

ALABAMA LEGISLATURE COMMITTEE FILES

1999-2000

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HOUSE LABOR & COMMERCE

# Alaska State Legislature

REPRESENTATIVE  
**GENE THERRIault**

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## House Of Representatives

While in session  
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House District 33

### MEMORANDUM

MAR 22 1999

TO: Representative Norm Rokeberg, Chair  
House Committee on Labor and Commerce

FROM: Representative Gene Therriault *Gene J.*

DATE: March 22, 1999

SUBJECT: Scheduling of HB 136

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I respectfully request that HB 136 be scheduled for a hearing in the House Economic Committee on Labor and Commerce on Wednesday, March 31, 1999 pending its referral from the House Tourism and Economic Development Committee.

HB 136 is based on the Millenium Plan as developed by the tourism industry. This will consolidate all of our marketing efforts into a single program, to be matched by funds from the private sector.

Please contact me if you have any additional questions.

# Alaska State Legislature

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House District 33

## House Of Representatives

House Bill 136

"An Act relating to tourism and tourism marketing; eliminating the Alaska Tourism Marketing Council; and Providing for an effective date."

SPONSOR: Representative Gene Therriault

### SPONSOR STATEMENT:

House Bill 136 is based on a plan brought forward by the tourism industry and is similar to legislation sponsored last session by the House and Senate Finance Committees. It consolidates the state's tourism marketing efforts, reduces the size and functions of the Division of Tourism, and allows the state to reduce its contribution to tourism marketing over time.

Currently, Alaska's statewide tourism marketing efforts are carried out by three organizations—the Alaska Tourism Marketing Council, the Alaska Visitors Association, and the Division of Tourism. These efforts will be consolidated into a single marketing function that is broadly representative of the various sectors of the visitor industry in the state. This organization will put together a marketing program to address media advertising, visitor inquiries, publishing and distributing information regarding vacation planning, and establishing and maintaining Internet sites that provide tourism information.

The Division of Tourism will provide inquiry assistance, administer visitor information centers, and plan and advocate for tourism and tourism development in coordination with the private sector, municipalities, and state and federal agencies. They will enter into a contract with a single, qualified trade organization for the purpose of planning and executing the state's destination tourism marketing campaign. The contract may include promotion of distinct segments of tourism, such as highway, seasonal, cultural, regional, rural, and ecotourism. This will take the state out of the business of marketing and reduce the number of employees required to carry out the functions of the division.

A central feature of the contract is that the organization awarded it will be required to match the state's effort with 30% of its own money. It is expected that the organization

will grow and its membership collections increase. Therefore, the match will rise to 60% in 2002. The benefits of this are twofold: first, the state will be able to reduce its contribution without doing extreme harm to the industry; second, the private sector will contribute more of its own funds towards the marketing efforts they benefit from.

The industry is coming forward with more of its own dollars. Coupled with efficiencies provided by consolidation, the marketing efforts to bring more visitors to the state will be more effective. This is a responsible approach to reduce the state's monetary contribution without harming the growth of the industry.

# **The New Millennium Plan**

*A Concept for the Future of Tourism in Alaska*

**Alaska Travel Industry Association  
Organizational Outline**

Revised December 1998

# Alaska Travel Industry Association

*A New Concept for the Future*

## A. OVERVIEW

Presented in this document is an industry-led initiative to regain Alaska's competitive position as a visitor destination and to consolidate Alaska's statewide tourism organizations - the Alaska Tourism Marketing Council, the Alaska Visitors Association, and the marketing functions of the Alaska Division of Tourism - into one new, non-profit organization.

This streamlined structure is the industry's solution to several issues facing Alaska tourism: greatly reduced government funding, continued threats of industry taxes, increased competition from other destinations, and a decline in the rate of visitor growth. Without a renewed effort to regain our position in the marketplace, the downward trends will continue.

Rather than continue to watch Alaska's marketing decline further, the tourism industry has taken a proactive approach to deal with the problem. Under this plan, the industry would greatly increase its marketing contribution and the State would continue to provide a core level of funding through a fee-for-services contract with the new non-profit organization. After a phase-in period, the goal is to raise a minimum of \$10 million, with \$6 million coming from the private sector and \$4 million coming from the State. This represents a 25 percent reduction in state general funds and a more than 300 percent increase in private sector funds.

## B. A NEW ORGANIZATION

Dissolve the Alaska Tourism Marketing Council, the Alaska Visitors Association, and the marketing functions of the Alaska Division of Tourism. In their place, create a new statewide organization that would accomplish much of what is being done by all three, while realizing efficiencies from streamlining. While all the marketing functions would be consolidated, the Division of Tourism (DoT) would remain a separate entity within state government for planning, government coordination and advocacy.

Within the organization, there would be three major program areas. A board of directors would set overall policy and budget, overseeing the Tourism Industry Services, Administration and Marketing functions. The marketing program would be implemented by a professional staff at the direction of the Alaska Travel Industry Association board of directors or a committee thereof. It is intended that developmental programs aimed at expanding fall/winter/spring, highway travel, and international markets would continue.

**Marketing Membership Dues**

Based on peak-season employee counts, as follows:

<u># of Employees</u>	<u>Amount</u>
< 5	\$200
5-15	300
16-50	500
51-100	1,000
101-300	2,000
301-500	3,000
501-1,000	4,000
1000+	5,000

**Cruise Lines**

In addition to the membership fees, cruise lines would pay a voluntary assessment based on their percentages of the total Alaska cruise market. The formula-based assessment would be phased in over a three-year period, with a funding goal of \$2 million in the third year.

<u>Company's Alaska passenger cruise days*</u>	x \$1.0 million in FY01
<u>Total passenger cruise days* in Alaska market</u>	x \$1.5 million in FY02
	x \$2.0 million in FY03

See Appendix for contributions beyond FY03.

**Destination Marketing Organizations and Communities**

Local destinations would have the opportunity to dovetail with the state program as a community partner and leverage their marketing dollars with the Visit Alaska efforts. In addition to the membership benefits, participating destinations would receive additional marketing and promotion tools for their communities, such as advertising and label discounts.

Partnering communities and destination marketing organizations (DMOs) would receive benefits such as:

- Participation in press trips coming to Alaska
- 25 percent discount on mailing labels
- Editorial coverage in marketing materials
- Convention and meeting leads
- Vacation Planner advertising\*
  - Buy-ins between \$500-\$4,000 receive a narrative ad
  - Buy-ins between \$4,000-\$7,000 receive a 2" color display ad
  - Buy-ins between \$7,000-\$30,000 receive a ¼ page display ad
  - Buy-ins above \$30,000 receive a ½ page display ad
  - Opportunity to access Pay-to-Play and all other cooperative marketing programs

\*Based on community buy-in at FY01 level see Appendix for further details.

- State Vacation Planner ads
- Sector Guide ads, such as highway travel, winter guide, sportfishing guide
- Mailing label and film footage access
- Trade Show participation, both international and domestic
- Newspaper cooperative ads, Internet ads and link purchase
- Brochure distribution
- Trade promotion, media events, and fam participation
- Research
- Meeting and workshop registrations

### E. STATE PARTICIPATION

The State's responsibility to assist Alaskan businesses with economic development and growth dictates a need to help level the playing field for Alaska's tourism industry as we compete against other destinations receiving millions of dollars from their own states' general funds. In addition, the tourism industry's direct contributions to government (over \$123 million in taxes and fees to state and local governments in 1995) demonstrate that funds spent on tourism promotion are a long-term investment which would come back to the state in increasing amounts as the industry continues to grow.

The state fee-for-service contract of \$4 million represents a 25 percent decrease from current state general fund spending on tourism programs and a 40 percent decrease in total tourism program spending. This decrease would be phased in over a three-year period as the private sector's contributions increase.

The new, non-profit Alaska Travel Industry Association would contract with the State of Alaska to provide marketing services, which may include:

- Producing and distributing a state vacation planner or other materials
- Producing and maintaining a tourism web site
- Responding to visitor inquiries received by the state
- Including state information such as border crossings, hunting/fishing licenses, and road conditions in visitor publications and on the Internet
- Support to communities just beginning tourism development

#### **Division of Tourism**

A separate Division of Tourism within the Department of Commerce and Economic Development (DCED) would be maintained for governmental coordination, state policy development, business development, advocacy, planning, and any visitor information centers. The DoT would also serve as a liaison to the new organization and enter into the marketing contract with ATIA.

H. TIMELINE

Implementation of this proposal would require approximately one full transition year, beginning in 1999. A transition team comprising representatives from the ATMC, AVA, State of Alaska, Destination Marketing Organizations, and Alaska Wilderness Tourism & Recreation Association was formed in July 1998 to write bylaws, incorporate the new organization, and facilitate the election of the first board of directors. The directors of each of the existing organizations (AVA, ATMC, and DoT) also serve as advisors to this transition team.

To ensure a smooth transition, the three current organizations would continue to operate concurrently with the new organization for a period of 6 to 12 months. On or before July 1, 2000, the new organization would officially take over the marketing functions currently served by the existing organizations. Once seated, the Alaska Tourism Industry Association Board of Directors would hire the Chief Staff Executive. Staff of the current organizations would be given first priority for positions with the new organization.

## 1998

January	Revised plan distributed to travel and tourism businesses statewide for approval
March	Legislation introduced
May	Legislature adjourns before enacting plan
July	Transition team formed to begin work on bylaws and articles of incorporation

## 1999

Winter	New legislation introduced
Spring	Transition team coordinates election of first board of directors
July 1	New organization begins initial operations

## 2000

Spring	Full plan takes effect: marketing duties of ATMC and DoT are transferred to new organization and AVA and ATMC are dismantled.
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# Background

## BUILDING ON OUR SUCCESS

### **History of Cooperative Marketing in Alaska**

Cooperative Marketing in Alaska really began with the creation of the Alaska Visitors Association (AVA) in 1950. The major emphasis of the association was promotion, including production of the *Alaska Yukon Travel Manuals*. In fact, between 1959 and 1970, AVA was known as the Alaska Travel Promotion Association and worked on marketing projects with the Division of Tourism after it was formed in the '60s.

In 1976 the first formal cooperative tourism marketing efforts between the State of Alaska and the tourism industry began, when AVA approached the state with an innovative proposal to co-mingle private and state funds to draw visitors to Alaska. The idea was simple: combine funding from the state with money, marketing talent, and knowledge contributed by the private industry to build a program to promote the entire state as a destination. Program recommendations were provided by the Alaska Visitors Association Marketing Council and implemented by the Division of Tourism.

### **A Model Program**

This melding of industry and state tourism efforts went a step further with legislation passed in 1988 to form the Alaska Tourism Marketing Council (ATMC). Jointly managed by the state and AVA, the ATMC oversees promotion of Alaska to the domestic and Canadian markets, while the State Division of Tourism (DoT) manages the international marketing efforts for Alaska.

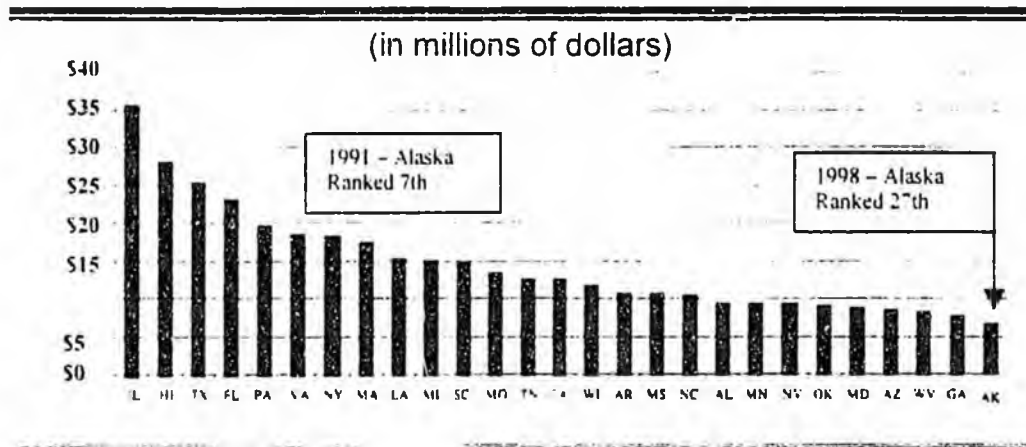
This unique program has created a consistent, high-quality marketing plan that has bolstered industry expansion efforts, as evidenced by the phenomenal growth in the number of visitors to the state. For many years, Alaska's sophisticated marketing techniques and public-private structure served as a model for other destinations. The marketing materials produced were award-winning.

## TOURISM IN TRANSITION

### **Alaska is Losing Ground**

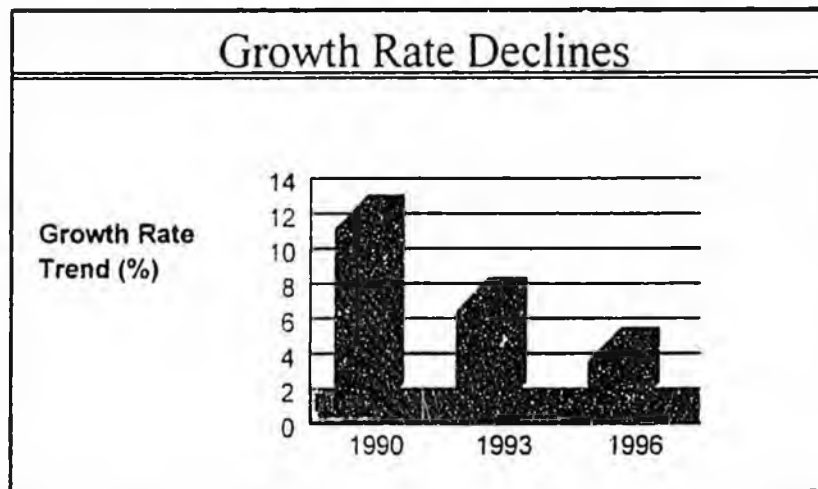
Since 1989, state funding for tourism programs has declined nearly 62 percent, from \$15 million in FY90 to under \$6.7 million in FY99. At the same time, other states have *increased* their tourism promotion by 26 percent in the last five years.

## Top 27 State Tourism Budgets, 1998



### Growth Rate is Declining

Alaska's relative decline in marketing competitiveness is being felt within the industry. While overall visitor numbers have continued to rise, the rate of growth has slowed. Some segments of the industry, most notably highway-dependent businesses, have felt the first effects of decline.



### Visitor Industry Taxes and Fees Increase

Between 1992 and 1995, state taxes paid by visitors and visitor industry businesses increased by 99 percent, fees by 62 percent, and other revenue assessments by 6 percent. Despite these increases, general fund dollars going back to the industry *decreased* by over \$2 million - the equivalent of a 24 percent decrease during the same period of time.

### Industry Attitudes Surveyed

The AVA surveyed its members in July 1997 to gauge the opinions and attitudes toward various funding and organization scenarios. As a result of this survey, four general points of agreement were clear:

- Members strongly believe a statewide tourism marketing program is needed.
- Members strongly believe the state has a role to play in providing funds for tourism promotion.
- Members oppose additional taxes focused on the visitor industry for the purpose of funding general government.
- Two out of three members believe some sort of assessment or fee should be used to support tourism marketing, although there is no consensus about what specific option should be implemented.

### Developing A Concept

After researching funding alternatives and studying the survey results, the AVA board of directors contacted convention & visitors bureaus, government officials, and other industry leaders for input and ideas. When all of this information was taken into account, an outline of what was desired emerged. A plan was designed to accomplish the following:

- Shift marketing efforts to a private entity that combines the activities of the Division of Tourism and Alaska Tourism Marketing Council
- Return Alaska's marketing efforts to a competitive position
- Reach a goal of \$10 million for marketing
- Utilize pay-to-play programs
- Increase private sector funding while state general funds decrease under a phased-in approach
- Increase participation from businesses

### New Millennium Plan Takes Shape

This concept was first presented to 650 industry members during the October 1997 AVA convention. There was general consensus for the proposal as outlined, both during the meeting and in follow-up questionnaires. Convention & visitors bureaus, tourism associations, chambers of commerce, and other organizations arranged meetings to distribute and debate the proposal. The administration and members of the Legislature were briefed and the details of the proposal were published in AVA's newsletter and other print media statewide. A number of changes were made to the draft based on feedback.

In January 1998 a revised plan was mailed to 3,000 tourism businesses statewide in order for them to determine if the plan should be further developed for presentation to the Legislature. Eighty-five percent of respondents recommended moving forward with the plan.

Legislation to implement much of the plan was introduced in 1998 and was passed by both the House and Senate, but failed to reach a final concurrence vote. The industry continued to actively support the legislation, communicating support to their legislators and AVA. A transition team formed in July 1998 to begin working on the details of implementing the plan. The team presented proposed changes to the 1998 AVA convention delegation and, based on their feedback, revised the plan to this present form for increased industry distribution and comment throughout the fall/early winter of 1998/1999.

Community	%	Estimated Contribution FY01	Estimated Contribution FY02	Estimated Contribution FY03
Anchorage	32%	\$160,000	\$240,000	\$400,000
Fairbanks	9%	45,000	67,500	112,500
Juneau	8%	40,000	60,000	100,000
Denali	6%	30,000	45,000	75,000
Ketchikan	5%	25,000	37,500	62,500
Skagway	5%	25,000	37,500	62,500
Kenai / Soldotna	3%	15,000	22,500	37,500
Sitka	2%	10,000	15,000	25,000
Homer	2%	10,000	15,000	25,000
Seward	2%	10,000	15,000	25,000
Valdez	2%	10,000	15,000	25,000
Other Communities*	24% combined			

\*Individual community percentages not available, but each receives less than 2 percent of total visitor expenditures

# TOURISM WISE

## WHAT ALASKANS SHOULD KNOW ABOUT ALASKA'S VISITOR INDUSTRY

### Second Edition

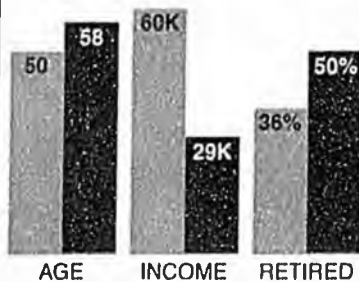
#### TOURISTS ...

## Who are these guys and gals?

- **Well-educated**  
College graduates (25%)  
Attended graduate school (27%)
- **Moderately well-to-do**  
Average household income \$60,000
- **Average Age 50**
- **Gender**  
About half female; half male.
- **Employment**  
About half are employed (52%)
- **Where They Come From**  
United States (83%)  
Canada (10%)  
Overseas (7%)
- **Reason for Visiting**  
Vacation (72%)  
Visiting friends & relatives (11%)  
On business (10%)  
Business and pleasure (7%)

#### DEMOGRAPHIC CHANGES AMONG VISITORS

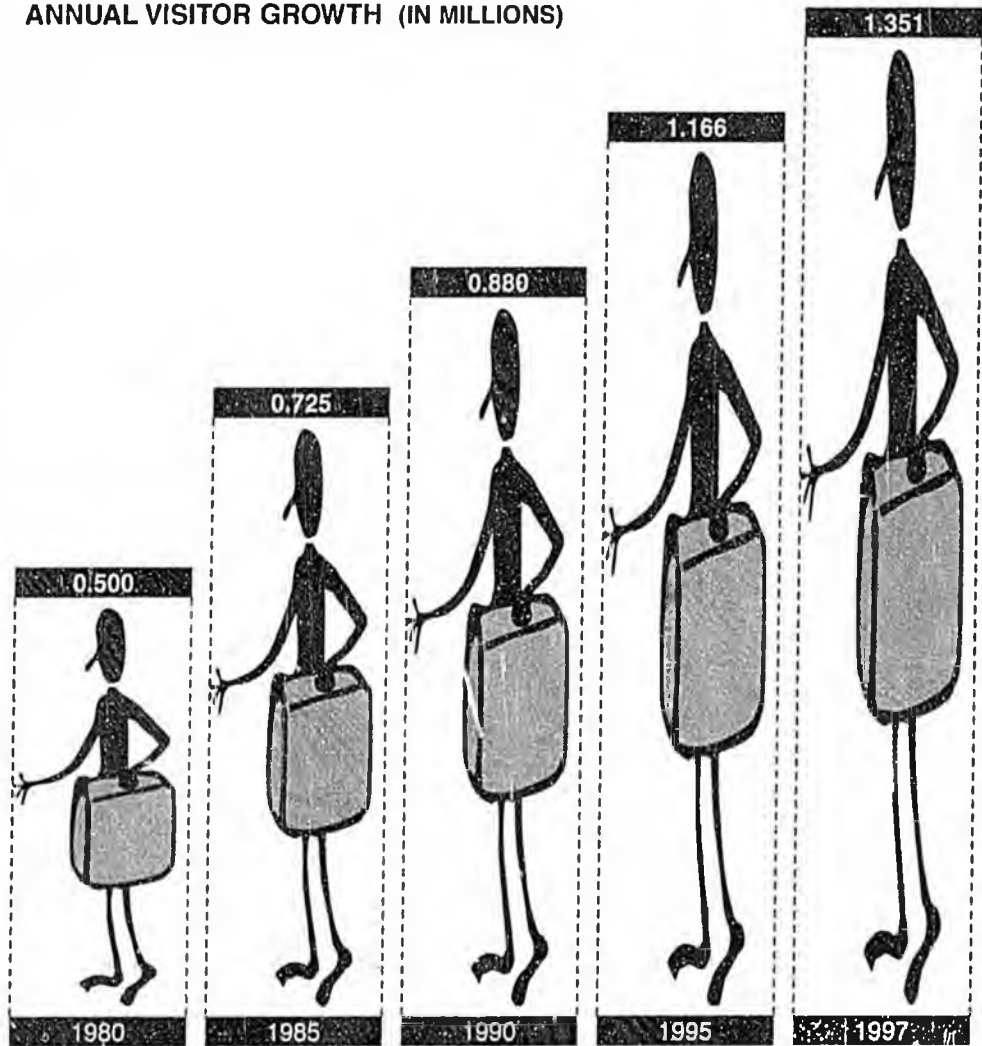
1996 VS. 1980



#### VISITOR GROWTH ...

## How many Alaska visitors?

#### ANNUAL VISITOR GROWTH (IN MILLIONS)



More than 1.3 million visitors travel to Alaska every year — about 80% of which come during the expanding "peak" summer season, May through September. The past two decades have seen tremendous growth in the number of visitors to Alaska. However, the rate of growth has declined in recent years. Annual growth between 1989 and 1994 averaged 10%. In 1993 and 1994, the number of visitors jumped 12% each year. Visitor volume growth has slowed to less than 6% per year. For insight into why growth is slowing, read inside ...

**SPREADING THE WEALTH ...**

## Where do Alaska's visitors go?

Alaska's tourism industry is truly statewide — It's no wonder ... our vast and varied territory offers completely different experiences, depending on the region. That's probably one reason Alaska gets so many repeat visitors. It's just not possible to see it all on one trip. Recent studies estimate nearly 40% of Alaska's current-year visitors have traveled here before.

**25 MOST VISITED ATTRACTIONS**  
(In % of Visitors)

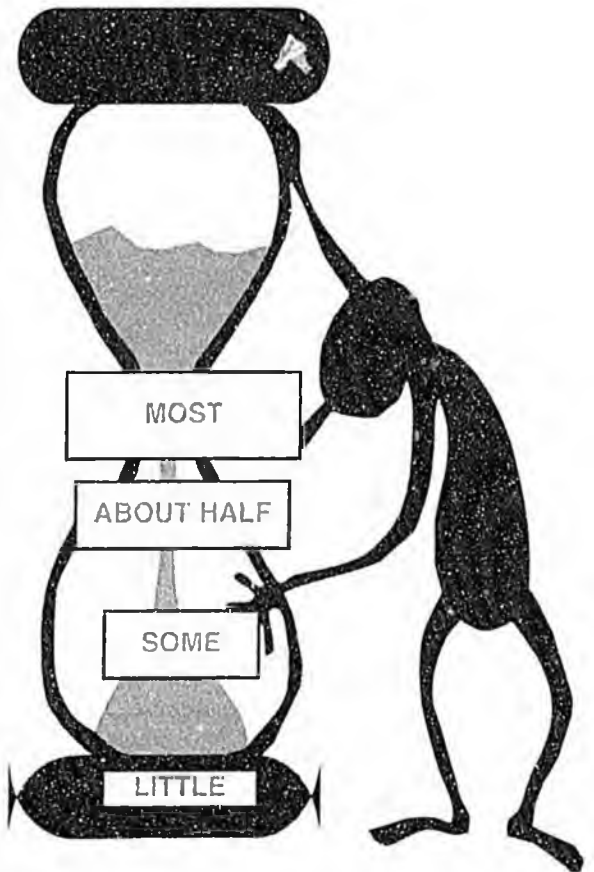
Inside Passage	46
Portage Glacier	44
Mendenhall Glacier	40
Ketchikan Totems	40
Denali/McKinley	36
Skagway Gold Rush District	35
Glacier Bay	31
Anchorage Museum	26
Transalaska Pipeline	24
Sitka's Russian Church	22
University of Alaska Museum	20
Sitka National Historical Park	20
Prince William Sound	20
Kenai River	20
Alaska Highway	19
Alaska State Museum	17
Columbia Glacier	16
Chugach State Park	15
Resurrection Bay	15
Valdez Pipeline Terminal	13
Lake Hood Air Harbor	13
Alyeska Ski Resort	13
Chena River Trips	13
Alaskaland	12
College Fjord	12

**SPREADING THE WEALTH ...**

## How do they spend their time?

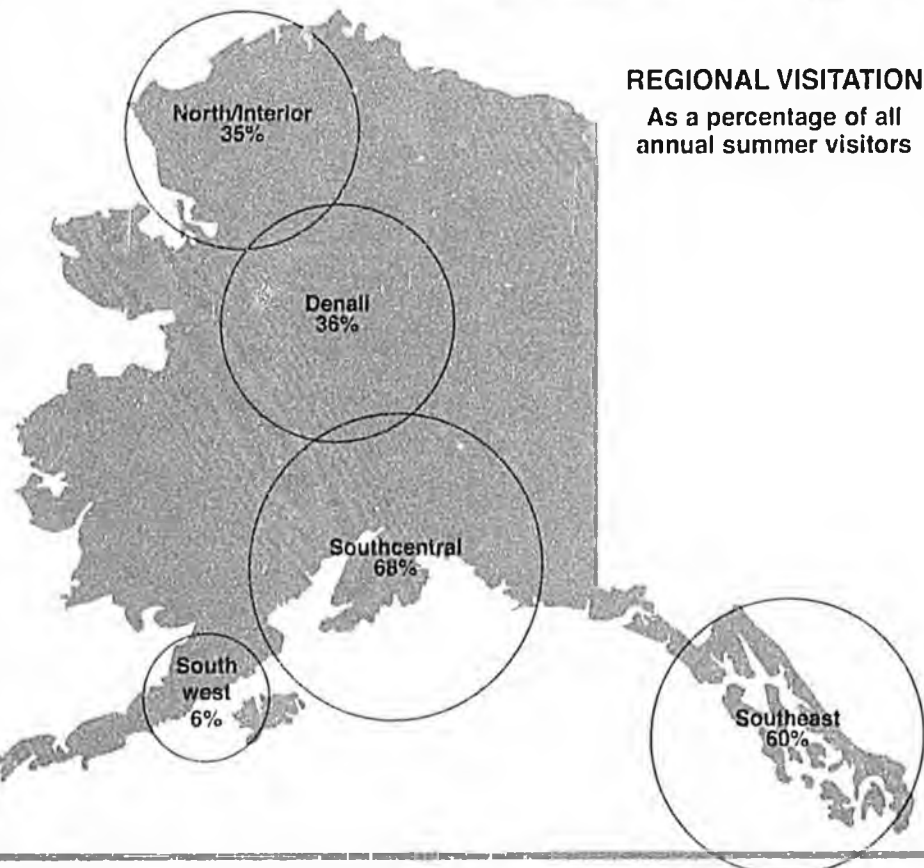
Alaska's visitors do a lot of things — from touring the state's metropolitan hubs to enjoying Alaska's great outdoors. According to the latest studies, the following are our visitors' favorite things to do (The % range indicates the region with the lowest to highest participation).

Activity	% Participating
Shopping	49-81%
Visitor Information Centers	58-71%
Restaurants/Nightlife	52-70%
Wildlife Viewing	37-58%
City Tours	32-54%
Day Cruises	25-29%
Bird Watching	17-29%
Hiking	13-22%
Flightseeing	5-27%
Freshwater Fishing	7-18%
Rafting	2-13%
Hunting	0-1%



**REGIONAL VISITATION**

As a percentage of all annual summer visitors

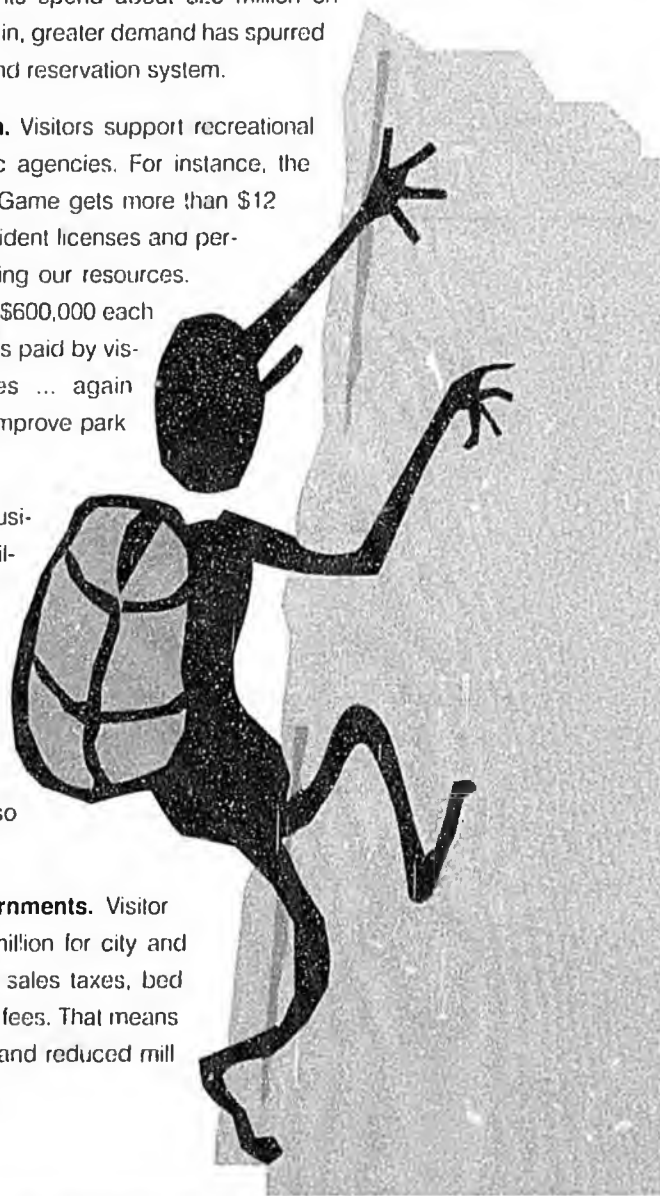


**ALASKANS' QUALITY OF LIFE ...**

## How do I benefit from visitors?

**Alaskans want what visitors want** — reliable transportation, adequate services along transportation systems and a variety of ways to experience Alaska. Demand from visitors has been the catalyst for improvements in all three areas.

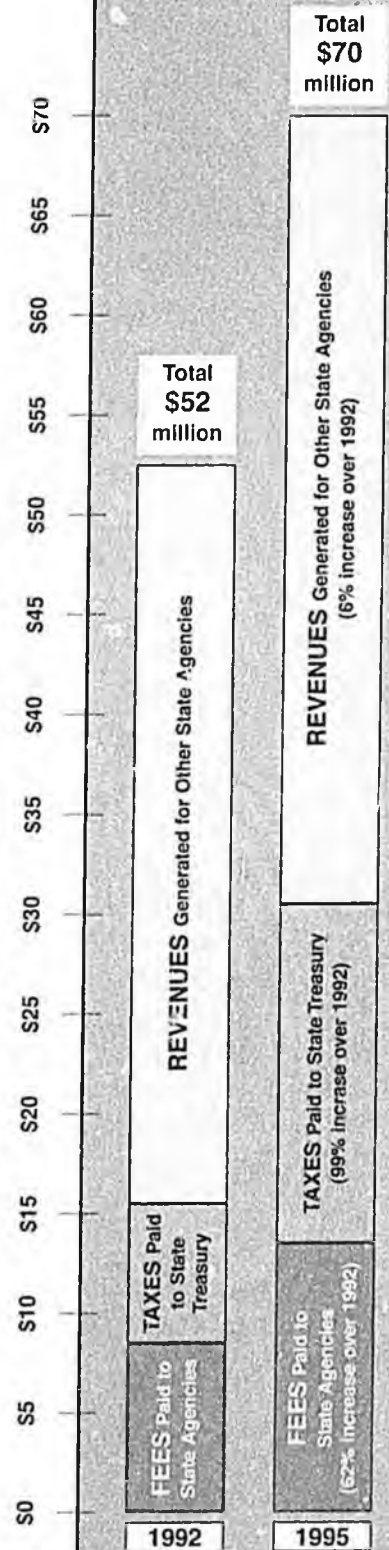
- **Road Improvements.** Visitors pay nearly \$8 million a year in gasoline taxes. For every dollar paid in federal gas taxes, Alaska gets at least \$5 back from the feds to improve roads, trails and the marine highway system.
- **Air Transportation.** Major airlines have responded to visitor travel needs by offering more regular air service to dozens of communities across the state. In rural Alaska, a number of tourism businesses are partnering with public agencies to improve safety and access to remote airports.
- **Rail Transportation.** Visitors and tourism businesses generate nearly \$9 million each year for the Alaska Railroad, a self-sustaining public entity. The increase in visitor use and revenue has been the impetus behind an expanded passenger schedule and service to more areas.
- **Marine Highway.** Non-residents spend about \$20 million on Marine Highway passage. Again, greater demand has spurred a more conducive schedule and reservation system.
- **Enhanced Public Recreation.** Visitors support recreational enhancement efforts of public agencies. For instance, the Alaska Department of Fish & Game gets more than \$12 million each year from non-resident licenses and permits ... money spent on building our resources. Alaska State Parks gets about \$600,000 each year from user fees and permits paid by visitors and tourism businesses ... again money used to maintain and improve park facilities.
- **New Experiences.** Tourism businesses invest hundreds of millions of dollars each year to develop or improve lodges, restaurants, adventure excursions, marine and flightseeing charters, cultural and historical attractions and other activities that residents also enjoy.
- **New Dollars for Local Governments.** Visitor activity generates about \$54 million for city and borough governments through sales taxes, bed taxes, property taxes and other fees. That means more money for local services and reduced mill rates for property owners.



### REVENUES DIRECTLY CONTRIBUTED TO STATE GOVERNMENT FROM ALASKA'S VISITOR INDUSTRY

1992 vs 1995

In Millions of Dollars



## VISITOR VOLUME ASIDE ...

**How big is the Alaska tourism industry?**

**Pretty big** — the visitor industry is one of the largest industries in the state. It's the second-largest private-sector employer in the state and contributes billions to Alaska's economy.

**Key Growth Industry**

- Tourism remains the state's fastest growing industry, both in terms of visitor volume and tourism business start-ups.
- Tourism is truly statewide. It is a leading industry in Southcentral, Southeast and Interior Alaska; and is a growing industry in the Southwest and Far North regions.

**Number Two Employer**

- One out of every eight private-sector employees works in the visitor industry.
- Alaska's visitor industry accounts for an annual average of approximately 18,900 jobs and \$360 million in total earnings.
- Non-resident visitor activity indirectly creates another 9,500 jobs in other sectors of the economy statewide.
- The visitor industry employs 78 percent Alaska residents, the highest percentage of all key Alaska industries.

**Economic Powerhouse**

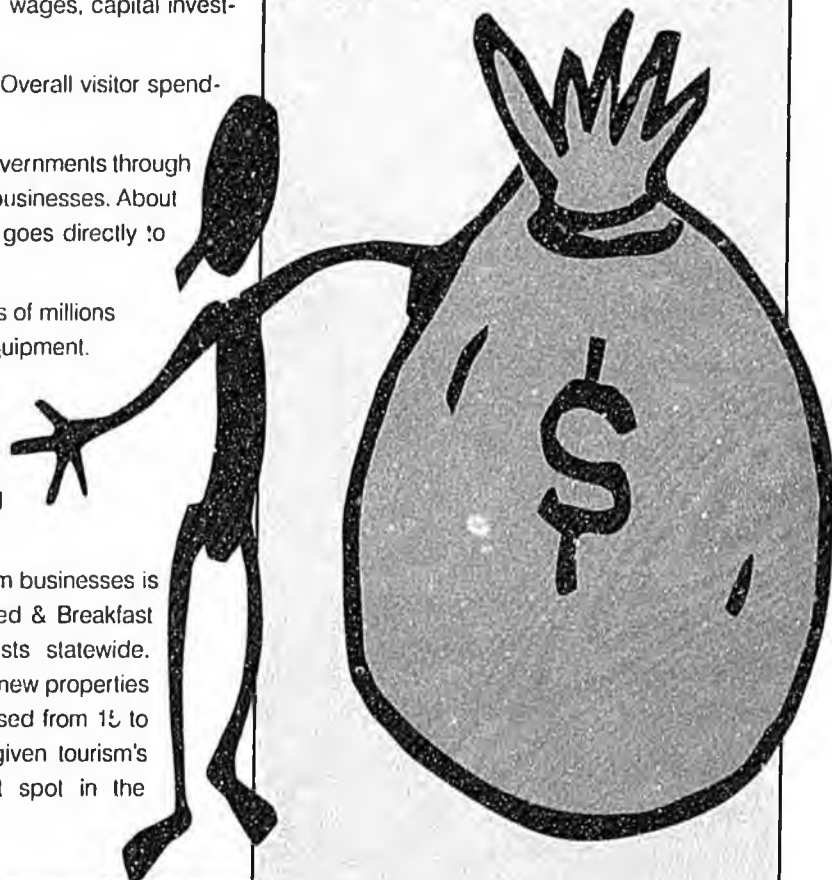
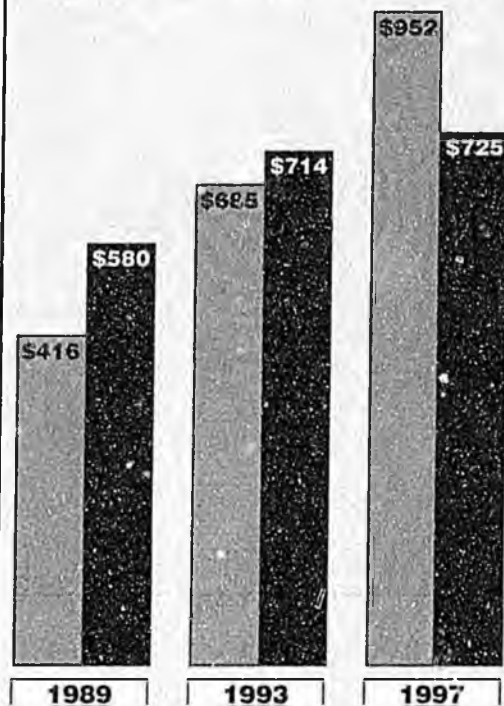
- Visitors spend nearly \$1 billion directly in Alaska and the average visitor dollar circulates two-and-a-half times before leaving the state, for an economic impact of \$2.6 billion each year.
- An additional estimated \$1 billion is spent on travel to and from the state, much of which comes back to Alaska in landing and docking fees, fuel taxes, wages, capital investments and other expenditures by visitor industry businesses.
- On average, each visitor spends about \$725 in state, per trip. Overall visitor spending has increased nearly 40% since 1993.
- About \$124 million is contributed each year to state and local governments through taxes, fees and other assessments paid by visitors and tourism businesses. About \$70 million of that goes directly to the state, while \$54 million goes directly to municipal and borough treasuries.
- Tourism enterprises invest heavily in Alaska, spending hundreds of millions of dollars annually on capital expenditures, construction and equipment.

**The Big Business of Tourism is Based in Small Business**

- Small businesses account for 90% of the industry.
- About 6,000 Alaska business licenses can be attributed to travel and tourism.
- There is some indication that the growth in the number of tourism businesses is surpassing the growth in visitors. For example, the Alaska Bed & Breakfast Association reports there are more than 2,000 bed and breakfasts statewide. The Alaska Campground Owners Association says a number of new properties are coming on line every year. Sportfishing lodges have increased from 15 to 150 in the past 20 years. This proliferation is not surprising given tourism's entrepreneurial nature and tourism's reputation as a bright spot in the economy.

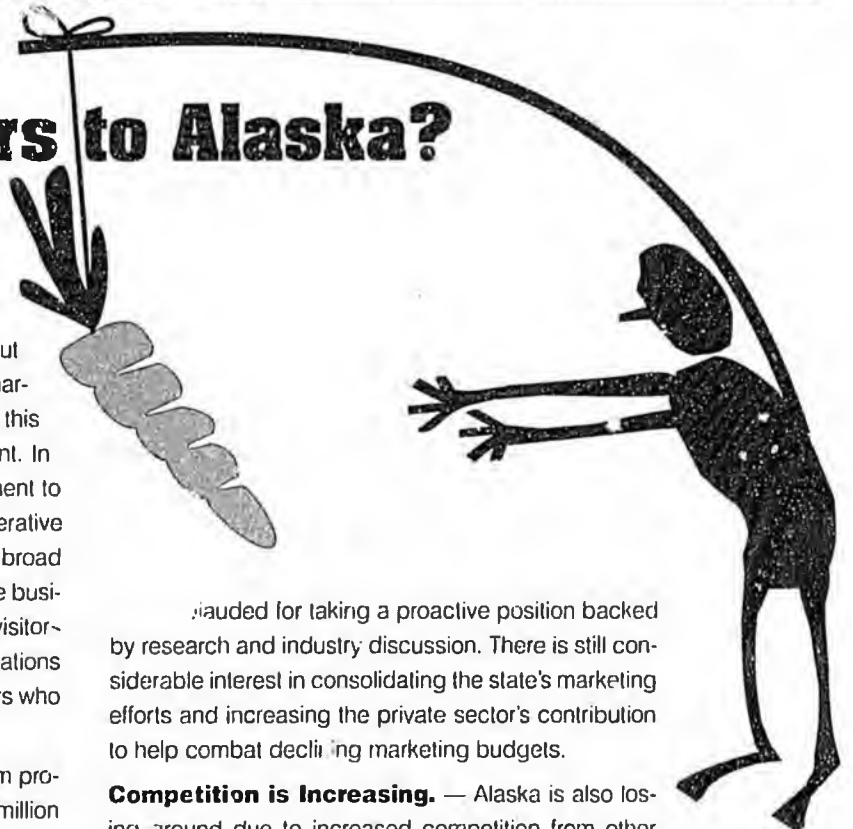
**IN-STATE VISITOR SPENDING**

- Total Annual Spending In Millions of Dollars
- Estimated Per Person/Per trip Spending In Dollars



**PRIMING THE PUMP ...**

## What draws visitors to Alaska?



**Cooperative Marketing.** — Like any product, tourism businesses need to market themselves. What is different about tourism is that consumers need to be enticed to an area before individual businesses — such as a bed & breakfast or gift shop — can bring them directly to their door. Thus, just about every country, state or city engages in some form of collective marketing in which the destination is the featured product. Often this destination marketing is coordinated and funded by government. In Alaska, the private industry has participated with state government to fund and implement generic marketing campaigns. This cooperative marketing allows the tourism industry to collectively reach broad national and international markets that would be too costly for one business to reach alone. And, at the local level, convention & visitor bureaus, chambers of commerce and other community organizations participate by cooperatively marketing their own regions to visitors who are first attracted by statewide efforts.

**Alaska is Losing Ground.** — Since 1990, funding for tourism programs has declined by 60%, from \$15 million in FY90 to \$6.6 million today. Other states have increased their tourism promotion by 31% in the last five years. Total tourism spending by the Alaska Tourism Marketing Council (ATMC) and Division of Tourism (DoT) combined has been:

FY90	\$15,029,050
FY91	\$12,446,571
FY92	\$10,526,171
FY93	\$10,933,387
FY94	\$10,913,338
FY95	\$8,038,963
FY96	\$8,384,047
FY97	\$7,990,100
FY98	\$6,728,950
FY99	\$6,696,950

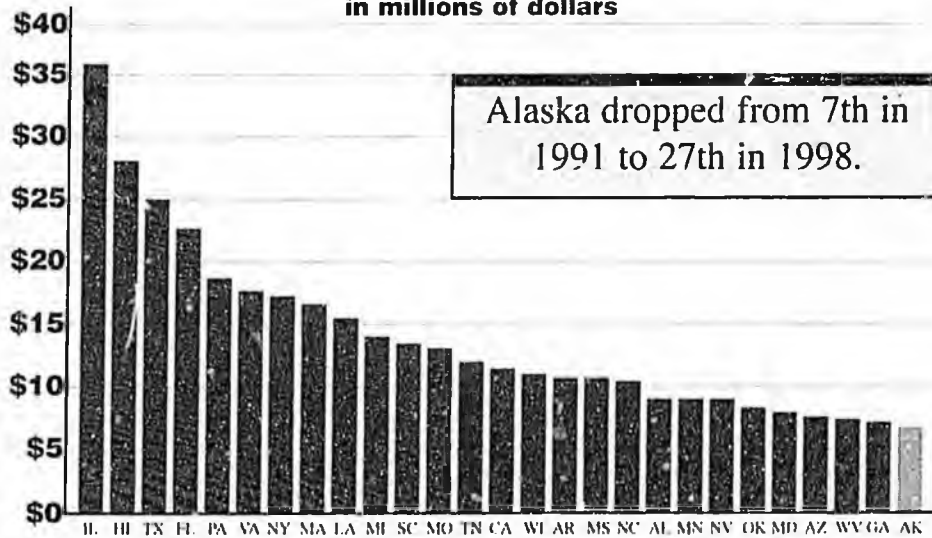
If recent budget processes are any indication, funding support for tourism will continue

to decline. Recent budget proposals have threatened to eliminate the DoT, restructure all tourism programs, combine the ATMC and DoT or reduce the Division of Tourism into an "Office of Tourism." In effect, tourism restructuring was occurring through the budget process, rather than through thoughtful planning and discussion with the industry. In 1998, the industry sought to counter continued cuts by presenting a plan for marketing consolidation. Although legislation failed to pass during the final hours of the session, the industry

is lauded for taking a proactive position backed by research and industry discussion. There is still considerable interest in consolidating the state's marketing efforts and increasing the private sector's contribution to help combat declining marketing budgets.

**Competition is Increasing.** — Alaska is also losing ground due to increased competition from other

### 1997-98 Top 27 State Tourism Budgets in millions of dollars



Alaska dropped from 7th in 1991 to 27th in 1998.

Source: Travel Industry Association of America 1997-98 Survey of State Tourism Offices

states, countries and new destinations. While our most direct competitors are foreign countries, other states and even cities are outspending Alaska in terms of promotion and advertising. The result is an Alaskan industry at a competitive disadvantage.

**Growth Rate Is Declining.**

— Decreasing market competi-

tiveness is taking its toll on Alaska tourism businesses. While overall visitor numbers have continued to rise, the rate of growth has slowed. Some segments of the industry — most notably highway-dependent enterprises — have experienced a downturn, with highway traffic falling for several years in a row.

The visitor industry believes that state government should continue to pursue its role of promoting economic development by investing in tourism, as it does for Alaska's other basic industries.

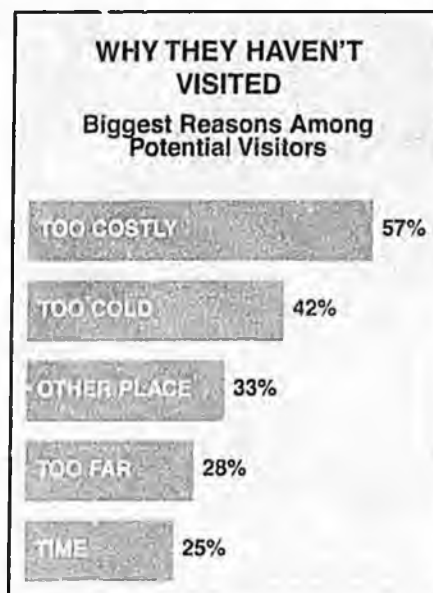
## KEEPING THEM COMING ...

## Is marketing the only challenge to generating north-bound travel?

**Absolutely not** — A trip to Alaska takes a lot of planning, and a good chunk of money. So getting people to make the trip means convincing them it's worth their while (marketing) and then delivering on the goods (providing a quality experience). Alaska certainly has its work cut out on both counts.

Future expansion of the visitor industry must address many challenges while also providing new opportunities. Creating new business opportunities requires infrastructure, government policies that are conducive to business, access to public lands, and hospitable residents who welcome visitors and delight in sharing Alaska. Some of the challenges the industry currently faces are:

- **Traveler Perceptions.** Results from a recent study commissioned by the Alaska Tourism Marketing Council were a mixed bag. The good news is there are about 18 million U.S. adults who are "high potentials" for visiting. The bad news is that many of these would-be visitors think travel to Alaska is too costly and the weather is too cold. Those are tough perceptions to overcome.
- **Time and Distance.** Alaska's very location may cause travelers to postpone their trip. Surveys show that Americans in particular are seeking shorter vacations, closer to home. This pervasive trend increases the difficulty in drawing travelers up north.
- **Tourism Taxation.** Visiting Alaska is expensive and is comparable to the cost of an adventure tour to Southeast Asia, Costa Rica, Scandinavia, Nepal, China, Italy, etc. In recent years, the traveler has become an increasing revenue target as governments seek to impose taxes on the voice-less, non-voting visitor, thereby making Alaska less attractive as a destination. Communities have sought ways to fund local government through bed taxes (up to 9%) and other assessments on visitor activities. At the state and federal level, governments have increased park entrance and camping fees, aviation and tour bus fuel fees, and non-resident fishing and hunting permits. Recent legislative proposals seek to impose further taxes.
- **More Slices from the Same Pie.** As other industries decline, more residents and communities are looking to tourism to replace lost income. The result is that tourism businesses are entering the market at a faster rate than visitor growth. Expectations for new jobs and profits will be difficult to meet without a boost in visitor numbers.
- **Expanding Infrastructure.** The state has many infrastructure challenges to meet the basic needs of our visitors. These include road, air and marine access to visitor attractions and communities as well as adequate rest stops along our road system.



- **Increasing the Range of Visitor Experiences.** Alaska is largely made up of public lands and there is growing pressure to further restrict commercial purposes of all kinds in these areas. Tourism businesses are working with public land managers to facilitate responsible development while maintaining the wild and scenic nature of our environment. The need for increased access is clearly demonstrated by one of Alaska's premier attractions, Denali National Park, where visitation demand has reached current capacity. Improved access to areas such as South Denali, Wrangell-St. Elias National Park and Prince William Sound will help relieve congestion at Denali and other popular locations within the state. This will benefit residents, too, by providing new business opportunities and new experiences for in-state travel.
- **Enhanced Wildlife Viewing.** Many visitors come for the opportunity to view wildlife, but they are often disappointed. While there are some excellent viewing spots in the state, most are not easily accessible due to the cost of air access. To meet visitor expectations, Alaska must create wildlife viewing areas that are readily accessible and developed in an environmentally sensitive manner.

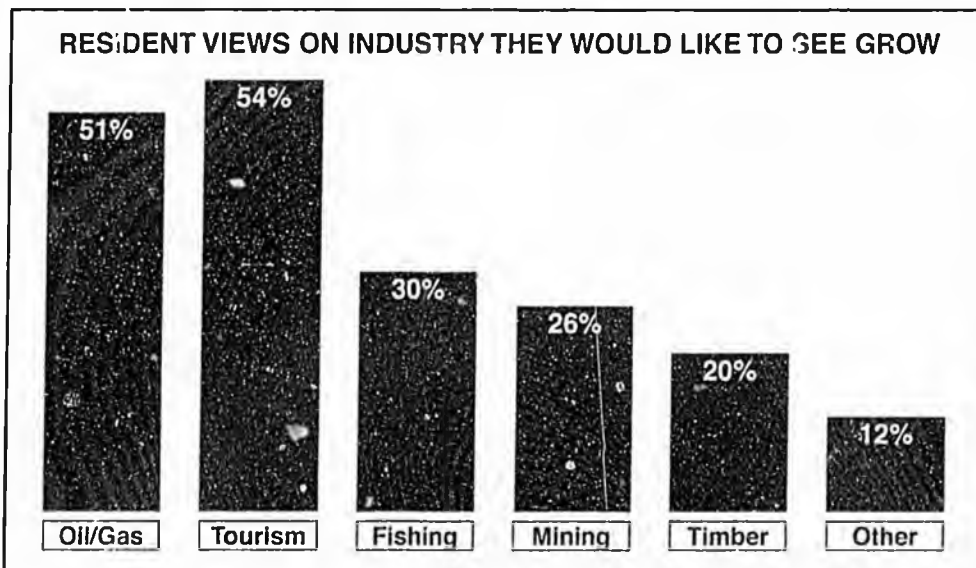
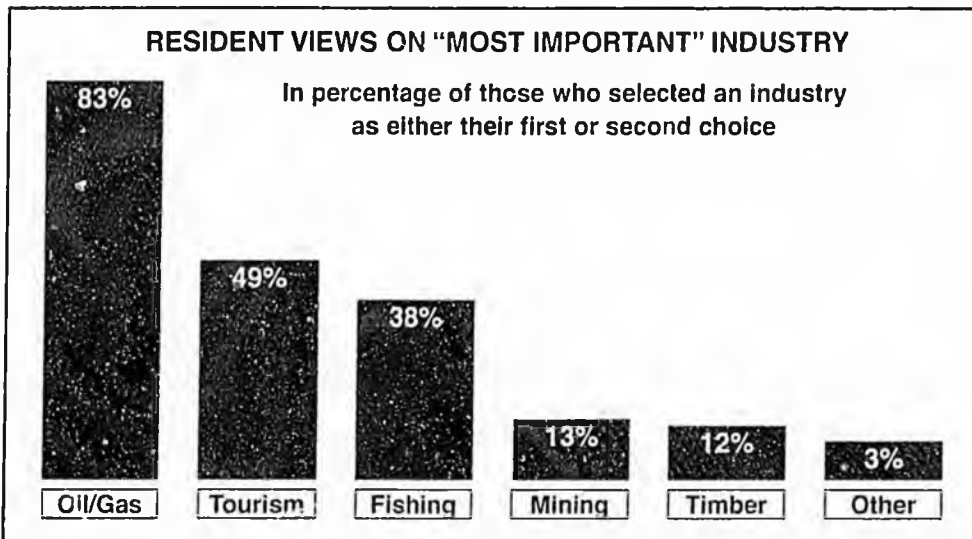
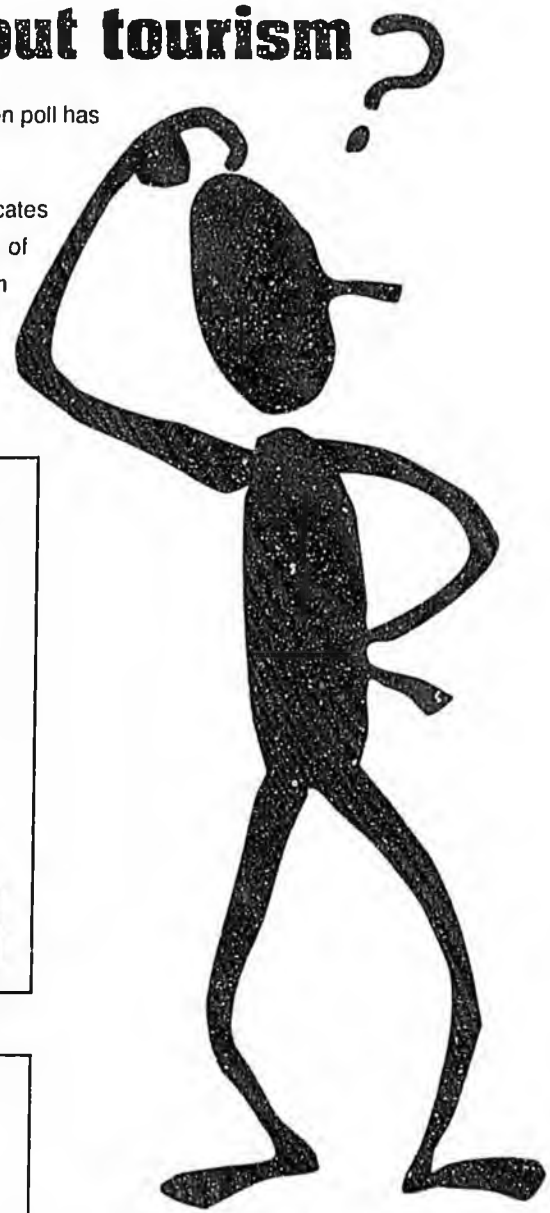
The Alaska Visitors Association has created a long-range strategic plan (Destination: Alaska) that addresses many of these challenges. With responsible planning, Alaska can become a world-class destination of unparalleled natural beauty and cultural diversity; a place that offers a spectrum of high quality experiences for anyone interested in visiting.

**PUBLIC OPINION ...**

## What do Alaskans think about tourism?

By and large, Alaskans think tourism is good. — Public opinion poll after public opinion poll has shown that Alaska residents believe tourism is an important part of Alaska's economy.

The most recent survey, a statewide March 1997 Minute Poll of 400-plus Alaska voters, indicates that tourism is seen as a positive and promising industry for the state. When asked which of Alaska's industries is currently the most important to the state's economy, half picked tourism as their first or second choice. When asked which one industry they would like to see grow in the next five years, tourism ranked highest with 54% of the first and second choice votes.



**"Think about the future, 10-15 years from now. Which industry do you think will be most important to Alaska's economy then?"**

- Tourism — 44%
- Oil & Gas — 36%
- Fishing — 13%
- Mining — 4%
- Timber — 1%

Declima Research  
Survey of 300 Alaskan adults  
October 1994

FOR MORE INFORMATION ...

## Who advocates tourism in Alaska?

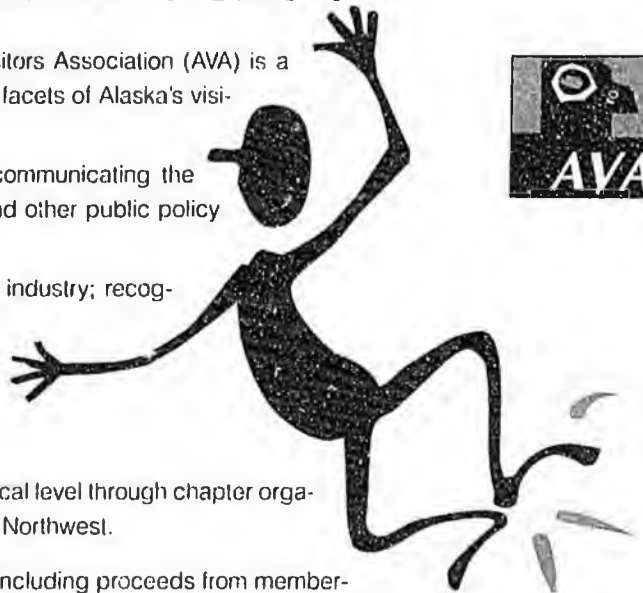
**The Alaska Visitors Association.** — Incorporated in 1951, the Alaska Visitors Association (AVA) is a statewide organization representing the common interests and concerns of all facets of Alaska's visitor industry. As a trade association, AVA:

- Provides tourism businesses and organizations with a collective voice, communicating the industry's perspective during land management, transportation planning and other public policy processes;
- Develops strategic plans to facilitate responsible growth of Alaska's visitor industry; recognizing protection of Alaska's environment is an issue of foremost concern.
- Coordinates private sector efforts to promote travel to and within the state;
- Delivers professional training, networking opportunities and other cost-saving benefits to its members;
- Provides a grassroots forum for communication and problem-solving at the local level through chapter organizations in Anchorage, Fairbanks, Juneau, Ketchikan, Sitka and the Pacific Northwest.

Established as a 501(c)6 non-profit, AVA is funded entirely by private sources, including proceeds from membership dues and annual fund-raising events. Its some 650 member businesses employ more than 25,000 Alaskans.

For more information on the Alaska visitor industry, AVA and/or association membership, contact the AVA office at the address/phone below.

*Note: Sources for the statistical data presented in "Tourism Wise" are available for review at the Alaska Visitors Association Resource Library.*

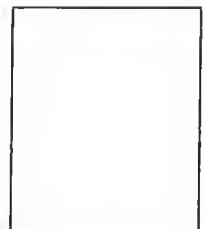


## TOURISM WISE

*Produced as a public service by the*

ALASKA VISITORS ASSOCIATION

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Email: [ava@alaska.net](mailto:ava@alaska.net)  
Web Site: [www.visitalaska.org](http://www.visitalaska.org)



FOR MORE INFORMATION ...

## Who advocates tourism in Alaska?

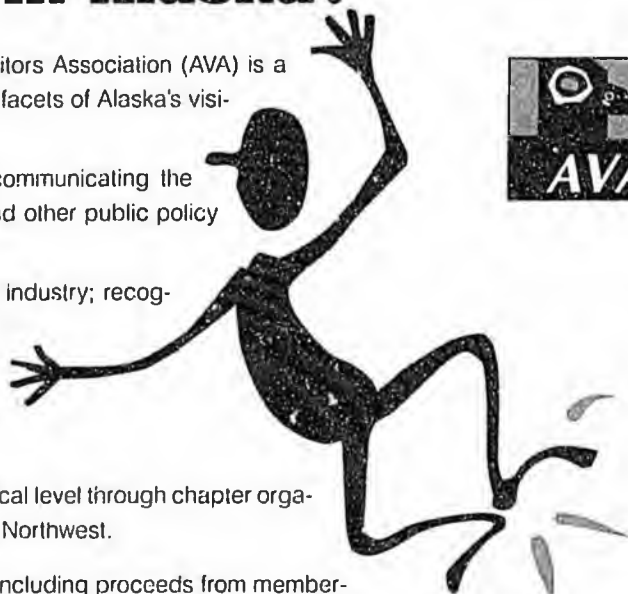
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Web Site: [www.visitalaska.org](http://www.visitalaska.org)



**HB**

**139**

# ALASKA PSYCHOLOGICAL ASSOCIATION

Advancing Psychology as a Science, Profession, and Means of Promoting Human Welfare

Honorable Norman Rokeberg  
State Capitol Building  
Juneau, AK

Dear Representative Rokeberg:

I'm contacting you regarding **HB 139** prescriptive authority legislation for appropriately trained psychologists, which had a hearing on May 10, 1999, in the House Labor and Commerce Committee. In respect of Chairman Rokeberg's request that we have few presenters and take no longer than 20 minutes for our total presentation a number of serious issues were raised by others testifying that were left unanswered. I would like the opportunity to address all these issues, however because they are quite extensive I will address only two issues in this letter:

1. The final report of the Department of Defense PDP (project training psychologists to prescribe in the military).
2. The educational requirements leading to prescriptive authority for psychologists.

Accompanying this letter is a copy of the final US GAO report on Prescribing Psychologists, subtitled, DOD Demonstration Participants Perform Well but Have Little Effect on Readiness or Costs. I thought you would be interested to see that the final report puts prescribing psychologists in quite a favorable light. The report notes the only drawbacks were that training costs were not substantially lower than that of psychiatrists and that prescribing psychologists did little to increase the readiness of the armed services to fulfill their mission.

The report confirms that initial problems in the project were more related to the behaviors and attitudes of medical doctors than to any shortcomings of the psychologists themselves. In fact, in direct contradiction to the testimony provided by the General against HB 139, the final GAO report states, "...though several graduates experienced early difficulties being accepted by physicians and others at their assigned locations, the clinical supervisors, providers, and officials we spoke with at the current and prior locations - as well as a panel of mental health clinicians who evaluated each of the graduates - were complimentary about the quality of patient care provided by the graduates."

The final GAO report documents the fine job prescribing psychologists do contrary to information you might have received. The report tells the real story of prescribing psychologists who hold positions of responsibility. Please take the time to review Page 2, "Results in Brief," and pages 5 through 9, "PDP Graduates Are Well Integrated Into MHS." The report notes these psychologists prescribe from comprehensive formularies, carry average or larger caseloads, practice independently, and have won the admiration and respect of doctors and nurses who work with them. Additionally, there is anecdotal information that suggests that with the behavioral and psychotherapy training that psychologists have (unlike medical doctors) the prescribing psychologists actually prescribed less often, not relying on simply writing a script as treatment.

RECEIVED  
FEB 03 2000


The education and training that psychologists get compared with medical school education was attacked during the hearing. However you only received part of the picture. Comparing the totality of medical school training and residencies with only the post-doctoral training recommended prior for psychologists to be able to prescribe was very misleading. What wasn't described is that the hours involved in getting a Ph.D. in clinical psychology and the post doctoral training hours required in getting licensed along with the proposed 300 hours of post-doctoral education in psychopharmacology is roughly the same as medical school and residencies. In addition there is a significant degree of overlap in the educational programs between modern psychology and medical school. The training developed for the DOD project was based on recommendations from medical doctors (including psychiatrists), pharmacists, neurologists, and other knowledgeable professionals. It is insulting to compare the 300 hours of post-doctoral training for fully licensed psychologists to post high school training required for a hair dressers license.

For many years other health care professions have contributed to patient care by prescribing medications in many states. These include dentists, podiatrists, nurse practitioners, optometrists, physician assistants, and pharmacists. None have had medical school training and all have prescribed safely.

Using the American Psychological Association's model, psychologists will have significantly more training in prescribing than most of these groups. Psychologists have the highest degree of education and training in the diagnosis and treatment of mental and emotional disorders of any health profession. This is especially important when you consider 75% to 85% of all psychotropic medications (drugs used in treating mental health) are prescribed by non-psychiatric physicians such as internists, general practitioners, and pediatricians, who typically have minimal (one course or less) psychopharmacology training (the statistical information comes from the medical profession itself in articles published in the *Journal of the American Medical Association* and *Archives of General Psychiatry*).

The Alaska Psychological Association would like the opportunity to discuss this issue with you further as there really were a number of areas where it would appear that misleading testimony was provided by those opposed to this bill. We understand the burden of proof is on us to show that prescribing psychologists can safely prescribe at a benefit to the Alaska public. We can demonstrate that given the opportunity to fairly and completely present our case.

Respectfully,



Robert Lane, Ph.D., Past President  
Alaska Psychological Association

cc.

Representative Jeanette James  
Representative Fred Dyson

GAO

Report to the Chairman and Ranking  
Minority Member, Committee on Armed  
Services, U.S. Senate

June 1999

# PRESCRIBING PSYCHOLOGISTS

## DOD Demonstration Participants Perform Well but Have Little Effect on Readiness or Costs



GAO

Accountability \* Integrity \* Reliability

Health, Education, and  
Human Services Division

B-280869

June 1, 1999

The Honorable John Warner  
Chairman  
The Honorable Carl Levin  
Ranking Minority Member  
Committee on Armed Services  
United States Senate

The Military Health System (MHS) provides for the mental health care needs of the approximately 8 million active-duty members, retirees, and their dependents. To meet these needs, MHS employed 431 psychiatrists and 430 clinical psychologists in fiscal year 1999. Some functions of psychiatrists and clinical psychologists overlap. As physicians, however, psychiatrists are trained in and licensed to practice medicine and are permitted to prescribe medication for the treatment of both mental and physical conditions. Because no medical training is required to practice clinical psychology, clinical psychologists—whether in the military or the civilian sector—historically have not been permitted to prescribe drugs. In 1991, however, MHS instituted the Psychopharmacology Demonstration Project (PDP), which was designed to train and use military psychologists to prescribe psychotropic medications.<sup>1</sup> By June 1997, when the project was terminated, 10 psychologists had completed the training and were subsequently assigned to various Air Force, Army, and Navy military medical facilities across the country.<sup>2</sup> At the time of our review, 9 of the 10 program graduates were still treating patients and prescribing medications at military hospitals and clinics.

The Senate report accompanying the fiscal year 1999 National Defense Authorization Act directed us to study the results of this program, including the use and performance of the PDP graduates. Based on the Senate report and subsequent discussions with your offices, our evaluation (1) describes how PDP graduates have been integrated into MHS, (2) provides information on the quality of care they provide to military personnel and beneficiaries, (3) discusses their effect on medical readiness, and (4) compares the costs of the program graduates to those of other military psychologists and psychiatrists. To address these issues, we talked with all 10 PDP graduates and other providers and officials at the facilities where the graduates were practicing or had practiced. Although

<sup>1</sup>These drugs affect psychic function, behavior, or experience.

<sup>2</sup>In April 1997, we issued a report on PDP, *Defense Health Care: Need for More Prescribing Psychologists Is Not Adequately Justified* (GAO/HEHS-97-105), Apr. 1, 1997.

one graduate left the military during the course of our review, our evaluation includes information about this graduate's service as a prescribing psychologist before leaving the military to reflect the full range of information available on the performance of the graduates. We also reviewed the PDP graduates' credentials files,<sup>3</sup> performance reviews, and relevant reports.

Our work was performed from June 1998 through May 1999 in accordance with generally accepted government auditing standards. Further information on our scope and methodology is included as appendix I.

## Results in Brief

The 10 PDP graduates seem to be well integrated at their assigned military treatment facilities. For example, the graduates generally serve in positions of authority, such as clinic or department chiefs. They also treat a variety of mental health patients; prescribe from comprehensive lists of drugs, or formularies;<sup>4</sup> and carry patient caseloads comparable to those of psychiatrists and psychologists at the same hospitals and clinics. Also, although several graduates experienced early difficulties being accepted by physicians and others at their assigned locations, the clinical supervisors, providers, and officials we spoke with at the graduates' current and prior locations—as well as a panel of mental health clinicians who evaluated each of the graduates—were complimentary about the quality of patient care provided by the graduates.

However, granting drug prescribing authority to 10 military psychologists cannot substantially affect the medical readiness of an organization staffed by more than 800 psychiatrists and psychologists. Moreover, according to military psychiatrists and psychologists we talked to, it is unlikely that the graduates' prescribing abilities and knowledge of psychotropic drugs would be needed during wartime because these types of drugs are not generally the treatment of choice in combat. Rather, in treating combat stress, the preferred course of treatment according to service readiness officials and field commanders is adequate rest, counseling, and a quick return to the front lines. Nonetheless, clinic and hospital officials told us that the graduates—by reducing the time patients must wait for treatment and by increasing the number of personnel and dependents who can be

<sup>3</sup>The credentials files contain information on education, licenses, performance evaluations, and other information, as well as a record of any quality problems that resulted in adverse outcomes.

<sup>4</sup>As used here, "formulary" refers to the set of prescription drugs that a provider is permitted to prescribe to patients when treating illnesses.

treated for illnesses requiring psychotropic medications—have enhanced the peacetime readiness of the locations where they are serving.

We project that the Department of Defense (DOD) will spend somewhat more on these 10 prescribing psychologists than it would have spent to provide similar services without the prescribing psychologists. Primarily because of DOD's higher training costs, we estimate that over the course of the PDP graduates' careers, DOD will spend an average of about 7 percent more (or about \$9,700 annually) per PDP graduate than it would spend on a mix of psychiatrists and psychologists who would treat patients in the absence of the PDP graduates.

## Background

The principal mission of MHS is medical readiness. As defined by DOD, medical readiness encompasses both wartime and peacetime components. The wartime mission is primary, according to DOD's Medical Readiness Strategic Plan (MRSP), requiring MHS "to provide top quality health services, whenever needed, in support of primary operations."<sup>5</sup> In peacetime, according to MRSP, the military medical departments are "to maintain and sustain the well-being of the fighting forces in preparation for war." Finally, MRSP states that the military may provide care to dependents or retirees in peacetime, "when not employed in preparation and training for the wartime role." The Army, Navy, and Air Force all use military and civilian health care providers to meet their readiness needs.

PDP was established by DOD in response to a conference report dated September 28, 1988, which accompanied the fiscal year 1989 DOD Appropriations Act (P.L. 100-463). The report directed DOD to "establish a demonstration pilot training program in which military psychologists may be trained and authorized to issue appropriate psychotropic medications under certain circumstances."

This training program began in August 1991 with four participants. Training for the initial class consisted of 2 years of classroom training at the Uniformed Services University of the Health Sciences plus 1 additional year of clinical training. For subsequent classes, however, the training was modified to consist of 1 year of classroom training and 1 year of clinical training. PDP participants obtained their clinical experience on inpatient wards and at outpatient clinics at Walter Reed Army Medical Center in Washington, D.C., or at Malcolm Grow Medical Center located at Andrews Air Force Base in Maryland. During the clinical part of the training,

<sup>5</sup>See DOD, Medical Readiness Strategic Plan (MRSP) 1998-2004 (Washington, D.C.: Aug. 1998), p. 22.

participants were trained to take medical histories and incorporate them into treatment plans and to prescribe medication for patients with certain types of mental disorders.

Two prescribing psychologists graduated from the initial training class in 1994. The three subsequent graduating classes included 1 prescribing psychologist in 1995, 4 in 1996, and 3 in 1997—for a total of 10 graduates.<sup>6</sup> These 10 graduates—three women and seven men<sup>7</sup>—represented each of the three services: 4 from the Navy and 3 each from the Air Force and Army. In 1995, as part of the program, guidelines were issued on the graduates' roles, including a suggested drug formulary that they would use, a scope of practice limited to patients between the ages of 18 and 65, and the level of supervision or proctoring of graduates for 1 year after graduation.

Several evaluations of the program have been completed since its inception. The American College of Neuropsychopharmacology (ACNP),<sup>8</sup> under contract to DOD, conducted six annual assessments of PDP and issued a final report on the program in 1998. In conducting these assessments, an ACNP evaluation panel interviewed PDP participants and graduates, program officials, classroom instructors, clinical supervisors, and others. Vector Research, Inc. (VRI), also under contract to DOD, conducted an evaluation of the program to determine its cost-effectiveness and feasibility. VRI's report was issued in May 1996 and concluded that PDP was cost-effective.<sup>9</sup> In our April 1997 report, we expressed concern about VRI's analysis because in our view it was based, in part, on unrealistic assumptions.

Additionally, as required by the National Defense Authorization Act for fiscal year 1996 (P.L. 104-106), GAO conducted a study of PDP, which included (1) an assessment of the need for prescribing psychologists in MHS, (2) information on the implementation of PDP, and (3) information on PDP's costs and benefits. In our resulting 1997 report, we concluded that training psychologists to prescribe medication was not adequately justified

<sup>6</sup>Three participants left the program during the training.

<sup>7</sup>To safeguard the graduates' privacy, we use only masculine pronouns in this report.

<sup>8</sup>ACNP is a professional association of about 600 scientists from disciplines such as behavioral pharmacology, neurology, pharmacology, psychiatry, and psychology.

<sup>9</sup>VRI, Cost-Effectiveness and Feasibility of the DOD Psychopharmacology Demonstration Project: Final Report (Arlington, Va.: May 17, 1996).

because MHS had not demonstrated a need for prescribing psychologists, the cost of the program was substantial, and the benefits were uncertain.

In response to the same act, PDP was terminated in June 1997. However, those psychologists who had graduated from or were currently enrolled in the program were permitted by the legislation to continue prescribing psychotropic medication.

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## PDP Graduates Are Well Integrated Into MHS

PDP graduates are well integrated into MHS. They hold positions of responsibility, such as clinic or department head, and treat a broad spectrum of patients, including active-duty personnel, retirees, and dependents. They can prescribe medication from comprehensive drug formularies and have patient caseloads that are comparable to those of psychiatrists and other psychologists who practice at their clinics and hospitals. Although the graduates were initially supervised closely, all but two have been granted independent status, meaning that they are subject only to the same level of review as psychiatrists at their locations. However, although the graduates are currently well integrated, several experienced early difficulties being accepted at their locations.

---

## PDP Graduates Hold Positions of Responsibility, and Most Treat a Mix of Patients

The nine program graduates remaining in the military at the time of our visits are serving as the chief of a clinic or department, suggesting the high professional esteem in which they are held. For example, one serves as the chief of an Army division mental health clinic, one as the commander of an Air Force mental health clinic, and another as the chief of a Navy hospital's mental health department. Serving as clinic or department chief includes performing administrative duties, such as supervising other mental health providers and managing the day-to-day operations of the clinic. The one graduate who left the military did not serve as clinic or department chief during his year of post-PDP service.

Although PDP guidance limits graduates to seeing patients between the ages of 18 and 65, most graduates see a mix of patients, including active-duty personnel, retirees, and dependents. Two graduates serve in clinics that treat only active-duty personnel, and one serves in a clinic that treats primarily active-duty personnel but also treats dependents when mental health providers are available. The remaining seven treat a mix of active-duty personnel, dependents, and retirees.

### PDP Graduates Prescribe From Comprehensive Drug Formularies

To guide medical facilities when granting prescribing privileges to the program graduates, a suggested drug formulary listing psychotropic drugs by name was created as part of PDP.<sup>10</sup> Six of the 10 graduates are assigned to facilities that granted the graduates drug formularies that are at least as comprehensive as the drug formulary recommended for them. The remaining four graduates have formularies that lack some drugs listed on the suggested formulary but contain additional drugs not listed on the suggested formulary. Although these four graduates' formularies do not include all drugs on the recommended formulary, none noted that this lack of some drugs reduced their effectiveness in providing patient care.

Some graduates' authority to prescribe is broader than others'. While four of the graduates have formularies consisting of lists of specific drugs they can prescribe, five have formularies listing classes of drugs from which they can prescribe. Formularies listing drugs by class, rather than by name, allow the flexibility to prescribe a new medication if it falls into a class of drugs already authorized. Otherwise, the graduates have to petition to have the new drug added to their authorized drug formulary. One graduate's formulary is even more flexible, granting the graduate broad authority to prescribe "psychotropic drugs and their adjuncts."<sup>11</sup>

### PDP Graduates' Average Monthly Caseloads Are Comparable to Colleagues'

Eight of the 10 graduates' caseloads are comparable to those of psychiatrists and other psychologists at the same location. (The remaining two graduates practice at locations without psychiatrists or other psychologists, so their caseloads could not be compared to other mental health providers'.) For example, one graduate sees an average of 47 cases per month—higher than both the average for other psychologists at the same location (40 cases per month) and the average for psychiatrists at the same location (30 cases per month). Another graduate—the chief of the clinic in which he works—sees between 60 and 70 cases per month. Although this is lower than the average of 100 cases per month seen by the psychiatrist in the same clinic, the graduate told us that 30 to 50 percent of his time is spent on administrative duties associated with his position as chief.

<sup>10</sup>Although all graduates received training in the use of psychotropic drugs to treat mental disorders in patients, they may not prescribe medications until granted prescribing privileges by the medical facility where they are assigned. Each facility is responsible for establishing the list of drugs, or formulary, from which providers at the facility can prescribe.

<sup>11</sup>Adjuncts are drugs that are commonly used in the treatment of the side effects of psychotropic medications.

Variation in the graduates' average monthly caseloads—which range from 40 cases for one graduate to 185 cases for another—results in part from the graduates' locations and responsibilities. For example, the graduate with the lowest monthly caseload is stationed overseas and treats only active-duty personnel and their dependents who have been screened for suitability for overseas assignment. In addition, this graduate is the chief of the mental health department and of the hospital credentials committee and serves on the medical staff executive committee. Conversely, the graduate with the highest monthly caseload was the only graduate not serving as a clinic or department chief, allowing this graduate more time to treat patients.

### Most Graduates Have Been Granted Independent Status

Initially, all graduates received close supervision by psychiatrists, in accordance with guidance issued as part of PDP. For example, each graduate's supervisor reviewed the graduate's charts for patients receiving medication. Other elements of supervision varied but included observing patient sessions or meeting separately with patients; holding formal weekly meetings to discuss cases; and requiring written approval for either starting, stopping, or changing the dosage of medications. The level of supervision was subsequently reduced for all graduates, seven of whom were granted independent status—meaning that they are subject only to the same level of chart review as other providers at their location. Another graduate has been granted independent status for treating outpatients—the bulk of the graduate's caseload—but is supervised when treating inpatients. Granting these graduates full or partial independent status indicates hospital officials' belief that the graduates need no more supervision than do other prescribing providers.

The remaining two graduates have not been granted independent status. Officials stationed at one graduate's location told us that they had anticipated granting him independent status; however, before officials reevaluated his status, the graduate was transferred to a new location.<sup>12</sup> The second graduate serves at a facility that has a policy requiring continued supervision of all physician extenders (such as prescribing psychologists, physician assistants, and nurse practitioners) who prescribe medication, regardless of length of service or level of performance.

<sup>12</sup>According to the graduate, hospital officials at the graduate's new location have not yet determined whether he will be granted independent status.

### Some Graduates Experienced Initial Problems With Acceptance

While ultimately well integrated at their locations, some graduates experienced some initial difficulty in this regard. For example, a graduate from one of the first PDP classes waited 10 months at his initial location to receive prescribing privileges and waited another 3 months before treating a patient requiring medication. Another graduate told us he learned that certain drugs on his formulary had been eliminated only after being informed by a patient that the hospital pharmacy had rejected a prescription written by the graduate. However, both graduates have been reassigned to different locations, and both have been accepted at their new locations.

Some of the graduates encountered initial skepticism from supervising psychiatrists, primary care physicians, nurses, and hospital officials who were uncomfortable with the idea of allowing psychologists to prescribe drugs. For example, one graduate told us that a physician at his location was so opposed to giving him prescribing privileges that the doctor resigned from the credentials committee after these privileges were granted. One psychiatrist at another location told us that upon learning that he was assigned to supervise a PDP graduate, he contacted the American Medical Association to inquire about the ethical propriety of a psychiatrist serving as a proctor for a prescribing psychologist. However, nearly all of the physicians and others we spoke to told us that the graduates' performance subsequently convinced them that the graduates were well trained and knowledgeable. Several physicians also told us that they came to rely on the graduates for information about psychotropic medications.

### Graduates Are Reported to Provide Good Quality of Care

Overwhelmingly, the officials with whom we spoke, including each of the graduates' clinical supervisors, and an outside panel of psychiatrists and psychologists who evaluated each of the graduates rated the graduates' quality of care as good to excellent. Further, we found no evidence of quality problems in the graduates' credential files.

The graduates' clinical supervisors have the most extensive knowledge about the graduates' clinical performance because they have been responsible for reviewing the graduates' charts, discussing cases with the graduates, and observing the graduates' interactions with patients. Without exception, these supervisors—all psychiatrists—stated that the graduates' quality of care was good. One supervisor, for example, noted that each of the graduate's patients had improved as a result of the graduate's treatment; another supervisor referred to the quality of care provided by

the graduate as "phenomenal." The supervisors noted that the graduates are aware of their limitations and know when to ask for advice or consultation or when to refer a patient to a psychiatrist. Further, the supervisors noted that no adverse patient outcomes have been associated with the treatment provided by the graduates.

External evaluators also provided information on the graduates' quality of care. In 1998, an ACNP panel composed of board-certified psychiatrists and licensed clinical psychologists performed a final evaluation of the graduates—interviewing the graduates, their supervisors, and other officials, and reviewing a portion of each graduate's patient charts. In its resulting report, ACNP described each graduate's location and role, discussed the results of interviews with the graduates' clinical supervisors and others, and discussed the results of patient chart reviews. In its report, ACNP stated that the graduates had performed well in all the locations where they were assigned, that they had performed safely and effectively as prescribing psychologists, and that no adverse outcomes had been associated with their performance.<sup>13</sup>

### Graduates' Effect on Readiness Is Minimal

Although the graduates have been well integrated and have been reported to provide good care, their effect on DOD's medical readiness could not be more than minimal. DOD has approximately 400 psychiatrists and 400 psychologists; granting prescribing privileges to 10 psychologists is unlikely to affect combat readiness. Further, because psychotropic drugs are not used extensively during combat, the graduates, if deployed in combat, would likely have little effect on readiness beyond their role as clinical psychologists. However, evidence we gathered suggests that the graduates have modestly enhanced the peacetime readiness of military personnel at their current locations.

### Graduates Are Unlikely to Need Prescribing Ability in Wartime

Many officials—including service readiness officials and field commanders—told us that the graduates would likely have little effect on readiness in combat because psychotropic drugs are not generally the treatment of choice in combat and thus prescribing authority would not be in great demand. Because none of the PDP graduates have been deployed to

<sup>13</sup>During our review, we received allegations regarding certain graduates' performance from two individuals involved in overseeing or evaluating the graduates. In all cases, we reviewed available evidence and held discussions with relevant officials. In all but one case, we found that there was not sufficient evidence to support the allegations. In the one case, the hospital's chief of medical staff considered the issue insignificant.

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a combat zone, however, no data exist on the actual use of the graduates in wartime situations.

According to many officials with whom we spoke, the preferred course of treatment for combat stress is adequate rest, counseling, and a quick return to the front lines. Soldiers who require medication are generally evacuated to hospitals located away from combat areas. Psychologists' counseling skills can be valuable front-line tools to handle stress, although this can be accomplished without the special training given to prescribing psychologists. A service-level medical readiness official told us that the most effective techniques to minimize combat stress are proactive—that is, counseling troops upon their arrival in the combat zone to reduce their anxiety level before combat. According to officials, the social workers, psychologists, and psychiatrists who provide this type of proactive counseling have a far greater effect on the well-being of the troops in battle than those who treat personnel after combat stress has set in. This proactive approach does not require prescribing authority.

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### Graduates Contribute to Readiness at Their Locations

Although the PDP graduates' prescribing skills may not be needed in combat situations, the graduates reportedly improve medical readiness at their peacetime locations. According to officials, the graduates improve readiness by reducing the time that patients must wait for treatment or by increasing the number of patients who can be treated.

Before the graduates were stationed at their current locations, some patients requiring mental health care received both psychotherapy from a psychologist and drug therapy from a psychiatrist because psychologists had not been permitted to prescribe drugs. Patients who needed to see two providers for treatment could, according to officials, wait up to 3 weeks to get an appointment with a psychiatrist. Prescribing psychologists, however, can treat some patients needing drugs who otherwise would require an appointment with a psychiatrist. Since these patients see only one provider—their prescribing psychologist—the time and effort needed to receive treatment is reduced.

Other benefits may accrue as well. For example, one official told us that when only a portion of the units in his division—which is staffed with a psychologist and a psychiatrist—get an order to deploy, the division has to consider which providers should remain at the division's permanent location so that the division as a whole has adequate medical support. In the past, if the division decided to deploy its psychiatrist, the permanent

location would be without a prescribing mental health provider. Having a prescribing psychologist enables the division to deploy one prescribing provider while keeping another at the division's permanent location.

The graduates may also contribute to medical readiness through the care of dependents. According to several officials with whom we spoke, personnel who are worried about whether their family members are receiving adequate care may be affected in their ability to carry out their duties. One official told us that the PDP graduate in his unit—who primarily treats dependents—contributes to readiness in this manner. Because the facility did not have enough psychiatrists to care for dependents before the graduate was assigned to this location, those who needed to see a psychiatrist were referred to civilian psychiatrists in a nearby city. According to this official, many dependents did not seek care from these psychiatrists because they could not afford the copayment. The PDP graduate gives the facility the additional capability to provide care to dependents without charging them. The official believes that, consequently, more dependents seek and receive the care they need and fewer active-duty personnel worry about their family members' treatment.

## PDP Graduates Are More Costly Than Traditional Psychologist and Psychiatrist Mix

We project that DOD will spend somewhat more on its 10 prescribing psychologists than it would have spent on providing mental health services using the traditional mix of psychologists and psychiatrists. When all DOD expenditures for various mental health care providers—including salaries and acquisition, training, and retirement costs—are averaged over the length of time the providers are expected to serve, the average yearly cost of a PDP graduate is about 7 percent higher than that of the combination of psychologists and psychiatrists who would have provided treatment similar to that provided by the graduates.<sup>14</sup>

Adapting a methodology developed by VRI,<sup>15</sup> we analyzed and compared DOD's costs for providing salaries, training, retirement pay, and other career-related benefits to military clinical psychologists, prescribing psychologists, and psychiatrists. We found that mental health providers' overall yearly costs to DOD are not identical. Of the three types of providers we analyzed, the costs for military psychiatrists are the highest—in part because psychiatrists receive more yearly pay than military clinical

<sup>14</sup>Other physicians—such as family practice and internal medicine doctors—also prescribe psychotropic medications. However, psychiatrists are the only physicians included in our analysis.

<sup>15</sup>VRI previously evaluated PDP, under contract to DOD. We updated VRI's model with more current information.

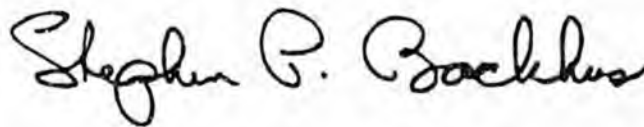
psychologists or prescribing psychologists. The PDP graduates' costs are the next highest and are considerably more than clinical psychologists—primarily because the costs involved in training the graduates and evaluating them (including evaluations by ACNP and VRI) far exceed the training costs for clinical psychologists.

Considering all career-related costs, we project that, on average, the PDP graduates will each cost DOD about \$9,700 per year—or about 7 percent—more than the cost of the combination of psychologists and psychiatrists that would be used to treat patients in their absence. Appendix II describes our analysis in more detail.

## Agency Comments

In comments received April 26, 1999, responding to a draft of this report, the Executive Director of DOD TRICARE Management Activity stated that DOD agreed with the report and had no further comments.

Copies of this report are being sent to Representative Floyd Spence, Chairman, and Representative Ike Skelton, Ranking Member, House Committee on Armed Services; and to the Honorable William Cohen, Secretary of Defense. Copies will also be made available to others upon request. If you have any questions about this report, please call me at (202) 512-7101 or Ronald J. Guthrie, Assistant Director, at (303) 572-7332. Other major contributors to this report are Steve Gaty, Sigrid McGinty, and Arthur D. Trapp, Senior Evaluators; and Timothy J. Carr, Economist.



Stephen P. Backhus  
Director, Veterans' Affairs and  
Military Health Care Issues



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## Abbreviations

ACNP	American College of Neuropsychopharmacology
DOD	Department of Defense
MHS	Military Health System
MRSP	Medical Readiness Strategic Plan
PDP	Psychopharmacology Demonstration Project
USUHS	Uniformed Services University of the Health Sciences
VRI	Vector Research, Inc.

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# Objectives, Scope, and Methodology of Our Review

The objectives of our review were to

- describe how the 10 Psychopharmacology Demonstration Project (PDP) graduates have been integrated into the Military Health System (MHS);
- obtain information on the quality of care they provide to military personnel, dependents, and retirees;
- determine their effect on medical readiness; and
- assess the cost-effectiveness of the PDP graduates.

To address the first two objectives, we visited the current or former duty locations of nine of the graduates and contacted the remaining graduate, who is stationed overseas, by telephone. At the locations we visited, we also interviewed the graduates' clinical supervisors, the hospital commander or designee, and various other clinicians and personnel to obtain information about the graduates' performance and level of integration.

Lacking a uniform definition of integration, we used several measures of how the graduates were used in order to assess their integration. We obtained information on each graduate's current position and role, scope of practice, drug formulary, average monthly caseload, and level of supervision received. We also reviewed the graduates' credentials files and performance reviews. We contacted all the members of an American College of Neuropsychopharmacology (ACNP) panel that performed a 1998 review of the graduates to obtain their views about the quality of care provided by the program graduates. We analyzed ACNP's May 1998 report and the report's supporting documentation, as well as prior ACNP evaluations of PDP.

To collect information on the PDP graduates' impact on medical readiness, we spoke with officials from each of the services and from the Office of the Assistant Secretary of Defense (Health Affairs), as well as officials at the graduates' locations. In addition, we reviewed DOD's Medical Readiness Strategic Plan to determine the role of MHS in supporting DOD's medical readiness.

To assess the cost-effectiveness of the graduates, we used a model developed by Vector Research, Inc. (VRI), under contract to DOD. Using updated data and assumptions, we calculated the life-cycle costs of the graduates, as well as those of other DOD psychologists, psychiatrists, and other physicians, and compared the annual life-cycle costs of these providers to determine the cost of the graduates relative to that of other

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**Appendix I  
Objectives, Scope, and Methodology of Our  
Review**

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providers. Appendix II provides a more detailed description of the model and the assumptions we used in calculating life-cycle costs.

# Analysis of PDP Graduates' Costs Relative to Those of Other DOD Providers

This appendix presents the methodology, data sources, and principal assumptions we used to calculate the career costs of military psychiatrists, psychologists, and prescribing psychologists. It also discusses how we compared the costs of prescribing psychologists to those of these other mental health care providers. Our analysis builds on a 1996 VRI study, in which VRI compared the cost of various types of military health care providers to the cost of a prescribing psychologist and assessed the relative cost-effectiveness of training the psychologists to prescribe medication and having them deliver this service in MHS.<sup>16</sup>

For the purposes of this report, we have updated and extended the VRI analysis, most notably by

- revising the figures used by VRI to represent the costs involved in training the prescribing psychologists and
- estimating the career length of the graduates who currently remain in the military, based on their career length to date, and calculating their career costs.

Except where noted, the data we used—such as military pay rates and health care costs—were provided by VRI. However, we did not verify the accuracy of these data.

## Cost Analysis

DOD uses several types of providers to deliver mental health care, including psychologists, psychiatrists, family practice doctors, and internal medicine doctors. However, their career-related costs—including salaries, training, and retirement pay—are not identical and are generally lower for psychologists than for these physicians. For example, psychologists are not eligible for all special payments above salaries that physicians may receive.

We calculated the average career costs of the graduates and other providers and compared them to one another, using costs based on the anticipated career length and overall cost to DOD of the PDP graduates and other providers. Most PDP graduates spent a part of their military careers as clinical psychologists (before they entered PDP) and part of their military careers as prescribing psychologists (after they entered PDP). For comparison purposes, we assumed that the mental health services provided by PDP graduates as prescribing psychologists are comparable to

<sup>16</sup>Other tasks in the study included identifying impediments to integrating prescribing psychologists into MHS and evaluating the potential roles and functions of prescribing psychologists in DOD.

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those provided by psychiatrists<sup>17</sup>—that is, they are trained to perform a function (prescribing psychotropic medication) that psychiatrists would have to perform in their absence.<sup>18</sup>

Because a PDP graduate's career, on average, is a combination of the functions performed by psychologists and psychiatrists, we compared the portion of a PDP graduate's career spent as a psychologist (that is, before the graduate became a prescribing psychologist) to the yearly cost of a military psychologist, and we compared the portion of a PDP graduate's career spent as a prescribing psychologist to the yearly cost of a military psychiatrist. For example, one PDP graduate served about 10 years as a military psychologist before entering PDP and, since then, has served about 4 years as a prescribing psychologist—for a total of 14 years. Thus, the graduate spent 71.4 percent (10 years) of his practicing career in the military as a clinical psychologist and 28.6 percent (4 years) as a prescribing psychologist. The yearly cost of the graduate could then be compared to 71.4 percent of the yearly cost of a psychologist plus 28.6 percent of the yearly cost of a psychiatrist.

Another PDP graduate served 3 years as a military psychologist before entering PDP and has served 3 years as a prescribing psychologist, for a total of 6 years. Thus, 50 percent of his practicing career in the military was spent as a clinical psychologist and 50 percent was spent as a prescribing psychologist. As a result, the yearly cost of this graduate could be compared to 50 percent of the yearly cost of a psychologist plus 50 percent of the yearly cost of a psychiatrist.

The 10 PDP graduates differed in the length of time they had served as military psychologists before entering PDP, ranging from not having served in the military to having served 10 years,<sup>19</sup> with a mean average of about 4.5 years as military psychologists. Similarly, the participants can be expected to differ in the length of time each remains in the military as a prescribing psychologist. We calculated the average length of their projected careers as prescribing psychologists, based on the length of their

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<sup>17</sup>Some—including ACNP and the American Psychological Association—have pointed out that the graduates are not intended to replace psychiatrists. ACNP wrote, "PDP was not designed to replace psychiatrists . . . and it did not do so. Instead, the program 'products' were extended psychologists with [the] value-added component prescriptive authority provides."

<sup>18</sup>Other physicians—such as family practice and internal medicine doctors—also prescribe psychotropic medications. However, their annual life-cycle costs are higher than those of psychiatrists, primarily because they serve shorter careers than psychiatrists and, thus, their overall costs are larger on an annual basis. Because psychiatrists' costs were the lowest of the physicians' costs analyzed, we used their costs in order to provide the most conservative comparison.

<sup>19</sup>Two PDP graduates entered PDP immediately upon joining the military.

military service to date and the rates at which DOD psychologists have historically left the military. Using these data, we project that each program participant will serve an average of 6 years as a prescribing psychologist after entering PDP (including service to date as prescribing psychologists). Thus, we expect the participants to serve an average combined career total of 10.5 years in the military as clinical psychologists and subsequently as prescribing psychologists: an average of 4.5 years (or 43 percent of their careers) as clinical psychologists, plus an average of 6.0 years (or 57 percent of their careers) as prescribing psychologists. The average yearly cost of the graduates can thus be compared to 43 percent of the yearly cost of a psychologist plus 57 percent of the yearly cost of a psychiatrist.

Our estimates of the overall cost of the various types of providers included

- acquisition costs that DOD incurs when recruiting someone into the military;
- training costs to provide DOD-sponsored training to military health care providers;
- force costs, which cover basic pay and allowances (such as allowances for housing), special pay, miscellaneous expenses, and health care benefits over the course of an active-duty career; and
- retirement costs, which include retirement pay and retiree health care benefits over the expected life of the retiree.

## Data and Assumptions

Although our analysis resembles VRI's—and in most cases relies on VRI's data and assumptions—in several instances we used data or assumptions that differed from VRI's. These differences reflect our emphasis on incorporating data that reflect, to date, the actual costs and experience of the program as it was implemented by DOD, rather than VRI's projections of how the program might be implemented. We discussed these changes with a VRI official, who stated that while he disagreed with our estimate of the cost of classroom training, the assumptions we used in our calculations were reasonable given the history of the program. The remainder of this appendix discusses the major assumptions we made in performing our analysis and explains where and how our data or assumptions differed from VRI's.

## Different Scenarios

In calculating the cost-effectiveness of PDP, VRI used two case scenarios: start-up and optimal. Costs in the start-up scenario included the nonrecurring, fixed costs associated with PDP development and initial

implementation, such as the cost of the external evaluation by ACNP, as well as other costs that VRI believed would diminish or disappear in the long run.

The optimal scenario represented PDP in a long-term, steady state during which no nonrecurring costs associated with program start-up would accrue. In this scenario, VRI set the cost of supplies and training to levels that indicate long-term efficiency.

In contrast to VRI, we did not project different scenarios because the program has been terminated. Instead, we used data that reflect, to date, the actual costs and experience of the program as it was implemented by DOD.

#### Pre-PDP Service

VRI assumed that PDP participants would have at least 6 years of experience as military clinical psychologists when they entered PDP. However, we found that although the 10 PDP graduates served an average of almost 7 years in the military before entering PDP, on average only about 4.5 of those years were spent as a clinical psychologist. We did not include nonpsychologist years in our cost comparison.

VRI assumed that the yearly continuation rates—that is, the probability that a given provider will stay within a given service occupation during a given year—for program participants before entering PDP were identical to those for military psychologists, including some psychologists who leave the military each year after the first 2 years of service. In contrast, based on the experience of the program, we used yearly continuation rates that reflect the fact that no participants left the military before entering PDP.<sup>20</sup>

#### PDP Characteristics

VRI used two different estimates of class size, depending on the scenario. In the start-up case, VRI assumed that, on average, 3.25 psychologists would enter each PDP class, from which 2.25 prescribing psychologists would graduate. These numbers were based on the program experience at the time of VRI's report: 13 psychologists had entered the program and, according to a VRI official, it appeared that 9 would graduate. VRI set the retention rate during the program to reflect the assumption that 9 of 13 participants would graduate.

In the optimal case scenario, VRI assumed that, on average, 8.7 psychologists would enter PDP each year, while 6 prescribing psychologists

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<sup>20</sup>The continuation rate used affects the length of service calculated by the model. Because annual costs depend in part on this expected length of service, different continuation rates will result in different annual costs.

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would graduate. The continuation rate during the program was identical to that used in the start-up case.

However, of the 13 participants, 10—not 9—graduated from the four PDP classes. Consequently, we used an average of 3.25 (that is, 13/4) psychologists entering PDP each year and 2.5 (that is, 10/4) graduating. We set the continuation rate during the program accordingly. Further, in order to reflect the fact that 13 psychologists entered PDP—effectively “leaving” the services’ clinical psychologist force for cost-comparison purposes—we used a continuation rate for clinical psychologists that differed slightly from the historical DOD rate to account for these psychologists.

Our estimates of the cost of training the graduates also differed from those used by VRI. For its cost model, VRI estimated the overhead costs associated with the program to be \$2,890,343. However, based on ACNP’s annual reports (some of which were not yet published when VRI conducted its study) and our interviews with the former PDP training director, we estimated the overhead costs to be about 14 percent lower at \$2,474,578.

While our estimate of overhead costs is lower than VRI’s estimate, our estimate of 1 year of classroom training at the Uniformed Services University of the Health Sciences (USUHS) is markedly higher than that used by VRI. VRI estimated the classroom training costs (which do not include the PDP overhead costs it estimated) for participants to be \$39,969, based on its 1995 study of the costs of graduate medical education and on a survey of the costs of graduate medical education in the Washington, D.C., area. However, based on our previous analysis of USUHS costs,<sup>21</sup> we estimated the classroom training costs to be \$110,028—or about 175 percent higher than VRI’s estimate.

#### Post-PDP Service

To project how long the PDP graduates could be expected to serve as prescribing psychologists, VRI assumed no graduates would leave the military for the 2 years immediately following the program. VRI also assumed that the rate at which the graduates leave the military thereafter would be identical to the rate at which other clinical psychologists leave.

In contrast, our projections of the graduates’ post-PDP careers were based on their actual length of service to date. Because all graduates completed at least 1 year of post-PDP service, we set the continuation rate for the first year after the program to 1. However, the yearly rate for the second year

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<sup>21</sup>Military Physicians: DOD’s Medical School and Scholarship Program (GAO/HEHS-95-211, Sept. 29, 1995).

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**Appendix II**  
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was set to 0.9, because only 9 of the 10 graduates completed a second year of post-PDP service. To estimate how much longer the graduates who are still in the military could be expected to remain in the military, we used information gathered during our interviews with the graduates (such as the graduates' future plans for military service) as well as historical continuation rates for DOD clinical psychologists. Based on these calculations, we estimate that the participants will serve an average of about 6 years as prescribing psychologists, including the productive portion of their training.<sup>22</sup> (We conducted a sensitivity analysis, described at the end of this appendix, to determine the effect this estimate had on our final cost estimates.)

VRI also assumed that the PDP graduates posed no more of a malpractice risk to DOD than any other mental health providers delivering the same treatment to the same types of patients. Further, VRI assumed that PDP graduates did not receive the special pay paid to psychiatrists and other physicians in the military, assuming instead that the salary for PDP graduates was identical to that for military clinical psychologists. We also used these assumptions.

### Supervisory Time

VRI estimated that the PDP graduates would require 5 percent of a supervisor's time for the remainder of their careers. However, based on our fieldwork, we reduced that estimate to zero. Although two graduates have still not been granted independent status, supervision of the graduates in general has been reduced significantly. For example, one graduate required about 1 hour per week (or less than 3 percent) of supervisory time during the first 18 months after the program; during the subsequent 18 months, this graduate has required about 0.5 hours per month (or less than 0.3 percent) of supervisory time. Eight of the graduates currently require less than 1 hour per week of supervisory time. However, not all supervisors were able to quantify the amount of time they spent supervising the graduates. Even when supervisors could quantify this time, it was often less than 1 percent, and as a result we used an estimate of zero to provide a conservative estimate of the cost of the graduates. Had we used a percentage larger than zero, our estimate of the PDP graduates' costs would have been higher. (We conducted a sensitivity analysis, described at the end of this appendix, to determine the effect this assumption had on our final cost estimates.)

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<sup>22</sup>In accordance with VRI's estimate, we assumed that PDP participants were not productive (that is, saw no patients) during the classroom portion of their training and were 50 percent productive (that is, were half as productive as fully trained clinicians) during the clinical portion of their training.

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**Retirement Costs**

Based on DOD figures, VRI calculated pension rates based on an average service time for military retirees of 22.5 years. However, our estimates of the graduates' expected length of service yield an average service time for retirees in this group of 23.8 years. In other words, the graduates who serve at least 20 years in the military—and are thus eligible to earn a pension—will likely have served an average of 23.8 years. We calculated retirement costs accordingly.

Further, since only some of the graduates' years of service before entering PDP were spent as military clinical psychologists and because some of the retirement costs for the graduates are associated with service as neither clinical psychologist nor prescribing psychologist, we believe it is not appropriate to include this portion of retirement costs in our cost comparison. As a result, retirement cost estimates for the graduates were reduced.

**Updated Costs**

The data used in VRI's earlier calculations were in 1996 dollars. For our analysis, we updated the figures to 1999 dollars using the most recent estimates of the DOD medical consumer price index.<sup>23</sup>

**Results of Analysis**

Table II.1 shows the results of VRI's calculations and our calculations.

**Table II.1: VRI's Cost Estimates and GAO's Cost Estimates**

Provider group	Yearly life-cycle cost per full-time equivalent (1999 dollars)	
	VRI total	GAO total
Psychiatrist	\$188,472	\$188,472
Psychologist	96,819	92,703
Psychologist and psychiatrist combination	136,895	147,532
Prescribing psychologists (start-up case scenario; graduating class size set to 2.25)	133,942	<sup>a</sup>
Prescribing psychologists (optimal case scenario; graduating class size set to 6)	120,463	<sup>a</sup>
PDP graduates (based on program experience)	<sup>a</sup>	157,226

<sup>a</sup>Not applicable.

<sup>23</sup>Neither we nor VRI discounted the costs included in these calculations. Discounting determines the present value of an amount of money that will be spent in the future. For example, a dollar paid by the government today is more costly than a dollar paid at some future date because it increases the burden of making interest payments on the national debt. See Office of Management and Budget, *Guidelines and Discount Rates for Benefit-Cost Analysis of Federal Programs*, Circular A-94 (Washington, D.C.: Office of Management and Budget, Revised Oct. 29, 1992).

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VRI's estimates for the annual cost of the prescribing psychologists in both the start-up case (\$133,942) and the optimal case (\$120,463) were less than that of the combined psychologist and psychiatrist cost (\$136,895). VRI concluded that the program was cost-effective. On the other hand, our estimate of the annual cost of prescribing psychologists (\$157,226) was higher than that of the combined psychologist and psychiatrist cost (\$147,532), by about \$9,700.

Our estimate of the cost of the graduates is higher than VRI's because of the different data and assumptions we used, our estimate of the cost of the psychologists is lower than VRI's because we adjusted the psychologist continuation rate slightly, and our estimate of the combination of psychologist and psychiatrist costs is higher than VRI's because our estimates of the length of time the graduates served as military clinical psychologists and will serve as prescribing psychologists differ somewhat from VRI's estimates. Because the combination of psychologist and psychiatrist costs depends on the proportion of time the graduates spend as clinical psychologists and prescribing psychologists, differences in these proportions will result in different estimates for the combination of psychologist and psychiatrist.

### Sensitivity Analysis

To assess the influence that our assumptions of length of service and supervisory time had on the results of our calculations, we performed a sensitivity analysis on each of these assumptions. To perform each analysis, we varied our assumptions about length of service or supervisory time while holding all other values constant.

First, we performed a sensitivity analysis on our projections of the length of time the graduates can be expected to remain in the military. Using DOD's historical continuation rate for psychologists, we projected that the participants will serve for about 6 years as prescribing psychologists, including service to date. This resulted in our estimate that the annual cost of the graduates is about \$9,700 more than the combined psychologist and psychiatrist costs used for comparison. If the participants were to serve for 7 years as prescribing psychologists, the estimated cost differential between the PDP graduates and the combined psychologist and psychiatrist costs is reduced to about \$6,300. Projecting an average length of service of 8 years as prescribing psychologists reduces that differential to about \$3,800; 9 years, to about \$2,100; and 10 years, to about \$800. Thus, given this program's experience, the graduates would not be less expensive than the combined psychologist and psychiatrist unless they served as prescribing psychologists for an average of more than 10 years.

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In addition, because we could not precisely quantify the amount of supervisory time required by the graduates, we assumed in making our calculations that the supervisory time was zero. To determine the effect that this assumption had on our final cost estimates, we performed a sensitivity analysis using other estimates of supervisory time. First, we used VRI's estimate that the graduates would require 5 percent of a supervisor's time throughout their career. This assumption raised the estimated differential between the cost of the graduates and the combined psychologist and psychiatrist cost from \$9,700 to about \$11,800. Assuming 3 percent of a supervisor's time raised the estimated cost differential to about \$11,000 per year; assuming 1 percent of a supervisor's time raised the estimated cost differential to about \$10,100 per year.

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Alaska Psychiatric Concepts

David B. Robinson, M.D., M.P.H.  
Diplomate, American Board of Psychiatry and Neurology  
in Child, Adolescent and Adult Psychiatry

DEC 20 1999

December 20, 1999

Representative Norman Rokeberg  
Chairman, Labor and Commerce Committee  
716 West Fourth  
Anchorage, AK 99501-2133

Dear Representative Rokeberg:

Thank you for the opportunity to meet with you May 10, 1999, to discuss the Alaska Psychiatric Association's opposition to House Bill 139 "An Act authorizing certain psychologists to prescribe and dispense certain psychotropic medications and their adjuncts within the practice of psychology." I want to express my personal gratitude for your listening to our explanation of the vital differences between a psychologist and psychiatrist. I hope that in our time with you, individually and with the Labor and Commerce Committee, we were able to describe clearly the reasons that formal medical education is the only preparation suitable to qualify practitioners to prescribe psychotropic medications safely.

During the coming legislative session, I look forward to continuing our discussion of any questions that might arise regarding this issue of great importance to Alaskans.

Wishing you and yours a happy holiday season, sincerely,



David B. Robinson, M.D., M.P.H.  
Diplomate, American Board of Psychiatry and Neurology  
in Child, Adolescent and Adult Psychiatry

mf

STATE OF ALASKA  
HOUSE OF REPRESENTATIVES

**Representative Jeannette James**



P.O. Box 56622  
North Pole, AK 99705  
TEL 488-1546, FAX 488-4271

State Capitol  
Juneau, AK 99801  
TEL 465-3743, FAX 465-2381

**SPONSOR STATEMENT**

**House Bill 139  
Prescription Privileges for Psychologists**

4/9/99

I have introduced HB 139 to open the discussion of an important public policy issue. This bill, similar to proposals currently under review in several states, would authorize qualified psychologists with appropriate pharmacological training to prescribe medications within the scope of their professional practice.

In addition to the substantial education and training psychologists already have in the diagnosis and treatment of mental health and emotional disorders, this bill would require completion of rigorous additional training as determined by the Board of Psychology prior to being authorized to prescribe medication.

Alaska has a large, under-served population with mental health problems. Prescription privileges for psychologists will help increase access to appropriate, comprehensive treatment for many of these Alaskans. It will also streamline patient care, give consumers more choices, and reduce costs.

## PREScription PRIVILEGES FOR PSYCHOLOGISTS

We are requesting introduction of a bill to authorize qualified psychologists with appropriate pharmacological training to prescribe medications within the scope of their professional practice. Prescription privileges for psychologists will help increase access to appropriate treatment, reduce costs, streamline patient care and give consumers more choices. Here are the short answers to several important questions about this proposal:

### **1. How will patients benefit if psychologists are able to prescribe medications?** There are many benefits:

**More Consumer Choices/Continuity of Service/Streamlined Patient Care:** Currently, patients often see two doctors, a psychologist for psychotherapy and a M.D. for the medication. Under our proposal, patients would have the option of receiving the full range of services from one health care professional with the most training in mental health. This will also allow those patients to maintain continuity of care.

**Greater Access:** It will be easier to access quality care. Waiting lists to see psychiatrists, even in urban areas like Anchorage, are long. In rural areas there are even fewer psychiatrists. National trends suggest a continuing decline in the number of medical school graduates choosing psychiatric specialties. Family practitioners and other doctors also can prescribe but they have less training or expertise relating to psychotherapy.

**Less Cost:** Prescription privileges for psychologists will lower the cost of health care to the private sector since patients will no longer have to see two doctors. Psychologists also are generally less expensive than psychiatrists/MD's. Particularly hard hit by these costs are the elderly and the working poor.

Prescription writing privileges would also lower the cost to the state of mental health facilities, private nursing homes and correctional facilities that now require a psychiatrist/MD to write a prescription.

### **2. Will every psychologist be allowed to prescribe?** No. Only upon completion of appropriate and rigorous training as determined by the Board of Psychology - with a core emphasis on mental health, psychopharmacology and related medical science - will these experts in the diagnosis of mental disorders be permitted to prescribe medication.

These training requirements will be comparable to or exceed those of other non-MD health care professionals who are authorized to prescribe medication including nurse practitioners, optometrists, physician assistants and dentists. The safety record of these other professionals is outstanding. Recent experiences at the Department of

Defense, which permits military psychologists who have completed training requirements to prescribe medications for patients, confirm this conclusion.

**3. If psychologists prescribe medication will the authority of psychiatrists be undermined?** It will not. Instead the spectrum of services available to better serve Alaskans will be improved by making care more accessible and affordable.



## MODEL LEGISLATION FOR PRESCRIPTIVE AUTHORITY

### A. Definitions

- (1) "Prescriptive authority" means the authority to prescribe and dispense drugs and/or other treatment procedures within the scope of practice of psychology in accordance with regulations adopted by the [state board of psychology].
- (2) "Psychologist certified to prescribe" means a licensed, doctoral-level psychologist who has undergone specialized training and has passed an examination accepted by the [state board of psychology], and has received from the [state board of psychology] a current certificate granting prescriptive authority, which has not been revoked or suspended.
- (3) "Drug" shall have the same meaning as that term is given in [state's "Food, Drug, and Cosmetic Act"].
- (4) "Prescription" is an order for a drug, laboratory test, or any medicine[s], device[s] or treatment[s], including a controlled substance[s], as defined by state law.

### B. Certification

- (1) The [state board of psychology] shall certify licensed, doctoral-level psychologists to prescribe and dispense drugs in accordance with applicable state and federal laws.
- (2) The [state board of psychology] shall develop and implement procedures for reviewing educational and training credentials for that certification process, in accordance with current standards of professional practice.<sup>1</sup>

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<sup>1</sup> In developing certification procedures and criteria, some state legislatures may request that other government agencies be involved as well. In this case, states may consider a third, optional certification element.

- (3) The [state board of psychology] may seek the advice of other [state agencies] with relevant experience in devising the certification procedures and criteria.

### C. Initial Application Requirements for Prescriptive Authority

A psychologist who applies for prescriptive authority shall demonstrate by official transcript or other official evidence satisfactory to the [state board of psychology] all of the following:

- (1) Completion of a doctoral program in psychology from a regionally-accredited university or professional school, or, if the program is not accredited at the time of graduation, applicants shall have completed a doctoral program in psychology that meets recognized acceptable professional standards as determined by the [state board of psychology];<sup>2</sup>
- (2) Holding of a current license to practice psychology in [the state];
- (3) Completion of a program of education in an organized program of intensive didactic instruction<sup>3</sup> as defined by the [state board of psychology] within the five-year period immediately preceding the date of application, consisting of the following core areas of instruction: neuroscience, pharmacology, psychopharmacology, physiology, pathophysiology, appropriate and relevant physical and laboratory assessment, and clinical pharmacotherapeutics;
- (4) Having obtained supervised and relevant clinical experience<sup>4</sup> sufficient to attain competency in the treatment of a diverse patient population under the direction of qualified practitioners as determined by the [state board of psychology] within the five-year period immediately preceding the date of application;
- (5) Passing of a certifying examination administered by [the state board of psychology] and developed by a nationally recognized body approved by the [state board of psychology], or developed by the [state board of psychology].

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<sup>2</sup> A "grandparent" provision may be added to waive the *coursework* for psychologists who have obtained relevant training and experience, including (a) psychologists who are dually licensed as physicians, nurse practitioners, or who have comparable prescriptive authority under another license; and (b) psychologists who have completed the Department of Defense Psychopharmacology Demonstration Project.

<sup>3</sup> The didactic portion of the education shall consist of a minimum of 300 contact hours.

<sup>4</sup> The clinical program of instruction shall consist of the treatment of a minimum of 100 patients.

#### **D. Renewal of Prescriptive Authority**

- (1) The [state board of psychology] shall prescribe by rule a method for the renewal of prescriptive authority at the time of or in conjunction with the renewal of licenses.
- (2) Each applicant for renewal of prescriptive authority shall present satisfactory evidence to the [state board of psychology] demonstrating the completion of [number of] contact hours of instruction relevant to prescriptive authority during the previous [licensure renewal period].

#### **E. Prescribing Practices**

- (1) Every prescription by a psychologist certified to prescribe:
  - a. shall comply with all applicable state and federal laws; and
  - b. shall be identified as issued by the psychologist as "psychologist certified to prescribe" and shall include the prescriber's identification number assigned by the [state board of psychology].
- (2) Records of all prescriptions shall be maintained in patient records.
- (3) A psychologist shall not delegate the prescribing of drugs to any other person.

#### **F. Controlled Substance Prescriptive Authority**

- (1) When authorized to prescribe controlled substances, each psychologist certified to prescribe shall file in a timely manner any and all individual Drug Enforcement Agency (DEA) registrations and numbers with the [state board of psychology].
- (2) The [state board of psychology] shall maintain current records of every psychologist certified to prescribe, including DEA registrations and numbers.

#### **G. Interaction with the [State Board of Pharmacy]**

- (1) The [state board of psychology] shall transmit to the [state board of pharmacy] an annual list of psychologists certified to prescribe containing the following information:
  - a. the name of the psychologist;

- b. the psychologist's identification number assigned by the [state board of psychology]; and
  - c. the effective date of prescriptive authority.
- (2) The [state board of psychology] shall promptly forward to the [state board of pharmacy] the names and titles of psychologists added to or deleted from the annual list of psychologists certified to prescribe.
- (3) The [state board of psychology] shall notify the [state board of pharmacy] in a timely manner upon termination, suspension, or reinstatement of a psychologist's prescriptive authority.

#### H. Grounds for Suspension or Revocation of Licenses

The [state board of psychology] shall prescribe by rule criteria for disciplining, suspending or revoking the prescriptive authority or license of a psychologist certified to prescribe. The [state board of psychology] shall have the power and duty to require remediation, suspension or revocation of a psychologist's prescriptive authority for a specified period of time to be determined at the discretion of the [state board of psychology] in accordance with [state law].

#### Possible Additions to Existing State Laws

1. Amendment to the state controlled substances act to ensure that psychologists certified to prescribe are authorized prescribers of controlled substances.
2. Amendment to the state nurse practice act to ensure that nurses can implement prescriptions written by psychologists certified to prescribe.
3. Amendment to the state pharmacy act to ensure that pharmacists can dispense drugs ordered by psychologists certified to prescribe.
4. The laws of thirteen states prohibit the prescription of drugs by psychologists. One possible way to address this problem would be to seek legislative authorization to prescribe only for those psychologists who obtain certification, while retaining the general prohibition on prescribing. For these states, state psychological associations may consider including the following provision:

The practice of psychology shall not include:

Prescribing drugs, with the exception of drugs prescribed by psychologists certified to prescribe [or by psychologists who have graduated from the U.S. Department of Defense Psychopharmacology Demonstration Program].

Approved by the APA Council of Representatives  
August 12, 1990

s:\legalreg\modlaw.rx

**Subject: HB 139**

**Date:** Wed, 14 Apr 1999 16:53:45 -0800

**From:** phillip baker <pwbaker@alaska.net>

**To:** "representative\_norman\_rokeberg@legis.state.ak.us" <Representative\_Norman\_Rokeberg@legi

**CC:** "dcc@alaska.net," <dcc@alaska.net>, >

Representative Norman Rokeberg  
Chairman, House Labor and Commerce Committee  
Alaska State Legislature

Re: HB 139

Dear Representative Rokeberg;

I am writing to urge you to schedule a hearing on HB 139 as soon as possible. Psychologists with appropriate post-doctoral training in psychopharmacology will make a safe and excellently trained group of new health care providers to care for Alaskan Residents. Appropriately trained psychologists would take their place along side the many prescribing non-physician providers. Psychologists are in an ideal position to provide mental health services because of their average 6-8 years of post Masters degree training in human functioning and problem resolution. In addition, appropriately trained Alaskan Psychologists would save residents and employers many additional expenses that arise in having to refer to a medical doctor for medication to supplement psychotherapy treatment.

Great cost and time savings and less duplication of effort would arise from one doctor --- an appropriately trained Psychologist, both providing needed counseling and medication for a client as needed.

As a side note, I remember you when you were running for office. You crashed our block party in Turnagain on a Sunday afternoon. You laughed with us; you ate our food; you urged us to vote for you and then you walked away. Please don't walk away from us now! Please schedule a hearing on HB 139 at your earliest convenience.

Thank You,

Phillip Baker Ed.D.  
Licensed Clinical Psychologist

Paul L. Craig, Ph.D.  
Diplomate, American Board of Clinical Neuropsychology

2751 DeBarr Road, Suite 390  
Anchorage, AK 99508

Phone (907) 274-8200  
Fax (907) 274-8211

April 14, 1999

Representative Norman Rokeberg  
Chairman, House Labor and Commerce Committee  
Alaska State Legislature

VIA FAX ONLY

Re: HB 139

Dear Representative Rokeberg:

I write to you today in support of HB 139 and encourage you to schedule a hearing for this legislation at the earliest possible opportunity. I believe that with appropriate post-doctoral training psychologists will safely prescribe psychotropic medications and this has been proven in the Department of Defense demonstration project examining this issue.

This legislation would not allow any psychologists currently practicing in Alaska to prescribe psychotropic medications. There are psychologists currently trained within the United States through the Department of Defense Demonstration Program who are fully competent to prescribe medications. And some Alaskan psychologists may choose to seek postdoctoral fellowship training in this specialty skill. Much of the scientific research regarding efficacy of psychotropic medications has been promulgated by psychologists. After a decade of consideration and debate, the American Psychological Association and the Alaska Psychological Association support HB 139 and related legislation. The American Psychological Association has spent \$800,000.00 to develop a test that can be used at the State level to assess competency and knowledge regarding prescribing psychotropic medications.

Across the nation, virtually all states allow non-physician health service providers (e.g. optometrists, podiatrists, nurse practitioners, physician assistants, dentists, midwives, pharmacists) to prescribe medications for patients consistent with their training. HB 139 is a logical extension of this trend.

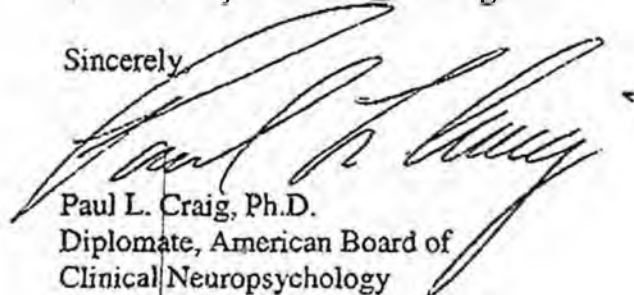
There are many reasons why this legislation will be good for the people of Alaska and these points will be clarified during legislative hearings. Psychologists have extensive training and experience in the diagnosis and treatment of mental health problems and emotional disorders. Psychologists receiving specialty training relative to prescribing medications would be of benefit to some patients with regard to proper selection of

psychotropic medications within the context of integrated care. It's difficult enough for many individuals to seek treatment in the first place, but needing to go to multiple providers to get their psychotherapy and medication needs met only complicates the difficulty. Prescribing psychologists may also contribute to cost savings as duplication of services will be cut down. Yet another reason to authorize appropriately trained psychologists to prescribe is the increased availability of providers in underserved populations. There is evidence that 75% to 85% of all psychotropic medications are prescribed by non-psychiatric providers (internists, family practice physicians, nurse practitioners, physician assistants, etc.) who may have no training in psychotherapy, behavioral treatment or differential diagnosis of mental health problems. We've all heard of depressed patients being prescribed valium or a tiny dose of a tricyclic antidepressant medication that is grossly inadequate to alter the symptoms of depression. The research completed with psychologists who are currently prescribing within the federal health care system suggests that these professionals use medications very judiciously within the context of psychotherapeutic treatment of emotional and behavior problems. This integrated approach is cost effective and good for consumers.

I am fully aware that HB 139 may be controversial to some other professionals who view it as a threat to their turf. However, licensure to practice in any field does not exist for guild protection, it exists for consumer protection. In this context, HB 139 is a step forward in relation to safely and efficiently meeting the burgeoning mental health needs of Alaskans.

I encourage you to schedule a hearing for this important legislation. Thank you in advance for your action in this regard.

Sincerely,



Paul L. Craig, Ph.D.  
Diplomate, American Board of  
Clinical Neuropsychology

*Carriage House Psychological Associates, PLLC*

600 Jackson Street, Suite B  
P. O. Box 2161  
Roanoke Rapids, NC 27870-2161  
252 537-6164  
Fax: 252 537-9199

April 15, 1999

RE: HB 139

Norman Rokeberg  
Chairman, House Labor and Commerce Committee  
Alaska State Legislature

Subject: Scheduling of HB 139

Dear Representative Rokeberg:

This letter is written to address HB 139 and to lend my strongest support. Please consider the positive benefits of rapid scheduling of hearings for this legislation.

This issues addressed in this legislature concern consumer protection at a level that is relevant to your constituents and to persons in need or and receipt of mental health treatment throughout the United States. Sometimes the persons with the least capacity to address their own needs are torn between the two caregivers, the person who prescribes their medication and sees them only briefly and the person who is involved in their ongoing treatment and sees them regularly. This is a distinct disadvantage to the patient who must explain to two caregivers, and must hope they are in agreement regarding his or her needs. The need for coordination of treatment is an important one for those receiving the services.

There is good evidence that with appropriate post-doctoral training Psychologists can safely prescribe psychotropic medications and this has been proved in the Department of Defense (DOD) demonstration project that examined this issue. Across the nation, many states permit non-physician providers (optometrists, podiatrists, nurse practitioners, physician assistants, dentists, midwives, pharmacists) to prescribe medications for patients. In fact the state of Indiana has already approved legislation that would permit graduates of the DOD demonstration project to prescribe.

There are many reasons why this legislation will be good for the people of Alaska and these points will be fully detailed in legislative hearings. Several issues bear brief mention at this time. Psychologists already have extensive training and experience in the diagnosis and treatment of mental health problems and emotional disorders. Prescribing will be yet another tool for those Psychologists seeking this additional post-doctoral training. Prescribing Psychologists would offer their clients who would benefit from psychotropic medications a greater continuity of care. It's difficult enough for many individuals to seek treatment in the first place, but having to go to multiple different providers to get all their needs met only complicates the difficulty and

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Norman Rokeberg  
RE: HB 139  
Page 2  
April 15, 1999

significantly increases costs. Thus, prescribing Psychologists will reduce this need to see multiple providers, save time for the individual, and provide a significant cost savings to both the individual and any third party payer as duplication of services will be cut down. Yet another reason to authorize appropriately trained Psychologists to prescribe is the increased availability of providers in undeserved populations. Further, I do not believe the prescriptive authority for appropriately trained Psychologists will result in a significant increase in prescriptions or "pill pushing." Psychologists with the extensive training in behavioral treatment and psychotherapy actually prescribe less than those that are only provide medications for psychological disorders, according to the current trend. There is ample evidence that 75% to 85% of all psychotropic medications are prescribed by non-psychiatric physicians (internists, general practitioners...) who have no training in psychotherapy or behavioral treatment.

Please consider the importance of these issues when you schedule a hearing for this important legislation, at the earliest possible opportunity.

Sincerely,

*Nancy Boylan Alford, Psy D*

Nancy Boylan Alford, Psy. D., FPPR  
Licensed Psychologist, North Carolina  
Carriage House Psychological Associates, PLLC

# David C. Deal, Ph.D. and Associates

1450 South Clinton Street  
Toledo, Ohio 43512

Phone 419 784 3393  
Fax 419 784 3393  
Email drdc@dfnet.com

April 14, 1999

**Representative Norman Rokeberg**  
Chairman, House Labor and Commerce Committee  
Alaska State Legislature

APR 14 1999

Subject: Scheduling of HB 139

Representative Rokeberg:

I'm writing to you today to inform you of my extremely strong support of HB 139 and encourage you to schedule hearings for this legislation at the earliest possible opportunity. I'm sure you can understand the tremendous need for additional, full service mental health doctors, being from a rural area as am I in Northwest Ohio. While Doctors of Psychology have chosen to focus on the complicated social, family and dynamic aspects of mental health we now realize there is a tremendous need for us to add medications to our treatment arsenal. Most current medications are prescribed by family physicians with very little mental health training and with hands full with various demands. As is tradition in our profession, the American Psychological Association has gone to great lengths to provide training standards that ensure competency levels that exceed any reasonable doubts.

Thanks for your time.

Sincerely,

*David C. Deal*  
David C. Deal, Ph.D., FPPR

**Gilbert O. Sanders, Ed.D.**  
**Counseling / Addictions Psychologist**  
Fellow, American Academy of Doctors of Psychology  
2550 Denali, Suite 1606  
Anchorage, Alaska 99508  
(907) 274-0444  
email: sandersg@alaska.net

APR 14 1999

April 14, 1999

**Representative Norman Rokeberg**  
**Chairman, House Labor and Commerce Committee**  
**Alaska State Legislature**

**Subject: Scheduling of HB 139**

**Representative Rokeberg:**

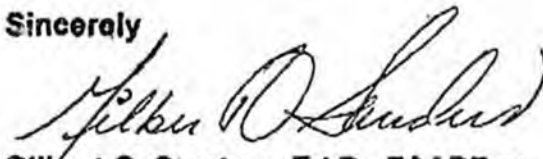
I'm writing to you today to inform you of my extremely strong support of HB 139 and encourage you to schedule hearings for this legislation at the earliest possible opportunity. I believe that with appropriate post-doctoral training Psychologists can safely prescribe psychotropic medications and this has been proved in the Department of Defense (DOD) demonstration project that examined this issue. Across the nation, many states permit non-physician providers (optometrists, podiatrists, nurse practitioners, physician assistants, dentists, midwives, pharmacists) to prescribe medications for patients. In fact the state of Indiana has already approved legislation that would permit graduates of the DOD demonstration project to prescribe.

There are many reasons why this legislation will be good for the people of Alaska and these points will be fully detailed in legislative hearings. I would like to point out just a few at this time. Psychologists already have extensive training and experience in the diagnosis and treatment of mental health problems and emotional disorders. Prescribing will be yet another tool for those Psychologists seeking this additional post-doctoral training. Prescribing Psychologists would offer their clients who would benefit from psychotropic medications a greater continuity of care. It's difficult enough for many individuals to seek treatment in the first place, but having to go to multiple different providers to get all their needs met only complicates the difficulty and significantly increases costs. Thus, prescribing Psychologists will reduce this need to see multiple providers, save time for the individual, and provide a significant cost savings to both the individual

and any third party payer as duplication of services will be cut down. Yet another reason to authorize appropriately trained Psychologists to prescribe is the increased availability of providers in underserved populations. Further, I do not believe the prescriptive authority for appropriately trained Psychologists will result in a significant increase in prescriptions or "pill pushing." I believe that there mounting evidence that Psychologists with the extensive training in behavioral treatment and psychotherapy actually prescribe less than those that are only provide medications for psychological disorders. There is ample evidence that 75% to 85% of all psychotropic medications are proscribed by non-psychiatric physicians (Internists, general practitioners...) who have no training in psychotherapy or behavioral treatment.

I ask that you to schedule a hearing for this important legislation at the earliest possible opportunity.

Sincerely



Gilbert O. Sanders, Ed.D., FAADPsy  
Counseling / Addictions Psychologist

Subject: HB 139

Date: Wed, 14 Apr 1999 11:47:55 -0700

From: Lois Michaud <"michaud@alaska.net"@alaska.net>

To: Representative\_Norman\_Rokeberg@legis.state.ak.us

APR 14 1999

Representative Rokeberg,

I am writing today with regard to HB 139, to request a hearing on this legislation. Prescription privileges are granted to many non-physicians, non of whom have the mental health expertise of a psychologist. With the APA-recommended post-doctoral work, a psychologist would be in a uniquely qualified position to address the medication portion of the treatment process, in conjunction with the psychotherapy and assessment we already do.

There are advantages to having a psychologist prescribing medication. Contrary to the belief put forth by psychiatry that this would lead to over-prescribing, most current subscribers are those without psychiatric training, such as general practitioners and pharmacists. These individuals have no training in psychotherapy, either. Psychologists have extensive doctoral-level training in the diagnosis and treatment of mental health problems, many with post-doc training in specialty areas. Currently, it is necessary to refer a patient to a psychiatrist or nurse practitioner for medications, to augment their therapy. Getting as far as the therapy session itself is traumatic for many of these individuals. It would be impossible to track the number of people who dropped out of therapy because of the need to go to a second provider for medications, too intimidated to get past the psychiatric visit or unable to face another practitioner to re-tell their story to yet another stranger. It turns into further traumatization of the patient and creates a hindrance to rapport. In areas with minority or underserved groups, this referral is even more difficult to effect, due to a lack of trust and availability of services. Prescribing by psychologists would cut out this duplication and need for re-telling their traumas and provide better continuity of service. I don't know that I will seek further post-doc training, but I do believe that prescription privileges for psychologists should be an option and will be in the future, as it is now in Guam. I am not concerned with the financial aspect of this issue. I don't need to make more money. But, I do wish my clients to be able to get the help they need, without being further traumatized, stigmatized, or shut out due to lack of funds for a psychiatrist. The bill proposed makes sense. It should be heard. Thank you.

Sincerely,

Lois Michaud, Ph.D.

Licensed Psychologist, AK 451

Diplomate, American College of Forensic Examiners #17119

APR 14 1999

**Subject: HB 139****Date: Wed, 14 Apr 1999 11:31:03 -0800****From: "Robert A. Lane, Ph.D." <ahsral@alaska.net>****Organization: Alaska Human Services, Inc.****To: Representative\_Norman\_Rokeberg@legis.state.ak.us**

Representative Norman Rokeberg  
Chairman, House Labor and Commerce Committee  
Alaska State Legislature

Re: HB 139

Representative Rokeberg:

I write to you today in support of HB 139 and encourage you to schedule hearings for this legislation at the earliest possible opportunity. I believe that with appropriate post-doctoral training psychologists will safely prescribe psychotropic medications and this has been proven in the Department of Defense demonstration project examining this issue. Across the nation, many states permit non-physician providers (optometrists, podiatrists, nurse practitioners, physician assistants, dentists, midwives, pharmacists) to prescribe medications for patients.

There are many reasons why this legislation will be good for the people of Alaska and these points will be fully elucidated in legislative hearings. I would like to point out just a few however. Psychologists already have extensive training and experience in the diagnosis and treatment of mental health problems and emotional disorders. Prescribing

will be yet another tool for those psychologists seeking this additional

post-doctoral training. Prescribing psychologists would offer their clients who would benefit from psychotropic medications a greater continuity of care. It's difficult enough for many individuals to seek treatment in the first place, but having to go to multiple different providers to get all their needs met only complicates the difficulty. Prescribing psychologists may also contribute to cost savings as duplication of services will be cut down. Yet another reason to authorize appropriately trained psychologists to prescribe is the increased availability of providers in undeserved populations. I do not

believe the prescriptive authority for appropriately trained psychologists will result in "pushing more pills." I believe with the extensive training in behavioral treatment and psychotherapy we may actually find that psychologists prescribe less than those whose only area of expertise is in providing medications. There is ample evidence that 75% to 85% of all psychotropic medications are prescribed by non-psychiatric physicians (internists, general practitioners...) who have no training in psychotherapy or behavioral treatment.

I encourage you to schedule a hearing for this important legislation.

Sincerely  
Robert Lane, Ph.D.  
President, Alaska Psychological Association

Robert Lane, Ph.D. <[ahsral@alaska.net](mailto:ahsral@alaska.net)>  
Executive Director  
Alaska Human Services, Inc.

**Sharon K. Schneider, PsyD**  
*Diplomate in Clinical Neuropsychology*  
*American Board of Professional Psychology*

**APR 14 1999**

Three Office Park, Suite 306  
Mobile, Alabama 36609

Telephone: (334) 414-5005  
Facsimile: (334) 414-5544

**April 14, 1999**

**Representative Norman Rokeberg**  
**Chairman, House Labor and Commerce Committee**  
**Alaska State Legislature**

**Subject: Scheduling of HB 139**

**Representative Rokeberg:**

**I'm writing to you today to inform you of my extremely strong support of HB 139 and encourage you to schedule hearings for this legislation at the earliest possible opportunity.**

**There are many reasons why this legislation will be good for the people of Alaska and these points will be fully detailed in legislative hearings. I would like to point out just a few at this time. Psychologists are already trained and licensed to diagnosis and treat of mental illnesses. Prescribing Psychologists could offer greater continuity of care. Prescribing psychologists are cost efficient. It is unconscienable to force a patient to see at least two doctors when one qualified doctor is sufficient. This provides a significant cost savings to both the individual and any third party payer as duplication of services will be cut down. One third of Alabama citizens fail 200% below the poverty line. These citizens are underserved and prescribing psychologists who are eligible for National Health Service Corp loan repayment can fill this niche. While organized medicine would have you believe that prescribing psychologists would be a danger to the public, there is ample evidence indicating that 75% to 85% of all psychotropic medications are prescribed by physicians (internists, general practitioners, family practice...) who have no training in psychotherapy or behaviorical treatment. Many of these physicians will**

**acknowledge that they will prescribe a medication such as Prozac when they have no idea how to diagnose depression or an anxiety disorder because they feel it is safe.**

**I ask that you to schedule a hearing for this important legislation at the earliest possible opportunity.**

**Sincerely,**

A handwritten signature in cursive script that reads "Sharon K. Schneider". There is a small mark above the letter 'e' in "Schneider".

**Sharon K. Schneider, PsyD, ABPP, FPPR  
Licensed Psychologist**

**Subject: House Bill 139**

**Date: Wed, 14 Apr 1999 23:38:25 -0400**

**From: Ralph Welsh <rswelsh@snet.net>**

**To: Representative\_Norman\_Rokeberg@legis.state.ak.us**

**CC: mszd@pcnet.com, sandersg@alaska.net**

APR 15 1999

Honorable Norman Rokeberg  
Chairman, House Labor and Commerce Committee  
Alaska State Legislature

Dear Representative Rokeberg:

I wish to call your attention to HB 139, which provides the opportunity for psychologists to prescribe.

This bill is not only important to the people of Alaska, it will help pave the way for those of us in the other 49 states who are also seeking to obtain this privilege. Many of us have all ready spent 8 to 10 years in college, plus an internship and residency in a psychiatric facility to practice clinical psychology. By the time we go through the requisite program to prescribe, we will have spent a large part of our life in school and in training--but we think it will be well worth it for our patients and our ability to treat the entire person. Many of our patients suffer terribly as a result of their emotional conditions; when they have to wait for a psychiatric consult, their suffering is only extended.

Please take a careful look at this bill, and consider how it may benefit virtually everyone by ultimately reducing the cost of psychiatric care. That is, it will reduce the number of double billings now required when a patient is forced to see two practitioners for treatment instead of one, and allow the patient to get immediate relief for his/her symptoms when it is apparent that medication is required. In psychiatrically underserved areas, the advantage of having a prescribing psychologist is obvious.

Sincerely,

Ralph S. Welsh, PhD, ABPP  
Diplomate in Clinical Psychology  
89 West Street  
Danbury, CT 06896

P.S. Right out of high school I worked one summer on the White Pass and Yukon RR between Skagway and Clifton Station 8 miles up the line, laying rail and tamping ties. I love the place. Alaska is definitely God's country.

G

**Subject: HB 139**

**Date:** Thu, 15 Apr 1999 10:53:22 -0000

**From:** "Dr. Kiffer" <jkiffer@ns.gov.gu>

**Organization:** Superior Court of Guam

**To:** "representative\_norman\_rokeberg@legis.state.ak.us" <Representative\_Norman\_Rokeberg

April 15, 1999

Representative Norman Rokeberg  
Chairman, House Labor and Commerce Committee  
Alaska State Legislature

Subject: Scheduling of HB 139

Representative Rokeberg:

Guam passed legislation in December 1998 that provided appropriately trained and licensed clinical psychologists prescriptive authority. There was opposition primarily from the psychiatric community. P.L. 24-329 (Bill 695) was introduced by Dr. Cruz, a physician/senator, who understood the issues involved and the benefits of having clinical psychologists with prescription authority in our remote location. Dr. Cruz was able to address the arguments and concerns of the Guam Medical Society who appeared split on the issue. I thought it was interesting how the non-psychiatric medical doctors had few objections privately but felt pressured to publicly support the psychiatrists' position.

I support Dr. Sanders and encourage you to schedule the hearing for House Bill 139. I hope your Legislature is able to sort through the chaff to the heart of the matter and pass HB 139 into law.

Respectfully,

James J. Kiffer, Ph.D.  
Clinical Psychologist  
Superior Court of Guam



"Fostering Native Self-Determination in Primary Care, Prevention and Health Promotion"

YUKON-KUSKOKWIM HEALTH CORPORATION

APR 15 1999

April 15, 1999

Representative Norman Rokeberg  
Chairman, House Labor and Commerce Committee  
Alaska State Legislature

Re: HB 139

Dear Representative Rokeberg:

This letter is written in support of HB 139, and I encourage you to schedule a hearing on this legislation at the earliest possible opportunity. I have no doubt that properly trained psychologists can and will safely prescribe psychotropic medications. This has been proven by the Department of Defense demonstration project.

HB 139 would allow only psychologists properly trained to prescribe psychotropic medications. There are psychologists currently trained within the United States through the Department of Defense Demonstration Program who are fully competent to prescribe medications. Some, but not all, Alaskan psychologists may chose to seek postdoctoral training in this specialty. I am one who has chosen the arduous task of obtaining this training while maintaining a practice. By the end of May, I will have completed the recommended 300 classroom hours of training in the field of pharmacopsychology.

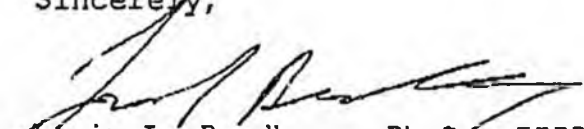
Most states allow non-physician health service providers (e.g., optometrists, podiatrists, nurse practitioners, physician assistants, dentists, midwives, pharmacists) to prescribe medications for patients within their scope of training and practice. HB 139 is a logical extension of this trend.

In no way is this legislation intended to encourage psychologists to move away from the use of psychotherapy as a healing art. In contrast, it will allow psychologists to add to their repertoire of tools and techniques available to engender a positive outcome. Through the years, as psychotropic medications have advanced and improved, with a

reduction of the side effects, research has proven the efficacy of the use of medication in conjunction with psychotherapy. For properly trained psychologists to be prohibited from using tools and techniques which have proven to be efficacious in the healing of mental disorders would almost seem to constitute malpractice on the part of those making the laws.

I encourage you to schedule a hearing for this important legislation. Thank you in advance for your prompt action in this matter.

Sincerely,



Lorin L. Bradbury, Ph.D., EPPR  
Licensed Psychologist

GAO

Report to the Chairmen and Ranking  
Minority Members, Committee on Armed  
Services, U.S. Senate, and Committee on  
National Security,  
House of Representatives

April 1997

# DEFENSE HEALTH CARE

## Need for More Prescribing Psychologists Is Not Adequately Justified



Printed copies of this document will be available shortly.



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Health, Education and Human Services Division

B-276291

April 1, 1997

The Honorable Strom Thurmond  
Chairman  
The Honorable Carl Levin  
Ranking Minority Member  
Committee on Armed Services  
United States Senate

The Honorable Floyd Spence  
Chairman  
The Honorable Ronald V. Dellums  
Ranking Minority Member  
Committee on National Security  
House of Representatives

The Military Health Services System (MHSS) provides for the mental health care needs of the approximately 1.7 million active-duty members of the U.S. armed services. To meet its military readiness requirements, the MHSS had 478 psychiatrists and 395 clinical psychologists on board in fiscal year 1996.

Some functions of psychiatrists and clinical psychologists overlap. As physicians, however, psychiatrists are trained in and licensed to practice medicine and are therefore qualified to prescribe medication for both mental and physical conditions. Because no medical training is required to practice clinical psychology, clinical psychologists, whether in the military or the civilian sector, historically have not been permitted to prescribe drugs.

This changed for some clinical psychologists in the military when the MHSS instituted the Psychopharmacology Demonstration Project (PDP) in 1991. The PDP has trained military psychologists to prescribe psychotropic medication<sup>1</sup> for mental conditions such as depressive and adjustment disorders. Before the PDP, MHSS psychologists were not allowed to prescribe medication. The first

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<sup>1</sup>These are drugs that affect psychic function, behavior, or experience.

Although DOD met its goal to train psychologists to prescribe drugs, it faced many difficulties in implementing the PDP. Not all of these were resolved. For example, the MHSS never had a clear vision of the prescribing psychologist's role, did not meet recruitment goals, and repeatedly changed the curriculum. Consequently, ACNP recommended in 1995 that unless these issues were addressed, the PDP should end.

The total cost of the PDP, from start-up through the date the last participants will complete the program, is about \$6.1 million or about \$610,000 per prescribing psychologist, according to our estimate. Ultimately, the PDP will have added 10 mental health care providers who can prescribe drugs to an MHSS that already has a surplus of psychiatrists. Opinions differ on the effect of adding these prescribing psychologists to the MHSS concerning such issues as quality of care and collaboration between psychologists and physicians.

Without a clear purpose or role for prescribing psychologists and given the uncertainty about the extent to which they would replace higher cost providers, we cannot conclude that the benefits gained from training prescribing psychologists warrant the costs of the PDP. Training psychologists to prescribe medication is not adequately justified because the MHSS has no demonstrated need for them, the cost is substantial, and the benefits are uncertain.

#### BACKGROUND

The main mission of the MHSS, which spends more than \$15 billion a year, is medical readiness.<sup>4</sup> This mission requires the MHSS to (1) provide medical support to active-duty military personnel in preparation for and during combat and (2) maintain the health of the active-duty force during peacetime. The Army, Navy, and Air Force all maintain uniformed health care providers to fill their MHSS medical readiness needs.

To the extent that military space, staff, and other resources are available, the MHSS may also support DOD's mission to care for nonactive-duty beneficiaries (dependents of active-duty members, retired members and their dependents,

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<sup>4</sup>According to DOD, "Medical readiness encompasses the ability to mobilize, deploy and sustain field medical services and support for any operation requiring military services; to maintain and project the continuum of health care resources required to provide for the health of the force; and to operate in conjunction with beneficiary health care." See Medical Readiness Strategic Plan, 1995-2001, DOD (Washington, D.C.: Mar. 20, 1995).

# CORRECTION

THE FOLLOWING DOCUMENT(S)  
HAVE BEEN REFILMED TO  
ASSURE LEGIBILITY OR PAGINATION



Rev. 6/98

Central Microfilm Services  
Department of Education & Early Development  
State of Alaska

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Health, Education and Human Services Division

B-276291

April 1, 1997

The Honorable Strom Thurmond  
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