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.

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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

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integrated treatment may be best suited to the needs of people with comorbid substance misuse and severe mental disorder.

Setting up the service

We describe the setting up of an integrated service and the evaluation of its impact on staff and service users in two of the eight community mental health teams (CMHTs) in Lanarkshire (Hamilton and Cumbernauld). A specialised dual diagnosis community psychiatrist nurse post was positioned within each of these teams to provide a service for individuals with substance misuse and comorbid 'severe or enduring mental health problems' (almost all had established psychotic illness). The experienced community psychiatrist nurses appointed were already serving at G grade level within the Hamilton and Cumbernauld teams. They received training in addiction studies at diploma level. Their remit included:

(a) providing a clinical service within their own multidisciplinary CMHTs
(b) conducting assessment of needs throughout Lanarkshire
(c) helping to conduct an evaluation of the impact of their service on colleagues and staff within their own CMHTs.

Clinical service (Hamilton and Cumbernauld)

Main responsibilities of dual diagnosis community psychiatrist nurses included (in ascending order of their clinical involvement):

- signposting colleagues to existing resources to help them with their clinical work
- providing consultation on ongoing cases
- providing assessment of service users followed by appropriate advice on clinical management
- time-limited joint work with CMHT colleagues
- taking over care of very complex cases.

Needs assessment (Lanarkshire-wide)

Our clinical impressions prior to the study were that addiction teams were not engaging many individuals with comorbid severe mental disorder, and that CMHTs were under-reporting or under-referring substance misuse problems among their service users. To test these impressions, National Health Service addiction teams across Lanarkshire (predominantly trained psychiatric nurses) were asked by questionnaire to estimate the prevalence of major psychiatric diagnoses among their service users. Also, staff in the six Lanarkshire CMHTs not hosting a dual diagnosis community psychiatrist nurse were asked by questionnaire to estimate the number of their 'severe or enduring' service users with coexisting alcohol or drug misuse, and the number that would benefit (in their opinion) from referral to specialist addiction services. They were also asked about the proportion of individuals they had actually referred to such services, and about potential barriers to referral (they could choose from among four barriers provided in the questionnaire).

Evaluation (Hamilton and Cumbernauld)

Locally in the Hamilton and Cumbernauld CMHTs (served by the dual diagnosis community psychiatric nurses), the same group of staff was asked to identify service users with problem substance misuse in 2004 and again in 2006, to determine if any persons not identified in 2004 (and still on case-load) were identified 2 years later. New discharges and new referrals since 2004 were excluded. Therefore, the comparison involved the same service user cohort across 2 years.

Staff perceptions of working with individuals misusing alcohol and drug were assessed using two validated instruments: the Alcohol and Alcohol Problems Perception Questionnaire, and the Drugs and Drug Users Problems Perception Questionnaire. These instruments break down perceptions into seven domains (Tables 1 and 2). Baseline data were collected in 2004 and questionnaires were repeated in 2006, to detect any changes in staff perceptions coinciding with the presence of dual diagnosis community psychiatric nurses in their teams.

Improvement in the measures above would mean little if service users did not also benefit. To gauge this, the clinical status of Hamilton and Cumbernauld service users was assessed in 2004 and again in 2006 using the validated Christo Inventory for Substance misuse Services. This scale measures substance misuse and social functioning. Individuals whose clinical care was taken over at any stage by the dual diagnosis nurse were excluded, the intention being to detect clinical improvement achieved via their impact on staff colleagues. The results would reflect the key worker's own assessment of change in their patients. A reduced score represents a clinical improvement; the same cohort (n=65) were assessed in 2004 and again in 2006.

Results

Needs assessment (Lanarkshire-wide)

Lanarkshire addiction teams had 1212 service users on case-load in 2004. Of those, 19 (1.6%) were reported to have schizophrenia or other psychoses, and 7 (0.6%) bipolar affective disorder.

Lanarkshire CMHTs not hosting dual diagnosis community psychiatric nurses had 804 service users with 'severe or enduring' mental health problems in 2004. Of these, 156 (19%) were deemed to have a substance misuse problem but it was thought that only 108 (13%) 'would benefit' from referral to specialist addiction services. However, only 73 (9%) had actually been referred. Community mental health team staff were presented with four potential barriers to referral and asked to comment (in general) on the relevance of each for their patients. Of the 33 staff questioned, 21 (64%) agreed that 'some individuals refuse to consider referral,' 24 (73%) that 'some individuals would be unlikely to

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Table 1. Alcohol and Alcohol Problems Perception Questionnaire results

	Mean score (s.d.)		
	2004 (*n*=25)	2006 (*n*=23)	Mean difference in score (95% CI)
Total score	112.28 (15.84)	99.91 (8.29)	12.37 (4.92 to19.81)**
Role adequacy	27.00 (8.17)	22.09 (6.27)	4.91 (0.65 to 9.17)*
Role legitimacy	12.12 (4.06)	9.57 (3.09)	2.55 (0.44 to 4.66)*
Role support	9.72 (4.09)	4.43 (2.00)	5.29 (3.39 to 7.18)***
Motivation	21.04 (3.69)	21.26 (4.69)	−0.22 (−2.66 to 2.22)
Task-specific self-esteem	23.20 (3.35)	23.30 (3.28)	−0.1 (−2.04 to 1.83)
Work satisfaction	19.20 (2.38)	19.26 (1.66)	−0.06 (−1.26 to 1.14)

*$P<0.05$, **$P<0.01$, ***$P<0.001$.

Table 2. Drug and Drug Users Problems Perception Questionnaire results

	Mean score (s.d.)		
	2004 (*n*=31)	2006 (*n*=22)	Mean difference in score (95% CI)
Total score	87.77 (21.72)	71.50 (18.19)	16.27 (4.89, 27.66)**
Role adequacy	36.87 (11.39)	31.55 (10.19)	5.32 (−0.78, 11.43)*
Role legitimacy	9.32 (4.29)	6.73 (3.30)	2.59 (0.41, 4.78)
Role support	9.45 (4.93)	3.95 (1.65)	5.50 (3.30, 7.69)***
Motivation	3.87 (1.57)	3.59 (1.50)	0.28 (−0.58, 1.14)
Task-specific self-esteem	10.84 (4.21)	9.64 (3.61)	1.20 (−1.02, 3.43)
Work satisfaction	17.42 (4.31)	16.05 (4.17)	1.37 (−1.01, 3.75)

*$P<0.05$, **$P<0.01$, ***$P<0.001$

Table 3. Christo Inventory for Substance misuse Services results

	Mean score (s.d.)		
	2004 (*n*=65)	2006 (*n*=65)	Mean difference in score (95% CI)
Pair 1	10.65 (3.18)	9.02 (3.92)	1.63 (0.67, 2.60)*

*$P<0.001$.

engage with addiction services,' 19 (58%) that 'some individuals are unable or unwilling to acknowledge their substance misuse problems,' and 12 (36%) agreed that 'the addiction team model would be unlikely to provide the kind of input needed.'

Evaluation (Hamilton and Cumberland)

Within Hamilton and Cumbernauld CMHTs (hosting community psychiatric nurses) there was a striking increase over the 2-year period in the number of individuals with comorbid mental health and substance misuse problems identified. Combining results for both teams, of the 453 users in 2004 who were still in contact with the CMHTs in 2006, 71(16%) were initially deemed by their key workers to have 'dual diagnosis'. From this same group, an additional 33 users had been further identified by 2006, representing an increase in identifications by 46.5%.

Tables 1 and 2 show changes in CMHT staff perceptions over the 2-year period of their work with service users misusing alcohol and drugs (in Hamilton and Cumbernauld). A lower score represents an improvement in the staff member's perceptions of working with substance misusers. For working with problem drinkers, there were significant changes in the domains of 'role adequacy' (P=0.025), 'role legitimacy' (P=0.019), 'role support' (P=0.001), and in total score (P=0.002). For problem drug users, there was a significant change in the domain of 'role support' (P=0.000) and in total score (P=0.006).

Table 3 Shows the Christo Inventory results for 2004 and 2006. There was a significant improvement in service users' clinical assessment results over this period (P=0.001).

Discussion

The main limitation of the evaluation was the lack of control groups for service users and staff. Community mental health team service users reported on here included only those with 'severe or enduring mental

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health problems'. In view of comorbidity levels reported in the literature, it is likely that people with major psychiatric disorder were underrepresented on addiction service case-loads across Lanarkshire.

It is likely that CMHT staff are underreporting alcohol and drug misuse problems among their service users. Even if identified, such people are often not referred to specialist addiction services for a variety of reasons. Community mental health team staff in Hamilton and Cumbernauld improved their performance in detecting these problems in their patients during the period when they were supported by the dual diagnosis community psychiatric nurses. If we speculate that the other Lanarkshire CMHTs might similarly improve in their detection of comorbidity, the discrepancy between the number of their service users with comorbidity and the number referred for specialist treatment would be even wider than those reported (19% and 9%, respectively). In Cumbernauld and Hamilton, CMHT staff perceptions of working with people with comorbidity had significantly improved over the 2-year period. Also, there was evidence of a general clinical improvement among service users with comorbidity in the same period, which was achieved indirectly via the dual diagnosis nurses' impact on staff colleagues (since their own direct clinical work was excluded from the evaluation).

Overall, dual diagnosis community psychiatric nurses were successful in improving the quality of care for complex and vulnerable individuals and their full integration within the CMHTs was crucial in providing the necessary level of staff trust and support. By not positioning posts externally (for example within addiction teams), unnecessary cross-boundary tensions and the so-called 'ping pong effect' could be avoided. We would argue that the outcomes reported here support the 'mainstream' approach to service provision for individuals with comorbidity.

Declaration of interest

None.

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References

APPLEBY, L., SHAW, J., SHERRATT, J., *et al* (2001) *Safety First. Five-Year Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness*. Department of Health.

BARTELS, S. J., TEAGUE, G. B., DRAKE, R. E., *et al* (1993) Service utilisation and costs associated with substance use disorder among severely mentally ill patients. *Journal of Nervous and Mental Disease*, **181**, 227–232.

CANTWELL, R. & HARRISON, G. (1996) Substance misuse in the severely mentally ill. *Advances in Psychiatric Treatment*, **2**, 117–124.

CANTWELL, R., BREWIN, J., GLAZEBROOK, C., *et al* (1999) Prevalence of substance misuse in first episode psychosis. *British Journal of Psychiatry*, **174**, 150–153.

CLINICAL STANDARDS BOARD FOR SCOTLAND (2001) *Clinical Standards for Schizophrenia, Standard 11*. Clinical Standards Board for Scotland.

DEPARTMENT OF HEALTH (1999) *A National Service Framework for Mental Health* (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598). Department of Health.

DRAKE, R. E. & WALLACH, M. A. (1989) Substance abuse among the chronically mentally ill. *Hospital and Community Psychiatry*, **40**, 1041–1046.

EL-GUEBALY, N. (2004)Concurrent substance-related disorders and mental illness: The North American experience. *World Psychiatry*, **3**, 182–187.

NATIONAL HEALTH SERVICE SCOTLAND (1997) *Framework for Mental Health Services in Scotland* (http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/). Scottish Office.

MENEZES, P., JOHNSON, S., THORNICROFT, G., *et al* (1996) Drug and alcohol problems among individuals with severe mental illness in south London. *British Journal of Psychiatry*, **168**, 612–619.

REGIER, D. A., FARMER, M. E., RAE, D. S., *et al* (1990) Comorbidity of mental disorders with alcohol and other substances: Results from the Epidemiological Catchment Area (ECA) Study. *JAMA*, **264**, 2511–2518.

SWANSON, J., HOLZER, C. & GANJU, V. (1999) Violence and psychotic disorder in the community: Evidence from the Epidemiological Catchment Area Study. *Hospital and Community Psychiatry*, **41**, 761–770.

THE SCOTTISH GOVERNMENT (2003) Mind the Gap: Meeting the Needs of People with Co-occurring Substance Misuse and Mental Health Problems (http://www.scotland.gov.uk/Resource/Doc/47063/0013752.pdf). Scottish Executive.

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