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▶ Psychosocial interventions for people with both severe mental illness and substance misuse.

Cleary M., Hunt G., Matheson S. et al.

Cochrane Database of Systematic Reviews: 2008, 1, Art.No.: CD001088

Latest update from the respected Cochrane review process still finds no reason to advocate replacing conventional care with specialised therapeutic approaches/teams when severe mental illness is complicated by substance use.

Abstract Over 50% of people with a severe mental illness also use illicit drugs and/or alcohol at hazardous levels. Even low levels of substance misuse among these groups is associated with detrimental effects including higher rates of treatment non-compliance, relapse, suicide, incarceration, hepatitis, HIV, homelessness and aggression. It is therefore extremely important to determine the most effective psychosocial (non-pharmaceutical) interventions for reducing substance use in this population. To date, trials assessing the effectiveness of interventions such as cognitive-behavioural therapy, motivational interviewing, 12-step recovery, skills training and psychoeducation have had mixed results.

This review analysed all relevant trials which randomly allocated severely mentally ill patients to different treatments in order to assess whether a psychosocial intervention intended to reduce substance use improved on standard care or treatment as usual. 25 such trials were found with a total of 2478 participants, testing either one-off treatments or integrated or non-integrated programmes. Therapeutic approaches included case management, cognitive-behavioural therapy, motivational interviewing and combinations of these. Meta-analytic techniques were used to combine outcomes from similar interventions in order to test whether the composite outcome differed from that achieved with standard/usual care. Among the outcomes considered were substance use, psychological health, social and other dimensions of functioning, quality of life, and retention in the treatment or in the study.

No compelling evidence was found to support any one psychosocial treatment over

treatment as usual. Pooling results was hindered by differences between trials with regards to outcome measures (particularly substance use), sample characteristics, settings (community or hospital), levels of adherence to treatment guidelines, and the nature of standard care. More quality trials are required which adhere to proper randomisation methods, use clinically valuable, reliable and validated measurement scales, and accurately report data, including retention in treatment, relapse, hospitalisation and abstinence rates. It is also crucial that future trials offer programmes which adhere to treatment guidelines.

FINDINGS Most disappointing was the lack of evidence for interventions custom-made for patients whose severe mental illness is complicated by substance use. At the pinnacle are the integrated models, whose multi-disciplinary teams are intended to overcome service coordination gaps by unifying addiction, mental health and other services at the point of delivery, rather than expecting patients to negotiate separate mental health and substance use programmes. Featuring small caseloads and assertive outreach to maintain contact with patients, they should also have helped overcome their reluctance or inability to stay in touch, a key obstacle to service delivery. In theory, this combination should have been a major advance on the typical 'falling between the gaps' scenario. In practice it was not according to this analysis.

If even intensive and integrated approaches fail, commissioners and service providers could be forgiven for thinking they might just as well carry on as usual. However, just four studies fell in this category and, as for other studies, often it was impossible to exploit the power of meta-analysis by pooling their results. In this situation, meta-analysis was perhaps an inappropriate review methodology. By confining itself to fully randomised trials, the analysis also missed out on the results of about 20 otherwise relevant studies. Many allocated patients sequentially to the different treatments, sometimes a reasonable alternative to random allocation. More on this issue below.

Aware of this issue, later four of the five authors of the featured study conducted a broader review which included non-randomised trials, as long as there was a comparison group against which to benchmark the treatment being trialled. Though findings were somewhat mixed, among this wider selection of studies, motivational interviewing in psychiatric settings had the strongest evidence for at least short-term reductions in substance use; combined with cognitive behavioural therapy, there were also improvements in mental state. Cognitive behavioural therapy alone was not well supported. Long-term residential programmes tackling substance use and mental health together also evidenced improvements in substance use and mental health, but studies were generally methodologically poor.

A study previously analysed by Drug and Alcohol Findings offers an example of the data loss resulting from restricting oneself to randomised trials. One of the rare tests of a fully integrated approach, it was excluded from the featured study because two of the three centres in the trial did not allocate patients randomly. Nevertheless patients allocated or not to integrated treatment were very similar on the dimensions recorded by the study. Several indicators did not support integrated care, but some important ones did. All three service access indicators of mental health crises fell under integrated care but increased under conventional care, creating statistically significant differences between the regimens. Relative to virtually no improvement under conventional care, the proportion arrested also fell significantly.

Variability in outcomes may itself be related to variations in relationships between substance use and mental health problems across the caseloads of the studies. Some evidence suggests that a degree of integrated care may have more of a role when mental

health symptoms are not a transient consequence of substance use, but the primary problem, and more specifically when drugs or alcohol are used to ameliorate these symptoms. Another source of variability may be the degree to which specialised models of care are actually implemented as intended; that is, truly are integrated, assertive and/or sensitive to the vulnerabilities and capabilities of mentally ill patients.

In line with the featured study, UK guidance avoids recommending any particular therapeutic approach. Guidance for England stresses the 'mainstreaming' of treatment for severely mentally ill substance users within mental health services. These patients are among those considered candidates for a specially designated care coordinator to orchestrate provision from a range of services, an alternative to integration which also avoids the patient having to negotiate multiple care systems. Rather than advocating a particular treatment programme, the guidance offers principles such as taking care not to prematurely advance in treatment or treatment goals when clients are not yet ready or willing. In cases of severe mental illness, drug and alcohol services are seen as supporting mental health services rather than taking the therapeutic lead, though (with reciprocal support from mental health services) they are seen as handling less severe cases themselves. Indeed, this seems inescapable due to the prevalence of psychiatric problems among their clients, as high as three quarters in inner city areas of England. Since less severe cases will not be severe enough to be taken on by psychiatric services, drug and alcohol services must develop relevant competencies and programmes and/or work with GPs if they are not to leave a high proportion of their clients under-served.

Corresponding guidance in Scotland also avoids advocating any particular therapeutic approach in favour of general principles. Though less prescriptive than the English guidance, it too sees the response to severe mental illness complicated by substance use as being led by mental health services. When substance problems are severe but mental health problems milder, substance misuse services are seen as taking the lead. When both are severe, it calls for a pragmatic, individualised approach, possibly delivered through specialist regional units. In other cases coordination across mental health and substance misuse services is seen as the core delivery vehicle. Repeatedly however, coordination has been found to be inadequate; details below. Given this disjunction, the argument for a degree of integration remains strong as a way of closing the gaps in service provision. Specialist joint services may have a role, but general provision is likely to rely on less ambitious initiatives, such as training some staff in both settings to deal with co-occurring substance use and mental illness.

In London severe psychotic illness was common among patients of mental health services but relatively rare among drug and alcohol service clients, in line with what would be expected from national guidelines. However, the degree to which mental health units are themselves capable of dealing with substance misuse problems, or plug this gap by linking with substance misuse services, has been questioned. Over a third of mentally disordered offenders in secure psychiatric units had serious problems due to alcohol or drugs, yet in this area of their work staff expertise and treatment programmes were underdeveloped, and few units systematically drew on the resources of substance misuse services. One problem is that the substance use profile of psychiatric patients (often dominated by alcohol and cannabis) does not match the availability of substance use services, which focus on opiate use. In Scotland, typically substance use services did not work with the substance use problems of mental health patients, and mental health services did not address the less severe forms of mental illness common among substance use service caseloads. In England, alcohol and mental health services commonly failed to work together, and some mental health services refused to care for alcohol patients until

their drinking was resolved.

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