Implications of non-medical prescribing of controlled drugs

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Mental health nurses working in the substance misuse field will soon be able to prescribe controlled drugs as part of their role. This article discusses the implications of this and its potentially positive impact on the existing prescribing services.

The NHS Plan (Department of Health, 2000) emphasises the need to organise and deliver services around the needs of patients. Demands by patients for a more streamlined, accessible and flexible service (DoH, 2000) has meant that traditional demarcations between clinical roles are being challenged in order to facilitate new ways of working and improve service delivery (National Prescribing Centre, 2005).

The National Treatment Agency (NTA, 2005) has set targets for substance misuse services to improve the accessibility of treatment and increase the number of individuals who access services and reduce waiting times. Some services have found it difficult to meet the current targets and, unless there are opportunities to alter service provision, it is unrealistic to expect more demanding targets to be met.

In the field of substance misuse, nurses have an increasing role in working with addiction (drug and alcohol) and its associated health problems as well as comorbid presentations where mental health problems are complicated by the use of illicit psychoactive substances (Rassool, 2005; Nkowane and Saxena, 2004). Providing an appropriate and responsive prescribing service in primary or secondary care means that nurses should have the potential to prescribe controlled and other appropriate drugs.

Mental health nurses and the prescription of controlled drugs

There has been growing recognition of the potential benefits of nurses prescribing controlled drugs. The Royal College of Psychiatrists has indicated that prescribing by substance misuse nurses using a shared care protocol with GPs could be a positive way forward (RCP, 2001). A report by the Audit Commission (2002) suggested that nurse prescribing could offer new ways of managing treatment for drug misusers. More recently, the chief nursing officer for England has announced that there will be a major review of mental health nursing. The review will consider how nurses can contribute in a number of areas, including non-medical prescribing, to improve outcomes for service users (DoH, 2005a).

Recent developments that allow controlled drugs to be included within supplementary prescribing will provide substance misuse nurses with opportunities to work in new ways. Training for supplementary prescribing was introduced in 2003, which allows the nurse to prescribe medication relative to the context of care they work in and relative to their scope of practice. From April/May 2005 (subject to parliamentary approval) substance misuse nurses, as well as other nurses, have been permitted to prescribe controlled drugs within the parameters set out by a clinical management plan (Table 1) (DoH, 2005b).

The Home Office is satisfied that the supplementary prescribing legislation is very tightly drawn and there is little scope for nurses acting as supplementary prescribers to be manipulated to authorise an inappropriate supply of controlled drugs (Drug Legislation and Enforcement Unit, 2003).

Prescribing within substance misuse is an innovative project that has government support. Indeed, the NTA and the Advisory Council on the Misuse of Drugs agree that supplementary prescribing provides a robust and safe structure to enable nurses to prescribe controlled drugs used in substance misuse (NTA, 2005). This is a positive development as there had been doubt cast on whether the prescribing of controlled drugs by nurses should be allowed following the Shipman case (NTA, 2005). However, the Shipman inquiry did not object to the idea of nurses prescribing and evidence from the US suggests that it may be a major way forward in improving the way controlled drugs are prescribed, as nurses are accustomed to following strict guidelines for clinical interventions (Hemingway et al, 2004).

Although the idea of nurses prescribing is not new and has been used in the fields of palliative care and midwifery (Rassool, 2005), the decision to allow controlled drugs to be included in supplementary prescribing is an exciting development and
potentially a major step forward for substance misuse services.

Along with psychosocial interventions, medication is one of the main treatment components for people with substance dependence. Nurses are heavily involved with medication – they give advice, monitor effects and, in reality, may make de facto prescribing decisions by advising junior and/or non-specialist medical staff.

This high percentage of de facto prescribing by nurses suggests that they are involved in sanctioning wider medicine use and frequent changes to treatment regimes (Ramcharan et al, 2001). In many services, supplementary prescribing will merely formalise informal arrangements that already exist. As noted by Hawkins (2000): ‘It is acknowledged that current practice often involves the sessional GPs rubber-stamping prescriptions following advice on a patient’s prescribing needs by a specialist nurse.’

Extending the role of nurses in the prescribing and supply of medication has clear benefits and is advantageous for both clients (providing timely access to treatment and a reduction in waiting times) and health care staff (by maximising their use of professional skills) (Drug Legislation and Enforcement Unit, 2003). Allowing nurses to initiate, titrate and adjust doses without medical input would free up valuable medical time to deal with service users at the first point of contact and manage those with complex needs. The NTA suggests that allowing supplementary prescribing would lead to better-quality prescribing, improve services and indirectly reduce waiting times (NTA, 2005). Clear policies and a strong clinical governance framework need to be in place to ensure prescribing enhances service user care without increasing risk or compromising safety (NPC, 2005).

Competency

Some have questioned whether mental health nurses specifically and nurses in general have had adequate substance misuse training at basic and postregistration levels (Nkowane and Saxena, 2004). At this early stage of mental health nurse prescribing doubts have been expressed regarding the generic prescribing course available to mental health nurses and how this prepares them to prescribe at all, let alone prescribe controlled drugs (NPC, 2005). Nurse educators and trusts will need to help mental health nurses working in substance misuse to identify the pharmacological knowledge and psychotherapeutic skills needed to legitimise the role.

One way forward could be to limit the prescribing of controlled drugs to senior nurses who have built up experience and expertise in this area. Research has confirmed that nurses working in substance misuse services are willing to take on this role if it is limited to experienced nurses (Scottish Executive, 2004). Evidence from the US has shown that these nurses do consult with psychiatrists when controlled drugs are prescribed (Campbell et al, 1998). Thus nurses are prepared to use the appropriate supervisory arrangements to ensure safe and appropriate prescribing. This supervision will hopefully become an established part of the extended/supplementary prescribing training, where nurses’ 12-day supervised practice period with a doctor will foster a collaborative atmosphere.

Conclusion

Prescribing of controlled drugs by other nurses should be planned with appropriate caution and rigorous preparation. With the ever-increasing demand on health care services and the shortages of doctors, in particular psychiatrists, making use of mental health nurses is surely a pragmatic way of improving the service (Nkowane and Saxena, 2004). The addition of prescriptive authority to the nurse’s role is one positive way of making the service more responsive for service users, as well as helping to resource increasing demands on health services.

| KEYWORDS | Mental health | Substance misuse | Non-medical prescribing |

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**TABLE 1. COMPONENTS OF A CLINICAL MANAGEMENT PLAN (NPC, 2005)**

- **Name of the patient**
- **The illness**
- **Date on which the plan is to take effect**
- **Date for review by doctor**
- **Reference to the class/description of medicines that may be prescribed/administered to patients under the plan**
- **Any restrictions as to the strength or dose of any medicine that may be prescribed/administered under the plan, and any period of administration of any medicine**
- **Warnings about any sensitivities/difficulties of the service user with particular medicines**
- **Arrangements for notification of:**
  - Suspected or known reactions to any medicine prescribed/administered under the plan and reactions to any other medicine taken at the same time
  - Incidents occurring with any prescribed appliance that may lead to serious deterioration in the health of the service user
  - Circumstances in which the supplementary prescriber should seek the advice of the doctor who is party to the plan