the british psychological society
promoting excellence in psychology

Prescribing rights for psychologists

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CHAPTER 1

Introduction

NHS England (NHSE) asked the British Psychological Society (BPS) to consider whether there is a need for the extension of prescribing and medicines supply mechanisms to include qualified statutorily regulated psychologists. The Practice Board commissioned a Task and Finish (T&F) Group to work on establishing the BPS' position in this matter.

The group was recruited following the BPS process of a society-wide call out for statements of interest which were then judged according to the BPS selection process. It was noted that the applications did not include psychologists from across the domains of psychology and several attempts were made to target those member networks where gaps were noted; however no further statements of interest were received. Once formed, the group also repeatedly tried to recruit psychologists from differing contexts and with differing views to the group but nobody put themselves forward.

As the work progressed we recognised the need to include someone with knowledge of prescribing – an NHS Consultant Physician and Fellow of the Royal College of Physicians known to a group member agreed to join the group to advise on this. We asked one of the experts by experience who attended an early focus group and who had been keen to be involved to join the group. We also co-opted a psychologist who is against the acquisition of prescribing rights for psychologists to be part of the group.

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CHAPTER 2

Prescribing

WHAT ARE PRESCRIBING RIGHTS?

Under UK law[1], only 'Appropriate Practitioners' can prescribe medicine in the UK. A prescriber is a healthcare professional who can write a prescription and deprescribe (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 has 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 become an independent prescriber if they choose.

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) – a written instruction, signed by a prescriber, for medicines to be supplied and/or administered to a named service user. These enable a health care professional (often a nurse) to dispense and administer 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) – provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber. Supplying and/or administering medicines under PGDs should be reserved for situations in which this offers an advantage for patient care, without compromising patient safety; for example, routine immunisations.

Legal exemptions – these are specific to different professions. For example, paramedics may administer certain medicines by injection on their own initiative for the immediate, necessary treatment of sick or injured people.

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).

WHY IS DIAGNOSIS IMPORTANT?

There is ongoing debate within the psychological community about diagnostic systems and their use. It is a controversial topic which promotes passion. There is a movement by some psychologists away from diagnosis altogether[2]. In order to prescribe within the current prescribing guidelines, prescribers are required to use a diagnostic framework.

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 a specific diagnosis in order to help other people with the same diagnosis.

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-11). There are other diagnostic systems in use in specific countries, but this is by far the most commonly used globally, and is the only agreed system across Europe and the UK and is the one used by the NHS for standardised coding on electronic patient records.

Prescribing guidelines such as the British National Formulary (BNF) draw on the same diagnostic classification system and clinical guidelines to describe medications, the diagnoses for which they are appropriate and what may be harmful or must be used with caution, as well as possible side effects and contra-indications for their use. 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.

We recognise that diagnosis is part of the current healthcare system and in some cases service users ‘need’ a diagnosis in order to receive, for example, benefits or reasonable adjustments. It is the BPS’ position that psychologists can use diagnosis in the best interests of their clients but that this should be underpinned by formulation.

TYPES OF MEDICATION

Prescribing professions have theoretical access to the whole medicines formulary, and have the legal right to prescribe any drug for any condition (apart from controlled drugs). All prescribers must work within their professional competence and expertise.

The types of medications non-medical prescribers have access to vary and require different legal permissions:

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

Off-label medications are medications that are licensed, but which are used for a different treatment of a particular condition or population than they are licenced for. 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 licenced and off label medication is given under the Human Medicines Regulations. The authority to prescribe controlled drugs is given separately under the Misuse of Drugs Act.

Most medications used in the treatment of mental health conditions are licensed and would be used in the majority of settings. However, in specialist services, medications are routinely prescribed 'off-label'. Similarly, in contexts such as addictions services, the use of controlled drugs may be appropriate.

CHAPTER 3

Non-medical prescribers

PRESCRIBING IN THE UK

In the UK, all dentists and medical doctors have prescribing rights. Some other professions also have prescribing rights in the UK and they are known as non-medical prescribers or 'NMPs'. Currently these are:

Independent and supplementary prescribers

- Nurses/midwives
- Pharmacists
- Physiotherapists
- Podiatrist
- Paramedics
- Optometrists
- Therapeutic radiographers

Supplementary prescribers only

- Diagnostic radiographers
- Dietitians

Community practitioner prescribers

- Nurses (health visitors and district nurses)

These are the professions who currently have prescribing rights. In addition, occupational therapists are currently exploring prescribing rights and dietitians are looking at extending their rights to be independent prescribers. There are also international moves towards psychologists prescribing including psychologists from Brazil, Canada, the Netherlands, and Norway.

All NMPs must work within their area of competence, only using a small number of medicines and only in their clinical area where they have existing expertise. For example, NMPs working in mental health contexts (e.g. dementia) can only prescribe a small number of medications specific to that setting (e.g. cholinesterase inhibitors) and not broader groups of medications in that setting or medications used in a different setting altogether where they do not have the competencies or expertise (e.g. antibiotics).

PSYCHOLOGISTS WHO PRESCRIBE

Psychologists already have prescribing rights In the United States of America (USA); in the Department of Defense (American military), the American Indian Health Service[3] and in five states (New Mexico, Louisiana, Illinois, Iowa, Idaho).

Psychologists who wish to prescribe in these areas must be statutorily regulated as an applied psychologist and complete a post-doctoral Master's in Clinical Psychopharmacology.

Current literature states that these groups of psychologists prescribe safely in these areas. Prescribing is optional and only those who choose to become prescribers train as prescribers. Linda and McGrath[4] have carried out 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.

Overall, the findings of Linda and McGrath (2017) are that that psychologists are 'prescribing successfully' and that others who work with them are 'overwhelmingly favourable' of such prescribers.

The American College of Neuropsychopharmacology (ACNP, 1998), composed of psychiatrists and psychologists, was contracted to perform an analysis of the Department of Defense project; they judged the psychologists with specialised training to be safe prescribers; some had assumed positions as chiefs of mental health clinics. The report noted the absence of a single significant adverse event among patients treated by the prescribing psychologists.

An evaluation report from the US General Accounting Office stated that 'Overwhelmingly, the officials with whom we spoke, including each of the graduates' clinical supervisors and an outside panel of psychiatrists and psychologists who evaluated each of the graduates, rated the graduates' quality of care as Good to Excellent.' (GAO, 1999, p.8).

These results concur with and expand upon the findings of past evaluations of both the US Department of Defense's Psychopharmacology Demonstration Project (PDP) and a military prescribing psychologist[5] to include an assessment of providers working across states and settings.

Although there are some limitations to the methodology used in these studies, they are the only ones currently available and there are no studies which show that psychologists prescribers are unsafe or do harm to their clients.

TRAINING AND POST-QUALIFICATION GOVERNANCE

The Royal Pharmaceutical Society (RPS) publishes the current competency framework[6] for all prescribers in the UK, including non-medical 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:

THE CONSULTATION

1. Assess the patient
2. Consider the options
3. Reach a shared decision
4. Prescribe
5. Provide information
6. Monitor and review

PRESCRIBING GOVERNANCE

7. Prescribe safely
8. Prescribe professionally
9. Improve prescribing practice
10. Prescribe as part of a team

Royal Pharmaceutical Society (2016)

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

To complete the undergraduate or post-graduate degree that confers eligibility for professional registration;

Be registered with their statutorily regulated governing body; and

Have a minimum of three years of 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 to the post-graduate training course.

The HCPC is the regulator for some non-medical prescribers and regulates for the competencies associated with this work alongside usual regulation. Professions regulated by the HCPC must complete training in prescribing accredited by the HCPC. They use a series of standards that they developed jointly 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 history, including an appropriate medication history.

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.

The RPS suggests that post annotation/ approval, three categories are used to describe prescribers (1) novice, (2) experienced and (3) expert.

Non-medical prescribers receive mentorship/ supervision during and post training to support them to prescribe safely and to develop in competency from novice to expert in their specialised field of practice. The rules around this have recently been amended. There are specified criteria which define experienced prescribers; experienced non-medical prescribers can also act as mentors to trainee NMPs.

During the consultation process undertaken by the BPS T&F group, there was concern from some respondents that psychologists should not prescribe as they do not have medical training. However, psychologists would need to complete appropriate postgraduate training, just as other NMPs, before they were able to prescribe and would need to meet the same criteria before being eligible to train.

The T&F 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 that registered practitioner psychologists have already passed. Currently the majority of NMPs have some anatomy input in their core training and this is therefore not a feature of the NMP courses. Similarly, there is not much emphasis in the courses on medicines for mental health and their effects. Therefore, we expect that training for psychologist prescribers would include physical anatomy and content pertaining to standard 1.1.'understand pharmacodynamics, pharmacokinetics, pharmacology and therapeutics relevant to prescribing practice' in order to gain these competencies.

The current process for designing all NMP courses is that the HCPC and the RPS agree what curricula would be required for a profession to meet the standard competencies. This is shared with universities, who wish to develop appropriate courses/ modules to fulfil these requirements in order for them to be accredited as approved courses. Some modules in existing courses are delivered across all professions but with specialised additional modules for different professions where their core competencies vary.

The British Pharmacological Society set out Ten Principles of Good Prescribing which all prescribers follow, which include advice such as 'the likely beneficial effect of the medicine should outweigh the extent of any potential harms, and whenever possible this judgement should be based on published evidence'. Should psychologists acquire prescribing rights, they would be expected to follow these. There would also be an emphasis within professional guidelines that prescribing would be an 'additional' treatment that could be used within a primarily psychologically focused framework; these safeguards are important in order to help prevent over-prescribing and the medicalisation of distress.

CHAPTER 4

Next Steps

If the BPS position is that some psychologists should have prescribing rights, there are still several other stages before psychologist prescribing could happen. These would be managed by other organisations but would have involvement from the BPS, ensuring that the different domains of practice would participate.

1. **Support from the NHS to write a case of need**
   This will need to concentrate on the potential benefits to service users in different settings and will be presented to MPs.

2. **Ministerial agreement for a public consultation**
   This public consultation is run by the NHS, is nationwide and open to anyone to comment including psychologists, other healthcare professionals, professional bodies (e.g. Royal Colleges), service users and the public. The paramedic's consultation information is available as an example of this process: www.england.nhs.uk/ahp/med-project/paramedics/

3. **Presentation to the Commission on Human Medicines (CHM)**
   This is where all the evidence is presented, including the additional training requirements, to ensure that a profession could meet the competencies set out for all non-medical prescribers, to make a recommendation to parliament. There is more information about the commission: https://www.gov.uk/government/organisations/commission-on-human-medicines/about

4. **Amendment to the statutory instrument on the Human Medicines Regulations (and potentially the Misuse of Drugs Act)**
   This is done through parliament, for the human medicine regulations there are two opportunities per year to add professions – spring and autumn. Professions who wish to prescribe controlled drugs then have to apply to be added to the Misuse of Drugs Act, again this goes through parliament.

5. **Change to the prescribing training accredited by the HCPC**
   As stated in the training and governance section above, the training curriculum would need to be devised in collaboration with HEIs, HCPC and BPS.

The stages are both robust and thorough, focusing on the benefit to the public of any change in legislation. This process could be halted at any of these stages if the case of need is not demonstrated. For example, paramedics had to present their case to the CHM three times. Other professions which have obtained non-medical prescribing rights have faced up to 10 years or more until they saw the first prescribers in their profession trained.

CHAPTER 5

Work of the Task and Finish group

LITERATURE REVIEW

A literature review[7] regarding existing non-medical prescribers was completed at the start of the T&F group work. This 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 health care professionals;
- Is becoming a well-integrated and established means of managing conditions and providing access to medicines;
- Makes better use of their skills, improving quality of care, saving time and money for staff and service users.

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 both 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.

THE PSYCHOLOGIST MAGAZINE – MARCH 2019

The T&F group wrote a letter to *The Psychologist* magazine inviting BPS members to send comments about psychologists prescribing via email.

The main points from the responses 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 multi-disciplinary team in order 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.'
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…'

EXPERTS BY EXPERIENCE FOCUS GROUPS

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 15 participants. Information about the current prescribing arrangements in the UK and the USA were described and case studies were presented for discussion. The case studies were developed by group members using real (anonymised) examples from their contexts of practice. 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'.

12.5 per cent voted 'Don't know'.

One service user in the group said, 'Service users would be lucky to have access to this.'

All attending Bradford/Airedale groups had complex physical and mental health problems from diverse ethnic and socio-economic backgrounds and had some contact with clinical psychologists.

100 per cent voted 'Yes'.

0 per cent voted 'No'.

0 per cent voted 'Don't know'.

One service user added at the end of the discussions: 'It's a good idea from both patient and professional perspective… don't know why they haven't done it before.'

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.

One of the experts by experience gave detailed feedback during a one-to-one interview where they were asked to share their comments and amendments to the draft of the discussion paper. Their comments and amendments were incorporated into the document. They also 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 that the T&F group 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.

PSYCHOLOGIST FOCUS GROUPS

T&F group members also held focus groups with psychologists in their contexts of practice. Again, the psychologists in these groups were broadly supportive of psychologist prescribers. The main themes included:

1. Psychologists are not trained in anatomy or pharmacology.
2. Psychologists may have more time with service users than psychiatrists and therefore may be in a better position to prescribe and monitor the effects of medication.
3. In some settings, psychiatrists can have an almost experimental approach to prescribing because of their limited time. Allowing psychologists to prescribe may lead to a closer relationship between psychologists and psychiatrists.
4. Concern about how private prescribing would be managed.
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 at a workshop as to whether psychologists who wished to do so, and who had adequate training, should be able to prescribe (24 voters in total):

83 per cent 'Yes'.

4 per cent 'No'.

12 per cent 'Abstain'.

FOCUS GROUPS WITH 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 about 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 range of medicines 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 have been given a diagnosis of personality disorder); it is not recommended in services where service-users are complex or have a high level of co-occurring physical health conditions.
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 must ensure that they are ethical prescribers and do not acquiesce to pressure to prescribe where this isn't indicated.

However, overall the consensus was that it was a role that psychologists could undertake 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 an MDT. 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.

BPS ANNUAL CONFERENCE

At the Society's annual conference in May 2019 the group held a workshop on whether prescribing rights should be extended to some psychologists. Some experts by experience were able to attend and present alongside members of the T&F 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 (23 voters in total):

57 per cent 'Yes'.

13 per cent 'No'.

30 per cent 'Unsure'.

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 (22 voters in total):

73 per cent 'Yes'.

9 per cent 'No'.

18 per cent 'Unsure'.

There was limited time for discussion but the main comments from the audience were about whether psychologists have sufficient training and potential benefits to service users.

DISCUSSION PAPER CONSULTATION

The group wrote a discussion paper to engage a larger number of people both internally and externally. The aim of the paper was to present the information obtained so far and to seek the opinion of readers as to particular aspects of prescribing.

The discussion paper was publicised internally (sent to BPS member networks for engagement with members), and externally to key stakeholders (including Royal College of Psychiatry, NMC, ACP-UK and HCPC) and more broadly via social media and other networks. For example, it was shared on the Cumbria Northumberland Tyne & Wear NHS FT intranet and internet; this NHS FT is one of the largest mental health and learning disability/autism providers in the UK, employing psychologists in services across the lifespan, as well as forensic services and specialist services such as gender dysphoria, MH and deafness, neurorehabilitation, perinatal, personality disorder and specialist psychotherapies.

It is notable that the discussion document can now be found in a wide range of forums such as Mumsnet and even on Wikipedia as a result of the social media community sharing posts from BPS official social media accounts. It has also been discussed extensively in service-user forums such as MadInTheUK (who had over 3,400 views just on the website).

As part of the consultation, the BPS presented the discussion paper with a Q and A session to the National Psychological Professions Workforce group on 28 November 2019. There was considerable discussion, including contributions from the HEE representative about potential training and Professor Paul Salkovskis (BABCP representative) and Dr Mike Wang (ACP-UK representative). As a result of the discussion, Adrian Whittington submitted a response on behalf of the group in his role as Chair. An open invitation was given to all of the individual organisations represented for the Task and Finish group to come and engage with their organisations but no requests were made.

The discussion paper received over 130 responses which is the highest number of responses to a BPS consultation, certainly within the last four years. We had responses from across the Society membership and beyond, from psychologists (both academic and practitioner), professional organisations, other professionals and service users.

There was some criticism of the paper by some members suggesting that it was biased as it asked about the details without asking, or knowing, whether readers thought psychologists should prescribe. However, our preliminary work indicated that although some people were confident in their opinion about psychologists prescribing, others required some detail in order to make their decision or to even give comment. Rather than the group dictating the potential details we presented options in the paper to gauge the opinion of respondents.

We had a mix of responses from people who had read the document and commented explicitly on the questions, as well as from people who were offering comment on the topic but not as a specific response to the document itself.

Responses varied from 'Please hurry up and get this proposal approved' to 'Please stop this project' with passion on both sides!

A summary of the responses to each question is presented below. General responses (not using the form) are included below with the question 12 comments.

1. WHAT DO YOU THINK ABOUT PSYCHOLOGIST PRESCRIBERS WORKING IN CONTEXTS WHERE THE MAIN EMPHASIS WOULD BE TO DEPRESCRIBE?

I am totally opposed to psychologists prescribing drug treatments. Our role as psychologists is to promote social, environmental, psychological and behavioural 'treatments', and to stand critical of a medical model of mental health.

I think often we see patients where there are high levels of poly-pharmacy and we suspect it is not good for the health of the patient but we can do little about it, therefore, deprescribing of psychotropic drugs could be helpful even if it was only to give advice from a qualified stance.

It would enable shorter use of such medication.

There is already enough risk of splitting within MDTs. The applied psychologist's role is surely to offer psychological expertise within the boundaries of their existing training, not to risk entering into further wrestling matches with other professions.

Good but they would have to know about how to withdraw people slowly from psychotropic drugs, how to recognise withdrawal effects and how to deal with the problems that might arise physically and psychologically and not confuse withdrawal effects with further mental illness.

Medication reduction is essential in many cases however, I do not agree with giving psychologists this added responsibility. The workload is immense and adding this responsibility and weight onto the shoulders of psychologists isn't right (especially for burnout).

Makes sense – in pain and addiction services particularly.

The main emphasis should be on determining the delivery of the best possible care for the service user. Any expectations of a specific action such as to deprescribe suggests the autonomy of the professional to assess, diagnose and treat is removed. The right to prescribe should enhance the role of the professional to achieve good outcomes for the individual by combining psychological interventions with prescribing, amending medicines already prescribed or stopping medicines.

I don't think that there should be a role for psychologists to be prescribers, or to be deprescribers. Our specialist skills/knowledge/ reason for training to be CPs, is to work with a non-medical model.

I think this could be very useful. Psychological formulation could add to care management in cases of deprescribing. Psychological opinions could also help with effective deprescribing

I do not think that this is an appropriate part of a practitioner psychologist's role, and I believe it to be contrary to the ethics

and values of the profession. We should be working together to de-medicalise distress, not reinforce an outdated and non-evidence based psychiatric framework.

Often service users have six-monthly outpatient reviews with psychiatry and GPs are unwilling to make adjustments to psychiatric medication. Service users who are being seen by our team of clinical psychologists and therapists have weekly contact during therapy and would be well placed to support deprescribing, offering psychoeducation about effects of reducing medication, strategies to cope differently and support a psychosocial model of understanding distress

As a profession that has historically been sceptical about the use of psychotropic medication, clinical psychologists (CPs) might not be an obvious profession to whom prescribing rights might be offered. However, I would argue that it is precisely for this reason – the scepticism – that CPs are in fact very well placed to prescribe.

I don't think that psychologists are uniquely protected from over medicating or mis-medicating and I am concerned that our key competencies will be diluted (and our ability to provide an alternative response to medication) as psychologist prescribers.

This is a terrible idea. It divides the professional into prescribers and non-prescribers. Employers will consider prescribers more valuable.

2. DO YOU THINK PSYCHOLOGIST PRESCRIBERS SHOULD BE INDEPENDENT OR SUPPLEMENTARY PRESCRIBERS OR HAVE THE OPTION FOR BOTH?

Psychologists should not be prescribers.

I believe they should have the option to be independent prescribers given they have undertaken the necessary postdoctoral training. I don't think psychologists should prescribe psychtropic drugs. Otherwise how can they connect with the true person?

They should be independent. We already have nurse prescribers who rely quite heavily on psychiatry to get the 'go ahead.' I don't think we need another role that draws heavily on psychiatry in this way. If adequately trained I see no reason why clinical psychologists cannot be independent prescribers for certain conditions.

I don't think they should do any, they do not have the skills or knowledge in anatomy or physiology.

Option for both of course if competent, what is the advantage to our clients to limit ourselves?

I do not think that psychologists should become prescribers, it is not a good use of our unique and scarce skills.

Supplementary prescribing only would mean psychologists remain confined by psychiatry driven prescribing which would greatly limit the presumed benefits of psychologically driven prescribing/deprescribing.

3. DO YOU THINK PSYCHOLOGIST PRESCRIBERS SHOULD ADMINISTER MEDICINES?

Unsure, depends on the mode and level of compulsion. We don't have the background competence re physical health to know the risks of injection I don't think, and I would hate to be in the position of being required to do IM PRN in restraint situation for acute distress as a therapist as I was 'the only one on the ward at the time'.

Since we do not believe that prescribing rights should be extended to psychologists, we do not agree with this proposal.

No, with exceptions: Only in remote locations where there are no other prescribers or clinicians able to administer medications available.

No. This again adds to the intense workload of a psychologist and moves the focus away from what a psychologist is able to/should do. I particularly do not agree with administering any type of medication (injecting or orally) as it complicates the interaction between the client and the psychologist (as it has the potential to become a medical interaction).

Yes, with the appropriate training and in specific contexts where this would improve/ enhance the care of the patient.

No. From experience, my nurse colleagues are frequently expected to administer medication and provide depots to service users not on their case load to cover for the wider team and this has a significant impact on their daily caseload. I would not want to be in a position where I would have to further stretch my limited time to administer medication as a central role as I believe over time this would take priority for organisations over the psychological interventions we are trained to provide.

Yes, in certain clinical settings I imagine this would be particularly useful; for example, in a health psychology setting, psychologist prescribers would be able to utilise their expertise in procedural anxiety to improve service user experience and reduce distress.

I think it unlikely that administration of medications would fit with the role of most psychologists so I would not advocate for this as being part of prescribing rights.

Yes. I believe there are several settings where this is useful. In psychological health settings, many medications are a source of anxiety (e.g. needle phobias being the most common phobia in paediatrics) and psychologist prescribers would be well placed to improve treatment of these conditions should they be allowed to administer the medication.

In general, no, definitely not, this is poor practice and can lead to drug errors. The value of having someone else administer the drug is that it provides a second check.

4. CAN YOU THINK OF ANY OTHER CONTEXTS WHERE PSYCHOLOGISTS BEING ABLE TO ADMINISTER MEDICINES MAY BE USEFUL OR RELEVANT?

I cannot think of any context where psychologists should prescribe CPNs have been used in our board to supplement flu vaccination clinics and other Public Health urgent strategies to control disease spread.

That could be helpful if we were able to supplement the workforce.

Since we do not believe that prescribing rights should be extended to psychologists, we have no comments on this statement.

Working with clients who do not want to have to have yet another appointment (GP/psychiatrist – who are not always sympathetic) to explain their issues before medication is prescribed.

Diabetes care, when working with people with high anxiety about injections.

No, I absolutely cannot fathom any context or reason for psychologists to prescribe or administer medicines.

Clients having alcohol or benzodiazepine withdrawal fits in my office.

No, we should be advocating social prescribing and not becoming part of the problem.

Emergency/crisis services, primary care, memory clinics etc, eating disorders services, ADHD etc assessment, sleep clinics.

I strongly believe that psychologists should not prescribe medication, and that to introduce this would be profoundly dangerous.

Only in emergency allergy, resuscitation situations.

No, I don't think administering mental health medications lacking long term safety research should be done by psychologists.

Mental health units, forensic settings, pain services, neuropsychology services, prisons, brain injury rehabilitation services, dementia services, progressive neurological diseases services, acute mental health services, community mental health teams.

5. DO YOU THINK THAT PSYCHOLOGIST PRESCRIBERS SHOULD HAVE ACCESS TO PRESCRIBE (1) LICENSED MEDICATIONS (2) LICENSED AND UNLICENSED MEDICATIONS (3) LICENCED, UNLICENSED/OFF-LABEL AND CONTROLLED MEDICATIONS

Psychologist should have option to prescribe any medicine that is scientifically proven as efficient in treatment of mental health problems and comorbid medical conditions that are results of psychopharmacology.

No, no and no.

Option 3 seems too far – I think when it comes to unlicensed/off-label medications then a more thorough understanding of psychopharmacology and physical health would be required by the proposal.

Absolutely not, the psychology training does not cover the appropriate anatomy and physiology.

Need to have flexibility to optimise benefits for patients using evidence-based medicines.

The statement 'Most medications are licensed and would be used in the majority of settings' applies mainly to adults. A very large number of medications used for children are used off label – this will require far more medical and prescribing expertise than would be possessed by a psychologist, even with considerable training I think it would be beneficial for psychologists to prescribe licenced, unlicensed/off-label and controlled medications, since it would significantly limit the potential benefits of psychological prescribing/ de-prescribing practice to exclude certain medications form prescribing rights.

As discussed, the role of a psychologist as a prescriber is not a position that I would advocate. If this role did become a reality, by allowing individuals decision making over unlicensed and controlled drugs, there is a real risk of serious harm. Psychologists are not medically trained.

Licenced, unlicensed/off-label and controlled medications; of course, psychologists would only use unlicensed/off-label on a clear need basis (just like any other prescribers would, taking into account their own scope of competence, which is also linked to their experience)

6. SHOULD PSYCHOLOGIST PRESCRIBERS FOLLOW THE SAME FRAMEWORK AS OTHER NMPS?

Not relevant as they should not prescribe.

Yes, I think that is a tried and tested model that is likely to have less resistance.

No, we shouldn't be NMPs. If I believe (per case example 'John' on p.22) that an SSRI would be of benefit, I can easily and quickly liaise with a medical colleague.

Psychologists should follow similar framework, but they need more knowledge from anatomy, physiology, chemistry, and basic pharmacodynamics and pharmacokinetics.

Yes, consistent approach removes ambiguity for service users.

They should follow a framework that means they work with a psychosocial model and consider austerity, deprivation, social factors that cause or contribute to mental and psychological distress. Medics can do medical work.

Yes, psychologist prescribers should be trained to the same standards and competencies as other NMPs.

We would not consider this framework to be anywhere near rigorous enough, because there is nothing here about competence in understanding pharmacology, typical and atypical development, interactions of medications, medication with children with complex neurodevelopmental difficulties and overlapping medical/genetic conditions etc. and nothing about experience required.

The NMP framework should be followed; however, psychologists should also have be expected to perform their prescribing duties within a formulation framework, and so evidence that psychological thinking has been incorporated into the prescribing plan should also be required.

7. DO YOU THINK THESE PRE-TRAINING REQUIREMENTS WOULD BE SUFFICIENTLY ROBUST TO PREVENT INAPPROPRIATE ACCESS TO PRESCRIBER TRAINING FOR PSYCHOLOGISTS?

I am not well enough informed to answer. I am concerned that 'psychologists' covers a mixed array of competencies. Would it specify the remit between the different practitioner psychologists? Would a sports psychologist be prescribing anxiety or depression meds or PRN?

I think these pre-training requirements would be sufficient in preventing inappropriate access to prescriber training as it demonstrates a strict criteria and specific level of experience required to be considered for the training.

No, because the training does not consider the ability of the individual to handle the workload and have the understanding of what this means for service users.

No, in addition should have support of employer:

1. There is a need for psychologists to be able to prescribe.
2. Relevant clinical governance arrangements are in place.
3. Two gaps in pre-registration training have been identified in the document – anatomy and pharmacology. This suggests a need for bespoke training in these areas prior to undertaking NMP training.

No, most nursing and medical staff have five to six years training and experience in the anatomy and physiology/medical model of working within their framework or practice before prescribing medication. Why would such an essentially short course be suitable for a non-medically informed professional? By psychologists prescribing this would open floodgates for others to follow, such as social workers and psychotherapists – where would the governance be in this?

The amount of training required for a psychologist to safely prescribe, would only be if they are also trained in medicine or pharmacy.

Yes. I think clinical psychology training provides a strong base in ethics, risk management and patient care. I can't imagine a situation where it would be inappropriate for a clinical psychologist to access training.

Clinical psychology training would not be sufficient to prepare candidates for completing the post graduate qualification. Supplementary training would be needed.

Yes, with the caveat that expectation of continued expansion of knowledge is essential. I would recommend review of the National Alliance of Professional Psychologist Providers.

I do not think any form of prescribing training for psychologists would be considered sufficiently robust in the eyes of the medical and legal systems, therefore pre-training requirements would not be relevant. If we were to re-train as medical doctors then of course this would be fine and we would also be able to command their salaries as fair remuneration for this responsibility.

8. WHAT DO YOU THINK ABOUT THIS CURRICULUM PROPOSAL?

I think it is a useful extension to our therapeutic stance, within a psychobiological model, for those who want it.

This curriculum proposal needs more knowledge from basic and clinical medical sciences.

It is inclusive with various standards to be met in order complete accredited training set by the HCPC. I do feel a standard in understanding the importance of and using clinical formulation and supervision would be a useful addition to this otherwise sufficient curriculum.

Bad for psychology.

I agree with the comments in the consultation document that psychologist prescribers would

need bespoke training to address physical anatomy and psychopharmacology.

I dislike it intensely. Applied psychologists in healthcare settings (especially clinical and counselling psychologists) are a small, fragile group under vast pressure; because of the abject failure of the BPS over the past two decades to stand up for us in any useful way, we are adrift and at risk. What is being suggested here is tantamount to 'train as a psychologist, then go and train as something else entirely'. How is this of any use to us or to the people with whom we work?

I disagree that 'Psychologists usually have a different academic background to other prescribing professions.' Many of us have BSc not BA, my own degree was a BPS psychology pathway in a modular life sciences degree with units in chemistry, anatomy, physiology, neurophysiology, pharmacology (kinetics, dynamics), as well as the usual BPS stuff. I know more about these things than most nurses I work with. So I would not want to waste my time because existing relevant knowledge is assumed absent.

I cannot understand where it has come from, who might be behind it, where big pharma might fit in, and why anyone wishing to become a clinical psychologist would consider it at all appropriate for CPs to prescribe.

I think it is a fantastic way to enhance and envolve the profession. Biopsychosocial models are at the forefront of psychological discourse and this would be a new way of putting these models into practice. It would also add to new treatment avenues and approaches.

As noted I believe we are treading a dangerous path and we should not go down this route. I know I haven't put the research in here but there is plenty out there about the dangers of these drugs, the biased nature of the research and the power the pharma has over all of this. As responsible people who should do no harm you should be looking at this research and stop going down this path, an absolute disgrace of a situation for our profession.

10. WHO DO YOU THINK SHOULD MENTOR PSYCHOLOGIST PRESCRIBERS NOW AND IN THE FUTURE?

I am always more of the view that we should follow a competency-based approach rather than named professions. I would that any pharmacist, non-medic prescriber and medics competent in the clinical area should.

Psychiatrists are experts in the field of psychopharmacology so they are in perfect position to mentor psychologists, or other prescribing psychologists with adequate years of clinical prescribing experience.

Psychologists should not prescribe drugs.

Another issue is that while job descriptions may be rewritten to include prescribing – mentoring arrangements etc will not be included in the job descriptions. This means that the psychologists will be legally in a poor position if they refuse when there are mentoring staff shortages.

Experienced prescribers in the setting where the psychologist is prescribing, over time this could include experienced psychologist prescribers.

Terrible idea altogether.

If psychologists were to become prescribers then the mentorship must be client group relevant – for example a psychologist prescriber working with children with autism must be mentored by a medical professional sufficiently experienced in working with children with autism.

As discussed, the role of a psychologist as a prescriber is not a position that I would advocate. If this were to occur, then it would be fundamental that this remain within the psychology profession, in order to protect the core role.

It would be helpful to be mentored by pharmacists, medical doctors, and/or experience and qualified psychologist prescribers provided the latter is not confined to 'clinical'

psychologists. Psychologist mentors should be qualified in the prescribing in the appropriate conditions – mental and/or physical.

No-one. This is a terrible idea, open to institutionalised abuse by those following the latest 'trends' and will not end well. You cannot compare yourselves to medics as your training has nothing in common.

11. DO YOU THINK THE IDEA OF USING THE DEVELOPMENTAL FRAMEWORK OF (1) NOVICE, (2) EXPERIENCED AND (3) EXPERT IS USEFUL?

I think recognising the developmental aspect to any new qualification is important.

Not sure how this would work in practice – if you prescribe more often does that make you an expert – is that a good thing?

Yes, as it gives an indication of the different levels of experience in prescribing psychotropic medication and which level would be appropriate for future mentorship/supervision of prescription training.

No. I think these categories are far too concrete to capture the nuances in skills development and experience.

Yes, seems best to fit in with pre-existing structures.

How might this affect confidence in professional if register is checked? It could impact on therapeutic relationship.

No. I think the idea of a framework that does not include medical models within psychology is more appropriate and in touch with reality and current developments and thinking and progress.

The terms 'novice', 'experienced' and 'expert' should be reconsidered due to their connotations – both to the patient, but also how this may seem to other professionals. It is likely that as a 'psychologist' you are relatively 'expert' in your area of practice/clinical skills but a 'novice' in prescribing and so in such instances it is likely to affect how the psychologist is perceived which may not give a true reflection of their actual 'expertise'.

I don't think so. Prescription should be a small part of the prescribing psychologist's repertoire of interventions and I don't know that it needs a hierarchy to be set up within that one activity. We do not do this for cognitive assessment or for therapy.

I do not think that psychologists should be prescribing medications at all.

12. DO YOU HAVE ANY OTHER COMMENTS?

There is so much we can contribute in terms of early intervention and prevention using psychological/behavioural interventions – we are not doing this. Talk about prescribing is a distraction from our real work.

This is not an avenue that will be universally welcomed by psychologists but I think even having better knowledge of pharmacology could be very helpful in our interactions with patients.

In CMHTs (in Scotland at least) psychiatrists don't prescribe – they liaise with GPs and ask them to up or lower dosages as appropriate – the GP is the main point of contact for medications because they know the patients' health history the best.

I cannot respond to many of these questions, because I feel very strongly that psychologists should not be prescribers. I feel that the psychologists who would like to prescribe medication to their clients should retrain as psychiatrists.

I think this is a great idea. It will help evolve the profession into a truly biopsychosocial discipline and contribute to patient care if done correctly and carefully.

Elsewhere in the world where this has occurred, pharmaceutical industry 'educational/CPD' has immediately targeted non-medical prescribers – this would occur in the UK.

I fear that opening up psychology to prescribing takes us down the route of over-medicalising

what are often normal reactions to difficult situations. I do recognise that there are times when medication will help, or indeed, is necessary, but I do not think that this is for psychologists to decide.

We are concerned about the lack of coverage given to children and young people here – a large number of medicines for children are used off licence and although this is considered, the implications of it are not.

I think the benefits outweigh the risks. I use the Approved Clinician/ Responsible Clinician role change as an example of where psychologists and clinical psychologists have been a revolutionary force for good. The potential impact on service user and patient care could be phenomenal. But service evaluations and commissioned clinical research would give us the answers to these empirical questions.

The idea that there will be an individual choice about whether or not one becomes a prescriber is naive and divisive. If for example a job advert says must be able to prescribe.

The medicalisation of human distress has been highly problematic for individuals seeking support from mental health services with an over reliance on medication to 'fix' or 'cure' the person or problem – but there is no cure for being human!

Overall, this is a positive development for psychologists. I agree that the issue is not whether psychologists can/are able to prescribe, but one of how we can achieve this and having the necessary/appropriate training/ governance in place to achieve this objective.

I was initially very hesitant about this for many of the common objections raised in the paper, but feel provided this is optional and appropriate training and ongoing mentoring/supervision is in place, this could be a very useful addition to MDT working. I am particularly drawn to the value of being involved in deprescribing.

I do not think that psychologists should become prescribers; it is not a good use of our unique and scarce skills. We do not need psychologist time to be spent on prescribing activities when we have NHS waiting times for therapy and intervention of over two years from referral. We have a diverse and unique combination of skills and continue to develop these throughout our career specialising and giving psychological expertise and consultation. What the NHS needs is more psychologists, not more prescribers!

The reason it's important for psychologists to prescribe is because they take a wider view than just medicine (understanding the social and environmental context in a way that other professionals don't and can't), but ultimately doing so may prove to hand treatment over to people even less qualified in this respect.

If psychologists start to prescribe, what is the difference between a psychologist and a psychiatrist? Ultimately will both professions merge? And if they do, what happens to patient choice? Many people do not want to take psychotropic drugs for a whole host of reasons, these people should be allowed access to alternatives not forced to fit a model which they have already rejected.

Only that I think as a profession we have wasted a decade or more keeping behind the times. As a profession I believe we need to step up and take responsibility for people's care and treatment and abdicating that responsibility has meant that we have not been in a place to promote a psychosocial trauma informed philosophy because we have been squeezed out of mental health, particularly, adult mental health, for far too long.

I am, and always have been, completely against psychologists prescribing medication. It makes a mockery of the 'psychological approach' in my opinion.

I also work in the NHS and have seen non medical prescribing in practice – often my colleagues have asked why I haven't done the course!

I firmly believe that psychologists should not have prescribing rights; we should be given the same respect, clinical support and roles as those who can, but there are so many reasons why we should not be prescribing. I am incredibly proud of our profession where we can help and support people without medicating them.

I am in support of considering prescribing rights for psychologists. I agree with the potential benefits outlined in the paper and I think the concerns that have been raised can be easily managed by appropriate training/ supervision or they are unfounded.

As an ex-service user (35 years recovered from bouts of psychosis, no meds for 35 years), I deplore the idea that psychologists should prescribe. The relief on seeing a psychologist (as opposed to psychiatrist) was massive. They did not waive chemicals at me, they listened, and had ideas about how things could improve nonpharmaceutically.

ONGOING ENGAGEMENT

The chair submitted a further letter to *The Psychologist* in March 2020. The group set up a webpage which houses the discussion paper, psychologist letters and FAQs and, later, an animation to outline the basic facts of the work. All these invited comment from anyone via email.

A small but steady stream has been received throughout the process. Comments were broadly similar to those mentioned above:

To understand what a patient's overall needs are must include their current medication. Any knowledge or skills in medication would be crucial in offering the best support.

Prescribing rights could enable, and empower, better multidisciplinary working relations with medical staff.

…given that there are obvious risks involved, I would prefer to get supervision or advice from psychiatrists.

If a psychologist is very anti medication, this could be very detrimental or even dangerous to the patient.

Becoming prescribers becomes complicit with the system as it is – perpetuating diagnosis and drug treatments – so that the mental health system never changes.

As a psychiatrist I would support psychologists who are interested to get further training in prescribing.

Although I can see some of the potential benefits for prescribing rights, such as de-prescribing and having more understanding of the biological picture, I am very concerned and cannot find a way to reconcile the huge ethical issues this raises for the profession.

YOUGOV SURVEY

A survey to capture wider public opinion was put in YouGov's omnibus survey. Since HCPC registered psychologists work in a wide range of settings, and most of us will have prescribed medication at some point in our lives of some form, anyone from the general public could be considered an expert by experience so the purpose of the survey was to capture the thoughts of the public on whether some psychologists should prescribe, as well as having an understanding of how this opinion may differ according to contact with psychological therapy, and medication.

YouGov's omnibus panel is made up of representative adults from across ages range, ethnicity, socio-economic background, region and gender.

The questions suggested by the group were checked and edited by YouGov's health team

and political team to ensure they were not biased. The full survey is available in Appendix 1 and a summary of the main results are below:

The total sample size was 2070 people.

59 per cent of people had themselves (or a close family member) been treated by a psychological professional, psychological therapist or psychiatrist.

Numbers across the other options indicate some people had seen more than one type of psychological professional.

45 per cent of people had (or a close family member had) been prescribed medication for a mental health condition.

70 per cent of people had (or a close family member had) been prescribed medication for a physical health condition.

63 per cent of people felt medication for mental health conditions was useful, 14 per cent felt it was not useful.

86 per cent of people felt medication for physical health conditions was useful, 5 per cent felt it was not useful.

18 per cent of respondents thought that psychologists can currently prescribe medication.

46 per cent of respondents support psychologists have the right to prescribe medication. 15 per cent oppose, 26 per cent neither support nor oppose and 13 per cent said they didn't know.

Of those that oppose psychologists having prescribing rights (310 people):

The main reasons were:

64 per cent think that medical doctors should prescribe medication, not psychologists.

35 per cent think that psychologists don't have enough training to prescribe medication.

Other reasons:

17 per cent said psychologists should only concentrate on talking.

12 per cent said that it's not helpful to use medical diagnoses to label people's mental distress.

Eight per cent felt people would have less trust in their psychologist if they could prescribe medication.

(NB: People could tick all that apply)

Of those that support psychologists having prescribing rights (957 people):

71 per cent think that people wouldn't then have to see two professionals for one condition.

53 per cent think that people wouldn't have to wait for their medication.

40 per cent think that people would have more trust in their psychologist to prescribe medication appropriately.

Other reasons:

34 per cent think that psychologists could help decrease the amount of medication prescribed to people.

(NB: People could tick all that apply).

Across all genders, age groups, social classes, UK region and ethnicities, there is more support for psychologists to have prescribing rights than opposition to it. The exceptions to this are people from Irish (*N*=24), White & Asian (*N*=16) and Pakistani (*N*=12) backgrounds where more people were opposed to prescribing by psychologists. Of these groups Irish people's responses to the other questions roughly followed the total responses. White & Asian people indicated that a higher proportion had been treated by a psychiatrist (24 per cent vs 10 per cent total), fewer had not been treated by a mental health professional (39 per cent vs 55 per cent) and more had taken medicine for mental health conditions (52 per cent vs 39 per cent total). Pakistani people were less likely to have had contact with a psychological professional (73 per cent vs 55 per cent).

There was a free text option for respondents to explain why they supported or opposed prescribing rights for psychologists. A selection of comments was:

Most of the medication has been shown to be either ineffective or damaging and I think doctors are already incorrectly overprescribing. This would make it even worse.

More specialised view of peoples needs.

Most psychologists have an anti-medication attitude and I don't believe therefore this would be the right group of professionals to be deciding therefore whether someone did or did not need a prescribed medication.

Take some of the strain off of other NHS departments.

Medication could be over-prescribed, psychologists may start reaching for medication as an 'easy solution' rather than proper therapy.

It would help alleviate the pressure on GPs, in addition psychologists often spend more time with patients than GPs and understand their condition better.

I would have thought if a physiologist [sic] would know what a mentally ill person needed to be taking.

Medicalising problems which are often caused by social or personal issues means that simpler and more effective measures will likely not be taken, in favour of a pill.

If you're suffering from mental health issues it can be exhausting having to explain and repeat everything to separate people.

I doubt whether they would have a complete picture of a patient's medical history so prescribing additional medication could be dangerous.

A psychologist would understand more in depth the problem and have explored other avenues before just resorting to medication.

I feel that people need to talk out their problems rather than medicate them unless they are seriously harming others or themselves – but there is usually an alternative to medication.

Helps to maintain sense of privacy for patient.

It would change the entire nature of the job. Different type or person would apply, which would be bad. Psychology is quite different from psychiatry. Psychologists seek to understand you, psychiatrists to 'make you feel better'.

Psychologists know their patients best.

WEBINAR

On the 24 September 2020 there was a webinar question and answer event. This was chaired by Claudia Hammond and the panellists were Rebecca, Peter and Cheryl from the T&F group along with Elaine Levine who was one of the first prescribing psychologists in the US. The audience, made up of BPS members, submitted questions via Slido (a virtual interaction tool) which were posed to the panel by Claudia.

Some of the questions and comments received through Slido included:

How do we challenge the dominance of the medical model enabling a choice of narratives about mental health if we prescribe?

Psychologists who prescribe will, according to the proposals, be required to add a diagnosis to their formulations. Isn't this a direct threat to our role?

How would the role of psychiatrists and psychologists be differentiated if psychologists were also medication prescribers?

What are the moral implications of prescribing? If we indicate we accept the medical model of distress, what societal harms are we then complicit with?

As a patient I am concerned about the harmful impacts of the multiple medications I take. I would like to know many service users have been consulted so far?

We need more psychology funding, more senior posts and a louder voice for our profession Surely prescribing rights would paradoxically improve access to therapies.

Will this not allow us to apply for more funding? Increase in places? Change the broader narrative to a psychological not psychiatric one?

Medical treatment is cheaper than psychotherapy and therapy is already hardly available – would psychologist prescribers not further unbalance the scales?

Psychiatric drugs have been shown to cause various forms of harm and may impede recovery, so would prescribing be against our ethical code?

What would happen to the profession if psychologists refuse to allow access to prescribing training, if we end up being the only profession who has 'opted out'.

How would the prescribing be regulated? I am worried that some psychologists might prescribe medication where other solutions, such as CBT, might suffice.

Surely its a matter of choice – if a psychologist wishes to undertake additional training to prescribe to improve their practice, then shouldn't they be allowed.

CHAPTER 6

The numbers

Overall during the project we have received 246 emails between 21 February 2019 and 13 October 2020. These were from 228 individual people over the 18-month period.

125 individuals and 6 organisations responded during the discussion paper consultation (3/10/19 – 21/11/19).

There have been 572 downloads of the discussion paper (correct on 12/10/20) – this does not include the people who would have received the discussion paper by email during the consultation period.

There were 800 views of the web news story about the consultation (correct on 12 October)

There have been 1,404 views of the prescribing rights webpage which includes all the information about the project and details on how to get in touch and contribute.

This includes 581 views of the FAQs and 162 views of *The Psychologist* articles. (Correct on 12/10/20)

There have been over 16,200 views of the animation across the BPS YouTube, Twitter, Facebook and LinkedIn pages (correct on 12 October 2020) this contains information on how to get in touch and contribute.

400 people registered to attend the webinar (all these people were sent a link to the prescribing webpage and details on how to get in touch), and 276 people actually attended it.

Since 1 October when it was available there have been 622 views of the webinar video (correct on 12 October 2020). Again, this contains information of how to get in touch.

CHAPTER 7

What we have learned

Taking into account all the information from the above work, engagement and consultation, we have identified the main themes and considerations which are outlined below in order to inform decision making.

WHY PSYCHOLOGISTS SHOULD HAVE PRESCRIBING RIGHTS

The therapeutic relationship between the psychologist and the service user could allow a psychologist to work collaboratively with service users to develop the psychological assessment/interventions that work best for that person which may include relevant medication. It could also mean that service users would not need to tell their 'story' to more than one health professional.

Psychologist prescribing could help with current problems with over medicalisation in general and over prescription of medications. Psychologists with prescribing rights would be able to deprescribe medications; reducing or in some cases stopping medication as service users improved. The psychological interventions offered alongside medicine reduction would enable monitoring for side effects or withdrawal effects more regularly than the existing arrangements; this may prompt more timely help from a medical professional if these were identified.

Prescribing rights could be seen as the next step in the evolution of the psychological profession. Psychologist roles are already being lost in favour of other professions who are often remunerated at lower Agenda for Change bands and are seen as having a broader set of competencies. Many other professions are now extremely skilled in psychological formulation and single model therapies as well as being able to prescribe and to act as multiprofessional Responsible Clinicians, particularly in secondary and tertiary mental health care. There is a risk of the profession becoming limited to lower banded purely therapy focused roles in an environment where the NHS' future direction is for professionals to 'take on tasks and responsibilities traditionally held by others' (AOMRC report *Developing professional identity in multi-professional teams,* 2020) to be able to meet service user needs more flexibly.

Based on the growth and increase in professional status that other non prescribing professions have gained, this skill could attract additional investment to the profession, especially where the NHS is unable to recruit to other professions that are in short supply (e.g. psychiatry), and could provide more continuity in care than expensive, temporary agency or sessional staff who would not be required, over and above supervision of a prescribing psychologist. The same could be equally true in any setting where a single practitioner could deliver the main treatment (psychological) as well as any additional treatment (pharmacological).

There is the potential that some service users could be seen and treated more quickly and efficiently, as other professionals may not need to be involved. There would not need to be a delay as service users are referred to other professionals or wait for their, less frequent, appointment with a prescriber. Where psychologists are multiprofessional Responsible Clinicians, a recent HEE publication has also argued that prescribing is advantageous to the role for the same reason as currently, service users need to wait for medical Approved Clinicians to prescribe or reduce medication as part of a treatment plan that a psychologist is legally responsible for. This also potentially limits the role of the psychologist RC in leading the treatment and care of the service users.

There could be an increase in research opportunities. Currently, many ethics committees require a prescriber to be primary or chief investigator in charge of pharmacological studies, limiting the research

opportunity of psychologists to lead and shape psychopharmacological research. It may also give greater opportunities to conduct research and influence prescribing practice and guidelines in the broad range of settings where psychologists practice which in turn may make guidelines more psychological.

It would be optional for psychologists to train in prescribing but the training may be something that some psychologists may find enriching to their practice, even if they choose not to prescribe; they are prohibited from doing at the moment as training is only open to professions on the approved practitioner list.

It could offer service users greater choice. If they were seen by a prescribing psychologist, they would still be able to choose whether they wanted to have certain medications prescribed by the psychologist or whether they would prefer to continue to have all of their prescribing done by their existing prescribers.

WHY PSYCHOLOGISTS SHOULD NOT HAVE PRESCRIBING RIGHTS

Prescribing rights could damage the therapeutic relationship; offering a primarily formulation-focused model as a profession provides a clear alternative to a diagnostic model. It could mean that some service users may be reluctant to see a psychologist if they think that a psychologist would be offering them medication.

Programmes such as STOMP, STAMP and Call to Action have identified over-prescription of anti-psychotic medications. There is also a consensus that globally, there has been an over prescription of SSRI antidepressant medications. Increasing the number of prescribers by adding psychologists to this that this could result in more prescribing.

There are fears that job descriptions could change to include prescribing as an essential/desirable competence. This may cause differences in remuneration between those psychologists who do and those who do not undertake NMP training.

Demand for psychological therapies provided by psychologists outstrips supply currently. The additional burden of prescribing could add to this, which may result in less time for psychologists to offer psychological therapy if there weren't additional investment in the profession.

The need to use the current diagnostic categorical frameworks which inform the prescription of medications for specific 'diagnoses', rather than symptoms, feels at odds with the views of some psychologists who are working towards influencing the use of more formulation-informed frameworks/discourses, particularly in mental health contexts.

Psychologists having prescribing rights could impact on our professional identity, potentially bringing division to the profession as it could lose its uniqueness of being primarily formulation focused and instead appear to become medicalised.

CHAPTER 8

Recommendation from the Task & Finish group

The group are now confident that all of the arguments for and against have been identified and no new themes have emerged in the months following the publication of the discussion paper. Taking into account all the evidence and opinion which the group gathered over the last two years, the recommendation to the Practice Board was that it should approve the position that psychologists should have prescribing rights.

Specifically, it is recommended that psychologists seek the right to choose to become independent prescribers and to choose to train to administer medication.

It should be noted that one member of the task and finish group felt that there was a need for more debate and discussion before a position could be reached on issues relating to (1) the use and efficacy of medications generally and in specific groups and (2) the use of diagnosis.

PRACTICE BOARD

This paper was presented to the BPS Practice Board on 9 October 2020 and, following robust discussion, they approved the position that psychologists should have prescribing rights by majority vote.

We now present this information to the Board of Trustees for consideration.

APPENDIX 1

Appendix 1 – YouGov Questionnaire

BASE: ALL GB ADULTS

Question type: Text

[Varlabel – Sensitivity]

The following questions are on the topic of medication, mental and physical health. We understand this can be a sensitive topic, but please remember your answers will always be treated anonymously and will never be analysed individually.

We will provide you with a 'Prefer not to say' option for particularly sensitive questions, which you can select if you do not wish to share your opinion or experiences on a particular question.

Please click forward to continue

BASE: ALL GB ADULTS

Question type: Multiple

[Varlabel – Professionals treated by]

[BPS_1] Have you or a close member of your family ever been treated by any of the following professionals? (Please select all that apply)

<1>	Clinical psychologist	<8>	Another type of psychologist
<2>	Counselling psychologist	<9>	Psychiatrist
<3>	Educational psychologist	<10>	Psychological therapist (e.g. a Psychological Wellbeing Practitioner (PWP) / High Intensity Therapist (HIT) etc.)
<4>	Forensic psychologist	<966 fixed xor>	None of these
<5>	Health psychologist	<977 fixed xor>	Don't know
<6>	Occupational psychologist	<988 fixed xor>	Prefer not to say
<7>	Sport and exercise psychologist		

BASE: ALL GB ADULTS

Question type: Single

[Varlabel – Ever taken prescribed medication for mental health condition]

[BPS_2] For the following question, by 'prescribed medication', we mean taking medication which has specifically been prescribed by a medical professional (i.e. not including over the counter medicine).

Have you or a close member of your family ever taken prescribed medication for a mental health condition (e.g. depression, anxiety etc)?

<1>	Yes
<2>	No
<977 fixed xor>	Don't know
<988 fixed xor>	Prefer not to say

BASE: ALL GB ADULTS

Question type: Single

[Varlabel – Ever taken prescribed medication for physical health condition]

[BPS_3] As a reminder, by 'prescribed medication', we mean taking medication which has specifically been prescribed by a medical professional (i.e. not including over the counter medicine).

Have you or a close member of your family ever taken prescribed medication for a physical health condition (e.g. asthma, diabetes, headache etc)?

<1>	Yes
<2>	No
<977 fixed xor>	Don't know
<988 fixed xor>	Prefer not to say

BASE: ALL GB ADULTS

Question type: Grid

#row order: Randomise

[Varlabel – Usefulness of prescription medications]

[BPS_4] In general how useful, if at all, do you think prescription medications are for each of the following? (Please select one option on each row)

-[BPS_4_1]	Prescription medications for mental health
-[BPS_4_2]	Prescription medications for physical health
<1>	Very useful
<2>	Fairly useful
<3>	Not very useful
<4>	Not at all useful
<977 fixed xor>	Don't know

BASE: ALL GB ADULTS

Question type: Multiple

#row order: Randomise

[Varlabel – Which professionals can prescribe medication]

[BPS_5] Other than GPs, which, if any, of the following medical professionals do you think is currently able to prescribe medication in the UK? (Please select all that apply)

<1>	Occupational therapist	<8>	Dietician
<2>	Dentist	<9>	Radiographer
<3>	Nurse	<10>	Paramedic
<4>	Psychologist	<11>	Pharmacist
<5>	Psychiatrist	<966 fixed xor>	None of these
<6>	Physiotherapist	<977 fixed xor>	Don't know
<7>	Speech and language therapist		

BASE: ALL GB ADULTS

Question type: Single

[Varlabel – Support or oppose psychologists being able to prescribe medication]

[BPS_6] Psychologists cannot currently prescribe medication in the UK. They refer their patients to another professional if they feel medication is an appropriate treatment.

Practitioner Psychologists train for at least six years and to a doctoral level.

To what extent would you support or oppose psychologists being able to prescribe medication in the UK?

<1>	Strongly support
<2>	Tend to support
<3>	Neither support nor oppose
<4>	Tend to oppose
<5>	Strongly oppose
<977 fixed xor>	Don't know

BASE: ALL GB ADULTS WHO OPPOSE PSYCHOLOGISTS BEING ABLE TO PRESCRIBE MEDICATION IN THE UK

Question type: Multiple

#row order: Randomise

#Question display logic:

If [BPS_6] - Tend to oppose or Strongly oppose, is selected [if BPS_6 in [4,5]]

[Varlabel – Reasons for opposing]

[BPS_7] You previously said you $BPS_6. lower psychologists being able to prescribe medication in the UK.

Which, if any, of the following area reasons for this? (Please select all that apply)

<1>	Psychologists don't have enough training to prescribe medication.
<2>	Medical doctors should prescribe medication, not psychologists.
<3>	Psychologists should only concentrate on talking.
<4>	It's not helpful to use medical diagnoses (e.g. schizophrenia) to label people's mental distress.
<5>	People would have less trust in their psychologist if they could prescribe medication.
<955 fixed>	Other [open] please specify
<977 fixed xor>	Don't know

BASE: ALL GB ADULTS WHO SUPPORT PSYCHOLOGISTS BEING ABLE TO PRESCRIBE MEDICATION IN THE UK

Question type: Multiple

#row order: randomize

#Question display logic:

If [BPS_6] – Strongly support or Tend to support, is selected [if BPS_6 in [1,2]]

[Varlabel – Reasons for supporting]

[BPS_8] You previously said you $BPS_6. lower psychologists being able to prescribe medication in the UK.

Which, if any, of the following area reasons for this? (Please select all that apply)

<1>	People wouldn't have to see two professionals for one condition.
<2>	People wouldn't have to wait to receive their medication.
<3>	People would have more trust in their psychologist to prescribe medication appropriately.
<4>	Psychologists could help decrease the amount of medication prescribed to people.
<955 fixed>	Other [open] please specify.
<977 fixed xor>	Don't know

APPENDIX 2

Appendix 2 – Case studies

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.

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) that can help with John's low mood but a 'wanted' side effect is that it lowers John's libido, 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 that 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 straightaway 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.

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; Carl 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 Desensitization 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 his sleep and to commence the EMDR but believes that in the short term he would benefit from sleep aid medication.

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 he has finished the psychological treatments, unaware of the plan. Carl returns to the psychology appointment extremely distressed and hopeless and the psychologist recommends he goes 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, he 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.

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 anti-depressants. 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.

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 the meaning attached to her experience of her pain. It emerges that she has a history of complex trauma and is also self-medicating using 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 agree to very slowly reduce her medication.

In the current system, it would not be possible to do this in a responsive way as Sofia and the psychologist would need to liaise with the Pain Management Consultant (an anaesthetist) weekly and this may not be feasible in a busy anaesthetist's practice. If the psychologist had been an independent prescriber, they could have gradually supported Sofia to reduce the medication responsively as part of the psychological work, empowering them to make choices about reducing their 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.

CASE EXAMPLE: GENDER CLINIC

Karen is a trans woman who was assigned male at birth. They ask 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.

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 different ward where a psychologist (rather than a psychiatrist) 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 he did not feel listened to by mental health professionals responsible for his care. Their psychologist RC worked closely with Dev to review their formulation in the context of Dev's current life events.

Based on their formulation, a Positive Behaviour Support (PBS) plan was developed. Whilst this was developed and Dev's distress was still very high, the psychologist asks 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 and then, gradually as Dev responded to the PBS plan the alternative medication was able to be reduced responsively.

Currently: Whilst the MDT, pharmacy colleagues and the service user supported a proposed change in treatment, the psychologist had to find a supportive psychiatrist to make the amendment to medication as psychologist RC's are unable to prescribe. This would lead to an unfortunate delay in the delivery of the alternative pharmacological treatment that was subsequently shown to be more effective. The psychologist must contact a psychiatrist to prescribe/adjust dosage meaning the person needs to see two professionals, who may disagree, and result in a delay to Dev in changing their treatment.

A psychologist prescriber could change the medication to one with improved side effects as well as reducing the need for any medication alongside the Positive Behaviour Support

plan. As the Approved Clinician in charge of the treatment in question, the psychologist prescriber would 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).

REFERENCES

References

1. Human Medicines Regulations (2012). available at: www.legislation.gov.uk/uksi/2012/1916/contents
2. British Psychological Society (2018). Power Threat Meaning Framework available at: https://www.bps.org.uk/power-threat-meaning-framework
3. https://www.ihs.gov/aboutihs/
4. Linda, W.P. & McGrath, R.E. (2017). *ibid*
5. Shearer, D.S., Harmon, S.C., Seavey, B.M., & Tiu, A.Y. (2012). The primary care prescribing psychologist model: Medical provider ratings of the safety, impact and utility of prescribing psychology in a primary care setting. *Journal of Clinical Psychology in Medical Settings, 19,* 420–429.
6. Royal Pharmaceutical Society (2016). A Competency Framework for all Prescribers. Available at: www.rpharms.com/resources/frameworks/prescribers-competency-framework (accessed 12/07/2019)
7. Hubbard, A. & Hayley, K. (2018) Psychologists as prescribers? Document prepared for the British Psychological Society Task and Finish Group. Unpublished.

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