

'From glorious to infamous': the life span of (addiction) specialists in psychiatry

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Summary In this editorial we look at the implications of organisational changes to the National Health Service and financial constraints on addiction psychiatrists, and how creativity and adaptability could be the key to fostering survival and sustainability of subspecialties in danger of extinction.

Declaration of interest None.

They came first for the Communists,
and I didn't speak up because I wasn't a Communist.
Then they came for the trade unionists,
and I didn't speak up because I wasn't a trade unionist.
Then they came for the Jews,
and I didn't speak up because I wasn't a Jew.
Then they came for me
and by that time no one was left to speak up.

Pastor Martin Niemöller (1892–1984)¹

The metamorphosis of addiction services

They came first for the Communists,
and I didn't speak up because I wasn't a Communist.

The National Health Service's (NHS) reorganisation that started with the Darzi report² is shaping up with the most recent White Paper *Liberating the NHS*.³ This is taking place in the light of a constrained financial climate. The interaction between these translates into the ongoing metamorphosis of services, aiming to provide the best care at competitive costs. Over the past couple of years, the working landscape of addiction psychiatry has been witnessing gradual reshaping with an increased risk of extinction.⁴ This prospect continues to grow and has become even more real with the recent Coalition's announcement⁵ involving the dissolution of the National Treatment Agency (NTA, an NHS special health authority established to improve the availability, capacity and effectiveness of drug treatment in England) alongside the merging of addiction monies within the ring-fenced public health budget.⁶ During its lifespan – and in the context of an implicit exclusion of funding for people with alcohol dependency – the ethos of the NTA has been based on raising the involvement of primary care physicians in the provision of services for drug addicts. The model indulged patients in the evidence-based victories of a methadone or buprenorphine prescription as the end-point of their treatment.^{7–9} The emphasis on harm reduction is swiftly shifting towards the broader concept of 'recovery' that decentralises the medical model aiming to foster reintegration of addicts in society with abstinence as the prime goal.^{7,10,11}

The 'ownership' of addiction services has become blurred with decommissioning and retendering being the

ruling processes of redesign in a financially drained NHS.^{4,12–14} According to an interim report of a survey performed by the Specialist Clinical Addiction Network (SCAN, www.scan.uk.net/) in 2009, 45 services were involved in the process of retendering in England and Wales.¹² In total, 31 of those services completed the retendering process and only 16% were regained by the NHS, 42% went to non-statutory agencies and 13% to a partnership between both. The report also highlighted inconsistencies in the bidding process, lack of clarity when awarding bids and perceived poor rationale in the decommissioning of innovative and well-functioning services.¹²

Driving competition to achieve excellence at lower costs is leading to a combination of partnerships between the NHS, non-statutory services and the private sector that more often than not tend to re-evaluate the need to employ 'expensive' consultant psychiatrists, favouring general practitioners (GPs) or senior nurses with a special interest in the area.⁴ As is the case for many other subspecialists, we now have to redesign our future and 'charm' commissioners trying to attract investments.¹⁵ This is the current cost-effective NHS in which we can only make ourselves financially worthwhile as long as we can differentiate what we do from cheaper options.¹⁵

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General adult psychiatrists have not been immune to ongoing reshaping of services with functionalisation being the upcoming controversy.¹⁶ Furthermore, challenges raised around the model of functionalisation against the status quo¹⁶ have resembled those affecting retendering of addiction services, for instance: threats to continuity of care, staff uncertainties, low morale and animosity among providers, with patients falling into precarious interfaces.^{4,12,15} There is recognition that weaknesses associated with these transitional models will undoubtedly impact on the training of developing professionals^{4,13} and there are questions as to whether their objectives will be ultimately achieved (lower costs with better services).^{13,16,17}

Resuscitating old classics and reinventing new ones

Mental illness combined with substance misuse: working with the departed

The current trend underpinned by costs and the functionalisation of services is leading to narrowed gaps between primary and secondary care. People addicted to drugs and alcohol without comorbid conditions or within the mild-to-moderate spectrum of mental illness have been increasingly embraced by GPs.^{18,19} General psychiatrists are absorbing those with additional risks intertwined with more complex mental disorders, with addiction specialists losing ground in the wider equation.^{19,20}

In this context, working on existing fractures in the system may offer sustainable opportunities. Areas that merit consideration are individuals with dual diagnosis in the 'new functionalised world', as well as their care – and that of non-mentally ill addicts – at the interface between the acute and mental health trusts,^{19,20} particularly given the high rates of comorbidity, poor identification and inadequate treatment of this dually diagnosed population.²⁰

According to the Comorbidity of Substance Misuse and Mental Illness Collaborative (COSMIC)²⁰ study, a sizeable proportion of individuals using drug (74.5%) and alcohol (85.5%) services experience mental health problems, with almost 44% of those utilising mental health services reporting drug use or alcohol misuse in the previous year. Historically, people with dual diagnosis have been in receipt of poor access to specialist services,^{20,21} and although a national strategy was launched in 2002,²² reports still show regional inconsistency and variability of resources throughout England.²³ National inquiries into suicides and homicides by people with mental illness^{24–26} continue to stress the enhanced risks associated with the harmful use/dependence on substances in this population. Mindful of this situation, the National Institute for Health and Clinical Excellence is drawing up national guidelines²⁷ to streamline service provision, with the acknowledgment that 40% of people with psychosis will develop substance misuse in their lifetime. The complex nature of mental illness in these individuals,^{21,28} associated with potential risks,^{24,25} poor engagement with services, multiple admissions to hospital and an overall poor prognosis^{29,30} with reutilisation of services^{29,31} still constitute an ideal opportunity for addiction consultants. By leading consultation and liaison dual diagnosis teams with peripatetic input we might offer the desperately sought integrated and continuous care required by this overlooked population, in future functionalised partnerships.^{19,28}

Making alcoholism NICE

Another area of participation involves the detrimental impact on public health resulting from the harmful use/dependence on alcohol that has been the 'elephant in the room' across the NHS for many years. Almost 1.6 million people are alcohol dependent in the UK and the estimated cost of alcohol misuse (including health, loss of productivity and crime) is £18–25 billion a year; for the NHS alone the financial burden of the harmful use of alcohol is around £2.7 billion.¹¹ Recently, the World Health Organization reached a consensus for the first time about implementing a global strategy with ten target areas aiming to confront this

problem.³² The National Institute for Health and Clinical Excellence has published two^{33,34} out of three planned national guidelines aiming to offer these individuals what they have long deserved: the right for recognition through a comprehensive and standardised package of care. This has been reinforced by the newly released drug strategy that embraces alcoholism as well as drug-related problems.¹¹ This acknowledgment underpinned by financial support would allow addiction specialists to offer a myriad of expertise associated with recognised neuropsychiatric complications of alcoholism, bridging gaps between primary care and the acute and mental health trusts.

Innovative pilot schemes^{15,35} with combined liaison psychiatry and addictions expertise are already developing to enhance patient care at the front door of the NHS. Such models, based on a multidisciplinary mental health rapid assessment interface and discharge (RAID) approach are starting to demonstrate how effectively a responsive integrated service can help acute general hospitals comply with national target outcomes and quality standards (reduce waiting times, length of in-patient admissions and re-attendance rates).³⁶ With 40% of accident and emergency attendees having alcohol issues complicating their care, rising to 70% at peak times,³⁷ embedding substance misuse specialists into the fabric of general hospitals via established liaison psychiatry services can enable addiction experts to play a vital role in addressing the complex interplay between physical health, mental health and substance misuse.

Primum non nocere

Then they came for the Jews,
and I didn't speak up because I wasn't a Jew.

Although the number of substance misuse consultants in the UK is limited to 361 (Royal College of Psychiatrists' Addiction Faculty personal communication, 2011), the issues they face are as complex as in any other subspecialty. They lead rich, rounded quality services with a uniquely wide range of high-level skills to manage the most severe cases.¹⁹ They foster a supportive and therapeutic setting that offers liaison with other professionals from primary and secondary care. They provide training to expand the provision of high-quality services and there is a commitment to research and innovation to improve effectiveness and efficiency.^{38,39}

This combination of leadership and expertise is presently being threatened by the current ethos of the NHS reorganisation. There is a consensus of concern about price competition damaging healthcare quality.⁴⁰ Besides, the monetarisation of the transitional process in which redesign is implemented by the retendering of services is likely to see many casualties among highly qualified professionals.⁴¹ Service providers should be mindful to apply the principle of *Primum non nocere* to professionals as well as patients, in particular because of the need for personal integrity to be the riding force leading quality, enhancing outcomes and absorbing accountability in a cost-effective and creative way.

Then they came for me
and by that time no one was left to speak up.

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