for psychiatric services as a function of need, and not as a function of availability!

Thank you for the opportunity to provide my mana'o.

TO: Senate Committee on Commerce and Consumer Protection

# Testimony in Support of Senate Bill 597 SD1

**Relating to Psychologists**

**Submitted by Sid Hermosura, Psy.D., I Ola Lāhui**

**March 1, 2011, 9:30 a.m., Conference Room 229**

Honorable Chair Baker, Vice Chair Taniguchi and members of the committee, my name is Dr. Sid Hermosura. I am a post-doctoral psychology fellow with I Ola Lāhui, a psychology training program that sends psychology trainees to Hawaii's rural areas. As part of my training, I have had the pleasure of providing behavioral health services to the rural and underserved at Molokai Community Health Center, Na Pu'uwai and Waimanalo Health Center. Due to my experience in working within these communities, I would like to provide testimony **in strong support of SB 597** that would allow prescriptive authority for appropriately trained psychologists practicing at federally qualified health centers (FQHCs).

Psychiatrists that serve these rural and underserved communities are rare and often overworked. This often leads to considerable delays in initiating and maintaining treatment from a pharmacological perspective. While working in these communities, I have witnessed this gap in care. When this gap is present, then this increases the likelihood of patients not coming into treatment and worsening of symptoms. Some patients would have to wait 4 weeks or longer to get an appointment to see their psychiatrist. Furthermore, due to the millions of dollars cut from the Adult Mental Health Division and the consequent decrease in services, this gap is likely to increase, having dire consequences for the people of Hawai'i. By supporting prescriptive authority for appropriately trained psychologists who work in federally qualified health centers (FQHCs) would significantly improve and increase access to needed mental health services for the people of Hawai'i.

Psychologists have been prescribing medications since 1974. They have done so in state systems, in the Indian Health Service, and in the Department of Defense. Most recently, prescriptive authority was passed in New Mexico and Louisiana. Additionally, the U.S. Department of Defense Psychopharmacology Demonstration Project (PDP) and the safety data from Louisiana and New Mexico clearly demonstrate that appropriately trained psychologists can safely and effectively prescribe psychotropic medications. Therefore, the current gap that exists in mental health care, particularly for those residing in rural and underserved communities, can be reduced by prescribing and appropriately trained psychologists in the FQHCs.

Thank you for considering my **testimony in support SB597.**

Respectfully Submitted,

Sid Hermosura, Psy.D

**March 1, 2011**

**TO: The Hon. Rosalyn H. Baker, Chair, Senate Commerce and Consumer Protection Committee**
**The Hon. Brian T. Taniguchi, Vice Chair, Senate Commerce and Consumer Protection Committee**

**FROM: John L. Myhre, Psy.D.**
**Licensed Psychologist**
**Director of Behavioral Health**
**Waianae Coast Comprehensive Health Center**

**Re: TESTIMONY IN STRONG SUPPORT OF S.B. 597, SD1**

**March 1, 2011, 9:30 am Agenda, Room 229**

The time has long-since come to afford improved access to quality mental health care for those in Hawai□i who have little voice. As a Native Hawaiian Health Scholar, a servant at Wai□anae Coast Comprehensive Health Center, a faculty-mentor at an accredited medical school and the focus of many personal attacks by those who have lost their moral compass—I urge you to help us, help others.

To date I have personally seen very nearly as many patient visits as there are seats at a crowded Aloha Stadium. We have never asked the legislature for money to deliver empty promises. Instead, we stand with our community in need, just humbly delivering quality mental health care on a daily basis one patient at a time for the past 10 years to our brothers and sisters.

Very respectfully, please cast your vote in favor of S.B. 597, SD1.

Sincerely,

John L. Myhre, Psy.D.

Edward Fisher, PhD, RPh.
HC 1 Box 4175
Keaau, Hawaii 96749
Cell: 623-521-0658

Testimony in Support of SB 597, Relating to Psychologists

February 15, 2011:

Honorable Senator Roz Baker, Chair , Senator Brian Taniguchi, Vice Chair and members of the Committee, my name is Edward Fisher, PhD, RPh. I would like to provide testimony in strong support of SB 597 that would allow prescriptive authority for appropriately trained psychologists practicing at federally qualified health centers (FQHCs). I am currently Professor and Associate Dean for Academic Affairs at the University of Hawaii at Hilo College of Pharmacy. I am also a pharmacist licensed to practice in Pennsylvania and Arizona. (My opinions presented here are mine as an individual and do not necessarily represent the opinions of the University of Hawaii at Hilo).

If passed this current proposed bill will allow qualified clinical psychologists help ease the mental suffering and anguish of patients in community health centers in Hawaii. By expanding the number of qualified individuals with prescriptive authority there is not only benefit to patients suffering from mental disorders, but also to their family members who see their loved ones going untreated.

As part of my duties at College of Pharmacy in Hilo I am responsible for the creation of the Master of Science degree in Clinical Psychopharmacology (MSCP). Briefly, the objective of the MSCP program is to provide a rigorous, advanced education in clinical psychopharmacology to licensed, doctoral-level, practicing psychologists to enable them to safely and effectively prescribe medications for their patients in accordance with all relevant state and federal laws. Additionally, in states that do not allow such prescriptive authority, this program will enhance the ability of clinical psychologist's to consult with primary care physicians and psychiatrists about the appropriate drug therapy for their patients. The curriculum is designed to provide an in-depth coverage of the pharmacotherapy associated with the treatment of mental disorders. I want to assure the Committee that this program is of sufficient rigor and scope to provide Clinical Psychologists all of the skills in pharmacotherapy necessary to prescribe appropriate and safe drug therapy for patients suffering from mental disorders. In addition to the successful completion of the MSCP, the proposed bill requires a year-long clinical practicum and the Psychopharmacology Examination for Psychologists.

I respectfully ask that the committee to adopt this bill allowing appropriately trained psychologists to provide safe drug therapy to patients, who are currently underserved, and suffering from mental disorders.

Respectfully submitted,

Edward Fisher, PhD, RPh.

Testimony for CPN 3/1/2011 9:30:00 AM SB597

Conference room: 229
Testifier position: oppose
Testifier will be present: No
Submitted by: Rodger C Kollmorgen, MD, PhD, JD
Organization: Individual
Address:
Phone:
E-mail: rkollmorgen@hhsc.org
Submitted on: 2/25/2011

Comments:
I am a psychiatrist and a clinical psychologist, practicing psychiatry at the Kona Community Hospital. I am quite as pleased and proud to be a member of one profession as the other.
I received both my psychiatric training (residency) and clinical psychology training at the same institution (viz. the University of Minnesota).

I aver that, except for a few elective courses, there is virtually no crossover in the education and training between psychiatry and psychology.

Psychologists and not medical doctors, and they cannot become quasi-MD's with a few courses in physiology and psychopharmacology. Psychiatry is a specialty branch of MEDICINE, and the prescribing psychiatrist relies very heavily on his/her medical background when prescribing psychotropic medications. The practice of psychiatric medicine is hazardous and daunting,and a humbling experience for even the most seasoned medical practitioner.

For a psychologist to make incursions into the field of prescriptive psychopharmacology, even after taking some crash courses, is at best hubris and audacious. At worst, it is perilous to the health and welfare of the citizenry, and a prescription for disaster!
Rodger C Kollmorgen, MD, PhD, JD
808-322-4500 facsimile 808-322-4502

Rafael A. Salas, PSY.D., MP
45-020 B Malulani Street
Kaneohe, HI 96744
PHONE: (830) 857-3664 (cell)
Testimony in Support of SB 597, Relating to Psychologists

February 24, 2011

Honorable Senator Roselyn H. Baker, Chair, Senator Brian T. Taniguchi and members of the committee, my name is Dr. Rafael A. Salas. I would like to provide testimony in **strong support of SB 597 that would allow prescriptive authority for appropriately trained psychologists practicing at federally qualified health centers (FQHCs).** I am a clinical psychologist who is currently licensed in the State of Louisiana to prescribe psychotropic medications. As a United States Public Health Services Commissioned Officer I am assigned to Tripler Army Medical Center (TAMC), Department of Psychology (My opinions presented here are mine as an individual and do not necessarily represent the opinions of the United States Public Health Services, Tripler Army Medical Center, or the Department of Defense).

The community health centers in Hawaii are not currently able to appropriately meet the high demand of patients needing adjunct psychopharmacology therapy to address their mental health symptoms. The above mentioned bill, if adopted, will enhance the community health centers' ability to provide comprehensive mental health treatment to patients who are under-insured and do not have the financial resources to acquire this treatment from private mental health providers. Authorizing qualified clinical psychologists to provide the highly needed psychopharmacology therapy will greatly reduce the significant gap that currently exists in the provision of comprehensive mental health treatment in the community health centers in the State of Hawaii.

The Opponents of this bill, largely psychiatrists, argue against it because of patient safety. There is enough evidence that property trained clinical psychologists have a track history of prescribing in a safe manner. For example, there are clinical psychologists prescribing within the Department of Defense (US Army, US Air Force, and US Navy), the Indian Health Services, the US Public Health Services, and in two separate States (New Mexico and Louisiana). As a matter of fact, the Department of Defense has credentialed appropriately trained clinical psychologists (see appendix # 1 for formulary) since early 1990 to prescribe psychopharmacology therapy in military installations, Navy Ships and combat zones.

The current proposed bill not only requires that prescribing psychologists have a doctorate in psychology, but also requires postdoctoral training in psychopharmacology, requires a year-long clinical supervision, requires passing a national exam (Psychopharmacology Examination for Psychologists), and requires ongoing collaboration with physicians. This bill is more restrictive than the requirements established by the State of Louisiana for prescribing psychologists. The State of Louisiana only requires postdoctoral training in psychopharmacology and passing of a national exam before the psychologist is allowed to apply for licensure to prescribe.

As part of my duties in my current position, I oversee the psychopharmacology training postdoctoral program offered for clinical psychologists in our three two-year Postdoctoral Clinical Psychology Fellowship Training Programs (Child Psychology, Health Psychology, Neuropsychology Fellowships). Through these programs, twenty four psychologists have either obtained a postdoctoral certificate in psychopharmacology or a Master of Science in Psychopharmacology. Currently, our fellows obtain their Master of Science in Psychopharmacology from the University of Hawaii, School of Pharmacy (see Appendix II). As part of the Master s, each psychologist participates in an intensive year psychopharmacology practicum during the second year of the program. The psychopharmacology practicum takes place at Waianae Coast Comprehensive Health Center. The psychologists participating in the year practicum gain significant experience in the psychopharmacology treatment of patients that not only suffer from severe mental health disorders but also experience complex comorbid disorders such as diabetes, obesity, cardiac disorders, hepatic disorders, renal disorders, substance abuse and other medical conditions. During the year practicum, psychologists gain experience with psychotropic agents that include antidepressants, antipsychotics and mood stabilizers. Psychologists also gained experience with lab tests commonly used with patients with mental health disorders and the associated comorbid conditions. Moreover, psychologists gain significant training experience with the interaction of various pharmacology agents since these patients often take several medications to address their complex health problems. At the completion of the program, our psychologist fellows must take and pass the Psychopharmacology Examination for Psychologist (PEP) and are eligible to be credentialed to prescribe psychotropic medications in Military Medical Facilities, Indian Health Services Medical Facilities, United States Public Health Services, as well as meeting the requirements to be licensed in the State of New Mexico and Louisiana.

Eighty percent of our graduates have either worked or are working in community health centers in Hawaii. Ten percent are working with the Department of Defense and are prescribing medications in different military installations.

Because fellows of our training programs participate in other training opportunities in community health centers in Hawaii, I have been able to appreciate the immense mental health needs that patients in these centers have. Often these patients' mental health treatment needs are unmet, given the scarcity of qualified personnel to prescribe medications. Most of these patients do not have the needed health insurance coverage. When they do, they have to wait for several months to obtain the mental health services needed.

I respectfully urge the committee to adopt this bill that will allow properly trained psychologists to provide psychopharmacology services, significantly minimizing the existing mental health service gap.

***Rafael A. Salas, Psy.D., MP.***

Rafael A. Salas, Psy.D. MP

## US Army Formulary

## Policy and Procedures for Credentialing Army Clinical Psycholigist (13 February 2009)

### Table 1: Antidepressants (excluding MAOs and TCAs)

| Generic | Brand (Manufacturer) | Initial FDA approval date | Patent Listings/Expiration | FDA-Approved Indications (as of July 2005) |
|---|---|---|---|---|
| **Selective Serotonin Reuptake Inhibitors (SSRIs)** | | | | |
| Citalopram | Celexa, generics | 17 July 98 | - | MDD |
| Escitalopram | Lexapro (Forest) | 14 Aug 02 | Patent/exclusivity through 2009; however, some analysts | MDD, GAD |
| Fluoxetine | Prozac (Lilly), generics | 29 Dec 87 | - | MDD, OCD, PD, bulimia (pediatric labeling MDD, OCD) |
| Fluoxetine 90 mg caps (weekly regimen) | Prozac Weekly (Lilly) | 26 Feb 01 | Patents through 2017, no unexpired exclusivity | MDD (maintenance of response only) |
| Fluoxetine (special packaging) | Sarafem (Lilly) | 6 Jul 00 | Patents through 2008; exclusivity expired 12 Jun 2005 | PMDD |
| Fluvoxamine | Generics | 5 Dec 94 | - | OCD (depression outside U.S.) |
| Paroxetine HCl | Paxil (GSK), generics | 29 Dec 92 | - | MDD, GAD, OCD, PD, PTSD, SAD |
| Paroxetine HCl controlled release | Paxil CR (GSK) | 16 Feb 99 (02 launch) | Patents through 2017; exclusivity through Jan 2007 | MDD, PD, PMDD, SAD |
| Paroxetine mesylate | Pexeva (Synthon) | 11 Mar 02 | Patents through 2017; no unexpired exclusivity | MDD, OCD, PD |
| Sertraline | Zoloft (Pfizer) | 30 Dec 91 | Patents through 2012, but generics expected June 2006 | MDD, OCD, PD, PTSD, PMDD, SAD |
| **Serotonin – Norepinephrine Reuptake Inhibitors (SNRIs)** | | | | |
| Duloxetine | Cymbalta (Lilly) | 3 Aug 04 | Patents through at least 2009 | MDD, DPNP |
| Venlafaxine | Effexor (Wyeth), generics | 28 Dec 93 | At least one generic version likely in 2006 | MDD |
| Venlafaxine extended release | Effexor XR (Wyeth) | 20 Oct 97 | Generic availability unclear, authorized generic likely 2010 | MDD, GAD, SAD |
| **Serotonin-2 Antagonist/Reuptake Inhibitors (SARIs)** | | | | |
| Nefazodone | Generics only* | 22 Dec 94 | - | MDD |
| Trazodone | Desyrel, generics | 24 Dec 81 | - | MDD |
| **Norepinephrine and Dopamine Reuptake Inhibitors (NDRIs)** | | | | |
| Bupropion | Wellbutrin, generics | 30 Dec 85 | - | MDD |
| Bupropion sustained release | Wellbutrin SR, generics | 4 Oct 96 | | MDD |
| Bupropion extended release | Wellbutrin XL | 28 Aug 03 | Patents through 2018; no unexpired exclusivity. Generic availability unclear. | MDD |
| **Alpha-2 Receptor Antagonists** | | | | |
| Mirtazapine tablets | Remeron, generics | 14 Jun 96 | | MDD |
| Mirtazapine ODT | Remeron SolTab, generics | 12 Jan 01 | | MDD |

## Curriculum for MS degree in Clinical Psychopharmacology

## Appendix II

## UH College of Pharmacy, Hilo Campus

OVERVIEW: Beginning with a strong foundation in biochemistry and physiology, the curriculum for the MS degree in Psychopharmacology reflects current best practice in teaching evidence-based medication therapy management through intensive coursework in Integrated Pharmacotherapy. The integrated pharmacotherapy series is the core of the curriculum and combines all aspects of pharmaceutical care with therapeutic knowledge. Advanced Psychopharmacology I and II, taught during the final two semesters serves as the capstone courses. This curriculum is designed to provide an in-depth coverage of pharmacotherapy associated with the treatment of mental disorders.

| First Year Fellows | | Credits |
|---|---|---|
| **Fall** | The Biochemical Basis of Therapeutics I - Biomolecules | 3 |
| | The Biochemical Basis of Therapeutics II- Metabolism | 3 |
| | Human Physiology | 3 |
| | | |
| **Spring** | Integrated Pharmacotherapy I | 7 |
| | | |
| **Summer** | Integrated Pharmacotherapy II | 7 |
| | | |
| Second Year Fellows | | |
| **Fall** | Integrated Pharmacotherapy III | 4 |
| | Advanced Psychopharmacology I | 2 |
| | Psychopharmacology Practicum I | 1 |
| | | |
| **Spring** | Advanced Psychopharmacology II | 2 |
| | Psychopharmacology Practicum II | 1 |

COURSE DESCRIPTIONS:

**The Biochemical Basis of Therapeutics I - Biomolecules** (3 credits)

This course is designed to provide a basic foundation for the understanding of medicinal biochemistry, pharmacology, and the structure and function of various biomolecules. Topics will include structural and physical properties of proteins, nucleic acids (DNA and RNA),

carbohydrates, lipids and their relationship to their biological function, fundamentals of signal transduction, and DNA replication and repair. These principles will provide the basic concepts for understanding the biochemical basis for disease states and drug action that are central to therapeutics.

**The Biochemical Basis of Therapeutics II - Metabolism** (3 credits)

This course will delve into metabolism and the interrelationships of metabolic processes. The biochemistry of metabolism focuses on glycolysis, the tricarboxylic acid cycle, gluconeogenesis, and the synthesis and breakdown of biomolecules (carbohydrates, lipids, and amino acids). Metabolic control and regulation of pathways will be emphasized. Clinical correlates and metabolic diseases will be discussed.

**Human Physiology** (3 credits)

This course is designed to provide an in-depth overview of topics in human physiology that provide a basis for understanding of pharmacology. The course will begin with a review of basic physiological topics including the autonomic nervous, central nervous, and the cardiovascular systems. Following this will be an introduction to the discipline of pathology with an emphasis on diseases of the nervous system. This course will be composed of recorded lectures, live workshops, and synchronous video chat sessions. There is also a requirement of a research paper on a topic of physiology chosen by the student with approval of the Course Coordinator.

**Integrated Pharmacotherapy I** (7 credits)

In this first of a series of three courses, pathophysiology, pharmacology, toxicology, and therapeutics will be integrated into one discipline that will examine pharmacotherapy based on organ systems of the body. The course will begin with a discussion of SOAP notes and an introduction to pharmaceutical principles. Students will learn to blend their factual knowledge of the basic sciences and apply this knowledge to drug treatment of specific disorders in disparate patients. Synchronous video chats will tie in the pharmacotherapy discussed in lecture with the treatment of CNS disorders. During the semester, students will submit six SOAP notes on disease states discussed in class, and a research paper covering the current and future pharmacotherapy of a disease state selected by the student and approved by the Course Coordinator. The course will culminate with each student presenting their research paper.

**Integrated Pharmacotherapy II** (7 credits)

The second of a series of three courses will begin with a discussion of pharmacoepidemiology and resources to obtain Drug Information. However, the major focus of this course will a detailed coverage of the pathophysiology, pharmacology, toxicology, and therapeutics of CNS disorders

that may require pharmacotherapy. Students will learn to blend their factual knowledge of the basic sciences and apply this knowledge to drug treatment in disparate patients. During the semester students will submit six SOAP notes covering patients suffering from both somatic and CNS related disorders. Synchronous video chats will be employed to extend the understanding of the previous week's lectures. A research paper will also be submitted covering the current and future pharmacotherapy of a CNS related disease state. The research topic will be selected by the student with approval of the Course Coordinator. The course will culminate with each student presenting their research paper.

**Integrated Pharmacotherapy III** (4 credits)

In this third and final course in the series, pathophysiology, pharmacology, toxicology, and therapeutics will be integrated into one discipline that will examine pharmacotherapy based on organ systems of the body. Students will learn to blend their factual knowledge of the basic sciences and apply this knowledge to drug treatment of specific disorders in disparate patients. Additional topics discussed will be professional, legal, ethical, and interprofessional issues that relate to ethics, standards of care, laws, and regulations relevant to the practice of psychology involving psychopharmacology. During the semester students will submit six SOAP notes covering patients with both somatic and CNS related disorders. Synchronous video chats will be employed to extend the understanding of the previous week's lectures. A research paper will be submitted covering the current and future pharmacotherapy of a CNS related disease state selected by the student and approved by the Course Coordinator. The course will culminate with each student presenting their research paper.

**Advanced Psychopharmacology I** (2 credits)

This course serves as the first of two capstone courses that will provide an in-depth coverage of psychopharmacology associated with the treatment of mental disorders. Students will present patient cases in weekly seminars that are based on patients seen in clinical settings from the **Psychopharmacology Practicum I** course taught concurrently. This course will require students to demonstrate competence in medication therapy management specific to psychopathology. In addition recent literature will be discussed that covers synergistic interactions between psychotherapy and pharmacotherapy and will examine the single practitioner vs. the split-treatment model.

**Advanced Psychopharmacology II** (2 credits)

This course serves as the second of two capstone courses that will provide an in-depth coverage of psychopharmacology associated with the treatment of mental disorders. Students will present patient cases in weekly seminars that are based on patients seen in clinical settings from the **Psychopharmacology Practicum II** course taught concurrently. This course will require

students to demonstrate competence in medication therapy management specific to psychopathology.

In addition current and future pharmacotherapy of CNS disorders will be discussed: including methodology, standards and conduct of research of psychoactive substances. Drugs classes to be covered include: antipsychotics, antidepressants, mood stabilizers, anti-anxiety agents, sedative/hypnotic agents, narcotic analgesics, drugs used to treat the cognitive and behavioral effects of Alzheimer's disease, and drugs used to treat ADHD.

**Psychopharmacology Practicum I (1 credit)**

In this first of two psychopharmacology practicum courses students receive a minimum of two hours experiential training per week supervised by a qualified practitioner with demonstrated skills and experience in clinical psychopharmacology in accordance with the prevailing jurisdictional law. During the two psychopharmacology practicum courses students will treat a minimum of 100 patients and will be actively involved in consultation with physicians and/or appropriately credentialed psychologists regarding the prescribing of psychoactive medications. The Clinical Psychopharmacology Practicum components will be consistent with APA Recommendations. The Psychopharmacology Practicum courses will require students to demonstrate competence in medication therapy management specific to psychopathology. Students will present cases from this practicum in the **Advanced Psychopharmacology I** course taught concurrently.

**Psychopharmacology Practicum II (1 credit)**

In this second of two psychopharmacology practicum courses students receive a minimum of two hours experiential training per week supervised by a qualified practitioner with demonstrated skills and experience in clinical psychopharmacology in accordance with the prevailing jurisdictional law. During the two psychopharmacology practicum courses students will treat a minimum of 100 patients and will be actively involved in consultation with physicians and/or appropriately credentialed psychologists regarding the prescribing of psychoactive medications. The Clinical Psychopharmacology Practicum components will be consistent with APA Recommendations. The Psychopharmacology Practicum courses will require students to demonstrate competence in medication therapy management specific to psychopathology. Students will present cases from this practicum in the **Advanced Psychopharmacology II** course taught concurrently. At the end of the training program, a capstone competency evaluation will be completed.

COVERAGE OF KNOWLEDGE-BASED CONTENT AREAS IN PSYCHOPHARMACOLOGY EXAMINATIONS FOR PSYCHOLOGISTS (PEP):

| PEP content area | Course |
|---|---|
| Integrating clinical psychopharmacology with the practice of psychology | **Advanced Psychopharmacology I** |
| | **Psychopharmacology Practicum I,II** |
| Neuroscience | **The Biochemical Basis of Therapeutics I - Biomolecul** |
| | **The Biochemical Basis of Therapeutics II - Metabolisn** |
| Nervous system pathology | **Human Physiology** |
| | **Integrated Pharmacotherapy II** |
| Physiology and pathophysiology | **Human Physiology** |
| | **Integrated Pharmacotherapy I,II,III** |
| Biopsychosocial and pharmacologic assessment and monitoring | **Advanced Psychopharmacology I** |
| | **Psychopharmacology Practicum I,II** |
| Differential diagnosis | **Integrated Pharmacotherapy II** |
| | **Psychopharmacology Practicum I,II** |
| Clinical psychopharmacology | **Integrated Psychopharmacology II** |
| | **Psychopharmacology Practicum I,II** |
| Research | **Advanced Psychopharmacology II** |
| Professional, legal, ethical, and interprofessional issues | **Integrated Pharmacotherapy III** |

| Week | | # | Integrated Pharmacotherapy I | Recorded | Instructor |
|---|---|---|---|---|---|
| 1 | 5/16/11 | 1 | Dosage form design | Pharmaceutics | Morris |
| | | 2 | Dosage form design | Pharmaceutics | Morris |
| | | 3 | Dosage form design | Pharmaceutics | Morris |
| | | 4 | Dosage form design | Pharmaceutics | Morris |
| | | 5 | Dosage form design | Pharmaceutics | Morris |
| | | 6 | Dosage form design | Pharmaceutics | Morris |
| | | 7 | Dosage form design | Pharmaceutics | Morris |
| | | 8 | **Video chat** | | TBD |
| | | | | | |
| 2 | 5/23/11 | 9 | Dosage form design | Pharmaceutics | Morris |
| | | 10 | Nutrition | Wellness | Fisher |
| | | 11 | Nutrition | Wellness | Fisher |
| | | 12 | Nutrition | Wellness | Fisher |
| | | 13 | Nutrition | Wellness | Fisher |
| | | 14 | Obesity and weight control | Wellness | Fisher |
| | | 15 | Obesity and weight control | Wellness | Fisher |
| | | 16 | **Video chat** | | TBD |
| | 5/22/11 | 17 | **On-site workshop -SOAPing** | NEW | TBD |
| | | | **Exam one** | | |
| | | | | | |
| 3 | 5/30/11 | 18 | Obesity and weight control | Wellness | Fisher |
| | | 19 | Lab values | Foundations of IT | Tan |
| | | 20 | Lab values | Foundations of IT | Tan |
| | | 21 | Lab values | Foundations of IT | Tan |
| | | 22 | Lab values | Foundations of IT | Tan |
| | | 23 | Lab values | Foundations of IT | Tan |
| | | 24 | Lab values | Foundations of IT | Tan |
| | | 25 | **Video chat** | | TBD |
| | 6/4/11 | 26 | **On-site workshop - physical assessment** | NEW | Davis |
| | | | **SOAP Obesity** | | |
| | | | | | |
| 4 | 6/6/11 | 27 | Intro to Pharmacodynamics | Intro Pharm Sci | Konorev |
| | | 28 | Intro to Pharmacodynamics | Intro Pharm Sci | Konorev |
| | | 29 | Drug Targets | Intro Pharm Sci | Konorev |
| | | 30 | Drug Targets | Intro Pharm Sci | Konorev |
| | | 31 | Drug Targets | Intro Pharm Sci | Konorev |
| | | 32 | Intro to Gen Pharmacology/Drug Transport | Intro Pharm Sci | Chougule |
| | | 33 | Intro to Pharmacokinetics | Intro Pharm Sci | Chougule |
| | | 34 | **Video chat** | | TBD |
| | | | **Exam two** | | |
| | | | | | |
| 5 | 6/13/11 | 35 | Intro to Pharmacokinetics | Intro Pharm Sci | Chougule |
| | | 36 | Variability in Drug Action | Intro Pharm Sci | Chougule |
| | | 37 | Intro to Pharmacogenomics | Intro Pharm Sci | Chougule |
| | | 38 | ANS Review | IT I Fall 2010 | Connelly |
| | | 39 | ANS Review | IT I Fall 2010 | Connelly |
| | | 40 | Cholinergic agonists PC | IT I Fall 2010 | Konorev |
| | | 41 | Cholinergic agonists PC | IT I Fall 2010 | Konorev |
| | | 42 | **Video chat** | | TBD |

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|---|---|---|---|---|---|
| 6 | 6/20/11 | 43 | Anticholinergics PC | IT I Fall 2010 | Konorev |
| | | 44 | Anticholinergics PC | IT I Fall 2010 | Konorev |
| | | 45 | Adrenergic agonists PC | IT I Fall 2010 | Konorev |
| | | 46 | Adrenergic agonists PC | IT I Fall 2010 | Konorev |
| | | 47 | Adrenergic agonists PC | IT I Fall 2010 | Konorev |
| | | 48 | Adrenergic antagonists PC | IT I Fall 2010 | Konorev |
| | | 49 | Adrenergic antagonists PC | IT I Fall 2010 | Konorev |
| | | 50 | **Video chat** | | TBD |
| | | | **Exam three** | | |
| | | | | | |
| 7 | 6/27/11 | 51 | Cardiovascular Physiology review PP | IT I Fall 2010 | Connelly |
| | | 52 | Cardiovascular Physiology review PP | IT I Fall 2010 | Connelly |
| | | 53 | Hypertension PP | IT I Fall 2010 | Ciarleglio |
| | | 54 | Hypertension PC | IT I Fall 2010 | Konorev |
| | | 55 | Hypertension PC | IT I Fall 2010 | Konorev |
| | | 56 | Hypertension PC | IT I Fall 2010 | Konorev |
| | | 57 | Hypertension TP | IT I Fall 2010 | Ciarleglio |
| | | 58 | **Video chat** | | TBD |
| | | | | | |
| 8 | 7/4/11 | 59 | Hypertension TP | IT I Fall 2010 | Ciarleglio |
| | 7/5/11 | | **Topic for research paper due** | | |
| | | 60 | Hypertension TP | IT I Fall 2010 | Ciarleglio |
| | | 61 | Hypertension TP | IT I Fall 2010 | Ciarleglio |
| | | 62 | Hypertension TP | IT I Fall 2010 | Ciarleglio |
| | | 63 | Hyperlipidemia PC | IT I Fall 2010 | Konorev |
| | | 64 | Hyperlipidemia TP | IT I Fall 2010 | Ciarleglio |
| | | 65 | Hyperlipidemia TP | IT I Fall 2010 | Ciarleglio |
| | | 66 | **Video chat** | | TBD |
| | | | **Exam four** | | |
| | | | **SOAP Hypertention** | | |
| | | | | | |
| 9 | 7/11/11 | 67 | Hyperlipidemia TP | IT I Fall 2010 | Ciarleglio |
| | | 68 | Hyperlipidemia TP | IT I Fall 2010 | Ciarleglio |
| | | 69 | Heart Failure PP | IT I Fall 2010 | Ciarleglio |
| | | 70 | Heart Failure PP | IT I Fall 2010 | Ciarleglio |
| | | 71 | Heart Failure PC | IT I Fall 2010 | Konorev |
| | | 72 | Heart Failure PC | IT I Fall 2010 | Konorev |
| | | 73 | Heart Failure TP | IT I Fall 2010 | Ciarleglio |
| | | 74 | **Video chat** | | Steinman |
| | | | **Exam five** | | |
| | | | **SOAP Hyperlipidemia** | | |
| | | | | | |
| 10 | 7/18/11 | 75 | Heart Failure TP | IT I Fall 2010 | Ciarleglio |
| | | 76 | Heart Failure TP | IT I Fall 2010 | Ciarleglio |
| | | 77 | Heart Failure TP | IT I Fall 2010 | Ciarleglio |
| | | 78 | Heart Failure TP | IT I Fall 2010 | Ciarleglio |
| | | 79 | Thromboembolic disorders PP | IT I Fall 2010 | Ciarleglio |

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|---|---|---|---|---|---|
| | | 80 | Thromboembolic disorders PP | IT I Fall 2010 | Clarleglio |
| | | 81 | Thromboembolic disorders PC | IT I Fall 2010 | Konorev |
| | | 82 | **Video chat** | | Steinman |
| | | | **Exam six** | | |
| | | | **SOAP Heart failure** | | |
| | | | | | |
| 11 | 7/25/11 | 83 | Thromboembolic disorders PC | IT I Fall 2010 | Konorev |
| | | 84 | Thromboembolic disorders TP | IT I Fall 2010 | Clarleglio |
| | | 85 | Thromboembolic disorders TP | IT I Fall 2010 | Clarleglio |
| | | 86 | Thromboembolic disorders TP | IT I Fall 2010 | Clarleglio |
| | | 87 | Thromboembolic disorders TP | IT I Fall 2010 | Clarleglio |
| | | 88 | Peripheral vascular disease PP-TP | IT I Fall 2010 | Clarleglio |
| | | 89 | Cerebrovascular accidents PP-TP | IT I Fall 2010 | Clarleglio |
| | | 90 | **Video chat** | | Steinman |
| | | | **Exam seven** | | |
| | | | **SOAP Thromboembolic disorders** | | |
| | 7/30/11 | | **Research paper due** | | |
| 12 | 8/1/11 | 91 | Cerebrovascular accidents TP | IT I Fall 2010 | Clarleglio |
| | | 92 | IHD – MI & AP PP | IT I Fall 2010 | Tokumaru |
| | | 93 | IHD – MI & AP PP | IT I Fall 2010 | Tokumaru |
| | | 94 | IHD – MI & AP PC | IT I Fall 2010 | Konorev |
| | | 95 | IHD – MI & AP PC | IT I Fall 2010 | Konorev |
| | | 96 | IHD – MI & AP TP | IT I Fall 2010 | Tokumaru |
| | | 97 | **Video chat** | | Steinman |
| | | | **Exam eight** | | |
| | | | | | |
| 13 | 8/8/11 | 98 | IHD – MI & AP TP | IT I Fall 2010 | Tokumaru |
| | | 99 | IHD – MI & AP TP | IT I Fall 2010 | Tokumaru |
| | | 100 | IHD – MI & AP TP | IT I Fall 2010 | Tokumaru |
| | | 101 | IHD – MI & AP TP | IT I Fall 2010 | Tokumaru |
| | | 102 | Overview of antibiotics | NEW | Jacobs |
| | | 103 | Overview of antibiotics | NEW | Jacobs |
| | | 104 | Overview of antibiotics | NEW | Jacobs |
| | | 105 | **Video chat** | | Steinman |
| | | | **SOAP IHD** | | |
| | | | | | |
| 14 | 8/15/11 | | **Presentations** | | Faculty |
| | | | **Presentations** | | Faculty |
| | | | **Final exam** | | |

**Integrated Pharmacotherapy II**

| | | | | | |
|---|---|---|---|---|---|
| 1 | 8/29/11 | 1 | Pharmacoepidemiology | NEW | Steinman |
| | | 2 | Pharmacoepidemiology | NEW | Steinman |
| | | 3 | Pharmacoepidemiology | NEW | Steinman |
| | | 4 | Pharmacoepidemiology | NEW | Steinman |
| | | 5 | Pharmacoepidemiology | NEW | Steinman |
| | | 6 | Drug Information Resources | NEW | Kneenans |
| | | 7 | Drug Information Resources | NEW | Kneenans |

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|---|---|---|---|---|---|
| | | 8 | **Video chat** | | |
| | | | | | |
| 2 | 9/5/11 | 9 | Drug Information Resources | NEW | Kneenans |
| | | 10 | Drug Information Resources | NEW | Kneenans |
| | | 11 | Drug Information Resources | NEW | Kneenans |
| | | 12 | Drug Information Resources | NEW | Kneenans |
| | | 13 | Drug Information Resources | NEW | Kneenans |
| | | 14 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 15 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 16 | **Video chat** | | |
| | | | **Exam one** | | |
| | | | | | |
| 3 | 9/12/11 | 17 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 18 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 19 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 20 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 21 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 22 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 23 | **Video chat** | | |
| | | | | | |
| 4 | 9/19/11 | 24 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 25 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 26 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 27 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 28 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 29 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 30 | **Video chat** | | |
| | | | **Exam two** | | |
| | | | | | |
| 5 | 9/26/11 | 31 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 32 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 33 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 34 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 35 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 36 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 37 | **Video chat** | | |
| | | | | | |
| 6 | 10/3/11 | 38 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 39 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 40 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 41 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 42 | Substance of abuse/addiction/treatment | Toxicology | Fisher |
| | | 43 | CNS review | IT III Fall 10 | Jacobs |
| | | 44 | **Video chat** | | |
| | | | **SOAP - withdrawal** | | |
| | | | **Exam three** | | |
| | | | | | |

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|---|---|---|---|---|---|
| 7 | 10/10/11 | 45 | CNS review | IT III Fall 10 | Jacobs |
| | | 46 | CNS review | IT III Fall 10 | Jacobs |
| | | 47 | CNS review | IT III Fall 10 | Jacobs |
| | | 48 | Migraine PP | IT III Fall 10 | Guendisch |
| | | 49 | Migraine PC | IT III Fall 10 | Jacobs |
| | | 50 | Migraine TP | IT III Fall 10 | Guendisch |
| | | 51 | **Video chat** | | |
| | | | | | |
| 8 | 10/17/11 | 52 | Schizophrenia – PP | IT III Fall 10 | Chavez |
| | | 53 | Schizophrenia – PC | IT III Fall 10 | Jacobs |
| | | 54 | Schizophrenia – PC | IT III Fall 10 | Jacobs |
| | | 55 | Schizophrenia – TX | IT III Fall 10 | Chavez |
| | | 56 | Schizophrenia – TX | IT III Fall 10 | Chavez |
| | | 57 | Depression – PP | IT III Fall 10 | Chavez |
| | | 58 | **Video chat** | | |
| | | | **SOAP - schizophrenia** | | |
| | | | **Exam four** | | |
| | | | | | |
| 9 | 10/24/11 | 59 | Depression – PC | IT III Fall 10 | Jacobs |
| | | 60 | Depression – PC | IT III Fall 10 | Jacobs |
| | | 61 | Depression – TX | IT III Fall 10 | Chavez |
| | | 62 | Depression – TX | IT III Fall 10 | Chavez |
| | | 63 | Anxiety Disorders – PP | IT III Fall 10 | Chavez |
| | | 64 | Anxiety Disorders – PC | IT III Fall 10 | Jacobs |
| | | 65 | **Video chat** | | |
| | | | **SOAP - depression** | | |
| | | | **Exam five** | | |
| 10 | 10/31/11 | 66 | Anxiety Disorders – TX | IT III Fall 10 | Chavez |
| | | 67 | Anxiety Disorders – TX | IT III Fall 10 | Chavez |
| | | 68 | Bipolar Disorder – PP/PC | IT III Fall 10 | Jacobs |
| | | 69 | Bipolar Disorder – PC | IT III Fall 10 | Jacobs |
| | | 70 | Bipolar Disorder – TX | IT III Fall 10 | Chavez |
| | | 71 | Bipolar Disorder – TX | IT III Fall 10 | Chavez |
| | | 72 | **Video chat** | | |
| | | | **SOAP - anxiety disorders** | | |
| | | | | | |
| 11 | 11/7/11 | 73 | Sleep Disorders – PP/PC | IT III Fall 10 | Jacobs |
| | | 74 | Sleep Disorders – TX | IT III Fall 10 | Chavez |
| | | 75 | Sleep Disorders – TX | IT III Fall 10 | Chavez |
| | | 76 | ADHD - PP/PC | IT III Fall 10 | Jacobs |
| | | 77 | ADHD - TX | IT III Fall 10 | Chavez |
| | | 78 | Anesthetics (Local, General, and Skel Musc Relax) – PC | IT III Fall 10 | Jacobs |
| | | 79 | **Video chat** | | |
| | | | **SOAP - sleep disorders** | | |
| | | | **Exam six** | | |
| | 11/12/11 | | **Topic for research paper due** | | |
| | | | | | |
| 12 | 11/14/11 | 80 | Anesthetics (Local, General, and Skel Musc Relax) – PC | IT III Fall 10 | Jacobs |

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|---|---|---|---|---|---|
| | | 81 | Anesthetics (Local, General, and Skel Musc Relax) – PC | IT III Fall 10 | Jacobs |
| | | 82 | Parkinson's PC | IT III Fall 10 | Jacobs |
| | | 83 | Parkinson's Pathophysiology and Treatment | IT III Fall 10 | Barbato |
| | | 84 | Parkinson's Treatment | IT III Fall 10 | Barbato |
| | | 85 | Alzheimer's PC | IT III Fall 10 | Jacobs |
| | | 86 | **Video chat** | | |
| | | | **exam seven** | | |
| | | | | | |
| 13 | 11/21/11 | 87 | Alzheimer's Pathophysiology | IT III Fall 10 | Barbato |
| | | 88 | Alzheimer's Treatment | IT III Fall 10 | Barbato |
| | | 89 | Alzheimer's Treatment | IT III Fall 10 | Barbato |
| | | 90 | Seizure Pathophysiology and PC | IT III Fall 10 | Jacobs |
| | | 91 | Seizure PP, PC | IT III Fall 10 | Jacobs |
| | | 92 | Seizure PC | IT III Fall 10 | Jacobs |
| | | 93 | **Video chat** | | |
| | | | **SOAP - Alzheimer's** | | |
| | | | | | |
| 14 | 11/28/11 | 94 | Seizure Treatment | IT III Fall 10 | Chavez |
| | | 95 | Seizure Treatment | IT III Fall 10 | Chavez |
| | | 96 | Pain management PC | IT IV Spring 11 | Jacobs |
| | | 97 | Pain management PC | IT IV Spring 11 | Jacobs |
| | | 98 | Pain management TP | IT IV Spring 11 | Ma |
| | | 99 | Pain management TP | IT IV Spring 11 | Ma |
| | | 100 | **Video chat** | | |
| | | | **exam eight** | | |
| | 40878 | | **Research paper due** | | |
| 15 | 12/5/11 | 101 | Special populations - peds - autism | IT IV Spring 11 | Chavez |
| | | 102 | Special populations - geriatric | IT IV Spring 11 | Barbato |
| | | 103 | Special populations - geriatric | IT IV Spring 11 | Barbato |
| | | 104 | Special populations - geriatric | IT IV Spring 11 | Barbato |
| | | 105 | **Video chat** | | |
| | | | | | |
| 16 | 12/12/11 | | **Presentations** | Faculty | |
| | | | **Presentations** | Faculty | |
| | | | **Final exam** | | |

**Integrated Pharmacotherapy III**

| | | | | | |
|---|---|---|---|---|---|
| 1 | 1/9/12 | 1 | Introduction to toxicology | Tox | Fisher |
| | | 2 | Introduction to toxicology | Tox | Fisher |
| | | 3 | Introduction to toxicology | Tox | Fisher |
| | | 4 | Introduction to toxicology | Tox | Fisher |
| | | | | | |
| 2 | 1/16/12 | 5 | Introduction to toxicology | Tox | Fisher |
| | | 6 | Endocrine Review | | Jacobs |
| | | 7 | Gastro-intestinal PC | | Jacobs |
| | | 8 | **Video chat** | | |
| | | | | | |
| 3 | 1/23/12 | 9 | Gastro-intestinal PC | | Jacobs |

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|---|---|---|---|---|---|
| | | 10 | Gastro-intestinal PC | | Jacobs |
| | | 11 | Genito-urinary PC | | Konorev |
| | | 12 | Osteoporosis PP/PC | | Jacobs |
| 4 | 1/30/12 | 13 | Osteoporosis PC | | Jacobs |
| | | 14 | Special populations peds | IT IV Spring 11 | Robinson |
| | | 15 | Special populations peds | IT IV Spring 11 | Robinson |
| | | 16 | **Video chat** | | Jacobs |
| | | | | | |
| 5 | 2/6/12 | 17 | Endocrine Review | | |
| | | 18 | Diabetes PP | | Owusu |
| | | 19 | Diabetes PP | | Owusu |
| | | 20 | Diabetes PC | | Jacobs |
| 6 | 2/13/12 | 21 | Diabetes PC | | Jacobs |
| | | 22 | Diabetes TP | | Owusu |
| | | 23 | Diabetes TP | | Owusu |
| | | 24 | **Video chat** | | |
| | | | | | |
| 7 | 2/20/12 | 25 | Diabetes TP | | Owusu |
| | | 26 | Diabetes TP | | Owusu |
| | | 27 | Thyroid/Pituitary disorders PP | | Ciarleglio |
| | | 28 | Thyroid/Pituitary disorders PC | | Jacobs |
| | | | **SOAP - Dibetetes** | | |
| 8 | 2/27/12 | 29 | Thyroid/Pituitary disorders PC | | Jacobs |
| | | 30 | Thyroid/Pituitary disorders TP | | Ciarleglio |
| | | 31 | Thyroid/Pituitary disorders TP | | Ciarleglio |
| | | 32 | **Video chat** | | |
| | | | **SOAP - Thyroid** | | |
| | | | | | |
| 9 | 3/5/12 | 33 | Adrenal PC | | Jacobs |
| | | 34 | Adrenal PC | | Jacobs |
| | | 35 | Cushing's/Addison's disease PP/TP | | Barbato |
| | | 36 | Asthma/COPD/Allergic rhinitis PP | | Chong |
| 10 | 3/26/12 | 37 | Asthma/COPD/Allergic rhinitis PP | | Chong |
| | | 38 | Asthma/COPD/Allergic rhinitis PP | | Chong |
| | | 39 | Asthma/COPD PC | | Konorev |
| | | 40 | **Video chat** | | |
| | | | | | |
| 11 | 4/2/12 | 41 | Asthma/COPD PC | | Konorev |
| | | 42 | Asthma/COPD/Allergic rhinitis TP | | Chong |
| | | 43 | Asthma/COPD/Allergic rhinitis TP | | Chong |
| | | 44 | Asthma/COPD/Allergic rhinitis TP | | Chong |
| | | 45 | **SOAP - Asthma** | | |
| | | | | | |
| 12 | 4/16/12 | 46 | Professional, Ethical, and Legal Issues | NEW | |

| | | | | |
|---|---|---|---|---|
| | | 47 | Professional, Ethical, and Legal Issues | NEW |
| | | 48 | Professional, Ethical, and Legal Issues | NEW |
| | | 49 | Professional, Ethical, and Legal Issues | NEW |
| | | | **Topic for research paper due** | |
| | | | | |
| 13 | 4/23/12 | 50 | Professional, Ethical, and Legal Issues | NEW |
| | | 51 | Professional, Ethical, and Legal Issues | NEW |
| | | 52 | Professional, Ethical, and Legal Issues | |
| | | 53 | Professional, Ethical, and Legal Issues | NEW |
| | | | | |
| | | | | |
| 14 | 4/30/12 | 54 | Professional, Ethical, and Legal Issues | NEW |
| | | 55 | Professional, Ethical, and Legal Issues | NEW |
| | | | **Research paper due** | |
| | | 56 | Professional, Ethical, and Legal Issues | NEW |
| | | 57 | Professional, Ethical, and Legal Issues | NEW |
| | | | | |
| 15 | 5/7/12 | 58 | Professional, Ethical, and Legal Issues | NEW |
| | | 59 | Professional, Ethical, and Legal Issues | NEW |
| | | 60 | Professional, Ethical, and Legal Issues | NEW |
| | | | | |
| 16 | 5/14/12 | | Final | |

**Advanced Pharmacotherapy**

| | | | | |
|---|---|---|---|---|
| | | | | |
| 1 | 1/9/12 | 1 | Synergistic interactions between psychotherapy/pharmacotherapy | NEW |
| | | 2 | Current and future pharmacotherapy Antipsychotics | NEW |
| | | 3 | Synergistic interactions between psychotherapy/pharmacotherapy | NEW |
| | | | | |
| 2 | 1/16/12 | 4 | Current and future pharmacotherapy Antipsychotics | NEW |
| | | 5 | Synergistic interactions between psychotherapy/pharmacotherapy | NEW |
| | | 6 | **Case presentations** | |
| | | | | |
| 3 | 1/23/12 | 7 | Current and future pharmacotherapy Antidepressants | NEW |
| | | 8 | **Case presentations** | |
| | | 9 | **Case presentations** | |
| | | | | |
| 4 | 1/30/12 | 10 | Current and future pharmacotherapy Antidepressants | NEW |
| | | 11 | Synergistic interactions between psychotherapy/pharmacotherapy | NEW |
| | | 12 | **Case presentations** | |
| | | | **Exam one** | |
| 5 | 2/6/12 | 13 | Synergistic interactions between psychotherapy/pharmacotherapy | NEW |
| | | 14 | Current and future pharmacotherapy Mood stabilizers | NEW |
| | | 15 | **Case presentations** | |
| | | | | |
| 6 | 2/13/12 | 16 | Synergistic interactions between psychotherapy/pharmacotherapy | NEW |
| | | 17 | Current and future pharmacotherapy Mood stabilizers | NEW |

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|---|---|---|---|---|
| | | 18 | **Case presentations** | |
| | | | | |
| 7 | 2/20/12 | 19 | Synergistic interactions between psychotherapy/pharmacotherapy | NEW |
| | | 20 | Current and future pharmacotherapy Anti-anxiety agents | NEW |
| | | 21 | **Case presentations** | |
| | | | | |
| 8 | 2/27/12 | 22 | Synergistic interactions between psychotherapy/pharmacotherapy | NEW |
| | | 23 | Current and future pharmacotherapy Anti-anxiety agents | NEW |
| | | 24 | **Case presentations** | |
| | | | | |
| 9 | 3/5/12 | 25 | Synergistic interactions between psychotherapy/pharmacotherapy | NEW |
| | | 26 | Current @ future pharmacotherapy Sedative/hypnotic agents | NEW |
| | | 27 | **Case presentations** | |
| | | | **Exam two** | |
| 10 | 3/26/12 | 28 | Synergistic interactions between psychotherapy/pharmacotherapy | NEW |
| | | 29 | Current @ future pharmacotherapy Sedative/hypnotic agents | NEW |
| | | 30 | **Case presentation** | |
| | | | | |
| 11 | 4/2/12 | 31 | Single practitioner vs. the split-treatment model | NEW |
| | | 32 | Current and future pharmacotherapy - Alzheimer's | NEW |
| | | 33 | **Case presentations** | |
| | | | | |
| 12 | 4/16/12 | 34 | Single practitioner vs. the split-treatment model | NEW |
| | | 35 | Current and future pharmacotherapy - Alzheimer's | NEW |
| | | 36 | **Case presentations** | |
| | | | **Exam three** | |
| 13 | 4/23/12 | 37 | Single practitioner vs. the split-treatment model | NEW |
| | | 38 | Drugs used to treat ADHD | NEW |
| | | 39 | **Case presentations** | |
| | | | **Research paper due** | |
| | | | | |
| 14 | 4/30/12 | 40 | Single practitioner vs. the split-treatment model | NEW |
| | | 41 | Drugs used to treat ADHD | NEW |
| | | 42 | **Case presentations** | |
| | | | | |
| 15 | 5/7/12 | 43 | Single practitioner vs. the split-treatment model | NEW |
| | | 44 | Narcotic analgesics | NEW |
| | | 45 | **Case presentations** | |
| | | | | |
| 16 | 5/14/12 | | **Final exam** | |

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21 February 2011

Hawaii State Legislature
Senate Consumer Protection

RE: OPPOSITION to SB 597 amended Relating to prescription privileges for psychologists

Dear Honorable Senators:

This is individual testimony that is informed from my experience as a doctoral level psychologist since 1980. My experience includes being a Professor of Psychology at the University of Hawaii at Manoa since 1981, a Hawaii Licensed Psychologist since 1982, and a member of the Board of Psychology since 2005. My opinions do not represent the University or the Board.

Reasons for Opposition involve risk to the consumer

- Training for a doctorate in psychology is not medical training.
- There is virtually no evidence that reducing medical training to far less than half of that required for physicians or advanced practice nurses will protect the consumer.
- 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.
- The impact of prescribing privileges in New Mexico and Louisiana should be objectively evaluated for consumer safety before this experiment is repeated in Hawaii.
- Given proponents spent over $500,000 to pass a prescribing bill in Louisiana alone speaks to the availability of funds to conduct such a consumer safety study.

Consider this analogy:

- A drug company wants to distribute a newly developed drug in Hawaii that has not been evaluated.
- The drug company tells this Committee that they do not want to spend the time and money on a clinical trial.
- The drug company says that it has given its new drug to some people and no one came to them to claim that their new drug harmed or killed anybody.
- The company says it will make this new untested drug accessible to poor part-Hawaiians and other poor people in Hawaii.
- Would this Committee approve of the distribution of this new untested drug in Hawaii?
- If the answer is "no", then there is no reason to pass this bill.

Solutions to access to psychoactive drugs

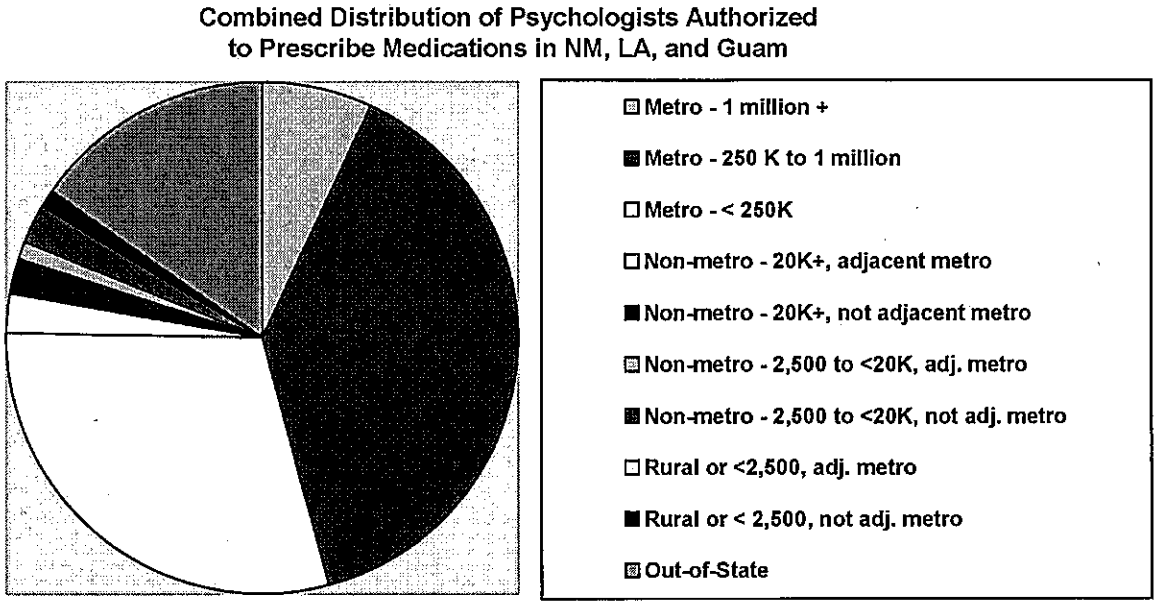
1. Collaboration between psychologists and physicians
2. Completion of medical or nursing school by psychologists
3. Encouraging medical and nursing schools to offer executive track programs for psychologists and social workers
4. Encouraging all professionals to serve rural areas. The prescribing laws in Louisiana and New Mexico did not result in psychologists moving their practices to rural areas (see attached chart).

Thank you for your kind consideration of this opinion.

Respectfully,

Elaine M. Heiby, Ph.D.
Psychologist (HI license 242)
Professor of Psychology

(Source: Prof. T. Tompkins, 2010; used with permission; no prescribing psychologists in Guam identified despite enabling legislation in 1999)



Testimony for CPN 3/1/2011 9:30:00 AM SB597

Conference room: 229
Testifier position: comments only
Testifier will be present: No
Submitted by: Cathleen Pomponio, M.S.
Organization: Individual
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Phone:
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Submitted on: 2/22/2011

Comments:
I do not support PhD level psychologists ability to write prescriptions even on a limited basis such as refills. M.D. is necessary in order to do this. Please keep the writing of all prescription drugs in the domain of a qualified physician. Even though I have spoken with psychologists, I recognize that they are limited in their scope and are trained in listening skills. If a patient or client needs medications, the psychologist then should refer the client out for a referral and assessment for prescription drugs. I have some study in psychology myself, a nearly one year of study including some advanced coursework, my understanding of this is that we should keep our health professionals in their correct areas and not confuse their roles.

Testimony for CPN 3/1/2011 9:30:00 AM SB597

Conference room: 229
Testifier position: oppose
Testifier will be present: No
Submitted by: Wailua Brandman APRN-Rx BC
Organization: Individual
Address:
Phone:
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Submitted on: 2/20/2011

Comments:
Senators Baker and Taniguchi and members of the Senate Committee on Commerce and Consumer Protection, thank you for the opportunity to testify in opposition to SB 597. I have reviewed the testimony submitted so far and I am quite pleased to see the varied expressions coming from physicians. Their testimonies are rational and reasonable, and clearly NOT turf oriented. I hear them supporting the role of psychologists on the health care team for the valuable contributions they make within the scope of their practice as psychologists. I also hear the physicians calling for utilization of their colleague prescribers, e.g., PAs and APRNs, and for funding to retain these prescribers and reimburse them at rates that reflect their value as prescribers. I commend these physicians for their collective insight, and sincerely hope that you pay close attention to their comments. Patient safety is just as important as access to care, if not more important. I have a fair number of APRN colleagues who have also gone to school to become lawyers or psychologists because they wanted to expand their expertise. Psychologists can also expand their expertise, should they want to prescribe, by pursuing academic degrees in biomedical studies that would fully prepare them to understand the complexities of the human body, complementing their understanding of the complexities of the human psyche. I have no problem with a psychologist prescribing psychotropic medications IF they are prepared adequately in the biomedical sciences. None of the bills relating to psychologists prescribing that are being heard in this session provide a requirement for adequate eduction in the biomedical sciences. As this issue continues to evolve, these bills are not ready for passage. Please hold them all.

I appreciate the opportunity to testify in Opposition to SB 597.

Wailua Brandman APRN-Rx PMHCNS/NP BC;
Immediate Past President Hawaii Association of Professional Nurses; APRN Advisory Committee, Hawaii Board of Nursing; O'ahu Director-at-Large, American Psychiatric Nurses Association Hawaii Chapter