

House Bill 30 Workgroup Meeting Minutes
Department of Health Professions
Board Room 2
9960 Mayland Drive, Henrico, VA 23233
Monday, August 17, 2026, at 10:00 a.m.

MEETING CHAIR: David Brown, D.C., Agency Director

WORKGROUP MEMBERS: Adam Kaul, MD
Aliya Chapman, Ph.D., LCP
Anita Clayton, MD
Gary Sibcy, Ph.D.
Honorable David Christian
James Morris, PhD
Jason Burton, MD
Jeremy Walden, PhD
L. Blanton Marchese
Lauren Webb, MD
William Hathaway, Ph.D., LCP

BOARD STAFF PRESENT: Jennifer Lang, Deputy Executive Director
Maria Stransky, LPC, CSOTP, CSAC, Executive Director
Meagan Ohlsson, Senior Licensing Specialist

DHP STAFF PRESENT: Caroline Juran, RPh, Executive Director
Erin Barrett, Director of Legislative Affairs and Policy, Department of Health Professions
Jennifer Deschenes, Deputy Executive Director
William Harp, MD, Executive Director

CALL TO ORDER: Dr. Brown called the meeting to order at 10:04 a.m.

MISSION STATEMENT: Dr. Brown read the mission statement of the Department of Health Professions and the emergency egress procedures.

ADOPTION OF AGENDA: The agenda was adopted as presented.

PUBLIC ATTENDEES: Colleen Grady-Koerner, Assistant Vice President of Government Affairs and Public Policy, Medical Society of Virginia (MSV)
Allyson Flinn, Assistant Director of Health Policy, Medical Society of Virginia (MSV)
Bo Keeney, Executive Director & Legislative Counsel, Virginia Academy of Clinical Psychologists (VACP)

PUBLIC COMMENT: Medical Society of Virginia (MSV) provided written public comment (Attachment A)

NEW BUSINESS:**Review of Current Directive**

Ms. Barrett reviewed the workgroup's objective to assess and vote on the conditions under which clinical psychologists may appropriately be granted prescription authority. Ms. Barrett stated that Senate Bill 752 directed the workgroup to identify the regulatory framework necessary to implement such authority, if approved by the General Assembly, including requirements for education, training, supervised experience, and licensure.

**DISCUSSION OF POTENTIAL
(REGULATORY)
FRAMEWORK:**

The workgroup discussed potential educational requirements, including post-baccalaureate or post-master's coursework in foundational sciences such as anatomy, physiology, biochemistry, molecular biology, and chemistry, as well as post-doctoral master's degree in clinical psychopharmacology. The workgroup further discussed variations in clinical prescription requirements across jurisdictions.

A consensus was reached in support of a post-doctoral Master of Science degree in clinical psychopharmacology and 24 months of post-degree supervised experience under the supervision of a physician, followed by a collaborative practice agreement with a physician upon receiving prescriptive authority. Such agreements would establish oversight requirements. The workgroup voted to have requirements regarding scope of practice and limitation of prescribing to mental and emotional disorders defined by statute.

The workgroup discussed collaborative practice options, including time limits before collaboration would no longer be required, collaborative practice agreements, and identification of the appropriate patient population. The workgroup reached consensus that any prescriptive authority should include ongoing collaborative practice and be limited to adults ages 18-65, excluding pregnant or postpartum individuals. The workgroup voted to have these requirements defined by statute.

RECESS:

The Board recessed at 11:48 a.m.

RECONVENTION:

The Board reconvened at 12:09 p.m.

The workgroup discussed the range of medications that could be prescribed by clinical psychologists. Following extensive discussion, and with two workgroup members opposing, a consensus was reached that prescriptive authority should only encompass Schedule IV medications and that REMS medications, opioids, and benzodiazepines should be prohibited.

The workgroup reached consensus in support of allowing clinical psychologists to prescribe Scheduled VI non-REMS medications, to adults, subject to appropriate education and experience requirements and physician-approved collaborative agreements. The workgroup voted to have these requirements defined by statute.

The workgroup also discussed the pathway of obtaining prescriptive authority and discussed the possibility that a separate license may be required, similar to the Virginia Advanced Practice Registered Nurse (APRN) license.

NEXT STEPS:

Ms. Barrett will draft the required report documenting the workgroup's discussion and consensus recommendations. Once drafted, other agency staff will review the report and provide feedback prior to its submission to the Chairs of the House Committee on Health and Human Services and the Senate Committee on Education and Health.

ADJOURNMENT:

Dr. Brown adjourned the meeting at 1:03 p.m.

August 14, 2026

Leroy B. Vaughan, Jr., M.D., President, Virginia Board of Medicine

William Hathaway, Ph.D., Board Chair, Virginia Board of Psychology

DELIVERED VIA ELECTRONIC MAIL: medbd@dhp.virginia.gov, psy@dhp.virginia.gov

Re: Concerns Regarding the Workgroup on Conditions for Prescriptive Authority for Licensed Clinical Psychologists

Dear Leroy Vaughan, Jr., M.D., and William Hathaway, Ph.D.,

The Medical Society of Virginia represents over 10,000 Virginia physicians, PAs, residents, and medical students of all specialties and localities across the Commonwealth. On behalf of these clinicians and the clinician associations undersigned on this letter, we offer the following public comment for consideration of the workgroup in its discussion of the appropriateness of granting prescriptive authority to licensed clinical psychologists (LCPs).

While the Medical Society of Virginia (MSV) and the undersigned clinician associations deeply value the essential role LCPs play in supporting the mental health of Virginians as members of the care team, and believe that granting prescriptive authority is not in the best interest of patient care. Our primary concern is patient safety, given the substantial differences between medical and psychological training. Safely prescribing psychotropic medications requires comprehensive knowledge of physiology, pharmacology, diagnostics, and the management of complex medical conditions—areas in which LCPs are not formally trained. Moreover, there is little evidence that expanding prescriptive authority to LCPs would meaningfully improve access to care, particularly in underserved areas. Finally, we believe it is vital to preserve the distinct, non-medicalized approach that LCPs bring to mental health care—a proven framework that could be compromised by expanding their scope of practice.

We maintain the stance from last year's workgroup on this topic, which is that there are no circumstances in which it would be appropriate for licensed clinical psychologists to prescribe here in Virginia. As a reminder, the workgroup from 2025 resulted in the following decision:

Workgroup discussions focused on the directives of SB752 and attempted to identify under what circumstances, if any, clinical psychologists should be granted prescriptive authority in Virginia. SB752 did not direct the workgroup to make a recommendation, and **the workgroup did not reach defined consensus on a path forward** [emphasis

added]. Some members strongly opposed prescriptive authority under any circumstances, while others may support it conditionally.¹

Despite the report's implication that a path forward was not reached because SB752 did not require the workgroup to develop recommendations, the workgroup was unable to reach consensus on the more fundamental question of whether LCPs should have prescriptive authority at all. Without consensus on that foundational issue, the workgroup cannot develop recommendations that would establish a viable path forward.

The letter below outlines the continued position that there are no circumstances in which it would be appropriate to grant prescriptive authority to licensed clinical psychologists (LCPs). This position is grounded in the risks to patient safety, the lack of evidence demonstrating that prescriptive authority would meaningfully improve access to care, and the stark differences in the education and clinical training of physicians and psychologists. The MSV and the undersigned clinician associations support a collaborative model of care that mitigates these risks to patients while preserving the distinct and valuable role LCPs play in patient care.

Patient Safety Risks and Vulnerable Populations

Psychotropic medications are among the most powerful drugs used in modern medicine, requiring comprehensive medical training for safe and effective prescribing. These medications exert broad and significant effects on multiple body systems, including the cardiovascular, metabolic, nervous, gastrointestinal, endocrine, and hematologic systems.² Even the most commonly prescribed medications carry a direct risk of fatal events and increased morbidity.³ Anecdotally, MSV members surveyed emphasized an extreme hesitancy towards prescribing psychotropic medication due to their risks of broad-ranging and severe effects on patient health.

In addition to the inherent risks of prescribing psychotropic medications, LCPs lack the medical training and legal authority to conduct comprehensive evaluations necessary for safe prescribing. Numerous medical conditions, including thyroid dysfunction, neurological

¹ Report regarding prescriptive authority for clinical psychologists pursuant to SB752 of the 2025 General Assembly Session

² Tueth, M. J. (1994). Emergencies caused by side effects of psychiatric medications. *The American Journal of Emergency Medicine*, 12(2), 212–216.
[https://doi.org/10.1016/0735-6757\(94\)90248-8](https://doi.org/10.1016/0735-6757(94)90248-8)

³ Ibid.

disorders, or infections, can closely mimic psychiatric symptoms.^{4,5,6,7} Failure to identify potential underlying medical issues can result in serious harm or even death. Unlike psychiatrists, LCPs are not equipped with the diagnostic tools and training needed to rule out additional clinical diagnoses before pursuing serious psychopharmacological interventions. Furthermore, many commonly prescribed psychotropic medications require regular blood tests to monitor life-threatening side effects.⁸ LCPs are not authorized to order or interpret these diagnostic or laboratory tests, which compromises patient safety when managing complex medication regimens.

Patient safety concerns are most acute among our most vulnerable populations, including children, older adults, individuals with substance use disorders, and those with serious mental illness (SMI). The heightened medical risks associated with psychotropic medications in these groups demand a prescriber who is extensively trained in pharmacology and its effects on the entire body.

While many psychotropic medications are prescribed across age groups, their effects can vary substantially. In pediatric patients, developmental differences in drug metabolism and sensitivity carry increased risk compared to the adult population.⁹ In addition to the well-documented risk of increased suicidality, psychotropic medications in children are also associated with adverse cardiometabolic effects and reduced bone mineral density, which can have lasting consequences for lifelong health.^{10,11}

The geriatric population is similarly vulnerable to increased risks of adverse side effects of psychotropic medications. Aging is associated with a slowed metabolism and altered drug clearance, which makes the elderly population more susceptible to side effects like sedation, confusion, or falls from psychotropic medications.¹² This population is also at an increased risk

⁴ Nuguru, S. P., Rachakonda, S., Sripathi, S., Khan, M. I., Patel, N., & Meda, R. T. (2022). Hypothyroidism and Depression: A Narrative Review. *Cureus*, 14(8), e28201. <https://doi.org/10.7759/cureus.28201>

⁵ Madhusoodanan, S., Ting, M. B., Farah, T., & Ugur, U. (2015). Psychiatric aspects of brain tumors: A review. *World journal of psychiatry*, 5(3), 273–285. <https://doi.org/10.5498/wjp.v5.i3.273>

⁶ Bean, P., Heck, A., Habis, R., Sowmitran, S., Cartaina, Z., Gupta, R., Probasco, J., Hasbun, R., & Venkatesan, A. (2025). Psychiatric manifestations of encephalitis. *Annals of clinical and translational neurology*, 12(2), 405–414. <https://doi.org/10.1002/acn3.52260>

⁷ Cebeci, A. N., & Güven, A. (2012). Delirium in diabetic ketoacidosis: a case report. *Journal of clinical research in pediatric endocrinology*, 4(1), 39–41. <https://doi.org/10.4274/Jcrpe.478>

⁸ Paton, C., & Beer, D. (1996). Blood tests for patients prescribed psychotropics: what, when and why? *Psychiatric Bulletin*, 20(6), 356–358. doi:10.1192/pb.20.6.356

⁹ Sareen, H., & Trivedi, J. K. (2013). Child psychopharmacology: Is it more similar than different from adult psychopharmacology?. *Indian journal of psychiatry*, 55(3), 301–304. <https://doi.org/10.4103/0019-5545.117158>

¹⁰ Solmi, M., Fornaro, M., Ostinelli, E. G., Zangani, C., Croatto, G., Monaco, F., et al. (2020). Safety of 80 antidepressants, antipsychotics, anti-attention-deficit/hyperactivity medications and mood stabilizers in children and adolescents with psychiatric disorders: A large scale systematic meta-review of 78 adverse effects. *World Psychiatry*, 19(2), 214–232. <https://doi.org/10.1002/wps.20765>

¹¹ Feuer, A. J., Demmer, R. T., Thai, A., & Vogiatzi, M. G. (2015). Use of selective serotonin reuptake inhibitors and bone mass in adolescents: An NHANES study. *Bone*, 78, 28–33. <https://doi.org/10.1016/j.bone.2015.04.042>

¹² Balam, K., & Balachandran, S. (2022). Psychopharmacology in the Elderly: Why Does Age Matter?. *The Psychiatric clinics of North America*, 45(4), 735–744. <https://doi.org/10.1016/j.psc.2022.07.004>

of additional medical conditions, such as urinary tract infections, and neurodegenerative conditions, such as dementia or Parkinson's disease, all of which may manifest as psychological symptoms. Misdiagnosis and treatment of these conditions as psychiatric disorders can prolong treatment and even worsen symptoms or mortality.^{13,14,15}

In addition to the risks of adverse reactions from psychotropic medications, medical oversight is essential when treating patients with co-occurring physical and psychological conditions. Data suggests that patients with SMI comprise over one-third of the adult population who receive mental health treatment.¹⁶ In addition to the heightened severity of their psychological condition, individuals with SMI are more likely to experience comorbid physical health conditions. Patients with SMI have an excess mortality two to three times greater than the general population and a 13-30 year shortened life expectancy.¹⁷ These overlapping health challenges increase the complexity of care and significantly elevate the risk of adverse outcomes, particularly when psychotropic medications are involved.

Differences in Training Between Psychiatrists and Licensed Clinical Psychologists

A closer look at the educational requirements for psychiatrists and LCPs reveals why prescriptive authority should remain within the scope of medically trained professionals. As physicians, psychiatrists complete four years of medical school during which they receive extensive education in pharmacology and its integration into all branches of medicine, including psychiatry. Their understanding of pharmacotherapy, including implications for every organ system is tested as a component of the United States Medical Licensing Examination.¹⁸

After medical school, psychiatry residents undergo more than four additional years of intensive supervised training, completing 12,000 to 16,000 hours of patient care across diverse clinical settings. This hands-on experience allows them to develop deep clinical judgment and manage complex cases involving co-occurring medical and psychiatric conditions. Such rigorous

¹³ Weintraub, D., Chen, P., Ignacio, R. V., Mamikonyan, E., & Kales, H. C. (2011). Patterns and trends in antipsychotic prescribing for Parkinson disease psychosis. *Archives of neurology*, 68(7), 899–904. <https://doi.org/10.1001/archneurol.2011.139>

¹⁴ Dutta, C., Pasha, K., Paul, S., Abbas, M. S., Nassar, S. T., Tasha, T., Desai, A., Bajgain, A., Ali, A., & Mohammed, L. (2022). Urinary Tract Infection Induced Delirium in Elderly Patients: A Systematic Review. *Cureus*, 14(12), e32321. <https://doi.org/10.7759/cureus.32321>

¹⁵ Marcinkowska, M., Śniecikowska, J., Fajkis, N., Paśko, P., Franczyk, W., & Kołaczkowski, M. (2020). Management of Dementia-Related Psychosis, Agitation and Aggression: A Review of the Pharmacology and Clinical Effects of Potential Drug Candidates. *CNS drugs*, 34(3), 243–268. <https://doi.org/10.1007/s40263-020-00707-7>

¹⁶ National Institute of Mental Health. (n.d.). Mental illness. U.S. Department of Health and Human Services, National Institutes of Health. <https://www.nimh.nih.gov/health/statistics/mental-illness>

¹⁷ Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I., Detraux, J., Gautam, S., Möller, H., Ndeti, D. M., Newcomer, J. W., Uwakwe, R., & Leucht, S. (2011). Physical illness in patients with severe mental disorders: I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, 10(1), 52–77. <https://doi.org/10.1002/j.2051-5545.2011.tb00014.x>

¹⁸ United States Medical Licensing Examination. (n.d.). Exam resources. Retrieved June 24, 2025, from <https://www.usmle.org/exam-resources>

medical training is essential to ensuring the safe, effective use of pharmacological treatments in mental health care.

In contrast, LCPs typically complete three years of graduate coursework, followed by a one-year internship and 1,500 hours of supervised clinical experience. In Virginia, licensure regulations for LCPs require only a single 3-credit course in the biological bases of behavior.¹⁹ Among the eight universities in the state with active accreditation from the American Psychological Association, none require hard science prerequisites for admission, and none include psychopharmacology in their core curricula. Only three programs offer psychopharmacology as an elective, significantly limiting students' exposure to essential knowledge about the biological and pharmacological dimensions of mental health treatment.

The stark difference in training between psychiatrists and LCPs demonstrates the critical importance of extensive medical education and clinical experience in safely managing pharmacological treatments. Psychiatrists' rigorous and comprehensive training equips them to understand the complex interactions, side effects, and medical considerations essential for prescribing psychiatric medications responsibly. In contrast, licensees whose training requires only a singular hard science course are woefully unprepared to assume the significant risks involved in prescribing these powerful medications.

Granting Prescriptive Authority to Licensed Clinical Psychologists Will Not Improve Patient Access or Care

Despite legislative approval in some states, uptake of prescriptive authority among LCPs has remained minimal, casting serious doubt on its effectiveness as a strategy to expand access to mental health care. As of March 2024, only 226 LCPs had obtained prescriptive authority, representing less than 2% of the LCP workforce in applicable states.²⁰

Due to the small number of prescribing LCPs, high-quality research on the impact of prescriptive authority on access to mental health care remains limited. Attempts at simulated research models to predict the impact of prescriptive authority on access to care exclude vital determinants of access, including the geographic distribution of providers, as well as the presence of primary care physicians and other advanced practiced clinicians with prescriptive authority.²¹

¹⁹ Virginia Administrative Code, 18VAC125-20-54. Education requirements for clinical psychologists.

²⁰ Robiner, W. N., & Tompkins, T. L. (2025). The Workforce of Prescribing Psychologists: Too Small to Matter? Worth the Cost? *Clinical Psychology* (New York, N.Y.), 32(2), 193–201. <https://doi.org/10.1037/cps0000253>

²¹ Hughes, P. M., McGrath, R. E., & Thomas, K. C. (2024). Simulating the Impact of Psychologist Prescribing Authority Policies on Mental Health Prescriber Shortages. *Professional psychology, research and practice*, 55(2), 140–150. <https://doi.org/10.1037/pro0000560>

Available data from New Mexico and Louisiana—states where psychologists have had prescriptive authority for over two decades—suggests that prescribing psychologists primarily serve patients who are demographically akin to those seen by psychiatrists.²² Moreover, data suggests that LCPs in New Mexico and Louisiana primarily treat patients in urban areas rather than rural areas, offering little evidence that prescriptive authority improves access in underserved rural communities.²³

According to the Virginia Health Care Foundation (VHCF), 54 Virginia localities had no practicing psychiatrist as of June 2021.²⁴ Comparing similar VHCF data on the number of full-time equivalent (FTE) LCPs by locality, data suggests that even under a highly optimistic scenario—assuming 10% of LCPs across all regions obtain prescriptive authority—only 6 of the 54 underserved localities would gain access to a mental-health specific prescriber if prescriptive authority is granted to LCPs.^{25,26}

In addition to geographic barriers, the limited acceptance of common payment methods of underserved communities poses an additional barrier to access. Only 17% of LCPs in Virginia accept Medicaid, and only 36% accept private insurance, making cash/self-pay the most accepted form of payment for psychologists in Virginia (59%).²⁷ Moreover, Medicare beneficiaries would likely be excluded, as Medicare does not reimburse psychologists for pharmacologic management due to their insufficient medical training in evaluation and prescribing.²⁸

Support for a Collaborative Model to Ensure Patient Safety and Preserve the Unique Non-Medical Contributions of Licensed Clinical Psychologists in Mental Health Treatment

LCPs are trained to diagnose and treat patients using a behavioral and psychological evidence-based approach that is distinct from the medical model of care. This separation from pharmacological treatment allows patients access to a broader range of therapeutic options

²² Hughes, P. M., Niznik, J. D., McGrath, R. E., Tak, C. R., Christian, R. B., Sleath, B. L., & Thomas, K. C. (2024). Demographics and clinical characteristics of patients of prescribing psychologists, psychiatrists, and primary care physicians. *The American psychologist*, 10.1037/amp0001352. Advance online publication. <https://doi.org/10.1037/amp0001352>

²³ Tompkins, T. L., & Johnson, J. D. (2016). What Oregon Psychologists Think and Know About Prescriptive Authority: Divided Views and Data-Driven Change. *Journal of Applied Biobehavioral Research*, 21(3), 126–161. <https://doi.org/10.1111/jabr.12044>

²⁴ Virginia Health Care Foundation (2021). Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce, Psychiatrists by Locality June 2021. <https://www.vhcf.org/wp-content/uploads/2022/01/Psychiatrists-By-Virginia-Locality-June-2021.pdf>

²⁵ Ibid.

²⁶ Virginia Health Care Foundation (2020). Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce, FTE Licensed Clinical Psychologist by Locality 2020. <https://www.vhcf.org/wp-content/uploads/2022/01/FTE-Licensed-Clinical-Psychologists-by-Locality-2020.pdf>

²⁷ Virginia Department of Health Professions, Healthcare Workforce Data Center (2026). Virginia's Licensed Clinical Psychologist Workforce: 2026. <https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/behsci/0810CP2026.pdf>

²⁸ Centers for Medicare & Medicaid Services. (2013, December 10). Medicare and Medicaid Programs: Revisions to payment policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, and other revisions to Part B for calendar year 2014 (CMS-1600-FC; Final rule). *Federal Register*, 78(236), 77794–79162. (FR Doc. 2013-28696)

tailored to their individual needs. Psychiatry and psychology are complementary disciplines, each contributing essential expertise to a comprehensive mental health care system.

The movement to grant LCPs prescriptive authority remains highly contested within the field. Surveys show that less than half of LCPs express support for expanding the scope of practice to include prescribing.^{29,30} While some proponents argue that psychological training would serve as a preventative measure against overprescribing, studies on prescribing practices of LCPs indicate that a majority of licensees prescribe medications to a majority of their patients.^{31,32}

A collaborative care model in which LCPs provide psychotherapy and behavioral interventions in collaboration with a medical provider who is trained to prescribe and manage pharmacological treatment is already an established and well-functioning approach.³³ As healthcare becomes increasingly integrated, this team-based model ensures patients receive comprehensive, coordinated care without compromising safety. Given the effectiveness of this existing framework, there is no need to introduce the risks associated with expanding prescriptive authority to professionals whose training does not follow the rigorous medical standards required for safe medication management.

Primary care physicians and advanced practice clinicians are more appropriate providers to fill the gap in access to psychiatric care. These providers receive the medical education and training required to manage pharmacological treatment safely and effectively. At the same time, the physician psychiatric workforce is growing to meet demand. As of 2024, the number of students matching into psychiatric residency programs increased for the 13th year in a row.³⁴

Conclusion

The safety and well-being of patients must remain the foremost priority in any decision regarding changes to clinical scope of practice. While LCPs play a vital and valued role in Virginia's mental health care system, the significant disparities in medical training between

²⁹ Prescriptive Authority for Psychologists: Despite Deficits in Education and Knowledge? (2003). *Journal of Clinical Psychology in Medical Settings*, 10(3), 211–221. <https://doi.org/10.1023/A:1025419114038>

³⁰ Tompkins, T. L., & Johnson, J. D. (2016). What Oregon Psychologists Think and Know About Prescriptive Authority: Divided Views and Data-Driven Change. *Journal of Applied Biobehavioral Research*, 21(3), 126–161. <https://doi.org/10.1111/jabr.12044>

³¹ Peck, K. R., McGrath, R. E., & Holbrook, B. B. (2021). Practices of Prescribing Psychologists: Replication and Extension. *Professional Psychology, Research and Practice*, 52(3), 195–201. <https://doi.org/10.1037/pro0000338>

³² Linda, W. P., & McGrath, R. E. (2017). The Current Status of Prescribing Psychologists: Practice Patterns and Medical Professional Evaluations. *Professional Psychology, Research and Practice*, 48(1), 38–45. <https://doi.org/10.1037/pro0000118>

³³ Reist, C., Petiwala, I., Latimer, J., Raffaelli, S. B., Chiang, M., Eisenberg, D., & Campbell, S. (2022). Collaborative mental health care: A narrative review. *Medicine*, 101(52), e32554. <https://doi.org/10.1097/MD.00000000000032554>

³⁴ Moran, M. (2024). Number of students matching into psychiatry increases for 13th year. *Psychiatric News*, 59(5), 36. <https://doi.org/10.1176/appi.pn.2024.05.5.36>

LCPs and physicians underscore the substantial risks of expanding prescriptive authority to non-medical professionals. The use of psychotropic medications, especially in vulnerable populations, requires a deep understanding of pharmacology and its effects on the entire body in order to safely manage the complex interplay of medical and psychiatric conditions. Given these realities, it is incumbent upon the Boards of Psychology and Medicine to act with prudence and uphold their responsibility to protect patient safety.

Granting prescriptive authority to providers without medical education and clinical training poses an unacceptable risk to the health and lives of patients across the Commonwealth. We urge the Boards to preserve the distinct, non-medicalized role of LCPs and to support collaborative care models that leverage the complementary strengths of psychology and medicine.

To discuss this matter or written comment further, please contact Colleen Grady-Koerner at cgrady@msv.org or 571-438-1142.

Sincerely,



Colleen Grady-Koerner
Assistant Vice President of Government Affairs and Public Policy
The Medical Society of Virginia



Shariff Tanious, MD, FAPA
President
Psychiatric Society of Virginia





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A handwritten signature in black ink that reads "Verneeta L. Williams, MD". The signature is fluid and cursive.

Verneeta L. Williams, MD, FAAFP
President
Virginia Academy of Family Physicians



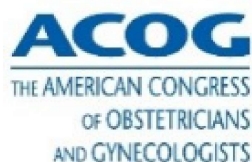
A handwritten signature in black ink that reads "Joran Sequeira". The signature is cursive and stylized.

Joran Sequeira, MD
President
Virginia College of Emergency Physicians



A handwritten signature in black ink that reads "Carrie Sopata". The signature is cursive and stylized.

Carrie Sopata, MD
Chair
Virginia Section of the American College Obstetricians and Gynecologists





ATTACHMENT A

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Devon Possanza

Devon Possanza, CMP
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Percita L. Ellis MD, FAAP

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CC:

Colleen Grady-Koerner, Assistant Vice President of Government Affairs and Public Policy/MSV
Scott Castro, Senior Director of Health Policy/MSV
W. Scott Johnson, Esquire/Hancock, Daniel & Johnson, General Counsel/MSV
Tyler S. Cox, Government Affairs Manager/Hancock, Daniel & Johnson
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