2.12 Promising approach to 'dual diagnosis'

Findings 'Assertive outreach' has gained popularity as a way to avoid hospitalising seriously mentally ill clients who otherwise would not engage with services. Staff persistently and proactively contact patients on their own territory, providing client-led help often with practical issues such as housing and finance. Clients include many with alcohol and drug problems whose instability has caused concern. Outreach can form part of an integrated service tackling substance and mental health problems together.

New Hampshire in the USA operates the best known services. The featured study (reported in two papers) compared two variants. The smaller workload (12 v. 25) of the *assertive community treatment* teams and their specialisation enabled them to directly deliver many services; *standard case management* teams relied more on other personnel – a less integrated option. 223 referrals (typically white unemployed men in their 30s) were randomly assigned to the treatments. 203 completed the study. Data from interviews before treatment and then every six months for three years were combined with clinical ratings and urinalysis. At three years improvements in both groups (in substance problems, independent living, and psychiatric symptoms) were similarly encouraging. The (minor) differences favoured assertive treatment. Over the three years each approach achieved comparable improvements per $ spent; though less intensive, standard treatment drew more on other services and on informal help, meaning that it was not significantly cheaper. But by the *final* six months, assertive treatment costs had declined to the point where it was more cost-effective.

In context Evidence supports assertive treatments for the mentally ill; a British report has made detailed recommendations ◤ *Secondary sources* ❶. However, trials with mentally ill *substance abusers* are few and disappointing. A British review of the most sound studies (◤ *Secondary sources* ❷) found no evidence that integrated treatments confer greater benefits than routine care and queried whether they represent value for money, though the latest programmes are more promising (◤ *Secondary sources* ❸).

The current study benefits from low drop out, long follow up, sophisticated measures, and comprehensive costings. The main query is how far results will generalise to urban, ethnically diverse and homeless populations, and to areas lacking support services. In these areas the more all-in-one option might have been preferable. Conversely, in countries like Britain with free comprehensive social and health care, approaches which rely on such services might perform at least as well as all-in-one treatments. Though there was no 'unintegrated' comparison, the outcomes in this study provide indirect support for integrated treatment.

Practice implications Services with low caseloads and highly trained staff directly delivering comprehensive help can be at least as cost effective as less intensive services which compensate by accessing supplementary support. Outcomes depend on the adequacy of the services. Though the advantages of integrated treatment (in theory, this eliminates falling between stools and conflicting treatments) have yet to be demonstrated, a profile is emerging of them most promising approach: assertive outreach to engage and retain clients; intensive case management to ensure they receive services; and interventions geared to the patient's own agenda and willingness to recognise their problems. Support services and staff training will be the keys to success. At this stage such initiatives should be tested against standard practice.

Main sources ❶ Drake R.E., *et al*. "Assertive community treatment for persons with co-occurring severe mental illness and substance use disorder: a clinical trial." *American J. of Orthopsychiatry*: 1998, 68(2), p. 201–215 ❷ Clark R.E., *et al*. "Cost-effectiveness of assertive community treatment versus standard case management for persons with co-occurring severe mental illness and substance use disorders." *Health Services Research*: 1998, 33(5), p. 1285–1308. Copies: for both apply ISDD.

Secondary sources ❶ Sainsbury Centre for Mental Health. *Keys to Engagement*. 1998. Copies: apply Sainsbury Centre *etc*, phone 020 7403 8790 ❷ Ley A, *et al*. "Treatment programmes for those with both severe mental illness and substance misuse." *Cochrane Library*: 1999, 4. Copies: apply Update Software, phone 01865 513902, e-mail info@update.co.uk ❸ Drake R.E., *et al*. "Review of integrated mental health and substance abuse treatment for patients with dual disorders." *Schizophrenia Bulletin*: 1998, 24(4), p. 589–608. Copies: apply ISDD.

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