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Prescribing by mental health nurses: Scripting the issues in the United Kingdom
The UK Perspective

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Purpose. To discuss the growth of mental health nurse (MHN) prescribing in the United Kingdom as an exemplar for readers to compare progress in their own countries and context.

Structure. Provide historical overview and reasons why nurse prescribing has developed and, specifically, relate this to MHNs' practice. Establish the requirement for MHNs to prescribe safely and competently in the United Kingdom. Compare the United Kingdom with other countries' developments and specifically the United States.

Conclusions/Practice Implications. Finally, evidence has shown that MHNs with prescriptive authority are competent when prescribing as compared to psychiatrists. Despite organizational barriers and educational concerns MHN prescribing is becoming embedded in the healthcare context in the United Kingdom.

Search terms: Mental health nursing, nurse prescribing, United Kingdom

Prescribing by mental health nurses (MHNs) was first introduced in 2001 in the United Kingdom. Since that time approximately 10,000 nurses have undertaken educational programmes that allow them to act as independent or supplementary prescribers; however, the current estimate is that only 1000 MHNs have completed programmes, representing less than 3% of the workforce in the United Kingdom (**Snowden** 2008). In the United Kingdom, prescribing programmes are closely regulated and are required to include 27 days of theoretical input at undergraduate level 3 (equivalent to the final year level of a baccalaureate degree) with a minimum

of 12 days supervised practise by a medical practitioner (National Prescribing Centre, the National Institute for Mental Health in England, and the Department of Health [NPC], 2005). On successful completion of both elements, the MHN can potentially prescribe any drug from the British National Formulary (BNF).

The number of nurse prescribers has very recently increased exponentially after a relatively low level of uptake of programmes in the early 2000s. Government support for national implementation in mental health was published (NPC, 2005). This was followed swiftly as one of the key roles identified in the recent Chief Nursing Officer's (England) review for MHNs to truly make a difference to care delivery (Department of Health [DH] 2006a, 2007). There is now growing evidence of increased prescribing activity by MHNs (Grant, Page, & Maybury, 2006; Hemingway & Harris, 2006; Jones & Jones, 2007; Norman et al., 2007; Wix, 2007). Despite the momentum behind prescribing, some commentators continue to question the efficacy of this development. These include doubts that MHNs in the United Kingdom are educated to a level that will underpin competent and safe prescribing, concerns that the programmes (27 theory and 12 days of clinical supervision placement) are insufficient to prepare a nurse prescriber, and the understanding that the relationship between numbers of nurse prescribers and improved service provision for the service user has yet to be established (NPC, 2005).

This article will provide an overview of the brief history of nurse prescribing in the United Kingdom and discuss the issues driving its development. Then issues associated with the law, safety, and competency will be explored. A comparison of MHN prescribing in the United Kingdom with the rest of the world, but specifically the United States, will be offered, followed by a discussion of the future direction of MHN prescribing in the United Kingdom.

MHNs and Their Role in Prescribing Psychotropic Medication

MHNs in the United Kingdom have always played a major role in the delivery of physical treatments, but this has traditionally been under the direction of the medical superintendent (Nolan, 1993). Asylum attendants, the Victorian predecessors of MHNs, exercised considerable autonomy in determining which treatments to utilise when faced with severely disturbed patients. Although in many cases appropriate decisions about use of medical treatments may have been made by *asylum* nurses up to the 1960s, reports of the care of the mentally ill are littered with scandals concerning the abuse of patients and an emphasis on control rather than care. The emergence of treatments for symptoms of many of the major mental illnesses, such as depression, schizophrenia, bi-polar affective disorder, and anxiety, in the 1950s changed the face of mental health care in the United Kingdom and advanced the eminence of the psychiatrist (Rogers & Pilgrim, 2001), with the now professionally recognised and registered MHN administering these new treatments. This also offered the opportunity that those experiencing mental health problems could be seen by a doctor, diagnosed and prescribed medication that enabled them to remain at home and avoid becoming a long-term institutionalised hospital patient. Alongside advances in treatment, came the championing of community as a way for mental health care to be located in society rather than hidden away in the asylums (Rogers & Pilgrim).

Although it took a further 4 decades to develop the more comprehensive inpatient *and* community-based specialist services found today, the MHNs who emerged from the asylum system have, by necessity, had to adapt to primary care as the prime context of care. This led to the emergence of community psychiatric nurses (CPNs) who could work more autonomously with service users to manage their

problems in the home setting, liaising as appropriate with other service providers (e.g., social services, housing, etc.) in order to support care in the community (Nolan, 1993).

Within these new roles, CPNs played a significant role in prescribing decisions, although frequently in the absence of specific training post-qualification, particularly about psychotropic medication. This was evident in primary-care liaison with general practitioners (GPs) and in discussions with junior doctors (Gournay & Gray, 2001; Ramcharan Hemingway, & Flowers, 2001). For example, Ramcharan et al. found CPNs were consulted by GPs in an advisory capacity on what psychotropic medication was appropriate to prescribe for the service user. This prescribing activity, known as *defacto* or *proxy* prescribing was unauthorised, with no legal endorsement. Given the shift to primary care as the chief location for mental health services and the availability of a mental health workforce in place, a rational and natural development was for the proxy role to be formalised. This state, coupled with a national shortage of psychiatrists, proved an economic alternative and one that offered greater prescribing choice and flexibility for people with mental illnesses (NPC, 2005).

The non-medical prescribing (NMP) initiative began in the United Kingdom with nurse, midwife, and health visiting prescribing. Humphries and Green (2002) noted that as far back as 1980 the U.K. Royal College of Nursing was advocating registered nurses should be allowed to prescribe medicines. However it was not until the publication of the Cumberlege Report in 1986 that it first achieved Government policy status (Department of Health & Social Security, 1986). The conservative government of the time was keen to increase care in the community (DH, 1989a); Cumberlege, in preparation, was asked to investigate how the role and responsibilities of *neighbourhood nurses*, namely district nurses and health visitors, would need to

change to facilitate the shift to greater primary-care-led health care. Cumberlege reported that neighbourhood nurses regularly and independently assessed patients for conditions related to their practice and subsequently made treatment decisions. It was noted that to enact those clinical decisions, they needed to request prescriptions for their patients from GPs. The nurses often exercised de facto prescribing in the sense that they gave to GPs, but the process resulted in much time wasting for the patients, GPs, and the district nurses/health visitors' alike (Luker, Austin, Ferguson, & Smith, 1997). More significantly, Otway (2002) noted that these de-facto prescriptions were often rubber stamped by the GPs. This could compromise the safety of patients and undermine the accountability of the GPs involved, since prescribing decisions were undertaken by a medical practitioner distanced from the assessment and examination of the patient concerned and dependent on the capability of the nurse undertaking it.

Building on the recommendations of the Cumberlege report, the first Crown Report (DH, 1989b) proposed prescribing by district nurses and health visitors from a limited formulary, referred to as the Nurse Prescribers Formulary. The belief was that implementation of the limited prescribing would have direct patient benefit (DH, 1989a, Brew 1999).

In 1994, a pilot project undertaken on eight sites across the country allowed suitably prepared district nurses and health visitors to prescribe from a limited formulary. The evaluation demonstrated that these limited prescribing rights improved services by facilitating more effective use of resources (Luker, **Author: is this Luker et al**, 1997(a)). Nevertheless worries remained about the possible cost of implementation, particularly as there was a (misplaced) belief that limited nurse prescribing would encourage wasteful dispensing of unused items. Despite these concerns and following the successful implementation of limited nurse prescribing,

the Government supported the case made for prescribing to be within the scope of practice of all registered nurses (DH, 1999). This was the first opportunity for MHNs to prescribe, as prior to this the limited formulary was not seen as within their scope of practice. Further developments in support of widening the scope of nurse prescribing emanated from the **National Health Service (NHS) Plan** (DH, 2000), as it was seen to offer service improvement by reducing delays waiting for a doctor to prescribe for the service user and recognised the potential to draw on and build upon MHN's expertise.

In 2001, nurse prescribing was extended, and this included MHNs (DH, 2001, 2002). This formulary allowed all first-level registered nurses who had undertaken an approved educational programme and supervised practise to prescribe all general sales list pharmacy medicines and a further 200 specified prescription-only medicines. A year later, supplementary prescribing (similar to complementary prescribing in the United States) was introduced (DH, 2003). Supplementary prescribing requires the production of a written clinical management plan (CMP) agreed between the independent prescriber (doctor), nurse, and service user. However, the doctor must first confirm the assessment and diagnosis before then setting out the prescription, including types of drugs and extent to which they can be prescribed by the supplementary prescriber. CMPs are dependent upon the parameters defined by the individual doctor (and their confidence in the competence of the supplementary prescriber) and can limit the scope of the MHN or can be facilitative, thus allowing the nurse to prescribe any class of psychotropic drug (NPC, 2005).

More recently, the law has been extended, allowing nurses to qualify and practise as independent prescribers (similar to substitutive practice in the United States). Following approved training, nurses can now prescribe any licensed medicine,

including some controlled drugs, as long as they work within the limits of their knowledge and competence (DH, 2007). Full independent nurses, including prescribing of all controlled drugs, is imminent. This change will allow nurses working in the field of substance misuse to prescribe methadone, a Schedule 2 controlled drug, once full-controlled drug prescribing is legalised. This would offer a major role enhancement and facilitate more effective case management (Risk Review, 2008). Table 1 summarises the milestones that have contributed to the development of nurse prescribing in the United Kingdom. It is worth noting that non-medical prescribing in the United Kingdom is not just an extension of the scope of practice of nurses, midwives, and health visitors. Since 2002, pharmacists have been allowed to train as supplementary prescribers. Physiotherapists, podiatrists, radiographers, and optometrists have, since 2005, also been included. The extension to independent prescribing was offered to Pharmacists in 2006, and even more recently, in 2007, optometrists have been allowed to independently prescribe for conditions of the eye and surrounding tissue.

The Development of Nurse Prescribing

Nurse Prescribing: A Positive Development?

Given that the health service is resource finite, there are political attractions in nurse prescribing, not least in relation to potential savings (DH, 1999; Gournay & Gray 2001; Jones, 2004). Evidence suggests that many people diagnosed with schizophrenia, depression, bi-polar affective disorder, and dementia are not receiving appropriate medical treatment. The reasons are many but include the shortage of psychiatrists (Gournay & Gray), failure of GPs to diagnose and prescribe appropriately (Nolan, Haque, Badger, Dyke, & Khan, 2001), and volume of cases,

particularly from what has been described as a pandemic of depression (Bailey & Hemingway, 2006). Alongside, service users report feeling disempowered during consultations with their doctors, particularly feeling that their non-medical needs are not given due consideration. The NPC (2005) suggested that non-medical prescribing undertaken by MHNs could:

- Allow service users quicker access to medication
- Provide services more efficiently and effectively
- Increase service user choice, and
- Make better use of nurses' skills and knowledge.

Indeed early results suggest that appropriately trained MHNs have shown they can make a significant difference to both health- and social-care outcomes (Grant et al., 2007, Wix, 2007; Jones & Jones 2008) and improve the prescribing experience of service users.

Extension of non-medical prescribing is not without criticism. It has been argued that prescribing has been used by the current Government to challenge the power of the medical profession [Author: Is "medicine" correct?] (McCartney, Tyrer, Brazier, & Prayle, 1999). Non-medical prescribing, in effect, eliminates the gate-keeping role traditionally exerted through doctors' prescribing powers, thus removing their control. Others suggest that there is danger of *dumbing down* the underlying expertise inherent in medical prescribing by this role extension. James, Sheppard and Rafferty, (1999) offered a different perspective by suggesting that the development of nurse prescribing was part of a quest for professional aggrandisement, removing dependence on the medical profession for professional legitimacy. Indeed Jones (2004) extends this by arguing that prescribing has become the territory of

gender divisions; he offered that prescribing was kept on the Government's agenda by "female nursing" asserting itself alongside "male medicine."

In contrast McCann and Baker (2002) locate the argument against prescribing in the *care versus cure* debate. Suggesting that MHNs who adopt prescribing may place too great an emphasis on diagnostic activity and pharmacological cures, thus diminishing their attention on caring. Countering that position Bailey and Hemingway (2006) suggest prescribing by MHNs positively challenges nurses to work within a holistic framework, one where psychobiologic perspectives can be seen alongside psychosocial approaches. The skills and knowledge associated with the pathophysiology of illness is ~~[Author: word OK as changed? This sentence needs a verb.]~~ an area that has become increasingly absent from the education and practise of MHNs for some time (Jordan, 2002~~[Author: please add to the reference list];~~ Nolan et al., 2001; Gournay & Gray, 2001; Bailey & Hemingway). Cressey (2007) questions whether MHNs possess the requisite skills and knowledge necessary to deliver the prescribing services already available from doctors. Others suggest the increased emphasis on psychopharmacological approaches emerged from the decade of the brain (1990s) and was a consequence of the increasing influence of pharmaceutical companies in health care (Cutliffe, 2002; Keen, 2006).

Despite these criticisms, non-medical prescribing is developing rapidly. In the United Kingdom, in the aftermath of the case involving Dr. Harold Shipman, a GP who abused his position to murder frail older people with controlled drugs, professional autonomy is increasingly under surveillance. Nurses will soon be able to independently prescribe controlled drugs in the United Kingdom; this represents a major professional development from nurse prescribing from the limited formulary in the 1990s to today. It also presents new challenges, temptations, and burden for

professional integrity. The recent reviews of mental health nursing in England and Scotland, although encouraging of prescribing, envisage frameworks to facilitate and monitor its development and activities of practitioners (Snowden, 2007).

Nurse Prescribing and the Law (See Table 2)

The Medicines Act of 1968 remains the legislative framework for prescribing medicines in the United Kingdom. The Act restricts the prescribing of prescription only medicines to appropriate practitioners including nurses, originally doctors, dentists, and veterinarians. *The Medicines Act* was amended by *The Medicinal Products: Prescription by Nurses Etc Act 1992* to allow nurses to prescribe from a limited formulary [Author: please provide references for all of these Acts in this paragraph in the reference list so readers will be able to find them.]. This was followed by amendments to the Pharmaceutical Services Regulations 1994 that allowed pharmacists to dispense prescriptions written by nurses. Extended nurse prescribing rights were enabled by the same statutory provision. Supplementary Prescribing was enacted by *The Health and Social Care Act (2001)*.

With the enactment of *The Mental Capacity Act (2005)* and [Author: correct as changed?] the changes to *The Mental Health Act 2007* the complexity of consent came to the fore. For MHNs, extending their role to include prescribing brings another layer of complexity to capacity to consent. Further exploration of this important topic is beyond this paper, but Jones et al. (b), Hemingway and Williams [Author: which one? Jones, Bennett, Lucas, Miller, & Gray or Jones, Hemingway, & Williams?] (2007) and Dimond (2008) offer further discussion about this topic.

The Authority to Prescribe

MHNs who successfully complete the required programme(s) of theory and practice can undertake two modes of prescribing. These are:

- Independent prescribing, where any licensed medicine including some controlled drugs can be prescribed by a non-medical prescriber with the requisite knowledge and competence working within their scope of practice,
- **Supplementary prescribing**, where the non-medical prescriber in partnership with the psychiatrist (independent prescriber) and service user are able to prescribe any medicine, including all controlled drugs and unlicensed medicines, that are listed in a clinical management plan (DH, 2007).

The mode of prescribing the MHN adopts in practise is dependent on the context and service user presentation (Jones, M., Bennett, Lucas, Millar, & Gray, 2007; Wix, 2007). Most MHNs (at the time of writing) are more likely to be acting as supplementary rather than independent prescribers~~[Author: sentence OK as changed?]~~. Some MHNs have indicated they would feel more comfortable working within the boundaries of a CMP~~[Author: citation?]~~. This allows the novice prescriber to establish their confidence under the supervision of a psychiatrist (Hemingway, 2004). In contrast to this, MHNs have identified where acting as an independent prescriber is more appropriate based on practice context and service user need (Wix; Bradley, Wain, & Nolan, 2008).

Prescribing Competence

Whether MHNs have the appropriate assessment, diagnosis, and consultation skills as well as adequate understanding of psychopharmacology needed to prescribe

psychotropic drugs has been much debated (Skingsley, Bradley, & Nolan, 2006; Bailey & Hemingway, 2006); ~~Jones & Jones, 2006~~~~[Author: please add Jones & Jones, 2006 to the reference list]~~). Indeed much questioning of nurses' capacity to prescribe safely has emerged, particularly from medical commentators (Avery & Pringle, 2005; Cressey, 2007). The adequacy of the preparation programmes for the Independent and Supplementary Nurse Prescribing course, with its 27 days of theory and 12 days of supervised practise, have received scrutiny. The Nursing and Midwifery Council [NMC] (2006) stipulated the minimum academic level be an undergraduate level 3 for the course in contrast with the master's prepared programmes in the United States (Bailey & Hemingway, 2006). This, however, may well have been a pragmatic decision given that many pre-registration nursing programmes in England remain at sub-degree level (diploma, advanced diploma) and many post-registration continuing professional development (CPD) ~~courses?~~~~pProgrammes?~~ for nurses remain at bachelor's degree level. This is, however, changing, and many higher education institutions (HEIs) have approved programmes at both bachelor's and master's levels. Interdisciplinary prescribing education has, in part, brought about this change. Most HEIs offer non-medical prescribing students one programme irrespective of discipline. As the majority of eligible non-medical professions require graduate level entry for initial registration, master's level CPD is the norm.

The unique nature of MH ~~[Author: MHN?]~~ prescribing has questioned the need for a specific MH ~~[Author: MHN?]~~ module (Wright & Jones 2007; Snowden 2007). Further, some suggest that potential students should complete a mandatory module on medicines management and psychopharmacology as a pre-requisite to entry to prescribing programmes (Skingsley et al., 2006). The author believes that

placing additional uniform pre-requisites on MHNs is unnecessary but suggests emphasis on individual prior experience and baseline knowledge. Key components to achieving competence are:

- Pre-course confidence regarding knowledge of medication;
- appropriate, supportive supervision by a medical practitioner, in the case of MHNs, a psychiatrist;
- accessing medicines management and psychopharmacological education opportunities;
- developing practise within a supportive and well-organised environment.

These components are not unique to MHNs but incorporate lessons learned from other healthcare settings where more widespread adoption of prescribing has occurred. Changing patterns of service delivery in primary and secondary care settings has facilitated greater adoption of non-medical prescribing and, in particular, independent prescribing. Mills (2008) offered an example of organisations that have sound clinical governance systems in place, an essential feature for successful implementation.

The Context of Mental Health Nurse Prescribing

In a review of 46 students exiting prescribing programmes in the north of England, Hemingway and Harris (2006) found that the students (all MHNs) were recruited from a range of settings (See Table 3).

Jones et al. [~~Author: which one? Jones, Bennett, Lucas, Miller, & Gray or Jones, Bennett, Lucas & Gray 2006, Jones, Hemingway, & Williams?~~] (2007) confirms this picture in their mapping of the locations where nurses are issuing

prescriptions. The highest levels of MHN prescribing activity seem to be taking place in older peoples' services (Grant et al., 2007[~~Author: Please add Grant et al., 2007 to the reference list (unless this is Grant et al. 2006, then please correct the date)~~]; Gray, Parr, & Brimblecombe, 2005; Murray, 2007). There is also significant activity in adult services, albeit mostly in services provided in secondary care, community, and out-patient clinics (Snowden, 2007). Nevertheless, significant developments are emerging in adult mental health in-patient care (Jones M., Bennett, et al. 2007; Jones & Jones, 2008), forensic services, prisons, and primary care settings (NPC, 2005). Some activity also exists in child and adolescent services (Ryan, 2007).

Implementation

Despite the evidence that prescribing by MHNs is developing across a wide range of services, and positive news that MHN prescribing has evaluated safely (Norman et al., 2007), the reality in the United Kingdom is that its implementation by mental health service providers (NHS Trusts) has been patchy (Bradley et al., 2008). In 2004 just four NHS trusts employed 81% of the MHN prescribers who had completed their training (Murray, 2007; NPC, 2005). It would appear that employers that championed the implementation of MHN prescribing have identified tangible benefits (Bradley et al.; Jones & Jones, 2007, 2008; Jones M., Bennett, et al., 2007). However this picture does not reflect the United Kingdom as a whole where service improvement through the introduction of non-medical prescribing is best described as piecemeal and haphazard (Mazhindu & Brownhill, 2003[~~Author: please add to the reference list~~]; NPC, 2005). Too frequently, MHNs have undergone training to prescribe without the employing organisation having a governance framework in

place. One study illustrates this in its finding that only 51% of MHNs trained were actually practising as prescribers (Gray et al., 2005). Mental health service providers appear to be more cautious and roll out slower than in acute and primary care settings (DH, 2005b; NPC, 2005). Despite this finding, the significance of prescribing by nurses in mental health has been signalled in both reviews of mental health nursing in England and Scotland (DH, 2006a; Snowden, 2007) as central to improving mental health service-user recovery.

Recommendation 13 of *Values to Action* (DH, 2006^a[**Author: a or b?**]) set the agenda for organisations, stating:

Service providers are to put in place arrangements to support the implementation of nurse prescribing, based on local need, taking into account the potential for service redesign and skill mix review, using both supplementary and independent prescribing arrangements (p. 13).

This apparent slow development is unsurprising as the NHS deals with “boom bust” resourcing. The adoption of prescribing across NHS organisations is often dependent on local championing. Unfortunately other initiatives and priorities such as patient safety and reduction of medication-related errors exert competing demands and concerns about risk. In the micro world of local service planning between trusts (hospital and community organisations) and health commissioners, other issues inevitably become greater priorities.

How does the UK nurse prescribing compare to the rest of the world?

Nurses in several countries apart from the United Kingdom have the authority to prescribe medicines. These include Canada, Sweden, Australia, and the United States (Buchan & Calman, 2004[**Author: please add to the reference list**]). In New Zealand, the role of prescribing by nurses has been developing slowly for some time

(Hughes & Lockyer, 2004). The potential of nurse prescribing is also being debated in Ireland (Lockwood & Fealy, 2008), and plans are in place to push it forward in Holland (Van Ruth, Mistiaen, & Francke, 2008). The potential gain of nurses obtaining prescriptive authority has been reported in the United States (Cornwell & Chiverton, 1997) and Sweden (David & Brown, 1995), and ~~are similar~~ follow those [Author: What “are similar”?] ~~to~~ those set out in the United Kingdom by the NPC (2005; see p. 7 of the article). Other contextual reasons, such as access to patients living in remote areas, shortage of doctors, and nurses working independently in these areas, has meant prescribing by nurses developed in Australia, Sweden, and Canada. In Africa, prescribing training for nurses is available (Meyer et al., 2001 [Author: please add to the reference list]) and is needed in low-income countries like Botswana and South Africa where the pandemic of AIDS could be helped by nurses’ abilities to prescribe medication (Miles, Seitio [Author: spelled “Seitio” in the reference list. Which is correct?], & McGilvray, 2006).

Prescribing by MHNs is being slowly implemented in Australia as part of MHNs’ advanced practice activities. Perhaps unsurprisingly a recent study (Elsom, Happell, Manias, 2007) found that Australian nurses have undertaken roles considered the legal domain of the medical profession, such as strongly influencing the prescribing of medicines, although the ultimate decision was made by the doctor. At the other extreme, nurse respondents in the study reported that they would make decisions in the absence of the doctor, clearly contravening the medical code. This defacto or proxy prescribing echoes the results of the Ramcharan et al. (2001) study in the United Kingdom where MHNs felt that the authority to prescribe would make legal even the rubber stamp interventions they undertook as part of their role.

Prescriptive authority for nurses is evidently developing across the globe. However the only context or evidence base to compare the developments in MHN prescribing in the United Kingdom is the U.S. context. The picture in the United Kingdom is not dissimilar to that in the United States where the extension of advanced practice psychiatric nurse (APRNs) roles through nurse prescribing was not smooth. Barriers were identified that have hindered widespread adoption of prescriptive authority (Kaas, Dahe, Dehn, & Frank, 1998; Campbell, Musil, & Zauszniewski, 1998; Talley & Richens, 2001). Studies suggest that lack of support from key professionals, especially psychiatrists, was a significant block. Psychiatrists reportedly either did not want to have the extra responsibility of supervising an MHN in their new prescribing role and the burden of vicarious responsibility (Kaas et al.;

McCaallister~~[Author: spelled "McAllister" in the reference list. Which is correct?]~~, 1998), or they saw APRNs as potential economic rivals and a threat to their credibility (Glod & Manchester, 2000; Haber, Hamera, & Hillyer, 2003).

Furthermore, it seems that there were some practice environments where bureaucratic barriers, such as excessive paperwork and a tortuous application process, hindered the progress of the MHN, as did a lack of recognition for the role and the added responsibility of nurse prescribing for APRNs (Glod & Manchester; Howard & Greiner, 1997; Kaas et al.). Other factors that appeared to hinder MHN prescribers feeling comfortable in their new role was their perceived knowledge deficits in prescribing, in addition to more generalised anxieties (Hales 2002; Howard & Greiner; Kaas et al.).

Further examination of the U.S. literature shows many similarities with the United Kingdom. Barriers such as lack of support and restrictive work environments (Hemingway, 2005~~[Author: is this Hemingway, 2004 or 2005? Or Hemingway &~~

~~Harris, 2006? Or a new citation that needs to be added to the reference list?];~~

NPC, 2005) as well as anxieties about knowledge and abilities to undertake

prescribing are described in the literature (Hemingway 2004, 2005~~6[Author: Same as~~

~~above]; Jones et al. a, 2007[Author: Jones, Hemingway of Jones, Bennett?]);~~

Resistance voiced by physicians in the United States to APRNs practising with

prescriptive authority has not been echoed in the United Kingdom in mental health.

There has been acceptance of widening prescribing to MHNs, and some psychiatrists

have welcomed the change (Jones et al., 2007~~a [Author: Jones, Hemingway of~~

~~Jones, Bennett?]; Hemingway, 2008). The potential economic impact of APRN~~

prescribing on doctors in the United States is not mirrored in the United Kingdom

with its model of socialised health care. This may have influenced the acceptance of

MHN prescribing by U.K. psychiatrists.

What is positive about the U.S. context is that research studies have shown

that the prescribing APRNs are as competent as psychiatrists in prescribing

medication and also spend more quality time with the patient (Feldman, Bachman,

Cuffel, Friesen, & McCabe, 2003; Fisher & Vaughan-Cole, 2003; Jacobs, 2005). This

mirrors the Norman et al. (2007~~8[Author: Should this be 2007 or is it a new~~

~~citation that needs to be added to the reference list?]) study in the United Kingdom~~

that had similar findings regarding the competency of MHNs prescribing compared to

psychiatrists. More studies like these are needed to provide robust evidence for

service providers to plan for expanding MHN prescribing as well as service users to

gain confidence in the change of prescribing service.

Inevitably change takes time, and after a slow start and resistance to MHN

prescribing, it is gaining momentum as the impact on workload and care delivery has

become apparent (DH, 2007). As MHNs have adopted some of the routine activities

of prescribing, psychiatrists have more opportunity to concentrate on complex and demanding cases, in keeping with the Government vision (DH 2005a; DH 2006b). This two-tier prescribing could be seen as a form of dumbing down care provision, as forecast by McCartney et al. (1999). This has not been evident in evaluation to date that shows service users have responded to the greater inclusivity inherent in MHN prescribing (Grant et al., 2007~~[Author: 2006 or a new citation that needs to be added to the reference list?]~~; Jones & Jones 2008; Wix, 2007). The challenge incumbent on MHNs is that they remain committed to prescribing and use their powers to empower service users to effectively self-manage their prescribed medication, individualised to their wishes and lifestyle (Hales, 2002; Jones & Jones, 2007; NPC, 2005).

Mental Health Nurse Prescribing in the future

The introduction of independent prescribing by MHNs throws up challenges for future educational provision. Independent prescribing can be seen as advanced practice. Autonomous practice, including assessment, diagnosis, requesting tests and retests, demands sound knowledge and decision-making skills. How effectively HEIs facilitate the development of MHNs' skills and knowledge to fulfil advanced practice roles is not yet fully evaluated. As graduate entry to nursing programmes ~~[Author: OK as changed?]~~ becomes the norm in the United Kingdom, the inevitable consequence is that prescribing education will be delivered at the master's level, similar to advanced practice courses undertaken by APRNs in the United States (Bailey & Hemingway, 2006).

Conclusion

The widespread adoption of MHN prescribing has spread and is impacting on

service users across the lifespan, from adolescence to older people, from inpatient to community and primary care (Hemingway & Harris, 2006). Critical debate around adoption of new roles continues to provide healthy challenges for MHNs to demonstrate their prescribing effectiveness, safety, effect on service improvement, and service user satisfaction (Bailey & Hemingway; Keen, 2006; Snowden, 2007). The national evaluation of MHN supplementary prescribing in the United Kingdom by Norman et al. (2007) displayed no significant difference in health- and social-care outcomes or the costs of prescribing. This study examined data from a sample of 90 service users, suffering from depression or schizophrenia, whose medication was managed by an MHN supplementary prescriber or by an independent medical prescriber for a period of at least 6 months. The research team also established that there were no significant differences in the safety of prescribing between the two groups using National Institute of Clinical Excellence (NICE) audit instrumentation (Norman et al.). They did report that the quality of documentation was generally poor, with a substantial amount of information relevant to safe prescribing practice absent from the records of patients in both groups (Norman et al.). Thus there can be cautious optimism.

Nevertheless, what is paramount is the need for careful planning and implementation of MHN prescribing. This needs to be undertaken on the basis of service need, organisational readiness, and availability of adequate resources. The benefits of role change of the MHN to incorporate prescribing also requires full consideration, particularly does the individual nurse understand the demanding requirement of education programmes, ongoing maintenance of competency, and burden of the additional responsibility that comes with greater autonomy. Prescribing is a powerful tool to support recovery but nurses adopting this role need to be

competent, confident, and above all aware that it is only one part of the therapeutic toolkit available to underpin their interventions with service users.

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