DRUG & ALCOHOL FINDINGS *Matrix cell*

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Alcohol Treatment Matrix cell E3

Treatment systems; Medical treatment

Seminal and key studies on local, regional and national systems for effectively and cost-effectively providing medical interventions and treatment in medical settings. Includes discussions of what a good quality alcohol service would look like and whether the UK is making progress on systems for treating the overlap between substance use and mental health problems.

S Seminal studies **K** Key studies **R** Reviews **G** Guidance **MORE** Search for more studies

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

S Workplace culture key to broadening treatment opportunities (1980). Commissioners are encouraged to make every service contact an opportunity to tackle problem drinking and its consequences, but influential English studies showed that training will not substantially engage staff in this work unless they feel drinking is a legitimate priority back at work.

K Missed opportunities to prevent deaths from alcohol-related liver disease in UK (National Confidential Enquiry into Patient Outcome and Death, 2013). Based on 594 relevant deaths in the first half of 2011 identified by hospitals in the UK other than in Scotland. Most patients had recently attended hospital but there was a failure to screen adequately for harmful drinking, and even when this was identified, patients were not referred for support. See also an in-depth analysis (2012) revealing missed opportunities to prevent alcohol-related deaths in 2003 in the Glasgow region.

K Hospital alcohol teams spreading but underpowered (Public Health England, 2014). Survey results document the spread of alcohol services to all but a few hospitals in England, but fewer than a quarter took the form of multidisciplinary teams or could implement the assertive outreach recommended for patients with multiple and severe difficulties. Recommends which types of services should be commissioned in different categories of hospitals.

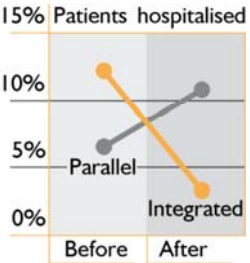
K Case management links detoxification to treatment (2006). Siting case managers at detoxification services transformed them into gateways to longer term treatment. They targeted patients with a history of multiple detoxifications, motivating them to complete the process and arranging support and follow-on treatment, part of a broader 'recovery revolution' in Philadelphia. For discussion click and scroll down to highlighted heading.

K Don't assume you know what characterises an effective service – find out! (2009). That's what the US health service for former military personnel did by testing the relationship between possible indicators of a treatment service's quality and the degree to which in practice it generate remission in problem drinking. The strongest indicator of the best average outcomes was the proportion of a service's patients who had attended it at least three times during the first month of treatment. For discussion click and scroll down to highlighted heading.

K 'Dual diagnosis' provision falls short in England ([UK] Care Services Improvement Partnership, 2008). First national assessment of progress towards implementing government good practice guidelines issued in 2002 (listed below) revealed there remained "a long way to go to genuinely meet the complex and changing needs of people with dual diagnosis". Regional reports also available. See also Effectiveness Bank hot topic on 'dual diagnosis'. For discussion click and scroll down to highlighted heading.

K Caring at the overlap between substance use and mental illness; more nobody's job than everybody's ([UK] Institute of Alcohol Studies, 2018). Entry title refers to Public Health England's insistence in guidance listed below that caring for people with both substance use and mental health problems should be seen as "everyone's job". Instead a survey and seminar involving people working in these sectors found that "too many people are bounced between services despite being highly vulnerable. Too often, instead of being everybody's business, comorbidity is nobody's business." See also Effectiveness Bank hot topic on 'dual diagnosis'. For discussion click and scroll down to highlighted heading.

K Integrated dual diagnosis teams help prevent crises (2006). From Texas, a rare (largely) randomised trial of truly integrated substance use and mental health care for severely mentally ill problem substance users found these arrangements reduced the frequency of psychiatric and legal crises ▸chart. Related review and guidance below. See also Effectiveness Bank hot topic on 'dual diagnosis'. For related discussion click and scroll down to highlighted heading.



R Evidence weak for integrating addiction and mental health treatment (2013; free summary and commentary from the US Centre for Reviews and Dissemination). Synthesis of research finds some evidence that integrating treatment for substance use and mental

health problems improves psychiatric symptoms and (in residential settings) reduces drinking more than non-integrated care, but none of the slight advantages approached statistical significance, and only one of the studies assessed whether treatment truly was integrated. See also study not included in this review above, related guidance below, and Effectiveness Bank hot topic on 'dual diagnosis'. For discussion click and scroll down to highlighted heading.

Psychiatric admissions in the years before and after allocation to integrated versus parallel care

R Pay-for-performance systems an evidential leap in the dark (Cochrane review, 2011). Overview of reviews on financial incentives for healthcare professionals in general could find no evaluations which reported on patient outcomes. Also conducted under rigorous Cochrane procedures, a similar review (2011) but of individual studies found "insufficient evidence to support or not support the use of financial incentives to improve the quality of primary health care". A review (2014) specific to drug and alcohol treatment could find "no peer-reviewed evidence that [pay-for-performance] … improves client outcomes post-treatment". For related discussion click and scroll down to highlighted heading.

G NICE synthesises official guidance on the organisation and procurement of alcohol treatment and brief intervention services ([UK] National Institute for Health and Care Excellence, 2011). England's gatekeeper to the public provision of health care interventions extracts the messages for commissioners from its own and other official guidance and distils these in to a single document to guide the organisation and procurement of treatment and brief intervention services in an area. Also offers reasons for organisations responsible for spending health service resources to devote these to alcohol services.

G NICE alcohol use disorders treatment and care pathways ([UK] National Institute for Health and Care Excellence, accessed 2020). From England's gatekeeper to the public provision of health care interventions, care pathways and associated resources and guidance relating to the prevention, diagnosis and management of alcohol-related disorders. See also earlier guidance ([UK] Department of Health, 2009) on alcohol treatment pathways and current substance use guidance collated by Public Health England (2019). For related discussion click and scroll down to highlighted heading.

G Integrated care for substance users in Scotland (Report produced for the Scottish Advisory Committee on Drug Misuse, 2008). Guidance on how to construct a treatment system that combines and coordinates all the services required to meet the assessed needs of the individual. Includes care pathways and responding to patients with mental illnesses.

G Expert advice on commissioning substance use treatment ([UK] Joint Commissioning Panel for Mental Health, 2013). Co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, a collaboration of organisations and individuals with an interest in commissioning mental health services explains the rationale for commissioning effective services and offers practical advice. For discussions click here and here and scroll down to highlighted headings.

G NICE advises against specialist 'dual diagnosis' services ([UK] National Institute for Health and Care Excellence, 2016). England's gatekeeper to the public provision of health interventions says that rather than creating specialist services, health and social care (including substance use) services should adapt to mentally ill substance users, and in severe cases care should be led by mental health services. Another NICE guideline (2011) deals specifically with psychosis and substance use. Guidance is reflected in NICE quality standards (2019). See also earlier dual diagnosis good practice guide ([UK] Department of Health, 2002) and Effectiveness Bank hot topic. Related review review and study above. For discussion click and scroll down to highlighted heading.

G "No wrong door" for patients with mental health and substance use problems (Public Health England, 2017). Authority overseeing substance use treatment in England calls for commissioners to organise compassionate and non-judgemental care for patients with mental health problems centred on their needs and accessible at every entry point to health and social care systems. Stressed that caring for these patients is "everyone's job" and there should be "no wrong door" to accessing help. See also Effectiveness Bank hot topic on 'dual diagnosis'. For discussion click and scroll down to highlighted heading.

G What specialist addiction doctors should do and be able to do ([UK] Public Health England, Royal College of Psychiatrists, Royal College of General Practitioners, 2014). Guidance for commissioners from the body overseeing addiction treatment in England and from UK professional bodies on the part doctors who specialise in addiction are expected to play in promoting recovery and the importance of retaining their expertise.

G Organising to address problem drinking in NHS hospitals (undated). Guidance and advocacy from London's Health Innovation Network on the steps that need to be taken in NHS hospitals to tackle alcohol-related harm, including commissioning and models for service delivery systems.

G How to assess the performance of specialist doctors ([US] American Society of Addiction Medicine, 2014). Criteria designed to be used as the basis for local reimbursement and quality-control systems which evaluate performance against the standards ([US] American Society of Addiction Medicine, 2014) expected of specialist addiction physicians. For discussion click and scroll down to highlighted heading.

MORE Search for all relevant Effectiveness Bank analyses or search more specifically at the subject search page. See also hot topics on commissioning and dual diagnosis.

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listed above) from NICE.

Among the principles the panel advocated were that commissioning should be "outcome based" and "recognise recovery as central". Its views on these and other issues gain authority because compared to other advice, its particular contribution was to integrate national guidance with the views of drug and alcohol professionals, people who use drug and alcohol services, and carers, in a report developed independently of both government and official guidance-setting authorities.

The resulting text meant we placed the report at the heart of both of this commentary's "Issues to consider …" sections. Firstly, the panel boldly specified what in their opinion a good drug and alcohol service would look like, the starting point for our consideration below of the same issue. Secondly, their report was one of a series of such guidance from the Joint Commissioning Panel intended to aid implementation of England's No Health without Mental Health strategy. Given this context, it can be seen as exemplifying the incorporation of responding to substance use within mental health provision, which it and other guidance and policies have called for on the ground – progress on which is explored last in the section of this commentary.

Highlighted study – How best to help patients who cycle repeatedly through managed withdrawal from alcohol and/or drugs without getting anywhere in terms of their recovery from the underlying addiction? Listed above is our account of a simple idea from Philadelphia, a city visited (report listed above) for the recovery-oriented transformation of its substance use treatment system. At issue was how to make the most of the city's inpatient detoxification centres, whose patients typically experienced multiple overlapping substance use problems. For just over half these involved cocaine, nearly half alcohol, and around a third heroin; the most common combination was alcohol, cocaine and cannabis.

All too often detoxification was an isolated episode of care followed by relapse and then repeat detoxifications. The solution was to site clinical case managers at the centres to identify and make contact with patients who had been cycling repeatedly through withdrawal, seemingly getting nowhere in terms of sustainably overcoming dependence. Case managers sought to motivate these patients to complete detoxification and (for at least a year) tailored to guide and support them through the follow-on services needed to sustain their recovery. The effect was to transform revolving-door patients into patients with typical treatment admission patterns. Benefits were apparent across the entire caseload of the

detoxification centres in increased capacity (the number of patients treated rose by well over a half), a halving in the proportion of admissions accounted for by repeated detoxifications, and an increase in successful referrals to longer term care instead of isolated detoxifications – one way to make a reality of this critical link in the care pathways advocated by NICE in guidance listed above.

The authors explained why their results mattered not just from a clinical perspective, but also from a health systems management perspective: "… repeated use of these expensive acute-care services was a major source of system inefficiency. Moreover, because detoxification and stabilization is a necessary first step for most publicly supported patients in their treatment episodes and some of these scarce detoxification beds were being re-occupied multiple times by a small group of [multiple-detoxification] patients, this inefficient, expensive utilization of the system had the additional perverse effect of reducing treatment access for other patients."

This simple tactic offers one way to make a reality of the continuing care advocated (in a document listed above) by experts convened by England's medical colleges for GPs and psychiatrists. In cell D2 we learnt that continuing care is seen as an essential element of recovery-oriented treatment, matching that treatment to the chronic nature of the kinds of dependence experienced by the kinds of patients who present to services. Engaging exiting detoxification patients in longer term care would also improve a treatment system's standing on the only performance measure recommended by the American Society of Addiction Medicine, described in the next section.

Issues to consider and discuss

▸ **What would a good quality alcohol service look like?** Coming as it does from a heavyweight collaboration led by England's colleges for general practice and psychiatry, a portrait painted in 2013 of what commissioners should look for in an alcohol (and/or drug) treatment service is not to be taken lightly. Take a look at the specifications on page 14 of the report listed above. Note that the list is subheaded, "Key components of a good quality service"; presumably the experts saw these as the *minimum* needed to justify a "good quality" tag. On the following page you will find their recommended "Model of service delivery and core principles," including: comprehensive assessment of patients' needs going well beyond substance use problems; NICE-recommended substance use interventions, plus broader interventions to safeguard children and vulnerable adults and promote the welfare of carers and families; and assuring a competent and appropriately qualified workforce.

Is this also your vision of what quality consists of? It might help to look at the alternative set of criteria listed above (turn to pages 15–16 of the document) selected by a US expert panel as feasible, scientifically valid and unlikely to have unintended adverse consequences. Among the list are 'process' and 'context' measures like screening for related complaints and the proportions of patients prescribed medication and followed-up after detoxification. The effectiveness of these measures is to be assessed by a single 'performance' measure – the proportion of patients readmitted within three months of discharge for a further episode of inpatient or residential care. It was selected as an easily collected indicator of relapse or complications after initial treatment, interpretable as a direct outcome of poor coordination of services and/or an indirect outcome of poor continuity of services. Testing how to reduce this kind of readmission was the aim of the study from Philadelphia highlighted in the section above.

Discuss these criteria with colleagues, size up services in your area against them, and see how they square with your understanding of what makes for a good service. Here are some starter questions. Are these the attributes to be expected of each individual service, or (perhaps more realistically) of the local service network? Can we specify what constitutes a good quality service in isolation from the local service and case-mix context? Could good quality in one area be poor in another? Is this vision universally applicable, or particular to a certain kind of service – the "specialist integrated" teams staffed by "professional health and social care staff" which on page 15 the expert guidance for England listed above sees as the best model for addiction treatment? Were they right to imply that a specialist and professionally staffed service is the least anyone with severe substance use problems should expect? Do you also see this as the ideal? What of the continuity and integrated care in theory on offer from GPs? Certainly there is a case for integrating primary medical care and substance use treatment for patients whose medical and psychiatric complaints are 'integrated' with their dependent drinking, but research is less clear about whether the best locus is a primary care surgery or a specialist substance use treatment unit.

The English report's focus was on professional competence – obviously essential for safety, but is it a driver of recovery? Look back at cell B3's bite on practitioners in medical treatment. There we cite this

advice from a review of why patients do better with one clinician than another: "Select and evaluate clinicians based on their 'track record' … assumptions that levels of training, experience, or other simple therapist variables could account for such differences [in effectiveness] does not hold." Cited in the same cell are studies which highlight relationship-building and the instilling of hope and confidence as prime recovery-generating qualities of clinicians.

Following the lead given to evaluate practitioners by their track records, why not do the same for whole treatment agencies, and simply recognise what is or is not a good quality provider by how well its patients do, regardless of the services it offers or how it is staffed? That sounds very simple, but the reality (see documents listed above) has proved complicated and of unproven value.

Obstacles include the fact that it can be difficult and costly to check whether patients have sustainably overcome their drinking problems by routinely following them up; expert and experienced research teams with dedicated funding have struggled to make valid assessments. A halfway house is to conduct a one-off or rarely repeated exercise to identify more easily measured features of a service which predict its patients' subsequent drinking. Then rather than having to re-assess the patients, these features of the service can be assessed and presumed to reflect service quality in terms of how well patients do.

That's what the US health service for former military personnel did (study listed above) by analysing the relationships between candidate quality indicators and remission in problem drinking seven months after treatment started. The strongest indicator of which agencies had the best average outcomes was the proportion of their patients who had attended at least three times in the first month of treatment. Importantly, this was assessed at the agency level. The chosen measure did not reflect the degree to which *individual* patients who initially attended three times improved more than others, but whether a whole agency characterised by good initial attendance tended to do better across *all* its patients. Our analysis interpreted these findings as suggesting that "treatment services which offer and are able to encourage their patients to accept several visits are the kind of organisations which foster the greatest positive change. It is reasonable to expect these agencies to be welcoming and to rapidly forge relationships with patients which encourage them to return."

That's how it worked out at these services for former military personnel in the USA. For your local services, results might differ, but could the principle still be applied – that is, to develop a list of candidate indicators of service quality, follow-up patients to see which is related to later drinking, and then use these indicators as a proxy for effectiveness?

▸ **Are we making progress on systems for treating 'dual diagnosis'?** At the turn of the millennium the aim at the top of government in the UK was not just to make progress, but huge strides in caring for people with both substance use and mental health problems, conventionally termed the 'dual diagnosis' caseload. Listed above, unambiguous policy issued in 2002 by England's Department of Health on who should take the lead in caring for these patients stressed that when mental health problems are severe, care "should be delivered within mental health services," which "have a responsibility to address the needs of people with a dual diagnosis". At the heart of the policy was "mainstreaming", meaning substance use was to be no excuse for patients with mental health diagnoses to be "shunted between different sets of services". Achieving this objective required not just tinkering, but a "radical rethink of the way services are organised – they need to be organised around the user rather than around social, professional or service constructions of 'abnormal' behaviour". How radical a change was needed had been exposed by research funded by the same government department responsible for the policy, for which unfold the supplementary text. In 2018 the Institute of Alcohol Studies portrayed the 2002 policy report as the "one exception" to a series of government policies which had "largely ignored" the links between alcohol treatment and mental health.

Close supplementary text

Formally published in 2003, a survey conducted in 2001–02 of statutory sector drug and alcohol teams in English cities had found that over 8 in 10 alcohol service patients suffered from poor mental health, including a third each with severe depression and severe anxiety. Of the depressed patients, about a fifth were judged to be severe and vulnerable enough to warrant referral to mental health services, leaving the bulk of the problems to be addressed if at all by the substance use services or other non-psychiatric services. However, half the patients suffering the most common psychiatric disorders (anxiety or depression or other emotional problems) had not been recognised as such by substance use services, leaving them unable to adequately intervene. In the reverse direction, when interviewed for the study a quarter community mental health patients evidenced harmful drinking, but their mental health keyworkers identified problem drinking in just under a third of cases.

> For the researchers their findings indicated that in substance use services, "a high proportion of patients with affective and/or anxiety disorders had an unmet need for specialist intervention and our findings raise doubts over whether these patients are receiving appropriate medical interventions," while among mental health patients, "it was clear that a large proportion of … patients with substance misuse problems did not receive the specialist substance-misuse intervention that they required." In respect of non-psychotic patients with depressive and/or anxiety disorders, they argued that "resources need to be deployed to enable substance-misuse services to implement available evidence-based pharmacological and psychotherapeutic treatments to a much higher proportion". In mental health services, they identified "a need for all mainstream … staff to be equipped to manage comorbidity at basic level eg, core knowledge on comorbidity and the skills (and instruments if appropriate) to take a detailed drug and alcohol history".
>
> Close supplementary text

Echoing the 2002 policy, in 2011 and again in 2016 the stipulation that mental health services must take responsibility featured in guidance from NICE listed above. Similarly, in 2019 NICE saw (document listed above) the identification of a "care coordinator working in mental health services in the community [who] can liaise with the different services and act as a central point of contact for the person, their carers and service providers" as one criteria for good quality service provision for co-occurring severe mental illness and substance misuse.

In between came the unofficial but still authoritative commissioning advice for England discussed in the section above. Issued in 2013, it did not directly contradict official policy and guidance, but the emphasis seemed more on substance use services shouldering or sharing the load. For these authorities, one sign of a high-quality substance use service was that it can "manage the full range of complexity of need, including … mental and associated physical health needs". Funding bodies were encouraged to commission "services that recognise the connections and linkages between drug and alcohol misuse". Coming from major charities and public service representative bodies coalescing in the Joint Commissioning Panel for Mental Health, it represented a significant recognition of the importance of substance use in mental health.

About what happened on the ground, there is little current information. At least initially, it seems the "radical rethink" called for in 2002's health department policy did not materialise. In his foreword to the policy, Professor Louis Appleby, National Director of Mental Health, had been "confident it will be a very useful tool for developing effective services in the future". But when in 2007 implementation was assessed (report listed above), in a second foreword he admitted there remained "a long way to go to genuinely meet the complex and changing needs of people with dual diagnosis". A survey of the authorities and staff responsible for local implementation had showed that mental health services in England had not been able to adequately gear up for problem substance use among their caseloads. "Fundamental requirements for planning services such as monitoring service use and carrying out local needs assessments had been achieved only patchily." For a policy intended to promote user-centred service provision, most revealing was that "Only two fifths of [local implementation teams] had collated evidence on user satisfaction with services." The 2002 policy might have made sense in Whitehall, but in practice it was not working out.

Also in 2007, at a micro level some of the reasons for the steepness of the challenge became apparent in an article based on interviews with mental health nurses in the south of England. Despite (or perhaps, because of) their being practised in working with substance using clients, the difficulty of adequately responding was a prominent theme, prompted by what was experienced as a lack of skills and support. Set against what was needed, the time available was seen as inadequate: "Dually diagnosed people required long-term commitment in order to build trusting relationships and to establish enough contact with them over time. Community mental health nurses felt that they never had enough time to achieve their goals of care." The result was that clients were experienced as "hard to engage and often appeared helpless and lacking in hope". Many were seen as "reluctant to accept help" and working with them was "thought to be hard, not often rewarding and often seeming like an impossible challenge". That dead-end word "impossible" will crop up again below, suggesting that these nurses were speaking for colleagues across the world.

> *Working with people who have a dual diagnosis seemed like an "impossible challenge"*

The nurses' views are strikingly reminiscent of those expressed at a Boston emergency hospital in the 1950s, when disturbed 'skid-row alcoholics' were dismissed as intractably treatment-resistant. Evaluated by a study discussed in cell A2 and also more fully analysed for the Effectiveness Bank, the answer was to give more listening, time, attention and respect to these seeming 'no-hopers'. The effect was to transform

'Skid-row alcoholics' seen at a US emergency department were also seen as intractably treatment-resistant.

them into more normal patients. That transformation rested on a new management determined to turn things around not by directly changing the patients, but the staff, the culture they worked in and the resources devoted to the task.

Obstructions to adequate care experienced by the mental health nurses in England were classically of the kind training alone is unable to shift. Also published in 2007, that finding (see cell D2) emerged from a study in London of training for mental health staff in working with the conjunction between mental illness and substance use. Though the mental health case managers selected for the study had all attended at least four days of a five-day course and been offered monthly supervision, their patients could not be shown to have further reduced their substance use or to have subsequently required less hospital care.

These studies date from many years ago. With further new guidance and more experience, do today's substance users find welcoming and effective care in mental health services? For problem drinkers, a survey conducted in England in 2014 suggested that the "failure to meet the needs of the dually diagnosed" remains, and may be worsening because mental health budgets had been cut, and services were now commissioned separately from substance use services.

The following year, Professor Liz Hughes, who has extensive clinical and academic experience in mental health, substance use, and in their co-occurrence, delivered a similar verdict under the banner, "The NHS is failing people with mental health and substance use problems." Things were, she warned, no better now than in the 1990s; in some ways, worse. Again, budget cuts and commissioning processes and structures were spotlighted: "Since the localism agenda of the coalition government, and now the Conservative government, and the cuts to government central budgets, many of the national programmes have disappeared. This is further complicated by the almost complete transfer of substance use services to the third sector and the absence of mental health staff in these new services. Currently, dual diagnosis work is based on a postcode lottery, and is piecemeal at best."

In 2017 came this admission in a report listed above from Public Health England on co-occurring mental health and alcohol/drug use: "Evidence suggests that the recommendations contained in the Department of Health 2002 national guidance *Dual diagnosis policy and implementation guide* and the 2009 Department of Health and Ministry of Justice publication *A guide for management of dual diagnosis in prisons* have not been widely implemented." Further evidence was said to suggest "that people are frequently unable to access care from services, including when intoxicated/experiencing mental health crisis … It is not uncommon for mental health services to exclude people because of co-occurring alcohol/drug use, a particular problem for those diagnosed with serious mental illness, who may also be excluded from alcohol and drug services due to the severity of their mental illness." Fifteen years and much guidance and exhortation later, the 2002 "radical rethink" seemed little if any further to its realisation, at least in England, and the lead in caring at the conjunction of substance use and severe mentally illness intended to be taken by mental health services was, it seems, commonly replaced by denial of service.

A year later the evidence was added to by an analysis listed above of a survey conducted by the Institute of Alcohol Studies and Centre for Mental Health of people working in alcohol and mental health services across the UK. Enough responses (108) were received to analyse those for England, and the results were dispiriting. Key finding was that "The vast majority (84%) of respondents agreed that having an alcohol use disorder was a barrier to getting any kind of mental health support," though the reverse was less clearly the case. More generally, the investigation painted "a picture of a lack of joined-up action and service users falling through cracks … those with co-morbid conditions are struggling to access treatment, and … funding shortages, a lack of crosstalk between mental health and alcohol services, workforce shortages and the stigma facing people with comorbid problems all serve to place further barriers ahead of them." As others have also said, the report's authors felt things had recently got worse due in particular to cuts to alcohol services: "financial pressures have led local authorities to recommission substance misuse services outside the NHS, at ever lower costs. This has fractured existing good working relationships, and further reduces the chances of the two services working together effectively as well as eroding the capacity in the system for training and developing specialist workers in addictions."

Britain is not alone in finding the engineering of even basically adequate 'dual diagnosis' care an

intractable task. In 2013 a review (listed above) of international research on treating serious mental illness and substance use sounded a "Mission impossible" warning in its title, explaining that "Treating adults with severe mental illness and substance use disorder has been considered 'mission impossible' [exemplifying] the challenges consumers confront in obtaining treatment for both disorders concurrently". The term 'impossible' directly echoed the "impossible challenge" despair of mental health nurses in England described above. Nevertheless, in the next sentence the review insisted that "the challenge must be met" – "must" due to the substantial overlap (1 2) between mental illness and problem substance use and the serious consequences of failing to respond effectively to their co-occurrence.

"Must" for the sake of the patients – but how? One opportunity came in 2016 in the form of the UK government's Life Chances Fund. Announcing it, then prime minister David Cameron said "up to £30 million" would be available "to encourage the development of new treatment options for alcoholism and drug addiction, delivered by expert charities and social enterprises". Commenting on the policy, an independent Mental Health Taskforce said applicants should "demonstrate how they will integrate assessment, care and support for people with co-morbid substance misuse and mental health problems". However, the central money was intended merely as a "top-up"; not just the ideas, but most of the funding would have to be raised locally. In the event, none of the grants were for improving core dual diagnosis care for adults and just one directly concerned this population – a project focused on frequent emergency department attendees with complex and multiple problems, including problem substance use.

Faced with this persistent and potentially very costly gap in service provision, rather than relying on mental health services, should we change tack in ways hinted at in 2013 in the document discussed above from a coalition of service providers in England and their actual or potential users? That might include helping substance use specialists take a more prominent role in supporting mental health services, perhaps even skilling up to themselves deal with more of the psychiatric problems so common among their caseloads. Or would that be counterproductive and possibly risky in cases of severe mental illness? Where should the line be drawn across which mental illness is too severe and/or of a type requiring mental health services to take the lead? If they are to take the lead, what can feasibly be done to enable mental health services to welcome and offer an appropriate response to patients whose condition is complicated by substance use? Was NICE right so firmly to close the door ("Do not create a specialist 'dual diagnosis' service") on services dedicated to the overlap between substance use and mental health? Are these services the best way to meet the coalition's call for "services that recognise the connections and linkages between drug and alcohol misuse"? Explored more fully in our hot topic on the issue, how best to deal with these crossover patients just does not seem to get any clearer.

Close Matrix Bite