

APA GUIDELINES for Psychologists' Involvement in Pharmacological Issues

**APA WORKING GROUP ON THE GUIDELINES ON PSYCHOLOGISTS'
INVOLVEMENT IN PHARMACOLOGICAL ISSUES**

**APPROVED BY APA COUNCIL OF REPRESENTATIVES
AUGUST 2025**



**AMERICAN
PSYCHOLOGICAL
ASSOCIATION**



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Introduction

Since the *Practice Guidelines Regarding Psychologists' Involvement in Pharmacological Issues* were first published in 2011, psychologists' involvement in pharmacological issues has expanded markedly. Informal estimates are that the number of psychologists licensed or credentialed to prescribe psychotropic medication in 2011 was in the dozens, compared to over 300 today. Moreover, approximately 1500 psychologists have completed master's degrees in clinical psychopharmacology, which is required to gain prescriptive authority at the state level. At the time of publication of the original guidelines, only two states, certain segments of the military, the Indian Health Service (IHS), and the U.S. Public Health Service (USPHS) granted qualified psychologists the authority to prescribe psychotropic medication. At the time of this publication, all federal military services, the USPHS, IHS, and seven states have regulations and guidelines permitting appropriately trained psychologists to practice pharmacotherapy.¹ The states granting authority to psychologists to prescribe psychotropic medication include New Mexico, Louisiana, Illinois, Iowa, Idaho, Colorado, and Utah. Additionally, 25 jurisdictions throughout the United States have explicitly identified certain activities related to medication management as within the scope of practice of psychology. However, the description of permitted activities and the circumstances under which they are allowed vary (APA, 2024). For psychologists working in global contexts, laws for psychological support in pharmacological issues vary by country, ranging from permissive to restrictive, depending on the regional governmental approaches to the practice of psychology.

The expansion of prescriptive authority for qualified psychologists, along with the growing recognition of the role of nonprescribing psychologists in psychopharmacologic consultation, has led to a corresponding growth in research and practice articles on prescriptive authority for psychologists. The developing literature provides evidence that suggests psychologists practicing clinical pharmacotherapy¹ have a comparable safety record to other prescribers, improve access to underserved and general populations, and have adequate training to provide these services (for a summary of this literature, see Curtis, Hoffman, & O'Leary, 2023, and Sephry et al., 2024). In preparation for revising the 2011 guidelines, the task force reviewed the most recent research in the area as well as foundational research and writings related to prescriptive authority for psychologists. Although the current guideline authors are familiar with the historical and evolving research in the area, broad queries on the topic of prescriptive authority for psychologists were made in APA PsycINFO and PubMed. Finally, the task force considered specific implications of the *Ethical Principles of Psychologists and Code of Conduct* (hereafter referred to as

¹ The use of psychotropic medications for the treatment of psychological disorders will be referred to as "pharmacotherapy" in this document.

Ethics Code; APA, 2002; amended 2010 and 2017) for psychologists' involvement in the practice of pharmacotherapy.

The guidelines presented in this document are intended to provide a resource for psychologists interested in factors related to optimal practice in pharmacotherapy. They are not intended to apply to those psychologists who choose not to be involved in medication management, regardless of their level of training and competency, as noted below. As background to these guidelines, it is worth noting that psychologists' involvement in pharmacotherapy can be conceptualized on a continuum. Prior APA documents (e.g., Smyer et al., 1993) have identified three particularly salient levels along that continuum:

- Level 1, probably the most common, describes psychologists who provide information that may be relevant to pharmacotherapy decision makers. A Level 1 information-providing psychologist may offer opinions relevant to pharmacotherapy. However, they would not play a formal role in the decision-making process. Examples of information-providing roles include reporting treatment concerns to the prescribing professional, referring patients for a medication consult, providing patients with vetted referrals or information sources, or discussing with patients how to address their medication concerns with the prescriber.
- Level 2 occurs when psychologists actively collaborate in the medication decision-making process; however, the psychologist is not responsible for the medical decision in these circumstances. The psychologist plays a substantive role in the process, but the ultimate decision to prescribe rests with the actual licensed prescriber. It is important to note that in this update, we are further defining Level 2 to include only psychologists who have completed a master's degree in clinical psychopharmacology (MSCP) in a program designated by the APA (2010). This provides a clear and well-defined level of education required to play a "substantive" role in medical decision making. For example, this level of involvement might be practiced by psychologists integrated into specialty health care settings. However, psychologists with this level of training may find opportunities for collaboration across a wide variety of settings.
- Level 3 occurs when the psychologist serves as the prescriber and assumes responsibility for the outcomes related to the decision to prescribe psychotropic medications.

Some guidelines presented in this document are targeted specifically to the population of psychologists with prescriptive authority. Others are considered relevant in any case where the psychologist is actively involved in decision making, whether as a prescriber or collaborator. Still others are considered applicable any time a psychologist engages in the practice of pharmacotherapy, whether as a prescriber, col-

laborator, or information provider. Given the unique characteristics of the population of psychologists who can prescribe on the one hand, and the frequency with which psychologists participate in collaborative and information-providing activities on the other, providing guidelines appropriate to each activity level is critical. However, it is also important to recognize that a principle of optimal practice may have different implications in the context of active participation versus providing information. In particular, the distinction between active participation and providing information can often be blurred in the practice setting, as psychologists occupy different roles at varying points in the treatment. Given the ambiguity surrounding these activities, it is recommended that these guidelines be read with the understanding that the most precise practice delineation occurs between psychologists who possess prescriptive authority and those who do not. Psychologists who do not possess prescriptive authority should use critical judgment in determining which guidelines best inform their practice.

Considering the ever-growing and evolving role of technology in health care, the task force members reaffirm the statements made on this topic in the original guidelines. Telehealth has significantly impacted the nature of interactions with patients, with the potential to expand services to frequently underserved populations (e.g., rural, indigent, limited mobility). E-prescribing and secure electronic correspondence between patients and providers regarding medication are expanding and are likely to remain significant mechanisms for service delivery. For example, prescription renewal can often be safely and efficiently accomplished without in-person contact between the prescribing professional and the patient. These guidelines may be considered relevant regardless of the modality of contact.

Standards Versus Guidelines

To clarify the goals of the APA Professional Practice Guidelines for Psychologists' Involvement in Pharmacological Issues, it is worth summarizing the differences among treatment guidelines (or clinical practice guidelines), standards, and professional practice guidelines. Treatment guidelines offer recommendations for clinical interventions that are typically specific to a particular disorder and/or method of treatment (APA, 2015). Professional practice guidelines and standards differ from treatment guidelines in that they pertain to general professional conduct within a specific domain of psychological practice. Professional practice guidelines refer to statements that suggest or recommend general principles of optimal behavior or conduct for psychologists, differing from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. Professional practice guidelines are instead aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help encourage a high level of professional

practice by psychologists. Professional practice guidelines are not intended to be mandatory or exhaustive and may not apply to every professional or in every clinical situation. They are not definitive and they are not intended to take precedence over the professional judgment of psychologists.

Finally, nothing in these guidelines is intended to contravene any limitations set on psychologists' activities based on ethical standards, federal or local statutes or regulations, or, for those psychologists who work in agency and public settings, the policies of those agencies in which they provide services. As in all other circumstances, psychologists must be aware of the standards of practice for the jurisdiction(s) or setting(s) in which they function and are expected to comply with those standards. Psychologists who participate in collaboration and information provision should be aware of the local statutory and regulatory language or opinions of their respective state psychology licensure board(s) concerning their involvement in pharmacotherapy, as well as the use and interpretation of laboratory and other medical tests.

Guidelines for Psychologists' Involvement in Pharmacological Issues

General

GUIDELINE 1

Psychologists are encouraged to consider objectively the scope of their competence in pharmacotherapy and to seek consultation as appropriate before recommending or prescribing psychotropic medications.

Rationale

Standard 2.01 of the APA *Ethics Code* (APA, 2002/2010/2017) indicates psychologists provide services within the boundaries of their competence. Two aspects of the code complicate psychologists' efforts to comply with this standard in the context of pharmacotherapy. The first aspect, pertaining to psychologists without prescriptive authority, is pressure exerted on psychologists to serve in a collaborative or information-providing role. Patients or family members who find it difficult or uncomfortable requesting information from a nonpsychologist prescriber may seek specific advice from the psychologist with whom they have established a therapeutic relationship. Primary care physicians and other prescribers with limited specialized training in psychological disorders and their treatment, or who do not know the patient as well as the psychologist does, sometimes look to the psychologist for input on the choice of medication. The second aspect that affects psychologists in all three levels of involvement is the rapidly evolving nature of treatment guidelines in pharmacotherapy. While the psychologist with prescriptive authority, or under supervision to gain prescriptive authority, faces a statutory obligation to remain current, their level of expertise may vary across treatment populations and classes of medications. The psychologist without prescriptive authority who is asked to serve in a collaborative or information-providing role has no similar statutory obligation. However, the APA has established educational expectations for psychologists serving in a collaborative role, as well as a model training program for those psychologists pursuing prescriptive authority (Brown et al., 2021). These aspects of the *Ethics Code* (APA, 2002/2010/2017) may create a situation in which psychologists feel pressured to discuss their patients' treatment with medication at a level beyond their expertise.

Application

Psychologists are encouraged to consider their level of competence for addressing questions raised by other professionals, patients, or significant others. At any level of involvement in pharmacotherapy, psychologists take care to clarify their role in the process and, based on their competence, when appropriate, limit or decline to offer an opinion. If experiencing

excessive pressure to offer an opinion about medication, psychologists are encouraged to explore the factors underlying the request and address those directly. Particularly when asked to serve as prescribers or collaborators, psychologists are encouraged to consider the extent to which their beliefs about the appropriate course of action come from reliable sources (such as peer-reviewed journals or reputable summaries of that literature) or from potentially biased or unreliable sources (such as unfamiliar websites, sales representatives, advertisements, or casual conversations with colleagues who may be relying on the same unreliable sources of information). It is important to remember that research suggests health care providers may be susceptible to relying on easily accessible sources of information, even when those sources are potentially unreliable (Case, 2012; Haug, 1997; Isah & Byström, 2017; Perley, 2006).

GUIDELINE 2

Psychologists are urged to evaluate their beliefs and attitudes about the role of medication in the treatment of behavioral health disorders, as these beliefs and attitudes may potentially affect communications with patients.

Rationale

There is some evidence to suggest the clinician's faith in the treatment can be an important predictor of treatment response (Constantino, Ametrano & Greenberg, 2012; Finsrud, Nissen-Lie, Ulvenes, et al., 2022; Lewin, Peris, Bergman, et al., 2011). Unfortunately, treatment with medication has at times been associated with excessive optimism and skepticism (e.g., Kramer, 1993; Kronström, Karlsson, Nabi et al., 2013; Valenstein, 1998), and media and social media attention have exaggerated both positions. Psychologists will inevitably form their own opinions about medications. These opinions can, in turn, affect patients' decisions about taking a prescribed medication and even medication effectiveness if they are not addressed openly in the process of the psychologist and patient discussing psychopharmacological interventions.

Application

Psychologists who are aware of their beliefs and attitudes towards medications and who openly accept the possible validity of alternative viewpoints are in the best position to discuss the potential risks and benefits of using medication in a balanced manner with the patient. Psychologists are encouraged to explore their perceptions about medication

and to consider the possible role of those perceptions in discussions about pharmacotherapy with the individuals they serve. This supports the practice of shared decision making, which combines the patient's preferences with the psychologist's expertise and experience.

GUIDELINE 3

Psychologists involved in prescribing or collaborating in pharmacotherapy strive to be sensitive to the individual's developmental, age and aging, educational, sex and gender identity, disability status, socioeconomic, language, health status, and cultural/ethnicity factors that may moderate the interpersonal and biological aspects of pharmacotherapy relevant to the patients they serve.

Rationale

Principle E of the *Ethics Code* (APA, 2002/2010/2017) focuses on the importance of considering cultural and personal variables in the populations served. This standard takes on additional implications in the context of pharmacotherapy because individual differences may affect the interpersonal aspects of medication management, the effectiveness of the treatment, and its side effect profile. Issues that may be important include the following (Lin et al., 2001; Smith et al., 1999; Manias & Williams, 2010; Roberts et al., 2023):

1. Differences in presentation

- a. Both the physical and psychological presentation of emotional distress can vary across cultures (e.g., Atari-Khan et al., 2024; Carr, 1978; Chowdhury, 1996). This finding has led to controversy over whether any specific presentation is truly culture-bound or simply more prevalent in some cultural settings than others (Sakamoto et al., 2005) and whether such syndromes may be fully understood in terms of standard psychiatric diagnoses (e.g., Kriegl & Bester, 2014; Guarnaccia & Rogler, 1999). Such issues aside, it is important that clinicians be aware of the existence of cultural variants in presentation. Culture affects the experience of distress and its perceived causes, help-seeking behaviors, and may have an existential or religious meaning (Choudhry et al., 2016).
- b. Cultural factors affecting presentation are complex and involve the intersectionality of multiple social identities, so care must be taken not to rely on categorical or stereotypical ideas of symptom presentation when working with individual patients (Carrillo et al., 1999).

2. Differences in participation in treatment

- a. Psychosocial factors such as differences in help-seeking behaviors and symptom expression, beliefs about the doctor-patient relationship, and beliefs about healing may influence the interpersonal context of pharmacotherapy (Haller et al., 2016; Rey, 2006).
- b. Certain cultures encourage the use of alternative healing practices, including herbal and other folk and traditional remedies that can moderate the effectiveness and safety of psychotropic medications (Asakitikpi, 2022; Georg Jensen et al., 2024; Lin & Cheung, 1999; Lin et al., 2001). Directly addressing these concerns with patients, while honoring cultural beliefs and practices, can create an opportunity for understanding and compromise. Such consensus may increase safety and improve outcomes while maintaining respect for cultural healing practices (e.g., Cerqueira et al., 2025).
- c. Age, intellectual development, language barriers, formal education, challenges with numeracy, and disability of a patient may affect communications about and the ability to participate effectively in pharmacotherapy treatment (Bayard-Burfield et al., 2001; Flaskerud, 1986; Stephenson et al., 2019).
- d. The patient's level of health literacy, which has been defined as "the degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health decisions" (U.S. Department of Health and Human Services, 2000, pp. 11-20), can influence all aspects of treatment planning (Shahid et al., 2022).
- e. There is an interaction of age and gender such that treatment with psychotropics is more common in male children and female adults (Cerdeña et al., 2021; Maestri et al., 2021; Simoni-Wastila, 1998; Zito et al., 1998).

3. Differences in response to treatment

- a. Unique individual physiological factors related to cultural/ethnic status, age, and gender, such as genetic polymorphisms, dietary factors, and other lifestyle habits, may affect drug protein binding, metabolism, and clearance. These, in turn, can affect bioavailability and subsequent therapeutic and adverse effects (Campinha-Bacote, 2007; Cerdeña et al., 2021; Dawkins & Potter, 1991; Johnson, 1997; Maestri et al., 2021). For example, normal aging can affect how drugs are metabolized, requiring dose adjustments (Nicholson et al., 2024).
- » Limited diversity of participants in treatment trial samples can raise concerns about the generalizability of results across populations.

4. Differences in access to appropriate treatment

- a. Socioeconomic factors may affect treatment availability and the potential for sustained medication use. These can include both the cost of medication and the ability to participate effectively in treatment.
- b. Since women and ethnic/cultural minorities are over-represented among the impoverished, these groups may be particularly affected by a lack of access to and/or affordability of treatment (Vasiliadis, Roberge, Shen-Tu, & Vena, 2024).

Application

As the preceding list illustrates, the number and range of variables that can potentially moderate the process or outcome of pharmacotherapy are daunting, and no one psychologist can be expected to be familiar with all the potential variables. Psychologists who prescribe or collaborate strive to educate themselves on those factors that are particularly relevant for the individuals they serve regularly and are sensitive to the possible role of such factors in the pharmacological treatment of other groups as well. When clinicians work with patients or clients who are different from themselves, they recognize that the presentation or description of the clinical syndrome may reflect culturally specific referents and may not conform to those of the dominant group. Clinicians are also aware of personal factors that can influence the presentation of symptomatology and the interpretation of symptoms. In such instances, clinicians attempt to obtain information about presenting complaints in behavioral terms rather than in terms that could be misinterpreted or misunderstood. Clinicians avoid using unfamiliar or ambiguous terminology with patients. Whenever unfamiliar terminology or cultural referents are used in presenting complaints, psychologists are strongly encouraged to seek further explanation or consultation as needed to avoid misunderstanding.

The Cultural Formation Interview (Lewis-Fernandez et al., 2016) included in the *DSM-5* may be a valuable tool to assist with assessment when there are differences in cultural backgrounds between the clinician and the patient, or when there are difficulties discerning between cultural-specific factors and diagnosis, engagement in treatment, in disagreements between the clinician and the patient or understanding the severity of symptoms or impairment (Lewis-Fernandez et al., 2016).

Education

GUIDELINE 4

Psychologists are encouraged to assess the level of knowledge and training required to prepare for the desired role of pharmacotherapy in their practice (e.g., informational, consulting, or prescribing role) and to engage in educational experiences, including continuing education requirements, to maintain that level of knowledge.

Rationale

Where Guideline 1 emphasizes practicing within one's scope of competence, this practice guideline focuses on participation in continuing education activities that are appropriate for delivering optimal care to one's patients. Psychologists must have a basic knowledge of pharmacotherapy, as it is included in many state licensure exams. Various studies suggest most doctoral programs in professional psychology offer education about psychopharmacological interventions; however, the educational requirements are relatively limited in scope (Collins, 2000; Monti et al., 1983; Smyer et al., 1993). Foltz et al. (2024) obtained PhD and PsyD data from 216 of the 254 APA-accredited programs (85%). Of these, 66 programs (31%) required a course in psychopharmacology. For psychologists with prescriptive authority, state legislation will ultimately establish the minimum criteria for basic and continuing education, as well as the boundaries of acceptable practice. For example, the credentialed prescribing psychologist in New Mexico is required to complete 60 continuing education credits every two years, with 40 of those credits relating directly to pharmacology. The psychologist who engages in a collaborative or information-providing role operates under more ambiguous expectations about the appropriate degree of continuing education. The conceptualization of psychologists' involvement in pharmacotherapy in these guidelines as a continuum with three defined levels may help reduce this ambiguity.

Application

Psychologists are encouraged to consider the level and type of formal education and training, including continuing education, on psychotropic medications that would be appropriate for the patients they serve, recognizing that scientific and clinical information about pharmacotherapy is rapidly evolving. The range of options is greater for the psychologist without prescriptive authority, since often no mandated minimum training exists. In making judgments about how much training is important, psychologists who find themselves involved in collaborating or providing information may consider various factors,

including but not limited to the psychiatric and medical complexity of their patients, psychopharmaceutical and pharmaceutical medications taken by their patients, use of recreational drugs, polypharmacy, the ages of patients served, the severity of side effects of medications, and the degree to which specialized psychiatric care is available to their patients. For example, in communities where psychiatric services are unavailable, psychologists may have a stronger motivation to seek a level of education that will allow them to collaborate effectively with primary care providers.

As previously described, three levels of participation in pharmacotherapy have been defined: Level 1, providing information; Level 2, collaborating; and Level 3, prescribing (Smyer et al., 1993; see page 3 for further explanation). Kirby et al. (1997) proposed a curriculum to identify the additional didactic training needed to collaborate effectively (Level 2). However, education programs have not universally developed training specifically for Level 2 services by psychologists. Therefore, in practice, many psychologists interested in collaborating with prescribers pursue the didactic training associated with Level 3 without completing the experiential component. A revised description of the didactic and experiential training for Level 3 was updated and approved as APA policy in 2019 (APA, 2021). The APA policy provides guidance to psychologists seeking to identify the appropriate level of training for their intended or anticipated involvement in pharmacotherapy.

In August 2019, the APA Council adopted a revised version of the Designation Criteria for Education and Training Programs in Psychopharmacology for Prescriptive Authority (APA, 2021). In 2020, COR approved the application of the American Society for the Advancement of Pharmacotherapy (now named the Society for Prescribing Psychology), Division 55, recognizing clinical psychopharmacology as a specialty area, based on a recommendation from the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (APA, 2019). Psychologists and doctoral students in health service psychology programs who wish to acquire the competencies needed to prescribe competently are encouraged to complete the Master of Science in Clinical Psychopharmacology degree in an APA-designated program. Psychologists with prescriptive authority are encouraged to evaluate their need for initial and continuing education beyond the minimum defined in state statutes and/or regulations. Such a self-evaluation might involve consideration of special patient populations (e.g., children or the elderly), classes of medications, new drugs, novel mechanisms of action, treatment of side effects, the evaluation of contraindications, and other factors. Psychologists with prescriptive authority are encouraged to update their knowledge of current evidence-based treatment guidelines regularly, including the relative value of pharmacological, psychosocial, and combined interventions.

GUIDELINE 5

Psychologists strive to be knowledgeable about the potential for adverse effects associated with the use of psychotropic medications by their patients.

Rationale

Adverse effects of medication are widespread, and in some studies, represent the most common reason cited for premature termination of pharmacotherapy (e.g., Ashton et al., 2005; Brambilla et al., 2005; Semahegn et al., 2020). Iatrogenic medication effects can arise from several sources, including the patient's reaction to a medication protocol; the use of inappropriate medications or polypharmacy (Corvaisier et al., 2024); use of excessive dosages (Antonuccio et al., 2002); a problematic drug–drug and/or drug–diet interaction; a known or undiagnosed medical condition; or poor patient adherence with the medication schedule or dosing (Brown et al., 2006). Additionally, too often, low-probability adverse effects do not become evident until well after the medication has been approved by the U.S. Food and Drug Administration (FDA; Downing et al., 2017; Lasser et al., 2002). The possibility even exists that effects may not emerge until many years later.

Application

The prescribing psychologist strives to maintain access to current information about the side-effect profiles of the medications or combinations of medications they prescribe and uses this information in treatment planning and monitoring. This expectation does not apply to the psychologist providing psychotherapy to an individual receiving medication from another prescribing professional. However, it is important to remember that this psychologist typically sees the patient more frequently than the professional who is responsible for medication management and can therefore play a valuable role in the early detection of possible side effects. All psychologists are sensitive to the possibility that physical events after the initiation of medication may represent adverse events and either intervene or refer the patient for intervention as appropriate within their scope of practice. The prescribing psychologist is aware of the importance of evaluating adverse effects and of reporting serious events to the FDA when they occur, while other psychologists are aware of the importance of referring the individual to the prescribing professional when concerned about the possibility of an adverse event. Resources for identifying adverse events, drug–drug interactions and contraindications for medications include but are not limited to online services (<https://www.drugs.com>, <https://www.epocrates.com>, <https://www.uptodate.com>, <https://www.pdr.net>, www.guidelines.gov, www.cochrane.org, www.psychiatry.org) and standard pharmacology and toxicology texts such as Goodman & Gilman's *The Pharmacological Basis of Therapeutics*, the *Handbook of Clinical Psychopharmacology for Therapists* by Preston et al., *Stahl's Essential Psychopharmacology*, and *Lange's Basic & Clinical Pharmacology*.

GUIDELINE 6

Psychologists involved in prescribing or collaborating with prescribers are encouraged to familiarize themselves with the technological resources that may enhance decision making during treatment to mitigate potential risks and optimize outcomes.

Rationale

Pharmacotherapy is a dynamic and rapidly changing area of practice, especially as it relates to the awareness of positive and negative effects of various medications. Mastery of the relevant literature is difficult to achieve and maintain, especially when one considers such issues as drug–drug and drug–diet interactions. A range of electronic resources has emerged in recent years that many prescribing professionals find indispensable in their daily practice. Technological applications are even assisting prescribers with the often daunting and complex decisions associated with reducing risk, increasing adherence by patients, and optimizing outcomes in individuals with severe and chronic mental illness (Asmal & Kredo, 2023; Pillinger et al., 2023; van Dijk et al., 2022).

Application

Psychologists with prescriptive authority and those who are direct collaborators are urged to familiarize themselves with available technology used to improve accuracy in prescribing psychotropic medications (Aemissegger et al, 2022; Lennon & Harmer, 2023; Rathnam et al, 2024). The use of artificial intelligence and digital mental health technologies in patient care has influenced prescription selection and electronic medical record keeping (Chin et al, 2022; Smith et al., 2024). It is important to note, however, that technology offers a supplement to personal knowledge of pharmacotherapy literature and is not an alternative to being well-informed about current medications and practices. As always, patient data privacy and security should be protected and considered when utilizing these resources.

Assessment

GUIDELINE 7

Psychologists with prescriptive authority strive to familiarize themselves with key procedures for monitoring the physical and psychological sequelae of the medications used to treat psychological disorders, including laboratory examinations and overt signs of adverse or unintended effects.

Rationale

Methods of assessing medication effects and indications, positive and negative, represent a body of knowledge that is distinct from the literature devoted to the medications themselves. The psychologist with training in clinical psychopharmacology and/or prescriptive authority strives to remain current in both bodies of literature as a means of ensuring optimal patient care.

Application

Among the topics relevant to this guideline are knowledge of laboratory tests, normative ranges, test interpretation, variation in results across ethnicity and genders, and how often such tests are warranted, particularly in populations commonly served by the psychologist. When the psychologist with prescriptive authority encounters anomalies that indicate a medical health issue, they endeavor to ensure rapid and appropriate consultation with the patient's primary medical provider or another appropriate resource.

Equally important to assessing a patient to whom medication has been prescribed is a prescribing psychologist's knowledge and ability to conduct and interpret physical examinations, obtain and interpret laboratory values, and imaging. In practice, prescribers may also utilize feedback from psychological tests, outcome questionnaires, and checklists to enhance decision making. For example, a prescriber may use behavior checklists in the treatment of attention deficit hyperactivity disorder (ADHD) and validated patient questionnaires to evaluate response to pharmacotherapeutic treatment of depression and/or anxiety.

GUIDELINE 8

Psychologists with prescriptive authority regularly strive to monitor the physiological status of the patients they treat with medication, particularly when there is a physical condition that might complicate the response to psychotropic medication or predispose a patient to experience an adverse reaction.

Rationale

When serving as a prescriber, a psychologist is participating in the medical treatment of the patient. An important starting point for optimal medical care includes a thorough medical history, including subjective and objective complaints, diagnosis, and assessment and planning. The prescribing psychologist also attains competency in evaluating medication contraindications, prior therapeutic responses or side effects to a medication, and potential drug-drug interactions, as well as prevention and management of medication-related adverse reactions.

Application

Psychologists with prescriptive authority are encouraged to consider comorbid medical conditions that can complicate the primary diagnosis, course of treatment with behavioral therapy and/or pharmacotherapy, as well as possible drug-drug and drug-diet interactions. A thorough medical history that includes medical signs and symptoms, laboratory findings, and all medications (including over the counter, off-label prescriptions, vitamins, herbal supplements, and dietary agents) that the patient is taking can contribute a great deal to understanding the patient's current physiological status (Bayer et al., 2022; Beitman & Klerman, 1991; Gurley et al., 2022; Himmerich et al., 2021; Jarvis, 2019; McCance & Huether, 2018; Momen et al., 2022; Sammons & Schmidt, 2001; Sperry, 1995; Toader et al., 2024). Medication reconciliation and deprescribing of medications that pose a threat to the patient's health are key responsibilities of psychologists who prescribe.

Intervention and Consultation

GUIDELINE 9

Psychologists are encouraged to recommend medications in the context of a trusting relationship and, whenever possible, to employ a shared decision-making model.

Rationale

Historically, patients' communications of concerns about medication and adherence to recommended regimens have been relatively low. Olsson et al. (2006) reported that 42% of patients discontinued use of antidepressants within 30 days, and 72% stopped within 3 months. Treatment adherence to antipsychotic medication for patients treated for schizophrenia is equally concerning, with up to 50% of these patients being noncompliant in 1 year and 75% after 2 years (Sadok et al., 2005). Patients do not or cannot adhere with treatment for many reasons, including:

- a. lack of access to a prescribing provider;
- b. the financial and organizational challenges involved in seeing multiple health providers, only one of whom would be the prescriber;
- c. high costs of medications, particularly those that are newer and do not have generic versions available;
- d. ambivalence or fears about medication;
- e. distressing side effects;
- f. misinformation about the latency of the therapeutic effect;
- g. shame or self-consciousness about taking psychoactive medications;
- h. the perception (which can be valid but is sometimes mistaken) that the treatment is ineffective or insufficiently effective;
- i. concerns about medication changing their behavior, ways of thinking, or fundamental personality style; as well as
- j. fear of the prescriber's disapproval or worry that the prescriber will terminate the relationship (Grover et al., 2021; Velligan et al., 2017).

The patient's characteristic patterns of interpreting interpersonal situations inevitably play a role in the desire for medication, the reaction to the recommendation of medication, and compliance with the treatment regimen (e.g., Archioli et al., 2016; Brockman, 1990; O'Neill & Bornstein, 2001; Totura, Fields, & Karver, 2018).

Shared decision making enhances patient engagement and treatment adherence, improving trust and mitigating feelings of helplessness (Zisman-Ilani et al., 2021). In underserved communities, shared decision making facilitates communica-

tion strategies that account for cultural and socioeconomic factors, addressing issues such as stigma and medication alternatives (Reilly et al., 2024; Vega et al., 2021).

Nevertheless, while shared decision making empowers patients, the prescribing psychologist may face systematic and structural limitations to this model (Kaminskiy et al., 2021). This is important as there is a growing literature suggesting patients with mental health disorders may benefit from shared decision-making models (e.g., Aoki et al., 2019; Drake et al., 2010; Stein et al., 2013).

Application

The effectiveness of joint decision making can be enhanced when the patient's opinions are solicited about varied means of intervention, their effectiveness, and side effects (Chin et al., 2022; Correll, 2020; McIntyre et al., 2022; van Dijk et al., 2018; Yeo et al., 2021). The use of frequent outcome measurements can also be helpful (Jayasree et al., 2024). The psychologist with prescriptive authority is encouraged to consider a patient's excessive faith in the effectiveness of the medication, emotional reactions to the medication, and overt or passive resistance to the medication as clues to the patient's cognitive assumptions or characteristic patterns in interpersonal situations, or at least in interpersonal situations that involve health care professionals. These responses, and the hypotheses they generate about the patient, can help develop a shared decision-making model.

Suppose it is necessary to forego shared decision making because the patient cannot participate cognitively or is a danger to themselves or others. Then the psychologist attempts to engage in shared decision making with family members or the legal representative for the patient's care and begin shared decision making with the patient as soon as the patient can participate (Dell'Osso et al., 2020). Barriers to effective shared decision making include difficulties that patients may have in explaining mental health symptoms, the distractions of being in a hospital environment, and engaging all interested parties in the decision-making process (Giacco et al., 2018).

Finally, prescribing psychologists are sensitive to the potential for diversion of medications and will discuss this issue thoroughly with the patient whenever appropriate. Efforts to minimize medication diversion include the use of screening tools to evaluate risk of misuse; prescribing medications with longer half-lives, limiting the number of pills prescribed in between visits, discussing risks with patients, and establishing a schedule for tapering, switching or deprescribing medications with potential for tolerance (Tong et al., 2019; Brandt et al., 2024).

GUIDELINE 10

Psychologists with prescriptive authority strive to maintain follow-up on recommended medications that ensure the greatest level of cooperation by the patient, minimize side effects, and address patients' hesitation to consider psychotropic intervention because of previous adverse or ineffective intervention.

Rationale

Research on the timing of follow-up after initiation of psychotropic medications highlights the need for close monitoring within the first month to minimize adverse effects, make timely dosage adjustments, and encourage adherence through a caring, trusting patient-prescriber relationship (Shih-Yin et al., 2010). Intervals between when a medication is first prescribed and ongoing follow-up appointments vary and can range from days to months, depending on the medication and psychiatric condition being treated (see <https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines>). The American Association of Community Psychiatrists (n.d.) has developed guidelines for the level of care and utilization systems adopted by over 20 states that highlight the importance of considering the complexity of the condition, risk of serious adverse events, patient support network, and patient's ability to initiate self-reporting in determining frequency of follow-up. The FDA recommends frequent monitoring of all drugs with black box warnings, as indicated for many psychotropics. When working in institutional settings, the prescribing psychologist strives to inform the administration of the importance of individualizing frequency and length of appointments to the patient's individual needs while recognizing that the frequency of follow-up must be balanced with the number of patients that the psychologists need to see (Garcia-Perez, 2020). Research about prescribing psychologists' practice behaviors demonstrates a strong trend of frequent monitoring, often combining psychotherapy and medication management (Shearer et al., 2012; Linda & McGrath, 2017; Peck et al., 2021).

Application

One effective means for determining the frequency of appointments is to measure patient satisfaction and systematic symptom reduction throughout the treatment process. Patients can be requested to complete an outcome questionnaire as well as to report satisfaction before each or many appointments. Assessment and intervention using the stages-of-change model and motivational interviewing may be useful approaches to evaluating and addressing motivation for treatment (Beitman et al., 1994; Frost et al., 2018; Miller, 2023; Miller & Rollnick, 2002).

A recent addition to the New Mexico Prescribing Psychologist Act allows prescribing psychologists to supervise prescribing psychologist trainees (NM SB127; see <https://www.nmlegis.gov/Sessions/24%20Regular/bills/senate/SB0127.HTML>); other states have also included prescribing psychologists as supervisors in their prescriptive authority bills, but the majority of regulations require the supervisor to be a physician; in some cases, a licensed nurse practitioner may also provide supervision. Supervisors of clinical trainees are urged to consider supervisees as one of the populations for which this guideline is relevant to create an environment in which trainees may raise concerns about their patients' medications and to encourage trainees to address questions to their patients about their medications in a timely fashion. This guideline may be equally helpful for those psychologists who are actively collaborating with a prescriber as well as those psychologists prescribing medication(s).

GUIDELINE 11

To the extent deemed appropriate, psychologists involved in prescribing or collaboration are encouraged to consider adopting a biopsychosocial approach to case formulation that considers both psychosocial and biological factors.

Rationale

The biopsychosocial model for the understanding of human health (Bolton, 2023; Borrell-Carrió et al., 2004; Engel, 1977) represents the dominant model in the health care disciplines. At a minimum, this model suggests that psychosocial factors (including interpersonal, intrapersonal, gender, cultural, spiritual, and socioeconomic variables) play an important role in the etiology of and response to medical conditions as well as the recognition that psychoeducational and psychological services can be essential in coping with and recovering from illness. Within this broad perspective, there is much room for variation in the degree to which these different perspectives are considered important for understanding the nature of psychological disorders.

The prescribing or collaborating psychologist is encouraged to conduct a full evaluation of the patient's current condition, considering the psychological, biological, and social issues relevant to treatment. The concurrent provision of psychotherapy and medication management, either through direct prescribing or collaboration with a prescriber, is a functional extension of the biopsychosocial model. A biopsychosocial approach to prescribing or collaborating in medication decision making appropriate for psychologists would assume that behavioral, social, psychological, and educational interventions are treated as equal to, and in certain circumstances, perhaps more important than biological interventions. Indeed, evidence has emerged

that substantiates this assertion. For example, behavioral parent training and classroom behavior management, when implemented with integrity, yield effect sizes comparable to stimulants for the treatment of the core symptoms of attention-deficit/hyperactivity disorder and are superior to medication for functional outcomes in family, school, and peer settings (see Brown et al., 2008).

Fabiano et al. (2007) demonstrated that the amount of stimulant medication needed to maintain improvements in symptoms and classroom functioning among children with attention deficit disorder can be reduced when concurrent behavioral classroom management is provided. Combinations of psychosocial interventions, specifically cognitive behavioral therapy (CBT), and medication have also been shown to be more effective than either approach alone (Ojinnah et al., 2022). A large multi-site study found that effect sizes were comparable for cognitive-behavioral and drug therapy when treating pediatric anxiety (Walkup et al., 2008). A more recent study (Wang et al., 2017) suggests a combination of CBT and medication is most effective. Similar conclusions have been drawn concerning the relative efficacy of medication and psychotherapy for depression (Antonuccio et al., 1999; Cuijpers et al., 2020). Encouraging findings about the superiority of combined drug and psychosocial treatment over either drug or psychosocial treatment alone have also been reported for childhood anxiety (Walkup et al., 2008); adolescent major depression (Vitiello, 2009); major depressive disorder (Friedman et al., 2004; Guidi & Fava, 2020; Thase, 2003); and pediatric obsessive-compulsive disorder (Cervin et al., 2024). As encouraging as these findings are, additional research is needed to identify other conditions and populations for which psychosocial and drug interventions may be comparably effective or where psychosocial treatments may enable reductions in drug dosages. An ongoing responsibility for prescribing psychologists will be developing formal recommendations, including treatment guidelines, concerning the best integration of biological interventions into a broader psychological and social context of treatment.

Application

Psychologists actively involved in decision making about medication are encouraged to consider both the interpersonal/psychosocial and the biological aspects of treatment. Increasing hopefulness, reducing demoralization, and providing support represent elements of good patient care and maximize the potential for effective intervention (e.g., Costanza et al., 2022; Hernandez & Overholser, 2020). The psychologist will likely conclude that a sufficient biopsychosocial evaluation requires more time than is currently typical for medication management.

Psychologists with prescriptive authority will sometimes find themselves called upon to provide consultations to other health care providers solely for purposes of evaluating the patient for medication, for example, when on call or when asked to serve as a consultant to another professional who is providing

psychosocial services. Even under these circumstances, psychologists with prescriptive authority are encouraged to evaluate the clinical presentation from a biopsychosocial perspective to the extent possible. Even in emergency circumstances, or when the patient has an ongoing relationship with another mental health provider, the opportunity exists to consider psychosocial and interpersonal as well as biological issues and interventions. This can be an important tool for avoiding overreliance on medications even when psychologists are explicitly involved because of their prescriptive authority.

In summary, prescribing psychologists, or psychologists collaborating with prescribers, are encouraged to consider the evaluation and treatment of patients using a comprehensive biopsychosocial model. Such an approach is likely to require more time for the initial evaluation than would be needed for a separate biological/medical and psychological evaluation. The prescribing or collaborating psychologist is encouraged to consider the evidence for combined treatment, psychosocial intervention alone, or medication alone. When considering treatment options, the psychologist strives to weigh the relative risks, possible benefits, and potential for side effects inherent to each approach.

GUIDELINE 12

The psychologist with prescriptive authority is encouraged to use an expanded informed consent process to incorporate additional issues specific to their prescribing role.

Rationale

The *Ethics Code* (APA, 2002/2010/2017) requires psychologists to obtain informed consent before any professional interaction whenever possible. The decision to prescribe medication for a patient optimally results from collaboration between that patient and the psychologist, rather than from a unilateral decision by the prescriber. A collaborative decision depends upon the appropriate education of the patient about alternative treatments and fully informed consent. The informed consent process, particularly when pharmacotherapy is considered, is of sufficient importance that it necessitates a separate guideline. The prescribing psychologist takes care to include informed consent as a critical component of the shared decision-making model in Guideline 9.

Application

When medication is given voluntarily, full informed consent is the norm for all prescribing professions. Optimally, the elements of informed consent are discussed verbally between a psychologist and their patient, presented in writing, signed by both the patient and the psychologist, and placed in the patient's medi-

cal record. Even when the recipient of the intervention is not capable of giving informed consent, the psychologist with prescriptive authority should consider providing education about the medication at a level appropriate to the patient's cognitive ability. Psychologists in forensic settings may work with individuals who are unable or unwilling to provide informed consent. In these circumstances, it is incumbent upon the psychologist to be aware of both institutional rules and regulations and APA ethical expectations for how to manage the administration of medications in the absence of the individual's consent, which is to seek consent from a legal entity (e.g., parent, health care proxy, court).

The psychologist endeavors to provide the same level of education and disclosure to patients unable to provide informed consent about medication and its efficacy, iatrogenic effects, and medication procedures as they would for a patient capable of providing informed consent. The use of medication increases the universe of topics to be addressed as part of the informed consent process. Depending on the prescribing psychologist's practice and/or organization in which they work, the following is a sample of the sorts of topics a psychologist with prescriptive authority may choose to discuss with a patient or a patient's legal representative (including a health care proxy *ad litem*) in cases of involuntary treatment when pharmacotherapy is being considered as a treatment option (Grisso & Appelbaum, 1998):

1. Describing the agent to be used
2. Indicating the symptoms it is intended to address
3. Providing the rationale for the treatment relative to other treatment options. This may involve outlining alternatives to the recommended treatment, including a review of other medications that can be considered as well as nonpharmacological treatment options
4. When discontinuing or reducing levels of existing medication use, explain the reason for this course of action and address any concerns about the changes
5. Describing the benefits and potential risks of the proposed protocol, including both therapeutic and potential adverse effects of the medication
6. Estimating the duration and cost of treatment and the time to therapeutic effect. Simply indicating how long to remain on the medication has been found to reduce the rate of premature termination (Bull et al., 2002)
7. Providing information about relative or absolute contraindications for the treatment and possible drug interactions
8. Reviewing the risks associated with sudden, unilateral discontinuation of the medication
9. Explaining any indicated physical examination, laboratory tests, or requirements for ongoing therapeutic monitoring of drug levels
10. Offering appropriate references for further patient education in formats that are accessible to and understandable by the patient and their health care proxy

11. Describing the ongoing psychologist–patient partnership in deciding on medication changes (including titration) or criteria for termination of medication. This can involve orienting patients to the psychologist's new combined role of prescriber and psychotherapist
12. Remaining open and responsive to the patient's questions and concerns, including—at the patient's request and with appropriate consent—providing information and education to family members or significant other
13. Underscoring how psychopharmacology can be a key, but often not the exclusive, component of a successful treatment plan
14. Explaining why the combined use of psychotherapy and psychopharmacology is recommended over either intervention alone, describing how sessions will be structured to combine both, and estimating the expected time course for overall treatment
15. Inviting patient questions and concerns. Directly encouraging questions about the range of obstacles can be helpful, because patient concerns may include practical and financial as well as physical or psychological issues
16. Evaluating the patient's likelihood of adherence to the treatment selected

It is important to remember that acceptance does not imply agreement. Patients may accept the prescription with little or no intention of complying, mixed feelings about the treatment, or fully intending to comply. The psychologist with prescriptive authority is encouraged to look beyond patients' acceptance of the prescription to evaluate their likelihood of compliance with the treatment. As with any effective informed consent process, the psychologist with prescriptive authority seeks to address patients in ways congruent with their level of education and ability to understand. This may require prescribing psychologists' considering a patient's developmental status, health literacy, willingness to question an authority figure, and other factors. The collaborative agreement that emerges from the informed consent process can benefit from individual tailoring about any disability that might impair the patient's ability to give fully informed consent. When the prescribing psychologist is engaging in telepsychology services, the informed consent they strive to address any unique concerns related to the remote delivery of services.

Informed consent is a dynamic process to be revisited repeatedly throughout treatment, refreshing the patient's understanding of relevant issues and when substantive changes to the treatment agreement or process are being considered. Psychologists are encouraged to consider using a strategy such as the “teach-back” method, where patients are asked to explain in their own words what the provider has said (e.g., Talevski et al., 2020), to confirm patient comprehension and improve retention during the consent process. The process is best completed in an environment in which the patient feels safe to disagree with the psychologist, to pose questions, and to report concerns.

Relationships

GUIDELINE 13

Psychologists with prescriptive authority strive to maintain appropriate relationships with other providers of psychological services in their treatment of a shared patient.

Rationale

Various circumstances exist in which one mental health professional may refer to a psychologist for specialized services, with referral for a psychological assessment perhaps being the most common. The emergence of the psychologist with prescriptive authority will undoubtedly produce circumstances in which mental health professionals refer to a psychologist for purposes of medication consultation only. With this potential division of labor, there exists a risk of miscommunication, differences in interpreting a patient's issues, and differences in opinion about optimal interventions. Rivalry can also develop between clinicians with unintended iatrogenic effects that may result in a patient receiving "...contradictory messages about their diagnosis or treatment. Therapists must avoid competing for the role of primary treatment provider because it interferes with the collaborative process, and by extension, optimal patient care." (Feldman & Feldman, 1997).

Standard 10.04 of the *Ethics Code* (APA, 2002/2010/2017) emphasizes the importance of considering patient welfare and treatment issues when a psychologist provides therapy to a patient receiving mental health services elsewhere, which could include receiving medication management from another psychologist. The successful coordination of services and roles of a prescriber of psychiatric medication and a nonprescribing psychologist, as well as other ancillary health care professional roles, can have positive treatment implications for patients (Nestoros et al., 2006; Reist, 2022).

Application

Psychologists with prescriptive authority are encouraged to be alert to the potential for conflict when collaborating with nonprescribing colleagues. Ways to navigate this potential conflict to promote the welfare of patients can include maintaining frequent contact and/or working collaboratively to establish a comprehensive treatment plan that encompasses the activities of both providers. When a patient is shared by a prescribing psychologist and nonprescribing psychologist, providers strive to establish clear boundaries and expectations by coordinating, identifying, and communicating their separate and distinct roles to the patient.

GUIDELINE 14

Psychologists with prescriptive authority or acting in a collaborative or information-providing role with prescribers are encouraged to maintain appropriate relationships with nonpsychologist medical providers as part of a multidisciplinary team.

Rationale

Standard 3.09 of the *Ethics Code* (APA, 2002/2010/2017) highlights the importance of cooperation with other professionals in service to patients. Psychologists who prescribe, collaborate, or provide information about pharmacotherapy will, at times, find they are working together with other health care professionals, which may include traditional healers offering complementary medical treatments. Collaborating and information-providing psychologists often work in conjunction with prescribing providers from allied professions. Prescribing, collaborating, and information-providing psychologists are often serving patients who demonstrate comorbid medical conditions. Given the potential for drug-drug interactions and medical complications in such situations, collaboration with other health care providers actively involved in treating the patient can be critical. To date, all prescribing psychology regulations require some level of coordination and information sharing with medical primary care providers.

Application

The psychologist is encouraged to contact other health care providers involved in patient care, with appropriate authorization, and to establish clear guidelines regarding responsibilities within their overlapping functions. Psychologists with prescriptive authority update the patient's primary medical caregiver of the pharmaceutical treatment plan as appropriate. The psychologist with prescriptive authority is also encouraged to establish policies to prevent confusion or redundancy in roles played or the medications prescribed. When a transfer of care or consultation with another provider is indicated and/or requested by the patient, the psychologist with prescriptive authority is encouraged to seek appropriate communication between all parties and to ensure optimal continuity of care. Whenever a psychologist engages in the practice of pharmacotherapy, the psychologist is encouraged to maintain ongoing consultation with the patient's primary health care provider(s), consistent with relevant state requirements. The primary care provider may, in turn, be reminded to alert the psychologist to any changes in the patient's health status that could affect the patient's treatment by the psychologist, whether that treatment involves pharmacotherapy or psychosocial interventions.

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