

Nurse practitioners in drug and alcohol: where are they?

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KEY WORDS

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ADDENDUM

Since the acceptance of this article the Australian Federal Government has announced funding of \$59.7 million over the next four years to expand the role of Nurse Practitioners throughout Australia. This funding includes support to allow access for Nurse Practitioners to the Medicare Benefits Schedule and to the Pharmaceutical Benefits Scheme (PBS) from 2010 (Australian Government 2009). Whilst this is welcome news for Australian Nurse Practitioners the details of the funding have not yet been released. It remains to be seen as to whether the budget announcement will provide Medicare and PBS access to all Nurse Practitioners or to a restricted few. It is also as yet unknown as to whether this level of funding will be sufficient, particularly with the role of the Nurse Practitioner being one still in development.

ABSTRACT

Objective

The role of nurse practitioner encompasses advanced levels of practice with the potential to prescribe a range of medications within a recognised area of practice along with the use of appropriate ordering of pathology tests and referral practices. This paper introduces the nurse practitioner in drug and alcohol.

Setting

The nurse practitioner in Drug and Alcohol has the potential to support and enhance existing medical models of patient care in a variety of settings.

Primary Argument

Employment of nurse practitioners may be a way of addressing workforce issues. The advanced level of practice and resultant responsibility also requires higher levels of remuneration, which need to be accepted within an advanced practice framework. In many cases this model of care may in fact be acknowledging existing practices in areas where nursing staff are forced to undertake more advanced roles due to the shortage of appropriately trained Medical staff. Collaborative care involving nurse practitioners can lead to increased access, reduced waiting times and longer consultation times.

Conclusion

Nurse practitioners in the alcohol and other drugs field have enormous potential to support other experts in collaborative care for patients with substance use disorders. This potential does not come without some additional financial costs but the potential benefits to a health service in employing a nurse practitioner skilled in the management of substance use disorders can be enormous. The full potential of nurse practitioners in drug and alcohol will not however be realised until financial arrangements for outpatient care become a reality.

INTRODUCTION

Throughout Australia in recent years there has been a steady decline in the use of tobacco but an increased use of alcohol. Around one-third of Australians over the age of 14 years have tried cannabis and over one third have tried an illicit substance within their lifetime (AIHW 2007). The use, abuse and dependence upon opioid analgesics has also been increasing during the last 10-15 years with increases in Emergency Department presentations for opiate related complaints (Compton and Volkow 2006). Despite declines in tobacco use, tobacco remains the largest cause of drug related mortality in Australia every year with approximately 18,000 deaths per annum. This is followed by alcohol with approximately 3,000 deaths per annum and illicit substances causing around 1,705 deaths in 2003 (AIHW 2007; Chikritz et al 2003; Ridolfo and Stevenson 2001).

The role of the nurse practitioner (NP) is relatively new to Australasian health care systems. Formal development of the model in New South Wales began in 1990 with the convening of the first nurse practitioner committee although significant work had previously been undertaken to establish that process (Nurses Registration Board of New South Wales 2003; Appel and Malcolm 1999). The first NPs were authorised in December 2000 following wide consultation and development of authorisation processes. Amendments to multiple Acts of Parliament were required to include the NP title and to allow nurses to function in the NP role (Siegloff Clark 2000; Appel and Malcolm 1999). In 2003 a workshop was held by the then Drug Programmes Bureau of the New South Wales Department of Health to train senior nurse clinicians in the drug and alcohol field to a level at which they could seek authorisation as NPs. Approximately 20 nurses attended the workshop run by staff of the University of Newcastle. Whilst attendees to the training were required to commit to a 12-month time frame in seeking authorisation, this was never a realistic requirement. The first NP in drug and alcohol nursing in New South Wales was authorised in June 2004. Research is currently being undertaken by the author into the barriers facing senior drug and alcohol nurses in seeking authorisation.

DISCUSSION

Defining the nurse practitioner

In 2006, the NP was described by the Australian Nursing and Midwifery Council as:

“..a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations.” (ANMC 2006, pp. 1).

In New South Wales two pathways to authorisation have been utilised. Pathway 1 refers to authorisation of a NP who has undertaken a Masters level degree approved by the Nurses and Midwives Board of New South Wales as having prepared the applicant under the National Competency Standards for the Nurse Practitioner (ANMC 2006), with supporting documentation of 5000 hours of advance nursing practice within the specific area of expertise within the previous six years.

The second pathway is for those nurses who already work at an advance level of practice with knowledge and experience not necessarily obtained from a tertiary institution. Nurses applying under pathway 2 must still demonstrate appropriate competence as defined by the National Competency Standards for the Nurse Practitioner (ANMC 2006). This is assessed by peer interview and submission of a case study and development of a ‘package of evidence’ with supporting documentation of 5000 hours of advanced nursing practice within the specific area of expertise within the previous six years (Nurses and Midwives Board of New South Wales 2006).

What are the barriers to authorisation?

Potential barriers to senior nurse clinicians seeking authorisation to the NP level have been examined by a limited number of studies. None have concentrated specifically on drug and alcohol staff and none have examined the New South Wales context. Organisational barriers including funding of roles,

area health services failing to see the value of the NP positions, leave relief only being able to be provided by other authorised nurse practitioners, lack of orientation into the role and loss of other senior nursing positions to fund NP positions have been identified (van Soeren and Micevski 2001). Lack of support from other stakeholders due to fear of encroachment into medical territory, fears of deskilling junior medical staff, concern over lack of line authority amongst other nurses, disparity between clinical and academic qualifications and ignorance have also been identified (Lloyd Jones 2005; van Soeren and Micevski 2001). Role ambiguity may also be a potential barrier (Lloyd Jones 2005). Many nurses do not necessarily feel comfortable with the idea of practicing at a more advanced level where prescription of medications would be required (McCann and Baker 2002). It may also be that other barriers exist in the New South Wales context such as geographical barriers and personal barriers such as personal choice, lack of confidence, time constraints, perceived lack of support in enacting the role and perceived lack of support for professional development (eg. attending conferences, external meetings) some of which have been identified as issues in enacting Clinical Nurse Consultant roles (Vaughen et al 2005).

What are the benefits?

Despite the potential barriers there are significant potential benefits to investment into NP authorisation. At a personal level, authorisation provides legislative authority to perform tasks beyond the scope of a registered nurse with resultant increases in remuneration (Bagg 2004). Increased access to services, reduced waiting times, improved quality of treatment, the formalising of processes which already exist, greater provision of information, greater responsibility for nurse decision making, the freeing up of consultant time, enhancement of multidisciplinary relationships and the provision of longer consultation times allowing complex issues to be addressed in more detail have all been suggested (Gallagher et al 2006; Wand and Fisher 2006; Wortans et al 2006; Victorian Alcohol and Drug Association 2005; Bagg 2004). Reduction in patient length of stay

without increases in readmission rates or mortality has been shown with collaborative models involving nurse practitioners as members of a multidisciplinary team employed within hospital settings (Cowan et al 2006). Nurse practitioners in the United States of America have been shown to provide similar outcomes for their patients as their physician colleagues with similar levels of patient satisfaction (Mundinger et al 2000). This has been replicated in small studies in Australia in fields outside of drug and alcohol (Wortans et al 2006). The less formal relationship provided by nurses when compared with medical professionals has also been shown to influence patient satisfaction in a positive way (Wortans et al 2006). It has also been suggested nurse practitioner positions may legitimise the current practice of some nurses who are already functioning in the role without being formally authorised or recognised (Bagg 2004; McCann and Baker 2002). There is also evidence of support for the implementation of nurse practitioners from health professionals within the drug and alcohol field (Shoobridge 2005).

These benefits in a drug and alcohol context are likely to be seen in such areas as the provision of opiate maintenance treatment where long waiting lists for treatment are often the norm. In a report from the New South Wales Bureau of Crime Statistics and Research 40% of opiate dependent respondents before the criminal justice system in New South Wales reported they would enter methadone maintenance treatment 'tomorrow' if waiting lists were not a barrier to treatment (Weatherburn 2000). General practitioners are sometimes reluctant to identify and treat patients with substance use disorders and in some cases have shown either ineffective or harmful treatment practices (Fucito et al 2003). Nurse practitioners are in a position to not only assess and treat such patients but to provide support for their colleagues in general practice requiring advice around the complexity of substance use issues.

What are the costs?

There are potential costs in enacting the NP role. Higher levels of pay are required to employ a NP,

increases in nursing workload can be anticipated and organisations may decrease funding for other health care professional positions in a response to what administrators might view as a cheaper option (Gallagher et al 2006). Disruption of the division of tasks within teams with the introduction of NPs, altered working relationships within teams where the NP is responsible for the training and supervision of junior medical staff and the difficulties in dealing with evolving working models are not always easily rationalised in real world situations (Reay et al 2003). Whilst those nurse practitioners employed within the public health system of New South Wales do not require professional indemnity insurance due to employer vicarious liability, although this has not been tested in the courts to the author's knowledge, privately employed nurse practitioners will be required to carry such insurance (Fisher 2005). It has further been suggested the isolation faced by remote area workers has the potential to place the nurse practitioner at risk (Victorian Alcohol and Drug Association 2005).

Potential operational models

Several operational models for the NP in drug and alcohol have been identified. Consultation liaison NPs are able to provide care to hospital inpatients during an acute presentation to hospital. These nurses are based at an individual site or limited number of sites. This model may also involve NPs working within a detoxification unit with an expanded role in assessment and in implementing treatment plans. Outpatient care can be managed through community health centres and opioid replacement treatment programs where outpatient appointments can be made on an as needed basis. Positions covering a specific geographical area may combine components of both the aforementioned models (Wand and Fisher 2006; New South Wales Department of Health 2005).

The current situation

The New South Wales government have amended multiple Acts of legislation to enable the emergence of the nurse practitioner in that state (Hatzistergos 2006; Driscoll et al 2005; Nurses Registration Board

of New South Wales 2003; Siegloff Clark 2000; Appel and Malcolm 1999). The Poisons Act, The Nurses and Midwives Act and the Poisons and Therapeutic Goods Regulation among others, have all been amended to allow a nurse practitioner authorised by the Director General of the New South Wales Department of Health to possess, use, supply or prescribe medications including drugs of addiction. These are vital amendments for the drug and alcohol field in allowing NPs to prescribe opiate maintenance treatments in particular.

Unfortunately, NPs have not been supported with access to the national Medicare Benefits Schedule (MBS) or to the Pharmaceutical Benefits Scheme (PBS) at a Federal level. This means any medication or pathology ordered by a NP for an outpatient requires the patient to pay full costs for the item, effectively leaving the full potential for NPs unfulfilled. Referral to specialist medical services is likewise affected (Cashin 2006; Driscoll et al 2005; Fisher 2005). This is likely to impact mostly on those NPs in drug and alcohol involved in the prescription of maintenance or anti-craving treatments in community settings and those in outlying areas with limited access to a medical consultant who require access to appropriate patient referrals.

At the time of writing 99 NPs had been authorised in New South Wales with three of those being NPs in drug and alcohol nursing (New South Wales Department of Health 2007). The Hunter New England Area Health Service based in New South Wales was the first to approve a set of practice guidelines for a nurse practitioner in drug and alcohol along with a formulary of prescribed medications and a scope of practice document outlining appropriate levels of care. Guidelines exist for the management of opiate withdrawal, alcohol withdrawal, cannabis withdrawal, benzodiazepine withdrawal, amphetamine withdrawal and nicotine withdrawal. Many of these allow for the prescription of appropriate medications by the nurse practitioner in drug and alcohol specific to their needs and the needs of their patients (Hunter New England Area Health Service 2006). The nurse practitioner maintains

close contact with a senior medical staff specialist at all times and works within a multi-disciplinary framework.

CONCLUSION

Nurse Practitioners in the alcohol and other drugs field have enormous potential to support other experts in collaborative care for patients with substance use disorders. This potential does not come without cost but the potential benefits to a health service in employing a NP skilled in the management of substance use disorders can be enormous. It is vital nursing managers and other administrators are not short sighted in their utility of NPs by using such positions as a replacement for other nursing or medical positions. The full potential of NPs in drug and alcohol will not however be realised until access to the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme with financial arrangements for outpatient care and access to hospital admission rights become a reality.

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