Prescribing rights for psychologists
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Foreword from the Chair of the Task and Finish Group

The Society’s Professional Practice Board established a project group in 2018 to review and respond to a request from NHS England (NHSE) to consider whether there is a need for the extension of prescribing and medicines supply mechanisms to include qualified statutorily regulated psychologists. This development could have the potential to improve the experience of service users as well as giving the profession an opportunity to continue to progress.

The group is made up of applied psychologists who work in a range of contexts including psychological liaison, secondary care mental health, gender and sexuality, secure settings, older people, intellectual disabilities, and vulnerable children. Some members of the group are also non-medical approved responsible clinicians.

As a group we have completed a year of consultation with individuals and small focus groups of stakeholders including psychologists, medical doctors, pharmacists, psychiatrists, nurses and experts by experience. The results of which have been used to form this discussion paper. The document brings together all the information we have learned so far along with some of the opinions we have gathered and some case studies to illustrate what it could look like if psychologists have prescribing rights. It is designed to invite comment from members of the British Psychological Society (BPS) and other stakeholders.

When thinking about the issues, it is important to consider the broad range of practitioner psychologists and contexts where prescribing might be relevant. Many are involved in mental health, but others work with addictions, sexual health, neurorehabilitation and gender, for example. While some medications for some conditions may be seen as contentious, this is by no means true for all medicine or all conditions. Therefore, the remit of this document is to discuss whether appropriately placed psychologists who wish to become prescribers should have the legal authority to prescribe and deprescribe if they wish to, once they have completed appropriate training and not to discuss the efficacy of certain medications.

The positive feedback we’ve received so far, from the majority of people we have consulted with, has given us the confidence to proceed to this next, wider stage of consultation. At this time, we are still at an exploratory stage and no decisions have been made, but we have recognised the need for further information and details to allow an informed decision as to whether psychologists should have prescribing rights. We refer to formulation informed prescribing and psychologist prescribers when presenting information and posing questions about what psychologist prescribing could look like; this is for clarity and ease rather than an assumption that such a role will exist.

During our preliminary consultations three main areas of concern were raised multiple times by many stakeholders, so I wanted to address these up front:

1. Should psychologists as a profession gain prescribing rights, the choice of an individual psychologist to train and prescribe would be optional.

2. A programme of training, mentoring and post qualification governance would have to be agreed to meet the regulations and standards set out by the Royal Pharmaceutical Society and the Health and Care Professions Council to ensure that Psychologists have the appropriate competencies to fulfil the role. Possible options for this are discussed in the paper.
Throughout this document we use the term ‘service user’ to refer to those people who are in direct contact with the psychologist, sometimes referred to as ‘client’ or ‘patient’. We also use the term ‘expert by experience’ to refer separately to those people who have lived experience and have contributed to this work.

**NEXT STEPS**

The comments and responses from this discussion paper will inform a framework document which will add more details to the aspects discussed here, including the training requirements. There will be further opportunity for engagement and comment from both BPS members and external stakeholders. The Society’s senate will have an opportunity for comment and discussion and the final paper will go to the Society’s Practice Board for approval.

If the BPS mandate suggests that psychologists would wish to have prescribing rights, there are still several other stages before psychologist prescribing could happen:

- Support from the NHS and ministers for a consultation with a wide variety of stakeholders.
- Presentation to the Commission on Human Medicines (CHM).
- Amendment to the statutory instrument on the Human Medicines Regulations (and potentially the Misuse of Drugs Act).
- Major change to the prescribing training accredited by the HCPC.

Other professions which have obtained non-medical prescribing rights have faced up to ten years or more until they saw the first prescribers in their profession trained.

At this stage, we want to ensure that we have engaged as far as possible with BPS members and other stakeholders to ensure that your views are listened to. I would like to take this opportunity to thank you for your time to consider the document and give your comments and would also like to thank the other members of the task and finish group and our experts by experience who have given their time and energy to developing the project so far.

**Rebecca Courtney-Walker**
Chair, BPS Prescribing Rights Task and Finish Group (August 2019)

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1. Introduction
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1.1 Where the Discussion Began

The discussion around psychologists having the right to prescribe medication has been running for almost 30 years, when psychologists first began a ‘demonstration’ pilot in 1991 in the US Department of Defence to see if psychologists in the military could be trained in and safely practice the prescription of medication.

This discussion travelled across the Atlantic to the UK at the start of the new millennium, where it was considered in various circles including the seventeenth Maudsley Debate titled ‘They all want to be doctors’.

Professor Kevin Gournay, a psychologist and nurse, presented the potential benefits of non-medical prescribers, discussing the benefits of existing nurse prescribing, the possible benefits of this in mental health and he:

‘...wholeheartedly endorse[d] clinical pharmacy and clinical psychology as being equally valuable in this attempt...to disseminate skills and knowledge to as many people in the workforce as possible... Let's think of the benefits to patients.’

(Professor Kevin Gournay, 2002)

Professor Gournay described how he and his colleagues were liaising with the American prescribing psychologists to support the development of the early UK non-medical prescribing curriculum. They had identified that a key enabler was the provision of high quality training in pharmacology and medication management and in 2002, they had yet to develop the training programme that they have today.

Professor Phil Barker, a psychotherapist and professor of nursing, presented the opposing arguments that focused on the different professions following their vocational values referring to nursing being underpinned by ‘compassionate care’ and psychology by ‘understanding’, as compared to medicine, which he saw as being underpinned by ‘treatment’. His overriding view was that prescribing medication should remain in the sole domain of medically trained staff.

A year later, in 2003 the lively discussion arrived in the BPS professional publication The Psychologist with an American psychologist Robert Resnick proposing the case in favour of psychologists prescribing, based on the experience in the US.

Peer commentaries opposing the proposal presented various concerns, including questioning the efficacy of medication in mental health and stating that ‘psychological and pharmaceutical interventions simply do not mix’, the potential influence of pharmaceutical firms on prescribing practice, and a view that, at that time:

‘[Resnick] wants to take us somewhere I believe most British psychologists do not want to go. There are other ideological locations where psychology might do more good. Some of us are disturbed that clinical psychology has already moved quite far in the direction of acquiescing in an individualistic, diagnostic model of human distress and difficulty – prescribing will only escalate that trend.’ (Orford, 2003)

Resnick responded to the commentary, acknowledging that:

‘Not all psychologists are interested in prescribing medications. This is as it should be. Not all psychologists are psychoanalysts, psychodynamic or cognitive-behavioural in orientation. We can agree to disagree. Psychology, after all, is like Joseph’s coat of many colours. We are a diverse group of professionals with diverse professional interests. But one group of psychologists should never decide what is good for another group of psychologists resulting in: “If I don’t want it you can’t have it.” That would, indeed, be a crippling and divisive blow to our profession.’ (Resnick, 2003)
1.2 KEY CHANGES AND POLICY DRIVERS

1.2.1 THE INTRODUCTION OF THE NATIONAL INSTITUTE OF CLINICAL EXCELLENCE (NICE)

NICE had only recently launched in April 1999 when UK psychologists initially considered prescribing. Indeed, NICE has just completed its review of the last twenty years.

Up until the launch of NICE and its robust guideline process, decisions about treatments had usually been made at a local level, based on an individual clinician’s specialist knowledge and expertise. Prescribing choices were also more open to influence by the pharmaceutical industry. This meant that there was no assurance that treatment was consistent between clinicians and concerns had also been raised about ‘so-called postcode prescribing’ (NICE, 2019) as ‘patients in some areas of the country could access treatments that people elsewhere, sometimes in neighbouring streets, could not’ (NICE, 2019).

This led to the adoption of a national approach to decide what treatments the NHS should provide universally on the basis of the research informed evidence base and cost effectiveness of treatments, consequently the NICE clinical guidelines were born. A year later, in 2002, the first clinical guideline was published for schizophrenia. The recent NICE review reflects that:

‘The guideline had a significant effect, as there was then little in the way of national guidelines for mental health. It has been used in Australia and the state of California and translated and adopted in Spain and Italy.’ NICE (2019)

As NICE moves into its third decade of existence, the adherence to NICE guidelines is now considered the routine benchmark for auditing clinical practice. It is used to inform commissioning of services for a wide range of biopsychosocial interventions. The use and audit of practice against such robust guidelines provides a safeguard for ensuring that assessment and treatment, including psychological and pharmacological treatment, is evidence-based and provides an overarching guidance framework for clinicians.

The impact of NICE has also had a significant influence on minimising the influence from the pharmaceutical industry. This is reflected in specific advice from the British Medical Association who recommend following: ‘The Seven Principles of Public Life applied to doctors’ (see Table 1), based on the Nolan Principles and developed by the Royal College of Physicians to provide a basis for governing the relationship between doctors and the pharmaceutical industry. Should they prescribe, it would be logical for psychologists to adopt a similar position.
INTRODUCTION

1.2.2 NEW WAYS OF WORKING IN MENTAL HEALTH (2003)

The New Ways of Working (NWW) programme was a joint initiative between the National Workforce Programme (NWP) of the National Institute for Mental Health in England (NIMHE) and the Royal College of Psychiatrists that enabled:

'A new way of thinking which includes the development of new, enhanced and changed roles for mental health staff, and the redesigning of systems and processes to support staff to deliver effective, person-centred care in a way that is personally, financially and organisationally sustainable.'

(National Institute for Mental Health in England; NIMHE, 2007, p.19)

As a result, a range of new roles appeared in mental health contexts such as assistant practitioners and Support Time and Recovery (STR) workers. There was also an impact on the psychological professions as there was a surge in training professions other than psychology in psychological therapies. Furthermore, psychologists also gained the opportunity to train as non-medical approved/responsible clinicians (AC/RC), who can oversee the treatment and care of people detained under the Mental Health Act, as a result of the role of the Responsible Medical Officer being replaced by that of Responsible Clinician in the revision of the 1983 Mental Health Act (2007).

NWW also became a key enabler for the development of nurse prescribers and a number of other professions. A review of this is discussed in section 1.3.1.

NWW highlighted a number of potential concerns arising from the workforce changes including:

| **Selflessness** | Doctors should act solely in the public interest. Their responsibility to patients must override all other interests. |
| **Integrity** | Doctors should not place themselves under any financial or other obligation to industry, which might influence the performance of their duties as a doctor. |
| **Objectivity** | Doctors should make decisions based on the best available independent scientific evidence. |
| **Accountability** | Doctors are accountable for their decisions and actions. They must submit themselves to whatever scrutiny is appropriate to assure the integrity, objectivity, and honesty of their work. |
| **Openness** | Doctors must be as open as possible about the decisions and actions they take. They must be prepared to give reasons for their decisions. |
| **Honesty** | Doctors have a duty to declare any private interests relating to their public duties. They should take steps to disclose or resolve any conflicts arising in a way that protects the public interest. |
| **Leadership** | Doctors should promote and support these principles through leadership and example. |

Source: The Royal College of Physicians, cited by The British Medical Association
1. Members of some professions may feel that by taking on extended roles, colleagues will lose their traditional focus and outlook, and that they might perhaps be ‘infected’ with the ‘medical model’, but NWW is about enhancing and broadening capabilities, not substituting them. (NIMHE, 2007, p.24)

2. It is very easy, perhaps especially so in mental health, to oppose change by raising the spectre of risk, and by asking for ‘evidence’ that cannot possibly be provided to the standards demanded. (NIMHE, 2007, p.25)

3. NWW is not about replacing people who can do a particular task with people who can’t; therefore, it is not about increasing risk. It is about ensuring that everyone working in services is appropriately skilled to do the tasks required of them and that suitable supervision and support are in place for all. (NIMHE, 2007 p.26)

However, the document sets out that there are ‘many ways in which clinical risk can be reduced by NWW; for example, by having more people in the team with a greater awareness of physical health problems and the potential side effects of medication’ (NIMHE, 2007, p.26).

The document also signals the start of the importance of developing co-production, emphasising the importance of service users and carer involvement from the beginning as a key way to help NWW happen. (NIMHE, 2007, p.25)

1.3 THE CURRENT CONTEXT

The landscape that psychologists work in has changed significantly since psychologists last considered whether to have the option of training as prescribers in 2003:

- Non-medical prescribing in other professions is now widespread in a broad range of professions in the UK (see section 2.1).

- Psychologists have been successfully practising as non-medical approved/responsible clinicians (AC/RC) for almost a decade.

- The profession and practice of psychology continues to develop as psychologists take on a wider range of roles and psychological therapies are routinely provided by other professions.

- NICE guidelines are available for most service user groups receiving health services.

- There have been no ethics complaints or malpractice claims relating to prescribing against psychologists who routinely prescribe in the US.¹¹

- It is notable that one of the anxieties about psychologists undertaking the non-medical AC/RC role was that it had the potential to medicalise the profession as it was taking on a role previously held only by psychiatrists. In contrast, the reviews of the role emerging from the literature and anecdotal evidence support the opposite position.

- The Health Education England New Roles programme¹² suggest that the non-medical AC/RC role has benefits including:
  - Better service user choice with quicker decision-making made by the person who knows the service user.
  - More time for consultant psychiatrists to specialise in more complex medical cases.
  - Reduced length of stays, increased rate of discharge and reduced number of emergency readmissions.
Greater social engagement and participation in meaningful activities.

Introducing

Timely use of prescriptions with reduced use of:
- sedation
- antipsychotics
- restraint
- violent incidents
- falls

A number of review articles are emerging focusing on various elements of the non-medical AC role, including its impact on leadership with one study identifying ‘themes focused on enabling person-centred care, clinical leadership and culture change more broadly within mental health care. The AC role is supporting clinical leadership by a range of professionals, promoting service user choice by enabling access to clinicians with the appropriate skills to meet needs’13. For example, quoting one participant (non-medical approved clinician) who reflected that:

‘[…] the clinical team meeting was […] very psychiatry led, now that meeting is held in the ward, the person attends the meeting and everything that we discuss is discussed with them and they are equal participants in that process.’ (cited Ebrahim, 2018)

Based on the themes emerging from practice it would appear that psychologists in these roles have maintained their strong sense of identity and if anything, it has demedicalised the experience for service users and improved service delivery.

This is relevant to the current discussion regarding prescribing, as parallels can be made about the concerns regarding potential medicalisation of the professional role of psychologists and the need to balance this against the potential benefits to service users of psychologist prescribers. As a result, service users could receive a more holistic, primarily formulation-informed approach where alternatives to medication are considered as the primary intervention.

Just as in the role of non-medical prescriber, the fears from psychiatrists were whether psychologists would be able to safely carry out the role and as a psychiatrist says in one study:

‘I think, it has taken some adjustment from both sides […] in terms of […] medics, having to share that privileged position […] I think it’s best for the patient.’ (cited Ebrahim, 2018)

Although the world has moved on in many ways, the NHS is facing many of the same challenges and more, which were the original driver for NWW in 2003.
It is also notable that there is now an urgent shortage of nurses, who were one of the main professions where non-medical prescribing had been targeted. Therefore, despite the NWW initiative, a gap that the NHS wanted to fill has in fact widened.

In the context of the Interim NHS People Plan, psychologists will be working even more closely with other professions especially where a person has physical health needs. It sets out a vision of 'more proactive, effective and person-centred care, particularly for people with more complex health and care needs, we need to move more decisively to a model where teams of professionals from different disciplines work together to provide more joined-up care. This multidisciplinary way of working will become the norm in all healthcare settings over the next five years.' (Department of Health, 2019, pp.32–33)

The Interim People Plan recommends that the NHS continue to enhance the skill mix of its workforce by scaling up the development and implementation of new roles and new models of advanced clinical practice. The plan suggests that this ‘will require further investment in developing these new roles. It will also require the right professional standards and systems of professional regulation to ensure clarity about the scope of new and extended roles and provide patients and the public with the assurance that staff in these roles will meet the highest standards of safety.’ (Department of Health 2019, p.33). Given these recommendations, this is an ideal time for the reconsideration of prescribing rights being extended to psychologists.
National initiatives have been set up to stop the overuse of medicines for adults and children with learning disabilities, autism or both, whose behaviour challenges – Stop the Over Medication of People with a learning disability, autism or both (STOMP)\textsuperscript{13}; Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP)\textsuperscript{16}. We note that:

‘Public Health England says that every day about 30,000 to 35,000 adults with a learning disability are taking psychotropic medicines, when they do not have the health conditions the medicines are for. Children and young people are also prescribed them.’ (NHS England, 2019)

Apart from the negative effect on the quality of life of the person from over-sedation, there is a deprivation of their liberty as they are often unable to consent to these treatments. These medications have a long-term impact on the person’s physical health due to metabolic side-effects in a service user group that already suffers significant health inequalities and poorer mortality than most groups within the UK population. NICE recommends that ‘psychological or other interventions’ should be considered and tried before psychotropic medication but as can be seen from the public health figures, there are large numbers of service-users who are still prescribed them inappropriately.

Older people are also routinely prescribed antipsychotic medication to reduce agitation with questionable benefit and significant risks to health and life. This has resulted in the national A Call to Action initiative.

QUESTION 1: What do you think about psychologist prescribers working in contexts where the main emphasis would be to deprescribe?

Psychologist prescribers, would be ideally placed to reduce these medications systematically, while they implement evidence-based person-centred psychosocial interventions centred on ethical models such as:

2. *The Newcastle Model*\textsuperscript{17}; Dementia Care Mapping\textsuperscript{18} in older people’s services.

One area where it has been successful was as a result of an innovative pilot in Sunderland and latterly Newcastle Community Learning Disabilities Services, in Northumberland Tyne and Wear NHS Foundation Trust where a pharmacist prescriber developed a STOMP clinic working with behavioural nurse specialists and psychologists using Positive Behavioural Support (PBS). As a result, ‘there was a significantly higher success rate for medication reduction and discontinuation when PBS assessment and intervention was provided as an alternative to medication.’\textsuperscript{19} Should psychologists gain prescribing rights, this would significantly increase the capacity to work in this way and improve the lives of people with learning disability, autism and older people.
2. Non-medical prescribers
2. Non-medical prescribers

2.1 Prescribing in the UK

In the UK, all dentists and medical doctors have prescribing rights. Some other professions also have prescribing rights and are known as non-medical prescribers or ‘NMPs’, these include chiropodists/podiatrists, nurses, optometrists, paramedics, pharmacists and dietitians.

A literature review of existing non-medical prescribers was completed at the start of the Task and Finish Group work, which indicated that overall, UK studies show that non-medical prescribing in a range of physical and mental health settings:

- Is safe and clinically appropriate.
- Delivers similar levels of care to that provided by GPs and generate a higher satisfaction rating from patients.
- Is popular with service users.
- Is viewed positively by other healthcare professionals.
- Is becoming a well-integrated and established means of managing conditions and providing access to medicines.

There appear to be relatively few documented disadvantages of non-medical prescribing in the UK. Concerns relating to safety and to cost are reported to be unsubstantiated. Other potential barriers to NMPs included:

- Prescriber confidence.
- Legislation.
- Lack of support and recognition by organisations in terms of pay, supervision and governance.
- Practical barriers such as lack of access to prescribing pads and computer software.

The literature emphasises the important role core educational programmes have on clinical practice. Research indicates that mentoring schemes have a positive impact for newly qualified NMPs. Literature also indicates that the implementation of a new professional group with prescriptive authority benefits from mentoring, support and supervision and that these are key factors in the facilitation of the initial implementation process for all NMPs.

2.2 Psychologists who prescribe

Whilst the position of psychologists differs in different countries, according to role and legislative framework, it can be useful to consider psychologists who already prescribe in different jurisdictions. Psychologists already have prescribing rights in the US in the Department of Defense (American Military), the American Indian Health Service, Guam and in five US states (New Mexico, Louisiana, Illinois, Iowa and Idaho).

Psychologists who wish to prescribe in these areas must be statutorily regulated as an applied psychologist and complete a postdoctoral master’s in Clinical Psychopharmacology.

Current literature states that these groups of psychologists prescribe safely in these areas. Prescribing is optional and only those that choose to become prescribers train
as prescribers. Linda and McGrath\textsuperscript{21} have completed the most recent literature review in this area as well as completing a study where 30 prescribing psychologists and 24 of their medical colleagues completed surveys evaluating perceptions and practices of prescribing psychologists.

They observed that opposition to psychologists prescribing has often centred on concerns about how it would impact the practice of psychology\textsuperscript{22,23}, reflecting the concerns raised by Orford in the 2003 peer commentary\textsuperscript{24}. However, McGrath\textsuperscript{25} has suggested that a strength of psychologists is their theoretical background and that this ‘may actually protect against over-reliance on medication’ (see also Muse & McGrath\textsuperscript{26}).

Linda and McGrath also discussed the initial concerns about the safety of psychologists’ prescribing\textsuperscript{27} and the adequacy of the training to ensure competent prescribing\textsuperscript{28}. This had also been raised by Gournay\textsuperscript{29} in relation to the training for nurse prescribers in the UK. However, Linda and McGrath argue that ‘non-physician prescribers have demonstrated the ability to prescribe successfully with less extensive training than medical school\textsuperscript{30,31}, even though similar concerns were raised at the time they pursued prescriptive authority’ (Linda and McGrath, 2017). They suggest that the real issue is:

‘How to define the minimum training for psychologists that can generate safe and effective prescribers of psychotropic medications, not how that training compares to other professions with different roles in health care.’ (Linda and McGrath, 2017)

Overall, the findings of Linda and McGrath (2017) are that psychologists are ‘prescribing successfully’ and that others who work with them are ‘overwhelmingly favourable’ of such prescribers. These results concur with and expand on the findings of past evaluations of both the US Department of Defense’s Psychopharmacology Demonstration Project (PDP) and a military prescribing psychologist to include an assessment of providers working across states and settings.

They conclude that:

‘Given that the practice is not going to evaporate, future research should focus more on the practices of prescribing psychologists and on how we as a profession can enhance that practice so that the prescriptive practice can be optimized and less on whether it is a good idea.’ (Linda & McGrath, 2017, p.44)
3. What needs to be considered?
3. What needs to be considered?

3.1 WHAT ARE PRESCRIBING RIGHTS?

Under UK law, only ‘Appropriate Practitioners’ can prescribe medicine in the UK. A prescriber is a healthcare professional who can write a prescription and de-prescribe (reduce or stop a particular medication or treatment).

There are two kinds of ‘Appropriate Practitioner’:

An independent prescriber – someone who is able to prescribe medicines under their own initiative (e.g. start or stop a medication independently with a service user).

A supplementary prescriber – someone able to prescribe medicines in accordance with a pre-agreed care plan that’s been drawn up between a medical doctor and the service user already.

Some professions including nurses and paramedics allow professionals to be either supplementary or independent prescribers. In these professions, a supplementary prescriber may do a top-up course to then become an independent prescriber if they choose.
CASE EXAMPLE: Self-harm

Ada regularly uses self-harming as a coping mechanism when she is acutely distressed. A psychiatrist prescribes Pro Re Nata (PRN) sedative medication to calm Ada during and after periods when she has self-harmed; this is being over-used and Ada finds the use of Intra-Muscular PRN degrading and re-traumatising.

Staff expressed concerns regarding the overuse of PRN (benzodiazepine) medication and intra-muscular antipsychotic medication (prescribed ‘for severe agitation’) and noted that Ada would use PRN after incidents of self-harm rather than before, and would also monitor the time to see when she could have a further dose.

As a result of the current prescribing regime, Ada is developing an unwanted psychological association that self-harming is calming as the body and mind associates this with the sedative effects of the PRN; this is increasing Ada’s self-harm.

The psychologist works closely with Ada to develop a biopsychosocial formulation of her distress and to develop psychological grounding dialectical behavior therapy (DBT) strategies to support Ada to take control when she is acutely distressed to help her avoid the need to self-harm.

There is a time delay between putting the collaborative plan in place for staff to support Ada to use her strategies prior to considering PRN use. Ada is being disempowered by the use of PRN medication rather than supporting her to use the psychological strategies from therapy that enable Ada to gain control over her self-harm in the longer-term.

Currently: The psychologist must discuss this with a medical professional who may be reluctant to reduce the PRN until there is evidence that the self-harming has decreased due to the level of risk meaning a time delay.

An independent psychologist prescriber could work with Ada to collaboratively understand her self-harm and the maintaining effects of the PRN medication and co-produce strategies to reduce the PRN prescription and empower her to manage her self-harm without medication.

QUESTION 2: Do you think psychologist prescribers should be independent or supplementary prescribers or have the option for both?

In addition, local arrangements can be made to allow health and care professionals who are not prescribers to supply or administer medicines. The different methods or “mechanisms” that enable this are:

- Patient specific directions (PSDs) where a direction to administer a specific medication is made for a specific service user in hospital. A prescription chart is written and commonly a nurse dispenses and administers the medication in accordance with the PSD rather than a prescriber writing a prescription and the service user taking this to a pharmacy for the medication to be dispensed.

- Patient group directions (PGDs) – This is a list of medications that can be dispensed and administered to a service user without a specific PSD or prescription. This is normally for common health problems like headache where paracetamol may
WHAT NEEDS TO BE CONSIDERED?

be administered respectively or for life saving medication in an emergency, such as oxygen.

Legal exemptions.

These mechanisms are not the same as prescribing. Registrants must have the proper skills, knowledge and experience before acting under any mechanism and should follow policies set by their employer.

The right to prescribe involves the writing of a prescription or a PSD (hospital prescription chart). It does not enable the prescriber to give a person a tablet or injection (administration of medication).

Although unlikely, it is foreseen that there may be occasions where psychologist prescribers would want to be able to administer medication in specialist settings, with appropriate training.

EXAMPLE 1: Within psychosexual services, Caverject is the last line of medical intervention for erectile dysfunction. This medication requires a prescriber to demonstrate how to administer it. It would be appropriate and convenient for a psychologist working in these settings and prescribing such medication as a last medical intervention to be able to demonstrate the use of such medication to service users.

EXAMPLE 2: Within gender services, GnRH analogues are used to suppress natural hormone production and synthetic testosterone is administered intra-muscularly by injection to introduce testosterone to trans men.

QUESTION 3: Do you think psychologist prescribers should be able to administer medicines?

QUESTION 4: Can you think of any other contexts where psychologists being able to administer medicines may be useful or relevant?

3.2 TYPES OF MEDICATION

Although a profession may have access to the whole medicines formulary, and have the legal right to prescribe any drug for any condition, all non-medical prescribers must work within their professional competence and expertise. This would be the case for psychologist prescribers as the profession has a very broad practice context base.

The types of medications non-medical prescribers have access to vary and require different permissions that have to be applied for:

**Licensed medications** are medicines which have undergone clinical trials to show they are safe for a specific condition.

**Unlicensed/off-label medications** are medications that are not licensed for treatment of a particular condition or population. For example, medication licensed for treatment of adults may be used ‘off-label’ to treat children.

**Controlled drugs** are medicines covered by the Misuse of Drugs Act.

The authority to prescribe licensed and off label drugs medication are given under the Human Medicines Regulations. The authority to prescribe controlled drugs are given separately under the Misuse of Drugs Act.
Most medications are licensed and would be used in the majority of settings. However, in specialist services, such as gender services, medications are routinely prescribed off-label. Similarly, in contexts such as addictions services, the use of controlled drugs may be appropriate.

Psychologist prescribers would be working with an experienced mentor, and would initially be using a small formulary of medications within their area of expertise. Further details on mentors are discussed below in section 3.4.

**CASE EXAMPLE: Gender clinic**

Karen is a trans woman who was assigned male at birth. She asks to be referred to the gender clinic to align her body with her gender identity. Karen is assessed by a psychologist as a suitable candidate for physical treatments.

The psychologist works with Karen to support her with psychosocial adjustment (e.g. social transition and life stressors). People whose gender does not align with that assigned at birth – trans and non-binary people – often seek physical treatments so as to closer align their bodies with their gender identity. For those assigned male at birth this may include anti-androgens and oestrogens.

Currently: The psychologist recommends cross-sex hormones for Karen. An endocrinologist determines the type and dosage of medication and monitors and evaluates the physical outcomes. Ongoing dose adjustment is then undertaken between the psychologist (who evaluates psychosocial outcome and assists as necessary) and prescriber (who evaluates physical outcomes).

A psychologist prescriber could prescribe the hormones required and adjust the dosage as necessary to support this process. This would offer service users more person-centered, holistic, biopsychosocial approach with more responsive treatment delivered through one person. Any prescribing in the context of complex medical problems would be referred to endocrinologist colleagues.

As they are granted under separate legislation there is the potential to request authority under the Human Medicines Regulations then seek authority for controlled drugs at a later date. However, it should be noted that medications can change. Recently, pregabalin changed from licensed to controlled. This drug was used routinely in pain management in severe acute pain by paramedics who only requested the use of licensed drugs when they had prescribing rights extended to them. They are now having to apply for the right to prescribe controlled medications to enable them to continue to include this in their formulary as they are unable to prescribe it at the moment because of the change in classification.

**QUESTION 5: Do you think that psychologist prescribers should have access to prescribe:**
(i) licensed medications (ii) licensed and unlicensed medications (iii) licensed, unlicensed/off-label and controlled medications.
3.3 What could formulation-informed prescribing look like?

Psychologist prescribers in the UK would continue to work using collaboratively developed psychological formulation. When discussing potential psychological strategies and interventions that are informed by the psychological formulation, there would be the additional option for the psychologist prescriber and the service user to discuss evidence-based medications alongside these and, when appropriate, for the psychologist prescriber to prescribe them.

Psychologist prescribers would also be able to monitor the effect of the psychological intervention and work collaboratively with service users to reduce or stop their medications.

Psychologist prescribers would likely only be involved in physical health where it is directly related to a medicine; for example, checking blood pressure or for symptoms of adverse reactions. For complex symptoms or cases outside of their competency, psychologist prescribers would consult with other colleagues just as existing NMPs do or a psychiatrist may consult with a neurologist or geriatrician.

Case Example: Forensic/prison setting

John has a history of sexual offending. He is engaging in psychological assessment and treatment as he wants to reduce his risk of reoffending and work through the psychological trauma caused by his own sexual abuse as a child.

Whilst exploring John’s lived experience, it emerges that John is experiencing a lot of distress because of low mood and anxiety. John’s anxiety is partly because he is fearful of his own sexual risk to others.

His psychologist recommends a type of anti-depressant called a selective serotonin reuptake inhibitor (SSRI)\(^3\) that can help with John’s low mood but a ‘wanted’ side effect is that it lowers John’s libido\(^3\)\(^6\), reducing his sexual risk and his anxiety about this risk, which John and the psychologist had jointly formulated as a psychological driver of John’s anxiety and low mood.

Currently: The psychologist must discuss this with a psychiatrist which delays the prescription. The psychiatrist may wish to meet with the service user before making a final decision, adding a further delay.

A psychologist prescriber could prescribe the medication straight away for John and could monitor his improvement in mood and the ‘wanted’ side effect of reduced sex drive. The prescription could be reduced by the psychologist prescriber as John responds to psychological therapy.

Why is diagnosis important?

To prescribe within the current prescribing guidelines, psychologist prescribers would also need to utilise a diagnostic framework alongside formulation. At present, all medicines are licensed for use with a specific diagnosis, or list of diagnoses. Furthermore, clinical guidelines are based on rigorous research-based evidence that is collated by seeing what works well for people with clusters of symptoms correlating with specific diagnosis in order to help other people with the same diagnosis.
Prescribing rights for psychologists

To make a diagnosis for clinical and research purposes, guidelines need to be followed about what the different presentations are for each diagnosis. The collection of symptoms for each diagnosis (which may include personal, social and/or biological factors) are agreed by an international committee of clinical experts, including psychologists and medical doctors, at the World Health Organization (WHO). They are then collated into the standardised diagnostic system of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) – with the eleventh edition currently in its implementation stage. There are other diagnostic systems in use in specific countries, but this is the only globally agreed system and is the one used by the NHS in the UK.

Prescribing guidelines such as the British National Formulary (BNF) draw on the same diagnostic classification system and clinical guidelines to describe medications, what diagnoses they are appropriate for, and what may be harmful or must be used with caution. The BNF is reviewed periodically to ensure that it reflects the most recent evidence; it also alerts clinicians if there are any urgent changes between annual reviews to ensure that medications are being used as safely as possible.

The availability of evidence-based diagnostic guidelines, diagnostic classification systems, and a robust formulary enables all prescribers to make evidence-based clinical treatment choices. Psychologist prescribers would use the same resources alongside psychological formulation.

Figure 1: How psychologist prescribers would use formulation and diagnosis together in formulation-informed prescribing

- Service user shares their lived experience with the psychologist prescriber, including the impact of this on their functioning
- Monitor, evaluate and review benefits and side effects and adjust treatment responsively
- Evidence based and person-centred interventions based on National/Specialist guidelines (e.g. NICE)
- Formulation
- Diagnosis
- Psychological
- Pharmacological
WHAT NEEDS TO BE CONSIDERED?

3.4 TRAINING AND POST-QUALIFICATION GOVERNANCE

The Royal Pharmaceutical Society (RPS) publishes the current competency framework set out for all prescribers in the UK, including non-medical prescribers, which would include psychologist prescribers. It lays out the set of competencies necessary to become a prescriber, what is expected of a prescriber, and governance post qualification.

The framework sets out 10 competencies split into two domains to describe what good prescribing looks like (see Figure 2).

It is anticipated that psychologist prescribers would utilise the same competency framework.

CASE EXAMPLE: Post-traumatic stress disorder

Carl is a veteran with a diagnosis of post-traumatic stress disorder (PTSD) who is referred to a psychologist for therapy by combat stress.

Carl and the psychologist formulate Carl’s lived experience. Carl experiences flashbacks, sleep problems, high levels of anxiety and low mood. He is also experiencing problems with his partner as a result of this, as well as difficulties with sleep.

Carl has had a significant period of distress due to symptoms associated with the diagnosis of post-traumatic stress disorder (PTSD). He has been fast-tracked by Combat Stress, a charity for veterans, for some eye movement and desensitisation and reprocessing (EMDR) therapy. This is an evidence-based interactive psychotherapy technique used to relieve psychological stress and is an effective treatment for trauma and post-traumatic stress disorder (PTSD). Carl is triaged initially by telephone and then by a nurse a few weeks later, before seeing the psychologist in secondary care.

The psychologist formulates a treatment plan with Carl, including strategies to improve their sleep and to commence the EMDR but believes that in the short term he would benefit from a selective serotonin reuptake inhibitor (SSRI; also recommended in the NICE guidelines).

Currently: The psychologist must contact a GP who can’t return the call until the clinic letter is received. In the meantime Carl had been to a GP who asks them to wait until they have finished the psychological treatments, unaware of the plan. Carl returns to the psychology appointment extremely distressed and hopeless, and the psychologist recommends they go back to the GP as the GP has acknowledged the clinic letter and is in agreement with the plan. As the therapy progresses, Carl feels able to reduce a sleep aid the GP has prescribed but this continues to be prescribed by the GP at the same dose and is only subsequently reduced several weeks after the psychological treatment is completed and a clinical letter is sent.

A psychologist prescriber could formulate the treatment options collaboratively, including medication. If Carl decided to pursue this option, it could have been commenced immediately and then been gradually reduced in response to how Carl was. Carl would be reviewed weekly and therefore potentially harmful side effects, such as serotonin syndrome would be identified more quickly. Carl could be deprescribed the sleeping aid as he progresses in therapy. It would also reduce the burden of GP services and improve the quality of care to the service user.
WHAT NEEDS TO BE CONSIDERED?

QUESTION 6: Should psychologist prescribers follow the same framework as other NMPs?

The current pathway for supplementary and independent non-medical prescribers training is:

- To complete an undergraduate degree that confers eligibility for professional registration.
- To be registered with their statutorily regulated governing body.
- To have a minimum of three years clinical experience in the context where they will be prescribing.
- They must also have support from a potential prescribing mentor within the setting before they are eligible for entry on the postgraduate training course. Again, it is anticipated that there would be the same expectations of psychologist prescribers.

QUESTION 7: Do you think these pre-training requirements would be robust enough to support appropriate access to prescriber training for psychologists?

Professions regulated by the HCPC must complete training in prescribing accredited by the HCPC. They use a series of standards that they jointly develop with the Royal Pharmaceutical Society (RPS):

1.1 Understand pharmacodynamics, pharmacokinetics, pharmacology and therapeutics relevant to prescribing practice.
1.2 Understand the legal context relevant to supplementary and independent prescribing, including controlled drugs, mixing of medicines, off-label prescribing of medicines and the prescribing of unlicensed medicines.
1.3 Understand the differences between prescribing mechanisms and supply/administration of medicines.
1.4 Be able to distinguish between independent and supplementary prescribing mechanisms and how those different mechanisms affect prescribing decisions.
1.5 Be able to make a prescribing decision based on a relevant physical examination, assessment and history taking.
1.6 Be able to undertake a thorough, sensitive and detailed patient
WHAT NEEDS TO BE CONSIDERED?

1.7 Be able to communicate information about medicines and prescriptions clearly with service users and others involved in their care.

1.8 Be able to monitor response to medicines and modify or cease treatment as appropriate within professional scope of practice.

1.9 Be able to undertake medicine calculations accurately.

1.10 Be able to identify adverse medicine reactions, interactions with other medicines and diseases and take appropriate action.

1.11 Be able to recognise different types of medication error and respond appropriately.

1.12 Understand antimicrobial resistance and the roles of infection prevention and control.

1.13 Be able to develop and document a clinical management plan to support supplementary prescribing.

Additional standards for independent prescribers only:

2.1 Understand the process of clinical decision making as an independent prescriber.

2.2 Be able to practise autonomously as an independent prescriber.

2.3 Understand the legal framework of independent prescribing as it applies to their profession.

Psychologists usually have a different academic background to other prescribing professions. The task and finish group have looked at the curricula of a number of existing non-medical prescribing (NMP) courses which are aimed at the full range of NMPs. These tend to be broad but not always to the high level of qualifications which psychologists have passed. Therefore, it is expected that psychologist prescribers would need bespoke training to address physical anatomy and psychopharmacology, just as a course was developed for psychologists and other eligible professionals (nurses, social workers and occupational therapists) who required specialist training in mental health law (University of Northumbria, Professional Practice in Mental Health Law Postgraduate Certificate) to fulfil the competency framework set out in the Mental Health Act (1983, amended 2007) Code of Practice for all Non-Medical Approved Clinicians.

Having said this, it is anticipated that psychologist prescriber courses would be based around these HCPC standards, as courses would be accredited in the same way to ensure the competencies are met.

QUESTION 8: What do you think about this curriculum proposal?

The RPS suggests that post annotation/approval, three categories are used to describe prescribers: (i) novice; (ii) experienced; and (iii) expert. Just as psychologists receive supervision for the psychological areas of their practice, mentorship/supervision would need to be identified during and post training to support psychologist prescribers to prescribe safely and to develop in competency from novice to expert in their specialised field of practice. Just as with any area of clinical practice, psychologist prescribers would be regulated by the HCPC for this new area of practice.
Other non-medical prescribers are mentored as they train. The rules around this have just been amended meaning that non-medical prescribers can act as mentors to trainees. This would, eventually, be the case for psychologist prescribers.

Psychologist prescribers will be psychologists who are established in their field. As such, it would be usual for Psychologist Prescribers along with other psychologists who have substantially increased their portfolio of skills from those gained upon first qualification, to have their remuneration increased appropriately.

CASE EXAMPLE: Primary care

Emma has a diagnosis of irritable bowel syndrome and asthma. She has a very stressful job, is not sleeping, and feels ‘on the edge’ with her nerves all the time. She is on lots of medication, including an anti-depressant. Emma has complex physical and mental health issues. She has never had contact with mental health services and she is very much a ‘coper’. Emma has had to cope with numerous investigations and increasingly poor health.

She visits her GP because she doesn’t know where else to turn and feels like she ‘just can’t cope’ and despite being prescribed a lot of her medications for almost five years, she feels that she isn’t getting any benefit. Emma is triaged and offered an appointment with a psychologist. The psychologist is able to explore the history of Emma’s difficulties, including her history of trauma. They are also able to introduce a biopsychosocial framework to help Emma understand the connectivity of her physical and mental health, including understanding her patterns of avoidance with a lack of care towards her body.

Emma realises that she holds a lot of her distress in her gut and that many of the symptoms she experiences and has experienced are related to feelings. With the practice of coherent breathing and psychological formulation, and some manual therapy and treatment from a physio, Emma is able to recognise how interconnected her whole body is and with the help of the practice physio, symptoms significantly reduced (both physical, emotional and psychological). Medication also was able to be reduced, and so did her need for repeated hospital care. Emma felt more in control and learned strategies to be more resilient.

Currently: The psychologist must contact a GP, causing a delay and the risk that the GP may not understand the complexity of the situation, and may be more likely to prescribe further antidepressants. The GP may offer referral to IAPT – but this would not deal with complex difficulties Emma has brought.

A psychologist prescriber could review Emma’s medication and explore what was needed, what was prescribed for side effects or for symptoms that might be more appropriately treated by a physio or what might be understood from a psychological perspective. This biopsychosocial approach with a psychologist prescriber would ultimately lead to a holistic approach and reduce risk of over-medicating through focus on medication alone.

QUESTION 9: Who do you think should mentor psychologist prescribers now and in the future?

QUESTION 10: Do you think the idea of using the developmental framework of: (i) novice, (ii) experienced and (iii) expert is useful?
4. What do others think?
4. What do others think?

The following sections are designed to illustrate the general opinions we have gathered so far. We acknowledge that the sample sizes here are small and reiterate that this paper is a way of gathering the opinions of a larger number of stakeholders for a more robust indication of opinion.

4.1 Psychologists

The task and finish group wrote a letter to The Psychologist magazine inviting BPS members to send comments about psychologists prescribing via email. Of the 12 emails received to date, nine were broadly in support of psychologist prescribers, two were against, and one didn’t give an opinion.

The main points from the letters were:

1. Psychologist prescribers would be good for specific settings:
   ‘Given the dangers of overprescribing in chronic pain, and the lack of efficacy of opioids for chronic pain, I would like to see this included.’

   ‘Psychologists in addictions services will be working in a multidisciplinary team to support clients to recover from addiction... Having the option to adjust established medications within... formulation could enable more nuanced and client-centred conversations about the value and utility of the medications, as well as support clients to come off the medications.’

CASE EXAMPLE: Chronic pain

Sofia has a history of chronic pain and is referred to the local pain management service. Sofia is on a significant quantity of pain medication. The consultant anaesthetist in the pain management service reviews Sofia and given her unresolved chronic pain and other symptoms, believes that she has chronic fatigue syndrome. They believe that they have exhausted the potential pharmacological treatment options and refer them to a psychologist for psychological assessment and treatment whilst maintaining their current regime.

The psychologist works with Sofia to understand her experience of her pain. She has a history of complex trauma and is also self-medicating with alcohol to block out intrusive thoughts and flashbacks. The combination of the alcohol, medication and the feelings of hopelessness, in part due to her frustration that ‘nothing is working’ and a belief that professionals are being dismissive of her psychological and physical pain are contributing to Sofia feeling deeply unhappy.

As the therapy progresses, Sofia and the psychologist agree to try some strategies to help her to manage her sleep, pain and distress. They work together using graded exposure to gradually increase her activity and very slowly reduce her medication.

Currently: The psychologist must contact the busy consultant anaesthetist causing a delay; the reduction may not happen in a timely/gradual manner alongside the therapy as the Consultant wants to review the service user in person before changing the prescription. Due to the addictive properties of the pain medication, it is difficult to reduce without psychological support.

A psychologist prescriber could slowly reduce Sofia’s medication as she benefits from the self-management strategies to manage her physical pain and she reduces her alcohol use as a result of a trauma-focused therapy. This improves her mood, her physical health and activity levels which also improve her physical pain.
2. Concern/comment about training:
‘...for those without prior knowledge, there might also need to be a requirement for some study of basic anatomy, basic physiology and basic biochemistry.’

‘The training required for competence to prescribe should be, in my view, a basic necessity for applied psychologists working in any mental health setting.’

‘It would be possible to introduce training for prescribing, but given the nearly infinite number of potential drug interactions, how would it be possible for the training to cover all potential adverse interactions?’

3. Service users don’t see the difference between professions:
‘I find services users often do not distinguish the psychologist who they see as different from their medical colleagues and expect you to be able to advise them on all matters mental health.’

4. Prescribing rights may medicalise the profession:
‘The field of professional psychology is generally moving away from medicalised approaches and we are seeing increasingly the destructive effects of psychiatric drugs on people that take them. Why... would we as a profession want to start moving in the opposite direction...’

CASE EXAMPLE: Mental Health Act (1983, revised 2007)

Dev was detained under the Mental Health Act (1983, amended 2007) as their mental health had deteriorated and was associated with high risk of harm to others. Following admission, Dev became very unsettled and their behaviour was challenging; an antipsychotic medication was prescribed to manage their ‘agitation’ by the psychiatrist. This gave Dev very distressing side effects.

Dev moved to a ward where a psychologist was their responsible clinician (RC). The comprehensive formulation already developed indicated that Dev’s disturbed behaviour was likely to be the product of anger relating to a failed relationship, and Dev not understanding the reasons for their detention. In addition, the formulation suggested that they did not feel listened to by mental health professionals. The psychologist RC worked closely with Dev to review their formulation in the context of Dev’s current life events.

Based on this, a positive behaviour support (PBS) plan was developed. Whilst Dev’s distress was still very high, the psychologist asked the psychiatrist whether they could consider a different medication with less side effects. This was changed, enabling Dev to be calm enough to engage in psychosocial interventions.

Currently: Whilst the MDT, pharmacy colleagues and the service user supported a proposed change in treatment, the Psychologist must find a psychiatrist to make the amendment to medication. This could lead to an delay in the delivery of the alternative treatment that was subsequently shown to be more effective.

A psychologist prescriber could change the medication to one with improved side effects without delay as well as gradually and responsively reducing medication as Dev responded to the PBS plan. As the Approved Clinician in charge of the treatment in question, the psychologist prescriber would also be able to independently assess the capacity to consent to this treatment and request a Second Opinion Approved Doctor (SOAD) for service users detained under the Mental Health Act (1983 – amended 2007).
At the Society’s annual conference in May 2019 the group held a discussion about whether prescribing rights should be extended to some psychologists. Some experts by experience were able to attend and present alongside members of the task and finish group.

Attendees were asked to vote ‘Should prescribing rights be extended to some psychologists?’ With answer options of ‘Yes’, ‘No’ or ‘Unsure’.

Prior to receiving any information, the attendees voted 57 per cent ‘Yes’, 13 per cent ‘No’, 30 per cent ‘Unsure’ (23 voters in total). Attendees were then given a presentation containing information similar to that in this discussion paper, including the case studies. Following this, attendees were asked to vote again, this time 73 per cent voted ‘Yes’, 9 per cent ‘No’ and 18 per cent ‘Unsure’ (out of 22 voters).

Task and finish group members also held focus groups with psychologists. Again, the psychologists in these groups were broadly supportive of psychologist prescribers. The main themes included:

5. Concern about potential medicalisation of the role.

6. Concern about the influence of the pharmaceutical industry on prescribing choices.

7. Psychologists could be pressured into seeing patients for prescribing rather than prioritising psychological formulation and treatment.

Members of the Division of Counselling Psychology, at their annual conference, were also polled as to whether psychologists who wished to do so, and who had adequate training, should be able to prescribe. The results were 83 per cent ‘Yes’, 4 per cent ‘No’, 12 per cent ‘Abstain’ (24 voters in total).

Two service user focus groups have taken place, one in Newcastle, hosted by ReCoCo Recovery College and a second in Bradford/Airedale.

Both groups were open to up to fifteen participants. Information about the current prescribing arrangements in the UK and the US were described and case studies were presented for discussion. At the end of the focus group, the participants were asked to vote on anonymous voting slips whether they believed psychologists should become prescribers (Yes), whether they shouldn’t (No) or whether they weren’t sure (Don’t know).

Eight attended the Newcastle group, a number of which had experience of working with psychologists. 87.5 per cent voted ‘Yes’, 0 per cent voted ‘No’ and 12.5 per cent voted
A number of themes emerged from the focus groups:

**Theme 1: Psychologists have a deep understanding of their service users because of their formulation focus, which enables more trust and a stronger therapeutic alliance**

‘Greater credibility from a psychologist knowing them, making a decision on really knowing you.’

‘The psychologist knows the person and the strategies and things.’

‘Psychologist is a protective shield working in their best interests.’

‘Would trust the psychologist.’

**Theme 2: Psychologists could tailor the medication and psychological strategies in a more person-centred way**

‘Moving away from one size fits all like a conveyor belt.’

‘Not having to go over it over and over again with the psychiatrist [too].’

**Theme 3: Psychologists work collaboratively with service users and service users stated that psychologists as prescribers would give them greater ownership about their medication treatments**

‘Joint ownership between the psychologist and the service user.’

‘May appreciate the control and ownership.’

‘Giving... some control changing... thoughts and behaviours.’

The service users were also asked for reasons why people may feel less comfortable with psychologists prescribing:

‘They could question whether the psychologist has the right training; if they do have it, it would need explaining.’

‘Need to make sure they don’t just give the tablets.’

The members of the focus groups were also invited to contribute to the development of this document. One of the experts by experience gave detailed feedback during a one-to-one interview. They said that they felt that experts by experience had been fully involved and that the document was an accurate reflection of the work developed with the group so far. They said that seeing it written down gave reassurances that the HCPC, regulatory structures, resources, training and post-annotation mentorship process described in the document ‘provide protection’ for the service user. They said it was clear we had listened to and responded to the feedback from the focus groups. They were happy for the document to progress to the next stage of consultation on this basis.

### 4.3 Other Professionals

A number of interviews and focus groups were completed with different professionals who were already prescribers. Early feedback from other professionals was broadly positive, with some concerns over training that would be needed by psychologists.

Several themes from mental health and learning disability and autism services emerged, including:

1. Need for investment from organisations to support non-medical prescribers to ensure they have policies, governance and post annotation mentorship frameworks in place and are committed to deployment.

2. Training would need to address gaps in knowledge and competencies, particularly around psychopharmacology, side effects and drug interactions.
3. Clear referral protocols would need to be in place in the prescribers clinical setting to advise when medical advice should be sought and when it would be most appropriate to refer on.

4. The most successful pilot sites for non-medical prescribing so far have been where either:
   (i) there is a high volume of service users and the prescriber routinely uses a small pharmacy so they can become highly skilled in prescribing a small number of medications very competently (e.g., services for service users who have been identified as receiving pharmacological treatment for symptoms of attention deficit and hyperactivity disorder, dementia, psychosis, substance misuse); or
   (ii) where non-pharmacological/psychological approaches are the primary choice of treatment (e.g., learning disability and autism services and services where individuals may be given a diagnosis of personality disorder).

5. Prescribers are expected to have a high level of clinical expertise in the area where they prescribe and prescribing is seen as an ‘additional’ enhancing option of treatment and not a replacement.

6. Psychologists will need to ensure that they are ethical prescribers and do not acquiesce to pressure to prescribe where this isn’t indicated.

Overall, the consensus was that it was a role that psychologists could ‘step-up to’ with the right training to meet knowledge and competency gaps.

The focus group with prescribers in gender services had similar themes, with the group agreeing that, certainly within the gender setting, psychologists being able to prescribe is very sensible, and will enable treatment to be started and managed in a timelier manner rather than the current situation which requires waiting for a letter to be generated by the endocrine team.

Themes expressed included:

1. There was agreement that technically having access to the whole formulary, but being expected to prescribe within one’s specific competency – as medical doctors and some nurse prescribers do – would be reasonable.

2. Joined up care is important and prescribing should ideally be done where the prescriber works within a multidisciplinary team. Communication is key for safe prescribing – gathering and sharing important and relevant information between clinicians involved in a person’s care.

3. Revalidation in this setting would be important and this will need to be outlined in terms of number of hours per year spent actively prescribing with robust revalidation process.

QUESTION 11: Are there any other settings where psychologist prescribers would be a benefit?

QUESTION 12: Do you have any other comments?
5. Summary of questions
5. Summary of questions

QUESTION 1: What do you think about psychologist prescribers working in contexts where the main emphasis would be to deprescribe?

QUESTION 2: Do you think psychologist prescribers should be independent or supplementary prescribers or have the option for both?

QUESTION 3: Do you think psychologist prescribers should be able to administer medicines?

QUESTION 4: Can you think of any other contexts where psychologists being able to administer medicines may be useful or relevant?

QUESTION 5: Do you think that psychologist prescribers should have access to prescribe: (i) licensed medications (ii) licensed and unlicensed medications (iii) licensed, unlicensed/off-label and controlled medications.

QUESTION 6: Should psychologist prescribers follow the same framework as other NMPs?

QUESTION 7: Do you think these pre-training requirements would be robust enough to support appropriate access to prescriber training for psychologists?

QUESTION 8: What do you think about this curriculum proposal?

QUESTION 9: Who do you think should mentor psychologist prescribers now and in the future?

QUESTION 10: Do you think the idea of using the developmental framework of: (i) novice, (ii) experienced and (iii) expert is useful?

QUESTION 11: Are there any other settings where psychologist prescribers would be a benefit?

QUESTION 12: Do you have any other comments?
Decisions for prescribing rights for psychologists can be represented in the following decision tree:

1. **Supplementary & independent**
   - OR
   - **Prescribe and administer**
   - OR
   - **Prescribe only**

2. **Licensed drugs only**
   - OR
   - **Licensed and unlicensed drugs**
     - OR
     - **Licensed, unlicensed and controlled drugs**

3. **Curricular requirements set out by HCPC and RPS**
   - No

4. **Governance as set out by RPS: Novice, experienced and expert**
   - Yes
   - No
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7. References
7. References


43. Care Quality Commission (2008). *Guidance for SOADs: Consent to treatment & the SOAD role under the revised Mental Health Act*. 

Prescribing rights for psychologists