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Mental Health Nurse Prescribing: Challenges in Theory and Practice

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Abstract

This article addresses the historical context of mental health nursing and its relationship to nurse prescribing.; examines some of the theoretical and philosophical forces that have molded modern mental health nursing, discussing the tensions between the medical model and the psychosocial models favoured by many mental health nurse academics and practitioners over the last forty years; and finally discusses the issues and challenges around commencing prescribing in practice, especially when nurse prescribing is not integral to the practitioner's role.

The article intends to examine the theoretical basis for mental health nurse prescribing, to discuss some of the theoretical tensions which are implicit; and describes briefly the author's own experience as a recently qualified nurse prescriber.

Key words:

- Mental Health Nurse Prescribing
- Conflict of theoretical basis of mental health nursing
- Competence of mental health nurses to diagnose

It would be apt to first take a critical look at the policy drivers behind mental health nurse prescribing over the last decade and how an ability which was once considered a preserve of the medical profession came to be obtained by nurses. The advent of nurse prescribing needs to be seen in the context of the changing face of the N.H.S. This has included changing expectations of patients and carers, the changing structure of health care, and the switching in emphasis from secondary health care to primary health care and the changing roles in care provision of health and social care. Commentaries such as those by Blaxter (1995) and Calman, Hunter, and May (2001) provide a backdrop to these developments. In order to meet these pressures, the Government produced a number of policy initiatives and position statements which provided policy drivers for the expansion of nurse prescribing.

Changing pressures and expectations of NHS provision were reflected in Government documents and position papers such as Working Together-Securing a Quality Workforce for the NHS (DOH 2000) which promoted the use of inter professional working as a tool to modernise the NHS and emphasised the recruiting and retaining of a quality N.H.S. workforce.

Another key policy document, Making a Difference (1999) specifically proposed extending nurse prescribing, with the explicit aim of making better use of the time of GP's. There is also implicit support for nurse prescribing in the NHS Plan (2000), a seminal New Labour blueprint for the NHS which stressed the importance of new ways of working and breaking down the traditional demarcation lines between professional groups in the NHS in the interests of improved access to and quality of health care; indeed this appears to have been a key policy driver in the development and expansion of nurse prescribing. Early public reactions to nurse prescribing appeared to be favourable (Luker et al 1997), although some

concerns were raised about training, supervision and possible expansion of the nurse prescribing remit. A further study by Brooks et al (2001) regarding patients' perceptions of nurse prescribing, again in a primary care context, also reported favourable results regarding perceived timeliness and effective use of doctors' and nurses' time.

Thus it can be seen that changing the practice of mental health nurses does not seem to have been at the top of the agenda in terms of the introduction and expansion in the prescribing powers of registered nurses in the U.K. As stated above, the traditional boundary of practice in terms of medication between doctors and qualified nurses in the UK was that doctors prescribed and nurses administered to patients; this had been changed by the developments of the last fourteen years. In a similar period, the role of mental health nursing has also undergone a significant change; Nolan (1998) traces the development of qualified nurses in the UK from being 'asylum attendants' in the Victorian era to 'mental health nurses'. Authors such as Oliver (1997) have described the systematic closure of the large all encompassing mental asylums of the Victorian era, not only in Britain but also in other developed nations such as the United States. Oliver (1997) attributes this to a combination of public concern about the negative effects of mass institutionalisation in the 1950s and the increased therapeutic effectiveness of new treatments such as neuroleptic medication and psychological treatments, and their subsequent impact on mental hospital admission rates.

In the context of the United Kingdom, this led to the slow but steady decline of old mental health institutions and the end of what authors have referred to as the 'Great Confinement' (Wright 1997). The numbers of beds in mental health institutions in England and Wales declined from 150,000 in 1955 to a mere 80,000 in 1985 (Carrier and Tomlinson 1996). At the same time, the amount of community provision for people with mental health problems increased markedly as part of the Government's efforts to provide mental health care in the community, with qualified nurses playing roles in services such as Community Mental Health Teams (Nolan 1998); it is the writer's contention that it was around this time that mental health nurses in the UK and elsewhere began to strive for a different role for themselves, rather than being the medicalised asylum attendants of earlier periods. Writings from mental health nursing textbooks from the last twenty years indicate this effort to find, define and retain this new identity. An example of this are the American authors Fortenish, and Holoday - Wannet (2000) who describe mental health nursing as the art of being able to establish a therapeutic alliance with the patient in order to promote growth and heal emotional and psychological wounds. Authors of British mental health nursing textbooks, determined not to be left behind, have joined this redefining of mental health nursing; Wright (1993) talks of the role of the mental health nurse as that of understanding the emotional life of their patients so that they can respond in a therapeutic way. Newell (2000) advocates a 'cognitive behavioural' model for mental health nurses when interviewing patients, whilst Watkins (2001) writes about mental health nurses developing a 'humanistic' approach in order to achieve effective helping relationships with patients. The humanistic models described above are a world away from the medical model formulae of assessment, diagnosis, formulation and treatment with their international classifications of psychiatric diagnoses, and appear to draw heavily on the work of American person-centred counselling psychologists such as Carl Rogers (1902 – 1987). Rogers, for example, interpreted psychological disturbance as the development of problems with a person's 'self concept' (Rogers 1961) and involved a conceptual framework very different from the paradigm of the medical model. When addressing the issue of 'professional accountability', it is the view of the writer that the issue of what

mental health nurses in the United Kingdom consider to be their therapeutic role is of fundamental importance and that, therefore, there are ethical and professional issues involved in assuming a prescribing role, as mental health nurses in the UK are now presenting themselves to the public as a profession which has stepped out of the shadow of the medical model. Two specific areas where this has occurred, for example, are the participation of mental health nurses in the 'Recovery Model' and person-centred care for people suffering from dementia. The Recovery Model takes a psychosocial approach to mental illness and its treatment (NIMHE 2004), whilst person-centred care for people with dementia also takes a viewpoint that is rooted in psychological explanations for mental health phenomena; the concept of the medicalised view of persons suffering from dementia being based on 'a malignant social psychology' as described by the late Tom Kitwood, (see Kitwood 1993). A recent example of how qualified nurses are following psychosocial and psychologically based care is by Richardson and Richards (2007) who describe the transforming of an underused ward into a therapeutic environment for people with dementia. The activities described in this article and in many others indicate how far mental health nursing has moved away from the medical model which dominated the asylums.

Arguably, the dilemma regarding the nature of mental health nursing which is inherent in the concept of independent and supplementary nurse prescribing is central to the issue of legal, ethical and professional accountability in relation to this practice. In the writer's view, it could be argued that for mental health nurses to adopt a prescribing role, whilst at the same time presenting a non medicalised psychosocially orientated image to the general public, breaches the ethical principles of informed consent and autonomy (Edwards 1996). The public image that mental health nursing now presents in the United Kingdom promotes the image of a profession that has moved away from medicalised solutions to mental health issues and could also infringe the principle of preserving patient autonomy by discretely promoting a medical model agenda from within a profession which now claims to have a person-centred psychosocially orientated ideological base.

A further ethical issue may be the increased involvement of mental health nurses with the pharmaceutical industry and the ethical dilemmas they face when offered information and help from drug company representatives; for example, While and Biggs (2004) in a survey of 123 prescribing health visitors and district nurses, found that 50% stated that they had been influenced by information given by drug companies; prescribing mental health nurses need to be aware of the professional and ethical issues raised by contact with pharmaceutical companies.

These issues have recently been the subject of debate within the mental health nursing profession and have brought to the surface ome of issues discussed above. For example, Keen (2006) makes a number of pointed criticisms of the role of mental health nurses as nurse prescribers. He states that mental health nurses should examine what patients want their role to be prior to deciding to 'expand' it into prescribing. He also questions what mental health nurses can usefully prescribe and ironically comments that mental health nurses should consider 'prescribing' socially and therapeutically useful activities such as holidays and learning practical skills, and quoted research studies that indicated that mentally and emotionally distressed service users preferred therapists skilled in 'talking therapies' rather than being offered prescriptions of medications, and questioned the motivation behind the Government's current enthusiasm for nurse prescribing. He pointedly remarks that the desire of some mental health nurses to become nurse prescribers may be linked more to their desire for an improved status rather than a desire to improve the care of their patients. On the other side of this debate,

Bailey and Hemingway (2006) place mental health nurse prescribing firmly in the accepted remit of mental health nurses. The need for some patients to receive medication is not questioned and suggests that the therapeutic relationships and the fulfilment of clinical management plans can be enhanced by mental health nurses being in a prescribing relationship with patients. They further state that the increasing prevalence and seriousness of mental health problems in the world population is indicative of the necessity of a group of appropriately trained mental health nurses to engage in medication prescribing activities with patients.

If one goes on to look at the legal and professional accountability of nurse prescribers, this dispute with regard to the nature of modern mental health nursing continues. The NMC. Code of Professional Conduct (2002) states that registered nurses and midwives are professionally accountable for their practice, regardless of advice or directions given by another professional, and further emphasises that they owe a duty of care to their patients and clients. This begs the question as to what the practice of mental health nurse ought to be. The N.M.C. has developed the 'Standards of Proficiency for Nurse Prescribers' (2006). These standards state that nurses have a duty to prescribe competently, engage in taking a thorough history and to be able to diagnose and interpret a patient's signs and symptoms. This clearly indicates that mental health nurses who prescribe should have a good working concept of medical psychiatric diagnosis, which returns to the argument about the nature and knowledge base of mental health nursing. If one looks at the legal basis of professional negligence for mental health nurses, it is the writer's view that the debate about what constitutes the knowledge base of the profession is fundamental. The case of Bolam v Freirn Hospital Management Committee (1957) established that the test of professional competence that should be used is that of the ordinary skilled professional and that evidence could be admitted to demonstrate that there was a body of professional opinion that would support the actions of the professional (McHale, Tingle and Peysner 1998). In the writer's view there are a number of connections that can be made here; it would seem reasonable to assume from the above, that all qualified nurse prescribers owe a duty of care to their patients, (NMC Code of Conduct 2008), that the model that nurse prescribers are required to have competence, is essentially the medical model; (NMC Standards of Competence for Nurse Prescribers 2006) and that when challenged about their practice, the standard of competence that will be applied will the standard of the ordinary skilled professional (the 'Bolam Test' 1957). This leads the writer to ask a question; can mental health nurses qualifying as nurse prescribers claim to have the same knowledge of the medical model of diagnosis and disorder classification as doctors who prescribe psychiatric medication and, if not, do they acquire it, as part of their training as nurse prescribers?

As can be seen from the discussion above, it would appear that for the last twenty years or more, mental health nurses in the UK have been following an increasingly psychosocial model of health care; this being the case, can they also claim to fulfil the above criteria with regard to knowledge of the medical/psychiatric model? In this regard, it may be interesting to take a look at the NMC.'s standards for nurse prescribing courses. The NMC standards (2006) state that nurse prescribers should be able to: assess and consult with patients and carers, undertake a thorough history of the patient, including a medication history of the patient, demonstrate an understanding of relevant legislation, critically appraise sources of information, understand the influences that can affect prescribing practice, understand the affect of drug actions, understand the roles of the various professions in the supply, prescription and administration of medication, and be able to practise within a framework of professional accountability and

responsibility. These requirements appear to set a high standard for actual and potential nurse prescribers and this standard is reinforced by the requirement for a period of 'supervised practice' under the supervision of a 'medical mentor', (NMC 2006). However, it is the argument of the writer that the increasing emphasis on the humanistic and psychosocial elements of patient care by mental health nurse practitioners and educators, makes it challenging for mental health nurses to meet these criteria. The current University of Huddersfield Prospectus (University of Huddersfield 2008) for student mental health nurses, which contains subjects such as: 'The science of holistic nursing', 'Mental Health and People' and 'Recovery Based Therapeutic Interventions'; appears to illustrate this trend. Bailey and Hemingway (2006), make two interesting points about the educational level of the preparation for nurse prescribers in the UK; the first is that the academic level of the training is lower than in the United States, where the level of preparation is at Masters level, and the second but related point is to ask whether this level of training is adequate to prepare nurses, mental health or otherwise, to assume the role of prescribing. However they argue that the level of practical experience gained by mental health nurses in their field of expertise may compensate for this.

Nurse prescribers can now independently prescribe medication, as outlined above, in terms of professional and legal responsibility; arguably in order to competently prescribe medication independently, mental health nurse prescribers need to be competent in medical psychiatric diagnosis. Gelder, Harrison and Cowen (2006) state that in medical terms, a 'diagnosis' has come to mean a knowledge of the signs and symptoms that a patient may be displaying. In nursing terminology, especially North American nursing terminology, the term diagnosis has come to mean something quite different; it has become a systemised way of enabling nurses to provide nursing care and contains concepts such as a 'wellness diagnosis' : (Perry and Potter 2004); (Anderson 1998), since the prescription of psychiatric medication is dependent on the medical paradigm of diagnosis and has grown from that tradition; my view that mental health nurses in the U.K. should be able to demonstrate competence in psychiatric diagnosis.

However, the recent preoccupation of the mental health nursing profession in the UK with humanistic, psychosocial approaches to mental health answers to mental health problems has meant that little effort has been spent to acquire expertise in this field. A recent 'Ovid' search carried out by the writer, failed to produce a single reference to mental health nursing diagnosis, however a similar 'Ovid' search of 'mental health nurse prescribing' produced 13 results, a result which would appear to indicate that not a great deal of academic mental health time is being devoted to the subject.

This situation invites speculation on how the Bolam Test (1957) would be applied if the competence of an independent mental health nurse prescriber was challenged in a legal arena. It could be argued that the standard applied would be that of a reasonably competent psychiatrist, as it is difficult to envisage that a court of law would tolerate a lower standard from a mental health nurse prescriber for the performance of the same activity. This could then lead a court to a detailed examination of the nurse prescriber's professional background, the nurse's knowledge of mental health diagnostic criteria, the medical mentorship and supervision of the nurse and that nurse's involvement with Continuous Professional Development activities.

The development of Independent and Supplementary Nurse Prescribing in the United Kingdom was an initiative which developed apparently without mental health nursing particularly being in mind, and has been an initiative slow to take

root. In 2004, a survey showed that of 26,116 mental health nurses employed by 44 NHS Trusts in England, only 102 had completed extended and supplementary nurse prescribing training (NPC et al 2005). However, more mental health nurses are now qualifying as nurse prescribers. Hemingway and Ely (2009) state that this number has now increased to over one thousand practitioners and therefore more attention is now being paid to the issue, as can be seen from the debate exemplified in articles by Keen (2006) and Bailey and Hemingway (2006). A study by Gray et al (2007) in which the views of patients, mental health nurses and psychiatrists were examined, concluded that participants from all three groups had developed a favourable view and that prescribing by mental health nurses was seen as person-centred, evidence-based and retained a focus on the physical health of patients, although some interesting problem issues were identified including issues of supervision, lack of experience and lack of service redesign to support nurse prescribing. There are those who argue that prescribing for mental health nurses bolsters the creation of 'advanced nurse practitioner' roles (see Elsom et al 2007). Prescribing for mental health nurses in the UK definitely challenges traditional healthcare practices and, as can be seen, raises a number of issues of legal, ethical and professional accountability One of the main issues that mental health nurses need to address, as the number of mental health nurses increases, is what the profession regards as the knowledge base of the profession and in what theoretical direction mental health nursing wishes to travel as it continues its journey through the twenty first century.

Until recently, the author worked in a team within the Wakefield locality of the Trust, within older people's services, called the General Hospital Liaison Team. When the author had qualified as a nurse prescriber, he had to use his qualification not only to deepen his knowledge of medication issues with regard to patient assessment but also to work as a supplementary prescriber to the consultants in general hospitals with regard to working within clinical management plans and possibly carry out reviews with patients after discharge. However, as the patients were under the care of another trust, organisational issues prevented the writer from commencing this aspect of his work.

As the writer had been unable to use his qualification within his normal role he then offered to commence with supplementary prescribing within the Rapid Access Team, a team within older peoples services which provides rapid community based assessments and follow up work with patients (independent nurse prescribing does not yet take place within SWYMHT). The plan was that the writer would work two days a week in the Rapid Access Service and undertake supplementary prescribing for two identified consultants. Although the writer commenced one clinical management plan with regard to supplementary prescribing, this new way of working was overtaken by events when the writer accepted a post with another trust, in which independent and supplementary prescribing was central to the role.

These experiences indicate the problems of attempting to carry out mental health nurse prescribing as an 'add on' where prescribing is not integral to the role, as discussed by Gray at al (2007). It would seem to be the case that nurse prescribing has matured much more in primary care with the development of the Advanced Nurse Practitioner role. It would be interesting, in view of the writer's comments above with regard to diagnostic competency, whether a complementary course to the Independent and Supplementary Nurse Prescribing course, at Masters Degree level, regarding diagnosis and psychopharmacology would encourage mental health trusts to adopt more specifically nurse prescribing roles. Bailey and Hemingway (2006) comment that these type of skills have decreased

in emphasis within the content of mental health nurse training courses in recent years. However, it is certainly the case that the experience and knowledge the writer has gained by qualifying as a nurse prescriber has benefitted both his career and the quality of clinical work which he is able to achieve.

Benefits and Challenges of Mental Health Nurse Prescribing

- Increases the number of prescribers available in a service

- Allows the fullest use of nurses' experience

- Assists in the transition of services from being hospital based to being community based

- Nurses need to demonstrate that they are diagnostically competent to assess and prescribe

- Prescribing may detract from other aspects of the nurse's role

- Dangers in developing prescribing as 'add ons' to nurses' roles

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