Abstract

In 2007, Health Canada proposed a new framework to regulate prescriptive authority for controlled substances, titled New Classes of Practitioners Regulations (NCPR). The new regulatory framework was passed in November 2012; it gives nurse practitioners (NPs), midwives and podiatrists the authority to prescribe controlled medications under the Controlled Drugs and Substances Act. It is expected that authorizing NPs to write prescriptions for certain controlled substances commonly used in primary care will enhance flexibility and timeliness in primary care service delivery. Studies from the United States have shown positive outcomes in primary care access, decreased healthcare costs and the evolution and advancement of the NP role when prescriptive authority was expanded to include controlled substances. The purpose of this paper is to examine how NPs’ prescriptive authority for controlled substances affects access to primary care and NP role development. Three key issues identified from the experience of one group of NPs in the United States (access to care, professional autonomy and prescriber knowledge) offer insight into the practice changes that may be anticipated for NPs in Canada now that they have acquired prescriptive authority for controlled substances. Recommendations are offered to assist nurse leaders and educators to best support NPs as they take on this new and important role responsibility.
The push in Canada for nurse practitioners (NPs) to have full prescriptive authority, including the ability to prescribe controlled substances (CS), comes from the drive to improve access to and quality of healthcare services with increased choice of provider, and to make better use of the skills of non-medical healthcare professionals (Forchuk and Kohr 2009; Government of Canada 2012). Prescription medications are seen as playing an essential and growing role in the health of Canadians, and they are a major reason that people access primary care (Hillmer et al. 2008). Effective pain management, associated with appropriate medication use, unmistakably contributes to positive clinical outcomes and improved quality and quantity of life (Gerhardt 2004; Hillmer et al. 2008). Until recently, under federal legislation (Government of Canada 2012) only physicians, veterinarians and dentists have been authorized to prescribe CS in Canada. The shortage of family physicians has resulted in decreased access to appropriate healthcare services, including prescriptions for CS, for many people (Forchuk and Kohr 2009).

The role of the nurse practitioner (NP) is being developed and promoted as a key component to increasing access to primary care for Canadians (CNA 2008). Studies have shown that NPs have a positive impact on the healthcare system when they are able to practise to their full scope, with full professional autonomy, to deliver comprehensive, high-quality care (Kaplan et al. 2010).

The focus of this paper is to examine how NPs’ prescriptive authority for CS affects access to primary care and NP role development. We identify the current state of NP prescribing authority in Canada and the United States; explore how one group of NPs in the United States experienced the transition to full prescribing authority; and review recommendations from the literature, as methods for supporting and facilitating the impending changes in practice in Canada. The experience of a group of NPs in Washington state – who received full prescriptive authority in 2005 – may provide useful guidance to Canadian NPs.

**Primary Care in Canada**

Patient access to primary care is a significant issue in Canada (CNA 2008; DiCenso et al. 2010; Government of Canada 2012). Schoen and colleagues (2007) surveyed the results of an international study that compared patient access to family physicians in seven industrialized countries: Canadian adults were the least likely to report same-day access, the most likely to report long waits of six days or more for appointments and the most likely to have visited the emergency room in the past two years to receive medical care that their family doctor could have provided (Schoen et al. 2007).
Advanced practice nursing (APN) roles are being developed in Canada as a result of a push for better access to healthcare at decreased cost (CNA 2008; DiCenso et al. 2010; MacDonald et al. 2005). Nurse practitioners are a class of advanced practice nurses who have graduate education and the legislative authority to diagnose and treat health conditions, order diagnostic tests, make referrals to other healthcare providers and prescribe most commonly used medications (CNA 2008).

According to Gerhardt (2004), the most common reason people visit their healthcare provider is to obtain a prescription for pain management; many of these prescriptions are for controlled substances. In Canada, until recently, only physicians, veterinarians and dentists were federally legislated to prescribe medications that fell under the Controlled Drugs and Substances Act (CDSA) (Government of Canada 2012). NPs have expressed frustration that they are unable to do more for their clients, such as being able to provide better pain control for those with chronic pain (Shamian 2011). In an era in which access to care is increasingly problematic, this barrier limits the number and types of patients that a NP can see. It also unnecessarily increases the patient’s visit time when the NP must obtain the needed prescription from a physician, who is then also taking time away from his or her own clients (Kaplan and Brown 2004). Thus, the inability of NPs to prescribe CS creates a barrier that has implications for timely access to care as well as quality of care.

In 2007, Health Canada proposed changes to the CDSA that would allow podiatrists, midwives and nurse practitioners to prescribe certain controlled drugs and substances (Government of Canada 2012). Following initial stakeholder feedback, the New Classes of Practitioners Regulations (NCPR) were republished in May 2012 for additional input and formally accepted in November 2012. Thus, NPs now have federal authority to prescribe CS. Once this change is also enacted at the provincial/territorial level (Government of Canada 2012), it is expected that CS prescribing will become part of NPs’ scope of practice in many, if not all, Canadian jurisdictions. This change to the NCPR is meant to recognize the broadened scope of practice of regulated non-physician healthcare professionals and, more generally, to improve care through increasing patients’ timely access to controlled drugs where and when needed (Government of Canada 2012). In addition, studies have suggested there are no significant differences in prescribing practices between these health professionals and physicians (Government of Canada 2012; Laurant et al. 2004; Wiysonge and Chopra 2008).

Healthcare organizations are seeking ways to decrease the cost of healthcare yet still provide the same high quality of care. The nursing profession promotes the advanced practice nurse as a solution to this dilemma. However, NPs will be most effective – and cost-effective – only when working to their full scope of practice
(CNA 2008; DiCenso et al. 2010; Government of Canada 2012). Thus, by enabling NPs to work to their full scope, the NCPR supports high-quality as well as cost-effective healthcare.

**Prescriptive Authority for NPs in the United States**

Currently, 17 US states, including the District of Columbia, have legislation in place that grants NPs prescriptive authority for CS without direct physician involvement (AANP 2012). The experience of Washington state NPs, who were granted full prescriptive authority including CS in 2005, was reviewed to gain insight into the implications for the future practice of Canadian NPs.

**The Washington NP Experience**

In 2005, a Washington state law was removed that had required NPs to sign a joint practice agreement (JPA) with a physician to prescribe class II–IV schedule medications (Kaplan et al. 2010). As a result of this change in scope of practice, most NPs in Washington (90% versus 60% before the change) are now licensed to prescribe CS.

A study by Kaplan and colleagues (2010) looked at how the ability to prescribe CS has changed the practice of NPs in Washington. Of the NPs who responded to the study (n=1,488), 92% have full prescriptive authority. Of those who responded to open-ended questions relating to how it changed their practice, more than a third cited being able to provide increased access at decreased expense because the need for a second provider (i.e., a physician to provide prescriptions for CS) was eliminated (Kaplan et al. 2010). Being able to better manage clients with chronic pain was also seen as a benefit. Over a quarter of the respondents stated that they felt an increased sense of autonomy and a “perception that the law was finally aligned with their capability” (Kaplan et al. 2010: 50). Other positive outcomes identified by participants included feelings of liberation, affirmations of the NP’s skills and knowledge, and legitimacy (Kaplan and Brown 2007).

Although 92% of Washington state NPs obtained a licence to prescribe CS, the 8% who chose not to cited reasons including not wanting to pay the cost of licensing, not having a need for CS in their practice, having to worry over the increased potential for disciplinary action by their regulatory body, having to work with clients with drug-seeking behaviours and feeling that they did not have enough knowledge (Creedon et al. 2009; Kaplan and Brown 2007; Kaplan et al. 2010). It is interesting to note that having an increase in the number of clients with chronic pain because the NP could prescribe CS was seen as a negative outcome by some (Kaplan et al. 2010); this finding could be due to the added responsibility of having to discern clients who may be drug seeking from clients who have legitimate pain.
Another key finding of this study was that 22% of respondents indicated that their basic NP education had not adequately prepared them to prescribe CS (Kaplan et al. 2010). Specific reasons to corroborate this lack of education were not included in this study, but the results speak to the importance of preparing NPs in their graduate education to prescribe CS.

Implications for Canadian NPs
The experience of the Washington state NPs demonstrates how NPs can have a positive impact on the access to and delivery of care when restrictions and limitations on scope of practice are eliminated. NPs themselves generally feel a greater sense of autonomy and professional legitimacy when barriers to practice are removed (Kaplan and Brown 2004). Three key themes that emerged from the literature were access to healthcare services, professional autonomy of NPs and prescriber knowledge. These three themes will be discussed, with a focus on the relevance to Canadian NPs.

Access to Healthcare
The Washington state NPs cited being able to provide more comprehensive primary care to their clients with chronic illness, including chronic pain, as a result of having full prescriptive authority. Advances in medical science and improved living standards have contributed to longer life expectancy, resulting in more people living with chronic health conditions that demand ongoing support. Across industrialized nations, chronically ill patients account for a disproportionate share of national health spending (Schoen et al. 2009), placing them at the centre of initiatives to improve health system performance. The holistic approach, grounded in nursing practice, which typifies NP practice, makes the role of the NP especially valuable in this endeavour.

Accordingly, this experience suggests that other special groups or marginalized populations also have the potential to benefit by having access to NPs able to provide comprehensive primary care, including prescriptions for CS. This is especially true in Canada, where a sparse population is spread out over a large geographical area (Forchuk and Kohr 2009). NPs with full prescriptive authority have the potential to provide more equitable access to care for clients who live in rural and remote communities, a large number of whom are Aboriginal and economically disadvantaged, and who experience high rates of chronic disease (Forchuk and Kohr 2009). Notably, NPs are ideally suited to provide comprehensive primary care to these vulnerable client populations (Browne and Tarlier 2008) that historically have experienced profound disparities in access to healthcare (Tarlier and Browne 2011).
Professional Autonomy
Of the NPs who were evaluated in the study by Kaplan and colleagues (2010), 83% cited a positive impact on professional and personal autonomy when new legislation removed barriers on prescriptive authority (Kaplan et al. 2010). Many studies have cited the degree of prescriptive authority as an important indicator of professional autonomy with an impact on the advancement of the profession (Forchuk and Kohr 2009; Kaplan and Brown 2007; Kaplan et al. 2010; Pruitt et al. 2002). Indeed, many nurses have argued that they are unable to meet best practice guidelines because their legislated scope of practice restricts them from using the most appropriate treatment in a particular situation. For example, an outreach nurse who was the only provider for a group of homeless clients felt she could not provide high-quality care owing to limitations on the diagnostic tests and medications that she could order under her legislated scope of practice (Macdonald et al. 2005).

One of the barriers to fully autonomous NP practice, as widely cited in the literature, is the lack of knowledge of the NP’s role on the part of physicians and policy makers (DiCenso et al. 2010; Forchuk and Kohr 2009; MacDonald et al. 2005). Part of the problem has been ambiguity and inconsistency regarding the NP’s role description and the lack of a national standard implemented across all jurisdictions (Forchuk and Kohr 2009). While inconsistencies in the level of NP education and scope of practice continue to exist among Canadian provinces and territories, the need to move towards a consistent understanding of NP roles at the national level was identified as a priority by the Canadian Nurses Association (2008); work towards this goal is ongoing.

Prescriber Knowledge
The Washington state study found that while the majority of NP respondents believed their basic NP education had prepared them for prescribing CS, a high percentage (22%) did not feel adequately prepared (Kaplan et al. 2010). This has been a finding in other studies as well (Creedon et al. 2009; Lazarus and Downing 2003). The fear of not knowing enough or of becoming overconfident were two reasons that deterred some NPs from expanding their prescriptive authority (Creedon et al. 2009; Kaplan et al. 2010). It is known that adverse events related to medication use are a leading cause of patient morbidity and mortality, with errors in dispensing, monitoring and adherence to medications as contributing factors (Taylor et al. 2005); thus, a heavy burden of responsibility accompanies the authority to prescribe CS. Many of these drugs are potentially addictive if not taken for the purpose intended, and moreover, their potential for diversion and misuse has legal ramifications (Sains 2008).
According to the US Food and Drug Administration, prescription drug abuse is that nation’s fastest-growing problem. Healthcare providers who prescribe controlled substances often receive minimal training in how to prescribe appropriately to avoid adverse effects and addiction, as well as how to recognize substance abuse in their clients (McMullen and Howie 2011). For example, two recent cases involving Washington NPs who were criminally charged as a result of poor CS prescribing practices (McMullen and Howie 2011) emphasize the importance of safe and careful prescribing practice.

Discussion and Recommendations

Reviewing the experience of NPs in Washington state suggests strategies in two key areas that may facilitate the transition to NP prescribing authority for CS in Canada. The role of nurse leaders and educators is vital to ensuring that NPs are prepared to take on the responsibility of prescribing CS. The following recommendations are related to (a) supporting NPs to practise to their full scope and competency and (b) ensuring that initial educational preparation, continuing education, and systems and resources that support safe prescribing practices are accessible to NPs.

Supporting NPs to Practise to Full Scope

In one Canadian province (British Columbia), the intent of provincial NP legislation and regulation passed in 2005 was to mandate a broad scope of practice to allow for increased autonomy and flexibility, and to facilitate safe and responsive healthcare (DiCenso et al. 2010), with the goal of improving access to primary care. The recent changes at the federal level of legislation to grant NPs the authority to prescribe CS will allow NPs to practise to their full scope and thereby further enhance their ability to meet this goal. The evidence base that supports the safety and efficacy of NP prescriptive authority for CS should be widely disseminated as a strategy to uphold changes to NPs’ prescribing ability, to gain credibility for expanded NP prescribing authority among other health disciplines, to meet social obligations of accountability and to build a nursing knowledge base that can be used to further influence health policy at the agency, provincial and federal levels (DiCenso 2003). Evidence from the United States showing that NPs with expanded prescriptive authority and fully autonomous practice actually have lower malpractice claims, compared to NPs with restricted prescriptive authority who work under the supervision of a physician, is a key finding to support expanded scope of practice for Canadian NPs (CNA 2009).

According to Lomas (2000), policies are formed based on the principles of information and values, and it is only through repeated exposure to the evidence from research that beliefs eventually change. In their report, *Clinical Nurse Specialists and Nurse Practitioners: A Decision Support Synthesis*, DiCenso and Bryant-
Lukosius (2010) used Lomas’s framework to understand the values that facilitate or impede the integration of advanced practice nurses into the system. Thus, it is important to encourage NPs not to underestimate their political role with regard to influencing changes in health policies that support improved access to appropriate healthcare services. Nurse practitioners will become more effective when they speak with a unified collective voice that sends a consistent message to policy makers, other healthcare professionals and the public about the substantive evidence base – collected over the past 45 years – that supports how NPs improve timely access to high-quality healthcare. Becoming involved in professional organizations, such as provincial nurse practitioner associations (e.g., the British Columbia Nurse Practitioner Association, the Canadian Nurses Association and the Canadian Association of Advanced Practice Nurses) are examples of steps NPs can take towards having a collective and influential professional voice in healthcare decision-making.

The Canadian Nurse Practitioner: Core Competency Framework (CNA 2010) provides a national standard for NP core competencies, but it lacks specificity in addressing prescribing practices. It is important for nurse leaders to advocate for a comprehensive, national guideline that addresses prescribing practices so that nurse educators can prepare students to become safe prescribers anywhere they may work in Canada (Kaplan et al. 2010). This approach has also been recommended in the United States, as there is a recognized need for nurse practitioner students to learn how to prescribe CS safely (Klein 2012).

Supporting NP Prescribing of CS
All healthcare providers, including NPs, need to have access to appropriate and current information to be able to practise safe and cost-effective prescribing (Hillmer et al. 2008). Fortunately, there is a recognized need to have systems in place that assist the prescriber. Two examples of such programs that currently exist in Canada include the national e-Prescribing initiative (Canada Health Infoway 2012) and British Columbia’s provincial PharmaNet; both have been designed to improve prescription safety (BC Ministry of Health n.d.; Taylor et al. 2005). However, NPs in British Columbia currently do not have independent access to PharmaNet; this is a prime example of a barrier to NPs’ safely exercising broader prescriptive authority, and an area in which nurse leaders and regulators can advocate for changes that will better support safe prescribing practices by NPs.

Developing the knowledge base and clinical skills necessary to identify clients with a legitimate need for controlled drugs is a recommended part of NPs’ education (Kaplan and Brown 2007; Sains 2008). Development may include such methods as active learning strategies for online courses that accommodate different learning styles (Hoebeke 2009). Peer-reviewed journal articles, systematic reviews and
best practice guidelines are also recognized as important in helping the clinician to provide current, evidence-based care. For example, the Canadian National Opioid Use Guideline Group has written guidelines to aid in prescribing opioids for chronic non-cancer pain (NOUGG 2010). NPs require ready access to these resources in their practice settings through, for example, an online resource such as UpToDate.

Klein (2012) offers recommendations on ways in which pharmacology education for NPs in the United States might change to better reflect the current climate of prescription utilization, because there is an identified discrepancy between curricular design and actual regulatory requirements. For example, although prescription drug marketing directly to the public is illegal in Canada, in reality consumers have ready access to pharmaceutical advertising on US television stations, written materials and the Internet. Evidence has shown that this exposure has influenced the purchasing and prescribing habits of Canadians (Klein 2012). Thus, NP students should be educated to understand the influences of pharmaceutical marketing and learn how to engage their clients in conversations with regard to safe and effective prescribing (Klein 2012). In this way, client expectations are aligned with best prescribing practices.

Other areas of prescribing that are important in NP curricula include the practice of off-label prescription safety, compounding medications and ethnopharmacology, the study of how genetic and cultural factors influence the use of and response to pharmaceutical treatments (Klein 2012). The goal of education is to limit the impact of adverse effects of drugs. The diversity of the Canadian population in terms of ethnicity and culture makes this topic very relevant to the education of NPs in Canada.

There have been recommendations for NP education programs in the United States to include a prescribing practicum as part of the pharmacotherapy requirement (Hales et al. 2004). This strategy has not yet been put into practice, and thus its potential benefits have not been demonstrated. However, this is a recommendation that Canadian NP educators and regulators might consider for NP curricula in Canada.

**Conclusion**

NPs are becoming increasingly integral to primary care delivery and reform in Canada. Because people most commonly see their provider for prescription pain medication (Gerhardt 2004), the ability to prescribe these medications needs to be part of NPs’ scope of practice in primary care (DiCenso et al. 2010). Practising to full scope with full autonomy will be the most effective way for NPs to make a difference in healthcare access and costs. The evidence suggests that countries with
strong primary care systems have improved population health and reduced costs (DiCenso and Bryant-Lukosius 2010). In addition, a recent synthesis of evidence in the United States supports that, consistently over the past 45 years, NPs have been shown to be cost-effective providers (AANP 2010).

As discussed in this paper, nurse leaders in Canada were instrumental in advocating for legislative changes at the federal level for CS prescriptive authority for NPs. These changes were enacted in November 2012. The example of the Washington state NPs has shown positive outcomes in terms of increasing access and providing comprehensive care to clients without the need to involve a secondary provider. In Canada, multi-level systems are already in place – federal and provincial – to assist NPs in gaining the knowledge, confidence and ethical awareness necessary to adding this new responsibility to their practice.

The issues and recommendations presented in this paper were derived from the literature with the intent of providing insights into how NPs in Canada might experience a change in their prescriptive authority to include controlled substances. Nurse leaders and educators have an important role in ensuring that educational curricula, as well as continuing education opportunities, reflect the future environment of prescriptive practice as changes to the federal legislation regulating CS unfold. This change stands to improve access to care by enabling NPs to practise to their full scope and competency as fully autonomous professionals.

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References


