**National Survey of Nurse Prescribing in Mental Health Services;**

**a follow up six years on.**

**Introduction**

This paper describes the process and outcomes from a national survey of nurse prescribing in mental health Trust across England in 2014, and follows on from two previous surveys – in 2005 (Brimblecombe et al. 2005; Gray et al. 2005) and 2008 (Dobel-Ober *et al.* 2010). The two previous surveys both showed great variability between organisations as to uptake of nurse prescribing, although there was a large proportional increase in total numbers of nurse prescribers identified between 2004 and 2008. In 2008, the majority of prescribers were supplementary prescribers, prescribing within the limits of a medically defined plan, rather than independent prescribers.

NP provides a useful case study of the challenges of developing, introducing and sustaining new roles and models in mental health services, particularly where such changes mark deviation from traditional role boundaries of specific professions (Brimblecombe 2005). This article reports the current position and provides a detailed insight into the nature of the spread of nurse prescribing in mental health settings over a ten year period. It provides information regarding patterns of development and usage that may be of particular value in those countries currently developing similar roles.

Nurse prescribing has spread massively since its introduction to the UK with pilot schemes for community nurses in 1994 (Luker *et al.* 1998). It has since progressively developed in scope and in the number of prescribers. Generally, the breadth of the model of prescribing in the UK is wider than in the rest of the world. As well as within the UK, NP has been advancing in other countries including Australia (Fisher 2005), New Zealand (Hughes & Lockyer 2004) and the USA where nurse practitioners have been prescribing for four decades (Cipher *et al*. 2006), although different models exist across individual states. In 2011 Kroezen *et al*. (2011) reported that seven Western European and Anglo-Saxon countries had implemented nurse prescribing of medicines: Australia, Canada, Ireland, New Zealand, Sweden, the UK and the USA. Since that time Finland, the Netherlands and Spain have also now introduced models of NP. To date, there is no summative published evidence as the number or proportion of nurses prescribing in mental health settings internationally and how their levels of prescribing activities compare with medical practitioners’.

Prescribing opportunities for mental health nurses (MHNs) were made available later in the UK than for most other nursing specialities. The introduction of supplementary prescribing (SP) in April 2003 represented the first specific opportunity for MHNs to prescribe. Nurse SP is a voluntary partnership between an independent prescriber (a doctor) and a NP to implement an agreed patient-specific clinical management plan (Department of Health 2005). If appropriate, and indicated in the clinical management plan, a supplementary prescriber can prescribe repeat prescriptions, adjust dosage, switch and stop medicines (Department of Health 2006).

Since May 2006, it has become possible for MHNs to become independent prescribers (IP), i.e. to diagnose and prescribe medicines without the direct involvement of a medical practitioner. In 2011, a government commissioned evaluation of IP by nurses across a range of health specialities (not specifically mental health) concluded that, overall, nurse and pharmacist prescribing is currently safe and clinically appropriate (Latter *et al.* 2011). From 2012, NPs have been able to prescribe controlled drugs (Department of Health 2012) with consequent implications for potential new roles in substance misuse services (Public Health England 2014).

In order to be able to legally prescribe (supplementary or independent), registered nurses in the UK are required to attend a generic 26-day university-based training programme and undergo a period of supervised practice with an experienced doctor (Nursing and Midwifery Council 2003). Nurses must ensure that prescribing practice remains within their area of competence and the limits of their knowledge (Department of Health 2007) and must be supported to prescribe by their employers. Take up of the prescribing role is, therefore, dependent on organisational ownership and support.

Nationally, programmes of work have taken place to improve mental health services by creating new roles and developing new skills (Department of Health 2007). It was envisaged that nurse prescribing could contribute to this agenda in the following ways:

• enable redesign and streamlining of mental health services;

• increase service user access to medicines;

• improve information and education provided to service users;

• address difficulties with concordance and adherence.

Research evidencing that NP is safe and therapeutic specifically in mental health settings has lagged behind service developments. Only one empirical study has been conducted to date comparing outcomes between those patients treated by nurses using supplementary prescribing and those treated by psychiatrists (Norman *et al.* 2010). All participants in this study had a diagnosis of psychosis. Medication adherence, the primary outcome measures was equivocal across all participants. Participants treated by NPs were more satisfied with their treatment by health care services generally. No differences in clinical or cost outcomes were elicited. Jones *et al.* (2007) have reported positive views of service users to the idea of NP in a small scale qualitative study. Ross et al (2014) carried out interviews and focus groups with 57 key stakeholders. The researchers concluded that nurse prescribing was well received by service users who had experienced it; service users valued the continuity of care offered by nurse prescribers who were also involved in their therapeutic treatment.

To date, a number of barriers to the introduction of NP have been identified, including:

• generic prescribing training course which does not meet the needs of MHNs (Skingsley *et al*. 2006);

• support during and after training (Bradley *et al*. 2008);

• concerns about keeping prescribing practice within competency (Bradley *et al*.

2007).

**Aims**

The aims of the survey were to collect information about the numbers of mental health nurse prescribers currently working in mental health Trusts in England and to monitor developments in this area; to monitor changes in governance and strategic approaches; to gather views from NP leads about structures and sources of support for mental health nurse prescribing; and to elicit future intentions with regard to the development of NP.

**Methods**

A mixed methods questionnaire (i.e. including both open and closed questions) was designed specifically for this project. Some of the questions replicated those used in two previous surveys of NP activity (Gray *et al*. 2005; Dobel-Ober *et al*. 2010) in order to allow comparison of data.

The questionnaire included 16 questions and 1 table (collating numbers of NP by area of practice, status and level of activity); questions were grouped under 4 main headings: Your organisation, Strategic development, Workforce development, and Governance). Each question included a range of fixed choice answer (e.g. Do you have any strategies to promote transition from supplementary to independent prescribing? Formal strategies: Yes / No; Informal strategies: Yes / No); 13 questions also included space for additional comments and information in free text to specify their response or describe process in more depth. Respondents were also asked to use an empty page to add any information about barriers to implementation, examples of good practice and areas where NP had been particularly effective. The Questionnaire is available from the corresponding author on request.

Directors of Nursing were selected as the most appropriate group of respondents because they have access to strategic information, are likely to have a significant role in NP implementation, should have access to the views of NP in their trust, and were the respondents for the earlier surveys of NP activity.

Fifty-three Trusts providing mental health services in England were identified and contacted. This was a smaller number than in previous surveys, due to the merging of some organisations over the last few years.

The data collection period ran for approximately six months in 2014. Postal questionnaires were addressed personally to Directors of Nursing. An information sheet and freepost envelope for return of the questionnaire was included with the questionnaire package. Formal reminder letters and emails were sent after 6 and 12 weeks respectively. Directors of nursing were also reminded informally (phone or email) about the survey via personal communication where there were further delays in response.

The process was not anonymous, but confidentiality was guaranteed. Consent to participate in the study was assumed with return of the questionnaire, so a separate consent form was not included with the questionnaire package.

Quantitative data were entered into SPSS (V17) before carrying out descriptive statistics. All qualitative data were entered into NVivo8 and analysed using thematic content analysis (Miles & Huberman 1994); this approach to qualitative data analysis allowed identifying and considering themes emerging through whole questionnaires rather than within individual questions only.

**Findings**

***Current number of nurse prescribers***

Re-organisations in the NHS have led to significant changes in the number and sizes of organisations providing mental health care in England; this has made it complex to monitor the development of NP.

Table 1 shows that the number of Trusts identified as providing mental health services has reduced between previous and present surveys, whereas the average number of mental health nurses (MHNs) working in responding trusts has increased (n=659 in 2008; n=840 in 2014); this reflects mergers of provider units in the sector.

[Table 1 here]

Amongst the responding trusts in 2014, 16 had also provided a full set of responses in 2008 and had not merged with other organisations and therefore, provide a good basis for direct comparison. In this sub-sample, the average number of MHNs employed in these 16 trusts went down from 904 to 852

[Table 2 here]

Over the last 6 years, the mean number of trained NPs has increased by 19 per trust amongst all responding organisations and by 21 amongst the more stable sub-sample.

The distribution of NPs was extremely varied across organisations, with the number of trained NPs ranging from 3 to 146.

[Figure 1 here]

The overall proportion of trained but non-active NPs went down from 28% (n=166) in 2008 to 23% (n=256) in 2014.

***Area of practice and prescribing status***

The 2005 survey provided a breakdown of the number of active NPs within 7 main clinical areas. The 2014 study included additional categories based on information received regarding other areas of practice.

Table 3 includes the original 7 categories and provides direct comparison between successive surveys. Despite the overall increase in the number of NPs, the general distribution has remained relatively constant. Community mental health teams (CMHT) remain the service making the largest use of NP with nearly a third of all NPs. Since 2005, the proportion of NPs working in older people community services has reduced by 6 percentage points whilst it has increased by the same number in drugs & alcohol (substance misuse) services.

[Table 3 here]

Figure 2 displays information from the additional service categories included in the 2008 and 2014 surveys. It reveals that the vast majority of prescribers (76%, n=623) are now working independently; compared to 2008, when 75% (n=267) of NPs were supplementary only. CAMHS and older people community services are the two areas where over a third of active NPs have maintained supplementary status only. Twelve trusts indicated that all their NPs were independent.

[Figure 2 here]

***Strategic development***

*Identifying NP roles*

The vast majority of respondents (n=29, 74%) indicated that their organisation had formal policies or processes to identify roles that would benefit from the inclusion of NP. Organisations without formal policies had fewer trained NPs (mean=29.6, SD=14.7) than the others (mean=36.8, SD=32.1). Relatively few organisations provided detailed information about actual policies and processes. Amongst those that did, half of the organisations (n=15) seemed to have integrated NP into processes of service re-design.

*‘We have a comprehensive programme of strategic business planning; as part of this, there is explicit requirement to consider new roles as part of strategic and business plans. NMP is specifically referenced as potential for new roles.’*

In 5 other cases, the formal processes or policies related to governance and approval of individual candidates for training, rather than for actual NP roles; a further 3 respondents described a process driven by individual teams or services:

*‘We have a number of* [training] *places and then a process whereby nurses are asked to identify: improvements in patients’ outcomes; impact on service delivery in terms of productivity & efficiency.’*

*Embedding NP roles*

Over three-quarters of respondents (n=30, 77%) indicated that job descriptions were routinely amended in their organisation to reflect NP practice in a role. However, 22 organisations (58% of respondents) reported evaluating each case individually or only including NP qualification as a desirable criterion when recruiting to a position vacated by a NP.

***Governance***

*Non-medical Prescribing (NMP) Lead*

All responding trusts had a senior staff member as NMP lead; post holders generally had a nursing background, excepting four instances where the role was held by pharmacists. The majority of NMP leads (62%, n=24) dedicate less than 1 day a week to the role; the role is full-time in two trusts.

*Register*

All trusts reported having a local NP register but the amount of information kept by each organisation varied widely. The most complex registers included detailed information about qualifications, professional registration, continued professional development (CPD), access to support and supervision, scope of practice, portfolio and audit of practice.

Criteria to remain on local registers are extremely varied. Five organisations provided no information at all, which may reflect a lack of clarity in this area. The lowest requirements for remaining on the register were described by 3 respondents who indicated that staff would remain on the register as long as they are employed by the Trust; a further 5 respondents indicated that staff only need to be currently prescribing in order to maintain their registration. The remaining 26 organisations use various combinations of criteria (Table 4); CPD was the most common criteria, and requirements varied from ‘*evidence of CPD*’ to more clearly defined standards such as ‘*attendance to at least two approved events*’ or ‘*a minimum of 12 hours/year*’.

[Table 4 here]

*Terminology issues*

Fifteen respondents indicated that the *active status* of each NP was either recorded on the register or used as a criterion for remaining on the register. Overall, 21 respondents indicated that their organisation had an operational definition of *active prescriber* but only 5 provided a clearly operationalised definition.

All 5 definitions were based on writing at least one prescription over a specific period of time (once every 3 months, n=2; every 12 months, n=1; monthly, n=1; or weekly, n=1). Two other respondents specified that providing advice and guidance could be considered as active prescribing.

*‘Where no prescription has occurred they must supply evidence of how they are continuing to use their prescribing skills and knowledge.’*

*‘Not written in any policy but an understanding that advice and guidance given in a change of prescription can be seen as active prescribing; does not always involve putting pen to paper.’*

Out of the 5 organisations stating that being an active prescriber was the unique criteria for remaining on the local register, only 2 had a clearly operationalised definition of *active prescribing*. The other 3 described a somewhat circular argument by defining an active prescriber as someone who is on the register whilst also requiring to be actively prescribing in order to be on the register.

***Workforce development***

*Identifying and selecting candidates for NP training*

Several Trusts have set additional training requirements before allowing candidates to undertake NP training; such training includes: medication management (n=4), diagnosis and assessment (n=3), numeracy skills (n=4), psycho pharmacology (n=5). One organisation expected candidates to have studied at academic level 6 (i.e. graduate level) in the last 2 years to make sure they are prepared for the demands of the course.

*Continued professional development*

The vast majority of respondents (87%, n=34) indicated that they had a formal programme of CPD in place. Table 5 presents key CPD elements provided; NPs are expecting to attend regular forums in 15 organisations; the occurrence of such forums vary from annual to monthly in different Trusts. Five respondents stated that education sessions are provided by higher education institutions. Eight Trusts expect NPs to attend a local annual conference.

[Table 5 here]

*Transition from supplementary to independent prescribing*

Most organisations indicated that they had either formal (n=17, 44%) or informal (n=14, 36%) strategies to support transition from SP to IP (Table 6). A common strategy requires NPs to prescribe by supplementary processes for a minimum period of time before gaining independent status; this varies between 6 and 12 months. The other most common strategy is to provide mentorship for NPs when they start prescribing independently; NPs become truly independent once they have completed this mentorship period.

[Table 6 here]

One respondent specified that no transition strategies were in place because all NPs in the Trust are expected to prescribe independently from the start: once qualified, NPs define their scope of practice with their supervisor and identify developmental needs; this Trust also maintains a directory of who needs to be under the supervision of a consultant and who can prescribe off-licence medications (in this context, *off-licence* or *off-label* refers to prescribing a medicine which product licence does not cover the indication for which it is being prescribed) .

*Career progression and remuneration*

Most respondents (64%, n=25) expected NPs to be employed in a post at Band 6 (This is a level of NHS pay scales that is received by the majority of mental health community nurses as well as junior ward sisters/charge nurses in inpatient care settings). The survey found that employment at a minimum level of Band 6 for NPs was clearly stated policy in 16 cases; in 9 other cases, there was no strict policy but, all NPs were expected to be at least in a Band 6 post in all but exceptional cases:

*‘I would be very reluctant to have anyone below B6* [Band 6]. *The circumstances would need to be truly exceptional, e.g. previous NP who is in a step-down role after retirement.’*

Nine other respondents stated that approval to train and prescribe were based on

skills and experience rather than banding:

*‘Training and practice are based on service need, competence and skills and not grade.’*

Finally, one Trust requires supplementary prescribers to be at Band 6, whilst independent prescribers need to be at Band 7.

Only 2 organisations reported providing a specific pay award for being an NP: one of them stated that remuneration reflected the number of prescriptions written (no further information provided); the other Trust had negotiated an agreement with commissioners for one service (substance misuse) where NPs are paid at Band 7 to provide an incentive and reflect their level of responsibility. Another organisation was considering offering an annual retainer or a sessional payment for NP running clinics (e.g. memory clinics).

Most trusts indicated having no direct link between NP and career progression; only 2 reported a link: in both cases, candidates to senior nursing roles (e.g. clinical nurse specialist, nurse consultant or advanced practitioner) were expected to be active NPs.

**Discussion**

This survey follows two similar projects undertaken in 2005 (Gray *et al*. 2005) and 2008 (Dobel-Ober *et al*. 2010); it demonstrates a continued increase in the number of trained NPs in mental health services in England. This development is however not taking place consistently across all Trusts. In a small number of organisations, NP seems to have been implemented on a large scale, whilst in others it has remained a role for just a few individuals, led by individual nurses with a personal interest in developing their practice.

Increasing variations in the use of NP between Trusts may lead to significant differences in the care experience of service users in various geographical areas. There is also a differential effect on the workforce; with some nurses expected to routinely integrate prescribing to their practice in some Trusts, whilst this remains the domain of medical practitioners and of a minority of nurse specialists in other organisations.

The response rate to this survey (75%, n=39) was higher than for previous ones. This may have been a result of the informal processes used to improve initial non response and/or simply that more Trusts had a greater population of nurse prescribers and had more information to contribute.

CMHTs, Drug /Alcohol services and Older People Community services remain the areas employing most NPs. A growth in NP in Drug/Alcohol services appears to be directly related to the removal of some restrictions on the use of controlled drugs by independent non-medical prescriber (Home Office, 2012). It is likely that the true level of NP in Substance Misuse services is underestimated in this current survey as the changing provision of Substance Misuse services from NHS to independent sector providers makes it likely that this survey would miss many NPs in the sector (Mundt-Leach and Atkinson 2014).Crisis Resolution & Home Treatment (CRHT) also increased their use of NP in the last 6 years. Services with short periods of treatment such as CRHT are unlikely to be able to make major use of SP arrangements, so the growth in IP offers a more responsive approach in this context.

Indeed, one of the most striking findings emerging from his survey is the development of independent over supplementary prescribing. In 2008, only 25% of NPs were independent against 76% in 2014; this change is apparent in all clinical areas. Nearly one in three responding Trusts also indicated that all their NPs were independent. The 2008 survey reported that respondents were significantly more likely to rate IP as more useful than SP in the majority of areas of practice (Dobel-Ober et al 2010). This view has now been translated into practice.

Governance arrangements for NP seem to have been strengthened significantly. In 2008, 21% of responding Trusts had no strategies in place to audit, register or support NP; in 2014, every organisation surveyed had a dedicated NMP lead, maintained a register, and the vast majority provided a formal CPD programme despite the diverse numbers of NPs employed in each Trust (varying from 3 to 146). NPs working in Trusts with no formal CPD may require to access events delivered by other organisations in order to meet the requirements for revalidation of their professional registration.

The 2008 survey found little evidence of formal strategies to maximize the expansion of NP; development often seemed to occur on an ad hoc basis, under the leadership of individual nurses who expressed a personal interest in prescribing. An increasing number of Trusts now seem to be applying a more strategic approach, often integrating implementation to service re-design. However, in half the organisations surveyed, needs for NP were still identified at service or team level, or by individual nurses themselves.

Very few Trusts have a clear definition of *active prescriber,* despite the fact that this is often described as key criteria to maintain staff on local NP registers. Non-active NPs are likely to be under-reported and although their proportion has reduced slightly, it remains an issue.

Despite the significant growth of NP in many organisations, links between prescribing and career progression or remuneration are weak. Being a prescriber is a condition to advancement in some cases, an essential part of some senior roles, but is not in itself sufficient to progress a career. This may be significant if it suggests that organisations see NP as one amongst several skills that nurses may need to possess, rather than being a nurse’s *main* role.

Overall, NP is still a minority practice in mental health nursing. This survey suggests that 4.2% of MHNs are trained to prescribe (in those Trusts providing sufficient data) and although NP has the potential to positively change ways of working and delivering care, it has not been embraced universally. There is currently little definitive evidence regarding clinical outcomes and financial value from NP. This lack of evidence may have helped to stall development in organisations facing significant financial pressure: the initial investment in training and support structure for a relatively unproven practice might have been considered too much of a risk.

The authors of the 2008 survey (Dobel-Ober et al 2010) concluded that NP may have been at a crossroads, with Trusts opting to prioritise the development of either independent or supplementary prescribing. Recent developments seem to indicate that IP is currently the main direction of travel for most Trusts actively promoting NP.

Although the acceptability of NP in mental health settings to service users has been increasingly well evidenced (Jones et al. 2007; Norman et al 2010; Ross et al 2014) it is noteworthy that since the last survey in 2008 no significant new research has provided evidence as to issues of the safety, effectiveness and cost of independent NP in this setting. A future research priority is to address this lack of knowledge, in the context of which, both nurses and medical practitioners are reported as seeing both potential benefits in NP and risks as well (Devane & Leahy-Warren 2015 ; Earle *et al.* 2011; Gumber *et al.* 2012). With the large scale growth of NP in several Trusts in England, these services have also now reached a scale that may provide opportunities for researchers to undertake comparative studies of different care delivery systems with and without NPs, as well as looking at outcomes with individual practitioners. It would also be of great interest to track the development of non-medical prescribing within other professions (e.g. pharmacists or occupational therapists) and get a better understanding of its impact on service delivery and patient’s experience.

This study confirms international evidence that the introduction of nurse prescribing can present difficulties and take many years to reach numbers which can make a major difference to service delivery models (Fisher 2005; Chaston and Seccombe 2009; McBrien 2015). The conditions under which nurses prescribe medicines vary considerably, from countries where nurses prescribe independently to countries in which prescribing by nurses is only allowed under strict conditions and the supervision of physicians (Kroezen et al 2012). This current survey confirms other perceptions that the model of nurse prescribing adopted is liable to influence its applicability in different clinical settings (Fisher 2005). This survey also reveals that there has been a stark change in the type of non-medical prescribing practiced by mental health nurses in England: in most services, organisations find Independent Prescribing more appropriate as a model than Supplementary Prescribing, where nurse prescribing takes place only within the parameters laid out initially by a medical practitioner; Independent Prescribing has gradually transitioned from a minority to a majority practice amongst mental health nurse prescribers. Organisations employing the highest number of nurse prescribers are also those making the highest and sometime exclusive use of Independent Prescribing.

**Conclusions**

Nurse prescribing continues to grow in mental health organisations although is still characterised by wide variations in the level of usage. Such variation is likely to continue in the absence of a definitive evidence base demonstrating clear advantages of nurse prescribing either in terms of clinical, experiential or financial outcomes.

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Table 1: Mental Health Nurses and Nurse Prescribers (all responding trusts)

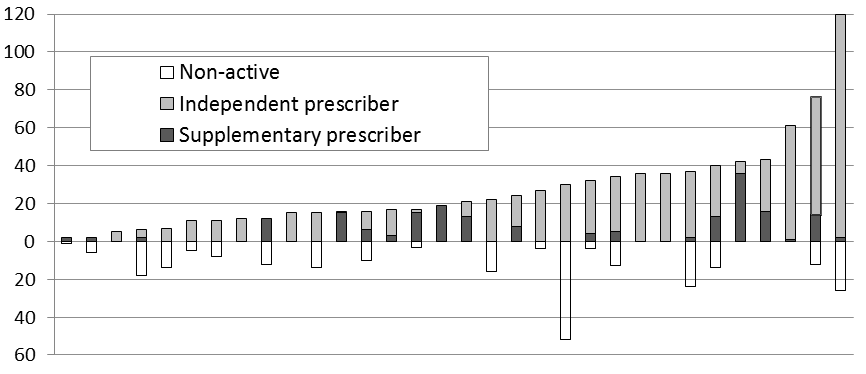
|  |  |  |  |
| --- | --- | --- | --- |
|  | 2005 | 2008 | 2014 |
| Trusts providing MH services in England | 83 | 66 | 52 |
| Responding Trusts (response rate) | 45 (54%) | 39 (59%) | 39 (75%) |
| MHN (mean per Trust)\* | 524 | 659 | 840 |
| Mean number trained NPs\*\* | 4.0 *(0.8%)* | 15.9 *(2.4%)* | 35.0(*4.2%)* |
| Active NPs\*\*(mean) | 1.8 | 11.5 | 27 |
| NPs in training | 2.4 | 3.2 | 4.2 |

Table 2: Mental Health Nurses and Nurse Prescribers (16 trusts who responded to survey in 2008 and 2014)

|  |  |  |
| --- | --- | --- |
|  | 2008 | 2014 |
| MHNs\* | 904 | 852 |
| Trained NPs\* | 15.1 *(1.7%)* | 36.1 *(4.3%)* |
| In training\* | 5.1 | 4.7 |

\* Mean per trust, head count *(average % of NP trained*)

Figure 1: Nurse prescribers by status in each Trust (frequencies)\*



\*Full set of data available for 32 Trusts

Table 3: Number of mental health nurse prescribers by service setting (2005, 2008 & 2014)

|  |  |  |  |
| --- | --- | --- | --- |
| *Service type* | *Frequency (and % of total) of MHN prescribers* | | |
| **2005** | **2008\*** | **2014** |
| CMHT | 61 (*29%*) | 97 (*27%*) | 243 (30*%*) |
| Older people community | 42 (*20%*) | 53 (*15%*) | 113 (14*%*) |
| Drugs and alcohol | 29 (*14%*) | 67 (*19%*) | 163 (20*%*) |
| Assertive outreach teams | 18 (*8%*) | 25 (*7%*) | 44 (5*%*) |
| Crisis/home treatment | 12 (*6%*) | 26 (*7%*) | 66 (8*%*) |
| Acute inpatient | 8 (*4%*) | 17 (*5%*) | 31 (4*%*) |
| Older people inpatient | 8 (*4%*) | 12 (*3%*) | 30 (4*%*) |
| Other | 35 (*16%*) | 59 (*17%*) | 127(16*%*) |
| **Total** | **213** | **356** | **817** |

\*Information only available for 356 out of 437 prescribers.

Figure 2: Distribution of NPs by status and service in 2008 (left) and 2014 (right)

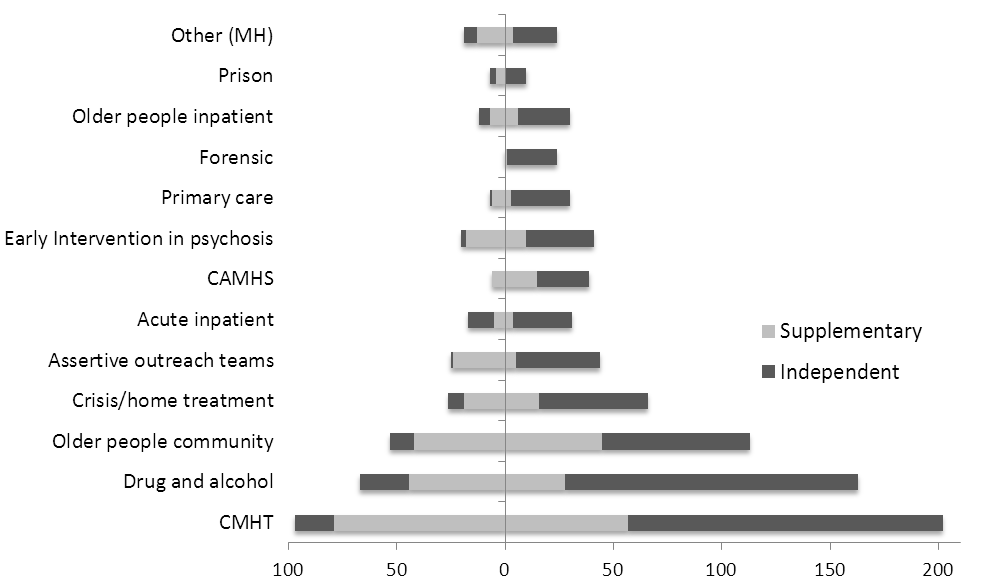


Table 4: Criteria to remain on register (number of organisations)

|  |  |
| --- | --- |
| Evidence of CPD | 15 |
| Active status | 10 |
| Receives clinical supervision | 9 |
| NMC registration | 8 |
| Submit scope of practice | 7 |
| Employed by Trust | 5 |
| Regular audit | 5 |
| Annual competency framework | 2 |
| In a clinical role | 2 |
| Portfolio | 2 |

Table 5: Elements of CPD provided (number of organisations)

|  |  |
| --- | --- |
| Forum | 15 |
| Education sessions | 11 |
| Local conference | 8 |
| Group supervision | 5 |
| Competency framework | 3 |
| Portfolio / audit of practice | 3 |

Table 6: Key strategies to promote transition from SP to IP

|  |  |
| --- | --- |
| 6 to 12 months SP practice | 8 |
| Probationary period IP with mentorship | 8 |
| Individual review | 6 |
| Formal competency assessment | 2 |
| Individual formulary | 2 |
| Psychopharmacology course | 1 |
| Minimum number of prescriptions & competency review | 1 |