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# Gaining prescription rights: a qualitative survey mapping the views of UK counselling and clinical psychologists

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**ABSTRACT**

**Objective:** 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. This qualitative study aimed to survey the views of UK-based, qualified counselling and clinical psychologists.

Method: Qualitative data was collected from 82 participants via an online survey (37 counselling and 45 clinical psychologists). Along with the survey items, the last question asked participants to select one of three answers (yes/no/unsure) in relation to whether they supported prescription rights for psychologists. The qualitative data was analysed using thematic analysis, from a critical realist perspective, to develop 3 themes.

**Results:** Theme 1 explores how psychologists grapple with their professional identity within structures dominated by the medical model of distress, and constructions of the prescription rights debate as a crossroads for both discipline and profession. Theme 2 explores participants' assumptions about psychiatric drugs as they seem to serve as a springboard to their views on prescription rights. Theme 3 examines the belief that gaining prescription rights will result in increased status and power for psychologists and what might be gained or lost as a result. Regarding the final question: 18 participants answered yes; 42 no; and 22 were unsure.

**Conclusion:** We advocate for increased criticality in how UK psychology continues to consider this issue. We caution against an optionality approach that might risk obscuring wider implications for psychology beyond the preferences of individual practitioners.

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Prescription rights; qualitative survey; clinical psychology; counselling psychology; professional issues; thematic analysis

## Introduction

This study focuses on the views of UK-based counselling and clinical psychologists regarding gaining prescription rights. The introduction starts with the history of psychiatry and the medical model of distress, before providing some background to non-medical prescribing for health professionals, including psychologists and finishes by introducing this qualitative research.

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There is considerable debate about the causes of mental health problems, and the most appropriate way to respond to them (Cooke, 2017; Cromby et al., 2013; Johnstone & Boyle, 2018). One dominant approach, exemplified in psychiatry, is the medical model and treatments using psychiatric medication. Definitions of the term 'medical model' vary (Cooke et al., 2019). Here, we use it to refer to a system that sees mental health problems as akin to physical diseases.

The history of mental health knowledge and intervention entails many versions and debates (see Cromby et al., 2013). Key phases include the influence of supernatural forces and demonology, Cartesian dualism (Scull, 2011), and the 'age of reason' which associated madness with unreason and therefore deviance (Foucault, 1967; Parker et al., 1995). During the 1700s, those who were considered seriously mentally ill were separated out from society into psychiatric institutions. These were run by medical doctors who essentially had captive populations to study and 'treat' (Newnes et al., 1999). For them, the causes of pathological distress were understood to lie within their terrain of study; the human body and brain. These doctors became experts in this area (Scull, 2011) and their arrangement of knowledge, practice, and power became known as psychiatry (Johnstone, 2000).

In general medicine, diagnosis points to a physiological framework determining which condition or disease explains a person's symptoms (Timimi, 2020). Medical interventions such as drugs are then dispensed in hospitals and clinics. In this spirit, in the twentieth century, Emil Kraeplin produced the first systematic classification of mental disorders (Bentall, 2006). And yet, since Kraeplin, psychiatry's diagnostic manuals have failed to connect diagnosable categories of mental illness with physiological causes or biomarkers (Insel, 2009; Timimi, 2020). Moreover, this approach risks placing both the cause and solution to mental health struggles within the skin of individual patients, reducing the need to consider their relational history and context. It is also worth noting that many argue that applied mainstream psychology is not immune to individualising distress in a similar way (e.g. Kagan et al., 2019; McPherson & Sutton, 1981; Moloney, 2013; Nightingale & Cromby, 2001).

In psychiatry, and arguably areas of wider society, the medical model and psychiatric medication are still considered the core treatment for mental health issues, with psychosocial interventions viewed as supplementary (Craddock et al., 2008). As such the use of psychiatric drugs remains the front-line treatment option for human distress not only in the UK but across the globe (Moncrieff, 2008a).

The medical model of distress has been subject to sustained critiques highlighting scientific, practical, and ethical issues (e.g. Bentall, 2010; Cooke & Kinderman, 2018). Some of these criticisms have come from within psychiatry itself (e.g. Moncrieff, 2013). Even the authors of the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) when reflecting back on previous editions suggested that the high rates of comorbidities between psychiatric diagnoses undermine the hypothesis that they represent distinct conditions and suggest that the current system possibly obscures research findings and might even pathologize what it means to be human (Kupfer et al., 2002).

The links between mental health and medication have arguably been cemented by the relationship between psychiatry and the pharmaceutical industry. The pharmaceutical industry is both powerful and profitable (Johnstone, 2000) with a direct influence on psychiatry through its sponsorship of conferences, journals, and research agendas (Read,

2005). Some have also traced financial relationships between the pharmaceutical industry and both individual psychiatrists (Angell, 2000) and those creating diagnostic manuals (Cosgrove et al., 2006). Others have explored the mutually beneficial relationships established when new diagnoses are matched with specific drug treatments (Boyle, 2007; Moncrieff, 2007). And while the pharmaceutical industry plays a key role in producing data about the efficacy of psychiatric drugs, some argue it highlights their efficacy while downplaying any adverse effects (Healy, 2006; Hopton, 2006; Moncrieff, 2007).

Nonetheless, there is a large body of evidence for drug treatment of mental health problems. This evidence is based on Randomised Control Trials (RCTs) the, arguably faulted, gold standard of empirical research. Potential issues include the validity of the measurements used, publication bias, unblinding, and withdrawal effects being interpreted as relapse (Moncrieff & Stockmann, 2019). The results of multiple RCTs are aggregated in meta-analyses and used to inform treatment recommendations by groups such as the National Institute for Health and Care Excellence (NICE).

Recent guidance produced by the All-Party Parliament Group for Prescribed Drug Dependence (APPG for PDD) summarised the evidence base to help therapists understand and discuss psychopharmacology with clients (Guy et al., 2019). For example, the report highlights how although the traditional biomedical view is that antidepressants correct a chemical imbalance, this is not supported by evidence or expert opinion (Lacasse & Leo, 2005; Moncrieff & Cohen, 2005). Indeed, the Royal College of Psychiatrists (RCP) have removed the chemical imbalance hypothesis as a potential cause of depression from their public information leaflet (RCP, 2019a). More broadly the report shows that antidepressants have modest superiority over placebo in short-term clinical trials of depression. However, the small difference could be explained in other ways and the findings of the many short-term trials do not capture possible long-term effects of treatment (Guy et al., 2019). Other sections of the guidance explore medication for anxiety and psychosis.

### *Non-medical prescribing*

Non-medical prescribing (NMP) refers to the prescription of medication by a health professional who is not a medical doctor. In the UK, this began with the Cumberlege Report (Department of Health and Social Security, 1986) which led to limited prescribing rights for health visitors and district nurses. More recently, 'The NHS Plan' of the Department of Health (DoH) promoted nurse prescribing (DoH, 2000) and in 2002 a consultation on the introduction of supplementary prescribing for nurses and pharmacists was launched (DoH, 2002a), with approval granted later that year (DoH, 2002b).

There are two main types of NMP: supplementary and independent. Supplementary prescribing involves collaboration between independent prescribers (e.g. doctors), supplementary prescribers (e.g. nurses), and the patient (Department of Health, 2005). Conversely, independent prescribers are solely responsible and accountable for the assessment of patients and their prescribing (BNF, 2018). After a consultation in 2005 (Medicines & Healthcare Products Regulatory Agency, 2005a; 2005b), legislation to implement independent prescribing by nurses and pharmacists was passed (NHS, 2006). Since that time independent prescribing rights have also been extended to other healthcare professionals including paramedics (NHS England, 2018).

In a systematic policy review, it was suggested that the government approach to non-medical prescribing had changed since 2006 (Graham-Clarke et al., 2019). It was originally intended as a means of improving patient choice and access to medicines, whilst also developing the workforce. However more recent shortfalls in finances and staffing have resulted in the emphasis subtly shifting to supporting, or even replacing, traditional medical practitioners (Graham-Clarke et al., 2019).

NMP for psychologists is not just a UK issue – indeed in other parts of the world the debate is more advanced. For example, in the United States some psychologists already prescribe. This is often called 'prescription privileges', which may suggest an advantage or even an honour. Currently psychologists can prescribe in five states (APA, 2014). From 1991-1997 the Department of Defense carried out a successful pilot demonstrating that psychologists could prescribe safely within the military setting. Then New Mexico allowed psychologists to prescribe in 2002, with Louisiana, Illinois, Iowa and Idaho following since (APA, 2014). The APA strongly endorses prescribing rights for psychologists. Some argue this view trumped critical debate and opposing views (DeNelsky, 1996). Moreover, some suggest the APA prevented affiliates whose members oppose prescription rights from stating this on their websites (Heiby, 2010). However, data concerning the views of psychologists on prescription privileges has produced mixed and varied results (see: Baird, 2007; Linda & McGrath, 2017; Walters, 2001).

The applied psychological professions in Canada, Australia, New Zealand and Croatia have also engaged in similar debates. In Canada, articles have explored the issue (e.g. Dobson & Dozois, 2001; Nussbaum, 2001; St. Pierre & Melnyk, 2004) and a Task Force on Prescriptive Authority concluded that 'prescriptive authority' should evolve organically rather than being the primary goal and focus of professional advocacy (Canadian Psychological Association Task Force, 2010).

In Australia, the Australian Psychological Society (APS) conducted a survey of its members with regards to prescription rights due to a potential shortage in psychiatric services. The majority of respondents supported prescribing in principle and the APS developed a proposal for the training and registration of prescribing psychologists (APS, 2007). However, at present, the issue has not developed further. In New Zealand, again against a background of depleted psychiatric services, a survey of psychologists produced split results with half endorsing and half expressing ambivalence or opposition (George & Semp, 2013). Other countries have also been debating the issue within their psychological communities. For example, in Croatia, in a survey of 139 psychologists', the majority of respondents supported prescribing rights for psychologists (Zečević, 2022).

In the UK, the main groupings of mental health practitioner psychologists are doctoral qualified counselling and clinical psychologists. Between 2018 and 2020, the BPS (British Psychological Society) carried out a consultation with regards to prescription rights for practitioner psychologists (British Psychological Society, 2019, 2020a, 2020b). Similar to other parts of the world, this consultation was not a new discussion (see: Johnstone, 2003; Resnick, 2003; Sammons & Levant, 2003).

The BPS Professional Practice Board produced discussion papers and initiated preliminary consultation of stakeholders (British Psychological Society Professional Practice Board, 2018). The conclusion to this initial stage reported a 'mixed bag of diverse views' (Courtney-Walker, 2020). In parallel, as per arguments explored earlier in this introduction, concerns were raised. For example: fear of uncritically using diagnostic constructs

when prescribing, over-prescription of psychiatric drugs, and links to the pharmaceutical industry (MITUKadmin, 2019).

In late 2020, the BPS published a report recommending the Practice Board should approve the position that psychologists should have prescription rights (BPS, 2020a). It felt more people were in favour of giving some psychologists the option to prescribe, compared to those that opposed it. However, a parallel survey of 439 psychologists conducted by the UK Association of Clinical Psychologists (ACP) found 58% did not want prescribing rights for themselves (Harvey, 2021). In October 2020 the BPS Practice Board approved the position that psychologists should have prescribing rights by majority vote following a 'robust discussion' (BPS, 2020b). At the time of writing prescription rights have not yet been agreed (BPS, 2020b) and the debate continues (Harvey, 2021).

Despite these figures, there is currently no published research exploring the views of psychologists on acquiring prescription rights in the UK. As such, the present study aims to explore qualified counselling and clinical psychologists' views on acquiring prescription rights. As the literature suggests polarisation in views, a qualitative exploration of this topic seems both pertinent and timely. The research question is simply: *what are UK-based counselling and clinical psychologists' views on gaining prescription rights for mental health*?

## Materials and methods

The qualitative study was conducted from a critical realist stance (Pilgrim, 2014, 2019), leaning into social constructionism (Gergen, 2009). An online qualitative Qualtrics survey was used to gather data, with a single, additional, quantitative question. This approach allowed for the collection of data from a large, dispersed, sample (Terry & Braun, 2017), while still having the capacity to collect 'rich, deep and complex data' (Braun et al., 2021, p. 644). Demographic questions appeared at the end of the survey.

The main survey questions went through several phases of development. The final survey consisted of 8 qualitative and one quantitative question. Early in recruitment, one participant misunderstood the scope of the survey and asked to withdraw their data. Discussing this event, we agreed to change one word in the survey from 'drugs' to 'medication', to ensure precision and clarity.

### *Recruitment, sample and demographics*

Participants had to be residents and/or working in the UK and fluent in English. They had to be qualified counselling or clinical psychologists, eligible to register for chartership with the BPS and the Health and Care Professions Council (HCPC). Other applied psychologists were excluded due to the focus on those trained to provide therapy. Given that different modalities of therapy are taught across training programs, we inquired into auxiliary professional identities beyond clinical/counselling psychology.

Varied recruitment strategies were used, including online fora, social media, professional networks, and adverts in BPS publications and outlets. Recruitment stalled at around 60 participants. Although the data was richer than anticipated, we aimed to reach a sample of 80. The sample was relatively recently qualified, with most participants having qualified in the last 5 years. Therefore, stratification was used to try and increase

the diversity of perspectives (Braun & Clarke, 2013). 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. Most participants identified as female ($n = 67$), white ($n = 67$) and heterosexual ($n = 69$) with a mean age of 41 years. There was a relatively even balance of counselling ($n = 37$) and clinical ($n = 45$) psychologists. Participants had 1–45 years' post-qualification experience with a mean of 10 years. Participants reported a variety of identities that they felt related to the research question such as: feminist, mental health nurse, activist, psychodynamic psychotherapist, community psychologist, approved clinician, neuropsychologist, and having lived experience. For brevity, when presenting quotations from the data we only report participants' main professional identity, as the most meaningful descriptor in this analysis. For full demographic information, please refer to Table 1.

### *Ethics, analytical approach and reflexivity*

Ethical approval for this study was granted by the Faculty Research Ethics Committee at the host university (HAS.18.10.046). Participants read information sheets, provided online consent and were able to request the withdrawal of their responses after participation if they wanted.

Thematic analysis (TA) was used to analyse the data. Braun and Clarke's (2006) six-steps of TA were followed, mixing inductive and deductive readings of the dataset. Phase one involved familiarisation with the data. In phase two initial codes were manually generated on hard copies. Phase three began once data collection had closed and all coded data were collated. This involved broadening a focus from codes to themes. Phase four involved two rounds of reviewing to refine candidate themes further. First, collated extracts were read to ensure they were coherent and 'adequately captured the contours of the coded data' (Braun & Clarke, 2006, p. 91). Then themes were explored in relation to the whole data set ensuring they were reflective of its entirety. In phase five there was further refining of themes to clarify the central organising concept(s) of each theme as such the thematic map developed alongside this process. Seven versions of a thematic map were produced, with the final one merging sub-themes into the main themes as the former added negligible variation and nuance to the latter. Once the themes were clearly named, we moved on to phase six: the final analysis and write up.

In terms of author reflexivity, the first two authors are counselling psychologists and the third is a clinical psychologist. Our cumulative post-qualification experience is 32 years. Even though we recognise the complexity of this issue and have examined many arguments for and against prescribing, taking different views regarding some of these arguments, all 3 of us would choose 'no' if we were asked the quantitative question of our survey, reported below.

## Results

Drawing attention to the bottom of table 1, at the end of the survey, after participants had answered all demographic questions, they were asked: '*Overall, do you think psychologists should gain prescription rights*?' Of the 82 participants: 18 (22%) answered *yes*; 42 (51.2%)

**Table 1.** Participants' Demographics and Relevant Information.

| Characteristics | Number | % |
|---|---|---|
| Gender | | |
| Male | 14 | 17 |
| Female | 67 | 82 |
| Other | 0 | 0 |
| No Response | 1 | 1 |
| | 82 | 100 |
| Race | Number | % |
| White | 67 | 82 |
| Mixed | 2 | 2 |
| Black | 1 | 1 |
| Asian | 3 | 4 |
| Indian | 1 | 1 |
| Other | 4 | 5 |
| No Response | 4 | 5 |
| | 82 | 100 |
| Age | Number | % |
| 25–30 | 11 | 13 |
| 31–40 | 35 | 43 |
| 41–50 | 20 | 24 |
| 51–60 | 10 | 12 |
| 61–70 | 3 | 4 |
| 71–80 | 2 | 2 |
| No Response | 1 | 1 |
| | 82 | 100 |
| Sexuality | Number | % |
| Heterosexual | 69 | 84 |
| Gay | 3 | 4 |
| Bisexual | 6 | 7 |
| Other | 3 | 4 |
| No Response | 1 | 1 |
| | 82 | 100 |
| Profession | Number | % |
| Clinical Psychologist | 45 | 55 |
| Counselling Psychologist | 37 | 45 |
| | 82 | 100 |
| Disability | Number | % |
| Yes | 8 | 10 |
| No | 73 | 89 |
| No Response | 1 | 1 |
| | 82 | 100 |
| Class Category | Number | % |
| Working | 11 | 13 |
| Middle | 55 | 67 |
| Upper | 0 | 0 |
| No Class Category | 5 | 6 |
| No Response | 4 | 5 |
| Other | 7 | 9 |
| | 82 | 100 |
| Years Qualified | Number | % |
| <5 Years | 27 | 33 |
| 05–10 | 20 | 24 |
| 11–20 | 18 | 22 |
| 21–30 | 3 | 4 |
| 31–40 | 4 | 5 |
| 41+ | 2 | 2 |
| No response | 8 | 10 |
| | 82 | 100 |
| Should Psychologists Gain Prescription Rights? | | |
| | Number | % |
| Yes | 18 | 22 |
| No | 42 | 51 |
| Unsure | 22 | 27 |
| | 82 | 100 |

**Table 2.** Themes constructed from the analysis of the dataset.

| **Theme 1:** Prescription rights: A crossroads in our identity | **Theme 2:** If the drugs (don't) work, I should(n't) prescribe them | **Theme 3:** The cost of power |
|---|---|---|

answered *no*; and 22 (26.8%) were *unsure*. While most participants answered *no*, just over a fifth answered *yes*, with a quarter remaining *unsure*.

The qualitative analysis below attempts to summarise the findings in relation to the main research question through participants' responses to the qualitative questions. Table 2 presents a thematic overview of the dataset.

## *Prescription rights: a crossroads in our identity*

A 'story' of the entire dataset can be captured in the above theme title, which centres the dilemma at the heart of the prescription rights debate: a move towards gaining prescription rights will signal a significant departure from current practice, with implications for who psychologists are, what they do, and the values that underpin the profession. Under this reading we are standing at a crossroads, pondering which direction to take.

One of the most succinct and representative articulations of how participants felt about this crossroads was expressed as: '*why try on someone else's clothing? Ours is fine*' [P74, *CP*]. Here, we see an overt distancing from the act of prescription, which is likened to an unnecessary, perhaps even artificial and ill-fitting, attire. It expresses a relatively straightforward and common view regarding which path to follow, or rather, not follow.

For many participants, grappling with their professional identity is a familiar issue; something that they are continuously working through when trying to integrate into systems dominated by the medical model:

> 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) [P29, CoP]

P29 believes psychologists are already much influenced by the medical model and shares concern that prescribing would lead the profession to further collude with it. Gaining prescribing rights was, for many participants, equivalent to adopting a diagnostic framework, fuelling concerns about following a path that involves further medicalisation of distress:

> I feel as though counselling psychologists would be firmly placed within the 'medical camp' which I feel slightly uneasy about [P46, CoP]

> Our profession should be moving away from the medical model rather than embracing it [P33, CP]

Tensions between the perceived philosophical stance, value-base, and epistemologies guiding psychologists on the one hand, and the assumed practicalities of carrying out

a practitioner role with prescription rights are clearly demonstrated by the following excerpts:

> 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 [P47, CP]

> 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 [P41, CoP]

> Conceptually it does not sit well, in the way I understand psychological distress [P78, CP]

> 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 [P42, CoP]

Many participants did not explicitly define their 'psychological approach'; however, responses such as the above argue that it does not align with the medical model. Medication seems to be perceived as a short-cut that bypasses wider issues, a position that seems at odds with many participants' understandings of their role in battling the root causes of psychological distress such as trauma and wider societal issues. The value of systemic interventions, often considered an alternative to the 'treatment' of individuals, is captured by the following quotes:

> 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 … [P1, CP]

> [We] run the risk of undermining awareness of the ways in which social contexts, discrimination and oppression are key causes of distress [P31, CoP]

Participants' also raised anxieties related to blurred boundaries between psychiatry and psychology:

> 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 [P21, CP]

> I would worry that society may begin to see psychologists as more aligned with the medical model [P47, CP]

For some participants gaining prescription rights was an undesirable destination as they juxtaposed it with what '*being a psychologist is about*' [P41, CoP]:

> 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 [P74, CP]

> I cannot fathom why any psychologist who understood everything they did in their doctoral training would want to prescribe. This constitutes madness in a system [P44, CP]

P44 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 frequently constructed as a strength:

> Our strength is in providing something different to the medical model [P8, CoP]

> It may impede our useful role where we act as a cautionary voice in a team, offering an alternative perspective to the medical model [P31, CoP]

The participants above position themselves not only as practitioners able to offer an alternative understanding of distress, but also as important voices within multidisciplinary teams, advocating for clients by sharing those perspectives. The analysis revealed participants' fear that the power of this voice could be diluted through stepping into medicalised discourse.

Despite most respondents articulating the incongruence between psychology and prescribing, which often translated into a relatively clear stance regarding which direction to follow at the crossroads, the dataset contained other views. Several participants expressed the view that psychology could benefit from more focus on the 'bio' part of the biopsychosocial approach through the introduction of prescription rights. These participants detected a niche for psychologists via the act of de-prescribing or helping people withdraw from medication. In addition, a few expressed the view that prescribing psychologists could do better than their psychiatry colleagues:

> I would support prescription privileges and the right to reduce/withdraw medication [P17, CP]

> 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) [P19, CP]

> We are already able to take on some traditional psychiatry roles but my experience 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 [P76, CP]

### *If the drugs (don't) work, I should(n't) prescribe them*

Participants' views and assumptions about psychiatric drugs seem to influence whether or not they believe psychologists should gain prescription rights. This is perhaps an unsurprising finding, nonetheless it is important to document it within a qualitative paradigm. Some participants note:

> I am aware that I hold quite strong views against the medical model, which influences whether I think psychology should be involved in prescribing [P12, CP]

> If this were imposed upon me, I would feel: 1) incongruent, and would need to grapple with my personal and professional beliefs about medication [P5, CoP]

A few participants appear to subscribe to a view which assumes that psychiatric drugs work by targeting and reversing an underlying chemical imbalance or brain abnormality:

> Medication is used in a variety of ways to treat symptoms of a disorder, or in some instances, address an underlying biological cause [P17, CP]

> 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 [P38, CoP]

However, more participants were dubious about this view of how psychiatric drugs work as seen by the below quotes:

> 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 [P48, CP]

> [Medication] is generally used to treat symptoms rather than underlying causes of distress [P3, CP]

> They are prescribed by doctors and are widely used as a front-line defence in General Practice as well as psychiatric services [P27, CoP]

Participants generally expressed that the prevalence of psychiatric drugs in our health systems and their 'first line option' status, means that clients are not given a choice over their mental health care. However, despite many participants being sceptical that drugs worked by correcting an underlying disease, some still saw 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 [P2, CP]

> I certainly believe that medication has a useful role to play [P10, CP]

> I believe that medication needs to be thought about on an individual basis rather than any assumptions made based on diagnosis [P48, CP]

These quotes suggest that it is ill-advised to express practitioners' views on psychiatric drugs as singularly for or against and calls for nuancing their 'role' or place, as it demonstrably feeds into views on gaining prescription rights.

Some participants shared that their views were influenced by personal experiences rather than a professional reading of the empirical literature on efficacy or clinical experience alone:

> 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 [anxiolytics] could have been helpful at times of very heightened worry. 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 will always consider connecting through the process of talking therapy a more powerful tool than medication [P46, CoP]

> I have also utilised medication myself, so this is more than a professional assessment, but also something I have … experienced myself [P31, CoP]

These quotes suggest an integration of personal and professional experience that is often emphasised and encouraged in psychotherapeutically inflected professional doctoral trainings.

### *The cost of power*

In this final theme we capture participants' accounts of prescription rights as a means for psychologists to gain increased status and power in the workplace and wider society. We explore what power means for the participants and how they constructed psychologists'

status in relation to other professions. Overall, the data speak of a shared ambivalence towards professional power as this theme also demonstrates what might be lost, for some, in the process of increasing the profession's scientific status:

> Some may think [prescription rights] add to a psychologist's status, authority and respect [P9, CoP]

> Hopefully, it would increase our standing in society's eyes as prescribing is rightly or wrongly viewed as prestigious [P28, CoP]

A notable feature of the data concerned acknowledgment that prescription rights could afford more power, with a concomitant deliberation regarding the desirability of such an outcome. Some participants expressed that they wanted more power for themselves, whereas others speculated that this was the motive behind other psychologists' desire for prescription rights:

> [Prescription rights] would seem to me like a power grab on the medical profession, presumably to justify being paid more? [P64, CP]

> Could be helpful in protection and promotion of our profession overall in the long run, particularly in maintaining higher bandings [P43, CP]

Participants contemplated the benefits of gaining prescription rights particularly in relation to maintaining higher pay. To explain the terminology used by participants 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. It seeks to harmonise pay scales and career progression across traditionally separate pay groups. Job posts go through an evaluation process where several factors are considered such as training, experience, responsibility, and effort. Posts are then either matched to a national profile and its band or further evaluated if there is no suitable profile to match. NHS Jobs are banded 1-9; the higher the band, the higher the salary (for more information see: Royal College of Nursing, 2018). A quick search through NHS job adverts reveals that independent nurse prescribers are paid at a band higher than non-prescribing nurses. The participant below acknowledges that in a context where the medical model dominates, such as the NHS, prescribing rights would be a valued skill, affording greater power/status in the hierarchy:

> Within the dominant medical model, a psychologist will gain power and prestige. They will also be seen as higher in the hierarchy … I think that Western society … perceives psychiatrists as more qualified for treating severe mental health problems [P11, CoP]

> Maybe [psychologists seeking prescribing rights] are pursuing 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 [P41, CoP]

Despite most counselling and clinical psychologists' doctoral level qualifications, participants seem to express feeling inferior to psychiatrists. Participant 35 gave an example from practice:

> I had a placement at a hospital some years ago and when I asked for Dr X (my ClinPsych 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. [P35, CoP]

The prefix Dr is bestowed upon most clinical and counselling (among other) psychologists as a professional doctoral qualification. The quote highlights that despite being trained to doctoral level and being afforded the Dr title, hospital settings might render the lack of medical training as a deficiency.

> 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. [P30, CP]

> 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? [P61, CoP]

Participants seem to be suggesting that others can perceive psychology as an easy or soft subject, which struggles to be taken seriously as a science. For some participants, the introduction of prescription rights seems to offer the possibility of bolstering the disciplines credibility and legitimacy, not just to medical colleagues but to society as a whole.

> Medics might see it as encroaching on their role. But, being a resilient profession, I think it more likely that [psychiatrists] would soon find a way to use prescribing psychologists as handmaidens (much like nurse prescribers are already) to do some of the routine, uninteresting and unrewarding work [P77, CP/ex-MH nurse]

This clinical psychologist, previously qualified as a mental health nurse, describes psychiatry as a 'resilient profession', hinting at its capacity to bounce back from adversity, in this case psychologists encroaching on their role. The participant further speculates that psychologists could instead become subservient to the more dominant profession of psychiatry. Many participants appeared dubious that gaining prescription rights would change our relationship with psychiatry. In fact, most argued that the cost of psychologists gaining prescription rights could translate into further deference to and legitimisation of psychiatry. The above quotes touch on issues of boundaries and competition between professions for authority. There was no suggestion in the dataset that instigating a 'turf war' with psychiatry was a welcome implication of the prescription rights debate.

A common consideration of what prescription rights entail related to power imbalances in the therapeutic relationship. The medical model positions the doctor as expert who diagnoses, treats, and cures the passive patient, a stance at odds with many of the participants practice as outlined by the counselling psychologist below:

> 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? [P61, CoP]

This participant seems to be grappling with how to marry the underpinning humanistic ethos of counselling psychology with the more directive expert position that is implicit in the medical model. This quote also demonstrates that there might be unique challenges

for counselling and clinical psychology of various orientations with regards to gaining prescription rights due to the different theories and traditions that influence their professional development. Showing just how complex this theme is, accounts switched between a therapy room context (which invokes a dyadic helping relationship) and more contextual positionings that spoke to participants' varied professional responsibilities as psychologists:

> 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 [P43, CP]

It is striking that although psychologists frequently attain leadership positions within the mental health services of the NHS, this was not reflected in participants' responses, which tended to communicate psychologists' perception of being powerless to instigate change.

> We lack confidence as a profession and potentially this causes defensiveness and desire to acquire more skills and attributes [P23, CoP]

> 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 of IAPT on psychology, [and the] need for psychologists to have more selling points. [P47, CP]

Both of the above participants indicate the wider profession's lack of confidence as a possible motivation for seeking out prescription rights. P47 specifically considers the threat of an increasing number of other professions training in psychological therapies particularly within the Improving Access to Psychological Therapies (IAPT) system in England (since renamed NHS Talking Therapies). Prescription rights would arguably demonstrate that psychologists have an additional, socially sanctioned skill, which might protect them from redundancy in an increasingly underfunded and stressful professional setting.

Earlier some participants speculated that psychiatrists might view psychologists as encroaching on their territory by prescribing medication. Perhaps some psychologists and/or their professional bodies are feeling threatened by other professional groups delivering therapy. In this way prescription rights become a potential 'selling point', marketing psychologists as superior to rival therapists who *only* offer therapy. The above might go some way to explain why some participants expressed a desire for extra 'tools', prescription rights being one of them.

## Discussion

The aim of this research was to explore UK counselling and clinical psychologists' views on gaining prescription rights. This was achieved through an online qualitative survey that allowed participants to express their own views, in their own words. The findings suggest that practitioner psychologists have diverse views; yet an overall questioning

can be inferred across the dataset in relation to what prescribing rights might mean for the future of applied psychology in the UK. Participants repeated that prescribing rights could change the role and identity of a psychologist. This was constructed as problematic for some and an opportunity for others.

According to those who took part in this survey, prescribing rights represents a pivotal decision or a 'crossroads' in their identity. Participants grappled with identity and professional role not only in relation to the prescription rights debate but also in other contexts dominated by the medical model of distress. This highlights a potential gap between the contemporary philosophical stance of counselling/clinical training in the UK and real-world practice. It also echoes previous research in the area (Cooke et al., 2019; Hadjiosif & Karlsen, 2021; Rizq, 2006; Strawbridge, 2016). Some participants found it hard to fathom why any psychologist would want prescribing rights, while for others, prescribing on the horizon encouraged a deeper engagement with the bio element of the biopsychosocial model, presenting a niche role for the therapist-prescriber and opportunities to change the narrative around psychiatric drugs by formulation driven prescribing and de-prescribing. A clash of idealism (how things should be) and pragmatism (what to do given how things are) could be underlying some of these conflicting views and visions about the future of the profession in the UK.

The second theme captured participants' assumptions about the efficacy and dangers of psychiatric drugs and how these inform whether they believe prescribing to be a worthy pursuit for psychologists or not. Some participants subscribed to what Moncrieff (2008b) describes as a disease centred model of drug action where they understood medication as correcting a brain abnormality. However, the majority of participants understood the benefits from a drug-centred model. Interestingly, no participants referenced this model explicitly despite many speaking from this position. The final theme developed the view that prescribing could be a means for psychologists to gain status and power and also the possible repercussions of such a move. This view seemed particularly pertinent to psychologists working in the NHS due to the perceived dominance of the medical model of distress within this institution. Concerns regarding how psychology is viewed by the public were drawn upon in these deliberations as participants, once again, report conflicting but not necessarily mutually exclusive visions of the profession, its practitioners and the services we can offer to the public. In the final theme there was some speculation that the recent drive for prescription rights could be a response to the proliferation of professionals who might replace chartered psychologists for a cheaper workforce that provide therapy. This concern is not necessarily unfounded. The initial discussion paper by the BPS Task and Finish Group (BPS, 2019) states one of the reasons for considering prescribing is because therapies are now routinely provided by other professions.

To the best of our knowledge, this qualitative study is the first of its kind on this topic globally. It expands on previous quantitative research (APS, 2007; Fitzgerald & Galyer, 2008; St. Pierre & Melnyk, 2004; Walters, 2001) and opinion pieces (Dobson & Dozois, 2001; George & Semp, 2013; Johnstone, 2003; Nussbaum, 2001; Resnick, 2003; Sammons & Levant, 2003) which suggest that prescription rights remains a controversial topic globally. The study was carried out simultaneously to the BPS consultation on prescription rights (BPS, 2019, 2020a). Some participants speculated that the researchers were pro-prescription rights due to medicalised language in how we framed some

survey questions. We understand this as further evidence of the tensions the topic evokes and a harbinger of the tensions that might follow the granting of prescription rights to psychologists.

The BPS consultation advised that prescribing rights would be an optional training offered post doctorate. There are possible issues here. Firstly, attempting to appease both camps by emphasising optionality suggests an individualistic approach. Those who are against prescribing rights may not only be worried about their practice, but for the entire field of practitioner psychology. In the light of the first theme, which documents perceived shifts in psychologists' identity and the third theme looking at the implications of power for the entire profession, we would caution against optionality in defence of prescription rights. Such individualism, dovetailing with consumerism and the neoliberal marketisation of care (Goodman, 2016), fails to heed how these forces could erode therapeutic sensibilities and make it difficult to think of alternatives (Rizq, 2013). We are all impacted by changes in the profession and the framing of this important issue as an optional choice potentially obscures the wider ramifications for all psychologists. Secondly, whilst optional in theory, it seems reasonable to wonder whether prescribing will eventually be written into job descriptions for psychologist posts. In the future, might it become necessary to obtain a prescribing qualification to remain employable?

Moreover, the BPS have advised that being a prescribing psychologist would require an engagement with diagnostic constructs (BPS, 2019). This would be problematic for many psychologists. Many no longer ignore the evidence challenging the reliability and validity of diagnostic constructs, including the criticism from psychiatry and those intimately involved in the construction of the DSM (Boyle, 2007; Johnstone & Boyle, 2018; Kupfer et al., 2002).

De-prescribing was one reason some participants gave as a rationale for wanting prescription rights. De-prescribing has been widely suggested as one of the advantages for psychologists prescribing in previous literature (Linda & McGrath, 2017; Resnick, 2003; Ross, 2015). Of course, the desire to de-prescribe acknowledges a problem with overprescribing (Dorwick & Frances, 2013; Rice-Oxley & Fishwick, 2013). Previous research suggests that for many service-users, medication is the only intervention on offer (Beresford et al., 2016) which many of our participants echoed from their clinical experience. One could argue that rather than increasing the number of prescribers to encourage de-prescribing, psychologists could simply challenge the overprescribing of psychiatric drugs from their current position. Moreover, research from the US suggests prescribing psychologists are equally likely to increase and decrease the number of medications prescribed on their most recent workday (Linda & McGrath, 2017). This highlights the complexity, contradictions, and interconnectedness of practices when it comes to predicting what the future will actually look like.

Our study also highlighted that some participants felt they lacked knowledge of psychopharmacology. Perhaps more adequate training and CPD together with the recent guidance for psychological therapists (Guy et al., 2019) could be helpful for psychologists to have more deprescribing conversations with their clients, psychiatrists and other professionals – without needing to be able to prescribe themselves.

Other participants argued they would use their 'prescribing power' to disrupt the medical model by limiting prescriptions, something that becomes more plausible if

one speaks from within the dominant discourse of biomedicine. A potentially unintended consequence is that this might further entrench the medical model of distress within psychology, thus inhibiting the extent to which it can be challenged as inappropriate for understanding people's emotional distress, relational struggles, and problems in living that have material (e.g. poor housing) or social (e.g. oppression, barriers in civic participation) drivers.

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). Given psychology's perceived 'softness' by some, we wonder whether moves towards psychiatric drugs symbolises a counterbalancing 'hardness'. This mirrors a historical concern to align with scientific approaches in an effort to establish credibility and build legitimacy (Hadjiosif, 2019; Parker & Shotter, 1990) that will inevitably shape how psychology is taught in schools and universities.

Finally, as noted by one of our anonymous reviewers, one additional wider factor to consider could be that, in time, increasing numbers of other health professions may choose to take up prescribing rights. This is in addition to the increasing number already able to offer forms of talking therapies. Both of these changes may have implications for the space in which practitioner psychologists operate. Any influence this has on psychologists and whether they decide to prescribe or not is yet to be seen.

Overall, the study appears to have successfully gathered a range of perspectives from UK psychologists. It is important to note that this study took place within the UK which has its own relationships and interrelationships with different areas of psychology, with professional psychological training, with medicine, with psychiatry and with the medical model of distress. Other countries, even within Europe, may well have different relationships and interrelationships. It should not be assumed that these UK based findings will generalise to different contexts.

Online surveys run the risk of producing thin data (Braun et al., 2021), but in this instance, the dataset was rich, yet manageable enough to allow for a textured analysis. That said, any survey with predetermined questions, requiring written responses from participants likely limits the detail that goes into those responses.

There was more scope to nuance and further conceptualise the views within the obtained dataset. Before the critical turn in social psychology (Gergen, 2009; Parker, 2005), whether practitioner psychologists were interested in gaining prescription rights could have been conceptualised under an 'attitudes' research paradigm (Edwards, 1997). One of the distinctive features of critical qualitative research is the rejection of traditional notions of attitudes as fixed cognitions inside people's heads (Burr, 1995; Parker, 2005). Instead, views such as the ones under investigation are understood as having discursive functions which are deployed in linguistic interactions (Potter, 1996; Potter & Wetherell, 1987). There was 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 in other parts. We considered creating a theme to capture this apparent contradiction, but eventually abandoned the idea as it was not directly responding to the research question. This research rests largely on our sample's perceptions and predictions, as expressed in discursive formations.

Notwithstanding a critical/discursive reading of the data, should more quantitative and attitudes-focused researchers wish, there is scope to conduct future research in that direction, building on other recently published European data (i.e. Zečević, 2022).

In terms of recruitment, it should be noted that the researchers share some professional networks (i.e. community psychology) which might have skewed the sample towards the critical edge of the spectrum of views. This might have been further exacerbated by the use of snowball sampling (Parker et al., 2019).

Preliminary evidence, from North American participants, suggests that experienced psychologists are less likely to pursue prescription rights than those who are more recently qualified (Walters, 2001). Our sample consisted of a sizeable number (n = 27) of newly qualified psychologists (less than 5 years). The sample also largely consisted of white, middle-class, heterosexual women. This perpetuates the criticism levelled at much psychological research, namely that it captures the views of the 'usual suspects' (Terry & Braun, 2017), at the expense of marginalised groups. As the targeted sample was a professional group it also potentially speaks to the lack of representation within psychology more broadly. Indeed, the BPS (2016) has recognised that there is underrepresentation of certain groups within its membership and the wider discipline.

## Conclusions

Over the last decade, there have been several challenges to the medical model of distress and the use of psychiatric drugs for psychological conditions. Outside of psychology, the Royal College of Psychiatrists in the UK has moved away from the language of antidepressants correcting 'a chemical imbalance' in the brain (2019b). NICE guidelines (2021) on the treatment of adult depression have recently been updated to advise that people with mild depression should be offered therapy before anti-depressants. Against this backdrop, it may seem strange to some that UK psychologists are being asked to consider prescribing medication. Conversely, some participants in this study feel this is a journey we should be taking.

As authors, we take the view that the UK's current mental health needs call for more resources for understaffed mental health services generally. Evidence from before the pandemic and cost-of-living crisis shows how income equality relates to mental health (Wilkinson & Pickett, 2010). Inequality causes stress, erodes social capital and increases social fragmentation. Psychologists seeking or gaining prescribing rights seem an unlikely part of any solution to these issues.

This debate on UK psychologists gaining prescribing rights will continue. It seems important that diverse views continue to be gathered and listened to. Moreover, it seems to matter that any decisions made, consider the current and future implications for all practitioner psychologists – both those who may be keen to prescribe and those who, for various reasons, remain against the idea.

## Data availability statement

The participant data from this manuscript will not be publicly available as the participants did not explicitly agree to their data being archived publicly when they consented to take part in the research project.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

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