REPORT ON VISITS WITH NURSING ACADEMICS
NURSE LED CENTRES & AN OPIOID SUBSTITUTION
TREATMENT SERVICE
IN
NEW YORK AND PHILADELPHIA

IMPRESSIONS & IMPLICATIONS
FOR THE NEW ZEALAND CONTEXT

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NOVEMBER 2010
ACKNOWLEDGEMENTS

The New York and Philadelphia visits with nursing leaders, the National Nursing Centers Consortium (NNCC) and nurse led centres and the Jefferson Narcotic Addiction Center Rehabilitation Programme (NARC) were undertaken during a period of research and study leave in October 2010. I acknowledge the generous funding support from the University of Otago and the Specialist Mental Health Service of the Canterbury District Health Board.

The overseas component of my study leave would not have been possible without the assistance of the three people who hosted my visits in New York and Philadelphia. They were:

1. Professor Madeline Naegle, APRN, BC, Ph.D, FAAN
   Professor and Coordinator, Advanced Practice Nursing: Psychiatric-mental Health
   Director, New York University College of Nursing, International Programs
   Director, New York University WHO Collaborating Center for Geriatric Nursing Education

2. Tine-Hansen Turton, MGA, JD, Executive Director, The National Nursing Centers Consortium (NNCC), Philadelphia

3. Constance Pechura, PhD, Executive Director, Treatment Research Institute, Philadelphia
   Adjunct Associate Professor of Neuroscience in Psychiatry, University of Pennsylvania.

I also acknowledge the invaluable assistance of the following people who assisted with organising my schedule

- Associate Professor Mary Rosedale PhD, PMHNP-BC, NEA-BC
  Assistant Professor, College of Nursing, New York University
  Joint Appointment, Department of Psychiatry, New York University Langone Medical Center
- Brian Valdez, Health Policy Manager, NNCC
- David Festinger, PhD
- Veronica Murray, Administrator, Treatment Research Institute

Finally, I acknowledge the funding support from Matua Raki to assist with the preparation of this report.
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1.0 INTRODUCTION

I have extensive experience as a mental health nurse in working in community based outpatient services with people with co-existing substance and mental health problems, and in the specialty areas of addiction and family and youth mental health. Since 1997 I have worked in a joint academic/clinical position within the interdisciplinary team at the National Addiction Centre (NAC) University of Otago, Christchurch and the Specialist Mental Health Service of the Canterbury District Health Board. I have been involved with national addiction nursing workforce developments with a focus on advanced practice nursing. I am a member of Drug and Alcohol Nurses of Australasia (DANA) and the current President of Te Ao Māramatanga New Zealand College of Mental Health Nurses (NZCMHN).

A key aim of the overseas component of my 2010 research and study leave was to increase my understanding of the potential of advanced practice nurses through visiting an overseas university advanced practice nursing programme and nurse led services. My study leave took place at the time of the release in the US of the Report titled The Future of Nursing: Leading Change, Advancing Health which was a Robert Wood Johnson Foundation Initiative (RWJF) at the Institute of Medicine (IOM). This report, initiated in 2008, was undertaken within the context of the Obama 2010 Affordable Care Act which has the goal of achieving national health insurance cover for all Americans. With potentially more than 32 million uninsured American citizens ‘entering’ the health care system the potential of nursing as the largest health care workforce has become a focus of critical importance. It is expected that advanced practice nurses and nurse led services will have a significant role in providing access to health care and improving health outcomes for vulnerable populations including those with chronic conditions and the elderly.

The unleashing of nursing potential recognises several decades of innovation with respect to the establishment and development of nurse led centres, nurse specialist and nurse practitioner roles.

While there are clear differences in population size and health care policy and delivery systems between the US and New Zealand, there are similarities with respect to aging populations, increasing prevalence of chronic health care problems and lifestyle related disorders, increasing complexity of health care presentations and the trend towards a greater emphasis on people receiving continuing care within primary care and non-government (NGO) sectors. There are similar trends with respect to workforce issues including shortages of doctors, particularly in rural areas and in areas of greater deprivation.

Such factors promote the urgent need to consider the strategic development of advanced practice nursing roles in the New Zealand mental health and addiction treatment sectors. While nurse practitioner roles have been introduced in New Zealand there have been significant barriers to their widespread implementation, and their potential has yet to be realised with respect to providing health care for people with addiction related problems. To date, there are few mental health nurse practitioners and a only a small number of nurses on postgraduate education pathways who are working towards nurse practitioner status specifically with an addiction related scope of practice.
2.0 OVERALL IMPRESSIONS AND IMPLICATIONS FOR NEW ZEALAND

Within the context of a fragmented health care system I was impressed by the passion and commitment of the people I met; nurses and non-nurses who were committed to the professional development of advanced practice nurses and to providing accessible and responsive health care (including opioid substitution treatment) for vulnerable populations and underserved people within their local communities. Strategic partnerships with other professionals, organisations, universities, researchers and communities as well as advocacy for resources based on outcomes were noted features of the nurse-led health services I had contact with.

If the potential for nursing is unleashed then I strongly believe that there is great potential for advanced practice nurses in New Zealand to expand their roles in working with people receiving opioid substitution treatment as well as those with other addictions and co-existing physical and mental health problems. This potential includes the continuing development of a range of advanced practice roles including the nurse practitioner role (addiction related) with a broad scope of practice. Nurse practitioners could be based in a range of settings including primary care, NGO and specialist service settings, working collaboratively with medical and other practitioners across multiple health and other sector boundaries.

Implications

1. All nurses should have capability for providing substance use related interventions; screening, health promotion, education, brief assessments and interventions, referral, and provision of continuing care for people discharged from specialty treatment settings.

2. Advanced practice nurses should have a specific role in providing care for vulnerable populations, those who are underserved by health care services, individuals with chronic conditions, and individuals with multiple and complex health needs. The elderly are increasingly being recognised as a vulnerable and underserved population.

3. Legislative, regulatory, organisational and other barriers to advanced practice nurses working to their full potential must continue to be identified and overcome.

4. In a changing health care environment, advanced practice nurses working in the mental health and addiction specialty areas have enormous potential for: 1) contributing to improving access, responsiveness and health outcomes for people with mental health and addiction problems, 2) contributing to integrated, interdisciplinary models of care inclusive of peer support and, 3) leading innovative models of care such as nurse-led clinics and services.

5. Nursing within the broad mental health and addiction specialty areas should have a voice in developing health policy and in shaping and implementing health care reforms and quality and evaluation frameworks.

6. The support of multiple stakeholders is required to maximise nursing potential within the mental health and addiction specialty areas. This includes nursing leaders and professional nursing bodies, other professional/practitioner organisations, workforce development bodies, government and policy makers, health care organisations and nursing and interdisciplinary postgraduate education providers.

7. It is essential that advanced practice addiction specialty nurses have expertise in the delivery of both clinical and psycho-social interventions.

8. Nurse practitioners with prescribing rights and an addiction scope of practice have the potential to be based in specialty services, primary care and NGO settings and work across service and sector boundaries. They will have expertise in health promotion, illness prevention, early intervention, withdrawal management, motivating behaviour and lifestyle change as well as in
providing a range of psycho-social interventions. Their roles should be community and family and whānau focused.

9. Postgraduate qualifications at masters level are essential in order for advanced practice nurses to: 1) meet the needs of people with complex addiction related problems who commonly experience multiple (and intertwined) mental and physical health and social problems, 2) be responsive to changes in health care organisation and models of care delivery, 3) lead and coordinate care and, 4) work in partnership with other health professionals who have postgraduate qualifications.

10. Postgraduate education pathways need to be flexible and incorporate addiction related interdisciplinary courses in order to promote collaborative models of care and multi-disciplinary team functioning.

11. Professional nursing standards and knowledge and skills competency frameworks should underpin mental health and addiction specialist nursing practice.

12. Professional nursing standards and competencies pertaining to specialist mental health and addiction nursing practice should provide the basis for certification, accreditation and credentialing processes.

13. Effective workforce planning for nurses working in the specialty areas of mental health and addiction requires targeted data collection and information infrastructure.
3.0 SUMMARY OF VISITS MADE IN NEW YORK

3.1 NEW YORK UNIVERSITY COLLEGE OF NURSING

New York University College of Nursing is one of the largest colleges of nursing in the US and offers both undergraduate and postgraduate nursing programmes including nurse practitioner programmes. In 2005, acknowledging the trend towards interdisciplinary education and fostering new healthcare paradigms the College of Nursing was aligned with the College of Dentistry. The College of Nursing provides a Faculty Practice run by nurse practitioners with a focus on providing accessible care to low income patients. As the Practice grows the offering of more extensive mental health interventions including counselling are planned by a licensed social worker or psychiatric nurse practitioner.

3.1.1 Meeting with Professor Madeline Naegle

Professor Madeline Naegle is one of the few nursing leaders in the addiction field. She is an internationally recognised educator and researcher who has received many awards related to nursing, mentorship and leadership in the area of mental health and addiction. She has extensive experience as an advanced practitioner in mental health and addiction nursing, in faculty and curricula design and in developing competencies for mental health and addiction nursing. She has delivered specialty nursing education programmes in psychiatric-mental health and addictions and designed, implemented, and evaluated masters’ level psychiatric mental health nurse practitioner programmes. She has designed and implemented continuing education for nurses and other health providers, including an on-line course.

My discussions with Madeline provided support for a broad advanced practice nursing focus that is inclusive of substance use/addictions and mental health. The rationale (congruent with our New Zealand focus) is that people commonly experience co-existing substance use/addictions and mental health problems. Advanced practice nurses need to have knowledge and skills related to health assessment, pharmacology, motivating behaviour and lifestyle change as well as individual and family psychosocial interventions.

In accordance with national trends, the New York University advanced practice programme is moving to a family orientation across the lifespan, inclusive of specific population modules – eg mental health and addiction. Masters programmes will comprise essential components and incorporate integrative learning strategies. Essential components included courses on genomics, applied health assessment, pharmacology and pathophysiology and cultural competency enhancement. As with all broad based programmes it is essential to ensure adequate substance use/addictions and mental health content and competency based learning outcomes.

Other key points from discussion with Professor Naegle

- Opportunities for interdisciplinary health education are increasingly important.
- Nicotine and alcohol remain primary substance use issues of concern.
- Generic nurses and mental health and addiction specialist nurses both have important roles in providing assessment and interventions – depending on the clinical situation, taking into account such factors as the level/complexity of the person’s presenting issues, the role of the work setting, and the nurse’s level of practice and competencies.
- Nurses should focus on the whole continuum of substance use as they work in both primary care and specialty settings – hence the need for all nurses to have capability in providing screening, health promotion, education, brief assessments and interventions and continuing care for people with addiction related problems.
• Intervention gaps exist for older adults with substance use/addiction related problems and for impaired professionals.

NB In general, addiction services in the US are staffed mainly by counsellors (many with personal addiction experience). Trends I noted in my visits was an emphasis on the need to recruit staff from health professional disciplines in order to better respond to the complexity of health related needs of people attending addiction treatment services and for primary care teams to incorporate nurses/behavioural health consultants with mental health expertise.

3.1.2 Meeting with Associate Professor Mary Rosedale

My meeting with Mary provided me with an overview of the role of a licensed (certified) Psychiatric Nurse Practitioner and an overview of the developing field of neurostimulation. It was through Mary and Professor Naegle that I had the opportunity to meet with advanced practice nurses on a Nurse Practitioner academic pathway and to sit in on their evening classes.

Mary is a certified Psychiatric Nurse Practitioner with psychotherapy training and is a leading expert in the area of neurostimulation. She received the 2010 American Psychiatric Nurses Association award for Excellence in Leadership. She is the only nurse to have completed fellowships in electroconvulsive therapy (ECT) and Transcranial Magnetic Stimulation (TMS). These interventions for the treatment of depression have recently been approved by the US Food and Drug Administration (FDA). TMS is an outpatient intervention and utilises an electromagnet placed on the scalp that generates magnetic field pulses about the strength of a MRI scan. The pulses stimulate the cerebral cortex. Few adverse side effects have been reported to date including effects on memory or concentration. FDA criteria require a previous unsuccessful trial of antidepressant medication. A current trial is being conducted with people suffering from post traumatic stress disorder.

The advanced practice classes I sat in on were attended by nurses on a nurse practitioner programme who were seeking to work in the area of mental health and addiction. The nurses had diverse nursing backgrounds (women’s health, medical, armed forces and pediatrics) and a range of years of nursing experience. They were supported in their work in mental health or addictions treatment settings by nurse practitioner preceptors. Poor access to primary health care for clients of mental health services had implications for the scope of the role of nurse practitioner within a mental health/addiction service context.

On gaining their Masters level qualification the nurses apply to be certified by a professional nursing body to enable them to practice as a nurse practitioner. They can seek dual credentials e.g. mental health and adult primary care. However actual prescribing arrangements may be restricted by the employing organisation or by varying state regulations.


This lecture was hosted by the College of Nursing and given by John W Rowe, MD, Professor Health Policy and Management, Mailman School of Public Health, Columbian University. Dr Rowe was an IOM Committee member involved in developing the report.

3.2.3.1 Background to the lecture

With more than 3 million members, the nursing profession is the largest segment of the US health care workforce. Working on the front lines of patient care, nurses can play a vital role in helping
realise the objectives set forth in the 2010 Affordable Care Act legislation that represents the broadest health care overhaul since the 1965 creation of the Medicare and Medicaid programs. However, a number of barriers prevent nurses from being able to respond effectively to rapidly changing health care settings and an evolving health care system. These barriers need to be overcome to ensure that nurses are well-positioned to lead change and advance health.

In 2008, The Robert Wood Johnson Foundation (RWJF) and the IOM launched a two-year initiative to respond to an identified need to assess and transform the nursing profession. The IOM appointed the Committee on this RWJF funded initiative ($4 million) with the purpose of producing a report that would make recommendations for an action-oriented blueprint for the future of nursing. The committee was chaired by Dr Shalala, President of University of Miami, former US Secretary of Health and Human Services and comprised experts in medicine, nursing, economics and law. The process included five committee meetings, two public workshops, literature reviews, and case studies. Importantly, funding was allocated for addressing the implementation of the Report’s recommendations beginning with a conference in November/December 2010.

Through its deliberations, the committee developed four key messages:

1. Nurses should practice to their full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and information infrastructure.

The report emphasised that the US has the opportunity to transform its health care system, and that nurses can and should play a fundamental role in this transformation. The report also emphasised that the power to improve the current regulatory and organisational conditions does not rest solely with nurses. Government, businesses, health care organisations, professional associations, and the insurance industry all must play a role. Multiple stakeholders are required in order to ensure that the proposed health care system provides seamless, affordable, quality care that is accessible to all and leads to improved health outcomes.

3.2.3.2 Key points made by Dr Rowe relevant to the New Zealand context

General points

- The health workforce shortage is becoming evident.
- The goal to have as healthy a population as is possible requires integrated care at the level of the person and his/her family.
- There is a critical need to provide home-based interventions to support older people to remain in their homes versus prematurely enter rest homes e.g. via nurse practitioners and nurse specialists in collaboration with physicians and other multi-disciplinary team members (often nurse led).
- Nurses have a large role to play in health care with the elderly, those with multiple health related issues and/or chronic conditions.
- It is important to look outwards – nursing needs champions outside of nursing who have levers. The irony of being a well respected profession but not at always at ‘the top table’ was noted.
There is a need to utilise social marketing strategies. Nurse practitioners are being seen as a significant solution to the provision of high quality affordable health care.

_Nurses should practice to the full extent of their education and training_

- Removal of barriers related to scope of practice regulations across states is required to enable nurses to prescribe without physician supervision (signing) on the basis that: 1) there is no evidence that physicians provide better basic primary care than nurse practitioners and, 2) in order to manage the overwhelming needs of patients the focus should not be on nurses or doctors, but rather on patients – access, responsiveness and outcomes.
- In order to remove barriers changes in regulations are required at multiple levels including federal (Congress), state, centres for Medicaid and Medicare services, Office of Personnel Management, Federal Trade Commission and Division, Department of Justice.
- To bring about change all key stakeholders have a role to play – government, business, health care institutions, professional organisations, other health professionals and the insurance industry.
- There is a need to expand opportunities for nurses to lead initiatives.
- Nursing residency (transition to practice/internship) programmes need to be introduced to reduce turnover – both for pre-registration and advanced practice programmes. The audience was reminded of the annual funding allocation per-medical student of $100,000 (US).
- Higher levels of education are associated with higher quality care and there is a need to prepare nurses to lead change. Therefore, a target was set of 10% of all nursing graduates with a bachelor degree accessing a masters or doctorate programme within five years following graduation i.e. the importance of similar levels of qualifications to other health professionals.
- A target of doubling nurses with doctorates by 2020 to strengthen nursing research and faculty.
- The education levels of nurses working in long term care (particularly the aged care sector) must be addressed.
- Inter-professional opportunities for education must become more available to support health care team functioning – it is expected that in a decade from now health professional education and health care delivery will look very different.
- A culture of life long learning needs to be strengthened.
- An infrastructure for collection and analysis of inter-professional health workforce data is required.

N.B. Nursing programmes in NZ are at bachelor’s degree level
4.0 SUMMARY OF VISITS MADE IN PHILADELPHIA

4.1 THE NATIONAL NURSING CENTERS CONSORTIUM (NNCC)

Location: 260 South Broad Street, Philadelphia
Contact: Tine Hansen Turton, Chief Executive

The NNCC was founded in southeastern Pennsylvania in 1996 and is now a national membership association of nurse-managed health centres with centres throughout the US (http://nncc.us). The NNCC is the largest organisation of nurse-managed centres. Centres (neighbourhood clinics) are located in or near medically underserved areas in rural and urban communities. The mission of the NNCC is to strengthen the capacity, growth and development of nurse-managed health centres, to provide quality health care services to vulnerable populations and to eliminate health disparities in underserved communities. The goals of the NNCC are to provide national leadership in identifying, tracking and advising healthcare policy development, to position nurse-managed health centres as a recognised mainstream health care model and to foster partnerships with people and groups who share common goals (Hansen-Turton, Miller & Greiner, 2009; Torresi & Hansen-Turton 2005).

The aims of the centres which are led by advanced practice nurses are to reduce health disparities and meet primary care and wellness needs as well as the management of chronic illnesses. Behavioural health is increasingly being incorporated through the employment of behavioural health consultants and therapists and psychiatric nurse practitioners. The centres provide health care for the uninsured, underinsured and vulnerable populations and act as safety net providers. They may be free standing or affiliated with universities or other institutions (e.g. public housing) and each neighbourhood clinic provides a mix of interventions to meet the needs of their local community. The centres enhance learning opportunities for nursing and other students. In June 2010, $15million was provided by the government to support the work of the centres. The Affordable Care Act, the current crisis in health care, together with the trends towards primary care as a persons ‘medical home’ and co-ordinated integrated continuous care have provided a great opportunity to maximise the potential of the nurse-led centres and therefore the role of advanced practice nurses.

4.1.1 Meeting with Tine Hansen-Turton, Chief Executive and Brian Valdez, Health Policy Manager

Tine is the Chief Executive of NNCC, with affiliations to a number of other organisations. She teaches health policy, programme planning and outcome evaluation to nursing students in the Public Health Masters Programme at La Salle University, School of Nursing, Philadelphia and is a guest lecturer at a number of other universities. Tine and NNCC have won multiple awards for championing nurse led centres as a cost-effective model of health care. As a 2005 Eisenhower Fellow Tine came to New Zealand with Donna Torresi, MSN Family Nurse Practitioner, Chief Executive, Family Health and Counselling Network (see below). Tine and Donna were hosted by Dr Frances Hughes, former Chief Nurse, Ministry of Health. They raised awareness in New Zealand about the role of nurse practitioners and nurse led models of care for vulnerable and underserved populations.

Tine and Brian Valdez, Health Policy Manger, highlighted several key strategies with respect to achieving legislative and policy change and acquisition and maintenance of funding which have relevance for nursing leaders in the New Zealand context.

- Developing strategic partnerships with a range of health care providers.
- Understanding political systems, policy and regulations at national and state levels, as well as having an in-depth understanding of funding streams, policy and regulations of multiple funders and insurers.
• Developing strategic relationships with key stakeholders and the building of strong relationships with bipartisan policy makers, funders, civic and business leaders, legislative advocates and key staff assigned to working with politicians, policy makers and funders.
• Continual scanning for policy change and funding opportunities.
• Expertise in policy writing and preparing funding applications.
• Developing succinct key messages and speaking with a unified voice (“staying on message”).
• The importance of a human face – community board members, recipients of health care services telling their stories in order to provide personal illustrations of health care accessibility, responsiveness and improved health outcomes.

4.1.2 Mary Howard Health Center

Location: 125 South 9th Street, Philadelphia

Contact: Elaine Fox

The Mary Howard Health Center opened in 1997 and is a nurse managed health centre for homeless people. At the time of my visit the centre was in the process of renovation – colours and furniture were carefully chosen to give the centre a bright, welcoming and professional interior.

The underpinning rationale for the centre is that comprehensive, continuous health care for homeless people is achievable. The Centre provides health care to homeless people at all points along of the continuum: from the street, to shelter, to transitional housing, to self-sufficiency. Integrated services include primary care, family planning, assistance with benefits and behavioural health. The nurses and nurse practitioners use outreach opportunities for health promotion and disease prevention. The result is that care is as comprehensive as clients are ready to accept.

The integrated team includes a Psychiatric Nurse Practitioner, Rhonda Flemming. She emphasised the time that is required to engage people who are homeless into health care and the importance of delivering community based care where people are, and for the centre to be well linked with the local community (she offers outreach clinics in the shelters for homeless people). Nearly all clients have lifestyle related substance use issues and depression. Other problems/disorders include substance induced psychosis and schizophrenia. Ambivalence about taking medication as well as practical barriers influence clients’ adherence to medication which requires an outreach approach and close linking with the shelters in order to keep in contact with clients. As a Nurse Practitioner, Rhonda consults and supports the work of the other staff and has her own caseload. The local hospital is able to be accessed for emergencies.

Evaluations of the services provided showed that 79% percent of the clients at the Mary Howard Health Center had successful follow-up/treatment for abnormal test results. The staff considered that this success was possible in part because of the multiple partnerships developed with service providers, advocates and homeless people.

4.1.3 Care Clinic

Location: 1200 Callowhill Street, Suite 101, Philadelphia

Contact: Jacqueline Link, Program Director

This centre had been relocated and was also in the process of renovation. The clinic had expanded its scope to incorporate primary care with its former primary role of providing HIV related services. The present focus was on developing strong strategic relationships in the new neighbourhood and expanding the client base. Demonstrating value to the community through number of visits, client characteristics and other statistics were required for ongoing funding.

4.1.4 Temple Health Connection

Location: 1035 W. Berks St, Philadelphia

Contact: Nancy Rothman, EdD, RN Director
This centre opened in 1994 following successfully securing a five year government grant on the basis of a Temple University feasibility study. The study results showed that over 90% of those who had coverage for primary care did not have a consistent provider and that the community was tired of waiting in impersonal clinics. The mission of the centre is to develop culturally competent and effective primary level health care. The community advisory board approves all services and research that takes place via the centre.

About 60,000 people and 13,000 families are within walking distance of the centre and 95% of people who access the centre are African American. Close to 50% live below the government identified poverty line. Single families headed by women are the predominant family structure. Similar to other areas with high levels of poverty, within this local community there are high rates of unemployment, teenage pregnancy, low birth-weight babies, inadequate prenatal care, infant mortality, TB, sexually transmitted diseases, asthma, lead poisoning, mental health and substance related issues.

Staffing includes advanced practice nurses (certified nurse practitioners and clinical nurse specialists), public health nurses, outreach staff and medical assistants. A family medicine physician works in collaboration with the centre. Nursing and pharmacy students, university faculty and community residents volunteer time for various programmes. Programmes include: smoking cessation, family planning, health promotion, prenatal care, childbirth and parenting education, exercise, weight control, diabetes and asthma programmes, health fairs, immunisation clinics, HIV counselling and testing. The centre provides or facilitates extensive outreach and home visiting, a cancer programme, after-school programmes, holiday camps and violence prevention programmes for children and youth.

The centre has strong relationships and working collaborations with housing services, a parent child centre, arts and humanity organisations, the Salvation Army, early childhood, youth and women’s services, other health and social services and Philadelphia’s lead poisoning programme.

Proposed developments include the high possibility of moving to larger premises and the inclusion in the staff mix of behavioural health workers and psychiatric/mental health advanced practice nurses.

4.2 The Family Health and Counselling Network

Location: Abbotsford-Falls
4700 Wissahickson Ave, Building D-Suite 119, Philadelphia
Contact: Donna Torrisi MSN, Family Nurse Practitioner (FNP)
Chief Executive, Family Health and Counselling Network

The Family Health and Counselling Network has three sites including Abbosford-Falls which venues the central administration staff. The three sites provide a health care service to 14,000 patients in total with 70,000 primary care and behavioural health visits per year. The Network qualifies for federal government funding but in order to meet the multiple health related needs of its patients, supplementary funding from multiple other sources is required e.g. funding support to reduce the cost to families for prescribed medications.

The Network was established in 1991 as a result of Donna Torrisi co-writing a proposal to the Health Resources Service Administration Bureau of Primary Health Care to allow Resources for Human Development to provide health care to residents of public housing under public law related to the Disadvantaged Minority Improvement Act of 1990. Abbotsford Community Health Center,
with a nursing model of care opened its doors to the community in 1992 (Torrisi & Hansen Turton 2006).

The people living in the target Network areas are primarily African American (88% vs 43% in the whole of Philadelphia) and female (58%) with high numbers of single parent families. As within other vulnerable populations living in underserved areas, health and social issues include high rates of unemployment, poverty, obesity, hyperlipademia, diabetes, asthma, arthritis, depression, substance use including nicotine dependence, violence and child and adult trauma and abuse. Interventions provided include health education, maintenance and coaching e.g. fitness coach and an onsite gym, cooking/nutrition groups, pre-natal care, management of chronic illnesses e.g. for diabetes, asthma and depression and hypertension, living well with chronic health problems, medication management, home assessment, smoking cessation, pain management and mindfulness, coping skills, yoga etc. Other on site services include eye care (optometrist on site), dental care, pharmacy, immunisations, vaccinations and HIV testing.

All primary health care is provided by nurse practitioners. A collaborating physician is available by telephone contact and attends in person on a regular basis for consultation. A psychiatrist provides monthly consultation and training (Family Nurse Practitioners can prescribe psychiatric medications from a mandated list). On site behaviour therapists (Masters/PhD level psychologists) provide an outpatient service and a behaviour health consultant (social worker – see section below) provides consultation to the nurse practitioners, makes referrals to the behaviour therapists and other external services as well as attends crisis calls and provides scheduled appointments.

*Developments planned* include employing a Psychiatric Nurse Practitioner to work in and across the integrated teams providing a consultation service to staff inclusive of prescribing (as required) mandated medications. The Network is a research site in a joint funding proposal with the Treatment Research Institute to investigate the feasibility of integrating substance use treatment within the model of primary care.

### 4.2.1 Abbotsford-Falls Center

**Location:** 4700 Wissahickson Ave  
Building D-Suite 119, Philadelphia  
**Contact:** Donna Torrisi MSN, Family Nurse Practitioner (FNP)

From its beginning in a small apartment the Abbotsford-Falls Center has expanded and now resides in large premises. The centre is beautifully and professionally presented and welcoming. The paintings and other artworks were created by individuals who experienced mental health problems. The full range of health promotion, illness prevention and chronic illness management is provided as described above.

**Meeting with Donna Torissi and Susan Bash (LCSW, Behavioural Health Consultant)**

Donna has been the Director of the Network since 1991 and continues her work as a FNP on a part-time basis. She was a key leader in bringing about legislative change in Pennsylvania that re-defined a primary care provider to include nurse practitioners and thereby provided nurse practitioners with entry into managed care as participating providers. She was a founding member and the first chairperson of the Network. She is a faculty member for the Institute for Health Improvement Depression Collaborative. Donna has received numerous awards and written and lectured widely on ‘the nurse-managed care model’, ‘negotiating with managed care organisations’ and ‘integrating behavioural health with primary care’.

Susan had been employed as a behavioural consultant for about a year. She had previously worked in a specialty eating disorders service as well as in other mental health related services. She noted
the diversity of issues people present with and their frequently intertwined nature. Commonly occurring presenting issues included sleep related problems associated with stress, depression, anxiety, attention deficit hyperactivity disorder (ADHD) and substance use problems. She commented on the issue of medication adherence which she found was frequently underpinned by the individual’s ambivalence about taking medications for psychiatric illness e.g. due to beliefs/misperceptions about medications, experience of negative side effects, or other unwanted effects. She utilises multiple lifestyle focused interventions including yoga, mindfulness, sleep hygiene, problem solving, stress and anxiety management which includes addressing substance use. When individuals who have just been released from prison make contact with the centre Susan finds they often need assistance with adjusting back to living in the community and medication management.

Susan also provides consultation to the Family Nurse Practitioners. She considered that 80% of situations were managed in consultation with the nurse practitioners or directly by herself and 20% she referred to the behavioural therapists or externally e.g. for specialist treatment that is outside the scope of the centre she refers to specialty mental health and addiction treatment services.

We had a discussion about the potential role of a staff member with addiction treatment expertise. Donna commented that with the potential Treatment Research Institute related project on integrating substance use interventions into primary care settings this constitutes a potential area for greater development. She also commented that substance use does get addressed but to varying degrees depending on the individual staff member’s level of confidence and competence.

4.2.2 Eleventh Street Family Health Services of Drexel University

Location: 850 North 11 Street, Philadelphia
Led by: Patricia Garrity, Drexel University Assoc. Dean for Community Programmes
Contact: Jane Franks

This nurse-managed service was established 14 years ago as a partnership between Drexel University Nursing and Health Professions, residents of four public health housing developments in North Philadelphia and the Family Practice and Counselling Network. The centre was busy and welcoming with every space utilised. An area for a pharmacy was being completed to enable residents to better access medications.

Since 1996 the centre has utilised a multi-disciplinary model of service delivery. Staff include: nurse practitioners, midwives, behavioural health consultants, health educators, dentists, social workers, couple and family therapists, creative and physical therapists, a complementary health practitioner and a fitness trainer (gym on site). A nurse consultant from the Public Health Service Corporation is co-located with the service. She is an expert in emergency/disaster response. The centre hosts a range of students who provide direct input. These include nursing and pharmacy students along with pediatric and dentistry residents.

The Centre volumes are about 2,500 visits a month (can get same day appointment) with an annual total of 27,000 primary care and behavioural health visits.

Health and social issues and the range of interventions are as reported above. The five key foci for this centre are as follows.

- Multidisciplinary model of care with a focus on chronic illness management
- Treating and preventing childhood trauma
- Centering approach (mother and child prenatal, postnatal and well child care)
- Improving healthy behaviours
- Tracking health behaviour data
4.3 Behavioral Health Services of the Public Health Management Corporation (PHMC)

**Location:** 260 South Broad St, Philadelphia
**Contact:** Leslie Hertig, Vice President, Behavioural Health Services

The Public Health Services of the Public Health Management Corporation (PMHC) was established in 1972 and is a non-profit health institute with a mission to improve the health of the community by providing outreach, health promotion, education, research, planning, technical assistance and direct services. It has an emphasis on collaboration, affiliation and provision of an umbrella management organization for a number of health care service providers. It is a large organization with around 1500 employees and 250 programmes. Tine Hansen-Turton is Vice-President, Health Care Access and Policy (acknowledging the affiliation with the NNCC) and Leslie Hertig is Vice President for Behavioral Health Services.

I met with Leslie who oversees nine behavioural health treatment programmes under the PMHC umbrella in the Delaware Valley area.

- **The Bridge:** An adolescent residential programme for 35 males with substance use and/or co-occurring mental health problems. They also operate a generic outpatient service and a continuing care in-home programme for graduates and an E Youth Opportunity Programme that includes services and programmes for out of school youth and youth returning from corrections facilities.
- **Bridges' Step Down:** A recovery house for 16 women recovering from drug or alcohol addiction, and up to three of their children. It provides 24-hour on-site staff support, ongoing case management and life skills activities. The women residents also participate in outpatient treatment and self-help recovery meetings.
- **Chances:** An outpatient and intensive outpatient substance abuse treatment program for up to 100 women with children.
- **Family Therapy Programme:** Home and office-based couples and family therapy for clients referred by the criminal justice system, Philadelphia Family Court and other referrers.
- **Interim House Inc:** A residential programme for women with co-occurring disorders and outpatient programmes for women. The outpatient programmes are based on trauma informed care and holistic health approaches.
- **Interim House West:** A residential treatment program for women with substance abuse and mental health disorders and their children. The program serves up to 20 pregnant and parenting women, and up to 45 children under the age of 12. Participants are offered a range of comprehensive services. Services for children include an on-site pre-school and after-school program.
- **Joseph J. Peters Institute:** A non-profit mental health agency specialising in outpatient assessment and treatment for sexual abuse survivors (children, adolescents and youth) and offenders.
- **Westhaven:** A long term structured residence for adults with serious mental illness. A strengths based, trauma informed, culturally sensitive recovery-oriented focused treatment approach is taken.
- **Clinical Evaluation Unit** of the Department of Public Health’s Forensic Recovery Programme. This unit provides assessment, referral, case-management and a community service programme for offenders with substance use problems (who meet legal and clinical criteria).

Over 60 staff are employed with Masters level qualifications. Important underpinning concepts are cultural competence, strengths based, wellness, and trauma informed care. Co-existing disorders are a focus. Leslie commented on the difficulty in attracting high quality staff to work in the addictions field. Sadly, she said that she had to oversee the shutting down of two youth facilities last year. One of the programmes was specifically for girls. The level of structure did not meet the needs of the girls who had issues with violence, criminal offending histories and co-existing mental health issue.
She said that the residential service for boys was working well. It is led by an ex-military director, has a high level of structure and a family orientation, incorporating family involvement wherever possible.

Developments within the PHMC included a potential collaborative research project with the Treatment Research Institute in respect to incorporating substance use interventions in primary care settings (referred to above).

4.4 JEFFERSON NARCOTIC ADDICTION REHABILITATION PROGRAM (NARP)

**Location:** 1021 South 21st Street (Corner, 21st Street and Washington Avenue), Philadelphia

This site visit was arranged for me by the Treatment Research Institute staff. The NARP is an outpatient centralised adult methadone treatment service for South Philadelphia. It is affiliated with Jefferson Medical College, Department of Psychiatry and Human Behaviour, Jefferson University, Philadelphia. I met with the following people.

- **Robert C Sterling, PhD**
  Associate Director, Division of Substance Abuse Assoc.
  Professor of Psychiatry & Human Behaviour, Thomas Jefferson University

- **Stephen Weinstein, PhD,**
  Director, Division of Substance Abuse Programs
  Professor, Psychiatry and Human Behaviour
  Assistant Professor, Family and Community Medicine, Jefferson Medical College

- **Dr Abigail Kay, MD**
  Medical Director
  Assistant Professor, Psychiatry and Human Behavior, Jefferson Medical College

- **Sari Trachtenberg, MA, CAC, CCS, CCIS**
  Programme Co-ordinator, Counsellor

The local neighbourhood within which NARP is situated had, until recently, the highest concentration of heroin in Philadelphia. It has high levels of unemployment, health and social issues. Many of the people who live in the neighbourhood rarely leave the neighbourhood which impacts on their willingness to seek or receive services from “outside”. The street entrance to the service opened onto a waiting/dispensing area which included, behind the dispensing counter, a monitor for observing urine collection. As in all buildings I went to in New York and Philadelphia, a security guard (woman at this service) sat in the waiting room. All available space in the building was utilised and bordered on overcrowding. However, the atmosphere was notably friendly and welcoming.

At the time of my visit the service client caseload was 380, of whom about 38-40 paid fees. About 5% were aged 18-24 years and 25% were aged 55-64 years. The staff said the retention rate was good, perhaps influenced by the culture of the neighbourhood.

The service has well established links with the intensive outpatient service in the same building which provides access to 9 hours of psycho-social group therapy interventions per week. Interventions offered by NARP include the following.

- Medical and psychiatric evaluations
- Methadone initiation, monitoring and maintenance
- Ambulatory detoxification services
Psychotropic medication management as needed for other behavioural health problems;
- Referrals for medical problems
- Individual and group psychotherapies; specialty groups (e.g. parenting, anger management, grief recovery, relapse prevention)
- Family and couples education and therapy
- NA meetings on-site
- TB testing, hepatitis, HIV/AIDS/STD testing and pre and post test counselling

Counselling staff members are expected to have a relevant Masters level qualification (State expectation). The three nursing staff were primarily involved with dispensing methadone and observation of clients. The senior nurse was involved in the client orientation to methadone treatment group which enabled her to gain an understanding of each client’s life context. As a university related service, the medical director said she was well supported by resident doctors therefore nurse practitioners were not employed. The staff members I met with were supportive of the nurse practitioner role.

Sari commented on the impact of stigma associated with receiving methadone and noted that there is discussion about changing the names of opioid prescribing services to Medication Assisted Recovery Centres.

**Admission**
For referral, the person telephones or comes to the service. A counsellor assists completion of a self-report application (two pages). Admission requirements are that the person is over 18 years, has a one year history of opioid addiction and has a current addiction. An identification card is required, which after admission is held at the service (prevents loss of card). The staff emphasised that admission is as prompt as possible within their US Philadelphia context (two days – two weeks). Should a waiting time eventuate the person is invited to attend the weekly orientation group and to maintain contact with the staff.

The person is required to consent to the release of information for the purpose of processing payment services and quality review, to confirm he/she has been informed about admission documents and processes (clinic policies and State regulation requirements that include tuberculosis (TB) testing, HIV and hepatitis C pre and post test education). Vaccines are provided for hepatitis A and B. Staff commented on a decrease in the rate of HIV to about 5% of admissions and high rates of hepatitis C.

The person’s intake information then goes via the counsellor (in person) to the Intake Coordinator who schedules a medical appointment and completes (often on the same day) the assessment information using the Addiction Severity Index (ASI) and another screening instrument. Once the level of care is supported and confirmed by the relevant funding organisation and there are no concerns e.g. threats of serious violence, such as shooting someone, the admission proceeds.

The nurse who dispenses the first dose of methadone reviews the checklist of requirements and observes that the person is not intoxicated (have breath testing equipment for alcohol). If intoxicated the client is asked to return a few hours later.

**Pregnant women**
The staff attempt to refer pregnant women to the Jefferson Hospital service in order for them to access the pregnancy service established by Dr Loretta Finnegan (now retired). If there is a delay then the Jefferson staff would admit the pregnant woman to their service on the assumption that she would then not be considered a priority for the Jefferson Hospital service.
Methadone doses
State regulations specify a commencing methadone dose no higher than 30mg, increasing to 50mg over five days. The average dose is 105mg (range 5-300). Over the past 15 years doses have increased in response to the increase in heroin purity and in accordance with current research.

Buprenorphine (Suboxone)
Buprenorphine is not routinely prescribed (not within service scope). The staff commented that buprenorphine is primarily prescribed locally by the medical office based (primary care) service which provides a service for a different population – individuals are usually more stable, more likely to be employed and not wanting to attend a named opioid prescribing service due to the associated stigma. Advantages of the office based primary care prescribing service are “normalisation” and few restrictions - including less than daily dispensing.

A difficulty commented on by Dr Kay was transferring an individual’s medication from methadone (at about 30mg or less) to buprenorphine due to the difficulty frequently experienced by clients in managing interim withdrawal symptoms.

Naltrexone
I asked about the use of naltrexone (oral and implant). Dr Kay, the Medical Director was sceptical of the claim that naltrexone stops craving for everyone, although she supported access to naltrexone for people with opioid dependence. She was concerned about the need for well resourced opioid prescribing programmes.

Concurrent substance use and management
More generally in the US there was increasing concern being expressed about oxycodone as a drug of abuse. Locally, clients continued to use cocaine which was freely available in the local neighbourhood. Concurrent benzodiazepine use and dependence continued to be a major concern. Options to manage concurrent benzodiazepine use/dependence included increasing the client’s methadone dose (clients are not discharged for using benzodiazepines) and providing treatment for anxiety disorders and depression. A mindfulness group was piloted for clients who experienced difficulty in reducing their benzodiazepine use facilitated by a highly experienced and engaging counsellor. The pilot group had shown promise and was being further developed with a view to more systematic evaluation.

Takeaway methadone doses (take home doses)
253 clients are currently dispensed methadone daily and the remaining clients have a range of dispensing arrangements of between one and 6 days per week.

Takeaway arrangements in Philadelphia are governed by regulations which refer to…demonstrated responsibility in handling narcotic drugs and his/her rehabilitation progress would be improved by decreasing the frequency of his/her attendance at the clinic. Data to support these conclusions include:

• Absence of recent drug use evidenced by urine screens free of illicit substances
• No evidence of alcohol abuse in the past 60 days
• Maintains and is punctual for counselling sessions (requirement not specified)
• Appropriate behaviour around clinic e.g. no loitering
• Absence of known criminal activity e.g. drug dealing
• Stable living situation
• Minimum of 120 days retention
• Assurance of safe storage of medications in the home.
Requests for 2\textsuperscript{nd}, 3\textsuperscript{rd} or 4\textsuperscript{th} take-home doses per week need to meet the regulation requirements and be presented at an administration staff meeting. Clients are required to provide a telephone contact number and to be actively engaged in treatment planning and working towards goals, addressing their health care needs and recovery including developing a recovery support system which may include voluntary work.

\textbf{Co-existing mental health/physical health problems}
Dr Kay, the Medical Director, is a psychiatrist and is supported by psychiatric registrars. She noted the high risk of sleep apnoea. Clients are expected to have a primary care provider.

\textbf{Developments}
The staff would like to utilise incentives more. While payment and vouchers worked well in research programmes ‘day to day’ funding did not allow for these. However, where possible they had made use of incentives e.g. early dispensing times when dispensing was limited to particular times of the day. They commented on the value a vocational programme would add to the service. The service had offered an education coach – but this offer was not taken up by clients and there was also a low take-up of access to child care. A State wide development is the planned requirement for peer support workers to be incorporated into service staffing.

\textbf{The value} of visiting the Jefferson prescribing programme was to have reinforced the universal nature of issues facing opioid treatment services which are often underpinned by stigma, lack of resources and high levels of regulation as well as the move to greater integration with primary care, an increased health and wellness focus, a greater emphasis on client centred treatment and incorporation of peer support and research/practice partnerships. Somewhat paradoxically, I was also reminded of the uniqueness of these services which are very much influenced by factors related to the local context.
5.0 REFERENCES


National Nursing Centers Consortium website http://nncc.us/