COMMONWEALTH of VIRGINIA

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TO: The Honorable Mark D. Sickles
Chair, House Committee on Health and Human Services

The Honorable Ghazala F. Hashmi
Chair, Senate Committee on Education and Health

FROM: Arne W. Owens
Director, Virginia Department of Health Professions

DATE: November 10, 2025

RE: **Report regarding prescriptive authority for clinical psychologists pursuant to SB752 of the 2025 General Assembly Session**

This report is submitted in compliance with SB752 of the 2025 General Assembly Session, which directed:

> The Boards of Psychology and Medicine shall jointly convene a work group . . . to study the education, training, and qualifications of clinical psychologists licensed in the Commonwealth, including the level of education and training clinical psychologists receive in pharmacology, and assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority. The bill requires the work group to report its findings to the Chairs of the House Committee on Health and Human Services and the Senate Committee on Education and Health by November 1, 2025.

Should you have questions about this report, please feel free to contact me at (804) 367-4648 or arne.owens@dhp.virginia.gov.

AO/EB
Enclosure

CC: The Honorable Janet Kelly, Secretary of Health and Human Resources

Preface

This report is submitted in compliance with Chapter 590 (SB752) of the 2025 General Assembly, which stated:

> That the Boards of Psychology and Medicine shall jointly convene a work group to include two representatives of the Board of Psychology who are licensed clinical psychologists, two representatives of the Board of Medicine who are physicians, one representative of the Board of Pharmacy, two licensed clinical psychologists who are faculty at accredited institutions of higher education in the Commonwealth, two representatives from departments of psychiatry at schools of medicine located in the Commonwealth, a representative of the Virginia Academy of Clinical Psychologists, a representative of the Psychiatric Society of Virginia, and other stakeholders as deemed necessary to study the education, training, and qualifications of clinical psychologists licensed in the Commonwealth, including the level of education and training clinical psychologists receive in the area of pharmacology, and assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority.

SB752 requires the work group to report its findings to the Chairs of the House Committee on Health and Human Services and the Senate Committee on Education and Health by November 1, 2025.

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I. Executive Summary

Pursuant to SB752, the Virginia Board of Psychology and the Virginia Board of Medicine convened a workgroup to include two representatives of the Board of Psychology who are licensed clinical psychologists, two representatives of the Board of Medicine who are physicians, one representative of the Board of Pharmacy, two licensed clinical psychologists who are faculty at accredited institutions of higher education in the Commonwealth, two representatives from departments of psychiatry at schools of medicine located in the Commonwealth, a representative of the Virginia Academy of Clinical Psychologists, a representative of the Psychiatric Society of Virginia, and other stakeholders as deemed necessary. The workgroup met twice on July 9, 2025[1] and August 15, 2025[2] to study the education, training, and qualifications of clinical psychologists licensed in the Commonwealth, including the level of education and training clinical psychologists receive in the area of pharmacology, and assess under what conditions it may be appropriate for clinical psychologists to be granted prescriptive authority.

Although reflected in the public comment received for the workgroup meetings, the workgroup did not debate whether granting prescriptive authority to clinical psychologists would address access to care issues created by a shortage of psychiatrists. Instead, the workgroup focused on the directive of SB752 and attempted to determine under what circumstances, if any, clinical psychologists should be granted prescriptive authority in Virginia. The workgroup did not reach consensus on a path forward.[3] Some members strongly opposed prescriptive authority under any circumstances, while others may support it conditionally.

This report attempts to capture under what conditions some members of the workgroup were comfortable moving forward. Support among workgroup members for providing psychologists prescribing authority changed depending on the combination of requirements. Members did agree, however, that any prescriptive authority should require additional science-based knowledge, clinical experience, passage of a national exam, and structured supervision.

[1] The agenda materials for the July 9, 2025 meeting may be found at https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting\31\41951\Agenda_DHP_41951_v2.pdf and minutes of the meeting may be found at https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting\31\41951\Minutes_DHP_41951_v3.pdf.

[2] The agenda materials for the August 15, 2025 meeting may be found at https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting\31\42032\Agenda_DHP_42032_v1.pdf and minutes of the meeting may be found at https://townhall.virginia.gov/L/GetFile.cfm?File=Meeting\31\42032\Minutes_DHP_42032_v1.pdf.

[3] SB752 did not direct the workgroup to provide recommendations regarding changes needed to allow psychologists prescriptive authority.

Workgroup Members

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II. Education and Requirements for Clinical Psychologists

A. Existing Educational Requirements

Pursuant to SB752, the workgroup reviewed the existing education, training, and qualifications for licensure as a clinical psychologist in Virginia. Those requirements are outlined in the Regulations Governing the Practice of Clinical Psychology.[4] Obtaining a license as a clinical psychologist in Virginia requires graduation from a doctoral program that includes a general core curriculum containing a minimum of three or more graduate semester hours or five or more graduate quarter hours in the following:[5]

- Biological bases of behavior (e.g., physiological psychology, comparative psychology, neuropsychology, sensation and perception, health psychology, pharmacology, neuroanatomy);
- Cognitive-affective bases of behavior (e.g., learning theory, cognition, motivation, emotion);
- Social bases of behavior (e.g., social psychology, group processes, organizational and systems theory, community and preventive psychology, multicultural issues);
- Psychological measurement;
- Research methodology;
- Techniques of data analysis; and
- Professional standards and ethics.

Additionally, the doctoral program curriculum must include at least three or more graduate semester hours or five or more graduate quarter hours in each of the following clinical psychology courses:[6]

- Individual differences in behavior;
- Human development;
- Dysfunctional behavior, abnormal behavior, or psychopathology;
- Theories and methods of intellectual assessment and diagnosis;
- Theories and methods of personality assessment and diagnosis including its practical application; and
- Effective interventions and evaluating the efficacy of intervention.

Licensure candidates must also complete a supervised practicum experience, which is a minimum of nine graduate semester hours. The supervised experience includes assessment,

[4] 18VAC125-20-10 *et seq.*
[5] 18VAC125-20-54(B)(5).
[6] 18VAC125-20-54(B)(6).

diagnosis, and psychological interventions. Candidates additionally complete an internship and a 1,500-hour supervised residency. Finally, candidates must take and pass the national exam.[7]

B. Previous Legislative Proposal

Prior to the introduction of SB752, the Virginia Academy of Clinical Psychologists ("VACP") presented draft legislation that would enable prescriptive authority for licensed clinical psychologists and presented the legislation as a starting point for discussion. The proposal would grant prescriptive authority to licensed clinical psychologists in good standing in the Commonwealth who complete the following additional training and experience requirements:

- Completion of three years of active practice as a clinical psychologist;
- Successful completion of a postdoctoral master of science degree from a university program in clinical psychopharmacology approved by the American Psychological Association ("APA");[8] and
- Successful completion of the national qualifying examination endorsed by the APA and the Association of State and Provincial Psychology Board ("ASPPB").

VACP's proposal limits the scope of prescriptive authority to psychotropic medications, or only drugs recognized and customarily used for management of mental, nervous, emotional, behavioral conditions, substance abuse, and cognitive diseases or disorders. Under the proposal, clinical psychologists could not prescribe narcotics or treat patients for primary medical conditions. The proposal additionally limits prescribing by a clinical psychologist to prescriptions made in consultation and collaboration with a patient's primary care physician, an attending physician, or another independently practicing primary care medical provider, and with the concurrence of that physician or provider.

[7] Currently, the Association of State and Provincial Psychology Boards ("ASPPB") administers the national exam, called the Examination for Professional Practice in Psychology ("EPPP").

[8] Curriculum is intended to include instruction in anatomy and physiology, biochemistry, neurosciences, pharmacology, psychopharmacology, clinical medicine/pathophysiology, and health assessment, including relevant physical and lab assessment. The curriculum would additionally include completion of a supervised clinical experience that would be defined by regulation to include observational clinical assessment and diagnostic pathophysiology, including diagnostic tests and procedures and treatment of mental health disorders, with a minimum of 100 patients.

III. Prescriptive Authority Models for Clinical Psychologists

The workgroup reviewed prescriptive authority models in other states. Seven states have granted prescriptive authority to clinical psychologists with varying requirements and scopes of practice.

A. New Mexico

New Mexico[9] passed legislation in 2002 that grants prescriptive authority to clinical psychologists who have completed 450 postdoctoral credit hours in clinical psychopharmacology, passed the Psychopharmacology Examination for Psychologists ("PEP"), and completed 400 hours of clinical supervision in psychopharmacology. New Mexico law limits prescribing psychologists to treating mental and emotional disorders and prohibits psychologists from prescribing Schedule II controlled substances. After two years under supervision by a physician or designated primary care provider and meeting peer review requirements, the clinical psychologist can prescribe independently.

B. Louisiana

Louisiana[10] passed legislation in 2004 that authorizes the State Board of Medical Examiners to grant prescriptive authority to clinical psychologists by issuing a medical psychologist license to those psychologists who have graduated with a postdoctoral master's degree in psychopharmacology or obtained equivalent training as approved by the Board, obtained supervised clinical experience, and passed the PEP. Medical psychologists can only prescribe medications related to mental health conditions and are prohibited from prescribing Schedule II controlled substances.

C. Illinois

Illinois[11] granted prescriptive authority to clinical psychologists in 2014 to practitioners that have completed specialized education in clinical psychopharmacology and completed a supervised clinical rotation lasting 14 months to 28 months that consists of nine medical rotations.[12] The residency must total at least 1,620 hours and accumulate 20 hours per week. Additionally, clinical psychologists must pass the PEP. Illinois prohibits prescribing psychologists from prescribing to patients under 17 or older than 65, pregnant patients, or patients with a serious medical condition. Psychologists also may not prescribe Schedule II controlled substances.

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[9] *See* NMSA 1978 § 61-9-17.1.
[10] *See* La. Rev. Stat § 37:1360.51 *et seq.*
[11] *See* 225 ILCS § 15/15.2.
[12] The nine rotations are in family medicine, internal medicine, psychiatry, pediatrics, geriatrics, obstetrics/gynecology, emergency medicine, surgery, and one other elective, covering a variety of settings such as hospitals, prisons, and mental health clinics. *Id.*

D. Iowa

In 2016, Iowa[13] granted prescriptive authority to psychologists who have completed advanced education in psychopharmacology and completed 400 hours of supervised clinical training and practicum, with 25% of that training occurring in a primary care or community mental health setting. The supervised training includes specific, relevant clinical experience in clinical psychopharmacology and special training in assessment and pathophysiology. After two years of supervision by a physician or designated primary care provider, the prescribing psychologist can prescribe independently.

E. Idaho

In 2017, Idaho[14] granted prescriptive authority to psychologists who complete a postdoctoral master's degree in psychopharmacology from an APA-designated training program, complete a supervised practicum in clinical assessment and pathophysiology, and pass a nationally recognized examination. Idaho does not specify hour requirements for psychopharmacology training. After two years practicing under supervision, psychologists can prescribe independently. Psychologists may only treat mental health disorders and may not prescribe opioids or medications for non-psychiatric medical conditions.[15]

F. Colorado and Utah

Most recently, Colorado[16] and Utah[17] passed legislation granting prescriptive authority to psychologists who complete advanced coursework in psychopharmacology, pass the PEP, and undergo a minimum of 400 hours of supervised clinical training. In Utah, prescribing psychologists may only treat adults with mental health conditions and cannot prescribe narcotics or controlled substances.[18] In Colorado, the law gives authority to the State Board of Psychologist Examiners to determine the number of hours of supervised training and the scope of practice, although prescribing psychologists are still limited to prescribing medications to treat mental health conditions.

[13] *See* Iowa Code § 154B.9.
[14] *See* Idaho Code § 54-2316 (2024) *et seq.*
[15] IDAPA 24.12.01.200.
[16] *See* CRS § 12-245-309.
[17] *See* Utah Code Ann. § 58-61-701 *et seq.*
[18] *See* Utah Code Ann. § 58-61-308.

IV. Prescriptive Authority Models in Virginia

In addition to physicians, Virginia has granted prescriptive authority to other health professionals. Those models are detailed below.

A. Advanced Practice Registered Nurses

Advanced practice registered nurses ("APRN") have had the ability to prescribe since the early 1990s. APRNs[19] practice collaboratively with a patient care team physician or podiatrist and pursuant to a practice agreement between the APRN and a patient care team physician or podiatrist unless certain statutory requirements are met for autonomous practice.[20] For many years, statutory law required APRNs to maintain a separate license for prescriptive authority. The General Assembly eliminated this requirement in 2018 legislation, thus allowing APRNs to prescribe without obtaining separate approval from the Boards of Nursing and Medicine. Prescriptive authority is now incorporated into a license to practice as an APRN in Virginia.[21] APRN prescribing authority is limited to the terms of the practice agreement. An APRN in the category of nurse practitioner[22] may obtain authorization for practice without a practice agreement following three years of full-time clinical experience and upon Board approval. APRN nurse practitioners are, at that point, limited solely by standards of care, the Drug Control Act,[23] and other applicable statutes and regulations.

B. Physician Assistants

Virginia Code § 54.1-2952.1 authorizes licensed physician assistants ("PA") to prescribe. Generally, PAs are educated at a master's level and complete 24 – 27 months of academic instruction which includes didactic and clinical training. This education follows hard science prerequisites, generally resulting in a university degree.[24] In Virginia, Virginia Code § 54.1-2951.1 and 18VAC85-50-50 require an applicant for licensure to have completed an educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant ("ARC-PA").[25] Accredited training includes classroom instruction in anatomy,

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[19] Four types of APRNs practice in Virginia: nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists. *See* Va. Code § 54.1-2900.
[20] *See* Va. Code § 54.1-2957.
[21] *See* Va. Code § 54.1-2957.01.
[22] APRNs in other categories, such as certified nurse midwives, have other requirements for practice without a practice agreement. These requirements are found in Virginia Code § 54.1-2957.
[23] Va. Code § 54.1-3400 *et seq.*
[24] Some PA programs will allow entry from high school or only partial college credit, but those programs are longer in length, often requiring four to six years of training. *See* American Academy of Physician Associates at https://www.aapa.org/career-central/become-a-pa/.
[25] ARC-PA is the independent accrediting body for physician assistant training. Accreditation by ARC-PA requires a peer review process that includes documentation and periodic site visit evaluations to substantiate compliance with accreditation standards. ARC-PA reports collaboration with the American Academy of Family Physicians, AAPA, the American Academy of Pediatrics, the American College of Physicians, the American Medical Association, the PA Educational Association ("PAEA"), the Society of Emergency Medicine PAs, the Association of PAs in Psychiatry, the Society of PAs in Family Medicine, the Society of PAs in Pediatrics, and the Association of PAs in

physiology, biochemistry, pharmacology, physical diagnosis, pathophysiology, microbiology, clinical laboratory science, behavioral science, and medical ethics.[26] Students in accredited programs complete more than 2,000 hours of clinical rotations in medical and surgical disciplines with emphasis on primary care. Rotations may include disciplines such as family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, and psychiatry.[27]

PAs have prescriptive authority as part of licensure.[28] No scope of practice limitations exist provided the use of prescriptive authority remains within the boundaries of the PA's practice agreement.

C. Pharmacists

Pharmacists do not have the authority to prescribe in the traditional sense. Pharmacists do have the authority to initiate treatment following protocols developed by the Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health for certain diseases or conditions.[29]

Obstetrics and Gynecology. ARC-PA only accredits programs within the United States, including United States territories. *See* https://www.arc-pa.org/about/.

[26] *See* https://www.aapa.org/career-central/become-a-pa/.

[27] *Id.*

[28] *See* Va. Code § 54.1-2952.1.

[29] *See* Va. Code § 54.1-3303.1.

V. Summary of Workgroup Discussions

Initial workgroup discussions centered on the arguments presented in support of granting clinical psychologists prescriptive authority, such as increased access to care, integrated treatment, specialized focus, and the success of models in other jurisdictions. Concerns raised in opposition included training gaps, patient safety risks, overlap with psychiatry, oversight challenges, and the cost of implementation. The workgroup could not reach consensus on the validity and relevance of each of these points and thus focused solely on the directives outlined in SB752.

A. Determining a Pathway to Prescriptive Authority for Clinical Psychologists

Physician members of the workgroup asserted that existing professions with prescriptive authority, such as PAs and APRNs, have educational foundation in hard sciences including anatomy, physiology, biochemistry, molecular biology, genetics, and neurophysiology. In contrast, standard training in psychology lacks a foundation in hard sciences, even if some individual psychologists may have studied hard sciences. Physicians on the workgroup also reasoned that psychology programs lack supervised clinical experience at the level of direct medical care, which raised the physicians' concerns about preparedness for prescriptive authority. For these reasons, some of the physicians on the workgroup argued that clinical psychologists should not have prescriptive authority under any circumstances. After much discussion, the workgroup agreed that to move the discussion forward and adhere to the intent of SB752, the workgroup would consider parameters of prescriptive authority as if a future General Assembly granted clinical psychologists prescriptive authority. Furthermore, the members agreed that the goal of the workgroup would be to provide the General Assembly with a clear picture of the members' viewpoints considering the lack of consensus.

B. Additional Education Requirements

Although there was debate on this issue, the majority of the workgroup members determined that prescriptive authority could be granted to a clinical psychologist who had a postdoctoral master's degree in psychopharmacology from an accredited institution. Of the seven states that have granted prescriptive authority, only Louisiana and Idaho require postdoctoral master's degrees. The remaining five states require advanced education, with various hour requirements, in psychopharmacology. A few workgroup members felt that even a postdoctoral master's degree was insufficient, and that, to ensure patient safety, the deficiency in foundational science must be addressed. These members suggested requiring additional course work or completion of a post-baccalaureate program. Post-baccalaureate programs as recommended by these workgroup members are generally one year in duration and could bridge the gap between standard psychology undergraduate education and a master's level psychopharmacology program.

C. Collaborative Practice

The workgroup reached consensus that any prescriptive authority should include ongoing collaborative practice. Generally, direct supervision requires ongoing, active oversight. Under a supervision model, prescriptions are issued under direct guidance. By contrast, collaborative practice is more flexible and provides for an agreement that allows the psychologist to prescribe within agreed parameters and possibly with indirect consultation. The collaborative agreement defines the scope of prescribing for specific medications, including controlled substances. Collaborative agreements are adaptable as regulations, medications, and practice standards evolve.

D. Supervised Clinical Experience

The workgroup agreed that prescribing clinical psychologists should complete postdoctoral training that incorporates 24 months of supervised experience that includes clinical rotations in pediatrics, neurology, internal medicine, and psychiatry. After completion of the 24 months, supervision could transition to a collaborative practice model. Some workgroup members recommended supervision only by a psychiatrist, whereas others would allow for supervision by a physician in another specialty.

E. Scope of Practice

The workgroup agreed that any prescriptive authority should be restricted to treatment of mental health conditions. Additionally, the workgroup agreed that prescriptive authority should preclude prescribing Schedule II drugs and preclude prescribing to certain patient populations, such as pregnant women, pediatric patients, and patients over 65.

The workgroup determined that prescribing should initially be limited to adults to monitor or measure any safety concerns. The General Assembly could, in later years, revisit pediatric prescribing after first establishing safe and competent prescribing for adults. There was debate, however, whether to allow the authority to prescribe stimulants, which would be an exception to the prohibition on prescribing Schedule II controlled substances. All members agreed that such an allowance would require explicit collaborative agreements.[30]

F. Regulatory Board Oversight

The workgroup reached consensus that the Boards of Medicine, Psychology, and Pharmacy should be involved in the development of potential regulations. The establishment of an advisory board with cross-disciplinary representation could provide expertise for prescriptive authority decisions. Additionally, existing collaborative practice regulations may serve as a model for potential prescribing clinical psychologist collaborative practice regulations. Any potential regulations must be adaptable and involve ongoing review, reflecting changes in medications, standards of care, and prescriptive practices. The workgroup believed statutory

[30] Notably, this would also require statutory allowance both in the Drug Control Act and in the statutory authority for clinical psychologists to prescribe medications. It is not possible to both exclude clinical psychologists from prescribing Schedule II medication in statute and allow some prescribing of Schedule II medication (stimulants) in statute.

authority should be revisited after initial implementation, with data-driven adjustments made as necessary.

V. Conclusion

Workgroup discussions focused on the directives of SB752 and attempted to identify under what circumstances, if any, clinical psychologists should be granted prescriptive authority in Virginia. SB752 did not direct the workgroup to make a recommendation, and the workgroup did not reach defined consensus on a path forward. Some members strongly opposed prescriptive authority under any circumstances, while others may support it conditionally.

This report captures under what conditions some workgroup members were comfortable considering prescriptive authority for psychologists. Support among workgroup members for providing psychologists prescribing authority changed depending on the combination of requirements. Members did agree, however, that any prescriptive authority should require additional science-based knowledge, clinical experience, passage of a national exam, and structured supervision.