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# ***State of the Art in European Addictions Nursing: Perspectives from the UK, Ireland, and The Netherlands***

Addiction nursing as a 'specialist' nursing role in Europe, similar to other parts of the world, is in an 'embryonic' stage of development. Whilst there is a long and rich history of nurses working with individuals, families and communities impacted by problematic substance use, the European nursing community has, as yet, to establish a recognized framework for training, certification, standards and scope of practice in this field. If we are to safeguard and amplify the important role and contribution that nursing can make to this growing public health concern, there is a need to urgently tackle this status quo. As part of this response a group of European nurses, many of whom have been tirelessly working to change things in their respective countries, established the International Nurses Society in Addictions Nursing (IntNSA) European Region at the 10<sup>th</sup> ICN Nurse Practitioner and Advanced Practice Nurses Congress in Rotterdam, in August 2018. Nursing by its nature is about commitment to change things for the better, this effort and motivation has never been more needed and by doing it together the possibilities are endless.

## ***Nature and Scale of the Problem across Europe***

Established in 1993 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) collates and publishes detailed information on drug use and drug markets from over 30 European countries, and publishes a partial overview of the drug situation in 16 other countries (EMCDDA, 2018a). Data gathered annually provide governments and policy makers with comprehensive information on drug related trends which are used to inform laws and public health strategies. In addition to providing this information, the EMCDDA also seeks to provide the best evidence to ensure quality assurance and adherence to best principles in the prevention, treatment, harm reduction and social integration and recovery of drug users (EMCDDA, 2017b). In Europe 92 million people have reported having tried at least one illicit drug in their lifetime and there are over 1.2 million people in formal treatment for illicit drug use (EMCDDA, 2018b). The World Health Organization (WHO, 2018) also identify Europe as having the highest per capita alcohol consumption of the five WHO regions, and note alcohol consumption as a particular challenge in eastern European countries. In addition to an ageing population of opiate users, there are emerging needs among migrant and asylum-seeking groups. As a result of wars in the Middle East and extreme poverty in Africa, Europe saw a migration of 1.4 million asylum seekers between 2015-2016, presenting to services with trauma related conditions (e.g. PTSD, human trafficking) leaving them susceptible to developing addictions as part of an overall

response/coping strategy (Parliament, 2017). Furthermore, up to 80% of the population who access mental health services in Europe have some form of co-morbid addiction (EMCDDA, 2017a) and we are seeing an increasing role for nurses in dealing with behavioural addictions such as gaming, gambling and sex addictions, alongside working with families of those affected by addictions (Loth, Slee, & Peppel van de, 2012).

Now more than ever the need and demand for specialist competencies that nurses bring to alcohol and drug treatment warrants commentary. What is known is that there are an estimated 7.1 million nurses and midwives in the WHO European Region, over 90% are female, and salaries are below the national average in many countries. Standardized professional education and preparation for nurses has not yet been achieved, however most countries require 12 years of education before entry into an educational nursing or midwifery programme. Many countries recognize the need and are calling for nursing prequalifying preparation to move to graduate level education, but there are still countries where nurse training is at the level of a vocational qualification. Although the practice of nursing continues to evolve in response to new evidence-based treatments and changing technology, the disparity in scope of nursing practice persists, particularly when it comes to standardizing or describing advanced or specialist addiction nursing practice. For a full account on the situation of nursing and midwifery in general in the Member States of the European Region check out the following World Health Organisation report <sup>1</sup>. Despite these differences, nurses, as the single largest health professional group in Europe, are recognized as playing a vital role in assisting society to tackle public health challenges, including drug and alcohol use, with or without co-morbid mental health conditions, as part of achieving the goals of Health 2020<sup>2</sup> (see Figure 1).

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**Insert Figure 1 here**

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By historical standards, problematic substance use is going through a particularly dynamic phase in Europe and data suggest that drug availability by international standards is high and increasing (EMCDDA, 2018b). In this context, a multitude of factors have contributed to higher rates of drug related deaths in some areas (Bellerose, Carew, & Lyons, 2011; Public Health England, 2016). Within

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<sup>1</sup> [http://www.euro.who.int/\\_data/assets/pdf\\_file/0019/114157/E93980.pdf](http://www.euro.who.int/_data/assets/pdf_file/0019/114157/E93980.pdf).

<sup>2</sup> <http://www.euro.who.int/en/health-topics/Health-systems/nursing-and-midwifery/publications/2015/nurses-and-midwives-a-vital-resource-for-health-european-compendium-of-good-practices-in-nursing-and-midwifery-towards-health-2020-goals>

the illicit market, the increased availability of high potency synthetic drugs such as fentanyl, cannabinoids, and ecstasy as well as a range of new psychoactive substances has significantly increased the risks of drug use (EMCDDA, 2018b). The risk profile of people who are dependent on opiates is identified as having a linear relationship with the rising age profile and increases in poly drug and alcohol use. Within the general population in The Netherlands, UK and Ireland, prescription rates for narcotic analgesics and anxiolytic type drugs have seen a significant increase in the last ten years (Gallagher, 2018; Mordecai, Reynolds, Donaldson, & de C Williams, 2018; Van Amsterdam, Wartenberg, & Van Den Brink, 2015). While prescribing practices and overall monitoring is different from the USA, continuing vigilance is required in this area. The effects of the recent economic recession in the UK and Ireland, and the consequential rationalisation of services and cutbacks in the number of registered professional staff including specialist nurses, cannot be underestimated or ignored in terms of overall negative impact (Kelly, Hegarty, Barry, Dyer, & Horgan, 2018; Middleton, McGrail, & Stringer, 2016; Public Health England, 2016). Conversely, in the Netherlands, the value of the addictions nurses prepared at master's level is increasing and this role is being demanded by services. This need is being driven by the shortage of psychiatrists, a consequence of policy decisions to limit the number of training positions for psychiatrists, leaving an opening for nursing specialist roles to fill this vacuum (C.Loeth, personal communication, October 1, 2018).

### **Nature and scale across UK, Ireland and The Netherlands**

Based on data from the EMCDDA and the World Health Organisation, Table 1 provides a snapshot of the prevalence of opioid use and alcohol use across the three countries: UK, Ireland, and the Netherlands. It is notable that the prevalence of opioid use, drug related deaths, HIV transmission and some alcohol related harms is significantly higher per capita in Ireland and the UK, than it is in the Netherlands. The specific reasons for this are not clear, but historically there have been differences in policies in each country. For example, The Netherlands has one of the most liberal drugs policies in Europe and has historically placed greater emphasis on harm minimisation models. For example, in 1976 The Dutch opium law based on a 'risk scale' of sociological, pharmacological and psychological data, specifically separated 'hard' and 'soft' drugs, which eventually enabled cannabis to be sold legally in 'coffeeshops'<sup>3</sup>. The Netherlands has also provided medically supervised safe injecting centres in several regions for some time while Ireland and the UK have yet to reach consensus on this objective. Anecdotally at least, it is also easier for service users to access prescribed injectable diamorphine or methadone in The Netherlands. While both Ireland and the UK have expansive

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<sup>3</sup> In the Netherlands the term coffee shop has come to mean alcohol-free establishments where cannabis (weed, hash, marijuana) are sold and consumed.

methadone and needle exchange programmes, it is unclear if access to these is more advantageous in The Netherlands. Certainly, prescriptions for injectable diamorphine or methadone are available, albeit limited, in the UK, compared with Ireland where this practice is not supported. While per capita alcohol consumption in The Netherlands is almost as high as the UK and Ireland, alcohol related disorders, and death rates attributable to liver cirrhosis are significantly lower (WHO, 2018). It is not clear whether this is related to different drinking patterns, the number of abstinent drinkers in the population, or screening and detection rates for problematic alcohol use. These are all factors worthy of further investigation.

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**Insert Table 1 here**

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### **Responses to Addiction Treatment within the three countries**

In general, medical treatment is free 'at the point of access within the UK via the national health service (NHS), which the majority of citizens access. Private medical insurance is also available, should individuals opt to pay, which is considered to offer choice of doctor, and a more rapid response (i.e. no waiting lists). In Ireland healthcare is government funded, it is provided by a mix of public and private providers and users of the public system are often asked to pay a nominal fee. Despite this, over half of the population has private insurance as this facilitates access to better healthcare. In the Netherlands healthcare is provided by not-for-profit and profit institutions. All Dutch individuals have healthcare insurance – which is covered by the private healthcare insurance companies. If a person cannot afford these payments, social services provide support.

All three countries have published a national drug strategy each of which recognises the importance of providing a diverse range of treatment models and optimising access as central to successful long-term recovery. Emphasis is also placed on the value of empowering clients as they move through the treatment journey towards full reintegration within society. Of note is that both Ireland and the Netherlands have integrated alcohol within their overall strategy, unlike the UK who has published a independent strategy for alcohol.

Responsibility for the co-ordination of addiction care is largely 'de centralised' and delegated to regional (or national in the case of the UK) and local authorities or publicly funded agencies. Although historically addiction treatment fell within the remit of mental health services, and whilst still broadly

attached to the mental healthcare agenda in the Netherlands, addiction is viewed as 'separate' in terms of health care planning and service provision.

All three countries describe provision of drug treatment being available across a range of services. The Netherlands offers treatment via specialised addiction care organisations; municipal public health services, general psychiatric hospitals, several religious organisations and some private clinics. In the UK provision is provided via specialised drug treatment agencies which includes a mix of commissioned 'third-sector organisations' (i.e. registered charities) and/or in partnership with 'statutory (NHS type services). Residential inpatient treatment is available but limited, and if required treatment can be offered within prisons. The co ordination and management of Irelands drug treatment services comes under the remit of the Primary Care Division, which oversees a number of national care groups. Drug treatment is provided through a network of Health Service Executive (HSE) services (public), but also non-statutory/voluntary agencies, many of which are funded by the HSE. Some private organisations also provide treatment. Access to a complete overview by all EMCDDA reporting countries on the drug situation covering drug supply, use and public health problems as well as drug policy and responses is provided via the European Drug Report<sup>4</sup>.

### **Role of the Addictions Nurse: overview across three countries**

A narrative approach can help our perception of context and description of the emergent 'specialist' role of the addictions nurse, when considered in parallel with the history and account of drug and alcohol treatment within each country.

#### ***Ireland***

Illicit drugs did not become widely available in Ireland until the late 1960's and possibly later in many areas, but alcohol dependency was widespread and was historically treated through the mental health system, where mental health nurses had a key role (Butler, 2014). The development of addiction nursing in Ireland, has not been well documented thus far but may be best understood through a description of Irish policy responses to drug and alcohol use.

For both historical and political reasons, there has been a long history of a provision of healthcare in Ireland by the voluntary and private sector, especially by Catholic Church run organizations, many of whom worked in direct opposition to a medical model of recovery. This, amongst other influences,

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<sup>4</sup> [http://www.emcdda.europa.eu/countries\\_en](http://www.emcdda.europa.eu/countries_en)

has determined the current shape of services in Ireland (Butler & Mayock, 2005; Quin, 2005). The earliest addiction rehabilitation programs in Ireland from the 1970's onwards were largely run by members of the Catholic order and were heavily influenced by the disease model of addiction or 'Minnesota model' and were abstinence based while utilizing a confrontational counselling and education approach (Butler, 2011). This, in combination with the insurance industry, the role of private medicine and government policy have influenced the development of all health services in Ireland (Barrington, 1987,p285). Many treatment programs in Ireland were financed, and still are today, by a combination of public finance, private health insurance, direct service user payment and public fund raising (Butler, 2011). This has somewhat limited government leverage over, and responsibility for, addiction treatment services and the development of the workforce.

One of the implications of a historical and ideological opposition to the medical model and church involvement has been a strong emphasis on the role of counsellors in addiction treatment services (Butler, 2011). In this context, there is evidence of mental health nurses re-training as addiction counsellors and under the supervision of non-specialist nurses, taking up roles as counsellors in mental health services where their broad range of nursing skills were no longer utilized although this practice has now been phased out (Butler, 2011, 2014).

The emergence of the nursing specialism in addictions was still embryonic during the opioid epidemic in the capital Dublin in the 1980's when specialists in addiction nursing began to emerge. This occurred in conjunction with the development of a range of government funded services (Scully, Geoghegan, Corcoran, Tiernan, & Keenan, 2004). Substitute prescribing services at this time were provided mainly in Dublin, under the health services mental health division. The situation in Ireland at that time was reflective of other jurisdictions, where there was an overwhelming concern to prevent the spread of HIV. During this period, it seems that the role of the nurse initially at least, was confined to the dispensing of methadone, without any deference to the much broader nursing skillset. This began to change with the publication of a new Irish policy document 'Psychiatric Services: Planning for the future' (Department of Health, 1984). This sought to move the treatment of addiction problems into the community, and attributed addiction to a range of social and health problems which largely discredited the disease model of alcoholism (Butler, 2014). This, and the expansion of methadone prescribing, and the provision of needle exchanges marked this period where Irish treatment provision shifted towards a more liberal 'harm minimisation' approach (Butler & Mayock, 2005; Keenan, 2002).

The most controversial and significant policy shift of recent times, and a most important shift for nurses and the medical profession, occurred with the publication of the existing mental health policy 'A Vision for Change' (Department of Health and Children, 2006). This policy determined that people with addiction problems would no longer be treated within the mental health system apart from those with a co-occurring mental health problem and substance dependence. This policy, in conjunction with the publication of the National Service Plan for the National Health Service (Health Service Executive, 2005) saw responsibility for addiction treatment shared between the social inclusion and primary care directorates (National Documentation Centre on Drug Use, 2005). This policy shift drew much criticism from clinicians at this time and no evidence based justification for the dislocation of addiction from the mental health services has ever been provided (Butler, 2014). The implications of this policy for addiction nursing have been significant. Many of the statutory services in Dublin with a cohort of nurse specialists were retained, but as the opiate problem spread outside of Dublin, service provision was typically outsourced voluntary sector providers. This has had implications for nurses in many ways. Clinical governance, remuneration, stability of employment as well as career pathways for specialist nurses are a continuing source of concern.

There is a growing recognition of the role that specialist nurses can play in addictions and addiction nurses continue to provide leadership in developing services, research and initiatives such as the implementation of a national brief interventions programme for alcohol (O'Shea & Goff, 2009). Table 3 provides an overview of the extensive areas in which specialist addiction nurses work in Ireland. In 2016, The Ireland Chapter of IntNSA was established as IntNSA's first international chapter and now has 53 members. This group formally inputted into the development of Ireland's new national drugs strategy, which was a first for a specialist nursing group. This strategy signaled a more pragmatic health based approach to drug use, which is reflective of the broader social changes and shifting attitudes in Irish society (Department of Health, 2017). Since 2017, addiction nurses are also formally represented for the first time at a national level as IntNSA received ministerial invites to sit on The National Oversight Committee and The National Implementation Committee which oversee the implementation of the new national drug strategy. The strategy specifically mentions the development of the nursing role for treating young people, in midwifery and in substitute prescribing (Department of Health, 2017). More broadly, the de-criminalisation of drugs is now being openly debated, while the opening of Ireland's first medically supervised safe injecting centre in Dublin, which will be managed and staffed by nurses, is now imminent. In 2018, Ireland saw developed its first Advanced Nurse Practitioner in addictions and many nurses now prescribe medications albeit in a limited capacity. It is hoped that that the work of IntNSA nurses in Ireland supported by international

networks, will facilitate the full realisation of the potential benefit for service users of the expansion of specialist addiction nursing and non-specialist nursing roles, while marking the dawn of a new era.

### ***Netherlands***

Unsurprisingly when tracking the development of addictions nursing in the Netherlands, the influence of how addiction treatment was viewed historically offers insight. From 1880 till early 1900 addiction was seen as reprehensible behavior that must be managed through strict re-education (1880-1920). This definition progressed, and addiction was re described as weak behavior treatable by psychological interventions aimed at motivational growth (1920-1990), and subsequently this moved to a psychiatric disease with chronic aspects treated with the help of medication, cognitive behavioral therapy, and cognitive enhancement methods. More latterly attention to the relation between addiction and other psychiatric diseases is noted (Blok, 2011). This definition paradigm shift is considered to have a tremendous influence on the development of addictions nursing, especially the positionality of the nurse within the treatments being offered. For example, the role of the nurse changed from a minor role associated with dispensing medication, compared with the social worker who took the 'treatment lead' to more nurse driven treatment modalities (Loth, 2009). This paradigm shift, alongside a move away from expecting clients to achieve total abstinence to accepting harm minimisation, facilitated nurses to assert their role and competencies by making nursing work more visible and offered opportunities for nurses to demonstrate their value in addressing the spectrum of associated challenges particularly how nurses can work with impulsive-compulsive behaviors (Loth, 2009). This shift was accompanied by a parallel change in the title given to nurses working in the drug and alcohol field i.e. from alcohol and drug nurse to addictions nurse (post bachelor) and addictions specialist nurse (master/MANP level), in Dutch 'verslavingsverpleegkundige', meaning 'addictions nurse'. The focus is not only substances but also addictive behaviours e.g. eating disorders, gaming, etc. The roles, tasks and responsibilities of the 'verslavingsverpleegkundige' are formalized in legal frameworks and are aligned with physicians and psychiatrists. Dutch MANPs are permitted and qualified to prescribe anti-craving medication, and medication for detoxification; and are free to consult with addictions physicians or addictions psychiatrists concerning off label medications such as topiramate, baclofen etc.

Over the last number of years a number of addiction nurses had formed a 'special interest group' Dutch Society on Addictions Nursing which was formally merged and established as IntNSA Holland, and launched in 2018 ([www.intnsaholland.com](http://www.intnsaholland.com)). This group has been extremely active over the last 15 years in influencing the addiction agenda within the Netherlands, including connecting and

collaborating with the Dutch Society on Addictions Medicine (<https://www.vvgn.nl>) and other institutes concerning addictions treatment and research. The impact of this work has resulted in an increase in nursing content in national guidelines concerning relapse management in alcohol addiction, methadone maintenance treatment, heroin assisted treatment, and user rooms for alcohol and heroin.

In recent years, attention to nursing addiction education has seen the introduction of addictions and addictions treatment curricula, including 'dual diagnosis/co-morbidity' within the 3-year ANP Mental Health nurses training programme. It is proposed that this curricula provides a strong starting point for the development of a European CARN Advanced Nursing Practice award.

Addictions nursing research is increasingly better organized and recognized. In the latter part of the 20<sup>th</sup> Century and early 21<sup>st</sup> Century Loth initiated (Loth, 2009; Loth, Schippers, Hart, & Van De Wijngaart, 2007) a change project with employing action research methodology addressing methadone maintenance in Holland. This work offered a critical account of poor care facilities and poor care by managers, nurses, and those that commission such services. The findings from this research were picked up by the National Health Inspectorate who responded by calling for action, which led to establishment of the Dutch National guidelines for Methadone Maintenance Treatment (including Suboxone, and heroin assisted treatment). This study also offered an opportunity to highlight and promote the role of nurses, enhance their autonomy and to take reassert their nursing position within this field. Mumba and Snow (2017) discuss nurse driven treatment options like SBIRT and efforts to disseminate such practice was trialed in a general hospital setting in central Holland (Tijmenssen, van Etten & Loth, 2014). Two ANP nurses implemented alcohol and drug screening during admission on the Emergency Room (ER) units and offering clients who screened positive an opportunity to undergo brief intervention and/or enter treatment. The findings from this nurse driven research report that patients with Substance Use Disorders (SUD) in general hospitals have to deal with negative stigma, poor assessments, and poor treatment options. In addition, the study found that hospital staff had a poor image of the work of the addictions specialist nurse.

MANP's in Holland play an active and advanced role in a range of innovations in addiction treatment, for example in developing outpatient clinics for patients suffering from ADHD and SUD. Including developing 'dual diagnosis' treatment for patients suffering from SUD and autism spectrum disorders and or attentions deficit disorders (Kronenberg, Slager-Visscher, Goossens, van den Brink, & van Achterberg, 2014; Kronenberg, Verkerk-Tamminga, Goossens, van den Brink, & van Achterberg, 2015).

Furthermore, attention has been given to the special care needs for patients suffering from addictions and severe physical problems and end of life care. A national guideline for palliative care for these patients has been developed via practice driven research in collaboration with an addiction institute and the national center for palliative care 'Agora' (Ebenau et al., 2018). The most recent example of innovative practice is the supervised home detoxification model, delivered by a mobile multi-disciplinary team (addiction physician, addictions nurse specialist (MANP)) who visit the client at home for a 'Home Detox' (alcohol or drugs), funded via health care insurance (Bogaerts, 2018).

### ***United Kingdom***

There is evidence to suggest that nurses in the UK have been working with problematic substance use for over six decades, from nursing on the first in patient addiction treatment units for alcohol dependency in 1955, to reports of 100-150 nurses being appointed to newly created posts to support regional services for the treatment of drug dependency in the early 1960s, often referred to as 'DDUs' (Drug Dependency Units). Early roles and scope of practice have been well described (Rassool & Gafoor, 1997) and over the succeeding years, as services increased (primarily within the NHS system) so too did the numbers of nurses. By 1986 numbers had reached a critical mass to facilitate establishing a special interest group called The Association of Nurses in Substance Abuse (ANSA). In 1997 with funding from the Department of Health, ANSA published their 'scope of practice document' outlining the role of the nurse in respect of specialist assessment, management and care of individuals with problematic use of psychoactive substances (licit and illicit) (Clancy, 1997). At that time addiction nurses were working across a range of services including traditional hospital clinics and wards and community locations, such as police custody suites, primary care settings and needle exchange facilities.

Over subsequent years, and in conjunction with unprecedented levels of change to funding, commissioning, management and delivery structures across the addiction treatment landscape, driven at the time by what many viewed as the introduction of ideological competitive tendering by the Government, which witnessed the rapid shift of provision from established NHS addiction clinical services to third sector charities who were 'winning' tenders (often at reduced prices) overseen by local commissioning authorities. Whilst it would be unsafe to pre-suppose that the 'treatment efficacy' provided by the new providers would be any better or worse, what this shift did result in was a change in the profile of the addiction workforce. In the past decade and given that nurses are more strongly aligned to work within the NHS, the number of nurses working in third sector addiction services (which make up the largest share of service provision) are not as evident. This has had a

knock-on effect such that the merits of having a nurse working within an addiction service have all but been lost. In 2017 members of ANSA, along with the Royal College of Nursing (RCN) were invited by Public Health England to set up a steering group to publish *The Role of Nurses in Alcohol and Drug Treatment Services: A resource for commissioners, providers and clinicians* (Public Health England, 2017). This publication revisits and sets out the key behaviours, skills, and competencies that nurses offer in the care and treatment of individuals with problematic substance use.

Despite these challenges addiction nurses within the UK have continued to develop and enhance their role and have taken advantage of the broader changes within nursing including extension to prescriptive authority. Since May 2006, qualified nurses (along with pharmacists) have been permitted to prescribe independently, any licenced medicine for any medical condition, including some controlled drugs. This enhanced role has expanded opportunities for developing the role of addiction nurses across services, supporting the wider multidisciplinary team, whilst increasing access and continuity of care for clients who require substitution programme. In addition to clinical practice, addiction nurses can be found working within education (e.g. nursing schools); and research institutions.

With respect to preparation of the 'specialist' addiction nurse in the UK, due to increasingly limited availability of post graduate training, the gradual erosion of specific addiction courses for nurses and the move towards multi professional/interdisciplinary cross training programmes, it could be argued that formal role preparation for addiction nursing is in crisis. Notwithstanding the availability of the CARN and CARN-AP, these certifications primarily meet the needs of nurses working within North America and the curricula has been mapped accordingly. There are some excellent training courses available in the UK but they are not nursing specific. Consideration on how best to address this educational gap, and more importantly a recognised certification in Europe remains a challenge, and worthy of IntNSA Europe's attention.

### ***The 'hidden' role of addiction nursing in Europe***

Despite clear evidence that addiction nurses are employed across the European state, there is no workforce data available on numbers working either directly or indirectly with problematic substance use. Hence any information on actual numbers of nurses, their educational preparation and their scope of practice is one of conjecture. However, the authors in preparing this article, in addition to drawing on their personal experience and research as addiction nurses which stretch across 10 – 25

years (Clancy, Kelly, & Loth, 2018; Clancy, Oyefeso, & Ghodse, 2007; Kelly, Hegarty, Barry, Dyer, & Horgan, 2017; Loth et al., 2007) have engaged with key informants from 5 European countries (Albania, Belgium, The Netherlands, Republic of Ireland, and United Kingdom) and reviewed the nursing literature on role of addiction nurses, with the purpose of capturing an overview of what is the 'state of the art of addiction nursing' in 2018 in Europe. Based on this, Table 2 provides a brief overview of the best available estimates of the state of addictions nursing workforce in five EU countries.

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**Insert Table 2 here**

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### **Scope of Preparation and Practice**

In exploring the scope and practice of addiction nursing, key informants advised that there is no consensus on definition of what an addictions nursing role covers in their respective countries. This was also reflected in lack of clear career pathways. As noted earlier there is no workforce data available on numbers of addiction nurses, or indeed levels of expertise. All informants advised that there is no formal set of standardized qualifications to actively differentiate daily practice in addiction treatment services and accredited training is noticeably absent. Whilst the role of the addictions nurse is not clearly defined, informants do report that nurses can be found working across a range of addictions treatment facilities and settings (Table 3). An extra and positive development is the work of addictions nurses within primary care settings working alongside general practitioners, and for some countries the expansion of 'specialist roles' extending to midwifery.

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**Insert Table 3 here**

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Despite the paucity of data providing a coherent overview of the role of addiction nurses, a review of the literature (including 'grey literature') tells another, albeit modest, story. We identified a number of exemplars which provide insights on the role of addiction nursing in Europe (see Table 4). In addition to these exemplars there have been two studies that describe specifically the role development of addiction nurses, both within the UK. The first published by the Effective Interventions Unit, is an exploration of the role of substance misuse nurses in Scotland (Matheson et al, 2004); the second reports on a study by Clancy et al. (2007), within a English sample of addiction nurses, which explores factors influencing recruitment and retention in addiction nursing, and the stages and features of role acquisition and personal quality important to that role.

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**Insert Table 4 here**

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Of particular concern is the absence of visible and consistent provision of addictions training at both pre-qualifying (e.g. fundamentals, SBIRT) and post qualifying level (i.e. specialist accreditation). If training is available within undergraduate nurse education (Bachelor level), anecdotal evidence suggests this is primarily driven by individual nursing schools and associated presence of a faculty member on staff who has training or an interest in the subject of addictions, and students' attendance is optional. Key informants report that to progress and undertake advanced training as a 'specialist addiction nurse' there is no standard qualification either within country or across Europe. Nurses who have attained such status undertake individualized 'educational pathways' which may reflect masters level, but this is not automatic. The general picture is nurses choosing to take advanced practice courses in pharmacology (linked to prescriptive authority); and specific psychological interventions including for example motivational interviewing; and/or additional non-clinical academic courses on subjects such as dual diagnosis, substance misuse etc. to supplement on the job training within addiction services.

Of note when informants were invited to consider what in their view were the top priorities that needed attention within their respective countries; the issue of addressing persistent 'negative stigma' and reinforcing the notion of the role of the wider community within the recovery agenda for individuals and families impacted by addiction remain high on the list.

Despite the differences (i.e. economic, political, strategic) between each country, key themes also highlight clear commonalities: the absence of a consensus on role definition (what does it mean to be an addiction nurse), standard qualifications and accreditation, lack of cogent standards and scope of practice; no workforce data; limited research on the role and impact of; and by addictions nurses.

### **What next for European Addiction Nursing**

As the phenomenon of addiction continues to grip the global community, the nursing profession has a key role to play as one element of a response framework in preventing, reducing, and eliminating the harm caused by substance misuse. Indeed, this assertion was made by World Health Organisation (WHO) and the International Council of Nursing (ICN) when they defined the component roles of the nurse in relation to working with substance misuse as: provider of care, educator/resource person, counsellor/therapist, advocate, health promoter, researcher, supervisor/leader and consultant (WHO/ICN,1991). It is discouraging that despite this proclamation over 25 years ago, the opportunity for this role to be fully realised across Europe is still in abeyance. With the formal launch of IntNSA's European Region in 2018 there is a real sense of energy, commitment and community of practice. This platform offers, for the first time, a significant opportunity for addictions nurses to come together with a collective purpose. Key areas of work include:

- Fighting 'stigma' and raising awareness;
- Focusing on 'recovery'; and working with emerging groups e.g. older drug users;
- Developing and strengthening nursing expertise and explicit nursing interventions on addiction;
- Positioning addiction education within 'prequalifying' nursing courses (i.e. preparing the next workforce generation); and
- Seeking to develop, establish and gain recognition for the accreditation and certification of specialist addiction nurses (e.g. CARN and CARN-AP Europe)
- Designing the scope and standards for nursing addiction across Europe
- Developing clear career pathways and addressing pay and conditions

The power of nursing is through professional coalition - the collective voice is needed now more than ever in Europe to shape the role of nursing in respect of addiction policy, addiction practice, addiction research, and addiction education.



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