

CE Corner

Psychology's Growing Medication Responsibility

New guidelines address the reality that modern psychology increasingly involves medication conversations, regardless of prescribing authority

BY STEPHANIE PAPPAS

THE NUMBER OF psychologists who can prescribe medication is growing rapidly. Since New Mexico became the first state to allow licensed psychologists to prescribe in 2002, the field has grown from a few dozen to more than 300 today, with another 1,500 psychologists also holding master's degrees in clinical psychopharmacology.

This growth prompted APA's Council of Representatives to pass an update to the professional practice guidelines to help all psychologists—whether they prescribe, collaborate on medication decisions, or field questions about antidepressants and stimulants—navigate conversations around psychotropic drugs. In 25 jurisdictions in the United States, a role in medication management is part of a psychologist's scope of practice.

"We are at a place where there is an expectation that psychologists will know and understand a lot more about medication" than they used to, said David Shearer, PhD, a clinical and prescribing psychologist for the Department of the Army at Madigan Army Medical Center (MAMC) in Washington state. Shearer cochaired the working group that developed the guidelines along with Bret Moore, PhD, a clinical psychologist and prescribing psychologist in San Antonio. (Shearer said his views are his own and do not represent official Department of the Army or U.S. government policy.)

The professional practice guideline document contains 14 specific guidelines, aspirational in nature, that highlight the importance of knowing one's scope of practice as a clinician, as well as building trust with patients for shared decision-making about medications. Psychologists, with

their strengths in rapport-building and understanding of biological, psychological, and social factors in a patient's life, tend to be well positioned for these discussions, Shearer said. Prescribing psychologists are also in a unique position to monitor medication side effects and adherence because of how regularly they see their patients.

"We have become more than just another prescriber," Shearer said. "We really are psychologists first and prescribers second."

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Learning objectives

After reading this article, CE candidates will be able to:

- 1 Describe the three levels of involvement in medication management by practicing psychologists.
- 2 Explain why a biopsychosocial approach can be helpful for prescribing psychologists or psychologists who collaborate on medication decisions.
- 3 Discuss the growth of prescribing psychology and the potential benefits for access to care.

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Knowing your scope

When APA passed its first *Guidelines for Psychologists' Involvement in Pharmacological Issues* in 2011, there were only two states, two federal agencies, and portions of the military that allowed prescribing psychologists. Today, seven states allow appropriately trained and licensed psychologists to prescribe, as do Guam, all federal military services, the Indian Health Service, and the U.S. Public Health Service. Clinical psychopharmacology became a new APA specialty in 2020, and the American Board of Professional Psychology voted this year to recognize psychopharmacological psychology as a board specialty.

A step along the path toward becoming a prescribing psychologist

is a master's degree in clinical psychopharmacology, a credential that can allow the practitioner to take a substantive role in medical decision-making. Meanwhile, even those without advanced credentials often find that patients ask them about medications or side effects, meaning a baseline knowledge—as well as an understanding of where to refer the patient for specialty help—is important.

KEY POINTS

1

The role of prescribing psychologists is expanding, and many psychologists without prescribing privileges also have advanced psychopharmacological training and a role in medication management.

2

Appropriately trained psychologists are well positioned to have holistic conversations with their patients about medications informed by a biopsychosocial approach.

3

Psychologists at all levels of practice are advised to know their scope, be aware of their own beliefs and biases about medication, and be prepared to refer patients to appropriate prescribers.

The guideline document categorizes psychologists into three levels: Level 1 are general practitioners who may offer relevant information to medical decision-makers. Level 2 psychologists have completed a master's degree in clinical psychopharmacology and can take on a collaborative role in decision-making. Level 3 are prescribing psychologists. Some of the individual guidelines are intended specifically for prescribers, some for prescribers and collaborating psychologists, and some for psychologists at any level of practice.

Guideline 1 encourages psychologists at all levels to objectively consider the scope of their own competence before making prescribing decisions or recommending prescriptions to patients. This might include considering whether one has reliable knowledge of a particular drug class or patient population. In some cases,

they may need to decline to offer an opinion, even under pressure.

“A strength of this document is that it speaks to different levels of training—the psychologist who is a general practitioner, one who has the academic training, and one who has also had supervised practice and has a license to prescribe,” said Elaine LeVine, PhD,

a member of the guidelines working group and a prescribing psychologist in private practice who holds the first license of that kind issued in New Mexico. “It’s very important that all of this stay within the boundaries of our expertise,” she said.

Guideline 2 recommends that psychologists at all levels of practice evaluate their own beliefs about

and attitudes toward medication for behavioral or mental health disorders. Psychologists who understand their own opinions and the origin of those opinions can better approach conversations with patients with transparency and balance.

Guideline 3 focuses on the patient’s individuality. Practitioners are advised to be sensitive to the patient’s developmental stage, age, disability status, sexual and gender identity, educational experience, and cultural and ethnicity factors that might influence their beliefs and communication style around medications and symptoms.

“One of the things psychologists can do really well is emphasize the cultural and personal, religious and





other variables, including things like disability, into this decision-making process,” Shearer said. “It’s not just us paternalistically telling people to take this medication.”

Staying educated

Guidelines 4 through **6** emphasize the importance of psychopharmacology education for psychologists who will be prescribing or making recommendations about medications. Psychologists are encouraged to know what level of knowledge they need for their desired role and to seek out educational opportunities to stay current.

Psychologists often see their patients more frequently than

physicians do and may be the first health care professional to hear about adverse effects from a new medication. Resources on adverse effects include standard pharmacological texts as well as online repositories such as Drugs.com, Cochrane.org, or Psychiatry.org (see “Further Reading” for more recommendations).

Psychologists may also consider staying abreast of the electronic resources designed for prescribers. This includes informational resources as well as software for e-prescribing and telehealth platforms. AI is beginning to play a larger role in the practice of psychology, and big data has massive potential to help guide treatment options, but Shearer warns that AI is not always accurate and needs human oversight. “You have to know enough to know [when] it’s not right,” he said.

Even a psychologist without higher-level training in psychopharmacology might consider asking patients about their medications and being aware of potential side effects, Shearer said. Otherwise, they may misattribute symptoms to psychological issues when they are actually medication effects. For example, a common side effect of bupropion (Wellbutrin) is insomnia, and if a patient has not been given this information, they might seek psychological help for their sleeplessness. The psychologist might first recommend they consult with their prescriber about ways to reduce that side effect.

Assessment and intervention

Some of the guidelines are specific to psychologists with prescriptive authority.

Guidelines 7 and **8** focus on assessment and are aimed at prescribing

psychologists who are recommended to regularly monitor effects of a medication, both desired and undesired. This may include conducting physical exams, interpreting laboratory results, and using feedback from psychological tests or questionnaires. They also need to be aware of comorbid conditions that can affect how a patient responds to a medication or whether they experience adverse reactions.

When conducting interventions and consultations, psychologists at all practice levels are encouraged to build trust and practice shared decision-making with their patients. Shared decision-making, the focus of **Guideline 9**, involves getting the patient’s opinions on treatment options, providing information about potential risks and benefits, and deliberating together on the best course of action. Because adherence to psychotropic medications can be low, the goal is to improve the patient’s engagement with the process, address concerns or stigma, and build a treatment plan together. **Guideline 10** notes that psychologists with prescriptive authority can help improve cooperation by patients by following up regularly, especially within the first month, checking in on patient satisfaction and working to minimize side effects.

Guideline 11 urges a biopsychosocial approach for psychologists, regardless of prescriptive authority. This model recognizes the importance of psychosocial factors in medical conditions and coping or recovery. A prescribing or collaborating psychologist might consider how behavioral treatments and medication can complement each other. For example, research on attention-deficit/hyperactivity disorder suggests that psychosocial interventions alongside

medication are more effective than either one alone (Ojinna, B. T., et al., *Cureus*, Vol. 14, No. 12, 2022). Taking a biopsychosocial approach can also reduce overreliance on medication where different options are available.

“When we see patients on too many medications, inappropriate medications, or medications that have problematic drug interactions, we’re able to stop those medications and help patients reduce the risks,” Shearer said.

Prescribing psychologists are also primed to understand a person’s relationship with medication via the lens of their individual psychology, said Beth Rom-Rymer, PhD, the founder, president, and CEO of the Illinois Association of Prescribing Psychologists and a coauthor of the guidelines. Are they resistant to change? Do they put undue faith in new treatments? Are there cultural or family beliefs around medicine that might influence their decisions?

“That’s a very exciting part of what we do as prescribing psychologists—we have this holistic understanding of the patient and how we manage both psychological treatment and psychopharmacological therapeutic treatment,” said Rom-Rymer, a past president of APA Div. 55 (Society for Prescribing Psychology).

Guideline 12 highlights an expanded informed consent process that can enable shared decision-making and a deep relationship with patients. Psychologists are bound by APA’s Ethics Code and federal and state law to obtain informed consent before all professional interactions. But a collaborative decision around medication may need to go beyond the basics and into the gritty details. Psychologists might need to go in depth on the rationale for choosing one treatment over other options;

explain why medications are being switched, reduced, or discontinued; and educate patients on why pharmacological treatments are often combined with psychotherapy. This can involve explaining the dual role of a prescribing psychologist in prescribing medications and providing other therapeutic interventions. It might also involve being open to patient concerns such as financial costs or access, as well as assessing their likelihood to adhere to the treatment plan.

“I view my role as a prescriber is to give the patient options for treatment that are consistent with the literature, and then we talk about what fits for them, considering their time, circumstances, and preferences for treatment,” said guideline document coauthor Lynette Pujol, PhD, MCSP, the deputy director of the master’s in clinical psychopharmacology program at Fairleigh Dickinson University and the president of Div. 55.

Building relationships

Psychologists with a role in medication management are not only concerned with the psychologist-patient relationship; they also work in collaboration with other professionals.

Guidelines 13 and 14 suggest that psychologists with prescriptive authority strive to maintain appropriate relationships with other providers, both psychologists and nonpsychologists, on their patient’s care team. Nonprescribing psychologists may sometimes refer to prescribing psychologists for medication consultation only. In some cases, the two psychologists may have differing opinions on the optimal treatment plan. The guidelines urge prescribing psychologists to avoid competition if the patient has another psychologist, aligning with the APA Ethics Code Standard 10.04, which emphasizes the importance

of centering patient welfare in such cases. Successful collaborative care is linked to better patient outcomes and reduced wait time for treatment (Reist, C., et al., *Medicine*, Vol. 101, No. 52, 2022).

The guidelines provide some guidance on how to interact with nonpsychologists on the team. One advantage of a master’s degree in clinical psychopharmacology, Shearer said, is a shared language with the medical team. “For psychologists who are not prescribers, I think one of our challenges is to be brief,” he said. Shearer said he finds that primary-care physicians tend to value concise communication, so it is important to find



ways to spotlight crucial information quickly.

The reach of prescribing psychologists is growing. In 2019, APA's Council of Representatives adopted a revision of the designation criteria that allows psychologists to start their training in psychopharmacology at the graduate level rather than at the postgraduate level. This streamlines the career path and enables more psychologists to get this additional training, Rom-Rymer said. The Canadian province of Ontario announced in

September 2025 that it is considering expanding the scope of psychologists with psychopharmacological training to include prescription privileges.

As the number of prescribing psychologists grows, so do the data on their impact. Research suggests that prescribing psychologists have similar safety outcomes as psychiatrists and primary-care physicians (Hughes, P. M., et al., *American Psychologist*, Vol. 80, No. 7, 2025). Policies allowing prescribing psychologists are also associated with reductions in suicide

on a state level (Hughes, P. M., et al., *Professional Psychology: Research and Practice*, Vol. 54, No. 4, 2023).

There are currently about a dozen U.S. states with active efforts to expand the scope of practice to include prescribing for appropriately trained psychologists. The goal, Rom-Rymer said, is to increase access for patients.

"There is a dire need for mental health prescribers who are extraordinarily well trained," she said. "And prescribing psychologists certainly fit that criteria." ■

APA's updated professional practice guidelines emphasize shared decision-making between psychologists and patients when discussing psychotropic medications.



FURTHER READING

Stahl's essential psychopharmacology: Prescriber's guide (8th ed.)

Stahl, S. M.
Cambridge University Press, 2024

Kaplan and Sadock's pocket handbook of clinical psychiatry (7th ed.)

Ahmad, S.
Wolters Kluwer, 2024

The Carlat psychiatry report

Aiken, C. (Ed.)

NICE shared decision making guidelines and mental health: Challenges for research, practice and implementation

Zisman-Ilani, Y., et al.
BJPsych Open, 2021

Prescriptive authority gains new momentum

DeAngelis, T.
Monitor on Psychology, June 2023

Enhancing Learning through Commitment to Change

Greg J. Neimeyer, Ph.D.

The rapid proliferation of new knowledge in psychology has placed renewed demands on professional practitioners to keep pace with ongoing advances. Overall, knowledge may remain current in professional psychology for as little as about 6-7 years, with more rapidly diminishing durability in key areas of practice, such as psychopharmacology, child health, forensics, substance use, or neuropsychology, among others (Neimeyer, Taylor & Rozensky, 2014). This means that, in the absence of a commitment to ongoing professional development, many practitioners may begin to experience knowledge obsolescence even while they are still in the early stages of their career (Neimeyer, Taylor & Rozensky, 2012).

BEST PRACTICES

In response, the field of professional psychology, together with other allied health professions, have redoubled their efforts to formulate sets of “best practices” that can enhance learning and the translation of that learning into practice (Institute on Medicine, 2010; Taylor and Neimeyer, 2017). The collective objective of these best practices is to enhance the comprehension, retention, and application of new knowledge in support of ongoing professional competence. Some of these practices focus on the value of adapting the learning strategies to individuals’ unique learning styles, presenting information multiple times utilizing different media, and providing opportunities for individuals’ input, application and behavioral rehearsal of the material, in addition to receiving peer, or instructor, review and feedback (Neimeyer & Taylor, 2014; Taylor and Neimeyer, 2017).

In addition to identifying current best practices, the allied health fields have long dedicated themselves to the development and evaluation of novel mechanisms for enhancing new learning, as well, drawing from a wide range of literatures with common objectives. Research within the science-of-learning, adult education, and performance enhancement literatures have been particularly productive in identifying and assessing novel methods of learning and facilitating the translation of that learning into

practice. *Benchmarking* and *self-assessment* are two examples of educational practices that have arisen as mechanisms designed to facilitate quality assurance and ongoing professional development (Neimeyer and Taylor, 2014).

Benchmarking and Self-Assessment. *Benchmarking* refers to the express comparison of one’s own work with the work of other professionals in the field. Benchmarking can be understood as the systematic process of evaluating work based on best practices and using evidence-based practice (EBP) to improve performance. In a typical benchmarking procedure, a psychologist might be given videotapes of peers who are conducting a procedure, such as a substance use screening. The videos are pre-determined to depict varying levels of quality. They might range from depicting relatively poor, informal questioning through more thorough, systematic, structured interviews. The psychologist is then asked to evaluate his or her screenings in relation to those he or she has seen, and given information about key components that are present, and absent, in each of the video “benchmarks.” Benchmarking provides an anchor against which psychologists can compare themselves, increasing the accuracy of their self-assessment and incorporating elements of the “higher” benchmarks into their own practice.

Research has demonstrated the effectiveness of benchmarking in relation to improving the accuracy of self-assessment, which is a critical pre-condition for evaluating current clinical skills and needs. Lane and Gottlieb (2004), for example, found that when medical residents viewed videotapes of their performance, their self-assessment accuracy increased significantly. And their accuracy increased still more when they watched the videos with a faculty member. Similarly, Martin et al., (1998) found that comparing one's own performance to the performance of others increased the accuracy of self-assessment. In their study, these researchers invited family practice residents to conduct mock interviews with a mother suspected of physically abusing her child. The residents were then asked to rate their performance. Next, residents watched their videotaped interview, in addition to watching four benchmark interviews depicting varying levels of competence. After watching the benchmark interviews, the relationship between the residents' self-ratings and the independent ratings of the supervisor was significantly stronger.

Self-assessment can take many different forms. All forms share in common express efforts to reflect upon, and evaluate, one's own current skills and/or future professional needs and interests. The Quality Assurance Program in Ontario, Canada, is one example of a well-articulated program of self-assessment (Morris, 2011). The Quality Assurance Program requires that each psychologist undertakes a self-review every other year, though the completion of a stipulated Self-Assessment Guide and a Continuing Professional Development Plan. Through a series of questions, psychologists critically evaluate their strengths, growth areas, and gaps in their learning. After conducting the self-assessment, they develop their own personal plan to remediate areas of identified weakness and to enhance their overall professional competence, sharing their plans with a colleague who reviews it and provides

input. The Continuing Professional Development Plan is designed to 1) promote continuing competence and quality improvement, 2) remedy gaps in knowledge and skills identified in the self-assessments, 3) address changes in practice environments and workplace needs, and 4) incorporate evolving standards of practice and advances in technology. These Continuing Professional Development Plans are subject to peer review by members of the College of Psychology of Ontario according to stipulated regulatory requirements.

Both benchmarking and self-assessment reflect the considerable effort that can accompany efforts designed to promote professional growth and development. Facilitating new learning, and the translation of that knowledge or skill into practice can be an effortful process, requiring reflection, formulation and deliberate application. Transitioning new learning to practice often requires an individual to reflect on how new knowledge or skills may apply to their own experience and to formulate ways in which the new material can be modified, adapted, or utilized within their own professional contexts or workplace environments. If the value of this effort is justified by the anticipated improvement or outcomes that may follow from it, then individuals are more prone to commit themselves to changes in what they do, or how they go about doing it.

Although some mechanisms for triggering change are designed to be intensive and may require considerable time, others are designed as brief reflective exercises that can occur immediately after, or even during, a learning event. A longstanding literature on the concept of a Commitment to Change illustrates the value of utilizing this simple technique in the service of generating greater learning and the translation of that learning into actual practice (Mazmanian & Mazmanian, 1999).

COMMITMENTS TO CHANGE (CTCS)

CTCs have been the subject of attention for the last few decades, but only recently have they been imported into the fields of allied health, or more recently still within psychology. CTCs are generally generated following an educational event such as attending a lecture, participating in a workshop, or reading an article (Wakefield, 2004). To complete a CTC, participants are asked to identify a set of possible changes they would like to make in their own practice based on the educational event. They are asked to formulate these changes in specific, behavioral form, which requires them to reflect on the relevance and applicability of the new information, and to adapt its application to their own interests and experience. They are then asked to indicate a level of commitment to each of the changes they have formulated, utilizing a rating scale that reflects their commitment to change, from low (1) to high (5). In the Commitment to Change procedure, participants are often reminded of their commitments 1-2 months

later, and asked to indicate if they actually enacted, or attempted to enact, each of their stipulated CTCs and to describe their experience or outcomes.

The effectiveness of the CTC procedure seems to be related to its three steps. The timing of the administration, immediately after the learning event, provides the participant an opportunity to reflect on the most salient elements of the material and to formulate it in terms that are most relevant to their own experience, interests, or needs. Rating the level of commitment provides a concrete mechanism for reflecting on the importance or value of the change, and anchors the individual in a level of expectation about completing it. And the subsequent follow-up provides a sense of accountability and the opportunity to reflect on the translation of the material into practice, or the barriers that may have impeded or prevented that translation.

THE BACKGROUND ON CTCs

CTCs have been the subject of attention in relation to the organizational change literature for several decades, as a tool for facilitating critical shifts in organizational structure, processes or style. Within the allied health literatures, medicine was among the first to explore the utility of CTCs as a mechanism for facilitating the translation of new knowledge into actual clinical practice. Within this literature, the actual performance of CTCs varies widely, from 47-87% (Wakefield, 2004), based on a number of identified factors. These factors include the extent to which individuals feel as if the CTCs are relatively easy to do, and the extent to which they feel as though they have personal control over completing them (Fidler et al., 1999, Lockyer et al., 2001). The greater the environmental or institutional constraints, the less likely individuals are to be able to follow through on their commitments and accomplish the behavioral changes they have formulated (Parochka and Paprockas, 2001). A number of studies have demonstrated that the CTC procedure can trigger actual changes in practice-related behavior, including the specific prescriptions that physicians write following educational programs (Wakefield et al., 2003), and the specific interventions utilized by occupational therapists over the course of their work with their clients (Lowe, Rappolt, Jaglal, & Macdonald, 2007).

The precise mechanisms involved in triggering this translation into practice are not fully known, but recent work has begun to address them. Herbert, Lowe and Rappolt (cited in Lowe, Hebert & Rappolt, 2009), for example, wondered whether reflection alone at the end of a new learning experience was sufficient to promote practice change, or whether the express formulation of a commitment of change was an essential element. Reflection has long been a key component of ongoing professional development programs, as reflected in the Mann et al., (2009) systematic review of reflection within continuing medication education courses. In their study, Hebert et al. (2009) asked half of their participants to complete CTCs while the other half

were prompted to reflect on the workshop using the Critical Incident Questionnaire (CIQ). Two months following the workshop, there was a modest difference favoring the CTC group over the reflection-only group. The percentage of those who demonstrated significant change was significant in both groups, but it favored those who had formulated specific commitments to change. Overall, 67% of the individuals who used CTCs made changes in practice, compared to 50% of those in the CIQ group who reported doing likewise.

A recent study of the relationship between reflection and behavior change in continuing medical education provides further evidence in this regard (Ratelle, et al., 2017). In a cohort study of attendees at a national hospital continuing medical education course, 223 participants provided reflection scores for each presentation they attended, and formulated commitment-to-change statements at the conclusion of each course. Reflection scores consisted of ratings, on a 5-point scale, about the extent to which the presentation had prompted reflection, re-consideration, deliberation or critical re-evaluation of their practices. A 3-month post-course survey was conducted to determine whether planned CTCs were successfully implemented, and whether they were related to higher levels of reflection.

Overall, participants indicated that 65.5% of the CTC statements were implemented. Reflection scores correlated significantly with the number of planned CTC statements ($r=.65$, $p<.01$), suggesting the potential role of the CTC procedure in enhancing reflection and, potentially, translation into actual practice. In addition, higher reflection scores were related to the greater availability of opportunities for audience response and the use of clinical case illustrations. The researchers concluded that, “we found that reflection strongly correlates with CTC” and that “continuing education “curricula that stimulate reflections may actually promote positive patient care behaviors” (Ratelle et al., 2017, p. 166).

SUMMARY

Educators or learners who are interested in enhancing learning, and the translation of that learning into practice, may increase the retention and translation of material by incorporating CTCs into their programs. Although the overall effectiveness of CTCs as a tool to enhance the integration of new learning into practice is still under study, the current evidence is promising. The incorporation of simple reflective questions into a learning experience may itself be useful, as when the psychologist asks, “How can I use this new knowledge?”, “How does this apply to my practice and to what I do?”, or “What might I do differently based on what I have learned today?” Although simple reflection itself appears to facilitate both learning and the translation of that learning into practice, the express formulation of potential changes and a commitment to those changes may add further value (Lowe et al., 2009). Overall,

the formulation of CTCs represents a relatively simple mechanism for promoting reflection, anchoring expectations regarding adoption, and leveraging new learning into novel practice behaviors. Simple extensions to the CTC procedure that may provide additional benefit include conducting surveys of post-course behaviors to assess compliance with the CTCs, encouraging reports to colleagues or other peers regarding CTCs in order to build in additional elements of accountability, or establishing timelines for the completion of CTCs. With continued utilization and examination, Commitment-to-Change procedures may join the ranks of other processes, procedures and techniques that jointly constitute what has increasingly come to be recognized as the set of “Best Practices” in the field of ongoing professional education and continuing professional competence.

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