



An exploration of the role of substance misuse nurses in Scotland

research

Effective Interventions Unit



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Effective Interventions Unit

An exploration of the role of substance misuse nurses in Scotland

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Executive Summary

Background

With the increase of drug misuse over the past two decades, the role of the substance misuse nurse has increased dramatically. Research on the role of nurses working in this field is minimal and there is little known about what they do, what they think about their clients and their role, and how they approach treatment. A pilot study on substance misuse nurses in Grampian indicated that nurses may be key gatekeepers to specialist services and some nurses appeared to have an important role in clinical decision making. However, clinical decision making and other key aspects of nurse practice may vary across services in different geographical areas. This research was designed to gain a better understanding of the role of the substance misuse nurse in Scotland.

Aims and Objectives

The aim of this research was to describe and analyse the role of substance misuse nurses working with drug misusers in Scotland. The objectives were:

- to identify the population of specialist nurses working directly in the management of illicit drug users in Scotland and gain baseline data on their demography, caseload, services provided and level of interaction with other health professionals;
- to compare their attitudes to drug misusers with those of other health professionals;
- to explore their beliefs about the effectiveness of different treatment options;
- to examine their role in the initial client assessment and subsequent management;
- to describe their interaction with the client;
- to explore their relationship with other professionals.

Methods

Mixed quantitative and qualitative methods were used. The population of Substance Misuse Nurses and midwives working specifically with drug misusers across Scotland were identified and posted a comprehensive questionnaire. The questionnaire covered issues including qualifications, training, attitudes and beliefs about treatment and aspects of practice such as caseloads, services provided and relationships with other health and social professionals. Face-to-face interviews were conducted with a sub-sample of nurses including a range of gender, experience, and NHS areas. Interviews covered nurses' assessment and decision making regarding treatment and relationships with other professionals. Observations of specialist nurse and client consultations allowed for some insight into the general structure of the consultation, the setting where the consultation took place and the roles of nurse and client in assessment and treatment planning.

Characteristics of SMS nurses and services

- A scoping exercise identified 272 nurses. Of these 244 were sent a questionnaire (the remainder having left or being on sick leave). Of these, 79% responded.
- Seventy percent (70%) were Grade G or above indicating a senior level workforce.
- Most nurses were employed in substance misuse services (48%) or, similarly, drug and alcohol services (30%).
- Formal training (university certificate/diploma) in substance misuse had been undertaken by 40% of nurses, induction training (i.e. at the start of employment) by 62% of nurses.
- The median caseload was 38 clients.
- The majority of consultations took place in clinical consultation rooms but this was not observed to influence the consultation.
- Nurses reported that the average length of a consultation was 38 minutes. All of the observed consultations were scheduled for 30 minutes but half over-ran.

Motivation, attitudes and beliefs

- The challenging nature of working with drug misusers was a positive motivating factor for nurses working in this field.
- Seventy-seven percent (77%) of nurses considered working with drug misusers to be rewarding, although 79% also considered that this population were not easy to deal with. Opinion was split about whether drug misusers could be manipulative in consultations.

Initial assessment of clients

- Waiting times for assessment were generally an issue of concern to nurses.
- A detailed assessment was almost always conducted at the first consultation.
- An SMR24 was almost always completed at the first consultation.
- Interviews and observation of nurse-client consultations found that the approach to assessment seemed consistent across geographical areas.
- Assessment included: brief physical examination, urine sampling, detailed exploration of drug use, exploration of physical problems, discussion of social and family support, housing and employment status and history of involvement in the criminal justice system.
- Consultations were often brought to a close by discussing treatment expectations.
- Initial assessment could take place over more than one appointment and several appointments could be required before a treatment plan was implemented.

Making treatment decisions

- Clients were actively encouraged to participate in treatment decisions.
- Although 84% of nurses reported they were expected to follow a treatment protocol only 44% said they always did (for any treatment).
- Eighty-six percent (86%) of nurses had seen the National Clinical Guidelines (DoH, 1999), and those who were interviewed felt that these provided a good framework for treatment, although they were perhaps lacking in detail.
- Nurses reported that they often consulted widely with other health professionals but, most frequently, with the client, before making a treatment decision.
- A third of nurses reported writing prescriptions for a doctor to sign.
- Seventy percent (70%) of respondents felt nurses should be able write prescriptions but only if they were experienced nurses with appropriate training.

Comparing beliefs of nurses with those of GPs and pharmacists

Nurses were asked some questions which had been asked of GPs and pharmacists in previous national surveys conducted in 2000. This allowed for comparisons to be made:

- When making treatment decisions nurses were less influenced than GPs by the attitude and behaviour of drug misusers.
- When making treatment decisions nurses were more influenced than GPs by societal factors such as reducing the transmission of infectious disease.
- Nurses were less likely than GPs to favour detoxification as a treatment approach, although 83% of nurses agreed that a community based detoxification programme was an effective tool for the treatment of drug misuse.
- Nurses were more confident than GPs about their ability to successfully manage poly-drug users.
- Nurses and GPs were split in their beliefs about the effectiveness of dihydrocodeine.
- Nurses believed more strongly than pharmacists that maintenance prescribing could stop the use of illicit drugs.
- Fewer nurses than pharmacists believed that controlled drug dispensing should take place in central clinics rather than community pharmacies.

Multidisciplinary working

- Over half of nurses considered their relationship with pharmacists, GPs, health visitors/community nurses, hospital doctors and social workers to be good.
- Opportunities to discuss services with local policy makers were considered insufficient.
- Relationships with GPs seemed positive because nurses felt GPs valued their specialist knowledge.
- Nurses had frequent contact with pharmacists and respected the difficulties of a pharmacist's work.
- Relationships with social services were variable. Some nurses felt undervalued by their social work colleagues, or felt there was a lack of joint planning for individual client care.
- Nurses were clear about what circumstances should lead to a break in confidentiality between services and of how to go about this.
- Integrated drug services were seen as potentially beneficial but there were specific concerns about the implications for clients of sharing information with other agencies and practical concerns about the size of joint assessment tools.

Health and Safety at work

- Sixty-four percent (64%) of nurses reported that they had been physically or verbally abused by clients, and half of those who had been subject to abuse felt current safety provision in their service was insufficient. Nurses in most areas said that the safety of staff was considered to be a high service priority, but there was evidence from interviews this was still lacking in some areas.
- Greater use of personal alarms and alarms in consultation rooms, use of mobile phones, and specialised training were suggested as ways of improving safety.
- Nurses said that the majority of their consultations take place in clinics/consultation rooms rather than clients' homes.
- The feeling was commonly expressed among interviewees that their work could be stressful, and this was seen as due to paperwork, excessive caseloads and working in isolation.

Discussion of Findings

This study provides baseline information which can be used to inform individual nurses, services, policy makers and researchers. Some individual nurses reading this report might find an element that is simply describing what they already know. This is inevitable but it is hoped individual nurses will still find interest in the views and practice of others within their profession. The value of this report is that it has quantified these findings on a national basis, providing robust data for workforce planning and needs assessment. It has not been possible to compare findings, and thus the practice of substance misuse nurses in Scotland, with other areas or countries because there is no comparable published work. It is also not possible to give guidelines or examples of 'good practice' as this would have involved data collection from clients and other professionals which was outwith this study's remit.

This study has found a reassuring consistence of practice across Scotland. Although many substance misuse nurses work in some degree of isolation there is an apparently high level of discussion and consultation with other service colleagues which provides support. The role of the nurse in the initial assessment and treatment plan is critical. Nevertheless, decisions regarding treatment plans were made largely between nurses and clients, with nurses making use of service protocols/guidelines. Some might question whether a nurse is the most appropriate person to undertake these tasks. Ability to conduct physical examination, some knowledge of pharmacology, mental health and psychology as well as an ability to explore the wider social context is required. On reflection a nurse, with mental health qualifications seems to have the most appropriate skills for this.

There is a willingness by nurses to take on the role of prescribing albeit in a limited capacity, and only by very experienced nurses with appropriate training. Currently, a minority of nurses reported writing prescriptions to be signed by doctors, which is possible

for doctors with handwriting exemptions. This raises issues about clinical governance. In signing the prescription a GP is still taking responsibility even though s/he may know little about the patient's current condition.

An important strand of a substance misuse nurse's practice is ongoing support or counselling for clients. This raises issues about models of counselling followed and nurses' competencies in doing this. The nature or model of counselling used by nurses was not explicitly covered in this research and further exploration of counselling would be an area for future research.

Relationships with other professionals, were generally reported to be good. Nurses generally believed GPs valued their role. Comparison of attitudes of substance misuse nurses with earlier surveys of pharmacists and GPs indicates they are more positive in general and about treatment outcomes in particular. Nurses viewed the challenging aspect of working with drug misusers more positively than pharmacists and GPs.

Nurses were less positive about their ability to influence policy. Currently substance misuse nurses have little input at policy level. At a local level, through Drug and Alcohol Action Teams (DAATs) this could improve the feeling of ownership towards service developments related to the Joint Future agenda. Service managers are currently the key link between nurses and DAATs. Perhaps a service nurse with more client contact should also attend to provide client feedback. At a national level greater nursing input into policy could give this specialist group a greater feeling of professional cohesion as well as keeping policy makers informed. Concerns about health and safety at work need to be considered at a national professional level as well as locally. Whether these issues should be addressed through the involvement of an organisation such as the Association of Nurses in Substance Abuse (ANSA) or an appointed individual is for discussion.

Recommendations

- All substance misuse nurses should receive induction training prior to commencing their post. Greater time should be protected to allow participation in training.
- There should be further exploration of what models of counselling, if any, are followed to assess whether current training is adequate.
- Appointment scheduling may need review as there was evidence that consultation time was routinely underestimated. Frequency of missed appointments needs to be considered at the same time.
- Staffing of substance misuse nurses should be expanded in order to reduce: excessive caseloads; lengthy waiting lists; insufficient cover for holidays, training and absences; and occupational stress.
- Nurses could be involved in GP training to share their experience of managing difficult cases such as poly-drug users and widen GPs perspective of the social benefits of drug misuse treatment.
- Nurses should be kept aware of developments on integrated care for drug misusers. This would allow them to understand the principles behind integrated care and be aware of how their service fits into the overall plan.
- Extending the role of senior substance misuse nurses to include the prescribing of controlled drugs should be considered.
- A clearer job title should be given to nurses working in substance misuse so that they may be easily identified and representable at both DAAT and Scottish Executive level, e.g. Specialist Nurse in Substance Misuse.
- Efforts should be made to improve substance misuse nurses' opportunities to influence policy.
- All substance misuse nurses should be provided with appropriate on going training, procedures and practices to allow them to carry out their work safely.

Chapter 1: Introduction

Key points in this chapter

- With the increase of drug misuse over the past two decades, the role of the substance misuse nurse has increased dramatically.
- Previous research on the role of nurses working in drug problem/substance misuse services is minimal.
- Clinical responsibility resting with nurses may vary across services.
- Clinical responsibility between substance misuse nurses and doctors is not necessarily explicit in shared care models.
- Previous research on GPs in Grampian indicates nurses may be key gatekeepers to specialist services though little is known of the decision making process followed.
- Research is required to gain a better understanding of the role of the substance misuse nurse.

Background to drug misuse service delivery in Scotland

The increase in drug use over the last two decades has led to more drug misusers presenting to primary care services and thus an increase in the number of health professionals involved in providing their care. Opiates such as heroin remain the predominant drugs of misuse in Scotland but polydrug misuse with alcohol and benzodiazepines is common. Psychostimulant misuse is comparatively low but there is evidence of this increasing (ISD, 2003). In Scotland drug services are focussed heavily on opiate treatment rather than stimulant treatment.

Drug services in the UK, and Scotland particularly, are largely community based. In the UK, for many drug-misusing patients seeking treatment to become opiate-free, their first point of contact with the health services is their General Practitioner (GP). In 1984 the Medical Working Group on Drug Dependence proposed a major role for GPs in the treatment of drug misusers (Gossop *et al.*, 1999). This was supported by the publication of treatment guidelines, which encouraged a greater number of GPs to treat this patient group (Department of Health (DoH), 1999).

The complex needs of drug misusers and a combination of different factors has led to the development of effective collaboration between professional groups such as GPs, obstetricians, general psychiatrists, community pharmacists, prison medical officers, specialist drug treatment services, social services, voluntary sector and the criminal justice service (DoH, 1999). Some of these professionals have been widely researched (Matheson *et al.* 1999; Matheson *et al.*, 2002; Sheridan *et al.*, 1996; Matheson *et al.*, 2003; Ralston and Kidd, 1996), whilst research in others such as the substance misuse nurse is scarce¹ (Rassool, 1996).

¹ It is acknowledged that nurses working in this field may be referred to using a number of titles e.g. substance misuse nurse, drug specialist nurse. In the interest of continuity, the term 'substance misuse nurse' will be used throughout this document.

This multi-disciplinary approach (DoH, 1999) has been developed with the aim of:

- improving service delivery
- providing a balance in primary and secondary health care
- providing treatment in a primary care setting
- expanding the primary health care team to include a wide range of specialist services
- including patients in the treatment decision.

Shared care, a model of the multidisciplinary approach, is defined by the DoH as:

“The joint participation of specialists and GPs (and other agencies as appropriate) in the planned delivery of care for patients with a drug misuse problem, informed by an enhanced information exchange beyond routine discharge and referral letters. It may involve day-to-day management by the GP of the patient’s medical needs in relation to those of her drug misuse. Such arrangements would make explicit which clinician was responsible for different aspects of the patient’s treatment and care. These may include prescribing substitute drugs in appropriate circumstances.” (DoH, 1999).

The exact role of the substance misuse nurse within such shared care arrangements remains to be explored.

Over the two years it has taken to conduct this research there have been further developments, multi-disciplinary working has moved from shared care to the Joint Future Agenda and the concept of Integrated Care for Drug Users (EIU, 2002). Understanding the role of substance misuse nurses and how they relate to and communicate with other health and social professionals will help the planning and operation of integrated drug services.

Role of the substance misuse nurse in Scotland

In line with the general increased demand for services for drug misusers, the role of the substance misuse nurse has increased dramatically in recent years. Substance misuse nurses work in many different settings with drug misusers, and have different approaches to care. Their skills include assessing drug misusers’ needs, selecting treatment options, counselling, and carrying out other treatment procedures such as urine testing. Some GP surgeries have designated nurses who are assigned to the care and management of their drug-misusing patients. In other cases nurses employed by specialist service largely work in a general practice setting. Some evidence suggests that the role of the substance misuse nurse can be particularly demanding and stressful. This is mainly due to the increasing need for specialised skills in areas such as assessment, communication, counselling, encouraging patient involvement in decision making, organisational factors such as changes in services, loss of funding and in particular the lack of training and support for staff (Happell and Taylor, 1999; Farmer *et al.*, 1999, McMillan, 1997).

It is likely that there are variations in the role and expectations of drug specialist nurses across Scotland, depending on location and setting. For example health board areas may have different policies in place; different teams in general practice settings may also vary in the level of decision making delegated to the substance misuse nurse, with respect to treatment and prescribing. Yet there is a ‘grey area’ surrounding prescribing of substitute drugs since nurses cannot currently sign prescriptions and the signatory under current legislation, has clinical responsibility (Misuse of Drugs Act, 1971).

The Association for Nurses in Substance Abuse in Scotland (ANSA) was formed in 2000 as an interest group. This organisation has published a series of guidance documents for

nurses working in the field of drugs and alcohol. This organisation is still relatively new and under development. ANSA is funded by members subscription and does not receive any central funding or support.

Previous research and gaps in knowledge

Previous research on substance misuse nurses specifically is very limited. What has been done is either on a small scale or is out of date relevant to recent changes in service provision. Some research assessing the attitudes of different groups of nurses to drug misusers (including substance misuse nurses) has been conducted (Carroll, 1993; Carroll, 1996). One further study has looked at prison nurses' attitudes (Carroll, 1995^a) and another at midwives' views of perinatal drug use (Selleck and Redding, 1998). Other studies have started to look at nurses' role in more depth but only on a limited scale (Happell and Taylor, 1999) and not in the UK. There are numerous studies published which address other health professionals' attitudes towards drug misusers (George and Martin, 1992; Carroll 1993, 1995^a 1995^b and 1996; McGillion *et al.*, 2000; Howard *et al.*, 2000; McKeown *et al.*, 2001; Matheson *et al.*, 2003). However, there has been limited research conducted into the attitudes of drug misuse nurses.

As it is not known what views nurses hold towards their client group or the effectiveness of particular treatment approaches, it is not known what impact their views may have on service delivery. Nurses' delivery of services may have an impact on treatment retention and outcomes. Alternatively, some evidence does exist which suggests that the substance misuse nurse has a more positive attitude and greater knowledge of the issues surrounding drug use than nurses working with drug misusers in other areas such as Accident and Emergency, general practice and the penal system (Carroll, 1995^a).

From previous research with GPs in Grampian (Rae *et al.*, 2001), only 8% of GP respondents indicated their Substance Misuse Service (SMS) nurse had 'no' influence on which treatment to offer in opiate dependency, whereas 20% said the SMS nurse had 'total' influence and 72% had 'quite a lot' of influence. Thus nurses were key gatekeepers to the range of services (methadone maintenance, inpatient or community detoxification etc.) available to drug misusers. This raises questions about how nurses undertake decision making: do they have a rigid approach, following guidelines such as the Drug Misuse and Dependence: Guidelines on Clinical Practice (Department of Health, 1999) or local protocols; how influential are patients, GPs, and the consultant in the decision-making process; how much judgement is involved?

This brief overview of the literature has identified substantial gaps regarding the role of the substance misuse nurse compared with other professionals working in the field of drug misuse. Little is known about their demography, current practice, experiences, attitudes or overall role in the treatment of drug misusers. This study was designed to fill these gaps in knowledge of the structure and delivery of services which can provide baseline data for future drug policy making, service development and workforce planning

This two year research project was funded by the Effective Interventions Unit (EIU) through an open research competition conducted in 2001 under the Scottish Executive's Drug Misuse Research Programme.

Study Aim

The aim of the study was to describe and analyse the role of substance misuse nurses in the provision of drug misuse services in Scotland.

Specific Objectives

1. To identify the population of specialist nurses working directly in the management of illicit drug users in Scotland.
2. To gain baseline data from the above population on their demography, caseload, services provided, level of interaction with other health professionals.
3. To compare their attitudes to drug misusers with other health professionals.
4. To explore their beliefs about the effectiveness of different treatment options.
5. To compare certain aspects of practice to general practitioners.
6. To examine their role in the initial client assessment.
7. To examine their role in decision making about a client's management.
8. To describe their decision making process.
9. To explore their relationship with other professionals.

In addition to these nine objectives two further issues were highlighted early in the research following the survey questionnaire and piloting of interview schedule. A decision was taken to explore these issues further in interviews. Therefore two further objectives have been added:

10. To explore the issues of stress at work.
11. To examine nurses' views of safety procedures at work.

Structure of this report

Chapter 2 describes the methods used. The study findings are presented in chapters 3-8 by integrating the findings from different data collection methods. Findings are presented around the main study objectives but also structured to reflect the structure and process of care thus some objectives are combined in some chapters. In chapter 9 findings are discussed and interpreted in the wider context of other practice, policy and research developments and recommendations for these areas made. A comprehensive report with more detailed results and methods is available from the research team.

Chapter 2: Methods

Key points in this chapter

- The scoping exercise identified 272 drug specialist nurses working in 13 NHS areas across Scotland.
- A questionnaire was distributed by post to all drug specialist nurses identified.
- Nurses willing to take part in a face-to-face interview were purposively sampled to represent a range of gender, years of experience, attitudes and health board areas.
- Face-to-face interviews focused on nurses' assessment of patients seeking professional help with their drug misuse and subsequent treatment decisions.
- Observations of specialist nurse and client consultations gave interviews context and assessed the roles of client and nurse in formulating the treatment plan, the structure of the interview and the setting where the consultation took place.

Research design

Both qualitative and quantitative methods were used to gain an understanding of the role of the substance misuse nurse in the provision of drug misuse services in Scotland. The methods used consisted of three core components:

1. Questionnaire survey,
2. Semi-structured, in-depth, face-to-face interviews,
3. Observational fieldwork.

These are presented below.

Questionnaire survey

Identification of the population: scoping exercise

A scoping exercise was conducted in order to identify the substance misuse nurse population. The aim was to identify all substance misuse nurses directly involved in the care of drug misusers and working in statutory agencies. This will have included people who worked with drug and alcohol users but those that worked exclusively with alcohol users were excluded. Prison nurses were specifically excluded as they were considered to work in a very different service framework. All drug problem or substance misuse clinics in Scotland were identified by contacting Drug Development Officers and/or Drug Action Teams in each Health Board area across Scotland. Other agencies/services were identified on the Scottish Drug Forum and the Information and Statistics Division Drug Misuse websites. Non-statutory or voluntary agencies and each relevant agency/service were contacted by letter requesting names of all nurses working in the field of drug misuse. A database was set up and all names and addresses were listed. In total 272 substance

misuse nurses were initially identified by the scoping exercise. Table 1 presents the number of services and substance misuse nurses identified in each NHS area.

Table 1 Number of services and nurses identified in each NHS area

NHS AREA	Services N=47	Nurses N=272
Argyll & Clyde	3	14
Ayrshire & Arran	3	20
Borders	2	4
Dumfries & Galloway	2	9
Fife	4	19
Forth Valley	3	18
Grampian	3	33
Glasgow	8	56
Highland	2	9
Lanarkshire	3	32
Lothian	8	21
Tayside	3	33
Western Isles	3	4

Construction of the questionnaire

A questionnaire was developed informed by a literature review, previously used validated questionnaires in GPs (Matheson *et al.*, 2003) and pharmacists (Matheson *et al.*, 2002) and a previously conducted Grampian based pilot study (Graftham *et al.*, 2004). The questionnaire covered attitudes to drug misusers and current treatment options (maintenance prescribing, detoxification and rehabilitation), beliefs about treatment effectiveness, and possible barriers to treatment, number of drug misusers on caseloads, the use of protocols/guidelines, services provided (prescribing support, monitoring, counselling, community detoxification etc), and perceptions of service development priorities.

The questionnaire was anonymous. For the purposes of identifying non-respondents, responders were asked to post an identifiable reply paid postcard at the same time as they returned their questionnaire, thus notifying the research team they had replied. The questionnaire was then piloted following minor adjustments, between November 2002 and March 2003, and mailed to all substance misuse nurses identified by the scoping exercise (Forth Valley in March 2004), n=272. Where appropriate, up to three reminders were sent. The questionnaire is shown in Appendix 1.

Questionnaires were distributed to 244/272 nurses: 28 nurses who had been identified in the scoping exercise were no longer employed at the respective service/agencies and were removed from the database.

Data management and analysis

Data from returned questionnaire were coded and entered into Statistical Package for the Social Sciences (SPSS, version 11.5). Open-ended questions were analysed to identify themes, and were also entered into SPSS. Frequencies, descriptive statistics and cross tabulations were undertaken including chi-squared tests where appropriate. All data were

stored securely and confidentially, in line with the Data Protection Act (1998) and research governance guidance.

It was possible to compare some questionnaire data with data from similar questionnaire surveys conducted with pharmacists in 2000 (Matheson et al., 2002) and GPs in 2000 (Matheson et al., 2003). Simple comparisons of attitudes of nurses to drug misusers and service delivery are presented where relevant, in chapter 4. Similarly, comparison with GPs practice, beliefs about treatment and the organisation of services are presented at the end of chapter 6.

Semi-structured face-to-face interviews

Interviewee sampling

On the reply paid postcard referred to above, nurses were asked if they would be willing to take part in a face-to-face interview. In total, 79 nurses indicated that they would be willing to take part in a face-to-face interview. Using the agreed selection criteria i.e. number of years working with drug misusers, gender and geographical area, 38 nurses were selected. Of these, three nurses were signed off work long-term, five no longer worked for the service, one declined to take part (i.e. he was too busy) and one was on maternity leave. Therefore, 29 nurses, ten males and 19 females, were successfully interviewed (see table 2).

Table 2 Nurses interviewed in each NHS area

NHS Areas	Nurses interviewed N = 29
Argyll and Clyde	5
Ayrshire and Arran	5
Lothian	8
Lanarkshire	5
Tayside	4
Dumfries and Galloway	2

An interview schedule was informed by the previously conducted pilot study, issues identified in the literature, and discussion within the steering group. The primary focus of the interview schedule was on the nurse's assessment of patients seeking professional help with their drug misuse and the decision making process that followed. However, a section for demographic data was included. This was completed by the researcher at the start of each interview. The interview schedule was used in each interview to ensure consistency whilst allowing for in depth exploration of issues arising. The interview schedule was piloted with three nurses working with the Substance Misuse Service in Aberdeen in order to identify ambiguous or conflicting questions. Alterations were made as necessary. These primarily related to including views on stress and the specific issue of integrated drug services. The interview schedule can be found in Appendix 2.

Conducting interviews

Interviews were conducted with substance misuse nurses prior to a clinic. With the consent of nurses, all interviews were audio-taped and subsequently transcribed. Data were stored in a password-protected computer file and analysed by constant comparative analysis supported by Nudist software. Interviews were conducted between April and September 2003.

Observational fieldwork

Observational fieldwork was carried out during nurse consultations with drug misusers. The main purpose of observation was to give the interview context as well as to allow insight into: whether nurses take into account their clients' views when deciding on a treatment plan, the structure of the interview and the setting where consultation takes place. To reduce the influence of the researcher's perspective (Mason 1996) a data collection form was constructed to allow the researcher to record the content of the consultation. A copy of the observational checklist can be found in Appendix 3.

Recruitment of patients for observation

Two weeks prior to their consultation patients were sent information about the study. Clients were asked to inform their nurse if they were willing to allow a researcher to sit in on their consultation. Written consent was not requested until the day of the consultation. Both clients and nurses were informed that they were free to ask the researcher to withdraw from the consultation at any time.

Observation of consultations

The researcher observed either a half-day or full day of consultations. In total 15 patient consultations were observed. An overt non-participant role was assumed. Field notes were taken unless a request had been made by the nurse or patient for the researcher to leave. Observation notes were written up as soon as possible after leaving the scene and before speaking with the nurse. Additionally each nurse and patient was asked if they felt that the researcher's presence had influenced their behaviour in any way. All consultation observations were conducted between April and September 2003.

Ethical approval

Multi-Centred Research Ethics Committee (MREC) approval was granted in March 2003. Following this Local Research Ethics Committee (LREC) approval was obtained for the Health Boards where interviews and observation were planned.

Chapter 3: Characteristics of nurses and services

Key points in this chapter

- Seventy-nine percent (79%) of nurses identified in the scoping exercise, who were still in post (n=244) participated in the postal survey.
- Seventy percent (70%) were Grade G or above indicating a senior workforce.
- Nurses were employed in a variety of settings, including substance misuse services (48%), drug and alcohol services (30%) and residential detoxification (3%).
- Formal training (defined as University Certificate or Diploma) specific in substance misuse had been received/undertaken by 40% of nurses and induction training (i.e. in house training at the start of employment) by 62% of nurses.
- The median caseload was 38 clients.
- The majority of consultations took place in clinical consultation rooms but this was not observed to influence the consultation.
- Nurses reported that the average length of a consultation was 38 minutes. All of the observed consultations were scheduled for 30 minutes but half over-ran.

The questionnaire response rate was 79% (192/244).

Respondent characteristics

Table 3 shows that 65% of respondents were female (n=122). The average age of respondents was 39.5 years; range 24-60 years.

Table 3: Demography

Characteristic	Detail	N	%
Gender	Male	66	35.1
	Female	122	64.9
	Total ¹	188	100.0
Age	20-30 years	18	9.7
	31-39 years	87	47.0
	41-50 years	69	37.3
	51 years and over	11	5.9
	Total ²	185	100.0

¹ 4/192 incomplete

² 7/192 incomplete

Table 4 details the grade and qualifications of responding nurses. Seventy per cent of nurses were Grade G or above.

Table 4: Nursing grade and qualifications of respondents

Characteristic	Detail	N	%
Grade	D	4	2.1
	E	29	15.1
	F	18	9.4
	G	110	57.3
	H	21	10.9
	I	2	1.0
	Other e.g. acting-up grade	7	3.6
	Total	192	100.1
Qualification¹	Registered Mental Nurse	147	79.5
	Registered General Nurse	48	25.4
	Enrolled Nurse	21	11.1
	Registered Nurse	14	7.4
	Batchelor of Science/Nursing	10	5.3
	Registered Midwife	6	3.2

¹ respondents detailed all nursing qualifications held

In the questionnaire nurses were asked, to specify their job title. A wide range of self-reported job titles was identified (over 18 different titles), including *Charge Nurse* (16%), *Community Psychiatric Nurse* (12%) and *Staff Nurse* (14%). Few of these reflected the specialty of this area of work. The full list is displayed in Appendix 4 (table A1).

Just over half the respondents (56%) worked exclusively with drug misusers. The average number of years working with drug misusers was 6.6 years (range four months to 20 years). Most respondents worked full-time (85%).

Training

No formal training (defined as university certificate or diploma) in substance misuse had been undertaken by 59% of nurses. However, induction training, i.e. in house training at the start of employment, had been received by 62% of respondents prior to receiving their own patient list. Shadowing a member of staff was considered very beneficial by the greatest proportion of those that had received it during induction. The majority of those who had received induction training found it beneficial. Ninety-one per cent of respondents noted that their current job enabled on-going training and 41% reported that specific time was allocated for training. However, 12 nurses noted they were unable to use this time for training as a result of resource constraints and workloads.

Service characteristics

Location of services

From questionnaire data nurses were employed in a range of settings including Substance Misuse Service/Drug Problems Service (48%), Drug and Alcohol Services (30%) and Residential Detoxification (3%). Almost all services were solely or jointly funded by the local area Health Board (98%). The services provided by employing organisations included counselling, assessment, methadone maintenance prescribing (see Appendix 4 table A2). One hundred and seven nurses reported working with General Practice (62%), of these 66 worked for more than five practices.

Over half the respondents (58%) felt that the locally-provided services did not meet the needs of drug misusers in their area. When asked, in the questionnaire to consider how services could be improved more than half of respondent gave suggestions which included: issues of training, numbers of staff, accommodation, inpatient provision and 24-hour.

The health board location of services is displayed in Appendix 4 (table A3).

Caseloads and consultation setting and timing

Caseloads

From questionnaire data the median caseload was 38 (range 2 to 220, the latter being from a needle exchange nurse). This was not influenced by grade. Nurses working only with drug misusers had significantly higher caseloads ($p < 0.01$); there was no difference in median caseload by gender, age, location or years working with drug misusers. Nurses were asked in the questionnaire, how many clients they saw a week. The median number of patients/clients seen per week was 25 (IQR 17, 35) but 15 individuals saw over 60 clients a week. When asked about their 'ideal' 69% of nurses reported they would like to have fewer patients/clients.

Frequency of contact

From questionnaire data the frequency of patient contact varied from daily to once a month. Nurses reported that this contact depended on the service provided, such as residential care, and patient needs. Over 40% of nurses saw clients at least once a week. Some 41% of nurses spent over 67% of their time in direct patient care. Most time was spent in consultation with drug misusing clients, the least time was spent on management duties, attending courses and visiting drug misusers at home. There was no difference in proportion of time spent in direct/indirect activities by grade, gender or years working with drug misusers.

Consultation settings

Observation of consultations were conducted in three main locations, i.e. GP surgeries, drug services, or clients' homes. The majority of consultations took place in typical GP treatment rooms. Generally, these rooms were clinical and there was little or no information displayed. Some consultations, particularly those in drug services, were conducted in less clinical interview rooms. These rooms were brightly painted, had curtains, tables, lamps and pictures. Seating consisted of comfortable sofas or chairs. Most displayed an array of informative literature consisting of: health promotion and disease prevention, local services available to substance misusing clients, such as self-help groups, clinics offering advice on safe sex, harm reduction, HIV or AIDS, depression and anxiety. Other information relating to childcare, job clubs and back to work schemes was also displayed. The remaining consultations were conducted in clients' homes. From observation the consultation setting did not appear to affect the process of consultation. However, home consultations may have been beneficial to clients reducing the need for childcare and excess travelling.

Length of consultations

From questionnaire data the average reported length of consultation was 38 minutes (range five to 120 minutes). The length of the consultation did not appear to be related to the number of hours worked. Three quarters of nurses felt that the length of consultation was adequate, although some noted that this was insufficient to enable an in-depth or holistic consultation. Nurses with a caseload of over 50 clients were significantly more likely to spend less than 30 minutes with each client ($p < 0.001$).

Observed clinic consultations (N=15) were scheduled for 30 minutes. However, four exceeded this time by approximately 10 to 15 minutes and a further three lasted between 60 and 90 minutes. The main reason for the latter was that clients appeared anxious or distressed and more time was required to explore issues. Home visits tended to last for 40 to 60 minutes, but again some (n=3) lasted longer due to clients' anxiety and distress. Most consultations started on time or within 10 minutes of scheduled time. Unfortunately some clients were left waiting longer than this, sometimes up to 15 minutes and on one occasion 30 minutes. The reason for these delays were sometimes due to a prolonged consultation with another client, but generally it was due to the failure of reception staff to inform nurses that their client had arrived.

Chapter 4: Motivation, attitudes and beliefs

Key points in this chapter

- The challenging nature of working with drug misusers was a positive motivating factor for nurses working in this field.
- Seventy-seven per cent (77%) of nurses considered working with drug misusers to be rewarding.
- Seventy-nine per cent (79%) considered drug misusers were not easy to deal with.
- Opinion was split about whether drug misusers could be manipulative in consultations.
- Nurses believed more strongly than pharmacists that maintenance prescribing could stop the use of illicit drugs.
- Fewer nurses than pharmacists believed that controlled drug dispensing should take place in central clinics rather than community pharmacies.

The questionnaire included questions exploring nurses motivation to work in this field, their attitudes to working with this client group and beliefs about the organisation of service. The more general questions were based on a previous study of community pharmacists allowing some comparison of these professional groups.

Nurses were specifically asked to reflect on their motivation to work with drug misusers. They were asked to select up to three (of six) motivation statements provided. The importance of intrinsic motivations (challenge of working with drug misusers and having enjoyed previous work with drug misusers) was apparent (Table 5).

Table 5: Motivation to work with drug misusers

Motivational Statements ¹	N	%
I thought it would be challenging to work with drug misusers	123	64.1
I worked with drug misusers in other nursing posts and enjoyed it	92	47.9
I felt I lacked knowledge in this field and wished to correct this by becoming a substance misuse nurse	53	27.6
The job offers better prospects than other jobs/specialities I have applied for	37	19.3
I wanted to change direction in my career	38	19.8
My previous employment had terminated and there was a vacancy for a substance misuse nurse	9	4.7

¹ Participants selected up to three statements

In exploring nurses' attitudes to working with this group only 2% agreed with the statement "*I have no sympathy at all for drug misusers*" whilst 77% agreed that "*Working with drug misusers is rewarding*" and 85% agreed with the statement "*Drug misusers are professionally challenging*". This is further explained by the 79% that disagreed that "*Drug misusers are easy to deal with*" and the split in opinion about whether drug misusers were manipulative during consultations (44% agreed and 42% disagreed).

Table 6 presents data comparing nurses and pharmacists attitudes to drug misusers and providing services for drug misusers. At a population level a greater proportion of nurses disagreed with the statement "*I have no sympathy for drug misusers*" than pharmacists. Nurses appear to be more confident than pharmacists that maintenance prescribing will stop the use of street drugs. Perhaps not surprisingly there was a slightly higher proportion of pharmacists than nurses agreeing that controlled drugs should be dispensed through a central clinic than community pharmacies.

Table 6 Nurse and pharmacist attitudes to drug misusers and treatment approach (n=187 nurses and n= 969 pharmacists).

Comparative attitude statements	Respondent	Strongly agree %	Agree %	Disagree %	Strongly disagree %	Uncertain %	Missing value %
Providing drug misusers with a maintenance dose of a controlled drug can stop them using street drugs ¹	Nurse	22.6	61.6	12.6	1.6	1.6	1.0
	<i>Pharmacist</i>	<i>1.3</i>	<i>15.1</i>	<i>43.9</i>	<i>10.5</i>	<i>26.3</i>	<i>2.9</i>
Controlled drugs should be dispensed to drug misusers through a central clinic rather than a community pharmacy	Nurse	2.1	11.6	45.3	30.0	11.1	1.0
	<i>Pharmacist</i>	<i>16.3</i>	<i>22.2</i>	<i>31.9</i>	<i>6.0</i>	<i>20.7</i>	<i>2.9</i>
I have no sympathy at all for drug misusers	Nurse	0.5	1.6	26.8	71.1	0	1.0
	<i>Pharmacist</i>	<i>3.5</i>	<i>10.9</i>	<i>49.8</i>	<i>18.4</i>	<i>17.0</i>	<i>0.3</i>
Providing problem drug misusers with a maintenance dose of a controlled drug is a waste of NHS resources	Nurse	1.6	3.7	42.2	49.7	2.7	2.6
	<i>Pharmacist</i>	<i>4.7</i>	<i>13.7</i>	<i>47.4</i>	<i>7.4</i>	<i>23.6</i>	<i>3.1</i>

¹Pharmacist question was worded as "I believe providing drug misusers with a maintenance dose of a controlled drug will stop them using street drugs." (Matheson *et al.*, 2002).

Chapter 5: The initial assessment of clients

Key points in this chapter

- Waiting times for assessment were generally an issue of concern to nurses.
- A detailed assessment was almost always conducted at the first consultation.
- An SMR24 was almost always completed at the first consultation.
- Interviews and observation of nurse-client consultations found that the approach to assessment seemed consistent across geographical areas.
- Assessment included: brief physical examination, urine sampling, detailed exploration of drug use, exploration of physical problems, discussion of social and family support, housing and employment status and history of involvement in the criminal justice system.
- Consultations were often brought to a close by discussing treatment expectations.
- Assessment could take place over more than one appointment and several appointments could be required before a treatment plan was implemented.

Referrals for assessment

During interviews nurses said that they conduct initial assessments for clients referred to their service from GPs, maternity services, criminal justice, or voluntary services. Few nurses reported that their services had a self-referral scheme. Nurses explained that the depth of information provided in referrals about a client's drug misusing history or behaviours differed considerably.

Another issue was that the waiting time between referral and assessment could be a few days or a few months. The following is a typical example:

"..because of the volume of work that comes in there is usually a two to three week waiting time from referral entry, two week to be seen for the initial assessment, so if you added that on to it as well, you would be looking at possibly nine weeks from the point of referral to the point of a prescription." Nurse 14, Grade G

Although, there was general acceptance that some waiting period was almost always unavoidable, all were aware there were potential consequences, especially for chaotic users. One nurse stated:

"Because we had a waiting list things could change quite dramatically in the three or four months...a long time in the life of a drug addict". Nurse 13, Grade G

Indeed when asked specifically about waiting times in the questionnaire 60% agreed there was a long wait between GP referral and appointment.

As a result of the inconsistent level of information provided and the changes that could have taken place since referral, all nurses interviewed indicated that it is part of the treatment process to conduct their own assessment of new clients. This is always done during the first consultation between the nurse and the client.

The assessment

Purpose

From interviews and observation the purpose of an assessment was to identify the needs and expectations of the drug-misusing client and make decisions about their treatment, care and support.

Areas explored

The aims of the first assessment, as described by nurses were to: determine type of drugs used, drug-misusing history; assess problems associated with drug misuse; assess risk; identify medical, mental, social and environmental needs; determine client's motivation; explore client's treatment requests and expectations; inform and explain the treatment options available to clients; and determine those most suited to their needs. These assessments took the form of direct discussions between the substance misuse nurse and the client. Local protocols were generally followed. These might be based on national guidelines as some nurses indicated that they followed the guidelines in the *Drug Misuse and Dependence – Guidelines on Clinical Management*. Others indicated that they always used a Substance Misuse Register 24 (SMR 24) which is not an assessment tool but a monitoring form, and was devised to record systematic information on the characteristics of drug misusers. One nurse explained:

“We have quite a standard format. What we do is an initial assessment and during that time which is about a half hour appointment we would go through the standard form and we would use that as the basic assessment. So we are looking at: Where do you live? Who their GP is, who referred them, I would need to know if they receive anything on prescription for their drug use, what their illicit drug use is. If they are using any drug on top of their script.” Nurse 10, H Grade

Another nurse, who works with young people, said:

“We're sort of looking at general information, physical and health, school, education, social and social support from the family as well.” Nurse 12, G Grade

From observation and interviews it was evident that assessments explored similar content and took similar format regardless of the NHS area. These assessments explored the reasons for presenting for help with drug misuse: the age when starting drug use; types of drugs used; routes of administration; amount and cost of drugs used. Initially nurses would attempt to investigate clients' medical history and general health requirements. This was usually done by a physical examination, to assess complications of drug misuse for example abscesses, needle track marks, poor nutrition, deep vein thrombosis, pneumonia and dental disease. Other complications included anxiety, irritability, and blood-borne diseases such as HIV, Hepatitis B and C. Most of the nurses, especially those who worked alongside needle exchange and harm reduction clinics, also explored the need for new syringes and needles, injecting practices, making sure that clients were aware of how to inject properly with minimal risk, sexual health such as use of condoms, knowledge of HIV, Hepatitis B and C transmission. CPNs indicated that they would also explore the client's mental health history such as previous episodes of accidental or intentional overdose, periods of depression, suicide or self-harm. Additionally, clients' general behaviour was investigated to identify factors such as

irritability, anxiety, and restlessness as these may be associated with intoxication or withdrawal.

"I would be focusing on the physical elements of their addiction and what their experience of withdrawal had been like in the past and their anxiety around any withdrawals that they might experience." Nurse 8, G Grade

However, many nurses tended to extend assessments to incorporate a more psychosocial model of investigation. All expressed the need to explore their client's circumstances on a wider scale and this meant exploring and treating more than the client's physical needs. Therefore, social, economic and family situations, housing status and general welfare of clients were also explored. This included an overall investigation of the client's history of involvement in the criminal justice system. One nurse explained:

"We'd look at their accommodation, who they live with and if they are drug users. If they have been in prison, have outstanding charges or pending court cases. As a background as well you might ask people when they first started using drugs, why they felt they started using, when they first felt that their using became a problem and that's usually enough to be going on with." Nurse 10, H Grade

This in-depth exploration of the client's background and current situation is conducted to establish immediate medical needs and to highlight any additional factors which might warrant further referral to appropriate services, such as social work, dentists or housing. Factors which determined such referral included having no fixed abode, living with other drug users, living with children considered to be at risk, or suffering from acute dental problems. In addition employment and financial status were explored to establish how the clients were spending their time and funding their drug use.

Nurses indicated that it was also important to know if clients had previously attempted to reduce or stop their drug taking. If this was the case they explored whether or not they had attempted this on their own or if they had been in touch with treatment services before, and if so which treatments had they previously attempted.

This holistic approach to assessment was viewed by nurses to be crucial to ensure that clients were given the most appropriate treatment, thus giving them the best chance to gain control of their lives. From observation, nurses used simple open questions which enabled exploration of issues.

In addition, during observed consultations nurses always requested a urine sample on their first assessment to confirm the types of drugs being used such as amphetamines, benzodiazepines and heroin. This was routinely done at the end of the first assessment and, as noted in interviews, randomly throughout treatment. All nurses indicated that clients would not receive prescriptions for substitute drugs until they had received the results of the first urine sample. This usually took seven days and if the results were positive (as would be expected in those seeking treatment for a drug problem) they would then conduct one or more consultations with clients to discuss treatment options before deciding with the client the type of treatment and dose most suitable to the client's needs.

From observation, clients involved in first assessments were asked about their plans for the future. Most clients aimed for short-term goals, such as putting on weight or developing a regular sleep pattern. Other clients, observed during routine assessments were more likely to explore longer-term goals such as gaining employment or participating in further education. For the majority the main goals appeared to be to: develop a better relationship with their families and to develop and implement strategies for resisting drug use.

Closure

Nearing the end of the scheduled time nurses were observed to adopt a reflective role to ensure that they understood what clients had told them. They summarised issues and information and checked that clients understood what had been discussed during the consultation. Questions tended to be more closed and the conversation ended with an agreed date for the next consultation.

“Towards the end of the assessment we would be trying to establish what the patient might be looking for you know from the service, what they think might be helpful in terms of follow-up, you know, what they think their immediate needs are and trying to draw up some kind of action plan or care plan.” Nurse 15, G Grade

What happened next?

Nurses were asked in interviews how many times they would consult with their clients before deciding on their treatment plan. The number of consultations to complete an assessment and develop a treatment plan varied according to clients' needs and treatment requests. Before deciding on a treatment plan most nurses would expect to consult with their clients on at least two or more occasions. Even then, a prescription would not be given until toxicology results from a urine test confirmed positive drug use. One nurse explained this in more detail:

“It is likely that the process would be two initial assessments and a urine sample which could take a week to ten days to come back. Then a further assessment would have to take place which is slightly longer than the initial assessment, then there is a management discussion with the consultants and at that point it would determine if they need a substitute prescription based on the assessment information and the discussion with the consultants. If they were thought suitable for a methadone programme then it would be the next available space.” Nurse 5, B Grade

Chapter 6: Making treatment decisions

Key points in this chapter

- Clients were actively encouraged to participate in treatment decisions.
- Although 84% of nurses reported they were expected to follow a treatment protocol only 44% said they always did follow a treatment protocol (for any treatment).
- Eighty-six percent (86%) of nurses had seen the National Clinical Guidelines (DoH, 1999), and those who were interviewed felt that these provided a good framework for treatment, although they were perhaps lacking in detail.
- Nurses reported that they often consulted widely with other health professionals but, most frequently, with the client, before making a treatment decision.
- A third of nurses reported that they sometimes wrote prescriptions for a doctor to sign (which is possible if the doctor has a handwriting exemption certificate).
- Seventy percent (70%) of respondents felt nurses should be able write prescriptions but only if this practice was restricted to experienced nurses with appropriate training.

Comparing nurses and GPs beliefs:

- When making treatment decisions nurses were less influenced by the attitude and behaviour of drug misusers than GPs.
- When making treatment decisions nurses were more influenced by societal factors than GPs.
- Nurses were less likely to favour detoxification than GPs as a treatment approach although 83% of nurses agreed that a community based detoxification programme was an effective tool.
- GPs were less confident than nurses in successfully managing poly drug users.
- Both GPs and nurses were divided about their beliefs about the effectiveness of dihydrocodeine.

Nurse-patient interaction during decision making

During the observations of consultations nurses demonstrated a partnership with their clients, encouraging them to be actively involved in the development and advancement of their treatment. Clients' points of view were actively sought and they appeared comfortable to freely express themselves, speak openly and ask questions. For example, field notes for one first assessment read "Nurse very relaxed and does not use

leading questions". During this stage of the consultation nurses frequently used open questioning when exploring the above issues and continuously emphasised the importance of clients' subjective experiences. Nurses went on to discuss the benefits and risks of various treatment interventions and procedures to inform clients, which would enable them to be actively involved in a shared treatment decision. During this point clients appeared to adopt a passive recipient role absorbing the information, which was being presented to them.

For clients who were already engaged in treatment, nurses would explore their satisfaction with treatment and actively encourage clients to express any worries or concerns. This was done by using verbal and non-verbal prompts, for example asking direct open question, using hand gestures, facial expressions, nodding head in agreement and leaning forward towards the client if they were upset or discussing a sensitive issue. Generally most clients spoke clearly and fluently, and most actively engaged in the consultation.

Clients who had experienced some sort of difficulty since their last consultation would be asked to identify triggers or stressors, which they thought might have influenced their behaviour in either a positive or negative manner. In most cases clients appeared open and honest. Nurses then went on to introduce strategies, which may be developed and adopted by clients to help them avoid similar situations in the future.

The relative importance of factors influencing treatment

In the questionnaire nurses were asked to indicate how certain factors might influence their treatment of a drug misuser. As this exercise had been previously conducted with GPs it was possible to compare results (see Table 7). Generally, nurses were more strongly influenced than GPs by societal factors than patient factors. The factor that had the least influence for nurses and GPs was gender whilst the factor with the most influence on treatment decision for GPs and nurses was pregnancy. The most noticeable differences between GPs and nurses was that GPs reported that they were more strongly influenced by patients' attitude and behaviour. GPs were less influenced by societal factors than nurses.

Use of guidelines

The majority of nurses had guidelines they were expected to follow when carrying out their work. In 1999 the Scottish Office Department of Health produced Guidelines on Clinical Management of Drug Misuse and Dependence (the Orange Guide, DoH, 1999). A copy had been seen by 86% (n=161) and of these 87% believed it had influenced their practice. In other cases locally drawn up protocols were used. In interviews nurses referred to both. Nurses working with clients requiring substitute prescriptions and those working in detoxification emphasised the value of the Orange Guide in ensuring safety and in assuring GPs of appropriate prescribing. One nurse said:

"It does have quite a good framework and I think in terms of for us working with GPs it gives them the reassurance. As long as you are working within the guidelines then you have a relative degree of safety". Nurse 23, G Grade

However, the Orange Guide was also seen to have limitations:

"It doesn't go into huge amounts of detail. It kind of skims the surface but as far as ground rules go it's quite helpful, certainly when you first come into the job". Nurse 5, B Grade

Nurses also referred to specific protocols geared to particular services:

“Needle exchange is very tightly monitored. We have very tight levels that we have to work within. Its got to be first level, registered nurses, you can only give out a certain amount, you’ve got to do certain things which is checking sites etc so our protocols are very tight to deal with actual mechanics”. Nurse 7, H Grade

One nurse mentioned the Coordinated Addictions Network as providing a standardised approach to assessment which amounted to following a set of investigations based on good clinical practice.

Table 7 Factors influencing treatment of drug dependency (GPs, n = 583, nurses minimum n=168)

Patient Factors	Strongly Influence		Partly Influence		No Influence		Not Sure	
	Nurse %	GP %	Nurse %	GP %	Nurse %	GP %	Nurse %	GP %
Age	17.8	4.2	48.6	26.7	31.4	66.0	2.2	3.1
Gender	6.6	0.5	26.5	8.7	66.3	88.9	0.6	1.9
Carrying an infectious disease ¹	23.2	14.4	43.8	31.5	31.4	51.8	1.6	2.3
General health	28.6	10.3	48.6	39.8	21.6	47.5	1.1	2.4
Length of drug use	18.3	10.8	54.3	45.5	27.4	41.1	0	2.6
Improved standard of living	29.5	21.0	35.0	47.3	23.5	27.0	12.0	4.6
Nature of drug use	31.7	17.1	45.7	44.1	22.6	35.7	0	3.1
Poly-drug use	26.9	21.1	49.5	48.4	23.7	27.2	0	3.3
Main drug of use	29.3	19.9	43.5	45.6	25.5	31.4	1.6	3.1
Attitude of patient	34.6	65.1	44.3	26.7	20.0	7.1	1.1	1.0
Behaviour of patient	30.6	62.7	52.7	29.8	15.1	6.6	1.6	0.9
Being pregnant	81.0	52.5	14.3	29.8	4.8	15.3	0	2.4
Societal Factors								
Reduced transmission of infectious diseases	55.1	35.5	31.9	47.7	11.9	12.7	1.1	4.0
Reduced rate of problem drug use ²	49.2	29.7	39.3	49.0	10.4	16.7	1.1	4.7
Improved mortality rates	50.3	32.5	35.0	47.2	12.0	15.3	2.7	5.0
Improved morbidity rates	47.0	33.3	38.4	48.6	11.4	13.5	3.2	4.5
Reduced crime rate	31.4	28.7	48.6	46.4	17.8	20.0	2.2	4.9
Effect of family and friends	33.9	36.6	49.2	47.0	14.2	12.5	2.7	3.9

GPs question worded slightly differently: ¹HIV/ Hep B,C; ²Reduced use of illicit drugs

Other sources consulted to make decisions

In the questionnaire 84% of nurses reported that they were expected to follow a treatment protocol when considering a patient's/client's management; this was not influenced by Grade. However, when asked how they decided on a treatment plan only 44% said they followed a protocol. As shown in Table 8, nurses reported consulting a range of individuals when deciding on a treatment plan. The patient was the most frequently consulted individual.

Table 8: Information sources consulted in forming a treatment plan

Treatment plan ¹	N=192	%
Decide in consultation with the patient/client	164	85.4
Decide in consultation with a consultant	111	57.2
Decide in consultation with GP	103	53.1
Decide in consultation with other health/social care professionals	83	42.8
Decide in consultation with other Substance misuse nurses	97	50.5
Decide by self	40	20.8
Follow a protocol	85	44.3

¹ Participants selected all that applied

Nursing grade and age of nurse did not influence what resources were consulted in forming a treatment plan. However, more rural-based nurses than urban/city centre indicated they would follow a treatment protocol.

Prescribing medication

Nurses were asked in the questionnaire whether nurses should write prescriptions for medication and if so what level of nurse should undertake this: 70% of nurses felt that only specifically trained experienced nurses should sign prescriptions (see Table A4, Appendix 4).

In practice 29% (55/189) of nurses wrote prescriptions, for doctors to sign, for substitute drugs: of those 55, 28 did so 'sometimes' and 27 'always'.** The most commonly prescribed drugs were methadone, diazepam and lofexidine (Table A5 Appendix 4).

In interviews nurses were asked how they decided on a commencement dose for clients who were starting a methadone programme. Reported commencement doses of methadone ranged from 10 to 40mg, titrating upwards to a dose, over a number of hours or days, until the client felt comfortable and was experiencing little or no withdrawal symptoms. Nurses indicated that the starting dose depended entirely on the assessment of a client's individual needs:

"The nurses don't decide on that at all. We would discuss that with the medical staff and the consultant. The upper starting dose here as a policy is 40mls of methadone which would be the first daily dose, it would never be more than that." Nurse 2, G Grade

A nurse in another area suggest a lower starting limit:

** Note: nurse can write prescriptions for controlled drugs for medical practitioners to sign only if the medical practitioner has an exemption certificate.

"We really don't commence anything above 25 mls. Occasionally I have commenced someone on 30 mls but that is rare." Nurse 23, G Grade

However, many indicated that they did have some input into the starting dose:

"It's very much a medical decision. We have input into that, we're allowed to voice an opinion but the decision will be made by the medical staff." Nurse 2, G Grade

However from questionnaire findings only 30% of nurses believed prescribing should only be a medical decision, not a nursing responsibility (see table A4, Appendix 4). Indeed in interviews some nurses reported that they would often suggested a commencement dose to the GP, who would often then sign a prescription issuing that amount.

Treatment options and decision-making

In interviews nurses were asked to give more detail about how treatment decisions were made. In particular nurses were asked if clients approached them with particular treatment requests. One nurse indicated that the world-wide web was a major source of information for clients:

"Some people come with more knowledge than others because they have got computers and are extremely smart. They get on the internet and read up all about it so they have got a very clear idea of what they want...I would say most clients have a pretty clear idea what they want from the service before they come through the door. They often have no idea what our service can offer, but they know what they want from us." Nurse 13, G Grade

Another indicated that clients did not necessarily know what was good for them:

"I mean obviously if somebody comes to me with a particular treatment in mind then we need to look at that and sometimes you have to advise them that their ideas about what might work for them are maybe not appropriate at this stage. That's maybe somebody who's coming that's been injecting ten bags of heroin a day for the past couple of years and wants to detox in a week. Research will tell you that that's inappropriate it's doomed to failure and whatever else." Nurse 18, H Grade

From interview data it appears that clients are encouraged to actively participate in the decision-making process and to express their expectations of treatment, care and support. One nurse explained:

"I think most of them [the clients] have an idea that [our service] does prescribe methadone. The format that I take is that I ask them their view and what they think that [our service] can provide for them and that usually starts a discussion about the expectations and what we can actually offer them and it gives me an idea of what their perception is and what they are hoping to achieve and whether it is a prescription and then I would ask them what they hope to gain by their prescription and usually starts off the discussion. Most folk have the idea that [our service] prescribe but some also have the perception that we prescribe very quickly and they expect a prescription first day. That is slowly changing there are fewer people asking for a script straight away." Nurse 11, G Grade

Starting and ongoing treatment

In interviews the issue of starting a prescription was often mentioned and the subsequent need to arrange a pharmacy placement. Whilst some nurses contacted the pharmacist others left it to the patient. The latter method was seen as a demonstration of a patient's commitment to treatment:

"I will say "You know, if you are going on methadone it is going to be daily supervised in the chemist, and it is up to you to find a chemist that will take you on" and that gives them the opportunity to go round and find one...It is giving them motivation to do it and they are quite capable to go round a chemist and just say that they want to start this and have you got a space for me and again we have not had any problems with that".
Nurse 20, G Grade

Routine weekly assessments were arranged for clients who were already participating in treatment but were still perceived by their nurses as 'chaotic'. Generally clients considered stabilised were seen on a fortnightly or monthly basis. Discussion during these consultations focused on clients' general health, experiences since last meeting, concerns, achievements, goal setting, clients' reflection, and summarising of consultation. Urine samples were sometimes requested.

Comparing treatment beliefs to general practitioners

For some questionnaire data it was possible to compare with data from previous work conducted by the University of Aberdeen with GPs (Matheson *et al.*, 2003). This allowed a comparison to be made between nurses and general practitioners on approach to treatment and beliefs regarding the organisation of services. Table 9 compares nurses' beliefs with GPs' beliefs about the effectiveness of treatment.

There were some notable differences in beliefs about treatment:

1. Nurses generally did not favour detoxification whilst many GPs still consider this preferable. However although nurses did not consider this to be preferable 83% agreed that a community based detoxification programme was an effective tool.
2. Nurses were more confident than GPs in successfully managing poly drug users.
3. Both GPs and nurses were divided in their beliefs about the effectiveness of dihydrocodeine.

However, there was broad agreement that a holistic approach to treatment was necessary.

Table 9 Nurses' and GPs' beliefs about the effectiveness of treatment and organisation of services (min n=187 for nurses and n= 583 for GPs)

Comparative attitude Statements	Respondent	Strongly agree %	Agree %	Disagree %	Strongly disagree %	Uncertain %	Missing value %
A detoxification programme is always preferable to a maintenance programme.	Nurse	0.5	5.8	50.5	38.9	4.1	1.0
	GP	14.8	28.1	25.2	3.5	28.1	0.2
A holistic approach toward the problems associated with drug dependency is necessary in order for any care plan to be successful. (e.g. combined medical and social care).	Nurse	52.6	43.7	2.6	1.1	0	1.0
	GP	17.5	63.5	2.9	0.5	14.9	0.7
Prescribing dihydrocodeine instead of methadone for maintenance has advantages for some clients.	Nurse	5.3	35.1	29.3	10.6	19.7	2.1
	GP	1.2	23.5	21.6	12.0	41.5	0.2
Drug misusers should only be seen centrally by specialist services, rather than by GPs.	Nurse	4.2	12.1	41.6	36.8	5.3	1.0
	GP	30.4	35.7	15.8	4.3	12.7	1.2
If a client is a poly drug user it is unlikely that any treatment will be successful. ¹	Nurse	1.1	3.6	62.6	29.4	3.2	2.6
	GP	31.6	54.4	5.0	0.5	8.2	0.3
Having a drug dependency problem should in no way affect a client's access to health care services of any kind.	Nurse	72.1	25.3	1.6	0	1.1	1.0
	GP	29.2	59.7	4.5	0.7	5.8	0.2
I have no sympathy at all for drug misusers	Nurse	0.5	1.6	26.8	71.1	0	1.0
	GP	2.6	6.5	57.3	19.6	13.4	0.7

¹This question was worded slightly differently for GP: "I am less confident in the success of any treatment if the patient is a poly drug user" (Matheson *et al.*, 2003).

Chapter 7: Multidisciplinary working

Key points in this chapter

- Over half of respondents considered their relationship with pharmacists, GPs, health visitors/community nurses, hospital doctors and social workers to be good.
- Opportunities to discuss services with policy makers were considered insufficient.
- Relationships with GPs seemed positive because nurses felt GPs valued their specialist knowledge.
- Nurses had frequent contact with pharmacists and respected the difficulties of a pharmacist's work.
- Relationships with social service were variable. Some nurses felt undervalued by their social work colleagues or felt there was a lack of joint planning for individual client care.
- Nurses were clear about what circumstances should lead to a break in confidentiality between services and of how to go about this.
- Integrated drug services were seen potentially beneficial but there were specific concerns about the implication for clients of sharing information with other agencies and practical issues about the size of joint assessment tools.

Relationships with other professionals in the field

In the questionnaire the proportion of nurses who rated their relationship with other professionals as good/very good were as follows:

- Community Pharmacists, 83%
- GPs, 77%
- Health Visitors/Community nurses, 69%
- Hospital Doctors/Consultants, 58%
- Social Workers, 57%
- General Midwives, 49%
- Policy Makers, 26%

Nurses felt it was important to be able to discuss issues with all of the above professionals. Over three-quarters of nurses felt they had the opportunity to discuss services for drug misusers with other substance misuse nurses, social workers, GPs and pharmacists. Table 10 indicates that fewer nurses felt such an opportunity existed with policy makers. Over 90% of nurses felt that it was important to discuss issues with each of the professional groups listed, and over 50% of nurses felt that the level of communication was sufficient with other substance misuse nurses, pharmacists, social workers and GPs and not sufficient with policy makers. Nurses working with drug misusers for more than eight years were more likely to have the opportunity to discuss services for drug misusers with policy makers ($p < 0.01$).

Table 10: Interaction with health and social care professionals

Health and Social Care Professionals	Do you have the opportunity to discuss services for drug misusers with these professionals?			How important is it for you to be able to discuss issues with these professionals working with drug misusers?			Is your level of communication sufficient with these professionals?	
	Yes	No	Not Applicable	Very Important	Fairly Important	Not Important	Yes	No
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
GPs	153 (80.5)	31 (16.3)	6 (3.2)	163 (89.6)	18 (9.9)	1 (0.5)	103 (61.3)	65 (38.7)
Hospital Doctors/Consultants	101 (54.6)	69 (37.2)	15 (8.1)	103 (58.9)	64 (36.6)	8 (4.6)	86 (52.8)	77 (47.2)
Pharmacists	146 (78.5)	28 (15.1)	12 (6.4)	125 (70.2)	44 (24.7)	9 (5.1)	121 (74.2)	42 (25.8)
Social Workers	170 (90.4)	14 (7.5)	4 (2.1)	139 (77.2)	37 (20.6)	4 (2.2)	112 (57.7)	53 (27.3)
Other substance misuse nurses	167 (89.3)	15 (8.0)	5 (2.7)	146 (81.1)	32 (17.8)	2 (1.1)	126 (75.9)	40 (24.1)
Policy Makers	76 (43.2)	82 (46.6)	18 (10.2)	111 (69.4)	39 (24.4)	10 (6.3)	44 (30.1)	102 (69.9)

General Practitioners (GPs)

In the questionnaire most nurses reported working regularly with GPs; and 78% believed that GPs/doctors 'highly' or 'reasonably' valued substance misuse nurses.

In interviews nurses generally described positive relationships with GPs. What made relationships work well seemed to be associated with GPs valuing the nurses' skills and knowledge. However this seemed to be dependent on the individual GP.

"It's usually individual GPs, you know, it's just when you're sort of working with them it's good. I find that they are willing to listen to you". Nurse 14, G Grade

Others reported a very good working relationship:

"We have actually got quite a healthy relationship with the GPs. We don't seem to have any problems on what we recommend what the patients should be starting on. The GPs usually follow that on, take our advice". Nurse 20, G Grade

These quotes also demonstrate that it can be the nurse taking the lead in recommending treatment and doses of medication. However the division of labour between nurses and GPs was not clear or consistent.

Pharmacists

Nurses described having good relationships and frequent contact with pharmacists. Although some contact occurred for purposes of arranging pharmacy placements for clients the relationship had a broader role. There was evidence of nurses and pharmacists working together for the well-being of the client:

"I am in and out of the chemist all the time so we have got a really good relationship with them and they will phone us if people are missing or if they have any concerns. Even if they have someone on a monthly prescription they can phone and say "so and so doesn't look so well" and I can say "Okay, I will leave them a wee note, telling them to come to the clinic, stop their prescription, give it up until that day and that is your appointment" and I'll get them to come in". Nurse 23, G Grade

It was acknowledged that pharmacists sometimes had a difficult role to play and there was evidence of respect for that:

"The community pharmacists are really good, really good. Most of them, I think nearly all of them, are on board and it's a job I wouldn't envy. if we send a prescription that is reducing, they're the first kind of point of contact that the person's frustration hits so the pharmacists do put up with a lot so our relationship with them is good because it has to be good". Nurse 5, B Grade

Where nurses worked with clients requiring substitute prescriptions, their involvement in assisting clients in finding a pharmacist varied among services. In many cases, the nurse or another service representative would make first contact with the pharmacy. In some settings this was because that was how pharmacists liked it to be or because it was part of a local treatment protocol. Nurses also arranged pharmacy placements for clients because it provided some certainty that the prescription would be dispensed. One nurse stressed the importance of keeping pharmacists well informed:

"I like to do that so they know the patient is the genuine article". Nurse 19, G Grade

Other health professionals

Nurses mentioned having good relationships with midwives and health visitors. Contact was not made routinely but, when required, was found to be valuable. Joint working between substance misuse midwives and health visitors seemed to have been facilitated where relationships were well established:

"I have been with the same surgery for so long it is the same health visitor, so the health visitor and I have a great relationship, so all the mums who have kids we are all working together, so they are getting a really good service". Nurse 19, G Grade

Social Services

Relationships with social care professionals were less consistently reported as favourable when compared with those they had with other health professionals though there was some evidence of effective joint working. One nurse described the following relationship:

"I'm thinking of one client in particular, the health visitor, the social worker and myself, or one of us, tries to see this person every week and we're on the phone to each other every week saying "Have you seen her?" she's so elusive and so somebody knows that somebody is seeing and monitoring this girl and come the case conference we will all be able to put in our thoughts and findings". Nurse 10, H Grade

Another nurse described a set up where the health and social care services kept one another informed on a monthly basis. Some nurses described difficulties in working effectively with social care professionals. This was sometimes due to a lack of shared planning:

"We do try our best to have the closest links as possible but some of them tend to work quite isolated within the social work departments and some of them have got drugs workers themselves a lot of the time, I think it is what is called treatment developments, they seem to have developed or set up these services without really the consultation of the whole, the other people who are already doing the job...sometimes you feel that there could be better co-ordination with that". Nurse 3, G Grade

Another nurse described feeling undervalued:

"I think that social workers do not see us as equal professionals. They don't even know who you are. They don't really take an interest. You are just someone who is expected to do a wee job "Take a urine sample for me please" ". Nurse 22, G Grade

Confidentiality across services

Maintaining client confidentiality and knowing when to seek the support of other professionals may pose difficult dilemmas for substance misuse nurses requiring them to weigh up issues of safety and trust. Nurses were asked how they handled such situations. When the safety of the client or other individuals were under threat, nurses were clear about informing other services and they would be open about this to their clients:

"I will ask them permission however if I felt somebody else was in danger or they were in danger then I would take it upon myself and I would inform them that I was contacting them [social services] and I would go ahead and do that" Nurse 1, G Grade

Although clear about when to inform other services, doing so could be distressing as this nurse noted after witnessing a child play acting part of an injecting ritual:

"This child was obviously seeing something and I was going to have to do something. She wasn't particularly happy [the mother]...if you see something like that you have to tell the authorities because it's not fair. But that's quite rare because most female drug users I think are actually quite good with their children but this case was quite upsetting, then I did beat myself up about that". Nurse 7, H Grade

Nurses reported that clients with children often had fears that their substance misuse problem might threaten their custodial rights, although this rarely occurred:

"Some patients are quite concerned that information that they're drug users or in drug treatment goes to social work department will be, they'll have their children taken off them. Saying that, it's not common. It's not something we hear very often. Most people by the time we see them they seem to already have social workers allocated to the families. There's already been problems picked up earlier". Nurse 6, G Grade

Having clear guidelines about how to deal with issues that require breaking confidentiality was viewed as helpful to nurses.

Integrated Drug Services and the Joint Future Agenda

Nurses were asked if they were aware of the Scottish Executive's Joint Future Agenda and if so whether they thought it would be useful to them when treating their drug-misusing clients. The Joint Future Agenda is The Scottish Executive Strategy to promote working between local authorities, NHSScotland and other relevant organisations to improve community care (Scottish Executive, 2000). This spans all groups in the community but has been applied in the drugs field through the development of Integrated Drugs Services. All nurses had heard about Joint Future but few were aware of its key elements. One nurse admitted:

"...Joint Future. Is that regarding similar kinds of shared care?" Nurse 5, B Grade

Most nurses showed some awareness of what the aims of the Joint Future Agenda and agreed that there was scope for such strategies to be adopted across the services. One nurse said:

"I know we've got to work increasingly closer with our Social Work colleagues and Community Drugs Teams. We've had meetings about the joint assessment tools and I think it could be a good thing." Nurse 2, G Grade

In some areas services were already working in collaboration with others and did not feel that they required the changes suggested in the Joint Future plan:

"We do a lot of joint working though we don't sit in the same room together. Community Addiction Teams consist of Social Work and health worker working together which sounds great, but put a substance misuse nurse in there just to get a shared care element, its daft. "We work close enough from a distance." Nurse 20, G Grade

Another expressed concern regarding their service's identity and relative importance within an integrated care plan:

"I think there is a lot going on for our team at the moment with the Joint Futures which is more or less wiping out our drug service and I think it is really important that we consider keeping shared care, not in a diluted form but as a strength, as a strong body because it works well for a lot of people" Nurse 22, G Grade

Joint assessments were not considered appropriate for some clients. Clients approaching a service such as social work might not be ready to admit their drug use or approach drug misuse services. One nurse, working in a community detoxification service stated:

"We as a service have made a decision not to accept social work referral. The reason for this is that if people have got a heavy amount of social work input then we have to question whether they are ready to be doing a detox for example, because we feel if there is a lot of social work input then it suggests social chaos which is not in keeping with being able to support a detox programme. So you see there are some problems which could arise if we are using the same assessment tool and also because we would be inundated with inappropriate referrals from social work and some homelessness units." Nurse 8, G Grade

This quote also indicates this nurse's service is currently working against the basic principles of the Joint Future Agenda. In cases like this there may be more barriers to overcome in implementing Integrated Drug Services. Others were found to be working towards a joint assessment procedure as suggested in the Joint Future plan. In contrast, one nurse expressed strong opinions about what the joint assessment might mean for himself and his colleagues:

"... I think it's just going to be more paperwork for everybody because you're going to have the common assessment for joint future your own assessment and you're going to have all your own databases and things to fill in..." Nurse 10, Grade H

However, the majority of nurses were of the opinion that the Joint Future Agenda could be beneficial for both themselves and their clients as they felt that the sharing of information could lead to quicker and more effective outcomes for their clients, not just medically, but socially, financially and environmentally. One nurse said:

"There's all this integrated partnership and working together coming into place now and personally I think it's a very important thing because there's no point in me just keeping this client all to myself because I can't help him or her all by myself. " Nurse 21, G Grade

Nurses were asked if they thought the sharing of client's information between different services may deter clients from accessing treatment services. Several explained that social work and children was the big issue:

"Some of my clients are very frightened, they don't like it but I think if you are upfront with them at the start. It actually makes it a wee bit easier for you as a nurse, because you can then say there are these guidelines that we have to follow. You can't just lie and say you are not going to inform social work if you have concerns about their children." Nurse 22, G Grade

Although there were varying opinions about the effectiveness of the Joint Future Agenda, it was recognised by most nurses that there were pros and cons attached to the strategy.

Chapter 8: Health and safety at work

Key points in this chapter

- Sixty four percent (64%) of nurses had been physically or verbally abused by clients. Half of those who had been subject to abuse felt current safety provision was insufficient.
- Greater use of personal alarms and alarms in consultation rooms, use of mobile phone, and specialised training were suggested to improve safety.
- The majority of consultations take place in clinics/consultation rooms rather than clients' homes.
- The safety of staff was considered to be a high service priority in most areas but there was evidence this was still lacking in some areas.
- The feeling was commonly expressed among nurses that their work could be stressful and this was seen as being due to paperwork, excessive caseloads and working in isolation.

In the questionnaire 64% of nurses reported that they had been threatened physically or verbally by a patient. Of the 122 nurses who had been threatened, 65 (54%) felt that there was inadequate safety provision at work should a threatening incident occur. Nurses who felt that safety provision at work was adequate were significantly more likely to be Grade G and above ($p < 0.01$). There was no significant difference in perceived safety at work by age or gender of nurse.

In the questionnaire nurses felt their safety could be improved by the availability of personal alarms, emergency alarms in consultation rooms and better security arrangements when visiting a drug misuser's home. Other suggestions included the use of mobile telephones and provision of specialised training, such as managing aggressive behaviour. Most nurses met their patients/clients in the clinic (see Table 11).

Table 11: Location of patient/client contact

Location	Always N %	Most of the time N %	Occasionally N %	Never N %	Total N %
Clinic	41 (25.6)	72 (45.02)	42 (26.3)	5 (3.1)	160 (83.3)
GP Surgery	17 (11.7)	36 (24.8)	57 (39.3)	35 (24.1)	145 (75.5)
Hospital	11 (8.3)	6 (4.5)	90 (68.2)	25 (18.9)	132 (68.8)
Drug Misuser's Home	1 (0.7)	33 (22.0)	84 (56.0)	32 (21.3)	150 (78.1)

Personal safety

In interviews nurses were asked if they had concerns about their personal safety when dealing with drug misusing clients. All nurses indicated that they were usually aware of issues as this information would be requested from the client's GP:

"I would hope that the referring GP would highlight any safety issues. If I get some new referrals, some of the people you know who have been put off another GP's surgery list and there is a history of them maybe being aggressive." Nurse 19, G Grade

Not all services seemed to treat personal safety as an important issue. Nurses working in such surgeries/agencies, although they did not feel that they were in any danger, did point out the implications of this:

"if I did a home visit last thing on a Friday it would be first thing on the Monday before anyone would realise I had not turned up for work." Nurse 13, G Grade

Many nurses had previously conducted initial assessments in clients' homes and would consider doing so again. However, if they had the choice almost all would conduct initial assessments within a clinic. Others, especially those located in rural areas, indicated that home visits were conducted on a routine basis, but where possible first time assessments would usually be conducted in a central location, such as a GP's surgery or within their service. A home visit would be conducted if a client requested one, had childcare issues, was disabled in any way or if had travel difficulties.

Nurses who conducted home visits were asked if they were concerned about their personal safety. All were aware of the guidelines set out in the 'Orange Book' concerning home visits, which they felt were helpful. However, many of these nurses felt they were very observant and were aware of potential dangers and when visiting clients in their homes relied heavily on their own commonsense and intuition. One male nurse explained:

"I am selective about whose home I would go into, I wouldn't just offer to go and see anybody to be honest. If I am going to see somebody who is not toeing the line in terms of their behaviour or if they were quite confrontational then I wouldn't see them again in their home. I'd insist that they come to the surgery for their future visits." Nurse 17, E Grade

Surprisingly not all nurses who visited clients in their homes indicated that they were concerned about their personal safety. One nurse stated:

"No I've never, I've never felt threatened by the clients. I mean I've thought a lot about that and I don't know how much of that is approach or who we are as people but we've never had any hassle, any problem and in the thirteen years I've been working for drug using clinics I've been verbally abused." Nurse 7, H Grade

Safety provision varied between services. Most nurses felt that there were adequate guidelines and procedures set out by their agencies and that their personal safety was considered to be paramount by their management teams. One nurse said:

"We have quite a sophisticated phone system where before we go into a house we have to phone we select say fifteen minutes and if we don't cancel the call or phone within fifteen minutes then they will call us. If they don't get a reply it will go straight to the police." Nurse 7, H Grade

Stress of job

From questionnaire data 56% agreed with the statement "I find working with drug misusers stressful". It became apparent from interviews that it was not necessarily working with drug misusers themselves that was the source of stress. When asked if work caused them stress some responded by pointing out the job satisfaction they experienced:

"I think the easier question to ask is "Do I enjoy my work?" and I do...if you've got contentment with your work then I think that's quite important". Nurse 18, H Grade

Many nurses pointed out that stress relating to the work was often not to do with clients per se but to do with other factors such as paperwork and even taking holiday:

"You get odd days you feel really harassed and it's usually not the patients, it's usually trying to get all the pieces to fit together which involves prescriptions, computers, bits of paper, things like that are actually more harassing to me". Nurse 6, G Grade

"It's difficult at times if you go off on holiday because of the nature of the relationships you have with clients. When you come back and you feel things have slipped a bit ... you are often left feeling a bit frustrated". Nurse 14, G Grade

Isolation, particularly when combined with a high caseload, was also a factor as working in the community means sometimes not seeing colleagues for days:

"I have worked in addictions for 15 years and this is the loneliest job I have ever had...If you have a very busy clinic with 25 people sometimes and you are on your own doing it. It is quite lonely that way and you are away for days on end and you don't come into the office 'til Friday usually". Nurse 22, G Grade

Some people had adapted to the work patterns. Coping with the stress of the job was facilitated by two factors: having the support of the team; and having the ability to separate work life from home life. Generally, nurses described having informal support from colleagues and formal support through supervision:

"We've got quite a good supervision sort of network set up both organisational and personal, so we've got the organisation one in which we use a colleague for good practice as well as things that are annoying". Nurse 3, G Grade

Chapter 9: Discussion and Recommendations

Recommendations

- All substance misuse nurses should receive induction training prior to commencing their post. Greater time should be protected to allow participation in training.
- There should be further exploration of what models of counselling, if any, are followed to assess whether current training is adequate.
- Appointment scheduling may need review as there was evidence that consultation time was routinely underestimated. Frequency of missed appointments need to be considered at the same time.
- Staffing of substance misuse nurses should be expanded in order to reduce: excessive caseloads; lengthy waiting lists; insufficient cover for holidays, training and absences; and occupational stress.
- Nurses could be involved in GP training to share their experience of managing difficult cases such as poly-drug users and widen GPs perspective of the social benefits of drug misuse treatment.
- Nurses should be kept aware of developments on integrated care for drug misusers. This would allow them to understand the principles behind integrated care and be aware of how their service fits into the overall plan.
- Extending the role of senior substance misuse nurses to include the prescribing of controlled drugs should be considered.
- A clearer job title should be given to nurses working in substance misuse so that they may be easily identified and representable at both DAT and Scottish Executive level, e.g. Specialist Nurse in Substance Misuse.
- Efforts should be made to improve substance misuse nurses' opportunities to influence policy.
- All substance misuse nurses should be provided with appropriate on going training, procedures and practices to allow them to carry out their work safely.

Reflection on methods

The aim of this study was to explore the role of the drug misuse nurse in Scotland. In order to do this a scoping exercise was first carried out to identify the study population. In such an exercise it is never possible to be certain that every relevant individual will be identified. However, in consulting a number of sources, including representatives from all Drug Action Teams throughout Scotland, the authors are confident that the vast majority of relevant services was included.

By using three different methods of data collection (postal survey, observation of consultations and nurse interviews) a greater understanding was gained than by using any one method alone. The postal survey allowed for the collection of valuable, quantifiable data across this population. With a response rate of 79% the authors feel

certain that the findings of the postal survey are representative of the considerable majority of substance misuse nurses in Scotland.

Data collection by questionnaire does have its limitations however, particularly in the exploration of people's attitudes and experiences (Mason, 2002). The inclusion, therefore, of qualitative interviews provided the opportunity to explore topics and identify themes which would otherwise not have emerged by quantitative survey methods alone. Just over a third of substance misuse nurses surveyed agreed to participate in an interview. It is acknowledged this group may differ from the population as a whole. For example, in their willingness to participate, these nurses may have been more self-assured of their working methods than nurses that declined. However, efforts were made, when selecting the sample, to account for factors which may influence their views and opinions (i.e. gender, years of experience, attitudes towards working with drug misusers, and health board area).

The main purpose of the observational fieldwork was to provide a context for the nurse interviews. It is arguable that the act of being observed may have altered the usual roles taken by nurses and clients during a consultation, inducing a Hawthorne Effect (Baker, 1994). Ethical considerations require that observations must be overt in nature. Efforts were made to minimise the effects of observation by informing nurses that the researcher was not assessing the adequacy of the consultation. Furthermore, patients were made aware that they would not be identifiable.

One further issue of note was the poor recruitment of clients to the observation part of the study. This was disappointing given that clients were not the focus of the observation. Experience from nurses on the research team was that clients rarely objected to others (e.g. medical students or other nurses) sitting in on consultations. However the conditions of ethical approval were that prior notice should be given and written consent obtained. These conditions seemed to have inhibited client participation.

Description of population

Substance misuse nurses are a group of senior and experienced nurses, with 70% being G Grade or above, reflecting the responsibility of the post. Over three-quarters of these nurses had a Registered Mental Nurse (RMN) qualification as might be expected given that substance misuse medicine is based in psychiatry. However, there was still a quarter of substance misuse nurses with Registered General Nurse (RGN) training. A third were men, which is consistent with the gender ratio of CPNs generally (ISD, 2004).

Almost half of the population (48%) of specialist nurses working in drug misuse based in Substance Misuse/Drug Problem Service, a quarter in drug and alcohol services (although some Substance Misuse Services will cover alcohol as well). The remainder of the population was scattered across maternity services, social work and specialist or private clinics. Substance misuse nurses were represented in all NHS areas throughout Scotland, apart from Orkney and Shetland. (One CPN based in Orkney had a remit of alcohol problems and Shetland's community drug team had a non-nursing background).

Only 62% of substance misuse nurses had received induction training. As over 80% of those who had received it reported it beneficial, induction training should be normal practice. Formal training had been received by less than half of the respondents, consistent with previous research which has highlighted the lack of specialist training in this field (Rassool, 1996; Farmer *et al.*, 1999). This may at first seem surprising as over 90% of nurses reported that their current job gave opportunity for ongoing training, however only 41% of nurses reported that specific time was allocated for this. If a greater proportion of substance misuse nurses are to receive formal training, protected training time may be required.

All substance misuse nurses should receive induction training prior to commencing their post. Greater time should be protected to allow participation in training.

Work profile

Over half (62%) of respondents worked with general practices indicating the shared care model is reasonably widely practised. Counselling was the most frequent service provided (80%), but assessment (78%), methadone maintenance (77%) and community detoxification (72%) were all widely provided services. Further exploration of what is meant by counselling and whether this is simple information giving/exchange or whether this is based on particular models is recommended to ensure whether current training is adequate.

There should be further exploration of what models of counselling, if any, are followed to assess whether current training is adequate.

The median caseload was 38 with half of questionnaire respondents having between 25 and 49 cases. Surprisingly, caseload was not affected by location of the services whether city centre, urban or rural. The median number of cases seen per week was 25, but 15 nurses were seeing over 60 individuals per week. At over 12 people a day this is a high workload and it must be questioned how effective such consultations can be. The average length of a consultation was 38 minutes. Not surprisingly those with over 50 clients in their caseload were more likely to spend under 30 minutes with each client. It was notable that in the questionnaire survey, the majority reported consultation times between 16 and 45 minutes, yet in the observation of consultations, approximately half of the consultations which were scheduled for 30 minutes over ran their time by between 10 minutes to an hour. The nature of problems that substance misuse clients present with creates a tendency for consultations to over run. Both the survey and the interviews identified other impacts on quality of service that resulted from having an overstretched workload. These difficulties included not having sufficient staffing to cover holidays, training or absences due to ill health.

Appointment scheduling may need review as there was evidence that consultation time was routinely underestimated. Frequency of missed appointments needs to be considered at the same time.

The large caseloads reported by some nurses indicates the substantial demand for treatment for drug misuse in Scotland. This too was reflected by waiting times when explored in the interviews. Given that the Orange Guide (D0H, 1999) advocates the stages of change model (Prochaska and Diclemente, 1986) for assessing likely successful engagement in treatment, approaching treatment at an appropriate stage of readiness is viewed as central to the success of an intervention. With this in mind, having waiting times of several weeks could mean that effective intervention points are missed.

Staffing of substance misuse nurses should be expanded in order to reduce: excessive caseloads; lengthy waiting lists; insufficient cover for holidays, training and absences; and occupational stress.

Approach to treatment: attitudes and practice

General attitudes and approach

The questionnaire covered attitudes to the main treatment areas: maintenance prescribing and counselling. Clearly nurses were very aware of the wider social benefits of maintenance prescribing. Reducing the transmission of infectious disease, reduced problem drug use and improved mortality and morbidity were all perceived to be influential. However societal factors such as reduced crime rate and the effect on family and friends were also influential. These are rated slightly more highly by nurses than GPs. There is a role for nurses to work more closely with GPs, perhaps at a training level to widen GPs awareness of these social benefits.

In practice the majority of questionnaire respondents (84%) were expected to follow a treatment protocol. Awareness of the Orange Guide was wide with 86% having seen a copy. It is perhaps surprising and slightly concerning that this was not higher as this is probably the most important practice document to be published in this field in recent years. The majority of those that had seen the guide felt it had influenced their practice.

Nurses seemed rather more confident in their ability to provide treatment to poly-drugs users than GPs (Matheson *et al.*, 2003). Presumably this confidence is based on positive experience. Poly drug dependence is extremely common and is even considered to be the norm. Consideration should be given to developing training for GPs based on nurses' experiences. Nurses participate in drug misuse training of doctors in Grampian already and this could be implemented in other areas.

Nurses could be involved in GP training to share their experience of managing difficult cases such as poly drug users and widen GPs perspective of the social benefits of drug misuse treatment.

Attitudes to particular treatments

There is now considerable evidence to support methadone maintenance treatment (Simoens *et al.*, 2002) which was provided by three-quarters of the services in which respondents worked. Respondents believed strongly that maintenance prescribing could stop the use of street drugs. Nurses had varying degrees of influence on the starting dose of methadone and no clear pattern was evident; on the whole this seemed to be a medical decision to which the nurse could have input. However, 50 individuals wrote prescriptions for methadone which were then just signed by a doctor indicating these nurses were the chief decision maker on dose, dispensing interval and supervision. Research on the effectiveness of methadone maintenance indicates strongly that counselling increases the effectiveness of methadone maintenance (Simoens *et al.*, 2002). Although specific questions were not asked about whether counselling accompanied prescribing, 80% of surveyed nurses explicitly said they provided counselling and from observation and interviews counselling seemed to be an integral part of consultations.

Dihydrocodeine prescribing remains a controversial issue. Dihydrocodeine is not recommended in the Orange Guide (DoH, 1999) and it is not licensed for use in managing drug dependency. However, previous research has found it is still fairly widely prescribed in Scotland by GPs (Matheson *et al.*, 2003). Our study found that there was a reasonable proportion of nurses (40%) who believed it had advantages over methadone for maintenance for some clients. This was a considerably higher proportion than GPs (25%). Of the 50 individuals who wrote prescriptions, 20 wrote prescriptions for dihydrocodeine. The majority of those writing prescriptions for dihydrocodeine were

based in Lothian where there is a history of dihydrocodeine prescribing and a randomised controlled trial of dihydrocodeine versus methadone is nearing completion. Results of this study (available 2005) should allow clear recommendations on future practice.

Previous research has found that 43% of GPs believed that detoxification programmes are always preferable to maintenance programmes (Matheson *et al.*, 2003). Nurses were found to be less in favour of detoxification over maintenance (only 6% believed it to be 'always preferable') although over three quarters felt a community based detoxification programme was an effective tool in treatment. Thus it seems to be considered a useful option for some people. This is in line with clinical guidelines (DOH, 1999) and the body of evidence which suggests the effectiveness of detoxification programmes is limited (Simoens *et al.*, 2002). However, there did seem to be a strong belief that opiate withdrawal should be followed by a period of rehabilitation.

Attitudes to drug misusers

Not surprisingly, the vast majority of nurses was sympathetic towards drug misusers. They were found to be more sympathetic than pharmacists, GPs and, from previous research, they have more positive views than general nurses and those working in the prison system (Carroll, 1995). GPs and pharmacists displayed very similar responses when asked whether they agreed or disagreed with the statement "I have no sympathy at all for drug misusers" with approximately 70% disagreeing. The difference between their responses and those from nurses is in the strength of response with 98% either disagreeing (27%) or strongly disagreeing (71%).

The majority of nurses had positive attitudes to drug misusers before they worked in this field. Often it was the view that this would be a challenging and enjoyable group to work with that motivated them to move into this area of work.

Thus whilst other generalist health professionals who are involved in drug misuse services may display a degree of sympathy, many are happy for someone else to manage this group. For example over 60% of GPs feel drug misusers should only be seen by specialist services (Matheson *et al.*, 2003) and almost 40% of pharmacists believe drugs should be dispensed through a central clinic rather than community pharmacies (Matheson *et al.*, 2002). Pharmacists and GPs consider drug misusers to be a challenging group who take up a lot of time and are disruptive to other patients (McKeown *et al.*, 2003; Matheson, 1998). Nurses working with drug misusers seem to view drug misusers as a challenging group in a more positive way. Few considered drug misusers to be an easy group to deal with yet 75% considered working with drug misusers to be rewarding. Perhaps the greater challenge means there is a greater reward or feeling of achievement when positive results are seen. GPs and pharmacists are generalists and their views are likely to be dependent on how they compare drug misusers to other groups of patients. Whereas nurses, as specialists, have no such comparisons to make.

Relationships with other professionals

The Orange Guide (DoH, 1999) advocates a shared care approach to drug misuser management involving, as appropriate, a broad range of health and social care professionals. Nurses reported a high level of communication with other professionals. Presumably this has positive implications for patient care. There were some areas requiring improvement. Nurses seemed particularly dissatisfied with the level of communication they had with policy makers with 70% of nurses viewing the level of communication they had as being insufficient. Better representation of substance

misuse nurses on DATs may be one way of increasing their involvement. Given that a high proportion of nurses in the questionnaire felt local services did not meet the needs of drug users, the input of nurses at local service development level seems crucial. Perhaps DATs should have a local nurse representative who is largely involved in patient care (as opposed to managerial level).

Efforts should be made to improve substance misuse nurses' opportunity to influence policy.

The questionnaire survey indicated that substance misuse nurses generally felt they had a good working relationship with GPs. This was further demonstrated in the nurse interviews where good working relationships were associated with GPs valuing the skills and knowledge that substance misuse nurses brought to the service. Previous studies have shown GPs to lack confidence and knowledge of treatments, (McGillion *et al.*, 2000, Matheson *et al.*, 2003) so this may be why they value working with substance misuse nurses.

Although nurses reported having the opportunity for discussion with social workers, interviews with nurses revealed some discontentment among nurses on working arrangements with social work departments indicating that links could be improved.

Shared Care to Integrated Care

From questionnaire responses it was clear the majority of nurses was positive about a shared-care approach; for example approximately 70% agreed that drug misusers should be referred back to their GP when they had been stabilised and only 16% agreed that drug misusers should only be seen by specialist services. Nurses generally have a high level of input at general practice level indicating some form of shared care is widely practiced. However no clear pattern is evident in the delineation of tasks between general practitioners and nurses within shared care models. This is corroborated by previous research which found GPs input into shared care to be very variable (Graftham *et al.*, 2004). Thus it appears that GPs contribute as much into patient care as they can or wish and nurses do the rest. However, the implementation of GP contracts will clarify the tasks required of GPs.

Interviews were conducted at the time Integrated Care Services were becoming a topical area for development and discussion. Thus this subject was raised in pilot interviews and it was considered important to include in the interview schedule. Some interviewees were still fairly uninformed about plans for Integrated Care Services indicating a need to raise awareness. Among those who were more informed concerns were raised about the relevance of sharing information. This concern has been acknowledged in the Effective Interventions Unit (EIU) publication on Integrated Care (Integrated Care for Drug Users, 2002) yet still may be an issue for front-line workers. A particular area of concern is in sharing information with social work because of implications perceived by clients for child custody. (Note that guidelines on this are widely available (Scottish Executive, 2001)). However, the main concern raised was with the relevance and size of assessment tools to allow it to apply to all agencies. Joint assessment tools could overcome the problem of inconsistent information being available to substance misuse nurses from referrals as highlighted in this study.

A basic principle of the Joint Future Agenda is that services should be client focussed. Integrated Drug services are being developed to overcome problems for clients who have to always give the same information to different services. This intended benefit of Integrated service was not referred to by any of the nurses interviewed. Consequently,

there is a need to keep nurses more aware of developments in this area and the principles behind these service developments.

Nurses should be kept aware of developments on integrated care for drug misusers. This would allow them to understand the principles behind integrated care and be aware of how their service fits into the overall plan.

Decision making and autonomy in practice

This research was initiated by the hypothesis that nurses working with drug misusers had a pivotal role in the care of those drug misusers. It was speculated that nurses had a relatively high degree of autonomy compared to other areas of practice. Previous research with GPs had highlighted the high profile of nurses and demonstrated that GPs may rely heavily on their specialist nursing colleagues.

In fact the issue of autonomy is not straightforward. Many substance misuse nurses work in some isolation from their service colleagues particularly those whose clinics are largely based in GPs surgeries or, less frequently, those conducting home visits. There is an apparently high level of discussion with service colleagues which provides support. Support is also provided by the use of service protocols/guidelines which are the norm. Decisions such as starting doses, of methadone, for example are either a medical decision or are determined within a protocol so clinical decision making in this respect is limited. Even in cases where the prescription is written by the nurse and signed by a GP, the dose, dispensing interval and dispensing conditions (i.e. whether supervised) is generally covered within protocols.

The issue arising from the evidence that nurses sometimes write prescriptions to be signed by GPs is that of clinical responsibility/governance. In signing the prescription a GP is taking responsibility even though s/he may know little about the patient's current condition. Fewer than a third of questionnaire respondents (27%) felt writing and signing prescriptions was a medical responsibility not a nursing responsibility. There is a willingness to take on this role if it is limited to very experienced nurses with appropriate training. Although some nurses can prescribe certain items at present this does not include controlled drugs although this might soon be possible under the supplementary prescriber scheme (NHS Scotland, 2003). Nurse prescribing is a developing area and as part of the strategic development of this area prescribing of a very limited range of drugs, including controlled drugs, by suitably trained substance misuse nurses should be seriously considered so that they can accept fully informed responsibility for client prescriptions.

Extending the role of senior substance misuse nurses to include the prescribing of controlled drugs should be considered.

The level of autonomy is more evident in nurses' role in reaching the decision about what treatment approach to take e.g. maintenance or detoxification. Findings indicated decisions regarding treatment plans were made largely between nurses and clients with one other health or social care professional commonly being consulted before settling on a treatment plan. Approximately half of nurses consulted medical staff, whether a GP or consultant. Protocols are used less in this decision making process regarding treatment plan. Thus the role of the nurse in this initial assessment and treatment plan is critical. It was clear that a considerable number of factors, both patient related and societal, have an influence on the majority of nurses. Not surprisingly, in terms of patient

factors, pregnancy had the greatest influence. The strongest societal factor in influencing treatment decisions was the potential that drug treatment has in reducing transmission of infectious diseases. The broad range of factors which influenced the majority of nurses highlights the complex range of issues considered when making treatment decisions.

The other main strand of a substance misuse nurse's practice is ongoing support or counselling. The nature or model of this counselling was not explicitly covered in the questionnaire or interview section of this research. However, from observation this was evident. A study evaluating and comparing the cost effectiveness and outcomes of different models of counselling would be an area for future research.

Some may question whether a nurse is necessary for these tasks that define their current role. From this data it is clear that in the initial assessment discussion of medical complications and some degree of medical examination is essential. A nurse may not be essential for ongoing support and counselling which, from observational data, appears to focus more on social and personal aspects of their drug use or life in general. However, medical complications may still arise and there is often some discussion of their ongoing treatment, the dose of medication etc for which some pharmacological knowledge is necessary.

The range and variation in job titles does not reflect at a national level the core elements of practice undertaken by this group. This may undermine their input in policy and practice whether at DAT level or Scottish Executive because they are not defined and thus clearly representable.

A clearer job title should be given to nurses working in substance misuse so that they may be easily identified and representable at both DAT and Scottish Executive level, e.g. Specialist Nurse in Substance Misuse.

Health and safety issues

Stress

In the present research it was notable that a tenth of nurses had either left their post or were on long-term leave for ill health reasons at the time the questionnaire survey was disseminated. Similarly, at the time when the nurse interviews were being arranged, a further 10% were not available due to 4% being signed off work 'long term' and 6% no longer working for the service/agency they had been originally identified in. Both a high turnover of staff and sickness absence have been associated with stress and emotional exhaustion (Firth and Britton, 1989), consequently stress is considered to have a considerable impact on substance misuse nurses.

In identifying what causes stress, many nurses interviewed emphasised that it was not so much the direct contact with patients that was the cause of their stress but other aspects such as paperwork, caseloads and working in isolation. This corresponds with other research which has aimed to identify the stress factors in nursing. A number of studies focusing on psychiatric nurses have acknowledged that the stress of undertaking administrative requirements may be more stressful than direct patient care (Sullivan, 1993; Ryan and Quayle 1999; Hannigan *et al.*, 2000). Also emerging from the nurse interviews, holiday periods were identified as a difficult time which impacted on workload as there was insufficient cover. The observed levels of sickness and turnover of staff in conducting this research must also impact on their stress levels, as well as compromising quality of care. This is consistent with research which has focused on general nurses

and found that covering for absent colleagues has been identified as one of a number of stressors they experience (Fitter, 1987).

Factors were identified on how stress was *reduced* and *managed*. Team support was seen to help reduce the impact of stress and supervision was identified as having a valued role in this. Other studies have shown nurses to value the provision of clinical supervision (Scanlon and Weir, 1997; Palsson *et al.*, 1996). The nurses in this study also emphasised the value of informal support provided by others in their team. Despite this, the nature of the work, requiring movement around different locations, often meant these nurses felt isolated and this contributed to their stress.

This study identified elements of substance misuse nurses' work which could be part of the *causes* of stress and therefore should be addressed. In the interviews, nurses' caseloads emerged as a contributor to stress, particularly when colleagues were absent and pressure on remaining nurses increased. Also, in the questionnaire survey, almost two-thirds of nurses reported that their current caseload was larger than ideal. Furthermore, nurses with caseloads of over 50 patients reported shorter consultation times. It would seem that by increasing the numbers of nurses working in this field issues of occupational stress and quality of service could be jointly addressed.

Safety at work

Previous research has indicated that the workplace can be a particularly dangerous place for nurses (Farrell, 1999; Dalphond *et al.*, 2000). Substance misuse nurses may be especially at risk due to the nature of the vulnerability of the patient group they work with; due to their work being community based, lone visits may be required to be made to patients in their homes. A considerable proportion of the nurses surveyed (64%) had experienced physical or verbal threats from patients. This level of threat is certainly a concern. The finding that over half of respondents did not think they were adequately protected should a threatening incident occur highlighted the inadequacy of safety provisions in some settings. The need to provide safety procedures to protect nurses has been a focus of the Community and District Nursing Association (CDNA). The CDNA campaigned for all community based nurses to be provided by their employer with appropriate training, procedures and practices to allow them to carry out their work safely. It was clear from interviews that nurses' experiences of such procedures varied widely. Where such procedures existed, they were not always implemented. These findings suggest that employers in all work settings where substance misuse nurses are based should be reassessing the protection and safety procedures they have in place in order to better protect nurses. Some interviewees relied on their common sense and intuition. This itself does not amount to adequate safety provision.

All substance misuse nurses should be provided with appropriate on going training, procedures and practices to allow them to carry out their work safely.

Conclusions and Practice Implications

This research has been largely descriptive in nature, providing an overview of the role of substance misuse nurses in Scotland. This research highlights the seniority of this group of nurses in terms of grade and age. Many of these nurses are clearly confident in their practice and feel able to work in relative isolation, if not necessarily independently. There is clearly a consistency of approach to managing drug misusers across NHS areas which is reassuring.

Our research has identified a number of implications for future practice. An important consideration lies in the role of the substance misuse nurse in prescribing and whether

the present responsibility of senior, experienced nurses should be extended to signing prescriptions. As substance misuse nurses expressed greater confidence than GPs in working with poly drug users, an opportunity exists for nurses to work closer with GPs to provide support and help develop GPs' confidence in working in this area. Safety procedures may need review in some areas. Furthermore, appointment scheduling may need review as there was evidence that consultation time was routinely underestimated. However, it is acknowledged other problems such as frequency of missed appointments need to be considered at the same time.

This research has also raised other questions that may need further investigation through further research or local review. Particularly the tools used in assessment may need consideration at local level. There was some evidence from interviews that SMR24 monitoring forms were being used as an integral part of the assessment. An SMR24 form must be completed but this is not an assessment tool and does not allow for ongoing assessment. However as this study was not aimed at exploring assessment tools per se further clarification is suggested at local level. This could be considered in line with local development of joint assessment tools under the strategic development of integrated care for drug users. Similarly further investigation of counselling models used in practice may be beneficial.

Finally, this study highlighted the lack of clarity and consistence of job titles which is considered to add to the lack of professional identity of this group at a national level. This issue is also currently being considered by the Nursing and Midwifery Council. Greater clarity of role and recognition of this by more inclusion of substance misuse nurses (not just service managers) at local policy level would give this group greater recognition of the important role they play.

Appendix 1: Questionnaire



University of Aberdeen

An Exploration of the Role of the Specialist Nurse in the Provision of Drug Misuse Services in Scotland

Questionnaire

Do you have a nursing qualification?

YES (Please complete this questionnaire)

NO (Please return it **UNCOMPLETED** in the pre-paid envelope provided)

Please return the postcard even if you do not complete this questionnaire

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1. Job Description

1. What type of service are you based in? Please tick one box only

- Substance misuse service/drug problem service
- Drug and alcohol service
- Harm reduction clinic
- Drug crisis service
- Residential detox service
- Maternity hospital
- Other (**Please specify**) _____

2. How is this service funded?

Please tick one box only

- Health Board funded
- Voluntary/Charity
- Joint Health Board and voluntary/charity funded

3. Please list your nursing qualifications and the year you obtained them.

Qualification (e.g. RMN)	Year 1989
_____	_____
_____	_____

4. What is your job title? _____

5. What are your hours of work? Full time Part time

6. a) Do you only work with drug misusers* (Please see note below)

- Yes (Go to Q 7)
- No

b) If No, which other patient groups do you work with?

(Please specify) _____

7. What is the total number of years you have worked with drug misusers?
(Include time in current post and any previous posts. Please specify to the nearest year) _____ yrs

Note: *Drug misusers are typified by daily drug use, the development of a tolerance to the effects of such drugs, and the experience of severe withdrawal symptoms on abrupt cessation of such drugs (Ward J, Hall W, *et al.* 1999). Other terms used are 'illicit drug user' or 'problem drug user'. For the purpose of this questionnaire these should be considered synonymous.

2. Nurse Grade

8. What is your nursing grade?

B C D E F G H I J Other _____

9. Do you think other health professionals are sometimes confused about nurse grades and the responsibilities associated with them?

Yes Don't Know
 No

10. a) Are you ever asked to perform tasks that are not associated with your nursing grade?

Yes **(Please answer 10b)** Don't Know
 No **(Please go to Q12)**

b) If you answered yes to Q10a, how often are you asked to do these tasks?

Every day Every week Every month Very rarely

11. If you are asked to perform tasks outside your nursing grade who normally asks you to do these tasks? **(Please tick all that apply)**

GPs Senior Nursing Management Pharmacists
 Patients Other **(Please specify)** _____

3. Motivation

12. What motivated you to work with drug misusers? **(Please tick up to three statements)**

I worked with drug misusers in other nursing posts and enjoyed it.

The job offers better career prospects than other jobs/specialities I have applied for.

I thought it would be challenging to work with drug misusers.

I wanted to change direction in my career.

I felt I lacked knowledge in this field and wished to correct this by becoming a Drug Specialist nurse.

My previous employment had terminated and there was a vacancy for a Drug Specialist nurse.

Other reason **(Please specify)** _____

4. Attitudes towards work, drug misusers and treatment

13. Please indicate your attitudes to the following issues concerning drug misusers and their treatment by ticking the appropriate boxes. All answers will be treated as totally **confidential**. **(Please tick one box for each issue)**

	Strongly Agree	Agree	Disagree	Strongly Disagree	Uncertain
Drug misusers should only be seen centrally by specialist services, rather than by GPs.	<input type="checkbox"/>				
A detoxification programme is always preferable to a maintenance programme.	<input type="checkbox"/>				
Providing drug misusers with a maintenance dose of a controlled drug can stop them using street drugs.	<input type="checkbox"/>				
Drug misusers are easy to deal with.	<input type="checkbox"/>				
If a patient/client is a polydrug user it is unlikely that any treatment will be successful.	<input type="checkbox"/>				
A holistic approach toward the problems associated with drug dependency is necessary in order for any care plan to be successful. (e.g. combined medical and social care).	<input type="checkbox"/>				
Having a drug dependency problem should in no way affect a patient's access to health care services of any kind.	<input type="checkbox"/>				
Working with drug misusers is rewarding.	<input type="checkbox"/>				
Controlled drugs should be dispensed to drug misusers at a central clinic rather than community pharmacies.	<input type="checkbox"/>				
Drug misusers are disruptive to other patients whilst waiting for their consultation. Specialist nurses working with drug misusers, should be able to sign prescriptions for substitute drugs for their patients/clients.	<input type="checkbox"/>				
A community based detoxification programme is an effective tool in the treatment of drug misusers.	<input type="checkbox"/>				
Drug misusers are manipulative during consultations.	<input type="checkbox"/>				
Opiate withdrawal should be followed by a supported rehabilitation period.	<input type="checkbox"/>				
The benefits to the patient/client treated for drug Misuse are more important than the benefits to the population.	<input type="checkbox"/>				
Drug misusers should be transferred back to their GP once their drug use has stabilised.	<input type="checkbox"/>				

(Question 13 continued)

	Strongly Agree	Agree	Disagree	Strongly Disagree	Uncertain
I have no sympathy at all for drug misusers.	<input type="checkbox"/>				
I find work with drug misusers stressful.	<input type="checkbox"/>				
Prescribing dihydrocodeine instead of methadone, for maintenance has advantages for some patients.	<input type="checkbox"/>				
Providing problem drug misusers with a maintenance dose of a controlled drug is a waste of NHS resources.	<input type="checkbox"/>				
Drug misusers are professionally challenging.	<input type="checkbox"/>				

5. Treatment

14. Are you expected to follow a treatment protocol when deciding upon a patient's/client's management/treatment plan?
- Yes
 No
15. In practice, how would you decide upon a patient's/client's management/treatment plan? **(Please tick all that apply)**
- Decide by yourself
 Decide in consultation with the patient/client
 Decide in consultation with other Drug Specialist nurses
 Decide in consultation with GP
 Decide in consultation with a consultant
 Decide in consultation with other health/social professionals
 Follow a protocol
16. a) Do you ever write prescriptions for "substitute" drugs and then give them to a doctor to be signed?
- Always Sometimes Never **(Go to Q17)**
- b) If answering 'Always' or 'Sometimes' to Q 16a, what drugs do you write the prescription for?
- Dihydrocodeine Diazepam Lofexidine Methadone
 Naltrexone Nitrazepam Temazepam Zopiclone
 Zolpidem Others **(Please list)** _____
17. Which of the following statements do you most agree with? **(Please tick one box only)**
- GPs/doctors only should write and sign prescriptions as it is not a nursing responsibility.
- All nurses working with drug misusers should be able to write and sign prescriptions.
- Only very experienced nurses given extra training in prescribing should sign prescriptions.
18. How much, if at all, would each of these factors affect your treatment of your drug misusing patients/clients? **(Please tick one box for each factor)**

a) Patient Factors

	Strongly Influence	Partly Influence	No Influence	Not Sure
Age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying an infectious disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General health status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length of drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improved standard of life patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nature of drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poly-drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Main drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attitude of patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviour of patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lay support network	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

b) Societal Factors

	Strongly Influence	Partly Influence	No Influence	Not Sure
Reduced transmission of infectious diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reduced rate of problem drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improved mortality rates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improved morbidity rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reduced crime rate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Effect on patient's family and friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Please specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Barriers to Treatment

19. Based on your experience, please indicate your level of agreement with the following statements with respect to their effect on the success of treatments offered to drug misusers? **(Please tick one box for each statement)**
- | | Strongly Agree | Agree | Disagree | Strongly Disagree | Uncertain |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| There is a long wait between GP referral and appointment with the specialist nurse. | <input type="checkbox"/> |
| There is a long wait between recommendation for treatment and start of a specialised non-maintenance treatment (e.g. detoxification clinic, rehabilitation centre). | <input type="checkbox"/> |
| GPs lack knowledge of current treatment options available for drug dependency. | <input type="checkbox"/> |
| Drug Specialist nurses lack knowledge of current treatment options available for drug dependency. | <input type="checkbox"/> |
| There is a lack of communication between health professionals working with drug misusers. | <input type="checkbox"/> |

7. Workload and Attitudes towards Current Practice

20. Approximately how many patient/clients do you see per week? _____
21. a) How many of these do you consider to be chaotic drug misusers? _____
 b) Please explain briefly what you mean by 'chaotic' _____
22. Have you seen a copy of the Scottish Office Department of Health Guidelines on Clinical Management of Drug Misuse and Dependence (the Orange Guide, 1999)?
 Yes Don't know
 No
23. Have these guidelines influenced your practice?
 Yes Don't know
 No
24. Generally how often do you see your patients/clients?
 Once a week
 Once a fortnight
 Once a month
 Not on a regular basis
 Other **(Please specify)** _____

25. Approximately how long does a consultation last per patient/client? _____ hrs _____ mins

26. In your opinion are consultation times?

too short adequate too long

(Please explain) _____

27. How many GP practices do you work for?

1 2 3 4 5 More than 5 Not relevant

Other **(Please specify)** _____

28. What is your current *caseload? _____

***(By caseload we mean the number of patients allocated to your care at any one time)**

29. What would you consider to be an 'ideal' caseload? _____

(Please indicate the number of patients/clients) _____

30. How can drug misusers access your services? **(Please tick all that apply)**

- Referral from a GP or other health professional
 Self referral
 Can drop in at any time
 By phone
 Other

(Please specify) _____

31. Please estimate the percentage of time you spend on the following tasks per week? (e.g. 50% with drug misusing patients, 20% with non drug misusing patients, 20% doing paper work, 10% managing other nurses).

Activity	Percentage (%)
Consultations with drug misusing patients	
Consultations with non-drug misusing patients	
Administration/paper work (eg writing up notes etc.)	
Management duties	
Visiting drug misusers at home	
Attending training courses	
Other (Please specify)	
	100%

32. Which of the following are offered by the service you work for? (Please tick all that apply):

- Methadone maintenance prescribing
- Counselling services
- Community detoxification
- Drop in clinic
- Needle and syringe exchange
- Assessment of eligibility for treatment options
- Development of an aftercare management plan
- Other

(Please specify) _____

33. Do you think the services provided by the service you work for or by other local services meet the needs of drug misusers in your area?

Yes Don't Know

No (Please explain) _____

34. In your opinion, which of the following, if added to the service provided by your organisation could help drug misusers in your area? (Please tick one box for each factor):

	Greatly improve service	Slightly improve service	No difference	Uncertain
More staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Better training for staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Better accommodation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A needle exchange facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community detoxification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-patient rapid detox service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A residential rehabilitation unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A 24-hour crisis centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A 24-hour help line	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Please specify) _____

8. Location and Safety at Work

35. Where do you see your drug dependent patients/clients? (Please tick one box for each location)

	Always	Most of the time	Occasionally	Never
Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug misusers home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Please specify) _____

36. Have any drug misusers ever threatened you physically or verbally?

Yes

No

37. Do you feel that there is adequate safety provision for you at work should a threatening incident occur?

Yes (Please go to Q39)

No

38. Which of the following do you think could improve your safety should a threatening incident occur?

(Please tick all that apply)

- Personal alarms
- Emergency alarms in consultation rooms
- Better security arrangements when visiting a drug misuser's home
- Other (Please specify) _____

9. Interaction with other Health Professionals

39. How would you generally describe your professional relationship with the following occupational groups?

(Please tick one box for each group)

	Very Good	Good	Fairly Good	Not Relevant	Not Good
GPs	<input type="checkbox"/>				
Hospital Doctors/Consultants	<input type="checkbox"/>				
Community Pharmacists	<input type="checkbox"/>				
Health visitors/Community nurses	<input type="checkbox"/>				
General midwives	<input type="checkbox"/>				
Social workers	<input type="checkbox"/>				
Policy makers (e.g. Health Board Officials)	<input type="checkbox"/>				
Other, (Please specify) _____	<input type="checkbox"/>				

40. Do you work regularly with GPs?

- Yes
 No

41. Do you think GPs' attitudes towards drug misusers are generally?

- Very positive Positive Negative Variable

42. In your opinion how do GPs/doctors value Drug Specialist nurses?

- Highly Reasonably Not enough Not at all

Professionals	Do you have the opportunity to discuss services for drug misusers with these professionals?			How important is it for you to be able to discuss issues with these professionals working with drug misusers?			Is your level of communication sufficient with these professionals?	
	YES	NO	NOT APPLICABLE	VERY IMPORTANT	FAIRLY IMPORTANT	NOT IMPORTANT	YES	NO
GPs								
Hospital Doctors								
Pharmacists								
Social Workers								
Other drug specialist nurses								
Policy makers								

44. If you feel that you require more communication with the professionals mentioned in Q43, please explain briefly below:

10. Training

Formal Training in Drug Misuse

45. Have you had any formal training in substance misuse? (e.g. university certificate or diploma in drug and alcohol studies etc)

- Yes (Please specify) _____
 No

In-House Training

46. Did you undergo any training period prior to getting your own patient list?

- Yes (Please specify) _____
 No (Please go to Q48)

47. In your opinion, did your training prepare you for working with drug misusers?

- Yes
 No (Why not) _____

48. Of how much benefit were the following elements of induction in your current post? (Please tick one box for each option)

	Not Received	Very Beneficial	Quite Beneficial	Not Beneficial	Not Relevant
Shadowing a member of staff	<input type="checkbox"/>				
Training courses about substance misuse	<input type="checkbox"/>				
Information from relevant substance misuse research	<input type="checkbox"/>				
Attendance of conferences on substance misuse	<input type="checkbox"/>				
Training courses on motivational interviewing and relapse prevention	<input type="checkbox"/>				
Other	<input type="checkbox"/>				

(Please specify) _____

Appendix 2: Interview Schedule

The Role of the Substance misuse nurse in the Provision of Drug Misuse Services in Scotland

INTERVIEW SCHEDULE

DEMOGRAPHICS

- Male Female
- What is your job title: _____
- What is your nursing grade: _____
- How long have you worked with drug misusers? _____

ASSESSMENT & DECISION MAKING

- Can you tell me about the areas that you would usually explore when assessing patients' needs?
 - How many times would you see a patient before deciding on a treatment plan?
 - Do patients request specific treatment interventions?
 - How do you normally decide which treatment option would suit individual patients?
- How would you decide on the commencement dose to give each patient (e.g. Methadone mix BNF 1mg/ml) if they to follow a maintenance/reduction regime?
- Do you follow any guidelines/protocols for specific treatments (e.g. methadone maintenance) during an assessment?
- In your opinion do you work as part of a team with other HPs (e.g. social workers, psychologists, GPs, community pharmacists).
- How do you view your role in relation to other health professionals working in this field.
- What do you know about the integrated care plan?
- Do you find working in the field of drug misuse stressful?

Appendix 3: Observation Checklist

OBSERVATION DATA COLLECTION FORM

Date: _____

- Description of the consultation setting;
- Privacy, background noise and interruptions (telephone/knocks on door etc.);
- Start time of consultation? Did consultation start on time?
- Who introduces new topics in the discussion/consultation?
- In what order are topics discussed?
- Posture and eye contact, body language in general of nurse and client;
- Occurrence of silence;
- Questioning by nurse, appropriate use of open/broad questions;
- Questioning by nurse, appropriate use of closed/narrow questions;
- Appropriate answers/explanation by nurse;
- Evidence of reflecting on the main topic and summarising session by nurse;
- Who closes the consultation?
- Finishing time of consultation? Did consultation finish on time? Did client have enough time to ask questions etc.?
- Other relevant observations.

Appendix 4: Further Questionnaire Data

Table A1: Self-reported job title of respondents

Job Title¹	N=191²	%
Charge Nurse	31	16.2
Community Psychiatric Nurse (CPN)	21	11.5
Staff Nurse	27	14.1
Senior Charge Nurse	8	4.2
Addictions Nurse	7	3.7
Community Addictions Nurse	7	3.7
Midwife	7	3.7
Team Leader	8	4.2
Addictions Liaisons Nurse	6	3.1
Community Mental Health Nurse	6	3.1
Deputy Charge Nurse	6	3.1
Senior Community Mental Health Nurse	6	3.1
Clinical Nurse Specialist	5	2.6
Senior Staff Nurse	4	2.1
Clinical Nurse Manager	3	1.6
Nurse Team Leader	3	1.6
Senior Addictions Nurse	3	1.6
Other e.g. youth worker, public health nurse	32	16.8
Total	191	100.0

¹ Open-ended question, ² 1/191 incomplete

Table A2: Services provided by employing organisation

Services provided¹	N=192	%
Counselling Service	154	80.2
Assessment of eligibility for treatment options	150	78.1
Methadone maintenance prescribing	148	77.1
Community Detoxification	139	72.4
Development of an aftercare management plan	127	66.1
Needle and syringe exchange	92	47.9
Drop-in clinic	29	15.1

¹ Respondents selected all that applied

Table A3: Location of services

Location	Detail	N=192	%
Health Board	Argyll & Clyde	20	10.5
	Ayrshire & Arran	14	7.3
	Borders	4	2.1
	Dumfries & Galloway	8	4.2
	Fife	13	6.8
	Forth Valley	13	6.8
	Grampian	21	11.0
	Glasgow	23	12.0
	Highland	10	5.2
	Lanarkshire	28	14.7
	Lothian	19	9.9
	Tayside	15	7.9
	Western Isles	3	1.6
	Total	191	99.4
Location ^{1,2}	City centre/suburban (Aberdeen, Dundee, Edinburgh, Glasgow, Inverness)	76	40.9
	Urban (4,000-90,000 inhabitants)	88	47.3
	Rural (4,000)	32	17.2

¹ 10/186 nurses worked in multiple sites

² Definitions of city centre, urban and rural locations are based on previous national surveys of GPs and pharmacists.

Table A4: Views on prescribing practice

Prescribing practice	N=181	%
Only very experienced nurses given extra training in prescribing should sign prescriptions	127	70.2
GPs/Doctors only should write and sign prescription as it is not a nursing responsibility	49	27.1
All nurses working with drug misusers should be able to write and sign prescriptions	5	2.8
Total ¹	181	100.1

¹11/192 incomplete

Table A5: Nurse-prescribed medication

Medications¹	N=192	%
Diazepam	50	26.0
Methadone	46	24.0
Lofexidine	33	17.2
Zopiclone	21	10.9
Dihydrocodeine	20 ²	10.4
Naltrexone	16	8.3
Zolpidem	15	7.7
Temazepam	3	1.6
Nitrazepam	2	1.0

¹ Participants selected all that applied

² 13/20 from Lothian.

Appendix 5: Further Observation Notes

Structure

Regardless of the type of consultation or NHS setting all followed a similar structure, consisting of the five stages below:

1. introduction
2. exploration of clients' history
3. main body of consultation
4. exploration of future goals
5. closure.

Consultations began with a brief interaction between nurse and client to build rapport. Conversations topics included the weather, the day so far and general well being of both parties. There seemed to be appropriate physical space between nurses and clients at all times. Both parties were seated at equal heights and there were never any physical barriers such as a desk or table placed between them. If such a barrier did exist nurses would direct clients to a chair strategically positioned so both parties were able to interact without a physical barrier between them.

Interaction with clients

Nurses tended to spend a lot of time listening to clients and asking them to reflect on what had been said. For example, field notes read "Allows client to answer in her own words and in her own time". Additionally, they encouraged clients to think more about their own ideas and feelings in relation to their drug misuse and to interpret and clarify the meaning of their statements. Clients were given plenty of time to define problems and answer questions. It appeared that nurses maintained an empathetic, non-judgemental attitude which was particularly evident when clients appeared distressed or confused. Additionally, appropriate use of silence was used when clients felt that they could not answer sensitive questions. Nurses appeared interested and sympathetic towards their clients. They showed good use of non-verbal prompts such as direct eye contact, facial expressions, and posture. In contrast some clients avoided direct eye contact, especially when admitting to drug misuse, criminal behaviour or traumatic experiences but in most cases clients appeared open and honest.

Overall consultations were client-centred and nurses encouraged and facilitated clients' participation in consultations, thus establishing joint-decision making.

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ANSA Scotland: www.ANSA-Scotland.org

Nurse Prescribing Link: www.show.scot.nhs.uk/sehd/nurseprescribing

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