Gaining Prescription Rights: A Qualitative Survey Mapping the Views of UK Counselling and Clinical Psychologists

Thesis

Word Count: 35, 441

Alice Victoria Horton

September 2022

A thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol for the degree of Professional Doctorate in Counselling Psychology

Acknowledgements

Firstly, I want to say thank you to the whole Counselling Psychology team at UWE for supporting both my personal and professional development whilst I've been studying. Particular thanks to my Director of Studies, Miltos and supervisor Miles – I think we have made a great team! Miltos, we have been on quite the journey (wildfires and burglaries included), I'm glad you are still with us to read this acknowledgement! I have immensely appreciated your belief in me, your passion for this topic and the laughs along the way. Miles, thank you for your compassionate and pragmatic approach, which was much needed, particularly at the final stages and enabled me to make it to submission.

Thank you to all my participants for their thorough and passionate responses to my survey, they were a joy to read.

Thanks to my friend and course colleague Lucie Wheeler who was always at the end of the phone with a supportive text particularly during suspension due to ill health. Thank you for reassuring me that I would eventually make it. You were right!

To my friend, colleague and fellow Counselling Psychologist Jo Davies, thank you for all your informal supervision over the years which has no doubt influenced this thesis and who I am as a practitioner and person.

I could not have done this without the support of my family and friends. Thank you to my mum and dad, for enabling me to follow my passion. Thank you to my sister and brother for checking in with me, helping me with IT and cheering me on.

Finally, to my husband, Theo, who I met during my undergraduate psychology degree at UWE and who has been with me every step of the way. Thank you for your selfless support whilst I completed the doctorate, hopefully we get to spend some time together now.

Contents

Abstract

Background: Over the last 5 years the British Psychological Society (BPS) has been exploring whether its practitioner members are interested in gaining prescription rights for psychiatric drugs and what such a 'privilege' might look like.

Aims: This qualitative study aimed to survey the views of UK - based, qualified counselling and clinical psychologists with regards to gaining prescription rights.

Method: Qualitative data was collected via 82 online surveys. The sample consisted of 37 counselling and 45 clinical psychologists with a mean age of 41 and an average of 10 years post qualification experience. The data was then analysed using reflexive thematic analysis to develop themes.

Findings: The overarching theme – Gaining prescription rights: a crossroads in the professional identity of the psychologist: "why try on someone else's clothing? ours is fine" explores how psychologists grapple with their professional identity within existing structures dominated by the medical model of distress, and how gaining prescription rights may contribute to some of the issues they already experience. 4 additional themes sit under this overarching pattern that weaves throughout. Theme 1 explores participants' assumptions about psychiatric drugs as those assumptions serve as a springboard to their views on gaining prescription rights. Theme 2 examines the belief that gaining prescription rights will result in increased status and power for psychologists. Theme 3 illustrates how psychiatric drugs infiltrate the therapeutic space already (i.e., irrespective of psychologists' prescription powers) and how psychotherapeutic sensibilities and implicit relational dynamics might weigh into the debate. Finally, theme 4 explores the notion that psychologists have a desire to gain knowledge on psychiatric drugs and the type of knowledge they deem important to be competent psychologists and/or prescribers and whether this would be best achieved through gaining prescription rights.

Conclusion: Research from other countries and opinion pieces suggest that this is a controversial debate, spanning a broad range of views. Views on

prescribing rights for psychologists speak to issues of professional identity, what psychologists do or believe they should do in practice, but also about who they are as people. Implications for practitioner psychologists, the people they serve, and wider society are discussed, with a particular emphasis on what this debate means for counselling psychology. More specifically, the discussion highlights how psychologists "silently collude" with the medical model of distress despite many being critical of it.

1. Background Literature and Study Rationale

Introduction

The development of non-medical prescribers which is defined below has continually expanded in the United Kingdom over the last 9 years and now includes professions such as pharmacists, nurses, and paramedics amongst others. This research will explore counselling and clinical psychologist's views on gaining prescription rights. It is a complicated and controversial topic and therefore this section will cover broad areas of literature.

The introduction will begin setting the scene of this research study by exploring the expansion of non-medical prescribing across various professions in the UK. It will then delve into the expansion of prescription rights to psychiatric nurses arguably the closest prescribing profession to psychologists in the UK. It will then attempt to explain the history of the medical model of distress and alternative approaches including key critical voices in this area. It will then explore the links between psychiatry and the pharmaceutical industry before exploring the evidence base for drugs in the treatment of mental distress. It will then look at how prescription rights unfolded for psychologists in the United States before exploring the prescription rights in other English-speaking territories across the globe. Finally, it will outline the history of counselling and clinical psychology in the UK and the BPS consultation on prescription rights for psychologists which happened independently yet simultaneously to this study. This section will end by summarising the limitations of current research in this area, including the potential contribution counselling psychology research can make to this topic, and outline the aims of the current study. This brings the section to a close with the research question: what are UK-based counselling and clinical psychologists' views on gaining prescription rights in the realm of mental health?

1.1 Non-Medical Prescribing in the United Kingdom

Non-medical prescribing (NMP) is the prescribing of medications by a health professional who is not a medical doctor. Traditionally, prescribing medication has been perceived as a medical role, with only medical professionals having full prescribing rights in the UK. Two reports changed this view: the Cumberlege Report (Department of Health and Social Security, 1986) which led to limited prescribing rights for health visitors and district nurses, and the Crown report (Crown, 1999), which recommended extending prescribing rights for the benefit of patients and to utilise the skills of healthcare professionals. Healthcare policy is directed by the devolved governments, usually reflecting the principles of the governing party at the time (Graham-Clarke et al., 2019). Conservative governments tend to support free markets and expansion of the private sector, whereas Labour governments support the NHS over the private sector (Graham-Clarke et al., 2019).

Currently there are two non-medical prescribing models across the UK: supplementary and independent. Supplementary prescribing is a collaboration between an independent prescriber, supplementary prescriber, and patient to implement an agreed clinical plan for the individual (Department of Health, 2005). Independent prescribers are responsible and accountable for the assessment of patients with undiagnosed and diagnosed conditions and for decisions about the clinical management required, including prescribing (BNF, 2018).

At the time of the Cumberlege and Crown reports the NHS across the UK operated as one unit. However, since then healthcare has become a devolved area of government leading to policy and implementation differences between the four nations that make up the UK and with that in mind, I will consider the nations separately.

England

In 2000, 'The NHS Plan' was published by the governing Labour party, which described the government's intention to modernise healthcare services, breaking down the traditional boundaries between professions

and introducing new ways of working with the intention of improving patient experience (Department of Health, 2000). Nurse prescribing was highlighted in the plan and there was broad reference to other professionals extending their roles, which included prescribing (Department of Health, 2000). In 2002 a consultation on the introduction of supplementary prescribing for nurses and pharmacists was launched (Department of Health, 2002a), with approval granted later that year (Department of Health, 2002b).

It was argued that supplementary prescribing had significant limitations which impeded the government's desire to enhance patient care through the expansion of prescription rights. Therefore, in 2005 a consultation was launched to consider expansion into independent prescribing (Medicines and Healthcare products Regulatory Agency, 2005a; Medicines and Healthcare products Regulatory Agency, 2005b). In 2006 legislation to implement independent prescribing by nurses and pharmacists was passed (National Health Service, 2006), and since that time independent prescribing rights have been gradually extended to a range of healthcare professionals, most recently paramedics (NHS England, 2018).

Currently, the Department of Health (DoH) say that prescribing responsibilities include improving patient care without compromising patient safety, making it easier and quicker for patients to get the medicines they need, increasing patient choice in accessing medicines, making better use of the skills of health professionals, and contributing to the more flexible team working across the health service (Department of Health, 2012). The DoH argued that the development of non-medical prescribing within the health service enables suitably trained healthcare professionals to enhance their roles and effectively use their skills to improve patient care in a range of settings such as mental health services (Department of Health, 2012).

In a systematic policy review it was suggested that the English government's approach to non-medical prescribing had changed since its inception (Graham-Clarke et al., 2019). As outlined above NMP was

originally intended as a means of improving patient choice and access to medicines, whilst also developing the workforce. It has been suggested that a subsequent change in government (and associated political ideology) combined with shortfalls in finances and staffing have resulted in the emphasis subtly changing to NMPs supporting, or even replacing, medical practitioners (Graham-Clarke et al., 2019).

Scotland

Like in England, NMP was initially limited to nurses with a community qualification (health visitors or district nurses) from a very limited formulary (Rideout, 2017). However, in 2006 both the range of professionals and the formulary they could prescribe from was expanded to include all nurses and pharmacists with a further prescribing qualification (Rideout, 2017). In 2007 and 2012 further changes in professional guidance and legislation opened up NMP to allied health professionals to include off license drugs and the prescribing of controlled drugs with the same freedoms given to medically trained prescribers (Rideout, 2017). Evidence suggests that only 25% of prescribing nurses were issuing more than one prescription which rose to 43% in 2010 perhaps in line with the expansion of prescription rights (Drennan et al, 2014). In 2006, the Scottish government published guidance for independent nurse prescribers and community nurse prescribers (Scottish Executive, 2006a) which explained both the legislation and their vision for nurse prescribing. The goals for NMP were like those in England such as easier and more equal access to healthcare, more flexible team working and professionals using their time more appropriately (Scottish Executive, 2006a). Since this time there have been further reports by the Scottish government highlighting the role of NMP (eg. Scottish Executive, 2006b; Scottish Executive 2007; Scottish Government 2009). A review carried out by the University of Stirling (Watterson et al, 2009) found that many of the claims made about nurse prescribing back in the Crown Report (Crown, 1999) had been fulfilled such as: nurse prescribers believed their prescribing rights led them to be more effective nurses; GPs workloads were reduced as a result of nurse prescribing; nurses were considered safe

prescribers by patients and professionals with the public having confidence in nurse prescribing. In 2007, legislation and training came into effect for supplementary prescribing rights for some allied health professionals including radiographers, podiatrists and physiotherapists. Currently in Scotland nurses, midwives, pharmacists, paramedics, optometrists, podiatrists, physiotherapists and therapeutic radiographers are able to train as independent prescribers. Diagnostic radiographers and dieticians can train as supplementary prescribers.

Wales

Within Wales the first cohort of district nurses and health visitors qualified as prescribers towards the end of 2000 (Mills, 2017). Like other parts of the UK, Wales has published various policies in the drive towards NMP. In 2001 an NHS Wales plan was published that stated by 2004 patients should have more convenient and efficient access to medications and there should be an increase in number of professionals who can take on the responsibility to write and administer prescriptions (NAW, 2001a). Consequently, the Task and Finish Group for Prescribing published a report to consider the options to improve prescribing (NAW, 2001b). There were over 100 recommendations but in relation to NMP one of the key recommendations was that the role of pharmacist and nurse supplementary prescribing should be developed (NAW, 2001b). Shortly after, another plan was published by the National Assembly for Wales which focused on supporting the legal authority for other health professionals to prescribe (NAW, 2001c). In 2002 the Welsh Health and Social Services minister announced their intention to support the introduction of supplementary prescribing in Wales (Mills, 2017). In the same year a consultation document was published by the Welsh assembly government stating their commitment to expanding supplementary prescribing rights to pharmacists by 2004 (WAG, 2002). A strategy group was developed to take forward supplementary prescribing for nurses and pharmacists in Wales. Some of their considerations were whether a new Welsh training syllabus needed to be developed or whether there was a programme elsewhere in the UK that could be implemented, and whether nurses and pharmacists needed

separate training courses (Mitchell, 2003). In 2005 a policy was developed that drove the implementation of independent prescribing rights in Wales (WAG, 2005). The legislation that enabled this to happen came into place in Wales in 2007 and regulations were also amended to allow registered chiropodists and podiatrists; physiotherapists; radiographers and optometrists to practise as supplementary prescribers once qualified (National Assembly for Wales, 2007). In 2012, amendments to regulations meant that previous limitations on the prescribing of controlled drugs by nurses and pharmacists were removed (HMSO, 2012). Currently in Wales nurses, pharmacists, optometrists, physiotherapists, podiatrists and therapeutic radiographers can train to become independent prescribers (NHS Wales, 2017). Dietitians can train as supplementary prescribers in line with the rest of the UK (Mills, 2017).

Northern Ireland (NI)

A training programme for nurse prescribers was rolled out in NI in 2001 this included independent nurse prescribing from a limited formulary with this being extended in 2003 (Lloyd et al, 2017). In 2003 supplementary prescribing for pharmacists was introduced with physiotherapists, podiatrists or chiropodists, radiographers and optometrists being added to that list in 2005 although educative programmes did not emerge in NI until 2009 (Lloyd et al, 2017). In 2006 a UK based consultation brought about an amendment change in NI that enabled independent prescribing by pharmacists (Department of Health, Social Services and Public Safety 2006). This was closely followed by legislation to extend independent prescribing rights to optometrists (Department of Health, Social Services and Public Safety 2008) with a course becoming available in NI in 2016 (Lloyd et al, 2017). In 2014 regulations came into force in NI to extend independent prescribing rights to physiotherapists and podiatrists or chiropodists (Department of Health, Social Services and Public Safety 2015). Despite UK wide legislation that had been in place since 2012 to permit therapeutic radiographers and paramedics to act as independent prescribers and dietitians to act as supplementary prescribers (Human

Medicines Regulations, 2012) in NI such professionals are only permitted to prescribe in secondary care (Department of Health, 2020).

Although the timelines for NMPs to be introduced across the UK have differed, the professions that are eligible to train as non-medical prescribers across the four nations are now coordinated. There are 8 professions currently eligible to train as NMPs which includes nurses (including midwives and health visitors), pharmacists, physiotherapists, podiatrists, paramedics, optometrists, radiographers and dietitians. Each prescribing profession has a unique story but there is a common thread with the expansion of prescription rights to each new profession hoping to ensure a sustainable healthcare system responsive to growing and changing patient need (Davies, 2003). As outlined earlier in this section nurses (district nurses and health visitors) were the first non-medical profession to gain prescribing rights. The main benefit outlined was increased professional autonomy and enhanced perceptions of nurses as knowledgeable and skilful (Cope et al., 2016). There is research suggesting that nurses have been cautious in undertaking prescribing with concerns around their role becoming increasingly medical rather than nursing focused (Fawcett, 2007) and an increased emphasis on the medical model of curing rather than the traditional value of holistic caring (Baumann et al., 1998). Despite increased knowledge in pharmaceuticals through attendance of regulated training courses concerns about the adequacy of their knowledge in order to undertake prescribing responsibilities remained (Leathard, 2001; Offredy et al., 2008; Sodha et al, 2002). Followed closely by nurses were pharmacists who like nurses welcomed their prescribing role (George et al., 2006; Weiss et al., 2006). A key difference in the introduction of pharmacist prescribing was that they did not receive criticism about their pharmacological knowledge (Horton, 2003; Avery & James, 2007).

Broader literature on the views of students on NMP programmes, lecturers and stakeholders have reported mixed findings. Some students training to become NMPs reported that the programme provided them with adequate knowledge to prescribe (Green et al., 2009; Meade, et al., 2011). Some

NMPs have reported that gaining prescribing rights has increased their job satisfaction and self-confidence, made them more independent practitioners and enabled better use of their skills (George et al, 2007; Courtenay & Berry, 2007; Watterson et al, 2009). Some NMPs have reported that prescribing rights have enhanced their relationships with patients (Latter et al, 2005). However, whilst many NMPs have expressed benefits from gaining prescribing rights, some nurse prescribers have highlighted the increased pressure and workload that prescribing duties bring (Watterson et al., 2009). The views of professional colleagues have also been mixed. Some doctors suggested that working with NMPs improved teamwork and either reduced their workload or freed up their time to spend on more acute patient cases (Stewart et al., 2009; Watterson et al., 2009). However, other healthcare professionals have suggested that working with NMPs can add significant time to their workload because of the support they need to give to NMPs (Hacking & Taylor, 2010; Watterson et al., 2009). There have also been various articles, press releases and editorials by different doctors expressing concerns around non-medical prescribing (particularly independent prescribing rights) (e.g. Avery & Pringle, 2005; Day, 2005; Waring, 2007; Elsom et al., 2009).

This section has summarised the introduction and the gradual expansion of non-medical prescribing across the four nations that make up the UK. It has then summarised research into the mixed views of NMPs themselves, colleagues, and patients. If psychologists were to gain prescribing rights this would involve prescribing in mental health specifically. Therefore, the next section will focus on the expansion of non-medical prescribing to psychiatric nurses who's prescribing duties are within this area.

1.2 Psychiatric Nurse Prescribers in the United Kingdom

Psychiatric nurse prescribers were the first non-medical prescribers in the realm of mental health. In 2000, psychiatric nurse prescribing was introduced as part of the modernisation agenda which hoped to provide quicker and more efficient access to medication (Department of Health,

2000). In 2012 this was extended to any medication from the British National Formulary (BNF) for any medical condition, including controlled drugs, within nurses' own level of experience and competence (Department of Health, 2012). Despite nurse prescribing being reported as one of the most exciting role developments in a review of mental health nursing in England (Department of Health, 2006) research suggests that it has been taken up slowly (Ross & Kettles, 2012) and research into its success has provided mixed reviews (Jones, Bennett, Miller, Lucas & Gray, 2007; Ross & Kettles, 2012; Ross, 2015).

Some research has suggested that nurses, psychiatrists, and clients felt the benefits with nurse prescribing described as person-centred, collaborative, offering choice and minimising risks (Jones, Bennett, Miller, Lucas & Gray, 2007). Psychiatrists reported one of the main benefits of nurses prescribing is increased concordance of patients through a more collaborative rather than prescriptive prescribing style (Ross, 2015). In the same study, nurses also reported that they felt their biggest prescribing impact was stopping medication that they felt had been inappropriately prescribed by someone else (Ross, 2015). In contrast some psychiatric nurses reported that they felt the introduction of nurse prescribing was politically motivated by the government to save money by getting nurses to do the same role as doctors but without the financial reward (Ross & Kettles, 2012). Research into psychiatric nursing has also suggested that despite completing the relevant training many nurses choose not to prescribe (Bradley, Wain & Nolan, 2008; Snowdon, 2010; Dobel-Ober, Brimblecombe & Bradley, 2010). Ross and Kettles (2012) highlighted several potential barriers to nurse prescribing such as nurses feeling unsupported in their prescribing role. Participants expressed their managers did not seem to understand what the role of a prescribing nurse entailed and failed to put the practicalities in place following completion of prescribing training. Several nurses also expressed uncertainty around legal cover within their role. Another theme that Ross and Kettles (2012) found was that nurses felt the prescribing course they attended inadequately prepared them to prescribe particularly as it was too generic and there was lack of information regarding mental

health. Finally, the theme that Ross and Kettles (2012) found most emotive was remuneration. Nurses expressed their dissatisfaction with the lack of financial recognition and that prescription duties were often not included within their job description. Therefore, there was little incentive to take on this extra responsibility and a sense of injustice. Other research has suggested that nurses struggle with the anxiety that prescribing induces due to conflicts with the nursing role namely the therapeutic relationship (Snowden & Martin, 2010). This was also apparent in Ross' (2015) research which highlighted how difficult and controversial it was for nurses to acknowledge the power that prescribing afforded them. Instead, they preferred to frame themselves as having more autonomy which allowed them to empower their clients in their decisions around medication. However, although nurses seemed reluctant to own their power, other professionals observed a power shift in the team (Ross, 2015). This has been acknowledged by some psychiatrists who have expressed nurses are impinging on their traditional territory (Patel et al., 2009).

Whilst looking at other NMPs experiences in gaining prescription rights including psychiatric nurses has its strengths such as applying lessons learnt, there are issues with transferring the knowledge produced to applied psychology when considering how it should move forward with regards to a decision around gaining prescription rights. There are specific differences between health professions such as role and scope, training, and the philosophical underpinnings of these trainings. Therefore, the move to incorporate prescribing rights into a health professional's role is likely to bring about unique dilemmas and considerations depending on the profession that are not necessarily comparable. For example, radiographers utilise prescribing rights to prescribe and administer contrast dye in order to enhance MRI/CT scans. Whilst this will undoubtedly bring about additional responsibility for radiographers i.e., screening for patients who are at risk of side effects. This seemingly practical process is very different to the prospect of a psychologist prescribing a psychiatric drug.

In summary, whilst psychiatric nurse prescribing was considered an exciting role development, it has not been taken up in the way that was expected.

Although colleagues perceive that the benefits of prescribing have actualised, there appears to be hesitancy for psychiatric nurses to take up this role due to various barriers. Having explored psychiatric nurse prescribing in the UK the next section will explore the history of the medical model of mental health and alternative approaches to understanding human distress.

1.3 History of the Medical Model and Alternative Approaches to Mental Health

There is considerable debate about the causes of mental health problems or human distress and therefore the most appropriate way to respond (Cooke, 2017; Johnstone & Boyle, 2018). Definitions of the term medical model are said to vary (Cooke, Smythe & Anscombe, 2019). Therefore, throughout this thesis it is used in the sense that mental health problems are best understood as "illnesses like any other" (Pescosolido et al., 2010).

How we make sense of human distress could be seen as a product of our culture and time (Parker et al., 1995). To understand how human distress came to be an issue of health, within the domain of medicine and therefore treated with psychiatric drugs, it is vital to look at how these ideas have developed. This is no easy task, as competing historical accounts tell different stories. Many psychiatry and psychology textbooks present a progression from demonology to modern day enlightened (Cromby, Harper & Reavy, 2013). However, there is a parallel history of neglect, abuse, inquiries and reforming legislation, a pattern which is said to have persisted to the present day (Cromby, Harper & Reavy, 2013).

In the seventeenth century philosopher Descartes proposed a distinction between body and mind. This led some to believe that the rational mind was incapable of error and therefore madness was considered rooted in the body (Scull, 2011). Cartesian dualism is said to have had a profound influence on medical thought, in that it could justify medicine's jurisdiction over the mad (Scull, 2011). This superseded a supernatural model where

madness was understood as acts of external forces like gods or demons (Cromby, Harper & Reavy, 2013). According to Foucault, this was a defining moment in the history of madness, only in the age of reason did madness specifically come to be considered a form of unreason and therefore deviance (Parker et al., 1995). This led to those considered mentally ill being separated out from society and the consequent need for an extensive programme of psychiatric institution building which it has been suggested created the conditions for a group of experts on madness (Johnstone, 2000). The moral treatment for the mentally ill was said to be a rational and firm but kind approach with the goal of developing self-control and it has been suggested that this acted as a bridge to medical treatment (Cromby, Harper & Reavy, 2013; Parker et al, 1995). Scull (1993) argues that this was because it moved from external to internal treatments, from physical coercion to a regime designed to produce an internalisation of moral standards. From Foucault's perspective it was this internalisation that led to a powerful regulation of the self (Parker et al., 1995). Doctors became the new experts by adopting principles of the moral treatment whilst still arguing that the cause of madness was to be found in the body and thus within their territory (Scull, 2011). In the mid-19th century Acts of Parliament transferred the organisation of these institutions into the hands of the medical profession (Newnes et al., 1999). It has been suggested that doctors insisted that only they could manage asylums satisfactorily and therefore they were granted control. It has been suggested that from this position of power emerged the knowledge and practice that is now referred to as psychiatry (Parker et al, 1995; Johnstone, 2000). In these large institutions psychiatrists had access to captive populations which enabled them to conduct research leading to the foundation of biological psychiatry (Shorter, 1997).

Modern psychiatry and the medical model of human distress can be traced back to the work of Emil Kraeplin early in the 20th century where he developed the first basic textbook on a systematic classification of mental disorders with many of these categories still widely used today (Bentall, 2006). Around this time Kraeplin's assumptions were that there was a small

number of discrete types of mental illness which could be independently identified by direct observation or by discovering the aetiology of such illnesses (Bentall, 2004). In general medicine, diagnosis points to a causal process, determining which condition or disease explains a person's symptoms and signs (Timimi, 2020). These assumptions make human distress the territory of doctors, hospitals and clinics and legitimises interventions associated with medicine such as drugs and hospitals (Cromby, Harper & Reavy, 2013).

The medical model of human distress offers a vocabulary borrowed from medical practice in which mental and emotional health is seen as essentially consisting of two discrete states: health or illness (Woolfe, 2013). It relies on a philosophy with roots in positivism and the natural sciences in which it is held that truth resides in scientific knowledge (Woolfe, 2013). It assumes that mental disorder exists in objective reality, beyond the subjectivity of the person or practitioner and therefore divorces people from their contexts (Timimi, 2020). For example, if someone is labelled with depression, and this is assumed to be a condition that exists in objective, neurohormonal reality, there is no need to enquire about the context of that person and what may have led them to where they are. This means relevant psychological and social information such as trauma, loss, poverty etc. get either entirely lost or substantially diluted. A person's observed behaviour and/or their descriptions of their experiences are grouped into symptoms and assigned a diagnosis by a psychiatrist (Johnstone, 2014). Medication is generally considered the core treatment, with psychosocial interventions typically viewed as supplementary (Craddock et al., 2008). Despite its dominance, the medical model has been subjected to sustained critique (e.g., Bentall, 2010; Cooke & Kinderman, 2017; Moncrieff, 2013a). Some of which have come from within psychiatry itself (e.g., Moncrieff, 2013a). Critics highlight scientific, practical and ethical issues: real-life problems rarely divide up in the ways that the categories suggest (Cooke, Smythe & Anscombe, 2019). Even the devisers of the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) suggest that the high rates of comorbidities undermine the hypothesis that

they represent distinct conditions and suggest that it is a system that pathologises what it means to be human and possibly obscures research findings (Kupfer, First & Regier, 2002); Unlike the rest of medicine, which has developed diagnostic systems that build on a causal and physiological framework, psychiatric diagnostic manuals have failed to connect diagnostic categories with any causes or biomarkers (Insel, 2009; Timimi, 2020); Committees vote on what disorders should be included in the standard manuals suggesting that it is not a scientifically rigorous process but rather a set of people's opinions (Kamens, 2013). Despite these critiques' research aiming to uncover the biological origins of psychiatric disorders has flourished, gaining a high degree of credibility outside of psychiatry as well as within (Cohen, 1993). Use of psychiatric drugs has become increasingly popular as a treatment for human distress not only in the UK but across the globe (Moncrieff, 2008a). These developments parallel profound social and economic changes, that are sometimes referred to as "neoliberalism" and therefore it has been suggested that these developments could be related (Moncrieff, 2008a).

It has been argued that neoliberalism is an ideology that normalises the medicalisation of human life (Esposito & Perez, 2014). It has been suggested that neoliberal logic that downplays the social and pathologises thoughts and behaviours that deviate from what the market defines as functional, productive, or desirable supports the tendency to treat mental health as a problem within the individual (Esposito & Perez, 2014). Therefore, it has been argued that a biologically orientated psychiatry creates a social and cultural context favoured by neoliberal policies (Moncrieff, 2008a) and is perhaps one of the reasons why an opportunity for prescription rights for psychologists is an issue that is emerging now.

This is not to say that mainstream psychology has been immune to issues such as individualising distress. Research has long demonstrated the relevance of socio-political factors to psychologists, particularly the relationship between socioeconomic status and mental health (Brown & Harris, 1978; Hare, 1956; Weich & Lewis, 1998; Wilkinson & Pickett, 2010). However, critiques of mainstream psychology involve its uncritical

acceptance of dominant ideologies regarding the individual which is said to maintain and reproduce assumptions and practices that legitimise individualised notions of distress while simultaneously drawing attention away from any social underpinnings (Nightingale & Cromby, 2001). Critical and community psychologists argue that the individual needs to be reconceptualised and understood within the context of their social, political, and economic circumstances (Nightingale & Cromby, 2001). Therefore, it is suggested that any approach that does not pay attention to these contexts cannot hope to effect any sustainable change (Nightingale & Cromby, 2001). With some authors calling for a psychology practice that moves beyond the individual (McPherson & Sutton, 1981; Moloney, 2013; Kagan, Burton, Duckett, Lawthom & Siddiquee, 2019).

Statistics, academics, practitioners and patients have suggested that the mental health system is biased with minority groups more likely to be medicalised and pathologised (e.g. NHS Digital, 2014; Fernando, 2018; Taylor, 2022). For example, it was only in the last 50 years that "homosexuality" was removed from the DSM (Drescher, 2015). There is significant dispute around the drivers of this inequality. However, factors such as institutional racism, misogyny, ableism/disablism homophobia and heterosexism amongst others have been suggested (Fernando, 2004; Singh & Burns, 2006; Nazroo et al., 2019; Drescher, 2015; Mitchell et al., 2008; Taylor, 2022; Bradbury, 2010). This is such a vast and nuanced area to unpack that one could dedicate an entire thesis to its exploration. However, in relation to this thesis it is important to acknowledge how the expansion of prescription rights to psychologists could possibly feed into and complicate further an already biased and discriminatory mental health system. Taylor (2022) describes psychiatry as 'the patriarchy with a prescription pad and a pen full of ink'. She argues that women's trauma is ignored and instead they are quickly diagnosed with a range of psychiatric disorders, medicated and discredited. For example, women are more likely to be diagnosed with depression and subsequently medicated than men (NHS Digital, 2014) a process that Taylor (2022) suggests is rooted in objectification, sexualisation and misogyny. Research also suggests that

there is a gender difference in how the expression of emotions are understood with women's emotions more likely to be pathologised and men's more likely to be understood and contextualised as a response to situational factors (Barrett & Bliss-Moreau, 2009).

It is not only women who are disproportionately medicalised with statistics revealing that black and minority ethnic people experience significant differences in the categorisation and response to their distress comparatively to their white counterparts. A recent meta-analysis suggested that Black African, Black Caribbean, South Asian and White minority groups were at a higher risk of being diagnosed with schizophrenia in the UK (Halvorsrud et al., 2019). Research findings suggest an even greater and persistent over-representation at the severe end of the diagnostic spectrum, as reflected in rates of compulsory treatment (Bhui et al., 2015; Halvorsrud et al., 2019). Once in contact with mental health services black and minority ethnic people are more likely to report harsh experiences of services and poorer outcomes (Synergi, 2018). Black and minority ethnic people are less likely to access mental health support in primary care (i.e through their GP) and are more likely to end up in crisis care and experience longer-term detention (Jerag et al., 2014; Rabiee & Smith, 2014; NHS Digital, 2014). Black people's distress is more likely to be responded to with psychiatric drugs and electroconvulsive therapy and they are less likely to be offered non-physical treatments such as psychotherapy (Fernando, 2004; Jeraj et al., 2014; Bignall et al., 2019). This is particularly pertinent statistic in relation to the current study; will the move to prescription rights for psychologists further reduce black people's access to psychotherapy or would psychologists' training mean that they have better awareness of unconscious bias? (Brown, 2010).

This section has explored the history of the medical model of distress and some alternative approaches. It has also considered the bias within the mental health system leading to certain groups of people being more likely to be pathologised and medicated. The medical model has remained resilient despite sustained critique. A number of reasons have been suggested for the model's continued dominance including the influence of

the pharmaceutical industry which will be explored in the following section.

1.4 The Pharmaceutical Industry

When considering the impact of prescribing on the psychology profession it is important to consider the pharmaceutical industry and its relationship with psychiatry. Psychiatry is dominated by the drug companies who influence their conferences, journals, and research agendas through gifts (Read, 2005). Pharmaceutical companies are among the most powerful and profitable global corporations and have been ranked the first or second most profitable industries in the world in most years since 1955 and are exceeded only by the international arms industry (Johnstone, 2000).

It has been argued that there is an important and ever-growing alliance between the devisers of diagnostic concepts and pharmaceutical companies (Boyle, 2007). It has been argued that diagnosis appears more credible if there is a specific drug to treat a disorder, while drug marketing is strengthened if there appears to be a specific disorder the drug can target (Moncrieff, 2007). Pharmaceutical manufacturers have a role in the generation of much of the available scientific research data about psychiatric drugs within the field of mental health (Hopton, 2006; Healy, 2006). Much of the research appears to put an exaggerated emphasis on the efficacy of psychiatric drugs and neglects their adverse effects which is said to distort psychiatric knowledge and practice (Moncrieff, 2007).

Research into the financial ties between DSM-4 panel members and the pharmaceutical industry found that 56% of members had one or more financial links to a company in the pharmaceutical industry. 100% of panel members for the "mood disorders" and "schizophrenia and other psychotic disorders" work groups had links to the pharmaceutical industry (Cosgrove, Krimsky, Vjayaragharan & Schneider, 2006). Pharmaceutical industries provide substantial funding for conventions, journals and research related to what is included in the DSM, because what is considered diagnosable

directly impacts the sale of their drugs (Eriksen & Kress, 2005). Evidence of this "uneasy alliance" (Bodenheiner, 2000) came to light when a prominent journal reported that it was difficult to find research psychiatrists to write an editorial about the treatment of depression who did not have financial ties to the pharmaceutical companies that manufacture anti-depressant medications (Angell, 2000).

Considering these links between the profession of psychiatry and the pharmaceutical industry it is important to consider not just the possibility of being lobbied, but the subtle ways in which the pharmaceutical industry might seek to persuade psychologists as to the efficacy of its products.

This section has explored the relationship between the pharmaceutical industry and the psychiatry profession and how this relationship can obscure the evidence base of psychiatric drugs. The next section will attempt to unpick this evidence-base for psychiatric drugs in the treatment of human distress.

1.5 Psychiatric Drugs

The evidence for the effectiveness of drug treatments for mental health difficulties is largely based on Randomised Control Trials (RCTs), which are considered a robust measure of efficacy and therefore relied upon to provide clear and compelling evidence for treatment options (Moncrieff & Stockmann, 2019). As a result, the findings of these trials play a key role in the development of what is considered effective treatment. The accepted strength of the evidence from RCTs means that the dominant discourse around treatment for mental health problems champions a combination of medication and psychological therapy as the most effective treatment, which much of the NICE guidelines are based on (e.g., NICE, 2009).

Whilst RCTs are generally considered the 'gold standard' of evidence, they are not without problems (Moncrieff & Stockmann, 2019). There are a number of issues that can bring into question the validity of results or make them challenging to interpret. These include: the validity of the

measurements used, ignoring drug-induced alterations, publication bias, unblinding and withdrawal effects being interpreted as relapse (Moncrieff & Stockmann, 2019). Meta-analyses which combine the results of several different trials are also regarded as producing high quality evidence (Moncrieff & Stockmann, 2019). However, the conclusion of a meta-analysis relies upon the strength of the trials included and therefore, the evidence they produce is only as good as that from the trials it combines. If it includes poorly conducted trials, their inclusion adds weight to the evidence, which can lead to the results being even more misleading (Moncrieff & Stockmann, 2019). Therefore, this is a complex area that can be difficult for practitioners who work in the realm of mental health to decipher. Recent guidance produced by the All-Party Parliament Group for Prescribed Drug Dependence (APPG for PDD) skilfully presents the evidence base in a balanced way to enable therapists to enhance their knowledge, so they feel confident to discuss this information with clients (Guy, Davies & Rizq, 2019). This section will attempt to briefly summarise some of this information.

Anti-depressants

The traditional biomedical view of how antidepressants work is that they correct a chemical imbalance presumed to be present in depression by increasing the availability of various neurotransmitters that are thought to be deficient *(*Albert, Benkelfat & Descarries, 2012). Although the idea that depression is caused by a chemical imbalance has seeped into the public sphere, this theory of depression is not supported by evidence or expert opinion (Moncrieff & Cohen, 2005; Lacasse & Leo, 2005; Moncrieff et al., 2022). The Royal College of Psychiatrists (RCP) have removed the chemical imbalance theory as a potential cause of depression from their public information leaflet (RCP, 2019a) and have tweeted that "the old idea that ADs [antidepressants] correct a chemical imbalance in the brain is an over-simplication" which is not supported by the RCP (RCP, 2017).

There are several different groups of anti-depressants. Monoamine Oxadise inhibitors (MAOIs) reduce the activity of the enzyme MAO and

were the main type of antidepressants prescribed until the late 1980s (Moncrieff & Stockmann, 2019). MAO inhibitors are not currently first choice antidepressants and are usually only used when there is an intolerance or no benefit from newer drugs (Ramachandraih Subramanyam, Jurgen Bar, Baker & Yeragani, 2011). Tricyclic antidepressants (TCAs) have been described as a "revolution in the history of biological psychiatry" and were the dominant antidepressants for almost two decades and it was from TCAs that selective serotonin reuptake inhibitors (SSRIs) were developed (Healy, 2016). 'Prozac' was launched in 1988 and was the first in a series of new antidepressants (Moncrieff & Stockmann, 2019). The use of antidepressants in the treatment of depression is based on evidence from hundreds of placebo-controlled trials, which suggest that antidepressants are slightly better than a placebo in terms of scores on a depression rating scale (the primary outcome measure of these trials) (Moncrieff & Stockmann, 2019). However, the differences are argued to be small, particularly when unpublished trials are included which has caused some to question whether the results are worthwhile particularly when considering adverse and withdrawal effects (Moncrieff & Stockmann, 2019). There are several studies that show if you take people whose depression has improved while they are taking antidepressants and you randomise some of them to have their antidepressants stopped and substituted with a placebo, then the people transferred to placebo will have more relapses of depressive symptoms (Moncrieff & Stockmann, 2019). Based on these studies, people who have a single episode of depression are recommended to continue taking antidepressants for at least six months with those who have recurrent episodes being recommended to take them even longer (NICE, 2009). However, from this research it could be interpreted that these relapses are rather due to withdrawal effects.

Despite the medical model professing that these conditions are discreet categories and therefore there are specific drugs to treat them. Anti-depressants are a recommended treatment in response to anxiety that causes "marked functional impairment" (NICE, 2011). It could be argued

that this undermines the idea of drug specificity. A recent meta-analysis on the treatment of anxiety showed that SSRI and SNRI antidepressants were superior to placebo by reducing scores on anxiety rating scales modestly (Slee, Nazareth, Bondaronek, Liu, Cheng & Freemantle, 2019). Studies comparing SSRI antidepressants with benzodiazepines (BZs) for anxiety symptoms find that BZs have larger effects (Gomez, Barthel & Hoffman, 2018).

In summary, although antidepressants have been claimed to work by reversing underlying neurochemical problems, no consistent abnormalities have been demonstrated in depression, and there is little evidence that antidepressants work in this way. Antidepressants show modest superiority over placebo in short-term clinical trials of depression. However, the small difference could be explained in other ways such as drug induced effects of antidepressants, as well as methodological factors in trial design, analysis, and publication. Finally, the findings of the many short-term trials do not capture the effects of long-term treatment.

Anxiolytics

There are several types of drugs used for anxiety including anti-psychotics, anti-depressants, benzodiazepines, and beta blockers. This section will focus on benzodiazepines (BZs) which are otherwise known as minor tranquilizers. From the 1960s onwards BZs were widely prescribed to people with sleeping difficulties and people with anxiety (Moncrieff & Stockmann, 2019). In the 1980s it became apparent that many people who took BZs for more than a few weeks become physically dependant on them and experienced significant withdrawal effects when they stopped. As such they were described as "a drug more difficult to stop than heroin" (Healy, 2016). This has led to some proposing that they should be banned or severely restricted (Moore, Pariente & Begaud, 2015). Treatment guidelines advise that BZs are indicated only for short term relief up to a maximum of 4 weeks for anxiety that is severe, disabling or causing unacceptable distress, due to their highly addictive nature and problems withdrawing (BNF, 2017). The impact of BZs on the brain mean they cause

sedation and relaxation at lower doses (Moncrieff & Stockmann, 2019). Generally, BZs are regarded as non-specific treatments which means they are not assumed to reverse an underlying disease but rather by producing a drug-induced sedative state (Moncrieff & Stockmann, 2019).

Short term studies of BZs suggest that they reduce anxiety more than placebo and are slightly more effective than other common drug treatments for anxiety such as SSRI antidepressants (Gomez, Barthel & Hoffman, 2018). However, studies only tend to last a few weeks, so it has been suggested that it is difficult to ascertain whether the effect persists (Moncrieff & Hoffman, 2019). RCTs of BZs for insomnia show that they increase duration of sleep, but they do not improve the time it takes to get to sleep (Holbrook et al., 2000).

Due to their sedative properties BZs are frequently prescribed to people with severe psychiatric problems (Moncrieff & Stockmann, 2019). Therefore, they are often prescribed in emergency psychiatric situations to sedate people (Moncrieff & Stockmann, 2019). Studies show that in this context BZs are comparable to antipsychotics (Huf, Alexander, Gandhi & Allen, 2016). However, there is a little evidence using them in this way in the long-term.

Antipsychotics

In the realm of mental health anti-psychotics have been described as the most 'notorious' prescribed medication (Moncrieff, 2008b). They were previously referred to as neuroleptics or major tranquilisers although now they are generally called anti-psychotics (Moncrieff & Stockmann, 2019). They were first introduced in the 1950s and were initially understood as a suppressant and at their most extreme resembled Parkinson's disease (Moncrieff & Stockmann, 2019). As time has moved on, these drugs have been constructed as treatments that target an underlying brain abnormality particularly through their effects on the neurotransmitter, dopamine and it has been suggested that it was parallel to this, they came to be known as antipsychotics (Moncrieff, 2013a). A new wave of antipsychotics were introduced from the 1990s and it was claimed they

were more effective and less prone to side effects than the older drugs which has since been refuted (Jones et al., 2006).

Antipsychotics are the main treatment for people diagnosed with psychosis and schizophrenia. Those with an initial episode of psychosis are suggested to take these drugs for a further year or two after recovery and then may be supported to stop (NICE, 2014). However, those who have had more than one episode are recommended to stay on these drugs long term for relapse prevention (NICE, 2014).

As well as being used for those with a diagnosis of psychosis or schizophrenia they are also prescribed to people diagnosed with mania, personality disorder, dementia, learning disability, autism, anxiety, depression, insomnia and generally in situations to calm people (Moncrieff & Stockmann, 2019).

After a decade of use it was discovered that some of them strongly counteract the effects of the brain chemical called dopamine which led to the suggestion that schizophrenia was because of abnormally increased dopamine activity, known as the 'dopamine hypothesis' (Moncrieff & Stockmann, 2019). From this perspective, antipsychotics are thought to reverse the chemical imbalance causing the symptoms of schizophrenia or psychosis.

Although some experts continue to promote the dopamine hypothesis (Howes et al., 2017), it has been suggested that the majority of evidence has not confirmed any differences of dopamine activity between people with a diagnosis of schizophrenia or psychosis and without (Moncrieff, 2009). Placebo-controlled RCTs show that antipsychotics reduce experiences such as delusions and hallucinations in those who have an acute psychotic episode more than placebo (NIMH, 1964; Leucht et al., 2009). However, there is also a significant proportion of people who do not improve with the use of antipsychotics with their symptoms persisting (Robinson et al., 2006). Two trials suggested antipsychotics were superior to barbiturates, but studies comparing antipsychotics to opium and BZs

have not shown a clear difference (Wolkowitz & Pickar, 1991; Casey et al, 1960).

The natural course of psychosis without the use of antipsychotics received some interest several decades ago but this interest has waned. Previous research in this area in Finland found that 43% of people with a first episode of psychosis could be successfully managed without antipsychotics (Lehtinen et al., 2000). Therefore, it has been suggested that a reasonable proportion of people with a first episode of psychosis may recover without the need for antipsychotics but that this is an area that requires further research (Moncrieff & Stockmann, 2019).

What seems pertinent in looking at the evidence for the efficacy of psychiatric drugs broadly is that it is often conflicting and cannot be taken on face value making it very difficult to form an opinion on its usage in alleviating human distress particularly if you are not a medical professional. However, Moncrieff (2008a) goes some way to explain how psychiatric drugs work and makes a useful distinction between a disease-centred model and drug-centred model of drug action. She reports the disease-centred model suggests powerful chemicals work by targeting and reversing an underlying chemical imbalance or another brain abnormality. However, a drug-centred model suggests that drugs exert psychoactive effects in everyone regardless of whether they have a psychiatric diagnosis. These effects can interact with the symptoms of mental distress by creating an altered brain state that suppresses or replaces symptoms of mental and behavioural problems which may be preferrable for some. Moncrieff gives a useful example of a drug-centred model with regards to alcohol leading to a feeling of relaxation through creating an artificial state rather than reversing an underlying mechanism of anxiety (Moncrieff, 2013b). Moncrieff and Stockmann (2019) argue that if this model were to be adopted by psychiatrists and doctors it would change the relationship between prescriber and client. Instead of a specific drug being prescribed to treat a specific condition. It would require a collaborative and tailored discussion between prescriber and client about what drug-induced effects may or may not be useful in their specific situation.

This section has attempted to explore the evidence-base for psychiatric drugs in the treatment of distress. Most of the evidence-base and subsequent guidelines are based off RCTs. It highlights that whilst RCTs offer something useful they are by no means perfect. Therefore, they require unpicking which can be difficult and confusing. Having explored the evidence-base of psychiatric drugs, the next section will focus on how prescribing rights for psychologists unfolded in the US.

1.6 Prescribing Psychologists in the United States

What came across strongly in the available research is the difference in language used when talking about prescription rights. US research tends to use the phrase 'prescription privileges' which indicates that it is a special honour, an advantage that a psychologist should desire.

The first bill seeking to authorise prescription privileges for psychologists was introduced in Hawaii in 1985 (Murray, 2003). From 1991 to 1997, the United States Department of Defence (DOD) embarked on the Psychopharmacology Demonstration Project (PDP), a pilot project to train military clinical psychologists to prescribe psychiatric drugs to treat patients for mental illness. The outcome of this pilot was that the evaluation panel expressed that PDP program graduates were safe and effective prescribing psychologists (ACON, 1998). They agreed that the training program had successfully trained the graduates as prescribing psychologists who work safely and effectively in the military setting which expanded the delivery of mental health treatment and was cost effective. At the end of this pilot the future for prescribing psychologists was uncertain. Nonetheless the evaluation panel was adequately satisfied that their roles met a unique, professional need of the DOD (ACON, 1998).

Following this pilot, in 2002, New Mexico became the first state to enact a law allowing "appropriately trained psychologists to prescribe" psychiatric drugs (APA, 2014). Followed by Louisiana, Illinois, Iowa and Idaho meaning psychologists can currently prescribe in five states in the US (APA, 2014).

Many other states have introduced bills for the prescribing rights for psychologists but have yet to be approved (APA, 2014). In the state of Louisiana, medical psychology has been established as a distinct profession (APA, 2004). Medical psychologists are licensed by the Louisiana Board of Medical Examiners (LAMP, n.d.) making Louisiana the only state in the US where a medical board has authority over the regulation of prescribing psychologists.

There has been some quantitative research examining US psychologists' opinions on prescription rights. A meta-analysis examining opinion data to determine whether the views were as polarised as expressed in the literature, found minimal consensus and a general split of opinion (Walters, 2001). Walters (2001) found higher levels of agreement than disapproval for the statement: properly trained psychologists should be allowed to prescribe psychiatric drugs. However, he does not define nor question what 'properly trained psychologists' means. Psychologists in training were more in favour of prescription rights than their qualified counterparts. Practicing psychologists demonstrated support for prescription rights in theory but expressed they would not wish to pursue this for themselves (Walters, 2001). Seventy five percent of university-based directors of clinical psychology training expressed that their faculty would be unwilling to alter the core curriculum of their training programs to accommodate graduate level training in psychopharmacology (Walters, 2001). A more recent quantitative survey study with a sample size of 890 licensed psychologists and a return rate of 37.4% found that 61.2% of the sample endorsed prescription privileges and 25.9% planned to prescribe once trained (Baird, 2007). Research into the status of prescription privileges for psychologists in the US found that prescribing psychologists were perceived positively by their medical colleagues across various domains (Linda & McGrath, 2017). Psychologists also reported that on their most recent workday they were equally likely to increase and decrease medications (Linda & McGrath, 2017).

The move to prescription rights for psychologists in the US was not without controversy. The APA adopted prescription rights after suspending the

rules of the APA council of representatives that required consultation with constituencies. It has been argued that this stopped discussion that may have exposed the limitations of psychologists' support for it (DeNelsky, 1996). The APA also forbids affiliates whose members oppose prescription rights to state this on their websites (Heiby, 2010). An independent advocacy organisation for psychologists formed in 2007 to oppose legislation based on the APA psychopharmacology training model (Heiby, 2010). It has been suggested that this was due to concerns and objections to prescription rights being neglected and censored by the APA (Fowles, 2005, as cited in Heiby, 2010).

In summary the APA strongly endorses prescribing rights for psychologists. However, research into this area provides mixed reviews. This perhaps explains why prescribing rights for psychologists has not expanded beyond 5 states. The views on prescription rights for psychologists are no less divided in other English-speaking territories. Therefore, the next section will explore the prescription rights for psychologists' debate in other countries across the globe.

1.7 The Prescription Debate for Psychologists in Canada, Australia and New Zealand

Canada

The debate in Canada has generated many arguments for and against the movement. Several different points of contention have been explored such as the philosophy and future of psychology in Canada, liability, professional competency, ethical issues and whether psychologists even want prescription rights (Nussbaum, 2001; Dobson & Dozois, 2001). Nussbaum (2001) examined and debated Walters (2001) findings. He dedicated a substantial proportion of his article to the relevance of biology to psychologists and how the field of psychology has generally ignored this. He argues that prescription rights would allow psychologists to develop a truly integrative psychobiological treatment which would take therapy to a

new level. He argues against the idea that psychology would be diluted through teaching from the medical profession and suggests that eventually training and supervision of prescribing could be contained within the field of psychology (Nussbaum, 2001).

However, there are several papers arguing against prescription rights. Dobson and Dozois (1995; 2001) express that the identity and tradition of psychology does not lend itself to the attainment of prescription rights. They were less concerned with whether psychologists could be trained to competently prescribe but rather, they sought to explore whether psychologists should. They questioned the value and need of prescription rights given that psychiatric drugs are already among the most prescribed substances and suggested that instead there should be better collaboration between psychologists and psychiatrists (Dobson & Dozois, 2001). They also raised questions around the required training and curriculum adjustments that would need to be made and expressed concerns around the increased cost, availability of training and qualified lecturers, and whether there would be a move away from psychotherapeutic approaches which would dilute the profession's identity.

Research has followed on from the wealth of opinion papers in an attempt to gather data around the topic (St.Pierre & Melynk, 2004). They distributed an online quantitative survey to gather opinions from professionals and students from clinical, counselling, experimental and social psychology. There was a large and significant difference between the proportion of the sample that agreed with the following statements than those who disagreed: it is possible for psychologists to attain the required training to properly prescribe psychotropic medication; properly trained psychologists should be allowed to prescribe psychotropic medication; and the Canadian Psychological Association (CPA) should advocate in favour of prescription privileges for psychologists. Despite this, a large and significant proportion of the sample answered 'no' when asked if they would personally seek prescription privileges should they be made available. However, when this was split over the different psychology disciplines, a significant and moderate sized majority of clinical psychology students and

professionals said they would seek prescription privileges compared with the other psychological orientations such as counselling psychology. Finally, when asked whether they thought the attainment of prescription privileges is theoretically and philosophically opposed to the field of psychology a large and significant majority of students and professionals answered no.

The researchers also allowed participants to type comments at the end of the questionnaire and used grounded theory to analyse them. They split the comments into approval comments and oppositional comments. Themes of the approval comments were better service delivery, status and financial gains whereas the oppositional comments expressed concerns around a reliance on medication rather than psychotherapeutic approaches, loss of identity as a psychologist and increased liability and insurance costs (St.Pierre & Melynk, 2004).

In June 2007 a Task Force on Prescriptive Authority for psychologist practitioners was initially established by the CPA board of directors to consider the relevant professional literature and views on prescription rights for psychologists in Canada. The Task Force reported that all psychologists have a duty to have basic psychopharmacological knowledge in their areas of practice to work effectively and ethically with clients. However, whilst they expressed that prescriptive authority should not be precluded as a future step for psychologists, they saw it as something that should evolve organically rather than being the primary goal and focus of professional advocacy (CPA Task Force, 2010).

Australia

In 2007 the Australian Psychological Society (APS) conducted a survey of its members with regards to prescription rights due to a potential shortage in psychiatric services. Most respondents supported prescribing in principle and as a result the APS has developed a proposal for the training and registration of prescribing psychologists (APS, 2007). There is no public information about what has happened since this time.

New Zealand

Simultaneously in New Zealand the Ministry of Health was in the process of reviewing the Medicines Act whilst considering the national shortage of psychiatrists and increasing pressure to move more mental health services into the primary care sector. The result of this was a consultation document that invited the consideration of the need for collaborative prescribing (Fitzgerald, 2013).

In response to the Ministry's report Fitzgerald and Galyer (2008) undertook a survey of New Zealand psychologists. The questions largely replicated the APS survey and there was a 33% response rate. There was a sense of ambivalence as whilst half of respondents indicated support for psychologists prescribing most of them also expressed reservations. The most frequently endorsed concerns (with 20% of respondents agreeing with the statements) were an increase in insurance costs and prescribing rights changing the nature of psychology as a profession (Fitzgerald & Galyer, 2008). An additional question that was not asked in any other survey was what medication psychologists' thought would be useful to prescribe. Fifty two percent of respondents listed at least one medication and 91% of them listed anti-depressants and/or mood stabilisers.

Despite the extensive survey data available on psychologists' opinions on the prescription debate it appears the only clarity is themes of polarisation and ambivalence. Whatever the outcome at least half of the profession are likely to be in opposition. The result could be a splitting of the profession by creating a 'two-tier' model whereby psychologists who can prescribe are more attractive in mental health systems that historically favour biological explanations of human distress (George & Semp, 2013).

Having explored the current situation with regards to prescription rights for psychologists in other countries, the next section will attempt to outline the history of clinical and counselling psychology in the UK to set the scene for the prescription rights debate for these two professions.

1.8 History of Clinical and Counselling Psychology in the United Kingdom

Clinical Psychology

The birth of the profession of clinical psychology could be associated with the launch of the new National Health Service (NHS) in 1948 (Whittington & Lane, 2015). Psychology graduates found a place in this new service which typically involved assisting psychiatrists with diagnoses and psychometric testing. During this time Hans Eysenck, renowned for his opposition to psychoanalysis, positioned psychologists in the UK as scientist-practitioners who should not be concerned with psychotherapy, but with advancing psychological knowledge through research (Whittington & Lane, 2015). It has been suggested that clinical psychology's early development was heavily influenced by medical practice (Woolfe, 2016). The first UK clinical psychology course was based largely on this approach which was established in 1957. Behaviourism started being significantly utilised by clinical psychologists in the 1950s in a bid to expand their roles and as a result became part of the curriculum in the growing clinical psychology courses in the UK (Whittington & Lane, 2015). In the late 1970s, Beck's launch of cognitive therapy was attractive to clinical psychologists as it was located firmly within a scientific paradigm. In 2013 the Division of Clinical Psychology released a position statement on psychiatric diagnosis which argued for a paradigm shift away from psychiatric diagnosis and towards a contextual and multi-factorial approach that acknowledges the complexity of human experience (DCP, 2013). More recently the DCP published the Power Threat Meaning Framework which has been argued offers a new and radical perspective on why people experience mental distress (Johnstone & Boyle, 2018). Although, many of these ideas, as the authors acknowledge, are not entirely new but borrowed from other areas of psychology and psychotherapy. In a recent edition of the Clinical Psychology Forum clinical psychologists make a case for an engagement with power (Bostock, 2017) and critical consciousness raising (Fisher, 2017) as a means of revealing neoliberal ideologies that underpin much contemporary thinking around mental health. Community psychology is a Section of the BPS that sees

increasing numbers of clinical psychologists, especially trainees, coming to it looking for alternatives to mainstream and clinic-based practice.

Counselling Psychology

Counselling psychology emerged from a field dominated by positivism (Woolfe, 2016). In the late 1970s the BPS created a Working Party to consider the relationship between psychology and counselling in the UK. The role of the Working Party was to consider whether counselling was a legitimate activity for a psychologist and the extent to which it could be supported and located within the Society. In its final report the Working Party recognised counselling as an activity based on the understanding of psychological processes which is in stark contrast to Eysenck's view that psychologists should not be concerned with psychotherapy. The report resulted in the establishment and interest-based section for counselling psychology. The establishment of the section is generally regarded as the birth of counselling psychology in the UK (Orlans & Van Scoyoc, 2008). Counselling psychology was described as "an idea whose time had come" (Woolfe, 1990). However, it took some time before it became a Division within the BPS. A special group was developed due to the rejection of divisional status based on the profession not being adequately defined. The special group developed its own practice guidelines which were widely viewed as a stepping-stone to divisional status. The field continued to evolve with the establishment of the BPS Diploma in Counselling Psychology. This offered a training framework and curriculum that defined an area of theory and practice for the profession. Finally, in 1994, divisional status was achieved allowing graduates of the Counselling Psychology Diploma to call themselves Chartered Counselling Psychologists. What is clear, is that the profession has had to fight for a sustained period to gain the recognition it currently enjoys. Counselling psychology's interest in the whole person and the move away from an expert position does not sit easily with traditional ideas about science embedded in western psychology. Counselling psychology has also been driven by interest in and attention to subjectivity, context, and promoting wellbeing as opposed to a

focus on illness; commitments which still create tension for Counselling Psychologists working in the NHS (Orlans & Van Scoyoc, 2008; Woolfe, 2016). Fundamentally, Counselling Psychology believes in therapy as a relational encounter, where the person of the therapist matters as much as the techniques and theories that they employ.

Currently, both clinical and counselling psychologists are trained at doctorate level and both trainings incorporate clinical skills, research and leadership. Clinical psychologists in training are employed and funded by the NHS and it represents one of the most desirable destinations for psychology graduates with almost 4,544 applicants in 2021 and only 22% of these being successful to gain a place on an NHS clinical psychology training (Clearing House, 2021). Whilst counselling psychology is not funded, there has been a recent introduction of postgraduate doctoral loans and the Division of Counselling Psychology (DCoP) are working hard to address parity in employment (Mcintosh & Nicholas, 2015). More recently the BPS has issued a document on best practice in psychology recruitment advising that inclusive titles such as practitioner psychologist are used in advertisements and that recruitment processes include a review of essential and desirable criteria to ensure registered psychologists whose skills, knowledge and training would be appropriate for the job role are not inadvertently excluded (Dooley & Farndon, 2021).

Against this backdrop, in 2017 the British Psychological Society (BPS) started a consultation with regards to prescription rights for practitioner psychologists. This consultation has progressed simultaneously to the current study. The next section will attempt to outline the way in which this has unfolded over the last few years and the current situation.

1.9 The British Psychological Society's Consultation

During the British Psychological Society's (BPS) General Assembly in October 2017, it was reported that NHS England (NHSE) had approached

the Society to gather its members' views on acquiring prescription rights. Although this is the first formal consultation of its kind in the UK it is not a new discussion within the psychology world in the UK.

In a 2003 edition of The Psychologist magazine, a significant proportion was dedicated to a variety of opinion pieces on prescription rights for psychologists. A variety of perspectives were covered with each separate piece presenting a case for or against prescribing rights and any issues the authors felt to be pertinent. The writers also responded to each other's pieces. Some of the benefits highlighted by those that were for prescribing rights included a desire to meet urgent mental health needs, an implicit message that psychologists would do it better than their medical colleagues because they would focus on client strengths rather than deficits, they would be able to reduce or deprescribe inappropriate medications and they would be able to provide continuity to patients through being able to provide the whole package of therapy and medication (Resnick, 2003; Sammons & Levant, 2003). Concerns centred around the over-medicalisation and decontextualising of distress, resisting pressures from the pharmaceutical industry and the opposing intentions of medication and therapy with the former causing people to 'feel less' and the latter requiring people to be in contact with their emotions (Johnstone 2003; Orford, 2003). Sammons and Levant (2003) stated that they believed psychologists should be able to prescribe but they did encourage engagement with the pharmaceutical industry's 'enormous influence' on the marketing and promotion of drugs. However, they argued that as psychologists (clinical in particular) obtain more training in identifying 'mental disorders' than other professionals such as GP's this would buffer against the influence of the pharmaceutical industry and result in more ethical prescribing practices.

What was apparent from reading the opinion pieces was some conflicting assumptions regarding the theory and practice of psychology, how to make sense of distress and thus the best way to respond, and the evidence-base for psychiatric drugs. This led to diverse views on prescribing rights for psychologists ranging from seeing it as 'the logical next step' (Resnick,

2003) to 'infecting' (Orford, 2003) the discipline of psychology. Also, the interaction between the writers made for uncomfortable reading demonstrating that it is an emotive and divisive topic.

Whilst no counselling psychologists contributed to the debate in the 2003 issue. In 2001 King wrote an article on prescription rights specifically in relation to counselling psychology published in the Counselling Psychology Review (King, 2001). He suggested that counselling psychology had stayed quiet on prescription rights with most attention coming from clinical psychologists. He encouraged counselling psychologists to become more engaged in the topic and he argued that this could be best achieved through obtaining a recognised level of awareness of psychopharmacology (King, 2001).

In 2018 a Task and Finish Group was established to develop a position statement for the Society for consideration by the Professional Practice Board (The British Psychological Society Professional Practice Board, 2018). In late 2019, the group produced a discussion paper following a year of consultation with individuals and groups of stakeholders. Following these initial consultations three main concerns were highlighted which were subsequently clarified by the Task & Finish Group. Prescribing training would be optional, a programme of training, mentoring and post qualification governance would have to be agreed to meet the regulations and standards set out by the Royal Pharmaceutical Society (RPS) and the Health and Care Professions Council (HCPC) to ensure that psychologists had the appropriate competencies to fulfil the prescribing role and prescribing psychologists would be expected to be working within a multi-disciplinary team or professional network (BPS, 2019a). Members of the BPS and other stakeholders were invited to send in comments on the discussion paper (BPS, 2019a).

Around this time a group of 12 professionals, service users and experts by experience wrote an open letter outlining their concerns about the prescription rights debate to be considered by the BPS (MITUKadmin, 2019). Concerns centred around the need to use diagnostic constructs

when prescribing, what they viewed as an uncritical acceptance of the medical model and NICE guidelines in the discussion paper, overprescribing of psychiatric drugs generally, links with the pharmaceutical industry and prescribing psychologist's role in forced administration of psychiatric drugs (MITUKadmin, 2019). To this date the BPS has not responded to this open letter.

In early 2020, following the collation of responses to the discussion paper, Dr Courtney-Walker, Chair of the Prescribing Rights Task and Finish Group reported a "mixed bag of diverse views" and that ultimately the final decision would "rest in legislation" (Courtney-Walker, 2020). However, it was considered that there was enough support for the group to further engage with experts by experience, the RPS and the HCPC. Following this announcement from Dr Courtney-Walker, Alison Clarke the Chair of the BPS Practice Board wrote a letter for the BPS magazine 'The Psychologist' highlighting some of the comments she had received. She described the nature of these comments as not only about what psychologists do in practice but also about 'who we are, both as practitioners and as human beings' (Clarke, 2020). She also highlighted concerns that members who are most opposed to prescribing rights are not actively involved in this stage of the debate and invited them to 'step into what may be an uncomfortable conversation… so that all shades of opinion are reflected' (Clarke, 2020). In November 2020 the Task and Finish Group published a report that recommended the Practice Board should approve the position that psychologists should have prescription rights as it felt the evidence gathered through consultation indicated there was more people in favour of giving some psychologist's the option to prescribe psychiatric drugs, compared to those that opposed it (BPS, 2020a). However, in a survey of 439 people conducted by the Association of Clinical Psychologists (ACP) in the UK a 58% majority did not want prescribing rights for themselves (Harvey, 2021). Whilst this has not appeared to have been acknowledged by the Task and Finish Group, the final report did state that one member of the Task and Finish Group expressed a need for more debate and discussion before a position could be reached on issues relating to the use

and efficacy of psychiatric drugs generally and the use of diagnosis (BPS, 2020a). Despite this, the Task and Finish Group's report was presented to the BPS Practice Board on 9th October 2020 and following a "robust discussion", the details of which have not been published, they approved the position that psychologists should have prescribing rights by majority vote (BPS, 2020b).

Following the conclusion of this piece of work the BPS has confirmed that it wants to remain involved in discussions with NHS England (NHSE) about prescribing rights for psychologists. Despite this, it has suggested that its position on prescribing rights for psychologists is not fixed and that prescription rights have not yet been agreed (BPS, 2020b). The BPS also advises that NHSE does not need the BPS to have a firm position and that they can withdraw from the process at a later point (BPS, 2020b).

At the end of 2020 a blog was developed by clinical psychologists Peter Harvey, Pat Harvey and David Pilgrim. The content of their blog includes a variety of issues, some of which are beyond the scope of this study. However, one of their areas of focus has been their concern around the BPS prescription rights consultation. In March 2021 Pat Harvey wrote a blog post which included two letters sent to the BPS regarding concerns around the consultation (Harvey, 2021). The first letter, signed by 102 psychologists was sent in October 2020 prior to the Practice Board approving the position that psychologists should have prescribing rights (Harvey, 2021). The main point was a call for a thorough consultation process which is 'open and transparent, balanced and unbiased', with some more specific concerns that have not been directly addressed by the BPS (Harvey, 2021). In March 2021 another letter was sent to the Chair of Divisions and Faculties of the BPS on behalf of 20 clinical psychologists. Again, the main point made here was the need for a 'fair and transparent discussion' in which the best outcome for service-users and the profession could be considered (Harvey, 2021). There is no indication that this has been further responded to.

As outlined above, the proposal to expand prescription rights for psychologists is plagued by controversy regarding issues such as: who exactly would be eligible to prescribe? How would Professional Doctorate courses assimilate this training into curricula that navigate different ends of the biopsychosocial spectrum? Do clients want psychologists to prescribe medication? Do psychologists themselves want to prescribe? Many of these issues largely influenced by financial and political pressures. The current socio-economic and political climate in the UK means the quickest and cheapest interventions are preferred for an under resourced and underfunded mental health system (Gilburt, 2018; The Royal College of Psychiatrists, 2018). Medication fits well within this environment as it is quick to prescribe, and more clients can be seen in less time.

1.10 Rationale, Research Aim and Relevance to Counselling Psychology

There is currently no research into the views of psychologists on acquiring prescription rights in the UK. The research that has been conducted in the US has been largely quantitative so there is little insight into psychologists' views and the factors that may influence them. With this being an issue that appears to be so polarising, research that can help psychologists to express their views and opinions in their own words and further understand their motives is vital (Baird, 2007).

The aim of the current study is to explore qualified counselling and clinical psychologists' views and opinions on acquiring prescription rights. The literature suggests a polarisation of views regarding whether psychologists are for or against acquiring prescription rights. As a result, a qualitative exploration of this topic seems both pertinent and timely.

Given that counselling psychology professes to be a critical discipline that challenges the medicalisation of distress and is concerned with meaning (Strawbridge & Woolfe, 2010), it is in our interest to further explore the prescription rights debate as it will have significant consequences for the future of our profession. By conducting a 'wide-angle study' (Toerien &

Wilkinson, 2004) in an area that is yet to be researched in the UK, it is hoped that the findings will nuance the dialogue on prescription rights. The research also hopes to engage counselling psychologists in a debate that risks being dominated by clinical psychology due to their established position in the UK (King, 2001).

The research question therefore is what are UK based counselling and clinical psychologist's views on gaining prescription rights in the realm of mental health?

2. Methodology

2.1 Theoretical Framework

The study was conducted from a critical realist ontological stance (Braun & Clarke, 2013). Critical realism challenges the objectivity of knowledge and interrogates social, political, and cultural factors implicated in its construction. This sits well with the deconstruction of psychopathology which seeks to connect psychological critique with political contexts (Parker et al., 1995). In other words, critical realism assumes a real and knowable world which sits behind the subjective and socially located knowledge that a researcher can access (Madill et al., 2000; Pilgrim, 2013). Critical realism goes beyond what is currently observable and acknowledges that context and values are embedded in scientific enquiry, whereby the researcher is part of their object of enquiry (Pilgrim, 2013). I hold a contextualist perspective on epistemology whereby a single reality is not assumed but rather knowledge emerges from certain contexts and might hold true for those contexts, but not necessarily others. In any case, a contextualist epistemology embraces the subjectivity of the researcher and thus reflects my position(s) (Madill, Jordan & Shirley, 2000).

2.2 Research Design

Given the need to explore opinions on the subject matter in depth, a qualitative design seemed appropriate. This is geared towards a

documentation of richness and contradiction rather than reductionism, prediction and hypothesis-testing. As this study aimed to fill a gap in the literature, breadth was required, and online qualitative surveys allowed for the collection of data from a large population (Terry & Braun, 2017). However, qualitative surveys still have the capacity for 'rich, deep and complex data' (Braun, Clarke, Boulton, Davey & McEvoy, 2021). Qualitative surveys are well suited to research questions wanting to explore participants' views on a topic area (Terry & Braun, 2017). They have been used successfully to research similar topics including nurse prescribing in mental health (Dobel-Ober, Brimblecombe & Bradley, 2010) and psychiatrists' and nurses' attitudes towards prescribing and administering depot antipsychotic medication (Besenius, Bradley & Nolan, 2012).

2.3 Data Collection

Data was collected via the *Qualtrics* online survey software. An online qualitative survey (Appendix A) was employed to collect a breadth of views providing a "wide-angle" picture on the research area (Toerien & Wilkinson, 2004). Given that the way we make sense of human distress is socially, politically, and culturally influenced, participants' use of similar terms in their responses could provide evidence for shared understandings of the research topic (Toerien & Wilkinson, 2004). This perspective holds true in the current study, which targeted clinical and counselling psychologists in the UK, a population that shares explanatory frameworks, theoretical models, and NHS work experience, among other things. Despite the standardisation, qualitative surveys allow participants the freedom to use their own words thus prioritising their frameworks (Braun & Clarke, 2013; Terry & Braun 2017) and therefore gives space for differences between the two professions to emerge. However, a detailed and explicit comparison between the two professions is beyond the scope of this study. This approach allowed for quick, efficient data collection from a relatively large, geographically dispersed sample since it is not hugely demanding of researcher resources and does not involve data entry or transcription

(Braun & Clarke, 2013). Demographic questions (Appendix B) appeared at the end of the survey where they are considered less threatening, and participants are more likely to answer them once they have finished answering the questions about the main topics (Terry & Braun, 2017).

2.4 Survey Design Development and Pilot

The qualitative survey questions went through numerous phases of development. Initially questions were developed by reading previous research on the topic, namely quantitative surveys. Previous research that highlighted areas for further research were also used as inspiration for questions (Walters, 2001; St. Pierre & Melynk, 2004; Baird, 2007; Fitzgerald & Galyer, 2008). More general questions were included to gauge participants' understanding of psychiatric drugs and current prescribing practices. The initial survey draft contained 20 questions. This initial draft was discussed thoroughly at a supervisory team meeting where some questions were immediately discarded, some clarified, and some added. From this meeting a second draft was developed which included only 9 questions and the feedback from both supervisors revolved around changes to the wording for higher precision and the order of the questions for better flow. Issues concerning language continued to be grappled with which led to the fifth draft which was subsequently piloted. The survey was piloted to consider any problems with its design ahead of use. Piloting is considered vital due to the fixed nature of qualitative surveys (Braun et al., 2021). Five counselling psychologists in training and one clinical psychologist in training completed the fifth version of the survey via e-mail. Subsequently, I reviewed the responses with the supervisory team. We found that the responses were rich and detailed and considered the medical model of distress, the use of psychiatric drugs and views on prescription rights for psychologists. However, one question repeatedly produced thin responses and was eventually discarded. During this meeting, several changes were considered. This included rewording some questions for clarity and consistency, the deletion of a question, changes in

the format and considerations of a follow up survey. Survey length is an important consideration for design. The number of topic-based questions in qualitative surveys varies (eg. Frith & Gleeson, 2004; Davey, Clarke & Jenkinson, 2019; Braun, Tricklebank & Clarke, 2013). There are no hard and fast rules, but a minimum of 3 and a maximum of 30 has been suggested (Terry & Braun, 2017). Longer surveys remain rare due to greater potential for participant disengagement (Braun et al., 2021). With all of this in mind the final survey consisted of 8 topic-based questions. Once the survey was live, very early on in recruitment, one participant misunderstood the scope of the survey and eventually withdrew. This was discussed with the Director of Studies, and it was agreed to change one of the words in the survey from 'drugs' to 'medication', to ensure further precision and clarity. This is discussed further in the reflexivity section.

2.5 Recruitment, Sample and Demographics

To recruit participants a combination of purposive, criterion and snowball sampling was used (Braun & Clarke, 2013). Participants were required to be residents and/or working in the UK. Participants were also required to be qualified counselling or clinical psychologists that were eligible to register for chartership with the British Psychological Society (BPS) and the Health and Care Professions Council (HCPC) though they did not need to be currently registered. As this study is concerned with views on prescribing rights for psychologists particularly within the realm of mental health it made sense to include both counselling and clinical psychologists as the two main practitioner psychologists that work within this area and therefore would be the most affected psychologists by this change.

Whilst there are distinctions between the two professions, they serve the same populations and generally fill the same posts particularly within the National Health Service. Most applied psychology posts in the NHS tend to be open to any practitioner psychologist deemed to have the skill set to undertake the role as per recent guidelines on advertising (Dooley & Farndon, 2021). There are many instances where research is carried out

that only includes clinical psychologists in the sample despite being relevant to other practitioner psychologists (e.g. BPS, 2022). As prescribing rights appears to be an issue that is so polarising it is important that all perspectives are heard and that professions work together to serve their clients' best interests.

Other applied psychologists were excluded as the current study is concerned with psychologists who are trained in and provide therapy. Given that different modalities of therapy are taught across training programs, which may also influence participants' views, varied recruitment routes were used, including the clinical psychology online forum *Clinpsy* and advertisements on social media including Facebook, Twitter and Linkedin. I also contacted my professional networks, universities with doctoral programmes in clinical and counselling psychology (targeting their staff) and placed the advertisement for the study in various BPS publications and outlets. A sample size of 80-100 participants is considered sufficient for gaining rich and varied qualitative survey data (Terry & Braun, 2017). Recruitment stilted at around 60 participants and although the data was richer than anticipated, with most participants reflecting on their views in a detailed manner, the supervisory team considered ways to further push recruitment to reach a sample of 80. During this final push for participants, at progression review, a discussion around demographics highlighted that the sample was relatively recently qualified, with most participants having less than 5 years' post qualification experience. Therefore, stratification was used to try and increase the diversity of perspectives (Braun & Clarke, 2013), this seemed particularly important as previous research in this area had suggested that clinical experience was associated with different views on this topic (Walters, 2001). We used our professional networks to target more experienced psychologists and achieved greater diversification of the sample in terms of clinical experience post-qualification.

The final number of participants who completed the survey was 82. Participants overwhelmingly identified as female (n=67), white (n=67) and heterosexual (n=69) with a mean age of 41 years. There was a fairly even

balance of clinical (n=45) and counselling psychologists (n=37). Participants had between 1 and 45 years of post-qualification experience with a mean of 10 years. Participants also acknowledged a variety of different identities that they felt related to the research such as: feminist, mental health nurse, activist, psychodynamic psychotherapist, community psychologist, approved clinician, neuropsychologist, and having lived experience. When presenting quotations from the data, I chose to report only the participants' professional identity, as the most meaningful descriptor in this analysis. For full demographic information, please refer to Table 1 below.

Table 1: Participants' Demographics and Relevant Information

Characteristics	Number
Gender	
Male	14
Female	67
No Response	1
Race	
White	67
Mixed	2
Black	1
Asian	3
Indian	1
Other	4
No Response	4
Age	
25-30	11
31-40	35
41-50	20
51-60	10
61-70	3
71-80	2
No Response	1
Sexuality	
Heterosexual	69
Gay	3
Bisexual	6
Other	3

No Response	1
Profession	
Clinical Psychologist	45
Counselling Psychologist	37
Disability	
Yes	8
No	73
No Response	1
Class Category	
Working	11
Middle	55
Upper	0
No Class Category	5
No Response	4
Other	7
Years Qualified	
<5 Years	27
5-10	20
11-20	18
21-30	3
31-40	4
41+	2
No response	8
Should Psychologists Gain Prescription Rights?	
Yes	18
No	42
Unsure	22

2.6 Ethical Considerations

Ethical approval for this study was granted by the University of the West of England's, Faculty Research Ethics Committee (FREC) (Appendix C). In the online survey, on-screen participant information (Appendix D) was provided, in a printable format, which outlined the purpose of the study and what participation involved. All participants were provided with the researcher and supervisor's contact details prior to taking part in the survey. Participants were provided with an on-screen consent form

(Appendix E) and consent was obtained through an on-screen tick box, to protect anonymity. Participants were made aware of their rights to withdraw and encouraged to do so within one month due to constraints on retrospective withdrawal. Participants were then asked to create a unique identifier to respond anonymously, which ensured that they could request withdrawal of their responses after participation if they wanted. Although no risks were anticipated, there is always the possibility that participants may become distressed in response to a survey question. The information sheet included support lines should they be required by participants.

Qualtrics is recognised by UWE as a secure way to gather and store data. Once the study was closed, the data was downloaded, and the online survey was deleted from *Qualtrics*. Data that was saved on the researcher's laptop was on a password protected device and data that was printed was stored in a locked cabinet. I was the only person that had access to the data in its entirety with the supervisory team only having access to anonymised data. Data protection requirements that came into force in May 2018 were complied with throughout the study, the details of which are outlined on the information sheet. Any published work will only include anonymised extracts and demographic information will be reported in aggregate so that individual participants will not be identifiable.

2.7 Data Analysis

Data analysis was started prior to closing the survey whilst I simultaneously attempted to gain further submissions particularly from more experienced psychologists to diversify the sample as outlined at the end of the recruitment section. Thematic analysis is a method of data analysis where the researcher systematically identifies meaningful patterns across the data. I applied Braun and Clarke's (2006) six-phase reflexive thematic analysis using an inductive approach to identifying themes.

Phase one involved familiarisation with the data. I checked *Qualtrics* regularly to stay on top of new survey responses. As soon as survey

responses were submitted, I read and reread them in digital format to get an initial feel for the data. Once I had achieved 20 survey responses, I read through hard copies, and I made initial notes about things that interested me. I did not need to transcribe the data as it was collected digitally. Not transcribing the data and the volume and breadth of data collected meant immersion felt difficult and time consuming. It felt important to really take time and continually revisit this phase of analysis to ensure familiarisation with the data to aid the later phases of the analysis.

In phase two I started to manually generate initial codes on hard copies. I went through the data systematically, survey by survey, organising the data into meaningful groups, with a focus on anything related to participants views on gaining prescription rights. I then collated the codes together with data extracts into a word document. Once I collated the codes together, I examined whether there were overlapping codes that could be combined under one code or whether they were distinct enough to keep separate. As I left the survey open to try and diversify the sample, I moved between phase 1 and 2 in a recursive manner. My supervisor also coded some of the extracts independently which we collaboratively discussed in a reflexive manner to enrich the reading of the data (Braun & Clarke, 2019).

Phase three began once I had closed the survey and collated all coded data. This involved broadening my focus from codes to themes (Braun & Clarke, 2006). This was a process of analysing the relationship between the codes and how they may combine to form a theme. This involved moving between word documents containing tables of codes to mind maps on paper and clusters of post it notes. This was an overwhelming part of the process due to the sheer number of codes. There were various codes that did not seem to fit anywhere specific, so I followed Braun & Clarke's (2006) advice and temporarily kept these codes in a 'miscellaneous' word document. At the end of this phase I had 5 candidate themes and 1 miscellaneous theme.

Phase 4 involved 2 levels of reviewing to refine the themes further. First, I read through the collated extracts to ensure they were coherent and

'adequately captured the contours of the coded data' (Braun & Clarke, 2006). Some of the extracts did not fit where I originally envisaged and so were moved around into different themes which eventually led to a candidate thematic map (Appendix F). Once I was satisfied with the themes, I moved on to level 2 of this process where I looked at the themes in relation to the whole data set ensuring they were reflective of the data set as a whole.

In phase 5 there was further defining and refining of themes to try and capture the 'essence' (Braun & Clarke, 2006) of what each theme was about and how they related to each other and as such the thematic maps changed and developed alongside this process (Appendix G). Braun and Clarke (2006) advise against the themes being too diverse and complex, this phase was one which I continued to revisit to ensure the narratives were clear and consistent and related back to the research question.

Once the themes were clearly defined, I moved on to phase 6 which involved the final analysis and write up.

3. Reflexivity

Before I segue into the analysis, I want to introduce and position myself in relation to the research. This is an important step in qualitative research as the topics we find interesting are said to mirror who we are, therefore, any knowledge produced will reflect this (Braun & Clarke, 2013). In qualitative research our subjectivity can be used as a tool if it is thought about and considered through being reflexive (Etherington, 2004). This is often referred to as owning one's perspective (Elliott, Fischer & Rennie, 1999) and is considered a feature of quality in qualitative research.

There are three pillars to my engagement with this research: personal experience, professional experience, and the current BPS consultation. My personal relationship with the medicalisation of distress and psychiatric drugs stems from early family experiences. As a young person I was perplexed as to why people would take pills to address their feelings.

However, I did not have the language to be able to articulate this at the time, other than to label drugs as "bad". I believe these personal experiences unconsciously drew me to study an undergraduate degree in psychology and motivated me to embark on a journey to become a counselling psychologist. Therefore, my identity as a counselling psychologist is wrapped up in my personal experiences which I have attempted to unpack in personal therapy simultaneously to writing this thesis. This offered another forum aside from supervision where I could really explore my assumptions about this topic and how they may have influenced my research. When studying for my undergraduate degree in psychology I attended a lecture which drew me to counselling psychology. Ideas around the medicalisation of distress and key critical voices such as Joanna Moncrieff, Lucy Johnstone and Mary Boyle were introduced. Finding these voices helped me to start to nuance and articulate my views on the use of drugs in the treatment of distress, to begin to question the evidence base of psychiatric drugs, unpack issues around informed consent and to understand some of the problems with diagnostic constructs. This helped me shift from seeing these topics through a child's eyes and to develop my professional understanding.

Following the completion of my undergraduate degree I went out into the world of work. I believe these early work experiences were instrumental in developing my views on the use of psychiatric drugs in mainstream mental health services in the UK. What is important to note is that the stories I am about to tell are not rare and there are many that I could draw from. However, these are the ones that have stayed with me most. My first post was as a support worker on an inpatient unit. My role was to support clients to go out into the community. The funding for my post was assigned to one client. I was 21 at the time and my client was 18. She had been an inpatient for years with a diagnosis of schizophrenia and was medicated with Clozapine. At the time, I knew very little about this drug. However, she often seemed sedated and lethargic. Despite this, the ward nurses would insist that she would get up at 8am and make her bed. I remember being perplexed by this. The client had a significant trauma history and to my

recollection was never offered any therapy. I remember once we were talking about how she ended up being on this inpatient ward and she said she had been picked up drunk by the police one time and had not been let out since. She had very little resources available to her, but I honestly believe that if she did there would be grounds for a legal case, she had been completely failed by the system. Locked up, drugged up and institutionalised.

My next post was as a care coordinator for secondary mental health services. Part of my role was monitoring my client's drug regime's and organising and attending medication reviews with a psychiatrist. I started to become very familiar with different drugs and attending medication reviews meant I witnessed the spirit in which drugs were prescribed and the power imbalance between psychiatrist and client. It was during my time in this role where I learnt a significant amount about Clozapine. I wish I had had this knowledge when I was working on the ward so I could have felt able to question the inappropriateness of my client's Clozapine prescription, highlight the adverse effects she was experiencing or explore issues around informed consent.

There are many experiences that stand out to me in my role as a care coordinator but in particular was working with a middle-aged man who was also prescribed Clozapine. His perspective on how he came to be under mental health services and prescribed medication was that he was using a lot of recreational drugs in his 20s which caused him to "misbehave". He told me he was tried on a host of psychiatric drugs and eventually ended up on Clozapine as a last resort. By the time I met him, he was no longer using recreational drugs, he was renting a house with a long-term friend and had a job in a local shop. He also had some health problems that were being monitored and that he desperately wanted treatment for. However, doctors were reluctant to commence treatment for his health condition due to the interaction with Clozapine and felt it was preferrable that he waits until a new treatment becomes available. The client expressed to me that he felt he was being "fobbed off". His

health needs were not being met because of what seemed to be a fear of withdrawing him from Clozapine.

I have felt the weight of these experiences and many more whilst analysing the data and writing up this thesis. It is therefore important to acknowledge how my own frames of reference might limit the way the data is interpreted. I often felt frustrated by the survey responses that seemed oblivious to/ignorant of the socio-political context of the prescription rights debate and I have utilised supervision to consider my preconceptions to ensure I remained open to other frames of reference whilst engaging with the dataset.

The final pillar to my engagement with this research has been the British Psychological Society consultation which I outlined in the introduction. I developed my research idea in 2016, just before the consultation had started. At the beginning stage of this thesis the possibility of prescription rights for psychologists was nothing but a murmur. However, over the 5 years I have been conducting this research, the BPS consultation has developed in an almost parallel process. I have kept abreast of developments in this area via articles published in the *Psychologist* magazine or webinars organised by the BPS. I have tried to maintain a level of self-awareness during this process by journaling.

Following this process alongside developing this thesis led me to have some concerns over how the consultation was carried out. A key concern I had about the BPS consultation was that those who volunteer to be a part of a working group on this issue are likely to be those who have an interest in gaining prescription rights. It therefore follows that the consultation seemed to be heavily influenced by those views from the outset. It appears there was little space for those who were against prescription rights and the direction of the consultation and final paper appears to reflect this. In the introductory section I wrote about the BPS consultation, I quote Alison Clarke who calls for those opposed to prescription rights to step into an 'uncomfortable conversation'. However, as I have also outlined in the very same section, many attempts were made by psychologists against

prescription rights to communicate their concerns that have not been responded to by the BPS. Another key concern was the problems in retaining experts by experience although there is little detail as to why this happened and what, if anything, was done to rectify this situation.

I am concerned that psychologists were not surveyed for their views and that counselling psychologists were misrepresented. I attended a presentation on the prescription rights consultation at the annual DCoP conference in 2019 which ran alongside many other interesting seminar opportunities (it was not compulsory and made up a very small part of the programme). The attendees comprised of a small group of counselling psychologists. This presentation offered the pros of prescription rights for psychologists. At the end of the presentation, the presenter (a member of the task and finish group) asked the attendees to raise their hand if they agreed or disagreed that psychologists should gain prescribing rights with the option of abstaining. This was then written into the consultation paper as a "survey of counselling psychologists" which I believe is misleading. This seemed to assume that those who attended this presentation were representative of the views of counselling psychologists more broadly and required public acknowledgement of any views, in a session that was strongly based on practicalities rather than any philosophical concerns. This method raises issues such as social desirability bias whereby respondents answer questions in a manner that they believe will be viewed favourably by others. Respondents were only able to respond to this question based off the information they were given in the presentation and any prior knowledge they had.

Around a year later in late 2020, there was also a particular webinar that the BPS ran debating prescription rights for psychologists. Those that were meant to be on the webinar sitting on the "against" side of the debate were pulled by the BPS the day before and what ensued was again a very imbalanced "debate". As the BPS consultation appeared to become more and more in favour of prescription rights, I started to feel a weight of responsibility to give voice to psychologists who were against prescription rights during my analysis. However, I made sure to discuss this with my

supervisor to avoid falling into the same partisan trap as the BPS and to try and offer a somewhat balanced analysis of the data.

Finally, prior to submitting my thesis, I started to become very physically unwell. I was undeniably scared at the time and the symptoms significantly negatively impacted my quality of life. One appointment with my GP stands out to me, where I was waiting for MRI results. He did some generic checks and noticed that my pulse was high which he understood as "anxiety". He suggested that once my scan results came back, providing they were clear, I should consider medication for anxiety. I was shocked and expressed to him that I was scared because I was unwell and undergoing tests. I was subsequently diagnosed with a benign brain tumour and have undergone neurosurgery. I include this information as it happened prior to me writing my conclusion and this experience of my physical symptoms and the impact on my quality of life being disregarded, being labelled as an anxious woman, and being offered psychiatric drugs has undoubtedly impacted the lens through which I have finished my thesis. Not only that, but my GP is not a bad scary doctor who tried to drug me. I honestly believe this was the only way he knew how to help me. I think this illustrates how kind people, who are attracted to a helping profession can easily act unfavourably and as psychologists we are not immune to this. Coming back to this thesis after a year away from it and a life changing experience has been incredibly challenging, my perspective on life and what is important has undoubtedly shifted which has perhaps led to a different conclusion than would have been written otherwise but that I hope enriches the thesis.

3.1 A Note on Language

One of the difficulties when writing in the realm of human distress is the question of language. Terminology such as 'mental health disorders', 'mental illness', 'medication', 'treatment' etc. carry connotations. This was something I grappled with throughout the write up of this thesis and particularly in the development of the survey. Not only did I grapple with this, but many of the participants did in their survey responses. These

terms are so dominant and entrenched both in the mental health system and wider society that they are hard to get away from without risking becoming incomprehensible. This came to light early on in recruitment when I originally used the term 'drugs' instead of 'medication' in the survey which led to a participant misunderstanding the entirety of the survey and eventually withdrawing, this led me to change the wording of the question to 'medication'. Much to my discomfort I have also settled on using medicalised language particularly in the survey such as 'mental health problems' and 'disorders'. Whilst this is not an uncritical acceptance of this kind of language it speaks to how these terms are so dominant in practice that it is a struggle to disentangle oneself from the medical model despite constructing myself as a critical psychologist who is opposed to the medicalisation of distress.

4. Findings and Discussion

4.1 Summary of Data

The analysis led to the development of an overarching theme which sits as an umbrella over the four main themes, as shown in Table 2 (see also Appendix G).

Table 2

Table of Final Themes

Overarching Theme - Gaining Prescription Rights: A Crossroads in the Professional Identity of a Psychologist "why try on someone else's clothing? Ours is fine"			
Theme 1: **Assumptions about Psychiatric**	**Theme 2:** **A Quest for Status and Power**	**Theme 3: The** **Relationship Between Drugs and**	**Theme 4:** **Learning about drugs is more than just**

Drugs "it's an inexact science"		Therapy "bringing meds into the mix"	learning about drugs

4.2 Gaining Prescription Rights: A Crossroads in the Professional Identity of a Psychologist *"why try on someone else's clothing? ours is fine"*

The story of the whole data can be captured in the overarching theme *"why try on someone else's clothing? Ours is fine"* [Participant 74, Clinical Psychologist]. This captures the way in which psychologists grapple with their professional role identity both as a result of the prescription rights debate, and in spite of it, particularly when trying to fit into existing NHS structures. It also brings into focus questions, musings and reflections that are as much about what participants consider psychologists do, or should do, as they reveal who they are as people.

For many participants grappling with their professional identity is not a new issue resulting from the prescription rights debate; this is something that they are continuously battling when trying to integrate themselves into systems dominated by the medical model as captured by the quote below:

> *"I would hope that prescribing could be assimilated into the ethos of a psychologist, rather than the role of the psychologist becoming overly medicalised. Although, the role of the psychologist is already increasingly medicalised so I suspect it would push the psychologist more into a 'diagnosis then treat' role (rather than formulate with the individual and work within the therapeutic relationship)"* [Participant 29, Counselling Psychologist]

For this participant a psychologist's role is already much influenced by the medical model. Research has suggested that psychologists of a psychosocial orientation who work in the mental health system face 'conflict, compromise and collusion' in relation to the medical model (Cooke, Smythe & Anscombe, 2019). The participant above speculates that

gaining prescribing rights would further take the role in the direction of collusion.

Gaining prescribing rights for many of the participants also meant adopting the medical model of mental health and a diagnostic framework which did not sit comfortably for many of them due to concerns that it would medicalise the profession. The BPS consultation paper into prescribing rights for psychologists has confirmed that due to the way medications are licensed, psychologists would need to diagnose clients in order to prescribe medication (BPS, 2019a). There were concerns about what this would mean for them personally with many participants describing a sense of incongruence should this happen but also how it would affect the perception of psychology by others.

> *"I feel as though counselling psychologists would be firmly placed within the 'medical camp' which I feel slightly uneasy about"* [Participant 46, Counselling Psychologist]

> *"I would worry that society may begin to see psychologists as more aligned with the medical model"* [Participant 47, Clinical Psychologist]

> *"It may skew the profession to increased medical discourse and practice"* [Participant 31, Counselling Psychologist]

This could be understood an overt collusion with the medical model rather than a psychosocial approach to mental health. For many participants there was a clash between the philosophical underpinnings of the medical model and a psychological approach. This tension between the philosophical stance of psychologists, and the practicalities of carrying out their role as practitioners is clearly demonstrated by the following participants:

> *"I feel on the fence as I'm not sure how helpful it would be in my current role and I think medication use does not largely fit with psychological and trauma informed understanding of mental health difficulties"* [Participant 47, Clinical Psychologist]

"Giving a prescription also feels at odds with my philosophical underpinning of the value in psychology – seeing the person as trying to do the best they can in this world, with the experiences they have had and trying to help them understand that they are a product of their experiences and there is nothing wrong with them" [Participant 41, Counselling Psychologist]

"Conceptually it does not sit well, in the way I understand psychological distress" [Participant 78, Clinical Psychologist]

"The prescriber role views the client as a body that needs moderation and control. The therapist views client as a person struggling with problems in living" [Participant 42, Counselling Psychologist]

The participants above do not necessarily outline or define their 'psychological approach'; however, they make it clear that it does not sit well with the medical model. A psychosocial model provides a helpful alternative to understand the responses above. It has been defined as a framework that removes biology from the position of privilege in favour of a focus on the relational, interpersonal, and social contexts of distress (Boyle, 2007). One of the participants refers to a 'trauma-informed' approach. Trauma informed approaches have been largely influenced by research into adverse childhood experiences (ACEs) that found the more adverse events a person is exposed to in childhood, the greater the impact on physical and mental health (Felitti et al., 1998). The importance of considering an individual's history and circumstances when formulating their mental health difficulties is highlighted by the following quote:

"We might be seen as colluding with the idea medication is the answer rather than looking at the causes of mental health issues such as poor housing, poor education, poverty, families engage in abusive patterns etc etc…" [Participant 1, Clinical Psychologist]

Medication seems to be perceived as a short-cut that bypasses these wider issues, a position that seems at odds with the participants' own ethical stance as a practitioner. This speaks to the importance of social justice for

63

many counselling and clinical psychologists (Tribe & Bell, 2018; Zlotowitz, 2018).

One of the many issues that participants highlighted was how prescribing would blur boundaries between psychiatry and psychology and lead to role confusion. For some participants they believed that the public were confused about the difference between a psychologist and psychiatrist and so gaining prescription rights would further contribute to this confusion, whereas for other participants they felt it would make little difference.

> *"The general public are already confused about the difference between the various 'psy' professions so not sure if this would muddy the waters further or whether practically it would make little difference" [Participant 21, Clinical Psychologist]*

The participant above gives an impression of ambivalence towards role confusion, but the lack of clarity around roles highlights an undercurrent of battling for professional identity when operating within existing systems. For some participants gaining prescription rights was not the direction that they believed psychology should be going in and was not what *"being a psychologist is about"* [Participant 41, Counselling Psychologist] as it goes against the foundations of their training as outlined in the quotes below.

> *"Our profession should be moving away from the medical model rather than embracing it [Participant 33, Clinical Psychologist]*

> *"Why try on someone else's clothing? ours is fine - we just need to dress more appropriately for the fashions of the day, and tidy up our act a little...it's ridiculous - if you want to prescribe, then to put it crudely, fuck off and be a medic, or a nurse prescriber - this ain't the profession for you" [Participant 74, Clinical Psychologist]*

> *"I cannot fathom why any psychologists who understood everything they did in their doctoral training would want to prescribe. This constitutes madness in a system" [Participant 44, Clinical Psychologist]*

Many psychologists constructed their role as offering an alternative, or even a direct challenge to the medical model which they believed to be a strength of the psychologist. In the quote above "madness" is used to describe the system, which paradoxically might label distress in this way, therefore there is a clear rejection of those who seem to want a foot in both camps. According to these participants a psychologist prescriber is an oxymoron, you cannot both embrace the medical model of distress through prescribing medication whilst holding the understanding of distress developed through training as a psychologist. The last quote (participant 44) insinuates that there is a depth to clinical training that is perhaps missed by those who would want prescription rights after having completed it.

Having something different to offer to the medical model and psychiatrists was constructed as a strength which is demonstrated in the following quotes:

> *"Our strength is in providing something different to the medical model"* [Participant 8, Counselling Psychologist]

> *"It may impede our useful role where we act as a cautionary voice in a team, offering an alternative perspective to the medical model"* [Participant 31, Counselling Psychologist]

> *"Psychologists currently often adopt the role of holding a psychosocial perspective in what are often very medical model dominated contexts. If they have prescribing rights the danger will be that this focus is diluted"* [Participant 49, Clinical Psychologist]

The participants above position themselves not only as practitioners able to offer an alternative understanding of distress to clients, but also as important voices within multidisciplinary teams. This role is perceived as an important place for advocacy for the client, offering a wider perspective to other professionals. There seems to be some fear that the power of this voice could be lost if that message is "diluted" through stepping into a more medical role.

There was also concern that an increase in prescribers would jeopardise alternative interventions to psychiatric drugs such as psychotherapeutic work and would further obscure social determinants to mental health. These participants again demonstrate a strong social action element to their role as psychologists, with concerns over how this may be jeopardised by prescribing rights:

> *"Therapy is becoming more accessible, and I think a surge in another profession offering medication could jeopardise this movement" [Participant 46, Counselling Psychologist]*

> *"This runs the risk of undermining social awareness of the ways in which social contexts, discrimination and oppression are key causes of distress and should be attended to and tackled if we are going to really attend to human distress" [Participant 31, Counselling Psychologist]*

Fear of dilution of psychology's perceived strengths was not just a concern regarding existing roles, but also the ongoing development of psychologists. These participants were concerned that if they had prescribing rights inevitably something in their role and training would be lost to enable this to happen. Many participants believed that they would lose psychotherapeutic work, formulation, and reflective practice which is demonstrated in the quotes below:

> *"We may also be at risk of losing the therapeutic input we can offer – if our roles are expanded to include prescribing then something else in our current role would have to give to make way for this" [Participant 7, Clinical Psychologist]*

> *"It could put added pressure on the psychologist and eat into therapeutic time" [Participant 8, Counselling Psychologist]*

> *"Nobody can know everything, and I know that if I had to learn psychopharmacology, I would have to sacrifice some time and learning away from psychotherapy" [Participant 77, Clinical Psychologist]*

Despite some strongly held views on the incongruence between psychology and prescribing, this was not the only stance on gaining prescribing rights. Some participants framed the additional responsibility through the biopsychosocial model of mental health and considered it is possible not only to assimilate prescribing into their role but to also see how it may enhance their practice. The biopsychosocial approach posits that there are biological, psychological, and social determinants to distress (Douglas, 2016). This biopsychosocial approach was positioned by many participants as the gold standard and something which they deemed to be valued by clients. It seemed that many participants felt that they were lacking the 'bio' element and thus prescribing rights would enable them to offer a more holistic approach to their clients.

> *"It is possible that a more comprehensive treatment, based on biopsychosocial models may enhance the relationship" [Participant 65, Counselling Psychologist]*

> *"It could enhance the relationship as it could be incorporated into the treatment plan – fully exercising a bio-psycho-social approach to treatment – we promote psychological and social interventions why not ones which support the bio bit too when considered appropriate in line with formulation" [Participant 20, Clinical Psychologist]*

Many participants expressed that psychology could benefit from more focus on the 'bio' part of the biopsychosocial approach through the use of prescription rights. However there seems to be a lack of acknowledgement of the other ways in which psychologists might incorporate biology into their work. For example, psychologists working within a trauma informed framework acknowledge the role of threat responses such as fight/flight/freeze which can be understood and responded to with psychological strategies. The term biopsychosocial approach can mean various things within mental health settings; however, it has been suggested that when used the 'bio' element is prioritised to a point where it becomes the 'bio-bio-bio' model in practice (Sharfstein, 2005) leading to the psychosocial being obscured.

For these participants, there was a niche for psychologists which could involve de-prescribing, an opportunity to change the narrative around medication, offer continuity of care and formulation driven prescribing. There was a sense that these participants felt that this was something they could do better than their psychiatry colleagues.

> *Remove the bias against medication: allow conversations about why not to take medication and improve understanding of the function and limitations of medications when they are prescribed (no other professions explain the function) [Participant 19, Clinical Psychologist]*

> *"We are already able to take on some traditional psychiatry roles but my experience of this has been that psychologists take a different stance to psychiatry and would heavily advocate psychosocial options above medical ones - I think this would be reflected in prescribing" [Participant 76, Clinical Psychologist]*

> *"I would support prescription privileges and the right to reduce/withdraw medication" [Participant 17, Clinical Psychologist]*

The idea of supporting prescription rights with the view of being able to reduce/withdraw medication was an appealing one for many of these participants. However, the literature relating to prescribing psychologists in the US contradicts this view. Research has shown that prescribing psychologists in the US were equally likely to increase and decrease the number of medications prescribed on their most recent workday (Linda & McGrath, 2017). This highlights the way in which assumptions about how such responsibilities are managed, and the reality in practice can differ. The participants in this study were relying on the imagined consequences of any change in role, rather than drawing on evidence, and therefore the biopsychosocial approach was discussed in the context of perceptions that expertise was limited to the psychosocial. There seemed to be an assumption that the psychosocial approach would still hold a privileged position even once they developed further expertise in the "bio" through prescription rights.

The identity of a psychologist which has been explored in the overarching theme connects with all the other themes. Participants' assumptions about psychiatric drugs are driven by their knowledge and experiences both personal and professional. For example, some participants had experiences of psychiatric drugs personally and this linked to their motives to become a psychologist, which frames their professional identity. Whilst many participants believed that prescribing rights would increase their status and power this ultimately led to a change in their professional identity, which is explored in the second theme. In the third theme for many psychologists the type of therapy they utilised or whether they considered themselves a therapist at all influenced the lens through which they understood prescription rights. Finally, most participants acknowledged the need for a psychologist to have knowledge on psychiatric drugs, without necessarily having prescribing rights. Participants nuanced the type of knowledge that fit best with how they understood their role as a psychologist and therefore was of most importance to them. Increased knowledge was seen as enhancing a psychologist's identity which is further explored in the final theme.

4.3 Theme 1: Assumptions about Psychiatric Drugs "it's an inexact science"

This theme will capture participants views and assumptions about psychiatric drugs. It explores participants' views on how psychiatric drugs work, and how, where, and why they are prescribed. Participant's views and assumptions about psychiatric drugs very much influenced whether they believed psychologists should gain prescription rights. This is perhaps an unsurprising finding, nonetheless it is important to document it within a qualitative paradigm.

The utility of psychiatric drugs is very much influenced by how one makes sense of mental distress.

"I am aware that I hold quite strong views against the medical model, which influences whether I think psychology should be involved in prescribing" [Participant 12, Clinical Psychologist]

"If this were imposed upon me, I would feel: 1) incongruent, and would need to grapple with my personal and professional beliefs about medication" [Participant 5, Counselling Psychologist]

There was a relatively small number of participants who overtly subscribed to what Moncrieff explains as a 'disease-centred model of drug action'. A disease centred model of drug action assumes that psychiatric drugs work by targeting and reversing an underlying chemical imbalance or brain abnormality (Moncrieff, 2008b).

"Medication is used in a variety of ways to treat symptoms of a disorder, or in some instances, address an underlying biological cause" [Participant 17, Clinical Psychologist]

"I believe that sometimes depression and other mental health difficulties are caused or affected by lowered hormone chemical levels such as serotonin and medication can help increase the levels and result in more stable mood" [Participant 38, Counselling Psychologist]

Generally, participants understood psychiatric drugs from a 'drug-centred model of drug action' (Moncrieff, 2008b). A drug centred model assumes psychiatric drugs exert psychoactive effects in everyone regardless of whether they have a psychiatric diagnosis. These effects can interact with symptoms of mental distress.

"Medication is often used to alter the state of mind the person is experiencing" [Participant 45, Counselling Psychologist]

"I am sceptical as to whether medication 'corrects' a chemical imbalance given the differing responses people have to medication and the unhelpful side-effects many people report" [Participant 48, Clinical Psychologist]

Many participants understood psychiatric drugs as something that addressed "symptoms". Symptoms is a term borrowed from medical practice. In the realm of physical health the word symptom indicates a condition or disease. For example, a headache may be a symptom of dehydration, vitamin deficiency, sinus infection or brain tumour amongst many other things. This perhaps demonstrates the messiness of language in the realm of mental distress. On the one hand participants were expressing that psychiatric drugs do not address a root cause, generally speaking to a psychological model of distress whilst using the word symptom which speaks to a medical model.

> *"It* [medication] *is generally used to treat symptoms rather than underlying causes of distress" [Participant 3, Clinical Psychologist]*

Participants expressed that in their experience psychiatric drugs were generally the first line of treatment offered to people experiencing mental distress and it was utilised in this way in most settings including primary care, secondary care, and inpatient settings:

> *"Traditionally used as a first line intervention" [Participant 20, Clinical Psychologist]*

> *"They [medications] are prescribed by doctors and are widely used as a front-line defence in General Practice as well as psychiatric services" [Participant 27, Counselling Psychologist]*

> *"Medication is often used as a front line, initial attempt to help people suffering from psychological distress" [Participant 31, Counselling Psychologist]*

Research suggests that for many it remains the only intervention on offer (Beresford, Perring, Nettle & Wallcraft, 2016). There were various reasons as to why participants believed psychiatric drugs were prescribed so frequently for psychological distress. Participants generally expressed that due to the emphasis on psychiatric drugs in mental health systems as a first line option that clients are not given a choice over interventions.

Despite many of the participants being overtly critical of the medical model and a disease-centred model of drug action, many expressed "there was a place" for psychiatric drugs.

"It would be naïve and over simplistic to negate the entire value of medication in the field of mental health" [Participant 2, Clinical Psychologist]

"I certainly believe that medication has a useful role to play" [Participant 10, Clinical Psychologist]

"There is no purity in not using medication" [Participant 14, Counselling Psychologist]

This finding suggests that it is ill-advised to express practitioners' views on psychiatric drugs as singularly for or against and calls for nuancing what exactly is their "role" or "place".

Many participants understood psychiatric drugs to work in a "sedative manner". In line with this, an area in which participants expressed psychiatric drugs could be useful was risk management as outlined by the participants below:

"I think if the mental distress is extreme and affecting someone's ability to function, live life and risks to self/others are high then drugs can help calm symptoms" [Participant 6, Clinical Psychologist]

"I certainly believe that medication has a useful role to play, particularly when people present with very serious mental health related difficulties that put themselves or others at risk" [Participant 10, Clinical Psychologist]

The idea that those who are labelled mentally ill are considered dangerous (Foucault, Baudot & Couchman, 1978) is a construction that has preceded to the modern day. Parker et al., (1995) suggest that the Conservative government have conjured up an image of the mad and dangerous individual requiring confinement. Secondly, the use of psychiatric drugs in this way challenges the idea that modern psychiatric drugs have become

more complex and specific. Criticisms of past psychiatric drugs were that they were no more than 'chemical forms of restraint' (Braslow, 1997) or 'chemical straightjackets' that were used as a form of social control (Szasz, 1960). The history of psychopathology involves a time when people with emotional problems were constructed as deviants and the rise of the psy-professions occurred within a context of 'correcting' those deviants and bringing them back into the realms of 'normalcy' (Parker et al., 1995). Although it is unlikely that any clinical or counselling psychologist would consciously take this position now, there are perhaps remnants of this history when faced with issues around safety.

Risk is a broad area and participants are likely to have a variety of experiences in relation to risk management depending on the context that they have worked which could shape their views on the use of medication. For example, psychologists who are experienced in working in inpatient units, forensic settings and crisis teams are more likely to have worked with people who are in a highly distressed state and considered a serious risk to themselves or others. Anti-psychotic drugs are often used in these situations, to calm and subdue people who are considered agitated or aggressive (Moncrieff & Stockmann, 2019) which is sometimes called rapid tranquilisation and most used in acute inpatient settings. It has been suggested that within a medical context such as an inpatient unit compulsory measures such as forced admission, restraint and forced medication are seen as necessary for risk-management (Prytherch et al., 2020). However, service-users often experience these measures as highly distressing and traumatising (Lees et al., 2014). A medical approach is not the only approach to risk management. Research into service-user experiences has suggested that in the long-term a trauma-informed, relational approach to risk management was felt to be more effective (Prytherch et al., 2020). This challenges the view of the participants above (participant 6 & 10) and perhaps shines a light on the type of contexts and practises they have been exposed to where this sort of response to risk is normalised.

Participants referred to the prescribing of psychiatric drugs as an "inexact science" and as such called for prescribing to be individually tailored and client centred. This view of prescribing challenges the disease-centred model of drug action (Moncrieff 2008a), and drug specificity. Instead, it speaks to Moncrieff's drug-centred model of drug action.

> *"It's an inexact science in my opinion because different substances affect different people in a different way" [Participant 23, Counselling Psychologist]*

> *"As a clinician, I've seen medication be very helpful for some clients (and several regard it as life-changing) and yet it has been unhelpful for others" [Participant 2, Clinical Psychologist]*

> *"I believe that medication needs to be thought about on an individual basis rather than any assumptions made based on diagnosis" [Participant 48, Clinical Psychologist]*

Some participants assumptions about psychiatric drugs were influenced by their personal experiences rather than solely a reading of empirical literature on efficacy. This is outlined by the participants below:

> *"I think one thing that really influences all of my answers is that I have never used psychiatric medication myself even when a therapist recommended that I should consider it as an option. Growing up, I saw how medication was used frequently/daily to numb feelings of stress or anxiety or to aid sleep/mood. For me it was so important that I felt my feelings even when, on reflection a low-level dose of anti-anxiety medication could have been helpful at times of very heightened stress/worry in my life. Without a doubt I bring that personal template of medication into my work as a therapist. I no longer view it as entirely negative, but I do and will always consider that connecting through the process of talking therapy a more powerful tool than medication" [Participant 46, Counselling Psychologist]*

"I have lived with experience of mental health issues in the past and in the present. I have also taken medication and being diagnosed both helpfully and unhelpfully". [Participant 28, Counselling Psychologist]

"I have also utilised medication myself, so this is more than a professional assessment, but also something I have had the chance to experience myself". [Participant 31, Counselling Psychologist]

This idea has been researched under the umbrella term of 'the wounded healer' and it is a concept that has entered a variety of mental health professions (Kirmayer, 2003; Farber, Manevich, Metzger & Saypo, 2005; Barnett, 2007; MacCulloch & Shattell, 2009). For many counselling psychology trainees, it is an idea that is introduced in their professional training (Hadjiosif, 2021). There has been research in this area by counselling psychologists (e.g., Martin, 2011; Hadjiosif, 2021). It is interesting then that only counselling psychologists spoke in these terms in their responses. This supports the idea that this is a hallmark of counselling psychology practice with personal therapy being a requirement of counselling psychologists in training and beyond (BPS, 2019b) and a commitment to a relational 'use of self' in therapy which is a requirement of counselling psychologists only in the HCPC standards of proficiency for practitioner psychologists (HCPC, 2021).

4.4 Theme 2: A Quest for Status and Power

In this theme I explore how participants viewed the acquisition of prescription rights as a means for psychologists to gain increased status and power in the workplace and wider society. I explore what status means for the participants and how they constructed psychologists' status and power in relation to other professions, namely psychiatrists. Overall, there was a sense of ambivalence in the data towards increased status and power and this theme demonstrates how participants grapple with what they may gain or lose as a result.

Status refers to the relative level of respect, honour, assumed competence and deference afforded to people, groups and organisations in society (Anderson, Hildreth & Howland, 2015). It is different from power which is defined as the ability to influence others through the control over resources or the capacity to punish (Anderson, Hildreth & Howland, 2015). They are often associated, such as when people who are considered as possessing valued characteristics are placed in positions of leadership and authority and given control over resources (Blau, 1964).

There were frequent references to status throughout the data, with many participants speculating that prescription rights would bring increased status for psychologists within the hierarchical structures of the National Health Service (NHS) and society more broadly.

> *"Some may think it [prescription rights] adds to a psychologist's status, authority and respect" [Participant 9, Counselling Psychologist]*

> *"Hopefully, it would increase our standing in society's eyes as prescribing is rightly or wrongly viewed as prestigious" [Participant 28, Counselling Psychologist]*

In the first quote the participant is speculating that others may consider that prescription rights will lead to increased status. In the second quote participant 28 expresses hope that it would increase their own status due to the assumption that society considers prescribing as prestigious. This was common throughout the data set with some participants acknowledging that status and power were something they wanted for themselves, whereas others speculated that this was the motive behind other psychologists' desire for prescription rights.

The type of status that was assumed to be afforded to psychologists should they gain prescription rights varied across participant responses. Some participants wrote about prescription rights leading to and maintaining financial status.

"It [prescription rights] would seem to me like a power grab on the medical profession, presumably to justify being paid more?" [Participant 64, Clinical Psychologist]

The participant above is linking the desire for prescription rights with a quest for power. Power is something they perceive to be possessed by the medical profession and is portrayed here as something psychologists might seek with the primary motivation of earning more money.

"Could be helpful in protection and promotion of our profession overall in the long run, particularly in maintaining higher bandings" [Participant 43, Clinical Psychologist]

In this quote the participant contemplates the usefulness of gaining prescription rights particularly in relation to maintaining higher pay. The use of the term bandings indicates they are referring to the NHS pay system. Agenda for Change (AfC) is the main grading and pay system for NHS staff except doctors, dentists, and senior managers (Royal College of Nursing, 2018). It is said to harmonise pay scales and career progression arrangements across traditionally separate pay groups. Job posts go through an evaluation process where several factors are considered such as training, experience, responsibility, and effort (Royal College of Nursing, 2018). Posts are then either matched to a national profile and its band or further evaluated if there is no suitable profile to match (Royal College of Nursing, 2018). Jobs are banded 1-9, the higher the band, the higher the salary. A quick search through NHS job adverts shows that independent nurse prescribers are paid at a band higher than non-prescribing nurses. However, nurse prescribers have reported that they felt the introduction of nurse prescribing was to save money by getting nurses to do the same job as doctors but without the financial recognition (Ross & Kettles, 2012). Therefore, prescribing rights does not necessarily mean financial parity with medical doctors. The banding of roles in the NHS creates a hierarchical structure where skills are graded and those considered most valuable are financially rewarded. The participant below acknowledges that in a context where the medical model dominates, such as the NHS, prescribing rights

would be a skill that is valued which would afford them more power and status in this hierarchical structure.

> *"Within the dominant medical model, a psychologist will gain power and prestige. They will also be seen as higher in the hierarchy"* [Participant 11, Counselling Psychologist]

Throughout the data set participants compared their status to other professions – namely psychiatry. Participants regarded psychiatrists as having more status both in society and the National Health Service (NHS) mainly due to their medical training. This speaks to the dominance of the medical model and the high esteem in which medicine is held within the Western world.

> *"I think that Western society, generally speaking, perceives psychiatrists as more qualified for treating severe mental health problems"* [Participant 11, Counselling Psychologist]

Research into public perceptions of psychiatrists and psychologists suggests that psychiatrists were perceived as having more authority and power and were associated with more 'complex' presentations (Patel, Caddy & Tracy, 2018). Despite most counselling and clinical psychologists training to doctoral level, participants expressed a lack of status comparatively to psychiatrists. This was illustrated by participant 35 where she gives an example of a situation that arose on placement:

> *"I had a placement at a hospital some years ago and when I asked for Dr…. (My clin psyc supervisor) the ladies on reception were aghast and quite rude loudly saying 'he's not a doctor'. This was in a medical setting of course."* [Participant 35, Counselling Psychologist]

The prefix Dr is bestowed upon clinical and counselling (among other) psychologists as an academic qualification. This participant is highlighting that despite being trained to doctoral level and being afforded the Dr title, within a medical setting the lack of medical training means it is disregarded.

Several participants referred to psychology as an easy or 'soft' subject in the eyes of the public and that this leads to a lack of recognition of a psychologist's skill set.

> *"I am perhaps a little sensitive about the "easy subject" label all too often attached to psychology. Whilst it is certainly NOT the main motivating factor for me, I do feel anything that enables the wider public to see the complexity of what we do is to be welcomed."*
> [Participant 30, Clinical Psychologist]

Whilst this participant denies that this is the main motivating factor for her to welcome prescription rights, in her view being able to prescribe would create an impression of 'complexity' and therefore difficulty, legitimising the psychologist as a skilled professional. For this participant, the objective is to refute any perception that her profession is an 'easy subject' as she welcomes opportunities to change its public image. This mirrors psychology's historical concern with scientific approaches to establish its credibility (Parker & Shotter, 1990; Hadjiosif, 2019). However, in her view psychology is still considered a soft subject. Research indicates other fields of scholarship as well as the general public question whether psychology is a 'real' science (Fergurson, 2015).

> *"Psychology has often historically been seen as a 'soft' discipline, a bit waffly with many brands of theories and not rigorously scientific. This push toward specialism might be a cry for attention, for others to take us seriously as applied psychologists with gravitas! Will other professionals treat us like doctors? And is this a good or a bad thing?"* [Participant 61, Counselling Psychologist]

This participant also acknowledges the perception of psychology as a 'soft' discipline and associates prescription rights with specialism. She speculates whether this is a quest for psychologists to be taken more seriously. However, she questions whether prescription rights would result in other professionals treating psychologists the same as doctors and demonstrates ambivalence and uncertainty around the consequences of this.

"The awarding of prescription privileges wouldn't guarantee that psychologists would be treated in the same way as other professions necessarily" [Participant 57, Counselling Psychologist]

The participant above also challenges the notion that prescription rights would lead psychologists to be treated the same as other prescribing professions. Although they do not elaborate, one could speculate it could be due to the lack of medical training. Perhaps instead psychologists would be seen as attempting to imitate psychiatrists which could then undermine their skills and place them in an auxiliary position relative to the 'real' experts, the psychiatrists.

"It would undermine the value of a psychologist and I think professionals would see us as inferior psychiatrists" [Participant 63, Clinical Psychologist]

"Yes, it would reduce the distinctiveness of the psychologist's role, in some respects encouraging the view that they are a psychiatrist's assistant" [Participant 72, Clinical Psychologist]

"Medics might see it as encroaching on their role. But, being a resilient profession I think it more likely that they would soon find a way to use prescribing psychologists as hand-maidens (much like nurse prescribers are already) to do some of the routine, uninteresting and unrewarding work" [Participant 77, Clinical Psychologist (ex-MH nurse)]

These participants speculate that psychologists would be seen as inferior assistants to psychiatrists, something that would both undermine psychologists' value and reduce the distinctiveness of their role. Participant 77 describes psychiatry as a 'resilient profession' suggesting an ability to bounce back from adversity, in this case psychologists encroaching on their role. She speculates that psychologists would instead become 'hand-maidens' to psychiatrists. Parker et al., (1995) argue that the power of psychiatry is largely due to its ability to force psychologists and other professionals who are not medically qualified to 'play supporting parts'. These participants appear dubious that this would change should

psychologists gain prescribing rights. If anything, they argue it is a position that would be further cemented.

In relation to acquiring increased status and power, the overall sense across the data was one of ambivalence. As I have already partly demonstrated, some participants appeared to value the idea of increased status and power when considering what this would enable them to do, others rejected it when considering what they might lose, and some appeared to grapple with the pros and cons and expressed mixed views. A common consideration was what prescription rights would mean for the power differential in the therapeutic relationship. The medical model positions the doctor as expert who diagnoses, treats, and cures the passive patient, a stance which is at odds with the relational turn that is emblematic of counselling psychology (Douglas, 2016).

> *"Where do I begin?! The most obvious thought is about power dynamics here, are we as therapist-prescribers going to disempower our clients massively? Surely we will then be buying into the medical model of 'illness', labelling our clients as unwell, other, damaged, defective in some way, validating the sick role. CoP's foundations are based upon a humanistic ethos, where we 'work with' and not 'do therapy to', so how could we be expected to be with our clients, open and curious to their experiences and what has happened to them, while titrating up/down their doses of meds and being in control of this for them?"* [Participant 61, Counselling Psychologist]

The participant above talks specifically about the therapeutic relationship in relation to counselling psychology. With its roots in humanism, counselling psychology rejects the expert position and prioritises the helping relationship (Woolfe, 2016). The participant seems to be grappling with how this humanistic ethos and the medical model, with two opposing value bases, could be integrated. Research into public perceptions has suggested that power was considered a key aspect of a psychiatrist's authority to instigate involuntary treatment which was associated with less therapeutic alliance (Patel, Caddy & Tracy, 2018).

Participants also considered the impact of increased status on their relationships with colleagues, particularly psychiatrists.

> *"I think the relationship with psychiatrists will become strained due to the political implications this could have for their occupation"* [Participant 22, Counselling Psychologist]

> *"I think it might make it feel difficult working with psychiatry colleagues given that medication is their area of expertise"* [Participant 47, Clinical Psychologist]

These participants seem to be speculating that prescription rights would lead psychologists to encroach on psychiatry's territory which would result in tensions between the professions. Prescribing has traditionally been the sole domain and expertise of the medical profession and is perhaps one of the most distinctive parts of their professional identity. Professionals who are recognised as experts in a certain area, in this case psychiatrists in prescribing medication, possess a form of cultural capital whose ownership confers status and power (Mclaughlin & Webster, 1998). The expansion of prescription rights to psychologists touches on issues of professional domains and competition between professions for jurisdiction over tasks (Kroezen, Dijk, Groenewegen & Francke, 2013). Authority over certain tasks is important because livelihoods depend on it, without it, psychiatrists could be considered redundant (Bechky, 2003). There was no suggestion in the dataset that instigating a 'turf war' with psychiatry is a welcome implication of the prescription rights debate.

However, some participants seemed hopeful that prescribing rights would mean their opinions would be taken more seriously by other members of the team.

> *"I think it would help psychologists to be taken more seriously if they were authorised to prescribe medication and demonstrate a solid working knowledge of drugs"* [Participant 17, Clinical Psychologist]

In response to a question about professional relationships the participant above assumes that prescribing rights and increasing their knowledge on drugs would lead to them being taken more seriously by their colleagues. Not only this but participants argued that this knowledge would give them the power and authority to challenge over-prescribing and medicalisation of distress.

> *"The knowledge that goes alongside prescription rights could also give extra leverage to resist overuse of medication and strengthen our unique position"* [Participant 30, Clinical Psychologist]

> *"You can effect change from the inside easier than from the outside… If we have the right to prescribe, we are more likely to be perceived as being able to lead on mental health pathways and imagine a mental health system that is psychologically driven and led- it may have some prescribing psychologists in it but they are likely to prescribe less and more promptly… far from being a threat, psychological prescribing in the UK could be the greatest opportunity the profession has to progress and influence a more psychologically informed society and mental healthcare system"* [Participant 43, Clinical Psychologist]

Participants seemed to see the acquisition of prescription rights as a way of enabling them to affect change from the inside. This increased status would mean that psychologists would be trusted to lead in mental health services which could lead to a more psychologically informed service and the increase in power would give them more control over resources. What seems striking is that although psychologists frequently inhabit leadership positions within mental health services in the NHS, with this being a focus in both clinical and counselling psychology training, this does not seem to be reflected in participants' responses, which communicate psychologists' perception of being powerless to instigate change. Despite many of the participants not wishing to pursue prescription rights they still expressed a desire for increased status and recognition. This was usually expressed when they talked about their hopes for the future of the profession and a

desire to see more psychologists in leadership positions and to gain parity with or even supersede medics.

> *"Being heard and not just feeling like an added extra in an MDT"* [Participant 51, Clinical Psychologist]

> *"For psychologists to be understood as equals in knowledges and expertise with psychiatrist"* [Participant 51, Counselling Psychologist]

> *"To be given parity with medicine and truly valued"* [Participant 44, Clinical Psychologist]

> *"That psychology will be the leading profession on mental health care, and for psychiatry to be an option in a person's treatment plan"* [Participant 56, Counselling Psychologist]

Participants also speculated about where this desire for prescription rights was coming from.

> *"Maybe they [psychologists seeking prescribing rights] are just pursing a narcissistic quest for power as a result of feeling marginalised by psychiatrists within a very medicalised system that possesses a distinct and extremely unhealthy pecking order"* [Participant 41, Counselling Psychologist]

> *"We lack confidence as a profession and potentially this causes defensiveness and desire to acquire more skills and attributes"* [Participant 23, Counselling Psychologist]

In both quotes above the participants have formulated the drive for prescription rights as a defence against inferiority. The first participant suggests that in an 'unhealthy' medicalised hierarchical structure such as the NHS, psychologists feel insignificant to psychiatrists and so seeking prescription rights is a 'narcissistic quest for power'. The acquisition of prescription rights could be a way of achieving more status in this hierarchy to meet this narcissistic need. The second participant suggests that a lack of confidence causes psychologists to act defensively to acquire more skills

– in this case prescribing rights. It is also worth noting that both quotes come from counselling psychologists, a newer division than clinical psychology, perhaps less secure in its professional identity (Moller, 2011; Richards, 2019), which has had to fight for parity in employment with clinical psychologists (Mcintosh & Nicholas, 2015; Dooley & Farndon, 2021). Prescribing rights have been described as a "salve and salt" to the narcissistic wound (Sandberg, 2014). These rights could reaffirm the psychologist's "esteem and potency" but on the other hand highlights the limits of therapy (Sandberg, 2014).

> *"I am surprised, given that the debate has been going on for years, that it would suddenly jump to this [BPS consultation]. I think this might come from a need for psychology to prove their worth and cover more areas? Just a thought though, I don't know if this is true. But I wonder about the effect on psychology of IAPT, need for psychologists to have more selling points." [Participant 47, Clinical Psychologist]*

The participant above considers why the prescription rights debate has this time moved beyond where it has before. She considers the threat of an increasing number of professions training in therapies particularly within the Improving Access to Psychological Therapies (IAPT) system in England. This psychologist seems to be speculating that the recent drive for prescription rights could be in response to the diversification of professionals who can provide psychological therapy. Prescription rights would arguably demonstrate that psychologists have something extra to offer and protect them from being considered redundant. In the initial discussion paper by the BPS Task and Finish Group (BPS, 2019a) they state one of the reasons for considering prescribing rights is that psychologists are taking on a wider range of roles and that therapies are routinely provided by other professions. Much like some of the participants speculated that psychiatrists would feel psychologists are encroaching on their territory, perhaps psychologists are experiencing the same problem and as a result they are seeking other skills to increase their market value. The participant refers to prescription rights as a 'selling point' which

perhaps speaks to the need to market oneself as superior to rival therapists in IAPT, as professionals that not only offer therapy but also prescribe medication (Mcleod 2009). This marketing links well with the economic needs of the existing NHS system and the "cultural allure and capital of science" (Goodman, 2016). This might go some way to explain many of the participants desire for extra "tools", prescription rights being one of them.

> *"I want as many tools in my belt to help people" [Participant 19, Clinical Psychologist]*

> *"To my mind, as long as we are clear and boundaried, being able to provide medication would be another skill that could be part of the toolkit." [Participant 76, Clinical Psychologist]*

4.5 Theme 3: The Relationship Between Psychiatric Drugs and Therapy "bringing meds into the mix"

This theme will explore how participants make sense of the relationship between psychiatric drugs and therapy. Although prescription rights for psychologists in the UK is unchartered territory, the analysis identified a concern across the data set pertaining to the way in which psychiatric drugs currently affect the therapeutic space and how this may or may not change should they gain prescription rights. Despite different views, participants largely considered drugs as supplementary to therapy rather than a replacement for it.

There is a dominant narrative which is compounded by the NICE guidelines that a combination of medication and therapy produces the best outcomes (e.g., NICE, 2009). Many of the participants expressed this view with some taking this argument further and suggesting that some clients may require psychiatric drugs to be able to engage in therapy.

> *"For more common mental health problems they [psychiatric drugs] are helpful and a good combination with therapy" [Participant 15, Counselling Psychologist]*

"They [psychiatric drugs] can be seen as short-medium term measures to enable service users to then engage in psychological interventions which is in line with a growing evidence base" [Participant 43, Clinical Psychologist]

"From my experience I have noticed that some clients need medication to help get their heads above water before therapy can be effective" [Participant 25, Counselling Psychologist]

However, many participants instead expressed that medication interferes with therapy. This was partly due to the physical implications with many participants reporting that the clients they worked with experienced numbness and sedation.

"I worked with a client presenting with complex developmental trauma who also struggled with low mood and anxiety. She was prescribed medication for these. The client reported no longer feeling depressed but instead feeling 'numb' and lethargic. The medication simply blocked her from experiencing some of the emotions we needed to explore and manage within the therapy" [Participant 13, Counselling Psychologist]

The participant above gives an example of a client that she worked with. She expresses that the drugs that were prescribed for anxiety and mood resulted in the client feeling *"numb and lethargic".* She expresses a conflict between the physiological impact of the drugs on the client's affect and what she considers the function of therapy – to explore and manage emotions. This participant seems to be expressing that in this case the prescribing of drugs was counterproductive to the goals of therapy. For some participants it seemed that this was a source of motivation to gain prescribing rights. There was a sense of frustration that despite having long-term relationships with their clients they would not be consulted by the prescriber about any changes to a client's drug regime despite this having significant consequences for the therapeutic work.

"My frustration at not being asked by clients' psychiatrists about the recommended dosage, when I have had a longstanding therapeutic

relationship with the client" [Participant 25, Counselling Psychologist]

"I think it would be helpful for psychologists to have a clearer say in prescribing medication for patients who they are working with. I have many recent examples where patients I am working with have had medication introduced or increased by psychiatry colleagues without me being informed - this has impacted on my understanding of fluctuations in their presentation" [Participant 59, Clinical Psychologist]

In the second quote the participant reflects how a change to a client's prescription could result in changes in how they might feel and behave and thus present in therapy. The participant is highlighting that without knowing about the change in prescription this change could be interpreted differently.

Another way in which participants expressed drugs interfered with therapy was when a clients' distress had been framed within the medical model as an illness and therefore their understanding of what would help them was limited to finding the right drug. The client therefore comes to therapy with beliefs about what underlies their distress and assumptions around the role of drugs.

"It can be difficult to discuss engagement with psychological or social interventions because these clients have been given a diagnosis of a 'mental illness' and believe that finding the 'right' pharmacological intervention will cure this and make them feel better" [Participant 12, Clinical Psychologist]

This example demonstrates how the use of medicalised language such as mental illness positions the client in a particular relationship with their experience as someone who has a disease and thus the aim is to find the right drug to cure them. Recent guidance has suggested that in these instances therapists should explore the beliefs and meanings clients may hold about their distress and the role of drugs, considering their experience

as well as any unrealistic expectations they may have about drugs (Rizq, Guy & Stainsby, 2020).

Participants also speculated about the consequences of being both psychologist and prescriber. They considered how the client and themselves may be impacted if they were able to prescribe. There were also considerations around what the act of prescribing may communicate to a client.

> *"As medication can effectively numb symptoms and emotions, the prescribing of them within sessions could indirectly suggest that the presenting feelings of the client are too much or 'bad'"* [Participant 13, Counselling Psychologist]

In the quote above the participant considers the unconscious and/or implicit communication of prescribing medication within a session. She proposes that due to the sedative effect of psychiatric drugs, prescribing could unconsciously communicate to the client that their emotions are intolerable. From a psychodynamic perspective this could be considered the transferential meaning of the act of prescribing medication (Milrod & Busch, 1998). The definition of transference varies slightly across different psychodynamic schools of thought. Broadly speaking psychodynamic theories argue that people hold templates in their mind of how the world and relationships work which are based on actual early relational experiences and the sense they made of them (Howard, 2010). Transference refers to the client unconsciously experiencing the therapist in line with this template (Howard, 2010). There has been increasing appreciation of the significance of symbolic meanings of medication within the context of psychodynamic therapy (Tutter, 2006). Not only did participants consider the transferential meaning but also counter transferential meanings of prescribing. Traditionally countertransference has referred to the therapist's emotional response to the client's transference (Howard, 2010). However, relational traditions have argued that the teasing apart of transference and countertransference is artificial but rather the therapeutic couple co-construct the therapeutic space

though the coming together of both their conscious and unconscious minds (Howard, 2010).

> *"If psychologists feel frustrated that patients are not progressing fast enough in talking therapy, they may cut corners and prescribe something to bring immediate relief". [Participant 51, Counselling Psychologist]*

In the quote above the participant considers a situation where the psychologist prescribes medication as a way of demonstrating progress due to the assumption that this would bring 'immediate relief'. This participant does not explain what they mean by 'progress', however, the pressure to prescribe could be exacerbated in systems such as the NHS where symptom reduction is often used as a measure of successful therapy and psychologists experience increasing pressure to work short-term due to economic demands (Hammersley, 2016). What many of the participants appeared to be acknowledging is that prescribing may not always be based on rational decision-making and the acts of prescribing and receiving medication can be understood as representing aspects of the transference-countertransference enactments (Tutter, 2006). Enactments refer to feelings that are acted on rather than explored and understood in supervision, which can at times lead to unethical practice (Howard, 2010). This participant speculates that the frustration the therapist might experience in relation to the client's 'lack of progress' could be acted on through prescribing. There has been extensive discussion with little consensus in the psychodynamic literature as many psychiatrists in the past would take on the dual role of prescriber and psychoanalyst. Some medical analysts have suggested their presence as a prescriber has facilitated the analysis of meanings around medication (Greene, 2001) whereas others have advocated for 'split treatment' (a different prescriber and therapist) to minimise disruption to the therapy (Busch & Sandberg, 2001).

Another common consideration for participants was how prescribing psychologists would navigate medication requests from clients.

"I think this could cause potential ruptures between clients and psychologists if a psychologist declined a medication request, which might be difficult to repair and could therefore adversely affect the relationship" [Participant 10, Clinical Psychologist]

In the quote above the participant considers the possibility that declining a medication request from a client could cause a rupture. Ruptures in the therapeutic alliance usually occur because of conflicts, tensions and misunderstandings between client and therapist (Safran & Muran, 2000). The capacity to repair therapeutic ruptures is associated with good outcomes in therapy (Holmes, 2014). However, the participant shows concerns that in this instance repair could be difficult and therefore would adversely impact the relationship.

Participants also considered the scenario where a client makes contact outside of a session to discuss their medication.

"Thinking of this psychoanalytically presents challenges. For instance, if a counselling psychologist is working with a client, and the client seeks out of session contact to talk about adverse effects of the medication, then inevitably this would impact the frame. It would move the relationship closer to the doctor-patient type of relationship, and I would imagine this to be a really sad development" [Participant 75, Counselling Psychologist]

The participant above considers how this might be challenging when working from a psychoanalytic perspective. He refers to the therapeutic frame, a psychoanalytic concept which can be understood as the guidelines and boundaries within which the therapy takes place (Howard, 2010). Breaches of the frame, such as out of session contact are generally discouraged and subsequently explored and interpreted for their unconscious meaning (Gray, 2014). However, if a client is experiencing adverse effects of any type of medication, they would be encouraged to contact the prescriber for an urgent review which is at odds with the psychoanalytic frame. The participant considers how this reframing would

change the relationship and make it more akin to the doctor-patient relationship, a change that this participant does not welcome.

There were other participants who argued that being able to discuss and prescribe medication with clients would improve the therapeutic relationship by increasing confidence in the psychologist. In this instance knowledge of drugs was associated with competence and was therefore considered to offer a "containing" function. Containment is a term used in object relations theory which is the notion that either the mother or the therapist aids growth and alleviates anxieties by acting as a "container" or "holding environment" (Howard, 2010).

> *"I think the client might feel more contained by the psychologist having more confidence in imparting their knowledge around medication specifically in relation to how it might support their therapeutic journey or not" [Participant 25, Counselling Psychologist]*

> *"A helpful prescription may help foster trust and confidence in the psychologist" [Participant 10, Clinical Psychologist]*

Many participants expressed concern that if they could prescribe it would undermine their therapeutic skills and instead clients would come to a psychologist for drugs rather than therapy. Participants constructed medication as a quick, easy option and therapy as a long, painful process, where they assumed the former would be the preferred option.

> *"Change is very difficult at the best of times. I think most of us often look for the easy option… so perhaps it [psychologist prescribing] would make clients want medication" [Participant 1, Clinical Psychologist]*

> *"The client might seek medication rather than engaging fully in the often challenging and painful work involved in relational therapy" [Participant 81, Counselling Psychologist]*

It seems that the value that participants placed on therapy and their therapeutic stance had implications for how able they felt to integrate prescribing into their role.

> *"I would hope it [the profession] would continue to develop from the low level behavioural/therapeutic role of yesteryear to the consultative, holistic role that is currently developing"* [Participant 30, Clinical Psychologist]

This participant, a clinical psychologist, when talking about her hopes for the future of the profession equates therapy as a 'low level' activity of the past and welcomes the consultancy element of a psychologist's activity developing, which could be furthered by the acquisition of prescribing rights.

> *"I worry that counselling psychology's philosophical underpinnings in the humanistic approach, might fade, if we succumb to a seductively noble idea of treating the 'whole person' when in actual fact, we are getting caught up in medicine and losing the messiness and chaos of emotional work"* [Participant 61, Counselling Psychologist]

In contrast the participant above, a counselling psychologist, acknowledges the attraction of 'treating the whole person' through the acquisition of prescription rights but demonstrates concern that counselling psychology's roots in humanism will be diluted by getting caught up in medicine to the detriment of the therapeutic endeavour.

4.6 Theme 4: Learning about drugs is more than just learning about drugs

There seemed to be a consensus across the dataset that psychologists require knowledge on psychiatric drugs to enable them to undertake their role. However, some felt this could be adequately achieved through assimilation into doctoral trainings or Continuing Professional Development rather than the need to explicitly gain prescription rights. Some participants expressed a desire for increased knowledge on

psychiatric drugs for themselves whilst others felt they had enough knowledge but recognised the importance of this in their current clinical work. However, many participants nuanced the type of knowledge that was deemed important and relevant. There was an acknowledgement that learning about psychiatric drugs is not a neutral arena and is loaded with socio-political issues. There was a variety of reasons why participants felt a sound knowledge on psychiatric drugs was important such as: being able to respond to questions from clients in order to provide them with the information they need to make informed choices, to understand the physiological effects of psychiatric drugs and how this may impact on the therapeutic process, to be able to collaborate better with colleagues by 'talking the talk' and finally the role of knowledge in enabling psychologists to challenge the medicalisation of distress. It seems that without formalised training participants felt they did not have the authority to speak about psychiatric drugs to either clients or colleagues. Some participants reflected on concerns around their capabilities should they gain prescribing rights particularly with regards to causing harm to clients.

In 2018, the results of a survey of therapists found that despite a large proportion of them working with clients who were prescribed psychiatric drugs only 7.3% of them felt well equipped in responding to questions about withdrawing or taking them. Around half were unclear on where to find information on working therapeutically with people who were taking or withdrawing from psychiatric drugs (Guy, Davies & Rizq, 2019). These findings are echoed in this survey.

Many participants suggested their doctoral training had not provided them with the knowledge and understanding of psychiatric drugs that they deemed necessary to undertake their role. Participants expressed feeling ill equipped particularly in workplaces dominated by the medical model. This seemed to be more prevalent amongst those who had recently qualified.

> *"Having very recently completed my clinical training. I am aware*
> *that I have a significant lack of knowledge and awareness of mental*
> *health medications, when they are prescribed, what they treat and*

what are the side effects. The fact that medication is used in a very high number of cases and not having any teaching on this subject is problematic within clinical practice, particularly when working within a medical service model" [Participant 10, Clinical Psychologist]

For many participants like the one above this led to a call for teaching on the matter of psychiatric drugs with the goal of increasing knowledge to boost their competence in this area. For the participant above there is an explicit request for understanding "when" psychiatric drugs are prescribed. She wants to gain an understanding of when psychiatric drugs are considered necessary or useful and to develop competencies around assessing eligibility and suitability. This participant also requests an understanding of "what they treat". The use of the word treat strongly attests to the medical model of distress and a disease centred model of drug action. She assumes that psychiatric drugs act in a disease specific manner treating a physiological process that underlies particular symptoms. This is linked to the DSM which suggests that mental illnesses are discrete categories requiring specific interventions. This model of understanding distress places great power in the prescriber. Their specialised knowledge of the body and how things go wrong is required to identify a particular disease and its corresponding cure or treatment, a specialist knowledge that this participant feels she lacks. Finally, the participant wants information on "side effects". This suggests some understanding that psychiatric drugs like any drug can come with adverse effects which need to be known to the clinician in order to help clients make an informed choice about whether they want to take them and if they do, to be able to monitor changes in the body. However, Joanna Moncrieff questions the use of the term side effects remarking that it suggests they are seen as merely incidental and irrelevant to a drugs therapeutic action which speaks to a disease centred model of drug action (Moncrieff, 2013c).

Those that felt more confident in their psychopharmacological knowledge had completed further training or felt this had developed as they gained clinical experience.

> *"I have quite a large understanding of psychopharmaceuticals and how they act on people after opting to take an additional module on my degree and thank goodness I did as I have many a discussion to help my clients decide on/understand this"* [Participant 34, Counselling Psychologist]

This participant professes to have an extensive knowledge of psychiatric drugs which she credits to an optional module. It seems when she opted to take this further training, she was unaware of how invaluable it was going to be. Her discussions with clients about psychiatric drugs seem an unexpected part of her role and there is a sense of relief that her extra training has provided her with the knowledge to engage in these conversations with clients to support their decision making around psychiatric drugs. Both have identified the importance of developing knowledge on psychiatric drugs during training, however the BPS has stated that prescription rights would not be part of doctoral training for psychologists, but rather a post qualification option (BPS, 2019a). This raises questions about how well-equipped psychologists will feel to go into a training on prescribing rights with very little foundational knowledge. Regardless of the prescription rights debate there appears to be an appetite for psychopharmacology training suggesting an opportunity for CPD to be developed in this area.

Not only did many participants acknowledge the importance of having knowledge on psychiatric drugs they also nuanced the type of knowledge required. As seen above some participants wanted to know 'the basics' on psychiatric drugs in terms of what ones there are, how they 'work', when they are prescribed and adverse effects. This was considered the minimum knowledge required. However, some participants wanted this to be taken further and tailored to their role to include how psychiatric drugs might impact on the therapeutic work. Other participants wanted what was

described as a 'broader' knowledge which included the political and contextual landscape of prescribing practices in the realm of psychiatric drugs.

> *"I do think it is important for psychologists to be informed about psychopharmacology and this should include broader contextual knowledge about the pharmaceutical industry, politics and ideology in addition to more obvious biomedical understanding"* [Participant 27, Counselling Psychologist]

This participant is broadening the type of knowledge that is deemed important. She recognises that the knowledge base that is constructed in the area of psychiatric drugs is not objective but politically influenced. She highlights three powerful institutions that have an interest in promoting psychiatric drug treatment and the medical and biological paradigms that justify and inform their use: the pharmaceutical industry, psychiatry, and the government (Moncrieff, 2006). There is an alliance between the devisers of diagnostic concepts and pharmaceutical companies, and it has been suggested that the plausibility of diagnostic concepts is strengthened if there is a specific drug to treat a disorder and vice versa (Boyle, 2007). Pharmaceutical manufacturers have a role in the generation of much of the scientific research data about psychiatric drugs (Healy, 2006) and much of the research puts an exaggerated emphasis on efficacy of psychiatric drugs, neglecting adverse effects thus distorting knowledge (Moncrieff, 2007). It has been suggested that the government and their promotion of drug treatments is linked to longstanding political policies that have transformed social problems into individual scientific ones and their trust in psychiatry is evident in the legal powers they have been afforded (Moncrieff, 2006). The participant above deems this to be important knowledge for psychologists should they gain prescribing rights perhaps to ensure they are ethical prescribers.

There were concerns that if psychologists were given the option of training in prescribing that the training would be uncritical with certain types of knowledge being favoured.

97

"I would want them [prescribing psychologists] *to have a very critical/balanced view of what meds can and can't do. I would want them to be meeting with patient groups and those personally effected by current prescribing practices so that they can understand the personal consequences of over prescribing"*
[Participant 29, Counselling Psychologist]

The participant above demonstrates concerns around current prescribing practices and deems a critical view of psychiatric drugs important in defending against psychologists contributing to the issue of overprescribing. The way in which she argues this can be done is by giving a platform to those who have been harmed. The experiences of people who have been harmed by psychiatric practices have often been silenced (Newnes, Holmes & Dunn, 1999). Professionals such as psychiatrists and psychologists are positioned as having power over service-users which grants them the rights to speak, in this case about psychiatric drugs (Parker et al., 1995). This participant is requesting an opening up of space for new perspectives and expertise to be heard.

Not only was this feature of the data relevant to training but also clinical practice. Some participants expressed a desire for increased knowledge due to requests for advice from clients that they felt ill equipped to respond to. Many participants gave examples of situations where clients had asked them for advice or information relating to psychiatric drugs. In the examples participants gave it appeared that clients lacked information about the psychiatric drugs they had been prescribed and implicit in their requests was the assumption that psychologists have the knowledge necessary to respond. Many participants expressed they felt it was important to be able to provide this information to clients to empower them to make informed choices about their drug regime.

"This is a real example – a client asked me if she was feeling low or tired because she was withdrawing from medication and how long that would last. I don't know about all the medication but might be

98

more informed if it was part of the profession" [Participant 38, Counselling Psychologist]

"I believe it is helpful for psychologists to be trained in psychopharmacology to some extent, so that they can support clients to make the best choices for them about medication" [Participant 12, Clinical Psychologist]

In the first quote the participant reflects on a real example where a client asked her about possible withdrawal affects. The participant concedes a lack of knowledge about psychiatric drugs and speculates if psychologists could prescribe that she would be better informed and thus able to respond to questions from clients. Implicit in this quote is a search for causality. Arguably, no amount of knowledge would enable any prescriber to say with certainty that tiredness is due to withdrawal or something else. Nonetheless this participant is seeking a causal explanation. In the second quote the participant acknowledges the usefulness of some form of psychopharmacological training to support clients, although not necessarily with the goal to prescribe. What was unclear in the data was how participants currently responded to client questions that they did not feel they could answer. Some participants expressed a preference for "side stepping" any questions around psychiatric drugs and focusing instead on the therapeutic work. It seems that these participants did not consider providing information on psychiatric drugs part of their role and instead something they should stay out of. A participant constructed this as a *"silent collusion"* with the medical model [Participant 11, Counselling Psychologist]. Hammersley (2016) argues that psychologists need to recognise that scrutinising medication is not only the domain of the medical doctor, and this requires a shift in their beliefs. This shift requires acquiring new knowledge and an acceptance of greater responsibility. She accuses psychologists that stay out of medication as abdicating their responsibility. In recent guidance on working with clients taking or withdrawing from psychiatric drugs Rizq, Guy and Stainsby (2020) make a useful distinction between medical information and medical advice. They suggest discussions around drug choice, dosage and frequency should be

referred to the prescriber but discussing scientific evidence, information sharing or providing a different perspective could be considered part of a psychologist's responsibility to ensure informed consent. This distinction suggests that there are two different types of knowledges needed depending on role. It opens a position for psychologists to support their clients with their decision-making around psychiatric drugs that does not necessarily require prescribing rights and medical knowledge but rather skills in critically evaluating the evidence and being able to be curious with clients about the meaning of psychiatric drugs for them, skills that should already be familiar to psychologists.

For some participants they expressed the importance of having 'adequate' psychopharmacological knowledge to function as part of a multi-disciplinary team. In NHS services it is common to have a team of different professionals such as psychiatrist's, nurses, occupational therapists etc. For some participants, the goal of acquiring knowledge on psychiatric drugs was to develop a 'shared understanding' with colleagues who could prescribe which they deemed would improve collaboration.

> *"When I am in ward rounds and in discussion with my clinical & nursing colleagues as well as with clients, I often find my knowledge and information of medication limited. If psychologists were also to prescribe, then this would mean that we would develop a greater breadth of knowledge of the impacts of medication, which could inform and shape our client work as well as our collaboration in multi-disciplinary teams"* [Participant 82, Counselling Psychologist]

For other participants they suggested that having this knowledge would give them the power to challenge the medical model in multi-disciplinary meetings particularly when working in settings where they believed this model to be dominant.

> *"I think basic knowledge should be provided during training in order that we can challenge the medical model and offer an informed counter argument in MDT settings"* [Participant 55, Clinical Psychologist]

This relates to a point made in the second theme on status demonstrating the interconnectedness between these themes and in particular the relationship between knowledge and power.

The possibility of prescribing was met with concern by many of the participants in relation to fears around competence. Some felt they would lack confidence in prescribing, believing it to be beyond their capabilities. It was unclear whether this based off their current knowledge or with further training in mind.

> *"If this were imposed on me, I would feel: out of my depth in relation to health-related consequences and BNF limits" [Participant 5, Counselling Psychologist]*

In the quote above the participant refers to the British National Formulary (BNF) a pharmaceutical reference book which provides a variety of information on prescribing and pharmacology. The BNF sets limits on certain drugs and any prescribing outside of this guidance is unlicensed. This participant expresses concern that prescribing would be beyond their capabilities in relation to knowing and understanding the BNF guidelines and the impact of psychiatric drugs on physical health. What seems ironic about this quote is that this participant seems to speak from a position of knowing something about psychiatric drugs through their mention of the BNF. In their research around nurse prescribing Snowdon and Martin (2010) develop the idea of "understanding vs UNDERSTANDING" suggesting the difference between understanding in theory and understanding in practice. They argued that it was only once nurses became prescribers that they realised how much more they had to learn, and it was this that put a spotlight on nurse's previous levels of knowledge or lack of. It was suggested that gaining prescribing rights and the increased responsibility and accountability led to increased levels of awareness and attention. It seems that this is the case for the participant above, the knowledge they already have, makes them aware that they lack sufficient knowledge to prescribe adequately.

"I don't really feel much about this issue other than it is not wise to give prescribing rights to a profession with no medical training! I had a client who nearly died of an accidental overdose because of over prescription and interactions of the medications she was taking for both health and mental health" [Participant 40, Counselling Psychologist]

In the quote above the participant echoes the concerns around psychologists gaining prescribing rights due to issues related to competence. Interestingly, they express this to be the main element they take issue with. They express concern that given the lack of medical training that psychologists would not be equipped to be competent prescribers. She backs up this view by reflecting on an example from her clinical practice where the dose and cocktail of drugs almost resulted in the death of a client which highlights the tangible dangers and responsibility that come with prescribing. This would perhaps indicate that supplementary prescribing would be more appropriate in these situations. It seems for this participant the primary fear is causing harm to clients through a lack of competence and an acknowledgement of the complexity of drug management. Both participants seem sceptical about whether safe and competent prescribing could be achieved by psychologists. This is something that was raised in the BPS' consultation to which they have advised the training and mentoring would need to meet standards set out by the Royal Pharmaceutical Society (RPS) and the Health Care and Professions Council (HCPC) (BPS, 2019a). However, research into psychiatric nurse prescribing has suggested that they did not feel their prescribing course adequately prepared them to prescribe because it was not specific enough to psychiatric practice (Ross & Kettles, 2012). This does not bode well for psychologists who arguably will have less knowledge on psychiatric drugs than their nursing colleagues.

In summary, participants were not only asking for more knowledge on psychiatric drugs but for any learning on this topic to be comprehensive and embedded within a critical framework (irrespective of prescription rights) to ensure ethical and competent practice.

5. Conclusion

5.1 Summary of Findings

The aim of this research was to gather counselling and clinical psychologists' views on gaining prescription rights. This has been achieved through a qualitative survey which has enriched previous quantitative research in this area by offering participants the opportunity to express their views in their own words. The study highlighted that psychology is a broad church with diverse views; there was a sense of ambivalence within data items and across the data set in relation to prescribing rights for psychologists. Participants may agree on certain things for example that prescribing rights would change the role and identity of a psychologist. However, this was constructed as problematic for some yet an opportunity for others. The overarching theme conveys that whether or not psychologists gain prescription rights is a pivotal decision or a "crossroad" in the development of the profession. Identity and professional role are something the participants grappled with not only in relation to the prescription rights debate but in contexts dominated by the medical model of distress which for many caused a sense of incongruence. This highlights a gap between clinical training, philosophical stance and practice and contributes to previous research in the area (Cooke, Smythe, Anscombe, 2019). Some participants found it hard to fathom why any psychologist would want prescribing rights due to this clash. However, for others, prescribing encouraged a deeper engagement with the bio element of the biopsychosocial model and opened up a niche for psychologists to change the narrative around psychiatric drugs and to de-prescribe.

The first theme captures participants assumptions about psychiatric drugs which provides a springboard for the other themes as arguably participants attitudes towards psychiatric drugs shape whether they believe prescribing to be an appropriate endeavour for psychologists. The second theme developed the view that prescription rights for psychologists is a means to gain status and power. This seemed particularly pertinent within the NHS

due to the perceived dominance of the medical model in this institution. There were concerns about how psychology is viewed by others with many using the term 'soft', thus for some participants prescription rights would be an opportunity for psychologists to be taken more seriously by colleagues and society, a 'hardness' as an antidote to the perceived 'softness'. Though some participants believed they would gain status and power there were things they were concerned they would lose as a result. This included the distinctiveness of their role. There were also concerns about the impact on the therapeutic relationship and relationships with colleagues, namely psychiatrists. Theme 3 begins to sketch the complex relationship between psychiatric drugs and therapy and includes issues around how psychiatric drugs already infiltrate the therapeutic space and how prescription rights may serve to exacerbate this. As a trainee counselling psychologist, my analysis paid particular attention to unconscious communications of prescribing from a psychodynamic perspective and what considerations are illuminated from a process point of view. Finally theme 4 captures a desire for knowledge on psychiatric drugs and whether this could be better achieved through CPD or from gaining prescription rights. It seemed that participants agreed that knowledge on psychiatric drugs is necessary for psychologists to adequately carry out their role. For example, to provide clients with the information they need to make informed choices about psychiatric drugs, to understand the physiological effects of psychiatric drugs and how this may impact on the therapeutic process, to be able to collaborate better with colleagues through shared understandings and finally the role of knowledge in enabling psychologists to challenge the medicalisation of distress. However, the type of learning participants desired was varied. For many, there was a call for any teaching to be within a critical framework to ensure ethical and competent practice.

5.2 Evaluation of the Study and Opportunities for Future Research

This qualitative research study achieved its aim to explore clinical and counselling psychologists' views on gaining prescription rights. It offers a new depth to this research area by giving psychologists the opportunity to reflect on their views and motives. Despite rich data that met the study aims there are a few limitations as well as ideas for future research that are important to discuss.

Data Collection

This study sought to gather a range of perspectives from psychologists across the UK. Therefore, surveys made sense and arguably were the most appropriate method of data collection. However, surveys are often criticised for producing thin data (Braun et al., 2021). Whilst the data obtained was not thin, there were undoubtedly occasions during the analysis where participants made points that would have benefitted from further probing. A more interactive method of data collection, such as semi-structured interview would have provided this opportunity. Although qualitative researchers have challenged the assumption that qualitative surveys only generate data that lacks depth (Braun et al., 2021) the rigid nature of qualitative surveys could have limited the detail that participants went into in their responses. The data was also somewhat fragmented, snippets of ideas were offered by participants rather than each data-item containing a coherent narrative, as is common in qualitative surveys.

Since finalising the thesis, I have wondered about different methods of data collection that may have complimented the use of surveys. Focus groups could have provided a live opportunity to explore the different viewpoints both between the two different professions of counselling and clinical psychology but also those for and against prescription rights.

The unique advantage of focus groups is the participant interaction. The back-and-forth dialogue between participants can lead to benefits such as spontaneous ideas and personal disclosures being stimulated in a way they may not be in an interview or survey and as participants exchange opinions, they consider their own views in relation to others', this may encourage them to consider things they have not before and further refine

their perspectives (Smithson, 2000). It has also been suggested that focus groups increase the likelihood that a wide range of views and perspectives will be captured in one group session which can lead to new insights about a topic (Smithson, 2000).

Thinking beyond other ways of collecting data for this research question, there was perhaps more scope to nuance a diversity of views within the obtained dataset. Before the critical turn in social psychology (Parker, 2005; Gergen, 2009), whether and how practitioner psychologists gain prescription rights would have been conceptualised under research on 'attitudes'. One of the distinctive and most enduring features of critical qualitative research has been the rejection of traditional notions of attitudes as fixed cognitions inside people's heads (Burr, 1995; Parker, 2005). Instead, attitudes such as the ones under investigation are now widely understood as having discursive features and functions which are deployed in linguistic interactions (Potter & Wetherell, 1987; Potter, 1996). I detected an interesting feature in the survey responses whereby some participants expressed an explicit 'anti-medical model stance' in one part of the survey yet adopted a medical discourse when discussing mental health later (or earlier in some instances). I considered creating a theme to capture this diversity, or contradiction perhaps, in views but then I abandoned this idea as it was very difficult to execute due to using thematic analysis and because of the sheer volume of data. One of the criticisms that thematic analysis has attracted is that it fails to account for context because its insistence on thematic clustering leads to fixing meaning and erasing fluidity within accounts (Parker, 2005). However, a more experienced researcher might have been able to capture the contradictions and tensions expressed within the same response and make it a part of the analysis. Such an approach would have yielded a more critical reading of the data and would have aligned itself more explicitly with attempts to bring the issue of psychologists prescribing medication to bear on the deconstruction of psychopathology (Parker et al., 1995).

Another area of the analysis where diversity and difference could have been more enhanced relates to the collapse of the distinction between

counselling and clinical psychologists. While many debates are raging on regarding the difference between these two professional identities (Bernard & Wang, 2021;), it can be argued that counselling psychology has more to say about the relational nature of therapeutic encounters (McNamee & Gergen, 1992; Orlans & Van Scoyoc, 2009). I was wary from the start of this research not to privilege my own professional camp, which led to the design of a survey that could speak to both types of psychologists. An interview-based study would have allowed me to probe further into some relational and contextual considerations when discussing this complicated issue.

Sample

At a progression review it was highlighted that the sample was relatively newly qualified. This was possibly due to the recruitment routes that were used such as Facebook and Twitter. Research has suggested that experienced psychologists are less likely to utilise social media than their newly qualified counterparts (Taylor et al., 2010). Attempts were made to actively diversify the sample by targeting more experienced clinicians through our professional networks. This was important because previous research suggested that more experienced psychologists were less likely to pursue prescription rights than newly qualified psychologists (Walters, 2001). For some of the more experienced participants in this research, it was not worth seeking prescription rights as they were nearing retirement. This could be an interesting area to unpack in future research that was beyond the scope of the current study. It is also possible that due to the nature of both my professional networks and those of the supervisory team and some of the online groups where the survey was advertised such as the 'Drop the Disorder' Facebook group that this could have skewed the sample to the more critical edge. This might have been further exacerbated by the use of snowball sampling by asking potential participants to share with their networks. This is a sampling strategy that has received criticism for lack of diversity and representation as it relies on the researcher's resources and contacts (Parker et al., 2019).

The sample of psychologists who participated were largely white, middle-class heterosexual women. Unfortunately, this further perpetuates the criticism levelled at much psychological research, namely that it captures the views of the 'usual suspects' (Terry & Braun, 2017) of social science research, at the expense of historically marginalised groups. If I were to conduct the study again, I would heed some of the recommendations that have emerged from the 'Black Lives Matter' (Hargons et al., 2017) and trans rights movements (Ellis, et al., 2019) to ensure a sample that is more representative of the society we live in. At the very least, I would have ensured that the pilot phase included the views of a diverse range of people, who could have helped me scrutinise more closely the items of the survey. As the targeted sample was a professional group this also highlights the lack of representation within the psychology profession more broadly. The British Psychological Society has recognised that there is underrepresentation of certain groups within its membership and the wider discipline (BPS, 2016). Most divisions are dominated by white women with the exception of the sport and exercise division which has a higher number of male members (BPS, 2016).

There was a roughly equal split of the two professions. Fifty five percent were clinical psychologists and 45% were counselling psychologists. Seventy nine percent of the sample had up to 20 years post qualification experience with only 21% having more than 20 years post qualification. Twenty two percent of the sample agreed that psychologists should gain prescription rights, 51% disagreed and 27% were unsure. This finding is discussed further below. This finding remained similar when splitting it by profession. Twenty two percent of clinical psychologists agreed with the statement, 47% disagreed and 31% were unsure. Comparably, 22% of counselling psychologists agreed with the statement, 56% disagreed and 22% were unsure.

Terminology

Another point that came to my attention at progression review was that some of the language used in the inclusion criteria 'participants must be

living and working in the UK' could have inadvertently excluded psychologists that were not currently working for reasons such as sickness or retirement. This criterion was to ensure that the responses were relevant to the UK work context namely the NHS, rather than to exclude participants. I was contacted by a number of psychologists to check they could participate despite being retired, which I encouraged. There is no way of knowing exactly how much impact this did or did not have, but it is an important consideration, nonetheless.

Language is also a tricky area when writing in the realm of human distress. The terms used to describe experience are loaded with connotations. I describe in the reflexivity section my process of deciding what terminology to use in the survey to ensure consistency. Participants often used medicalised language in their survey responses which is something that I picked up on throughout the analysis section. It is therefore important to consider the use of terminology in the questions and the limitations this placed on data collection. Some participants implicitly challenged the medicalised language in the survey questions using quotation marks perhaps indicating they disputed the term and some participants explicitly challenged it and used it as a springboard to explore their perspectives as shown below:

> *"it isn't medication, it is powerful drugs" [Participant 36, Counselling Psychologist]*

> *"The question suggests that the notion of 'mental health problem' is without problem. And it isn't." [Participant 31, Counselling Psychologist]*

> *"Your question using language such as "mental health problems" betrays the propaganda to which you have been subjected." [Participant 9, Counselling Psychologist].*

Interestingly all the participants who actively challenged the language in the survey were counselling psychologists. However, it would be inappropriate to assume that any participant who did not subscribes to a medical model of distress as this would misrepresent the data. What it

does highlight is the complexity of language perhaps more so when speaking with other professionals. There is no neutral language in human distress, language is loaded with meaning and meaning is understood differently in different contexts and by different people. Therefore, despite collecting rich and varied data, I am aware that this dataset was co-produced in the context of the terminology I used in the survey questions, and this may have influenced how participants responded.

Interestingly, the survey was developed when I was in my first year of training and as the thesis has developed so too has my knowledge and thinking in this area. If I were to be writing the survey today I would perhaps phrase some of the questions differently. For example, in question 2 (Appendix A) I ask the participants if they believe medication is warranted. I would perhaps instead ask their view on the utility of medication. This raises implications for trainee research that is carried out over many years and does not have the flexibility to capture the personal and professional journey they go on during training.

Other areas of practice in relation to prescription rights

This study focused on prescription rights for psychologists in relation to mental health. Arguably because much of psychologist prescribing would be carried out in this area due to this being the field where most counselling and clinical psychologists work. Prescribing in different areas of practice is likely to raise different issues for psychologists. There are likely to be nuances in other areas of practice such as gender services, physical health services, and addictions to name a few. One participant highlighted this in their response:

> *"I see more of a role for psychologists prescribing where physiological issues are relevant eg hormone treatment where someone is transitioning, rather than in such problems as depression, anxiety, psychosis etc." [Participant 31, Counselling Psychologist]*

Prescribing rights in medical settings are unlikely to apply in the same way to mental health settings and vice versa, that is not to say it would be

without controversy. However, to explore this further is beyond the scope of the current study and is perhaps an area for further research. However, this does highlight a potential issue of offering prescription rights to psychologists as a whole with little regard to the different issues that may arise in each setting.

5.3 Implications for Practice

This study is the first qualitative study of its kind and the first at all to be carried out in the UK independently of a professional body. It expands on previous quantitative research (APS, 2007; Fitzgerald and Galyer, 2008; St.Pierre & Melynk, 2004; Walters, 2001) and opinion pieces (Dobson & Dozois, 2001; George & Semp, 2013; Johnstone, 2003; Nussbaum, 2001; Orford, 2003; Resnick, 2003; Sammons & Levant, 2003) which highlighted that this is a controversial topic with mixed views. This study is unusual in that it has been carried out simultaneously to the BPS consultation on prescription rights (BPS; 2019a; BPS, 2020a) and as such is a live piece of research that will continue to unfold beyond the submission of this thesis. This exploration of psychologists' views argues that gaining prescription rights is an overt collusion with the medical model but also highlights an existing undercurrent of silent collusion with the medical model as outlined by one of the participants:

> *"We need to…discuss and reflect more openly on our silent collusion to the medical model (the irony is that this is happening while we think we are critical to this model)" [Participant 11, Counselling Psychologist]*

which supports previous research (Cooke, Smythe & Anscombe, 2019).

This research goes beyond what prescribing rights mean for psychologists in practice but also who we are as people and what this means for wider society.

Implications for Psychologists

In some of the survey responses participants speculated about my position in relation to the prescription rights debate with some assuming that I am pro-prescription rights for psychologists perhaps due to the medicalised language used in the surveys and the way some questions were framed. This was often met with frustrations and occasionally criticism. This could offer a snapshot of the tensions and a possible schism that would be created should prescription rights for psychologists be granted. The BPS consultation has advised that prescribing rights for psychologists would be an optional training post doctorate. As outlined above 22% of psychologists who participated in this research agreed that psychologists should gain prescription rights, 51% opposed the statement and 27% were unsure. The BPS position statement was that there was enough support for prescription rights for the BPS to further engage with NHSE on this matter. However, my survey highlights that over half of the sample disagreed with prescribing rights for psychologists. The BPS response to those that disagree is usually that it is 'optional'. There are a couple of issues here. Firstly, making this optional is an individualistic approach. Those who are against prescribing rights may not have been against it just for their own practice, but for the field of psychology as a whole. Particularly as the overarching theme of this study conveys the possible changes to the identity of the psychologist. We are all impacted by the behaviour of others who represent our profession and framing it as individual choice does not account for the changes to psychology that will go beyond individual practitioners. Secondly, whilst it is optional in practice, it seems reasonable to wonder whether this will eventually be written into person specifications and job descriptions for psychologist posts in the NHS. This raises the question, would it become necessary to train to remain employable? This could further add to tensions between psychologists.

One of the themes highlighted participants would welcome further training in psychiatric drugs regardless of whether psychologists gain prescription rights. Many respondents suggest that an increase in knowledge (namely around the effects of psychiatric drugs) entails an increase in power (financial benefits, social capital, decision-making power). Some

participants argued they would use this power to disrupt the medical model of mental health by limiting prescriptions, something that becomes more plausible if one speaks from within the dominant discourse of biomedicine. An unintended consequence is that they further entrench the medical model in a dominant position, thus inhibiting the extent to which it can be challenged as inappropriate for understanding people's distress. The concept of 'professional socialisation' could be useful here. The term describes processes by which an individual acquires the necessary knowledge, disposition, and cultural skills to perform their professional role (Merton, 1963). Importantly, it does not just imply the learning of technical skills but can involve changing personal values and ways of thinking (Page, 2005).

Over the last few years there appears to have been a drive in challenging the medical model of distress and the subsequent use of psychiatric drugs from various areas. The Division of Clinical Psychology set out a position statement (DCP, 2013), followed by publishing the Power Threat Meaning framework as an alternative to diagnosis (Johnstone & Boyle, 2018). The Royal College of Psychiatrists produced a position statement on depression and stopping antidepressants (RCP, 2019b) which prompted them to release guidance on withdrawing from anti-depressants which includes tapering plans (RCP, 2020). In the last parliament the All-Party Parliamentary Group (APPG) for Prescribed Drug Dependence facilitated the creation of guidance for psychological therapists on enabling conversations with clients who are taking or withdrawing from psychiatric drugs by bringing together key professional bodies, practitioners and academics (Guy, Davies & Rizq 2019). Very recently the NICE guidelines on the treatment of depression in adults have been updated to advise that people with mild depression should be offered therapy before anti-depressants (NICE, 2021). It seems strange then at the same time psychologists are being approached and are considering prescribing.

Implications for Service-Users and Society

This research focused on exploring psychologists' views on gaining prescription rights. However, whatever the outcome arguably the greatest impact will be on service users. Therefore, further research exploring service users' views and elevating their voice is vital. There is little research into service users' views on this topic. However, the BPS consultation carried out two service user focus groups. The participants were given some current information on prescribing practices and then some case studies to consider (BPS, 2020a). There are limited details available about the sort of information the service-users were exposed to prior to the focus group and details on the number of participants are vague. Some of the themes that came out of these focus groups included: an expectation that psychologists would be more person-centred prescribers and that the therapeutic relationship between psychologist and client is more collaborative which would thus give service users more ownership over their prescriptions. There were some concerns by service users about psychologists having the appropriate prescribing training; it was suggested this would need to be transparent with service users and that psychologists need to ensure they are cautious prescribers. The current research suggests that views on prescribing rights are very much informed by the philosophical positions we take in relation to human distress. If distress is considered a medical problem rooted in the body, then a medical response such as drugs makes sense. There is no objective position and service users, like the psychologists that participated in this research, will have also been exposed to various discourses of psychological distress and its origins, that will shape their views on the prescription rights debate.

Deprescribing was a reason many participants gave as a rationale for wanting prescription rights. The desire to de-prescribe implicitly acknowledges a problem with the overprescribing of psychiatric drugs that has been highlighted in previous research (Dorwick & Frances, 2013; Rice-Oxley & Fishwick, 2013). One could argue that rather than increasing prescribers, psychologists have a duty to challenge the overprescribing of psychiatric drugs. As mentioned in the above paragraph a feature that the research highlighted was that psychologists generally felt they lacked

knowledge on psychiatric drugs, and this impeded their confidence in challenging prescriptions. Perhaps then, adequate CPD to increase knowledge on psychiatric drugs together with the recent 'guidance for psychological therapists on enabling conversations with clients taking or withdrawing from prescribed psychiatric drugs' (Guy, Davies & Rizq, 2019) could be useful for psychologists to increase their confidence and to equip them with the knowledge necessary to engage in these conversations to the benefit of their clients. Theme 3 highlighted that despite not currently prescribing, psychologists are involved in medication, they are in the room with the medicated client and to *"side-step the meds question"* [Participant 24, Clinical Psychologist] although perhaps more comfortable is arguably one of the ways psychologists are silently colluding with the medical model of distress.

Another area that was highlighted by the research was that psychiatric drugs as a treatment for distress are usually the first line of intervention in most settings in the NHS. This view is supported by research (Beresford, Perring, Nettle & Wallcraft, 2016; Read, Harrop, Geekie, & Renton, 2018). For many psychologists who were against prescribing rights they saw their role as offering an alternative to the medical model of distress particularly in contexts that were dominated by this view. This drive for further prescribers risks psychotherapeutic approaches becoming even more eclipsed within mental health services resulting in even less choice for service users.

Research evidence demonstrates the relevance of social-political factors to psychologists. For example, income equality has a strong correlation with mental health (Wilkinson & Pickett, 2010). It causes direct stress due to social comparisons where poorer individuals develop feelings of failure, resentment and shame and it erodes social capital in communities and societies leading to social fragmentation and leaving individuals vulnerable to psychosocial stressors (Wilkinson & Pickett, 2010). This is therefore the realm of psychologists which many of the participants in this research professed a commitment to. However, there is a risk that prescribing rights for psychologists will lead to psychosocial causes of distress becoming

further obscured. Therefore, the prescribing rights debate is an issue that extends beyond the individual to wider social issues.

5.4 Implications for Counselling Psychology

As outlined in the introduction, counselling psychology is a discipline whose value base is rooted in humanism and professes to take a critical stance to the medical model of distress (Woolfe, 2016). The BPS have advised that being a prescribing psychologist would require an engagement with diagnostic constructs (BPS, 2019a) which is problematic for counselling psychologists for a number of reasons. As practitioners with a commitment to evidence-based practice (DCOP, 2012) the validity of diagnostic constructs is questionable (Boyle, 2007), not only that, but research has also suggested that for some service-users diagnosis triggers shame, stigma and disempowerment, and results in the root causes of their distress being obscured (BPS, 2011). Therefore, one could argue that prescribing rights is antithetical to counselling psychology especially given its commitment to social justice (DCOP, 2020).

Strawbridge (2016) suggests that conflicts (arguably of which prescription rights is one) are valuable in prompting a honing of positions and clarifying ideas. Therefore, perhaps this is an opportunity for counselling psychologists to take a stand to maintain the profession's core values and distinctiveness, which is argued is already at risk due to being practiced in medical contexts (Strawbridge, 2016). To reconnect with the 'tacit dimension' of therapy which goes beyond a set of techniques and formal papers but captures experience, interaction and intuition which speaks to the 'professional artistry' that is called for in the discipline's official practice guidelines (DCOP, 2020). Not only is this an opportunity to advocate for the identity of the profession, but also for the clients we serve and wider society through social action and an explicit engagement with the process that is unfolding. Dianne Hammersley a key figure in the development of the counselling psychology profession in the UK aptly reflects "there is a danger that the NHS changes counselling psychology rather than the other

way around" (Hammersley, 2021). With this in mind rather than counselling psychology changing prescribing practices through the acquisition of prescription rights, the essence of the profession it is at risk of being changed, diluted if not entirely lost.

5.5 Dissemination

To ensure the findings of this study are disseminated to those who are impacted by the research I plan to submit a condensed article for publication with the supervisory team. This thesis has inspired a teaching session on the Professional Doctorate in Counselling Psychology at UWE as part of the "Professional Issues in Counselling Psychology" module which I have co-facilitated. This is in the hope that it will encourage trainee counselling psychologists to reflect on the implications of this debate for their practice pre-qualification. I have presented a poster at the annual Division of Counselling Psychology BPS conference. It is also important to consider how to disseminate the findings of this study to those who will be impacted by the research but may not necessarily access a published article or attend a professional conference or training. Some ideas have been considered such as a facilitating a debate or discussion at the Community Psychology festival ensuring both service-users and professionals are involved and/or submitting an essay to be considered for a blog such as Mad in the UK. These ideas will continue to be considered and implemented in due course.

6. References

Albert, P.R., Benkelfat, C. & Descarries, L. (2012). The neurobiology of depression – revisiting the serotonin hypothesis. Cellular and molecular mechanisms. *Philosophical Transactions of The Royal Society,* 367(1601), 2378-2381. https://doi.org/10.1098/rstb.2012.0190

American College of Neuropsychopharmacology. (1998). DOD prescribing psychologists: External analysis, monitoring, and evaluation of the program and its participants. Final report. http://documents.theblackvault.com/documents/dod/readingroom/2/966.pdf

American Psychological Association (APA). (2004). Louisiana becomes second state to enact prescription privileges law for psychologists [Press release]. https://www.apa.org/news/press/releases/2004/05/louisiana-rx

American Psychological Association (APA). (2014). RxP: A chronology. https://www.apaservices.org/practice/advocacy/authority/prescription-chronology

Anderson, C., Hildreth, J.A.D. & Howland, L. (2015). Is the desire for status a fundamental human motive? A review of the empirical literature. Psychological Bulletin, 141(3), 574-601. https://doi.org/10.1037/a0038781

Angell, M. (2000). Is academic medicine for sale? *The New England Journal of Medicine*, 342(20), 1516-1518. https://doi.org/10.1056/NEJM200005183422009

Australian Psychological Society Prescription Rights Working Group. (2007). Report of the APS prescription rights working group survey findings and recommendations. http://www.psych.usyd.edu.au/staff/iain/APS%20Report%20prescribing%20rights.pdf

Avery, A.J. & James, V. (2007). Developing nurse prescribing in the UK. British Medical Journal, 335(7615) 316. https://doi.org.uk/10.1136/bmj.39285.788808.3B

Avery, A.J. & Pringle, M. (2005). Extended prescribing by UK nurses and pharmacists. BMJ, 331, 1154-1155 https://doi.org/10.1136/bmj.331.7526.1154

Baird, K.A. (2007). A survey of clinical psychologists in Illinois regarding prescription privileges. *Professional Psychology: Research and Practice,* 38(2), 196-202. https://doi.org/10.1037/0735-7028.38.2.196

Barrett, L.F. & Bliss-Moreau, E. (2009). She's emotional. He's having a bad day: Attributional explanations for emotion stereotypes. Emotion, 9(5), 649-658. https://doi.org/10.1037/a0016821

Barnett, M. (2007). What brings you here? An exploration of the unconscious motivations of those who choose to train and work as psychotherapists and counsellors. *Psychodynamic Practice: Individuals, Groups & Organisations,* 13(3), 257-274. https://doi-org.ezproxy.uwe.ac.uk/10.1080/14753630701455796

Baumann, A.O., Deber, R.B., Silverman, B.E. & Mallette, C.M. (1998). Who cares? Who cures? The ongoing debate in the provision of health care. Journal of Advanced Nursing, 28(5) 1040-1045 https://doi.org/10.1046/j.1365-2648.1998.00809.x

Bechky, B.A. (2003). Object lessons: Workplace artifacts as representations of occupational jurisdictions. *The American Journal of Sociology,* 109(3), 720-752. https://doi.org/10.1086/379527

Bentall, R. (2004). *Madness explained: Psychosis and human nature*. Penguin.

Bentall, R. (2006). Madness explained: Why we must reject the Kraepelinian paradigm and replace it with a 'complaint orientated'

approach to understanding mental illness. *Medical Hypotheses,*
66(2), 220-233. https://doi.org/10.1016/j.mehy.2005.09.026

Bentall, R. (2010). *Doctoring the mind: Why psychiatric treatments fail.*
Penguin.

Beresford, P., Perring, R., Nettle, M. & Wallcraft, J. (2016). From a mental
illness to a social model of madness and distress.
https://www.shapingourlives.org.uk/wp-
content/uploads/2016/05/FROM-MENTAL-ILLNESS-PDF-2.pdf

Bernard, K. & Wang, M. (2021). ACP-UK Response to The British
Psychological Society's Guidance 'Best Practice in Psychology
Recruitment'. Association of Clinical Psychologists.
https://acpuk.org.uk/psychology_recruitment_response

Besenius, C., Bradley, E., & Nolan, P. (2012). Attitudes of psychiatrists,
nurses and service users towards prescribing and administering
depot antipsychotic medication. *The Journal of Mental Health
Training, Education and Practice*, 7(1), 9-19.
https://doi.org/10.1108/17556221211230552

Bhui, K., Ullrich, S., Kallis, C. & Coid, J.W. (2015). Criminal justice pathways
to psychiatric care for psychosis. Br J Psychiatry, 207(6), 523-529.
https://doi.org/10.1192/bjp.bp.114.153882

Bignall, T., Jarej, S., Helsby, E. & Butt, J. (2019). Racial disparities in mental
health: Literature and evidence review. Race equality foundation.
https://raceequalityfoundation.org.uk/wp-
content/uploads/2020/03/mental-health-report-v5-2.pdf

Blau, P.M. (1964). *Exchange and power in social life.* Wiley.

Bodenheimer, T. (2000). Uneasy alliance: Clinical investigators and the
pharmaceutical industry. *The New England Journal of Medicine*,
342(20), 1539-1544.

Bostock, J. (2017). Understanding power in order to share hope: A tribute
to David Smail. *Clinical Psychology Forum Number 297.*

Boyle, M. (2007). Diagnosis special issue part 1 & 2. *The Psychologist*, 20(5), 290-292. https://thepsychologist.bps.org.uk/volume-20/edition-5/diagnosis-special-issue-part-1-2

Bradbury, H. (2010). Institutional Racism in Mental Health Services: The consequences of compromised conceptualisation. Sociological Research Online, 15(3). https://doi.org/10.5153/sro.2197

Bradley, E., Wain, P., & Nolan, P. (2008). Putting mental health nurse prescribing into practice. *Nurse Prescribing*, 6(1), 15-19. https://doi.org/10.12968/npre.2008.6.1.28113

Braslow, J. (1997). *Mental ills and bodily cures.* University of California Press.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology,* 3(2), 77-101.

Braun, V. & Clarke, V. (2013). *Successful qualitative research. A practical guide for beginners.* Sage Publications Ltd.

Braun, V. & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise & Health,* 11(4), 589-597. https://doi-org.ezproxy.uwe.ac.uk/10.1080/2159676X.2019.1628806

Braun, V., Clarke., Boulton, E., Davey, L. & McEvoy, C. (2021). The online survey as a *qualitative* research tool. *International Journal of Social Research Methodology,* 24(6), 641-654. https://doi.org/10.1080/13645579.2020.1805550

Braun, V., Tricklebank, G. & Clarke, V. (2013). "It shouldn't stick out from your bikini at the beach": Meaning, gender, and the hairy/hairless body. *Psychology of women quarterly,* 37(4), 478-493. https://doi.org/10.1177/0361684313492950

British National Formulary. (2017). Hypnotics and anxiolytics: Treatment summary. *National Institute for Health Care and Excellence.*

https://bnf.nice.org.uk/treatment-summary/hypnotics-and-anxiolytics.html

British National Formulary. (2018). *Non-medical prescribing.* National Institute for Health Care and Excellence. https://bnf.nice.org.uk/guidance/non-medical-prescribing.html

British Psychological Society. (2011). Response to the APA: DSM-5 development. http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf

British Psychological Society. (2019a). Prescribing rights for psychologists. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Internal/Discussion%20Paper%20-%20Prescribing%20Rights.pdf

British Psychological Society. (2019b). Standards for the accreditation of Doctoral programmes in counselling psychology. https://www.bps.org.uk/sites/www.bps.org.uk/files/Accreditation/Counselling%20Accreditation%20Handbook%202019.pdf

British Psychological Society. (2020a). Prescribing Rights for psychologists. https://www.bps.org.uk/sites/www.bps.org.uk/files/BPS%20Prescribing%20Rights%20Report.pdf

British Psychological Society. (2020b). Prescribing rights for some psychologists – an update. https://www.bps.org.uk/news-and-policy/prescribing-rights-some-psychologists-update

British Psychological Society Professional Practice Board. (2018). Prescribing rights for psychologists – Chair and members. The psychologist, 31(5), 60.

Brown, G., & Harris, T. (1978). *Social origins of depression: A study of psychiatric disorder in women.* Tavistock.

Brown, R. (2010). *Prejudice: Its social psychology* (2nd ed.). Wiley-Blackwell.

Burr, V. (1995). *An introduction to social constructionism.* Routledge.

Busch, F.N. & Sandberg, L.S. (2007). *Psychotherapy and medication: the challenge of integration.* The Analytic Press.

Canadian Psychological Association. (2010). Report to the Canadian Psychological Association Board of Directors. https://cpa.ca/docs/File/Task_Forces/CPA_RxPTaskForce_FinalReport_Dec2010_RevJ17.pdf.

Casey, J.F., Bennett, I.F., Lindley, C.J., Hollister, L.E., Gordon, M.H. & Springer, N.N. (1960). Drug therapy in schizophrenia. A controlled study of the relative effectiveness of chlorpromazine, promazine, phenobarbital, and placebo. *Archives of General Psychiatry,* 2, 210–220. https://doi.org/10.1001/archpsyc.1960.03590080086012

Casey, J.F., Lasky, J.J., Klett, C.J. & Hollister, L.E. (1960). Treatment of schizophrenic reactions with phenothiazine derivatives. A comparative study of chlorpromazine, triflupromazine, mepazine, prochlorperazine, perphenazine, and phenobarbital. *The American Journal of Psychiatry,* 117, 97–105. https://doi.org/10.1176/ajp.117.2.97

Clarke, A. (2020). More debate on prescribing rights. The psychologist, 33. https://thepsychologist.bps.org.uk/volume-33/march-2020/more-debate-prescribing-rights

Clearing House. (2021). National numbers for NHS places. http://www.leeds.ac.uk/chpccp/numbers.html.

Cohen, C. I. (1993). The biomedicalization of psychiatry: a critical overview. *Community Mental Health Journal,* 29(6), 509-521. https//doi.org/10.1007/BF00754260

Cooke, A. (2017). *Understanding psychosis and schizophrenia.* British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Page%20-

%20Files/Understanding%20Psychosis%20and%20Schizophrenia.pd
f

Cooke, A., & Kinderman, P. (2017). "But what about real mental illnesses?"
Alternatives to the disease model approach to "Schizophrenia".
Journal of Humanistic Psychology, 58(1), 47-71.
https://doi.org/10.1177/0022167817745621

Cooke, A., Smythe, W., & Anscombe, P. (2019). Conflict, compromise and
collusion: dilemmas for psychosocially-orientated practitioners in
the mental health system. *Psychosis,* 11(3), 199-211.
https://doi.org/10.1080/17522439.2019.1582687

Cope, L.C., Abuzour, A.S. & Tully, M.P. (2016). Nonmedical prescribing:
where are we now? Therapeutic Advances in Drug Safety, 7(4) 165-
172. https://doi.org/10.1177/ 2042098616646726

Cosgrove, L., Krimsky, S., Vijayaraghavan, M., & Schneider, L. (2006).
Financial ties between DSM-IV panel members and the
pharmaceutical industry. *Psychotherapy and Psychosomatics*, 75(3),
154-160. https://doi.org/10.1159/000091772

Courtenay, M. & Berry, D. (2007). Comparing nurses' and doctors' views on
prescribing: a questionnaire survey. Nurse Prescribing, 5(5), 205-
210. https://doi.org/10.12968/npre.2007.5.5.23740

Courtney-Walker, R. (2020). A role for psychologists on prescription?. *The
Psychologist,* 32(3), 2.

Craddock, N., Antebi, D., Attenburrow, M., Bailey, A., Carson, A., Cowen, P.,
Craddock, B., Eagles, J., Ebmeier, K., Farmer, A., Fazel, S., Ferrier, S.,
Geddes, J., Goodwin, G., Harrison, P., Hawton, K., Hunter, S.,
Jacoby, R., Jones, I., … Zammit, S. (2008). A wake-up call for British
psychiatry. *The British Journal of Psychiatry,* 193, 6-9.
https://doi.org/10.1192/bjp.bp.108.053561

Cromby, J., Harper, D. & Reavy, P. (2013). *Psychology, mental health and
distress.* Palgrave Macmillan.

Crown, J. (1999). *Review of prescribing, supply and administration of medicines. Final report.* Department of Health. https://webarchive.nationalarchives.gov.uk/ukgwa/201301051433 20/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalasse ts/@dh/@en/documents/digitalasset/dh_4077153.pdf

Davey, L., Clarke, V. & Jenkinson, E. (2019). Living with alopecia areata: an online qualitative survey study. *Qualitative Outcomes and Research,* 180(6), 1377-1389. https://doi.org/10.1111/bjd.17463

Davies, C. (2003). *The future health workforce.* Palgrave MacMillan.

Department of Health. (2000). *The NHS Plan: A Plan for Investment. A Plan for Reform.* http://1nj5ms2lli5hdggbe3mm7ms5.wpengine.netdna-cdn.com/files/2010/03/pnsuk1.pdf.

Department of Health. (2002a, April 16). *Groundbreaking new consultation aims to extend prescribing powers for pharmacists and nurses.* [Press release]. https://webarchive.nationalarchives.gov.uk/ukgwa/200510120622 54/http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/ PressReleasesNotices/fs/en?CONTENT_ID=4013114&chk=JkprtS.

Department of Health (2002b, November 21). *PHARMACISTS TO PRESCRIBE FOR THE FIRST TIME NURSES WILL PRESCRIBE FOR CHRONIC ILLNESS.* [Press release]. https://webarchive.nationalarchives.gov.uk/ukgwa/200510120622 49/http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/ PressReleasesNotices/fs/en?CONTENT_ID=4025974&chk=BOhuz1.

Department of Health. (2003). *Supplementary Prescribing by Nurses and Pharmacists with the NHS in England: A Guide for Implementation.* https://webarchive.nationalarchives.gov.uk/ukgwa/201301071053 54/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalasse ts/@dh/@en/documents/digitalasset/dh_4068431.pdf.

Department of Health. (2005). *Supplementary Prescribing by Nurses, Pharmacists, Chiropodists/Podiatrists, Physiotherapists and*

Radiographers within the NHS in England.
https://webarchive.nationalarchives.gov.uk/ukgwa/200703060201
19/http:/www.dh.gov.uk/assetRoot/04/11/00/33/04110033.pdf.

Department of Health. (2006). *From values to action: the chief nursing
officers review of mental health nursing.*
https://webarchive.nationalarchives.gov.uk/ukgwa/+/www.dh.gov.
uk/assetRoot/04/13/38/40/04133840.pdf.

Department of Health. (2012). *Nurse and Pharmacist Independent
prescribing changes announced.*
https://www.gov.uk/government/news/nurse-and-pharmacist-
independent-prescribing-changes-announced.

Department of Health. (May 5, 2020). [Letter From Chief Pharmaceutical
Officer And Chief Allied Health Professional Officer]. Retrieved from
https://www.health-
ni.gov.uk/sites/default/files/publications/health/CPO-letter-
050520.pdf

Department of Health and Social Security. (1986). *Neighbourhood nursing:
a focus for care (The Cumberlege Report).* HMSO.

Department of Health, Social Services and Public Safety. (2006). Improving
patients' access to medicines: a guide to implementing nurse and
pharmacist independent prescribing within the HPSS in Northern
Ireland. *Department of Health, Social Services and Public Safety*.

Department of Health, Social Services and Public Safety. (2008).
Prescriptions from your high street opticians. Optometrists to get
independent prescribing powers [Press release].

Department of Health, Social Services and Public Safety (2015)
Independent prescribing by physiotherapists and podiatrists or
chiropodists.

DeNelsky, G.Y. (1996). The case against prescription privileges for psychologists. *American Psychologist,* 51(3), 207-212. https://doi.org/10.1037/0003-066X.51.3.207

Division of Clinical Psychology. (2013). Classification of behaviour and experience in relation to functional psychiatric diagnoses: Time for a paradigm shift. DCP Position Statement. https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Classification%20of%20behaviour%20and%20experience%20in%20relation%20to%20functional%20psychiatric%20diagnoses.pdf

Division of Counselling Psychology. (2012). Becoming a counselling psychologist. http:www.bps.org.uk/dcop/home/about/about_home.cfm

Division of Counselling Psychology. (2020). *Professional Practice Guidelines.* https://bpsshop.s3.eu-west-2.amazonaws.com/20841_cat-2020.pdf?X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIA3JJOMCSRTH3PTJ4W%2F20211123%2Feu-west-2%2Fs3%2Faws4_request&X-Amz-Date=20211123T203021Z&X-Amz-SignedHeaders=Host&X-Amz-Expires=10&X-Amz-Signature=e45b3486c98136a79ff8a906206be769799572193d90b88ad37c83c6ab6f6e28

Dobel-Ober, D., Brimblecombe, N., & Bradley, E. (2010). Nurse prescribing in mental health: national survey. *Journal of Psychiatric and Mental Health Nursing*, 17(6), 487-493. https://doi.org/10.1111/j.1365-2850.2009.01541.x

Dobson, K.S., & Dozois, D.J.A. (2001). Professional psychology and the prescription debate: Still not ready to go to the altar. *Canadian Psychology/Psychologie canadienne,* 42(2), 131-135. https://doi.org/10.1037/h0086888

Dooley, C. & Farndon, H. (2021). Best practice in psychology recruitment. The British Psychological Society.

https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%
20-
%20Files/Best%20practice%20in%20psychology%20recruitment.pdf

Dorwick, C. & Frances, A. (2013). Medicalising unhappiness: new classification of depression risks more patients being put on drug treatment from which they will not benefit. *BMJ,* 347(9), 1-5. https://doi.org/10.1136/bmj.f7140

Douglas, B. (2016). Conceptualising in client work. In B, Douglas (Ed.), *The Handbook of Counselling Psychology* (4th ed., pp. 151-168). Sage Publications.

Dozois, D.J.A. & Dobson, K.S. (1995). Should Canadian psychologists follow the APA trend and seek prescription privileges?: A reexamination of the (R)evolution. *Canadian Psychology/Psychologie canadienne,* 36(4), 288-304. https://doi.org/10.1037/0708-5591.36.4.288

Drennan, V.M., Grant, R.L. & Harris, R. (2014). Trends over time in prescribing by English primary care nurses: a secondary analysis of a national prescription database. *BMC Health Services Research,* 14(54), 1-9.

Drescher, J. (2015). Out of DSM: Depathologizing Homosexuality. *Behavioural Sciences,* 5(4), 565-575. https://doi.org/10.3390/bs5040565

Elliott, R., Fischer, C.T, & Rennie, D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology,* 38, 215-229.

Ellis, S.J., Riggs, D.W. & Peel, E. (2019). Lesbian, gay, bisexual, trans, intersex, and queer psychology: An introduction (2nd ed.), Cambridge University Press. https://doi.org/10.1017/9781108303750

Elsom, S., Happell, B. & Manias, E. (2009). Nurse practitioners and medical practice: opposing forces or complimentary contributions?

Perspectives in Psychiatric Care 45(1), 9-16.
https://doi.org/10.1111/j.1744-6163.2009.00195.x

Eriksen, K., & Kress, V.E. (2005). *Beyond the DSM story: Ethical quandaries, challenges and best practices.* Sage Publications Limited.
http://dx.doi.org.ezproxy.uwe.ac.uk/10.4135/9781452204581

Esposito, L., & Perez, F.M. (2014). Neoliberalism and the Commodification of Mental Health. *Humanity & Society*, 38 (4), 414-442.

Etherington, K. (2004). *Becoming a reflexive researcher: Using ourselves in our research.* Jessica Kingsley.

Farber, B. A., Manevich, I., Metzger, J. & Saypo, E. (2005). Choosing psychotherapy as a career: Why did we cross that road? *Journal of Clinical Psychology,* 61(8), 1009–1031.
https://doi.org/10.1002/jclp.20174

Fawcett, J. (2007). Nursing qua nursing: the connection between nursing knowledge and nursing shortages. JAN, 59(1) 97-99.
https://doi.org/10.1111/j.1365-2648.2007.04325.x

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Kloss, M.P. & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventative Medicine,* 14(4), 245-258.
https://doi.org/10.1016/S0749-3797(98)00017-8

Fergurson, C.J. (2015). "Everybody knows psychology is not a real science". Public perceptions of psychology and how we can improve our relationship with policymakers, the scientific community, and the general public. American psychologist, 70(6), 527-542.
https://doi.org/10.1037/a0039405

Fernando, S. (2004). *Cultural diversity, mental health and psychiatry: The struggle against racism*. Routledge.

Fernando, S. (2018). *Institutional Racism in Psychiatry and Clinical Psychology.* Palgrave Macmillan.

Fisher, M. (2017). 'It's not your fault': Consciousness-raising as a reversal of magical voluntarism. *Clinical Psychology Forum Number 297.*

Fitzgerald, J. (2013). Psychologist prescribing in New Zealand: Is it worth considering? *Psychology Aotearoa,* 5(2), 82-85.

Fitzgerald, J., & Galyer, K. (2008). Collaborative prescribing rights for psychologists: The New Zealand perspective. *New Zealand Journal of Psychology,* 37(3), 44-52.

Foucault, M., Baudot, A. & Couchman, J. (1978). About the concept of the "dangerous individual" in 19th-century legal psychiatry. *International Journal of Law and Psychiatry,* 1(1), 1-18.

Frith, H. & Gleeson, K. (2004). Clothing and embodiment: Men managing body image and appearance. *Psychology of Men & Masculinity,* 5(1), 40-48. https://doi.org/10.1037/1524-9220.5.1.40

George, J., McCaig, D.J., Bond, C.M., Cunningham, S., Diack, H.L., Watson, A.M. & Stewart, D.C. (2006). Supplementary prescribing: early experiences of pharmacists in Great Britain. Annals of Pharmacotherapy, 40(10) 1843-1850. https://doi.org/10.1345/aph.1H227

George, J., McCaig, D., Bond, C., Cunningham, I., Diack, H. & Stewart, D. (2007). Benefits and challenges of prescribing training and implementation: perceptions and early experiences of RPSGB prescribers. International Journal of Pharmacy Practice, 15(1), 23-30. https://doi.org/10.1211/ijpp.15.1.0005

George, N. & Semp, D. (2013). Questioning identity: A critique of arguments for prescribing rights for psychologists in New Zealand. *Psychology Aotearoa,* 5(2), 80-82.

Gilburt, H. (2018). Funding and staffing of NHS mental health providers: still waiting for parity. *The King's Fund.*

https://www.kingsfund.org.uk/publications/funding-staffing-mental-health-providers

Gomez, A.F., Barthel, A.L. & Hofmann, S.G. (2018). Comparing the efficacy of benzodiazepines and serotonergic antidepressants for adults with generalized anxiety disorder: A meta-analytic review. *Expert Opinion on Pharmacotherapy,* 19(8), 883-894. https://doi.org/10.1080/14656566.2018.1472767

Goodman, D.M. (2016). The McDonaldization of psychotherapy: Processed foods, processed therapies, and economic class. *Theory & Psychology*, 26(1), 77-95. https://doi.org/10.1177/0959354315619708

Graham-Clarke, E., Rushton, A., Noblet, T. & Marriott, J. (2019). Non-medical prescribing in the United Kingdom National Health Service: A systematic policy review. *PLoS ONE,* 14(7), 1-29. https://doi.org/10.1371/journal.pone.0214630

Gray, A. (2014). *An Introduction to the Therapeutic Frame.* Classic edition. Routledge.

Jones, M., Bennett, J., Miller, D., Lucas, B. & Gray, R. (2007). Mental health nurse supplementary prescribing: experiences of mental health nurses, psychiatrists and patients. *Journal of Advanced Nursing*, 59(5), 488-496.

Gergen, K. J. (2009). *An invitation to social construction* (2nd ed.). Sage.

Green, A., Westwood, O., Smith, P., Peniston-Bird, F. & Hollaway, D. (2009). Provision of continued professional development for non-medical prescribers within a South of England Strategic Health Authority: a report on training needs analysis. Journal of Nurse Management, 17(5), 603-614 https://doi.org/10.1111/j.1365-2834.2008.00892.x

Greene, M.A. (2001). The Effects of the Introduction of Medication on the Psychoanalytic Process: A case study. *Journal of the American*

Psychoanalytic Association, 49(2), 607-627.
https://doi.org/10.1177/00030651010490020901

Guy, A., Davies, J. & Rizq, R. (2019). Guidance for psychological therapists: Enabling conversations with clients taking or withdrawing from prescribed psychiatric drugs. APPG for Prescribed Drug Dependence. https://prescribeddrug.info/guidance-for-psychological-therapists/

Hacking, S. & Taylor, J. (2010) An evaluation of the scope and practice of Non-Medical Prescribing in the North West for NHS North West. Final Report. https://www.researchgate.net/publication/228406352_An_evaluation_of_the_scope_and_practice_of_Non_Medical_Prescribing_in_the_North_West_For_NHS_North_West

Hadjiosif, M. (2019, December 12). Here be 'cognitivism' [Blog post]. https://blogs.uwe.ac.uk/psychological-sciences/here-be-cognitivism/

Hadjiosif, M. (2021). The ethos of the nourished wounded healer: A narrative inquiry. *European Journal of Psychotherapy & Counselling,* 23(1), 43-69. https://doi.org/10.1080/13642537.2021.1881137.

Halvorsrud, K., Nazroo, J., Otis, M., Hajdukova, E.B. & Kamaldeep, B. (2019). Ethnic inequalities in the incidence diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses. *Social Psychiatry,* 54(11), 1311-1323. https://doi.org/10.1007/s00127-019-01758-y

Hammersley, D. (2016). The Interface between psychopharmacological and psychotherapeutic approaches. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.), *Handbook of Counselling Psychology (*4th ed., pp. 259-275). Sage Publications Ltd.

Hammersley, D. (2021). Wanderer to warrior. *Counselling Psychology Review*, 36(1), 55-62.

Hare, E. (1956). Mental illness and social conditions in Bristol. *Journal of Mental Science,* 102(427), 349–357. https://doi.org/10.1192/bjp.102.427.349

Hargons, C., Mosley, D., Falconer, J., Faloughi, R., Singh, A., Stevens-Watkins, D. & Cokley, K. (2017). Black Lives Matter: A Call to Action for Counselling Psychology Leaders. *The Counseling Psychologist,* 45(6), 873-901. DOI https://doi.org/10.1177/0011000017733048

Harvey, P. (2021). A challenge to the BPS on Prescribing Rights for psychologists. *BPS Watch.* https://bpswatch.com/category/prescribing-rights/

Health & Care Professions Council (HCPC). (2021). The standards of proficiency for practitioner psychologists. https://www.hcpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/

Healy, D. (2006). Manufacturing consensus. *Culture, Medicine and Psychiatry*, 30(2), 135-136. https://doi.org/10.1007/s11013-006-9013-3

Healy, D. (2016). *Psychiatric drugs explained (6th ed.).* Elsevier Limited.

Heiby, E.M. (2010). Concerns about substandard training for prescription privileges for psychologists. *Journal of Clinical Psychology*, 66(1), 104-111. https://doi.org/10.1002/jclp.20650

HMSO. (2012). The misuse of drugs regulations 2012 relating to nurse and pharmacist independent prescribing of controlled drugs (Amendment No.2) (England, Wales and Scotland) regulations 2012 No. 973. The Stationery Office. Available via https://www.gov.uk/government/news/nurse-and-pharmacist-independent-prescribing-changes-announced. Accessed 04 Jun 2022.

Holbrook, M.A., Crowther, R., Lotter, A., Cheng, C. & King, D. (2000). Meta-analysis of benzodiazepine use in the treatment of insomnia. *Canadian Medical Association Journal,* 162(2), 225-233.

Holmes, J. (2014). Attachment theory in therapeutic practice. In A, Danquah & K, Berry. *Attachment theory in Adult Mental Health A Guide to Clinical Practice* (pp. 16-32). Routledge.

Hopton, J. (2006). The future of critical psychiatry. *Critical Social Policy,* 26(1), 57-73. https://doi.org/10.1177/0261018306059776

Horton, R. (2003). Nurse-prescribing in the UK: Right but also wrong. The Lancet, 359(9321) 1875-1876 https://doi.org.uk/10.1016/S0140-6736(02)08786-X

Howard, S. (2010). *Skills in psychodynamic counselling & psychotherapy.* Sage Publications Ltd.

Howes, O.D., McCutcheon, R., Owen, M.J. & Murray, R.M. (2017). The role of genes, stress, and dopamine in the development of schizophrenia. *Biological Psychiatry,* 81(1), 9–20.

Huf, G., Alexander, J., Gandhi, P. & Allen, M.H. (2016). Haloperidol plus promethazine for psychosis-induced aggression (Review). *Cochrane Database of Systematic Reviews,* 11. https://doi-org.ezproxy.uwe.ac.uk/10.1002/14651858.CD005146.pub3

Human Medicines Regulations, 1916 UK Statutory Instruments (2012).

Insel, T.R. (2009). Disruptive insights in psychiatry: Transforming a clinical discipline. *The Journal of Clinical Investigation*, 119(4), 700-705. https://doi.org/10.1172/JCI38832

Johnstone, L. (2000). *Users and abusers of psychiatry. A critical look at psychiatric practice.* (2nd ed.). Routledge.

Johnstone, L. (2003). Back to basics. *The psychologist*, 16(4), 186-187.

Johnstone, L. (2014). *A straight talking introduction to psychiatric diagnosis.* PCCS Books Ltd.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The power threat meaning framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* British Psychological Society. https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/PTM%20Main.pdf

Jones, P.B., Barnes, T.R.E., Davies, L., Lloyd, H., Hayhurst, K.P., Murray, R.M., Markwick, A. & Lewis, S. (2006). Randomized control trial of the effect on quality of life of second vs first generation antipsychotic drugs in schizophrenia. *JAMA Psychiatry,* 63(10), 1079-1087. https://doi.org/doi:10.1001/archpsyc.63.10.1079

Jeraj, S., Shoham, T. & Islam-Barratt, F. (2014). Mental health crisis services for black and minority ethnic people. *Race equality foundation.* http://raceequalityfoundation.org.uk/wp-content/uploads/2018/10/REF-Overview-Report-Final-Version.pdf

Kagan, C., Burton, M., Duckett, P., Lawthom, R. & Siddiquee, A. (2019). *Critical community psychology: Critical action and social change* (2nd ed.). Routledge.

Kamens, S. (2013, May 15). Dr. Insel, or: how psychiatry learned to stop worrying and love the biomarker. A response to RDoC [Conference paper]. Global Summit on Diagnostic Alternatives. https://doi.org/10.13140/RG.2.1.1905.8725

Kirmayer, L. (2003). Asklepian dreams: The ethos of the wounded-healer in the clinical encounter. *Transcultural Psychiatry,* 40(2), 248–277. https://doi.org/10.1177/1363461503402007

King, M. (2001). Prescription privileges and the counselling psychologist. *Counselling Psychology Review*, 16(1), 10-13.

Kroezen, M., Dijk, L., Groenewegen, P.P. & Francke, A.L. (2013). Knowledge Claims, Jurisdictional Control and Professional Status: The Case of

Nurse Prescribing. *PLoS One*, 8(10), 1-9.
https://doi.org/10.1371/journal.pone.0077279

Kupfer, D.J., First, M.B. & Regier, D.A. (2002). A Research Agenda for DSM
V. American Psychiatric Association Press.
https://contextualscience.org/system/files/Kupfer,2002.pdf

Lacasse, J.R. & Leo, J. (2005). Serotonin and depression: A disconnect
between the advertisements and the scientific literature. PLoS
medicine, 2(12), 1211-1216.
https://doi.org/10.1371/journal.pmed.0020392

Latter, S., Mabben, J., Myall, M., Courtenay, M., Young, A. & Dunn, N.
(2005). An evaluation of extended formulary independent nurse
prescribing: executive summary. University of Southampton School
of Nursing and Midwifery on behalf of Department of Health.

Leathard, H.I. (2001). Understanding medicines: Conceptual analysis of
nurses needs for knowledge and understanding of pharmacology
(Part 1). Nurse Education Today, 21 260-271.

Lees, D., Procter, N. & Fassett, D. (2014). Therapeutic engagement
between consumers in suicidal crisis and mental health nurses.
International Journal of Mental Health Nursing, 23 (4), 306-315.
https://doi.org/10.1111/inm.12061

Lehtinen, V., Aaltonen, J., Koffert, T., Rakkolainen, V. & Syvalahti, E. (2000).
Two-year outcome in first-episode psychosis treated according to
an integrated model. Is immediate neuroleptisation always needed?
European Psychiatry, 15(5), 312-320.
https://doi.org/10.1016/s0924-9338(00)00400-4

Leucht, S., Arbter, D., Engel, R.R., Kissling, W. & Davis, J.M. (2009). How
effective are second-generation antipsychotic drugs? A meta-
analysis of placebo-controlled trials. *Molecular Psychiatry*, 14(4),
429-447. https://doi.org/10.1038/sj.mp.4002136

Linda, W.P. & McGrath, R.E. (2017). The current status of prescribing psychologists: Practice patterns and medical professional evaluations. *Professional Psychology: Research & Practice,* 48(1), 38-45. https://doi.org/10.1037/pro0000118

Lloyd, F., Adair, C.G., Agnew, J., Blayney, C., Boyd-McMurty, G., Brown, O., Campbell, A., Clarke, K., Crawford, P., Gill, D., Harrison, C., McClelland, J., McManus, M.F., McMullan, M., Moore, B., Hare, R.O., O'Loan, L., Tennyson, M. & Winning, H. (2017). Non-medical Prescribing in Northern Ireland. In. M.P. Franklin (Ed.), *Non-medical prescribing in the United Kingdom* (pp. 29-43). Springer.

Louisiana Academy of Medical Psychologists (LAMP). (n.d.). Retrieved from: https://louisianamedpsych.com/

MacCulloch, T., & Shattell, M. (2009). Reflections of a "wounded healer". *Issues in Mental Health Nursing,* 30(2), 135–137. https://doi.org/10.1080/01612840802601390

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology,* 91, 1-20.

Martin, P. (2011). Celebrating the wounded healer. *Counselling Psychology Review,* 26(1), 10-19.

Mcintosh, M. & Nicholas, H. (2015). Dispelling the myths about counselling psychologists whilst challenging discrimination. [Letter to DCoP members]. https://www1.bps.org.uk/system/files/user-files/Division%20of%20Counselling%20Psychology/public/dcop_dispelling_myths_letter_nov_2015.pdf

Mclaughlin, J. & Webster, A. (1998). Rationalising knowledge: IT systems, professional identities and power. *The sociology review,* 46(4), 781-802.

McLeod, J. (2009). *An introduction to counselling (4th ed.).* Open University Press.

McNamee, S., & Gergen, K. J. (1992). Introduction. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 1-6). Sage

McPherson, I., & Sutton, A. (1981). *Reconstructing psychological practice.* Croom Helm.

Meade, O., Bowskill, D. & Lymn, J. (2011). Pharmacology podcasts: a qualitative study of non-medical prescribing students' use, perceptions and impact on learning. BMC Medical Education, 11(2), 1-10 https://doi.org/10.1186/1472-6920-11-2

Medicines & Healthcare Products Regulatory Agency. (2005a). *Consultation on options for the future of independent prescribing by extended formulary nurse prescribers.* https://webarchive.nationalarchives.gov.uk/ukgwa/200504252246 58/http://www.dh.gov.uk/Consultations/LiveConsultations/LiveCon sultationsArticle/fs/en?CONTENT_ID=4104057&chk=xNuvDV

Medicines & Healthcare Products Regulatory Agency. (2005b). *Consultation on proposals to introduce independent prescribing by pharmacists.* https://webarchive.nationalarchives.gov.uk/ukgwa/201410080424 55/http://www.mhra.gov.uk/home/groups/comms-ic/documents/websiteresources/con007684.pdf

Merton, R. (1963). *Social theory and social structure.* Free Press

Milrod, B.L. & Busch, F.N. (1998). Combining psychodynamic psychotherapy with medication in the treatment of panic disorder: Exploring the dynamic meaning of medication. *Psychoanalytic Inquiry,* 18(5), 702-715. https://doi.org/10.1080/07351699809534221

Mills, E. (2017). Non-medical Prescribing in Wales: Implementation and Governance. In M.P. Franklin (Ed.), *Non-medical prescribing in the United Kingdom* (pp. 22-28). Springer.

Mitchell, M. (2003). Project initiation document—project to enable nurses and pharmacists in Wales to become supplementary prescribers by developing and introducing an appropriate training programme.

Mitchell, M., Howarth, C., Kotecha, M., & Creegan, C. (2009). Sexual Orientation research review 2008. *Equality and Human Rights Commission Research Report 34*. http://www.equalityhumanrights.com/publication/research-report34-sexual-orientation-research-review-2008

MITUKadmin. (2019, November 19). Prescribing Rights for UK Psychologists – Should We Be Cautious?. Mad in the UK. https://www.madintheuk.com/2019/11/prescribing-rights-psychologists-cautious/.

Moller, N. (2011). The identity of counselling psychology in Britain is parochial, rigid and irrelevant but diversity offers a solution. *Counselling Psychology Review,* 26(2) 8-16.

Moloney, P. (2013). *The therapy industry: The irresistible rise of the talking cure, and why it doesn't work.* Pluto Press.

Moncrieff, J. (2006). The politics of psychiatric drug treatment. In D. Double (Ed.), *Critical psychiatry: The limits of madness (pp. 115-132).* Palgrave Macmillan.

Moncrieff, J. (2007). Co-opting psychiatry: The alliance between academic psychiatry and the pharmaceutical industry. *Epidemiologia e Psichiatria Sociale*, 16(3), 192-196.

Moncrieff, J. (2008a). Neoliberalism and biopsychiatry: A marriage of convenience. In C. Cohen & S. Timimi (Eds.), Liberatory psychiatry: philosophy, politics and mental health (pp. 235-256). Cambridge University Press. https://doi-org.ezproxy.uwe.ac.uk/10.1017/CBO9780511543678.

Moncrieff, J. (2008b). *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment.* Palgrave Macmillan.

Moncrieff, J. (2009). A critique of the dopamine hypothesis of schizophrenia and psychosis. *Harvard review of psychiatry,* 17(3), 214-225. https://doi.org/10.1080/10673220902979896

Moncrieff, J. (2013a). *The bitterest pills: The troubling story of antipsychotic drugs.* Palgrave Macmillan. https://doi-org.ezproxy.uwe.ac.uk/10.1057/9781137277442

Moncrieff, J. (2013b, November 21). Models of drug action. *Critical Psychiatry Network.* https://joannamoncrieff.com/2013/11/21/models-of-drug-action/

Moncrieff, J. (2013c). Magic Bullets for Mental Disorders: The Emergence of the Concept of an "Antipsychotic" Drug. *Journal of the History of the Neurosciences,* 22(1) pp, 30-46. https://doi.org/10.1080/0964704X.2012.664847

Moncrieff, J. & Cohen, D. (2005). Rethinking models of psychotropic drug action. Psychotherapy and psychosomatics, 74(3), 145-153. https://doi.org/10.1159/000083999

Moncrieff, J., Cooper, R.E., Stockmann, T., Amendola, S., Hengartner, M.P. & Horowitz, A. (2022). The serotonin theory of depression: a systematic umbrella review of the evidence. *Molecular Psychiatry.* https://doi.org/10.1038/s41380-022-01661-0

Moncrieff, J. & Stockmann, T. (2019). 4. What psychiatric drugs do by class. In: A. Guy, J. Davies, R. Rizq (Eds.), *Guidance for psychological therapists: Enabling conversations with clients taking or withdrawing from prescribed psychiatric drugs.* APPG for Prescribed Drug Dependence. https://prescribeddrug.info/guidance-for-psychological-therapists/

Moore, N., Pariente, A., & Begaud, B. (2015). Why are benzodiazepines not yet controlled substances? *JAMA Psychiatry*, 72(2), 110-111. https://doi.org/10.1001/jamapsychiatry.2014.2190

Murray, B. (2003). A brief history of RxP. American Psychological Association, 34(9), 66. https://www.apa.org/monitor/oct03/rxp

National Assembly for Wales (2001a) Improving health in Wales. A plan for the NHS with its Partners. National Assembly for Wales.

National Assembly for Wales (2001b) Report of the task and finish group for prescribing in Wales. National Assembly for Wales.

National Assembly for Wales (2001c) Improving health in Wales—the future of primary care. National Assembly for Wales.

National Assembly for Wales (2007) The National Health Service, (miscellaneous amendments concerning independent nurse prescribers, supplementary prescribers, nurse independent prescribers and pharmacist independent prescribers) (Wales) regulations 2007. Statutory Instruments 2007, No 205 (W.19). http://www.legislation.gov.uk/changes/affected/wsi/2007

National Health Service. (2006). *The National Health Service (Miscellaneous Amendments Relating to Independent Prescribing) Regulations 2006.* https://www.legislation.gov.uk/uksi/2006/913/made.

NHS Digital. (2014). Psychological Therapies, Annual Report on the use of Improving Access to Psychological Therapies Services – England, 2012-13, Official statistics. https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2012-13

NHS Wales (2017). Non Medical Prescribing In Wales: Guidance. https://gov.wales/sites/default/files/publications/2019-07/guidance-on-non-medical-prescribing-in-wales-may-2017.pdf

National Institute for Health and Care Excellence. (2009). *Depression in adults: recognition and management.* NICE Clinical Guideline 90. https://www.nice.org.uk/guidance/cg90/resources/depression-in-adults-recognition-and-management-pdf-975742636741

National Institute for Health and Care Excellence. (2011). General anxiety disorder and panic disorder in adults: management. NICE Clinical Guideline 113. https://www.nice.org.uk/guidance/cg113/chapter/1-Guidance

National Institute for Health and Care Excellence. (2014). *Psychosis and schizophrenia in adults: prevention and management.* NICE Clinical Guideline 178. https://www.nice.org.uk/guidance/cg178/resources/psychosis-and-schizophrenia-in-adults-prevention-and-management-pdf-35109758952133

National Institute for Health and Care Excellence. (2021, November 23). NICE creates new menu of treatment options for those suffering from depression [Press release]. https://www.nice.org.uk/news/nice-creates-new-menu-of-treatment-options-for-those-suffering-from-depression

National Institute of Mental Health Psychopharmacology Service Center Collaborative Study Group (NIMH). (1964). Phenothiazine treatment in acute schizophrenia. *Archives of General Psychiatry,* 10(3), 246-261. https://doi.org/10.1001/archpsyc.1964.01720210028005

National Prescribing Centre. (2005). *Improving mental health services by extending the role of nurses in prescribing and supplying medication:* Good practice guide. National Prescribing Centre.

Nazroo J, Bhui KS, Rhodes J. (2019). Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism. Sociol Health Illn, 42(2), 262-276. https://doi.org/10.1111/1467-9566.13001

Newnes, C., Holmes, G. & Dunn, C. (1999). *This is madness: A critical look at psychiatry and the future of mental health services.* PCCS Books.

NHS England. (2018, March 31). Better treatment for patients as advanced paramedics prescribe medicines. [Press release]. https://www.england.nhs.uk/2018/03/paramedic-prescribing/.

Nightingale, D.J., & Cromby, J. (2001). Critical Psychology and the Ideology of Individualism. Journal of Critical Psychology, Counselling and Psychotherapy, 1(2), 117-128. https://www.researchgate.net/publication/228490083_Critical_psychology_and_the_ideology_of_individualism

Nussbaum, D. (2001). Psychologists should be free to pursue prescription privileges: A reply to Walters. *Canadian Psychology/Psychologie canadienne,* 42(2), 126-130. https://doi.org/10.1037/h0086887

Offredy, M., Kendall, S. & Goodman, C. (2008). The use of cognitive continuum theory and patient scenarios to explore nurse prescribers' pharmacological knowledge and decision-making. International Journal of Nursing Studies, 45(6) 855-868 https://doi.org.uk/10.1016/j.ijnurstu.2007.01.014

Orford, J. (2003). Don't go there. *The psychologist,* 16(4), 189.

Orlans, V., & Van Scoyoc, S. (2008). *A Short Introduction to Counselling Psychology.* Sage Publications Ltd.

Page, G. (2005). Professional socialization of valuers: What the literature and professional bodies offers. *International Education Journal,* 5(5), 105–116.

Parker, C., Scott, S. & Geddes, A. (2019). Snowball Sampling. *SAGE Research Methods Foundations.* https://eprints.glos.ac.uk/6781/

Parker, I., Georgaca, E., Harper, D., McLaughlin, T. & Stowell-Smith, M. (1995). *Deconstructing psychopathology.* Sage Publications Ltd.

Parker, I. & Shotter, J. (1990). *Deconstructing Social Psychology*. Psychology Press.

Parker, I. (2005). *Qualitative psychology: Introducing radical research.* Open University Press.

Patel, K., Caddy, C. & Tracy, D.K. (2018). Who do they think we are? Public perceptions of psychiatrists and psychologists. *Advances in Mental*

Health, 16(1), 65-76.

https://doi.org/10.1080/18387357.2017.1404433

Patel, M.X., Robson, D., Rance, J., Ramire, N., Memon, T.C., Bressington, D.
& Gray, R. (2009). Attitudes regarding mental health nurse
prescribing among psychiatrists and nurses: A cross-sectional
questionnaire study. *International Journal of Nursing Studies,*
46(11), 1467-1474. https://doi.org/10.1037/t25112-000

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C. &
Link, B. G. (2010). "A disease like any other"? A decade of change in
public reactions to schizophrenia, depression, and alcohol
dependence. *American Journal of Psychiatry,* 167(11), 1321–1330.
https://doi.org/10.1176/appi.ajp.2010.09121743

Pilgrim, D. (2013). Some implications of critical realism in mental health
research. *Social Theory & Health,* 12(1), 1-21.
https://doi.org/10.1057/sth.2013.17

Potter, J. (1996). *Representing reality: Discourse, rhetoric and social
construction.* Sage

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond
attitudes and behaviour.* Sage.

Prytherch, H., Cooke, A. & Marsh, I. (2020). Coercion or collaboration:
service-user experiences of risk management in hospital and a
trauma-informed crisis house. *Psychosis.*
https://doi.org/10.1080/17522439.2020.1830155

Rabiee, F. & Smith, P. (2014). Understanding mental health and experience
of accessing services among African and African Caribbean Service
Users and Carers in Birmingham. *Diversity and Equality in Health
and Care,* 11, 125-134

Ramachandraih, C.T., Subramanyam, N., Jurgen Bar, K., Baker, G., &
Yeragani, V.K. (2011). Antidepressants: From MAOIs to SSRIs and

more. *Indian Journal of Psychiatry,* 53(2), 180-182. https://doi.org/10.4103/0019-5545.82567

Read, J. (2005). The bio-bio-bio model of madness. *The psychologist,* 18(10), 596-597. https://thepsychologist.bps.org.uk/volume-18/edition-10/bio-bio-bio-model-madness

Read, J., Harrop, C., Geekie, J., & Renton, J. (2018). An audit of ECT in England 2011–2015: Usage, demographics, and adherence to guidelines and legislation. *Psychology and Psychotherapy: Theory, Research and Practice,* 91(3), 263–277. https://doi.org.uk/10.1111/papt.12160

Resnick, R. (2003). To prescribe or not to prescribe – Is that the question? *The psychologist,* 16(4), 184-186.

Rice-Oxley, M. & Fishwick, C. (2013, November 13). Medicalisation of misery to blame for soaring use of antidepressants, say GPs. *The Guardian.* https://www.theguardian.com/society/2013/nov/21/prescribing-culture-blame-rise-antidepressants

Richards, C. (2019). Editorial: CPR – The last 10 years and the next. *Counselling Psychology Review*, 34(2), 1-2.

Rideout, A. (2017). Non-medical Prescribing in Scotland. In M.P. Franklin (Ed.), *Non-medical prescribing in the United Kingdom* (pp. 13-21). Springer.

Rizq, R., Guy, A. & Stainsby, K. (2020). *A short guide to what every psychological therapist should know about working with prescribed psychiatric drugs.* APPG for Prescribed Drug Dependence. https://prescribeddrug.info/short-guidance/

Robinson, D.G., Woerner, M.G., Napolitano, B., Patel, R.C., Sevy, S.M., Gunduz-Bruce, H., Soto-Perello, J.M., Mendelowitz, A., Khadivi, A., Miller, R., McCormack, J., Lorell, B.S., Lesser, M.L., Schooler, N.R., & Kane, J.M. (2006). Randomized comparison of olanzapine versus

risperidone for the treatment of first episode schizophrenia: 4-month outcomes. *Am.J.Psychiatry,* 163(12), 2096-2102. https://doi.org/10.1176/ajp.2006.163.12.2096

Ross, J.D. (2015). Mental health nurse prescribing: The emerging impact. *Journal of Psychiatric and Mental Health Nursing*, 22(7), 529-542. https://doi.org/10.1111/jpm.12207

Ross, J.D. & Kettles, A.M. (2012). Mental health nurse independent prescribing: What are nurse prescribers' views of the barriers to implementation? *Journal of Psychiatric and Mental Health Nursing*, 19(10), 916-932. https://doi.org/10.1111/j.1365-2850.2011.01872.x

Royal College of Nursing. (2018). NHS job evaluation reviews: what to do if you think your pay band is wrong.

Royal College of Psychiatrists. [@rcpsych]. (2017, August 3). The old idea that ADs correct a chemical imbalance in the brain is an over-simplication [Tweet]. Twitter. https://mobile.twitter.com/rcpsych/status/893154811973185536

Royal College of Psychiatrists. (2018, February 21). Press release: Mental health trusts' income lower than in 2011-12 [Press release]. https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2018/02/21/mental-health-trusts-income-lower-than-in-2011-12

Royal College of Psychiatrists. (2019a). Depression in adults. https://www.rcpsych.ac.uk/mental-health/problems-disorders/depression

Royal College of Psychiatrists. (2019b). Position statement on antidepressants and depression. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps04_19---antidepressants-and-depression.pdf?sfvrsn=ddea9473_5

Royal College of Psychiatrists. (2020). Stopping antidepressants.
https://www.rcpsych.ac.uk/mental-health/treatments-and-
wellbeing/stopping-antidepressants

Safran, J.D. & Muran, C. (2000). *Negotiating The Therapeutic Alliance A
Relational Treatment Guide.* The Guildford Press.

Sammons, M.T., & Levant, R.F. (2003). Yes, but there is another question.
The psychologist, 16(4), 187-188.

Sandberg, L.S. (2014). On the prescribing analyst. *The Psychoanalytic
Quarterly,* 83(1), 97-120. https://doi.org/10.1002/j.2167-
4086.2014.00078.x

Scottish Executive (2006a) Non medical prescribing in Scotland: guidance
for nurse independent prescribers and for community practitioner
nurse prescribers in Scotland: a guide for implementation. Scottish
Executive Health Department.

Scottish Executive (2006b) Delivering care, enabling health: harnessing the
nursing, midwifery and allied health professions' contribution to
implementing delivering for health in Scotland. Scottish Executive
Health Department.

Scottish Government (2009) Improving outcomes by shifting the balance of
care: delivery framework. Scottish Government.

Scull, A. (2011). *Madness A Very Short Introduction.* Oxford: Oxford
University Press.

Sharfstein, S. (2005, August 19). Big pharma and American psychiatry: The
good the bad and the ugly. *Psychiatric News.*
https://doi.org/10.1176/pn.40.16.00400003

Shorter, E. (1997). *A history of psychiatry: From the era of the asylum to the
age of Prozac.* Wiley.

Singh, S.P. & Burns, T. (2006). Race and mental health: there is more to
race than racism. *BMJ,* 333(7569), 648-651.
https://doi.org/10.1136/bmj.38930.501516.BE

Slee, A., Nazareth, I., Bondaronek, P., Liu, Y., Cheng., Z. & Freemantle, N. (2019). Pharmacological treatments for generalised anxiety disorder: A systematic review and network meta-analysis. *Lancet,* 393(10173), 768-777. https://doi.org/10.1016/S0140-6736(18)31793-8

Smithson, J. (2000). Using and analysing focus groups: limitations and possibilities. *International Journal of Social Research Methodology*, 3(2), 103-119.

Snowdon, A. (2010). Integrating medicines management into mental health nursing in UK. *Archives of Psychiatric Nursing*, 24(3), 178-188. https://doi.org/10.1016/j.apnu.2009.12.003

Snowden, A. & Martin, C. (2010). Mental health nurse prescribing: A difficult pill to swallow? *Journal of Psychiatric and Mental Health Nursing*, 17, 543-553. https://doi.org/10.1111/j.1365-2850.2010.01561.x

Sodha, M., Mclaughlin, M., Williams, G. & Dhillon, S. (2002). Nurses' confidence and pharmacological knowledge: A study. British Journal of Community Nursing, 7(6) 309-315 https://doi.org.uk/10.12968/bjcn.2002.7.6.10476

St. Pierre, E.S., & Melnyk, W.T. (2004). The prescription privilege debate in Canada: The voices of today's and tomorrow's psychologists. *Canadian Psychology/Psychologie canadienne*, 45(4), 284-292. https://doi.org/10.1037/h0086999

Strawbridge, S. (2016). Science, craft and professional values. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket and V. Galbraith (Eds.) Handbook of counselling psychology (4th edn, pp.20–38). Sage.

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *The handbook of counselling psychology (*3rd ed*., pp. 3-22). Sage Publications Ltd.

Stewart, D., George, J., Bond, C., Diack, L., McCaig, D. & Cunningham S. (2009). Views of pharmacist prescribers, doctors and patients on pharmacist prescribing implementation. International Journal of Pharmacy Practice, 17(2), 89-94 https://doi.org/10.1211/ijpp.17.02.0003

Synergi. (2018). The impact of racism on mental health: briefing paper. https://legacy.synergicollaborativecentre.co.uk/wp-content/uploads/2017/11/The-impact-of-racism-on-mental-health-briefing-paper-1.pdf

Szasz, T. (1960). The myth of mental illness. *American Psychologist,* 15(2), 113-118.

Taylor, J. (2022). Sexy but psycho: How the Patriarchy uses Women's Trauma Against Them. Constable.

Taylor, L., McMinn, M.R., Bufford, R.K. & Chang, K. (2010). Psychologists' Attitudes and Ethical Concerns Regarding the Use of Social Networking Web Sites. Faculty Publications – Grad School of Clinical Psychology, Paper 166.

Terry, G., & Braun, V. (2017). Short but Often Sweet: The Surprising Potential of Qualitative Survey Methods. In V. Braun, V. Clarke & D. Gray (Eds.), *Collecting Qualitative Data: A practical guide to textual, media and virtual techniques* (pp.15-40). Cambridge University Press. https://doi.org/10.1017/9781107295094

Timimi, S. (2020). Insane Medicine, Chapter 2: The Scientism of Psychiatry (Part 1). https://www.madinamerica.com/2020/10/insane-medicine-chapter-2-part-1/

Toerien, M. & Wilkinson, S. (2004). Exploring the depilation norm: a qualitative questionnaires study of women's body hair removal. *Qualitative Research in Psychology*, 1(1), 69-92. https://doi.org/10.1191/1478088704qp006oa

Tribe, R. & Bell, D. (2017). Social justice, diversity and leadership. *The European Journal of Counselling Psychology,* 6(1), 111-125. https://doi.org/10.5964/ejcop.v6i1.145

Tutter, A. (2006). Medication as Object. *Journal of the American Psychoanalytic Association*, 54(3), 781-804. https://doi.org/10.1177/00030651060540031401

Walters, G.D. (2001). A meta-analysis of opinion data on the prescription privilege debate. *Canadian Psychology/Psychologie canadienne*, 42(2), 119-125. https://doi.org/10.1037/h0086886

Waring, J. (2007). Adaptive Regulation or Governmentality: Patient Safety and the Changing Regulation of Medicine. Sociology of Health and Illness, 29(2) 163-179. https://doi.org/10.1111/j.1467-9566.2007.00527.x

Watterson, A., Turner, F., Coull, A. & Murray, I. (2009). An Evaluation of the Expansion of Nurse Prescribing in Scotland (Final Report) https://www.gov.scot/publications/evaluation-expansion-nurse-prescribing-scotland/

Weich, S., & Lewis, G. (1998). Poverty, unemployment, and common mental disorders: Population based cohort study. *British Medical Journal,* 317(7151), 115-119. https://doi-org.ezproxy.uwe.ac.uk/10.1136/bmj.317.7151.115

Weiss, M., Sutton, J. & Adams, C. (2006). Exploring innovations in pharmacy practice: A qualitative evaluation of supplementary prescribing by pharmacists. Royal Pharmaceutical Society of Great Britain. https://pharmacyresearchuk.org/wp-content/uploads/2012/11/Exploring_innovation_in_pharmacy_practice_supplementary_prescribing.pdf

Welsh Assembly Government (WAG). (2002). Improving health in Wales: remedies for success—a strategy for pharmacy in Wales—a consultation document. Welsh Assembly Government.

Welsh Assembly Government (WAG). (2005). Designed for life. Creating world class health and social care for Wales in the 21st century. Welsh Assembly Government.

Whittington, A., & Lake, N. (2015). Clinical psychology: past, present, future. In G. Davey, N. Lake. & A. Whittington (Eds.), *Clinical Psychology* (2nd ed., pp. 273-286). Routledge.

Wilkinson, R. & Pickett, K. (2010). *The spirit level: Why equality is better for everyone.* Penguin Books.

Wolkowitz, O.M. & Pickar, D. (1991). Benzodiazepines in the treatment of schizophrenia: A review and reappraisal. *The American Journal of Psychiatry,* 148(6), 714-726. https://doi.org/10.1176/ajp.148.6.714

Woolfe, R. (1990). Counselling Psychology in Britain: An idea whose time has come. The Psychologist, 12, 531-535.

Woolfe, R. (2013). Foreword. In B. Douglas & P. James (Eds.), *Common Presenting Issues in Psychotherapeutic Practice.* Sage

Woolfe, R. (2016). Mapping the World of Helping: The place of Counselling Psychology. In B. Douglas (Ed.), *The Handbook of Counselling Psychology* (4th ed., pp. 5-19). Sage Publications.

Zolowitz, S. (2018). Psychology for social change. *The psychologist,* 31, 8-9.

7. Appendices

Appendix A: Online Survey

Appendix B: Online Survey Demographic Questionnaire

Appendix C: Ethical Approval Letter

Appendix D: Online Survey Participant Information Sheet

Appendix E: Online Survey Consent Form

Appendix F: Initial Thematic Map

Appendix G: Final Thematic Map

Appendix H: Journal Article

Appendix A: Online Survey

1. What is your understanding of how medication is used to treat mental health disorders and symptoms?
2. Are there any mental health problems that you believe warrant medication? Please explain your answer.
3. If psychologists were to gain prescription rights how do you think it would affect;
   a. The therapeutic relationship between client and psychologist
   b. A psychologist's professional relationships in the workplace
   c. Society's understanding of a psychologist's role
4. Can you give a case example that captures why you feel the way you do about this issue? This example can be personal, professional or fictional (please indicate if you are using a fictional example and do not use any identifying information).
5. When and how should clinical and counselling psychologists be trained in psychopharmacology to gain the necessary knowledge and experience to prescribe psychiatric medication?
6. What are your hopes for the future of psychology as a profession?
7. Looking back on the answers you have given, is there anything that you feel influences your responses that you would like to share?
8. Is there anything else you would like to add?

Appendix B: Online Survey Demographic Questionnaire

Practitioner psychologists' views on acquiring prescription rights in the United Kingdom: A Qualitative Study.
Some questions about you

In order for us to learn about the range of people taking part in this research, we would be grateful if you could answer the following questions. All information provided is anonymous.

Please either write your answer in the space provided or select the answer that best applies to you.

1.How old are you?
2.How would you describe your gender?
Male
Female
Other
3.How would you describe your sexuality?
Heterosexual
Bisexual
Lesbian
Gay
Other
4.How would you describe your racial/ethnic background?
5.Do you consider yourself to be disabled?
Yes
No
6.How would you describe your social class?
7.I am a:
Counselling Psychologist
Clinical Psychologist
8.When do you graduate from your practitioner psychology training?
9.Are there any other identities you have that relate to this research? (e.g., community psychology; feminist; CBT therapist; mental health nurse)
10.Overall, do you think psychologists should gain prescription rights?
Yes, No, Unsure

Appendix C: Ethical Approval Letter

(Page 1- REMOVED DUE TO IDENTIFYING PERSONAL INFORMATION)

Appendix D: Online Survey Participant Information Sheet

Practitioner psychologists' views on acquiring prescription rights in the United Kingdom: A Qualitative Study
Participant Information Sheet

Who are the researchers and what is the research about?
Thank you for your interest in this research which aims to gather the views of counselling and clinical psychologists with regards to acquiring prescription rights. My name is Alice Horton and I am a Counselling Psychologist in training at the Department of Health and Social Sciences, University of the West of England, Bristol. I am completing this research for my Professional Doctorate in Counselling Psychology thesis. My research is supervised by Dr Miltos Hadjiosif (see below for his contact details).

What does participation involve?
You are invited to complete an online qualitative survey (where you write the answers to questions in your own words, rather than ticking boxes). It should take around 30 minutes to complete. There are no right answers – I am interested in the range of opinions and thoughts that people have. You can write as much as you want, but it would be very helpful for my research if you could provide detailed answers. After you have completed the survey questions, there are also some demographic questions for you to answer (some of these will be tick box questions). This is for me to gain a sense of who is taking part in the research. You also need to answer a consent question, to confirm that you agree to participate, before beginning the survey.

Who can participate?
Anyone who is a qualified Counselling or Clinical Psychologist (i.e. eligible for Chartership with the BPS and registration with the HCPC). Please note that you do not have to belong to these organisations, but simply meet their eligibility criteria for qualification. You must be living and working in the United Kingdom.

How will the data be used?
The data will be anonymised (i.e., any information that can identify you will be removed) and analysed for my research project. This means extracts from your survey responses may be quoted in my thesis and in any publications and presentations arising from the research. The demographic data for all of the participants will be compiled into a table and included in my thesis and in any publications or presentations arising from the research. The information you provide will be treated confidentially and personally identifiable details will be stored separately from the data.

The personal information collected in this research project (e.g., online using the Qualtrics survey software) will be processed by the University in accordance with the terms and conditions of the Data Protection legislation. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used/processed as described on this participant information sheet. Data will be destroyed when the final output is accepted for publication. You have a number of rights in relation to your personal data. For data protection queries, please write to the Data Protection Officer, UWE Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY, or dataprotection@uwe.ac.uk.

What are the benefits of taking part?
You will get the opportunity to participate in a research project on an important social and psychological issue. It will also give you the opportunity to share your views on your hopes for the future of psychology.

How do I withdraw from the research?
If you decide you want to withdraw from the research please contact me via email alice2.horton@live.uwe.ac.uk quoting the unique participant code you will be asked to create before completing the survey. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my thesis. Therefore, I strongly encourage you to contact me **within a month** of participation if you wish to withdraw your data. I'd like to emphasise that participation in this research is voluntary and all information provided is anonymous where possible.

Are there any risks involved?
We don't anticipate any particular risks to you with participating in this research; however, there is always the potential for research participation to raise uncomfortable and distressing issues. For this reason we have provided some helpline numbers which are available to you. You could contact the Samaritans on 116 123 or Mind on 0300 123 3393.
If you have any questions about this research please contact me on:
Alice Horton, alice2.horton@live.uwe.ac.uk.
Or my research supervisor:
Dr Miltos Hadjiosif, Department of Health and Social Sciences, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY. Email: miltos.hadjiosif@uwe.ac.uk.

This research has been approved by the Health and Applied Sciences Faculty Research Ethics Committee (FREC)

Appendix E: Online Survey Consent Form

Practitioner psychologists' views on acquiring prescription rights in the United Kingdom: A Qualitative Study.

Consent Form

Thank you for agreeing to take part in this research on Counselling and Clinical Psychologists views on prescription rights for psychologists in the United Kingdom.

My name is Alice Horton and I am a Counselling Psychologist in training at the Department of Health and Social Sciences, University of the West of England, Bristol. I am collecting this data for my Professional Doctorate in Counselling Psychology dissertation. My research is supervised by Dr Miltos Hadjiosif. He can be contacted at the Department of Health and Social Sciences, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY. Tel: (0117) 3281234.
Email: miltos.hadjiosif@uwe.ac.uk if you have any queries about the research.

Before we begin I would like to emphasise that:

- your participation is entirely voluntary
- you are free to refuse to answer any question
- you are free to withdraw at any time within the limits specified on the information sheet.
  You are also the 'expert'. There are no right or wrong answers and I am interested in everything you have to say.

By consenting to take part in this research, you consent to the following:

- I confirm that I am over 18 years of age.
- I confirm that I have been provided with information about this study and have had the opportunity to ask questions.
- I understand that my participation in this research is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that after participating in the study, I have two weeks to request to withdraw my data. After this time, it may not be possible to withdraw my data from the study.
- I understand that all the information I provide will be treated as confidential and used for research purposes only.

- I understand that I will never be personally identified in publications (e.g., conference presentations, journal articles) that stem from this study.
- I agree that the data collected from me and about me may be held for as long as it retains research value and processed by the researcher for the purposes of research and publication.
 I agree to the University processing my personal data as described below:

"The personal information collected in this research project (e.g. online using Qualtrics survey software) will be processed by the University (data controller) in accordance with the terms and conditions of the Data Protection legislation. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used/processed as described on the participant information sheet. You have a number of rights in relation to your personal data. For data protection queries, please write to the Data Protection Officer, UWE Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY, or dataprotection@uwe.ac.uk."
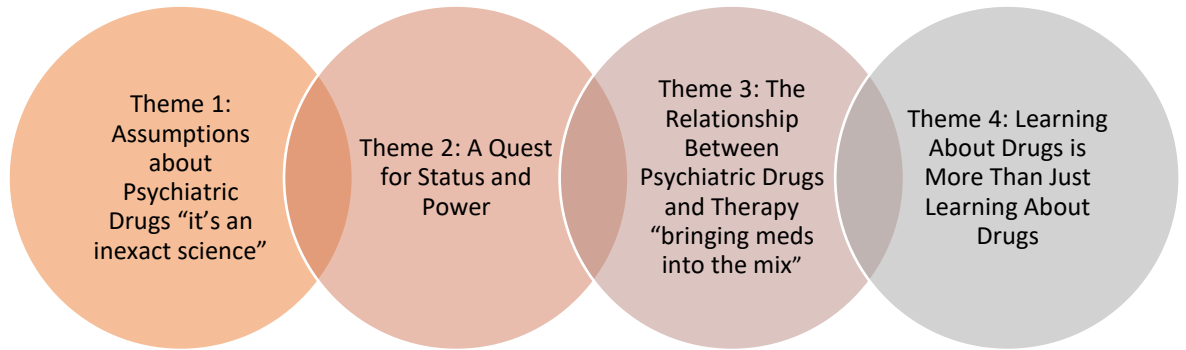
This research has been approved by the Health and Applied Sciences Faculty Research Ethics Committee (FREC).

Please select this box to show that you have read the information and consent to participate in this research.

Appendix F: Initial Thematic Map
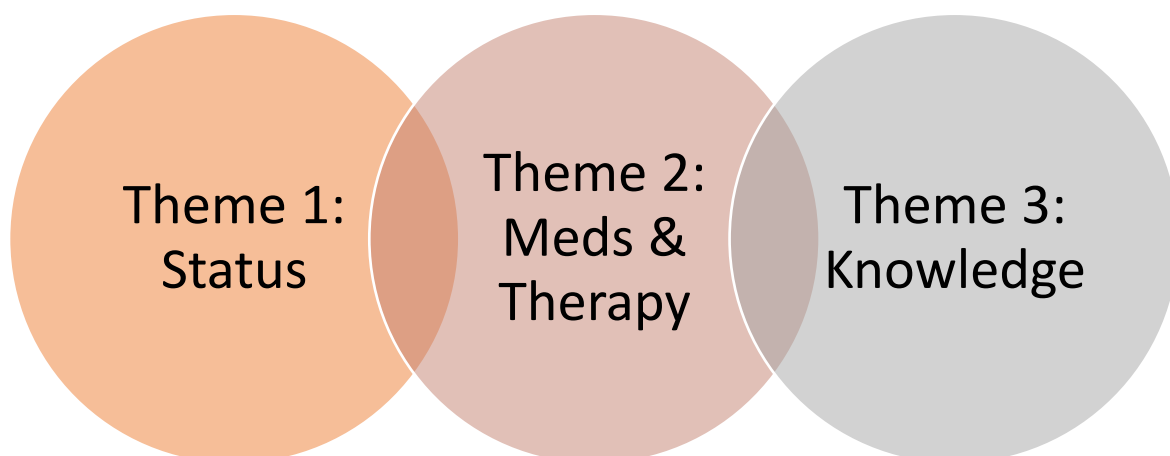
Theme 1: Status

Theme 2: Meds & Therapy

Theme 3: Knowledge

Overarching Theme: Gaining prescription rights: A crossroads in the professional identity of a psychologist *"why try on someone else's clothing? ours is fine"*

Theme 1: Assumptions about Psychiatric Drugs "it's an inexact science"

Theme 2: A Quest for Status and Power

Theme 3: The Relationship Between Psychiatric Drugs and Therapy "bringing meds into the mix"

Theme 4: Learning About Drugs is More Than Just Learning About Drugs

Appendix H: Journal Article

Gaining Prescription Rights: A Crossroads in the Professional Identity of a Psychologist "why try on someone else's clothing? Ours is fine"

Alice Horton

Trainee Counselling Psychologist

Miltiades Hadjiosif

Senior Lecturer in Counselling Psychology

Miles Thompson

Senior Lecturer in Psychology

Abstract

Background: Over the last 5 years the British Psychological Society (BPS) has been exploring whether its practitioner members are interested in gaining prescription rights for psychiatric drugs and what such a 'privilege' might look like.

Aims: This qualitative study aimed to survey the views of UK - based, qualified counselling and clinical psychologists with regards to gaining prescription rights.

Method: Qualitative data was collected via 82 online surveys. The sample consisted of 37 counselling and 45 clinical psychologists with a mean age of 41 and an average of 10 years post qualification experience. The data was then analysed using reflexive thematic analysis to develop themes.

Findings: The overarching theme – Gaining prescription rights: a crossroads in the professional identity of the psychologist: "why try on someone else's clothing? ours is fine" explores how psychologists grapple with their professional identity within existing structures dominated by the medical model of distress, and how gaining prescription rights may contribute to some of the issues they already experience.

Conclusion: Research from other countries and opinion pieces suggest that this is a controversial debate, spanning a broad range of views. Views on

prescribing rights for psychologists speak to issues of professional identity, what psychologists do or believe they should do in practice, but also about who they are as people. Implications for practitioner psychologists, the people they serve, and wider society are discussed, with a particular emphasis on what this debate means for Counselling Psychology. More specifically, the discussion highlights how psychologists "silently collude" with the medical model of distress despite many being critical of it.

Background and Rationale

Counselling psychology emerged from a field dominated by positivism (Woolfe, 2016). In the late 1970s the BPS created a Working Party to consider the relationship between psychology and counselling in the UK. The role of the Working Party was to consider whether counselling was a legitimate activity for a psychologist and the extent to which it could be supported and located within the Society. In its final report the Working Party recognised counselling as an activity based on the understanding of psychological processes which is in stark contrast to Eysenck's view that psychologists should not be concerned with psychotherapy. The report resulted in the establishment and interest-based section for counselling psychology. The establishment of the section is generally regarded as the birth of counselling psychology in the UK (Orlans & Van Scoyoc, 2008). Counselling psychology was described as "an idea whose time had come" (Woolfe, 1990). However, it took some time before it became a Division within the BPS. A special group was developed due to the rejection of divisional status based on the profession not being adequately defined. The special group developed its own practice guidelines which were widely viewed as a stepping-stone to divisional status. The field continued to evolve with the establishment of the BPS Diploma in Counselling Psychology. This offered a training framework and curriculum that defined an area of theory and practice for the profession. Finally, in 1994, divisional status was achieved allowing graduates of the Counselling Psychology

Diploma to call themselves Chartered Counselling Psychologists. What is clear, is that the profession has had to fight for a sustained period to gain the recognition it currently enjoys. Counselling psychology's interest in the whole person and the move away from an expert position does not sit easily with traditional ideas about science embedded in western psychology. Counselling psychology has also been driven by interest in and attention to subjectivity, context, and promoting wellbeing as opposed to a focus on illness; commitments which still create tension for Counselling Psychologists working in the NHS (Orlans & Van Scoyoc, 2008; Woolfe, 2016). Fundamentally, Counselling Psychology believes in therapy as a relational encounter, where the person of the therapist matters as much as the techniques and theories that they employ.

Currently, counselling psychologists are trained at doctorate level training incorporates clinical skills, research and leadership. Whilst counselling psychology is not funded, there has been a recent introduction of postgraduate doctoral loans and the Division of Counselling Psychology (DCoP) are working hard to address parity in employment (Mcintosh & Nicholas, 2015). More recently the BPS has issued a document on best practice in psychology recruitment advising that inclusive titles such as practitioner psychologist are used in advertisements and that recruitment processes include a review of essential and desirable criteria to ensure registered psychologists whose skills, knowledge and training would be appropriate for the job role are not inadvertently excluded (Dooley & Farndon, 2021).

Against this backdrop, in 2017 the British Psychological Society (BPS) started a consultation with regards to prescription rights for practitioner psychologists. This consultation has progressed simultaneously to the current study. The next section will attempt to outline the way in which this has unfolded over the last few years and the current situation.

During the British Psychological Society's (BPS) General Assembly in October 2017, it was reported that NHS England (NHSE) had approached the Society to gather its members' views on acquiring prescription rights.

This is not a new discussion within the psychology world in the UK (Johnstone, 2003; Orford, 2003; Resnick, 2003; Sammons & Levant, 2003). However, it is the first formal consultation of its kind in the UK.

In 2018 a Task and Finish Group was established to develop a position statement for the Society for consideration by the Professional Practice Board (British Psychological Society Professional Practice Board, 2018). In late 2019, the group produced a discussion paper following a year of consultation with individuals and groups of stakeholders. Following these initial consultations three main concerns were highlighted which were subsequently clarified by the Task & Finish Group. Prescribing training would be optional, a programme of training, mentoring and post qualification governance would have to be agreed to meet the regulations and standards set out by the Royal Pharmaceutical Society (RPS) and the Health and Care Professions Council (HCPC) to ensure that psychologists had the appropriate competencies to fulfil the prescribing role and prescribing psychologists would be expected to be working within a multi-disciplinary team or professional network (BPS, 2019a). Members of the BPS and other stakeholders were invited to send in comments on the discussion paper (BPS, 2019a).

In early 2020, following the collation of responses to the discussion paper, Dr Courtney-Walker, Chair of the Prescribing Rights Task and Finish Group reported a "mixed bag of diverse views" and that ultimately the final decision would "rest in legislation" (Courtney-Walker, 2020). However, it was considered that there was enough support for the group to further engage with experts by experience, the RPS and the HCPC. Following this announcement from Dr Courtney-Walker, Alison Clarke the Chair of the BPS Practice Board wrote a letter for the BPS magazine 'The Psychologist' highlighting some of the comments she had received. She described the nature of these comments as not only about what psychologists do in practice but also about 'who we are, both as practitioners and as human beings' (Clarke, 2020). She also highlighted concerns that members who are most opposed to prescribing rights are not actively involved in this stage of the debate and invited them to 'step into what may be an

uncomfortable conversation… so that all shades of opinion are reflected' (Clarke, 2020). In November 2020 the Task and Finish Group published a report that recommended the Practice Board should approve the position that psychologists should have prescription rights as it felt the evidence gathered through consultation indicated there was more people in favour of giving some psychologist's the option to prescribe psychiatric drugs, compared to those that opposed it (BPS, 2020a). However, in a survey of 439 people conducted by the Association of Clinical Psychologists (ACP) in the UK a 58% majority did not want prescribing rights for themselves (Harvey, 2021). Whilst this has not appeared to have been acknowledged by the Task and Finish Group, the final report did state that one member of the Task and Finish Group expressed a need for more debate and discussion before a position could be reached on issues relating to the use and efficacy of psychiatric drugs generally and the use of diagnosis (BPS, 2020a). Despite this, the Task and Finish Group's report was presented to the BPS Practice Board on 9th October 2020 and following a "robust discussion", the details of which have not been published, they approved the position that psychologists should have prescribing rights by majority vote (BPS, 2020b).

Following the conclusion of this piece of work the BPS has confirmed that it wants to remain involved in discussions with NHS England (NHSE) about prescribing rights for psychologists. Despite this, it has suggested that its position on prescribing rights for psychologists is not fixed and that prescription rights have not yet been agreed (BPS, 2020b). The BPS also advises that NHSE does not need the BPS to have a firm position and that they can withdraw from the process at a later point (BPS, 2020b).

The proposal to expand prescription rights for psychologists is plagued by controversy regarding issues such as: who exactly would be eligible to prescribe? How would Professional Doctorate courses assimilate this training into curricula that navigate different ends of the biopsychosocial spectrum? Do clients want psychologists to prescribe medication? Do psychologists themselves want to prescribe? Many of these issues are largely influenced by financial and political pressures. The current socio-

economic and political climate in the UK means the quickest and cheapest interventions are preferred for an under resourced and underfunded mental health system (Gilburt, 2018; The Royal College of Psychiatrists, 2018). Medication fits well within this environment as it is quick to prescribe, and more clients can be seen in less time.

Aim and Study Design

There is currently no research into the views of psychologists on acquiring prescription rights in the UK. The research that has been conducted in the US has been largely quantitative so there is little insight into psychologists' views and the factors that may influence them. With this being an issue that appears to be so polarising, research that can help psychologists to express their views and opinions in their own words and further understand their motives is vital (Baird, 2007).

The aim of the current study is to explore qualified counselling and clinical psychologists' views and opinions on acquiring prescription rights. The literature suggests a polarisation of views regarding whether psychologists are for or against acquiring prescription rights. As a result, a qualitative exploration of this topic seems both pertinent and timely.

Given that counselling psychology professes to be a critical discipline that challenges the medicalisation of distress and is concerned with meaning (Strawbridge & Woolfe, 2010), it is in our interest to further explore the prescription rights debate as it will have significant consequences for the future of our profession. By conducting a 'wide-angle study' (Toerien & Wilkinson, 2004) in an area that is yet to be researched in the UK, it is hoped that the findings will nuance the dialogue on prescription rights. The research also hopes to engage counselling psychologists in a debate that risks being dominated by clinical psychology due to their established position in the UK (King, 2001).

Methods

Data was collected via the *Qualtrics* online survey software. An online qualitative survey was employed to collect a breadth of views providing a

"wide-angle" picture on the research area (Toerien & Wilkinson, 2004). Qualitative surveys allow participants the freedom to use their own words This approach allowed for quick, efficient data collection from a relatively large, geographically dispersed sample since it is not hugely demanding of researcher resources and does not involve data entry or transcription (Braun & Clarke, 2013). Demographic questions appeared at the end of the survey where they are considered less threatening, and participants are more likely to answer them once they have finished answering the questions about the main topics (Terry & Braun, 2017).

Survey Design and Pilot

The qualitative survey questions went through numerous phases of development. Initially questions were developed by reading previous research on the topic, namely quantitative surveys. Previous research that highlighted areas for further research were also used as inspiration for questions (e.g. Walters, 2001). More general questions were included to gauge participants' understanding of psychiatric drugs and current prescribing practices. The survey was piloted to consider any problems with its design ahead of use. Piloting is considered vital due to the fixed nature of qualitative surveys (Braun et al., 2021). Five counselling psychologists in training and one clinical psychologist in training completed the fifth version of the survey via e-mail. Subsequently, responses were reviewed with the supervisory team. It was found that the responses were rich and detailed and considered the medical model of distress, the use of psychiatric drugs and views on prescription rights for psychologists. The final survey consisted of 8 topic-based questions.

Recruitment, Sample and Demographics

To recruit participants a purposive criterion sampling method was used (Braun & Clarke, 2013). Participants were required to be residents and currently working in the UK. Participants were also required to be qualified counselling or clinical psychologists that were eligible to register for chartership with the British Psychological Society (BPS) and the Health and Care Professions Council (HCPC) though they did not need to be currently

registered. Other applied psychologists were excluded as the current study is concerned with psychologists who are trained in and provide therapy. Varied recruitment routes were used, including the clinical psychology online forum *Clinpsy* and advertisements on social media including Facebook, Twitter and Linkedin. I also contacted my professional networks, universities with doctoral programmes in clinical and counselling psychology (targeting their staff) and placed the advertisement for the study in various BPS publications and outlets. A sample size of 80-100 participants is considered sufficient for gaining rich and varied qualitative survey data (Terry & Braun, 2017).

The final number of participants who completed the survey was 82. Participants overwhelmingly identified as female (n=67), white (n=67) and heterosexual (n=69) with a mean age of 41 years. There was a fairly even balance of clinical (n=45) and counselling psychologists (n=37). Participants had between 1 and 45 years of post-qualification experience with a mean of 10 years. Participants also acknowledged a variety of different identities that they felt related to the research such as: feminist, mental health nurse, activist, psychodynamic psychotherapist, community psychologist, approved clinician, neuropsychologist, and having lived experience. When presenting quotations from the data, I chose to report only the participants' professional identity, as the most meaningful descriptor in this analysis. For full demographic information, please refer to Table 1 below.

Table 1: Participants' Demographics and Relevant Information

Characteristics	Number
Gender	
Male	14
Female	67
No Response	1
Race	
White	67
Mixed	2
Black	1
Asian	3
Indian	1

Other	4
No Response	4

Age	
25-30	11
31-40	35
41-50	20
51-60	10
61-70	3
71-80	2
No Response	1

Sexuality	
Heterosexual	69
Gay	3
Bisexual	6
Other	3
No Response	1

Profession	
Clinical Psychologist	45
Counselling Psychologist	37

Disability	
Yes	8
No	73
No Response	1

Class Category	
Working	11
Middle	55
Upper	0
No Class Category	5
No Response	4
Other	7

Years Qualified	
<5 Years	27
5-10	20
11-20	18
21-30	3
31-40	4
41+	2
No response	8

Should Psychologists Gain Prescription Rights?	
Yes	18
No	42

Ethics

This project received ethical approval from the Health and Applied Sciences Faculty Research Ethics Committee at The University of the West of England and adhered to the British Psychological Society's Code of Human Research Ethics (BPS, 2014). Informed consent was obtained before participation in the survey.

Analysis

Data was analysed using thematic analysis (Braun & Clarke, 2006) An inductive, reflexive approach was taken to identifying themes.

Results

The overarching theme *"why try on someone else's clothing? Ours is fine"* [Participant 74, Clinical Psychologist] was developed to capture the way in which psychologists grappled with their professional role identity both as a result of the prescription rights debate, and in spite of it, particularly when trying to fit into existing NHS structures. It also brings into focus questions, musings and reflections that are as much about what participants consider psychologists do, or should do, as they reveal who they are as people.

For many participants this was not a new issue resulting from the prescription rights debate; this is something that they are continuously battling when trying to integrate themselves into systems dominated by the medical model as captured by the quote below.

> *"I would hope that prescribing could be assimilated into the ethos of a psychologist, rather than the role of the psychologist becoming overly medicalised. Although, the role of the psychologist is already increasingly medicalised so I suspect it would push the psychologist more into a 'diagnosis then treat' role (rather than formulate with the individual and work within the therapeutic relationship)"*
> *[Participant 29, Counselling Psychologist]*

For this participant a psychologist's role is already much influenced by the medical model. Research has suggested that psychologists of a psychosocial orientation who work in the mental health system face 'conflict, compromise and collusion' in relation to the medical model (Cooke, Smythe & Anscombe, 2019). The participant above speculates that gaining prescribing rights would further take the role in this direction.

Gaining prescribing rights for many of the participants also meant adopting the medical model of mental health and a diagnostic framework which did not sit comfortably for many of them due to concerns that it would medicalise the profession. The BPS consultation paper into prescribing rights for psychologists has confirmed that due to the way medications are licensed, psychologists would need to diagnose clients in order to prescribe medication (BPS, 2019a). There were concerns about what this would mean for them personally with many participants describing a sense of incongruence should this happen but also how it would affect the perception of psychology by others.

> *"I feel as though counselling psychologists would be firmly placed within the 'medical camp' which I feel slightly uneasy about"* [Participant 46, Counselling Psychologist]

> *"I would worry that society may begin to see psychologists as more aligned with the medical model"* [Participant 47, Clinical Psychologist]

> *"It may skew the profession to increased medical discourse and practice"* [Participant 31, Counselling Psychologist]

This could be understood an overt collusion with the medical model rather than a psychosocial approach to mental health. For many participants there was a clash between the philosophical underpinnings of the medical model and a psychological approach. This tension between the philosophical stance of psychologists, and the practicalities of carrying out their role as practitioners is clearly demonstrated by the following participants:

"I feel on the fence as I'm not sure how helpful it would be in my current role and I think medication use does not largely fit with psychological and trauma informed understanding of mental health difficulties" [Participant 47, Clinical Psychologist]

"Giving a prescription also feels at odds with my philosophical underpinning of the value in psychology – seeing the person as trying to do the best they can in this world, with the experiences they have had and trying to help them understand that they are a product of their experiences and there is nothing wrong with them" [Participant 41, Counselling Psychologist]

"Conceptually it does not sit well, in the way I understand psychological distress" [Participant 78, Clinical Psychologist]

"The prescriber role views the client as a body that needs moderation and control. The therapist views client as a person struggling with problems in living" [Participant 42, Counselling Psychologist]

The participants above do not necessarily outline or define their 'psychological approach'; however, they make it clear that it does not sit well with the medical model. A psychosocial model provides a helpful alternative to understand the responses above. It has been defined as a framework that removes biology from the position of privilege in favour of a focus on the relational, interpersonal, and social contexts of distress (Boyle, 2007). One of the participants refers to a 'trauma-informed' approach. Trauma informed approaches have been largely influenced by research into adverse childhood experiences (ACEs) that found the more adverse events a person is exposed to in childhood, the greater the impact on physical and mental health (Felitti et al., 1998). The importance of considering an individual's history and circumstances when formulating their mental health difficulties is highlighted by the following quote:

"We might be seen as colluding with the idea medication is the answer rather than looking at the causes of mental health issues

such as poor housing, poor education, poverty, families engage in abusive patterns etc etc…" [Participant 1, Clinical Psychologist]

Medication seems to be perceived as a short-cut that bypasses these wider issues, a position that seems at odds with the participants' own ethical stance as a practitioner. This speaks to the importance of social justice to many counselling and clinical psychologists (Tribe & Bell, 2018; Zlotowitz, 2018).

One of the many issues that participants highlighted was how prescribing would blur boundaries between psychiatry and psychology and lead to role confusion. For some participants they believed that the public were confused about the difference between a psychologist and psychiatrist and so gaining prescription rights would further contribute to this confusion, whereas for other participants they felt it would make little difference.

> *"The general public are already confused about the difference between the various 'psy' professions so not sure if this would muddy the waters further or whether practically it would make little difference"* [Participant 21, Clinical Psychologist]

The participant above gives an impression of ambivalence towards role confusion, but the lack of clarity around roles highlights an undercurrent of battling for professional identity when operating within existing systems. For some participants gaining prescription rights was not the direction that they believed psychology should be going in and was not what *"being a psychologist is about"* [Participant 41, Counselling Psychologist] as it goes against the foundations of their training as outlined in the quotes below.

> *"Our profession should be moving away from the medical model rather than embracing it* [Participant 33, Clinical Psychologist]

> *"Why try on someone else's clothing? ours is fine - we just need to dress more appropriately for the fashions of the day, and tidy up our act a little…it's ridiculous - if you want to prescribe, then to put it crudely, fuck off and be a medic, or a nurse prescriber - this ain't the profession for you"* [Participant 74, Clinical Psychologist]

"I cannot fathom why any psychologists who understood everything they did in their doctoral training would want to prescribe. This constitutes madness in a system" [Participant 44, Clinical Psychologist]

Many psychologists constructed their role as offering an alternative, or even a direct challenge to the medical model which they believed to be a strength of the psychologist. In the quote above "madness" is used to describe the system, which paradoxically might label distress in this way, therefore there is a clear rejection of those who seem to want a foot in both camps. According to these participants a psychologist prescriber is an oxymoron, you cannot both embrace the medical model of distress through prescribing medication whilst holding the understanding of distress developed through training as a psychologist. The last quote (participant 44) insinuates that there is a depth to clinical training that is perhaps missed by those who would want prescription rights after having completed it. Having something different to offer to the medical model and psychiatrists was constructed as a strength which is demonstrated in the following quotes:

"Our strength is in providing something different to the medical model" [Participant 8, Counselling Psychologist]

"It may impede our useful role where we act as a cautionary voice in a team, offering an alternative perspective to the medical model" [Participant 31, Counselling Psychologist]

"Psychologists currently often adopt the role of holding a psychosocial perspective in what are often very medical model dominated contexts. If they have prescribing rights the danger will be that this focus is diluted" [Participant 49, Clinical Psychologist]

The participants above position themselves not only as practitioners able to offer an alternative understanding of distress to clients, but also as important voices within multidisciplinary teams. This role is perceived as an important place for advocacy for the client, offering a wider perspective to other professionals. There seems to be some fear that the power of this

176

voice could be lost if that message is "diluted" through stepping into a more medical role.

There was also concern that an increase in prescribers would jeopardise alternative interventions to psychiatric drugs such as psychotherapeutic work and would further obscure social determinants to mental health. These participants again demonstrate a strong social action element to their role as psychologists, with concerns over how this may be jeopardised by prescribing rights:

> *"Therapy is becoming more accessible, and I think a surge in another profession offering medication could jeopardise this movement" [Participant 46, Counselling Psychologist]*

> *"This runs the risk of undermining social awareness of the ways in which social contexts, discrimination and oppression are key causes of distress and should be attended to and tackled if we are going to really attend to human distress" [Participant 31, Counselling Psychologist]*

Fear of dilution of psychology's perceived strengths was not just a concern regarding existing roles, but also the ongoing development of psychologists. These participants were concerned that if they had prescribing rights inevitably something in their role and training would be lost to enable this to happen. Many participants believed that they would lose psychotherapeutic work, formulation, and reflective practice which is demonstrated in the quotes below:

> *"We may also be at risk of losing the therapeutic input we can offer – if our roles are expanded to include prescribing then something else in our current role would have to give to make way for this" [Participant 7, Clinical Psychologist]*

> *"It could put added pressure on the psychologist and eat into therapeutic time" [Participant 8, Counselling Psychologist]*

> *"Nobody can know everything, and I know that if I had to learn psychopharmacology, I would have to sacrifice some time and*

learning away from psychotherapy" [Participant 77, Clinical
Psychologist]

Despite some strongly held views on the incongruence between psychology and prescribing, this was not the only stance on gaining prescribing rights. Some participants framed the additional responsibility through the biopsychosocial model of mental health and considered it is possible not only to assimilate prescribing into their role but to also see how it may enhance their practice. The biopsychosocial approach posits that there are biological, psychological, and social determinants to distress (Douglas, 2016). This biopsychosocial approach was positioned by many participants as the gold standard and something which they deemed to be valued by clients. It seemed that many participants felt that they were lacking the 'bio' element and thus prescribing rights would enable them to offer a more holistic approach to their clients.

> *"It is possible that a more comprehensive treatment, based on*
> *biopsychosocial models may enhance the relationship" [Participant*
> *65, Counselling Psychologist]*

> *"It could enhance the relationship as it could be incorporated into*
> *the treatment plan – fully exercising a bio-psycho-social approach to*
> *treatment – we promote psychological and social interventions why*
> *not ones which support the bio bit too when considered appropriate*
> *in line with formulation" [Participant 20, Clinical Psychologist]*

Many participants expressed that psychology could benefit from more focus on the 'bio' part of the biopsychosocial approach through the use of prescription rights. There are other ways in which psychologists incorporate biology into their work. For example, psychologists working within a trauma informed framework acknowledge the role of threat responses such as fight/flight/freeze which can be understood and responded to with psychological strategies. The term biopsychosocial approach can mean various things within mental health settings; however, it has been suggested that when used the 'bio' element is prioritised to a

point where it becomes the 'bio-bio-bio' model in practice (Sharfstein, 2005) leading to the psychosocial being obscured.

For these participants, there was a niche for psychologists which could involve de-prescribing, an opportunity to change the narrative around medication, offer continuity of care and formulation driven prescribing. There was a sense that these participants felt that this was something they could do better than their psychiatry colleagues.

> *Remove the bias against medication: allow conversations about why not to take medication and improve understanding of the function and limitations of medications when they are prescribed (no other professions explain the function) [Participant 19, Clinical Psychologist]*

> *"We are already able to take on some traditional psychiatry roles but my experience of this has been that psychologists take a different stance to psychiatry and would heavily advocate psychosocial options above medical ones - I think this would be reflected in prescribing" [Participant 76, Clinical Psychologist]*

> *"I would support prescription privileges and the right to reduce/withdraw medication" [Participant 17, Clinical Psychologist]*

The idea of supporting prescription rights with the view of being able to reduce/withdraw medication was an appealing one for many of these participants. However, the literature relating to prescribing psychologists in the US contradicts this view. Research has shown that prescribing psychologists in the US were equally likely to increase and decrease the number of medications prescribed on their most recent workday (Linda & McGrath, 2017). This highlights the way in which assumptions about how such responsibilities are managed, and the reality in practice can differ. The participants in this study were relying on the imagined consequences of any change in role, rather than drawing on evidence, and therefore the biopsychosocial approach was discussed in the context of perceptions that expertise was limited to the psychosocial. There seemed to be an assumption that the psychosocial approach would still hold a privileged

position even once they developed further expertise in the "bio" through prescription rights.

Conclusion

The aim of this research was to gather counselling and clinical psychologists' views on gaining prescription rights. This has been achieved through a qualitative survey which has enriched previous quantitative research in this area by offering participants the opportunity to express their views in their own words. The study highlighted that psychology is a broad church with diverse views; there was a sense of ambivalence within data items and across the data set in relation to prescribing rights for psychologists. Participants may agree on certain things for example that prescribing rights would change the role and identity of a psychologist. However, this was constructed as problematic for some yet an opportunity for others.

Summary of Findings

The overarching theme conveys that whether or not psychologists gain prescription rights is a pivotal decision or a "crossroad" in the development of the profession. Identity and professional role are something the participants grappled with not only in relation to the prescription rights debate but in contexts dominated by the medical model of distress which for many caused a sense of incongruence. This highlights a gap between clinical training, philosophical stance and practice and contributes to previous research in the area (Cooke, Smythe, Anscombe, 2019). Some participants found it hard to fathom why any psychologist would want prescribing rights due to this clash. However, for others, prescribing encouraged a deeper engagement with the bio element of the biopsychosocial model and provided a niche for psychologists to change the narrative around psychiatric drugs and to de-prescribe.

Evaluation of the Study and Opportunities for Future Research

This qualitative research study achieved its aim to explore clinical and counselling psychologists' views on gaining prescription rights. It offers a

new depth to this research area by giving psychologists the opportunity to reflect on their views and motives. Despite rich data that met the study aims there are a number of limitations as well as ideas for future research that are important to discuss.

Data Collection

This study sought to gather a range of perspectives from psychologists across the UK. Therefore, surveys made sense and arguably were the most appropriate method of data collection. However, surveys are often criticised for producing thin data (Braun et al., 2021). Whilst the data obtained was not thin, there were undoubtedly occasions during the analysis where participants made points that would have benefitted from further probing. A more interactive method of data collection, such as semi-structured interview would have provided this opportunity. The data was also somewhat fragmented, snippets of ideas were offered by participants rather than each data-item containing a coherent narrative, as is common in qualitative surveys.

Focus groups could have provided a live opportunity to explore the different viewpoints both between the two different professions of counselling and clinical psychology but also those for and against prescription rights.

Sample

Despite attempts to diversify the sample it remained relatively newly qualified. This was possibly due to the recruitment routes that were used. For some of the more experienced participants in this research, it was not worth seeking prescription rights as they were nearing retirement. This could be an interesting area to unpack in future research that was beyond the scope of the current study. It is also possible that due to the nature of both my professional networks and those of the supervisory team that this could have skewed the sample to the more critical edge.

The sample of psychologists who participated were largely white, middle-class heterosexual women. Unfortunately, this further perpetuates the

criticism levelled at much psychological research, namely that it captures the views of the 'usual suspects' (Terry & Braun, 2017) of social science research, at the expense of historically marginalised groups. If I were to conduct the study again, I would heed some of the recommendations that have emerged from the 'Black Lives Matter' (Hargons et al., 2017) and trans rights movements (Ellis, et al., 2019) to ensure a sample that is more representative of the society we live in. At the very least, I would have ensured that the pilot phase included the views of a diverse range of people, who could have helped me scrutinise more closely the items of the survey.

Terminology

Another point that came to my attention at progression review was that some of the language used in the inclusion criteria 'participants must be living and working in the UK' could have inadvertently excluded psychologists that were not currently working for reasons such as sickness or retirement. This criterion was to ensure that the responses were relevant to the UK work context namely the NHS, rather than to exclude participants. There is no way of knowing exactly how much impact this did or did not have, but it is an important consideration, nonetheless.

Language is also a tricky area when writing in the realm of human distress. The terms used to describe experience are loaded with connotations. I describe in the reflexivity section my process of deciding what terminology to use in the survey to ensure consistency. Participants often used medicalised language in their survey responses which is something that I picked up on throughout the analysis section. It is therefore important to consider the use of terminology in the questions and the limitations this placed on data collection.

There is no neutral language in human distress, language is loaded with meaning and meaning is understood differently in different contexts and by different people. Therefore, despite collecting rich and varied data, I am aware that this dataset was co-produced in the context of the terminology

I used in the survey questions, and this may have influenced how participants responded.

Other areas of practice in relation to prescription rights

This study focused on prescription rights for psychologists in relation to mental health. Arguably because much of psychologist prescribing would be carried out in this area due to this being the field where most counselling and clinical psychologists work. Prescribing in different areas of practice is likely to raise different issues for psychologists. There are likely to be nuances in other areas of practice such as gender services, physical health services, addictions and children and adolescents services to name a few.

Prescribing rights in medical settings are unlikely to apply in the same way to mental health settings and vice versa, that is not to say it would be without controversy. However, to explore this further is beyond the scope of the current study and is perhaps an area for further research. However, this does highlight a potential issue of offering prescription rights to psychologists as a whole with little regard to the different issues that may arise in each setting.

Implications for Practice

This study expands on previous quantitative research in the US (eg. Walters, 2001) and opinion pieces (eg. Dobson & Dozois, 2001; Johnstone, 2003; Nussbaum, 2001; Orford, 2003; Resnick, 2003; Sammons & Levant, 2003) which highlighted that this is a controversial topic with mixed views. This study is unusual in that it has been carried out simultaneously to the BPS consultation on prescription rights (BPS; 2019a; BPS, 2020a) and as such is a live piece of research that will continue to unfold beyond the submission of this thesis. This exploration of psychologists' views argues that gaining prescription rights is an overt collusion with the medical model but also highlights an existing undercurrent of silent collusion with the medical model which supports previous research (Cooke, Smythe & Anscombe, 2019).

Implications for Psychologists

In some of the survey responses participants speculated about my position in relation to the prescription rights debate with some assuming that I am pro-prescription rights for psychologists perhaps due to the medicalised language used in the surveys and the way some questions were framed. This was often met with frustrations and occasionally criticism. This could offer a snapshot of the tensions and a possible schism that would be created should prescription rights for psychologists be granted.

The BPS consultation has advised that prescribing rights for psychologists would be an optional training post doctorate. As outlined above 22% of psychologists who participated in this research agreed that psychologists should gain prescription rights, 51% opposed the statement and 27% were unsure. The BPS position statement was that there was enough support for prescription rights for the BPS to further engage with NHSE on this matter. However, my survey highlights that over half of the sample disagreed with prescribing rights for psychologists. The BPS response to those that disagree is usually that it is 'optional'. There are a couple of issues here. Firstly, making this optional is an individualistic approach. Those who are against prescribing rights may not have been against it just for their own practice, but for the field of psychology as a whole. Particularly as the overarching theme of this study conveys the possible changes to the identity of the psychologist. We are all impacted by the behaviour of others who represent our profession and framing it as individual choice does not account for the changes to psychology that will go beyond individual practitioners. Secondly, whilst it is optional in practice, it seems reasonable to wonder whether this will eventually be written into person specifications and job descriptions for psychologist posts in the NHS. This raises the question, would it become necessary to train to remain employable? This could further add to tensions between psychologists.

As outlined in the introduction, counselling psychology is a discipline whose value base is rooted in humanism and professes to take a critical stance to the medical model of distress (Woolfe, 2016). The BPS have advised that

being a prescribing psychologist would require an engagement with diagnostic constructs (BPS, 2019a) which is problematic for counselling psychologists for a number of reasons. As practitioners with a commitment to evidence-based practice (DCOP, 2012) the validity of diagnostic constructs is questionable (Boyle, 2007), not only that, but research has also suggested that for some service-users diagnosis triggers shame, stigma and disempowerment, and results in the root causes of their distress being obscured (BPS, 2011). Therefore, one could argue that prescribing rights is antithetical to counselling psychology especially given its commitment to social justice (DCOP, 2020).

Strawbridge (2016) suggests that conflicts (arguably of which prescription rights is one) are valuable in prompting a honing of positions and clarifying ideas. Therefore, perhaps this is an opportunity for counselling psychologists to take a stand to maintain the profession's core values and distinctiveness, which is argued is already at risk due to being practiced in medical contexts (Strawbridge, 2016). To reconnect with the 'tacit dimension' of therapy which goes beyond a set of techniques and formal papers but captures experience, interaction and intuition which speaks to the 'professional artistry' that is called for in the discipline's official practice guidelines (DCOP, 2020). Not only is this an opportunity to advocate for the identity of the profession, but also for the clients we serve and wider society through social action and an explicit engagement with the process that is unfolding. Dianne Hammersley a key figure in the development of the counselling psychology profession in the UK aptly reflects "there is a danger that the NHS changes counselling psychology rather than the other way around" (Hammersley, 2021). With this in mind rather than counselling psychology changing prescribing practices through the acquisition of prescription rights, the essence of the profession it is at risk of being changed, diluted if not entirely lost.

References

Baird, K.A. (2007). A survey of clinical psychologists in Illinois regarding prescription privileges. *Professional Psychology: Research and Practice,* 38(2), 196-202. https://doi.org/10.1037/0735-7028.38.2.196

Boyle, M. (2007). Diagnosis special issue part 1 & 2. *The Psychologist*, 20(5), 290-292. https://thepsychologist.bps.org.uk/volume-20/edition-5/diagnosis-special-issue-part-1-2

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology,* 3(2), 77-101.

Braun, V. & Clarke, V. (2013). *Successful qualitative research. A practical guide for beginners.* Sage Publications Ltd.

Braun, V., Clarke., Boulton, E., Davey, L. & McEvoy, C. (2021). The online survey as a *qualitative* research tool. *International Journal of Social Research Methodology,* 24(6), 641-654. https://doi.org/10.1080/13645579.2020.1805550

British Psychological Society. (2011). Response to the APA: DSM-5 development. http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf

British Psychological Society. (2014). British Psychological Society's code of human research ethics, 2nd edition.

British Psychological Society. (2016). Achieving representation in psychology. https://www.bps.org.uk/psychologist/achieving-representation-psychology

British Psychological Society. (2019a). Prescribing rights for psychologists. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Internal/Discussion%20Paper%20-%20Prescribing%20Rights.pdf

British Psychological Society. (2020a). Prescribing Rights for psychologists. https://www.bps.org.uk/sites/www.bps.org.uk/files/BPS%20Prescribing%20Rights%20Report.pdf

British Psychological Society. (2020b). Prescribing rights for some psychologists – an update. https://www.bps.org.uk/news-and-policy/prescribing-rights-some-psychologists-update

British Psychological Society. (2022). Clinical Psychology in Primary Care – how can we afford to be without it? A briefing for Clinical Commissioners and Integrated Care Systems. Division of Clinical Psychology. https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Clinical%20Psychology%20in%20Primary%20Care%20-%20Briefing.pdf

British Psychological Society Professional Practice Board. (2018). Prescribing rights for psychologists – Chair and members. The psychologist, 31(5), 60.

Cooke, A., Smythe, W., & Anscombe, P. (2019). Conflict, compromise and collusion: dilemmas for psychosocially-orientated practitioners in the mental health system. *Psychosis,* 11(3), 199-211. https://doi.org/10.1080/17522439.2019.1582687

Clarke, A. (2020). More debate on prescribing rights. The psychologist, 33. https://thepsychologist.bps.org.uk/volume-33/march-2020/more-debate-prescribing-rights

Courtney-Walker, R. (2020). A role for psychologists on prescription?. *The Psychologist,* 32(3), 2.

Division of Counselling Psychology. (2012). Becoming a counselling psychologist. http:www.bps.org.uk/dcop/home/about/about_home.cfm

Division of Counselling Psychology. (2020). *Professional Practice Guidelines.* https://bpsshop.s3.eu-west-2.amazonaws.com/20841_cat-

2020.pdf?X-Amz-Algorithm=AWS4-HMAC-SHA256&X-Amz-Credential=AKIA3JJOMCSRTH3PTJ4W%2F20211123%2Feu-west-2%2Fs3%2Faws4_request&X-Amz-Date=20211123T203021Z&X-Amz-SignedHeaders=Host&X-Amz-Expires=10&X-Amz-Signature=e45b3486c98136a79ff8a906206be769799572193d90b88ad37c83c6ab6f6e28

Dobson, K.S., & Dozois, D.J.A. (2001). Professional psychology and the prescription debate: Still not ready to go to the altar. *Canadian Psychology/Psychologie canadienne,* 42(2), 131-135. https://doi.org/10.1037/h0086888

Dooley, C. & Farndon, H. (2021). Best practice in psychology recruitment. The British Psychological Society. https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Best%20practice%20in%20psychology%20recruitment.pdf

Douglas, B. (2016). Conceptualising in client work. In B, Douglas (Ed.), *The Handbook of Counselling Psychology* (4th ed., pp. 151-168). Sage Publications.

Ellis, S.J., Riggs, D.W. & Peel, E. (2019). Lesbian, gay, bisexual, trans, intersex, and queer psychology: An introduction (2nd ed.), Cambridge University Press. https://doi.org/10.1017/9781108303750

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Kloss, M.P. & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventative Medicine,* 14(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

Gilburt, H. (2018). Funding and staffing of NHS mental health providers: still waiting for parity. *The King's Fund.*

https://www.kingsfund.org.uk/publications/funding-staffing-mental-health-providers

Hammersley, D. (2021). Wanderer to warrior. *Counselling Psychology Review*, 36(1), 55-62.

Hargons, C., Mosley, D., Falconer, J., Faloughi, R., Singh, A., Stevens-Watkins, D. & Cokley, K. (2017). Black Lives Matter: A Call to Action for Counselling Psychology Leaders. *The Counseling Psychologist,* 45(6), 873-901. DOI https://doi.org/10.1177/0011000017733048

Harvey, P. (2021). A challenge to the BPS on Prescribing Rights for psychologists. *BPS Watch.* https://bpswatch.com/category/prescribing-rights/

Johnstone, L. (2003). Back to basics. *The psychologist*, 16(4), 186-187.

King, M. (2001). Prescription privileges and the counselling psychologist. *Counselling Psychology Review*, 16(1), 10-13.

Linda, W.P. & McGrath, R.E. (2017). The current status of prescribing psychologists: Practice patterns and medical professional evaluations. *Professional Psychology: Research & Practice,* 48(1), 38-45. https://doi.org/10.1037/pro0000118

Mcintosh, M. & Nicholas, H. (2015). Dispelling the myths about counselling psychologists whilst challenging discrimination. [Letter to DCoP members]. https://www1.bps.org.uk/system/files/user-files/Division%20of%20Counselling%20Psychology/public/dcop_dispelling_myths_letter_nov_2015.pdf

Orford, J. (2003). Don't go there. *The psychologist,* 16(4), 189.

Orlans, V., & Van Scoyoc, S. (2008). *A Short Introduction to Counselling Psychology.* Sage Publications Ltd.

Resnick, R. (2003). To prescribe or not to prescribe – Is that the question? *The psychologist,* 16(4), 184-186.

Royal College of Psychiatrists. (2018, February 21). Press release: Mental health trusts' income lower than in 2011-12 [Press release]. https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2018/02/21/mental-health-trusts-income-lower-than-in-2011-12

Sammons, M.T., & Levant, R.F. (2003). Yes, but there is another question. *The psychologist,* 16(4), 187-188.

Strawbridge, S. (2016). Science, craft and professional values. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket and V. Galbraith (Eds.) Handbook of counselling psychology (4th edn, pp.20–38). Sage.

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *The handbook of counselling psychology (*3rd ed., pp. 3-22). Sage Publications Ltd.

Terry, G., & Braun, V. (2017). Short but Often Sweet: The Surprising Potential of Qualitative Survey Methods. In V. Braun, V. Clarke & D. Gray (Eds.), *Collecting Qualitative Data: A practical guide to textual, media and virtual techniques* (pp.15-40). Cambridge University Press. https://doi.org/10.1017/9781107295094

Toerien, M. & Wilkinson, S. (2004). Exploring the depilation norm: a qualitative questionnaires study of women's body hair removal. *Qualitative Research in Psychology*, 1(1), 69-92. https://doi.org/10.1191/1478088704qp006oa

Tribe, R. & Bell, D. (2017). Social justice, diversity and leadership. *The European Journal of Counselling Psychology,* 6(1), 111-125. https://doi.org/10.5964/ejcop.v6i1.145

Walters, G.D. (2001). A meta-analysis of opinion data on the prescription privilege debate. *Canadian Psychology/Psychologie canadienne*, 42(2), 119-125. https://doi.org/10.1037/h0086886

Woolfe, R. (1990). Counselling Psychology in Britain: An idea whose time has come. The Psychologist, 12, 531-535.

Woolfe, R. (2016). Mapping the World of Helping: The place of Counselling Psychology. In B. Douglas (Ed.), *The Handbook of Counselling Psychology* (4th ed., pp. 5-19). Sage Publications.

Zolowitz, S. (2018). Psychology for social change. *The psychologist,* 31, 8-9.