

Prescribing change

Last year a change in the law allowed nurses to prescribe medication. At ANSA's first conference on the subject, nurses and other medical professionals debated how this is working in practice. Malcolm Carr reports.

➤ 'If it ain't broke – break it', alongside 'we must not be afraid of change' and 'we must work to make change work' were the closing words of ANSA's first national non-medical prescribing conference in substance misuse. They were a reflection of changing times and changing roles within the field of healthcare provision.

Delegates had gathered to listen to key speakers talking about the change in law allowing 'non-medical' personnel to prescribe medication and the nitty-gritty of being nurse prescribers. The conference was organised by ANSA (Association of Nurses in Substance Misuse), with support from SMP and Brent DAAT, to respond to questions and concerns raised during their annual conference last year. Most who attended were nurses, who were joined by commissioners, pharmacists and doctors.

Dr June Crown gave a history of the changes in prescribing law, beginning with the Crown Report (1999) and culminating with the changes enacted this year identifying the role of Nurse Independent Prescribers (NIPs). It was interesting to hear of the concerns of the BMA some 15 years ago, when a small group of nurses were able to prescribe (alongside bandages and dressings) 'Nystatin'. 'This will be the thin edge of the wedge', a doctor was reported to have said. Indeed it was, but it has been a thin wedge and a long time forcing the door open.

Shan Barcroft of the NTA explained the NTA's work in trying to identify and develop the role of non-medical prescribers in the field of substance misuse. In a later session with Stephane Ibanez de Benito of SMP, she looked at how the roles could be further developed by identifying the needs of those who had completed additional training in non-medical prescribing.

Simon Greasley and Beverly Harniman, both actively working as nurse prescribers within their primary care teams, gave an overview of some of the problems they had

encountered and some of the systems they had developed to facilitate their role.

The question and answer session was busy, with questions to all members of the panel. One of the most disconcerting was from a nurse who having completed training as a non-medical prescriber felt under pressure to work above what she felt was her level of competence. One of the messages that came across very strongly was that non-medical prescribers should not be seen as a cheap alternative to doctors, but rather as a separate part of the substance misuse workforce, able to work alongside and complement the skills of doctors. Virginia Radcliffe who led a session on 'interprofessional approaches to prescribing' reinforced this message.

The afternoon debate was one of the highlights of the day with Dr Chris Ford proposing the motion 'this house believes that all substance misuse prescribing should be done by medical doctors', to be answered by Dr June Crown. Dr Ford inevitably gave a spirited performance, which once again emphasised the point that non-medical prescribers of any discipline need to work alongside and in partnership with other professionals for the benefit of the service users. The outcome of the debate was a forgone conclusion, considering the audience, but the content of the debate was of higher importance in reminding all present that the needs of service users should always be paramount.

The low point of the day was the straw poll at the very start which identified that over half those attending had completed non-medical prescriber training but were unable to practice because of local or internal politics. It was a sad reflection on the earlier comment on putting service users' needs first.

Still to come? ANSA is already thinking about format of a further one-day prescribing conference early next year to complement its annual three-day conference held each September.

Malcolm Carr is vice chairman of ANSA.



Nurse prescribing in practice

Two nurse prescribers explain the difference their enhanced role has made to services – and the positive reactions from drug-using patients.

As a clinical nurse specialist for substance misuse at a London medical centre, **Beverley Harniman** works alongside a GP and a senior house officer to run a weekly prescribing clinic. She also manages the drug clients on substitute prescriptions, registered at the GP practice.

Clients are able to collect a script without having to wait around for a signature or having to return later. Harniman can carry out supplementary prescribing for methadone, buprenorphine and diazepam (with the initial diagnosis made by a doctor) and can independently prescribe a range of other drugs such as naltrexone, antidepressants, and drugs for alcohol withdrawal.

'Our clients are very happy with the service,' she says. 'It makes it easier for them to stay in treatment.' Her GP colleagues are 'positive and supportive' she says, and it is important to work within a shared care framework and have prescribing protocols in place.

'Nurses need to formally agree with their employers what dose ranges and medications they are happy to prescribe,' says Harniman. 'They must also realise that as the person who signs the script they are accountable, so they need to make sure they have adequate indemnity cover.'

But with clear clinical management plans in place, she says the benefits for patients are obvious. 'We can strengthen the shared care framework considerably. I can treat holistically, looking at blood borne virus screening and Hepatitis B vaccination, as well as prescribing. It's satisfying for me to manage all aspects of a client's treatment.'

Simon Greasley is a nurse prescriber at the Kakoty practice, a GP practice in Barnsley, South Yorkshire. The clinic was the first practice in the UK to take advantage of changes to the Misuse of Drugs Act 2005, which opened the gateway for nurse prescribing.

Greasley believes the self-managed nursing team is needs-led in providing an accessible service for patients. The team is supported by a GP with special interest in substance misuse, but now has the capacity to offer drop-in appointments, catching patients who 'are too chaotic to jump through all the hoops to access secondary care services'.

Staff use a computer template devised by the practice to make sure all assessment procedures are followed, and a urine test and examination are carried out. A clinical management plan is then agreed, following a joint consultation with the doctor.

The practice has a good record of retaining patients, most of whom provide negative samples. More importantly, all have reduced harm. 'As long as we're following RCGP guidelines, we should give patients what they want – methadone up to 120mg and subutex up to 32mg,' he says. 'Where's the sense in some people who have done the prescribing course still not being allowed to prescribe?'

Want to be Unhooked?

William Pryor invites you to take part in an alternative interpretation of addiction

Do you suspect there might be a better way of describing and understanding addiction? Do you feel your practice might work better if you had a more persuasive interpretation of the phenomenon you work with every day? How do you like your theory of addiction – what mix of the medical, sociological, neurochemical, psychological, psychiatric, philosophical, political and spiritual do you want it to contain? What part do you think families, relationships and love play in the genesis of the phenomenon and in its treatment?

Unhooked Thinking is precisely that: unhooked, uncertain, discursive, open, free to go wherever it needs to go, having let go of the insecurities that prop up the more doctrinal approaches to addiction. Unhooked Thinking has no doctrine except to say that to be unhooked from addiction it helps to be unhooked in your thinking. One of the many charms of Unhooked Thinking is that we make it up as we go along – like life. We offer no prescriptions. And there seems to be an appetite for this approach.

A list of the subjects Unhooked Thinkers are interested in would be endless, but here's a few: addiction as expression of family dysfunction, the relationship between prohibition and addiction, the stories or myths that keep addiction afloat, the connection between addiction and the self, treatment as life-training, the idea that love is the absence of addiction, and much, much more. None of these subjects has any kind of 'answer', definitive or not, but they are all the source of a lot of unhooked discussion.

Bolstered by the wide range of positive feedback we've had from Unhooked Thinking 2006 (see for yourself at the website to: www.unhookedthinking.com), we, the management group, are now planning Unhooked Thinking 2007, which will happen from 9 to 11 May next year in the Guildhall in central Bath, a venue with much better acoustics and breakout facilities than the Assembly Rooms where we held this year's event. The theme of the conference will be: 'Love and Baggage – the part love, families and relationships



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And we're inviting your participation. As the theme implies, not only will the conference be for drugs and law enforcement workers, doctors, service users and academics, but for that largely forgotten group, the families of users. We believe that such apparently very different groups can and want to talk to each other. If you have any ideas for a solo or group presentation or a seminar or other breakout session, please let us know. We particularly want to encourage women and ethnic minorities to participate. In the first instance email a short (50 words or less) synopsis of your idea to william@unhookedthinking.com.