TESTIMONY OF MORGAN T. SAMMONS, PhD, ABPP IN FAVOR OF HB 326

Good morning. I am here to testify on behalf of HB 326, a bill that would allow appropriately trained psychologists to augment their current skills with a certain formulary of psychotropic drugs. My name is Morgan Sammons, I am the Executive Officer of a national credentialing organization for psychologists, the National Register of Health Service Psychologists. I am also a retired Navy Captain and one of the first graduates of the Department of Defense's Psychopharmacology Demonstration Project. Since there has been some discussion of that project, let me take a moment to correct some of the inaccurate information you may have heard. The Psychopharmacology Demonstration Project was begun as a true experiment in order to determine if doctoral level licensed psychologists could efficiently acquire the skills to prescribe psychotropic medications without duplicating the expense and time of a medical education. It ran from 1991 to 1998 and I was one of the graduates of the first cohort. As its name implies, this was a demonstration project designed to test a new approach in mental health service provision. I will not dwell on the details of this project, as it ended two decades ago. As intended, it gave rise to a number of other quality training programs designed to equip licensed, doctoral level psychologists with the skills need to use psychotropic medications as a portion of their clinical work. I will simply say that the 1999 GAO report that summarized the project was dispository. It concluded that the psychologist trainees in this project prescribed safely, effectively, and rendered high quality care. Unlike what you may have heard from opponents of this bill, almost uniformly the trainees in this project went on to be successful prescribing clinicians and military leaders. I retired from the Navy in 2008, having provided pharmacological services to active duty forces and their families throughout the world, including a tour in Fallujah, Iraq, with the first Marine Division. When I retired, I was the specialty leader

for Navy clinical psychology and the Navy Surgeon General's special assistant for mental health and traumatic brain injury.

As I speak to you this morning, it is with the realization that much of the nation is the grip of an opioid crisis and that the incidence of suicide is rising rapidly. Ohio and the Midwest, particularly in rural areas, are as you well know particularly hard hit. But it is not just these crises, but a rising need for all forms mental health services that we must all band together to address. Unfortunately, the current number of providers is not sufficient to allow us to do so. The profession of psychiatry has for many years been concerned about the inadequate number of psychiatrists entering the work force. In every state of the union, child psychiatrists are in critically short supply. It is an uncontested fact that the current and projected numbers of psychiatrists will be insufficient to meet the demand. We simply cannot address these public health needs without adopting innovative approaches. Telepsychiatry and telepsychology provides one such approach, but this approach is insufficient to address the needs of the population. While holding promise, it must be acknowledged that telepsychiatry and telepsychology are distributive, not additive mechanisms, and rely on the same small number of providers to meet clinical need. Allowing appropriately trained psychologists to prescribe will expand expert mental health services. After over 20 years of safe and effective practice by prescribing psychologists, prescribing psychology can no longer be considered experimental. Instead it should be acknowledged as the innovative approach to mental health service expansion that it is, at a time when such innovation is desperately needed in order to meet burgeoning demand.

I mentioned the opioid crisis. In managing this and other substance abuse disorders, the data are clear that for many patients a combined approach of medication and psychological interventions

provides the best and most enduring outcome. This combined approach, called medication assisted treatment, is unfortunately beyond the reach of most patients suffering from substance use disorders, simply because there are not enough appropriately trained and certified providers to offer medication assisted treatment. Let me be clear – the substitution of a prescribed medication for a drug of abuse is not the goal of medication assisted therapy. The goal is to provide patients with a set of behavioral and psychological skills that they can employ in the future to avoid a return to substance abuse. Prescribing psychologists, well trained in behavioral approaches to substance abuse, are ideally suited to step into this role.

But as I previously said, we cannot limit our discussion to opioids or suicide alone. Combined treatments for most common mental disorders, such as depression, yield superior results in the long term than does the mere prescription of a medication. Unfortunately, in our current system, most patients with depression are afforded only one treatment choice- medication. Prescribing psychologists are fundamentally trained in psychological and behavioral interventions, making them the optimum type of provider to bring more effective, combined therapies to patients with depression and other mental disorders.

I respect my psychiatric colleagues and admire their expertise. In this instance, however, many psychiatrists have chosen to interpret the issue of prescribing psychologists purely in terms of guild interests. I request that my psychiatric colleagues rise above narrow guild interests in order to augment the supply of skilled providers of psychotropic drugs. We would welcome their collaboration and, as I have done in the past, work closely with them to improve patient care. At the same time, I hope legislators will appreciate that while we wish to work collaboratively with psychiatry, independently licensed health care professions should be able to determine their own scope of practice, and not have these scopes of practice dictated by other professions.

While it is understandable that certain medical professions might have anxiety about other professions encroaching on their scope of practice, history speaks loudly that when other professions expand into areas once considered the exclusive purview of medicine, they do so safely and effectively. Consider that when optometrists sought the ability to prescribe therapeutic, in addition to diagnostic agents, opthalmologists predicted an epidemic of blindness. This did not occur. Nor were standards of practice degraded when nurse practitioners became independent primary care providers – instead, nurse practitioners are becoming the bedrock of much primary care throughout the nation, particularly in rural and traditionally underserved areas.

In 1991, when I began in the Psychopharmacology Demonstration Project, prescribing psychologists were truly an experiment. Today, 20 years after the end of the Psychopharmacology Demonstration Project, and with hundreds of prescribing psychologists rendering high quality care in the DoD, Indian Health Service, and 5 states, this can no longer be considered an experiment. Instead, I encourage you to view prescribing psychologists as a true and proven innovation in health care. For all the reasons I've outlined before, this is the type of innovation we must embrace in order to meet the mental health needs of the citizenry. HB 326 reflects this type of innovative, solution focused thinking, and I urge your support for this important bill.