Boards of Psychology and Medicine Workgroup
HB30

Monday, August 17, 2026
10:00 am

Perimeter Circle
9960 Mayland Drive, Suite 201, Board Room 2
Henrico, VA 23233

Call to Order

Emergency Egress Procedures

Introduction of Workgroup Members

Adoption of Agenda

Public Comment on Agenda Items

New Business

1. Review of prior workgroup meetings
    a. July 9, 2025 minutes …… 2
    b. August 15, 2025 minutes…… 96
    c. Report regarding prescriptive authority for clinical psychologists pursuant to SB752 of the 2025 General Assembly Session …… 122

2. Current directive to the workgroup …… 139

3. Mandate for and assumptions of the current workgroup

4. Educational options

5. Collaborative practice options

6. Scope of practice

7. Pathway for allowance

8. Adjourn

Senate Bill 752 Workgroup Meeting Minutes
Department of Health Professions
Board Room 1
9960 Mayland Drive, Henrico, VA 23233
Wednesday, July 9, 2025, at 10:00 a.m.

MEETING CHAIR: Jaime Hoyle, JD, Executive Director

WORKGROUP MEMBERS:
Adam Kaul, MD
Aliya Chapman, Ph.D.
Anita Clayton, MD
Elliott Lucas, MD
Gary Sibcy, Ph.D.
James Morris, PhD
Jason Burton, MD
Jeremy Walden, PhD
Krishna Madiraju, MD
Lauren Webb, MD
Sonal Pancholi Doran, Psy.D., LCP
William Hathaway, Ph.D., LCP

BOARD STAFF PRESENT:
Caroline Juran, RPh, Executive Director
Charlotte Lenart, Deputy Executive Director
Jennifer Lang, Deputy Executive Director
Meagan Ohlsson, Licensing Supervisor
William Harp, MD, Executive Director

DHP STAFF PRESENT:
Arne Owens, Agency Director, Department of Health Professions
Erin Barrett, Director of Legislative Affairs and Policy, Department of Health Professions

CALL TO ORDER: Ms. Hoyle called the meeting to order at 10:06 a.m.

MISSION STATEMENT: Ms. Hoyle 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:
Aimee Seibert, Virginia College of Emergency Physicians (VACEP)
Bo Keeney, Virginia Academy of Clinical Psychologist (VACP)
Richard Webb
Scott Castro, Medical Society of Virginia (MSV)

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

Psychiatric Society of Virginia (PSV) and the Northern Virginia Chapter of the Washington Psychiatric Society (WPS), provided written comment (Attachment B)

Virginia Chapter of the American Academy of Pediatrics (VA-AAP), provided written comment (Attachment C)

Virginia Academy of Physician Assistants (VAPA) provided written comment (Attachment D)

University of Virginia Center for Telehealth, provided written comment (Attachment E)

Virginia Academy of Clinical Psychologist (VACP), provided written comment (Attachment F)

Virginia College of Emergency Physicians (VACEP, provided written comment (Attachment G)

OVERVIEW OF SENATE BILL 752 (FAVOLA)

Ms. Barrett and Ms. Hoyle provided information on Senate Bill 752 which directs the Board of Psychology and Medicine to jointly convene a workgroup to study the education, training, and qualifications of clinical psychologists licensed in the Commonwealth and assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority. Ms. Barrett and Ms. Hoyle provided background information, the history and examples of education and supervised experience requirements in other jurisdictions that permit and regulate prescriptive authority for clinical psychologists. (Attachment H)

DISCUSSION SUMMARY:

The workgroup discussed a range of issues related to prescriptive authority, including access to care, whole-body healthcare, the role of research, and the responsibility of regulators to ensure public safety. Additional topics included testing, interdisciplinary collaboration, the rise in mental health needs among children, and the importance of providing practical solutions. Members explored the possibility of a middle ground, noting that certain settings may be more appropriate than others. Telehealth, substance use disorders, pregnant women—and the potential for carving out specific medications or patient populations were also considered. The group discussed the related training, education, and supervision requirements for physician assistants and nurse practitioners for context.

RECESS: The Board recessed at 12:00 p.m.

RECONVENTION: The Board reconvened at 12:45 p.m.

The workgroup reviewed and discussed the designation criteria for education and training programs in psychopharmacology for prescriptive authority approved by the American Psychological Association (APA). (Attachment I)

NEXT STEPS: The workgroup will reconvene for further discussion.

NEXT MEETING DATE: The next workgroup meeting is scheduled for August 15, 2025.

ADJOURNMENT: Ms. Hoyle adjourned the meeting at 2:42 p.m.

ATTACHMENT A

MEDICAL SOCIETY OF VIRGINIA

2924 Emerywood Parkway
Suite 300
Richmond, VA 23294

TF 800|746-6768
FX 804|355-6189

www.msv.org

July 1, 2025

John R. Clements, DPM, President, Virginia Board of Medicine
Aliya Chapman, Ph.D., Board Chair, Virginia Board of Psychology
DELIVERED VIA ELECTRONIC MAIL: medbd@dhp.virginia.gov, psy@dhp.virginia.gov

Re: Medical Society of Virginia Concerns on SB 752 Work Group on Conditions for Prescriptive Authority for Licensed Clinical Psychologists

Dear John R. Clements, DPM and Aliya Chapman, 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, 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 deeply values the essential role LCPs play in supporting the mental health of Virginians as members of the care team, we 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.

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.[1] Even the most commonly prescribed medications carry a direct risk of fatal events and increased morbidity. [2] Anecdotally, MSV members surveyed emphasized an extreme hesitancy towards prescribing

[1] 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
[2] Ibid.

2924 Emerywood Parkway
Suite 300
Richmond, VA 23294

TF 800|746-6768
FX 804|355-6189

www.msv.org

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, licensed clinical psychologists (LCPs) lack the medical training and legal authority to conduct comprehensive evaluations necessary for safe prescribing. Numerous medical conditions, including thyroid dysfunction, neurological disorders, or infections, can closely mimic psychiatric symptoms.[3,4,5,6] 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.[7] 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.[8] In addition to the well-documented risk of increased suicidality, psychotropic medications in children are also

[3] 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

[4] 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

[5] 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

[6] 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

[7] 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

[8] 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

2924 Emerywood Parkway
Suite 300
Richmond, VA 23294

TF 800|746-6768
FX 804|355-6189

www.msv.org

associated with adverse cardiometabolic effects and reduced bone mineral density, which can have lasting consequences for lifelong health. [9,10]

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.[11] This population is also at an increased risk 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.[12,13,14]

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.[15] 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.[16] These overlapping health

---

[9] 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

[10] 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

[11] Balaram, 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

[12] 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

[13] 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

[14] 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

[15] 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

[16] Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I., Detraux, J., Gautam, S., Möller, H., Ndetei, 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

2924 Emerywood Parkway
Suite 300
Richmond, VA 23294

TF 800|746-6768
FX 804|355-6189

www.msv.org

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 licensed clinical psychologists (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.[17]

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 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.[18] 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

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

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

2924 Emerywood Parkway
Suite 300
Richmond, VA 23294

TF 800|746-6768
FX 804|355-6189

www.msv.org

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 licensed clinical psychologists (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.[19]

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.[20]

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.[21] 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.[22]

[19] 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

[20] 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

[21] 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

[22] 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

MSV℠ MEDICAL SOCIETY OF VIRGINIA

2924 Emerywood Parkway
Suite 300
Richmond, VA 23294

TF 800|746-6768
FX 804|355-6189

www.msv.org

According to the Virginia Health Care Foundation (VHCF), 54 Virginia localities had no practicing psychiatrist as of June 2021.[23] Comparing similar VHCF data on the number of full-time equivalent (FTE) licensed clinical psychologists 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.[24,25]

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 34% accept private insurance, making cash/self-pay the most accepted form of payment for psychologists in Virginia (57%).[26] 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. [27]

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

Licensed clinical psychologists (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 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 licensed clinical psychologist express support for

---

[23] 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

[24] Ibid.

[25] 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

[26] Virginia Department of Health Professions, Healthcare Workforce Data Center (2024). Virginia's Licensed Clinical Psychologist Workforce: 2024. https://www.dhp.virginia.gov/media/dhpweb/docs/hwdc/behsci/0810CP2024.pdf

[27] 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)

2924 Emerywood Parkway
Suite 300
Richmond, VA 23294

TF 800|746-6768
FX 804|355-6189

www.msv.org

expanding the scope of practice to include prescribing.[28,29] 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.[30,31]

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.[32] 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.[33]

Conclusion

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

[28] 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
[29] 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
[30] 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
[31] 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
[32] 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.0000000000032554
[33] 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

MSV SM MEDICAL SOCIETY OF VIRGINIA

2924 Emerywood Parkway
Suite 300
Richmond, VA 23294

TF 800|746-6768
FX 804|355-6189

www.msv.org

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 Counseling 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 Clark Barrineau at cbarrineau@msv.org or 704-609-4948.

Sincerely,

M. Clark Barrineau
Vice President of Government Affairs and Public Policy
The Medical Society of Virginia

DRAFT 6.17.25

To: William Harp, Board of Medicine

Jaime Hoyle, Board of Psychology

Re: SB 752 work group on prescriptive authority

On behalf of the Psychiatric Society of Virginia (PSV) and the Northern Virginia Chapter of the Washington Psychiatric Society (WPS), we thank you for organizing the work group required by SB 752 "*to study the education, training, and qualifications of clinical psychologists licensed in the Commonwealth, including the level of education and training clinical psychologists receive in the area of pharmacology, and assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority*." Exploring proposals to expand access to high quality mental health care in Virginia is at the forefront of our legislative advocacy efforts. It is a wise step that this work group convenes knowledgeable health professionals to discuss a proposal that would be a dramatic departure from status quo. We want policy makers to have the information to make the right decision about patient safety.

We look forward to contributing to an extensive and robust discussion on prescriptive authority and the education and training necessary to ensure high quality and safe care delivered to Virginians. Psychiatric medications, some of the most complicated used in health care, affect not only the mind but also the entire body and can interact intensely with other drugs. This is a heightened concern when considering side effects, contraindications, dosage, and timing. More than half of patients living with mental illness also have an underlying physical illness. As such, our organizations advocate that advanced medical training is required to best understand how and when psychiatric drugs should be included in patient care.

Standards and Limitations to Ensure Safety and Quality

As you are aware, there are substantial and meaningful differences in the level of education, training, and experience between professionals trained for medical care versus non-medical care. Physicians, nurse practitioners, and physician assistants are in medical disciplines where these professionals study and train to effectively diagnose and treat illness, injury, and conditions impacting the entire human body. Clinical psychologists and other valued mental health professionals study social and environmental processes and related behaviors and provide important services. However, psychologists do not attend medical school and therefore do not have critical science requirements in areas like anatomy, biology, genetics, physiology, pathology, and pharmacology that psychiatrists and other prescribing professionals receive. Even with postdoctoral training, clinical psychologists will not have the scientific medical foundation important to safe prescribing and, more importantly, they will not have the supervised clinical training that psychiatrists and other physicians receive in residencies, or that NPs and PAs have in preceptorships and on medical teams.

Expanding Access Must Prioritize Quality and Equity

When it comes to the problem of access to mental health care, granting prescriptive authority is not proven to be effective. In the seven states that allow clinical psychologists to prescribe medication, there have been very few who undergo the additional education required and those who have are not migrating out of densely populated areas. Therefore, the idea that this would relieve access problems in underserved communities (or medical deserts), is unsubstantiated at best. We believe that other solutions to this problem exist. Evidence-based models like telepsychiatry and Collaborative Care enable psychiatrists and primary care providers to deliver great quality of care to rural and isolated areas of the Commonwealth. Investment and expansion in these models is currently helping get high quality psychiatric care to more Virginians. Lowering standards for prescribing psychotropic medications is not only unfair to patients in well-served communities, it lacks any evidence that that access to care is expanded.

Psychiatrists are Here to Discuss What is Best for Patients

We are eager and willing to participate openly in this very important study. We are providing materials that should help work group members, regulatory leadership, and legislators understand the factors to be considered when determining which health professionals should be granted prescriptive authority. Forty-three states have current laws similar to Virginia and many states have recently rejected the proposal to give psychologists the ability to prescribe.

Please let us know how we can be of further assistance. We have psychiatrists in virtually every subspecialty and practice environment who can offer perspectives about their patients and how to maintain high standards while reaching more.

Sincerely,

Karl W. Northwall, MD

President, Psychiatric Society of Virginia

Todd Cox, MD, DFAPA

President, Northern Virginia Chapter, Washington Psychiatric Society

ATTACHMENT C

Virginia Chapter
Incorporated in Virginia
American Academy of Pediatrics

July 7, 2025

To: William Harp, Board of Medicine

Jaime Hoyle, Board of Psychology

Re: SB 752 Work Group on Prescriptive Authority

On behalf of the Virginia Chapter of the American Academy of Pediatrics (VA-AAP), thank you for convening the work group required by SB 752 to "assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority." We appreciate your efforts to bring together knowledgeable stakeholders for a thorough review of this proposal, which could significantly impact how mental health care is delivered in Virginia.

We are committed to contributing constructively to this process and ensuring that any policy changes reflect the highest standards of safety, particularly for children and adolescents. Psychiatric medications, among the most complex in healthcare, can have wide-ranging effects on a child's development and often interact with medications prescribed for physical health conditions. Children with mental health disorders often present with co-occurring physical health conditions, requiring careful coordination between behavioral and medical care providers. Prescribing in such cases requires medical judgment rooted in comprehensive training.

Medical Training Matters for Safe Prescribing

There are critical differences between medical and non-medical training. Pediatricians, like other physicians, complete years of education in anatomy, physiology, pharmacology, pathology, and clinical science, followed by extensive hands-on training in managing illness across organ systems—including mental health conditions. Clinical psychologists, while highly skilled in behavioral and emotional assessment, do not receive this type of medical or pharmacological training.

Even with postdoctoral coursework, psychologists do not undergo the kind of supervised, team-based clinical experience that residency provides for physicians, or that nurse practitioners and physician assistants complete through structured clinical rotations. Without this foundation, they are not equipped to safely prescribe medications, particularly in vulnerable pediatric populations where small dosage differences can have significant impacts.

Access Must Be Improved Through Proven Models

We recognize Virginia's shortage of pediatric mental health services, especially in rural and underserved areas. However, there is no clear evidence that granting

prescribing authority to clinical psychologists addresses this need. In states where such authority has been granted, few psychologists pursue the additional training required, and those who do often remain in urban centers rather than relocating to high-need communities.

Evidence-based alternatives do exist. Telepsychiatry, Collaborative Care models, and integrated behavioral health services in pediatric primary care are already demonstrating success in increasing access while preserving safety and quality. We believe Virginia should continue investing in and scaling these approaches, rather than lowering clinical standards for care.

VA-AAP is Committed to This Discussion

We welcome the opportunity to participate in this work group and to offer pediatric insight on how to strengthen mental health care delivery while maintaining appropriate clinical safeguards. Pediatricians across the Commonwealth stand ready to share their experiences and help craft policies that protect children and improve outcomes.

Thank you again for your leadership on this important issue. Please don't hesitate to reach out if we can provide additional input or support.

Sincerely,

Natasha Sriraman, MD, FAAP
President

ATTACHMENT D

July 3, 2025

William Harp, M.D., Board of Medicine
Jaime Hoyle, Board of Psychology
9960 Mayland Drive, Suite 300
Richmond, VA 23233-1463

Re: SB 752 Work Group on Prescriptive Authority

On behalf of the Virginia Academy of Physician Assistants (VAPA), we appreciate the opportunity to participate in the SB 752 Work Group tasked with evaluating whether it's appropriate for clinical psychologists to be granted prescriptive authority. As the professional voice for nearly 5,000 physician assistants (PAs) in the Commonwealth, we take seriously our responsibility to advocate for high standards of care, patient safety, and evidence-based practice across all health professions.

Virginia PAs are trusted healthcare providers who practice in every setting and specialty, and who do so in close collaboration with physicians. With over 50 years of experience in safe, team-based prescribing, PAs understand the importance of ensuring that those who are granted prescriptive authority are trained thoroughly in the medical, pharmacologic, and systemic implications of that responsibility.

Prescriptive authority is not simply a legal privilege; it is a clinical responsibility grounded in rigorous education and practical experience. PAs undergo thousands of hours of graduate-level medical education, including coursework in pathophysiology, clinical pharmacology, and diagnostics, followed by extensive supervised clinical training across specialties. Our prescriptive practices are rooted in comprehensive medical knowledge and a systems-based understanding of the human body.

While clinical psychologists play a critical role in mental and behavioral health, their training does not include the foundational medical sciences or supervised clinical experience necessary for independent medication management. Postdoctoral prescribing programs for psychologists, even when available, do not replicate the scope or depth of PA or physician training.

VAPA supports efforts to expand access to mental health services, especially in underserved and rural areas. However, there is limited evidence that granting prescriptive authority to clinical psychologists achieves this goal. In states where psychologists have prescribing rights, uptake remains low and access disparities persist.

Effective, evidence-based models to improve access do exist and we've seen success here in the Commonwealth with them. Integrating behavioral health teams into different types of practice settings, telepsychiatry, and the Collaborative Care Model in family practice and pediatric offices have all shown to improve access without compromising clinical oversight. These approaches are scalable, sustainable, and maintain the high standards that patients deserve.

VAPA welcomes the opportunity to bring our clinical expertise and real-world experience to this important discussion. As practicing medical professionals, PAs are uniquely positioned to offer insight into how safe prescribing is taught, learned, and implemented. We are committed to being a collaborative partner in any policy process that centers on quality, patient outcomes, and equitable access.

Forty-three states, including Virginia, have maintained the view that prescriptive authority belongs with medically trained providers. We encourage the Commonwealth to continue prioritizing clinical rigor and public safety as the foundation of mental health policy.

Please do not hesitate to reach out to us for further discussion or information. We are proud to stand with our colleagues in medicine to support responsible, patient-first approaches to mental health care in Virginia.

Sincerely,

Jenna Rolfs, DMSc, MBA, PA-C
President, Virginia Academy of PAs

UNIVERSITY of VIRGINIA HEALTH SYSTEM
Center for Telehealth | Office of Telemedicine

July 8, 2025

William Harp, Board of Medicine
Jaime Hoyle, Board of Psychology
Department of Health Professions
9960 Mayland Drive Suite 300
Henrico, Virginia 23233

Re: SB 752 Work Group on Prescriptive Authority

On behalf of the University of Virginia Center for Telehealth, we are grateful for the opportunity to contribute to the discussion surrounding the work group established by SB 752 regarding appropriateness for clinical psychologists to be granted prescriptive authority.

As health professionals, including my colleagues in the Department of Psychiatry and Neurobehavioral Sciences, we are dedicated to improving access to care including through telemedicine. UVA Health is home to a 133 site telemedicine network across the Commonwealth and provides care to patients without geographic or originating site restrictions. Indeed, 44% of our Department of Psychiatry ambulatory encounters and 33% of our substance use disorder visits are conducted via telemedicine. The latter requires in-person testing, but still represent significant services provided via video visits. Telemedicine has been demonstrated to be an effective tool for behavioral health care and is fully (and by statute, permanently) supported by federal programs (including Medicare, the Veterans Health Administration), Virginia Medicaid, and by commercial insurers.

We strongly believe that prescriptive authority should be offered **only** to providers who are fully trained in physiology, medicine, pharmacology, and clinical decision making with knowledge of drug interactions, co-morbidities, and with expertise in medical conditions that can present with symptoms that resemble mental health disorders. The training of clinical psychologists does not include the aforementioned requisites for the prescribing of medications. That does not negate their critically

PO. Box 800707 | Charlottesville, VA 22908-0707
434.924.5470 | fax 434.244.7521 | www.telemed.virginia.edu

important role in the evaluation and delivery of psychotherapeutic treatments for behavioral health conditions.

We believe that through the use of telemedicine, care teams with appropriate supervision by physicians can further facilitate access to the highest quality behavioral health services including with prescribing by physicians and advanced practice providers. Virginia has also demonstrated the effectiveness of virtual care through the delivery of behavioral health services integrated into primary care, including through such programs as VMAP, Project ECHO, and the Virginia Telemental Health Initiative.

We look forward to continuing the expansion of telehealth and further empowering providers to offer safe, effective high quality behavioral health services across the Commonwealth.

Please do not hesitate to reach out with any questions surrounding telemedicine as a tool for enhanced access and high quality care.

Gratefully,

Karen S. Rheuban

Karen S. Rheuban M.D.
Professor of Pediatrics
Director, Center for Telehealth

ATTACHMENT F

7/9/2025

Senate Bill 752: VACP RxP Position Paper

Senator Barbara Favola, Chief Patron

Work Group Members:

Jason Burton, M.D.
Aliya Chapman, Ph.D.
Anita Clayton, M.D.
Sonal Doran, Ph.D.
William Hathaway, Ph.D.
Caroline Juran, RPh.
Adam Kaul, M.D.
Elliott Lucas, M.D.
Krishna Madiraju, M.D.
James Morris, Ph.D.
Gary Sibcy, Ph.D.
Jeremy Walden, Ph.D.

Executive Summary
Psychotropic Medication Prescriptive Authority
for Virginia Licensed Clinical Psychologists

Overview:
The Virginia Academy of Clinical Psychologists (VACP) seeks to enhance behavioral health treatment access in Virginia through legislative authority allowing qualified clinical psychologists to prescribe psychotropic medications. This initiative addresses severe shortages in psychiatric services, particularly in underserved and economically challenged areas.

Key Points:
- Psychotropic prescribing authority has been implemented in seven states, positively impacting access to mental health care, especially for Medicaid and rural populations.
- Nationally, shortages of psychiatrists and psychiatric nurse practitioners limit access to care. In Virginia, only 292 psychiatrists accept Medicaid, with nearly 61% nearing retirement age.
- Approximately 40 Virginia psychologists have completed the required American Psychological Association (APA)-approved postdoctoral Master of Science in Clinical Psychopharmacology (MSCP) degree, qualifying them for prescribing authority upon legislative approval.

Training & Safety Measures:
- Prescribing psychologists must complete: 3 years of clinical practice, APA-approved MSCP degree, supervised clinical experience, and national psychopharmacology examination.
- The APA MSCP curriculum includes comprehensive training in basic sciences, clinical medicine, neurotherapeutics, pharmacology, and supervised patient care, ensuring rigorous preparation.
- Prescriptive authority implementation mandates collaborative care models, requiring psychologists to coordinate prescribing decisions with patients' primary care providers.

Evidence & Precedent:
- Studies from New Mexico and Louisiana show improved treatment access without reducing psychiatrist caseloads.
- Prescribing psychologists demonstrate lower adverse drug events compared to psychiatrists and improved medication adherence compared to primary care providers.
- Expanded prescribing roles for psychologists in public sector and underserved areas can improve treatment continuity, leadership in behavioral health teams, and specialized care delivery.

Challenges & Considerations:
- Organized medicine, including the AMA and psychiatric societies, oppose psychologist prescribing authority, citing competitive and political motivations rather than pure safety concerns.
- Internal debates within psychology persist, though empirical evidence supports the safe, effective integration of prescribing psychologists into collaborative care teams.

Conclusion:
Granting prescriptive authority to Virginia licensed psychologists with appropriate postdoctoral training can address critical access gaps in behavioral health services. The VACP advocates for this initiative to enhance patient care, particularly for underserved communities, while maintaining rigorous training, safety, and collaborative care standards.

Senate Bill 752 Study Report

Psychotropic Medication Prescriptive Authority for Viginia Licensed Clinical Psychologists
Submitted by: The Virginia Academy of Clinical Psychologists (VACP)

Senate Bill SB 752 enrolled text: Be it enacted by the General Assembly of Virginia:

§ 1. That the Boards of Psychology and Medicine shall jointly convene a work group to include:

- ***Two representatives of the Board of Psychology who are licensed clinical psychologists,***
- ***two representatives of the Board of Medicine who are physicians,***
- ***one representative of the Board of Pharmacy,***
- ***two licensed clinical psychologists who are faculty at accredited institutions of higher education in the Commonwealth,***
- ***two representatives from departments of psychiatry at schools of medicine located in the Commonwealth,***
- ***a representative of the Virginia Academy of Clinical Psychologists,***
- ***a representative of the Psychiatric Society of Virginia,***
- ***and other stakeholders as deemed necessary.***

To study the education, training, and qualifications of clinical psychologists licensed in the Commonwealth, including the level of education and training clinical psychologists receive in pharmacology, and assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority. The work group shall report its findings to the Chairs of the House Committee on Health and Human Services and the Senate Committee on Education and Health by November 1, 2025.

Acknowledgements:
The members of the Virginia Academy of Clinical Psychology (VACP) express our extreme gratitude to Senator Barbara Favola, (Chief Patron), and Senator Creigh Deeds (Co-patron) for their exemplary work in supporting SB 752. We also express thanks to the members of the Virginia General Assembly for their unanimous passage of the bill, and to Governor Youngkin for enabling the enrollment of SB 752.

Introduction:

Primum non nocere, "First do no harm." Adherence to this ancient primary rule for all who provide any form of medical care, including behavioral health treatment, has been and shall remain the rule for licensed clinical psychologists. As we proceed to engage in the SB 752 study, it is fitting to underscore the value to the Commonwealth of ensuring that sought-after innovations to scope of practice of any class of health care provider warrants appropriate review and scrutiny. The opportunity for the VACP to demonstrate the "the time has come" for qualified clinical psychologists to augment our current array of professional practice skills by obtaining statutory authority to prescribe psychotropic medication treatment ("RxP") for our patients is welcomed.

It is an honor that the study of our initiative brings together the esteemed group of expert colleagues from medicine, psychiatry, pharmacology, and psychology to jointly review the parameters and options

for implementing prescriptive authority in the Commonwealth. The VACP membership is grateful to have our initiative considered by such an astute group of experts as we move forward to attain prescriptive authority for appropriately trained clinical psychologists in Virginia.

As outlined in succeeding sections, the current landscape for access to behavioral health medication treatment includes gaps in access to expert behavioral health services, including scarcity of access to psychotropic medication treatment in underserved geographic areas and with economically challenged demographic groups. Of particular concern is the dearth of psychiatric services in Virginia for those of our residents who have Medicaid insurance.

Formal, thorough legislative scope of practice reviews, such as the SB 752 study can provide insightful prescriptive recommendations for ensuring proposed, significant goals for legislative approval. In the case of any medical practice goal, comprehensive reviews serve to ensure that the safety of the public would be maintained when the Virginia General Assembly enacts the proposed legislation.

Unfortunately, sometimes entities voicing objections to a proposed practice scope objective are motivated by guild-related, competitive *restraint of trade* interests, rather than by more esoteric reasons. It is our hope that the SB 752 study will proceed in a context that relates directly to the proposed change in the treatment range of qualified clinical psychologists in a manner that obviates such inappropriate overtures from participants opposing the proposed legislation for purely competitive, "business" reasons.

The VACP members welcome the opportunity to review our Academy's prescriptive authority goals with our Board, academic and professional colleagues in the study process. The proposed addition of psychotropic prescriptive authority to the current statutory scope of practice granted to Virginia licensed clinical psychologists comports closely with the current national initiative for this goal. Seven states have already granted prescriptive authority for appropriately trained psychologists; fourteen other state legislatures are considering the granting of prescriptive authority. It is our collective hope that those members of the study group will develop a collective consensus regarding best ways to safely realize the prescriptive authority goal advanced by the members of the VACP.

Legislative Goal:

The VACP is proposing that section 54.1-3606.3, *Medical Prescriptive Authority for Clinical Psychologists* be added to the Code of Virginia*,* enabling prescribing authority for clinical psychologists who complete the following requirements which are consistent with existing national professional training and experience requirements:

- Licensed as a clinical psychologist in good standing in the Commonwealth of Virginia
- Completion of three years of active clinical psychology practice
- Successful completion of a postdoctoral Master of Science degree from an American Psychological Association approved university program in Clinical Psychopharmacology
- Completion of a supervised clinical experience as defined in Virginia Administrative Code
- Successful completion of the national qualifying examination endorsed by the American Psychological Association and the Association of State and Provincial Psychology Boards.

Psychologists completing these requirements shall be eligible to obtain authorization to prescribe psychotropic medications from the relevant U.S. government authorities.

Professional Goals:

- To address unmet need in the Commonwealth for access to behavioral health treatment services for Virginia residents, with focus on those excluded from treatment by distance, poverty or the shifting of psychiatry providers to high priced "concierge" retail practices.
- To evolve and broaden the professional knowledge base and expertise of clinical psychologists regarding the delivery of medical and pharmacological aspects of treating behavioral health disorders.
- To provide an expanded range of evidence-based treatment solutions for behavioral health disorders, in an integrated health care collaboration with primary care providers.
- To provide effective treatments for people with more severely disabling types of diagnostic categories and severity levels of mental health disorders than has previously been possible.
- To enable and facilitate the initiation of a unique capability for interdisciplinary basic and applied research aimed at improving the quality of behavioral health treatment.

Section I: The need for improved access to expert behavioral health psychotropic medication treatment

The National Institute of Mental Health (2002) estimated that 52.9 million, or about 1 in 5 adults in the United States live with mental illness. In 2021, 48,000 U.S. residents died from suicide. Suicide is the second- leading cause of death among people aged 10-34 in the United States. Regarding U.S military veterans Ruiz, et.al. (2022) report that suicide rates among veterans are higher than those of the general US population. Although veterans compose only 7.6% of the US population, 14% of American adult suicides are among veterans. The rate of suicide is 1.5 times higher among all veterans and 2.1 times higher among female veterans compared with the general population. The rate of suicide has been three times higher for veterans aged 18-34. The National Institute on Drug Abuse (2022) reported that people with mental health disorders often develop substance use disorders, which contributes to the skyrocketing increase in drug overdose deaths.

The shortage of mental health providers having prescriptive authority has been particularly severe. (Andrilla et al., 2021; Satiani et al., 2018), Getting an initial appointment with a psychiatrist can take weeks or months because of labor shortages (Cama et al., 2017); this can be a major problem for patients in acute distress (Gallucci et al., 2005). In response to that shortage, prescribing of psychotropic medication is now being conducted primarily by non-psychiatrist medical providers, including primary care MDs, nurse practitioners and physicians' assistants.

In 2022, the National Center for Health Workforce Analysis (2002) projected increasing shortages for several behavioral health professions. Their report included the following statistics:

- The number of psychiatrists per 100,000 U.S. population declined 10.2% from 2003 to 2013.
- In the U.S., 96% of counties have an unmet need for psychiatrists.
- Half of the psychiatrist workforce is approaching retirement.

- Nationally, 55-60% of the population of psychiatrists are in so-called "concierge" practices, preventing most U.S. residents from obtaining their services.
- (This shortage has prompted efforts of medical schools to increase the number of U.S. psychiatrists; 30% of the current psychiatry workforce are graduates of foreign medical schools that have abbreviated curricula.)

Focusing on our Commonwealth, for the more than 8 million Virginia residents, in 2022 the *Virginia Healthcare Foundation* depicted the Virginia behavioral health workforce as having a serious lack of behavioral health workforce to meet current access needs:

"Virginia ranks poorly in availability of behavioral health (BH) services. While Virginia ranks at the top of national scorecards as the best state for business and a top state for public education, when it comes to availability of BH services, that is not the case:

- Virginia ranks 39th in the U.S. for access to mental health care and 41st for availability of its BH workforce.
- 37% of Virginians live in the 93 localities that are federally designated Mental Health Professional Shortage Areas (MHPSAs), compared to about 30% nationally.
- Access to BH services is a top concern in Community Health Needs Assessments conducted by Virginia's nonprofit hospitals every three years.
- Most alarming is the age of such a significant percentage of Psychiatrists and Psychiatric-Mental Health Nurse Practitioners (Psych NPs). Virginia is fast approaching a provider cliff with 61% of Psychiatrists aged fifty-five or older and 39% of Psych NPs age sixty or older. ***This is particularly distressing, because these providers are the only types of BH professionals specifically licensed to prescribe and manage psychotropic medicines, which are a primary method of treating mental health conditions."*** (italics added).

Additional specific concern is the report that a total of only 292 psychiatrists in Virginia accept patients with Medicaid insurance (Doctor.com, 2025) This lack of access to psychiatry services objectively can increase the risk for unstable individual and family functioning among disabled and low-income Virginians, as well as related increases in community violence, chemical dependence and criminality in economically challenged areas of the state. Given the documented shortage of psychiatric services to underserved areas and with underserved populations, the addition of prescribing clinical psychologists to the current landscape of mental health could have significant potential to expand access to mental health medication treatment in these areas. Adding prescribing psychologists is such a manner has already taken place in an impactful way in New Mexico and Louisiana.

Of signal note has been the finding that adding prescribing psychologists to the workforce in the NM and LA communities (Shoulders and Plemmons, 2024) only complemented the availability of services in their communities; in did not reduce other services use. While prescribing psychologists enhanced timely access to psychotropic medication treatment, doing so had no negative impact upon the numbers of patients treated by psychiatrists in those localities. Opening more doors to treatment each day has served to broaden, not squander treatment access in the two states studied.

Section II: The Prescriptive Authority Model

Currently, psychologists with approved expertise have attained the authority to prescribe psychotropic medication treatment in seven states in the United States (Appendix 1). Each state law requires a collaborative arrangement with patients' primary care providers.

- There are additional prescriptive authority legislative initiatives in fourteen other states, currently.
- There are approximately 1,000 clinical psychologists who have completed or are completing the M.S.C.P. degree and other requirements for prescriptive authority eligibility.
- About forty licensed clinical psychologists in Virginia have already completed the requisite postdoctoral Master of Science in Clinical Psychopharmacology (M.S.C.P) degree and could be eligible for prescriptive authority soon after RxP licensing has been enacted.
- In Virginia Dept. of Defense-employed clinical psychologists with proper expertise are already eligible to prescribe psychotropic medication treatment to active-duty members of the U.S. military.
- Clinical psychologists are already recognized as having superior training and expertise with psychological diagnostic evaluation and psychotherapy skills.
- Clinical psychologists have current equal status to psychiatrists with Virginia courts and state agencies for conducting forensic evaluations and providing treatment recommendations.

The prescriptive authority practice model under consideration for implementation in Virginia represents a ***highly collaborative approach*** to the provision of mental health treatment services. Emulating the best components of RxP statutes in other states, the treatment model proposed by the VACP requires a strong, mandatory initial and continuing collaborative engagement with the patient's primary care provider regarding all prescribing decisions and all other factors of relevance to the patient's care. All medication treatment patients must have a primary care provider or attending physician to receive that service from a prescribing psychologist.

The proposed prescriptive authority statutory model reviewed here (Appendix 2) represents the next stage in the progression of clinical psychology as a profession. Building upon our uniquely deep and broad training in psychological, neuropsychological, behavioral management and psychotherapy training and experience, it is the stance of many in the profession that the time has come for prescriptive authority to become another arrow in our professional quivers to help those under our care to realize their full potential.

Not every clinical psychologist chooses to attain prescriptive authority when RxP laws are enacted. With any change in scope of professional practice, some psychologists will choose to complete the academic and experiential training required for adding a subspecialty. This self-selection process is highly likely to include a cadre of psychologists from subspecialty career areas that already focus on medical-related areas, such as clinical neuropsychology, health psychology and those with combined clinical practice and neuroscience research components. These advanced practitioners have typically completed two years of fellowship training and a challenging evaluation process and exam before attaining their area's board certification.

The VACP prescriptive authority model does not intend to convey the same set of skills acquired in physicians' training. (Medical school training seems more likely to be suitable for aspiring pharmaceutical chemists or basic researchers than for clinically practicing MDs.) Rather, our goal, in

accord with the original DOD psychopharmacology project, has been to craft a training and experience basis for safe, effective, and beneficial prescribing within the integrative, collaborative approach to treatment that is currently in place in clinical psychology practice. The primary goal sought would be to extend the "path with a heart" approach used in psychotherapy to this extended range of clinical treatment.

The superiority of the type of integrated care advocated with the prescriptive authority initiative has been affirmed by Potash, et.al (2025). Entitled *The Future of the Psychiatrist*, their report cites the need for *psychiatry* as a profession to adopt the use of objective diagnostic measures, such as those used by psychologists for many decades, as well as the need for psychiatrists in training to finally have instruction in evidence-based psychotherapy treatments, such as cognitive behavioral therapy. Doing so it is asserted, along with becoming more "tech savvy" will serve to stave off any compromise of the "leadership" role with which psychiatry has been endowed, even though psychiatrists comprise only 5.1% of the current 980,511 workforce of mental health professionals.

Psychologists' formal interest in and action for prescriptive authority has had an extensive history. According to McGrath (2012): "It was the Indian Health Service that first approved a psychologist to prescribe medications in 1988 in response to a shortage in the availability of appropriate psychiatric care in the Santa Fe, New Mexico, region". This interest gained further traction in the late 1990's when, at the behest of then Senator Daniel Inouye of Hawaii, the U.S. Department of Defense (DOD) implemented a comprehensive clinical research protocol—The DOC Psychopharmacology Demonstration Project—a project organized by a group of psychologists and psychiatrists to assess the viability of training military psychologists to prescribe psychotropic medications.

Ten DOD psychologists completed training in a piloting approach that included three different models. The results of that project showed that the best approach to training the psychologists was one that veered away from mimicking regular MD training and built upon the psychologists' extant expertise and adding all the necessary components for the safe and effective provision of psychotropic medication treatment. The American College of Neuropharmacology oversaw the project and deemed the resulting model program to provide the best training model (McGrath, 2010)

After the DOD project, several independent RxP training programs were established. To provide a formal structure for evaluating the quality of these training, The APA developed formal *Designation Criteria for Education and Training Programs in Psychopharmacology for Prescriptive Authority* (APA, 1996, 2019) certification standards for postdoctoral training programs offering the M.S.C.P. degree to ensure that such programs provide appropriate and relevant academic training for those seeking to obtain prescriptive authority. The current required courses and course content for the M.S.C.P are depicted in table 1. Similarly, the APA has stipulated criteria for the (postdoctoral) supervised experience required for completion of the M.S.C.P. degree. They are summarized below.

Table 1. APA Education and Training Domains for Prescriptive Authority

Training Domain	Topics/Subtopics
I. Basic Science	a. Human anatomy b. Human physiology c. Biochemistry d. Genetics
II. Functional Neuroscience	a. Neuroanatomy b. Neurophysiology c. Neurochemistry
III. Physical Examination	a. Measurement and interpretation of vital signs b. Neurological exam c. Cardiovascular exam d. Respiratory exam e. Abdominal examination f. Eye, ear, nose, and throat (EENT) g. Gastrointestinal (GI) h. Genitourinary (GU) i. Integumentary j. Allergic/immunologic k. Musculoskeletal
IV. Interpretation of Lab Tests	a. Therapeutic drug monitoring b. Other blood and urine tests c. Radiology d. Electrocardiogram (EKG) and brain electrophysiology e. Neuroimaging techniques (MRI, fMRI, CT) f. Applied genetics
V. Pathological Basis of Disease	a. Pathophysiology of common clinical cardiovascular, respiratory, gastrointestinal, hepatic, neurological, and endocrine conditions
VI. Clinical Medicine	a. Clinical manifestations, differential diagnosis, and laboratory or radiological evaluation

	b. Special cases: children, women, older adults, and people with chronic health conditions c. medical emergencies and their management
VII. Clinical Neurotherapeutics	a. Electrophysiology (EEG, neurofeedback) b. Non-invasive interventions (TMS, EEG neurofeedback, biofeedback) c. Electroconvulsive therapy (ECT)
VIII. Systems of Care	a. Coordination of care with other medical specialties b. Consultations and referrals c. Coordination and consultation in long-term care
IX. Pharmacology	a. Pharmacokinetics and drug delivery systems b. Pharmacodynamics c. Neuropharmacology d. Toxicology e. Mechanisms of medication interactions
X. Clinical Pharmacology	a. Major drug classes b. Nutritional supplements c. Special groups (children, women, older adults, chronic conditions)
XI. Psychopharmacology	a. Sedatives/hypnotics b. Antidepressants c. Antipsychotics d. Mood stabilizers e. Anxiolytics f. Stimulants g. Medications for drug dependence h. Medications for drug adverse effects i. Pediatric psychopharmacology j. Geriatric psychopharmacology k. Issues of diversity and cultural competence l. Clinical decision-making and guidelines m. Guidelines for prescribing controlled substances

XII. Psychopharmacology Research	a. Phases of drug development b. Clinical trials in psychiatry c. Critical evaluation of evidence
XIII. Professional, Ethical, and Legal Issues	a. Documentation b. Conflicts of interest/industry relationships c. Scope of practice d. Diversity and equity issues
Supervised Clinical Experience	Integrated training to assess competencies in physical assessment and psychopharmacology with population-specific exposure

Table 2, APA requirements for supervised experience for M.S.C.P. programs

Requirement Area	Competency/Description
Physical Assessment	Mastery of skills to evaluate health status for medication treatment suitability, monitor health parameters, refer/collaborate with physicians for complex patients, practical experience with supervised assessments.
Patient Contact Requirements	Treatment of at least 100 patients across psychopharmacological stages; demonstration of mastery in listed competencies.
Physical Exam and Mental Status	Knowledge and execution of comprehensive/focused physical exams and mental status evaluations; use of instruments; understanding variations by developmental stage and diversity.
Review of Systems	Systematic description and integration of patient reports, signs, symptoms; recognition of developmental variations; referrals.
Medical History Interview and Documentation	Conduct clinical interviews; create integrated reports covering medical, surgical, psychiatric, medication, and family history

	within a cultural context; effective communication of findings.
Assessment—Indications and Interpretation	Order and interpret tests (psychometric, laboratory, radiological) for differential diagnosis and treatment monitoring.
Differential Diagnosis	Use appropriate processes and criteria (ICD-10, DSM-5) to determine diagnoses.
Integrated Treatment Planning	Identify/select treatment alternatives; sequence treatment within the biopsychosocial context.
Consultation and Collaboration	Understand the prescribing psychologist's role; collaborate and consult with other professionals.
Treatment Management	Apply, monitor, modify treatments; write prescriptions, referrals, consults; evaluate costs; monitor health impacts.

Psychopharmacology Exam for Psychologists (PEP).
Successful passing of this comprehensive test of knowledge necessary for prescribing competency is a key additional component in all current state laws which authorize statutory prescriptive authority. Qualifying to take this 4 hour, professionally supervised exam currently requires prior completion of the MSCP degree and at least two years of licensed professional psychologist practice. The components of the PEP are viewable in table 3.

Table 3. Elements of the Psychopharmacology Exam for Psychologists (PEP) (APA, 20)**

Domain	**Topics/Subtopics**
I. Basic Science	a. Human anatomy b. Human physiology c. Biochemistry d. Genetics
II. Functional Neuroscience	a. Neuroanatomy b. Neurophysiology c. Neurochemistry

III. Physical Examination	a. Measurement and interpretation of vital signs b. Neurological exam c. Cardiovascular exam d. Respiratory exam e. Abdominal examination f. Eye, ear, nose, and throat (EENT) g. Gastrointestinal (GI) h. Genitourinary (GU) i. Integumentary j. Allergic/immunologic k. Musculoskeletal
IV. Interpretation of Lab Tests	a. Therapeutic drug monitoring b. Other blood and urine tests c. Radiology d. Electrocardiogram (EKG) and brain electrophysiology e. Neuroimaging techniques (MRI, fMRI, CT) f. Applied genetics
V. Pathological Basis of Disease	a. Pathophysiology of common clinical cardiovascular, respiratory, gastrointestinal, hepatic, neurological, and endocrine conditions
VI. Clinical Medicine	a. Clinical manifestations, differential diagnosis, and laboratory or radiological evaluation b. Special cases: children, women, older adults, and people with chronic health conditions c. medical emergencies and their management
VII. Clinical Neurotherapeutics	a. Electrophysiology (EEG, neurofeedback) b. Non-invasive interventions (TMS, EEG neurofeedback, biofeedback) c. Electroconvulsive therapy (ECT)
VIII. Systems of Care	a. Coordination of care with other medical specialties

	b. Consultations and referrals c. Coordination and consultation in long-term care
IX. Pharmacology	a. Pharmacokinetics and drug delivery systems b. Pharmacodynamics c. Neuropharmacology d. Toxicology e. Mechanisms of medication interactions
X. Clinical Pharmacology	a. Major drug classes b. Nutritional supplements c. Special cases (children, women, older adults, chronic conditions)
XI. Psychopharmacology	a. Sedatives/hypnotics b. Antidepressants c. Antipsychotics d. Mood stabilizers e. Anxiolytics f. Stimulants g. Medications for drug dependence h. Medications for drug adverse effects i. Pediatric psychopharmacology j. Geriatric psychopharmacology k. Issues of diversity and cultural competence l. Clinical decision-making and guidelines m. Guidelines for prescribing controlled substances
XII. Psychopharmacology Research	a. Phases of drug development b. Clinical trials in psychiatry c. Critical evaluation of evidence
XIII. Professional, Ethical, and Legal Issues	a. Documentation b. Conflicts of interest/industry relationships c. Scope of practice d. Diversity and equity issues

Supervised Clinical Experience	Integrated training to assess competencies in physical assessment and psychopharmacology with population-specific exposure

The comprehensive, multi-faceted training requirements established by the APA serve to provide a full, appropriate and verifiable complement of prescribing knowledge and training to the professional training and experience required of all clinical psychologists who are candidates for the M.S.C.P. degree.

A primary distinguishing factor between medical school and clinical psychology graduate school is the requirement that psychologists in training are required to author a comprehensive dissertation, a scholarly work worthy of referred journal publication that is based upon the results of their scientific research.

Section III: Current Practice Precedents:

Prescriptive authority permits psychologists to provide both psychotherapy and medication management, potentially increasing continuity of care and reducing fragmentation (Shearer, Harmon, Seavey, & Tiu, 2012). Psychologists with prescribing authority, drawing on expertise in both behavioral and biological interventions, may be well-positioned to provide integrated mental health care (Vento, 2014). Psychologists with prescriptive authority become more likely to acquire enhanced professional status parity with other doctoral-level providers (Linda & McGrath, 2017).

In New Mexico, where the number of psychiatrists in 2017 totaled 274, the addition of fifty prescribing psychologists represented an 18.25% increase in the number of actual mental health prescribers available to provide medication treatment in that state. In Louisiana, with a census of 471 psychiatrists, the addition of 110 Medical (prescribing) Psychologists increased patient access to psychotropic medication treatment by about 24%. These additions have the additional benefit of adding a group of prescribers who also have more training and experience with the professional diagnosis and psychotherapeutic treatment of mental health disorders than do either primary care physicians or nurse practitioners.

The matters of whether granting prescriptive authority has positively impacted the behavioral health landscape in the areas served or has changed the risk of adverse treatment outcomes have been addressed in some depth. Early research in NM and LA indicated that prescribing psychologists often serve Medicaid, Medicare, minority, and rural populations at proportions exceeding statewide provider averages, hinting at improved access for marginalized groups (Vento, 2014).

A major 2024 cohort study spanning 307,478 privately insured patients in NM and LA compared outcomes among patients receiving prescriptions from psychologists, psychiatrists, and primary care physicians (Hughes et al., 2024). Findings included:

- Lower rates of adverse drug events (ADEs) and polypharmacy for psychologist patients compared to psychiatrists.

- Similar rates of psychiatric emergency department (ED) utilization and medication nonadherence to psychiatrists
- Compared to PCPs, psychologist patients had higher polypharmacy and ED utilization, but better medication adherence.

Policy simulations and quasi-experimental studies found small but significant reductions in suicide and mental health-related mortality following RxP implementation in NM and LA, suggesting that RxP may confer public health benefits in some contexts (Hughes, McGrath, & Thomas, 2023; Roy Choudhury & Plemmons, 2023). These policies were cost-effective as suicide prevention interventions in some analyses (Hughes, Phillips, McGrath, & Thomas, 2023).

Prescribing psychologists in NM and LA are working in a variety of settings (private practice, clinics, and hospitals) and overwhelmingly espouse a preference for combination therapy, though both monotherapy and psychotherapy-only regimens are common (Peck et al., 2021). Surveys indicate that combination approaches and collaborative models are widespread, with medical colleagues viewing psychologists' contributions as safe, competent, and clinically valuable (Shearer et al., 2012; Linda & McGrath, 2017).

Later-adopting states (Illinois, Iowa, Idaho, Colorado) currently have too few prescribing psychologists for robust outcomes research, but early data and policy simulations project modest workforce benefits if prescribing psychologist uptake increases (Hughes, McGrath, & Thomas, 2023; Peck et al., 2021). Workforce modeling suggests the size of the impact is directly proportional to the number of psychologists who complete RxP training and obtain licensure.

Section IV: Challenges surrounding the prescriptive authority goal:

Clinical psychologists in the U.S. share much of our behavioral health history and pedigree with our psychiatry colleagues. Both professions arose fully in the first part of the twentieth century and matured following World War II, with psychiatry focused on the use of pharmaceuticals and other physical interventions, and clinical psychology veering toward developing evidence-based diagnostic approaches and psychosocial/psychotherapeutic treatments.

Clinical psychologists and psychiatrists work jointly in inpatient locations as part of multidisciplinary treatment teams, or in public or private practice settings with shared patient treatment goals. Clinical psychologists serve as key faculty in medical school departments of psychiatry, pediatrics, or other specialty medical settings, highly valued by their medical colleagues. Clinical psychologists have taught and learned from our medical colleagues, instructed and supervised medical interns and residents, and conducted joint research endeavors, all executed in a manner that is supportive and responsive to the missions in the various settings. This on-the-ground, day-to-day collaboration has no doubt served to enhance the quality of treatment available to those seeking our help, while also promoting providers' reciprocal awareness of the others' professional approach.

Given the close, long term collaborative history of shared mission with psychiatrists and clinical psychologists, and the esteem with which our medical colleagues are typically held by psychologists, it is regrettable to have to report, and startling to learn the degree to which medical and psychiatric professional organizations have made their opposition to the granting of prescriptive authority to

psychologists into a cause for prompting contributions to their political action committees (PAC) fundraising activities. Implicit and explicit calls for funding in medical PAC missives note that this opposition to prescriptive authority for psychologists needs to be "paid for" with strategic PAC contributions to politicians' war chests.

The American Medical Association (AMA) and the American Psychiatric Society (APS) (which has its own "*Non-Physician Scope of Practice Action Center*" with resources for attacking initiatives such as prescriptive authority for psychologists) and state psychiatric PAC sites typically contain inflammatory and inaccurate statements regarding psychologists' training and experience basis for prescriptive authority. Appendix 3 includes an AMA broadside (AMA, 2024), attacking the qualifications of psychologists. The contents of this report fully illustrate the distortions in the broadside.

Closer to home in Virginia, in the spring 2025 *PSV News*, the Psychiatric Society of Viriginia leadership stated: "A legislative issue that is confronting us is psychologists in Virginia wanting the privilege of prescribing!... ***The Executive Board of the PSV have all contributed to our PAC to help fund this fight***." (italics added).

In a similar mode, a February 2025 email titled: "***Urgent call to action! PAC Plea***" (italics added) the Washington (DC) Psychiatric Society (2025) stated: "The Virginia Academy of Clinical Psychologists introduced legislation to 'study the feasibility of authorizing clinical psychologists licensed in Virginia to obtain and utilize prescriptive authority'… psychologists have been aggressively fundraising and made sizable donations to the leadership of healthcare committees. **It *must* be a goal of psychiatrists in Virginia to dramatically increase our political activity to raise our visibility and voice our concerns to legislators… A well-resourced PsychMD-PAC allows us to support legislators who support our profession…"**

This resistance **by Psychiatric organizations to adding more qualified prescribers to our communities, and, thereby increasing access to care, is puzzling. Currently** more than seventy-five percent of psychotropic medication prescriptions are penned by primary care physicians and nurse practitioners, eclipsing the contribution of psychiatry to the provision of psychotropic medication treatment.

Within our own profession of clinical psychology there has also been sometimes virulent criticism of the prescriptive authority goal (Robiner, et. al., 2002, 2020). Psychology colleagues focused upon traditional models of practice have minimized the evolution of our profession into a more comprehensive provider of needed mental health treatments while ironically trumpeting the value of their medical colleagues' practice tools.

Section V*: *Concluding remarks.

The unique preexisting focus of clinical psychologists upon behavioral health assessment and treatment services for our patients would seem to render our profession as ideal candidates for attaining prescriptive authority, particularly given the collaborative approach in current use.

It is the position of the VACP that enactment of legislation granting statutory psychotropic prescriptive authority to qualified Virginia clinical psychologists with the appropriate postdoctoral degree and

experience will serve to enhance access of Virginia residents to needed and often scarce behavioral health treatment services. Granting psychologists prescriptive authority in the Commonwealth can serve to enable them to provide integrated treatment to patients in underserved rural and urban communities, where economic factors currently render such services impossible to provide.

Psychologists with prescriptive authority in public sector clinics and inpatient facilities would be enabled to provide more effective team leadership than do the inexperienced and inadequately trained *de facto* locum tenens providers who currently fill that role, when psychiatrists are not interested in working in those settings. The high level of skills possessed by psychologists in specialty areas such as forensic evaluation and treatment, neuropsychological assessment and rehabilitation services or substance use treatment services could be recruited in conjunction with prescriptive authority to fortify and stabilize services provision in those areas, where lack of qualified professionals often scuttles programs.

The VACP values the opportunity provided to our members with the convening of the SB 752 study. The primary consideration in all our work is and has been to maintain the health and safety of our patients while assisting them to reach their fullest potential. In alignment with that commitment, we appreciate greatly that our esteemed colleagues have elected to convene with us for the Senate Bill 752 study. It is our hope that this review of our professional goal of improving access to behavioral healthcare treatment in Virginia will yield greater understanding of our mission and endorsement of our legislative goals.

Appendix 1: Comprehensive Overview of Statutory Authority for Psychologists to Prescribe Psychotropic Medications

1. ***New Mexico*** enacted legislation in 2002 under NMSA 1978, § 61-9-17.1 authorizing qualified psychologists to prescribe psychotropic medications. Applicants must hold a Ph.D. or Psy.D. in psychology, complete a post-doctoral master's degree in clinical psychopharmacology, pass a national examination (PEP - Psychopharmacology Examination for Psychologists), and complete at least 400 hours of supervised practicum treating patients with psychotropic medications.

Prescribing psychologists are limited to treating mental and emotional disorders and cannot prescribe controlled substances classified as Schedule I or II.

2. ***Louisiana*** granted prescriptive authority to medical psychologists in 2004 via La. Rev. Stat. § 37:1360.51 et seq. To qualify, psychologists must earn a doctorate in psychology, complete a post-doctoral master's degree in clinical psychopharmacology, obtain supervised clinical experience, and pass a board-approved examination.

Medical psychologists may prescribe medications related to mental health conditions but cannot prescribe Schedule I controlled substances.

3**.** ***Illinois*** enacted prescriptive authority for clinical psychologists in 2014 under 225 ILCS 15/15.2. Eligible psychologists must possess a doctorate in psychology, complete specialized education in clinical psychopharmacology, perform supervised clinical training, and pass the PEP exam.

Prescribing psychologists can treat mental health disorders in adults but cannot prescribe benzodiazepines, Schedule II controlled substances, or medications for patients under 17 or over 65 years of age.

4. ***Iowa*** authorized prescriptive authority for psychologists in 2016, codified in Iowa Code § 154B.9. Applicants are required to have a doctorate in psychology, complete advanced education in clinical psychopharmacology, pass the PEP exam, and fulfill a supervised practicum with a licensed physician.

Prescribing psychologists may prescribe medications for mental health conditions but cannot prescribe Schedule I or II controlled substances.

5. ***Idaho*** passed legislation in 2017, found in Idaho Code § 54-2301 et seq., allowing prescribing psychologists. Requirements include a doctorate in psychology, a master's degree in clinical psychopharmacology, completion of the PEP exam, and a supervised practicum.

Prescribing psychologists may treat mental health disorders but cannot prescribe opioids, Schedule I or II controlled substances, or medications for non-psychiatric medical conditions.

6. ***Utah*** enacted prescriptive authority for psychologists in 2023 under Utah Code Ann. § 58-61-701 et seq. Qualified psychologists must earn a doctorate, complete advanced coursework in

psychopharmacology, pass the PEP exam, and undergo a minimum of 400 hours of supervised clinical training. Prescribing psychologists are restricted to treating adult mental health conditions and cannot prescribe Schedule I controlled substances or medications for individuals under 18 years old.

Appendix 2:

VACP Model Prescriptive Authority Statute
(next page)

DRAFT

VACP Model RxP Statute

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 54.1-3606.2 as follows:

§ 54.1-3606.3. *Medical Prescriptive Authority for Clinical Psychologists*.

ARTICLE 1.
PURPOSE

Whereas available national and state data confirm that the current cohort of psychiatrists in Virginia is insufficient to provide mental/behavioral health services to the population of residents in need of such treatment; that psychiatry as a profession is experiencing a loss of members due to currently high rates of retirements and low entry of newly trained psychiatrists, and

Whereas it is a known fact that a sizable proportion of all primary medical care patient contacts are behavioral health-related, and that most primary care providers have neither the time nor the expertise to fully address such treatment needs, and

Whereas members of the profession of clinical psychology are already recognized by other behavioral health professionals and the public as possessing the highest levels of training and experience with the diagnosis of, and psychological evaluation and behavioral treatment of behavioral health disorders, and

Whereas licensed clinical psychologists in Virginia have existing legal parity with psychiatrists in providing expertise for the criminal courts, and regarding emergency inpatient behavioral health treatment, and

Whereas a total of seven U.S. states, including Colorado, Idaho, Illinois, Iowa, Louisiana, New Mexico, and Utah have already granted prescriptive authority to properly trained clinical psychologists, and psychologists in other states are currently pursuing prescriptive authority privileges with their legislative bodies, and

Whereas the median number of psychiatrists per 100,000 U.S. population is on the decline; the number of practicing psychiatrists in 2024 is less than it was 10 years ago. Approximately half of the

existing psychiatrist workforce is approaching retirement. A decreasing number of physicians are seeking training in psychiatric residency programs, and

In the U.S., 96% of counties have been reported to have an unmet need for psychiatrists. Nationally, 55-60% of the population of psychiatrists are in so-called "concierge" practices, not accepting health insurance and thereby limiting access to their services. In Virginia, the number of psychiatrists who accept Medicaid insurance is in the low hundreds, and

Whereas Virginia regularly ranks at the top of national scorecards as the best state for business, and is a top state for public education, when it comes to availability of behavioral health services, that is not the case: Virginia ranks 39th in the U.S. for access to mental health care and 41st for availability of its behavioral health workforce (Mental Health America, 2021), and

Whereas in Virginia 37% of our residents live in the 93 localities that are federally designated Mental Health Professional Shortage Areas (MHPSAs), compared to about 30% of all Americans. Virginia ranks 30th in the number of psychiatrists per capita. Access to psychiatry services is restricted in rural areas and in neighborhoods housing people with low incomes, and

Whereas 54 Virginia localities have no psychiatrists and 51 have no nurse practitioners in the Commonwealth. In addition, 88 localities have no child/adolescent psychiatrist. Significantly, 35 localities are without a prescriber (psychiatrist, psychiatric nurse practitioner) specifically trained in psychotropic medicines, and an additional 25 have only 1 prescriber. These are both professions with the highest percentage of those at or near retirement age, and

Whereas, according to public messages from the current Governor of Virginia and members of the General Assembly, in conjunction with recent media accounts of lack of access of persons with behavioral health treatment needs to adequate treatment, a sense of urgency has developed in Virginia legislative circles to identify and implement solutions to this current crisis with behavioral health services delivery. This sense of urgency regarding the need for improved access to behavioral health treatment in the Commonwealth supports the need for implementation of this proposed legislation in a timely manner.

ARTICLE 2
Applicant Qualifications

I: Authorization of clinical psychologists to prescribe psychotropic medication treatment.

1) Notwithstanding any other provision of the Code of Virginia, on or before July 1, 2025, Virgina licensed clinical psychologists shall be approved by the Board of Psychology for a prescriptive authority license, upon satisfaction of all the following criteria:

i) The applicant holds a current and unrestricted license in good standing to practice

clinical psychology issued by the Virginia Board of Psychology of Psychology.

ii) Has successfully graduated with a post-doctoral master's degree in clinical psychopharmacology from a regionally accredited institution that has been designated by the American Psychological Association and the Board of Psychology. The curriculum shall include instruction in anatomy and physiology, biochemistry, neurosciences, pharmacology, psychopharmacology, clinical medicine/pathophysiology, and health assessment, including relevant physical and laboratory assessment.

iii) Has passed a national exam in clinical psychopharmacology approved by the Board of Psychology.

iv) Maintains commercial professional liability insurance with an insurer authorized to provide such coverage in Virginia. The liability insurance limits shall be consistent with both the limits defined by Virginia regulations and by existing national standards for clinical psychologists having prescriptive authority.

v) Has successfully completed a practicum of supervised primary care experience. The practicum shall include observational clinical assessment and diagnostic pathophysiology, including diagnostic tests and procedures. The practicum should also include treatment of mental health disorders with a minimum of one hundred patients.

2) Prescriptive authority psychologists licensed by the Board of Psychology shall be eligible for a controlled and dangerous substance permit and registration issued by the United States Drug Enforcement Agency.

3) Upon satisfactory completion of the requirements, the Board of Psychology shall determine that the applicant is eligible for a prescriptive authority license to prescribe medication treatment in accordance with the regulatory requirements of the Virginia Administrative Code.

4) Prescriptive authority by endorsement. Upon payment of the required licensing fees and approval of the application for prescriptive authority in the Commonwealth of Virginia, the Board of Psychology may certify by endorsement and grant a prescriptive authority license to an applicant who has: a current license in good standing to practice psychology or medical psychology from another state; a Virginia practice location; unrestricted prescriptive authority from another state that imposes the education, supervision and training requirements required by this section, or the equivalent.

II) : Scope of practice for clinical psychologists with primary prescriptive authority.

1) The prescriptive authority psychologist may: prescribe and administer psychotropic medication and medications commonly used to treat side effects of psychotropic medications

within the recognized scope of practice; order the administration of medication by appropriately licensed or certified nursing personnel; order medical laboratory tests and diagnostic procedures in conjunction with prescribing and monitoring treatment of mental, nervous, emotional, behavioral, substance abuse, and cognitive diseases or disorders

2) The prescriptive authority psychologist shall obtain the informed consent of the patient before prescribing any medication. Informed consent of a legal parent or guardian shall be required prior to the prescribing of any medication to a person under 18 years of age.

3) The prescriptive authority psychologist may prescribe only in consultation and collaboration with the patient's primary care physician, attending physician, or other independently practicing primary care medical provider, and with the concurrence of that physician or provider. Whenever a patient's primary medical care provider is a licensed nurse practitioner or licensed physician's assistant under supervision, consultation and collaboration shall include the physician supervising those prescribers.

4) The prescriptive authority psychologist shall, after obtaining a written release from the patient or the patient's legal guardian, consult with the patient's primary medical care provider or attending physician, and obtain concurrence with the primary medical care provider regarding the appropriateness of any recommended medication, and any necessary additional medical actions that may be required, prior to prescribing a medication.

5) The prescriptive authority psychologist shall also re-consult with the patient's primary care provider prior to making changes in the patient's medication treatment plan, as established with the primary care provider, or as otherwise directed by that provider. The prescriptive authority psychologist and the primary medical care provider shall each document the consultation and concurrence in the patient's medical record(s).

6) In the event a patient does not already have a primary medical care provider, the prescriptive authority psychologist shall assist the patient with obtaining a primary care provider. If the patient does not agree to obtain a primary medical care provider, the prescriptive authority psychologist shall inform the patient that the psychologist cannot prescribe psychotropic medication treatment for that patient. The prescriptive authority psychologist shall consult with the patient regarding alternative sources for psychotropic medication treatment.

Standards of practice for prescriptive authority psychologists

1) Prescriptive authority psychologists shall be authorized to administer and prescribe only drugs recognized and customarily used for the management of mental, nervous, emotional, behavioral, substance abuse, and cognitive diseases or disorders, as defined in the current Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association or as listed in the International Classification of Diseases of the World Health Organization.

A. Prescriptive authority psychologists may not order, administer, prescribe, or distribute narcotics, as defined in the Code of Virginia, except for the treatment of opioid use disorders.
B. Nothing in this Part shall be construed as permitting a prescriptive authority psychologist to pharmacologically treat patients for primary medical conditions.
C. Practitioners licensed under this section may order and interpret laboratory studies and other medical diagnostic procedures including electrophysiological and imaging tests, as necessary for adequate pretreatment health screening and monitoring and, diagnosis of mental, nervous, emotional, behavioral, substance abuse, and cognitive disorders and treatment maintenance, including those necessary for the monitoring of potential side-effects associated with medications prescribed by the prescriptive authority psychologist.
D. Prescriptive authority psychologists shall obtain and maintain Basic Life Support certification.
E. Prescriptive authority psychologists shall retain full status as clinical psychologists, in accordance with the provisions of the Code of Virginia for such licensure. Notwithstanding any law to the contrary, nothing in this section shall prohibit or restrict prescriptive authority psychologists, licensed under the provisions of this section, from employing or otherwise utilizing psychological technicians or psychometricians to assist in the provision of psychological service provision.
F. Prescriptive authority psychologists retain the authority to supervise psychology students, interns, and postdoctoral residents for licensure under the psychology board. Prescriptive authority psychologists may also provide supervision of clinical psychologists completing required supervised experience for prescriptive authority licensure.
G. Prescriptive authority psychologists shall practice in accordance with all professional regulations defined in the applicable sections of the Virginia Administrative Code for this professional activity.

2)Prescriptive authority psychologists who have satisfied the requirements specified in Section I, and who possess the following additional qualifications to the satisfaction of the Board of Psychology shall be issued a certificate of advanced practice:

A. Three years of experience practicing as a prescriptive authority psychologist. Such experience period shall have commenced with the issuance of the original prescriptive authority license issued by the Virginia Board of Psychology.
B. Treatment of a minimum of one hundred patients, including fifty or more involving the use of major psychotropic medications, which demonstrate the competence of the prescriptive authority psychologist.
C. The recommendation of two collaborating primary care providers, each of whom holds an unconditional license to practice in Virginia, and who are each familiar with the applicant's competence to practice medical psychology.
D. Recommendation of the Prescriptive Authority Advisory Committee, as implemented by the

Virginia Board of Psychology.

E. The completion of a minimum of one hundred hours of continuing medical education related to psychopharmacology and pharmacological treatment.

F. A certificate issued under this Part shall designate the licensee's status with respect to advanced practice.

Standards of practice for prescriptive authority psychologists holding certificates of advanced practice

1) Patients receiving care from a prescriptive authority psychologist who holds a certificate of advanced practice issued under this section shall have an established primary, attending, or referring physician, or other qualified primary medical care provider, as defined above, who shall be responsible for the patient's overall medical care.

A. The primary, attending, or referring provider shall evaluate the patient for medical conditions in accordance with customary practice standards, and as might be indicated based on the medications that the patient is receiving and/or risk factors that may be present. If the patient has been referred by the primary, attending, or referring medical provider, to a prescriptive authority psychologist holding a certificate of advanced practice for the express purpose of evaluation and treatment, to include drug management, this condition shall be considered met.

B. The advanced practice prescriptive authority psychologist shall provide the primary, attending, or referring medical provider with a summary of the treatment planned at the initiation of treatment.

C. The advanced practice prescriptive authority psychologist shall provide the primary, attending, or referring medical provider with follow up reports as may be dictated by the patient's condition.

D. The advanced practice prescriptive authority psychologist shall provide the patient's primary, attending, or referring medical provider with a summary of the patient's condition and treatment no less than annually.

E. The requirements for Subsections B, C, and D, of this section shall be considered satisfied if the prescriptive authority psychologist provides the primary, attending, or referring medical provider with a copy of the initial examination and follow up visit records.

Prescriptive Authority Advisory Committee

A. A Prescriptive Authority Advisory Committee shall be established by the Board of Psychology for the purpose of awarding advanced practice certification to applicants. The Committee shall also have authority for reviewing and recommending action on the process of application for certification, for recommending educational requirements for certification and for defining other medical activities that may be provided by prescriptive authority psychologists. The Committee may recommend changes in related statutes and rules, as well as other activities as might be requested by the Board of Psychology.

B. The Prescriptive Authority Advisory Committee shall consist of the following five members selected by the Board of Psychology.

(1) One member shall be a physician who is certified by the American College of Medical Specialties or the American Osteopathic Association equivalent in the specialty of psychiatry and who is licensed to practice medicine in this state, selected from a list of names submitted by the Virginia Medical Society and who is recommended by the Virginia Psychiatric Society and the Prescriptive Authority Committee of the Virginia Academy of Clinical Psychologists.

(2) Four members shall be prescriptive authority psychologists selected from a list of names recommended by the Virginia Academy of Clinical Psychologists. Initially, these four positions would be filled by prescribers chosen by the psychology board for one-year renewable terms. As prescriptive authority psychologists are licensed, these positions would be filled by prescriptive authority psychologists as described in this paragraph.

(3) The executive director of the Board of Psychology shall- serve as ex officio, non-voting member of the committee.

(4) Members shall serve at the pleasure of the Board of Psychology. A vacancy in an unexpired term shall be filled in the manner of the original appointment.

C. The committee may meet as needed but shall meet at least four times per year. A majority of the members of the committee shall constitute a quorum for the transaction of all business.

D, Members of the committee shall serve without compensation but shall be reimbursed for travel expenses incurred in attendance at meetings and other official business on behalf of the committee or the Board of Psychology

Appendix 3:

American Medical Association Broadside Re: Prescribing Psychologists

(next page)

Reference List

American Medical Association (2024); Protect Physician-led Care and clinic characteristics of a prescribing psychology practice in New Mexico. *Journal of Health Care for the Poor and Underserved* https://www.ama-assn.org/system/files/scope-of-practice-physician-training-psychologists.pdf

Andrilla CHA, Garberson LA, Patterson DG, Quigley TF, Larson EH. Comparing the Health Workforce Provider Mix and the Distance Travelled for Mental Health Services by Rural and Urban Medicare Beneficiaries. J Rural Health. 2021 Sep;37(4):692-699. doi: 10.1
authority expansion for psychologists. *Contemporary Economic Policy*, *43*(1), 116–134. https://doi.org/10.1111/coep.12643

Baird, K. A. (2007). A survey of clinical psychologists in Illinois regarding prescription privileges. *Professional Psychology: Research and Practice, 38*(2), 196–202. https://doi.org/10.1037/0735-7028.38.2.196

Brown, R. T., Abrahamson, D. J., Baker, D. C., Bevins, R. A., Grus, C. L., Hoover, M., LeVine, E. S., Lincoln, A. J., & Foster, E. O. (2021). The revised 2019 standards for psychopharmacological training: Model education and training program in psychopharmacology for prescriptive authority. *American Psychologist, 76*(1), 154–164. https://doi.org/10.1037/amp0000729

Cama S, Malowney M, Smith AJB, Spottswood M, Cheng E, Ostrowsky L, Rengifo J, Boyd JW. Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities. *Int J Health Serv*. 2017 Oct;47(4):621-635 *Clinical Psychology in Medical Settings, 19*(4), 451–454.

Doctor.com (2025) Total number of Psychiatrists in Virginia on Doctor.com who Accept Medicaid: https://www.doctor.com/VA/Medicaid-Psychiatrists-Virginia

Gallucci G, Swartz W, Hackerman F. Impact of the wait for an initial appointment on the rate of kept appointments at a mental health center. *Psychiatric Serv*. 2005 Mar;56(3):344-6. doi: 10.1176/appi.ps.56.3.344. PMID: 15746510
https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-behavioral-health-workforce-report-2024.pdf

Hughes, P. M., McGrath, R. E., & Thomas, K. C. (2023). Evaluating the impact of prescriptive authority for psychologists on the rate of deaths attributed to mental illness. *Research in Social & Administrative Pharmacy, 19*(4), 667–672. https://doi.org/10.1016/j.sapharm.2022.12.006

Hughes, P. M., Niznik, J. D., McGrath, R. E., Tak, C. R., Christian, R. B., Sleath, B. L., & Thomas, K. C. (2024). Assessing the safety and efficacy of prescribing psychologists in New Mexico and Louisiana. *American Psychologist*. Advance online publication. https://doi.org/10.1037/amp0001373

Hughes, P. M., Phillips, D. C., McGrath, R. E., & Thomas, K. C. (2023). Examining psychologist prescriptive authority as a cost-effective strategy for reducing suicide rates. *Professional Psychology: Research and Practice, 54*(4), 284–294. https://doi.org/10.1037/pro0000519

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

Malowney M, Keltz S, Fischer D, Boyd JW. Availability of outpatient care from psychiatrists: a simulated-patient study in three U.S. cities. *Psychiatric Serv*. 2015 Jan 1;66(1):94-6. doi: 10.1176/appi.ps.201400051. Epub 2014 Oct 31. PMID: 25322445.

McGrath RE. Prescribing in integrated primary care: a path forward. *J Clin Psychol Med Settings*. 2012 Dec;19(4):451-4. doi: 10.1007/s10880-012-9356-6. PMID: 23224337.

McGrath, R. E., & Sammons, M. (2011). Prescribing and primary care psychology: Complementary paths for professional psychology. *Professional Psychology: Research and Practice, 42*(2), 113–120. https://doi.org/10.1037/a0022649

National Center for Health Workforce Analysis: State of the Behavioral Health Workforce, 2024 November 2024 https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-behavioral-health-workforce-report-2024.pdf

National Institute of Mental Health: Transforming the understanding and treatment of mental illnesses. https://www.nimh.nih.gov/health/statistics/mental-illness

National Institutes on Drug Abuse (US); Common Comorbidities with Substance Use Disorders Research Report. Bethesda (MD): 2020 Apr. PMID: 34185444. https://nida.nih.gov/sites/default/files/1155-

Newman, R., Phelps, R., Sammons, M. T., Dunivin, D. L., & Cullen, E. A. (2000). Evaluation of patterns and medical professional evaluations. *Professional Psychology: Research and Practice, 48*(1), 38–45. https://doi.org/10.1037/pro0000118

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

Potash, J. B., McClanahan, A., Davidson, J., Butler, W., Carroll, N., Ruble, A., Yaden, M., King, D., Torous, J., Zandi, P. P., Kennedy, K. G., Smith, T. E., Waghray, A., Trestman, R., & Wills, M. (2025). The future of the psychiatrist. *Psychiatric Research and Clinical Practice*. Advance online publication. https://doi.org/10.1176/appi.prcp.20240130
prescribing medications (Briefing Paper No. 142).

Psychiatric Society of Virginia (2025): Psychiatric News, Spring 2025 https://news.psva.org/?e-landing-page=psv-news-spring-2025

Robiner, W. N., Bearman, D. L., Berman, M., Grove, W. M., Colón, E., Armstrong, J., & Mareck, S. (2002). Prescriptive authority for psychologists: A looming health hazard? *Clinical Psychology: Science and Practice, 9*(3), 231–248. https://doi.org/10.1093/clipsy.9.3.231

Roy Choudhury, A., & Plemmons, A. (2023). Effects of giving psychologists prescriptive authority: Evidence from a natural experiment in the United States. *Health Policy, 134*, Article 104846. https://doi.org/10.1016/j.healthpol.2023.104846

Ruiz F, Burgo-Black L, Hunt SC, Miller M, Spelman JF. A Practical Review of Suicide Among Veterans: Preventive and Proactive Measures for Health Care Institutions and Providers. *Public Health Rep*. 2023 Mar-Apr;138(2):223-231. doi: 10.1177/00333549221085240. Epub 2022 Apr 9. PMID: 35403486; PMCID: PMC10031829.

Satiani A, Niedermier J, Satiani B, Svendsen DP. Projected Workforce of Psychiatrists in the United States: A Population Analysis. *Psychiatr Serv*. 2018 Jun 1;69(6):710-713. doi: 10.1176/appi.ps.201700344. Epub 2018 Mar 15. PMID: 29540118.

Shearer, D. S., Harmon, S. C., Seavey, B. M., & Tiu, A. Y. (2012). The primary care prescribing psychologist model: Medical provider ratings of the safety, impact and utility of prescribing psychology in a primary care setting. *Journal of Clinical Psychology in Medical Settings, 19*(4), 420–429. https://doi.org/10.1007/s10880-012-9338-8

Shoulders, A. & Plemmons, A. (2025) Supply of mental health practices after prescriptive authority expansion for psychologists. *Contemporary Economic Policy*, 43(1), 116–134. Available from: https://doi.org/10.1111/coep.12643

Thomas, K. C. (2024f). Demographics and clinical characteristics of patients of prescribing psychologists, psychiatrists, and primary care physicians. *American Psychologist*. Advance online publication. https://doi.org/10.1037/amp0001352

Vento, C. (2014). Report from the trenches: Survey of New Mexico prescribing psychologists' outpatient practice characteristics and impact on mental health care disparities in calendar 2013. *Archives of Medical Psychology, 5*, 30–34.

Virginia Healthcare Foundation, Assessment of the Capacity of Virginia's Licensed Behavioral Health Workforce, 2002. https://www.vhcf.org/wp-content/uploads/2022/01/BH-Assessment-Final-1.11.2022.pdf

Washington Psychiatric Society (2025)February, 2025 https://cdn.coverstand.com/23290/841899/f0aba0d66e2c9de99841d3a9239e0c235a2e625a.pdf

AMA AMERICAN MEDICAL ASSOCIATION

Protect physician-led care

Psychologists are well-trained behavioral experts, but they lack the comprehensive medical knowledge and clinical experience necessary to safely prescribe psychotropic medications—some of the most powerful medications in modern medicine—to patients. Safe prescribing depends on the education and years of clinical training completed by physicians.

PHYSICIANS ARE TRAINED TO LEAD

Psychiatrists (MD, DO)		Psychologists (PsyD)
4 years	Postgraduate education	4 years
1,352 hours on average	Science coursework required	0 hours
4–6 years	Residency	1-year internship (additional postgraduate hours may be required for state licensure)
12,000–16,000 hours	Clinical training	1,920 hours

PHYSICIANS RECEIVE A COMPREHENSIVE MEDICAL EDUCATION, PREPARING THEM TO PRESCRIBE MEDICATION

Education requires coursework in …	Psychiatrists	Psychologists
Biology	✓	x
Anatomy	✓	x
Pathophysiology	✓	x
Clinical medicine	✓	x
Pharmacology	✓	x

WHILE A PSYCHOLOGIST IS A WELL-TRAINED BEHAVIORAL EXPERT, A PSYCHOLOGIST IS NOT TRAINED TO PROVIDE PRIMARY CARE OR TO PRACTICE MEDICINE.

MYTH	FACT
Post-graduate instruction in psychopharmacology adequately prepares a psychologist to safely prescribe and manage medications.	**A crash course in prescribing is insufficient.** There is no standardized training for prescribing psychologists. The model curriculum developed by the American Psychological Association is taught in as little as 400 hours. **This is less than half the time a medical student spends in training in just one year of medical school.** The coursework and clinical experience gained during a crash course in prescribing does not prepare a psychologist to prescribe and manage medications.
Psychotropic medications predominately affect one body system—the nervous system—making them safe medications to be prescribed by a psychologist with non-medical training.	**Psychotropic medications affect the entire body.** Comprehensive medical knowledge of all body systems is necessary to safely prescribe medications.
Allowing psychologists to prescribe will increase access to care.	**Access to care has not substantially improved in states that allow psychologists to prescribe psychotropic medications.** In fact, the small number of psychologists who prescribe largely practice in the same areas as psychiatrists.

Eighteen of the 30 most prescribed psychotropic medications carry "black box warnings"—the FDA's most serious warning of potential side effects, including stroke, coma and risk of death. Only physicians have the comprehensive medical education and clinical expertise to safely prescribe medications.

Virginia College of Emergency Physicians

Virginia College of Emergency Physicians

2209 Dickens Rd.
Richmond, VA 23230
vacep.org

July 5, 2025

William Harp, MD
Executive Director
Board of Medicine

Jaime Hoyle
Executive Director
Board of Psychology

Sent via email

Dear Dr. Harp and Ms. Hoyle,

On behalf of the Virginia College of Emergency Physicians (VACEP), we appreciate the opportunity to submit our perspective to the work group established by SB 752 examining whether it's appropriate for clinical psychologists to be granted prescriptive authority. As part of the healthcare safety net in the Commonwealth, we feel a deep responsibility to contribute to this discussion, which has the potential to impact the standards of care in Virginia significantly. Patient safety and evidence-based medicine must be at the center of this conversation.

As emergency physicians, we urge you to engage in a robust and thoughtful analysis of prescriptive authority, particularly because it's in the context of psychiatric care. Many of the patients we see in the ER are having interactions with medications, those who have stopped taking psychiatric medications or those who's dosages need to be adjusted. These drugs that are used in psychiatric treatment are among the most complex and lethal in all of medicines. They can potentially cause addiction and dependency, worsen suicidal ideation, cause movement disorders, seizures, cardiac arrest and even death if taken in combination with the wrong medicine.

Psychiatric medications impact not only the brain but every system in the body, and their use often requires deep expertise in drug interactions, comorbid medical conditions, laboratory monitoring, and long-term management. When we treat patients having a mental health crisis, it also includes the pharmacological angle, which includes indications, contradictions, drug-drug interactions, side effects, reversal agents, and overdose management.

More than half of patients with mental illness also have a co-existing physical health condition, making prescribing even more complicated and requiring medical knowledge. As such, we believe strongly that prescriptive authority should rest with professionals who are comprehensively trained in both medicine and pharmacology.

There are clear and important differences in the scope and depth of training between those who are educated to practice medicine and those who are not. Physicians are trained

extensively in human biology, pathophysiology, pharmacology, and clinical reasoning. They undergo supervised clinical experiences across a wide range of specialties; in addition, they must complete residencies in their specialty after completing medical school where their supervised, hands-on learning is unparallelled. In contrast, while clinical psychologists make important contributions in mental and behavioral health, their training does not include the rigorous scientific and clinical foundation required to safely prescribe medications.

Forty-three states currently share Virginia's approach to prescriptive authority, and several states have recently rejected proposals to expand it to psychologists. We hope Virginia will similarly prioritize quality, safety, and long-term access through strategies rooted in evidence and medical rigor.

Please do not hesitate to call upon us for input, data, or discussion. We look forward to continuing our contribution to a safe and high-quality standard of care for all Virginians.

Sincerely,

Jesse Spangler, MD
President, Virginia College of Emergency Physicians

ATTACHMENT H

Public Comment

Overview of SB752

Direct the Boards of Psychology and Medicine to jointly convene a work group to study:

- The education, training, and qualifications of clinical psychologists licensed in the Commonwealth;
- and assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority.

Background

- Began in 1980's to address mental health treatment access disparities.
  - Mental health workforce shortage – critical shortage of psychiatrists, especially in rural and underserved areas
- Emphasis on integrated care
  - Focus on continuity of care within established psychologist/patient relationship
  - Clinical efficiency
- Demonstrated success in existing models
  - Department of Defense Psychopharmacology Demonstration Project since 1990
- Critics cite concerns over insufficient medical training and education needed to ensure safe prescribing

Brief Hx of the Evolution of RxP Nationally

- 1984 – Call to action by Daniel K. Inouye
- 1994 – DoD demonstration project: 10 military psychologists trained; Military RxP
- 1999 – Guam
- 2002 – New Mexico
- 2004 – Louisiana: First civilian Rx by the late Dr. John Bolter
- 2000's – US Public Health Service
- 2009 – LA MPs: Transfer regulation from LSBEP to LSBME
- 2010's – Indian Health Service Indiana (only for DoD trained prescribers)
- 2014 – Illinois
- 2016 – Iowa
- 2017 – Idaho
- 2023 – Colorado
- 2024 - Utah

Examples from other Jurisdictions

- Guam
  - Psychopharmacology training required

- New Mexico
  - Complete 450 hours of didactic instruction
  - Complete 400 hours of clinical supervision in psychopharmacology
  - Supervised by Physician or designated primary care provider for 2 years under a conditional prescription certificate

Louisiana

- State Board of Medical Examiners issues medical psychological license to:
  - Psychologists who are currently licensed and in good standing with State Board of Examiners for Psychologists;
  - Graduated with Postdoctoral Master's Degree in psychopharmacology or equivalent training as approved by the Board; and,
  - Passed national examination in psychopharmacology.

Illinois

- Completion of supervised clinical rotation, lasting 14 months and covering a variety of settings (hospitals, prisons, mental health clinics, etc)
- Requirements:
- Passing the Psychopharmacology Examination for Psychologists;
- Prescribing psychology residency between 14 and 28 months
  - Consisting of 9 medical rotations in family medicine, internal medicine, psychiatry, pediatrics, geriatrics, obstetrics/gynecology, emergency medicine, surgery, and one other elective
  - Must total at least 1,620 hours
  - Must accumulate at least 20 hours per week
- Prescribing psychologists may not prescribe to patients under 17 or older than 65, pregnant patients, or patients with a serious medical condition
- Prescribing psychologists may not prescribe Schedule II controlled substances

Iowa

- Complete postdoctoral master's degree in psychopharmacology
- Training requirements include 400 hours of supervised clinical training and practicum, with 25% being in a primary care or community mental health setting
- Requirement of specific relevant clinical experience in clinical psychopharmacology
- Special training in assessment and pathophysiology
- Supervised by a physician or designated primary care provider for 2 years under a conditional prescription certificate

Idaho

- Must complete a postdoctoral master's degree in psychopharmacology from an American Psychological Association-designated training program
- Supervised practicum in clinical assessment and pathophysiology
- Pass a nationally recognized examination
- 2 year supervised provisional prescribing period
- No hourly requirements for psychopharmacology training
- Psychologists prohibited from prescribing a list of illicit drugs

Effectiveness of Jurisdictional Models

Regulatory Variation

- 2 Seats for RxP Psychologists on Board
  - RxP Application Committee: Physician, NP, PA
  - Peer Review: Physician, NP, PA, Pharmacist
  - Joint board complaint committee
- Regulated by Medical Board for both Rx and Psychology Practice
  - MPAC – 1 physician; 4 MPs •
- 2 Seats for PPs; 2 Seats for physicians on Board
- Consultation with Board of Medicine on all rules
  - BH Board w/ psychology advisory committee
- Advisory board: 2 physicians, pharmacist, 2 psychologists
- Peer review-approved by Medical Board w/ physician, NP, PA, pharmacist; complaints reviewed by Medical Board that makes recs to Psychology Board for sanction

Prescriptive authority models in Virginia

- APRN
- Physician Assistant
- Collaborative practice agreements (pharmacists)

APRNs

- APRNs have had the ability to prescribe since the early 1990s
- For many years, APRNs had to maintain a separate license to prescribe
  - Boards of Nursing and Medicine required APRNs to maintain their practice license and obtain/maintain a separate license for prescriptive authority
  - Both had to be paid for, renewed, etc.
- In 2020 the Boards of Nursing and Medicine eliminated the requirement that an APRN maintain a separate license to prescribe
- APRNs can currently prescribe with a practice license, similar to physicians and physician assistants
- APRNs practice under a practice agreement unless they have received authorization to practice without a practice agreement (following 3 years of full-time clinical experience)

Physician Assistants

- Physician assistants have been able to prescribe since 1992
- Must work under collaborative agreements with physicians/podiatrists
- Physician/podiatrist name must appear on prescription, including label, of RX written by PA
  - Note – this is currently going through regulatory process to change
  - Once regulatory process is complete this will no longer be a requirement

Pharmacist initiation of treatment

- Not prescribing in the traditional sense
- Pharmacists can initiate treatment following protocols approved by the Board of Medicine and the Board of Pharmacy for certain diseases or conditions

Virginia Current Education and Training

-Clinical Psychologists

-Professions with Prescriptive Authority in Virginia

Benefits and Drawbacks of Prescriptive Authority for Clinical Psychologists

Issues to Consider

Which populations should/should not be treated?

Which problems should/should not be treated?

Level of independence as a prescriber?

Who regulates RxP? (Psych; Med; Pharm; some combination?)

Who supervises RxP? (physicians – primary care? Psychiatrists?)

How long under supervision?

- Overly restrictive rules can create burdens preventing needed provision of care. Insufficient supervision can create quality of care issues.
- Language matters – "direct supervision" is more than "collaborative agreement."

Which/how many licenses does an RxP need?

- Case of LA: Until 2024, their board of Medicine issued prescriptive psych license *only if the applicant had a current valid psych license*. In 2024 this requirement was taken away. For those who dropped their psych license there were some issues, including difficulty meeting requirements for insurance credentialing, job duties, and mobility licensure.

Significant benefits to high-need areas (e.g., rural communities).

Ways to Regulate:

- Some number of seats for RxP psychologists on med and/or pharm Boards; or RxP seats on med board.
- Joint (med, psych, pharm) complaint review committee.
- Joint licensing application review committee.
- Regulated by Psych with a joint advisory panel that has authority to approve/deny rules.
- Regulated by Psych with regular [Psych/Med/Pharmacy] consultation.

Recommendations

Next Steps

ATTACHMENT I

Designation Criteria for Education and Training Programs in Psychopharmacology for Prescriptive Authority

APPROVED BY THE APA COUNCIL OF REPRESENTATIVES
FEBRUARY 2019

AMERICAN PSYCHOLOGICAL ASSOCIATION

American Psychological Association
750 First Street NE
Washington, DC 20002-4242
(202) 336-5979
TDD: (202) 336-6123
Fax: (202) 336-5978

AMERICAN PSYCHOLOGICAL ASSOCIATION

Designation Criteria for Education and Training Programs in Psychopharmacology for Prescriptive Authority

APPROVED BY THE APA COUNCIL OF REPRESENTATIVES 2009

REVISIONS APPROVED FEBRUARY 2019

CRITERION P: PROGRAM (P) CHARACTERISTICS

The training program stands as a recognizable, organized sequence of study and experience. There is an identifiable, integrated program organization and specified faculty responsible for it. The intent of this criterion is that the education and training of psychologists for prescriptive authority occur within a program with an identifiable organization, curriculum, and faculty. Program resources provide for stability of funding and continuity of faculty allowing for sufficient opportunity to teach, supervise, and evaluate each student.

P1. Academic Institution

The degree program must be offered at a regionally accredited institution.

Documentation

1. Provide evidence that the program is offered at a regionally accredited institution.

P2. Admissions

To participate in education and training in psychopharmacology, programs must require students be admitted to (for those completing a portion of the education and training at the doctoral level) or have completed (for those pursuing training entirely at the postdoctoral level) a doctoral program in psychology. Students who complete a portion of their training at the doctoral level must be enrolled in a doctoral program accredited by the APA or an accrediting body recognized by the U.S. Secretary of Education for the accreditation of health service psychology in preparation for entry to practice.

1. Students are eligible for additional didactic coursework and training following the successful completion of the supervised clinical experience in physical assessment.
2. Students are eligible for the prescribing psychology fellowship following licensure as a doctoral-level psychologist.
3. Students will have met all eligibility requirements for entry into the prescribing psychology fellowship following the completion of all other didactic and experiential requirements for training as a prescribing psychologist.

All fellowship participants will:

1. be a graduate of a doctoral program in psychology;
2. hold a current license as a psychologist; and
3. practice as a "health service provider" psychologist as defined by state law, where applicable, or as defined by the APA1.

These admission standards must be disseminated to potential applicants of the program.

Documentation

1. Submit a copy of any documents and other materials (e.g., program website content, program brochures, catalogs) that demonstrate how you inform potential applicants of these requirements for participation in and completion of the program.
2. Submit a copy of the student application form and any other forms that you use to gather information about current licensure, completion of a doctoral program in psychology, and practice as a health service provider.
    - Does your program accept applicants who do not meet the above requirements?
    - If yes, please explain.
    - Over the last three years, what percent of your admissions were exceptions?

P3. Transfer of Credit

The program can develop policies for allowing credit from a previous graduate or postdoctoral education and training program(s).

Programs offering a master's in psychopharmacology may allow transfer of previous coursework limited to the basic science and functional neuroscience domains (Domains I & II). This does not preclude the development of program policies that would permit, on an individual basis, the meeting of program requirements through a current demonstration of competencies obtained through prior postdoctoral education and training. In such unusual cases, program policies should explicitly state the criteria for such decisions, and there should be an accompanying record of the specific competencies demonstrated by the psychologist and those yet to be acquired through the program.

Documentation

1. Does your program accept transfer credit?
    - If yes, describe your policies for accepting transfer credit. This should include courses in your curriculum for which you accept transfer credit and the maximum percentage of your curriculum for which you allow transfer credit.
2. If you allow advanced placement based on prior education and training, provide us with your program policy for establishing competency and currency of knowledge base.

P4. Ethical Standards

Program administrators and faculty who are psychologists abide by the current *Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association*.

Documentation

1. Describe how the current *Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association* is made available to faculty members and administrators who are psychologists.
2. Provide a copy of program policies indicating that students will be treated in a fair and ethical manner consistent with the current *Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association*.

P5. Public Representation of the Program

The program must have a clear and comprehensive mission statement that guides it, is approved by the governing body, and is publicly communicated. The program is clearly identified and labeled as a doctoral and/or postdoctoral education and training program for psychologists in psychopharmacology for prescriptive authority.

Documentation

1. Attach a copy of your current mission statement.
2. Indicate how this mission statement is communicated to the public.
3. Provide copies of materials for public dissemination indicating the program is an education and training program for psychologists in psychopharmacology for prescriptive authority.

P6. Program Resources

The program must have sufficient financial resources and access to appropriate physical resources to support its mission. The program provides access to facilities, services, and learning/information resources that are appropriate to support its didactic and experiential teaching, research, and service mission.

1 In 1995, the APA Council of Representatives approved the following definition of "health service provider" psychologists: "Psychologists are recognized as Health Service Providers if they are duly trained and experienced in the delivery of preventive, assessment, diagnostic, and therapeutic intervention services relative to the psychological and physical health of consumers based on: 1) having completed scientific and professional training resulting in a doctoral degree in psychology; 2) having completed an internship and supervised experience in health care settings; and 3) having been licensed as psychologists at the independent practice level."

Documentation

1. For those components of the program that are conducted in a classroom setting, describe the physical resources available to the program. For those components of the program that are provided via computer or other electronic media, describe the systems used to support those program components.
2. Describe all additional resources available to students. These can include laboratory space, clinical settings, library materials (electronic and/or physical), pedagogical resources, access to relevant websites, or any other resources that may enhance the student's learning experience.
3. Provide evidence to suggest that sufficient financial resources exist to ensure the program will be sustainable at least for the duration of the current student body. This can, for example, include description of the current financial status of the sponsoring organization if such an organization exists, or demonstration that the materials and resources needed for the completion of the current cohort are already in place. This description should address maintenance of those resources described in response to #1.

P7. Governance

The program must have qualified administrators, including a psychopharmacology program director, with appropriate administrative authority.

The legal authority and operating control of the program must be clearly described.

The program must have due process and grievance procedures for faculty that are publicly available.

Documentation

1. Describe the governance structure for the program and qualifications of the administrators. Please attach an organizational chart for the program, and job description and curriculum vitae for the program director and other program administrators.
2. Provide materials or otherwise describe the mechanism(s) by which faculty are informed of their rights and program policies.
3. Describe grievance and due process procedures available for faculty in the program.

P8. Faculty

Faculty and clinical supervisors must be qualified and sufficient in number to accomplish the program's education and training goals. The psychopharmacology program director must be a licensed psychologist trained in psychopharmacology. The program faculty and supervisors may come from a variety of appropriate disciplines to include neuroscience and licensed practitioners of medicine, pharmacy, and nursing. When possible, the inclusion of prescribing psychologists as faculty is encouraged. Faculty participate in the program's planning, implementation, and evaluation.

There is an identifiable key or essential faculty and clinical supervisors with appropriate credentials to teach curriculum courses and/or provide supervision for the supervised clinical experience.

Documentation

1. For each course or course module or supervised clinical experience, as appropriate to your curriculum, provide the name and current curriculum vitae of the primary instructor currently teaching that content area.
2. Provide evidence of licensure in good standing (if applicable) for each faculty member and clinical supervisor.

P9. Quality Assurance

The program must ensure the quality of education and training, including any consortial relationships or contractual agreements.

Documentation

1. Describe any consortial arrangements or contractual agreements used in the didactic or supervised clinical experience of students. This includes supervisors involved in the experiential component of the training.
2. Describe mechanisms used to ensure the quality of education training offered through those agreements, including methods for the evaluation of supervisor competence in the experiential component of the training.
3. Provide evidence of licensure in good standing (if applicable) for each faculty member and clinical supervisor.

P10. Program Self-Evaluation

The program engages in a process of self-evaluation every three years at a minimum and submits a written response as required by the Designation Criteria. Faculty members participate in the program's planning, implementation, and evaluation.

Documentation

1. Describe procedures for program self-evaluation, including how often formal self-evaluation takes place and how this information is used.
2. Describe how the program maintains currency of course materials given the rapid evolution of knowledge.
3. Provide evidence of licensure in good standing (if applicable) for each faculty member and clinical supervisor.

P11. Diversity

The program recognizes the importance of cultural and individual differences and diversity in the training of psychologists. The program has made systematic, coherent, and long-term efforts to attract and retain students and faculty from diverse backgrounds into the program.

Documentation

1. Describe how the program engages in systematic, coherent, and long-term efforts to attract and retain students and faculty from diverse backgrounds into the program.

CRITERION S: STUDENTS (S)

S1. Student Body

There is an identifiable body of students who are matriculating in the training program for prescriptive authority. The training program must also demonstrate that its admissions policy does not systematically exclude candidates from consideration on the basis of elements of human diversity.

Documentation

1. How do you define an active student in your program?
2. Please fill in the following information:

	Students Enrolled in the Training Program		
	Doctoral	Postdoctoral	
	Didactic	Didactic	Prescribing Psychology Fellowship
Number of Students Currently Enrolled			
Number of Students Who Completed in the Past 3 Years			

3. Please describe the diversity of your student body.
4. If any trainee has taken an excess of five years to complete the postdoctoral training program, please provide an explanation.

S2. Maintenance of Licensure

The doctoral program students maintain a status of "in good standing" during participation in the training program. Postdoctoral program students maintain licensure throughout the program.

Documentation

1. Provide materials or otherwise indicate how students are informed that they are expected to (a) maintain a status of "in good standing" for doctoral students and licensure for postdoctoral students throughout the course of the program; and (b) inform the program director at any time of changes to their standing or licensure.

S3. Student Records

The program must protect the security, confidentiality, integrity, and availability of student records.

The training program awards a degree or certificate upon satisfactory completion of all program requirements. Satisfactory completion of the program is reflected by a transcript or other official documentation reflecting the sequence of education and training, grades or scores earned in didactic instruction, and satisfactory completion of supervised clinical experiences.

Programs will keep records regarding the number of students matriculating in and graduating from the program. Transcripts or other official documentation will be made available at all times to students matriculating in and psychologists graduating from the training programs. The program will comply with federal and state regulations regarding confidentiality as appropriate (e.g., FERPA, HIPAA, etc.). Such transcripts or other official documentation will be maintained in a secure environment to ensure confidentiality.

Documentation

1. Describe methods used to ensure the security and maintenance of student records stored in either paper or electronic form.
2. Describe the mechanisms used to assure the long-term maintenance of student records.
3. Provide the sample of a transcript or official document that confirms successful completion of program requirements.
4. Provide a sample of the certificate of completion of all program components (didactic, supervised clinical experience, and capstone competency evaluation).

S4. Due Process

The program must have due process and grievance procedures that are publicly available.

Documentation

1. Provide materials or otherwise describe the mechanism(s) by which students are informed of their rights and program policies.
2. Describe grievance and due process procedures available for students in the program.

CRITERION C: CURRICULUM (C)

The training program stands as a recognizable, organized sequence of study and experience. There is an identifiable, integrated program organization and specified faculty responsible for it. Program resources provide for stability of funding and continuity of faculty allowing for sufficient opportunity to teach, supervise, and evaluate each student.

The program must offer an integrated, organized, and sequential program of instruction as evidenced through the following:

1. an organized sequence of courses with relevant syllabi;
2. frequent evaluation of students' knowledge and application of that knowledge and feedback to students of outcomes;
3. periodic program evaluation a minimum of every three years; and
4. certification of program completion upon demonstration of appropriate level of competence, the prescribing psychology fellowship, and the capstone competency evaluation.

C1. Didactic Curriculum

The didactic curriculum must consist of at least 400 contact hours.

Among the goals of the training is to ensure that graduates:

- are able to identify those patients for whom psychotropics may be indicated or not indicated;
- are able to recognize adverse effects that are associated with medications; and
- can recognize when medical consultation, collaboration, and/or referral is necessary.

With the goal of maintaining patient safety while prescribing psychotropic medication, the trainee is expected to demonstrate knowledge in the following domains (I-XIII), with clinical competence obtained by the completion of the fellowship in those indicated with an asterisk (*).

Programs may develop specific courses using different content integration approaches. The following ae not meant to mandate specific courses, rather these are content areas that must be covered in the didactic curriculum to ensure sufficient knowledge for safe prescribing. A psychopharmacology program might fulfil these requirements

in various ways. For example, the content covered in domains I and II below might be taught in a two-course sequence providing competency in physical and medical science sufficient to support safe prescribing.

I. Basic science (this domain can be taken at the undergraduate level, at the discretion of the program)
   a. Human anatomy
   b. Human physiology
   c. Biochemistry
   d. Genetics

II. Functional neuroscience
   a. Neuroanatomy
   b. Neurophysiology
   c. Neurochemistry

III. Physical examination
   a. Measurement and interpretation of vital signs*
   b. Neurological exam*
   c. Cardiovascular exam
   d. Respiratory exam
   e. Abdominal examination
   f. Eye, ear, nose, and throat (EENT)
   g. Gastrointestinal (GI)
   h. Genitourinary (GU)
   i. Integumentary
   j. Allergic/immunologic
   k. Musculoskeletal

IV. Interpretation of laboratory tests
   a. Therapeutic drug monitoring*
   b. Other blood and urine tests
   c. Radiology
   d. Electrocardiogram (EKG) and brain electrophysiology
   e. Neuroimaging techniques [e.g., magnetic resonance imaging {MRI}, functional MRI {fMRI}, computerized tomography {CT}]
   f. Applied genetics

V. Pathological basis of disease
   a. Pathophysiology of common clinical cardiovascular, respiratory, gastrointestinal, hepatic, neurological, and endocrine conditions

VI. Clinical medicine
   a. Clinical manifestations, differential diagnosis, and laboratory or radiological evaluation of commonly encountered medical conditions
   b. Special cases: children, women, and older adults, health related conditions (e.g., pregnancy hormone therapy), and people living with chronic health conditions, (e.g., hypertension, diabetes, HIV/AIDS, Hep C, breast and hematological cancers and conditions)
   c. Medical emergencies and their management

VII. Clinical neurotherapeutics
   a. Electrophysiology (e.g., quantitative electroencephalogram {EEG}, neurofeedback)
   b. Non-invasive interventions (e.g., transcranial magnetic stimulation, EEG neurofeedback, biofeedback)
   c. Electroconvulsive therapy (ECT)

VIII. Systems of care*
   a. Coordination of care with other medical specialties
   b. Consultations and referrals
   c. Coordination and consultation in long-term care

IX. Pharmacology*
   a. Pharmacokinetics and drug delivery systems
   b. Pharmacodynamics
   c. Neuropharmacology
   d. Toxicology
   e. Mechanisms of medication interactions

X. Clinical pharmacology*
   a. Major drug classes
   b. Nutritional supplements
   c. Special cases: children, women, and older adults, health related conditions (e.g. pregnancy, hormone therapy), and people living with chronic health conditions, (e.g., hypertension, diabetes, HIV/AIDS, Hep C, breast and hematological cancers and conditions)

XI. Psychopharmacology*
   a. Sedatives/hypnotics
   b. Antidepressants
   c. Antipsychotics
   d. Mood stabilizers
   e. Anxiolytics
   f. Stimulants
   g. Medications for drug dependence
   h. Medications for drug adverse effects
   i. Pediatric psychopharmacology
   j. Geriatric psychopharmacology (including medications for cognitive impairment, polypharmacy)
   k. Issues of diversity and cultural competence in pharmacological practice (e.g., sex assigned at birth, gender identity, race, ethnicity, culture, socioeconomic status, disability, nationality of origin, generational status, citizen status, other forms of population diversity, traditional practices, and lifespan factors related to drug metabolism access,

acceptance, and adherence)

l. Clinical decision-making and standard practice guidelines

m. Guidelines for prescribing controlled substances

XII. Psychopharmacology research*

a. Phases of drug development

b. Clinical trials in psychiatry

c. Critical evaluation of evidence

XIII. Professional, ethical, and legal issues*

a. Documentation (e.g., nomenclature, abbreviations, prescription writing)

b. Conflicts of interest/relationships with the industry

c. Scope of practice issues

d. Diversity and equity issues related to treatment access and adherence

Documentation

1. Provide a current syllabus for each course or course module. This syllabus should, at a minimum, include a description of expected student learning outcomes for each course or course module and how student performance is assessed.

2. Provide the curriculum vitae of each instructor for each course or course module.

3. Create a grid that indicates the number of hours in each course dedicated to each of the content domains required for the program. A template for the grid is attached.

Different programs share content but organize the curriculum in different ways and use different course titles. For each course in your program, indicate the number of contact hours associated with each content domain reflected in the model curriculum.

Content Mapping Chart	Course or Course Module: Identify courses below the grid (e.g., "1 = Clinical Medicine"). Add more columns if you have more than 10 courses or modules.									
	1	2	3	4	5	6	7	8	9	10
I. Basic science										
a. Human anatomy										
b. Human physiology										
c. Biochemistry										
d. Genetics										
II. Functional neuroscience										
a. Neuroanatomy										
b. Neurophysiology										
c. Neurochemistry										
III. Physical examination										
a. Measurement and interpretation of vital signs										
b. Neurological exam										
c. Cardiovascular exam										
d. Respiratory exam										
e. Abdominal examination										
f. Eye, ear, nose, and throat (EENT)										
g. Gastrointestinal (GI)										
h. Genitourinary (GU)										
i. Integumentary										
j. Allergic/Immunologic										
k. Musculoskeletal										
IV. Interpretation of laboratory tests										
a. Therapeutic drug monitoring										
b. Other blood and urine tests										
c. Radiology										
d. Electrocardiogram (EKG) and brain electrophysiology										
e. Neuroimaging techniques [e.g., magnetic resonance imaging {MRI}, functional MRI {fMRI}, computerized tomography {CT}]										
f. Applied genetics										
V. Pathological basis of disease										
a. Pathophysiology of common clinical cardiovascular, respiratory, gastrointestinal, hepatic, neurological, and endocrine conditions										
VI. Clinical medicine										
a. Clinical manifestations, differential diagnosis, and laboratory or radiological evaluation of commonly encountered medical conditions										
b. Special cases: children, women, and older adults, health related conditions (e.g., pregnancy, hormone therapy), and people living with chronic health conditions, (e.g. hypertension, diabetes, HIV/AIDS, Hep C, breast and hematological cancers and conditions)										
c. Medical emergencies and their management										

VII. Clinical neurotherapeutics										
a. Electrophysiology (e.g., quantitative electroencephalogram {EEG}, neurofeedback)										
b. Non-invasive interventions (e.g., transcranial magnetic stimulation, EEG neurofeedback, biofeedback)										
c. Electroconvulsive therapy (ECT)										
VIII. Systems of care										
a. Coordination of care with other medical specialties										
b. Consultations and referrals										
c. Coordination and consultation in long-term care										
IX. Pharmacology										
a. Pharmacokinetics and drug delivery systems										
b. Pharmacodynamics										
c. Neuropharmacology										
d. Toxicology										
e. Mechanisms of medication interactions										
X. Clinical pharmacology										
a. Major drug classes										
b. Nutritional supplements										
c. Special cases: children, women, and older adults, health related conditions (e.g. pregnancy, hormone therapy), and people living with chronic health conditions, (e.g. hypertension, diabetes, HIV/AIDS, Hep C, breast and hematological cancers and conditions)										
XI. Psychopharmacology										
a. Sedatives/hypnotics										
b. Antidepressants										
c. Antipsychotics										
d. Mood stabilizers										
e. Anxiolytics										
f. Stimulants										
g. Medications for drug dependence										
h. Medications for drug adverse effects										
i. Pediatric psychopharmacology										
j. Geriatric psychopharmacology (including medications for cognitive impairment, polypharmacy)										
k. Issues of diversity and cultural competence in pharmacological practice (e.g., sex assigned at birth, gender identity, race, ethnicity, culture, socioeconomic status, disability, nationality of origin, generational status, citizen status, other forms of population diversity, traditional practices, and lifespan factors related to drug metabolism access, acceptance, and adherence)										
l. Clinical decision-making and standard practice guidelines										
m. Guidelines for prescribing controlled substances										
XII. Psychopharmacology research										
a. Phases of drug development										
b. Clinical trials in psychiatry										
c. Critical evaluation of evidence										

XIII. Professional, ethical, and legal issues										
a. Documentation (e.g., nomenclature, abbreviations, prescription writing)										
b. Conflicts of interest/relationships with the industry										
c. Scope of practice issues										
d. Diversity and equity issues related to treatment access and adherence										

Courses:

e.g., 1 = Clinical Medicine, 2 =, etc.

C2. Supervised Clinical Experience

Supervised clinical experience in physical assessment

The supervised clinical experience in physical assessment must include mastery of the basic skills to evaluate those aspects of the patient's health status sufficient to ensure the patient's suitability for treatment with medication, the monitoring of health parameters that may be impacted by the medication, and the knowledge base necessary to refer to and collaborate with physicians in the management of more medically complex patients. The mastery of physical assessment should be achieved through practical experience in supervised patient health assessments done in collaboration with medical providers licensed to conduct independent physical assessment.

Documentation

1. The program will demonstrate the manner in which it verifies that the specific competencies have been achieved.
2. Should the program choose to integrate the physical assessment practical training with didactic coursework, the program shall demonstrate the manner in which it is integrated.

The prescribing psychology fellowship

The prescribing psychology fellowship must be completed with a minimum of 100 patients, which includes patients representative of all stages of psychopharmacological treatment (initiation and maintenance through termination of treatment) and encompasses mastery of the following clinical competencies:

1. **Physical exam and mental status:** Knowledge and execution of elements and sequence of both comprehensive and focused physical examination and mental status evaluation, proper use of instruments used in physical examination (e.g., stethoscope, blood pressure measurement devices), and scope of knowledge gained from physical examination and mental status examination recognizing variation associated with developmental stage and diversity.
2. **Review of systems:** Knowledge and ability to systematically describe the process of integrating information learned from patient reports, signs, symptoms, and a review of each major body system, recognizing normal developmental variations and making appropriate referrals to other licensed health professionals.
3. **Medical history interview and documentation:** Ability to systematically conduct a patient or parent/caregiver clinical interview in order to produce an integrated report of a patient's medical, surgical, and psychiatric (if any) history and medication history in cultural context as well as a family medical and psychiatric history, and to communicate the findings in written and verbal form.
4. **Assessment—indications and interpretation:** Ability to order and interpret appropriate tests (e.g., psychometric, laboratory, and radiological) for the purpose of making a differential diagnosis and for monitoring therapeutic and adverse effects of treatment.
5. **Differential diagnosis:** Use of appropriate processes, including established diagnostic criteria (e.g., ICD-10, DSM-5), to determine primary and alternate diagnoses.
6. **Integrated treatment planning:** Ability to identify and select, using all available data, the most appropriate treatment alternatives, including medication, psychosocial, and combined treatments and to sequence treatment within the larger biopsychosocial context.
7. **Consultation and collaboration:** Understand the parameters of the prescribing psychologist's role, including how to effectively work with other professionals in an advisory or collaborative manner in the treatment of a patient.
8. **Treatment management:** Apply, monitor, and modify (as needed) treatments; write valid and complete prescriptions, referrals, and consults; be aware of the impact of health care costs; evaluate and monitor the impact of biological and psychological interventions on the patient's health status.

Documentation

1. Describe how your program implements the prescribing psychology fellowship component of training. Describe in detail:
   a. how supervisors and settings are identified, approved, and overseen by the program;
   b. mechanisms for ensuring that the range of supervised clinical experience balances diversity, developmental considerations, and appropriateness to the student's practice;
   c. the skill sets considered critical for each of the eight competency domains and how developmental and diversity issues are addressed; and
   d. how progress toward attainment and mastery of competence is evaluated for each of the eight competency domains listed.
2. Provide copies of all materials used by the program to evaluate student performance in the completion of the prescribing psychology fellowship.
3. Provide copies of forms used by the student and the supervisor to document students' face-to-face patient contact hours.

C3. Capstone Competency Evaluation

Training programs developed under these standards provide a capstone competency evaluation that requires integration of the knowledge, skills, and attitudes that psychologists are expected to master during their matriculation in the program.

Competencies are conceived as holistic and represent:

- **knowledge** of subject matter concepts and procedures;
- **performance** of behaviors that demonstrate specific skills and abilities;
- **problem-solving** strategies and capabilities that involve elements of critical thinking and ethical responsibility; and
- **self-reflection** that focuses on knowing the limits of one's knowledge; clarification of attitudes, beliefs, and values; identification of self-perceptions and motivations in the context of prescriptive authority, cultural competency, and skills working with diverse populations; and recognition and identification of sources of bias.

This evaluation is distinct from any evaluation that focuses exclusively on mastery of information, such as the Psychopharmacology Examination for Psychologists (PEP). The capstone competency evaluation is summative and follows demonstrated mastery of multiple, foundational competencies throughout the training program. Successful completion of the prescribing psychology fellowship requires the presentation of an acceptable capstone competency evaluation that incorporates all relevant coursework and clinical work completed in preparation for and during the prescribing psychology fellowship.

Documentation

1. Describe in detail your program's capstone evaluation process, including how outcome is determined.
2. In each of the last three years, how many students have participated in the capstone competency evaluation? How many in each year have passed?

C4. Certification of Completion

In order to be certified as having fulfilled the APA Model Education and Training Program in Psychopharmacology for Prescriptive Authority, the student must complete the didactic, experiential, and capstone components of the program, typically within five years of the initiation of postdoctoral training.

Documentation

1. Some programs elect to provide a form of recognition upon completion of didactic coursework even if the supervised clinical experience is not yet completed. Does your program offer this option?
    - If yes, indicate what form this recognition takes (certificate, master's degree, etc.).
2. What form of recognition do you give for completion of all program components? Please submit a sample copy.
3. Your program may not represent students as having completed the *APA Model Education and Training Program in Psychopharmacology for Prescriptive Authority* until such time as they have completed the didactic, supervised clinical experience, and capstone components of the program.

We are compliant with this:

C5. Lifelong Learning

Programs developed under these standards place a special emphasis on preparing psychologists to evaluate future advances in psychopharmacological knowledge and on the critical importance of lifelong learning in psychopharmacological practice.

Documentation

1. Please describe how your program prepares students for lifelong learning. This could include exposure to software systems, electronic journals, or medication alerts (e.g., Epocrates, *Carlat Psychiatry Report*, Cochrane Reviews, guidelines.gov, UpToDate).


AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Senate Bill 752 Workgroup Meeting Minutes
Department of Health Professions
Board Room 1
9960 Mayland Drive, Henrico, VA 23233
Wednesday, August 15, 2025, at 10:00 a.m.

MEETING CHAIR:	Jaime Hoyle, JD, Executive Director
WORKGROUP MEMBERS:	Adam Kaul, MD Aliya Chapman, Ph.D. Anita Clayton, MD Elliott Lucas, MD James Morris, PhD Jason Burton, MD Jeremy Walden, PhD Krishna Madiraju, MD Lauren Webb, MD Sonal Pancholi Doran, Psy.D., LCP
ABSENT WORKGROUP MEMEBERS:	Gary Sibcy, Ph.D. William Hathaway, Ph.D., LCP
BOARD STAFF PRESENT:	Caroline Juran, RPh, Executive Director Charlotte Lenart, Deputy Executive Director Jennifer Deschenes, Deputy Executive Director Meagan Ohlsson, Licensing Supervisor
DHP STAFF PRESENT:	Arne Owens, Agency Director, Department of Health Professions Erin Barrett, Director of Legislative Affairs and Policy, Department of Health Professions
CALL TO ORDER:	Ms. Hoyle called the meeting to order at 10:06 a.m.
MISSION STATEMENT:	Ms. Lenart read the mission statement of the Department of Health Professions and the emergency egress procedures.
MINUTES:	Dr. Madiraju moved to approve the minutes as presented. Dr. Chapman seconded the motion, and it was approved unanimously.
ADOPTION OF AGENDA:	The agenda was adopted as presented.
PUBLIC ATTENDEES:	Aimee Perron Seibert, Commonwealth Strategy Group Allyson Flinn, Medical Society of Virginia (MSV) Cal Whitehead, Commonwealth Strategy Group Clark Barrineau, Medical Society of Virginia (MSV) Laura McHale, Virginia Academy of Clinical Psychologists (VACP) Sarah Thomas, Virginia Council of Nurse Practitioners (VCNP) Scott Castro, Medical Society of Virginia (MSV)
PUBLIC COMMENT:	Clark Barrineau, representing the Medical Society of Virginia, provided verbal comments reiterating the points outlined in his previously submitted written

public comment, as well as referencing the public comment email submitted by Dr. Robiner.

Psychiatric Society of Virginia (PSV) and the Northern Virginia Chapter of the Washington Psychiatric Society (WPS), provided written comment (Attachment A)

Virginia College of Emergency Physicians (VACEP), provided written comment (Attachment B)

Virginia Academy of Physician Assistants (VAPA), provided written comment (Attachment C)

SENATE BILL 752 LANGUAGE/OBJECTIVE

Ms. Hoyle stated that the objective of the meeting is to carry out the directive of Senate Bill 752, which requires the Boards of Psychology and Medicine to convene a workgroup to assess the conditions under which it may be appropriate or feasible to authorize clinical psychologists licensed in the Commonwealth to obtain and utilize prescriptive authority. As part of this task, the workgroup is responsible for identifying the regulatory framework that would be necessary to implement such authority, if approved by the General Assembly, including requirements for education, training, supervised experience, and licensure.

REVIEW OF EDUCATION, TRAINING, AND QUALIFICATIONS

Ms. Hoyle reviewed the PowerPoint presentation (Attachment D), which includes information on the minimum licensure and education requirements for licensed clinical psychologists and physician assistants, as well as the draft Virginia Proposal from the VACP.

DISCUSSION OF POTENTIAL (REGULATORY) FRAMEWORK:

Ms. Hoyle provided the workgroup with a comparative review of jurisdictional requirements for clinical prescriptive authority (Attachment E), highlighting variations across jurisdictions. She emphasized that the workgroup's mandate is to assess under what conditions prescriptive authority could be appropriately granted and to identify the regulatory framework that would be necessary if such authority were authorized.

The workgroup did not reach consensus in support of granting prescriptive authority to psychologists, even with additional education or training. Nonetheless, members and staff emphasized the importance of establishing a framework to provide input should legislation pass. Accordingly, the discussion centered on a conservative, safety-first approach. Members generally agreed that, if prescriptive authority were granted, initial prescribing should occur under indefinite supervision or collaboration, limited to adults aged 18–65, with the exclusion of pregnant individuals.

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, in addition to post-doctoral master's degree in clinical psychopharmacology. The

Virginia Association of Clinical Psychologists (VACP) provided a proposed preceptorship model for consideration (Attachment F).

Members emphasized the need for a supervised practice period, potentially lasting two years, rotating across relevant clinical areas before transitioning to a supervision or collaborative agreement with a physician. Such agreements would define the scope of practice, limit prescribing to mental and emotional disorders, and establish oversight requirements. The workgroup discussed whether supervision should be provided by any licensed physician or specifically by a psychiatrist. Controlled substances would remain restricted, with Schedule I substances, REMS-regulated medications, opioids, and benzodiazepines prohibited. Schedule II medications, except stimulants, could be prescribed for adults under appropriate education and experience within physician-approved supervision or collaborative agreements.

RECESS: The Board recessed at 12:09 p.m.

RECONVENTION: The Board reconvened at 12:29 p.m.

The group supports strong safeguards, documentation standards, and interdisciplinary oversight, whether administered by the Board of Medicine, the Board of Psychology, an advisory board, or a joint collaborative board.

The workgroup did not issue a formal recommendation but engaged in a thoughtful discussion and provided advice to the General Assembly through the report, highlighting valid concerns identified by its members.

NEXT STEPS: Ms. Hoyle will draft a formal feasibility report documenting that consensus was not reached, while outlining the conditions or parameters that could be considered if such legislation were pursued, including the workgroup's concerns and recommendations. Once drafted, Dr. Harp, Ms. Juran, Ms. Barrett, and Mr. Owens will review and provide feedback prior to submission of the report to the Chairs of the House Committee on Health and Human Services and the Senate Committee on Education and Health by November 1, 2025.

ADJOURNMENT: Ms. Hoyle adjourned the meeting at 1:42 p.m.

Attachment A

8.7.2025

To: William Harp, Board of Medicine

Jaime Hoyle, Board of Psychology

Re: SB 752 Work Group on Prescriptive Authority – 8.15.2025

The Psychiatric Society of Virginia (PSV) and the Northern Virginia Chapter of the Washington Psychiatric Society (WPS) appreciate the additional opportunity to provide input about granting prescribing authority to clinical psychologists in the Commonwealth of Virginia. As we continue in depth review of the concept and based on discussion from the first work group meeting, we respectfully maintain strong opposition to the expansion of prescribing privileges to clinical psychologists.

We firmly believe that there are no appropriate clinical conditions under which psychologists should be permitted to prescribe medications. Our position is grounded in a commitment to patient safety and the highest standards of medical care. The safe and effective prescription of psychotropic medications requires not only a deep understanding of psychiatric disorders but also comprehensive knowledge of human physiology, pharmacology, and the complex interactions between medications and systemic medical conditions. This level of training is achieved through medical school, a residency in psychiatry, and years of clinical experience managing patients with a wide range of comorbid medical and psychiatric conditions.

While a psychotropic medication may appear clinically appropriate when viewed solely through the lens of mental health symptomatology, the broader medical context may reveal critical safety concerns. These considerations include, but are not limited to, harmful drug-to-drug interactions, renal and hepatic metabolism, cardiovascular risks, endocrinologic effects, and the interplay with chronic diseases such as diabetes, hypertension, or autoimmune disorders. Recognizing these subtleties requires a level of training and clinical judgment that cannot be acquired through abbreviated courses in psychopharmacology or foundation-level education modules.

For example, prescribing an antidepressant to a patient with an undiagnosed cardiac arrhythmia or initiating antipsychotic medication in a patient with uncontrolled diabetes may lead to severe adverse outcomes if not properly evaluated and managed within a whole-body context. Psychiatrists are trained to navigate these complexities daily, often coordinating care with internists, neurologists, endocrinologists, and other specialists. In contrast, clinical psychologists are not educated or clinically trained to consider the systemic implications of pharmacologic treatment, nor are they equipped to manage the potential medical emergencies that may arise from adverse drug reactions.

We also emphasize that the model of collaborative care—where psychologists provide valuable psychotherapy and psychological assessment alongside psychiatrists who manage pharmacologic treatment—is effective, evidence-based, and safe. Expanding prescriptive authority to

individuals without medical training would weaken this model, create fragmentation of care, and increase the risk of harm.

In closing, we urge the workgroup to consider the long-term implications of altering prescribing standards and to maintain the essential distinction between medical and non-medical providers. Prescribing medication is a complex medical responsibility—one that must remain within the purview of professionals fully trained in the biological sciences and the practice of medicine. Virginia is in line with the overwhelming majority of states that have maintained that comprehensive medical education and training is essential to safe prescribing. Over many years and recently, a diverse list of states has rejected proposals to abandon this patient safety model.

Thank you for your time and your dedication to public health. We are available for further discussion or to provide additional information if needed.

Sincerely,

Karl Northwall, MD

President, Psychiatric Society of Virginia

Todd Cox, MD, DFAPA

President, Washington Psychiatric Society

Attachment B

Virginia College of Emergency Physicians

Virginia College of Emergency Physicians

2209 Dickens Rd.
Richmond, VA 23230
vacep.org

August 13, 2025

William Harp, MD
Executive Director
Board of Medicine

Jaime Hoyle
Executive Director
Board of Psychology

Sent via email

Dear Dr. Harp and Ms. Hoyle,

On behalf of the Virginia College of Emergency Physicians (VACEP), we appreciate the time and attention the work group spent discussing SB 752 in July. However, after hearing the discussion and learning about the few other states that allow this authority, we were not swayed into thinking there are any conditions where it would be appropriate for psychologists to be granted prescribing authority.

Currently, Virginia law limits prescriptive authority to professionals who have completed degrees with a basis in medical education—physicians, nurse practitioners, and physician assistants. This safeguard exists for a reason: prescribing medications, particularly psychiatric drugs, requires medical training to identify, prevent, and manage potentially serious adverse effects. It was clear from the discussion at the first meeting that psychologists do not receive any comparable medical training at any point in their education and training. To do so would essentially require them to complete another graduate level degree to come even close to the medical training of a physician assistant.

The clinical data underscore the risks as well. A study published in JAMA Psychiatry. *Emergency Department Visits by Adults for Psychiatric Medication Adverse Events*, analyzing U.S. emergency department (ED) visits between 2009 and 2011 found that adverse drug events (ADEs) from psychiatric medications alone account for an estimated 90,000 ED visits each year—nearly one in five resulting in hospitalization. Antipsychotics, lithium salts, sedatives, antidepressants, and stimulants were all implicated, with antipsychotics and lithium salts producing the highest rates of emergency visits per prescription.

Key findings include:

- **High Risk of Serious Harm** – Nearly 20% of psychiatric medication ADEs required hospitalization, indicating that complications are frequently severe.
- **Complexity of Management** – Antipsychotics, for example, are associated with movement disorders, metabolic disturbances, and increased mortality in older adults—conditions that require in-depth medical assessment and ongoing monitoring.

- **Age-Related Risks** – Adverse events were common not only in older adults but also in patients aged 19–44, underscoring that these risks are not confined to the elderly.
- **Off-Label Use Concerns** – Over half of antipsychotic prescribing is for non–FDA-approved indications, often with inadequate evidence of benefit, heightening the risk–benefit complexity that prescribers must weigh.
- **Polypharmacy and Comorbidity** – Many patients requiring psychiatric medication also have medical conditions and take other drugs, further complicating safe prescribing.

Even with the medical training clinicians with prescriptive authority receive—including anatomy, physiology, pharmacology, and supervised clinical rotations—psychiatric medications still account for tens of thousands of ED visits each year. Psychologists, even at the doctoral level, do not receive any medical education or clinical training in diagnosing and managing the systemic effects of medications. Expanding prescribing rights to non–medically trained professionals risks increasing avoidable harm to patients and adding preventable strain to already overburdened emergency departments.

Virginia's current prescriptive authority framework prioritizes patient safety by ensuring that only those with medical education and clinical experience can initiate and manage medications with significant risks. Given the existing evidence of harm from psychiatric medications—even in the hands of trained medical professionals—there is no pressing public health need or safety justification to expand prescriptive authority to psychologists.

We urge you to maintain Virginia's existing safeguards and reject any proposal that would allow psychologists to prescribe medication. Patient safety demands nothing less.

Sincerely,

Jesse Spangler M.D.

Jesse Spangler, MD
President, Virginia College of Emergency Physicians

Attachment C

August 14, 2025

William Harp, M.D., Board of Medicine
Jaime Hoyle, Board of Psychology
9960 Mayland Drive, Suite 300
Richmond, VA 23233-1463

Re: SB 752 Work Group on Prescriptive Authority

On behalf of the Virginia Academy of Physician Assistants (VAPA), we appreciate the additional opportunity to participate in the SB 752 Work Group tasked with evaluating "under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority." As the professional voice for nearly 5,000 physician assistants (PAs) in the Commonwealth, we take our responsibility to advocate for high standards of care, patient safety, and evidence-based practice across all health professions seriously.

Virginia PAs are trusted healthcare providers who practice medicine in every setting and specialty, working in close collaboration with physicians and other members of the healthcare team. With over 50 years of experience in safe, team-based prescribing, PAs understand that prescriptive authority encompasses more than just writing a prescription. It is the culmination of years of integrated education in the biomedical sciences, clinical diagnosis, and patient management.

From the undergraduate level, future PAs complete extensive coursework in foundational sciences such as biology, chemistry, anatomy, physiology, microbiology, and biochemistry. These subjects form the basis for understanding how diseases develop and how medications affect the whole person. At the graduate level, PA programs mirror the structure of medical school, with intensive training in pathophysiology, pharmacology, and systems-based medicine, followed by thousands of hours of supervised clinical rotations in multiple specialties.

By contrast, clinical psychology training, while critically important for mental and behavioral health, focuses on psychological theory, behavioral science, and therapeutic interventions. It does not require the same pre-medical science foundation, nor does it include comprehensive instruction in the functioning of organ systems, systemic disease processes, or the pharmacologic principles needed to manage medications that act on the brain but also impact cardiovascular, endocrine, hepatic, and other body systems.

Psychotropic medications are not isolated to the mind. Instead, they can have significant effects on virtually every organ system. Antipsychotics can alter metabolism and increase

cardiovascular risk. Antidepressants can influence blood pressure and heart rhythm. Stimulants can affect cardiac function and interact with other medications a patient may be taking for unrelated conditions.

Safe prescribing requires the ability to recognize, monitor, and manage these systemic effects, which demands a broad medical knowledge base and the ability to integrate laboratory findings, physical examination results, and complex patient histories. Without this whole-body medical training, prescribers risk overlooking interactions or complications that extend far beyond the brain.

VAPA supports expanding access to mental health care, particularly in rural and underserved communities, but believes that this must be done without lowering the standard of medical training required for prescribing. In states where psychologists have been granted prescriptive authority, uptake has been limited, and access disparities have not meaningfully improved.

Evidence-based approaches such as integrated behavioral health teams, telepsychiatry, and the Collaborative Care Model can expand access while preserving the level of medical oversight necessary for safe prescribing. These models have proven effective, scalable, and patient-centered.

VAPA welcomes the opportunity to bring our clinical expertise to this important discussion. As medically trained providers, PAs are uniquely qualified to speak to the level of preparation, judgment, and knowledge required to prescribe safely across all systems of the body.

Forty-three states, including Virginia, maintain the position that prescriptive authority should remain with medically trained providers. We encourage the Commonwealth to continue prioritizing clinical rigor and public safety as the foundation of its mental health policy.

Please do not hesitate to contact us for further discussion or information. We remain committed to partnering with all stakeholders to promote responsible, patient-first approaches to mental health care in Virginia.

Sincerely,

Jenna Rolfs

Jenna Rolfs, DMSc, MBA, PA-C
President, Virginia Academy of PAs

Attachment D

Public Comment

Overview of SB752

Direct the Boards of Psychology and Medicine to jointly convene a work group to study:

- The education, training, and qualifications of clinical psychologists licensed in the Commonwealth;
- and assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority.

Virginia Current Education and Training

Clinical Psychologist (LCP) Education Requirements

- Doctoral Program
  - 3 academic years of full-time graduate study
  - Core curriculum
    - Biological bases of behavior (e.g., physiological psychology, comparative psychology, neuropsychology, sensation and perception, health psychology, pharmacology, neuroanatomy)
    - Cognitive-affective bases of behavior (e.g., learning theory, cognition, motivation, emotion)
    - Social bases of behavior (e.g.) social psychology, group processes, organizational and systems theory, community and preventive psychology, multicultural issues)
    - Psychological measurement
    - Research methodology
    - Techniques of data analysis
    - Professional standards and ethics

Clinical Psychologist (LCP) Education Requirements *cont.*

- Core Clinical Psychology curriculum
  - Individual differences in behavior
  - Human development
  - Dysfunctional behavior, abnormal behavior, or psychopathology
  - Theories and methods of intellectual assessment and diagnosis
  - Theories and methods of personality assessment and diagnosis including its practical application
  - Effective interventions and evaluating the efficacy of interventions

Clinical Psychologist (LCP) Licensure Requirements

- Completion of doctoral level program (indicated on earlier slides)
- Completion of Practicum Experience (minimum of 9 graduate semester hours)
  - Involving assessment, diagnosis and psychological interventions
- Completion of Internship
- Completion of 1500 hour residency
- Passage of national exam

Physician Assistant Requirements

- Completion of PA program
  - Master's level – usually bachelor's level science degree as prerequisite
  - Typically includes 2-3 years full time combining classroom and supervised clinical rotations
  - Typically take pharmacology course and psychiatric clinical rotation
- No residency
- Prescriptive authority
  - 35 hours of pharmacology
  - Practice agreement
  - No scope limitations

Prescriptive Authority Models

Virginia Proposal

- Licensed as a clinical psychologist in good standing in the Commonwealth of Virginia
- Completion of three years of active clinical psychology practice
- Successful completion of a postdoctoral Master of Science degree from an American Psychological Association approved university program in Clinical Psychopharmacology
  - Curriculum shall include instruction in anatomy and physiology, biochemistry, neurosciences, pharmacology, psychopharmacology, clinical medicine/pathophysiology, and health assessment, including relevant physical and lab assessment
- Completion of a supervised clinical experience as defined in Virginia Administrative Code
  - To include observational clinical assessment and diagnostic pathophysiology, including diagnostic tests and procedures and treatment of mental health disorders with a minimum of 100 patients.
- Successful completion of the national qualifying examination endorsed by the American Psychological Association and the Association of State and Provincial Psychology Boards.
- Recommendation of 2 collaborating primary care providers
- Recommendation of Prescriptive Authority Advisory Committee
- Completion of 100 hours of CME related to psychopharmacology and pharmacological treatment
- Maintain commercial professional liability insurance

Virginia Proposal – Scope of Practice

- Psychotropic medications
  - Only drugs recognized and customarily used for management of mental, nervous, emotional, behavioral, substance abuse, and cognitive diseases or disorders
  - No narcotics
  - Not treat patients for primary medical conditions
- Only in consultation and collaboration with patient's primary care physician, attending, or other independently practicing primary care medial provider, and with the concurrence of that physician or provider.

Discussion Points

Next Steps

Attachment E

Comparison of Jurisdictional Requirements for LCP Prescriptive Authority							
	New Mexico	Louisiana	Illinois	Iowa	Idaho	Utah	Virginia Proposed
Psychology PhD or PsyD	x	x	x	x	x	x	x
License in good standing	x	x	x	x		x	x
Post-doctoral master's degree in clinical psychopharmacology	x	x			x		x
Specialized/Advanced Education in clinical psychopharmacology			x	x		x	
Pass PEP exam or board approved exam	x	x	x	x	x	x	x
Supervised practicum treating patients with psychotropic medications	400 hours	x	14- 28 months ; 9 medical rotations, 1620 hours, 20hrs/wk	x	x	400 hours	x
Limited to treating Mental and Emotional Disorders	x	x	x	x	x	x	x
Cannot Prescribe Schedule I	x	x		x	x	x	
Cannot Prescribe Schedule II	x		x	x	x		
Cannot prescribe benzodiazepines			x				
Cannot prescribe medications for patients under 17			x				

	New Mexico	Louisiana	Illinois	Iowa	Idaho	Utah	Virginia Proposed
Cannot prescribe medications for patients under 18						x	
Cannot prescribe medications for patients over 65			x				
Cannot prescribe opioids					x		
Cannot prescribe for non-psychiatric conditions					x		
Prescribe only in collaboration and with concurrence of physician							x
Prescribe under supervision for 2 years				x			

Attachment F

Proposed Preceptorship Model

Focusing upon serving underserved localities and income-challenged Virginia residents, it is proposed that the VACP and one or more clinics or medical practices jointly develop and implement a 500–800-hour collaborative voluntary preceptorship. This program would include the following parameters and training experiences:

1. **Qualifying criteria for candidate LCPs seeking to participate in the VAFCC/VACP preceptorship:**
   a. Licensure in good standing as a Clinical Psychologist in Virginia
   b. Successful completion of at least one year of enrollment in a postdoctoral *Master of Science in Clinical Psychopharmacology* (M.S.C.P.) program that has been approved by the American Psychological Association (APA)
   c. Meets all qualifying organizational criteria for clinical privileges with the identified preceptorship clinic or healthcare practice.
   d. Has agreed to consider becoming credentialed as a provider with one or more health insurer networks in which the identified clinic or practice participates.
   e. Agrees to donate the proceeds of any treatment services billed in the name of the LCP by the identified clinic to that organization's revenue.

2. **VACP Preceptorship program elements:**
   a. To the extent feasible, preceptorship Licensed Clinical Psychologists (LCPs) will work collaboratively with participating physicians and nurse practitioners to provide direct behavioral health treatment services, consistent with the LCP's scope of practice and clinical experience/specialty. These services may include:
      i. Initial behavioral health clinical assessment
      ii. Psychometric testing, interpretation and reporting
      iii. Provision of individual psychotherapy services
      iv. Development of behavioral health intervention plans
      v. Expert consultation to clinic personnel, as appropriate

   b. In conjunction with preceptorship supervisors, LCPs will complete standard medical examination and treatment training, to include, in accord with anticipated statutory supervision requirements:
      i. Mastering skills with the proper completion of physical examinations, including:
         1. Demonstrating mastery of the proper use of medical equipment.
         2. Manifesting knowledge gained from:
            a. physical examination and

b. mental status examination.

3. Exhibiting proper skills for recognizing variation associated with developmental stage and diversity.
4. Review of systems, including:
    a. Demonstrating skills with completing reviews of:
        i. each major body system,
        ii. recognizing normal developmental variations for accurate diagnosis
        iii. identifying relevant symptomatic indications

ii. Mastering and manifesting the ability to:
1. Order and interpret appropriate tests and procedures (e.g., psychometric, laboratory, and imaging)
    a. for differential diagnosis,
    b. and for monitoring therapeutic and adverse effects of treatment.

iii. Mastering skills with differential diagnosis and integrated treatment planning:
1. Ability to identify and select, using all available data, the most appropriate diagnosis and treatment options, including:
    a. medication,
    b. psychosocial,
    c. and combined treatments

iv. Mastering use of relevant diagnostic algorithms and related technologic diagnostic approaches

3. Treatment management:

a. Demonstrate mastery of the skills necessary to prescribe, monitor, and modify treatment.

v. Craft valid and complete prescriptions, referrals, and consults

vi. Use functional knowledge of accurate medical procedural coding.

vii. Develop enhanced awareness of patient perspectives on health care delivery, its costs and impact upon overall life adjustment.

b. Completion of all the above training activities with clinical examples of the following commonly treated diagnostic categories:

i. Each preceptorship participant will demonstrate the full range of functional diagnostic and treatment planning skills. These activities will include recommending appropriate pharmacological interventions, as well as the need for additional interventions and for proper referrals for specialty care with the following disorders:

1. Common symptom presentations
2. Infectious diseases
3. Immunologic disorders
4. Hematologic disorders
5. Behavioral health disorders
6. Neurological disorders
7. Cardiovascular disorders
8. Respiratory disorders
9. Endocrine and metabolic disorders
10. Hepatic disorders
11. Renal disorders
12. Epidermal disorders
13. Other designated categories

3. Preceptorship outcome report:

Satisfactory mastery of the preceptorship training elements within an agreed upon time frame will be validated by the preceptorship program in a report for submission to a participant's designated Master of Science in Clinical Psychology program. The report will also serve as a required element of any application for prescriptive authority to the Virginia Board of Psychology.

COMMONWEALTH of VIRGINIA

Arne W. Owens
Director

Department of Health Professions
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, Virginia 23233-1463

www.dhp.virginia.gov
PHONE (804) 367- 4400

TO: The Honorable Mark D. Sickles
Chair, House Committee on Health and Human Services

The Honorable Ghazala F. Hashmi
Chair, Senate Committee on Education and Health

FROM: Arne W. Owens
Director, Virginia Department of Health Professions

DATE: November 10, 2025

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

This report is submitted in compliance with SB752 of the 2025 General Assembly Session, which directed:

> The Boards of Psychology and Medicine shall jointly convene a work group . . . to study the education, training, and qualifications of clinical psychologists licensed in the Commonwealth, including the level of education and training clinical psychologists receive in pharmacology, and assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority. The bill requires the work group to report its findings to the Chairs of the House Committee on Health and Human Services and the Senate Committee on Education and Health by November 1, 2025.

Should you have questions about this report, please feel free to contact me at (804) 367-4648 or arne.owens@dhp.virginia.gov.

AO/EB
Enclosure

CC: The Honorable Janet Kelly, Secretary of Health and Human Resources

Preface

This report is submitted in compliance with Chapter 590 (SB752) of the 2025 General Assembly, which stated:

> That the Boards of Psychology and Medicine shall jointly convene a work group to include two representatives of the Board of Psychology who are licensed clinical psychologists, two representatives of the Board of Medicine who are physicians, one representative of the Board of Pharmacy, two licensed clinical psychologists who are faculty at accredited institutions of higher education in the Commonwealth, two representatives from departments of psychiatry at schools of medicine located in the Commonwealth, a representative of the Virginia Academy of Clinical Psychologists, a representative of the Psychiatric Society of Virginia, and other stakeholders as deemed necessary to study the education, training, and qualifications of clinical psychologists licensed in the Commonwealth, including the level of education and training clinical psychologists receive in the area of pharmacology, and assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority.

SB752 requires the work group to report its findings to the Chairs of the House Committee on Health and Human Services and the Senate Committee on Education and Health by November 1, 2025.

Contents

I. Executive Summary

Pursuant to SB752, the Virginia Board of Psychology and the Virginia Board of Medicine convened a workgroup to include two representatives of the Board of Psychology who are licensed clinical psychologists, two representatives of the Board of Medicine who are physicians, one representative of the Board of Pharmacy, two licensed clinical psychologists who are faculty at accredited institutions of higher education in the Commonwealth, two representatives from departments of psychiatry at schools of medicine located in the Commonwealth, a representative of the Virginia Academy of Clinical Psychologists, a representative of the Psychiatric Society of Virginia, and other stakeholders as deemed necessary. The workgroup met twice on July 9, 2025[1] and August 15, 2025[2] to study the education, training, and qualifications of clinical psychologists licensed in the Commonwealth, including the level of education and training clinical psychologists receive in the area of pharmacology, and assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority.

Although reflected in the public comment received for the workgroup meetings, the workgroup did not debate whether granting prescriptive authority to clinical psychologists would address access to care issues created by a shortage of psychiatrists. Instead, the workgroup focused on the directive of SB752 and attempted to determine under what circumstances, if any, clinical psychologists should be granted prescriptive authority in Virginia. The workgroup did not reach consensus on a path forward.[3] Some members strongly opposed prescriptive authority under any circumstances, while others may support it conditionally.

This report attempts to capture under what conditions some members of the workgroup were comfortable moving forward. Support among workgroup members for providing psychologists prescribing authority changed depending on the combination of requirements. Members did agree, however, that any prescriptive authority should require additional science-based knowledge, clinical experience, passage of a national exam, and structured supervision.

[1] The agenda materials for the July 9, 2025 meeting may be found at https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting\31\41951\Agenda_DHP_41951_v2.pdf and minutes of the meeting may be found at https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting\31\41951\Minutes_DHP_41951_v3.pdf.

[2] The agenda materials for the August 15, 2025 meeting may be found at https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting\31\42032\Agenda_DHP_42032_v1.pdf and minutes of the meeting may be found at https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting\31\42032\Minutes_DHP_42032_v1.pdf.

[3] SB752 did not direct the workgroup to provide recommendations regarding changes needed to allow psychologists prescriptive authority.

Workgroup Members

Jason Burton, MD
Psychiatrist
Virginia Commonwealth University, School of Medicine, Department of Psychiatry

Anita Clayton, MD
Psychiatrist
University of Virginia School of Medicine, Department of Psychiatry & Neurobehavioral Sciences

Aliya Chapman, PhD
Licensed Clinical Psychologist
Immediate Past Chair,
Virginia Board of Psychology

Sonal Doran, PhD
Licensed Clinical Psychologist
Virginia Board of Psychology

William Hathaway, PhD
Licensed Clinical Psychologist
Professor
Regent University, School of Psychology & Counseling, Psychology Department

Caroline Juran, RPh
Executive Director
Virginia Board of Pharmacy

Adam Kaul, MD
Psychiatrist
Psychiatric Society of Virginia

Elliott Lucas, MD
Obstetrician-Gynecologist
Virginia Board of Medicine

Krishna Madiraju, MD
Pediatrician
Virginia Board of Medicine

James Morris, PhD
Licensed Clinical Psychologist
Virginia Academy of Clinical Psychologists

Gary Sibcy, PhD
Licensed Clinical Psychologist
Professor
Liberty University, School of Behavioral Sciences, Psychology Department

Jeremy Walden, PhD
Licensed Clinical Psychologist
Virginia Academy of Clinical Psychologists

Lauren Webb, MD
Emergency Medicine

Staff Participants

Erin Barrett, JD
Director of Legislative and Regulatory Affairs
Virginia Department of Health Professions

Jennifer Deschenes, JD
Deputy Executive Director
Virginia Board of Medicine

William Harp, MD
Executive Director
Virginia Board of Medicine

Jaime Hoyle, JD, *Chair*
Executive Director
Virginia Board of Psychology

II. Education and Requirements for Clinical Psychologists

A. Existing Educational Requirements

Pursuant to SB752, the workgroup reviewed the existing education, training, and qualifications for licensure as a clinical psychologist in Virginia. Those requirements are outlined in the Regulations Governing the Practice of Clinical Psychology.[4] Obtaining a license as a clinical psychologist in Virginia requires graduation from a doctoral program that includes a general core curriculum containing a minimum of three or more graduate semester hours or five or more graduate quarter hours in the following:[5]

- Biological bases of behavior (e.g., physiological psychology, comparative psychology, neuropsychology, sensation and perception, health psychology, pharmacology, neuroanatomy);
- Cognitive-affective bases of behavior (e.g., learning theory, cognition, motivation, emotion);
- Social bases of behavior (e.g., social psychology, group processes, organizational and systems theory, community and preventive psychology, multicultural issues);
- Psychological measurement;
- Research methodology;
- Techniques of data analysis; and
- Professional standards and ethics.

Additionally, the doctoral program curriculum must include at least three or more graduate semester hours or five or more graduate quarter hours in each of the following clinical psychology courses:[6]

- Individual differences in behavior;
- Human development;
- Dysfunctional behavior, abnormal behavior, or psychopathology;
- Theories and methods of intellectual assessment and diagnosis;
- Theories and methods of personality assessment and diagnosis including its practical application; and
- Effective interventions and evaluating the efficacy of intervention.

Licensure candidates must also complete a supervised practicum experience, which is a minimum of nine graduate semester hours. The supervised experience includes assessment,

[4] 18VAC125-20-10 *et seq.*
[5] 18VAC125-20-54(B)(5).
[6] 18VAC125-20-54(B)(6).

diagnosis, and psychological interventions. Candidates additionally complete an internship and a 1,500-hour supervised residency. Finally, candidates must take and pass the national exam.[7]

B. Previous Legislative Proposal

Prior to the introduction of SB752, the Virginia Academy of Clinical Psychologists ("VACP") presented draft legislation that would enable prescriptive authority for licensed clinical psychologists and presented the legislation as a starting point for discussion. The proposal would grant prescriptive authority to licensed clinical psychologists in good standing in the Commonwealth who complete the following additional training and experience requirements:

- Completion of three years of active practice as a clinical psychologist;
- Successful completion of a postdoctoral master of science degree from a university program in clinical psychopharmacology approved by the American Psychological Association ("APA");[8] and
- Successful completion of the national qualifying examination endorsed by the APA and the Association of State and Provincial Psychology Board ("ASPPB").

VACP's proposal limits the scope of prescriptive authority to psychotropic medications, or only drugs recognized and customarily used for management of mental, nervous, emotional, behavioral conditions, substance abuse, and cognitive diseases or disorders. Under the proposal, clinical psychologists could not prescribe narcotics or treat patients for primary medical conditions. The proposal additionally limits prescribing by a clinical psychologist to prescriptions made in consultation and collaboration with a patient's primary care physician, an attending physician, or another independently practicing primary care medical provider, and with the concurrence of that physician or provider.

[7] Currently, the Association of State and Provincial Psychology Boards ("ASPPB") administers the national exam, called the Examination for Professional Practice in Psychology ("EPPP").

[8] Curriculum is intended to include instruction in anatomy and physiology, biochemistry, neurosciences, pharmacology, psychopharmacology, clinical medicine/pathophysiology, and health assessment, including relevant physical and lab assessment. The curriculum would additionally include completion of a supervised clinical experience that would be defined by regulation to include observational clinical assessment and diagnostic pathophysiology, including diagnostic tests and procedures and treatment of mental health disorders, with a minimum of 100 patients.

III. Prescriptive Authority Models for Clinical Psychologists

The workgroup reviewed prescriptive authority models in other states. Seven states have granted prescriptive authority to clinical psychologists with varying requirements and scopes of practice.

A. New Mexico

New Mexico[9] passed legislation in 2002 that grants prescriptive authority to clinical psychologists who have completed 450 postdoctoral credit hours in clinical psychopharmacology, passed the Psychopharmacology Examination for Psychologists ("PEP"), and completed 400 hours of clinical supervision in psychopharmacology. New Mexico law limits prescribing psychologists to treating mental and emotional disorders and prohibits psychologists from prescribing Schedule II controlled substances. After two years under supervision by a physician or designated primary care provider and meeting peer review requirements, the clinical psychologist can prescribe independently.

B. Louisiana

Louisiana[10] passed legislation in 2004 that authorizes the State Board of Medical Examiners to grant prescriptive authority to clinical psychologists by issuing a medical psychologist license to those psychologists who have graduated with a postdoctoral master's degree in psychopharmacology or obtained equivalent training as approved by the Board, obtained supervised clinical experience, and passed the PEP. Medical psychologists can only prescribe medications related to mental health conditions and are prohibited from prescribing Schedule II controlled substances.

C. Illinois

Illinois[11] granted prescriptive authority to clinical psychologists in 2014 to practitioners that have completed specialized education in clinical psychopharmacology and completed a supervised clinical rotation lasting 14 months to 28 months that consists of nine medical rotations.[12] The residency must total at least 1,620 hours and accumulate 20 hours per week. Additionally, clinical psychologists must pass the PEP. Illinois prohibits prescribing psychologists from prescribing to patients under 17 or older than 65, pregnant patients, or patients with a serious medical condition. Psychologists also may not prescribe Schedule II controlled substances.

---

[9] *See* NMSA 1978 § 61-9-17.1.
[10] *See* La. Rev. Stat § 37:1360.51 *et seq.*
[11] *See* 225 ILCS § 15/15.2.
[12] The nine rotations are in family medicine, internal medicine, psychiatry, pediatrics, geriatrics, obstetrics/gynecology, emergency medicine, surgery, and one other elective, covering a variety of settings such as hospitals, prisons, and mental health clinics. *Id.*

D. Iowa

In 2016, Iowa[13] granted prescriptive authority to psychologists who have completed advanced education in psychopharmacology and completed 400 hours of supervised clinical training and practicum, with 25% of that training occurring in a primary care or community mental health setting. The supervised training includes specific, relevant clinical experience in clinical psychopharmacology and special training in assessment and pathophysiology. After two years of supervision by a physician or designated primary care provider, the prescribing psychologist can prescribe independently.

E. Idaho

In 2017, Idaho[14] granted prescriptive authority to psychologists who complete a postdoctoral master's degree in psychopharmacology from an APA-designated training program, complete a supervised practicum in clinical assessment and pathophysiology, and pass a nationally recognized examination. Idaho does not specify hour requirements for psychopharmacology training. After two years practicing under supervision, psychologists can prescribe independently. Psychologists may only treat mental health disorders and may not prescribe opioids or medications for non-psychiatric medical conditions.[15]

F. Colorado and Utah

Most recently, Colorado[16] and Utah[17] passed legislation granting prescriptive authority to psychologists who complete advanced coursework in psychopharmacology, pass the PEP, and undergo a minimum of 400 hours of supervised clinical training. In Utah, prescribing psychologists may only treat adults with mental health conditions and cannot prescribe narcotics or controlled substances.[18] In Colorado, the law gives authority to the State Board of Psychologist Examiners to determine the number of hours of supervised training and the scope of practice, although prescribing psychologists are still limited to prescribing medications to treat mental health conditions.

[13] *See* Iowa Code § 154B.9.
[14] *See* Idaho Code § 54-2316 (2024) *et seq.*
[15] IDAPA 24.12.01.200.
[16] *See* CRS § 12-245-309.
[17] *See* Utah Code Ann. § 58-61-701 *et seq.*
[18] *See* Utah Code Ann. § 58-61-308.

IV. Prescriptive Authority Models in Virginia

In addition to physicians, Virginia has granted prescriptive authority to other health professionals. Those models are detailed below.

A. Advanced Practice Registered Nurses

Advanced practice registered nurses ("APRN") have had the ability to prescribe since the early 1990s. APRNs[19] practice collaboratively with a patient care team physician or podiatrist and pursuant to a practice agreement between the APRN and a patient care team physician or podiatrist unless certain statutory requirements are met for autonomous practice.[20] For many years, statutory law required APRNs to maintain a separate license for prescriptive authority. The General Assembly eliminated this requirement in 2018 legislation, thus allowing APRNs to prescribe without obtaining separate approval from the Boards of Nursing and Medicine. Prescriptive authority is now incorporated into a license to practice as an APRN in Virginia.[21] APRN prescribing authority is limited to the terms of the practice agreement. An APRN in the category of nurse practitioner[22] may obtain authorization for practice without a practice agreement following three years of full-time clinical experience and upon Board approval. APRN nurse practitioners are, at that point, limited solely by standards of care, the Drug Control Act,[23] and other applicable statutes and regulations.

B. Physician Assistants

Virginia Code § 54.1-2952.1 authorizes licensed physician assistants ("PA") to prescribe. Generally, PAs are educated at a master's level and complete 24 – 27 months of academic instruction which includes didactic and clinical training. This education follows hard science prerequisites, generally resulting in a university degree.[24] In Virginia, Virginia Code § 54.1-2951.1 and 18VAC85-50-50 require an applicant for licensure to have completed an educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant ("ARC-PA").[25] Accredited training includes classroom instruction in anatomy,

[19] Four types of APRNs practice in Virginia: nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists. *See* Va. Code § 54.1-2900.
[20] *See* Va. Code § 54.1-2957.
[21] *See* Va. Code § 54.1-2957.01.
[22] APRNs in other categories, such as certified nurse midwives, have other requirements for practice without a practice agreement. These requirements are found in Virginia Code § 54.1-2957.
[23] Va. Code § 54.1-3400 *et seq.*
[24] Some PA programs will allow entry from high school or only partial college credit, but those programs are longer in length, often requiring four to six years of training. *See* American Academy of Physician Associates at https://www.aapa.org/career-central/become-a-pa/.
[25] ARC-PA is the independent accrediting body for physician assistant training. Accreditation by ARC-PA requires a peer review process that includes documentation and periodic site visit evaluations to substantiate compliance with accreditation standards. ARC-PA reports collaboration with the American Academy of Family Physicians, AAPA, the American Academy of Pediatrics, the American College of Physicians, the American Medical Association, the PA Educational Association ("PAEA"), the Society of Emergency Medicine PAs, the Association of PAs in Psychiatry, the Society of PAs in Family Medicine, the Society of PAs in Pediatrics, and the Association of PAs in

physiology, biochemistry, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory science, behavioral science, and medical ethics.[26] Students in accredited programs complete more than 2,000 hours of clinical rotations in medical and surgical disciplines with emphasis on primary care. Rotations may include disciplines such as family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry.[27]

PAs have prescriptive authority as part of licensure.[28] No scope of practice limitations exist provided the use of prescriptive authority remains within the boundaries of the PA's practice agreement.

C. Pharmacists

Pharmacists do not have the authority to prescribe in the traditional sense. Pharmacists do have the authority to initiate treatment following protocols developed by the Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health for certain diseases or conditions.[29]

Obstetrics and Gynecology. ARC-PA only accredits programs within the United States, including United States territories. *See* https://www.arc-pa.org/about/.

[26] *See* https://www.aapa.org/career-central/become-a-pa/.

[27] *Id.*

[28] *See* Va. Code § 54.1-2952.1.

[29] *See* Va. Code § 54.1-3303.1.

V. Summary of Workgroup Discussions

Initial workgroup discussions centered on the arguments presented in support of granting clinical psychologists prescriptive authority, such as increased access to care, integrated treatment, specialized focus, and the success of models in other jurisdictions. Concerns raised in opposition included training gaps, patient safety risks, overlap with psychiatry, oversight challenges, and the cost of implementation. The workgroup could not reach consensus on the validity and relevance of each of these points and thus focused solely on the directives outlined in SB752.

A. Determining a Pathway to Prescriptive Authority for Clinical Psychologists

Physician members of the workgroup asserted that existing professions with prescriptive authority, such as PAs and APRNs, have educational foundation in hard sciences including anatomy, physiology, biochemistry, molecular biology, genetics, and neurophysiology. In contrast, standard training in psychology lacks a foundation in hard sciences, even if some individual psychologists may have studied hard sciences. Physicians on the workgroup also reasoned that psychology programs lack supervised clinical experience at the level of direct medical care, which raised the physicians' concerns about preparedness for prescriptive authority. For these reasons, some of the physicians on the workgroup argued that clinical psychologists should not have prescriptive authority under any circumstances. After much discussion, the workgroup agreed that to move the discussion forward and adhere to the intent of SB752, the workgroup would consider parameters of prescriptive authority as if a future General Assembly granted clinical psychologists prescriptive authority. Furthermore, the members agreed that the goal of the workgroup would be to provide the General Assembly with a clear picture of the members' viewpoints considering the lack of consensus.

B. Additional Education Requirements

Although there was debate on this issue, the majority of the workgroup members determined that prescriptive authority could be granted to a clinical psychologist who had a postdoctoral master's degree in psychopharmacology from an accredited institution. Of the seven states that have granted prescriptive authority, only Louisiana and Idaho require postdoctoral master's degrees. The remaining five states require advanced education, with various hour requirements, in psychopharmacology. A few workgroup members felt that even a postdoctoral master's degree was insufficient, and that, to ensure patient safety, the deficiency in foundational science must be addressed. These members suggested requiring additional course work or completion of a post-baccalaureate program. Post-baccalaureate programs as recommended by these workgroup members are generally one year in duration and could bridge the gap between standard psychology undergraduate education and a master's level psychopharmacology program.

C. Collaborative Practice

The workgroup reached consensus that any prescriptive authority should include ongoing collaborative practice. Generally, direct supervision requires ongoing, active oversight. Under a supervision model, prescriptions are issued under direct guidance. By contrast, collaborative practice is more flexible and provides for an agreement that allows the psychologist to prescribe within agreed parameters and possibly with indirect consultation. The collaborative agreement defines the scope of prescribing for specific medications, including controlled substances. Collaborative agreements are adaptable as regulations, medications, and practice standards evolve.

D. Supervised Clinical Experience

The workgroup agreed that prescribing clinical psychologists should complete postdoctoral training that incorporates 24 months of supervised experience that includes clinical rotations in pediatrics, neurology, internal medicine, and psychiatry. After completion of the 24 months, supervision could transition to a collaborative practice model. Some workgroup members recommended supervision only by a psychiatrist, whereas others would allow for supervision by a physician in another specialty.

E. Scope of Practice

The workgroup agreed that any prescriptive authority should be restricted to treatment of mental health conditions. Additionally, the workgroup agreed that prescriptive authority should preclude prescribing Schedule II drugs and preclude prescribing to certain patient populations, such as pregnant women, pediatric patients, and patients over 65.

The workgroup determined that prescribing should initially be limited to adults to monitor or measure any safety concerns. The General Assembly could, in later years, revisit pediatric prescribing after first establishing safe and competent prescribing for adults. There was debate, however, whether to allow the authority to prescribe stimulants, which would be an exception to the prohibition on prescribing Schedule II controlled substances. All members agreed that such an allowance would require explicit collaborative agreements.[30]

F. Regulatory Board Oversight

The workgroup reached consensus that the Boards of Medicine, Psychology, and Pharmacy should be involved in the development of potential regulations. The establishment of an advisory board with cross-disciplinary representation could provide expertise for prescriptive authority decisions. Additionally, existing collaborative practice regulations may serve as a model for potential prescribing clinical psychologist collaborative practice regulations. Any potential regulations must be adaptable and involve ongoing review, reflecting changes in medications, standards of care, and prescriptive practices. The workgroup believed statutory

[30] Notably, this would also require statutory allowance both in the Drug Control Act and in the statutory authority for clinical psychologists to prescribe medications. It is not possible to both exclude clinical psychologists from prescribing Schedule II medication in statute and allow some prescribing of Schedule II medication (stimulants) in statute.

authority should be revisited after initial implementation, with data-driven adjustments made as necessary.

V. Conclusion

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

This report captures under what conditions some workgroup members were comfortable considering prescriptive authority for psychologists. Support among workgroup members for providing psychologists prescribing authority changed depending on the combination of requirements. Members did agree, however, that any prescriptive authority should require additional science-based knowledge, clinical experience, passage of a national exam, and structured supervision.

2026 Special Session I

Budget Bill - HB30 (Chapter)

Bill Order » Office of Health and Human Resources » Item 288

Department of Health Professions

Item 288	First Year - FY2027	Second Year - FY2028
Regulation of Professions and Occupations (56000)	**$53,111,601**	**$53,111,601**
Technical Assistance to Regulatory Boards (56044)	$53,111,601	$53,111,601
Fund Sources:		
Special	$575,000	$575,000
Trust and Agency	$1,688,791	$1,688,791
Dedicated Special Revenue	$50,847,810	$50,847,810

Authority: Title 54.1, Chapter 25, Code of Virginia.

A. The Board of Counseling shall promulgate regulations that align with the regulations adopted by the Department of Behavioral Health and Developmental Services for peer recovery specialist-trainees in accordance with this Act. The department shall have the authority to promulgate emergency regulations to implement these changes within 280 days or less from the enactment of this Act.

B.1. The Department of Health Professions (DHP) shall provide the Virginia Health Care Foundation (VHCF) a useable electronic file (CSV, Excel spreadsheet) with record-level, de-identified data collected via the most recent license renewal period for each individual licensed behavioral health (BH) professional practicing in Virginia as a psychiatrist, child and adolescent psychiatrist, psychiatric-mental health nurse practitioner, psychiatric physician assistant, licensed clinical social worker, licensed professional counselor, licensed clinical psychologist and, if available, licensed marriage and family therapist.

2. The following specific data fields shall be provided to VHCF for each licensee: unique record identifier; birthyear; race and ethnicity; gender; practice site information (each locality of practice; number of hours worked/week at each site; hours/week worked virtually at each Virginia work site); forms of payment accepted (with ability to identify the proportion of each type of BH profession accepting only cash, and the proportion of each type of BH profession accepting only Medicaid as a payment source, as well as Medicaid in combination with each other payer source option available to licensees – e.g., Medicaid + Medicare, Medicaid + Medicare + Private Insurance); plans to reduce clinical hours in next two years; and anticipated time to retirement.

3. DHP shall also provide VHCF a code book, data definitions and/or user guides in an electronic format (Word, Excel, PDF) so it can clearly understand the data elements and their structure (alphanumeric, multiple responses – to include all possible options a licensee may select, open/free response). This code book shall also include record length and record count; known data quality issues and related documentation regarding resolution and, to the extent possible, impact on the data set and/or data functionality; and changes to policy and/or administrative practices that may have impacted the data set and implementation date.

4. VHCF shall protect the confidentiality and security of record-level data provided by the DHP and interim or working documents and/or data files consistent with state and federal law.

C. Out of this appropriation, $400,000 the first year and $400,000 the second year from Commonwealth Opioid Abatement and Remediation funds shall be provided for ongoing support and maintenance costs for system changes to the Prescription Monitoring Program pursuant to the provisions of House Bill 1902, passed by the 2025 General Assembly.

D. Out of this appropriation, $100,000 the first year and $100,000 the second year from nongeneral funds and one position shall be used to implement the provisions of Chapters 439 and 440, 2026 Session of the General Assembly.

E. Out of this appropriation, $154,900 the first year and $154,900 the second year from nongeneral funds and one position shall be used to implement the provisions of Chapters 450 and 451, 2026 Session of the General Assembly.

F. The Department of Health Professions shall convene a stakeholder workgroup to review the structure and purpose of the Committee of the Joint Boards of Nursing and Medicine. The workgroup shall consider pathways to modernize the Joint Boards' structure and governance of advanced practice registered nurses. The workgroup shall consist of representatives from the Virginia Council of Nurse Practitioners, Virginia Nurses Association, Virginia Association of Nurse Anesthetists, Medical Society of Virginia, and other stakeholders deemed appropriate by the Department. The workgroup shall report its findings to the Governor and General Assembly by November 1, 2026.

G. The workgroup established pursuant to Chapter 590 of the 2025 Acts of Assembly shall be continued. The workgroup shall report its findings to the Chairs of the House Committee on Health and Human Services and the Senate Committee on Education and Health by November 1, 2026.

H. In the event that expenses for operating health regulatory boards exceed current fees collected by the Boards, a treasury loan, not to exceed $3,500,000, shall be provided to the Department of Health Professions to finance these costs. This treasury loan shall be repaid by no later than June 30, 2030, with the proceeds collected from an increase in health regulatory board fees based on a four-year plan developed by the Department of Health Professions to determine the appropriate fee structure to ensure the sustainability of agency operations.