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PDP participants completed the program in 1994. To date, seven psychologists have finished the PDP training, and the MHSS has authorized all of them to prescribe certain medications for mental conditions. An additional three psychologists are expected to complete the PDP in June 1997.

The National Defense Authorization Act for Fiscal Year 1996 (P.L. 104-106) required that the PDP end by June 30, 1997, and that we evaluate the project. On the basis of discussions with your offices, our evaluation includes (1) an assessment of the need for prescribing psychologists in the MHSS, (2) information on the implementation of the PDP, and (3) information on the PDP's costs and benefits. To develop this information, we reviewed the military's needs determinations for psychiatrists and clinical psychologists. We examined reports and assessments of the PDP by the Army, the Army Surgeon General's blue ribbon panels, and the American College of Neuropsychopharmacology (ACNP) as well as several articles on the issue of psychologists prescribing drugs. We also reviewed both a feasibility study and a cost-effectiveness analysis conducted by Vector Research, Inc. (VRI).[2]

In addition, we interviewed all PDP participants who completed the project and others at the facilities where participants were practicing, Department of Defense (DOD) Office of Health Affairs officials, and other DOD medical officials. We also met with representatives of the American Psychiatric Association and the American Psychological Association. Our work was performed from July 1996 through February 1997 in accordance with generally accepted government auditing standards.[3]

RESULTS IN BRIEF

The MHSS has more psychiatrists than it needs to meet its current and upcoming readiness requirements, according to our analysis of DOD's health care needs. Therefore, the MHSS needs no prescribing psychologists or any other additional mental health care providers authorized to prescribe psychotropic medication. Moreover, DOD does not even account for prescribing psychologists when determining its medical readiness needs.

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[2]Cost-Effectiveness and Feasibility of the DOD Psychopharmacology Demonstration Project: Final Report, Vector Research, Inc. (Arlington, Va.: May 17, 1996). For a detailed description of this study's methodology and results, see app. I.

[3]See app. II for a more detailed description of our methodology.

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.[4] 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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[4]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).

and survivors of deceased members). Whenever nonactive-duty beneficiaries' need for health care exceeds the MHSS' resources available to them, DOD purchases services for them from the civilian health care sector.

The role of psychiatrists and clinical psychologists in meeting the MHSS medical readiness mission is to provide mental health care that helps military active-duty personnel perform their duties before, during, and after combat or some other military operation. Both psychiatrists and clinical psychologists, whether in the military or civilian sector, provide a variety of mental health services, some of which are similar. Both can diagnose mental conditions and treat these conditions with psychotherapy. A degree in medicine is required to practice psychiatry, however, so psychiatrists may treat mental disorders medically, that is, with medication. Because medical training is not required to practice clinical psychology, psychologists are not qualified to prescribe medication.

To practice medicine, psychiatrists complete 4 years of medical school and a 1-year clinical internship during which they are trained to evaluate and treat all types of organic conditions[5] and to perform general surgery. After this, they complete a 3-year psychiatric residency during which they learn to evaluate and treat mental conditions and the organic conditions associated with them. Because psychiatrists practice medicine, they can diagnose organic as well as mental conditions and treat each with medication. They consider a full range of possible organic causes for abnormal behavior when diagnosing a condition. Therefore, they can distinguish between mental conditions with an organic cause, such as schizophrenia[6] and bipolar disorder,[7] and organic conditions, such as diabetes and thyroid disease, which have symptoms that mimic a

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[5]These are diseases associated with observable or detectable changes in the organs or tissues of the body.

[6]This is a fundamental mental derangement characterized by loss of contact with the environment; noticeable deterioration in the level of functioning in everyday life; and disintegration of personality expressed as disorders of feeling, thought, and conduct.

[7]This is a disorder in which the patient exhibits both manic and depressive episodes. Mania is excitement manifested by mental and physical hyperactivity, disorganization of behavior, and elevation of mood. Depression is marked by sadness, difficulty in concentration, feelings of dejection and hopelessness, and sometimes suicidal tendencies.

mental disorder. Organic mental disorders are best treated through a combination of medication and psychotherapy, according to DOD officials.

Clinical psychologists, on the other hand, practice psychology, not medicine. Typically, they complete 6 years of graduate school leading to a doctoral degree and 1 to 2 years of postdoctoral clinical experience. Clinical psychologists are trained in theories of human development and behavior, so their general approach to diagnosing and treating mental illness is psychosocial[8] rather than medical. They are trained to diagnose and treat all mental conditions and rely on the behavior a patient displays to diagnose these conditions.

The MHSS created the PDP to increase the scope of practice of clinical psychologists in the military so they could treat their patients with psychotropic medication when needed. DOD established this project 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 specified that, "given the importance of addressing 'battle fatigue,' the conferees agreed that the Department should establish a demonstration pilot training program in which military psychologists may be trained and authorized to issue appropriate psychotropic medications under certain circumstances."

The Army's Office of the Surgeon General was tasked with designing and implementing the PDP. A blue ribbon panel[9] was formed by the Army Surgeon General in February 1990 to determine the best method for implementing the PDP. After considering various models, the panel endorsed a training model that included course work at the Uniformed Services University for the Health Sciences (USUHS). In February 1991, the Chairmen of the Senate and House Subcommittees on Defense of the respective Committees on Appropriations then recommended that DOD develop a 2-year training model for the PDP in accordance with the panel's recommendations. DOD later formed a committee to develop a suitable training program to provide clinical psychologists with the knowledge required for safely and effectively using a limited list or formulary of psychotropic medication. This committee recommended a special 3-year postdoctoral fellowship program for the PDP with (1) 2 years of course work at

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[8]This refers to relating social conditions to mental health.

[9]This panel consisted of representatives of the Surgeons General of each of the three services; the Office of the Assistant Secretary of Defense for Health Affairs; and professional organizations of psychiatrists, psychologists, and physicians.

USUHS, followed by (2) 1 year of clinical experience at Walter Reed Army Medical Center.

This training began in August 1991 with four participants. For subsequent classes, however, the PDP consisted of 2 years of training—1 year of classroom and 1 year of clinical training. Classroom training included courses at USUHS in subjects such as anatomy, pharmacology, and physiology. PDP participants' clinical experience took place on inpatient wards and outpatient clinics at Walter Reed Army Medical Center in Washington, D.C., or the Malcolm Grow Medical Center at Andrews Air Force Base in Maryland. There, 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. After their clinical year, participants received a certificate of "Fellowship in Psychopharmacology for Psychologists" and became known as "prescribing psychologists."

Once PDP participants graduated from training, they completed 1 year of supervised or proctored practice; their respective services assigned participants to military medical facilities for this 1 year of practice. These facilities authorized participants to prescribe a specified formulary of psychotropic drugs. Although the medical education received under the PDP qualified clinical psychologists to treat mental conditions with medication, it was less extensive than psychiatrists' medical training. Therefore, the MHSS limits prescribing psychologists' scope of practice. They may only treat patients between the ages of 18 and 65 who have mental conditions without medical complications as determined by their supervisors.

ACNP helped develop and evaluate the PDP. ACNP is a professional association of about 600 scientists from disciplines such as behavioral pharmacology, neurology, pharmacology, psychiatry, and psychology. ACNP's principal functions are research and education. It conducted several assessments of the PDP under contract to the Army and made a number of recommendations on the project's goals and implementation. One of them was for DOD to establish a PDP Advisory Council to help develop criteria and procedures on implementing the PDP. DOD established this council in 1994.

The American Psychiatric Association, American Psychological Association, and literature on this topic have noted the possible advantages or disadvantages of allowing psychologists in the civilian sector to prescribe medication. One article has suggested that training psychologists to prescribe psychotropic medication could be particularly beneficial if they were permitted to practice this skill in clinical settings such as nursing homes, mental institutions, or

medically underserved areas. Some have suggested that using prescribing psychologists could reduce the cost of care and maintain the continuity of patient care by eliminating the need to switch patients from psychologists to psychiatrists when drug therapy is indicated. On the other hand, because prescribing psychologists would receive only partial training in medicine, some are concerned about the quality of care these psychologists would be able to provide.

No state licensing authority allows psychologists to prescribe medication. A few states are considering legislation, however, that would allow those already licensed by the state's psychologist licensing board to be certified to prescribe medication after completing certain courses in medicine and gaining clinical experience. Under legislation introduced in Hawaii in 1997, psychologists seeking authority to prescribe would have to pass a standard examination. Legislation proposed in Missouri would require the development of a specified formulary of drugs for certified prescribing psychologists.

NUMBER OF MENTAL HEALTH CARE PROVIDERS IS ADEQUATE FOR READINESS REQUIREMENTS

None of the services needs additional mental health providers capable of prescribing medication to meet either current or upcoming medical readiness requirements, according to our review of DOD's health care needs. Each service has more than enough psychiatrists, as well as clinical psychologists, to care for its anticipated wartime psychiatric caseload. Given this surplus, spending resources to provide psychologists with additional skill does not seem justified.

Each of the three services has a model and procedures to determine the number of specific types of health care providers needed to support its MHSS medical readiness mission. These are based on the types and number of casualties anticipated under a wartime scenario. About one out of eight casualties would involve combat stress, according to an Army official.[10] Caring

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[10]Stress is the internal process of preparing to deal with events or situations referred to as "stressors." Stress involves physiological reflexes such as increased nervous system arousal, release of adrenaline into the bloodstream, change in blood flow to different parts of the body, and the like. Stress also involves emotional responses and the automatic perceptual and cognitive processes for evaluating an uncertainty or a threat. Combat stressors are those

for combat stress requires skill in (1) diagnosing combat stress, including the ability to distinguish it from neurological or other psychological disorders with like signs and symptoms, and (2) treating a range of severity levels of combat stress. Psychologists have many but not all of the skills necessary to care for combat stress and are therefore included, along with psychiatrists, in the services' staffing of those who treat anticipated wartime casualties. Psychologists cannot be substituted for psychiatrists, however. Even if trained to prescribe drugs, psychologists are not as equipped as psychiatrists to distinguish between actual combat stress and certain neurological disorders that appear to be combat stress. Psychiatrists are also better able to treat more severe or complicated combat stress cases.

The services have separate requirements for psychiatrists and clinical psychologists. None of the services has a separate readiness requirement for prescribing psychologists. Table 1 shows the number of MHSS psychiatrists each service has determined it needs[11] and the number assigned or on board for fiscal years 1995 through 1998.[12] Table 2 shows the number of clinical psychologists each service has determined it needs and the number assigned for fiscal years 1995 through 1998.

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occurring during combat-related activities, whether from enemy action or other events or situations. They may arise from a soldier's own unit, leaders, and mission demands or from the conflict between mission demands and a soldier's home life.

[11]The Air Force could not provide the number of psychiatrists or psychologists needed to meet its readiness requirements for fiscal years 1995 through 1997. The Air Force Surgeon General, however, stated in 1995 that his service had a surplus of psychiatrists.

[12]Projections of readiness requirements are available for all the services only through fiscal year 1998. Officials from each of the services, however, have observed that as the size of the military declines, MHSS readiness requirements for psychiatrists beyond fiscal year 1998 should stay the same or decline.

Table 1: Psychiatrists by Service: Number Needed and Assigned to Meet Readiness Requirements

	FY 1995		FY 1996		FY 1997	FY 1998
Service	Needed	Assigned	Needed	Assigned	Needed	Needed
Air Force	[a]	129	[a]	115	[a]	107
Army	205	226	205	219	198	228
Navy	105	166	107	144	107	107
Total	[a]	**521**	[a]	**478**	[a]	**442**

[a]Number is not available.

Table 2: Psychologists by Service: Number Needed and Assigned to Meet Readiness Requirements

	FY 1995		FY 1996		FY 1997	FY 1998
Service	Needed	Assigned	Needed	Assigned	Needed	Needed
Air Force	[a]	156	[a]	165	[a]	207
Army	118	130	118	113	103	98
Navy	135	157	92	117	92	92
Total	**397**	[a]	**443**	[a]	**395**	[a]

[a]Number is not available.

As these tables show, the MHSS has at least as many uniformed psychiatrists and clinical psychologists as it needs to meet its current and upcoming readiness requirements. Our discussions with psychiatry consultants[13] to the Surgeons General of the three services confirm the picture these numbers portray, and testimony of DOD officials at congressional hearings is consistent with the views expressed by these consultants. At a March 1995 Senate Armed Services Committee hearing, the Assistant Secretary of Defense for Health Affairs stated that, on the basis of DOD staffing guidelines, the MHSS has no shortage of active-duty physicians in general. The Navy Surgeon General also

[13]These are officials in each branch of the service who represent specific types of health care providers in that branch.

testified at this hearing that the Navy has no shortage of psychiatrists. In addition, an official from the DOD Office of Health Affairs said that DOD has a surplus of psychiatrists.

Although training psychologists to prescribe medication enables them to perform functions they do not normally perform, it does not give them all the skills needed to enable them to substitute for psychiatrists. Furthermore, the MHSS' current staffing level of psychiatrists and psychologists is more than enough to meet its readiness requirements for caring for psychiatric cases without adding to some psychologists' capabilities. Therefore, the MHSS seems to have no current or upcoming need for psychologists who may prescribe drugs.

PDP'S IMPLEMENTATION FACED DIFFICULTIES

Although DOD met the mandate to establish a demonstration project to train military psychologists to prescribe psychotropic medication for mental illness, the PDP implementation faced several problems. Some of these problems have been resolved. The problems include

- the lack of a clearly defined purpose for prescribing psychologists in the MHSS,
- difficulty recruiting the desired number of participants per class,
- unspecified participant selection criteria,
- repeated changes in the classroom curriculum,
- delays in granting prescribing privileges, and
- unresolved issues involving supervision.

The lack of precedent and experience with authorizing psychologists to prescribe medication, according to some officials at locations where PDP participants are stationed, is partly to blame for some of these problems. These include delays in granting prescribing privileges and disagreements over the extent of supervision.

Prescribing Psychologists' Role in the MHSS Not Clearly Defined

The PDP did not clearly define the role of prescribing psychologists in the MHSS. The ACNP's PDP evaluation panel noted in 1992 that the project's goal "to train psychologists to issue appropriate medication under certain circumstances" was "rich with ambiguities." The project was structured and revised periodically without specifying the (1) prescribing psychologists' duties and responsibilities, (2) types of clinical settings or facilities their skills would be best suited for, (3) types of psychotropic medication psychologists would be qualified to prescribe, and (4) level of supervision they would require. In September 1995, after the project had operated for 4 years, the ACNP panel suggested that DOD define clearly how PDP graduates could be used; this did not take place.

Recruiting PDP Participants Was Difficult

DOD had difficulty recruiting PDP participants throughout the project. The recruiting goal, which was not met, was six psychologists for each PDP class. Since the project started in 1991, 13 psychologists have participated. Seven have completed it. Three have dropped out, and three are expected to finish their clinical experience in June 1997 (see table 3). Those who dropped out did so for various reasons: One left the military. Another enrolled in the medical school at USUHS. The third left because of dissatisfaction with the program.

Table 3: Status of Psychologists Entering the PDP

Year	Entered the PDP	Left the PDP	Graduated from the PDP	Currently in the PDP
1991	4	2	2	0
1992	0	0	0	0
1993	2	1	1	0
1994	5	0	4	1
1995	2	0	0	2
Total	**13**	**3**	**7**	**3**

Because the PDP did not attract enough military psychologists, the program was opened to civilian clinical psychologists willing to enter the military. Two

of the five PDP participants who began the program in 1994 were civilians who joined the military to participate in the PDP. Finally, only two psychologists entered the PDP in 1995.

Candidate Selection Criteria Were Not Specified

The MHSS established no formal candidate selection criteria for the PDP. Four classes of candidates had entered the PDP before prerequisites for participation were first addressed in February 1995. At that time, the PDP Advisory Council recommended that a candidate for the PDP (1) be on active duty, in good standing as a psychologist, and have an active state license to practice clinical psychology; (2) have a minimum of 2 years of active-duty experience as a clinical psychologist in one of the uniformed services; (3) agree to meet the service's payback obligations for postdoctoral training; and (4) volunteer for the program.

Curriculum Repeatedly Changed

The duration, content, and sequencing of PDP training continued to change after the project began. Originally, PDP training was intended to last for 2 years and consist of both course work and clinical experience during each year. An additional year of clinical experience was added for the first class after it began the program, however, because the participants were not receiving enough clinical experience. Subsequent classes received 2 years of training as originally planned: the first dedicated exclusively to course work at USUHS; the second, to clinical practice.

In addition, the curriculum content and sequencing of the courses changed after the project began. Courses such as neuroscience and psychopharmacology were added, while others were dropped. In 1995, the ACNP panel noted that the curriculum for those who started the PDP in 1994 was "markedly different" from the curriculum for participants who started the PDP in 1991. The panel said at that time that the curriculum needed to be thought through more thoroughly, using the final scope of practice and formulary as a starting point. The panel also noted that assessing the adequacy of the curriculum was difficult because it changed frequently. The panel saw a need for a well-organized, structured approach to the design of courses as well as the selection of participants. It recommended at that time that unless the MHSS addressed these concerns satisfactorily, the project should end.

Prescribing Privileges for PDP Graduates Were Delayed

The first psychologists who completed the PDP faced delays of up to 14 months in getting prescribing privileges at the facilities where they were assigned possibly due to the facilities' lack of experience with this type of provider. Two recent graduates, however, received privileges within 2 months of arriving at their facilities. In each of these cases, PDP officials visited the facilities where these psychologists had been assigned to explain the project and training and provide information about the graduates to facility officials. Facility officials cited these visits as helpful in resolving their concerns about psychologists' prescribing privileges.

Supervision of Prescribing Psychologists Unresolved

The MHSS has not decided who should supervise prescribing psychologists. In 1994, the MHSS decided that after prescribing psychologists had completed their clinical year, they would spend the next year practicing under a psychiatrist's supervision. The MHSS originally anticipated that these psychologists would ultimately function independently. All of the PDP graduates, however, continue to practice under the supervision of a psychiatrist, and whether they will ever prescribe independently is unclear.

The PDP Advisory Council's February 1995 scope of practice statement, which has been used as guidance for allowing prescribing privileges for some PDP graduates, states that prescribing psychologists should prescribe psychotropic medication only under the direct supervision of a physician. According to the Advisory Council that developed this statement, PDP graduates' prescribing practice should be closely supervised. These psychologists should then gradually be permitted to practice under less supervision as they demonstrate their competence.

PDP WAS COSTLY AND ITS BENEFITS ARE UNCERTAIN

Even if the MHSS had a need for additional mental health care providers to prescribe medication, the cost of meeting this need by training clinical psychologists to prescribe drugs is substantial. Furthermore, although the PDP produced additional providers who can prescribe and some facilities have reported positive experiences with them, determining the PDP's cost-effectiveness is impossible at this time.

Cost of PDP

The total cost of the PDP will be about $6.1 million through the completion of the proctored year for those currently in the program--or about $610,000 per psychologist who completes the program (see table 4).

Table 4: Estimated Cost of PDP by Training Component and Type of Cost, FY 1991-98

Type of cost	Training component			Total cc
	Classroom year	Clinical year	Proctored year	
PDP training expenses	1,650,420	0	0	$1,650.
Student salary plus benefits (minus productivity benefit)	844,065	333,154	0	1,177.
Supervisor lost productivity	0	475,810	206,874	682.
PDP training overhead cost	[a]	[a]	[a]	2,584.
Total cost				**$6,094,**

Notes: These estimate. assume that the three current PDP participants will complete the clinical portion of the project in June 1997 and their proctored year in 1998.

Estimates as expressed in 1996 dollars.

[a]Not available by component.

On the basis of our previous estimates of the cost of a USUHS medical education,[14] we estimate that the cost of the classroom training for PDP participants provided by USUHS was about $110,028 per participant per year. Most of this amount consisted of faculty cost and costs for operating and maintaining USUHS. The remainder included the cost of research,

[14]Military Physicians: DOD's Medical School and Scholarship Program (GAO/HEHS-95-244, Sept. 29, 1995).

development, testing and evaluation, military construction, and other miscellaneous costs. Our estimate of total cost for PDP training includes the cost of 12 classroom years of training for 10 PDP graduates as well as 3 years of training for three psychologists who dropped out of the program.

Our estimates of psychologists' salaries while participating in the PDP are based the assumption that those entering the project would receive a salary of $56,071 during their first year in the PDP, $57,571 during their second year, and $58,985 during their third year.[15] Student salaries totaled $844,065 during the classroom training portion of the PDP, according to our estimate. This included the salaries of 11 participants for 1 year of classroom training each, 3 of whom ultimately dropped out of the PDP, and 2 participants for 2 years each.

Because PDP participants treated patients during their clinical and proctored years, we reduced our salary estimates for these years by a productivity factor representing the time they spent treating patients. We used a productivity factor of 50 percent for the clinical year and 100 percent for the proctored year.[16] On the basis of these productivity factors, total participant salary costs for the clinical portion of the PDP were $333,154, according to our estimates. This accounts for one participant who dropped out approximately halfway through the clinical year and another who received an additional year of clinical training.

To estimate faculty and supervisor salaries for the PDP for the clinical and proctored years, we assumed that one faculty member per psychologist would devote 40 percent of his or her time per clinical year of training. Likewise, we assumed that during the proctored year, one supervisor would spend 20 percent of his or her time supervising each prescribing psychologist.[17] On the basis of these assumptions, the total cost of lost faculty productivity due to training the

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[15]This is derived from VRI's DOD salary information for its cost-effectiveness and feasibility study (May 17, 1996).

[16]PDP participants and their supervisors generally agreed on the basis of their experience that participants spent about half their time in the clinical year and all of their time in the proctored year treating patients.

[17]These proportions are based on discussions with psychiatrists who supervised PDP participants in their clinical and proctored years. They generally agreed they had devoted 20 and 40 percent of their time, respectively, per year to supervising participants.

10 graduates for 11.5 years[18] of clinical training was $475,810, according to our estimate: the total cost of lost supervisor productivity was $206,874 for 10 participants for 10 proctored years of practice. The lost productivity cost is based in each case on an annual salary of $103,437.[19]

Total PDP overhead cost was $2.58 million, according to our estimate.[20] This included the cost of the evaluation contract ($1.75 million) and personnel support costs ($830,000) for a PDP Director and a Training Director for fiscal years 1992 (when the PDP began) through 1998, when those currently in training are expected to complete their proctored year. Also included in overhead costs are smaller amounts for invited lecturers, travel and per diem expenses, supplies, and other miscellaneous expenses during this time.

If the PDP had attracted a total of 24 participants and all of them had graduated, the cost would have been about $365,000 per prescribing psychologist. In addition, the cost per graduate would have been about $94,000 lower than this if the project had progressed beyond the developmental stage and external evaluations could have been discontinued. After operating for 7 years, however, the project was only able to attract about half the number of participants considered optimal and had not progressed beyond the stage for which external evaluations were needed.

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[18]This includes 1 year of clinical training for nine graduates, 2 years for one graduate, and 1/2 year for one participant who dropped out of the PDP halfway through the clinical year.

[19]This is the cost of the average fiscal year 1996 annual salary and benefits of all DOD psychiatrists as estimated by VRI in its cost-effectiveness and feasibility study of the PDP.

[20]This is based on overhead costs contained in PDP annual reports produced by the Army and costs reported by VRI in its cost-effectiveness and feasibility study of the PDP.

Perceptions of PDP and Its Benefits Differ

The PDP increased the number of MHSS mental health care providers who may prescribe drugs to treat certain mental conditions. This may reduce psychiatrists' workloads. Psychiatrists, psychologists, and primary care physicians, however, have different opinions on the effect of allowing psychologists to prescribe drugs on the quality of mental health care and collaboration among these providers.

As a result of the PDP, seven psychologists are prescribing medication at DOD military facilities, and three more are expected to complete clinical training in the summer of 1997 and receive prescribing privileges some time after that. The first three participants are seeing mainly patients who require medication, and one of these temporarily filled a vacancy created by the departure of a psychiatrist.

Having prescribing psychologists on staff has certain benefits to facilities where they are assigned. One of these facilities had been experiencing unusually heavy psychiatrist workloads because it did not have enough psychiatrists to fill all its psychiatry positions. In the interim, this facility specifically requested a prescribing psychologist to fulfill some of the responsibilities of a psychiatrist, reducing the psychiatry workload. Another prescribing psychologist temporarily saw the patients of a psychiatrist who transferred to another facility until the facility brought in another psychiatrist.

VRI obtained perceptions of the PDP by surveying MHSS psychiatrists, primary care physicians, and psychologists about the possible effects of allowing psychologists to prescribe medication.[21] The most frequent responses to the survey's open-ended questions about the potential benefit of this practice were that it would (1) increase the number of mental health care providers in the MHSS and (2) reduce psychiatrists' workloads. The most frequently noted limitation to allowing psychologists to prescribe medication was their perceived lack of knowledge about medicine, physiology, and adverse drug interactions and effects.

Survey results also indicated that psychiatrists, psychologists, and primary care physicians differed about whether adding prescribing psychologists to the MHSS was beneficial. Most psychologists responded that training psychologists

[21]See app. I for a detailed description of this survey.

to prescribe would improve the quality of mental health care in the military. Conversely, most psychiatrists believed quality of care would decline. Furthermore, psychiatrists thought this would undermine their working relationships with MHSS psychologists: most primary care physicians responded that this would improve their collaboration with psychologists. Most psychologists agreed that the authority to prescribe would enhance their collaboration with MHSS primary care physicians. But as far as their collaboration with MHSS psychiatrists was concerned, about half the psychologists believed this would improve such collaboration; the other half thought it would interfere with it.

Cost-Effectiveness of PDP Undetermined

The cost-effectiveness of having MHSS psychologists prescribe psychotropic medication is unclear at this time. Determining the cost-effectiveness of this effort would require information on the (1) proportion of the time remaining in the military that prescribing psychologists would have to perform functions that psychiatrists would normally perform and (2) extent to which having psychologists prescribe medication would result in fewer psychiatrists in the MHSS. The results of analyses designed to predict the relative cost-effectiveness of training and employing psychologists to prescribe compared with other providers with this authority differ depending on the cost estimates used. VRI's analysis concluded that the PDP would prove cost-effective under certain circumstances. Additional analyses using different cost estimates, however, suggest that the PDP would not be cost-effective under these same circumstances.

VRI found that the annual life cycle cost of a prescribing psychologist was potentially lower than that of a psychiatrist-psychologist combination, which is typically required to treat an MHSS patient with a mental condition requiring medication. As table 5 indicates, VRI's analysis accounted for acquisition costs (the cost of recruiting people into the military), training costs, basic and special pay and benefits (such as housing allowances), health care costs, risk management expenses (for potential malpractice claims), and retirement costs. It assumed various pay levels for different types of providers at different stages in their military careers as well as for different career lengths. It also assumed that PDP enrollees would enter the project after 6 years as DOD clinical psychologists.

Table 5: Annual Life Cycle Costs of Selected MHSS Providers Based on VRI's Cost Estimates

	Yearly life cycle cost per full-time equivalent					
Provider group	Accession	Training	Force	Retirement	Total	Required utilization
Psychiatrists	$23,470	$13,864	$112,697	$19,142	$169,173	[a]
Psychologists	$1,134	$3,766	$86,155	$15,849	$86,905	[a]
Psychologists/psychiatrists (base case scenario)	$10,901	$8,182	$86,506	$17,289	$122,878	[a]
Prescribing psychologists (start-up case scenario)	$1,218	$29,296	$71,979	$17,735	$120,227	92.6%
Prescribing psychologists (optimal case scenario)	$1,218	$17,197	$71,979	$17,735	$108,128	59.0%

Note: Estimates are expressed in 1996 dollars.

[a]Not applicable.

Source: VRI data.

VRI estimated the annual life cycle cost of prescribing psychologists given two scenarios, a start-up case scenario and an optimal case scenario. To predict the conditions under which the PDP would be cost-effective, VRI compared the annual life cycle cost of a prescribing psychologist under the start-up scenario with the life cycle cost of what it refers to as the "base" scenario. It used the start-up scenario rather than the optimal scenario because the former accounts for the nonrecurring, fixed (or start-up) costs actually associated with developing and implementing the PDP.[22] The base scenario is the annual life cycle cost of the current psychiatrist-psychologist combination required to treat MHSS mental health care patients who need medication.

Given the difference in annual life cycle costs between the base and the start-up scenarios, VRI predicted that the PDP would be more cost-effective than the

[22]The optimal scenario represents a modification of the start-up scenario. It assumes the PDP is operating in a long-term, steady state, so start-up costs are excluded and the recurring costs of supplies and training are set at levels that represent long-term efficiency. It also assumes the optimal class size of six participants.

base scenario if PDP participants in the start-up period functioned as prescribing psychologists, rather than traditional clinical psychologists, for more than 92.6 percent of their time remaining in the military. For this estimate, VRI assumed that (1) each PDP class would have three psychologists, (2) prescribing psychologists would be supervised for the remainder of their military service, (3) supervisory costs after the proctored year would amount to 5 percent of a physician's annual salary per prescribing psychologist per year, and (4) prescribing psychologists would remain in the military an average of 10.2 years after completing the PDP.

The validity of VRI's predictions about the circumstances under which the PDP would be cost-effective depends on how realistic VRI's cost estimates and other assumptions it used to estimate the annual life cycle cost of MHSS psychiatrists, psychologists, and prescribing psychologists are. Some of VRI's estimates were based on scant MHSS experience in training and employing psychologists to prescribe. Information about the PDP's overhead cost that we collected after VRI completed its work, for example, indicated that overhead cost was lower than originally thought. Also, VRI's estimate of the cost of training at USUHS was lower than our estimate of the cost of this training.

For a more realistic prediction of the circumstances under which the PDP would be cost-effective, we asked VRI to redo its analysis, replacing its estimate of $2.89 million for total overhead cost during the start-up period with an updated estimate of $2.58 million. We also asked VRI to substitute the $39,969 it used per participant per year for PDP classroom training and related overhead with $110,028, our estimate of the per student per year cost of USUHS training, which includes training overhead. See table 6 for the results of this analysis.

Table 6: Annual Life Cycle Costs of Selected MHSS Providers Based on Our Estimates of Overhead and Training Costs

	Yearly life cycle cost per full-time equivalent					
Provider group	Accession	Training	Force	Retirement	Total	Required utilization
Psychiatrists	$23,470	$13,864	$112,697	$19,142	$169,173	[a]
Psychologists	$1,134	$3,766	$66,155	$15,849	$86,905	[a]
Psychologists/psychiatrists (base case scenario)	$10,901	$8,182	$86,506	$17,289	$122,878	[a]
Prescribing psychologists (start-up case scenario)	$1,218	$32,611	$71,979	$17,735	$123,542	101.85%
Prescribing psychologists (optimal case scenario)	$1,218	$26,196	$71,979	$17,735	$117,127	84.01%

Note: Estimates are expressed in 1996 dollars.

[a]Not applicable.

Source: VRI data.

On the basis of our overhead and training cost estimates, PDP graduates under the start-up scenario[23] could not be cost-effective because they would have to function as prescribing psychologists more than 101.85 percent of their time remaining in the military. This prediction is based on the same assumptions that VRI made about PDP class size, prescribing psychologists' supervision, supervisory costs, and prescribing psychologists' remaining time in the military.

[23]Again, annual life cycle cost per prescribing psychologist under the start-up rather than the optimal case scenario was used to predict the cost-effectiveness of prescribing psychologists. The optimal case scenario assumes the PDP is training six psychologists per class and operating in a long-term, steady state in which start-up costs associated with project development, such as the cost of external evaluations, are not incurred. The start-up scenario better represents the PDP, therefore, because it did not train six psychologists per class and did not reach a steady state. In addition, costs associated with the PDP's development were incurred throughout the project.

CONCLUSIONS

In DOD's mental health care system, the main function of prescribing psychologists is to care for patients with certain types of mental conditions that require certain psychotropic medications. According to DOD's needs assessments, the MHSS has more psychiatrists to care for these patients than needed to meet medical readiness requirements. Therefore, the MHSS has no current or upcoming need for clinical psychologists who may prescribe medication. In addition, the cost of producing 10 prescribing psychologists was substantial. Regardless of the cost, spending resources to produce more providers than the MHSS needs to meet its medical readiness requirement is hard to justify.

The PDP has demonstrated that training psychologists to prescribe drugs, which increased the number of MHSS providers with this skill, reduced psychiatrists' workloads in some cases. A potential benefit of the PDP, therefore, is the savings associated with prescribing psychologists' delivering some of the services that psychiatrists in conjunction with psychiatrists have traditionally provided. These savings result because a prescribing psychologist can deliver this care with lower personnel-related costs than the combination of a psychologist and a psychiatrist.

To realize these savings, however, DOD must (1) use a prescribing psychologist to treat patients who normally would have been treated by a psychiatrist and a psychologist and (2) replace higher priced providers in the MHSS with prescribing psychologists. Otherwise, the PDP cannot save DOD money. Even if the 10 prescribing psychologists from the PDP do, in certain situations, function as psychiatrists, the PDP is still not guaranteed to save money. Although prescribing psychologists cannot totally replace psychiatrists, DOD does not account for the introduction of prescribing psychologists in the MHSS when determining its readiness needs for psychiatrists. Therefore, it is uncertain whether DOD will reduce its readiness requirement for psychiatrists in response to shifting some of a psychiatrist's functions to a prescribing psychologist.

Concerning the PDP's implementation, DOD has demonstrated that it can train clinical psychologists to prescribe psychotropic medication, and these psychologists have shown that they can provide this service in the MHSS. The implementation faced several problems, however, that persisted for the PDP's duration.

Given DOD's readiness requirements, the PDP's substantial cost and questionable benefits, and the project's persistent implementation difficulties, we see no reason to reinstate this demonstration project.

RECOMMENDATION TO THE CONGRESS

In the future, should prescribing psychologists be needed to meet DOD's medical readiness requirements, the Congress should require DOD to (1) clearly demonstrate that the use of those MHSS psychologists who have been trained to prescribe has resulted in savings, (2) clearly define a prescribing psychologist's role and scope of practice in the MHSS compared with other psychologists and psychiatrists, (3) design a curriculum appropriate to this role and scope of practice, and (4) determine the need for and the level of supervision that prescribing psychologists require.

AGENCY COMMENTS

In comments received March 26, 1997, in response to a draft of this report, the Assistant Deputy Assistant Secretary of Defense (Clinical Affairs) stated that, on the basis of the methodology employed in this study, DOD has no objections to its results and recommendations. Department officials did provide a few technical corrections to the report. We modified the report as appropriate.

Copies of this report will also be sent to other interested congressional committees and the Secretary of Defense. Copies will also be made available to others upon request. Please call me at (202) 512-7101 if you have any questions or need additional assistance. Contributors to this report include Clarita Mrena, Assistant Director; William Stanco, Senior Evaluator; and Deena El-Attar and Gregory Whitney, Evaluators.

Richard L. Hembra
Assistant Comptroller General

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ABBREVIATIONS

ACNP	American College of Neuropsychopharmacology
DOD	Department of Defense
FTE	full-time equivalent
MHSS	Military Health Services System
PDP	Psychopharmacology Demonstration Project
USUHS	Uniformed Services University of Health Sciences
VRI	Vector Research, Inc.

SCOPE AND METHODOLOGY OF AN EVALUATION OF THE PDP BY VECTOR RESEARCH, INC.

In September 1995, DOD contracted with Vector Research, Inc. (VRI) to conduct an evaluation of the PDP. The Assistant Secretary of Defense for Health Affairs requested this study to obtain an evaluation of the PDP that was independent of those performed by the American College of Neuropsychopharmacology. VRI's study was to

- assess the relative cost-effectiveness of training psychologists to prescribe medication and having them deliver this service in the Military Health Services System (MHSS),
- identify impediments to integrating prescribing psychologists into the MHSS, and
- evaluate the potential roles and functions of prescribing psychologists in DOD.

To accomplish the first objective, VRI compared the annual life cycle cost of various types of MHSS mental health care providers with the annual life cycle cost of a prescribing psychologist. To address the remaining two objectives, VRI conducted what it referred to as a feasibility analysis of the PDP. VRI issued a report on this work on May 17, 1996.

COST-EFFECTIVENESS ANALYSIS

To determine the relative cost-effectiveness of training and employing prescribing psychologists relative to other DOD health care providers, VRI compared its estimate of DOD's average annual life cycle cost of a prescribing psychologist with its estimate of this cost for clinical psychologists, psychiatrists, physicians specializing in internal medicine, and physicians specializing in family practice. It calculated these costs on the basis of three scenarios:

- the "base" case scenario, which is the status quo, a combination of psychologists and psychiatrists, with no prescribing psychologists in the MHSS;
- the "start-up" case scenario for prescribing psychologists, which had all the same elements of the base scenario but accounted for the introduction of prescribing psychologists into the MHSS; and
- the "optimal" case scenario for prescribing psychologists, which represented a modification of the start-up scenario.

Costs in the start-up scenario included the nonrecurring, fixed costs associated with the PDP development and initial implementation as well as other costs for the PDP that VRI also believed would diminish or disappear in the long run. The optimal scenario represents the PDP in a long-term, steady state, during which no recurring costs associated with start-up and optimal class size would accrue. In this scenario, VRI set the cost of supplies and training to levels that indicate long-term efficiency.

Steps in the Cost-Effectiveness Analysis

The following are the main steps in VRI's cost-effectiveness analysis:

1. Calculate life cycle costs for active-duty military psychiatrists, family practitioners, internists, and clinical psychologists; then calculate the cost per full-time equivalent (FTE) for each of these by dividing their respective life cycle cost by their respective expected length of service (length of service minus unproductive time while in training).

2. Calculate life cycle costs for prescribing psychologists using actual and anticipated costs for a PDP sized at six and at three psychologists per class; and then, under both the start-up and base scenarios, calculate the cost per FTE for prescribing psychologists assuming that they (1) serve as clinical psychologists before entering the PDP and (2) after which they prescribe psychotropic medication.

3. Calculate the cost per FTE for the combination of clinical psychologists and psychiatrists that could be replaced by a prescribing psychologist.

4. Compare the annual life cycle cost per FTE of prescribing psychologists under start-up and optimal scenarios with the cost per FTE of the psychologist-psychiatrist combination.

Calculating Life Cycle Costs

VRI's estimates of the annual life cycle cost per FTE of various types of providers accounted for the cost of acquiring each type of provider, training costs, "force" costs, and retirement costs associated with each. Acquisition cost is DOD's cost of recruiting someone into the military. Training costs include the cost of providing DOD-sponsored training to military health care providers. Force costs cover basic pay and allowances, special pay, miscellaneous expenses, and health care benefits of health care providers during their active-duty careers. Finally, retirement costs include the cost of retirement pay and retiree health care benefits.

VRI's overall estimates of the annual life cycle cost per FTE for different health care providers were based on a number of cost estimates and assumptions about these four cost categories that varied somewhat by provider and scenario. Following are the major assumptions VRI made when calculating life cycle cost for prescribing psychologists:

- For cost savings to be realized, the introduction of prescribing psychologists into the MHSS reduced FTEs for psychiatrists or other physicians.
- PDP participants had at least 6 years of experience as clinical psychologists when they entered the PDP.
- The PDP lasted 3 years--1 year for classroom training, 1 year for clinical experience, and 1 year for proctored practice.
- Each PDP class had three or six psychologists.
- PDP participants required 40 percent of a faculty member's time during their clinical year of training and 20 percent of a faculty member's time during their proctored year, which took time from faculty members' patient care.
- After completing the PDP, graduates were able to "safely and effectively" prescribe medication and were assigned to "utilize their new prescription skills along with their clinical psychology skills to treat patients that otherwise would have had to be treated by physicians for their mental health care."
- PDP participants continued to practice as prescribing psychologists for the rest of their military career.
- Prescribing psychologists required supervision amounting to 5 percent of a psychiatrist's time for the rest of their military career.
- 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.
- PDP graduates did not receive special pay otherwise paid to psychiatrists and othe physicians in the military.
- Pension rates for DOD prescribing psychiatrists were based on an average service time for military pensioners of 22.5 years as determined by a DOD actuarial study.

FEASIBILITY ANALYSIS

The objectives of VRI's feasibility analysis were to assess

- the barriers to employing prescribing psychologists in the DOD health care system and
- how prescribing psychologists would be used in the DOD health care system.

To address the first objective, VRI conducted two surveys. It conducted telephone interviews of about 400 DOD health care providers, including psychiatrists, primary care physicians, psychologists, and social workers to obtain their views on the PDP. This survey measured their awareness of the PDP, attitudes toward allowing psychologists to prescribe drugs, participant training, and ultimate ability of psychologists to prescribe medication. VRI also surveyed DOD medical beneficiaries to determine their awareness of the relative scope of practice of psychiatrists and psychologists and the PDP and to measure their attitudes toward allowing psychologists to prescribe drugs.

To address its second objective, VRI reviewed DOD medical regulations, records of the PDP Advisory Council, and military health care utilization data and interviewed PDP graduates and officials familiar with the PDP. VRI acknowledged that its conclusions about the use of prescribing psychologists were "conjectures" because of DOD's lack of experience with prescribing psychologists.

OBJECTIVES AND METHODOLOGY OF OUR EVALUATION OF THE PDP

The objectives of our evaluation were to

- assess the need for prescribing psychologists in the Military Health Services System (MHSS),
- provide information on the implementation of the PDP, and
- provide information on the PDP's cost and benefits.

To address the first objective, we used the need for MHSS psychiatrists as a proxy for the need for prescribing psychologists because psychiatrists are the only mental health care providers with full prescribing authority for which the military determines a readiness need. To assess the need for additional MHSS psychiatrists, we reviewed the Army, Navy, and Air Force methods for determining the number they need to fulfill their medical readiness mission and the results of their determinations. We compared the number of psychiatrists each branch of the service determined it needed, both now and in the future, with the number each currently has.

To collect information on the PDP's implementation, we reviewed many documents, annual reports, and assessments of the project. These included periodic evaluations conducted by the American College of Neuropsychopharmacology under contract to DOD and others done by the Army Surgeon General's blue ribbon panels as well as the Army's annual reports on the PDP.

We based our estimate of the PDP's cost on (1) information on cost in the Army's annual reports on the PDP, (2) our estimates of the cost of training provided by the Uniformed Services University of the Health Sciences (USUHS),[24] and (3) estimates of military salaries and benefits and the productivity of PDP participants and their supervisors found in Vector Research, Inc.'s (VRI) cost-effectiveness analysis of the PDP. This cost was calculated in constant 1996 dollars.

To identify the qualitative benefits of the PDP, we interviewed all PDP participants who completed the PDP and others at the facilities where they were practicing and representatives of the American Psychiatric Association and the American Psychological Association. We reviewed articles that addressed the advantages and disadvantages of

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[24]Military Physicians: DOD's Medical School and Scholarship Program (GAO/HEHS-95-244 Sept. 29, 1995).

allowing clinical psychologists to prescribe medication. We also examined the results of a VRI survey of DOD health care providers that collected information on providers' perceptions of PDP's benefits.

To determine what cost savings or quantitative benefit, if any, might be realized by enabling clinical psychologists to prescribe medication, we reviewed VRI's cost-effectiveness analysis of the program done under contract to DOD.[25] We compared the results of this analysis with those of a subsequent analysis VRI did at our request using different assumptions. In this subsequent analysis, VRI replaced its original assumptions on the number of participants and level of supervision with information we had collected about actual program experience. It also replaced its USUHS training cost estimates with our estimates noted above.

(101494)

[25]See app. I for a description of VRI's survey and cost-effectiveness analysis.

ALASKA PSYCHIATRIC ASSOCIATION

A District Branch of the American Psychiatric Association

P.O. Box 143147, Anchorage, AK 99514-3147
(907) 566-7800

POSITION STATEMENT RE:

SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 139

"An Act authorizing certain psychologists to prescribe and dispense certain psychotropic medications and their adjuncts within the practice of psychology."

The Alaska Psychiatric Association is strongly opposed to HB 139, because psychologists do not have the education and training to prescribe safely, nor is the proposed special training adequate to prepare them.

Psychologists are doctors of psychology or doctors of philosophy. They are trained to do psychotherapy and psychological testing. In order to prepare themselves to prescribe potentially life-threatening medications, they propose to spend 300 hours of classroom time focused mainly on medications that treat mental illness, and to participate in the supervised treatment of 100 patients.

Psychiatrists are medical doctors. They spend over 3,000 hours in the classroom learning about not only psychotherapy and medications, but the human body as a whole – its organ systems, biochemistry, structure, and how all these elements work together. They spend about 24,000 supervised hours with at least 1500 patients.

In order to prescribe medications safely, the prescriber must have adequate medical training. Physical illnesses must be understood and ruled out before medications can be administered without doing harm, because many "mental' illnesses are caused or exacerbated by physical illnesses. Psychotropic medications can be dangerous, with effects not only on the brain, but also on the rest of the nervous system, the heart, digestive system, kidneys – in other words, the whole body. There may also be complex interactions with other medications that are prescribed for other medical problems.

The addition of the abbreviated medical training program proposed by psychologists is just not adequate to prepare them to prescribe safely. Granting psychologists prescribing authority will increase health care costs with no apparent benefit to society and with great potential risk to patients. As prescribing psychologists would have only limited and inadequate training to detect and treat most non-mental medical conditions, physician services – at additional costs – would be required. Also, granting psychologists prescribing authority would entail increases in, for example, state regulatory costs and liability insurance rates. Ultimately, these costs are born by all taxpayers. Rather than by giving psychologists prescribing authority, the health care needs of underserved populations are best served by improving the mental health training of primary care providers (e.g., family physicians) who have better and broader health training and are more widely distributed than psychologists. In addition, the field of telemedicine in Alaska is expanding and provides psychiatric coverage to many rural and remote areas.

Psychologists are our colleagues, and we value their contributions to the understanding of the human psyche and behavior, as well as the clinical care they provide. However, they are not medically trained practitioners, and should not prescribe medications. If psychologists wish to prescribe safely, there is already a way to do this: complete medical school.

MEDICATIONS THAT PSYCHOLOGISTS WOULD LIKE TO PRESCRIBE

Drug Name	Use	Dangers
Major Tranquilizers	Schizophrenia or other psychoses.	Potentially irreversible, involuntary movements of the face, hands and trunk. (Tardive Dyskinesia)Increased heart rate, low blood pressure and EKG changes. Cases of sudden and unexpected death have been reported. May also cause high fevers, muscle rigidity, altered mental states and instability of blood pressure and pulse: potentially fatal. (Neuroleptic Malignant Syndrome)
Thorazine, Mellaril, Haldol, Prolixin, Stelazine and others	Used to decrease agitation, provide sedation, facilitate improvement of thought processing and to reduce or eliminate hallucinations, illusions and delusional thinking.	
Clozaril	Same as above.	Life-threatening low white blood cell count. (Agranulocytosis) High risk of seizures.
Antidepressants	Clinical depression, panic attacks.	Overdose may cause congestive heart failure, dilated pupils, severe hypotension, stupor, coma and death. May result in heart attack, stroke, heart block, hypertension and postural hypotension. Also may cause coma, seizures, hallucinations, delusions and tremor.
Tricyclics, Elavil, Sinequan, Tofranil and others	Used to facilitate improvement in mood and to alleviate insomnia, decreased appetite, poor concentration, fatigue, loss of interest, hopelessness and suicidal thinking associated with depression.	
Desyrel	Same as above.	Priapism (prolonged and inappropriate erection) requiring surgical intervention; may result in permanent impairment of erectile function or impotence.
Wellburtin	Same as above.	Seizures may exceed those of other marketed antidepressants by as much as four-fold.
MAO Inhibitors	Same as above.	Sometimes fatal hypertensive crises.
Serotonin Reuptake Inhibitors (SRIs) including Prozac, Paxil and Zoloft	Same as above.	Caution advised with patients with disease that could affect metabolism or hemodynamic response.

Taken from the 1995 Physicians Desk Reference (PDR). Dangers listed represent only some of the potential side effects that may occur with the administration of these medications.

(OVER)

MEDICATIONS THAT PSYCHOLOGISTS WOULD LIKE TO PRESCRIBE

Drug Name	Use	Dangers
Minor Tranquilizers	Generalized anxiety/panic attacks	*Schedule IV Controlled Substance* Psychological and physical dependence. Withdrawal symptoms **(convulsions, tremor, cramps, vomiting and sweating)** can occur with abrupt discontinuance.
Valium, Ativan, Xanax and others	To decrease agitation, anxiety and tension and to both treat and prevent panic attacks.	
Hypnotics (Halcion, Dalmane, Restoril and others)	Insomnia To facilitate sleep.	An increased risk of **congenital malformations** associated with the use of benzodiazepines during the first trimester of pregnancy
Lithium Carbonate	Manic depressive disorder. To decrease manic excitement in the immediate situation and to prevent mood swings when used over a longer period.	Risk of **toxicity** is very high in patients with dehydration, heart disease or renal disease. Toxicity is characterized by severe central nervous system and cardiovascular **abnormalities that may result in death.**
Stimulants		*(Schedule II Controlled Substance)* Often abused by adults. Although a causal relationship has not been established, **suppression of growth** has been reported with long term use in children.
Ritalin and Dexedrin	Used in children with attention deficit disorder. Used in narcolepsy.	
Antiparkinsonian		**Paralysis of the bowel, high fevers and heat stroke** have occurred in patients taking antiparkinsonism drugs in combination with anti-psychotic or tricyclic antidepressant medications.
Cogentin and Artane	To reduce or eliminate certain side effects caused by major tranquilizers.	

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Training Comparison
Psychiatrists and Psychologists

Discipline	Psychiatrist	Psychologist
Degree	M.D.(Doctor of Medicine) or D.O. (Doctor of Osteopathy)	Psy.D (Doctor of Psychology) or Ph.D (Doctor of Philosophy)
Undergraduate Education	Pre-med curriculum requires certain science, including chemistry, physics, biochemistry, physiology.	No specific undergraduate training required as a condition to admission, although some individual schools may have specific requirements.
Years of Post Graduate Education	8 years full-time in a university/university hospital setting.	Varies, full-time equivalent is four years, many are part-time , not required to be in a university setting.
Graduate School Curriculum (partial listing) (Calif. Business & Professions Code Secs. 2089 & 2089.5)	4 years medical school (statute requires 4000 minimum classroom hours), including advanced training in anatomy, human physiology, biochemistry, microbiology, pharmacology, psychotherapy, genetics, obstetrics, gynecology, internal medicine, radiology, neurology and modern neuroscience developments (such as EEG,EKG, MRI, PET and CAT scans), pediatrics, psychiatry, surgery, psychopharmacology, abnormal psychology, psychopathology, differential diagnosis, physical examination, biopsychosocial evaluation, psychological testing, epidemiology,urology.	Psychological testing and testing theory, abnormal psychology, physiology, history of psychology , psychological theory, research methods, statistics, psychotherapeutic techniques, psychosocial evaluation, and a dissertation, which may or may not focus on patient care and treatment. ***Is required by regulation to take only one course in the biological basis of behavior.*** At no point in training does a psychologist observe treatment of patients with medical problems other than mental disorders.

Source: Division of Public Affairs, American Psychiatric Association

What Therapists' Degrees Mean

Doctorate in Medicine (M.D.) or Doctorate in Osteopathy (D.O.)

Physicians who have full medical training with specialized residencies in psychiatry (10-12 years of medical education). Psychiatrists, because they are physicians, are the only mental health care professionals who can prescribe medications.

Doctorate in Philosophy (Ph.D.)

Psychologists who have completed 6-7 years of college and graduate work, including training in research methods and statistics, as well as psychotherapy internships. Generally perform psychological testing when needed and provide talk therapy.

Doctorate in Psychology (Psy.D.)

Psychologists who also have 6-7 years of training with a focus on practical clinical course work rather than on research.

Master of Science (M.S.)

Therapists who have completed a two-year graduate program that emphasizes training in psychotherapy and social work.

Master of Social Work (M.S.W.)

Therapists who have completed a two- year graduate program that emphasizes training in social work and counseling.

L.C.S.W., L.M.F.C.C., L.P.C., L.M.F.T

These designations - Licensed Clinical Social Worker, Licensed Marriage and Family Child Counselor, Licensed Professional Counselor, and Licensed Marriage and Family Therapist - do not refer to degrees, but to licensure by state professional boards. These initials usually follow others that indicate an academic degree. If they do not, inquire about the therapist's training.

Excerpted from Harvard Women's Health Watch, June 1996.

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Antiparkinsonian		Paralysis of the bowel, high fevers and heat stroke have occurred in patients taking antiparkinsonism drugs in combination with anti-psychotic or tricyclic antidepressant medications.
Cogentin and Artane	To reduce or eliminate certain side effects caused by major tranquilizers.	

Taken from the 1995 Physicians Desk Reference (PDR). Dangers listed represent only some of the potential side effects that may occur with the administration of these medications.

Training Comparison
Psychiatrists and Psychologists

Discipline	Psychiatrist	Psychologist
Degree	M.D.(Doctor of Medicine) or D.O. (Doctor of Osteopathy)	Psy.D (Doctor of Psychology) or Ph.D (Doctor of Philosophy)
Undergraduate Education	Pre-med curriculum requires certain science, including chemistry, physics, biochemistry, physiology.	No specific undergraduate training required as a condition to admission, although some individual schools may have specific requirements.
Years of Post Graduate Education	8 years full-time in a university/university hospital setting.	Varies, full-time equivalent is four years, many are part-time , not required to be in a university setting.
Graduate School Curriculum (partial listing) (Calif. Business & Professions Code Secs. 2089 & 2089.5)	4 years medical school (statute requires 4000 minimum classroom hours), including advanced training in anatomy, human physiology, biochemistry, microbiology, pharmacology, psychotherapy, genetics, obstetrics, gynecology, internal medicine, radiology, neurology and modern neuroscience developments (such as EEG,EKG. MRI, PET and CAT scans), pediatrics, psychiatry, surgery, psychopharmacology, abnormal psychology, psychopathology, differential diagnosis, physical examination, biopsychosocial evaluation, psychological testing, epidemiology,urology.	Psychological testing and testing theory, abnormal psychology, physiology, history of psychology , psychological theory, research methods, statistics, psychotherapeutic techniques, psychosocial evaluation, and a dissertation, which may or may not focus on patient care and treatment. ***Is required by regulation to take only one course in the biological basis of behavior.*** At no point in training does a psychologist observe treatment of patients with medical problems other than mental disorders.

Source: Division of Public Affairs, American Psychiatric Association

What Therapists' Degrees Mean

Doctorate in Medicine (M.D.) or Doctorate in Osteopathy (D.O.)

Physicians who have full medical training with specialized residencies in psychiatry (10-12 years of medical education). Psychiatrists, because they are physicians, are the only mental health care professionals who can prescribe medications.

Doctorate in Philosophy (Ph.D.)

Psychologists who have completed 6-7 years of college and graduate work, including training in research methods and statistics, as well as psychotherapy internships. Generally perform psychological testing when needed and provide talk therapy.

Doctorate in Psychology (Psy.D.)

Psychologists who also have 6-7 years of training with a focus on practical clinical course work rather than on research.

Master of Science (M.S.)

Therapists who have completed a two-year graduate program that emphasizes training in psychotherapy and social work.

Master of Social Work (M.S.W.)

Therapists who have completed a two- year graduate program that emphasizes training in social work and counseling.

L.C.S.W., L.M.F.C.C., L.P.C., L.M.F.T

These designations - Licensed Clinical Social Worker, Licensed Marriage and Family Child Counselor, Licensed Professional Counselor, and Licensed Marriage and Family Therapist - do not refer to degrees, but to licensure by state professional boards. These initials usually follow others that indicate an academic degree. If they do not, inquire about the therapist's training.

Excerpted from Harvard Women's Health Watch, June 1996.

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. SSHB 139

Revision Date/Time (Note if correction) _____ Dept. Affected Commerce & Econ Dev.

Title An Act authorizing certain psychologists to prescri BRU Occupational Licensing

and dispense certain psychotropic medications.... Component Occupational Licensing

Sponsor Representatives James, Kapsner

Requester House Labor and Commerce Component Serial No. 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

SSHB 139 authorizes qualified psychologists to obtain an endorsement to their license allowing the licensee to prescribe and dispense certain psychotropic medications. The bill will require expenditure of division staff time and money to write and public-notice regulations, pay the the Department of Law for regulation review, create and process endorsement applications, and respond to public complaints related to prescription by psychologists. The division is not requesting additional expenditure authority at this time, but may revise the fiscal note based on knowledge gained in legislative hearings. Fees charged for the endorsement will be stablished to cover any costs that may be incurred.

Prepared by Jennifer Strickler, Administrative Manager Phone 465-2144

Division Occupational Licensing Date/Time 5/10/99 2:14 PM

Approved by Commissioner Deborah B. Sedwick Deborah B. Sedwick Date 5.10.99

Agency Commerce & Economic Development

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CURRICULUM VITAE

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PERSONAL DATA

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Home Address: 1025 Rossmore Avenue
Baton Rouge, Louisiana 70810

Home Phone: (225) 757-9534

EDUCATION

Ph.D. Catholic University of America, Washington, DC
Counseling Psychology, APA-accredited program, October, 1976

B.S. Georgetown University, Washington, DC 1970, Psychology major, June, 1970

Clinical Psychology Internship (APA-accredited), Walter Reed Army Medical Center, Washington, DC , 1974-75

Fellowship in Clinical Neuropsychology, Madigan Army Medical Center, Tacoma, WA, 1986-87

PROFESSIONAL EXPERIENCE

May 1998 – present	Private practice Baton Rouge, LA
May 1997 – April 1998	Clinical Neuropsychologist The NeuroMedical Center Baton Rouge, LA
July 1995 - April 1997	Chief, Department of Psychology Walter Reed Army Medical Center, Washington, DC

August 1993 - June 1995	Chief, Clinical Neuropsychology Service Director, Neuropsychology Fellowship Walter Reed Army Medical Center, Washington, DC
November 1991 - July 1993	Chief, Psychology Service Landstuhl Regional Medical Center, Germany
September 1990 - October 1991	Chief, Psychology Service U. S. Army Hospital, Heidelberg, Germany
July 1987 - August 1990	Director of Clinical Neuropsychology Letterman Army Medical Center, San Francisco, CA
July 1984 - June 1986	Director of Training, Clinical Psychology Internship Silas B. Hays Army Community Hospital, Monterey, CA
July 1983 - June 1984	Staff Psychologist Silas B. Hays Army Community Hospital, Monterey, CA
December 1981 - January 1983	Director of Training, Clinical Psychology Internship Walter Reed Army Medical Center, Washington, DC
November 1979 - November 1981	Staff Psychologist Walter Reed Army Medical Center, Washington, DC
October 1976 to October 1979	Division Psychologist First Armor Division, Nuremberg, Germany

TEACHING APPOINTMENTS

Clinical assistant professor, Department of Medical and Clinical Psychology, Uniformed Services University of the Health Sciences, Bethesda, MD 1995-97

Instructor in Psychology, University of Maryland (European Division) 1977-79

PROFESSIONAL CREDENTIALS

Psychologist license # 776, Louisiana

Psychologist license # 1049, District of Columbia (inactive)

Diploma, American Board of Clinical Neuropsychology, American Board of Professional Psychology (ABCN/ABPP)

Registered in the National Register of Health Care Providers in Psychology

PROFESSIONAL ORGANIZATIONS

Member, American Psychological Association (APA)
Member, Louisiana Psychological Association
Member, Baton Rouge Area Society of Psychologists
Member, Division of Clinical Neuropsychology, APA
Member, National Academy of Neuropsychology
Member, International Neuropsychological Society

PUBLICATIONS

Klusman, L.E. (1998). Military health care providers' views on prescribing privileges for psychologists. *Professional Psychology: Research and Practice, 29(3),* 223-229.

Klusman, L.E. (1993) The evolution of clinical neuropsychology. *Journal of the US Army Medical Department, PB 8-93-11/12,* 28-32

Klusman, L. E., Moulton, J. M., Hombostel, L. K., Picano, J. J., & Beattie, M. T. (1991). Neuropsychological abnormalities in asymptomatic HIV-seropositive military personnel. *Journal of Neuropsychiatry and Clinical Neurosciences, 3,* 422-428.

Picano, J. J., Klusman, L. E., Hornbostel, L. K., & Moulton, J. M. (1991). Replication of a three component solution for common measures of attention in HIV-seropositive males. *Archives of Clinical Neuropsychology, 7,* 271-274.

Klusman, L. E., Cripe, L. I., & Dodrill, C. B. (1989). Analysis of errors on the Trail Making Test. *Perceptual and Motor Skills, 68,* 1199-1204.

Klusman, L. E. (1982). The Defense Mechanisms Inventory as a predictor of affective response to threat. *Journal of Clinical Psychology, 38(1),* 151-155.

Klusman, L. E. (1975). Reduction of pain in childbirth by the alleviation of anxiety during pregnancy. *Journal of Consulting and Clinical Psychology, 43,* 162-165.

PRESENTATIONS

Klusman, L.E. (1997). *Neuropsychological aspects of sexuality in people with disabilities.* Presented at the Professional Development Symposium of the Rehabilitation Counseling Program, Southern University, Baton Rouge.

Klusman, L. E., Southwell, G. D., Spector, J., Gahm, G. A., Tulin, S. (1995). *Neuropsychological findings in Gulf War veterans.* Paper presented at the Army Medical Department Behavioral Sciences Short Course, Miami.

Klusman, L.E. (1994). *Clinical Neuropsychology for the general practitioner.* Half-day continuing education workshop for psychologists at the National Security Agency.

Picano, J.J. & Klusman, L.E. (1993). *Interactive effects of education and disease progression on neuropsychological abnormality in asymptomatic HIV-1 seropositive males: An empirical evaluation of threshold theory.* Presented at the 13th annual conference of the National Academy of Neuropsychology, Phoenix.

Klusman, L. E. (1988). *Subcortical dementia and HIV infection.* Paper presented at the Army Medical Department Clinical Psychology Conference, Seattle.

Edwards, H. F., & Klusman, L. E. (1988). *Comparison of the Rey Auditory Verbal Learning Test and the California Verbal Learning Test in a neurologically impaired sample.* Presented at the Army Medical Department Psychology Conference, Seattle.

Klusman, L. E. (1987). *Qualitative errors on the Trail Making Test.* Presented at a meeting of the Northwest Neuropsychological Society, Seattle.

Govia, J. M., Klusman, L. E., & Zych, K. A. (1987). *Patterns of relationships between the MMPI and the Basic Personality Inventory.* Presented the Army Medical Department Clinical Psychology Conference: Military applications of clinical neuropsychology and health psychology. San Francisco.

Govia, J. M., & Klusman, L. E. (1985). *Measuring psychopathology: An alternative to the MMPI.* Presented at the Army Medical Department Clinical Psychology Conference, San Francisco.

Parkison, S. C., Klusman, L. E., Fishburne, F. J., & O'Mara, M. (1982). *Accuracy of clinical judgments of MMPI profiles.* Paper presented at the Army Medical Department Clinical Psychology Conference, Augusta.

Klusman, L. E. (1982). *MMPI Scale 4. Effects of age, IQ, and psychiatric diagnosis.* Paper presented at the ninetieth annual convention of the American Psychological Association, Washington.

October 1998

TIM T. DUKE, PSY.D
12490 QUIVIRA RD, APT #2214
OVERLAND PARK, KS 66213

EDUCATION:

November 1994 - Forest Institute of Professional Psychology, Doctorate of Psychology, APA approved Springfield, MO

May 1987 - Olivet Nazarene University, BA-Major: Psychology Kankakee, IL.

PROFESSIONAL EXPERIENCE:

October 1998 – Present **Clinical Director at Cass County Psychological Service**- Community Mental Health Consultants, Inc. Nevada, MO

June 1997 – Sept. 1998 **Prescribing Psychologist**- Darnall Army Community Hospital, Fort Hood, TX

June 1995 – June 1997 Psychopharmacology **Demonstration Project Fellowship**- 1 of 10 military psychologists trained to prescribe psychotropic medications. Walter Reed Army Medical Center, Washington, DC.

Dec. 1992 – Dec 1994 **Chief of Psychology Services**- 121st Evacuation Hospital. Seoul, South Korea

June 1991 – June 1992 **Psychology Intern-** Tripler Army Medical Center, APA approved Honolulu, HI.

TIM T. DUKE, PSY.D

LICENSURE:

Missouri – Psychologist
Mississippi – Psychologist

AFFILIATIONS:

American Psychological Association

MILITARY SERVICE:

June 1991 – July 1998 United States Army

MILITARY EDUCATION:

Sept. 92 - United States Army Officer Basic, Fort Sam Houston, TX.

Jan. 95 - United States Army Officer Advanced Course, Fort Sam Houston, TX

MILITARY AWARDS:

Dec. 94 - Army Commendation Medal

Dec. 94 - Oversea Ribbon

June 98 - Army Commendation Medal

TIM DUKE

PROFESSIONAL AWARDS:

American Psychological Association Presidential Citation – awarded for completion of the Psychopharmacology Demonstration Project.

PRESENTATIONS AND WORKSHOPS:

October 1998 - "Psychopharmacology and Addictions" - Community Mental Health Inc., Nevada, MO

November 1998 - "Clinical Use of Mood Stabilizers" - Texas Psychological Association Convention, Houston, TX.

American Association of Applied and Preventive Psychology
1010 Vermont Ave., NW, Suite 1100
Washington, DC 20005-4907
(202) 393-7073.
aaapp@scs.unr.edu

Representative Norman Rokeberg:

3/26/99

MAR 2 6 1999

Re: **HB 139 Opposition**

Dear Honorable Representative Rokeberg:

We are psychologists writing against HB 139 being considered by the 1999 Alaska State Legislature. We are the American Association of Applied and Preventive Psychology, which is an affiliate of the American Psychological Society. In 1995, we passed a Resolution Opposing Prescription Privileges for Psychologists. This AAAPP Resolution has been endorsed by Section III of the Clinical Division (12) of the American Psychological Association (Society for a Science of Clinical Psychology). Other professional psychological associations have opposed prescription privileges. The National Council of University Directors of Clinical Psychology programs voted against the pursuit of prescription privileges in 1995. In 1996, the Council of Graduate Departments of Psychology voted that a decision to pursue prescription privileges should not be made until those involved in providing university training support this major change to the profession.

While the American Psychological Association supports prescription privileges, the issue is clearly divisive. This Bill may be incorrectly predicated on the assumption that privileges are universally supported by the discipline of psychology and that there is an urgent need for society to train more prescribers.

We will list six reasons why we are against prescription privileges and why we conclude there is not a societal need to spend taxpayer money on making clinical psychology a new medical profession.

1) Prescription authority for psychologists may result in greater risk to the consumer of medical mental health services. Therefore, consideration of appropriate medical training and regulation must be a conservative process. Psychoactive substances are poorly understood. Many of these drugs have serious medical side effects and are drugs of abuse. Prescribing them requires extensive medical knowledge of areas which are not in the current domain of psychology.

No state in the country has licensed nonmedical mental health professionals, such as psychologists or social workers, to prescribe. Prescription authority has been extended in some states to nonphysicians,

such as nurses and optometrists, but training for these professions is already based upon the medical sciences. Psychologists are trained in the social and behavioral sciences and cannot be compared to nurses or optometrists. Licensed psychologists are trained to provide services that do not physically invade the body cavity, such as psychological assessment and psychotherapy.

The APA model curriculum for the training of psychologists in the practice of medicine has not been evaluated. There is a short-term evaluation of the U.S. Department of Defense (DoD) psychopharmacology training program conducted by the U.S. Congress General Accounting Office, but the DoD program included more medical training than what is proposed in the APA model curriculum. In addition, there has been no systematic follow-up report on the consumer effects longterm independent practice of the 10 DoD graduates. Therefore, the risk to the consumer of licensing nonmedical professionals to prescribe is unknown.

2) Societal needs for medical mental health services can be provided by those who are already trained in nursing and medicine. For example, there is no shortage of physicians. The 1995 report of the Pew Health Professions Commission states there is a surplus of about 150,000 physicians and 20% of medical schools should be closed. When needed, medication can readily and more inexpensively be provided by already trained medical professionals in collaboration with psychologists.

The U.S. Public Health Service's 1995 statistics on health professional shortage areas did indicate a geographic maldistribution of most health professionals. There is a resulting need to provide services to underserved populations, such as those living in rural areas. These needs can be met with existing health professionals if incentives are provided, such as the policy of many managed care companies to reimburse multidisciplinary care.

3) Because psychologists are not currently trained in medicine, to do so would be extremely costly to the taxpayers and consumers of mental health services. Expenses of include more faculty at universities, greater liability insurance, more state regulatory agents, and several additional years of training (currently 7 - 11 years of graduate school). The General Accounting Office reported to the U.S. congress in 1997 that the training of psychologists to prescribe in the military costs $610,000 per psychologist and was an unnecessary expense. These expenses are likely to be passed on to the consumer and taxpayer and thereby increase health care costs.

4) The costs of training and regulating prescription privileges for psychologists unnecessarily duplicates health care services already provided by medical professions. Psychologists who wish to prescribe may currently do so by completing nursing or medical school and utilizing the training and regulatory resources already provided by the taxpayer. Some psychologists have already earned prescription authority by becoming

advanced practice nurses.

5) Because prescription privileges would overhaul the training and practice of clinical psychology this issue is divisive among psychologists , including both practitioners and academicians. Prescribing medication is by definition a physical therapeutic activity, not a psychotherapeutic activity.

When nurses and optometrists have pursued prescription privileges, doing so was not divisive within their professions. This may be because their training was already medical in nature.

Prescription privileges would ultimately change psychology training at the undergraduate, graduate, post-doctoral, and continuing education levels. This divisiveness within psychology indicates that it is premature to legislatively redefine the science and profession.

and

6) Psychology is an identified health profession that allows the consumer choices of treatment modalities. Psychological treatments have been shown to improve the human condition, often more effectively than drugs. Many consumers of mental health services prefer not to use drugs to cope with daily living. Psychology is not outmoded and continues to make important contributions to society. Prescription privileges could impair the public's access to psychological services.

In conclusion, high quality and cost-effective treatment for mental health consumers can be provided by collaboration between psychologists and medical professionals. Such collaboration has worked well for many years and continues to be effective. It is commonly practiced, consistent with established disciplines, and in the best interest of the consumer. Psychologists who wish to prescribe can pursue training in nursing or medicine. This solution would not be divisive within psychology and would not rely on major additional taxpayer resources.

Thank you for your kind consideration of this opinion.

Respectfully,

Robyn Dawes
AAAPP Director

Cc: Andrew Halcro, John Harris, Lisa Murkowski, Jerry Sanders, Tom Brice and Sharon Cissna

jh

TO: S.S.

Pharmacy Subj

Subject: Psychologists prescribing privileges
Date: Fri, 5 Feb 1999 22:56:37 -0900
From: "Alaska Psychiatric Association" <apa@pobox.alaska.net>
To: "Williams, Bill, Rep." <Representative_Bill_Williams@legis.state.ak.us>,
"Whitaker, Jim, Rep." <Representative_Jim_Whitaker@legis.state.ak.us>,
"Therriault, Gene, Rep." <Representative_Gene_Therriault@legis.state.ak.us>,
"Smalley, Harold, Rep." <Representative_Harold_Smalley@legis.state.ak.us>,
"Sanders, Jerry, Rep." <Representative_Jerry_Sanders@legis.state.ak.us>,
"Rokeberg, Norman, Rep." <Representative_Norman_Rokeberg@legis.state.ak.us>,
"Porter, Brian, Rep." <Representative_Brian_Porter@legis.state.ak.us>,
"Phillips, Gail, Rep." <Representative_Gail_Phillips@legis.state.ak.us>,
"Ogan, Scott, Rep." <Representative_Scott_Ogan@legis.state.ak.us>,
"Murkowski, Lisa, Rep." <Representative_Lisa_Murkowski@legis.state.ak.us>,
"Mulder, Eldon, Rep." <Representative_Eldon_Mulder@legis.state.ak.us>,
"Morgan, Carl, Rep." <Representative_Carl_Morgan@legis.state.ak.us>,
"Masek, Beverly, Rep." <Representative_Beverly_Masek@legis.state.ak.us>,
"Kott, Pete, Rep." <Representative_Pete_Kott@legis.state.ak.us>,
"Kookesh, Albert, Rep." <Representative_Albert_Kookesh@legis.state.ak.us>,
"Kohring, Vic, Rep." <Representative_Vic_Kohring@legis.state.ak.us>,
"Kerttula, Beth, Rep." <Representative_Beth_Kerttula@legis.state.ak.us>,
"Kemplen, Allen, Rep." <Representative_Allen_Kemplen@legis.state.ak.us>,
"Kapsner, Mary, Rep." <Representative_Mary_Kapsner@legis.state.ak.us>,
"Joule, Reggie, Rep." <Representative_Reggie_Joule@legis.state.ak.us>,
"James, Jeannette, Rep." <Representative_Jeannette_James@legis.state.ak.us>,
"Hudson, Bill, Rep." <Representative_Bill_Hudson@legis.state.ak.us>,
"Harris, John, Rep." <Representative_John_Harris@legis.state.ak.us>,
"Halcro, Andrew, Rep." <Representative_Andrew_Halcro@legis.state.ak.us>,
"Grussendorf, Ben, Rep." <Representative_Ben_Grussendorf@legis.state.ak.us>,
"Green, Joe, Rep." <Representative_Joe_Green@legis.state.ak.us>,
"Foster, Richard, Rep." <Representative_Richard_Foster@legis.state.ak.us>,
"Dyson, Fred, Rep." <Representative_Fred_Dyson@legis.state.ak.us>,
"Davies, John, Rep." <Representative_John_Davies@legis.state.ak.us>,
"Croft, Eric, Rep." <Representative_Eric_Croft@legis.state.ak.us>,
"Cowdery, John, Rep." <Representative_John_Cowdery@legis.state.ak.us>,
"Coghill, John, Rep." <Representative_John_Coghill@legis.state.ak.us>,
"Cissna, Sharon, Rep." <Representative_Sharon_Cissna@legis.state.ak.us>,
"Bunde, Con, Rep." <Representative_Con_Bunde@legis.state.ak.us>,
"Brice, Tom, Rep." <Representative_Tom_Brice@legis.state.ak.us>,
"Berkowitz, Ethan, Rep." <Representative_Ethan_Berkowitz@legis.state.ak.us>,
"Barnes, Ramona, Rep." <Representative_Ramona_Barnes@legis.state.ak.us>,
"Austerman, Alan, Rep." <Representative_Alan_Austerman@legis.state.ak.us>

February 5, 1999

Dear Member of the Alaska State Legislature:

It has come to the attention of the Alaska Psychiatric Association and the American Psychiatric Association that a bill may be introduced this session which would grant prescribing privileges to psychologists in Alaska. As mental health professionals, such legislation, if passed, would have great impact on our members as well as all Alaskans. We do not believe there is a need for psychologists to have prescribing privileges, nor do we believe it is appropriate or even beneficial to mental health care consumers. If such legislation were passed, Alaska would be the only state in the United States permit prescribing privileges for psychologists.

We are deeply concerned about this issue and the impact it will have on mental health professionals and consumers throughout the state, and will be carefully tracking the status of any proposed legislation and will be actively involved in fighting any such legislation. Our members would be happy to meet with you to share our views and concerns.

Please feel free to contact the Alaska Psychiatric Association at (907) 566-7800 if you have any questions or if you wish to discuss this issue.

Sincerely,

Merijeanne A. Moore, D.O.
President, Alaska Psychiatric Association

Robert R. Ireland
HC 85 9291
Eagle River, Alaska 99577-9401
3 May 99

MAY 0 6 1999

Dear Representative Norman Rokebery,

I am an Alaskan resident, voter, and licensed physician (flight surgeon and psychiatrist). I am also the Mental Health Flight Commander at Elmendorf Air Force Base and senior military mental health provider in Alaska. I am responsible for assuring the 81,000 Department of Defense beneficiaries in Alaska receive quality mental health care.

Bill HB 139 in the House Labor and Commerce Committee proposes that psychologists in Alaska be allowed to prescribe medications without medical supervision. This bill absolutely depends upon the general public's lack of awareness that clinical psychologists have no medical training. The bill proposes 10 weeks (300 hours) of medical training as compared to a psychiatrist's 8 years of intensive medical training.

Psychotropic medications have complex bodily effects and extremely intricate medical interactions. In the hands of essentially untrained persons, there is great potential for causing harm—an unacceptable prospect for all Alaskans. A military trial of psychologists prescribing required an intensive 2 years of training beyond Ph.D., and most importantly, even then required supervision by medical doctors to actually prescribe.

Again, this bill depends upon the general public's confusion between psychologists and psychiatrists. Never has such a proposal been accepted by any state or country in the world. Let's not allow this serious compromise in qualifications for "medical training" slide through in Alaska. Neither the military nor TRICARE will approve such prescribing by non-medical professionals. Alaskans should not have to settle for this prospect, as well.

Please educate your colleagues about this bill and maintain the same medical standards observed throughout the United States and the world—vote "No" on HB 139.

Respectfully,

Robert R. Ireland MD

ANCHORAGE COMMUNITY MENTAL HEALTH SERVICES, INC.

Southcentral
COUNSELING CENTER

4020 Folker Street · Anchorage, Alaska 99508

(907) 563-1000
FAX 563-2045

April 29, 1999

David R. Samson, M.D.
Board Certified Psychiatrist
Specializing in Adult Outpatient Psychiatry

2600 Denali St., Suite 606
Anchorage, AK 99503

(907) 276-2978

The Honorable Norm Rokeberg, Chairperson
House Labor and Commerce Committee
House of Representatives
Alaska State Capitol
Juneau, Alaska 99801-1182

Dear Representative Rokeberg:

This letter concerns sponsor substitute for House Bill 139, a bill addressing psychologists prescribing medications. Hopefully, you have heard from many of my colleagues concerning this bill. I am quite concerned that the passage of such a bill would allow for substandard treatment of some of our most at-risk Alaskan citizens.

My specialty in psychiatry is primarily the pharmacologic treatment of persons with various mental disorders at this public mental health center as well as in my private practice in Anchorage. The nature of mental disorders, whether functional or psychological, or physiologic or brain-based, are so complex that accurate diagnosis and treatment must be left with physicians. Several weeks or months of training in psychopharmacology is insufficient to help any other allied mental health provider, such as a psychologist, to accurately be able to diagnosis, assess, or otherwise evaluate these complex interactions. Anything short of a four-year medical school, including a full psychiatric and neurological training residency program, is insufficient for the optimal diagnosis and treatment of the vast majority of mentally ill individuals. A preponderance of the major mental illnesses are enduring or chronic, and as people age they acquire multiple physical problems that make the whole area of psychopharmacology even more complex, due to the underlying illnesses and medication actions and interactions.

I hope to encourage you and your colleagues to reject this well-meaning but ill-conceived piece of legislation. I would be very happy to talk with you regarding this issue. I may be reached at Southcentral Counseling Center at (907) 261-5304, or my 24-hour answering service number is (907) 276-2978.

Sincerely,

David R. Samson, MD, FAPA
ACMHS Medical Director

DRS/sms

MAY 0 6 1999

Alaska State Legislature

REPRESENTATIVE
JEANNETTE JAMES
P O. Box 56622
North Pole, Alaska 99705
(907) 488-1546
FAX (907) 488-4271

While in Juneau
State Capitol
Juneau, Alaska
99801-1182
(907) 465-3743
FAX (907) 465-2381

APR 12 1999

House Of Representatives

House District 34

DATE: April 12, 1999

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

FROM: Representative Jeannette James

RE: Request for Hearing HB 139

Please schedule the following bill for hearing in your committee at your earliest convenience:

HB 139: Prescriptions by Psychologists

Attached are the SPONSOR STATEMENT, and a SPONSOR SUBSTITUTE which will be read across today or tomorrow.

Thank you for your help.

HB

143

HOUSE COMMITTEE REPORT

(7)

Date Referred to Committee: March 19, 1999 **FURTHER REFERRALS:** **Judiciary Finance**

Date of Committee Action: APRIL 9, 1999

The LABOR AND COMMERCE Committee considered: **HB 143**

HOUSE BILL NO. 143 **REAL ESTATE:SURITY FUND & DISCLOSURES**

"An Act relating to the executive officer employed for the Real Estate Commission, to educational materials published by the Real Estate Commission, to the Real Estate Surety Fund, to contracts by the Real Estate Commission, and to disclosures in real property transactions."

recommends it be replaced with the following committee substitute CSHB 143(L+C) [ ] the same title [✓] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[✓] fiscal note(s) DCED [ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____ [ ] zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
Norman Rokeberg	✓			
Cynthia	✓			
[illegible]			✓	
John L. Harris			✓	
[illegible]			✓	

CHAIR'S SIGNATURE Norman Rokeberg 4-9-99

1-LS0150\G
Bannister
4/6/99

CS FOR HOUSE BILL NO. 143(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - FIRST SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG

A BILL

FOR AN ACT ENTITLED

"An Act relating to the executive officer employed for the Real Estate Commission, to regulations of the Real Estate Commission, to the real estate surety fund, and to employees paid from money in the real estate surety fund."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** AS 08.88.031 is amended to read:

Sec. 08.88.031. Executive secretary of commission. The department shall, after consultation with the commission, employ a person, who is not a member of the commission, to serve as executive secretary for the commission. The executive secretary shall perform duties as assigned by the commission **<u>and may use the title "executive ~~director~~ [administrator]" when performing the duties</u>**.

* **Sec. 2.** AS 08.88.081 is amended to read:

Sec. 08.88.081. Commission regulations. The commission shall adopt regulations necessary to carry out the purposes of this chapter. **<u>The commission may adopt regulations concerning the disclosure of information in real estate</u>**

transactions.

* Sec. 3. AS 08.88.450 is amended to read:

Sec. 08.88.450. Real estate surety fund. The real estate surety fund is established in the general fund to carry out the purposes of AS 08.88.450 - 08.88.495. The fund is composed of payments made by real estate licensees under AS 08.88.455, [AND] filing fees retained under AS 08.88.460, and income earned on investment of the money in the fund. Money appropriated to the fund does not lapse. Amounts [. THE FUND CYCLE MAY NOT EXCEED $500,000 AND AMOUNTS] in the fund [IN EXCESS OF $250,000] may be appropriated for claims against the fund, for hearing and legal expenses directly related to fund operations and claims, and for real estate educational purposes [AS PROVIDED IN AS 08.88.091].

* Sec. 4. AS 08.88.450 is amended by adding a new subsection to read:

(b) The Department of Commerce and Economic Development shall provide the commission every three months with a statement of the activities of, balances in, interest earned on, and interest returned to the real estate surety fund.

* Sec. 5. AS 08.88.455(a) is amended to read:

(a) A real estate licensee, when applying for or renewing a real estate license, in lieu of obtaining a corporate surety bond, shall pay to the commission in addition to the license fee, a surety fund fee not to exceed $125. After each two-year licensing cycle, if the [FUND REACHES $250,000, THE] commission finds that the average balance in the surety fund during the two-year licensing cycle was less than $250,000 or more than $500,000, the commission shall by regulation adjust the surety fund fees so that the average balance of the surety fund during the next two-year licensing cycle is anticipated to be an amount that is not less than $250,000 or more than $500,000. In this subsection, "average balance" means the average balance after [,] taking into account anticipated expenditures for claims against the fund, for hearing and legal expenses directly related to fund operations and claims, and for real estate educational purposes [, THE FUND IS MAINTAINED AT A LEVEL NOT LESS THAN $250,000].

* Sec. 6. AS 08.88.472(a) is amended to read:

(a) The commission may charge to the real estate surety fund hearing and

legal expenses related to fund operations and claims [THE COSTS OF A HEARING ON A CLAIM FOR REIMBURSEMENT HELD UNDER AS 08.88.465]. The commission shall deposit into the real estate surety fund amounts recovered for these **expenses** [COSTS] from the licensee under AS 08.88.071(b) or from other parties under AS 08.88.490.

* Sec. 7. AS 08.88.472 is amended by adding new subsections to read:

(c) The commission may contract under AS 36.30 (State Procurement Code) with a person for the person to perform hearing and legal services for the commission with regard to a claim against the real estate surety fund. The contract may cover one or more claims.

(d) If the salary of an employee is entirely or partially paid for from money in the real estate surety fund, the employee may perform administrative duties for the commission in addition to any duties the employee performs that are related to the real estate surety fund. AS 08.88.910 does not apply to this subsection.

4/9/99 Dalcro moved
Adopted as amended

1-LS0150\G.1
Bannister✓
4/9/99

AMENDMENT #1 amended

OFFERED IN THE HOUSE BY REPRESENTATIVE ROKEBERG

TO: CSHB 143(L&C), Draft Version "G"

Page 2, line 6:

Delete "**and**"

Page 2, line 7, following "**in the fund**":

Insert "**, and money deposited in the fund under (b) of this section**"

Page 2, line 12:

Delete "a new subsection"

Insert "new subsections"

Page 2, following line 12:

Insert a new subsection to read:

"(c) If money from the real estate surety fund is expended to prepare, print, manufacture, sponsor, produce, or otherwise provide an item or a service to a member of the public, to a real estate licensee, to a potential real estate licensee, or to another person, any money paid by the person to the commission, either directly or through an agent or contractor of the commission, to receive the item or service shall be deposited in the fund. In this subsection, "an item or a service" includes an information pamphlet, an examination preparation packet, an educational course, the certification of a real estate education course, and the approval of a real estate education instructor."

Reletter the following subsection accordingly.

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. CSHB 143(L&C)

Revision Date/Time (Note if correction) 04/13/99 Dept. Affected Commerce & Econ Dev.
Title An Act relating to the executive officer employed for the Real Estate Commission, ... BRU Occupational Licensing
Component Occupational Licensing
Sponsor Representative Rokeberg
Requester House Labor & Commerce Component Serial No. 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1040 RESF						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

FY 2000 expenses from the Real Estate Surety Fund are documented in the department's operating budget submission.

Prepared by Jennifer Strickler, Administrative Manager Phone 465-2144
Division Occupational Licensing Date/Time 4/13/99 5:05 PM
Approved by Commissioner Deborah B. Sedwick Date 4.14.99
Agency Commerce & Economic Development Deborah B. Sedwick

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FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. CSHB 143(L&C)

Revision Date/Time (Note if correction)
Dept. Affected: Commerce & Econ Dev.
Title: An Act relating to the executive officer employed for the Real Estate Commission, ...
BRU: Occupational Licensing
Component: Occupational Licensing
Sponsor: Representative Rokeberg
Requester: House Labor & Commerce
Component Serial No.: 360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1040 RESF						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost: 263.8

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

FY 2000 expenses from the Real Estate Surety Fund are documented in the department's operating budget submission. CSHB 143(L&C) authorizes an appropriation to be made from the fund to pay for claims, hearing and legal expenses directly related to fund operations, and for educational purposes.

Prepared by: Jennifer Strickler, Administrative Manager — Phone: 465-2144
Division: Occupational Licensing — Date/Time: 4/9/99 5:45 PM
Approved by Commissioner: Deborah B. Sedwick — Date: 4/12/99
Agency: Commerce & Economic Development

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Barbara Granger
Associate Broker

RE/MAX Properties
2600 Cordova, Ste #100
Anchorage, AK 99503

Phone: 907/345-6462; Msg: 907/257-0121; FAX: 907/345-4226

Date: April 8, 1999 Pages to follow: 0

TO: Norm Rokeberg

SUBJECT: HB 143

Message: Just want you to know I support the current version of HB143.
I hope to be @ the hearing on April 9th.

Original is being sent by mail: ___Yes _X_No
(If any pages are not received, please call (907)345-6462)

This message is being sent to FAX No: 1/907/465-2040

Page 1 of 1 Pages

Public Opinion Message

Kodiak Legislative Information Office (LIO)
112 Mill Bay Rd • Kodiak AK 99615 • Phone: 486-8116 Fax: 486-5264

This form MUST be completely filled out. You may phone, fax, or deliver your POM to any LIO.

From: **Please PRINT the information below.**

Ms./Mr., Mrs.	First name	M.I.	Last name	Jr., Sr., III
Ms.	LINDA	L.	FREED	

Mailing address	Zip code
3295 WOODY WAY, KODIAK AK	99615
Residence (street) address if different from mailing address	Zip code

Daytime telephone number	Group affiliation (if applicable)	Signature	Date
(907) 486-5740	AK REAL ESTATE COMMISSION - PUBLIC MEMBER	[signature]	4/9/99

To: **Put a √ in the appropriate box(es).**

House Labor & Commerce Committee

Committees (H or S)
- Community & Regional Affairs (cra)
- Finance (fin)
- Health, Ed., & Social Services (hes)
- Judiciary (jud)
- [√ H] Labor & Commerce (l&c)
- Resources (res)
- Rules (rls)
- State Affairs (sta)
- Transportation (tra)
- Other:
- Other:

Caucuses
- Anchorage (anc)
- Bush (bus)
- Fairbanks/Interior (int)
- Matsu (mat)
- Majority (mjr)
- Minority (mnr)

House members
- Austerman (aus)
- Barnes (bar)
- Berkowitz (ber)
- Brice (bri)
- Bunde (bun)
- Cissna (cis)
- Coghill (cog)
- Cowdery (cwd)
- Croft (cro)
- Davies (dav)
- Davis (dag)
- Dyson (dys)
- Foster (fos)
- Green (gre)
- Grussendorf (grs)
- Halcro (hac)
- Harris (har)
- Hudson (hud)
- James (jam)
- Joule (jle)
- Kemplen (kem)
- Kerttula (ker)
- Kohring (koh)
- Kookesh (kos)
- Kott (kot)
- Masek (mas)
- Morgan (mor)
- Moses (mos)
- Mulder (mul)
- Murkowski (mur)
- Ogan (oga)
- Phillips, G. (phg)
- Porter (por)
- Rokeberg (rok)
- Sanders (san)
- Sattler (sat)
- Smalley (sml)
- Therriault (thr)
- Whitaker (whi)
- Williams (wil)

Senate members
- Adams (ada)
- Donley (don)
- Ellis (ell)
- Elton (elt)
- Green (gre)
- Halford (hal)
- Hoffman (hof)
- Kelly, P. (kep)
- Kelly, T. (kel)
- Leman (lem)
- Lincoln (lin)
- Mackie (mac)
- Miller (mil)
- Parnell (par)
- Pearce (pea)
- Phillips, R. (phi)
- Taylor (tay)
- Torgerson (tor)
- Ward (war)
- Wilken (wlk)

Subject: **Fill out the boxes below OR enter a Subject.**

HB or SB	Bill number
HB	143

and check one: [√] Support [ ] Oppose [ ] Amend **OR** *enter a general Subject (LIO staff may modify):*

Message: ***Your PRINTED message cannot exceed 50 words or contain any vulgar language.***

DUE	TO	ANOTHER	COMMITMENT	I
CAN	NOT	TESTIFY	TODAY.	HOWEVER
I	APPRECIATE	REP.	ROKEBERG'S	INTRODUCTION
OF	THIS	BILL	AND	THE
VERSION	OF	AMENDMENT	WHICH	REFLECT
A	DISCUSSION	OF	THE	BILL
WITH	THE	AK	REAL	ESTATE
COMMISSION	THIS	BILL	BENEFITS	AK
CITIZENS	AND	REAL	ESTATE	LICENSEES.

POM for Representative Rokeberg

APR 0 8 1999 H

From: Mr Willie Heinrichs
PO Box 2182

Kodiak, AK 99615 NON Constituent

Telephone: 486-6935

Registered Voter: U

Bill: HB 143 Title: REAL ESTATE:SURETY FUND & DISCLOSURES
Message:

I APPROVE OF THE BILL AS WRITTEN NOW!

Entered in KOD on 4/08/99 POMID: 3522 Distribution: 2

Main Menu . Store All . Store This One . Prev POM . Next POM

Message 1 out of 1.

FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 143

Revision Date/Time (Note if correction) 03/26/99
Dept. Affected Commerce & Econ Dev.
Title An Act relating to the executive officer employed for the Real Estate Commission, ...
BRU Occupational Licensing
Component Occupational Licensing
Sponsor Representative Rokeberg
Requester House Labor & Commerce
Component Serial No. 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	104.0	104.0	104.0	104.0	104.0	104.0
1037 GF/Mental Health						
Other 1040 RESF	(104.0)	(104.0)	(104.0)	(104.0)	(104.0)	(104.0)
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY99) cost: 263.8

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The funding source shown above represents a change from Real Estate Surety Funds to General Fund Program Receipts. The costs are documented in the department's FY 2000 operating budget submission as real estate surety funds. HB 143 limits use of the real estate surety fund to hearing, investigative, legal expenses, and claims only. Therefore, this fiscal note represents a funding source change of the real estate surety fund authorization used for educational expenses.

The funding source change made by this fiscal note anticipates real estate surety fund authorization in the amount of $105.6 in the FY 2000 operating budget and will switch an additional $104.0 to general fund program receipts, for a total of $209.6 as documented in the FY 2000 operating budget submission. Detailed information is provided on the attached page.

Prepared by Jennifer Strickler, Administrative Manager
Phone 465-2144
Division Occupational Licensing
Date/Time 3/26/99 11:53 AM
Approved by Commissioner Deborah B. Sedwick
Date 3/24/99
Agency Commerce & Economic Development

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FISCAL NOTE

STATE OF ALASKA
1999 LEGISLATIVE SESSION

BILL NO. HB 143

ANALYSIS: (Continued)

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
FISCAL NOTE CALCULATIONS FOR **HB 143**

HB 143 changes the title of the Executive Secretary of the Real Estate Commission to Executive Director. This fiscal note does not address a change in pay range for the position however, changing the title to Executive Director may have pay increase implications under the State's personnel system.

The FY 2000 operating budget requested $209.6 in real estate surety fund (RESF) authorization for the following:

Personal Services:		$ 61.1
Travel:		7.5
Contractual Services:		137.5
Supplies:		3.5
	Total:	$ 209.6

This fiscal note proposes to change the funding source of the $209.6 to the following:

	GF/PR	RESF	TOTAL
Personal Services	54.0	7.1	$61.1
- Move the Publications Specialist position to GF/PR;			
- RESF of $7.1 to cover the Executive Director's time associated with hearings and claims.			
Travel	7.5	0	7.5
Contractual Services	39.0	98.5	137.5
- Move educational-related funding to GF/PR;			
- RESF of $28.5 for Hearings and $70.0 for Claims remain as real estate surety fund source.			
Supplies	3.5	0	3.5
TOTAL:	$104.0	$105.6	$209.6

Date: **Friday, April 09, 1999**

To: **Alaska State Legislature**
Representative Norm Rokeberg
Phone: **800-773-4968**
Fax: **907-465-2040**

From: **Real Estate Professionals, Inc.**
Ron Johnson
Phone: **907-283-7755**
Fax: **907-283-8103**

Pages: **2**

Hello from beautiful downtown Kenai. . .and you thought I'd stay quiet ;-)
RE: HB143. .Page 1, line 8/9"and may use the title. . . The statute specifically precludes a licensee from misrepresenting designations 08.88.401 (a). I see this as a step to future changfes in the actual title therefore having significant fiscal impact. The "outside meetings" image is not affected by titles.
Page 1, line 13/14ADD. as required by 08.88.071(H) (7).
Page 2, line 7, "does not lapse" add: <u>into the general fund but is returned to the surety fund.</u>

The use of the surety fund for education must not be limited to the strict term education as defined by the statutes. The most important function of the real estate commission is its ability to communicate with the real estate licensees ie: Alaska Real Estate News, The pocket book of Statutes and Regulations Real Estate, and with the least protected but most concerned members of the public, landlords and tenants. The Landlord Tenant Act and what it means to you. . . .The equipment (computers/printers) it takes to develop those documents and the acquired knowledge of information to put into the (travel) Please do not put those items under Occ. Lic. let the Real Estate Commission do their own thing. . . .
Respectfully Ron Johnson

REALTOR ®

ALASKA ASSOCIATION OF REALTORS, INC.
741 Sesame Street, Suite 100 • Anchorage, Alaska 99503
Telephone 907-563-7133 • Fax 907-561-1779

April 8, 1999

Representative Norm Rokeberg
State Capital
Juneau, Alaska 99801

Sent by Fax: 456-2040

Dear Representative Rokeberg,

The Alaska Association of REALTORS, with over 1100 members statewide would like to express their support for House Bill 143, version "G", relating to the real estate commission surety fund.

This legislation would better regulate the operations and balance of the Surety Fund, and allow an employee funded by the surety fund to perform administrative duties for the real estate commission.

The Alaska Association of REALTORS encourages the passage of HB 143.

Sincerely,

Chachie Sandberg, CCIM, CRS, GRI
1999 President

Alaska State Legislature

APR 08 1999

Please enter into the record my testimony to the House Labor & Commerce committee name

committee on HB 143 - Real Estate bill/subject, dated 4/6/99.

I request that you support House Bill 143 for a number of reasons. As a licensed real estate agent, I have no problem paying dollars into the surety fund; however, I believe that it is unfair that when the fund is overfunded the additional dollars go to the general budget. An additional proposal that needs to be added is for any income from services provided by the surety fund to go back into the surety fund and not to the general budget.

I believe that it is a positive step that the commission be able to adjust the annual levy in relation to the need for additional dollars to maintain the fund between $250,000 and $500,000.

Representative Rokeberg, thank you once again for sponsoring this bill. Representative Austerman, I would appreciate your support. If you have any questions, please call me at 486-5421. You can also reach me by e-mail at planyourfuture@hotmail.com.

TM/jl

Signed: Tom Martin, Associate Broker
Testifier

Chelsea Realty
Representing (Optional)

104 Center St Ste 201
Address

907-486-3424
Phone No.

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS

LABOR &COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
SPECIAL COMMITTEE ON ECONOMIC DEVELOPMENT & TOURISM, MEMBER

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

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ANCHORAGE, AK 99501
PHONE: (907) 269-0117
FAX: (907) 269-0119

SESSION
ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

SPONSOR STATEMENT
HOUSE BILL 143

An Act relating to the executive officer employed for the Real Estate Commission, to educational materials published by the Real Estate Commission, to the Real Estate Surety Fund, to contracts by the Real Estate Commission, and to disclosures in real property transactions.

House Bill 143 is an omnibus real estate bill proposed to address various parts of the real estate licensing statute and results from concerns expressed by a number of real estate licensees.

The purpose of a large portion of the bill is to move the "educational" uses of fees collected from the Real Estate Surety Fund ("Fund") to the licensing fee portion of funds received by the Real Estate Commission ("Commission"). The Commission receives and appropriates both the licensing fees and the Fund fees. Licensees believe greater fiscal control and restraint will result from the rearrangement of how funds are used. This is because most of the 2,200 licensees do not understand the current use of the Fund moneys. In addition this bill authorizes expand use of surety fund on surety fund manners. It is important to recognize that the Fund was set up pay for awards made to persons who filed and prevailed on a complaint against a licensee.

The bill also states that there is no duty on the part or a real estate licensee or seller to disclose information regarding psychological impacted or stigmatized property.

I would appreciate your support of this measure.

ED 1:03/19/99

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR &COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
SPECIAL COMMITTEE ON ECONOMIC DEVELOPMENT & TOURISM, MEMBER

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

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716 WEST 4TH AVENUE, SUITE 640
ANCHORAGE, AK 99501
PHONE: (907) 269-0117
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ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

SECTIONAL ANALYSIS
HOUSE BILL 143

An Act relating to the executive officer employed for the Real Estate Commission, to educational materials published by the Real Estate Commission, to the Real Estate Surety Fund, to contracts by the Real Estate Commission, and to disclosures in real property transactions.

Prepared by Rep. Norman Rokeberg

Section 1:	**Changes "Executive Secretary" to "Executive Director"**
Section 2:	**Removes authority for Commission to publish any landlord-tenant related items if they primarily address landlord-tenant relationship.**
Section 3:	**Mandates that funds in the Real Estate Surety Fund ("Fund") do not lapse. Mandates that the Fund may not be used to pay for educational purposes.**
Section 4:	**Mandates that the Department of Commerce & Economic Development is to provide the Commission with a monthly statement of activities of and balance in the Fund.**
Section 5:	**Raises the floor of the fund to $300,000 before the fee paid by the real estate licensees can be adjusted. Provides that the fund should be maintained at a level of $300,000 but not more than $500,000.**
Section 6:	**Indicates that the Commission may charge the Fund for the costs of hearings on complaints, investigation of complaint, and any legal services provided to the Commission.**
Section 7:	**Provides that the Commission may contract out under the State Procurement Code the hearing, investigative, and legal services with regard to a claim or claims against a real estate licensee.**

Section 8: Establishes that there is no duty of a seller ("transferor") or agent of the seller (usually a real estate licensee) to disclose to the buyer ("transferee") any background information about: natural death, suicide, murder or other crime classified as a felony, HIV, AIDS, disease highly unlikely to be transmitted through dwelling occupancy, or sex offenders in the neighborhood.

Section 9: These provisions only apply to real estate transactions entered into on or after the effective date of this Act.

ED1:03/22/99

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR &COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
SPECIAL COMMITTEE ON ECONOMIC DEVELOPMENT & TOURISM, MEMBER

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Representative Norman Rokeberg

SUPPORTING INFORMATION
HOUSE BILL 143

An Act relating to the executive officer employed for the Real Estate Commission, to educational materials published by the Real Estate Commission, to the Real Estate Surety Fund, to contracts by the Real Estate Commission, and to disclosures in real property transactions.

House Bill 143 is an omnibus real estate bill to address various parts of the real estate licensing statute resulting from concerns expressed by a number of real estate licensees.

The bill would change the title of the "Executive Secretary" of the Real Estate Commission ("Commission") to "Executive Director" to more fully reflect the myriad of duties accomplished in that position. There would be no raise in pay with the change in title.

Changes to the Real Estate Surety fund make up the bulk of the legislation. HB 143 would amend the current language concerning this Fund so that the only expenses that may be paid for out of the Fund are those associated with investigations, holding hearings, and paying claims determined to be valid. The Fund is composed of collections from real estate licensees. The licensees, when obtaining or renewing a real estate license, pay to the state a fee in addition to the licensing fee. This surety fee, not to exceed $125, is paid in place of obtaining a corporate surety bond and the fees collected are then placed in the Fund. Alaskans who have claims against a licensee may file complaints with the Commission and if those claims are upheld, the award may be paid out of the Fund. The Fund is currently capped at $500,000; however, anything above $250,000 under current law may also be used for education purposes. The surety fund fee may be adjusted according to the amount in the fund and how close the fund is to its cap; however, the fee may not exceed $125 per licensee. The reimbursement from the real estate surety fund may not exceed $10,000 per transaction. As directed by the Office of Management and Budget and approved by the Legislature, $100,000 of the fund is earmarked to pay any awarded claims.

The Commission, under current law, has the ability to expend funds in the Fund which are over the $250,000 mark on educational purposes, such as real estate

clinics, meetings, courses, institutes, and the Landlord-Tenant Handbook. This legislation makes it clear that these educational functions are not to be paid from out of the Fund and that the Landlord-Tenant Handbook and other landlord-tenant educational materials are not to be published by the Commission. Fees from the real estate licensees fund the Commission and it is felt that the landlord-tenant publication is not properly placed here, as landlord-tenant disputes are not under the Commission's purview. This use of the Fund is a hidden tax on the licensees costing about $6,000 per year.

The bill further provides that money in the Real Estate Surety Fund does not lapse and stays in the Fund. Currently when the Fund reaches $250,000, the Commission adjusts the surety fund fee paid by the licensee. This floor is raised to $300,000 by this legislation.

Under Section 7 of the legislation, the Commission would be permitted to contract out the hearing, investigative and legal services for the Commission with regard to claims against the Surety Fund.

Section 8 of the legislation addresses psychologically impacted or stigmatized property. This change of law would state that a seller of real estate ("transferor") and the agent of same are not liability for damages or other penalties in a civil, criminal, or administrative action for failure to disclose to the buyer ("transferee") certain background information. "Certain background information" includes a natural death, a suicide, or a murder or other felony, not been owned or occupied by someone with HIV or AIDS or other disease determined by medical evidence to be highly unlikely to be transmitted through dwelling occupancy, and whether or not there are sex offenders living in the area.

AS 12.63.010 requires sex offender registration in Alaska. There is a great potential for the state-maintained list to be highly inaccurate (wrong addresses, wrong employers, etc.). An inaccurate disclosure, based on the sex offender registry, may open the licensee and/or seller to various kinds of lawsuits. In 1990, the Alaska Legislature enacted an agency disclosure statute (AS 08.88.396) which required licensees to disclose whose interests they are representing in each transaction. When a licensee represents both parties (i.e., shows a property listed by himself or within his own office), the principals' interests are not always compatible. In this instance, the relevant information about convicted sex offenders is public; the licensee can be released from a specific duty to disclose, but still assist a buyer by letting them know where to find information, that may or may not be important to them, without acting contrary to the seller's best interest.

During the last legislative session, the residential property disclosure form was amended so that notice was given to the buyer. This notice informs the buyer where to research the information on sex offenders in the area.

The exemptions of real estate licensee from disclosure of such things as murder, suicide, sex offenders in the area, etc. is not uncommon. The National Association of REALTORS® at is 1997 Mid-Winter meeting adopted a resolution concerning this matter:

> That the National Association of REALTORS® support the federal government's action to protect children from known sex offenders (Megan's Law), and encourages the development and implementation of state programs designed to provide notification of the location of released sex offenders. In order to insure that home buyers/tenants obtain timely and accurate information, all public disclosures should emanate directly from the appropriate law enforcement agency, and no affirmative disclosure duty regarding the location of released sex offenders should be placed on real estate licensees as a result of state public notification programs. (emphasis added)

Other states have seen the risk of having a licensee do the job of a law enforcement agency and have adopted laws similar to what is proposed in this legislation. Arizona, Pennsylvania, Minnesota, Oklahoma -- all provide the real estate licensee with no duty to disclose if a sex offender lives in the area. Delaware, Louisiana, Maryland, Michigan, New York, Oklahoma, and Texas have psychologically impacted property statutes and those provide that a real estate licensee has no duty to disclose such items as murder, suicide, AIDS, or death occurring on the property.

I would appreciate your support of this measure.

ED1:03/22/99

STATE OF ALASKA

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

DIVISION OF OCCUPATIONAL LICENSING

TONY KNOWLES, GOVERNOR

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To: Janet Seitz
From: Grayce Oakley
Date: March 19, 1999

Re: Information requested regarding Surety Fund
Update of original January 26, 1999, memo

1. The current balance in the surety fund:
   Cash balance as of 1/22/99: $480,448
   (See attached spreadsheet, prepared by Phil Bennett)

2. The amount paid out in claims last fiscal year:
   No claims were paid in FY 99; six claims were withdrawn or settled prior to hearing, resulting in $1,500 of filing fees being refunded.

3. One claim for $10,250 and three filing fees have been refunded since July 1, 1998. There are 19 open claims. The Commission has adopted a proposed decision to pay $10,000 on one of those and it is currently on appeal in Superior Court. A proposed decision to deny another claim for $10,000 will be acted on by the Commission at its March 25-26, 1999 meeting. One additional hearing has been held; a proposed decision is pending. The total amount of the remaining open claims is approximately $127,000 (approximate because one claimant has not specified any amount of loss)

4. The estimate of expenses for this year:
   The Commission received a final summary report for FY 98 at its September 98 meeting; in addition to the spreadsheet referenced in #1 above, a summary report provided by the fiscal officer for the Division of Occupational Licensing is attached to this report.

5. Does the Commission do the LL/T books or are you just a place for people to pick them up?
   The Publication Specialist for the Commission prepared the copy and the Commission paid for the printing from the Surety Fund.

6. Is there any charge to the general public?
   Until 12 AAC 02.360(c)(1) became effective, one copy per person was free to the general public. Requests for multiple copies were charged $1 per copy. Since the adoption of this regulation, everyone is charged $1 per copy. All revenue generated from the purchases of the LL/T books has been deposited into the general fund (credited as real estate revenue) since 1994 in accordance with the AG opinion dated January 12, 1994. This opinion was obtained in conjunction with the audit conducted by OMB at that time.

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
OCCUPATIONAL LICENSING

SUMMARY OF THE REAL ESTATE SURETY FUND

SUMMARY OF THE ***REAL ESTATE SURETY FUND***				
As of March 4, 1999				
Revenue:				
A.	Fund Balance as of March 4, 1999	$	480,448	
B.	Revenue Not Yet Deposited in Fund *Revenue is transferred to the Fund periodically. No FY99 revenue has been transferred to date.*	$	18,825	
C.	Transfer to Education/Hearing/Claims Appropriation. *Total FY99 authorization is $264.1, the remaining authorization is in the Fund.*	$	80,000	
Expenses:				
D.	Less Education Expenses	$	-30,331	
E.	Less Surety Claims Paid & Filing Refunds	$	-11,068	A
	RESF TOTAL:	$	537,874	
	Less FY 98 Balance in Excess of $500,000	-	60,450	B
	Revised RESF BALANCE:	$	477,424	

A) $68 was incorrectly posted to Claims instead of Education. The posting error will be corrected and the expense will be shown under Education in future reports.

B) The $60,450 excess from FY 98 has not yet been reduced from the RESF Balance shown of $537,874. FY 2000 budget language rolls the $60,450 excess forward to the division general fund operating budget for surety fund purposes.

Department of Commerce and Economic Development
Division of Occupational Licensing
Real Estate Surety Fund

Prepared by Division of Administrative Services

Description	Operating Appropriations 29704-98	Operating Appropriations 29704-99	Surety Fund 11121
	FY 98	FY 99	
Fund Beginning Cash Balance 7/1/98			188,105
Expenditure Authorized in Occupational Licensing Budget:			
Real Estate Surety Fund Claims	100,000	100,000	
Real Estate Educational Expenses	163,800	164,100	
Actual Expenses As Of 1/22/99:			
Real Estate Surety Fund Claims	-1,548	-11068	
Real Estate Educational Expenses	-98,489	-28445	
Unspent Revenue Returned To SF From Educ/Claims Approp 1/5/99	163,763	n/a	163,763
Fees/Revenue Collected In FY98 & Transferred To The SF 1/5/99	208,580		208,580
Fund Balance 7/1/98 *IF* Unspent & New FY98 Revenue Had Been Transferred to SF On That Date			560,448
Revenue Transferred From SF To FY99 Educ/Claims Approp 1/99		80,000	-80,000
Fund Cash Balance As Of 1/22/99			480,448
Possible Additional Activity:			
If Entire FY99 Education and Claims Authorization Is Spent			-184,100
If Excess FY98 Balance Is Transferred To General Fund			-60,450
If Anticipated Revenue Is Received During FY99			30,000
Projected Fund Cash Balance 6/30/99 If Additional Activity Occurs			265,898

Revised March 19, 1999

Note: the two different figures for the excess FY98 balance ($60,448 vs. $60,450) are the result of rounding. $60,450 is the figure which should be used.

State of Alaska
Residential Real Property Transfer Disclosure Statement

Prepared in compliance with AS 34.70.

I. General Information

AS 34.70.010 requires that before the Transferee (Buyer) of an interest in residential real property makes a written offer, the Transferor (Seller) must deliver a completed written disclosure form.

This statement is a disclosure in compliance with AS 34.70.010. It concerns the residential real property* located in the _____ Recording District, _____ Judicial District, State Of Alaska.

Property address _____

Legal description _____

- "Residential real property" means real property whose primary purpose is to provide a single-family dwelling or two single-family dwellings, including units in condominiums and common interest ownership communities.

*** *** ***

Notice to Buyer: Under AS 34.70.050 Transferee (Buyer) is independently responsible for determining whether a person who has been convicted of a sex offense resides in the vicinity of the property that is the subject of the Transferee's (Buyer's) potential real estate transaction. This information is available at the following locations: Alaska State Trooper Posts, Municipal Police Departments, and on the State of Alaska Information Center Internet site at: www.state.ak.us under Hot Topics for the "Registry of Sex Offenders".

*** *** ***

II. Transferor (Seller) Information

Instructions: AS 34.70.040(b) provides that if an item that must be completed in the disclosure statement is unknown or is unavailable to the Transferor (Seller), and if the Transferor (Seller) or Transferor's (Seller's) agent has made a reasonable effort to ascertain the information, the Transferor (Seller) may make an approximation based on the best information available. It must be reasonable, clearly labeled as an approximation, and not used to avoid the disclosure requirements of AS 34.70.010 - AS 34.70.200.

All disclosures made in this statement are required to be made in good faith (AS 34.70.060). The Transferor (Seller) is required to disclose defects or other conditions in the residential real property or real property interest of which the Transferor (Seller) has been notified or has personal knowledge as of the date this disclosure statement is signed. The disclosure need not include a search of the public records. The disclosure does not require the purchase of professional services to inspect the property.

If information in a disclosure statement becomes inaccurate as a result of an act or agreement after the disclosure statement is delivered to the Transferee (Buyer), the Transferor (Seller) is required to deliver an amendment for the disclosure statement to the Transferee (Buyer). An addendum form for that purpose is attached to this disclosure statement.

Failure to Comply: A Person who negligently fails to comply with AS 34.70.010 - AS 34.70.200 is liable to the Transferee (Buyer) for actual damages suffered by the Transferee (Buyer). If failure to comply is willful, a person is liable to the Transferee (Buyer) for up to treble damages. A court may also award the Transferee (Buyer) costs and attorney fees in addition to the damages to the extent allowed by the rules of court.

Transferor (Seller) authorizes any agent(s) representing any principal(s) in this transaction to provide a copy of this statement to any person or entity in connection with any actual or anticipated transfer of the property or interest in the property.

_____ / _____ / _____ / _____

Buyer Seller