This editorial summarizes the main recommendations of the NICE guideline on psychosis and coexisting substance misuse. It outlines the dearth of specific evidence (especially for integrated models), but emphasizes implementation of evidence for the treatment of psychosis and substance misuse separately for current best practice and policy. It highlights research options and training needs to further enhance effective treatment.

INTRODUCTION

The National Institute for Health and Clinical Excellence (NICE) has recently published the guideline on the assessment and management of psychosis and coexisting substance misuse (PSM) in adults and young people aged 14–60 years [1] (http://guidance.nice.org.uk/CG120). Its recommendations are summarized by Kendall et al [2]. It is intended to be useful to clinicians and commissioners in providing and planning high-quality care for people with PSM, while also emphasizing the importance of the experience of care for this group.

SCOPE OF THE PROBLEMS

Over the last two decades there has been increasing awareness of the extent and multi-faceted nature of PSM. Wide variations in drug and alcohol misuse rates in psychosis in the United Kingdom are reported [3]. Studies report rates between 20% and 37% in mental health settings, and lower rates of 6% to 15% in addiction settings. Rates in the United Kingdom are generally not as high as in US studies, but appear to be especially high in in-patient, crisis team and forensic settings, inner-city areas and some ethnic groups. This reflects the complex heterogeneity of the group as well as methodological differences in sampling, assessment and diagnostic tools. Increased mortality is associated with PSM, as are social problems including deprivation, disorganized environments, family instability, unemployment and homelessness.

WHAT IS THE EVIDENCE?

This guideline has been eagerly awaited, providing an authoritative statement on what works in this challenging area in health and social care settings, including primary and secondary care and criminal justice systems. Thus, it is disappointing that there is a dearth of specific evidence for effective psychosocial or pharmacological interventions in PSM. Moreover, there is a striking paucity of evidence for effectiveness of the much-promoted integrated service model where staff competent in mental health and substance misuse in specialist mental health services provide holistic care for patients with PSM. Because the review demonstrated only moderate to low-quality evidence from randomized trials relating to integrated service models, the findings were inconclusive.

The guidance for young people draws almost entirely upon the adult evidence base and is a descriptive consensus by practitioners. The virtual lack of evidence for this segment of the PSM population is disheartening, given their extreme vulnerability. Highlighted issues were the vital need for engagement, safety and clarity about the dependence diagnosis prior to prescribing pharmacological agents in addition to welcome support from families (if possible), consent, confidentiality and transitions to adult services.

So what are the implications for implementation of the recommendations?

PRACTICE

The information on best practice was gathered largely from NICE guidelines to date for psychosis and alcohol and drug misuse. In part, the recommendations were also experience-based, drawing on the Guideline Development Group (GDG), including service users and carers’ representatives and the response to the national consultation on the draft guideline. At face value, the recommendations provide useful practical guidance on assessment, treatment, care pathways, care coordination and the competencies of health-care professionals.

The GDG could not recommend an optimal service model. Indeed, it may be that one type of treatment programme is unlikely to encompass the heterogeneity of mental, physical and social problems with which this group presents. Nevertheless, it builds upon and supports the good practice models endorsed in the Good Practice Guide [4]. Care coordination of specialist services as outlined by the GDG could reduce hurdles to access and increase protection and resilience to hazardous...
environments. Comprehensive facilities which favour continuity are likely to reduce relapse, re-hospitalization and disruptive behaviour and to improve treatment adherence and recovery, although competition between services may create some barriers to best practice [2].

It is anticipated that the guideline will assist clinicians in the implementation of particular treatment approaches where the evidence from research and clinical experience exists for people with psychosis and coexisting substance misuse and their carers.

TRAINING

The guideline sets new standards for the core competence of staff. There is limited evidence to support the recommendations and hence the need for development informed by existing training programmes such as the Como Study [5]. This study demonstrated that brief training can have some limited effect on how people perceive their skills and on improving knowledge, but less impact on overall attitude change. It is unlikely that brief training courses without other expansion, such as specialist dual diagnosis workers providing intensive support, supervision and multi-agency strategies, will be sufficient.

Research is needed to delineate what makes trainees at all levels, from undergraduate to postgraduate, and a range of specialities and services, enhance skills so that it impacts upon clinical practice. Ultimately, new training packages—perhaps using a stepped approach—should be evaluated for effectiveness and cost-effectiveness in enhancing patient and staff outcomes.

POLICY

The guideline should inform national and international policy on quality standards and best practice care. Current policy in the United Kingdom recommends that mental health services should be the lead service in working with PSM, and the GDG felt it was important to make a recommendation reflecting this [4,5]. The guideline advocates and endorses the shared care model between general mental health and specialist substance misuse services enhanced by care coordination and optimal care pathways.

Almost 80% of mental health Local Implementation Teams (LIT) reported having a local definition of dual diagnosis, but more than 40% of LITs did not have a dual diagnosis strategy agreed with local stakeholders [6,7]. Therefore, commissioners of mental health and substance misuse services need to adopt the recommendations of this guideline for more effective and inclusive health and social care.

RESEARCH

It is self-evident that more research needs to be conducted, even if lack of evidence of effectiveness for an intervention is not evidence of ineffectiveness. The key research recommendation is that people with PSM should not be excluded from trials of interventions that are effective in the treatment of psychosis or substance misuse. As little research has been undertaken in the United Kingdom, it seems opportune that the major funding bodies [National Institute for Health Research (NIHR), Medical Research Council (MRC), Health Technology Assessment (HTA)] and the pharmaceutical industry consider the recommendations. The recommendations include investigation of the prevalence, risk factors that predict onset and protective factors, course of illness for different combinations of psychosis and coexisting substance misuse; what and how training be provided to relevant health-care professionals; and whether psychosocial, environmental or pharmacological interventions are clinically or cost-effective compared with standard care for PSM.

CONCLUSION

PSM is often a long-term condition with multiple psychological, physical and social problems affecting not only the individual, but families, communities and society. PSM is not inherently resistant to treatment. Poor health and social outcomes are, to some extent, attributed to major barriers which preclude the most favourable care, stigma, limited capacity in service provision and poorly coordinated care [8,9,10].

Part of the reason that solutions are so elusive is this complicated mix of problems which make it difficult to engage people in treatment, let alone research. Elucidation through research recommendations outlined is likely to take some time to emerge from long-term studies. We suggest that this costly investment is essential and not discretionary.

Declarations of interest

None.

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