

Testimony in Support of House Bill 326

Prescriptive Authority for Specially Trained Clinical Psychologists

Honorable(s) Chairman Huffman, Vice-Chairperson Gavarone, Ranking Member Antonio, and distinguished members of the House Health Committee:

I am Dr. Marlin Hoover, the seventh prescribing psychologist licensed by the state of New Mexico. I have been a faculty member of the Southern New Mexico Family Medicine Residency Program in Las Cruces for ten years where I have trained medical doctors, nurse practitioners, clinical pharmacists and prescribing psychology students in the management of mental health medications. I have a doctorate from the University of Chicago's Department of Behavioral Sciences and a Post-doctoral Masters in Clinical Psychopharmacology from Fairleigh Dickinson University.

I feel connected to Ohio as my mother and her four brothers and three sisters were raised on the Coppock family homestead near Tipp City, and where my mother began teaching grammar school in 1937. I spent many happy days of my youth on the dairy farm on the homestead which was founded by my great-great-grandfather and grandmother who are buried, along with my other ancestors in Tipp City. Additionally, my father was a graduate of the department of Chemistry at the University of Cincinnati. Because of this feeling of connection to Ohio where I still have many relatives I am eager to assist you in your consideration of the value of House Bill 326.

There are, I believe, three very important issues which should be examined. They are: (1) Is there a need for additional highly trained professionals who can provide mental health medication management services? (2) Are prescribing psychologists who are extensively trained using the model curriculum contained in House Bill 326 able to practice safely? (3) Are prescribing psychologists effective? Are we ***needed?*** Are we ***safe?*** Are we ***effective?***

I would like to address the question "Are we safe?" more fully because others have testified to the grievous shortage of psychiatrists which, by itself, puts citizens of Ohio at risk. The training that is proposed in House Bill 326 is based on the curriculum developed in the military when the first prescribing psychologists were trained and then served their comrades and their comrade's families with honor, safely and effectively. The American Psychological Association Recommended Curriculum is inspired by that training model and has been followed by all of the states currently authorizing doctoral clinical psychologists to prescribe. On the basis of that training, approximately 200 prescribing psychologists are practicing now.

A thoughtful opponent might ask questions like: *"How would a psychologist know whether it is medically safe to give a patient a particular medication? How would a psychologist know whether the medication they are prescribing will interact with other medications the patient is taking? How would a psychologist be able to monitor the effect of a medication on a patient's physical state? How would a psychologist know whether the patient's psychological symptoms aren't due to a medical condition rather than a psychological disorder?"* The answer to all of these questions is: "The Masters in Clinical Psychopharmacology, and the additional supervised training and collaboration arm the prescribing

psychologist with the knowledge and skills to insure that the medication management is safe and effective for the patient.”

It may be difficult to imagine how I, as a prescribing psychologist, would function in evaluating and treating a patient. Therefore, I will provide two examples of how I proceed to assess and treat patients without revealing information that would identify a specific patients.

Case (1) A patient referred for hospital follow-up. An older adult patient appears in my schedule with the request to “Evaluate and Treat - rule out elective mutism.” I review the inpatient records of the patient and examine the problems which led to the patient being hospitalized, in this case an “acute hypertensive crisis” secondary to “kidney failure.” I reviewed the discharge summary, the patient’s medication list, and ran an interaction check among the patient’s current medications. The hospital chart indicated that the team had concerns because the patient was not speaking to them and would display outbursts of emotion at times as they were examining her. The record also noted that there was consideration that the patient might be “catatonic” (a condition associated with schizophrenia) or experiencing a “conversion disorder” where she might be able to speak but was unable to do so because of her psychological condition. Among the ongoing problems the patient was experiencing were diabetes type 2, hypertension, hypocholesterolemia, osteoarthritis of hips, knees and other joints. In this case, as in all cases, an accurate diagnosis is of vital importance because the appropriate treatment would depend on the diagnosis. The interview of the patient with family members revealed that the patient had lost the ability to speak gradually, and that the loss of speech seemed to occur in the reverse order of how a child learns to speak – first with one-word telegraphic speech, then two words but still without complete sentences, and then finally in complete sentences. They also reported that she continues to have emotional outbursts which take some minuets to resolve. This suggested that the patient might have a degenerative brain disorder with the most likely cause being a cerebrovascular accident (stroke) or a frontotemporal dementia. I discussed my findings with a physician faculty member and also discussed which kind of brain imaging would be most appropriate to order. The brain imaging results were consistent with a diagnosis of Frontotemporal Dementia. The appropriate treatment would, therefore, be increased attention to the management of the patients Diabetes, Hyperlipidemia, and loving support from the family as well as a referral for speech therapy. Had the patient been treated for a catatonia with an antipsychotic medication, which would amplify the medical conditions contributing to her circulatory problems which were causing the dementia to increase. I did not prescribe mental health medication for this patient, as none would have been appropriate.

The knowledge and skill used in assessing this patient were gained through my having been trained using the same curriculum model as is contained in House Bill 326. Because I am a prescribing psychologist, I had the time to thoroughly evaluate the patient, discuss the patient’s history with the family, review the patient’s medical history, and to consider medical as well as psychological causes of a patient being unable to speak.

Case (2) Outpatient requesting treatment for “stress.” This middle-aged male patient came to the clinic stating that his spouse had urged him to come because of his stress level. A review of the patient’s medical history suggested that he was a relatively healthy person who exercised frequently doing cross

training and jogging. The patient was first evaluated by a primary care physician who confirmed his current state of health, and who decided against placing him on anti-hypertensive medication at that time due to the patient's not meeting criteria for hypertension in spite of slight elevations in his blood pressure over normal. A review of the patient's history revealed a previous episode of "depression" during a particularly stressful time at which time he was placed on Zoloft (sertraline) and to which "helped me feel better but I quit it after 6 months when I was feeling fine." The patient had not been offered cognitive/behavioral therapy or other forms of psychotherapy at that time.

The patient stated a preference for psychotherapy so we agreed to a trial of cognitive/behavioral therapy which the patient utilized diligently. However, at the end of a one-month trial he reported that his spouse and he both felt that he was 'stuck' and not much better. He agreed, at that time, to a trial of medication. I obtained medical clearance from his primary care physician for a trial of a medication and discussed medication options with him, evaluated the medication choices and restarted the Zoloft as the patient had responded to that medication previously. I reminded him that there is a Black Box Warning that suggests that some patients may experience an increase in suicidal ideation (which he had denied experiencing) and we discussed what he should do if that occurred in order to remain safe. We continued to meet weekly so that I could assess his progress and continue to provide cognitive/behavioral therapy. The patient reported, after taking the Zoloft for 2 weeks that he was "feeling a bit better" and the dosage was adjusted to increase the benefit. The patient continued to apply what he learned from the cognitive behavioral exercises, and attended follow-up appointments at 1 month, 3 months and 6 months where his vital signs continued to be monitored and the occurrence of side effects were monitored. His blood pressure normalized, reflecting the fact that his elevated blood pressure could have resulted from his psychological condition.

Again, this case management is what is taught to those who complete the curriculum and training contained house Bill 326. Prescribing psychologists trained in this model, through training like that established for us at Findley University, collaborate with physicians as part of the healthcare team.

- (1) We thoroughly assess the patient's medical and condition and obtain medical clearance for using mental health medications
- (2) We evaluate the patient's complete medication list and determine if the patient's psychological condition could be resulting from some of the medications the patient is already taking
- (3) We carefully select among possible medications based on the particular characteristics of the patient and the medications
- (4) We monitor the patient's physical and psychological response to medications
- (5) We provide alternatives to medication when they are appropriate and avoid their use when other effective treatments are acceptable to the patient
- (6) We take patient's off of inappropriate medications and collaborate in reducing polypharmacy
- (7) We obtain informed consent from patient's for treatment by a prescribing psychologist and for the treatments provided

We learn how to do all of these things through the education required by House Bill 326. Prescribing psychologist have been providing safe and effective treatments, combining the use of mental health

medications with other forms of psychological treatment for 20 years. We have a fine record of safety. I can simply illustrate our record of safety by stating that after 15 years of prescribing psychology in New Mexico, the additional cost to add coverage for prescribing to my malpractice insurance is \$135. This rate is based on the fact that no prescribing psychologist has ever been sued for malpractice.

I thank you for your consideration, and am happy to respond to any questions you may have.