

House Committee on Public & Behavioral Health & Human Services,

My name is Dr. Helena Villalobos, and I am a fourth year Internal Medicine-Pediatrics resident in Colorado. I am asking the committee to vote against HB23-1071. Below, I have outlined my patient safety concerns with this bill.

- As a primary care provider, I rely heavily on physiologists for their expertise. They are integral to patient care; however, this training is insufficient and below the threshold for prescriptive authority.
- For reference, the "physical exam" 80 hours requirement is the equivalent of one week I work as a resident in the hospital. I did not feel confident in my physical exam skills after one week of residency. In fact, it has taken me years to hone my skills.
- The 400 hour clinical rotation seeing at least 100 patients is equivalent to 8-10 week clinical rotation. In medical school, I completed a required five week Psychiatry rotation (approximately 60-80 hour work weeks) after two years of pre-clinical education. In those five weeks I was nowhere near equipped to prescribe psychiatric medications, and I completed more than half of the training that is being required for psychologists under this bill.
- The 2 year masters (450 hours) equates to approximately 4 months of a medical student's course work. At this point in my training, I was not fit to be a prescriber.
- For reference I have completed 4 years of medical school, a one year Masters in Clinical Research, and a 4 year dual Internal Medicine and Pediatrics residency. I feel very comfortable prescribing medications for depression and anxiety, in addition to stimulants for ADHD, however I often refer to Psychiatry for help.
- All medicines have side effects. Even over-the-counter medications including ibuprofen (Advil) can cause kidney injury in excess or acetaminophen (Tylenol) can cause liver injury in excess when used incorrectly. Psychiatric medications are particularly high risk with several meds having black box warnings. They contain side effects that can not only increase suicidality, but also cause other physical symptoms including seizures, arrhythmia, gastrointestinal side effects, rashes. I do not believe this post-doctoral masters degree provides a trained psychologist with a holistic view of pathophysiology to be able to manage these symptoms and side effects.
- Psychiatric medications may have several interactions with other medications, and physical illness and mental illness are often intertwined. For example, when I see a patient with fatigue and weight gain, I will likely check their thyroid in addition to administering a depression screen. Psychologists lack the clinical knowledge to have a holistic view of complex pathophysiology and organ systems. They are not equipped to provide a differential diagnosis for symptoms.

- MD/DOs must complete 4 years of medical school and at least three years of residency. Psychiatry is a four year residency with one year typically dedicated to general internal medicine. Physician Assistant school is a three year program. Nurse Practitioner must complete two years of Nurse Practitioner training after completing a 4 year Bachelors in Nursing.

- The type of psychiatric meds I prescribe are often influenced by a person's co-morbidities. For example, if a patient has both depression and diabetic neuropathy, I might choose a SNRI to treat both, instead of a SSRI alone. The post-doctoral masters and 80 hour physical exam course does not provide sufficient general internal medicine to address these nuances and see the patient as a whole entity, rather than just focusing on mental health.

- This is a patient safety issue. While I agree that the Mental Health shortage is a huge issue, the answer is not lowering the standard for prescribing authority. As in the case of doctor shortages, should we cut down the clinical requirements of MDs just to increase the number of doctors in the community?

- Other avenues that can be more fruitful are increasing telehealth and integrated care models.

Again, I urge you to vote NO on HB23-1071. This is not safe for our patients.

Best,

Helena Villalobos, MD PGY-4  
Internal Medicine-Pediatrics.

Supplemental Written Testimony: HB23-1071

Public & Behavioral Health & Human Services

Date Time: 02/01/2023; 01:30 PM

Bill: HB23-1071

Position on Bill: **Against**

Dear Committee Members and Committee Chair:

Thank you for this opportunity to testify in **opposition** of HB23-1071. I am Sandra Fritsch, a child and adolescent psychiatrist in practice for > 30 yrs and a fully trained pediatrician as well. I am representing myself in this testimony. I am the Medical/Project Director of CoPPCAP, the Colorado Pediatric Psychiatry Consultation & Access Program. With my role in CoPPCAP, I bring my own personal experience to this testimony and testified in front of this committee last April around SB22-147 and CoPPCAP. As you are all aware, we have a pediatric behavioral health crisis/pandemic, and pediatric behavioral health needs have increased dramatically since 2009, not just since the Covid-19 pandemic. I imagine everyone present has had some personal connection to a youth experiencing mental health concerns and the challenge of getting care. Contributing to the pediatric mental health crisis are the workforce shortage challenges for all child mental health providers, both nationally and notably in Colorado. In Colorado, 49/64 counties have no practicing child and adolescent psychiatrist, Colorado is deemed a state with "severe shortage", and even in the greater Denver area there is a "high shortage". With this workforce shortage, you may wonder why I am testifying "**Against**" **HB23-1017**. Granting psychologists prescriptive authority will not lessen the crisis, will not increase access to care, raises significant safety concerns, and may take away important available therapy and testing that is also greatly needed for our youth.

Psychologists are not medically trained professionals. The training proposed is the equivalent of the first 4 months of a 1<sup>st</sup> year medical school education; as per the "[Designation Criteria for Education and Training Programs in Psychopharmacology for Prescriptive Authority](#)" noted by the American Psychological Association (APA). The didactic curriculum minimum requirement is 400 hours; essentially 10 weeks. Pre-med requirements in undergraduate are notable for core science subjects; subjects to prepare medical students for greater understanding of the body. In addition, a child is a continually changing organism from synaptic pruning of the neurons in the brain to changing enzymatic responses of the liver to the impact of flooding with hormones during puberty. I would say the proposed psychologist prescriptive authority training is inadequate to **safely** prescribe psychotropic medications, especially for youth, and that psychologists should not be given prescriptive authority.

As an aside, I am also concerned that the very limited local and national reporting metrics are only through a psychology professional organization, a non-medical discipline. This professional self-monitoring is problematic, there is NO overseeing Medical Board in this bill. Frankly this diminishes the perceived value of physicians or allied medically trained professional input to the care of highly vulnerable patients with psychiatric concerns.

Our areas of workforce shortage are less in the urban areas and more in the very rural areas. Psychologists given prescriptive authority will not increase access to care in these areas. And for "cash-based" practicing psychologists, equitable access to care will not be addressed. The marginalized Coloradans will remain marginalized and not have increased access to care.

Helping primary care providers have more knowledge, comfort, and experience in treating mild to moderate mental health conditions will keep care in the medical home and lessen the need for mild to moderate conditions be treated by mental health experts. Programs such as CoPPCAP help support the pediatric primary care provider assess and treat in the primary care practice; often a preferred approach by families as they have trust in their medically trained primary care providers.

CoPPCAP is a Pediatric Mental Health Care Access Program (PMHCA) as noted by HRSA (Health Resources Services Administration). The original funding to develop and deliver CoPPCAP has come through a HRSA grant defined in the 21<sup>st</sup> Century Cures Act, and Supplemental Medicaid Funding administered through the University of Colorado. SB22-147 passed last year, this passage will allow further expansion of CoPPCAP with the goal to ensure all pediatric lives in Colorado will have their primary care providers receiving support from CoPPCAP. PMHCAs are developed to support the identification, assessment of, and treatment of mild to moderate behavioral health concerns presenting in pediatric primary care settings including school-based health programs. These programs are essential with the huge workforce challenges and not enough child and adolescent psychiatrists. PMHCAs are designed to support the pediatric primary care provider by providing timely peer-to-peer consultation, helping to identify resources (therapists/services/etc) that are evidence based and accept the patient's insurance, and offering formal education opportunities along with digital resources.

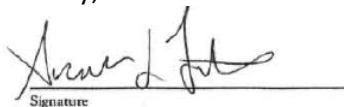
CoPPCAP enrolled its first practice in September 2019. Since 2019 we have enrolled 71 practices (front range, western slope, urban and rural), covering over 560,000 lives, supporting roughly 480 pediatric providers, and have provided nearly 1900 peer-to-peer consultations. Each peer-to-peer consultation is an educational opportunity and leads to a cascade effect of knowledge gained from the peer-to-peer consultation which can then be applied to other patients the provider treats. We provide formal education through lunch and learns, ECHO (Extension of Community Health Outcomes) series covering core and beyond core essentials of pediatric psychiatry in primary care, an annual learning collaborative, and ad hoc trainings. The Covid-19 pandemic has created opportunities for enhanced use of digital technology to support the pediatric primary care providers in addressing the pediatric mental health pandemic. In response to what we observed of the front-line pediatric providers' moral distress and considerations of leaving their practices, coinciding with the great increased mental health care needs of their patients, we have incorporated self-care principles into our formal learning sessions. We have also developed a wonderful website (yes, I am biased), [www.coppccap.org](http://www.coppccap.org) that provides extensive resources and tools for pediatric primary care providers. We are happy to provide any data the committee may want.

Some questions the legislators may have about CoPPCAP:

- *Does CoPPCAP serve rural/frontier practices in Colorado?* Yes, we have had ~ 1/3 of our participants in our formal educational series come from rural/frontier counties.
- *Does a provider have to come from an enrolled practice to call for a peer-to-peer consultation or participate in the educational opportunities?* No, we are open to all, but enrolled practice providers have first notifications of educational opportunities.
- *Do programs like CoPPCAP make a difference? Effect outcomes?* A letter to the editor of the Journal of the American Academy of Child & Adolescent Psychiatry in 2019 revealed that youth in states with a child psychiatry access program were more likely to receive mental health care.
- *What ages does CoPPCAP support?* CoPPCAP supports calls and education for 0 – 25-year-olds and caregivers in the perinatal period.
- *Where are the possible areas of return on investment?* Earlier identification and treatment of disruptive behaviors and anxiety disorders in younger children lead to less comorbidity, greater potential school success and matriculation, and less involvement of the correctional system. Primary care providers conducting a suicide screen for each visit for youth ages 10 and above identifies risk, allows for assessment and intervention, and saves lives. Identification and treatment of anxiety disorders in younger age children should offset development of comorbidity of worsening mental health conditions. Primary care providers with the knowledge, attitudes, and skills to assess and treat mild to moderate behavioral health conditions in primary care should support retention of their roles.
- *How have you been able to accomplish so much since 2019?* CoPPCAP has had wonderful partners with CDPHE, our Advisory Committee, American Academy of Pediatrics-Colorado Chapter, Children's Hospital Colorado, ECHO Colorado, and my own personal experience with child psychiatry access programs in Massachusetts and Maine. We have been able to create this program with few bureaucratic barriers.

I am happy to answer any questions or provide any supplemental materials. Please vote NO on HB-1071. Thank you.

Sincerely,



Signature

Sandra L. Fritsch, MD  
Medical Director and Project Director, CoPPCAP

**Testimony in Opposition to HB23-1071**  
**Provided by Caitlin Jones-Bamman, MD, FAAP**  
**February 1, 2023**

Good Afternoon,

My name is Caitlin Jones-Bamman, and I am a general pediatrician practicing at Pediatrics 5280 in the South Denver Suburbs. I'm here today to share my concerns regarding the psychologist prescribing bill, referred to as RxP. This bill, while well intended, misses the mark significantly and may have unintended negative consequences.

We can all agree that there is a pressing mental health crisis affecting our community. The COVID-19 pandemic led to unprecedented social isolation, disruption in healthcare services, and increased rates of anxiety and depression. I have seen this firsthand, and providers all over the state are being inundated with the overwhelming numbers of patients with new or worsening mental health concerns.

However, increasing access to medications will not solve this problem. As a general pediatrician, I am well trained to manage and prescribe medication for straightforward anxiety, depression, and ADHD. There is a wealth of evidence in the medical literature that medication alone is often not enough to help these patients, and in fact, therapy is often recommended first line before medications are considered. So, while I am perfectly capable of managing psychiatric medications within the patient's medical home, I cannot provide the therapy that is so desperately needed, and patients are increasingly having difficulty accessing therapy due to cost and/or availability. Thus, the main goal of this bill, to increase access to medication, misses the mark entirely. Patients don't need more pills, they need therapy, and these services are desperately lacking.

Expanding on this, proponents of the bill discuss how it will help improve access to care, especially for needy patients. Many therapists, including psychologists, do not take insurance due to poor reimbursement, and families are therefore asked to pay out of pocket for services. Additionally, most psychologists live and work in the popular front range cities, not in the rural communities that are already underserved. I see nothing in this bill that will require psychologists to accept insurance (especially Medicaid) for medication management, nor any provisions that may limit geographically where these individuals can practice. This bill, therefore, will only further worsen existing healthcare inequalities and will not improve access for patients who need help the most.

A final, and critical consideration is the health and safety of the children who will be impacted by this bill. As I previously mentioned, as a pediatrician and general practitioner, I am trained to prescribe psychiatric medications for children. This is advantageous to the patient because I am able to consider their whole health - mind and body. I can easily understand how a medication might affect underlying medical conditions, interact with other medications, or cause side effects such as high blood pressure, metabolic derangement, or organ dysfunction. When

side effects occur, I am able to order and interpret lab tests to make decisions about treatment going forwards. Children are not little adults - their bodies are still growing and developing, and function differently at different stages of life and puberty. Thus, prescribing psychiatric medications to children is a huge responsibility. It requires the provider to understand the nuances of these medications, many of which are used off label as they are not FDA approved for children. Through this bill, psychologists may receive additional training to prescribe medications, but none of it is pediatric centered. Although the intentions are good, children will be harmed when individuals with inadequate training are allowed to prescribe powerful medications, especially when they will be untrained to consider the child's health as a whole.

We can all agree that there is work to be done to improve the mental health care for all Colorado residents. Sadly, RxP is not the solution. Instead of passing legislation that will worsen and fracture care, let's instead focus on solutions that work at integrating care within the medical home. I would love to see legislation that strengthens integrative care models, improves reimbursement for mental health services, and supports existing models such as COPPCAP. There are better solutions than HB23-1071. Please vote no on this proposal.

January 30, 2023

To Whom It May Concern,

I am writing at the request of the Colorado Psychiatric Society to give insights into whether the mental health need in our community is being met now that we have medical psychologists approved in our state. I am a practicing psychiatrist in the state of Louisiana. I work for an academic medical school affiliated with the largest hospital in the state. The health system takes almost all forms of insurance and Medicaid.

In our clinic (which is a combination of faculty and residents), our current waiting list is 510 patients, 232 of whom are children. This list is in spite of medical psychologists practicing here as well as plethora of nurse practitioners.

Sincerely,

A handwritten signature in blue ink that reads "K Crapanzano, MD". The signature is fluid and cursive, with the first letter of "K" being a large loop.

Kathleen Crapanzano, MD  
Louisiana Psychiatrist  
kcrapanzano@pcaofbr.com



## **POLICY STATEMENT**

**Rates of suicide for adults and children in Colorado have steadily increased, with a noticeable impact from the COVID-19 pandemic and the resulting economic downturn. As the need for mental health interventions has increased, the number of prescribing psychologists has not. By expanding the number of psychologists with conditional prescription certificates, Coloradans experiencing severe mental health concerns will have greater access to specialized care in the forms of prevention and treatment. Envision:You strongly supports HB23-1071 in an effort to expand the behavioral health workforce and increase the number of available licensed psychologists with prescribing abilities for LGBTQ+ Coloradans.**

### **House Bill 23-1071 - Licensed Psychologist Prescriptive Authority**

House Bill 23-1071 as proposed would impact the membership of the State Board of Psychologist Examiners as well as provide opportunities for licensed psychologists to acquire a conditional prescription certificate. This bill requires the addition of 2 members to the State Board of Psychologist examiners and that 2 of the 9 members must be prescribing psychologists. The State Board of Psychologist Examiners oversees applications by licensed psychologists and will assess that psychologists have met criteria in specific educational, supervisory, and clinical requirements and will only be granted a conditional prescription certificate to prescribe psychotropic medications under the supervision of a licensed physician or advanced practice registered nurse. Psychologists with conditional status must also file all individual federal drug enforcement administration registrations and numbers with the State Board. Psychologists may receive prescriptive authority after 2 years of holding a conditional prescription certificate and the State Board determines the psychologist holds a current license in good standing, maintains malpractice insurance, and annually completes 20 hours of continuing education.

### **Why it Matters**

[The Colorado Psychological Association](#) found that as a state, Colorado residents have a high prevalence of serious mental health crises, as well as a significant shortage in mental health professionals throughout the state. When looking at the ratio of psychiatrists per 100,000 population, Colorado rates are lower than the national average. For individuals with marginalized identities, such as racial or ethnic minorities, indigenous communities, rural residents, low-

income populations, and the LGBTQ+ community, barriers to care increase due to systemic racism, homophobia, transphobia, and perceived or actual discrimination and harassment.

[The Colorado Health Institute](#) found that the rate of suicide deaths among Colorado residents aged 15-19 has increased with notable increases as a result of the COVID-19 pandemic, economic downturn, and growing awareness of the nation's racial injustices. [The Trevor Project](#) released a nationwide survey looking at the experiences of LGBTQ+ youth mental health by state and found that 45% of LGBTQ+ youth in Colorado seriously considered suicide in the past year, including 52% of transgender and nonbinary youth. [The Trevor Project](#) also found that 60% of LGBTQ youth in Colorado who wanted mental health care in the past year were not able to get it, often facing barriers around cost, transportation, parental support, or a lack of providers that affirm their LGBTQ+ identity.

Five states have established prescriptive authority for psychologists with additional training and education, which has yielded positive outcomes. Two of these states, New Mexico and Louisiana, found that deaths by suicide were reduced by 5-7% after implementing prescriptive authority policies. The additional education and training has been proven to be safe and effective for patients, and has led to psychologists feeling safer prescribing as well. According to the [Colorado Psychological Association](#), this bill has the potential to increase the number of specialized psychiatric providers in Colorado by approximately 35%. Providing more psychologists with prescriptive authority will increase access to comprehensive mental health services for children and adults navigating mental health conditions, particularly those who would benefit from specialized, prescription-based interventions, and are experiencing barriers to care.

For these reasons, Envision: You strongly supports HB23-1071.

#### Envision:You

Envision:You seeks to close gaps in behavioral health outcomes for LGBTQ+ individuals through co-created community programming, advocacy engagement, public awareness campaigns, and evidence-based training. To learn more please visit: [www.envision-you.org](http://www.envision-you.org).

For more information, please contact Steven Haden at [steven.haden@envision-you.org](mailto:steven.haden@envision-you.org).

February 1, 2023

Kristie Ladegard, MD  
Child and Adolescent Psychiatrist  
School-based Health Clinics

Good Afternoon Madame Chair Michaelson Jenet, Vice Chair Young, and Committee Members,

My name is Kristie Ladegard, MD and I am a child and adolescent psychiatrist who works in **school-based health clinics**. I am representing myself and the Colorado Child and Adolescent Psychiatric Society (CCAPS), not my employer. **I respectfully request a no vote on House Bill 1071.**

Rather than increasing access to care, allowing psychologists to prescribe could make wait times longer. I work in school-based health centers, and the wait time for a student to get neuropsychological testing, which can only be done by psychologists, is 6 months whereas they can often get a psychotropic medication evaluation within 24 hours through a telehealth platform and see a child and adolescent psychiatrist within 2 weeks. Without neuropsychological testing results, many insurance companies will not pay for occupational therapy or speech therapy and schools may not be able to provide needed accommodations. **Colorado cannot afford to shift psychologists away from therapy and testing only they are trained to do to prescribe medications, which they are not trained to do.**

I have included my comments below since I am not able to testify in person.

1. The demand for mental health services has been rising prior to COVID due to increased suicide rates in teens and several other factors.
2. In community settings such as school based clinics, we have seen an increase in the demand for more comprehensive behavioral health services such as individual therapy, accommodations in schools, family therapy, and neuropsychological testing.
3. For our system in the school clinics we are able to get youth in for psychotropic medication evaluation in 2 weeks, however our wait list for therapy is approximately 3 months, and to refer a youth for neuropsychological testing the wait list is 6 months or longer.
4. Psychologists are well trained to provide therapy and neuropsychological testing, however if their time is shifted to prescribe medications which they are not trained to do, this creates longer wait lists for both therapy and neuropsychological testing.
5. Youth on waiting lists for therapy do not just wait quietly, rather they often experience adverse outcomes such as hospitalization, failure in school, involvement with the juvenile justice system and the most negative outcomes include suicide and homicide.
6. Many youth who struggle significantly in school may be suffering from another mental health condition that often requires neuropsychological testing to confirm the diagnosis such as: intellectual disability, a

learning disorder, autism or a communication disorder etc.

7. Youth are unable to receive specialized services for many of these conditions until neuropsychological testing is completed since many insurance companies will not pay for occupational therapy, speech therapy etc. without an official diagnosis.

8. At school even when youth are struggling with these above conditions, they often do not receive educational accommodations until neuropsychological testing is completed. Once neuropsychological testing is completed it can really improve a child's life due to all the services they are able to receive and due to educational supports the school is able to provide.

9. I consult with 2 other school districts in the metro area and they are able to get a psychotropic medication evaluation for their students within 24 hours through a telehealth platform. However these two school districts still have wait lists for neuropsychological testing and sometimes therapy as well.

10. Telehealth and collaboration with pediatric providers has improved our ability to see patients for psychotropic medication appointments and patients no longer have to wait for a long time in between appointments.

I would be happy to answer any questions.

Thank you,

Kristie Ladegard, MD

# ADAM BURSTEIN, D.O., INC.

Board Certified Child, Adolescent & Adult Psychiatrist

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February 1, 2023

Dear House Public & Behavioral Health & Human Services Committee,

I greatly appreciate the opportunity to provide written testimony in strong opposition to HB-1071 on behalf of my colleagues and the Colorado Psychiatric Society and Colorado Child and Adolescent Psychiatric Society (CCAPS). I am a full-time private practice psychiatrist, board certified in treating children, adolescents, and adults, and a past president of CCAPS.

I am passionate about mental health and my role as a psychiatrist. Having had previous careers as a military officer and business consultant, I am pleased to say that I have found my passion in medicine. I want to outline some key reasons why I am – we are – so opposed to this legislation and will offer some very plausible alternate solutions.

It has been quite challenging to convey the seriousness and dangers of this proposed legislation. It's not that people can't learn what we do, it just takes a lot of time, training, and supervision. After a few drafts, I realize that there are a few main points I would like to convey.

1. **Uphold the extreme standards of medical professionals.** The rigorous standards of practicing medicine in the U.S. are unparalleled. Our training and licensing programs are world-renowned. Initially, I wrote an entire page outlining the *hundreds of hours* required in education and examination preparation that constitute prerequisites prior to *enrolling* in medical school. In my freshman class of medical school, 10% of practicing foreign doctors repeated medical school entirely to get the best education possible so that they could practice medicine in America. Having an accelerated track for psychologists to prescribe is akin to allowing physical therapists a fast track to prescribing pain medication and conducting surgery. Furthermore, having the American Psychological Association provide oversight over medical prescribing is a completely irresponsible.
2. **Prescribing medication is complicated.** Medical students take pharmacology during the second year of medical school. This course is commonly described as one of the more challenging courses of the year due to the complexity and volume of information. The course covers pharmacokinetics, pharmacodynamics, and requires an intimate understanding of the anatomy and physiology of all organ systems. There are over 80 FDA approved psychotropic medications that are prescribed on a regular basis in psychiatry. There are over a dozen more that are off-label. There are currently over 20,000 FDA approved drug products (<https://www.fda.gov/about-fda/fda-basics/fact-sheet-fda-glance>). This week alone, I have advised patients and parents about the risks, benefits, and potential side effects of dozens of medications. I discussed the concerns for hypothyroidism, increased creatinine functioning, tremors, weight gain, metabolic syndrome, medication toxicity, insomnia, akathisia, extra pyramidal symptoms, half-life, and platelet aggregation regarding concerns of excessive bleeding for a patient who is scheduled for a wisdom tooth extraction next month. While learn about the medications

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to treat mental health is achievable, psychiatrists and other medical prescribers learn the anatomy and physiology of every system of the body as well as drug-drug interactions. Moreover, there are special groups to consider when prescribing, i.e. children and adolescents, older adults, and pregnant women. Over a third of Americans currently take five or more prescription medications. (<https://www.merckmanuals.com/home/older-people's-health-issues/aging-and-medications/aging-and-medications>) In addition, I am currently supervising a nurse practitioner who has completed her degree and the 750 hours licensing required to be an independent practitioner. Nonetheless, she is incredibly knowledgeable, however, she still meets with me monthly because she felt that her training was inadequate and wants to feel more comfortable managing complicated cases.

3. **More medication is not necessarily the answer.** Lastly, has anyone even considered or questioned the notion that allow psychologists to prescribe more medication is the best approach to tackling mental health? More now than ever, I view medications as tools to help reduce symptoms so that individuals can do “the work” to live a healthier life. Psychologists have incredibly extensive training in psychotherapy – teaching individuals and families the tools that will help improve insight and overall functioning and health.

This is not a turf war. My strong opposition to this bill is about upholding the high medical standards in our country and utilizing the resources that we have. We already have highly trained professionals and clear pathways to licensing. Funding for mental health has been neglected for decades. Parity laws have been passed but not enforced. Insurance companies create unnecessary obstacles to care. Addressing these matters will help improve access, quality and at the same time, maintain our nation’s high standard of care.

The amount of time proposed for a psychologist to become a prescriber pales in comparison to the existing requirements of medical prescribers. I wouldn’t want to short cut the incredibly high standards of any professional, especially that of someone practicing medicine. Each specialty of medicine has their own boards, standards, and certification requirements. This way, every citizen knows that they have achieved at least the minimum standard of care. Changing this system would only decrease the confidence of every patient and defeat the purpose of this initiative entirely.

Psychologists have incredible expertise in diagnosis and treatment of mental health. Some of my closest friends and colleagues are psychologist. While I am extremely concerned about the lack of supply of prescribers, I would feel much more comfortable, having someone with a medical background, such as a pharmacist prescribe medication. The opportunity for primary care doctors to collaborate with pharmacists is a reasonable option and would achieve a much more accurate and safe solution than someone without any – or minimal – medical training.

America’s greatness is based partly on extremely high standards and enforcement of these standards. Medicine is no exception. Ultimately, if you decide to pass this bill, most physicians would vehemently advise you to require that all prescribers – including psychologists – be required to pass all three medical (STEP) exams, complete a residency in psychiatry and pass the American Board of Psychiatry and Neurology exam. At an absolute minimum, if a professional wants to practice medicine, have them meet the minimum standards set forth for nurse practitioners.

**ADAM BURSTEIN, D.O., INC.**

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If you should have any additional questions, please contact me by phone at 720-245-1125. Thank you for your attention in this matter.

Sincerely,

A handwritten signature in black ink, appearing to read "Adam Burstein D.O.", is centered below the word "Sincerely,". The signature is written in a cursive, flowing style.

Adam Burstein D.O.

Child, Adolescent & Adult Psychiatrist

NPI: 1114118742

CO License: DR 48075 (active)

## **Written Testimony Opposing HB23-1071**

**Provided by Autumn Orser, MD, FAAP**

**February 1, 20223**

As a pediatrician at a Federally Qualified Health Center, serving Colorado's most vulnerable population, I oppose HB23-10171. I share the goal of finding solutions to address Colorado's pediatric mental health crisis. However, this bill has associated risks and unintended consequences that could have substantial negative impacts on the children of Colorado.

Children are best served by wrap-around, whole-person care, which takes place in the medical home. There is an abundance of evidence that supports integrated medical and behavioral health in the primary care medical home. This model allows for clear communications, shared care plans with the family and all providers involved, and coordinated care. With HB23-10171, there is no clear path for a prescribing psychologist to communicate and share treatment plans. There are no requirements for an electronic health record and health information exchange. Due to the delicate nature of the pediatric developing mind and body, not having a shared treatment plan puts patients and providers at risk. As a primary care pediatrician, we ensure that weight, blood pressure, metabolic panels, organ systems, side effects, and interactions are monitored and that treatment plans are adjusted as necessary. Without complete information on the patient, it will be impossible to do this effectively and ensure the safety of our children.

Additionally, with HB23-10171, the gap in access has the potential to widen, not narrow for vulnerable populations. Patients who lack the means to pay out-of-pocket will not have increased access to independent prescribers who accept cash-only payments. This will worsen inequities that already exist in the system. A better way to address access needs is to focus on expanding the integrated healthcare model.

Furthermore, children benefit most from healthcare providers who have training and have expertise in the developing pediatric mind and body, who recognize the interplay of genetics and the mechanism of action of psychotropic medications, and who understand nuanced side effects and adverse events. A prescriber who is not fully trained and does not understand the intricacies of the pediatric patient puts our children at risk.

In order to address the pediatric mental health crisis in Colorado, let's focus our limited resources on expanding the gold standard of care, which is the integrated primary care medical home.



**Board of Advisors**

Elaine Heiby, Ph.D.  
Robert Klepac, Ph.D.  
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Tanya Tompkins, Ph.D.  
Timothy Tumlin, Ph.D.  
Richard Stuart, D.S.W.

## **Petition-Testimony **OPPOSE/VETO HB 23-1071****

### **A REQUEST TO OPPOSE LEGISLATION GRANTING PRESCRIPTION PRIVILEGES FOR PSYCHOLOGISTS (HB23-1071)**

We, the undersigned psychologists, along with other stakeholders concerned about quality healthcare, OPPOSE efforts to allow psychologists to prescribe medications. Prescribing by psychologists is different from other services provided by psychologists and is controversial, even among psychologists. The movement for prescriptive privileges originated within the Psychology profession. It was not championed by other stakeholders, such as patient advocacy or public health groups. 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. We are a diverse group of psychologists, including clinicians, educators, and researchers.

Psychologists have made major contributions to human health and wellbeing 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. Psychologists provide important clinical services including assessment, psychotherapy, and consultation, that adds substantially to the mental health of the communities where they serve. 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...even if they obtain the additional training advocated by the American Psychological Association. We consider the training model to be abbreviated, inadequate and inferior to that of physicians and other prescribing professionals.

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 medications should be prescribed only by professionals who have undergone suitable medical training that prepared them to manage these medications within the context of patients' overall health conditions. Patients have a right to expect that their medications will be managed by professionals whose education adequately trains them to understand their patients' health history, and assess their current health status as well as 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.

Unfortunately, the American Psychological Association's (APA) model for training doctoral psychologists to obtain limited training in psychopharmacology is minimalistic. It occurs after they complete graduate school, and does not match the levels required of other prescribing professionals (e.g., physicians, nurse practitioners, physician assistants, optometrists) in terms of their overall scientific foundation or their 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 clinical psychopharmacology. **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, chemistry, and other sciences) and has other inadequacies (e.g., lack of explicit requirements for supervision; no accreditation mechanism of programs).

It is noteworthy that the APA training model is substantially less rigorous than the training that the 10 psychologists undertook in the experimental program of the Department of Defense (DoD) that is often cited by proponents of psychologist prescribing. Despite the alarmingly small sample of that brief 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! In fact, the final report on the DoD project revealed that the psychologists were **"weaker medically"** than psychiatrists and compared their medical knowledge to **students** rather than physicians. We oppose psychologist prescribing because citizens who require medication deserve to be treated by fully trained and qualified health professionals rather than by individuals whose expertise and qualifications have been independently and objectively assessed to be at the student level. The training advocated by the APA that would be the basis of proposed legislation to enable psychologist prescribing is simply less rigorous than that of all other prescribers. This raises questions about the competence of psychologists who would seek to prescribe based on that training and about the safety, knowledge, and skill with which they would practice.

Research evaluating the master of science degree programs in clinical psychopharmacology that follow the APA model have revealed limitations of the training, criticized the inadequate prerequisites, and outlined how such training compares unfavorably to training of prescribers in other fields (i.e., physicians nurse practitioners, physician assistants).

**Proponents of psychologist prescribing have misleadingly invoked a range of unrelated issues to advocate for their agenda.** An article in the *American Journal of Law & Medicine* entitled, "Fool's Gold: Psychologists Using Disingenuous Reasoning To Mislead Legislatures Into Granting Psychologists Prescriptive Authority" critiques the rationales that advocates of prescription privileges use to promote their cause. Proponents point to problems in the healthcare system, such as the fact that rural and other populations 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 psychologists actually work. Other remedies are needed to address such problems that would not compromise the quality of care. For example, the marked increase of telehealth during the pandemic for example provides alternatives that enable prescribers to provide treatment remotely.

Other health professionals, including nurses and physicians, are concerned about psychologist prescribing. It is inappropriate to dismiss such concerns as a turf battle: There are legitimate concerns that the available training for psychologists to prescribe is too narrow and abbreviated. The International Society of Psychiatric-Mental Health Nurses position statement asserts, “nurses have an **ethical responsibility** to oppose the extension of the psychologist's role into the prescription of medications” due to concern about psychologists' inadequate preparation, even if they were to get *some* additional training, in accordance with the APA model. When it comes to prescribing psychoactive medications that have a range of potential therapeutic and adverse effects on the human body, including interactions with other medications, shortcuts to training are ill advised. Some psychoactive drugs come with black box warnings about their potential risks.

Another concern is the limited expertise of psychology regulatory boards 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 expertise, resources and systems to provide effective oversight of psychologist prescribing.

When considering this controversial cause, we urge legislators, the Governor, the media, and all concerned with the public health to take a closer look at the issues. Rather than permitting psychologists to prescribe, 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. This is an innovative, safer model of care delivery that draws on psychologists' strong assessment, psychotherapeutic, and consultative skills in providing patient care in conjunction with healthcare teams in primary care and specialty care settings and expands access to more coordinated mental health services for patients who need them.

In the decades since the American Psychological Association first proposed prescriptive authority for psychologists, very few states have passed it. The trivial impact of psychologist prescribing on the mental health services available is problematic. In the few states that have experimented with allowing psychologists to prescribe, very small minorities of psychologists have pursued it. The fact that so few psychologists could be expected to pursue the training suggests that the impact of allowing psychologists to prescribe is not likely to have substantive effects in expanding the number of prescribers or enhancing the quality of mental health services in your state. By contrast, in this same period, there have been large increases in the numbers of nurse practitioners and physician assistants who are now available to prescribe. Their training for managing medications is more extensive than psychologists who obtain limited, part-time training. The growth in the number of other prescribers has already expanded the number of health professionals who are adequately prepared to manage medications with holistic understanding of their patients' health. It has added far more prescribers than enabling psychologist prescribing would. Psychologists can collaborate with them as well as physicians in addressing the mental health needs of patients.

There are better and safer alternatives to psychologists prescribing that we believe will have a greater positive impact on mental health services. A more promising means for enhancing the mental health services available to all citizens than to allow psychologists to prescribe would be to dedicate efforts to better integrating mental health professionals, including psychologists, into the healthcare system, such as in primary care settings, where they can collaborate with other providers (including prescribers) in the care of people who may need medications and psychological services. The barriers to such care have been detailed in a recent report by the U. S. Department of Health and Human Services, *Reimbursement of Mental Health Services in Primary Care Settings*. Overcoming the barriers to such care is an objective upon which psychologists agree with each other, and with other health professionals, and is clearly in the public interest. It would improve the quality of mental health care available in urban and rural areas and would not rely on a training model that does not match that of the other types of health professionals who prescribe. Whereas we are pleased to refer patients to psychologist colleagues for various psychological services, we would not personally refer any patients to a psychologist who prescribes based on the American Psychological Association training model as proposed in this legislation.

**We respectfully request that you oppose HB23-1071 or similar legislation that would allow psychologists to prescribe based on training that we, and other health professionals, consider to be inadequate.**

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**Testimony in Opposition to HB23-1071**  
**Megan Stinar, MD, FAAP**  
**February 1, 2023**

My name is Megan Stinar. I am a pediatrician at Western Colorado Pediatrics and St. Mary's Hospital in Grand Junction. I have been practicing on the Western slope for the past 7 years. I oppose HB1071 and ask you to do the same.

The most difficult referral for me to make for the families whom I serve is to a therapist. They are few and far between on the Western Slope. Our wait lists for a therapist who offers therapeutic interventions such as counseling are months long, which is an impossible wait when a family is in crisis. I am able to prescribe medications if and when needed, and if I need more expertise, I can call the Colorado Pediatric Psychiatry Consultation and Access Program (CoPPCAP), and get support within an hour of calling.

Pediatric mental health is complex and nuanced. When evaluating a child or teen for a mental health diagnosis, I have to take in consideration the child's history, the family's history, their current developmental stage, family environment including the personalities of their parents and siblings, and family resources such as access to food. Getting the right diagnosis is the first step. And once a diagnosis is made, many are not best treated by medications, but therapy for either the child, parents or entire family unit.

In the past month I have had a school ask the parents to bring their 5-year-old child in to my office to discuss ADHD and medications. The school was threatening to kick him out of kindergarten because his behaviors were too difficult to manage. This is a family I have known since their first child was born, and I am familiar with some of the changes in the household. I was able to evaluate this child with our integrated behavioral health clinician in a few visits in my office. The child did have many symptoms that overlap with ADHD but the diagnosis was separation anxiety. If I had not known the family as well or had been rushed to make a diagnosis, I might have rashly prescribed a stimulant medication, which would have certainly increased this child's anxiety and behavioral problems, including aggression. Instead, the family entered child play therapy with our integrated therapist, in our office, and he is making huge improvements in just a few weeks. He has been able to stay in school, and at my last visit, he was telling me about all the great friends he was making at school.

Another common example that I see several times a week is a teen struggling with depression or anxiety. I tell families there are three major treatments for both anxiety and depression. One is to treat with medication, which gets fair results. Another is to work with a therapist, usually cognitive behavioral therapy, which gets much better results. And the third option is to use both medications AND therapy, which gets the best results. In addition to this, medication is not a long-term solution for teens. The goal of treatment for anxiety and depression is to give them the coping skills to manage their mental health as best as possible. This is done through therapy, not medication.

While this bill has intentions we strive for - addressing the mental health crisis, I do not think it is the best way to improve mental health in Colorado. Without a doubt, the most successful mental health treatments have been through integrated models, such as what we have in my clinic that allows collaboration and teamwork between the pediatrician and therapist. HB1071 does not increase access to this successful treatment for children or teens. Please vote no and let's work together to find better solutions to address Colorado's pediatric mental health crisis.

**Dana Krafchick, M.D.**

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**HB 23-1071 - A BILL FOR AN ACT CONCERNING THE AUTHORITY OF A  
LICENSED PSYCHOLOGIST TO PRESCRIBE PSYCHOTROPIC MEDICATION  
FOR THE TREATMENT OF MENTAL HEALTH DISORDERS.**

February 1, 2023

Dana Krafchick, MD

- Madame Chair and Committee Members, I appreciate the opportunity to provide written testimony. I am Dr. Dana Krafchick, member of the executive committee of the Colorado Child and Adolescent Psychiatric Society, and I am writing to testify in opposition of HB 1071 and to share my concerns about the proposal to allow psychologists to prescribe psychotropic medications.
- My focus is that although there is a mental health crisis for children and adolescents, prescribing more medication without a system of comprehensive care is not the answer.
- The state needs more good therapists, family therapists, in-home therapists, and wrap around services, not more prescribers.
- Medications are a band aid without comprehensive care, and because they are significantly cheaper than comprehensive care, there is a risk of overprescribing that increases as more providers are licensed to prescribe without a medical background
- Ironically, there are just as few private psychologists who take Medicaid as there are providers who are already licensed to prescribe. Giving prescribing privileges to psychologists will not address this flaw in the system, but it will increase the likelihood that children are prescribed medications by people without the medical background and experience to safely monitor them.
- The other big obstacle is financial coverage for mental health care, given the paucity of providers from any discipline who accept Medicaid, or any insurance for that matter.
- Thank you for allowing me to provide written testimony in opposition of prescriptive authority for psychologists.