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Non-medical prescribing: the story so far

SUMMARY
Non-medical prescribing is an element of the National Health Service modernisation agenda intended to change traditional professional roles and responsibilities, as part of *New Ways of Working*. This article describes concepts of non-medical prescribing and its implications for UK psychiatric practice. The perceived benefits of non-medical prescribing cannot be denied but debate continues about competence and clinical governance issues. Psychiatrists have an essential role to play in the success of non-medical prescribing. Further research and evaluation are needed to establish what works best in terms of clinical safety and training.

> 'By opening up the prescription pad to nurses, we have given them a powerful and symbolic tool. My vision is that non-medical prescribing moves into the mainstream. Non-medical prescribing sends a powerful message to the public and others that nursing is not subservient to medicine but an equal part of the health care team'.

So said former Minister for Health John Reid as he accelerated progress towards independent prescribing for nurses in England (National Prescribing Centre *et al*, 2005). An initial nurse prescribing report highlighted a potential to improve patient care (Department of Health, 1989). Eight demonstration sites were initiated in 1994; although none were in mental health, by 2000 primary care mental health nurse prescribing was mooted (Department of Health, 2000). Supplementary prescribing was introduced in 2003 specifically to enhance the care and treatment of people with medium- to long-term health problems. Independent prescribing for nurses and pharmacists has now been extended to the ability to prescribe any medication in the British National Formulary within professional competence. It is worth noting that non-medical prescribing has been practised in the USA since 1970 (Jones & Jones, 2005) with differences in the models of prescriptive authority between states (Kaas & Markley, 1998).

Within mental health, non-medical prescribing may support psychiatrists to move from traditional out-patient practice in which skills may be underused (Metha *et al*, 2007) towards the role envisaged in *New Ways of Working*. However, it also has the potential to be drawn into the debate about the future of the psychiatric workforce and its professional standing (Bhugra & Brown, 2007). Although much has been written about non-medical prescribing, very little has reached journals read by psychiatrists. We therefore outline the concepts of non-medical prescribing and its implications for UK psychiatric practice.

Forms of non-medical prescribing

Supplementary prescribing

This is a voluntary prescribing partnership between an independent prescriber, usually a doctor or dentist, and a supplementary prescriber (a nurse or a pharmacist) to implement a clinical management plan with the service user's agreement. Following medical assessment the plan is worked out jointly. It defines medication or class of medication as well as dosage, range to be prescribed, titrated or discontinued by the non-medical prescriber (NMP). It also defines conditions for referral back to the independent prescriber for review (National Prescribing Centre, 2003).

Independent prescribing

This is an umbrella term for all prescribing by a practitioner (dentist, doctor, nurse or pharmacist) who is deemed fully responsible and accountable for their assessment of patients with undiagnosed or diagnosed conditions, and for clinical decisions including prescribing (Department of Health, 2006). It also requires an initial patient assessment and interpretation of that assessment, a decision on safe and appropriate therapy and a process of ongoing monitoring. The independent nurse prescriber may prescribe any licensed medicine for any medical condition including some controlled drugs. Pharmacists cannot prescribe controlled drugs but can dispense them. It is also noted that the independent prescriber must be aware of the limits of their skills and knowledge. They must work within their own level of professional competence, and seek advice and make appropriate referrals to other professionals with different expertise.

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A patient group direction

This is not strictly prescribing, but instead a written instruction which applies to a defined service user group within a health provider organisation. It enables registered health professionals who have been named as competent to supply and administer a specified medication to service users who may not be individually identified before presenting for treatment (Department of Health, 2005). For example, in a crisis team setting where individuals need immediate treatment for specified problems out of hours, patient group directions for symptoms such as anxiety, agitation and insomnia can aid coping until full medication review takes place (National Prescribing Centre *et al*, 2005). Patient group directions are drawn up by a doctor, pharmacist and nurse with involvement of the drug and therapeutics committee. This is signed by a senior doctor and senior pharmacist and formally authorised by the National Health Service (NHS) trust. There is no direct medical involvement beyond drawing up and monitoring the patient group direction.

Training

Candidates for training are expected to have significant post-registration clinical experience (2 years for pharmacists and 3 years for nurses). An NMP studies for 26 days at a higher education institution plus 12 days of learning in practice during which a designated medical practitioner (see below) must provide the student with supervision. The employing organisation must ensure that appropriate clinical governance structures are in place to ensure competence. Once trained, NMPs are able in principle to engage in both supplementary prescribing and independent prescribing; in practice, NMPs often begin as more closely supervised supplementary prescribers, only progressing to independent prescribing if their organisational guidelines allow.

The role of doctors

A designated medical practitioner (DMP) offers clinical supervision during the period of training for the NMP. This involves establishing regular contact with the trainee and planning a learning programme, in order to meet the learning objectives and gain competence. The trainee prescriber will have opportunities to carry out consultation and then discuss with the DMP, enabling the trainee to integrate theory with practice. In this regard, the relationship is not unlike that of trainer and psychiatric trainee. The DMP has a role in assessing and verifying by the end of course that the trainee is competent to assume the prescribing role. Eligibility criteria for becoming a DMP includes at least 3 years' recent clinical experience with a group of patients in the relevant field of practice, support from the employing organisation and experience in teaching or supervision. Hence, the role is not confined to consultants alone. The DMP should normally be working directly with the trainee prescriber where possible (National Prescribing Centre, 2005).

Within supplementary (as opposed to independent) prescribing, the doctor's independent prescriber role is essential in providing the initial assessment, sharing in the drawing up of a clinical management plan and providing review of the patient as necessary. This does not require a broader clinical supervisory relationship with elements of continuing professional development, although this may be voluntarily entered into. The role of doctors in non-medical prescribing beyond the training period is less well-defined for independent prescribers and depends upon the policy of the employing organisation, together with the NMP's own assessment of their training and supervision needs. This does mean that individual prescribers and their organisations can seek substantial medical involvement to support non-medical prescribing and ensure its safety, but this is not part of the statutory requirements for independent prescribers.

Professional and service user attitudes to non-medical prescribing

Much professional debate followed the introduction of non-medical prescribing, focusing on the appropriateness of the role for other disciplines, adequacy of training and safety issues, but little of this has been evidence based. The literature on doctors' views on non-medical prescribing in mental health is particularly sparse. One qualitative study has explored the views of 12 psychiatrists, 11 nurses and 12 patients involved in supplementary prescribing. Overall the response was positive, although 22 participants described their experience so far as 'early days' with nurses still making only limited prescribing decisions (Jones *et al*, 2007). In a 2005 survey of mental health trusts in England examining mental health nurse supplementary prescribing, 66% of nursing directors believed that psychiatrists were not adequately prepared to support non-medical prescribers (Gray *et al*, 2005). A thematic review of non-medical prescribing across specialty areas showed that doctors appeared to be generally unaware of supplementary prescribing. Although they were broadly positive, they had a number of reservations relating to the erosion of doctors' traditional roles, professional hierarchies and safety. Some doctors had a negative view about independent prescribing (Cooper *et al*, 2008), but there is no clear evidence that this finding applies to the mental health field. When surveyed themselves, mental health nurses were positive about the prospects for improved access to medicines and prevention of relapse, but expressed anxiety about their knowledge and skills (Nolan, 2001), identifying needs for further training in practical therapeutics (Hemmingway, 2004).

Both medical and nursing attitudes can act as barriers to trained NMPs taking up their prescriptive authority (Kaas *et al*, 1998). The most frequently cited barrier in relevant literature is the lack of awareness of supplementary prescribing among the public, patients and other health professionals. Other barriers include

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problems obtaining prescription pads, lack of administrative support to run supplementary prescribing clinics and long delays between training and prescribing in practice (Cooper *et al*, 2008). Specifically in mental health, barriers cited include shortfalls in supervision and insufficient focus on redesigning the service to support the role of the non-medical prescriber (Jones *et al*, 2007). Allsop *et al* (2005) states that in her experience, nurse prescribing had received a mixed reception from some pharmacists who both expressed reservations about the skills and competencies of nurse prescribers and appeared to underestimate the level of knowledge and the skills of the nurses in their areas of professional practice.

There has been very little research exploring the opinions or experiences of patients using non-medical prescribing services (Cooper *et al*, 2008). Only one published UK study has addressed this in mental health (Jones *et al*, 2007), with positive responses from users describing better explanations, more choice and greater focus on side-effects, but the sample was small and further research is needed.

Discussion

Non-medical prescribing is rapidly expanding in the NHS. A recent review across specialties quotes figures of 1200 supplementary prescribing qualified pharmacists (Cooper *et al*, 2008). In 2006, only 1% of non-medical prescribers were mental health nurses (Snowden, 2006), but this group is growing. As of March 2008, there are approximately 49 112 nurse prescribers registered with the Nursing and Midwifery Council (NMC) of which 2420 are mental health nurse prescribers (personal communication, NMC, March 2008). Systematic data on the scale of actual prescribing is not in the published domain, but the NHS holds information on community prescribing items through its PACT (prescribing analysis and cost) system, which for instance shows a small but growing rate of psychotropic prescribing by pharmacists (Guillaume, 2008).

Many nurses taking up prescribing responsibilities are very positive about their new roles and quickly perceive benefits, including increased service efficiency and the freeing up of medical time for more complex cases. There are training, supervision and governance needs which must be addressed (Avery & Pringle, 2005) to properly integrate NMPs into comprehensive mental healthcare and ensure their ongoing development. Some courses focus on generic training with little mental health content, and NMPs will need to seek additional training and updates to ensure their competence. Although the issues relating to clinical governance and continuous professional development can be picked up during supervision in supplementary prescribing, this is not as clear-cut for independent prescribing, where legally the non-medical prescriber is on a par with doctors, raising the question of ‘who supervises who?’ There is some reassuring evidence from general medical practice surveys, showing that independent nurse prescribers generally prescribed appropriately when reviewed by medically trained assessors (Latter *et al*, 2005). Although there is no evidence as yet on which to judge the safety of non-medical prescribing in mental health, there is a similar paucity of evidence on the safety of prescribing by psychiatrists themselves.

We argue that as highly skilled and experienced prescribers, psychiatrists owe a duty of professional care to support NMPs and encourage a culture of continuing education for mutual benefit. We are familiar with training young psychiatrists who aid our own development by challenging our received notions. There may be as much to learn from the growing community of NMPs. It is a challenge to make a realistic contribution to the development of our NMP colleagues in the midst of competing demands, including the increased stringencies of workplace-based assessments for psychiatric trainees. Room should be made in specialist job plans for DMP and supplementary prescribing supervisory roles. Employing organisations can bring doctors and NMPs together to ensure best standards of practice, and interdisciplinary continued professional development may be one route to achieving this. Finally, we need to move from perception to reality by evaluating the true benefits and pitfalls of non-medical prescribing; perhaps only then will concerns be addressed and anxieties quelled.

Declaration of interest

None.

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DAVID CROSSLEY AND PETER LEPPING

Role confusion, values-based practice and the demise of the generalist

SUMMARY
As multidisciplinary work becomes less about profession than role and more about specialties than generalism, generalist roles are at risk of being overlooked (from a systemic perspective) and undervalued (from a values-based practice perspective). This article re-examines these issues and points to some practical implications of recovering the generalist role in mental health work.

Whatever happened to the generalist? Healthcare has become increasingly specialised over past decades yet surprisingly little has been written about the demise of generalism in mental health – for example, it gets very little attention in the *New Ways of Working* documentation (Royal College of Psychiatrists *et al*, 2005).

The roles of generalist and specialist have a reciprocal relationship to one another. This article is an attempt to respect (literally to 'look again' at) the idea of generalism as a role (or set of roles). First, roles will be defined as forms of enacted values and then further considered as values that often exist in tension with one another. An example of a value tension is when a service user's need to be protected (because of the consequences of having a mental disorder) comes into conflict with their therapeutic need for personal autonomy and development. We could summarise this tension as safety *v.* growth. This article will explore how this sort of tension can get unhelpfully acted out systemically when the generalist role gets lost within multidisciplinary teams whose specialist members may have different attitudes to treatment approaches (Lepping *et al*, 2004).

Historical context

Besides the irrepressible growth of specialties, a number of other trends are worth noting in the field of contemporary mental health service development. In multidisciplinary teams, the profession of origin of the team member does not exclusively demarcate their skills and competencies. There are considerable and growing overlaps. Sometimes nurses prescribe, doctors use activity schedules, occupational therapists care coordinate. There is general acknowledgement that old hierarchical structures have left consultant psychiatrists with an over-extended set of responsibilities, particularly general adult psychiatrists. *New Ways of Working* (Royal College of Psychiatrists *et al*, 2005) offers ideas to limit this burden (e.g. making consultants more consultative), although tensions may still exist inside teams where there are differential rates of pay status and responsibility.

A second trend that is clearly evident is the tighter level of professional regulation and managerial oversight, especially for doctors. Part of the regulatory approach has been to promulgate best practice based on best evidence (e.g. by the National Institute for Health and Clinical Excellence (www.nice.org.uk)). This is an expression of a desire to have a more standardised approach based on certain values: the attempt to deliver fair, safe and effective treatments while reducing risks of eccentric, unaccountable clinical practice.

Roles and values

It is worth considering from a systemic perspective what effect these trends are having on the consultant role. A

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