original papers

There is an urgent need to address the shortfall in this area and develop adequately staffed and resourced services across Wales. Unfortunately, liaison psychiatry has not been prioritised for development by trusts or the Welsh Assembly Government in the past. This needs to change if the current situation is to improve. The National Service Framework for Mental Health in Wales requires all NHS trusts to deliver effective liaison services by March 2009. Given the current picture, meeting this requirement will be a major challenge requiring considerable work and investment.

Declaration of interest

None.

References

BELL, G., REINSTEIN, D.Z., RAJIYAH, G., *et al* (1991) Psychiatric screening of admissions to an accident and emergency ward. *British Journal of Psychiatry*, **158**, 554–557.

HOWE, A., HENDRY, J. & POTOKAR, J. (2003) A survey of liaison psychiatry services in the south-west of England. *Psychiatric Bulletin*, **27**, 90–92.

KEWLEY, T. & BOLTON, J. (2006) A survey of liaison psychiatry services in general hospitals and accident and emergency departments: do we have the balance right? *Psychiatric Bulletin*, **30**, 260–263.

MARCHESI, C., BRUSAMONTI, E., BORGHI, C., *et al* (2004) Anxiety and depressive disorders in an emergency department ward of a general hospital: a control study. *Emergency Medicine Journal*, **21**, 175–179.

MAYOU, R., ANDERSON, H., FEINMANN, C., *et al* (1990) The present state of consultation and liaison psychiatry. *Psychiatric Bulletin*, **14**, 321–325.

MORGAN, J. F. & KILLOUGHERY, M. (2003) Hospital doctors' management of psychological problems – Mayou & Smith revisited. *British Journal of Psychiatry*, **182**, 153–157.

ROYAL COLLEGE OF PHYSICIANS & ROYAL COLLEGE OF PSYCHIATRISTS (2003) *The Psychological Care of Medical Patients: A Practical Guide* (Council Report CR108). Royal College of Physicians & Royal College of Psychiatrists.

RUDDY, R. & HOUSE, A. (2003) A standard liaison psychiatry service structure? A study of the liaison psychiatry services within six strategic health authorities. *Psychiatric Bulletin*, **27**, 457–460.

SWIFT, G. & GUTHRIE, E. (2003) Liaison psychiatry continues to expand: developing services in the British Isles. *Psychiatric Bulletin*, **27**, 339–341.

WELSH ASSEMBLY GOVERNMENT (2005) *Revised National Service Framework for Adult Mental Health Services in Wales: Raising the Standard*. Welsh Assembly Government.

Divya Sakhuja Gwent Healthcare NHS Trust, Newport, ***Jonathan I. Bisson** Cardiff University, Monmouth House, University Hospital of Wales, Heath Park, Cardiff, CF14 4XN, email: bissonji@cf.ac.uk

Psychiatric Bulletin (2008), **32**, 136–139. doi: 10.1192/pb.bp.107.016311

GILES HARBORNE AND ADRIAN JONES

Supplementary prescribing: a new way of working for psychiatrists and nurses

AIMS AND METHOD
To describe the implementation of supplementary prescribing and nurse-led care in an acute in-patient unit. The issues of delegation and distribution of responsibility were explicitly addressed. Structures were developed for training and supervision, to ensure improved medicines management in the acute setting.

RESULTS
We present our five-step model of nurse-led in-patient care and our experience of using a clinical management plan for 33 patients.

CLINICAL IMPLICATIONS
Implementation of supplementary prescribing provides a model for new ways of working, requiring engagement of both doctors and nurses, clear delegation and distribution of responsibilities, and well-developed governance structures.

Most psychiatrists are currently involved in an active review of roles and responsibilities as part of the New Ways of Working (Department of Health, 2005) initiative. Key to this are changes within the multidisciplinary team to prioritise consultant workload and the distribution of responsibility and leadership across teams. The General Medical Council has issued guidance on the legal framework for this process of distribution (General Medical Council, 2005) recognising the independent responsibility of nurses, working within their skills and competencies, for patients, without the responsibilities being in any way delegated or supervised by a doctor. The guidance also emphasises the important role of employers in creating a managed, safe environment for this.

Prescribing is no longer a solely medical task, we now have patient group directives, supplementary prescribing and lately independent nurse prescribing (Department of Health, 2006*a*). Supplementary prescribing is a delegated responsibility, where the overall responsibility for patient management remains with the delegating doctor (General Medical Council, 2006), although the persons delegated to are accountable for their own decisions and actions. The delegating doctor has responsibilities to ensure communication about the patient and the treatment needed, and must ensure that the person delegated to has the necessary qualifications, experience, knowledge and skills.

Supplementary prescribing has the potential to improve patient outcome (National Prescribing Centre, 2005). However, there are acknowledged difficulties in implementation. Organisational barriers and lack of knowledge and confidence have been identified as causes of non-adoption of supplementary prescribing by trained nurse prescribers (Brimblecombe *et al*, 2005) as has the

https://doi.org/10.1192/pb.bp.107.016311 Published online by Cambridge University Press

original papers

lack of supervisor support. Gray *et al* (2005) noted 'the need to explore further the knowledge, skills and confidence of psychiatrists undertaking a nurse prescribing supervision role'.

Little has been written about supplementary prescribing from the psychiatrist's perspective; implementation and research are nurse-led (Jones, 2006; Nolan *et al*, 2001). The impact on doctors, in terms of changes in the way of working and the training and supervision of prescribers, is barely mentioned in key documents (Department of Health, 2006*b*). Supplementary prescribing is repeatedly described as a 'voluntary partnership between an independent prescribing doctor and a supplementary prescribing nurse'. However, a partnership assumes that both sides work towards a common aim, through an agreed process, on an equal footing. Clearly the prescribing relationship is not equal; the consultant has a depth and breadth of psychopharmacological knowledge and therapeutic experience unavailable to even the most experienced supplementary prescriber.

We have developed a model of acute in-patient care which both delegates responsibility for prescribing and distributes responsibility for assessment and care management. We offer some observations based on our experience.

Method

Questions

Acknowledging the literature describing the difficulties of implementation of supplementary prescribing, we started by posing a series of questions, as follows.

Where do we prescribe?

Most community prescribing is carried out by general practitioners on the advice of psychiatrists, the exceptions being crisis situations and long-term depot or clozapine treatments. There is little incentive to take back work from primary care where the infrastructure and governance arrangements are well-established; this is contrary to the Director of Nursing survey (National Prescribing Centre, 2005) which saw the community mental health team as the focus for nurse prescribing. Most specialist prescribing occurs in in-patient settings, an area of medicines management highlighted by the Health Care Commission (2007) as needing urgent improvement.

How could supplementary prescribing improve on the existing arrangements?

Medical time on the wards has reduced, consultants are more community-focused and trainee time is disrupted by shift-working and the need to gain community and psychotherapeutic training. Specialist pharmacists are few in number and hard to recruit, and there is an increasing recognition of the effectiveness of nurse-led care in delivering behavioural change and medicines management (Gray *et al*, 2004).

How do we obtain the support for systems to change?

Our in-patient services had been through a 2-year refocusing process with a number of consultants, teams and wards developing new, devolved and more patient-focused ways of working. Consultants can be engaged in a teaching capacity, and a number have gone on to supervise nurses through 72 h of clinical practice as part of their prescribing course.

New way of working in an acute in-patient setting

Skilled expertise rests with the psychiatrist, but not all patients nor all aspects of patient care necessarily require the skills of the psychiatrist. We developed a five-step model where the prescribing responsibility was delegated and the assessment and care management responsibility distributed from the psychiatrist to the nurse consultant.

1. Acute care plan. Acute care is managed by the admitting nurse and psychiatric trainee, for up to 72 h. Priorities are risk management, management of distress, including emergency tranquillisation, and the exclusion of acute medical pathology.
2. Formulation and treatment plan. The consultant and nurse consultant interview the patient and agree the formulation and management plan. Within the plan specific responsibilities, such as medicines management and prescribing, may be delegated by writing a clinical management plan. Responsibilities such as coordinating care and discharge are distributed to the nurse consultant and senior nursing team. Responsibilities for overseeing risk management and Mental Health Act decisions are generally retained by the consultant.
3. Care and treatment. Patients are reviewed by the nurse consultant at least every other day, with formal assessments of mental state and target symptoms, and side-effect monitoring. The care management plan is referred to for prescribing and assessment guidance.
4. Ward rounds and Care Programme Approach reviews. The nurse consultant leads brief weekly ward rounds, to check that all aspects of care are being attended to, and progress is communicated to carers and community staff by written updates. With the relative inward focus of ward rounds, the Care Programme Approach review meetings become the venue for the consultant to provide expert advice and for the community staff to plan discharge options.
5. Consultancy when required. The consultant, although less tied to routine commitments, has to be available for urgent consultation throughout the week, with face-to-face, phone or email contact.

Developing the working relationships

The strength of the relationship lies in the psychiatrist being involved in the supplementary prescribers' training and ongoing personal development including their supervision. This allows the doctor to be sure of knowing the supplementary prescribers' strengths and weakness,

https://doi.org/10.1192/pb.bp.107.016311 Published online by Cambridge University Press

original papers

Table 1. Types of care management plan

	Dose titration of named anti-psychotic or mood stabiliser	Switching of named anti-psychotics	Adding hypnotic, anxiolytic or anticholinergic	Adding anti-depressant or mood stabiliser	Initiating and dose titration of clozapine	Initiating and dose titration of any anti-psychotic[1]
Care management plans, *n*	8	12	6	1	3	3

1. British National Formulary 4.2.1, excluding clozapine.

building trust and understanding. The primary syllabus for supplementary prescribing is generic to all areas of medicine, and there is an acknowledged gap in nurse education regarding biological psychiatry (Gournay, 2005). Key to the change in working has been the adoption of joint records, written in a shared language, with a shift from the nursing narrative style to the more analytical and hypothesis driven medical style.

Consultant's role

This has been an active change to standing back from acute patient contact and the clinical processes on the wards, and taking on more supervision and consultation work. This has raised issues of how this new way of working is accounted for in terms of activity, job planning and governance. Patient resistance, and a demand to regularly see the psychiatrist, have not been encountered once the system was up and running.

The central role of the clinical management plan

This is the legally required written plan of treatment which delegates prescribing authority; it is also an exercise in good medicines management. Decision-making is openly shared with the patient, who must consent to the plan. The evidence base is both noted in the plan and used by the supplementary prescriber. Common reference points for us include the British National Formulary, Maudsley Prescribing Guidelines (Taylor *et al*, 2005) and National Institute for Health and Clinical Excellence guidelines for the treatment of schizophrenia (National Institute for Health and Clinical Excellence, 2002) and mood disorders (National Institute for Health and Clinical Excellence, 2006). A care management plan requires a clear working diagnosis, goals for treatment and a plan of the types of treatments that would be offered with reasons for changing. This helps to prevent situations where patients can be admitted with unclear goals, or the discharge point slips as other issues intrude. Goals also help to define target symptoms for tracking progress, and this brings the whole in-patient nursing team into using the same parameters in their nursing record. The supplementary prescriber and nursing team are also engaged in tracking side-effects, imparting information and influencing behaviour for positive concordance.

Results

We have been working in this fashion for 12 months and, to date, 33 patients have been treated with a care management plan (Table 1), with only one refusal. We started with simple dose titrations, added in adjunctive and side-effect treatments, progressed to treatment crossovers and now write a care management plan that covers a choice of treatments from the relevant British National Formulary groups. In-patient staff are now engaged in formal mental state assessment and systematic medicines management.

Discussion

We have found that by properly acknowledging the issues of delegation and distribution of responsibility, and building systems which help both sides of the supplementary prescribing relationship to feel secure, we have been able to successfully implement this new way of working. This has been accompanied by an extension in practice, so that medical roles such as mental state recording, side-effect detection and coordinating in-patient care can be distributed. This new way of working has to be accompanied by a real change in the psychiatrist's role to educator and supervisor, with clinical contact confined to only the most complex cases, where delegation of medical work would fall outside the competency of even the most highly trained nurses.

Declaration of interest

G.H. and A.J. have received unrestricted travel and educational grants from Eli Lilly and Janssen.

References

BRIMBLECOMBE, N., PARR, A. & GRAY, R. (2005) Medication and mental health nurses: developing new ways of working. *Mental Health Practice*, **8**, 12–14.

DEPARTMENT OF HEALTH (2005) *New Ways of Working for Psychiatrists: Enhancing Effective Person-centred Services through New Ways of Working in Multidisciplinary and Multiagency Contexts. Final Report 'But not the End of the Story'*. Department of Health.

DEPARTMENT OF HEALTH (2006*a*) *From Values to Action: the Chief Nursing Officer's Review of Mental Health Nursing*. Department of Health.

DEPARTMENT OF HEALTH (2006*b*) *Improving Patients' Access to Medicines: a Guide to Implementing Nurse and Pharmacist Independent Prescribing within the NHS in England*. Department of Health.

GENERAL MEDICAL COUNCIL (2005) Accountability in multi-disciplinary and multi-agency mental health teams. *GMC Today*, **4**, 10.

GENERAL MEDICAL COUNCIL (2006) *Good Medical Practice. Working with Colleagues: Delegation and Referral*. 54–55. General Medical Council.

https://doi.org/10.1192/pb.bp.107.016311 Published online by Cambridge University Press

original papers

GOURNEY, K. (2005) The changing face of psychiatric nursing. *Advances in Psychiatric Treatment*, **11**, 6–11.

GRAY, R., WYKES, J., EDMUNDS, M., *et al* (2004) Effect of a medication management training package for nurses on clinical outcomes for patients with schizophrenia: cluster randomised controlled trial. *British Journal of Psychiatry*, **185**, 157–162.

GRAY, R., PARR, A. M. & BRIMBLECOMBE, N. (2005) Mental health nurse supplementary prescribing: mapping progress 1 year after implementation. *Psychiatric Bulletin*, **29**, 295–297.

HEALTHCARE COMMISSION (2007) *Talking About Medicines*. Commission for Healthcare Audit and Inspection.

JONES, A. (2006) Supplementary prescribing: potential ways to reform hospital psychiatric care. *Journal of Psychiatric and Mental Health Nursing*, **13**, 132–138.

NATIONAL PRESCRIBING CENTRE (2005) *Improving Mental Health Services by Extending the Role of Nurses in Prescribing and Supplying Medication*. Good Practice Guide.

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (2002) *Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care* (http://www.nice.org.uk/nicemedia/pdf/CG1NICEguideline.pdf). National Institute for Health and Clinical Excellence.

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (2006) *Bipolar Disorder* (http://www.nice.org.uk/nicemedia/pdf/CG38niceguideline.pdf). National Institute for Health and Clinical Excellence.

NOLAN, P., HAQUE, M. S., BADGER, F., *et al* (2001) Mental health nurses' perceptions of nurse prescribing. *Journal of Advanced Nursing*, **36**, 527–534.

TAYLOR, D., PATON, C. & KERWIN, R. (2006) *2005–2006 Prescribing Guidelines, 8th edition*. Taylor & Francis.

***Giles Harborne** Consultant Psychiatrist and Clinical Director, Wrexham Community Mental Health Team, 16 Grosvenor Road, Wrexham LL11 1BU, email: giles.harborne@new-tr.wales.nhs.uk, **Adrian Jones** Nurse Consultant, Llwyn-y-Groes Psychiatric Unit, Wrexham

Psychiatric Bulletin (2008), **32**, 139–142. doi: 10.1192/pb.bp.107.015263

SHAY GRIFFIN, ANDY CAMPBELL AND HAZEL McCALDIN

A 'dual diagnosis' community psychiatric nurse service in Lanarkshire: service innovation

AIMS AND METHOD
We established two 'dual diagnosis' community psychiatric nurse posts within community mental health teams in Lanarkshire to improve the service care for individuals with comorbidity. A questionnaire-based evaluation of the service over a 2-year period was conducted.

RESULTS
Comorbidity was under-reported by community mental health teams and under-referred to specialist addiction services. The presence of new specialist nurses enhanced the detection of comorbidity, improved staff perceptions of working with patients that misuse substances, and was associated with a clinical and functional improvement in patients over 2 years.

CLINICAL IMPLICATIONS
Our findings support the recent trend to provide integrated care for comorbid service users within mainstream mental health services, and suggest a model of service delivery that might be more widely developed to address the concern that such users 'fall through the gaps' between services.

It is widely accepted that severe mental health disorder and substance misuse are strongly associated in community and service user populations. This view is supported by studies in both the USA and the UK. Regier *et al* (1990) found that 47% of people with schizophrenia and 32% with bipolar disorder misuse drugs or alcohol. Substance misuse was found by Menezes *et al* (1996) in 36% of psychotic service users, and by Cantwell *et al* (1999) in 37% of those with first-episode schizophrenia.

Individuals with comorbidity in general are more likely than those with mental health disorder alone to show violent or suicidal behaviour (Swanson *et al*, 1999), be homeless (Drake *et al*, 1989), be admitted to hospital and make greater use of emergency services (Bartels *et al*, 1993). They may be more difficult to treat due to chaotic lifestyles and poor compliance with medication (Cantwell & Harrison, 1996) and may tend to 'fall between the cracks' of treatment and care (el-Guebaly, 2004).

Several national guidance documents have highlighted the service needs of individuals with 'severe or enduring mental health problems' who misuse drugs or alcohol (National Health Service Scotland, 1997; Clinical Standards Board for Scotland, 2001; The Scottish Government, 2003). Currently, because of boundary issues between different services, and busy case-loads, these people can face rejection by services, or be passed between services repeatedly with what has been called 'the ping pong effect'. Mental health services may see substance misuse as more salient than comorbid mental health problems and pass such individuals on to addiction services. On the other hand, addiction services may feel disconcerted by their coexisting mental disorder, deskilled and unqualified to take them on.

This discontinuity in care has been widely discussed and a consensus is emerging across the UK regarding best practice in caring for individuals with mental health and comorbid substance misuse problems. Two national reports have recommended a 'mainstream responsibility' for mental health services (Department of Health, 1999; Appleby *et al*, 2001). Three main patterns of treatment constitute the sequence of care by mental health services and addiction services (el-Guebaly, 2004). These are: (a) sequential treatment, (b) parallel treatment, and (c) integrated treatment. The last one provides the unified and comprehensive treatment programmes within one service for individuals with concurrent disorders. We believe that

https://doi.org/10.1192/pb.bp.107.016311 Published online by Cambridge University Press