Nurse prescribing: the experiences of psychiatric nurses in the United States


Abstract

Aim This study sought to elicit the views of psychiatric nurses in the United States on various aspects of nurse prescribing, with the aim of informing UK nurses about future problems and possible solutions.

Method A survey design with an opportunistic sample of psychiatric nurse clinical specialists was used. The questionnaire consisted of 14 items seeking to elicit information on demographic data, current involvement in medication management, perceptions of the advantages and disadvantages of nurse prescribing, awareness of research about nurse prescribing, accountability and autonomy, and the prescribers' relationship with the pharmaceutical industry. Of the 80 questionnaires distributed, 51 (43 completed by female nurses and eight by male nurses) were returned - a response rate of 64 per cent.

Results The results highlight the many advantages of nurse prescribing, which centre on improving the quality of care for patients; concerns relating to the relationship between nurse prescribers and non-prescribers; and the relationship between nurse prescribers and medical supervisors.

Conclusion Nurse prescribing has advantages for nurses and patients, including enhanced career development opportunities and better quality of patient care. However, though nurses may feel ready for this development, some members of the public may take longer to accept it.

M ENTAL HEALTH nurses throughout the world are making a significant contribution to the health care of increasing numbers of people (Hales 2002). Extensive changes in healthcare delivery and scientific progress related to the treatment of mental health problems offer new role dimensions and expanded scope for mental health nurses. By assuming more advanced roles, nurses are colonising areas of health care that were previously the province of doctors.

Devising systems of care that permit people rapid access to appropriate treatment has been a central objective of recent health policy in the UK (Cumberlege 2003, DoH 1995, Human Rights Ad 1998). Suggesting how this might be achieved, Nazareth et al (1995) and Jordan et al (1999) advise that nurses are ideally placed to improve the speed of healthcare delivery provided that they have up-to-date knowledge of medication. They conclude that all nurses should regard medication management as an essential part of their practice. Addressing the issue of nurse prescribing, Making a Difference (DoH 1999) estimated that 23,500 nurses and health visitors would be able to prescribe in a few years and The NHS Plan (DoH 2000) envisaged that the majority of nurses would be prescribing by 2004. Aldridge (2002) found that patients were highly satisfied with nurse prescribers and valued the advice on self-care they provided.

Gournay and Gray (2001) conclude that mental health nurses have a major contribution to make to improving prescribing and medication management for patients and carers. However, despite enthusiastic policy pronouncements, they argue that there are

Key words

- Nurse prescribing
- Psychiatric nursing
- Research methods

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are real concerns about the quality of training for nurse prescribers, supervision and ongoing professional support.

Focusing particularly on mental health nursing, Maslen et al. (1996) identify psychopharmacology as an area in which nurses are especially weak, while Godin (1996) shows that many mental health nursing courses devote scant time to exploring medication management and the conditions under which medication can be optimised for patients. Emphasising the bias in training, Frank and Kupfer (2000) point out that mental health nursing students are not made aware of the significant advances in psychobiology in the last two decades, while Clark et al. (1997) attribute such omissions to the subjugation of mental health nursing to the general nursing curriculum.

A failure of basic education may be the main reason why some nurses resist involvement in medication management to avoid situations where their ignorance might be exposed (Towers 1999). However, being able to prescribe should not be at the expense of good nursing care (Hales and Dignam 2002). Ashworth et al. (2001) state that the introduction of nurse prescribing could profoundly affect nurses' sense of identity, while Taylor et al. (1999) argue that it could be a means of introducing more uncertainty into what it means to be a nurse.

Despite these and other problems, the potential benefits of mental health nurse prescribing have been acknowledged. Far from reducing nurses to doctors' assistants, nurse prescribing provides an opportunity to improve the quality of care patients receive. Kendrick (2000) argues that nurse prescribers could significantly improve care for depressed patients. The presence of mental health nurse prescribers in primary care could greatly reduce the amount of psychotropic medication prescribed and the number of referrals to secondary care (Barr and Sines 1996, Bower and Sibbald 2000). The integration of the caring and prescribing roles is the best way of ensuring that patients are informed about and helped to understand their treatment regimens (Jorm 2000).

Medication not only deals with the symptoms of a person's condition, but should be part of the totality of care for an individual (Fischer et al. 1999). Moynagh and Worsley (2000) argue that nurses in the UK are set to assume many of the clinical responsibilities currently undertaken by doctors.

Although the evidence base for mental health nurse prescribing is relatively weak in the UK, there is a stronger body of literature in the United States (US). While no direct comparisons can be made between the two countries because of the different nature of their healthcare systems, some valuable insights can be acquired. It is more than 30 years since nurse prescribing was introduced in the US and it is now widely accepted as a means of improving the health care of large numbers of people. In the absence of a national research project, small-scale studies have indicated that nurse prescribers provide care at considerably lower cost than physicians and psychologists while achieving equivalent or better patient outcomes (Saur and Ford 1995), notably for mental health patients (Baradell 1995).

Although the extent and nature of nurse prescribing vary from state to state, US nurses are now assuming responsibility for the treatment and management of many more conditions than was envisaged 30 years ago, for example, cancer, cardiac disease and severe mental illnesses. Many nurses have also extended their scope of practice to patients with multiple disorders. Mundinger et al. (2000) found that patients consider that the quality of their care has improved.

Nurse prescribers in the UK can usefully learn from the American experience in anticipating their impact on mental health services. This study sought to elicit the views of US psychiatric nurses on various aspects of nurse prescribing with the aim of informing UK nurses about future problems and possible solutions.

Method

The study used a survey design with an opportunistic sample derived from a group of psychiatric nurse clinical specialists attending a two-day conference in the state of Colorado, US. Delegates to the conference, which was held in September 2002, were registered psychiatric nurses currently in contact with patients. On arrival at the conference, each delegate was asked to complete a questionnaire anonymously and return it before leaving at the end of the day. The data collection instrument consisted of 14 items. It had been previously piloted with a small sample of psychiatric nurses whose responses to the questions and additional comments shaped the final version. The questionnaire sought to elicit the following information:

- Demographic data.
- Current involvement in medication management.
- Perceptions of the advantages and disadvantages of nurse prescribing.
- Awareness of research in relation to nurse prescribing.
- Issues surrounding accountability and autonomy.
- Prescribers' relationship with the pharmaceutical industry.

The data were analysed by two of the authors (PN and NC) working independently to identify categories. Category agreement was achieved by the process outlined by Denzin and Lincoln (1998). Participants were assured that no identifiers were attached to the questionnaires and all data would be treated anonymously.

Results

Of the 80 questionnaires distributed, 51 (43% completed by female nurses and eight by male nurses)
were returned, giving a response rate of 64 per cent. All respondents were practising in the state of Colorado. Twenty five had prescriptive authority and 26 did not. Most of the respondents with prescriptive authority had had it for only a short period of time – less than one year (n=7), one to two years (n=10), three to four years (n=3) and more than five years (n=5). Respondents worked in different settings reflecting the diversity of employment opportunities available to US nurses, and it was not uncommon for respondents to hold more than one post. The posts they occupied were:

- Clinical nurse specialist in primary private practice (n=10).
- Clinical nurse specialist: quality improvement (n=8).
- Chief operations officer for mental health primary care (n=8).
- Nurse practitioner in family practice (n=7).
- Clinical nurse specialist for jail diversion programme (n=7).
- Clinical nurse specialist psychiatric hospital nurse consultant and liaison (n=6).
- Clinical instructor for nursing students; clinical nurse specialist for children and adolescents (n=5).

**Why respondents chose not to prescribe**

Non-prescribing respondents (n=26; 51 per cent) were asked why they had chosen not to have prescriptive authority. Lack of time for further training, lack of interest and lack of need were commonly cited: 'I practise part-time and have found ways to get medications for my patients. I have not needed prescriptive authority.'

Some respondents felt that having prescriptive authority would increase their work-related stress and some were fearful of increased liability. Greater concerns about nurse prescribing were also voiced: 'I have philosophical concerns about nurses and nursing slipping into the role of “physician extenders”.'

**Advantages of nurse prescribing for patients, doctors and health care**

Respondents were asked what they saw as the advantages of nurse prescribing for patients. Even those nurses who had previously expressed philosophical doubts about nurse prescribing cited advantages. Respondents felt that nurse prescribers would make better decisions than doctors about which drugs to prescribe because they practised holistically: 'I spend more time with patients. I am more holistic in my approach. I think I am more aware of issues that affect compliance and health maintenance issues.' Another commented: 'Nurses do complete assessments and have a terrific background in observing and documenting behaviour.'

Respondents felt that nurses were better able to monitor medication closely because they were more accessible to patients, especially those from deprived backgrounds, and maintained better contact with patients: 'Some patients cannot even get in to see doctors; nurses provide more follow-up and patients seem more comfortable with nurses prescribing, especially the indigent, low-income, children, incarcerated adults etc.'

Other nurses mentioned improved education for patients as an advantage of nurse prescribing: 'Nurses teach more than doctors about medications and their side-effects.'

When respondents were asked what they thought were the advantages of nurse prescribing for health care in general, they repeated their conviction that it provided improved access to care, especially for those who were currently under-served by healthcare services, and that it was cost-effective. Some felt that nurse prescribing would enable a philosophical shift in health care to take place, reaffirming human values and caring – a shift back to human connection in health care.

Many respondents felt that nurse prescribing would necessitate greater collaboration between nurses and doctors, and that the result would be doctors enjoying more support and less pressure, as well as 'decreased caseload; decreased stress; increased multidisciplinary communication; increased patient services'.

Nurse prescribing was felt to be a way of rationalising services, and ensuring that the skills of each profession were directed towards the most appropriate patients: 'Nurses can manage more “routine”, less complicated psychopharmacology very well, and therefore preserve doctors’ time for very complicated medication management.'

**Advantages of nurse prescribing for nurses**

Respondents felt that prescribing added another dimension to their scope of practice, which was 'intellectually stimulating'. It also had benefits in terms of enhancing career pathways and professional development: 'Nurse prescribing is an opportunity to expand and learn, for professional growth and progression.'

Some respondents were aware that nurse prescribing offered the nursing profession a chance to raise its profile and authority in the eyes of the public. They wrote about 'increased public awareness of the nursing profession', of 'empowerment and autonomy.' They also felt that their job satisfaction increased as a result of this 'new application of their skills', and were clear that nurse prescribers could be effective in all healthcare areas. Several respondents noted the benefits of having nurse prescribers working in communities that were ill-served by doctors: 'Nurse prescribers are excellent for small clinics and rural communities where it is difficult to get a doctor.'

**Autonomy, accountability and collaboration**

Eighteen of the nurse prescriber respondents said that they enjoyed total autonomy in their prescribing role, and seven said their autonomy was limited. These limitations were imposed by:

- Needing a collaborator.
- Only being able to prescribe under a physician’s supervision.
Insurance-regulated formulations.
What patients can afford to pay.
Prescription protocols.

Such limitations on their authority could be irksome. Seven of the respondents indicated that they prescribed from a predetermined formulary and 18 said that they did not. Five respondents worked to prescribing protocols and 20 did not.

A question regarding to whom respondents were accountable for their prescribing practice yielded a variety of answers, with one nurse summarising most of these as follows: 'My patients, State Board of Nursing, my employer, my colleagues, my collaborating doctor.'

Several respondents said that they were first and foremost accountable to themselves and to their own ethical codes of practice, and one said that she was accountable to patients' families.

Monitoring of respondents' prescribing practice appeared to be happening in a variety of ways, with some being engaged in frequent consultation about patients with the supervisor physician, while others were much less formally monitored: 'I seek consultation, as I need to.'

For all of the prescribing respondents, collaboration with a medically qualified person was a legal requirement in the state of Colorado. Twelve collaborated with more than one person and 12 with only one (one respondent did not answer this question). Twenty-three respondents had selected their own collaborator and two stated that their collaborator 'came with the job'. All of the collaborators were psychiatrists with the exception of one who was a gerontologist. Meetings between respondents and their collaborators varied in regularity from daily, half an hour a week, a couple of hours a month, yearly and as needed.

Relationship with pharmaceutical companies

The majority of respondents had never received any formal guidance about how nurse prescribers should work with the pharmaceutical industry. A couple mentioned that they had attended seminars which had discussed the ethics of prescribing and one said that she had learned from experience: 'I have learned the hard way that there are benefits - information, financial support for patients - but that there are distinct risks as drug companies are first and foremost sales orientated.'

Nurse contact with the pharmaceutical industry was mainly through drug representatives who were generally welcome to visit whenever they wanted because: 'We are so desperate for samples to keep people on medications that we are not able to set firm limits.'

Representatives provided a variety of services, many of which were valued by the respondents: 'I receive regular visits from drug reps who provide information, samples of medicines and marketing junk. The industry sponsors a lot of educational presentations which are very helpful but can have a marketing bent, so have to be screened well.'

Many nurses said that they had never attended any programme aimed at nurse prescribers. One said she had been to various events, but that they were for any practitioner with prescribing authority and not just for nurses; a few mentioned that they had been to discussion groups where drug-related topics had been considered. Educational seminars and presentations set up by drug representatives were therefore very welcome because there was so little else available.

Fear of litigation

Respondents were asked whether they felt that fear of litigation deterred nurses from becoming prescribers. Three people did not answer this question and the remaining 48 answered as follows; strongly (11), moderate amount (2), only slightly (29), not at all (3) and I don't know (3).

Twenty respondents said that their employers did little or nothing to allay their fears beyond providing malpractice insurance. Some spoke of harassment from employers who wanted nurses to work outside their realm of expertise: 'The reason I am in private practice is because I am afraid an employer would pressure me to go beyond my level of comfort.'

Awareness of research

When asked whether they felt there was evidence to support the claim that nurse prescribing is effective, some respondents were confident that research showed that nurse prescribers consistently produce better patient outcomes, but the general tone was one of uncertainty. Respondents were similarly unsure whether research showed that nurse prescribing enhanced patient satisfaction with treatment, or job satisfaction for nurses.

Criticisms of nurse prescribing

One non-prescriber commented that nurse prescribing: 'Increases prescribers' sense of prestige, power and control, and reduces their anxiety that they are not doing important or beneficial things for mental health clients.'

Several respondents felt that when there was criticism, it was because the role of the nurse prescriber was poorly understood: 'Many disciplines don't understand the role; nor do insurance liability providers, doctors, hospitals, patients and the general public.'

A number of respondents commented that doctors felt threatened by nurse prescribers, both financially and professionally. Doctors who disliked nurse prescribers attacked them on the grounds of insufficient knowledge and clinical experience. While some respondents had previously stated in their questionnaires that patients liked nurse prescribers, one nurse told a different story: 'Our local chapter of the National Alliance for the Mentally Ill is against nurse prescribers. They see this phenomenon as a way of compromising the quality of care given to their family members.'

Another commented on a recent critical article she had read in a health journal which stated: They called us "pseudo-doctors" — the public doesn't know what we do.' Several respondents mentioned...
that nurses could also be hostile to prescribers: ‘Some nurses feel that we have not fully developed our unique skills and expertise and knowledge, and are now spending a lot of time and energy to take on a new task that may well benefit other professions more than nursing.’

**Discussion**

This small-scale study provides some valuable insights into the current state of nurse prescribing in the US, but cannot be seen as necessarily representing the views of all American psychiatric nurses. Nonetheless, the authors believe that by including nurses in the sample who have not sought prescriptive authority, they have elicited a balanced response to the questions asked.

The findings reveal that not all nurses are convinced that nurse prescribing addresses the core problems in health care, nor the vexed questions surrounding how best to get appropriate health care to marginalized groups and those currently poorly served by health services. Some respondents questioned the motivation of prescribers, suggesting that they were principally interested in acquiring the status enjoyed by doctors. However, such criticisms were in the minority, and respondents provided a vigorous rationale to justify the introduction of nurse prescribing, mentioning improved assessment for patients, that nurses spend longer with patients than doctors, and improved education for patients regarding their treatment regimens in general and medication in particular.

The data presented add weight to the claims made by Kendrick (2000) that nurse prescribers improve the quality of care given to patients. Although the study provides no evidence to support the conjectures of Barr and Sines (1996) and Bower and Sibbald (2000) that medication can be reduced by means of nurse prescribing, it does suggest that nurses can and do undertake sole responsibility for supporting many patients through to recovery. As Jorm (2000) observed, and this study confirms, nurse prescribers are highly motivated to ensure that patients are informed about all aspects of their treatment. The data presented also second the findings of Fischer et al (1999) that nurse prescribers focus not just on patients’ symptoms, but are also equally interested in the totality of the individuals in their care and their treatment in the context of their lives. Nurse prescribing opens up new opportunities for research that cross the divide between medically and caring oriented studies.

The present study raises important issues for UK nurses regarding which medical colleagues they should liaise with, and on what terms. Nurses need to be clear whether the relationship is one of equals or one of subservience to a colleague with more developed skills in an area to which they are new. Professional bodies might also usefully consider how nurses can protect themselves and patients if their assessment of the medication required is in conflict with what their medical colleague or supervisor recommends.

It would appear that US nurses prescribe for a variety of mental health problems. In contrast, in the UK it is not clear whether nurses will prescribe for all patient groups or be confined to a specific diagnostic group. Equally it is not clear whether there will be National Institute for Clinical Excellence or National Institute for Mental Health in England guidance for nurses, and to what extent these organisations will get involved in nurse prescribing. The issue of professional support is an important one and raises concerns about who should provide it or whether or not it should be left to nurses themselves (Gournay and Gray 2001).

Similarly, thought needs to be given to how nurse prescribers will relate to and manage drug companies. This is a potentially useful but also uneasy alliance, where prescribers can benefit in terms of information being made available to them, but must also exercise caution and discrimination in assessing to what extent that information is selective and/or biased.

Fear of litigation was expressed by the majority of the US sample (n=42), and is bound to be an issue for nurse prescribers in the UK. It is vital that nurses feel they will have the support of management and professional bodies if the need arises. Unless this is the case, it will be difficult to entice nurses to be prescribers and their prescribing will be determined not by what may be best for patients, but by seeking to expose themselves to as little risk of litigation as possible. It would be helpful to nurse prescribers in allaying their fears if nurses were to be made more aware of the evidence that nurse prescribing is effective. A better and broader understanding of the research would help nurses to feel more confident to be autonomous practitioners in the realm of prescribing.

The lengthy responses to the final item on the questionnaire regarding current difficulties with nurse prescribing indicate that nurse prescribers in the US are still fighting to establish themselves as safe and effective practitioners. The public is not wholly convinced of nurses’ knowledge and skills to prescribe, and there remains considerable concern in nursing and medical circles about the blurring of professional boundaries. In the UK, there will need to be a programme of educating the public to accept, trust and value nurses as prescribers and it is the responsibility of both government and the professional organisations to undertake this, and to monitor its effectiveness.

**Conclusion**

The evidence presented in this study strongly suggests that nurse prescribing has considerable advantages for nurses and patients, not the least
of which are enhanced career development opportunities and better quality of patient care. However, key issues must be addressed, and these include the extent to which prescribing may drive a wedge into the nursing profession, placing prescribers and non-prescribers in opposing camps; the relationship between and perceived equality of supplementary and independent nurse prescribers; and most importantly, the nature, extent and accessibility of education and training for those who choose to become prescribers.

It is also of concern that those who acquire the right to prescribe may be seen as belonging to a separate therapeutic camp from the more psychologically orientated interventions which the nurse may use, thus militating against a holistic approach to care.

Finally, it may take some time for good mentoring systems to develop and in the intervening period, nurses may elect to seek educational updates from pharmaceutical companies, something which the medical profession may have been happy with in the past but nursing may not be. In all of these areas, there are valuable lessons that can be learnt from the experience of nurses in the US, and it is to be hoped that UK nurses are sufficiently astute to incorporate these into their deliberations and learn from them.

Implications for practice

- Nurse prescribers offer nurses opportunities for enhanced career development
- The nursing profession must ensure that nurse prescribers are not seen as elitist
- Nursing must continue to value socially orientated interventions
- UK nurses must learn from the experiences of their colleagues in the US

REFERENCES


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