

Nurse Prescribing in Mental Health



DR ADRIAN JONES, RN, BN (HONS), PHD

Nurse Consultant
North Wales NHS Trust & Visiting Reader in
Psychiatric Nursing, Glyndwr University

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To my wife Mairead, and my daughter Jessie and son Mikey.

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Chapter 1

Mental health nursing: Our journey and our future

Introduction

This book will begin by looking at the provision of psychiatric care in the past. We need to understand the past to put what we do now into perspective. For some people who read this chapter, it will raise uncomfortable awareness of where nursing has come from. However, our legacy has helped to create the environment for nursing to become an established and respected profession. We draw on many 'drivers for change' that are creating the climate where we now see mental health nurse prescribing and the plethora of services that nurses now lead.

Nurse prescribing is a logical extension of the medical role in response to professional, technological and cultural changes that have occurred over the last 50 years. Nurse prescribing is an innovation for psychiatry; however, the reality is that psychiatric nurses have prescribed medication 'by proxy' for decades, since the introduction of chlorpromazine. Earlier charge nurses would routinely give medication to patients and then have it prescribed at a later time by the doctor. Community nurses alter depot dosage and then have it agreed in team meetings. The point is that although psychiatric nurses have managed, advised and debated medication for decades, they cannot continue this ad hoc procedure as a necessary but only half-acknowledged part of their role. The continued focus on patient safety means that these functions must be legitimised and tied to training and governance structures. Undoubtedly, nurse prescribing will bring about a change for nursing and medical roles, and the benefits will be vast in their impact.

It is argued that medicine and nursing are distinct in their values, training and practices. This has led to tensions and power differences. Nurse prescribing is not some facile attempt to become like doctors. It is rather a challenge for nursing to develop a way of working that meets the needs of patients in settings of their own choice and a new and distinctive way of thinking about the role of drugs in recovery from mental illness.

It is extraordinary that mental health nurses are now embarking on a prescribing career, once the task of the medical superintendent who historically would have been in charge of the hospital staff. The journey through the various stages of psychiatric nursing, from the 'asylum days' right up to the myriad of teams that now make up mental health services, is an interesting one. Professions are changing, and health care too, because of the continuous drive to provide services to more people in different service contexts.

The training of psychiatric professionals has been subject to numerous reviews over the last two decades. This process has helped to extinguish the myth about the supremacy of knowledge and which professional group can lay claim to it. Professional knowledge, and the process of time, which witnesses a relentless march to deprofessionalise it, places a challenge on nursing and medicine. Such a challenge drives nursing forward to take on advanced skills. This book majors on nurse prescribing as one such example although other examples are coming to the fore such as the role of Responsible Clinician under the revised Mental Health Act (DoH 2008b).

A further driver is the role of the patient, or more popularly termed the consumer. Patients have a growing influence over the planning, implementation and evaluation of psychiatric care. People who use mental health services demand greater access, quality and information about the service they receive. Although consumers have often been negative about nurses, they do not distinguish the gap in medical knowledge and intervention to be as wide or necessarily important. We draw out this fact to illustrate a driver for nursing staff that will see them manage and be accountable for even larger aspects of patient care.

The origins of mental health nursing: Asylum attendants

There are institutions that have provided care for people with mental illness for hundreds of years. From 1744 to 1845, care of people with mental illness took place in the workhouse or the private madhouse. The local parish funded this informal form of care. Prior to and up to this period, life was generally organised around the village and so local magistrates and the church managed the care of mental illness. A variety of drivers challenged this arrangement, ranging from scandals in private madhouses to changes in the agricultural and industrial bases of Britain. Efforts were made to put the control and licensing of madhouses under the auspices of the Royal College of Physicians, which was the main medical organisation of the time. This led to medicine being the dominant profession that controlled and regulated people with mental illness.

The 7th Earl of Shaftesbury led the reform of services for lunatics in society and presided over the 1845 Act. In Victorian Britain, there was a massive programme of asylum building. Counties were obliged to establish asylums and admission to them became increasingly regulated through 'commitment' or legal detention. When asylums first opened, they were seen as an exercise in modern humane treatment but very quickly spiralled down into areas of ill treatment (Porter 2002).

The growth of asylums also witnessed an increase in the number of people who were cared for within them. Scull (1979) demonstrated this growth when he examined how many patients per thousand were being detained in 1844 (12.6 per 100 000) and then in 1890 (29.2 per 100 000). This twofold increase in asylum population was on top of the rising population trend. Quite clearly, the asylums were being used as a method of social disposal.

The development of the asylum model enabled an institutional power base in which the various professions developed an expertise in the treatment of lunatics. Each county asylum was under the control of a physician superintendent, a doctor who had complete administrative and clinical control over the institution. As early as 1841, the Association of Medical Officers of Asylums and Hospitals for the Insane was established, which underwent a series of transformations until it finally became the Royal College of Psychiatrists in 1971.

The day-to-day care of asylum residents was, from the beginning, entrusted to asylum attendants. The working life of asylum attendants was physically demanding with only modest pay and poor working conditions. The attendants were people who were not medically trained and who provided day-to-day care under the supervision of medical superintendents (Brimblecombe 2005). Very soon after the formation of the asylums, there was concern that asylum attendants were generally persons of poor character who provided low-quality care to residents. Medical superintendents tried to improve the way attendants cared for patients by instigating a training scheme and the *Red Handbook* was produced with successive editions printed for the next 60 years. Training of asylum attendants helped to put psychiatric nursing on the starting blocks of becoming a profession. It was not until 1951 that the General Nursing Council took over full responsibility for the training and registration of nurses (Nolan 1998).

Involvement of medical staff in this training also supported the public and professional standing of the medical profession as holding a special body of expertise in the treatment of people with abnormal behaviour. Psychiatric nursing was then seen as the arm of the medical superintendent in this regard.

Thirty years later, in 1982, nurse training curriculum embraced social and psychological theories to help explain mental illness and led to a departure from the medical model. The new curriculum brought the training of psychiatric nurses into line with that of other psychiatric professionals, although this was diluted with the adoption of Project 2000 and its aspirations to increase the professional standing of nursing.

The National Health Service

Until 1948, large mental hospitals were under local authority control. Mental health services became part of the National Health Service (NHS) in 1948, and the slow decline of asylums started immediately. Social welfare policies, coupled with the discovery of new drugs like chlorpromazine, led to an awakening of social psychiatry. It was realised that many of the occupants in hospitals did not need to be there. Changes in society also fuelled the fire for change. The process of 'deinstitutionalisation' led to nursing staff working in an environment where the once-closed wards were opened. Rehabilitation services, day hospitals and outpatient clinics emerged leading to new nursing roles. Coupled with this development was the expectation of using less oppressive practices. Nursing

staff needed to embrace a skill set that encompassed therapeutic engagement as opposed to containment.

The development of the NHS created the role of consultant psychiatrists, thus in effect diluting the power of medical superintendents. This was enshrined in law by the 1959 Mental Health Act. The Salmon Report led to the departure from direct supervision by medical superintendents upon the nurses. The reality of the changing relationship did not take place overnight. The concept of multi-disciplinary team working was seen as a driver behind it. The concept of multi-disciplinary team still thrives today where nursing takes place in the myriad of teams providing psychiatric services.

Over the past 30 years, services for adults, substance misuse and older people have been differentiated from the services of an asylum. The onward march towards specialisation started first in the asylums where wards were created for people with alcohol and substance addictions. These wards were seen as separate from the wards for people with mental illness. Nurses and psychiatrists worked in these wards. It was not until the late 1980s that they became completely dislocated from the asylums and developed as stand-alone units or were placed within general hospital grounds. Specialist community services developed in the 1980s. Mental health nurses and psychiatrists were still the main provider for these teams.

The modern crisis in hospital care

The belief in the concept of asylum to manage mental health problems has diminished rapidly. Inpatient care moved from large hospitals to smaller dispersed general hospital units and isolated private facilities. The reality is that the majority of resources continue to be spent on UK hospital care, although the time patients spend in acute psychiatric units is small, some studies pointing towards a mean time of 15 days (Malone *et al.* 2004). There have been relentless attempts to rely less on these units, which continues till date, although we all accept they are an essential component of a modern mental health service.

Mental health nurses are the largest group of staff in hospitals who have 24-h contact with psychiatric patients, and the majority of the professionals still work in many public and private hospitals and residential homes in the UK. What is disappointing are the countless studies even today demonstrating that nurses are reluctant to engage with adult and older people or provide therapeutic activities for them (Standing Nursing and Midwifery Advisory Committee 1999; Sainsbury Centre for Mental Health 2003, 2005).

The care vacuum that has developed on psychiatric wards today is a symptom of the malaise that had developed within psychiatry in general. Problems like understaffing and rising acuity increased detention rates. Dual diagnosis – to name but a few – exerted a fundamental need to review just what inpatient care should look like (Healthcare Commission 2007a; Royal College of Psychiatrists 2007).

It seems difficult to imagine that psychiatric nurses would be able to manage patient care episodes on top of the added responsibilities that come with assessment and treatment encompassed within nurse prescribing. However, this must be seen within the context of acute wards staying in their present state. Acute wards are changing and the fluidity of the system requires health professionals to be more accessible than ever before. Psychiatrists visiting wards once a week is becoming difficult to sustain given the rising acuity and necessity for quicker decision making for home treatment. Care arrangements will be increasingly made across the spectrum of health care for nursing staff to admit, diagnose, treat and discharge from hospitals. Nurse prescribing will help to oil the wheels of change and give nurses the tools to carry out these new tasks. Radical change is still required within our acute inpatient units to make them fit for purpose, but the future is certainly promising for nurses who work in hospital settings.

Care in the community

The process of deinstitutionalisation witnessed one of the biggest social advancements in the management of patients. The closure of wards in hospitals shifted the base where nurses and psychiatrists worked and began to change the relationship between nurses and psychiatrists (Brimblecombe 2005). In essence, as patients were discharged from hospitals and the concept of care moved from containment to therapeutic engagement, the location of nursing also shifted to community services. Hence, from the 1980s, there were a rapid expansion of community services and differentiated services to meet particular needs. Nurses increased their levels of autonomy over the management of patient care.

The most visible consequence of community care has been the establishment of community mental health teams. They were first established in the 1960s and gained prominence in the 1990s. When a community mental health team works well, it is able to harness the skills of many team members and disciplines to assess and deliver care. Overall, the dominance of the medical model in decision making and direction over care has been complemented by the influence of social work and nursing perspectives. One could argue that the movement of care from the hospital setting to a person's home led to a period of professional uncertainty for nursing staff too, as they competed with social work for position within the expanding community team.

The primary reason for establishing a community mental health team was to deliver more cost-effective approaches to care. However, early teams were found to be ineffective in managing staff resources towards caring for patients with a serious mental illness (Onyett *et al.* 1994). Even today, the evidence base for community mental health teams is inadequate and reveals no great difference in the reduction of suicides compared to non-team standard care (Malone *et al.* 2007).

In the mid-1990s, there were a number of high-profile cases where people with mental illness went on to kill members of the public, one notable example being Christopher Clunis (Ritchie *et al.* 1994). This added to the perception that

community-based services had failed. However, the community mental health team did enable nursing staff to receive referrals from general practitioners. This had the effect of increasing the professional stature of community nurses but consequently raised concerns within the medical profession, as their spheres of influence became challenged.

Growing resentment with the ineffective community mental health team led to the government producing a national service framework and advocating other types of teams to develop, such as assertive community treatment and crisis resolution home treatment teams (DoH 1999; DoH/CSIP 2007). At the front end of service provision, nursing staff are the clinicians who will deal with crisis situations. Nurses working in adult and older persons' services increasingly prioritise, formulate and treat without the patient ever being seen by the psychiatrist. The old assumption that doctors should be involved with all major decisions has collapsed. It is also fair to say that the expansion of community-based services has helped to bolt down a less reliant service response on hospital beds (Fawcett & Karban 2005).

The movement of care from the traditional asylum base also saw the emergence of independent sectors in providing care for people requiring differing levels of security; interestingly, these sectors have occupied the market in providing costly continuing care. Unlike the state facilities they have replaced, these private institutions are predominantly led by nurses but staffed by nursing assistants.

The movement of care into a community-based setting placed nursing staff into an arena where they had to work alongside other statutory and voluntary sector agencies. This in itself has led to both positive and negative consequences not only for the care and treatment of patients but also for the profession of nursing. However, the reality of health care over the last few decades has been a splintering of the care episode; nursing has tried to exploit areas where it can take on ever-larger elements of that care. In other words, the destiny of mental health nursing has grown from a reliance and dominance with medicine but is now shaped by costs and service user needs.

Chronic diseases and the overall burden of health

The most common form of disability is mental health problems. Up to 27% of Europeans experience mental illness in any given year (Wittchen & Jacobi 2005). Projections indicate that by 2020, depression will be the highest ranked disease in the developed world (World Health Organization 2001). Mental health nurses make up the largest proportion of the workforce in the UK, which places them in an ideal position to improve the care for people who are in need for services.

Chronic disease management describes a system that prioritises care for a group of patients who are high users of care and who are then specifically 'case managed' through the whole system of care (Katon *et al.* 2001; Gask 2005). The whole system speaks in terms of primary and secondary care but would prefer to see it as a complete unbroken care pathway (Wanless 2002). The second strand

to chronic disease management is the role of the consumer. Policy has been put forward that creates roles for nursing staff, such as 'community matrons', to empower patients to take decisions regarding their care and treatment (DoH 2005a). The concept of 'direct payments' where people can decide how to buy their own community support furthers this point (CSIP-NIMHE 2006).

Crucially, the concept of disease management sees the disease split up into a triangle approach. At the top of the triangle are the most complex patients who have an uncertain diagnosis and pathological pathway and thus require expert management from consultant medical staff (Katon *et al.* 2001). It is reasonable to argue that 75% of the diagnostic group can be managed to varying degrees by nursing staff. Although the aim of disease management is to provide better management of patient care, it has led to a direct driver for nursing staff to develop and further extend their skills into the domain of medical staff.

Another policy driver is the concept of nurse-led discharge where suitably trained nurses follow patient progress and execute discharge when the patients reach discharge markers identified in their care pathway (DoH 2004a). Teams or individuals, like home treatment teams, discharge nurse posts, and nurse practitioners have been trained to carry out these types of functions. Again this departs from the era where medical staff took decisions about admission and discharge of patients. For example, the situation still arises today where psychiatrists discharge patients on a certain day of the week, not unsurprisingly falling on the 'ward round' day.

A major challenge with the chronic disease model is for nursing and medical staff to depart from a generalist position and take on a specialist position (Gask 2005). When nursing takes on specialised functions like admission, treatment and discharge from parts of the care pathway, it ultimately leads to changes in the way medical staff work. The key difference with this model is that the nurse delivers care that cuts across the boundaries between hospital and community services. This means that for some patients, you are just as likely to find nurses managing patient care in a hospital setting than in a community setting. Changes to the law enabling nurses to prescribe medication really makes this way of thinking possible, which will be further catalysed by changes to the revised Mental Health Act. The next service innovation for mental health nurses will be the role of a responsible clinician (DoH 2008b). The role of a responsible clinician, coupled with being an independent prescriber, will allow some nurses to be employed to deliver complete packages of care. This will be truly the profession coming of age and will be able to support the longer term management of the disease burden facing the UK.

Role of the consumer

Over the past two decades, the NHS has gone through a sea change towards a consumerist ethos within health care. A business management agenda has attempted to challenge the foundations of healthcare provision by empowering

the user of care (Griffiths 1988). The Patient's Charter was an example of putting the rights of consumers in health care in the centre of care provision (DoH 1996). Recovery, which resonates strongly in mental health, has been a further development where recipients of health care have reacted against a system that for too long has traded on maintenance (Turner 2002). The DoH (1999c, 2001) has politicised this mindset where services are now supposed to be recovery focused. Patients can now receive direct payments so that they can have choice and purchase their own care packages (CSIP-NIMHE 2006). This business, consumer-driven agenda will be pushed further with the emergence of foundation NHS trusts.

But has consumer participation made any real difference? Consumer satisfaction has gained widespread recognition and, increasingly, is being seen as a driver to shape service delivery (Rose 2001). The challenge is to overcome the tokenistic impression of consumer involvement in all aspects of mental health care (Lammers & Happell 2004). A key battleground is who actually owns the patient record. It seems paradoxical that in today's climate of patient self-management, clinicians are reticent about handing control over to patients to write in their own notes or to see and comment about what clinicians are saying about them in the clinical record (Happell *et al.* 2002).

Early debates have centred on the validity of collecting views from patients on their experiences of care (Fitzpatrick 1991). However, the credibility of this claim has been dismantled as clear evidence has emerged that people with mental health problems can exercise and articulate their opinion on their experiences of health care (Noble *et al.* 2001). Patients will increasingly be concerned with exercising choice over the provider of their care, with less attention paid to profession and more to the quality of the service and time spent with the clinician. A systematic review of the views of mental health patients on receiving care from professional staff found that patients wanted staff to use a range of interventions to positively influence their mental health. This was irrespective of profession as long as the clinician concerned was trained appropriately and was competent to deliver the intervention (Noble *et al.* 2001).

Patients would like to spend more time with nursing staff, discussing their diagnosis and treatment options. Patients want nurses to be both professional and ordinary in their approach (Barker *et al.* 1999). This may explain why early nurse-prescribing research indicates that patients prefer the prescribing advice from nurses to that from doctors because of the different social language used (Luker *et al.* 1998).

One of the main benefits through empowerment of the user has been more information being given to the patient during the clinical encounter (Baker 1998). However, it is questionable if this can be said for people with mental illness, who have been perceived as being disempowered within society (Brandon 1991). Godfrey (1996) found that psychiatric patients were not perceived as active partners in the care planning process. However, this has also been noted in other settings such as primary care. For McIver (1999), there was a

perception that users had trouble in being an active participant and were not particularly committed towards changing service provision. Behind the drive for consumer power, there is an underlying assumption that patients want to be involved in decision making, although this is not always the case. In many respects, the rhetoric of consumerism seems to be overshadowed by the complexity of the relationship that patients assume and want when they are the recipients of health care.

The rise in consumerism appears to have greater impact on those who provide the services. Quite frankly, some clinicians feel threatened by a more interactive user. Lupton (1997) observed this in a study of the relationship between general practitioners and patients. Respondents spoke about a sense of the profession being 'devalued' and being held as more accountable to the needs of the patient. This is a positive feature of the rise in consumerism and challenges the perception of 'they must know what they are doing' attitude, which features in the clinical encounter (Baker 1998). A similar trend was observed between general practitioners and people who were depressed, with the low levels of involvement the latter felt in the consultation regarding their treatment options (Loh *et al.* 2006). Similarly, educators of mental health nurses were equally uncomfortable conceding ground as to who were the real experts in mental health care (Felton & Stickley 2004). Other studies on mental health nurses also demonstrated that patients are involved in selecting the right type of medication and deciding whether they should comply with treatment (McCann *et al.* 2008). A key factor may be the absence of skills in clinicians to involve patients in care-related decisions (Gravel *et al.* 2006). This is the key challenge for nurse prescribers as they enter the new world of patient-driven services.

There have been studies on what patients think about their inpatient care experience. Rogers & Pilgrim (1994) reported that over half of patients were either satisfied or very satisfied with their inpatient nursing care. Interestingly, 32% of patients ranked the helpfulness of nurses higher than that of psychiatrists. Again, what is being drawn out here is that patients are beginning to distinguish their preferences for a professional group. This is in contrast to a widely held view that patients would naturally prefer to have aspects of their care from doctors.

Patients are being encouraged to be active players in what medication they take. The key point here is that people are moving from being a passive recipient of care to being an active participant (Happell *et al.* 2002). A recent DoH (2008a) initiative on medication management identifies very clearly the responsibility mental health nurses have in empowering patients to question the steps in medication management. Patients are urged to ask questions about the role of medication, its safety profile, how the medication should be taken, side effects, information leaflets, how to stop taking it and the alternatives to medication. Patients armed with these questions will present a big challenge to nurses who may not have the knowledge or interpersonal awareness to engage in such a debate. However, patients want, expect and deserve this kind of interaction, given it is them who are taking the medication.