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Guidelines Regarding Psychologists' Involvement in Pharmacological Issues

Division 55 (American Society for the Advancement of Pharmacotherapy)

Task Force on Practice Guidelines

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## 1 Guidelines Regarding Psychologists' Involvement in Pharmacological Issues

2 Several factors have converged that will inevitably increase psychologists' involvement in  
3 the medication management of the individuals they serve. One is the increasing use of  
4 psychotropic medications for the treatment of psychological disorders, a clinical practice which  
5 will be referred to as pharmacotherapy in this document. A national survey of physician records  
6 suggested the proportion of the population using antidepressants increased from 6.7% in 1990 to  
7 15.1% in 1998, an increase of 125.4% even after adjusting for population growth (Skaer, Sclar,  
8 Robison, & Galin, 2000). According to VandenBos and Williams (2000), practicing  
9 psychologists on average estimated that 43% of their current patients were using psychotropic  
10 medications. Another factor is the movement for prescriptive authority within psychology.  
11 Appropriately trained psychologists are now eligible for prescriptive authority in two states  
12 (Louisiana and New Mexico) as well as in the military. With similar legislative agendas  
13 emerging in a number of other states, the number of states offering prescriptive authority to  
14 psychologists will inevitably increase further.

15 In response to a series of articles describing the professional challenges faced by  
16 psychologists as they become prescribers (e.g., Antonuccio, Danton, & McClanahan, 2003;  
17 Buelow & Chafetz, 1996; DeLeon, Robinson Kurpius, & Sexton, 2001; McGrath et al., 2004), it  
18 was recognized in discussions among members of the American Psychological Association  
19 (APA) Division 55, the American Society for the Advancement of Pharmacotherapy, that the  
20 implications of the APA (2002b) *Ethical Principles of Psychologists and Code of Conduct* (the  
21 Ethics Code) specifically for psychologists' involvement in pharmacotherapy merited  
22 clarification. Beth Rom-Rymer, president of the division at that time, convened a task force to

23 explore the issue. Three of seven task force members were psychologists with prescriptive  
24 authority in the civilian or military sector. The task force also included representation from  
25 Division 18 (Psychologists in Public Service).

26 Members of the task force reviewed relevant literature and participated in formulating the  
27 content of the guidelines. The literature review began with a document titled *Policies of Other*  
28 *Organizations and Background Materials: Pharmaceutical Marketing, Gifts, and Financial*  
29 *Support* (APA, 2002c), which provided primary sources addressing the relationship between  
30 prescribing professionals and the pharmaceutical industry. This document was updated with  
31 more recent publications on the topic. Medicine, nursing, pharmacy, and the pharmaceutical  
32 industry have all generated guidelines relevant to the objective practice of pharmacology. These  
33 were reviewed as well. Finally, the task force considered specific implications of the APA's  
34 (2002b) Ethics Code for psychologists' involvement in the practice of pharmacotherapy.

35 The guidelines presented in this document are intended to provide a resource to  
36 psychologists interested in the issue of what represents optimal practice in relation to  
37 pharmacotherapy. They are not intended to apply to those psychologists who may choose not to  
38 become directly or indirectly involved in medication management regardless of their level of  
39 competency. As background to these guidelines, it may be noted that psychologists' activities  
40 reflect three different levels of involvement in pharmacotherapy. The first level occurs when the  
41 psychologist serves as the prescriber. As indicated above, psychologists currently can only  
42 prescribe in the U.S. military and in two states. The population of psychologists with prescriptive  
43 authority is therefore small, but is one that is sure to increase in size in the coming years. It  
44 should be noted that some psychologists prescribe only through a second license, for example, as

45 a nurse practitioner or physician. Such individuals determine for themselves the degree to which  
46 the guidelines presented here for prescribing are relevant to their activities.

47 The second level occurs when psychologists actively collaborate in medication decision-  
48 making. The psychologist is not ultimately responsible for the decision that is made in these  
49 circumstances, but does play a substantive role in the decision-making process. VandenBos and  
50 Williams (2000) found that 87% of their sample of practicing psychologists reported they had  
51 been involved in the decision to prescribe medication for at least one of the patients on their  
52 caseloads. However, it is unclear what role they played in the decision, especially since over  
53 80% also indicated this was not a frequent occurrence. On the other hand, 7% of respondents  
54 indicated they participated in the decision to prescribe for more than half their patients,  
55 suggesting that they were consistently and perhaps formally involved in decisions about the  
56 appropriateness of medications for their patients. This might for example include making  
57 recommendations concerning specific classes of medications to be used or even specific  
58 medications, dosing, or other aspects of the treatment regimen, though the prescribing  
59 professional maintains ultimate responsibility for the decision.

60 The third, and probably most common, level of involvement occurs when psychologists are  
61 providing information in the process of pharmacotherapy. Examples of providing information  
62 include reporting concerns about the treatment to the prescribing professional, referring patients  
63 for a medication consult, pointing patients to vetted referral or information sources, or discussing  
64 with patients how to address their concerns about the medication with the prescriber. The third,  
65 and probably most common, level of involvement occurs when psychologists provide  
66 information that may be relevant to pharmacotherapy decision-makers. The information-  
67 providing psychologist may offer opinions relevant to the pharmacotherapy, but does not play a

68 formal role in the decision-making process. It is likely that many of those psychologists who  
69 indicated to VandenBos and Williams (2000) that they were infrequently involved in the  
70 decision to prescribe did so in an information-providing role. Table 1 summarizes the  
71 characteristics of the three roles.

72 Some of the guidelines presented in this document are targeted specifically at the population  
73 of psychologists with prescriptive authority. Others are considered relevant in any case where the  
74 psychologist is actively involved in decision-making, whether as a prescriber or collaborator.  
75 Still others are considered applicable any time a psychologist is involved in the practice of  
76 pharmacotherapy whether as a prescriber, collaborator, or information provider. Given the  
77 unique elements of the population of psychologists who can prescribe on the one hand, and the  
78 frequency with which psychologists participate in collaborative and information-providing  
79 activities on the other, it was considered important to provide guidelines appropriate to each set  
80 of activities. However, it is important to recognize that a principle of optimal practice may have  
81 different implications in the context of active participation versus providing information.

82 Technology-based alternatives to face-to-face contact with patients are proving particularly  
83 useful in the conduct of pharmacotherapy (Hyler, Gangure, & Batchelder, 2005). The telephone  
84 has dramatically affected the nature of interactions with patients; videoconferencing can expand  
85 these options even further, particularly in rural areas. E-prescribing and e-mail correspondence  
86 between patients and providers regarding medication will be used more and more as a  
87 mechanism for service delivery. For example, prescription renewal can often be safely and  
88 efficiently accomplished without face-to-face contact between the prescribing professional and  
89 the patient. These guidelines can be considered relevant across all modalities of contact.

## 90 Standards versus Guidelines

91 To clarify the goals of the present document, it is worth summarizing the differences among  
92 *treatment guidelines* (or *clinical guidelines*), *standards*, and *practice guidelines*. Treatment  
93 guidelines provide recommendations for clinical interventions that are usually specific to a  
94 certain disorder and/or method of treatment (APA, 2002a). Practice guidelines and standards  
95 differ from treatment guidelines in that they have to do with general professional conduct in a  
96 particular domain of psychological practice. Practice guidelines refer to statements that suggest  
97 or recommend general principles of optimal behavior or conduct for psychologists. Guidelines  
98 differ from standards in that standards are mandatory and may be accompanied by an  
99 enforcement mechanism. Guidelines are instead aspirational in intent. They are intended to  
100 facilitate the continued systematic development of the profession and to help encourage a high  
101 level of professional practice by psychologists. Guidelines are not intended to be mandatory or  
102 exhaustive and may not be applicable to every professional or in every clinical situation. They  
103 are not definitive and they are not intended to take precedence over the judgment of  
104 psychologists.

105 Given the degree to which involvement in pharmacotherapy represents a new activity for  
106 psychologists, and the level of controversy that has surrounded the use of psychotropic  
107 medications in general and the prescriptive authority movement for psychologists in particular, it  
108 is tempting to proscribe or mandate certain behaviors or professional practices associated with  
109 pharmacotherapy. This is not the intention of the present document. The task force speculated  
110 that at some point psychologists may decide it would be judicious to establish standards specific  
111 to the conduct of pharmacotherapy. However, such a decision at this time would be premature  
112 given the nascent state of prescriptive practice in psychology.

113 Finally, nothing in these guidelines is intended to contravene any limitations set on  
114 psychologists' activities based on ethical standards, federal or local statutes or regulations, or—  
115 for those psychologists who work in agency and public settings—the policies of those agencies  
116 in which they provide services. As in all other circumstances, psychologists must be aware of the  
117 standards of practice for the jurisdiction or setting in which they function and comply with those  
118 standards.

119 In particular, psychologists who participate in collaboration and providing information  
120 should be aware of local statutory and regulatory language or opinions by the state board of  
121 psychology concerning their involvement in pharmacotherapy and the use and interpretation of  
122 laboratory tests. Fourteen jurisdictions have explicitly identified certain activities related to  
123 medication management as within the scope of practice of psychology—California, District of  
124 Columbia, Florida, Louisiana (for psychologists without prescriptive authority), Maine,  
125 Massachusetts, Missouri, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Tennessee,  
126 and Texas—though the description of permitted activities and circumstances under which they  
127 are permitted varies. In contrast, several states have passed legislation prohibiting discussion of  
128 medication by school personnel (including psychologists employed by schools). Even so, the  
129 legal status of involvement in pharmacotherapy for psychologists who cannot prescribe remains  
130 an open question in other jurisdictions.

### 131 The Guidelines

132 The list of guidelines, with the types of activities for which each is relevant, may be found in  
133 Table 2.

134 **General**

135 ***Guideline 1. Psychologists are encouraged to consider objectively the scope of their***  
136 ***competence in pharmacotherapy and to seek consultation as appropriate before offering***  
137 ***recommendations about psychotropic medications.***

138 *Rationale.* Ethical standard 2.01 of the APA (2002b) Ethics Code indicates psychologists  
139 provide services within the boundaries of their competence. Two factors complicate  
140 psychologists' efforts to comply with this standard in the context of pharmacotherapy. The first  
141 factor is pressure exerted on psychologists to serve in a collaborative or information-providing  
142 role. Patients or family members who find it difficult or uncomfortable to request information  
143 from the prescriber may look to the psychologist with whom they have established a therapeutic  
144 relationship for specific advice. Primary care physicians and other prescribers with limited  
145 specialized training in psychological disorders and their treatment, or who do not know the  
146 patient as well as the psychologist does, sometimes look to the psychologist for input on the  
147 choice of medication.

148 The second factor affects psychologists at all three levels of involvement, that being the  
149 rapidly evolving nature of treatment guidelines in pharmacotherapy. While the psychologist with  
150 prescriptive authority faces a statutory obligation to remain current, their level of expertise can  
151 vary across treatment populations and classes of medications. The psychologist asked to serve in  
152 a collaborative or information-providing role has no similar statutory obligation, though APA  
153 has established educational expectations for the psychologist who serves in a collaborative role  
154 (American Psychological Association Board of Educational Affairs Working Group on  
155 Psychopharmacology Education and Training; 1997).<sup>1</sup> These factors can combine to create a

156 situation in which psychologists can feel pressured to discuss their patients' treatment with  
157 medication at a level beyond their expertise.

158 *Implications.* Psychologists are encouraged to evaluate objectively their level of competence  
159 for addressing questions raised by other professionals, patients, or significant others. At any level  
160 of involvement in pharmacotherapy, psychologists clarify their role in the process and admit the  
161 limits of their own competence when appropriate, up to and including refusing to offer an  
162 opinion if the psychologist objectively considers doing so to be inappropriate. Particularly when  
163 asked to serve as prescribers or collaborators, psychologists are encouraged to consider the  
164 extent to which their beliefs about the appropriate course of action comes from reliable sources  
165 (such as peer-reviewed journals or reputable summaries of that literature) or from potentially  
166 biased or unreliable sources (such as unfamiliar websites, sales representatives, advertisements,  
167 or casual conversations with colleagues who may be relying on the same unreliable sources of  
168 information). It is important to remember that research suggests health care providers can be  
169 susceptible to relying on easily accessible sources of information even when the source of that  
170 information is potentially unreliable (Haug, 1997).

171 ***Guideline 2. Psychologists are urged to evaluate their own feelings and attitudes about the role***  
172 ***of medication in the treatment of psychological disorders, as these feelings and attitudes can***  
173 ***potentially affect communications with patients.***

174 *Rationale.* There is some evidence to suggest the clinician's faith in the treatment can be an  
175 important predictor of treatment response (Jacobson & Hollon, 1996). Unfortunately, treatment  
176 with medication has at times been associated with both excessive optimism and skepticism (e.g.,  
177 Kramer, 1993; Valenstein, 1998), and both positions have been exaggerated by media attention.  
178 Psychologists will inevitably form their own opinions about medications. These opinions can in

179 turn affect patients' decisions about taking a prescribed medication, and even medication  
180 effectiveness, if they are not addressed openly in the process of discussing  
181 psychopharmacological interventions.

182 *Implications.* Psychologists who are aware of their attitudes and feelings towards  
183 medications, and who openly accept the possible validity of alternative viewpoints, are in the  
184 best position to discuss the potential risks and benefits of using medication in a balanced manner.  
185 Psychologists are encouraged to explore their own feelings about medication, and to consider the  
186 possible role of those feelings in discussions about pharmacotherapy with the individuals they  
187 serve.

188 ***Guideline 3. Psychologists involved in prescribing or collaborating are sensitive to the***  
189 ***developmental, age and aging, educational, sex and gender, language, health status, and***  
190 ***cultural/ethnicity factors that can moderate the interpersonal and biological aspects of***  
191 ***pharmacotherapy relevant to the populations they serve.***

192 *Rationale.* Principle E of the Ethics Code (APA, 2002b) focuses on the importance of  
193 considering cultural and personal variables in the populations served. This standard takes on  
194 additional implications in the context of pharmacotherapy, because individual differences can  
195 affect the interpersonal aspects of medication management, the effectiveness of the treatment,  
196 and its side-effect profile. Issues that can be important include the following (Lin, Smith, &  
197 Ortiz, 2001; Smith, Mendoza, & Lin, 1999; U.S. Department of Health and Human Services,  
198 2001):

- 199 1. Differences in presentation:
  - 200 a. Both the physical and psychological presentation of emotional distress can vary across  
201 cultures (e.g., Carr, 1976; Chowdhury, 1996). This finding has led to controversy over

202 whether any specific presentation is truly culture-bound or simply more prevalent in  
203 some (Sakamoto, Martin, Kumano, Kuboki, & al-Adawi, 2005), and whether such  
204 syndromes can be fully understood in terms of standard psychiatric diagnosis (e.g.,  
205 Guarnaccia & Rogler, 1999). Such issues aside, it is important that clinicians be aware of  
206 the existence of such cultural variants in presentation.

207 2. Differences in participation in treatment:

- 208 a. Psychosocial factors such as differences in help-seeking behaviors and symptom  
209 expression, beliefs about the doctor-patient relationship, and beliefs about healing can  
210 influence the interpersonal context of pharmacotherapy.
- 211 b. Certain cultures encourage the use of alternative healing practices including herbal and  
212 other folk and traditional remedies that can moderate the effectiveness and safety of  
213 psychotropic medications.
- 214 c. Age, intellectual development, language barriers, level of formal education, problems  
215 with numeracy, and disability can affect communications about and the ability to  
216 participate effectively in pharmacotherapy.
- 217 d. The patient's level of health literacy, which has been defined as "the degree to which  
218 individuals have the capacity to obtain, process, and understand basic health information  
219 and services needed to make appropriate health decisions" (U.S. Department of Health  
220 and Human Services, 2000, p. 11-20), are considered in all aspects of treatment planning.

221 3. Differences in response to treatment:

- 222 a. Biological correlates of cultural/ethnicity status, age, and gender, such as genetic  
223 polymorphisms, dietary factors, and other lifestyle habits may affect drug protein

224 binding, metabolism and clearance. These can in turn affect bioavailability and  
225 subsequent therapeutic and adverse effects.

226 4. Differences in access to appropriate treatment:

227 a. Socioeconomic factors can affect treatment availability and adherence. These can include  
228 both the cost of medication and the ability to participate in treatment effectively.

229 b. Limited diversity in treatment trial samples can raise concerns about the generalizability  
230 of results across populations.

231 *Implications.* As the preceding list illustrates, the number and variety of person variables that  
232 can potentially moderate the process or outcome of pharmacotherapy is daunting, and no one  
233 person can be expected to be familiar with all potential moderators. Psychologists who prescribe  
234 or collaborate strive to educate themselves on those factors that are particularly relevant for  
235 populations of individuals they serve on a regular basis, and are sensitive to the possible role of  
236 such factors in the psychopharmacological treatment of other groups as well. When clinicians  
237 work with patients or clients from different linguistic, ethnic, or cultural groups, clinicians  
238 recognize that the presentation or description of the clinical syndrome may reflect culturally-  
239 specific referents and may not conform to those of the dominant group. In such instances,  
240 clinicians attempt to obtain information about presenting complaints in behavioral terms rather  
241 than in terms that could be misinterpreted. Clinicians avoid the use of unfamiliar or ambiguous  
242 terminology with clients. Whenever unfamiliar terminology or cultural referents are used in  
243 presenting complaints, further explanation or as needed consultation is sought to avoid  
244 misunderstanding.

245 **Education**

246 *Guideline 4. Psychologists are urged to identify a level of knowledge concerning*  
247 *pharmacotherapy for the treatment of psychological disorders that is appropriate to the*  
248 *populations they serve and the type of practice they wish to establish, and to engage in*  
249 *educational experiences as appropriate to achieve and maintain that level of knowledge.*

250 *Rationale.* Where Guideline 1 focused on practicing within one's scope of competence, this  
251 guideline focuses on involvement in continuing education activities that are appropriate for  
252 providing optimal care to one's patients. Various studies suggest most doctoral programs in  
253 professional psychology offer training in psychopharmacological interventions, but the  
254 educational requirements are fairly limited in scope (Collins, 2000; Monti, Wallander, &  
255 Delancey, 1983; Smyer et al., 1993). For the psychologist with prescriptive authority, state  
256 legislation will ultimately establish the minimum criteria for basic and continuing education and  
257 the boundaries of acceptable practice. The psychologist who at times plays a collaborative or  
258 information-providing role operates under more ambiguous expectations about the appropriate  
259 degree of continuing education. At this time only one state mandates continuing education in  
260 psychopharmacology as a condition for maintaining licensure.

261 *Implications.* Psychologists are encouraged to consider what level of formal education and  
262 training about psychotropic medications would be appropriate to the populations they serve,  
263 recognizing that scientific and clinical information about pharmacotherapy is rapidly evolving.  
264 The range of options is greater for the psychologist without prescriptive authority, since there is  
265 often no mandated minimum training. In making judgments about how much training is  
266 important, psychologists who find themselves involved in providing information may consider  
267 various factors, including:

- 268 1. The proportion of their patients receiving psychotropic medication.
- 269 2. The severity of side effects associated with those medications.
- 270 3. The ages of the individuals they serve.
- 271 4. The degree to which specialized psychiatric care is available to their patients. For example, in
- 272 communities where psychiatric services are unavailable, the psychologist may experience a
- 273 stronger motivation to seek a level of education that will allow him or her to collaborate
- 274 effectively with primary care providers.

275 The three levels of participation in pharmacotherapy—prescribing, collaborating, and

276 providing information—parallel the three levels of education and training that have been

277 suggested for training in pharmacotherapy for psychologists (Smyer et al., 1993). Level 1

278 represents basic education in pharmacotherapy, with the expectation that this level of education

279 can be obtained through a single graduate-level course. The APA Board of Educational Affairs

280 provides a model curriculum for such a course (Kilbey et al., 1995). Level 2 is specifically

281 intended to represent the level of education and training appropriate for active collaboration with

282 prescribers in decision-making about medication. A similar didactic curriculum has been

283 generated to identify the additional didactic training beyond Level 1 considered appropriate for

284 this role (Kilbey et al., 1997). Since programs have not developed specifically for purposes of

285 Level 2 training, in practice many psychologists interested in collaborating with prescribers

286 pursue the didactic training associated with Level 3 without completing the experiential

287 component. At present, a revised description of the didactic and experiential training for Level 3

288 is in development, and should represent APA policy by the time these guidelines are completed.

289 These documents provide guidance to psychologists seeking to identify the appropriate level of

290 training for their intended or anticipated involvement in pharmacotherapy.

291 Psychologists with prescriptive authority are encouraged to evaluate their need for initial and  
292 continuing education beyond the minimum defined in statute or regulations. Such an evaluation  
293 might involve consideration of patient populations, classes of medications, treatment of side  
294 effects, the evaluation of contraindications, and other factors.

295 ***Guideline 5. Psychologists strive to be sensitive to the potential for adverse effects associated***  
296 ***with the psychotropic medications used by their patients.***

297 *Rationale.* Adverse effects of medication are widespread and in some studies represent the  
298 most common reason cited for premature termination of pharmacotherapy (e.g., Ashton,  
299 Jamerson, Weinstein, & Wagoner, 2005; Brambilla, Cipriani, Hotopf, & Barbui, 2005;  
300 Kampman & Lehtinen, 1999). Iatrogenic medication effects can arise from a number of sources,  
301 including the patient's reaction to a medication protocol, a drug-drug interaction, a drug-diet  
302 interaction, a known or undiagnosed medical condition, or poor patient adherence with the  
303 medication schedule or dosing (Brown, Frost, Ko, & Woosley, 2006). Newly introduced  
304 medications may prove to be associated with unexpected adverse effects. Often, these adverse  
305 effects are not identified until well after the medication has received Food and Drug  
306 Administration approval (Lasser et al., 2002). The possibility even exists that effects may not  
307 emerge until many years later, particularly in developmentally immature patients.

308 *Implications.* The prescribing psychologist strives to maintain access to current information  
309 about the side effect profiles of the medications he or she prescribes, and uses this information in  
310 treatment planning and monitoring. This expectation does not apply to the psychologist  
311 providing psychotherapy to an individual receiving medication from another prescribing  
312 professional. However, it is important to keep in mind that this psychologist typically sees the  
313 patient more frequently than the professional who is responsible for medication management,

314 and can therefore play a useful role in the early detection of possible side effects. All  
315 psychologists are sensitive to the possibility that physical events subsequent to the initiation of  
316 medication can represent adverse events, and either intervene or refer the patient for intervention  
317 as appropriate within their scope of practice. The prescribing psychologist is aware of the  
318 importance of evaluating adverse events and of reporting such events when they occur, while  
319 other psychologists are aware of the importance of referring the individual to the prescribing  
320 professional when concerned about the possibility of an adverse event.

321 ***Guideline 6. Psychologists involved in prescribing or collaborating are encouraged to***  
322 ***familiarize themselves with the technological resources that can enhance decision-making***  
323 ***during the course of treatment.***

324 *Rationale.* The practice of pharmacotherapy is undergoing rapid change as information is  
325 gathered about the positive and negative effects of various medications. Mastery of the relevant  
326 literature is difficult to develop and maintain, especially when one considers such issues as drug-  
327 drug and drug-diet interactions. A range of electronic resources has emerged in recent years that  
328 many prescribing professionals find indispensable in their daily practice.

329 *Implications.* Psychologists with prescriptive authority and direct collaborators are urged to  
330 familiarize themselves with Internet and other resources (e.g., [www.guidelines.gov](http://www.guidelines.gov),  
331 [www.cochrane.org](http://www.cochrane.org)) that offer critically evaluated synthesized information about the effective  
332 practice of pharmacotherapy. In terms of daily practice, psychologists with prescriptive authority  
333 and psychologists who directly collaborate in medication decision-making are well-served by  
334 products now available for computers and/or personal digital assistants which offer extensive and  
335 frequently updated information about pharmaceutical agents. This software offers a supplement  
336 to personal knowledge of the pharmacotherapy literature, not an alternative.

337 **Assessment**

338 *Guideline 7. Psychologists with prescriptive authority strive to familiarize themselves with key*  
339 *procedures for monitoring the physical and psychological sequelae of the medications used to*  
340 *treat psychological disorders, including laboratory examinations and overt signs of adverse or*  
341 *unintended effects.*

342 *Rationale.* Methods of assessing medication effects and indications, both positive and  
343 negative, represent a body of knowledge that is distinct from the literature devoted to the  
344 medications themselves. The psychologist with prescriptive authority strives to remain current in  
345 both bodies of literature as a means of ensuring optimal patient care.

346 *Implications.* Among the topics relevant to this guideline are knowledge of laboratory tests,  
347 normative ranges, test interpretation, and how often such tests are warranted, particularly in the  
348 populations served. When the psychologist with prescriptive authority encounters anomalies that  
349 indicate a medical health issue, the psychologist endeavors to ensure rapid and appropriate  
350 consultation with the patient's primary medical caregiver or another appropriate resource.

351 Though existing guidelines for training and education in psychopharmacology for  
352 psychologists (APA, 2007) highlight the importance of training in physical examination, and  
353 such training is considered valuable when the psychologist interprets the results of a physical  
354 examination, no position is offered here concerning the appropriate level of involvement of the  
355 psychologist with prescriptive authority in the practice of physical assessment. This is a matter  
356 for the psychologist with prescriptive authority to consider in light of the nature of his or her  
357 practice, the population served, the potential impact of the psychologist's conducting a physical  
358 examination on therapeutic interactions, and local statutory and regulatory limitations.

359 Psychologists are also sensitive and responsive to concerns expressed about physical  
360 examinations, particularly in the case of pediatric patients or members of certain cultural groups.

361 The extent to which it will be appropriate for psychologists to integrate psychological tests  
362 into prescriptive practice is unclear at this time. An extensive literature exists supporting the use  
363 of psychological tests for diagnosis and psychotherapeutic treatment planning (e.g., Beutler,  
364 Malik, Talebi, Fleming, & Moleiro, 2004). In contrast, comparatively few studies have  
365 specifically evaluated the use of such tests to enhance the quality of decision-making in  
366 pharmacotherapy, but it is a potentially fruitful avenue for future efforts.

367 ***Guideline 8. Psychologists with prescriptive authority regularly strive to monitor the***  
368 ***physiological status of the patients they treat with medication, particularly when there is a***  
369 ***physical condition that might complicate the response to psychotropic medication or***  
370 ***predispose a patient to experience an adverse reaction.***

371 *Rationale.* When serving as a prescriber, a psychologist is participating in the medical  
372 treatment of the patient at a level previously unparalleled in the history of psychology. A  
373 thorough medical history, including prior adverse responses to medication, represents an  
374 important starting point for optimal medical care and for avoiding adverse reactions.

375 *Implications.* Psychologists with prescriptive authority are encouraged to consider co-morbid  
376 medical conditions that can complicate the course of treatment with pharmaceutical agents, as  
377 well as possible drug-drug and drug-diet interactions. These relationships at times can be quite  
378 complicated. A thorough medical history that includes all other medications (over the counter,  
379 herbal, and dietary agents) that the patient is taking can contribute a great deal to understanding  
380 the patient's current physiological status (Beitman & Klerman, 1991; Sammons & Schmidt,  
381 2001; Sperry, 1995).

382 ***Guideline 9. Psychologists are encouraged to explore issues surrounding patient adherence***  
383 ***and feelings about medication.***

384 *Rationale.* Adherence rates in pharmacotherapy are quite poor. Olfson, Marcus, Tedeschi,  
385 and Wan (2006) found 42% of patients discontinue use of antidepressants within 30 days; 72%  
386 stopped within three months. Patients do not, choose not to, or cannot adhere with treatment for  
387 many reasons including lack of access; ambivalence or fears about the medication; distressing  
388 side effects; misinformation about the latency of the therapeutic effect; shame or self-  
389 consciousness about taking psychoactive medications; the perception (which can be valid but is  
390 sometimes mistaken) that the treatment is ineffective or insufficiently effective; and concerns  
391 about medication changing their behavior or ways of thinking. As a result, many patients receive  
392 less than optimal benefit from their medication (Mitchell, 2006). The frequent contact between  
393 psychologist and patient that characterizes traditional psychological treatment provides a setting  
394 for monitoring patient feelings about the medication and willingness to continue.

395 *Implications.* This guideline is not intended to imply any recommendation concerning the  
396 frequency of inquiry into patients' reactions to or use of their medications, particularly in the  
397 case of psychologists who serve only in an information-providing role. At the least, it does  
398 suggest that when the psychologist perceives ambivalence or negative feelings about the  
399 medication, the psychologist can play an important role in monitoring this aspect of the patient's  
400 treatment more closely and deciding on an appropriate course of action. This can be particularly  
401 important when working with families, if parents/caregivers demonstrate conflicting views about  
402 the medication among themselves, or if a pediatric patient disagrees with the views of the  
403 parents/caregivers. Finally, psychologists are sensitive to the potential for diversion of

404 medication and misrepresentation of its use in the case of stimulants and other drugs with resale  
405 value.

#### 406 **Intervention and Consultation**

407 ***Guideline 10. Psychologists are urged to develop a relationship that will allow the populations***  
408 ***they serve to feel comfortable exploring issues surrounding medication use.***

409 *Rationale.* This guideline is intended to complement the previous one. A sizeable proportion  
410 of patients who terminate medication treatment prematurely do so without informing the  
411 prescribing professional of this decision, and may even report continued use of the medication to  
412 the prescriber (e.g., Maddox, Levi, & Thompson, 1994). Research consistently demonstrates the  
413 communication style of the provider is a significant predictor of adherence to medication  
414 (Bultman & Svarstad, 2000; Di Matteo, 2003). Whether the psychologist serves as a prescriber,  
415 collaborator, or information provider, the effectiveness of monitoring attitudes concerning and  
416 adherence to prescribed medications depends on the degree to which the patient perceives the  
417 relationship with the psychologist as one that allows for such discussion.

418 *Implications.* In any exchange concerning medication, the psychologist may want to consider  
419 the potential impact of moderating factors that can interfere with the free flow of information,  
420 such as intellectual, development, emotional, interpersonal, or cultural factors. When a  
421 psychologist serves in the role of prescriber, this can include reticence on the part of the patient  
422 to express uncertainties about their adherence to the medication regimen. Assessment and  
423 intervention using the stages-of-change model and motivational interviewing may be useful  
424 approaches to evaluating and addressing motivation for treatment (Beitman et al., 1994; Miller &  
425 Rollnick, 2002).

426 Psychologists in general can help create such an environment by simply monitoring the  
427 patient's use of and concerns about their medications. This may involve posing specific  
428 questions to evaluate the level of adherence in as non-stressful a manner as possible, promoting  
429 adherence when it is sub-optimal, and normalizing the patient's concerns about medication. It is  
430 left to the psychologist to evaluate what is the appropriate level of inquiry for each patient.  
431 Supervisors of clinical trainees (practicum students, interns, etc.) are urged to consider  
432 supervisees as one of the populations for which this guideline is relevant, to create an  
433 environment in which trainees can raise concerns about their patients' medications, and to  
434 encourage trainees to address questions to their patients about their medications at appropriate  
435 points.

436 ***Guideline 11. To the extent deemed appropriate, psychologists involved in prescribing or***  
437 ***collaboration adopt a biopsychosocial approach to case formulation that considers both***  
438 ***psychosocial and biological factors.***

439 *Rationale.* The biopsychosocial model for the understanding of human health (Engel, 1977)  
440 represents the dominant model in the healthcare disciplines. At a minimum, this model suggests  
441 that psychosocial factors (including interpersonal, intrapersonal, cultural, spiritual, and socio-  
442 economic variables) play an important role in the etiology of and response to medical conditions,  
443 as well as the recognition that psychoeducational and psychological services can be essential in  
444 coping with and recovering from illness. Within this broad perspective, there is much room for  
445 variation in the degree to which these different perspectives are considered important for  
446 understanding the nature of psychological disorders.

447 The prescribing or collaborating psychologist conducts a full evaluation of the patient's  
448 current condition in light of the psychological and social issues relevant to treatment. It would

449 seem that a biopsychosocial approach to prescribing or collaborating in medication decision-  
450 making that is appropriate for psychologists would be based on the assumption that behavioral,  
451 social, psychological, and educational interventions are treated as equal to, and perhaps superior  
452 to, biological interventions in importance in certain circumstances. Indeed, evidence is beginning  
453 to emerge that substantiates this assumption. For example, behavioral parent training and  
454 classroom behavior management, when implemented with integrity, yield effect sizes  
455 comparable to stimulants for the treatment of the core symptoms of attention deficit-hyperactive  
456 disorder and are superior to medication for functional outcomes in family, school and peer  
457 settings (see Brown et al., 2008). Cognitive-behavioral therapy also yielded an effect size  
458 comparable to drug treatment for pediatric anxiety in a large, recent multi-site study (Walkup et  
459 al., 2008). In addition, Fabiano et al. (2007) have demonstrated that the amount of stimulant  
460 medication needed to maintain improvements in symptoms and classroom functioning among  
461 children with attention deficit disorder can be reduced when concurrent behavioral classroom  
462 management is provided. Similar conclusions have been drawn concerning the relative efficacy  
463 of medication and psychotherapy for depression (Antonuccio, Danton, DeNelsky, Greenberg, &  
464 Gordon, 1999). As encouraging as these findings are, much additional research is needed to  
465 identify other conditions and populations for which psychosocial and drug interventions may be  
466 comparably effective, or psychosocial treatments that may enable reductions in drug dosages.

467 Mantell, Ortiz, and Planthara (2004) noted the lack of information on the best means for  
468 integrating traditional psychological and biological treatments, and outlined some of the  
469 challenges and issues involved in creating an integrated model of treatment. One of the important  
470 tasks for the first generation of psychologists with prescriptive authority will be the development  
471 of formal recommendations, perhaps even treatment guidelines, concerning the best integration

472 of biological interventions into a broader psychological and social context of treatment.  
473 Encouraging findings about the superiority of combined drug and psychosocial treatment over  
474 either drug or psychosocial treatment alone have now been reported for childhood anxiety  
475 (Walkup et al., 2008), adolescent major depression (The Treatment of Adolescent Depression  
476 Study Team, 2004) and pediatric obsessive-compulsive disorder (Pediatric OCD Treatment  
477 Team, 2004), for example.

478 *Implications.* Psychologists actively involved in decision-making about medication are  
479 encouraged to consider both the interpersonal/psychosocial and the biological aspects of  
480 treatment. Increasing hopefulness, reducing demoralization, and providing support represent  
481 elements of good patient care, and maximize the potential for effective intervention (Stewart et  
482 al., 1995). The psychologist may conclude a sufficient biopsychosocial evaluation can require  
483 more time than is currently typical for medication management (Olfson, Marcus, & Pincus,  
484 1999).

485 Psychologists with prescriptive authority will sometimes find themselves called upon to  
486 provide consultations to other healthcare providers solely for purposes of evaluating the patient  
487 for medication, for example, when on call or when asked to serve as a consultant to another  
488 professional who is providing psychosocial services. Even so, the psychologist with prescriptive  
489 authority is encouraged to evaluate the clinical presentation from a biopsychosocial perspective  
490 to the extent possible. Even in emergency circumstances, or when the patient has an on-going  
491 relationship with another mental health provider, the psychologist with prescriptive authority is  
492 encouraged to consider psychosocial and interpersonal as well as biological issues and  
493 interventions. This can be an important tool for avoiding over-reliance on medications even  
494 when psychologists are involved specifically because of their prescriptive authority.

495 ***Guideline 12. The psychologist with prescriptive authority is encouraged to use an expanded***  
496 ***informed consent process to incorporate additional issues specific to prescribing.***

497 *Rationale.* The APA (2002b) Ethics Code requires psychologists to obtain informed consent  
498 before any professional interaction whenever possible. The decision to prescribe medication for a  
499 patient optimally results from collaboration between that patient and the psychologist, rather than  
500 from a unilateral decision by the prescriber. A collaborative decision depends upon appropriate  
501 education of the patient about alternative treatments and full informed consent.

502 *Implications.* Even when the recipient of the intervention is not capable of giving informed  
503 consent, the psychologist with prescriptive authority considers what sorts of information may be  
504 useful or anxiety-reducing for the individual. The use of medication increases the universe of  
505 topics that may meet these goals. The following is a sample of the sorts of topics a psychologist  
506 with prescriptive authority may choose to discuss with a patient when pharmacotherapy is being  
507 considered as a treatment option (Grisso & Appelbaum, 1998):

- 508 1. Describing the agent to be used.
- 509 2. Indicating the symptoms it is intended to address.
- 510 3. Providing the rationale for the treatment relative to other treatment options. This may involve  
511 outlining alternatives to the recommended treatment, including a review of other medications  
512 that can be considered as well as non-pharmacological treatment options.
- 513 4. When discontinuing or reducing levels of medication use, explaining the reason for this  
514 course of action and addressing any concerns about the change in regimen.
- 515 5. Describing the benefits and potential risks of the protocol, including both therapeutic and  
516 potential adverse effects of the medication.

- 517 6. Estimating the duration and cost of treatment, and the time to therapeutic effect. Simply  
518 indicating how long to remain on the medication has been found to reduce the rate of  
519 premature termination (Bull et al., 2002).
- 520 7. Providing information about relative or absolute contraindications for the treatment and  
521 possible drug interactions.
- 522 8. Reviewing the risks associated with sudden, unilateral discontinuation of the medication.
- 523 9. Providing an explanation of any indicated laboratory examinations or requirements for  
524 ongoing therapeutic monitoring of drug levels.
- 525 10. Offering appropriate references for further patient education, in formats that are accessible to  
526 and understandable by the patient.
- 527 11. Describing the ongoing psychologist-patient partnership in deciding on medication changes  
528 (including titration) or criteria for termination of medication. This can involve orienting  
529 patients to the psychologist's new combined role of prescriber and psychotherapist.
- 530 12. Remaining open and responsive to the patient's questions and concerns including, at the  
531 patient's request and with appropriate consent, providing information and education to  
532 family members or significant others.
- 533 13. Underscoring how psychopharmacology can be a key component, but often not the exclusive  
534 component, of a successful treatment plan.
- 535 14. When psychotherapy and psychopharmacology are used together, explaining why the  
536 combination is recommended over either intervention alone and how sessions will be  
537 structured to combine the two, and estimating the expected time course for treatment as a  
538 whole.

539 15. Inviting questions and the expression of concerns. It is important to remember that concerns  
540 can be practical and financial as well as physical, so explicitly encouraging questions about  
541 the range of obstacles can be helpful.

542 16. Evaluating the patient's likelihood of adherence to the treatment selected.

543 In regard to the last component, it is important to remember that acceptance does not imply  
544 agreement. Patients may accept the prescription with little or no intention of complying, with  
545 mixed feelings about the treatment, or with the full intention of complying. The psychologist  
546 with prescriptive authority is encouraged to look beyond patients' acceptance of the prescription  
547 to evaluate their likelihood of compliance with the treatment.

548 As with any good informed consent process, the psychologist with prescriptive authority  
549 seeks to address patients in terms that are congruent with their level of education and their ability  
550 to understand the language. The collaborative agreement that emerges from the informed consent  
551 process can benefit from individual tailoring with regard to any disability that might impair the  
552 patient's ability to give full informed consent. Informed consent is a dynamic process to be  
553 revisited repeatedly throughout the treatment, to refresh the patient's understanding of relevant  
554 issues and when substantive changes to the treatment agreement or process are being  
555 considered.. The process is best completed in an environment in which the patient feels safe to  
556 disagree with the psychologist, to pose questions, and to report difficulties complying with the  
557 protocol.

558 ***Guideline 13. When making decisions about the use of psychological treatments,***  
559 ***pharmacotherapy, or their combination, the psychologist with prescriptive authority considers***  
560 ***the best interests of the patient, current research, and when appropriate, the needs of the***  
561 ***community.***

562       *Rationale.* There is increasing evidence that, at least in some circumstances, combined  
563 psychotherapy and pharmacotherapy is superior to either treatment alone (Friedman et al., 2004;  
564 Thase, 2003; The Treatment of Adolescent Depression Study Team, 2004). The therapeutic  
565 relationship, characterized by empathic interaction with the patient and the enhancement of  
566 awareness, often provides the optimal framework for focal interventions including medication.  
567 However, the situational factors that predict which treatment option to select remain largely  
568 unknown. In the absence of clear guidelines, personal preferences for one approach or the other  
569 can become predominant in a practitioner's decision-making, rather than an individualized  
570 analysis of the best course of action. For example, given psychologists' traditional reliance on  
571 psychotherapy as a primary treatment, it would not be surprising to find some psychologists with  
572 prescriptive authority elect never to prescribe except in the context of a psychotherapeutic  
573 relationship.

574       *Implications.* The psychologist with prescriptive authority is encouraged to remain current in  
575 terms of the literature on additive and multiplicative effects associated with the effectiveness of  
576 pharmacotherapy and psychosocial interventions. Until these processes are better understood, the  
577 psychologist with prescriptive authority is encouraged to consider what might be reasonable  
578 predictors of the relative efficacy of alternative interventions. Not all patients who are interested  
579 in pharmacological treatment desire or are appropriate for psychological interventions. In rural  
580 areas, in economically distressed areas, or in agencies with insufficient resources for the  
581 catchment population, psychologists may also decide that serving solely as a prescriber in some  
582 cases represents the best response to the community's public mental health needs.

583       On the other hand, there is evidence that patients and guardians often report more positive  
584 feelings about psychosocial than pharmacological intervention (MTA Cooperative Group, 1999;

585 Pyne et al., 2005). As in any therapeutic decision, the patient is the ultimate decision maker  
586 regarding the choice of therapy. The psychologist strives to assess his or her preferences,  
587 expectations, and decisions regularly throughout the course of treatment. It is also important to  
588 note that *a referral from another professional for pharmaceutical treatment does not create an*  
589 *obligation to prescribe*, or to restrict one's focus to the physical aspects of the disorder. The  
590 psychologist with prescriptive authority is encouraged to consider combined treatment, or a shift  
591 from one treatment modality to the other, as part of decision-making either as the primary  
592 clinician or as a consultant.

593 ***Guideline 14. Psychologists involved in prescribing or collaborating strive to be sensitive to the***  
594 ***subtle influences of effective marketing on professional behavior and the potential for bias in***  
595 ***information in their clinical decisions about the use of medications.***

596 *Rationale.* A substantial literature indicates the pharmaceutical industry potentially  
597 influences decision-making about medications in at least four ways. First is through its role in  
598 research and journal publications. A recent comparison of seven meta-analyses published with  
599 pharmaceutical industry support versus parallel meta-analyses published under the auspices of  
600 the independent Cochrane Collaboration found every one of the former recommended the  
601 medication without reservations while none of the latter did, even though mean effect sizes  
602 reported were similar (Jørgensen, Hilden, & Gøtzsche, 2006). Panels created for the development  
603 of treatment guidelines rely heavily on researchers receiving funding from the pharmaceutical  
604 industry (Choudhry, Stelfox, & Detsky, 2002). However, even relatively independent analyses of  
605 the literature must rely on primary research that is heavily funded by pharmaceutical companies,  
606 and such studies tend to support the superiority of the funder's products (e.g., Heres et al., 2006;  
607 Lexchin, Bero, Djulbegovic, & Clark, 2003). This effect presumably reflects the funder's role in

608 both the design of the research and the decision whether or not to publish the results (Davidoff et  
609 al., 2001).

610 Second, the pharmaceutical industry remains the primary source of support for continuing  
611 education in medication (Holmer, 2001; Society for Academic Continuing Medical Education,  
612 2004). Third, direct-to-consumer advertising has a demonstrated tendency to increase the volume  
613 of prescriptions, even when the prescribing professional is ambivalent about the medication's  
614 appropriateness (Mintzes et al., 2003). Fourth, the industry markets directly to prescribers  
615 through advertisements, which studies find are often misleading about the effectiveness and  
616 safety of medications (Villanueva, Peiró, Librero, & Pereiró, 2003; Wilkes, Doblin, & Shapiro,  
617 1992), and through sales representatives (Avorn, Chen, & Hartley, 1982).

618 It is difficult to evaluate whether the net effect of this comprehensive and well-funded  
619 marketing system on healthcare practices is positive or negative. However, there can be no doubt  
620 that the system exists primarily to increase prescribing rates. The elements of that system have  
621 been spelled out in some detail here to emphasize the intensity of efforts to influence decision-  
622 making in pharmacotherapy.

623 *Implications.* Psychologists are encouraged to engage in activities likely to improve their  
624 awareness of pharmaceutical industry marketing on prescriptive practice, examples of which  
625 include:

- 626 1. Reviewing research on the effect of pharmaceutical industry advertising on prescriptive  
627 practice, and on the relationship between industry funding and the published literature.
- 628 2. Reading conflict of interest statements in publications of drug trials, as the presence of a  
629 financial relationship with the maker of a medication is consistently found to be a significant  
630 predictor of positive outcomes (e.g., Perlis et al., 2005).

- 631 3. Relying primarily on independent reviews of the literature, such as Cochrane reviews  
632 (www.cochrane.org).
- 633 4. Examining study methodology carefully to detect potential biases in patient or treatment  
634 selection or other threats to internal or external validity that might bias the outcome in favor  
635 of a pharmaceutical intervention (e.g., Smith, 2005).
- 636 5. Engaging in continuing education activities that challenge standard practice in  
637 pharmacotherapy.
- 638 6. Critically evaluating published literature for methodological weaknesses or medication risks.  
639 Psychological research has contributed substantially to the understanding of interpersonal  
640 processes such as marketing. To cite a pertinent and particularly well-known example, while  
641 current professional standards in the prescribing professions focus on limiting the size of gifts,  
642 cognitive dissonance theory suggests that small gifts can sometimes have a more powerful effect  
643 on attitudes and behaviors than large gifts (Festinger & Carlsmith, 1959). There is also research  
644 suggesting that more familiar products are generally assumed to be superior (Goldstein &  
645 Gigerenzer, 2002). This assumption is often effective in daily practice in that the better option is  
646 referenced more frequently, but marketing corrupts this process by directly increasing familiarity  
647 independent of relative effectiveness. Psychologists involved in prescribing or collaboration may  
648 benefit from considering the possible influence of well-known methods for attitude change on  
649 their decision-making.
- 650 Psychologists with prescriptive authority may also find it helpful to review their own  
651 prescribing practices: the number of prescriptions written, the frequency of prescriptions written  
652 for various medications, the length of time patients remain on medication, and so forth. This

653 information can alert psychologists that marketing may have subtly influenced their prescribing  
654 patterns..

655 ***Guideline 15. Psychologists with prescriptive authority are encouraged to use interactions with***  
656 ***the patient surrounding the act of prescribing to learn more about the patient's characteristic***  
657 ***patterns of interpersonal behavior.***

658 *Rationale.* The patient's characteristic patterns of interpreting interpersonal situations  
659 inevitably play a role in the desire for medication, the reaction to the recommendation of  
660 medication, and compliance with the treatment regimen (e.g., Brockman, 1990; O'Neill &  
661 Bornstein, 2001).

662 *Implications.* The psychologist with prescriptive authority is encouraged to consider  
663 reactions such as excessive faith in the effectiveness of the medication, emotional reactions to  
664 the medication, and overt or passive resistance to the medication as clues to the patient's  
665 cognitive assumptions or characteristic patterns in interpersonal situations, or at least in  
666 interpersonal situations that involve health care professionals. These responses, and the  
667 hypotheses they generate about the patient, can be useful in achieving a transition from a purely  
668 biological intervention to a more biopsychosocial approach to the patient's difficulties.

## 669 **Relationships**

670 ***Guideline 16. Psychologists with prescriptive authority are sensitive to maintaining***  
671 ***appropriate relationships with other providers of psychological services.***

672 *Rationale.* There are various circumstances in which one mental health professional may  
673 refer to another for specialized services, referral for assessment perhaps being the most common.  
674 The emergence of the psychologist with prescriptive authority will undoubtedly produce  
675 circumstances in which mental health professionals refer to a psychologist for purposes of

676 medication consultation only. Within this division of labor there exists the potential for  
677 miscommunication, differences in interpretation of the patient's problems, and differences in  
678 beliefs about optimal interventions. Rivalry can also develop between clinicians, with unintended  
679 iatrogenic effects. Feldman and Feldman (1997) noted that

680       Potential problems with two-therapist integration always exist, such as  
681       miscommunication, conflict, and competition between therapists ... [and as a  
682       result] the patient may receive contradictory messages about their diagnosis or  
683       treatment. Therapists must avoid competing for the role of primary treatment  
684       provider because it interferes with the collaborative process, and by extension,  
685       optimal patient care. (p. 2)

686       *Implications.* Psychologists with prescriptive authority are encouraged to be alert to the  
687       potential for conflict when collaborating with non-prescribing colleagues. This can include  
688       maintaining frequent contact, and/or working collaboratively to establish a comprehensive  
689       treatment plan that encompasses the activities of both providers.

690       ***Guideline 17. Psychologists are encouraged to maintain appropriate relationships with***  
691       ***providers of biological interventions.***

692       *Rationale.* Ethical standard 3.09 of the APA (2002b) Ethics Code highlights the importance  
693       of cooperation with other professionals in service to patients. Psychologists who prescribe,  
694       collaborate, or provide information on pharmacotherapy will find themselves working with other  
695       healthcare professionals at times, a category that in some cases will include traditional healers  
696       offering complementary medical treatments. Collaborating and information-providing  
697       psychologists by definition work in conjunction with prescribing professionals, most of whom  
698       are not psychologists at this point, though they increasingly may be. Prescribing, collaborating,

699 and information-providing psychologists are often dealing with patients who demonstrate co-  
700 morbid medical conditions. Given the potential for drug-drug interactions and medical  
701 complications in such situations, collaboration with other healthcare providers actively involved  
702 in treating the patient can be particularly important.

703 *Implications.* When making referrals for biological interventions, psychologists consider the  
704 competencies of the provider. For example, psychologists may be tempted to refer pediatric  
705 patients to a prescribing psychologist over another prescribing professional without first  
706 considering whether that prescribing psychologist has pediatric competency. Instead, the  
707 psychologist resists such temptations and consistently considers the competencies of the other  
708 professional when making referrals for medication.

709 The psychologist with prescriptive authority is encouraged to make contact with other  
710 healthcare providers involved in patient care, with appropriate authorization, and to establish  
711 clear guidelines regarding responsibilities within their overlapping functions. Psychologists with  
712 prescriptive authority update the patient's primary medical caregiver of the pharmaceutical  
713 treatment plan as appropriate. The psychologist with prescriptive authority is also encouraged to  
714 establish policies to prevent confusion or redundancy in roles played or the medications  
715 prescribed. When a transfer of care or consultation with another provider is indicated and  
716 requested by the patient, the psychologist with prescriptive authority is encouraged to seek  
717 appropriate communication between all parties, and to ensure optimal continuity of care.

718 Whenever a psychologist is involved in the practice of pharmacotherapy, the psychologist is  
719 encouraged to maintain on-going consultation with the patient's primary health care provider(s),  
720 assuming the patient agrees to such contact. The primary care provider may in turn be reminded  
721 to alert the psychologist to any changes in the patient's health status that could affect the

722 patient's treatment by the psychologist, whether that treatment involves pharmacotherapy or  
723 psychosocial interventions.

724

DRAFT

## 725 Author Note

726 These guidelines were developed by the American Psychological Association (APA)  
727 Division 55 (American Society for the Advancement of Pharmacotherapy) Task Force on  
728 Practice Guidelines. The task force was chaired by Robert E. McGrath, Ph.D. (Fairleigh  
729 Dickinson University). Task force members included Stanley Berman, Elaine LeVine, Elaine  
730 Mantell, Beth Rom-Rymer, Morgan Sammons, and James Quillin. Additional input on the  
731 guidelines was provided by Robert Ax, representing Division 18 (Psychologists in Public  
732 Service). None of the individuals involved in the development of this document has any personal  
733 investment in pharmaceutical products of any kind, nor did the developers receive any financial  
734 support for its creation.

735 The task force anticipates these guidelines may deserve reconsideration in a relatively brief  
736 time frame, given anticipated changes in psychologists' role in pharmacotherapy, as well as  
737 changes in the perceptions and use of psychotropic medications. In particular, it is the belief of  
738 the members of the task force that future efforts should include consideration of whether some  
739 elements of the enclosed guidelines merit elevation to the level of practice standards.  
740 Accordingly, this document is scheduled to expire as APA policy in five years from publication,  
741 by \_\_\_\_\_. After this date, users are encouraged to contact the APA Practice Directorate to confirm  
742 whether this document remains in effect.

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964 Footnotes

<sup>1</sup>This document is currently under review for revision.

965 Table 1

966 *Characterizing Psychologists' Activities Related to Pharmacotherapy.*

	Relevant Activities		
	Prescribing	Collaborating	Providing Information
Legal responsibility for decision-making	Yes	No	No
Involvement in decision-making	Yes	Yes	No

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967 Table 2

968 *List of Guidelines*

	Relevant Activities		
	Prescribing	Collaborating	Providing Information
<b>General</b>			
Guideline 1. Psychologists are encouraged to consider objectively the scope of their competence in pharmacotherapy and to seek consultation as appropriate before offering recommendations about psychotropic medications.	X	X	X
Guideline 2. Psychologists are urged to evaluate their own feelings and attitudes about the role of medication in the treatment of psychological disorders, as these feelings and attitudes can potentially affect communications with patients.	X	X	X
Guideline 3. Psychologists involved in prescribing or collaborating are sensitive to the developmental, age and aging, educational, sex and gender, language, health status, and cultural/ethnicity factors that can moderate the interpersonal and biological aspects of pharmacotherapy relevant to the populations they serve.	X	X	
<b>Education</b>			
Guideline 4. Psychologists are urged to identify a level of knowledge concerning pharmacotherapy for the treatment of psychological disorders that is appropriate to the populations they serve and the type of practice they wish to establish, and to engage in educational experiences as appropriate to achieve and maintain that level of knowledge.	X	X	X
Guideline 5. Psychologists strive to be sensitive to the potential for adverse effects associated with the psychotropic medications used by their patients.	X	X	X
Guideline 6. Psychologists involved in prescribing or collaborating are encouraged to familiarize themselves with the technological resources that can enhance decision-making during the course of treatment.	X	X	
<b>Assessment</b>			
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.	X		
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.	X		
Guideline 9. Psychologists are encouraged to explore issues surrounding patient adherence and feelings about medication.	X	X	X

	Relevant Activities		
	Prescribing	Collaborating	Providing Information
<b>Intervention and Consultation</b>			
Guideline 10. Psychologists are urged to develop a relationship that will allow the populations they serve to feel comfortable exploring issues surrounding medication use.	X	X	X
Guideline 11. To the extent deemed appropriate, psychologists involved in prescribing or collaboration adopt a biopsychosocial approach to case formulation that considers both psychosocial and biological factors.	X	X	
Guideline 12. The psychologist with prescriptive authority is encouraged to use an expanded informed consent process to incorporate additional issues specific to prescribing.	X		
Guideline 13. When making decisions about the use of psychological treatments, pharmacotherapy, or their combination, the psychologist with prescriptive authority considers the best interests of the patient, current research, and when appropriate, the needs of the community.	X		
Guideline 14. Psychologists involved in prescribing or collaborating strive to be sensitive to the subtle influences of effective marketing on professional behavior and the potential for bias in information in their clinical decisions about the use of medications.	X	X	
Guideline 15. Psychologists with prescriptive authority are encouraged to use interactions with the patient surrounding the act of prescribing to learn more about the patient's characteristic patterns of interpersonal behavior.	X		
<b>Relationships</b>			
Guideline 16. Psychologists with prescriptive authority are sensitive to maintaining appropriate relationships with other providers of psychological services.	X		
Guideline 17. Psychologists are urged to maintain appropriate relationships with providers of biological interventions.	X	X	X