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INTRODUCTION

The American Psychological Association advocates strongly for the increased involvement of psychologists in the primary health care sector, including providing psychotropic medications for their patients. In anticipation of the expanding role of psychologists to include prescriptive authority, the American Psychological Association published *American Psychological Association Recommendations for Postdoctoral Training in Psychopharmacology for Prescriptive Privileges* (APA Council of Representatives, August, 12, 1996) based upon the work of a Blue Ribbon Committee, which was comprised of physicians, prescribing psychologists, pharmacists and other experts in the field. After ten years of use of this document and the passage of two prescriptive authority laws, the recommendations for post-doctoral training in psychopharmacology were revised by the APA Council in the Fall of 2009. A copy of that revision is in the Appendix A.

With the passage of New Mexico House Bill 170 in March 2002, New Mexico became the first state to allow properly trained psychologists to prescribe psychotropic medications for their patients. The passage of House Bill 170 creates a compelling reason for New Mexico to offer psychologists post-doctoral training in psychopharmacology modeled after the recommendations of the American Psychological Association, as well as the requirements of the Prescribing Psychologists Law of New Mexico.
Philosophy of the New Mexico Psychologists
Seeking Prescriptive Authority

The twelve psychologists in the first iteration of classes that completed coursework in 2002 developed the following vision statement and action plan. Through self-evaluation and self-improvement, the current New Mexico University program strives to meet these goals.

Vision Statement

Our vision is to have competent mental health care accessible for all New Mexicans, including children, the poor, the elderly, and the silent sufferers – all of whom need and could benefit from our compassion, expertise, commitment and ever present advocacy on their behalf.

Mission Statement

Psychologists are trained in the empirical study and treatment of mental disorders. As our understanding of psychopathology evolves, so must our treatment. It is incumbent upon us to provide comprehensive, timely care that is consistent with the nature of mental health disorders. As scientists trained in the study of behavior, we too can become trained and competent practitioners in the prescription of psychotropic medications. To truncate our treatment plan to fit the exigencies of our patients’ lives is not the solution. The solution is to simultaneously keep ourselves knowledgeable in the field of psychotherapy, to learn the common skill set necessary for the competent administration of psychotropic medications, and to advocate for our patients’ well-being – including access to the full continuum of mental health treatment.

Our society has extended our prescription authority to optometrists, podiatrists, and other non-medical degree professionals. We doctoral level psychologists have shown the ability and determination to learn the curriculum and accept the supervision needed to develop expertise. We psychologists can do that, as shown by the Department of Defense Demonstration Project that trained 10 prescribing psychologists.

Action Plan

Our action plan is evolving and will be influenced by our Board of Examiners and the New Mexico Psychological Association.

We believe the plan will incorporate the following:

- That we will continue to train psychologists to be effective and safe prescribers of psychotropics;
- That we develop protocol of treatment that will include:
  - Obtaining relevant family, medical, and psychological histories;
  - Collaborating with primary care physicians;
  - Requesting medical records, including results of physicals, lab work, and lists of medications;
  - Ordering any unavailable baseline and follow-up laboratory tests that are necessary for the safe monitoring of psychotropic medications;
− Conducting ongoing, objective assessments of patient treatment gains; and

− Ensuring to the extent possible that patients receive comprehensive services, built upon the therapist-patient relationship, so that patients can use their individual strengths to make better choices in their lives.
**HISTORY OF THE COLLABORATION OF NEW MEXICO STATE UNIVERSITY AND THE SOUTHWESTERN INSTITUTE FOR THE ADVANCEMENT OF PSYCHOTHERAPY**

New Mexico State University (NMSU) in conjunction with The Southwestern Institute for the Advancement of Psychotherapy (SIAP) (a limited liability partnership corporation) has offered coursework in psychopharmacology from 1999 through the present. SIAP is approved by the American Psychological Association to offer continuing education for psychologists. SIAP maintains responsibility for all programs that it offers.

In September 2012, NMSU allotted a full time faculty position devoted to RxP. This faculty member is a part of the Department of Counseling and Educational Psychology; and the department offers an APA-accredited doctoral level counseling psychology program. SIAP continues to offer continuing education for the NMSU psychopharmacology program as well as other continuing education for licensed prescribing psychologists and continuing education for other practicing psychologists.

New Mexico State University has offered seven iterations to date of classes in Psychopharmacology to students within the continental United States. While a majority of the psychologists participating in the program reside in New Mexico, the program has also provided education to psychologists from across the United States and Canada.

Over 90 psychologists have completed the academic coursework from the NMSU program. The program originated as a certificate program offering Professional Development Credit through New Mexico State University. It progressed to a post-doctoral Master’s Degree in 2008. An eighth iteration will commence in September of 2014.

In 2008, SIAP/NMSU also began an international component. A class of twenty psychologists from the Netherlands completed the Interdisciplinary Master of Arts in psychopharmacology in the Summer of 2010. There are plans to initiate further international cohorts that would be available to students throughout Europe and Asia, with live classes held in Amsterdam, Netherlands.

Over 30 psychologists who completed the SIAP/NMSU program have obtained a New Mexico prescriptive authority license and are prescribing psychologists in New Mexico and elsewhere.
GOALS AND STRENGTHS OF THE NEW MEXICO STATE UNIVERSITY
INTERDISCIPLINARY MASTER’S OF ARTS IN PSYCHOPHARMACOLOGY

The SIAP/NMSU collaborative is academically very strong. It is modeled after the recommendations of the Blue Ribbon Committee that developed criteria for training for prescriptive authority, as well as the changes recommended in the American Psychological Association’s 2009 revised recommendations; (APPENDIX A).

The overall curriculum is divided into five primary units. The first unit provides an overview of the foundations of psychopharmacology. Anatomy, physiology, and neuroanatomy are studied in detail. Students will participate in a live dissection of the brain and spinal cord. A second unit focuses on principles of pharmacology. Students develop a sophisticated understanding of drug action and drug use, as well as learning about specific classes of drugs and their effects and side-effects. The third unit is pathophysiology and evidence-based medicine. One weekend a month for nine months, students study a different system of the human body. They learn about the physiology and pathophysiology associated with that organ system, lab tests used to measure functioning, and how to conduct a physical exam. These classes are taught by physicians from the Family Practice Residency Program at the Memorial Medical Center in Las Cruces, New Mexico. Skills are practiced within the clinic setting. By the end of this unit, students are skilled in conducting physical exams and have a strong understanding of disease conditions and drug effects throughout the body. Unit four is clinical psychopharmacology. In this unit, students learn about the integration of psychotherapy and psychopharmacology in the diagnosis and treatment of the varied mental disorders. In the last unit special topics include the treatment of children, elderly, ethnically diverse groups, pain patients, substance abusers, males and females. Special coursework is also provided regarding ethical and legal issues, with particular reference to the APA Code of Ethics, as well as the Practice Guidelines regarding psychologists’ involvement in pharmacological issues developed by Division 55 (American Society for the Advancement of Pharmacotherapy) Task Force on practice guidelines and adopted by the American Psychological Association Council in 2009; (APPENDIX B).

A great emphasis in the coursework is for psychologists to develop a “best practice model,” so that prescribing psychologists address access to care issues and create a new model based upon a psychobiosocial model that improves quality of care; (APPENDIX C).

One of the strengths of the NMSU Master’s Degree program is that there is much opportunity for hands-on experience and direct interaction with professors. As explained, the unit in pathophysiology is taught within a Family Practice Clinic associated with Memorial Medical Hospital in Las Cruces, New Mexico. This allows the students to practice physical assessment skills in examining rooms, while the teachers are watching through one-way mirrors. We also have an opportunity to participate in dissection of the brain.

All professors are trained at the Doctoral level and include prescribing psychologists, psychiatrists, physicians, and clinical nurse specialists. In selecting faculty, experts are drawn from within the state and nationally.

Students complete evaluations of each class. In addition, graduates of the program who are prescribing are surveyed to determine how well they believe the program prepares them to prescribe. This material is reviewed by the Training Director and the advisory council so the coursework is continuously modified for improvement.
NMSU has also been involved in providing continuing education in “best practice” psychotherapy to psychologists and other professionals. For example, in April of 2010 SIAP/NMSU sponsored a symposium attended by eighty licensed psychologists and graduate students in counseling psychology, social work, nursing, physicians from the Family Practice Residence Center, and twenty psychologists from the Netherlands regarding critical access to care issues around the world.

NMSU provides coursework that is of cutting edge significance to the field of psychology and crucial to New Mexico psychologists wishing to become prescribing psychologist in order to further access to quality care in New Mexico. In sum, coursework is rigorous and taught by experts in the field so that participants’ knowledge, critical inquiry, and judgment are enhanced.
### A TEMPLATE OF CONTENT DOMAINS SPECIFIED IN THE
“RECOMMENDED POST-DOCTORAL EDUCATION AND TRAINING PROGRAM IN
PSYCHOPHARMACOLOGY FOR PRESCRIPTIVE AUTHORITY, APPROVED BY THE APA
COUNCIL OF REPRESENTATIVES AUGUST 9, 2009”

#### Mapping Chart

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<tr>
<th>Content Mapping Chart</th>
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<tr>
<td>I. Basic Science</td>
<td>1 2 3 4 5 6 7 8 9 10</td>
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<tr>
<td>A. Anatomy &amp; Physiology</td>
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<td>II. Neurosciences</td>
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<td>A. Neuroanatomy</td>
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<td>B. Neurophysiology</td>
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<td>C. Neurochemistry</td>
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<td>III. Physical Assessment/Labs</td>
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<td>B. Lab and Radiological Assessment</td>
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<td>C. Medical Terminology</td>
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<td>C. Differential Diagnosis</td>
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<tr>
<td>D. Clinical Correlations</td>
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<td>V. Pharmacology and Psychopharmacology</td>
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<td>B. Computer Aids</td>
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<tr>
<td>C. Pharmacoepidemiology</td>
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<td>VII. Research</td>
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<td>A. Methodology and Design</td>
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<tr>
<td>B. Interpretation of Research</td>
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<td>C. Regulatory Processes</td>
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<td>VIII. Professional, Ethical and Legal Issues</td>
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A. Existing Law and Standards
B. Pharmaceutical Industry
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  2. Marketing Practices
  3. Critical Consumer

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GOVERNANCE STRUCTURE

The Acting Training Director of the NMSU Interdisciplinary Master’s Degree of Arts in Psychopharmacology is Elaine S. LeVine, Ph.D., ABMP. Dr. LeVine, prescribing psychologist, spearheaded New Mexico’s efforts to pass the first Prescribing Psychologist Act in the United States. She was the first psychologist in New Mexico to obtain a license to prescribe psychotropic medications for her patients. She maintains a private practice in Las Cruces, New Mexico and was the medical consultant to Pasos Adelante, a mental health clinic addressing an underserved, impoverished population in southern, rural New Mexico. In addition to her clinical work, she is the Training Director of the Southwestern Institute for the Advancement of Psychotherapy/New Mexico State University Master’s degree program, which is training psychologists from New Mexico and across the United States, Canada, and in the Netherlands in psychopharmacology. Dr. LeVine holds a part-time college professor position in the Counseling and Educational Psychology Department of New Mexico State University. Her publications include four books and numerous articles on child therapy, law and mental health, cross-cultural therapy, and psychopharmacology. She is also the consulting editor for Professional Psychology: Research and Practice. She is a fellow of the American Psychological Association (APA) through which she received 2003 APA Presidential Citation, Carl F. Heiser Award, Division 31 Outstanding Psychologist Award, Division 55 State Contribution to Psychotherapy Award, Division 55 National Visionary Leadership Award, and Division 47, Joan D. Black award.

The Training Director of the NMSU program is supervised by the Department Head of the APA accredited counseling psychology program of New Mexico State University. The present Department Head is Elsa Arroyos, Ph.D. The Training Director works with a program committee comprised of faculty from NMSU’s Counseling Psychology, Nursing and Special Education departments. The present program committee is Professor Michael Waldo, Department of Counseling and Educational Psychology, New Mexico State University, Jonathan Schwartz, Ph.D., Associate Dean, College of Education, Marlin Hoover, Ph.D., College Professor, Department of Counseling and Educational Psychology, New Mexico State University, Kathleen Chinn, Associate Professor of Special Education, New Mexico State University.

In addition, the Training Director of the NMSU Interdisciplinary Master’s Degree of Arts degree in Psychopharmacology also works with an advisory board. Key leaders in the field serve on this advisory board. The board members for 2014 are listed on a subsequent page.
GOVERNANCE STRUCTURE
NEW MEXICO STATE UNIVERSITY
Interdisciplinary Master’s Degree of Arts in Psychopharmacology for Psychologists

Advisory Board
- Prescribing Psychologist
- NMSU Leadership
- DOD Prescribing Psychologist
- Physicians

Training Director

Administrative Assistant

Graduate Assistant

NMSU Central Administration

Associate Dean of the Graduate School

Dean of College of Education

Dean of Distance Education

Department Head Of Counseling and Educational Psychology

Faculty Representative Special Education
## ADVISORY BOARD

<table>
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<tr>
<th>Name</th>
<th>Degree</th>
<th>Current Affiliation</th>
<th>Organizational Contribution to Program Planning</th>
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</thead>
<tbody>
<tr>
<td>Elaine S. LeVine</td>
<td>Ph.D.</td>
<td>Acting Training Director and Director of the Southwestern Institute for the Advancement of Psychotherapy</td>
<td>Training Director</td>
</tr>
<tr>
<td>Elsa Arroyos</td>
<td>Ph.D.</td>
<td>Acting Department Head of Counseling and Educational Psychology, New Mexico State University</td>
<td>Faculty liaison; helps establish curriculum, monitors administrative procedures through University</td>
</tr>
<tr>
<td>Jonathan Schwartz</td>
<td>Ph.D.</td>
<td>Associate Dean of the College of Education New Mexico State University</td>
<td>Administrative liaison offering overall program advice, assistance in seeking post-doctoral Master’s status</td>
</tr>
<tr>
<td>Elaine Foster</td>
<td>Ph.D.</td>
<td>One of the original prescribing psychologists from the Department of Defense Demonstration Project</td>
<td>Overall review of curriculum</td>
</tr>
<tr>
<td>Thomas Thompson</td>
<td>Ph.D.</td>
<td>Member of the New Mexico Board of Psychologists Examiners and Prescribing Psychologist of New Mexico</td>
<td>Overall review of curriculum</td>
</tr>
<tr>
<td>Don Fineberg</td>
<td>M.D.</td>
<td>Psychiatrist in Private Practice in New Mexico and RxP Admissions Committee of the New Mexico Board of Psychologists</td>
<td>Overall review of curriculum</td>
</tr>
<tr>
<td>John Andazola</td>
<td>M.D.</td>
<td>Director of the Family Practice Residency program in Las Cruces, NM</td>
<td>Advice about faculty and review of curriculum concerning evidence-based medicine</td>
</tr>
<tr>
<td>Juanita Mendoza-Hannan</td>
<td>Ph.D.</td>
<td>Dean of Distance Education, NMSU</td>
<td>Overall review of curriculum and particular guidance on administrative matters</td>
</tr>
</tbody>
</table>
HOW NMSU AND SIAP INTERFACE

The Southwestern Institute for the Advancement of Psychotherapy is a free-standing LLC developed for the explicit purpose of offering continuing education specializing in post-doctoral psychopharmacology. The staff of SIAP works collaboratively with faculty and administrators from New Mexico State University to assure quality of its post-doctoral Master’s Degree program and to provide continuing education. SIAP also collaborates with the New Mexico Psychological Association, the State Psychologists’ Association (an association for licensed, practicing prescribing psychologists), the Las Cruces Public Schools, the Department of Counseling and Educational Psychology at New Mexico State University, and others to jointly sponsor continuing education for psychologists.

In addition, the Training Director of SIAP meets frequently with members of the advisory board about the existing program and means for constant evaluation and improvement.
COUNSELING and EDUCATIONAL PSYCHOLOGY

Department website: http://cep.education.nmsu.edu

(575) 646-2121
cepdept@nmsu.edu

The courses listed below are from the NMSU Catalog. For a complete list of all courses offered by the Counseling and Educational Psychology Department, please go to the website link listed.

CEP 801. Introduction to Psychopharmacology for Psychologists I 3 cr.
This course is an introduction to physiology and an overview of gross and microanatomy, with a focus on gross, micro, and chemical anatomy of the nervous system. By the end of the course, psychologists will have an up-to-date understanding of human psychology, anatomy, and neuroanatomy. Prerequisites: Doctorate in psychology or consent of instructor.

CEP 802. Introduction to Psychopharmacology for Psychologists II 3 cr.
Principles of organic chemistry and human biochemistry necessary for the understanding of psychopharmacology are discussed and related to the major transmitter systems and dynamics of transmission. By the end of the course, students will have an up-to-date understanding of biochemistry on which to base further didactic study in psychopharmacology. Prerequisites: Doctorate in psychology or consent of instructor.

CEP 803. Clinical Psychopharmacology I 3 cr.
This course begins with an introduction to the scope of pharmacology; pharmacoepidemiology, ethical, and legal issues (informed consent, State and Federal regulation of drugs and prescribing, sources of drug information and computer aids) and continues with the principles of pharmacokinetics and pharmacodynamics as they relate to the use of psychotropic medications. It concludes with an introduction to the treatment of anxiety disorders from a biopsychosocial model of care with special emphasis on psychopharmacology for anxiety disorders. Prerequisites: Doctorate in psychology or consent of instructor.

CEP 804. Clinical Psychopharmacology II 3 cr.
This course is a thorough investigation of the diagnosis and treatment of affective disorders from a biopsychosocial model of care. Particular emphasis is given to psychopharmacological treatment of depressive disorders and bipolar disorders. Prerequisites: Doctorate in psychology or consent of instructor.

CEP 805. Clinical Psychopharmacology III 3 cr.
This course is an intensive study of the treatment of psychosis from a biopsychosocial model of care. Special consideration is given to: first, second and third generation antipsychotic drugs and their pharmacology and clinical uses; neurological and metabolic disorders associated with antipsychotic use; and appropriate use of antipsychotics in children and the elderly. Special attention is then given to child and adolescent psychopharmacology, including drugs used in pregnancy and lactation, teratogenicity, embryotoxicity, developmental disorders, conduct disorders, ADHD, and special considerations in use of approved drugs in children. Prerequisites: Doctorate in psychology or consent of instructor.

CEP 806. Pathophysiology for Psychologists I 3 cr.
This course is an introduction to human clinical physical assessment, history taking, charting, and laboratory testing and neuroimaging. An important emphasis is in functional neuroanatomy and diagnosis and assessment of neurological disorders; role of different components of human nervous system in health and disease; stroke, seizures, and movement disorders (chorea, athetosis, dystonias, dyskinesias, Parkinsonism, akathisia, iatrogenic neurological disorders). Prerequisite: Doctorate in psychology or consent of instructor.
CEP 807. Pathophysiology for Psychologists II 3 cr.
Physical assessment and pathophysiology of the cardiovascular system is studied in depth: structure and function of the heart and major blood vessels; innervation of the heart and vessels; electrocardiogram; components of blood; lymphatics; and physical assessment of cardiac function. The physical assessment and pathophysiology of eyes, ears, nose, and the immune system are studied in depth; anatomy and physiology of special senses; assessment of cranial nerves and sensory function; immune function and psychoimmunology. The physical examination and pathophysiology of the chest and pulmonary system and its relationship to the cardiac system is also studied. Prerequisites: Doctorate in psychology or consent of instructor.

CEP 808. Pathophysiology for Psychologists III 3 cr.
This course continues with an in-depth study of the chest and pulmonary system: pulmonary function and assessment; respiratory exchange and respiratory involvement in acid: base regulation, disorders of respiratory function. The physical assessment of pathophysiology of the gastrointestinal system is discussed in depth: digestion, absorption and excretion of drugs and nutrients from the GI system; disorders of GI function; hepatic function; innervation of GI tract; endocrine and exocrine functions of GI system; physical assessment of GI function. The functions and pathophysiology of the male and female reproductive system, endocrine system, and renal system are discussed as they relate to psychopharmacology. Prerequisites: Doctorate in psychology or consent of instructor.

CEP 809. Psychopharmacological Treatment in Special Populations I 3 cr.
The psychopharmacology of several special populations are discussed in detail in this course. Geriatric psychopharmacology includes: geriatric physiology; cardiac, renal, hepatic changes with aging; pharmacokinetics/dynamics in the elderly; cognition enhancers in Alzheimer’s and other dementias. Special treatment of personality disorders, eating disorders, the importance of racial, ethnic, and gender differences and culturally sensitive practice is presented with applications. Pain management psychopharmacology is over-viewed, including: pharmacology of opioid and non-opioid analgesics; pain syndromes; acute and chronic pain; headache; pharmacological and non-pharmacological approaches to pain management; pharmacology and actions of abused substances: acute effects, withdrawal, biochemistry of tolerance and dependence, brain central reward pathways. Prerequisites: Doctorate in psychology or consent of instructor.

CEP 810. Psychopharmacological Treatment in Special Populations II 3 cr.
The pathophysiology and treatment of substance use disorders from a biopsychosocial model is presented. Issues of medical comorbidity are studied: psychopharmacological treatment in the medically compromised patient, including case studies and review of comprehensive treatment models; mental disorders due to a general medical condition and/or adverse drug reactions; and referral practices to specialists. Diagnostic rating scales and psychiatric instruments of use to the prescribing psychologist are presented. The course ends with an integration of psychotherapy and pharmacotherapy, including ethical issues such as the right to refuse treatment, treatment compliance/adherence, risk management, and the role of the medical psychologist in the modern, integrated healthcare system. Prerequisites: Doctorate in psychology or consent of instructor.

CEP 811. Supervised Experience in Psychopharmacology I 3 cr.
In this applied course, students employ their knowledge of psychopharmacology in treatment setting. Students will participate in the treatment of 50 patients for a minimum of 200 hours under the supervision of a physician. Restricted to Post-Doctoral Master’s Programs. Prerequisite: Doctorate in psychology or consent of instructor.

CEP 812. Supervised Experience in Psychopharmacology II 3 cr.
Continuation and completion of supervised experience in CEP 811. Students will participate in the treatment of 50 patients for a minimum of 200 hours under the supervision of a physician. Restricted to Post-Doctoral Master’s Program. Prerequisite: Doctorate in psychology or consent of instructor.
FACILITIES

Classes are taught in specially equipped academic classrooms at New Mexico State University in which lectures can be projected for distant education and stored professionally for future use. The classes in pathophysiology and physical assessment are taught in a medical clinic.

Classrooms are handicap accessible. The Training Director maintains a personal relationship with each psychologist participant so that any necessary special provisions can be made. NMSU does, of course, allow those with auditory, visual, or other impairments, to make use of any equipment or personnel needed for their successful study.

The lecturer and Training Director (or an assistant) are present during class. Only enrolled students and special invited guests may attend. The Training Director reviews copies of all written materials before they are distributed to students. Most material is theoretical and in those cases issues of confidentiality are not of concern. The program makes extensive use of interactive cases. In all use of case material, anonymity is maintained and no identifying features are allowed.
**FACULTY**

*The core faculty is comprised of prescribing psychologists, psychopharmacologists, physicians from the Family Practice Residency Center located in Las Cruces, New Mexico. Guest professors are national experts with specialized research and applied skills in treating particular disorders and populations. Faculty includes:*

**Lia Billington, Ph.D.**, Child psychologist and prescribing psychologist, currently practicing in Albuquerque, New Mexico.

**Wanda Borges, CNS**, Clinical Nurse Specialist and nursing faculty, New Mexico State University.


**Kevin McGuinness, Ph.D.**, Prescribing Psychologist and Captain in the Public Health Service. 2014 recipient of the APA Leadership Award in Public Service. Currently in part-time private practice in Las Cruces, New Mexico while stationed in Washington, D.C.

**Marlin Hoover, Ph.D.**, Prescribing Psychologist, Behavioral Medicine Faculty, The Family Practice Residency Center at Memorial Medical Center in Las Cruces, NM.

**Tony Kreuch, Psy.D.**, Neuropsychologist and prescribing psychologist. Staff psychologist for Sandia Labs Health Clinic, Albuquerque, NM.

**Elaine LeVine, Ph.D.**, Prescribing Psychologist, Acting Training Director, NMSU RxP Program; Affiliate Professor, New Mexico State University; Director of the Southwestern Institute for the Advancement of Psychotherapy.

**Mai Oushy, M.D., MPH**, Specializing in obstetrics and gynecology. Ain Shams University School of Medicine, Cairo, Egypt, and college professor, Department of Health, New Mexico State University.

**Mario Marquez, Ph.D.**, Child psychologist and prescribing psychologist, consultant to Bernalillo School District, New Mexico.

**Joseph M. Masserano, Ph.D.**, Associate Professor of Pharmacy at the University of New Mexico in Albuquerque, NM Pharmacy teacher of the year, 2013, 2007, 2006, and 2002.

**John Preston, Psy.D.**, Board certified clinical neuropsychologist and author of numerous texts on psychopharmacology.

**Mitchell Simson, M.D.**, Internist and Chemical Dependency Specialist, Chair of Internal Medicine Clinic, University of New Mexico, Albuquerque, New Mexico.

**Linda Summers, Ph.D., RN, FNP**, Nursing Faculty New Mexico State University, Las Cruces, New Mexico and Family Nurse Practitioner, New Mexico Department of Health.
STANDARDS FOR AWARDING CREDIT

Participants are expected to complete all courses and exams. To obtain the Master’s degree, students must maintain a B average. The 36 hour curriculum is taught through day modules for 25 separate weekends. Five days of classes (the equivalent of 2 ½ weekends of classes) constitute a three credit course as listed in the catalog.

The details for passing each course are elucidated in the syllabi and on the website, www.siaprxp.com. In sum, students will complete open-book tests at the end of each day of class, as well as respond to case studies. If students have difficulty, they are given instructions for remediation until they meet the expected level of proficiency.

Records are kept in a locked office on a secured computer or as hard copies in files in a locked office at New Mexico State University, Department of Counseling and Educational Psychology.
GRIEVANCE PROCEDURES

All faculty in the SIAP/NMSU program have the same rights and privileges as other faculty at New Mexico State University. These documents are listed at:


On the following pages the sections of the New Mexico State University policy manual most relevant to you are included.
NEW MEXICO STATE UNIVERSITY POLICY MANUAL

3.94 Sexual Harassment – Gender Discrimination *(See also Policies 1.20; 3.22; 3.25; 4.05.10; 4.05.40)*

It is the policy of New Mexico State University to provide an atmosphere free of sexual harassment for all faculty, staff, students, and visitors.

According to the U.S. Equal Employment Opportunity Commission and the U.S. Office for Civil Rights, unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment or academic progress; (2) students’ educational pursuits are adversely impacted; (3) submission to or rejection of such conduct by an individual is used as the basis for academic or employment decisions affecting such individual; (4) such conduct has the purpose or effect of unreasonably interfering with an individual’s academic or work performance, or creates an intimidating, hostile, or offensive working or learning environment. Harassing conduct based on gender often is sexual in nature, but sometimes is not. Any unwelcome conduct based on gender is also forbidden by this policy regardless of whether the individual engaged in harassment and the individual being harassed are of the same or different gender. Common forms of harassment include offensive or abusive physical contact, joking, lewd language, suggesting sexual favors, displaying sexually suggestive objects, pictures, magazines, calendars, etc. Hostile Work/Academic Environment: A student or employee may file a claim based on sexually offensive conduct that is sufficiently severe and/or pervasive to create a hostile work or academic environment. A hostile work or academic environment based on unwelcome attention, leers, or remarks of a sexual nature may also be grounds for sexual harassment. The university extends this protection to students in the classroom or in any academic-related settings. Hostile environment harassment based on discrimination should be referred to the Institutional Equity/EEO Director. Nondiscriminatory hostile environment issues are regarded management matters under the purview of the appropriate administrator. Retaliation: Any university employee or student may report violations of this policy without fear of retribution. The university prohibits retaliation against individuals because they have in good faith: (1) opposed any discriminatory or employment practice covered by university policies/procedures or state/federal laws; (2) filed a complaint of discrimination or grievance with the Office of Institutional Equity/EEO or external state/federal agency with statutory jurisdiction over discrimination filings; (3) reported a discriminatory matter to a supervisor; or, (4) testified, assisted with, or participated in an investigation, proceeding, or hearing protected under same. Such retaliation in and of itself may result in disciplinary action, up to and including termination. Grievances: Persons who feel they have been harassed should whenever possible first approach the person or persons engaging in the inappropriate conduct indicating that the conduct is unwelcome. If the unwelcome behavior persists, the aggrieved should either report the complaint to the appropriate supervisor or the Institutional Equity/EEO director. All sexual harassment complaints made to a NMSU Policy Manual Chapter 3 Page 32 of 34 person in a position of authority must be reported to the Institutional Equity/EEO director (or the human resource services director if uncomfortable reporting the complaint to the Institutional Equity/EEO director) immediately, regardless of whether or not permission was given by the party subjected to the harassment. Allegations of sexual harassment are to be reported within 15 working days of occurrence, unless extenuating circumstances warrant exception. All employees and students should be aware that the university is prepared to take action in a timely manner to prevent and remedy such behavior, and that individuals who engage in such behavior are subject to disciplinary action. Any disciplinary action may be appealed through the appropriate procedure. To the extent possible, every effort will be made to safeguard confidentiality, consistent with reporting obligations and the need to investigate promptly and thoroughly. Contact the Institutional Equity/EEO director at (575) 646-3635 for any questions or clarifications to this policy statement. Sanctions: Individuals who engage in sexual harassment, or supervisors who neglect to control the work environment and/or learning environment, will be held accountable. If it is determined that a violation of this policy has occurred, appropriate disciplinary action, training, and other
measures will be taken to remedy the situation. All individuals are required to cooperate with any investigation in response to an allegation of harassment. Refusal to cooperate in an investigation may result in disciplinary action in accordance with university policy.

CHAPTER 4 - HUMAN RESOURCES – GENERAL POLICIES

4.05 Appeals/Grievances (See Due Process)

New Mexico State University is dedicated to providing equal employment opportunities in all areas of occupation without regard to age, ancestry, color, mental or physical disability, gender, gender identity, serious medical condition, national origin, race, religion, sexual orientation, spousal affiliation or veteran status, according to state and federal laws. This dedication extends to recruiting and hiring, promotion and other human resources actions such as compensation, benefits, transfers, layoffs, termination, training, education, tuition assistance, social and recreational programs. NMSU’s comprehensive affirmative action program supports this effort. A listing of applicable state and federal laws includes the following:

- Age Discrimination in Employment Act of 1975
- Americans With Disabilities Act of 1990
- Civil Rights Act of 1991
- Education Amendments of 1972, Title IX
- Executive Order 11141
- Executive Order 11246
- Equal Pay Act of 1963
- New Mexico Human Rights Act
- Pregnancy Act of 1978
- Section 504 of the Rehabilitation Act of 1973
- Titles VI and VII, Civil Rights Act of 1964
- Vietnam Era Veterans Readjustment Act of 1974

4.05.40 Appeals Discrimination - Faculty

Applicable to all faculty who allege discrimination, to include sexual harassment and disability. The grievance procedures for applicants, students and staff employees are contained in Section 4.05.10 Appeals Staff and External Applicants. The university is dedicated to providing equal employment opportunities in all areas of occupation without regard to age, ancestry, color, disability, gender, national origin, race, religion, sexual orientation, or veteran status, in accordance with state and federal laws. Employees shall be free to discuss matters with the director of Institutional Equity/EEO and file grievances without fear of reprisal. All discrimination allegations (to include sexual harassment and NMSU Policy Manual Chapter 4 Page 10 of 28 denial of disability accommodations) are to be reported to the Institutional Equity/EEO Office immediately. (See Grievance Exceptions section.)

PROCEDURES

Informal Complaint - The complainant may elect to file an informal complaint by completing the Informal Complaint Form within 15 working days of occurrence of the grievable action. During the informal stage, the complainant may elect not to self-identify. The remedy may include seminars (to include the party charged), exchange of information, newsletter articles, memorandums for campus distribution, or documentation for the record only. Informal actions (when the parties are identified) may include mediation, letters, memos, telephone calls, and other direct means of communication. If the informal filing does not result in resolution, the complainant may file a formal grievance.

Formal Grievance - Completion of the EEO Grievance Form is required within 15 working days of the occurrence or following the informal complaint process above. The complainant will specify the basis of the
grievance as either discrimination and/or employment practices and procedures. The grievance will be accepted or denied in writing by the Institutional Equity/EEO director (or designee). If denied, the complainant may appeal in writing to the executive vice president and provost (or designee) within 5 working days of receipt of written denial letter. If accepted, the party charged will be provided with a copy of the specific allegations, the name of the complainant, and will be extended 10 working days to respond. The complainant may also have an opportunity to receive a copy of the response (upon request), and amend the initial grievance within 2 working days of receiving the response. If the complaint is amended, the party charged will also be extended 2 working days from receipt of the amendment to provide any additional documentation. Additional time for filing may be granted on a case-by-case basis. The Institutional Equity/EEO director (or designee) will investigate relevant issues, secure appropriate statements, and prepare a formal report for administrative review. The executive vice president and provost will review the EEO report and render a decision. The determination letter will be transmitted in writing by the Institutional Equity/EEO director (or designee) to the complainant, party charged, and appropriate administrators. If the complainant or respondent are not in agreement with the decision, new or additional documentation may be provided through the Institutional Equity/EEO Office to the executive vice president and provost (or designee) within 5 working days of receiving the determination letter. Following the review of the new or additional information, a final decision will be issued from the executive vice president and provost (or designee) within 5 working days of receipt of the information to the complainant and party charged. (This stage exhausts the internal appeal process for grievances of discrimination, including sexual harassment.) Sexual harassment is a form of gender discrimination and is subject to the procedures outlined above.

4.05.50 Appeals - Faculty

This section includes (1) a description of procedures for appealing salary increase/performance evaluations to the Review Board of Faculty Salary Increase/Performance Evaluation; (2) a description of the procedures for appealing violations of procedure or due process regarding promotion/tenure and general administrative actions to the University Appeals Board; and, (3) a description of the procedures for appealing the involuntary termination of a continuous contract or a Temporary Contract During Its Term to the Senior Senator Review Committee. (See also Appeals - Discrimination) Under normal circumstances, employees are encouraged to resolve issues through discussion with the immediate supervisor(s). If resolution is not attained, the employee may appeal to the next level of administration. If resolution is not attained, an informal or formal grievance may be filed with the Office of Institutional Equity/EEO. Employees shall be free to file grievances without fear of reprisal. Grievance Exceptions: Any action or complaint commenced in any state or federal agency or court may, at the discretion of the president/executive vice president and provost, result in a stay of any pending internal proceeding (grievance, tenure review, appeal, etc.) filed by or on behalf of an employee, unless the complainant alleges any form of prohibited discrimination. In that case, the internal proceeding will continue until all administrative remedies are exhausted, without regard to the nature of and/or conclusions of any external proceeding. Upon termination of the external proceeding, except those involving discrimination allegations, as described above, the president/executive vice president and provost will review the status of the internal proceeding in the light of the results, if any, NMSU Policy Manual Chapter 4 Page 11 of 28 of the external proceedings. If, in the president's/executive vice president and provost’s opinion, further action is required, the internal proceeding will continue according to policy and procedure. If the president/executive vice president and provost decide that no further action is necessary, the internal proceeding will terminate.

Review Board of Faculty Salary Increase/Performance Evaluation: The Review Board of Faculty Salary Increase/Performance Evaluation hears appeals regarding salary increases and performance evaluation. Composition of the Review Board: The Review Board of Faculty Salary Increase/Performance Evaluation consists of three elected tenured faculty members and one member of the administration. The faculty members will serve staggered 3-year terms and the administration member will also serve a 3-year term. Three alternate members to the Review Board will also be elected. These will serve staggered 3-year terms as replacements for
regular members of equivalent terms, should a regular member be unable to complete the term, and may also be used as replacements when regular members are otherwise unable to serve for a particular case. Nominations for the faculty positions will be through members of the Faculty Senate. The nomination must specify the position for which the nominee will run. (Normally two positions, one Review Board member and one alternate, will be vacated each year.) Elected Review Board members in the faculty positions must be from different colleges. Two or more nominees for the administrative position on the Review Board will be made by the president; nominees will be at the level of department head, assistant dean, or above. Presidential nominations will be submitted after the election results are known in order to assure representation of the various colleges. The presidential nominee receiving the second highest number of votes will serve as alternate in cases involving the administrative member of the Review Board or administrative members staff. Faculty members of the Review Board will be elected by faculty ballot. The administrative position will be elected by ballot of Faculty Senate members. A plurality of 40 percent of the votes cast will be necessary for election for each position and, if necessary, a runoff election between the nominees with the largest number of votes will be held. A quorum of the Review Board will consist of four members. No member will sit in cases involving that Review Board member or members of that Review Board member’s department. In order to avoid actual or perceived conflicts of interest, the chair can excuse any member of the Review Board. The elected faculty Review Board member in the third year of service will serve as chair. The elected faculty Review Board member in the second year of service will serve as chair-elect. The chair-elect will serve as chair in case of absence or disqualification of the chair.

**GRIEVANCE PROCEDURES**

A working day is defined here and throughout this chapter as Monday through Friday, except for official university holidays. The faculty member first should seek to resolve a grievance by conferring with the department head and, if necessary, the dean. If the grievance is not resolved through these informal conferences, the following outlines the process for appealing salary/performance evaluation through the Review Board of Faculty Salary Increase/Performance Evaluation. If circumstances warrant, the chair or the executive vice president and provost may extend specified time limits upon the written request of any party. The opposite party will be given an opportunity to comment on such a request before a decision is made.

**STEP ONE - Filing:** Within 10 working days of notification of an administrative action, a faculty member may present in writing to the department head or appropriate administrator a memo with the subject line Grievance, containing a comprehensive rationale for the grievance, including the basis for the grievance and the remedy requested.

**STEP TWO - Administrative Review:** Within 10 working days of receipt of the grievance, the department head/appropriate administrator will meet with, the dean or appropriate administrator, the chair of the Review Board of Faculty Salary Increase/Performance Evaluation, and the appellant, in an attempt to settle the grievance. Within 5 working days of this meeting, the dean or appropriate administrator will reply in writing to the appellant, with copies to the department head, chair of the NMSU Policy Manual Chapter 4 Page 12 of 28 Review Board, and the executive vice president and provost, describing the action taken, if any, to adjust the matter.

**STEP THREE - Referral to Review Board of Faculty Salary Increase/Performance Evaluation:** If the grievance is not resolved by administrative review, the faculty member may initiate a formal appeal within 10 working days by petitioning the chair of the Review Board by memo through the Office of the Executive Vice President and Provost. The faculty member will provide the dean and the chair of the Review Board a copy of this appeal memo. The faculty member will forward to the Office of the Executive Vice President and Provost a copy of the following material:

- Appellant's evaluation form with summary sheet and appendages submitted by the faculty member during the evaluation period.
• Written statements from the department head to the faculty member outlining objectives agreed upon during the evaluation session.
• Memoranda and/or documents submitted by the faculty member, including the comprehensive rationale for the grievance.
• Written recommendations by the department head, deans, or appropriate administrators regarding the appeal.
• Correspondence and recommendations from the administrative review.

Within 5 working days of receipt of the above material, the Office of the Executive Vice President and Provost will provide four copies of all appropriate materials to the chair for distribution to the Review Board. The chair of the Review Board will submit a statement of its findings and recommendations within 10 working days to the executive vice president and provost, along with related correspondence.

STEP FOUR - Hearing: The Review Board meets no more than 20 working days after a petition has been referred to them according to the guidelines specified below. The chair of the review board will submit a statement of its findings and recommendations within 10 working days to the executive vice president and provost, along with related correspondence.

STEP FIVE - Disposition: A final decision by the executive vice president and provost, along with a copy of the Review Board's findings and recommendations, will be issued in writing to the parties involved, with copies of the decision to the members of the Review Board of Faculty Salary Increase/Performance Evaluation, within 10 working days. All documentation, including the executive vice president and provost's decision, will be filed in the Office of the Executive Vice President and Provost.

Review Board Guidelines:
1. The chair of the Review Board will attempt to settle an issue to the satisfaction of the parties involved before pursuing more formal avenues of action.
2. At least 2 working days in advance of the hearing, the chair of the Review Board will distribute to Review Board members and both parties (through the Office of the Executive Vice and Provost) copies of additional notices and communications from either party. The Review Board members will review these materials, along with those noted in STEP THREE above, previous to the hearing.
3. No new written information may be presented in the hearing by either party without the consent of the chair.
4. The chair will be designated the official timer.

Hearing Procedure: The Review Board will begin the hearing no more than 20 working days after a petition has been referred to them. Participants will be members of the Review Board, the appellant, department head and dean of the college or appropriate administrators, and the graduate dean or designee if the appellant is a member of the graduate faculty, and may include at the option of the appellant one faculty member to assist in the preparation and presentation of the case. Neither administrators nor appellant may be represented at the hearing by legal counsel. The hearing will normally be limited to 1 hour; however, the chair will assure that all parties have an opportunity to NMSU Policy Manual Chapter 4 Page 13 of 28 present their cases. Therefore, the appellant and administrators should be prepared to make concise statements of their respective positions. Each hearing will consist of the following elements:

Phase 1: All participants will be present. The main spokesperson for the administrators, usually the department head, will explain their rationale. Other administrators, keeping within a time constraint of no more than 15 minutes total time for administrators, may supplement the statement. The appellant’s rationale will also be presented within a time constraint of no more than 15 minutes. The next 15 minutes will be devoted to questions and brief statements from administrators and the appellant concerning previous statements.

Phase 2: Members of the Review Board and appellant will be present. Five minutes will be allotted should the appellant choose to make a statement to the Review Board with administrators not present.

Phase 3: Members of the Review Board and administrators will be present. Five minutes will be allotted to the administrators should they choose to make a statement to the Review Board with the appellant not present.

Phase 4: The Review Board will send its recommendation to the executive vice president and provost within 3 working days of the hearing. Within 10 working days, a final written decision will be provided to all
participants by the executive vice president and provost. All documentation, including the executive vice
departmental discipline in which the appellant has been serving, and the senior senator from a campus
campus college other than that described above. If two members have identical service on the Faculty Senate, the
campus member from the college which administers the departmental discipline in which the
appellant has been serving will chair the Senior Senator Review Committee. In the event that the
appellant is a Cooperative Extension Service representative on the Faculty Senate, the appellant will be disqualified
from the committee and the above procedure will be carried out, choosing five members instead of four from the six
colleges. A quorum of the Senior Senator Review Committee will consist of six members. In the event a hearing is requested during the summer months, the
Senior Senator Review Committee will be composed of the most senior senator available from each college. In
the event the elected senators from the community colleges or Cooperative Extension Service are not available
to serve, the chair of the Faculty Senate will select replacement(s) from their respective colleges or units.

PROCEDURE
The following is an outline of the hearing process. If circumstances warrant, the chair may change specified
time limits upon the written request of any party. The chair will give the opposite party opportunity to comment
on such a request before making a decision.
STEP ONE - Filing: Within 10 working days of notification of the termination for cause or termination of a
temporary contract during its term, a faculty member may file a request in writing to the executive vice
president and provost for a hearing before the Senior Senator Review Committee.
STEP TWO - Referral to Senior Senator Review Committee: Within 10 working days of the appellant's request,
the executive vice president and provost will direct the chair of the Faculty Senate to convene a Senior Senator
Review Committee following the guidelines above.
STEP THREE - Settlement Attempt: The chair of the Senior Senator Review Committee will meet with the parties involved and attempt a settlement. If a settlement is not attained, a hearing will be held within 30 working days, but not less than 15 working days without the consent of the petitioner. A comprehensive rationale for the grievance, including any documentary evidence supporting the allegations of unfair treatment, and the remedy requested must be submitted to the chair of the Senior Senator Review Committee 5 working days prior to the hearing. Any material from the respondent(s) must also be submitted to the chair of the Senior Senator Review Committee 5 working days prior to the hearing.

STEP FOUR - Hearing: The Senior Senator Review Committee meets according to the hearing guidelines. The chair of the Senior Senator Review Committee will submit a statement of its findings and recommendations to the president along with related correspondence.

STEP FIVE - Disposition: Within 10 working days of receipt of the recommendations of the Senior Senator Review Committee, a final decision by the president, along with a copy of the findings and recommendations of the Senior Senator Review Committee, will be issued in writing to the parties involved, with copies of the decision to the Senior Senator Review Committee. All documentation, including the president's decision, will be filed in the Office of the Executive Vice President and Provost.

Settlement: The chair of the Senior Senator Review Committee will attempt to settle an issue to the satisfaction of all parties before pursuing a formal hearing. If such a settlement is not possible, the Senior Senator Review Committee will then proceed with the hearing.

Hearing Procedure:
1. The chair will notify the petitioner and other appropriate persons in writing the date, time, and location of the hearing. The hearing will be scheduled within 30 working days, but no sooner than 20 working days from the attempted settlement.
2. The hearing will be limited to the specific cause(s) of termination. NMSU Policy Manual Chapter 4 Page 18 of 28
3. The Senior Senator Review Committee will decide if the hearing will be open or closed. A tape recording of the hearing will be preserved by the Senior Senator Review Committee, copies of which will be available to either party upon request.
4. The hearings of the Senior Senator Review Committee will not be bound by the rules of civil procedure, and any evidence of probative value in determining the issues involved may be admitted. Every possible effort will be made to obtain the most reliable evidence available.
5. Each party may bring a representative or legal counsel to assist in the preparation and presentation of the case. Both administration and the appellant may be represented at this hearing by legal counsel.
6. Each party may bring witnesses on his or her behalf; however, the statements of these witnesses must be made in the time allocated for the party having the floor.
7. The chair will assure that all parties have an adequate opportunity to present their cases, including witnesses. Upon the completion of formal statements by both parties, there will be an opportunity for cross-examination. Finally, each party may make a summary statement.
8. After all statements have been taken, parties and witnesses will be excused. The Senior Senator Review Committee will then deliberate and reach its decision. Within 15 working days of close of the appeal hearing, the chair of the Senior Senator Review Committee will submit a statement of its findings, its recommendations, the tape recordings, and related papers to the president. Each party will also receive a copy of the findings and recommendations. Within 10 working days of receipt of these materials, the president will issue a final written decision to the Senior Senator Review Committee and other appropriate persons. All documentation, including the president's decision, will be filed in the Office of the Executive Vice President and Provost.
4.30.20 Hiring of Individuals Named in Contract (Faculty and Exempt Staff Only)
Under certain conditions it may be necessary for an employing department to hire an individual named in a grant or contract. With prior approval of the Human Resource Services Office and the executive vice president and provost, a faculty or exempt staff member may be hired with full benefits under the following conditions:
1. The individual is named as principal or co-principal investigator of the grant or contract.
2. The individual named in the grant or contract possesses unique or highly specialized qualifications required by the granting agency in order to carry out the responsibilities required of the grant or contract.
3. The granting agency has approved the award of the grant or contract subject to the appointment of the particular individual named.
4. The university is awarded or assumes the oversight of an existing external workforce. Under these conditions, waiver of the advertising requirements for regular employment must be requested in writing to the Human Resource Services Office and the Office of the Executive Vice President and Provost. Employment of an individual named in a grant or contract is contingent upon funding of that specific grant or contract and is not transferable to another source of funding.

4.60 Public Affairs Participation (See also Chapter 3 Codes of Conduct - Conflict of Interest)
The policy of the Board of Regents is that faculty and staff have the same citizens' rights as other people. However, employees seeking elective office or serving in an elective office must not allow campaign and service activities to interfere with university responsibilities. Employees elected to the state legislature will be placed on leave without pay during the term of such office. Any possible conflict of interest shall be reported by the employee or by any other concerned employee to the administration through the appropriate channels. Unresolved issues shall be referred to the appropriate university appeals board. It shall be the responsibility of the employee to report appointment or election to public bodies and/or conflict of interest situations. Such reports shall be sent to the Office of the President. The written notification shall include the type of employment or type of office, the commencing and terminating dates or period of service, and, when applicable, the nature of the conflict of interest situation. The president has discretion to approve requests to serve on international, national, state, and local committees and commissions.
ETHICAL GUIDELINES

All professors are expected to follow the guidelines of the APA code of ethics in all their interactions with students and colleagues. The welfare of our students and patients must always be tantamount. The complete copy of the ethical guidelines can be found at:


On the following pages, the ethical principles regarding education and training are copied for your convenience.
Standard 7: Education and Training

7.01 Design of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that the programs are designed to provide the appropriate knowledge and proper experiences, and to meet the requirements for licensure, certification, or other goals for which claims are made by the program. (See also Standard 5.03, Descriptions of Workshops and Non-Degree-Granting Educational Programs.)

7.02 Descriptions of Education and Training Programs

Psychologists responsible for education and training programs take reasonable steps to ensure that there is a current and accurate description of the program content (including participation in required course- or program-related counseling, psychotherapy, experiential groups, consulting projects, or community service), training goals and objectives, stipends and benefits, and requirements that must be met for satisfactory completion of the program. This information must be made readily available to all interested parties.

7.03 Accuracy in Teaching

(a) Psychologists take reasonable steps to ensure that course syllabi are accurate regarding the subject matter to be covered, bases for evaluating progress, and the nature of course experiences. This standard does not preclude an instructor from modifying course content or requirements when the instructor considers it pedagogically necessary or desirable, so long as students are made aware of these modifications in a manner that enables them to fulfill course requirements. (See also Standard 5.01, Avoidance of False or Deceptive Statements.)

(b) When engaged in teaching or training, psychologists present psychological information accurately. (See also Standard 2.03, Maintaining Competence.)

7.04 Student Disclosure of Personal Information

Psychologists do not require students or supervisees to disclose personal information in course- or program-related activities, either orally or in writing, regarding sexual history, history of abuse and neglect, psychological treatment, and relationships with parents, peers, and spouses or significant others except if (1) the program or training facility has clearly identified this requirement in its admissions and program materials or (2) the information is necessary to evaluate or obtain assistance for students whose personal problems could reasonably be judged to be preventing them from performing their training- or professionally related activities in a competent manner or posing a threat to the students or others.

7.05 Mandatory Individual or Group Therapy

(a) When individual or group therapy is a program or course requirement, psychologists responsible for that program allow students in undergraduate and graduate programs the option of selecting such therapy from practitioners unaffiliated with the program. (See also Standard 7.02, Descriptions of Education and Training Programs.)

(b) Faculty who are or are likely to be responsible for evaluating students' academic performance do not themselves provide that therapy. (See also Standard 3.05, Multiple Relationships.)

7.06 Assessing Student and Supervisee Performance
(a) In academic and supervisory relationships, psychologists establish a timely and specific process for providing feedback to students and supervisees. Information regarding the process is provided to the student at the beginning of supervision.

(b) Psychologists evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements.

**7.07 Sexual Relationships With Students and Supervisees**

Psychologists do not engage in sexual relationships with students or supervisees who are in their department, agency, or training center or over whom psychologists have or are likely to have evaluative authority. (See also Standard 3.05, Multiple Relationships.)

It is hoped that as students proceed through the Psychopharmacology curriculum offered by the Southwestern Institute for the Advancement of Psychotherapy in collaboration with New Mexico State University, they will feel free to openly discuss any concerns that they may have with the Director of the SIAP/NMSU collaborative. As is suggested by the American Psychological Association (APA) Professional Code of Ethics, as professional psychologists, we should first attempt to work through any difficulties by communicating in a collegial fashion.

However, at times, issues do arise that are difficult to resolve on an informal or individual manner. In such cases, the SIAP/NMSU cooperative follows the grievance procedure from the graduate school at NMSU as follows:

1. Under normal circumstances, the student should discuss the issue with the instructor/adviser.
2. If the student is unable to resolve the issue through consultation with the faculty member, the student must submit a written memorandum detailing the grievance to the course instructor or adviser within 30 calendar days of the beginning of the following full (i.e., fall or spring) semester. The person to whom the memorandum is addressed must respond in writing within 30 calendar days to the student.
3. If the student is not satisfied with the response from Steps 1-2, he or she must submit a written appeal to the department head of the Department of Counseling and Educational Psychology within ten working days of the initial decision. If the student is initiating the appeal at the departmental level, he or she must do so, in writing, within 30 calendar days of the beginning of the following full (i.e., fall or spring) semester. The department head must respond in writing within ten working days to the student, the instructor or adviser (if one is involved), and the Dean of the Graduate School.
4. If after the third step the student or any of the other parties involved is still not satisfied with the response, he or she must present to the Dean of the Graduate School within ten working days a written complaint detailing the nature of the grievance and requesting a Graduate Student Appeals Board hearing. After receiving a written complaint, the Dean of the Graduate School will determine whether the complaint has merit. If the graduate dean determines that the appeal does not have merit, he or she will inform the appellant and other parties, in writing, within ten working days of receiving the appeal. If the graduate dean decides that the appeal does have merit, he or she will convene the Graduate Student Appeals Board, normally within three weeks. The Graduate Student Appeals Board will conduct, within 60 days of their convening, whatever investigations and deliberations are necessary, and will forward to the Dean of the Graduate School a recommendation to resolve the grievance.
5. After reviewing the recommendation of the Graduate Student Appeals Board, the Dean of the Graduate School will, within ten working days, inform all parties involved of his or her decision in writing. The decision of the Dean of the Graduate School is final. The Dean of the Graduate School may waive the normal time frame for grievances when either party presents compelling evidence justifying such a delay, but grievances must be launched within one year.
APPENDIX A

Recommended post-doctoral education and training program in psychopharmacology for prescriptive authority approved by the APA Council of Representatives August 9, 2009.
INTRODUCTION

Education and training in psychopharmacology for prescriptive authority has evolved rapidly over the past two decades. As of the writing of this document, there were approximately 10 programs in a range of educational contexts offering this training on a postdoctoral basis. As more states pass laws authorizing properly trained psychologists to prescribe it will continue to be necessary to define what is meant by “properly trained psychologists.” Psychology’s ethical responsibility to the public requires that the profession be able to define the training needs and minimum competencies required for prescriptive authority. This document reflects the most current thinking in the field as to the nature of such education and training. It incorporates knowledge and experience derived since the 1996 version of this document, Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges, became APA policy.

In accordance with Association Rule 30-8.3 requiring that all APA standards and guidelines be reviewed at least every 10 years, and in light of the advances that have been made in prescriptive authority education and training and legislation enacted since the document APA Recommended Postdoctoral Training in Psychopharmacology for Prescription Privileges (1996 Recommended Training) was approved in 1996,1 the Council of Representatives authorized a joint BEA-CAPP Task Force in February 2006 to review the current program requirements and recommend any necessary updates and revisions.

When the original model program standards were developed over a decade ago, few programs existed and no state legislation, enabling psychologists to prescribe, had been enacted. Since then, a number of new programs have developed operating under varying education and training models, and enabling legislation has been passed in two states and one U.S. territory (with legislation pending or planned in several others). These developments clearly called for revisions of the existing policy.

Contextual Framework

The program described in this document is a postdoctoral experience, which is intended to be an extension of doctoral education and training in psychological practice. Accordingly, the scientific basis of pharmacology and its application to clinical practices of prescribing must be viewed in the context of the total complex of factors influencing human psychology. Education and training should reflect the integration of research literature and practice experience on the relationship between psychopharmacological and psychological interventions.

Psychopharmacology education and training for psychologists, while building on training traditions in medicine, pharmacy, and nursing, should be conducted in a manner consistent with the education and training of psychologists. These standards are also designed specifically to meet the needs of practicing psychologists and their patients and are intended, in part, as a service to the public by describing the minimum requirements for this training.

1 The 1996 Recommended Training was based on several earlier documents, including the Department of Defense Psychopharmacology Demonstration Project curriculum, the report of the Blue Ribbon Panel of the Professional Education Task Force of the California Psychological Association, and an initial document prepared by the CAPP Task Force on Prescription Privileges. The final draft of the document was developed by the APA Presidential Working Group and submitted to the APA Council of Representatives.
Application for Psychologists Matriculating through the 1996 Recommended Training

A number of programs have emerged that included many, if not most, of the key elements of the 1996 Recommended Training, and many psychologists have completed significant portions of the 1996 Recommended Training through those programs. The revisions found in the present document reflect subsequent advances in learning models and methods of pedagogy, as well as feedback from psychologists who have completed a postdoctoral program in psychopharmacology. Inasmuch as the current document builds on the earlier model, those psychologists who completed programs based on that earlier model can be recognized as meeting the curriculum requirements relevant at the time of their matriculation. To address the needs of those psychologists who completed postdoctoral programs that did not meet all requirements of the 1996 Recommended Training, programs are encouraged to develop policies that would permit, on an individual case basis, the demonstration of competence to meet current program requirements.

Essential Elements

Postdoctoral Education and Training

These standards are intended to describe a postdoctoral experience. This program involves advanced training in a specific content area of psychology representing a significant expansion of scope of practice. The prerequisites for admission to a program continue to be (1) a doctoral degree in psychology; (2) current licensure as a psychologist, and (3) practice as a health services provider as defined by state law, where applicable, or as defined by APA. The 1996 Recommended Postdoctoral Training Program includes didactic coursework prerequisites that are included now in these standards in the basic sciences and neurosciences domains of instruction. Training programs in psychopharmacology for prescriptive authority can award transfer credit for no more than twenty percent (20%) of the total curriculum hours. This twenty percent shall be limited to the basic science and neuroscience domains of the curriculum.

These standards include three components that reflect an evolution in instruction and assessment from the 1996 Recommended Training. These include integration of didactic instruction and supervised experience, the incorporation of competence based assessment, and incorporation of a capstone competency.

Integrated Didactic Instruction and Supervised Clinical Experience

Relevant supervised clinical experiences are now integrated into the sequence of courses. These standards allow psychologists to assimilate new knowledge as it is learned through its application.

The revised curriculum integrates supervised clinical experiences with coursework so that as each content area is addressed in the curriculum, supervised clinical experiences relating to the course content are provided to the participant. Supervised clinical experience remains an important aspect of training. By building such experiences into the sequence of didactic coursework, participants will be able to apply the concepts acquired through coursework at the time that is optimal for cementing learning.

The term “supervised clinical experience” is substituted for the term “practicum” used in the 1996 Recommended Training.
Addition of Elements of a Competency Model

The curriculum promotes the integration of knowledge, skills and attitudes fundamental to professional practice with psychopharmacologic interventions. In this context, movement to competency-based models to measure education and training outcomes is occurring across the health professions. These models include both formative (ongoing) and summative (end point) assessment approaches. Various entities within psychology (e.g., the APA Benchmark Competencies Initiative, the APA Policy on Education and Training Leading to Licensure, and the Practicum Working Group on Competencies) are focusing on the identification and assessment of competencies in education and training that have resulted in important changes in how educational outcomes are defined and evaluated. The APA Task Force on the Assessment of Competence in Professional Psychology articulated 15 principles that are a useful resource in this process. By focusing on necessary competencies, these standards are intended to allow maximum flexibility in program design within the parameters of ensuring an optimal educational experience.

Capstone Competency Evaluation

To be consistent with a model that emphasizes the mastery of essential competencies, training programs developed under these standards provide a capstone competency evaluation that requires integration of the knowledge, skills, and attitudes the psychologist is expected to master during their matriculation in the program. Two recommended components of this could be a review of a portfolio of cumulative supervised clinical experiences and the application of the knowledge, skills, and attitudes to unrehearsed clinical situations ranging from routine, uncomplicated cases to those of a more complex nature involving multiple medical comorbidities. This evaluation is distinct from any evaluation that focuses exclusively on mastery of information, such as the Psychopharmacology Examination for Psychologists. The capstone competency evaluation is summative and follows demonstration of mastery of multiple, foundational competencies throughout the training program.

Education and Training in Issues of Diversity

Programs developed under these standards will continue their commitment to providing training courses and experiences that encourage sensitivity to the interactions between pharmacological interventions with development across the lifespan, gender, health status, and ethnicity of patients. This focus is reflected in both the didactic and experiential components of the program so that psychologists will develop the appropriate skill-based competencies to address diversity in the population being served.

Designation Process Requirement

Both the 1996 Recommended Training and these standards are exclusively relevant to the evaluation of programs, not individuals; they are not intended to be used for the evaluation of individuals’ qualifications to engage in any activities related to psychopharmacology. The policies do, however, have important implications for determining whether or not individual psychologists have completed an acceptable course of education and training. The shift to an emphasis on skills-based competencies and away from requirements presumed to be suggestive of the mastery of skills (such as the institutional location of the training, the number of hours allotted to each topic, or the type of credential awarded upon the completion of training) implies that it is the development of critical competencies that should decide whether or not the training is adequate. Experiences to date do not provide a convincing rationale for choosing any given training model over others. Furthermore, it seems prudent to encourage the development of viable alternative routes to training competent practitioners at this still early stage in the development of this area of practice.
The shift to include more of a competency-based model, the breadth of formats in which programs may operate, the integration of didactic coursework and supervised clinical experience, and other significant changes in demonstration of competency and methods of assessment of competencies require a mechanism to ensure that programs are providing the recommended education and training outlined in these standards. Therefore, APA will establish a formal designation body that represents psychopharmacology education and training programs, educators, relevant basic scientists, relevant public interests and practitioners to establish processes and procedures to evaluate consistency with these standards that will provide a system for assuring that programs are providing education and training presumed necessary for responsible psychopharmacological practices. Although detailed recommendations for establishing an appropriate designation process were beyond the scope of the task force that developed these standards, such a system is important and the establishment of a designation body is critical to establishing and maintaining minimal standards of program quality.

Maintenance of Competencies through Lifelong Learning

Postdoctoral training programs in psychopharmacology for prescriptive authority are rigorous and comprehensive in didactic content, clinical experiences, and the integration of psychological and pharmacological principles. Programs developed under these standards place a special emphasis on preparing psychologists to evaluate future advances in psychopharmacological knowledge and on the critical importance of lifelong learning in psychopharmacological practice.

Summary

These policies and procedures represent changes inherent in a shift toward a competency-based model of learning and assessment in preparation for prescriptive authority, and are intended to set the context for the understanding of the curriculum as further described in this document. Given the rapid evolution of the field, these standards should be reviewed in five years. This review should include a review of the quality assurance systems.

PREREQUISITES FOR ADMISSION TO EDUCATION AND TRAINING PROGRAMS IN PSYCHOPHARMACOLOGY

To participate in postdoctoral education and training in psychopharmacology, programs must require that psychologists meet the following prerequisites:

1. Be a graduate of a doctoral program in psychology;
2. Hold a current state license as a psychologist; and
3. Practice as a "health services provider" psychologist as defined by state law, where applicable, or as defined by APA.2

PROGRAM CHARACTERISTICS

The entire program of education and training should be an organized and sequenced program of instruction at the postdoctoral level.

The program is responsible for determining and disseminating admissions standards. The program could develop policies for allowing credit from a previous graduate or postdoctoral education and training program(s).
To ensure that the training experience is up-to-date, sequential, and cumulative, transfer of a limited number of credits as appropriate for previous coursework is not to exceed twenty percent (20%) of the postdoctoral curriculum and is to be limited to the basic science and neuroscience domains (Domains I & II). This does not preclude the development of program policies that would permit, on an individual case basis, the meeting of program requirements through a current demonstration of competence obtained through prior postdoctoral education and training. In such unusual cases, program policies should explicitly state the criteria for such decisions, and there should be an accompanying record of the specific competencies demonstrated by the psychologist and those yet to be acquired through the program.

The program is accountable for establishing and demonstrating evidence of appropriate quality assurance mechanisms. As such, the program will demonstrate the following characteristics:

*Ethical Standards*

The program administrators and faculty will abide by the current Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association.

*Mission*

The program has a clear and comprehensive mission statement that guides it, is approved by the governing body, and is publicly communicated.

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2 In 1995, the APA Council of Representatives approved the following definition of "health service provider" psychologists: Psychologists are recognized as Health Service Providers if they are duly trained and experienced in the delivery of preventive, assessment, diagnostic and therapeutic intervention services relative to the psychological and physical health of consumers based on: 1) having completed scientific and professional training resulting in a doctoral degree in psychology; 2) having completed an internship and supervised experience in health care settings; and 3) having been licensed as psychologists at the independent practice level.
Governance & Administration

The program has sufficient financial resources and access to appropriate physical resources to support its mission.

The program has qualified and competent administrators, including a director, with appropriate administrative authority. The legal authority and operating control of the program are clearly described.

Program Characteristics

- The program is an integrated and organized program of study.
- The program has an identifiable body of students.
- The program is clearly identified and labeled as a postdoctoral education and training program in psychopharmacology for prescriptive authority.
- The program ensures the quality of education and training, including any consortial relationships or contractual agreements.
- The program protects the security, confidentiality, integrity, and availability of student records.
- The program has due process and grievance procedures.
- The program regularly engages in a process of self-evaluation.
- The program ensures that students maintain licensure throughout the program.

Faculty

Faculty and supervisors are qualified and sufficient in number to accomplish the program’s education and training goals. In addition to psychology, the program faculty and supervisors may come from a variety of appropriate disciplines. Faculty will participate in the program’s planning, implementation and evaluation.

Learning Resources

The program provides access to facilities, services, and learning/information resources that are appropriate to support its didactic and experiential teaching, research, and service mission. This may include access to facilities, library materials, and an appropriate array of learning resources.

Further, the program will offer an integrated and sequential program of instruction as evidenced through the following:

1. An organized sequence of courses with relevant syllabi;
2. Frequent evaluation of students’ knowledge and application of that knowledge and feedback to students of outcomes;
3. Periodic program evaluation;
4. Certification of program completion upon demonstration of appropriate level of competence
DIDACTIC INSTRUCTION AND SUPERVISED CLINICAL EXPERIENCE

A competency-based approach entails educational objectives or defined competencies at each level of learning. Competences facilitate demonstration of the ability to perform defined tasks along a continuum with a wide range of possible outcomes. Competencies are conceived as holistic and represent:

- **knowledge** of subject matter concepts and procedures
- **performance** of behaviors that demonstrate specific skills and abilities
- **problem solving** strategies and capabilities that involve elements of critical thinking and ethical responsibility
- **self reflection** that focuses on knowing the limits of one’s knowledge; clarification of attitudes, beliefs, and values; and identification of self perceptions and motivations in the context of prescriptive authority.

Assessment of the delineated competencies for prescriptive authority includes approaches that integrate evaluation that is both formative (i.e., ongoing corrective feedback that advises for further development) and summative (i.e., determines attainment of a specific competency). Assessment is developmentally informed and conducted using multiple reliable and valid methods and varied sources of information. This approach shifts the focus from exclusively documenting what is taught to one based on demonstrating what students have learned and how they effectively apply didactic instruction in integrated practice. Throughout the curriculum, students will demonstrate threshold performance levels at identified benchmarks of competence across the delineated competencies.

The topics that should be addressed by the psychopharmacology curriculum must cover a broad range of both basic science and clinical content areas with sufficient specificity such that the learner is adequately prepared for the practical application of the knowledge and skills attained. All areas should also address cultural context, including variability due to development across the lifespan, gender, health status, and ethnicity. A foundation of knowledge should be laid so that the learner can continually develop an understanding of and ability to use emerging treatments. This foundation should include instruction in the core principles regarding the implementation and evaluation of research on psychoactive substances.

**Didactic Content Areas**

The approaches taken to the didactic instruction of content should make use of multiple pedagogical methods. In addition to the provision of knowledge via more traditional means such as readings, lecture and discussion, participants may make use of various means for applying, integrating and thereby broadening their knowledge via the analysis of clinical cases, problem based learning, computerized patients and simulations using layered decision models, and skills-based demonstrations throughout the curriculum.

Recognizing that this is a dynamic field and that subsequent revision may become necessary over time, 400 contact hours, at a minimum, of didactic instruction is expected in the following core content areas (I-VIII).

As programs may develop specific courses using different content integration approaches, these are not meant as specific courses and the contact hours are not broken down into each area. The program must demonstrate that all content is covered and that the students achieve clinical competency in all content areas.
Italicized content represents examples of some of the clinical competencies that may be associated with the domain of instruction.

I. Basic Science
   A. Anatomy & Physiology
   B. Biochemistry

II. Neurosciences
   A. Neuroanatomy
   B. Neurophysiology
   C. Neurochemistry

III. Physical Assessment and Laboratory Exams
   A. Physical Assessment
   B. Laboratory and Radiological Assessment
   C. Medical Terminology and Documentation

Integration of A-C through supervised clinical experience or lab experience in conducting physical exam, ordering psychometric and laboratory tests, understanding results and interpretation

IV. Clinical Medicine and Pathophysiology
   A. Pathophysiology with particular emphasis on cardiac, renal, hepatic, neurologic, gastrointestinal, hematologic, dermatologic and endocrine systems.
   B. Clinical Medicine, with particular emphasis on signs, symptoms and treatment of disease states with behavioral, cognitive and emotional manifestations or comorbidities
   C. Differential Diagnosis
   D. Clinical correlations-the illustration of the content of this domain through case study
   E. Substance-Related and Co-Occurring Disorders
   F. Chronic Pain Management

Integration of A-F through supervised clinical experience or lab experience in taking medical history, assessment for differential diagnosis, and review of systems

V. Clinical and Research Pharmacology and Psychopharmacology
   A. Pharmacology
   B. Clinical Pharmacology
   C. Pharmacogenetics
   D. Psychopharmacology
   E. Developmental Psychopharmacology
   F. Issues of diversity in pharmacological practice (e.g., sex/gender, racial/ethnic, and lifespan factors related to drug metabolism access, acceptance, and adherence)

Integration of A-F through supervised clinical experience or lab experience in Clinical Medicine and ongoing treatment monitoring and evaluation

VI. Clinical Pharmacotherapeutics
   A. Combined therapies - Psychotherapy/pharmacotherapy interactions
   B. Computer-based aids to practice
   C. Pharmacoepidemiology

Integration of A-C through supervised clinical experience or lab experience in integrated treatment planning and consultation and implications of treatment

VII. Research
   A. Methodology and Design of psychopharmacological research
   B. Interpretation and Evaluation of research
   C. FDA drug development and other regulatory processes

VIII. Professional, Ethical, and Legal Issues
A. Application of existing law, standards and guidelines to pharmacological practice
B. Relationships with pharmaceutical industry
   1. Conflict of interest
   2. Evaluation of pharmaceutical marketing practices
   3. Critical consumer

Supervised Clinical Experience

The supervised clinical experience should be an organized sequence of education and training that provides an integrative approach to learning as well as the opportunity to assess competencies in skills and applied knowledge. The intent of the supervised clinical experience is two-fold:

1. To provide ongoing integration of didactic and applied clinical knowledge throughout the learning sequence, including ample opportunities for practical learning and clinical application of skills.
2. To provide opportunity for programs to assess formative and summative clinical competency in skills and applied knowledge.

In addition to the didactic hours, the number of hours needed to achieve mastery of clinical competencies is expected to be substantial and will vary across individuals.

The supervised clinical experience is intended to be an intensive, closely supervised experience. The range of diagnostic categories, settings and characteristics such as development across the lifespan, gender, health status, and ethnicity reflected in the patients seen in connection with the supervised clinical experience should be appropriate to the current and anticipated practice of the trainee. It should allow the practitioner to gain exposure to acute, short-term, and maintenance medication strategies.

The trainee gains supervised clinical experience with a sufficient range and number of patients in order to demonstrate threshold performance levels for each of the competency areas. In order to achieve the complex clinical competency skills required for independent prescribing, a sufficient number of supervised patient contact hours must be completed. The supervised clinical training experiences must be approved by the Training Director prior to commencing that placement. The program must document the total number of supervised clinical experience hours that students experience. These must be broken out by face-to-face patient contacts versus other clinical experiences, and the clinical competencies employed.

In addition, the method and appropriate benchmarks for assuring each clinical competency must be described. These methods may include, for example, performing physical examinations and presenting cases based on actual and simulated patients. The trainee recommends/prescribes in consultation with or under a designated supervisor(s) with demonstrated skills and experience in clinical psychopharmacology and in accordance with the prevailing jurisdictional law.

The program is responsible for the approval and oversight of each supervised clinical experience. Final approval of the supervised clinical experience must be provided by the program prior to initiation.

The supervised clinical experience may be integrated into each level of education and training, provided in a final summative practical experience or a combination of both according to the design of the program. The last item in Domains of Instruction, Sections III-VI, encompasses areas where clinical experience can be integrated with didactic instruction.
In either event, the trainee must demonstrate competency in his or her ability to integrate didactic learning and applied clinical skill in a capstone competency evaluation.

There is also a responsibility to maintain competency through continuing education over the lifespan of maintaining and practicing in prescriptive authority or collaborative activities with prescribing professionals.

The clinical competencies targeted by this experience include the following:

1. PHYSICAL EXAM AND MENTAL STATUS
   Knowledge and execution of elements and sequence of both comprehensive and focused physical examination and mental status evaluation, proper use of instruments used in physical examination (e.g., stethoscope, blood pressure measurement devices, etc.), and scope of knowledge gained from physical examination and mental status examination recognizing variation associated with developmental stage and diversity

2. REVIEW OF SYSTEMS
   Knowledge and ability to systematically describe the process of integrating information learned from patient reports, signs, symptoms, and a review of each of the major body systems recognizing normal developmental variations

3. MEDICAL HISTORY INTERVIEW AND DOCUMENTATION
   Ability to systematically conduct a patient or parent/caregiver clinical interview producing a patient’s medical, surgical, and psychiatric (if any) history and medication history in cultural context as well as a family medical and psychiatric history, and to communicate the findings in written and verbal form

4. ASSESSMENT: INDICATIONS AND INTERPRETATION
   Ability to order and interpret appropriate tests (e.g., psychometric, laboratory and radiological) for the purpose of making a differential diagnosis and for monitoring therapeutic and adverse effects of treatment

5. DIFFERENTIAL DIAGNOSIS
   Use of appropriate processes, including established diagnostic criteria (e.g., ICD-9, DSM-IV), to determine primary and alternate diagnoses

6. INTEGRATED TREATMENT PLANNING
   Ability to identify and select, using all available data, the most appropriate treatment alternatives, including medication, psychosocial and combined treatments and to sequence treatment within the larger biopsychosocial context

7. CONSULTATION AND COLLABORATION
   Understanding of the parameters of the role of the prescribing psychologist or medical psychologist and working with other professionals in an advisory or collaborative manner to effect treatment of a patient

8. TREATMENT MANAGEMENT
   Application, monitoring and modification, as needed, of treatments and the writing of valid and complete prescriptions.
APPENDIX B

Practice guidelines regarding psychologist involvement in pharmacological issues. Accepted by the American Psychological Association Council 2009, as written by the task force on practice guideline of Division 55, The American Society for the Advancement of Pharmacotherapy.

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GUIDELINES REGARDING PSYCHOLOGISTS’ INVOLVEMENT IN PHARMACOLOGICAL ISSUES

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

In response to a series of articles describing the professional challenges faced by psychologists as they become prescribers (e.g., Antonuccio, Danton, & McClanahan, 2003; Buelow & Chafetz, 1996; DeLeon, Robinson Kurpius, & Sexton, 2001; McGrath et al., 2004), it was recognized in discussions among members of the American Psychological Association (APA) Division 55, the American Society for the Advancement of Pharmacotherapy, that the implications of the APA (2002b) Ethical Principles of Psychologists and Code of Conduct (the Ethics Code) specifically for psychologists’ involvement in pharmacotherapy merited clarification. Beth Rom-Rymer, president of the division at that time, convened a task force to explore the issue. Three of seven task force members were psychologists with prescriptive authority in the civilian or military sector. The task force also included representation from Division 18 (Psychologists in Public Service).

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

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

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

The third, and probably most common, level of involvement occurs when psychologists provide information that may be relevant to pharmacotherapy decision-makers. The information-providing psychologist may offer opinions relevant to the pharmacotherapy, but does not play a formal role in the decision-making process. Examples of providing information include reporting concerns about the treatment to the prescribing professional, referring patients for a medication consult, pointing patients to vetted referral or information sources, or discussing with patients how to address their concerns about the medication with the prescriber. It is likely that many of those psychologists who indicated to VandenBos and Williams (2000) that they were infrequently involved in the decision to prescribe did so in an information-providing role. Table 1 summarizes the characteristics of the three roles.
Some of the guidelines presented in this document are targeted specifically at the population of psychologists with prescriptive authority. Others are considered relevant in any case where the psychologist is actively involved in decision-making, whether as a prescriber or collaborator. Still others are considered applicable any time a psychologist is involved in the practice of pharmacotherapy whether as a prescriber, collaborator, or information provider. Given the unique elements of the population of psychologists who can prescribe on the one hand, and the frequency with which psychologists participate in collaborative and information-providing activities on the other, it was considered important to provide guidelines appropriate to each set of activities. However, it is important to recognize that a principle of optimal practice may have different implications in the context of active participation versus providing information.

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

Standards versus Guidelines

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

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

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

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

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

General

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.

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

The second factor affects psychologists at all three levels of involvement, that being the rapidly evolving nature of treatment guidelines in pharmacotherapy. While the psychologist with prescriptive authority faces a statutory obligation to remain current, their level of expertise can vary across treatment populations and classes of medications. The psychologist asked to serve in a collaborative or information-providing role has no similar statutory obligation, though APA has established educational expectations for the psychologist who serves in a collaborative role (American Psychological Association Board of Educational Affairs Working Group on Psychopharmacology Education and Training; 1997). These factors can combine to create a situation in which psychologists can feel pressured to discuss their patients’ treatment with medication at a level beyond their expertise.

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

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.

Rationale. There is some evidence to suggest the clinician’s faith in the treatment can be an important predictor of treatment response (Jacobson & Hollon, 1996). Unfortunately, treatment with medication has at times been associated with both excessive optimism and skepticism (e.g., Kramer, 1993; Valenstein, 1998), and both positions have been exaggerated by media attention. Psychologists will inevitably form their own opinions about medications. These opinions can in turn affect patients’ decisions about taking a prescribed medication, and even medication effectiveness, if they are not addressed openly in the process of discussing psychopharmacological interventions.

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

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.

Rationale. Principle E of the Ethics Code (APA, 2002b) focuses on the importance of considering cultural and personal variables in the populations served. This standard takes on additional implications in the context of pharmacotherapy, because individual differences can affect the interpersonal aspects of medication management, the effectiveness of the treatment, and its side-effect
pharmacotherapy is rapidly evolving. The range of options is greater for the psychologist without prescriptive authority, sin

1. Differences in presentation:
   a. Both the physical and psychological presentation of emotional distress can vary across cultures (e.g., Carr, 1976; Chowdhury, 1996). This finding has led to controversy over whether any specific presentation is truly culture-bound or simply more prevalent in some (Sakamoto, Martin, Kumano, Kuboki, & al-Adawi, 2005), and whether such syndromes can be fully understood in terms of standard psychiatric diagnosis (e.g., Guarnaccia & Rogler, 1999). Such issues aside, it is important that clinicians be aware of the existence of such cultural variants in presentation.

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

3. Differences in response to treatment:
   a. Biological correlates of cultural/ethnicity status, age, and gender, such as genetic polymorphisms, dietary factors, and other lifestyle habits may affect drug protein binding, metabolism and clearance. These can in turn affect bioavailability and subsequent therapeutic and adverse effects.

4. Differences in access to appropriate treatment:
   a. Socioeconomic factors can affect treatment availability and adherence. These can include both the cost of medication and the ability to participate in treatment effectively.
   b. Limited diversity in treatment trial samples can raise concerns about the generalizability of results across populations.

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

**Education**

*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.*

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

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

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

The three levels of participation in pharmacotherapy—prescribing, collaborating, and providing information—parallel the three levels of education and training that have been suggested for training in pharmacotherapy for psychologists (Smyer et al., 1993). Level 1 represents basic education in pharmacotherapy, with the expectation that this level of education can be obtained through a single graduate-level course. The APA Board of Educational Affairs provides a model curriculum for such a course (Kilbey et al., 1995). Level 2 is specifically intended to represent the level of education and training appropriate for active collaboration with prescribers in decision-making about medication. A similar didactic curriculum has been generated to identify the additional didactic training beyond Level 1 considered appropriate for this role (Kilbey et al., 1997). Since programs have not developed specifically for purposes of Level 2 training, in practice many psychologists interested in collaborating with prescribers pursue the didactic training associated with Level 3 without completing the experiential component. At present, a revised description of the didactic and experiential training for Level 3 is in development, and should represent APA policy by the time these guidelines are completed. These documents provide guidance to psychologists seeking to identify the appropriate level of training for their intended or anticipated involvement in pharmacotherapy.

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

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

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

Implications. The prescribing psychologist strives to maintain access to current information about the side effect profiles of the medications he or she prescribes, and uses this information in treatment planning and monitoring. This expectation does not apply to the psychologist providing psychotherapy to an individual receiving medication from another prescribing professional. However, it is important to keep in mind that this psychologist typically sees the patient more frequently than the professional who is responsible for medication management, and can therefore play a useful role in the early detection of possible side effects. All psychologists are sensitive to the possibility that physical events subsequent to the initiation of medication can represent adverse events, and either intervene or refer the patient for intervention as appropriate within their scope of practice. The prescribing psychologist is aware of the importance of evaluating adverse events and of reporting such events when they occur, while other psychologists are aware of the importance of referring the individual to the prescribing professional when concerned about the possibility of an adverse event.

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.

Rationale. The practice of pharmacotherapy is undergoing rapid change as information is gathered about the positive and negative effects of various medications. Mastery of the relevant literature is difficult to develop and maintain, especially when one considers such issues as drug-drug and drug-diet interactions. A range of electronic resources has emerged in recent years that many prescribing professionals find indispensable in their daily practice.
Implications. Psychologists with prescriptive authority and direct collaborators are urged to familiarize themselves with Internet and other resources (e.g., www.guidelines.gov, www.cochrane.org) that offer critically evaluated synthesized information about the effective practice of pharmacotherapy. In terms of daily practice, psychologists with prescriptive authority and psychologists who directly collaborate in medication decision-making are well-served by products now available for computers and/or personal digital assistants which offer extensive and frequently updated information about pharmaceutical agents. This software offers a supplement to personal knowledge of the pharmacotherapy literature, not an alternative.

Assessment

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

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

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

Though existing guidelines for training and education in psychopharmacology for psychologists (APA, 2007) highlight the importance of training in physical examination, and such training is considered valuable when the psychologist interprets the results of a physical examination, no position is offered here concerning the appropriate level of involvement of the psychologist with prescriptive authority in the practice of physical assessment. This is a matter for the psychologist with prescriptive authority to consider in light of the nature of his or her practice, the population served, the potential impact of the psychologist’s conducting a physical examination on therapeutic interactions, and local statutory and regulatory limitations. Psychologists are also sensitive and responsive to concerns expressed about physical examinations, particularly in the case of pediatric patients or members of certain cultural groups.

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

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

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

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

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

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

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

Intervention and Consultation

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

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

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

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

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.

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

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

Mantell, Ortiz, and Planthara (2004) noted the lack of information on the best means for integrating traditional psychological and biological treatments, and outlined some of the challenges and issues involved in creating an integrated model of treatment. One of the important tasks for the first generation of psychologists with prescriptive authority will be the development of formal recommendations, perhaps even treatment guidelines, concerning the best integration of biological interventions into a broader psychological and social context of treatment. Encouraging findings about the superiority of combined drug and psychosocial treatment over either drug or psychosocial treatment alone have now been reported for childhood anxiety (Walkup et al., 2008), adolescent major depression (The Treatment of Adolescent Depression Study Team, 2004) and pediatric obsessive-compulsive disorder (Pediatric OCD Treatment Team, 2004), for example.

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

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

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

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

1. Describing the agent to be used.
2. Indicating the symptoms it is intended to address.
3. Providing the rationale for the treatment relative to other treatment options. This may involve outlining alternatives to the recommended treatment, including a review of other medications that can be considered as well as non-pharmacological treatment options.
4. When discontinuing or reducing levels of medication use, explaining the reason for this course of action and addressing any concerns about the change in regimen.
5. Describing the benefits and potential risks of the protocol, including both therapeutic and potential adverse effects of the medication.
6. Estimating the duration and cost of treatment, and the time to therapeutic effect. Simply indicating how long to remain on the medication has been found to reduce the rate of premature termination (Bull et al., 2002).
7. Providing information about relative or absolute contraindications for the treatment and possible drug interactions.
8. Reviewing the risks associated with sudden, unilateral discontinuation of the medication.
9. Providing an explanation of any indicated laboratory examinations or requirements for ongoing therapeutic monitoring of drug levels.
10. Offering appropriate references for further patient education, in formats that are accessible to and understandable by the patient.
11. Describing the ongoing psychologist-patient partnership in deciding on medication changes (including titration) or criteria for termination of medication. This can involve orienting patients to the psychologist’s new combined role of prescriber and psychotherapist.
12. Remaining open and responsive to the patient’s questions and concerns including, at the patient’s request and with appropriate consent, providing information and education to family members or significant others.
13. Underscoring how psychopharmacology can be a key component, but often not the exclusive component, of a successful treatment plan.
14. When psychotherapy and psychopharmacology are used together, explaining why the combination is recommended over either intervention alone and how sessions will be structured to combine the two, and estimating the expected time course for treatment as a whole.
15. Inviting questions and the expression of concerns. It is important to remember that concerns can be practical and financial as well as physical, so explicitly encouraging questions about the range of obstacles can be helpful.
16. Evaluating the patient’s likelihood of adherence to the treatment selected.

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

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

**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.**

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

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

On the other hand, there is evidence that patients and guardians often report more positive feelings about psychosocial than pharmacological intervention (MTA Cooperative Group, 1999; Pyne et al., 2005). As in any therapeutic decision, the patient is the ultimate decision maker regarding the choice of therapy. The psychologist strives to assess his or her preferences, expectations, and decisions regularly throughout the course of treatment. It is also important to note that a referral from another professional for pharmaceutical treatment does not create an obligation to prescribe, or to restrict one’s focus to the physical aspects of the disorder.
The psychologist with prescriptive authority is encouraged to consider combined treatment, or a shift from one treatment modality to the other, as part of decision-making either as the primary clinician or as a consultant.

**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.**

Rationale. A substantial literature indicates the pharmaceutical industry potentially influences decision-making about medications in at least four ways. First is through its role in research and journal publications. A recent comparison of seven meta-analyses published with pharmaceutical industry support versus parallel meta-analyses published under the auspices of the independent Cochrane Collaboration found every one of the former recommended the medication without reservations while none of the latter did, even though mean effect sizes reported were similar (Jørgensen, Hilden, & Gøtzsche, 2006). Panels created for the development of treatment guidelines rely heavily on researchers receiving funding from the pharmaceutical industry (Choudhry, Stelfox, & Detsky, 2002). However, even relatively independent analyses of the literature must rely on primary research that is heavily funded by pharmaceutical companies, and such studies tend to support the superiority of the funder’s products (e.g., Heres et al., 2006; Lexchin, Bero, Djulbegovic, & Clark, 2003). This effect presumably reflects the funder’s role in both the design of the research and the decision whether or not to publish the results (Davidoff et al., 2001).

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

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

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

1. Reviewing research on the effect of pharmaceutical industry advertising on prescriptive practice, and on the relationship between industry funding and the published literature.
2. Reading conflict of interest statements in publications of drug trials, as the presence of a financial relationship with the maker of a medication is consistently found to be a significant predictor of positive outcomes (e.g., Perls et al., 2005).
3. Relying primarily on independent reviews of the literature, such as Cochrane reviews (www.cochrane.org).
4. Examining study methodology carefully to detect potential biases in patient or treatment selection or other threats to internal or external validity that might bias the outcome in favor of a pharmaceutical intervention (e.g., Smith, 2005).
5. Engaging in continuing education activities that challenge standard practice in pharmacotherapy.
6. Critically evaluating published literature for methodological weaknesses or medication risks.

Psychological research has contributed substantially to the understanding of interpersonal processes such as marketing. To cite a pertinent and particularly well-known example, while current professional standards in the prescribing professions focus on limiting the size of gifts, cognitive dissonance theory suggests that small gifts can sometimes have a more powerful effect on attitudes and behaviors than large gifts (Festinger & Carlsmit, 1959). There is also research suggesting that more familiar products are generally assumed to be superior (Goldstein & Gigerenzer, 2002). This assumption is often effective in daily practice in that the better option is referenced more frequently, but marketing corrupts this process by directly increasing familiarity independent of relative effectiveness. Psychologists involved in prescribing or collaboration may benefit from considering the possible influence of well-known methods for attitude change on their decision-making.

Psychologists with prescriptive authority may also find it helpful to review their own prescribing practices: the number of prescriptions written, the frequency of prescriptions written for various medications, the length of time patients remain on medication, and so forth. This information can alert psychologists that marketing may have subtly influenced their prescribing patterns.

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

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

Relationships

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

Rationale. There are various circumstances in which one mental health professional may refer to another for specialized services, referral for assessment perhaps being the most common. The emergence of the psychologist with prescriptive authority will undoubtedly produce circumstances in which mental health professionals refer to a psychologist for purposes of medication consultation only. Within this division of labor there exists the potential for miscommunication, differences in interpretation of the patient’s problems, and differences in beliefs about optimal interventions. Rivalry can also develop between clinicians, with unintended iatrogenic effects. Feldman and Feldman (1997) noted that

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

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

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

Rationale. Ethical standard 3.09 of the APA (2002b) Ethics Code highlights the importance of cooperation with other professionals in service to patients. Psychologists who prescribe, collaborate, or provide information on pharmacotherapy will find themselves working with other healthcare professionals at times, a category that in some cases will include traditional healers offering complementary medical treatments. Collaborating and information-providing psychologists by definition work in conjunction with prescribing professionals, most of whom are not psychologists at this point, though they increasingly may be. Prescribing, collaborating, and information-providing psychologists are often dealing with patients who demonstrate co-morbid medical conditions. Given the potential for drug-drug interactions and medical complications in such situations, collaboration with other healthcare providers actively involved in treating the patient can be particularly important.

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

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

Whenever a psychologist is involved in the practice of pharmacotherapy, the psychologist is encouraged to maintain ongoing consultation with the patient’s primary health care provider(s), assuming the patient agrees to such contact. The primary care provider
may in turn be reminded to alert the psychologist to any changes in the patient’s health status that could affect the patient’s treatment by the psychologist, whether that treatment involves pharmacotherapy or psychosocial interventions.

Author’s Note

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

The task force anticipates these guidelines may deserve reconsideration in a relatively brief time frame, given anticipated changes in psychologists' role in pharmacotherapy, as well as changes in the perceptions and use of psychotropic medications. In particular, it is the belief of the members of the task force that future efforts should include consideration of whether some elements of the enclosed guidelines merit elevation to the level of practice standards. Accordingly, this document is scheduled to expire as APA policy in five years from publication, by ___. After this date, users are encouraged to contact the APA Practice Directorate to confirm whether this document remains in effect.
Table 1

*Characterizing Psychologists’ Activities Related to Pharmacotherapy.*

<table>
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<tr>
<th>Relevant Activities</th>
<th>Prescribing</th>
<th>Collaborating</th>
<th>Providing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal responsibility for decision-making</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Involvement in decision-making</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
### List of Guidelines

<table>
<thead>
<tr>
<th>Relevant Activities</th>
<th>Prescribing</th>
<th>Collaborating</th>
<th>Providing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>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.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>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.</td>
<td>X</td>
<td>X</td>
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<tr>
<td><strong>Education</strong></td>
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<tr>
<td>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.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Guideline 5. Psychologists strive to be sensitive to the potential for adverse effects associated with the psychotropic medications used by their patients.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>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.</td>
<td>X</td>
<td>X</td>
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<tr>
<td><strong>Assessment</strong></td>
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<tr>
<td>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.</td>
<td>X</td>
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</tr>
<tr>
<td>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.</td>
<td>X</td>
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<tr>
<td>Guideline 9. Psychologists are encouraged to explore issues surrounding patient adherence and feelings about medication.</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Intervention and Consultation</td>
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<tr>
<td>Guideline 10. Psychologists are urged to develop a relationship that will allow the populations they serve to feel comfortable exploring issues surrounding medication use.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>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.</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>Guideline 12. The psychologist with prescriptive authority is encouraged to use an expanded informed consent process to incorporate additional issues specific to prescribing.</td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>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.</td>
<td>X</td>
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</tr>
<tr>
<td>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.</td>
<td>X</td>
<td>X</td>
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<tr>
<td>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.</td>
<td></td>
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<table>
<thead>
<tr>
<th>Relationships</th>
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</thead>
<tbody>
<tr>
<td>Guideline 16. Psychologists with prescriptive authority are sensitive to maintaining appropriate relationships with other providers of psychological services.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Guideline 17. Psychologists are urged to maintain appropriate relationships with providers of biological interventions.</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

Training Director’s note: Commander Dr. Sammons is a prescribing psychologist in the Navy stationed at Bethesda Naval Hospital in Washington, D.C. This letter represents his personal views, and is not an official position of the military.
APPENDIX C

Excerpts
From

LeVine, E. & Foster, E. 2010
Integration of Psychotherapy and Pharmacotherapy by Prescribing/Medical Psychologists;
A Psychobiosocial Model of Care
In R. McGrath & B. Moore (Eds.),
Pharmacotherapy for Psychologists: Prescribing and Collaborative Roles.
INTEGRATION OF PSYCHOTHERAPY AND PHARMACOTHERAPY
BY PRESCRIBING/MEDICAL PSYCHOLOGISTS:
A PSYCHOBIOSOCIAL MODEL OF CARE

INTRODUCTION

“The strategic integration of psychotherapy and pharmacotherapy by prescribing/medical psychologists is an evolutionary approach to addressing the critical and increasingly mental health needs of United States citizens. It is argued in this chapter that, because of their psychological training, prescribing/medical psychologists can apply the analysis of biological, social and psychological etiologies and treatment strategies from a somewhat unique framework we call the “psychobiosocial model of care.” In the psychobiosocial model posited within herein, the therapist-patient relationship and the patient’s phenomenological view of the psychotherapy and medication management are central. Patient-specific resiliency and vulnerability factors are analyzed within each sphere of functioning. By assessing resilience and vulnerability within all dimensions of functioning, the biopsychosocial model places patient’s perceptions, personal values and needs as the basis for deciding all forms of biological, psychological and social interventions.”

“Components of a Psychobiosocial Model of Care

The psychobiosocial model presented here is based upon three major tenets. The first is that psychologists, through unique training, offer a specialized skill set for addressing mental health concerns. In their initial training, psychologists are well-studied in aspects of behavioral change as well as the biological sciences. Education and training for prescriptive authority adds an additional skill set to an existing diagnostic and treatment armamentarium. Because these skills are taught through specialized programs for psychologists, who have already been trained in human development and the behavioral and cognitive components of psychopathology, psychologists can practice differently, integrating the medication into the therapy process and utilizing medications only when psychotherapy alone is not sufficient to improve functioning

The second tenet is a result of psychologists’ specialized training. Because psychologists are skilled in a broad range of therapeutic intervention techniques, they can help the patient choose the least invasive treatment while focusing on an empirically-supported approach as a first-line intervention. When empirical research indicates psychotropic intervention is efficacious, psychologists recommend this additional treatment to the psychotherapeutic regimen with extensive informed consent including standard education on indications, risks, benefits, average time-to-therapeutic effect, alternatives, and side effect profiles of each treatment. Information provided is tailored to the patient, particularly addressing side effects that are relevant to the patient’s concerns such as weight loss or gain, sleep difficulties or triglyceride levels. The premise is that the psychologist acts a consultant to the patient who, with occasional exception (e.g., when frankly psychotic or demented), is considered capable of making an informed decision and who is expected to remain an active problem-solver throughout the therapy partnership.

“The third tenet has many ramifications. It is postulated that a critical component of the psychologist’s psychobiosocial model of care is the integration of the meaning, impact, and usefulness of continued psychotropic medication across the various phases of the therapy process.”

“Psychologists, by virtue of their training in psychotherapy that requires verbal exploration and nonpharmacologic techniques to effect behavior change, are well versed in the dynamics of relationship building. When a collaborative decision is made to add medications to the therapeutic encounter, the relationship can be affected by a number of additional variables, including the meaning patients ascribe to
medication, the knowledge or misinformation they may have about certain medications, the patient’s intellectual/linguistic capacity to understand the complexities of medication use, cultural and religious beliefs pertaining to medications and their side effects, and pressures to use or avoid use of medications. The prescribing/medical psychologist must incorporate these variables into both the informed consent and the ongoing dynamics of the therapeutic relationship.”

“Summary

The causes of the worldwide crisis in mental health care and the breakdown in the mental health care system in the United States in particular are complex and multiple. Clearly, the dearth of sufficient providers, as well as the limitations in training that create fragmented care, are important contributors. Prescribing/medical psychologists, adopting the psychobiosocial model of care, can be an important part of the solution to this crisis. An integrated psychobiosocial model of care, including cognitive and behavioral intervention, changes in the social environment, and psychotropic aid is often more efficacious in patient treatment, especially complex cases.”