

## Severe mental illness and substance misuse

*Research is needed to underpin policy and services for patients with comorbidity*

Evidence from the United States suggests that half of all patients with schizophrenia also have a substance misuse disorder.<sup>1</sup> This comorbidity is associated with poor prognosis and heavy use of expensive inpatient care through recurrent "revolving door" admissions.<sup>2</sup> The phenomenon has only recently been recognised in the United Kingdom, but one survey of psychotic patients in an inner London district found that 36% misused drugs or alcohol. The same survey observed inpatient admission rates among comorbid patients that were almost double those of patients with psychosis alone.<sup>3</sup> This high prevalence, the problems of clinical management,<sup>4</sup> and a continued rise in the general rate of drug misuse make comorbidity a major public health issue, and the Department of Health is currently inviting applications for research into the prevalence and pattern of comorbidity.

The term "dual diagnosis" is used increasingly in psychiatric practice to describe this combination of severe mental illness (mainly psychotic disorders) and substance misuse. Unfortunately the term is imprecise and its use seems only to confirm the inadequacy of current classification systems in describing certain complex presentations.<sup>5</sup> We prefer the term "comorbidity" (the simultaneous presence of two or more disorders), though even this may fail to capture potential causal interactions between psychosis and substance misuse. Patterns of substance misuse vary considerably, but use as well as dependency may be problematic among people with psychosis. Whether there is any causal relation between substance misuse and psychotic disorders remains controversial. However, some types of substance misuse, particularly alcohol, cannabinoids, hallucinogens, and stimulants (such as amphetamines), can produce psychotic symptoms directly without mental illness. They may also precipitate psychotic disorders among people with a predisposition.

Services for drug misusers and mental health services have tended to develop in ways determined more by public anxiety and political ideology than by research evidence.<sup>6</sup> Although it is important that this history should not be repeated in relation to comorbidity, negotiating an evidence based path through existing policies may be difficult. For example, programmes to improve liaison between psychiatric and substance misuse services may appear attractive. Improved communication is never a bad thing, but there is a fashionable belief that it may be the crucial element missing.<sup>7</sup> The medical model of psychiatric

services, with their recourse to legal compulsion to treat those incapable of making rational health choices, contrasts sharply with the psychosocial orientation of substance misuse services. Thus the common language required for successful communication may not exist. Moreover, as both services often operate referral criteria that specifically exclude comorbid patients, liaison alone may be a recipe for buck passing.

Policy makers may also find liaison models attractive because they mesh with the brokerage models of case management adopted in the United Kingdom. Under these arrangements case workers assume responsibility for assessing clients' needs and managing packages of appropriate services. Unfortunately, evidence supporting the effectiveness of UK case management is minimal.<sup>8</sup> Assertive community treatment, which involves more intensive team based interventions, is now favoured in the United States. Such treatment has a secure evidence base<sup>8</sup> but one derived almost exclusively from trials that have specifically excluded comorbid patients. The few trials of assertive community treatment specifically targeted at comorbidity have shown little benefit.<sup>9</sup> Hence a growing body of opinion now argues that integrated treatment specifically for comorbidity must underpin an approach based on assertive community treatment and that clinical teams must be able to implement motivational therapy and treatment for both types of disorder without cross referral to other agencies.<sup>4</sup> Recent quasiexperimental studies of integrated treatment teams suggest that the approach does have benefit over multiagency treatment involving separate teams.<sup>10</sup>

Although the literature suggests that these broad principles should inform our response to comorbidity, evidence for the efficacy of interventions is limited. This makes the implementation of treatment for comorbid patients difficult for the NHS. Moreover, owing to an almost complete absence of evidence based service development in the recent past, current community care arrangements provide shaky foundations on which to develop appropriate services. There are three urgent priorities. Firstly, investment in an appropriately skilled workforce, trained in a range of treatment modalities, must be regarded as a basic building block of any future service. Secondly, we need research which investigates the extent and nature of comorbidity in the UK. Thirdly, new models for the delivery of services need to be developed and tested before widespread implementation. The policy

mistakes forced on us by expediency in recent years must not be repeated.

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## Managing smoking cessation

### *Implementing new guidelines in primary care presents a challenge*

Smoking remains the largest preventable cause of ill health in the United Kingdom, responsible for up to 120 000 deaths annually.<sup>1</sup> This week's publication of smoking cessation guidelines, both in full<sup>2</sup> and in summary form (p 183)<sup>3</sup>, marks what the NHS can do to fight this epidemic and emphasises that primary healthcare teams are central to this effort. This makes sense: most smokers will be in contact with primary healthcare services throughout their lives, and the potential effect of primary care is large.<sup>4</sup>

Much could be done to improve the management of smoking cessation in primary care,<sup>5</sup> so the guidelines are welcome, and most of their recommendations are sound. It is particularly important that smokers who are motivated to stop are instructed about the correct use of nicotine replacement therapy and offered supportive follow up.<sup>6</sup> The guidelines should increase awareness about the efficacy of nicotine replacement, and if specialist smoking cessation clinics become available these could provide further help to motivated smokers. The suggestion (in the full guidelines) that primary healthcare teams should adopt a systematic approach towards ascertaining and documenting smoking status in medical records is also useful. When this information is available during consultations it results in more opportunistic discussions about smoking.<sup>7</sup>

The guidelines correctly emphasise that most time and resources should be spent on motivated smokers. After raising the issue of smoking clinicians should assess smokers' motivation to stop and tailor any further discussion accordingly. Objective methods of assessing smokers' motivation to stop are badly needed, and developing them should be a priority for research. Such measures could help clinicians to decide whether to invest time in encouraging individual smokers to stop or merely gather information about their habit.

The recommendations that general practitioners should always advise smokers to stop and should repeat this advice at every opportunity are questionable because they have never been adequately tested. Most trials of general practitioners' antismoking advice

have been short term.<sup>4</sup> Although participating doctors have discussed smoking with all presenting smokers, this has usually only been for brief periods—less than a year in most studies. Most smokers will have been advised only once. When studies have involved doctors giving repeated advice, smokers have voluntarily reattended for this.<sup>8</sup> Such motivated smokers differ from unselected ones consulting general practitioners and are more likely to stop smoking. We do not know whether this is because of their increased motivation or the repeated advice. Fewer than half of all smokers consider that their smoking is a problem,<sup>9</sup> so repeated advice would be directed towards many smokers with little motivation to stop—and perhaps much resistance. Currently, patients rate general practitioners' lifestyle advice highly.<sup>9</sup> If general practitioners discussed smoking during every patient contact, would patients still value it and would it still be as effective?<sup>10</sup>

Implementing the guidelines will involve a massive change in clinical practice, as only about 30% of smokers who have seen their general practitioner in the previous year recall doctors' antismoking advice.<sup>11</sup> Merely publishing the guidelines is not an effective method of implementation.<sup>12</sup> If they are to have any impact on routine clinical practice they must be implemented by using multifaceted, evidence based strategies that take into account prevailing obstacles to change.<sup>12</sup> Unfortunately, this issue is not addressed by the guidelines.

Local discussion of research evidence is important in getting research into practice.<sup>13</sup> Primary care groups may be an ideal vehicle to promote local consensus about smoking cessation. They will be required to address national priorities such as coronary heart disease, cancer, and health inequalities<sup>14</sup>—all conditions to which smoking contributes. Primary care groups could adopt smoking cessation as a topic for clinical governance, using evidence based review criteria for audit and feedback.<sup>5</sup> They might also stipulate that chronic disease management clinics (for asthma and diabetes) should include the evidence based management of smoking cessation. As the new structures for primary care develop, other methods for integrating

*Education and debate*  
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