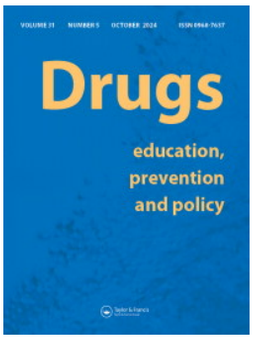

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RESEARCH ARTICLE

The role of UK alcohol and drug (AOD) nurses in a changing workforce

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ABSTRACT

Background: This paper presents the findings from an exploratory study on alcohol and other drugs (AOD) nurses' views on current career opportunities and challenges and on how their role has been affected by clinical and structural changes in service delivery.

Methods: The paper is based on qualitative interviews with a purposive sample of twelve AOD nurses in the UK. A narrative approach to interviewing aimed to encourage emergence of new insights and suggest theories for future examination. Interview domains were informed by the research team's knowledge of AOD nursing and by themes from published literature. Interviews were recorded, transcribed, and coded and a reflexive thematic analysis was conducted.

Results: Key themes emerging focused on the growth, advantages, and challenges of non-medical prescribing (NMP), and the impact on AOD nursing of changes in workforce structures and environments. The findings indicate considerable doubts about career opportunities for nurses in AOD services although NMP may offer some limited routes to career advancement.

Conclusions: Some long-standing issues around the identity and professional status of AOD nurses persist and current clinical and structural changes have created a "liminal space" within which the nursing role and AOD nurse identityare disrupted and in transition.

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Alcohol and drugs nursing; non-medical prescribing; structural change; professional status

Introduction

Although nurses have always been present in the alcohol and drugs (AOD) sector across prevention, treatment, harm reduction, and recovery contexts, their role within service delivery has received little attention in the UK and elsewhere (Clancy *et al.,* 2007; Gagnon *et al.,* 2019; Kennedy, 1986; Rassool & Gafour 1998; Searby & Burr, 2020). In the UK, nurses were part of the core clinical teams delivering alcohol and drug services from the 1960s (Ettorre, 1985; Glatt, 1982; Smart, 1985); they were central in the work of community alcohol teams home in-home detoxification in the 1970s and 1980s (Fleeman, 1997; Kennedy, 1986) and in community drug teams which emerged a little later (Strang 1992); and they were core members of general practice and hospital teams managing people with drug problems and HIV (Guthrie & Barton 1995). All the same, despite thirty years of growing involvement in both hospital and community treatment services, their role was barely recognized as a specialism within nursing until the beginning of this century. Part of the reason may have been because nurses were given a wide range of occupational labels such as "alcohol nurse", drug dependency nurse", "community psychiatric nurse (addiction)", "drug counsellor", or "therapist" and other labels that hid their professional identity (Rassool and Gafour 1998; Coyne & Clancy, 1996). In addition, as Rassool and Gafour (1998) pointed out, gaining recognition of addiction nursing as a specialty was seen as challenging, not least because caring for individuals and families affected by substance use had low priority at both pre- and post-professional levels. Another reason stemmed from the way in which addiction nurses, and nurses in general, were framed in the scientific literature as well as in the media and public arena. Hallam (1995) refers to the multiple and various stereotypes applied to nurses – among them, the ministering angel, the battle axe, the sexy nurse, and the "doctor"s handmaiden" - because AOD nurses generally worked under the direction of a doctor (Corser, 2000). Such images affect not only professional recruitment and retention but also nurse identity and nurses" sense of agency within their profession (Bridges, 1990).

By the 1970s, nurses in general in the UK were beginning to contest public and media images and the low status of their profession, manifesting in the demand for parity in pay with other professional groups (Webster, 1996). For AOD nurses specifically, a shift occurred during the 1990s when nurses working in the drug and alcohol sector started to gain a voice through collective, advocacy action, facilitated by the establishment of "professional societies" such as the Association of Nurses in Substance Abuse (ANSA). At the same time, the term "addiction nursing" was imported from the USA, signaling the

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emergence of "addiction nursing" as a specialism in its own right. Box 1 provides basic details of organized activity from 1975, starting in the USA, and spreading to the UK and globally. How nurses and the nurse role were "framed" began to shift as nurses took more control over their professional image and professional career pathways (Clancy & Fornili, 2019). By the start of the new millennium, although issues of job labeling and identity remained (Cameron *et al.,* 2006), UK studies reported an expansion in the tasks undertaken by AOD nurses, in the locations where they were employed, and greater opportunities for leadership positions and for autonomy in managing patients with alcohol and drug problems. (Cameron *et al.,* 2006; Dunn *et al.,* 2006; Public Health England, 2017).

The current contexts of AOD nursing

Currently, in the UK, alcohol and drug treatment is provided via a range of treatment agencies, including the National Health Service (NHS) - in general practice and hospital settings, commissioned "third sector" organizations - i.e. registered charities (NGOs), prisons and other criminal justice contexts, as well as the private sector. Latterly, the field has seen a rise in the number of midwives and health visitors who have specialised in the care of pregnant women with problematic substance use and the postnatal care of infants affected by maternal substance use (Clancy et al., 2019; Public Health England, 2017). A recent survey (England only) noted that 9% of the alcohol and drug workforce were nurses; 6% worked in the voluntary sector, 20% in the NHS, 11% in private settings, and 5% in treatment settings provided by local authorities (NHS Benchmarking Network, 2023). Most AOD treatment services in the UK are provided free of charge via the NHS or Local Government funding.

There is no specific recognized NMC (Nursing and Midwifery Council) qualification for working in addictions. The NMC has a number of registration and qualification codes, and broadly the majority of nurses working within AOD will be entered onto the register as a Mental Health or Adult Nurse. Increasingly, AOD nurses will also have a recordable qualification V200: Nurse independent prescriber (extended formulary), or V300: Nurse independent or supplementary prescriber. AOD nurses are not required to have specific training in alcohol and drug problems, although some do gain additional postgraduate qualifications in alcohol and drug studies or attend specialist post-registration AOD training courses. The work they do has been well described. It includes a wide range of clinical components (e.g., biopsychosocial assessment, care management, prescribing medications for the treatment of alcohol and drug problems, psychosocial interventions, blood-borne virus testing and vaccinations, wound care, needle and syringe exchange, etc.) as well as leadership roles (e.g., clinical supervision, team management, service development), quality improvement and governance, and teaching/training roles (Matheson *et al.,* 2004; Mendes & Palmer, 2018; Public Health England, 2017). Medication management is one important aspect of the role. For example, nurses are well placed to manage opioid substitution therapy; initiate and monitor alcohol detoxification in the community; supply and/or administer a named medicine to anyone who fulfills a pre-determined set of criteria, without the need for a specific prescription for a named service user (e.g. hepatitis vaccination, acamprosate and naltrexone for relapse-prevention, parenteral vitamins for severe vitamin B/C deficiency resulting from alcohol dependence) (Public Health England, 2017). The role varies depending on the specific service delivery context and the nurse's role within the team; but it is continually influenced and amended by both clinical guidelines and structural change. In this paper, we focus on these two change agents which have impacted UK AOD nursing over this century.

Box 1: Emergence and development of AOD nurses advocacy groups

USA
1975: National Nurses Society on Alcoholism (NNSA) founded, (component of the National Council on Alcoholism)
1982: NNSA became an independent specialty nurse organisation
1983: NNSA became National Nurses Society on Addictions
1997: NNSA merged with the Consolidated Association of Nurses in Substance Abuse (CANSA)
1999: CANSA merged with the Drug and Alcohol Nursing Association
2000: International Nurses Society on Addictions (IntNSA) combined the organisations

Europe
2018: Launch of IntNSA"s European Region (UK, Ireland, Netherlands)

UK
1983: Association of Nurses in Substance Abuse (ANSA) set up

Australia
1982: Drug and Alcohol Nurses Association (DANA)
1984: DANA became Drug and Alcohol Nurses of Australasia

Global
IntNSA: International Nurses Society on Addiction - developed from NNSA. Now includes chapters in USA, UK, and globally*.
*For an extended account of the growth of IntNSA see Clancy et al., 2019

Clinical change

One notable change over recent decades has been the development of advanced clinical practice roles to address workforce shortages and increasing patient numbers. Nurses were one of the relevant occupational groups targeted for these roles and by 2010 there was agreement that consistency was needed in applying the term to nursing roles and clarifying the expected tasks (Hill, 2017). Among other things, the role aimed to modernize nursing careers and support career progression. Advanced Nurse Practitioners (ANP) are experienced nurses, educated to a master's level, who can work autonomously, assessing, diagnosing, and treating patients, and taking on leadership roles (RCN., 2018). In some countries, including the UK, the ANP role includes prescribing medication in their field of practice (Public Health England, 2017). Prescribing, once seen purely as a doctor's privilege, has become more widely available to other professionals and is one of the skills that enable nurses to work as independent clinical decision-makers (Cooper et al. 2012; Courtenay *et al.,* 2017; Graham-Clarke *et al.,* 2018). As non-medical prescribers (NMPs), nurses can initiate and monitor pharmacological treatment which has the potential to shift service provision to a more nurse-led, streamlined, and faster access to treatment.

It is argued that NMP is an opportunity for development and career progression; it increases job satisfaction; it might help attract new nurses and retain the existing workforce; and has the potential to improve patient outcomes (Courtenay et al. 2017; Graham-Clarke *et al.,* 2018; Noblet *et al.,* 2018).

These clinical changes and the possible career advantages of NMP roles have been seen as relevant to AOD nursing and appear to be taken up by nurses. The English workforce survey recorded nurses as constituting 86% of active non-medical prescribers (NHS Benchmarking Network, 2023). It is suggested that for patients, it offers more cohesive, person-centered care and enables timelier and more accessible treatment (Bhanbhro *et al.,* 2011). In times where budgetary constraints become more prominent – and doctors and psychiatrists scarcer - nurse-led services fill the gap and improve patient outcomes (Courtenay *et al.,* 2017; Noblet *et al.,* 2018). However, challenges have also been voiced; these include a lack of organizational support and a clear framework for implementing NMP, lack of supervision from relevant senior members of staff, pressure on nurses to prescribe for patients with more complex care needs - something which they may not feel safe to do, and an inadequate number of NMPs in teams, leading to feelings of professional isolation (Avery *et al.,* 2007; Hemingway, 2005; Noblet et al. 2018).

Structural change

Changes within AOD nursing are, of course, closely linked to wider structural and systems changes both in the health service in general and regarding the delivery of AOD services in particular. Across the UK, the composition of the AOD workforce has been changing to build "multi-disciplinary teams" to include a wider range of occupational groups, volunteers, and people with lived experience in service development and delivery (Edison *et al.,* 2020). At the same time, especially in England, there has been a shift towards the delivery of alcohol and drug services out of the NHS and towards the third sector (i.e. organizations that are not for profit and non-governmental, in contrast to the public and private sectors). It has been noted that since local authorities in England became responsible for commissioning AOD services under the 2012 Health and Social Care Act, there have been cuts in AOD treatment budgets and a reduction in the number of psychiatrists, clinical psychologists, and nurses working in the addiction services (Drummond, 2017). Service commissioning is also changing, the aim being to move away from a competitive commissioning approach towards collaboration that brings together providers and commissioners of the NHS, local authorities, and other local partners in a geographical area (The King's Fund, 2020). While these shifts are apparent across the UK, there are some differences in how services are regulated; for example, nurses within third-sector organisations in England can become non-medical prescribers whereas in Scotland prescribing remains within the NHS. These structural changes, which affect where and how nurses are employed, raise issues of role expectations, role boundaries, and challenges to traditional ways of working and traditional leadership hierarchies.

The aim of this exploratory research was to investigate how nurses working in the AOD field across different service contexts viewed their current roles and opportunities for career advancement in a rapidly changing workforce environment. This paper has a particular focus on the impact of two key change agents - non-medical prescribing, and changes in workforce composition and service delivery location.

Methods

As the research was exploratory, beyond adopting a qualitative, interpretative approach (Tuffour, 2017), the study design did not use any specific theoretical framing. The intention was to allow themes and potential theories to emerge from the data. Interview domains were informed initially by the research team's knowledge of current issues in AOD nursing and themes in the published literature. An open, narrative approach (Anderson & Kirkpatrick, 2016) to interviewing was employed to encourage emergence of new insights and develop theories for future examination. Twelve interviews were conducted between June and August 2020 by two of the authors (FA and IJ). The sampling was purposeful, drawn from the research team's network to ensure that the planned topics were sufficiently covered and that there was at least one informant from each of the four UK countries (England, Scotland, Wales, and Northern Ireland). Interviewees were contacted by email; they received an information sheet and provided informed consent to participate. A structured questionnaire, which interviewees completed before the interview, collected basic demographic data, information about training, and previous AOD roles. Interviews were carried out online by Zoom, Teams, or telephone and took between 45 and 60 minutes. They were recorded (with permission) and transcribed. The open-ended interview schedule allowed participants to talk about their experiences and views as flexibly as possible within broad question domains, which covered: views on the current role of AOD nurses – challenges and possibilities; changes in the role over time; how the policy environment and changes in the structure of services have affected AOD nursing; the effects of COVID 19; perceptions on the needs for education and training, and views on the future of AOD nursing. The coding and analysis process followed the six phases of reflexive thematic analysis described in Braun and Clark (2012). All twelve of the interviews were coded initially by one member of the research team (FA) using a combination of deductive and inductive coding methods, and a draft thematic analysis was produced at this point. The interviews were then re-coded by a second researcher (BT) checking and expanding on the initial coding frame to reflect study aims and incorporate emergent themes. The coding, analytic notes, and interpretation of the synthesis of the data were discussed and refined at each stage by the whole research team. All team members assisted with drafting and commented on the final paper. Peer review of an earlier draft of this paper was provided by a nurse colleague who was not part of the project. Ethical permission was obtained from the Middlesex University Health and Social Care Ethics Committee (ethics application 14847). Research

procedures complied with ethical requirements to ensure anonymity, confidentiality, informed consent, and withdrawal at any point from the study. No incentives were offered for participation.

Findings

Following a brief overview of the twelve interviewees, this paper discusses participants" views on addiction nursing as a career, and their perceptions of the effects of recent clinical and structural changes on AOD nursing and career opportunities. In particular, we focus on the increase in non-medical prescribing, and, in England, changes in the structure and funding of services which have moved service delivery largely into the third sector. These two key examples of agents for change illustrate AOD nurses" experiences of working in a rapidly changing workforce. Other agents for change were mentioned, for instance, changes in the client groups and in the types of drugs and drug use patterns that impact on practice, and the influence of the COVID pandemic which brought about changes in access to services and the kinds of services provided. Education and training issues also emerged as important. However, these change agents are not discussed in this paper.

Table 1 provides details of the 12 study participants. They were AOD nurses from England (n = 7), Scotland (n = 2), Wales (n = 2), and Northern Ireland (n = 1), currently or previously working in NHS (n = 6), third sector (n = 3), in academic roles (n = 2), and both NHS and 3rd sector (n = 1). Nine interviewees were women and three were men. They were an experienced group of people who had been employed delivering alcohol and drug services in various positions in the National Health Service (NHS) and/or in third-sector organisations over many years. Six people reported having diplomas, masters, or, in one case, a course provided by the Royal College of General Practitioners on alcohol and drugs/addictive behavior. Nine people reported multiple short courses and brief training, such as motivational interviewing, non-medical prescribing, overdose prevention/naloxone, opioid substitution treatment, etc.

Table 1. Study participants.

Label	Country	Work setting	Main role	Years in AOD specialty
NI1	Northern Ireland	Hospital (NHS)	Substance misuse liaison team leader	22
W1	Wales	Hospital (NHS) acute admissions ward	Advanced nurse practitioner, mainly substance misuse & NMP	15
W2	Wales	Hospital (NHS) base & liaison with community services	Alcohol liaison nurse, teaching	12
S1	Scotland	NHS	Clinical nurse manager	28
S2	Scotland	Policy	Strategy co-ordinator	6
E1	England	NHS and third sector	CPNN	20
E2	England	Higher education	Management / supervision/ teaching	34
E3	England	Third sector provider	Associate director of nursing	11+
E4	England	Third sector provider	Lead nurse (and NMP)	8
E5	England	NHS	Clinical lead & consultant nurse	30
E6	England	NHS	Addiction specialist nurse in community service	24
E7	England	Higher education	Academic teaching role	29

AOD nursing as a career pathway

Most interviewees felt that addictions nursing was not an attractive career pathway for nurses, that nurses as a proportion of the workforce were shrinking, and that the nursing role had been contracting over recent years. It was thought that attracting young nurses into the addiction field and retaining them had become increasingly difficult. The loss of the "holistic" nursing role, delivering psychological interventions and a "comprehensive package of care" lay at the heart of many of the comments, for example,

> *I don"t think it would be a particularly appealing route to go, just because 1) the opportunities are so few and 2) unless you are going down the prescribing route, then I think it"s quite a narrow option these days; whereas in the past I felt it was quite a rich area to work in as a nurse. In the past I think we had a much more, dare I say, rounded role, because we would be expected to be delivering motivational interviewing type interventions, you know done in groups and having quite a satisfying role; whereas the role has contracted as well a lot. That is my experience, because services no longer offer those kind of options.* (E1, NHS & Third sector)

Other comments mentioned how nurses working in addiction services were "out on a limb and a bit stigmatised" (S2, policy & strategy coordination), how "substance use isn"t clearly defined enough and … there isn"t a clear structure for people, or training" (E2, academic), and that,

> *people hear drug and alcohol and that puts them off and I think they hear that they"re going to be prescribing sort of controlled drugs day in, day out, I think that kind of like scares people off.* (E4, Third sector)

One interviewee argued that, despite changes in the profession, nurses still faced "a glass ceiling" with respect to career progression.

> *I"m in a position of being the clinical lead of the service, but I definitely have got to a glass ceiling in terms of being able to be a clinical director, because I know that there"s medics within the organisation that will struggle with having a nurse who is a clinical director. … I think there"s many colleagues that are working in director positions within my Trust that would want nurses to be in clinical director positions, but the medics block it and I think it"s just a question of the culture within the organisation that we work in.* (E5, NHS)

The pessimism regarding addiction nursing as a career route, and the reasons for its decline, were summed up by one person as follows,

… professional career wise it's completely unattractive. I think the decimation of the services and the lack of career progression and although everybody has made great attempts around career progression, particularly the Blair Government around nurse consultants, as soon as you fragmented that pathway for nurses by having third sector organisations, you are going to end up perpetuating a model that they were trying to unpick, which is that nurses will just become managers within the third sector and you will end up having lost all that momentum that we wanted to make around clinical, academic posts. …. all the different nurse sub-specialties have a pathway. But when you start to look at addiction nursing, it's sort of disappeared as a sort of career to all intents and purposes. (E7, academic)

Despite the overall pessimism, a few interviewees did see positive developments to the nurse role; some felt there were pros and cons to the changes taking place, and two people stated that it was an attractive career proposition. As one person commented,

The role is kind of changing and getting bigger. . I think where it's expanding is, … nurses are getting more involved in stuff which used to be done primarily by doctors. (E4, Third sector)

This view was endorsed by another interviewee who also referred to changes in the doctor - nurse hierarchy,

Historically I would say a lot of nurses were very much "hand maidens" to the medical staff. Nowadays they are more autonomous in their practice and they work across addictions, across a variety of services from inpatient, acute, accident and emergency, prisons, custody suites and third sector and social care settings, not just the typical NHS nursing role. So, the diversity within the role has expanded and with that I think the nurses" skillset has expanded as well. The opportunities for nurses are greater (S1, NHS)

At least in part, positive change was associated with the adoption of NMP. This was seen to have increased nurses" independence and acted as a key driver of relaxation of a largely paternalistic service.

Non-medical prescribing as an agent for change

The importance of NMP was acknowledged by all interviewees. This expansion of the nurse role was seen to benefit both nurses and patients. It was seen as a way to re-professionalise nursing and enable nurses to re-establish their professional identity in a sector which had been "*downgraded*" through lack of funding (E6, NHS). In Scotland, it was noted that nurses are playing a key role in the delivery of opioid substitution treatment,

especially the development of non-medical prescribers, so nurses being able to take on that role; we've seen a lot more of that and I think that's crucial as well for, especially for that immediate access to treatment and nurses feeling confident to start people on prescriptions and do the kind of modifications of prescriptions as they see fit, rather than having to go to a consultant. (S2, policy & strategy coordination)

Comments from other interviewees supported the view that NMP had increased opportunities for nurses and also benefitted patients. The enhanced nursing role could reduce waiting times, provide more streamlined care and improve patient outcomes. For instance,

Nurse prescribing is something that this role does need to help expand the role and more nurses to deal with the ongoing demand of the service and start picking up the people who have fallen through the net. (W2, NHS)

. much improved patient outcomes … for example in an acute hospital at weekends, … there's less senior doctors on, junior doctors maybe not really experienced and that's where things can go wrong with detoxes; whereas if we are prescribing it, it would definitely cut that out, … definitely reduce risk and improve patient experience. (NI1, NHS)

Despite adding to their skill set, offering increased autonomy over their work and eroding the traditional doctor-nurse hierarchy to some extent, views on the changes brought about by the increase in NMP were mixed. Interviewees highlighted disadvantages for nurses and risks for patients associated with the change.

For some interviewees, becoming an NMP had resulted in a contraction of the traditional nurse role, a move away from holistic care to a more medical role:

… we've ended up in a situation where nurses are basically monitoring methadone prescriptions and that's become their key role. I don't think it should be, but that is what it currently looks like' (S2, policy & strategy coordination).

Furthermore, leadership opportunities were not necessarily greater, nor were the financial rewards.

. once people get into those community teams and they're on (income band), there's not really a huge amount of scope . I'm not suggesting that financial reasons is why people have done the non-medical prescribing, because it's a very challenging course, but even with that, it would appear that the role is not always recognised and rewarded. (NI1, NHS)

Changes in the nurse role also posed difficulties regarding professional boundaries and hierarchies, especially with doctors, and it was noted that lack of role boundaries could potentially lead to unsafe practice. For instance, pressure to prescribe when doctors' availability is limited could lead to frictions and nurses felt that there were patient safety concerns when prescribing for people with complex issues. Prior nursing experience and good training in NMP generally allowed the nurse to judge the extent to which nurse care was sufficient. However, as one interviewee mentioned, sometimes nurses were under pressure to extend their role to a point where they felt uncomfortable.

I mean I was able to say and that goes back to that thing about being an experienced person before you're a prescriber - I was able to say with confidence this is what I'm able to do and this is what I'm not prepared to do and that immediately produced some difficulties within the organisation. And the pressure was to be more flexible than I was comfortable with. (E1, NHS/Third sector)

This was linked to an issue that emerged prominently from the interviews, the lack of support and supervision, especially in some organisations, and the feeling of being isolated from colleagues:

… really there's not the set-up, there's not the governance there or the supervision available because if I can't find a consultant who feels confident and competent, dare I say, to support me around addiction

issues, then how can he or she be my medical supervisor and that's the reality of it. It comes back to that whole question of who is still around and who has got the experience to support and mentor people in addiction. (E1, NHS & Third sector)

Many services now are running with nurses doing the prescribing, but often in very exposed situations where they don't have access to clinical advice to consultant addiction psychiatrists. …. There's been both a restriction in some teams of the role of nurses where they are just doing the physical health assessments and vaccinations and those sorts of things and also an expansion of the roles of non-medical prescribers where they're carrying the clinical risk and prescribing for often very complex people and sometimes without the supervision and the support of the multidisciplinary team around them. (E5, NHS)

Overall, despite problems in the ways NMP was implemented and rewarded, it was seen as offering opportunities for career advancement. However, external factors, namely the wider context of service structures and funding, were mentioned as key factors in shaping the addiction nurse role.

Structural change: towards third sector provision and a broader based workforce

There were differences in perceptions of the effects of changes in the workforce and in the service delivery sector. The differences emerged most clearly between interviewees from Scotland and England.

In part, perceptions of the changes were positive, especially from the Scottish interviewees. They reported that the workforce was becoming more diverse and less clinical, with drug workers, peer workers and service user volunteers being part of the support offered. They saw some benefits of 3rd sector treatment delivery which included more flexible and friendly services for patients within a less medical model and nurses working in more diverse teams including peer workers and volunteers. This prompted a change in attitude around the topic of drug and alcohol problems for some nurses, who became less judgmental in their approach to patients. Having peer workers in the service was perceived to be particularly beneficial. (S1, S2). One of the Scottish interviewees provided this overview of the changes and the benefits:

Historically we've had systems where consultants, who are few and far between, absorb a huge part of the financial budgets in addictions and we can now see that they get far more from the nursing workforce who they've developed appropriately; and the workforce want to develop in that way. Those particular nurses have a desire to become CBT providers, or non-medical prescribers or advanced nurse practitioners. I think diversity within the workforce as well … multidisciplinary teams are always made up of nurses, doctors, psychologists and occupational therapists and now we have in our workforce, over the last couple of years, peer support workers in the workforce, people with lived experience; service user involvement is also part of management teams. So that kind of diversity has been a huge learning curve I would say and brought so much value to what can be provided within addiction services. Working in partnership with social care, voluntary sector and third sector broadened people's understanding and gave confidence in others being able to provide a significant part of care as well. So it was that partnership working that allowed the big machine that is the health service and other carers to be able to look at addictions in a more holistic way. (S1, NHS)

At the same time, it was noted that, in Scotland, the main core of community addiction teams is still within the NHS and they are the main prescribers. However, with different third sector providers coming in and taking over some areas of service provision tensions were arising because,

We've got people that work in those teams who are new to the team - kind of fresh eyes on that area of work - highly motivated, want to see change; but a large part of the workforce is people who have been there for many, many years and are quite stuck in their ways. So, the frustrations come from these dynamic change seekers who feel blocked by people who have been working in the service for many years, who are quite comfortable with their position that they're in. (S2, policy & strategy coordination)

By contrast, although some of the positive aspects of working in a more diverse team were acknowledged, in England, many NHS treatment services had been recommissioned in the third sector. This was seen as a cost saving exercise by several respondents. They felt that one of the results was that services were stripped back in terms of what was offered and focused on those at highest risk, people who use heroin. OST was the mainstay of treatment and formal psychosocial interventions became less available, according to the nurses interviewed. One interviewee described a "de-professionalisation" of services, meaning that fewer nurses and cheaper, less qualified staff were used to deliver the service. Some interviewees felt that unqualified workers in the 3rd sector were less experienced and had little understanding of addiction and this negatively affects patient outcomes. It was reported that nurses who wanted to work in addictions often felt "*that they had no choice but to be hived off into this other organisation*." (E2, academic). However, it was also noted that no evaluation of the effect of moving to the 3rd sector has been undertaken. Comments made by interviewees revealed their concerns.

Loss in the number of nurses working in alcohol and drugs and loss of skills and training opportunities were mentioned:

I was the clinical lead for the drug services in XXX for the last five years and we had about 15 nurses working across XXX in drug and alcohol services. The contract has just been taken over by (large 3rd. sector organisation) and they're going to have I think it's six (nurses), so they've thinned it down so much; you know the third sector providers bring the whole time equivalent of nursing and medical roles down to the absolute minimum. (E5, NHS)

I think the whole role of psychiatry is absolutely crucial and I think that when these organisations are taken away from the NHS, we lose a great deal in terms of the expertise and the training, … the ones that have always wanted to stay in the NHS, I think they had a much better training environment and I think they get much better support if they are in the NHS and I just think the whole ethos is much better if they are. (E6, NHS)

Closely linked to recommissioning - mentioned by interviewee E5 above - were the problems of funding and the stress of the re-commissioning cycle.

Re-commissioning is destabilising. … I mean they are having longer periods now, which is better. We've had like five to seven years in some areas. It's been three years before and often when you take over a service, it can take a year, eighteen months to really start to settle down and get the culture that you want and by then you are having to prepare for the re-tender. (E3, third sector)

The effects on nursing staff were explained by one interviewee but reflected the views of others,

> *… the one to one stuff, which I used to enjoy a lot, the key working thing, where you would really, dare I say, start to use your skills - that has more or less evaporated … because they weren't commissioned to do it; they said they weren't set up and there were too many other competing demands on them, and a lot of the work being focused on prescribing I guess, and trying to keep a large volume of people in the service. It's quite unsettling for nurses, because you'd have this situation where an organisation feels like it's changed, it's going to change its name every x number of years or whatever and I think it's quite confusing for service users as well if you are somebody who is a long-term service user. …So every time the service comes up for tender that it appears to be changing and what does that mean for them*. (E1, NHS & third sector)

In addition, pay and conditions in 3rd sector agencies were generally described as below that of nurses in the NHS and some nurses choose to leave and get another NHS post to avoid cyclical tendering which make it difficult for staff and patients to feel an allegiance to the service. One NHS based nurse described the tendering process as a "race to the bottom" (E6) which resulted in skills leeching from the system, and an acute loss of consultant psychiatrists from the field which she described as being crucial.

In sum, nurses acknowledged the benefits of working in teams which included practitioners with different backgrounds and skills but felt that too frequently the tasks they were given either stretched the boundaries of the nursing role too far or resulted in a contraction of their skills and opportunities. In particular, the fluidity and disruption caused by shifting addiction services out of the NHS had created a treatment "space" within which the nursing role was experienced as unsupported and poorly understood.

Discussion

This exploratory study has highlighted addiction nurses" views on how two current change agents have affected their work in drug and alcohol service delivery, their career opportunities, and their sense of identity as addiction nurses. Loss of identity was reflected in comments on continually changing and diverse job titles, role boundary tensions and lack of clarity regarding which tasks they felt "belonged" within the nursing role and which did not - or even threatened the integrity of nursing. Addiction nurses have always worked across different services and organisations and, in the UK, this has usually been within the National Health Service in teams where a medical/health approach predominated. Their roles were broad, employing clinical and caring skills, which adapted to meet changing client needs and changes in alcohol and drugs treatment approaches. Current challenges to the role have come from external sources, in particular the broadening of the workforce to include drug and alcohol workers from different professional and occupational backgrounds, volunteers and peer mentors, and people with lived experience. While these changes are welcomed, they have raised issues of boundary demarcation - both in the sense of AOD nurses being asked to carry out tasks they feel are not part of a nursing role and in the sense of nurses feeling that their traditional holistic approach is being eroded. The advantages gained from advances such as the expansion of NMP did not always offset the perceived restrictions on career progression, although they were seen to have contributed to changing the "handmaiden" status of nurses. Boundary and status issues are, perhaps, more prominent in England where most alcohol and drug services are now delivered by third sector providers. Comparisons made by interviewees drew attention to differences in salary, promotion, training opportunities and the availability of support and mentoring between the sectors.

Thus, the findings indicate continuing tensions around identity and the status of addiction nursing as a distinct professional sub-category. While new opportunities have opened up by way of NMP roles, this is seen to have eroded some key elements of the nurse role and, in England specifically, the re-location of addiction treatment away from the NHS and into third sector provision is perceived as increasing the risk of marginalising nurses. The shifting nature of the addiction nurse role as it responds to both internal changes in nursing and external pressures from changes in the structure and funding of services, may be seen as pushing nurses into a liminal space (Van Gennep 1960), where role tasks and role boundaries are unclear. This liminal space can offer positive opportunities for nurses to re-define their roles, but it can also cause uncertainty about identities, feelings of alienation from their profession, and possibly poor well-being as a result of the fluidity and unstructured nature of the individual's position within the space (Attenburgh, 2021; Bamber *et al.,* 2017). It remains to be seen whether current changes have created a temporary, transitional liminal space where new identities are being forged or a more permanent state of flux where identity remains ambiguous for a longer period of time and where the core and boundaries of the role are challenged (Beech, 2011). It may be, as Attenburgh's (2021) work suggests, that addiction nursing has always, to some extent, been on the margins.

Although based on a UK sample, the issues emerging from the research are relevant to considering the importance of occupational structures and locations as well as clinical conditions on AOD nursing and career progression for AOD nurses beyond the UK. For instance, similar issues were identified in research from Australia and New Zealand, where, as in the UK, "participants described working in diverse areas in addition to those considered "traditional" AOD settings, including maternal and child health, mental health, justice and prisons, consultation-liaison, and private practice" (Searby & Burr, 2020, p7). Participants reported challenges regarding recruitment, training, and the need to improve the attractiveness of AOD nursing, "as many believed it to be poorly promoted as a specialty, with misconceptions toward it in the wider nursing sphere" (Searby & Burr, 2020, p7). Comments were made about nursing roles being re-distributed to allied health professionals, including a move in some areas to integrate mental health and AOD services leading to role boundary and identity uncertainties (Searby & Burr, 2020). Lack of

perceived career opportunities and difficulties in recruiting young nurses into the field led to the conclusion that AOD nurses were becoming "endangered" (Searby *et al.,* 2022). Other work, looking specifically at the role of nurses in supervised consumption sites (SCS) across ten countries, found that their role remains poorly defined and understood, especially by decision-makers, employers, healthcare providers, and the broader community (Gagnon *et al.,* 2019). The authors also reported problems of recruitment, role ambiguity, the need for strong organizational support, and problems arising from dynamic and rapidly changing work environments.

Although healthcare systems and the role of nurses in delivering AOD treatment vary across countries and cultures, these examples illustrate some commonality in the structural and clinical factors that influence AOD nurses" sense of professional identity, motivation to join the alcohol and drug treatment field, and their perceptions of career opportunities and professional development.

Conclusion

A longer historical view highlights how AOD nurses have struggled to secure their place as a distinct group of nurses working in a specialized field and how they have forged a more defined identity through collective action and by adapting to new working conditions and contexts. It also highlights the centrality of nurses in providing an effective and appropriate response to alcohol and drug-related problems across various service delivery contexts.

The exploratory nature of the study imposes limits on the extent to which the findings can be generalized. For instance, our sample consists of experienced AOD nurses who have worked in service delivery for considerable periods of time. Further work needs to include younger and mid-career nurses at different stages in their careers; a larger number of participants from Scotland, Wales, and N. Ireland to further test and explore the findings in those countries; and nurses working in a wider range of locations (e.g. prisons, hospitals, private clinics). There is potential also, to examine further how AOD nurses can adapt to a rapidly changing workforce and seize the opportunities offered by new "liminal" treatment delivery spaces.

Given the small sample size and spread over four national jurisdictions, recommendations for policy and practice are tentative. However, our respondents were nurses in key positions, linked to nurse networks, and with a wide knowledge of professional issues. Our findings suggest that policymakers, service providers, and professional nurse leaders need to consider how benefits brought about by clinical advancement and structural changes may also prove threatening and alienating to some nurses. While embracing change intended to offer greater opportunities for career advancement (for example, Nurse Practitioner/NMP roles), it is necessary to take steps to ensure that transitions are carefully managed to avoid disengagement and to promote recruitment and retention in AOD nursing.

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The authors report there are no competing interests to declare.

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