Dear Chairman Huffman, Vice-chairperson Gavarone, Ranking Member Antonio and distinguished members of the House Health Committee, I am Don Stansloski, a principle in the Consulting Group Creative Solutions Enterprises and a retired pharmacy professor and Dean.

Thank you for allowing me to be here today.

The University Of Findlay College Of Pharmacy asked my consultant group to develop a program to teach Clinical Psychologists to prescribe medications correctly and to monitor patients for safety and efficacy. As we considered this idea one of our first questions was whether there was a need for persons trained in this way.

Data from the National Comorbidity Survey establish conclusively that patients with serious mental illness are underserved in both rural and urban settings. Some groups especially noted as being underserved include African Americans, young adults and persons treated in general medical settings.

There are simply not enough psychiatrists to see all the patients who are ill. Licensed psychologists are a group that could fill this gap in treatment availability and their ability to treat patients would be enhanced if they understood psychotropic medications better, whether licensed to prescribe or not. Many patients who see licensed psychologists require or are already taking a prescription drug for a serious mental illness. If a medication is to be started or adjusted or stopped, the procedure now followed is that the licensed psychologist arranges for the patient to see a physician, and recommends to the physician that a particular change in drug or dose be prescribed for the patient. This clumsy process delays time to effective treatment and requires the time of two health professionals to arrive at a decision.

Training psychologists to prescribe is not a new idea. The Department of Defense instituted a pilot program in 1991 to train military psychologists to prescribe. Many of the ten persons who were trained continue to prescribe. The General Accounting Office found they performed well and they received high marks during their training from supervising Physicians. Prescriptive Authority for properly trained Psychologist has since been approved in all three branches of the armed services (Department of the Navy, 2003; Secretary of the Air Force 2007; and the Army Medical Command 2009)

Ohio licensed psychologists were surveyed by the Ohio Psychological Association (OPA) about 10 years ago. Those results were consistent with national numbers and showed that Ohio licensed psychologists were interested in the subject because their patients were taking these medications. More could be, with the right supervision. In a more recent general survey, OPA asked as a side issue about interest in this subject. Those results indicate that as many as 875 (about 1 in 4) clinical psychologists in Ohio would rank this as very important or important for the profession going forward.

OPA conducted a focus poll on the subject in the summer of 2016. Those results also showed interest in the subject. About 170 Ohio licensed clinical psychologists responded. About three-fourths responded that the legislature should authorize

prescriptive authority for clinical psychologists in Ohio. Almost half (77 of 170) of those responding said they would be interested in pursuing the Master's degree to allow for this authority. If that level of interest is representative of the entire membership, the potential number of students could be as many as 825 out of 3300 psychologists in Ohio. The exact number attracted will depend on a number of factors, but almost two-thirds were comfortable with distance learning for the degree. In other words, we concluded that there were people interested in caring for these patients.

Our next step was to consider a curriculum for this program. We had three educational objectives. First, we wanted to develop a forward-leaning program that would empower students with the educational foundation and clinical experience to competently prescribe psychopharmacological medications consistent with state and federal laws.

Next we wanted to implement a program of rigorous academic preparation and meaningful clinical experiences to enable graduates to work collaboratively with physicians, nurses, and other healthcare providers in order to coordinate a high level of patient care.

Our third educational objective was to assure achievement of professional skills and practice competence such that graduates of the program will be well-equipped to be successful on the Psychopharmacology Exam for Psychologists (PEP).

Several options for achieving these objectives were considered and rejected until we settled on a Master's program. The specific courses we considered seemed to us to be pedagogically sound and complete. The process compared to that the College used to teach Doctor of Pharmacy students in that it began with basic scientific material, progressed to the science of pharmacology and concluded with clinical education. At some point we looked at medical school curricula and concluded that these students would have more didactic material on this subject than physicians would, but probably not as much clinical training in psychiatry as a psychiatrist. We thought that would be acceptable since the clinical psychologists all have a Doctor of Philosophy in clinical psychology and clinical experience in the discipline. Sometime in the process the American Psychological Association published a model curriculum. It was close to what we had planned and so we adopted it.

Many studies have established that delivering a degree online is as effective as a face to face program is. Of course, the clinical and laboratory portions of the curriculum would be delivered in a face to face manor.

The APA developed curriculum provides greater detail of those specific content areas in which mastery should be achieved by these students. APA provides the following guidance to use when considering this outline.

"As programs may develop specific courses using different content integration approaches, these are not meant as specific courses and the contact hours are not broken

down into each area. The program must demonstrate that all content is covered and that the students achieve clinical competency in all content areas."

The basic science didactic portion of this curriculum includes Anatomy and Physiology, Neuroanatomy, Neurophysiology and Neurochemistry. The Physical Assessment and Laboratory Exam didactic portions are taught in the clinical portion as well.

A major portion of the curriculum is devoted to Clinical Medicine and Pathophysiology with particular emphasis on organ systems and signs, symptoms and treatment of disease with behavioral, cognitive and emotional manifestations or comorbidities. Differential Diagnosis and Clinical correlations are an important part of this section. Substance-abuse and chronic pain management are covered. Again this section should be correlated with the clinical piece.

Research methodology in Pharmacology and Psychopharmacology is covered as well as the process of drug approval by FDA. Issues of diversity in pharmacological practice appear late in the curriculum.

Clinical Pharmacotherapeutics, drug interactions and pharmacoepidemiology are taught didactically and in the clinic.

The application of existing law, standards and guidelines to pharmacological practice as well as ethical relationships with pharmaceutical industry and the nature of drug product advertising practices and how they affect the critical consumer are all considered in a separate piece.

The supervised clinical experience should be an organized sequence of education and training that provides an integrative approach to learning as well as the opportunity to assess competencies in skills and applied knowledge. The program requires care of 100 patients, is one year long and occurs in multiple settings.

The intent of the supervised clinical experience is two-fold:

1. To provide ongoing integration of didactic and applied clinical knowledge throughout the learning sequence, including ample opportunities for practical learning and clinical application of skills.

2. To provide opportunity for the program to assess formative and summative clinical competency in skills and applied knowledge.

I will be happy to answer any questions you may have.