


Please cite the Published Version

Webb, Lucy  (2023) Improving end of life care for people with co-existing mental health and substance use. In: Substance Use, End of Life Care and Multiple Deprivation: practice and research. Routledge Research in Nursing and Midwifery . Routledge, London, pp. 91-104. ISBN 9781032035468 (hardback); 9781003187882 (ebook)

DOI: <https://doi.org/10.4324/9781003187882-9>

Publisher: Routledge

Version: Accepted Version

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Additional Information: This is an Accepted Manuscript of a book chapter published by Routledge/CRC Press in Substance Use, End of Life Care and Multiple Deprivation: practice and research, on 17th November 2022, available online: <http://www.routledge.com/9781032035468> It is deposited under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.

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CHAPTER 7 ACCESS AND TREATMENT CHALLENGES FOR PEOPLE WITH CO-EXISTING MENTAL HEALTH AND SUBSTANCE USE– Lucy Webb

Introduction

People who use alcohol or other drugs problematically often have mental health co-morbidities and associated physical health and social problems that present as multiple disadvantage to services (PHE, 2017). While it is neither useful nor easy to determine direction of causality of co-morbidities, co-existing mental ill health and substance use are commonly associated with poor physical health, homelessness, frequent use of emergency services and imprisonment (PHE, 2017).

‘Co-existing’ or ‘dual diagnosis’ are the terms often used to describe a cohort of people who use drugs and/or alcohol problematically and have severe psychotic mental illnesses such as schizophrenia and bi-polar disorder, severe depression, or schizotypal or delusional disorder (Department of Health, 2004 & 2009; NICE, 2019). The UK Department of Health/Offender Health (2009) suggests four categories of dual diagnosis:

1. Someone with a mental illness who uses substances to self-medicate, i.e. using opiates to control hallucinations in schizophrenia
2. Someone using substances that cause a mental illness, such as cannabis psychosis or crack psychosis, or mental illness caused by withdrawing from substances, such as depression following crack or amphetamine use withdrawal, or the emergence of a mental illness that has been previously ‘managed’ by substance use that is withdrawn, i.e. hallucinations returning when opiate use is stopped
3. Someone who has a mental illness that is worsened by substance use, even though this might offer short term relief, such as using alcohol to reduce or control anxiety
4. Someone who uses substances and has a mental illness without the two issues being related.

This typology aims to define dual diagnosis, perhaps for diagnostic purposes, however, this may further stigmatise people with multiple problems, and does not address the wider experiences of people beyond diagnosable labels (Drugscope, 2015). The NICE guidelines for co-existing substance use and mental illness (NICE, 2019) seek to ensure that both conditions are addressed together through joint-working and co-ordinated care, avoiding exclusion from any service because of the presence of either a mental illness or problem substance use (a ‘no wrong door’ policy). Prior to current recommendations, it was common for individuals to face barriers to either service because of the ‘ping pong’ effect: being bounced from one service to the other to receive separate treatments, or even have their referral refused until the other problem is treated first (Baldacchino, 2007). Currently, treatment delivery models are often based on localised arrangements for shared or integrated care depending on available expertise, with sequential treatment (one problem at a time) not recommended (CGDMD Independent Expert Working Group, 2017). This may go some way to addressing treatment access, but there are still multiple barriers to treatment due to the historical nature of having separate services, and service users’ reluctance to engage due to previous negative experiences (Black, 2021).

This chapter will explore the current problems of access to end-of-life care for people with co-existing problems, and examine evidence of end-of-life care for mental health and substance use patients separately to examine what can be learnt from these individual service challenges. Some of the practice challenges and solutions will also be outlined, as well as a critique of current service provision, identifying the key strategies that are likely to offer a way forward to improving access.

Background

Estimates of incidence of co-morbidity vary, but this may be a product of the narrow medical definition. Most diagnostic, prevalence, and incidence measures, as suggested above from the Department of Health, may only include people with severe mental illnesses such as schizophrenia and bipolar disorder (Abu-Saleh, 2004; NICE, 2019). If wider definitions that include complex trauma (personality disorder), generalized anxiety, and depression are taken into account, prevalence estimates of mental illness may be approximately 30%-50% of people with problem substance use globally (Hall et al, 2009; Lai et al, 2016; Torrens et al, 2015), or as high as 70% among drug users and 86% among problem alcohol users (Weaver et al, 2003; Delgado et al, 2012). Bramley et al (2015) report that, among people with intersecting disadvantages (i.e. substance use, homelessness, criminal justice involvement), rates of diagnosed mental illnesses are estimated around 42%-55% but this rises to approximately 80%-92% among those who self-report a mental illness that causes them significant problems.

Indeed, people with co-existing problems may have intersecting social disadvantage *because* of the social dislocation that mental illness, homelessness, criminal justice involvement and substance use may represent (Fitzpatrick & Stephens, 2014), and subsequently face stigma and problems accessing services (Drinkwater et al., 2015). This group also has low social capital; most report mainly relying on friends or social workers when in crisis, rather than family members, especially those with severe multiple disadvantage (defined as having three or more disadvantages) (Bramley et al., 2015).

While homelessness confers more severe multiple disadvantage on younger people with co-existing problems (Bramley et al., 2015), the average age of substance users is increasing as the surviving pre-millennial cohort of injecting drug users gets older, and contemporary problem alcohol use is increasing in this age group (Rao, 2015). People who attend substance use services in the UK are more likely than the general population to die prematurely and have multiple health challenges, and working age substance users have health issues more commonly seen in people of retirement age (McGregor, 2014; Atkinson, 2016). It is recognised that substance use services need to adapt to accommodate the needs of older substance users because of the rise in incidence (PHA/BSP, 2011; Rao, 2015; Crome & Rao, 2018) in recognition of their more complex health needs and different responses to interventions, but such accommodation has yet to focus on end-of-life care.

This population group already has difficulty accessing mainstream services due to multiple disadvantage (Fitzpatrick et al, 2012; CFE Research and The University of Sheffield, 2020). This is not just for practical reasons such as having no permanent address, but for cumulative problems associated with perceived discrimination from services, inability to navigate complex care pathways, and an expectation that services are 'not for them' (Galvani et al 2018; Making Every Adult Matter Coalition/Clinks, et al, 2015). This is compounded by underlying problems that present barriers to engaging in services. For instance, homelessness, substance use and mental illness are all associated with past experiences of childhood trauma leading to a distrust and reluctance to accept support (Magwood et al, 2019). Fond et al (2019) indicate that people with schizophrenia and terminal cancer in France are more likely to receive a late diagnosis due to diagnostic overshadowing (attributing physical symptoms to the mental illness) and also likely to refuse treatment because of paranoid delusions or mistrust. This is also reported globally by Park et al, (2020) and Baruth et al, (2020).

A vignette from practice illustrates the issue:

A woman in her late 50s presented to Accident and Emergency (A&E) with stomach pains and complaining of having insects crawling over her. She was known to mental health services, having a diagnosis of schizophrenia and personality disorder, and was a heavy drinker and smoker. Typically, she lived in a variety of hostel accommodations, but frequently moved on as her smoking behaviour became an unacceptable fire risk. She often arrived at various health and social care services without appointment, with a list of complaints associated with her income support, housing, medications, and a variety of illnesses. In A&E, her stomach pains were initially dismissed as 'attention-seeking' and the insects regarded as a sensory hallucination, until it was noticed she had alcohol withdrawal symptoms and the 'insects' was a sign of delirium tremens. After admission, a series of tests identified late-stage bowel cancer.

A common problem for people with multiple disadvantage is the stigma attached to the mental illness, the substance use and the additional or consequential issues of homelessness or criminality. For this woman, stigma resulted in diagnostic overshadowing whereby her behaviour was seen as attention-seeking due to a personality disorder, and her delirium tremens was seen as a part of her schizophrenia. It was fortunate that her other withdrawal symptom (severe tremor) and known history of heavy alcohol use meant she needed to be admitted for treatment for alcohol withdrawal.

Treatment access problems for end-of-life care however are likely to lie further up the chain of service planning and commissioning than service provision itself. Cancers are by far the most common disease types featured in hospice referrals (Hospice UK, 2016), and there is concern regarding unequal access to end-of-life care for people with conditions commonly occurring among substance users such as liver disease and chronic obstructive pulmonary disease (COPD) (Webb et al, 2018). However, such clinical bias may be because such diseases have unpredictable prognoses, and are more difficult to manage in the hospice environment (Kendrick, 2013; Cox-North et al., 2013; Higginson et al., 2017). Pain management can present complex care among those with a history of using opiates or requiring opiate substitution therapy, or for people who have cognitive impairments due to heavy alcohol use or repeated overdose (Witham et al., 2019). Also, there may be staff training and education needs in managing patients who have difficulty in discussing end-of-life (Ebenau et al., 2019). Problems with end-of-life care access and quality care for people with coexisting and multiple problems are therefore variously identified as stemming from both the individuals themselves showing reluctance to engage, and from the services who fail to identify health problems or present clinical barriers to access.

This is also reflected in the evidence for end-of-life care for people with severe and persistent mental illnesses. Late diagnosis leaves less time to get to know the patient and build trust, or involve families in care (Baruth et al, 2020; Fond et al 2019). Cognitive difficulties can also result in problems with involvement in decision-making about care and making advance directives (Baruth et al., 2020; McNamara et al, 2018). This is also likely to present difficulties for patients with alcohol-related brain damage such as Wernicke-Korsakoff syndrome (Alzheimer's Society, n.d.), and opiate users with cognitive impairments from repeated overdose hypoxia (O'Brien & Todd, 2009). Limited involvement of people in decisions about their care can lead to the continuation of invasive treatments and unnecessary interventions (Baruth et al, 2020), but also complicates processes for gaining informed consent. In the UK, as in most countries, legal mental capacity to consent to treatment does not rely on diagnosis but on the person's ability to understand the information given and the consequences of decision-making. This is separate from treatment for a mental illness without consent, which is governed in England and Wales by the Mental Health Act (1983). Staff without experience of mental health care may need to navigate complex issues of capacity to consent to treatment for a physical illness, when at the same time consent is not required for administering anti-psychotic medication

for someone under a treatment section of the Mental Health Act (McNamara et al., 2018; McKillip et al, 2019).

Interactions with existing psychotropic medication can also be a concern for end-of-life service staff. Some antipsychotics, such as clozapine, can produce severe side effects when combined with other medication and so this treatment may be reduced. It is not uncommon therefore for psychotic symptoms to worsen during end-of-life care (McKillip et al, 2019), and emerging symptoms of psychosis may go unrecognised or be interpreted as terminal delirium (McNamara, 2018; Park et al, 2020). Alcohol dependence also presents medication challenges for end-of-life staff as benzodiazepines to treat alcohol withdrawal are contraindicated for liver failure, and these are the same medications used for terminal agitation. As symptom control is the key medication goal in end-of-life care, staff may also need to navigate decisions around abstinence or controlled usage (McCormac, 2017).

End-of-life care services face challenges in managing complexity presented by those with multiple disadvantage. Staff can feel unqualified to manage patients with mental health or substance use problems, especially with those patients who lack insight, and have anxieties that discussions about death may de-stabilise such patients (McNamara et al., 2018). As one of McNamara et al's informants suggests, this group of patients go in the 'too hard basket' (McNamara et al., 2018; p5). Nurses are reported to find patients 'difficult' who have multiple physical, social and cultural problems, who are non-compliant with treatment and frustrating or have challenging relatives (Dobrina et al., 2020; Ingebretsen et al., 2016; Hawking et al, 2017). People with substance use and/or severe mental health histories often do bring challenging family dynamics (Bushfield & De Ford, 2009) because of the long history of family tensions and breakdown of relationships, or they may have no family members who can be involved in their care. This means that they will lack the informal social support and involvement that end-of-life care services are familiar with (McNamara et al, 2018). It is also suggested that, in community end-of-life care, there may be concerns about public safety when prescribing opiates to drug users in case they are diverted for street use (Mundt-Leach, 2016).

A key issue for many commentators and practitioners however is the division between end-of-life care providers and medical treatment providers such as addiction and psychiatric services. This division is argued to stem from the curative philosophy that underpins medical treatment services. The palliative approach aims to reduce symptoms and improve quality of life and is often at odds with the curative treatment goals of somatic and psychiatric medicine (Sheriden, 2019; McNamara et al., 2018). Strand et al (2020) suggest that the 'need to treat' in psychiatric case management overrides considerations of the palliative approach, indeed, the curative philosophy and risk aversion in psychiatry may fuel the drive to minimize risk of death. Strand et al (2020) do suggest, however, that moves away from the medical curative approach in psychiatry, towards a more person-centred mental health recovery approach that targets quality of life rather than control of symptoms, may present a gateway towards more palliative thinking in psychiatric goal-setting.

The issue of late detection of end-of-life care needs presents a barrier to receiving timely care that enables services the space to address the complex psychosocial needs for this population. As described earlier, patients' lack of trust of services, cognitive impairments, complex family dynamics and poor social support require time and relationship-building to deliver optimum end-of-life care. Late identification is, however, an upstream problem, located more at policy and service planning level. Substance use services are now structured to focus on recovery-oriented care, targeting reduction of use and corraling social and economic support to scaffold behaviour change. Substance use practitioners subsequently fail to identify end-of-life needs (Mundt-Leach, 2016), and

practitioners working with severely mentally ill people also do not refer patients to end-of-life services until late in disease progression (Fond et al., 2019). This may often be due to mistaking the signs of disease as symptoms of mental illness (McNamara et al., 2018).

Needs identified

A range of needs and strategies have been identified to improve quality of care for people with severe or enduring mental illnesses, and we can explore how these may apply equally or with adaptation to people with mental health and substance use co-morbidities. Much of the existing evidence and practice recommendations also take into account the multiple disadvantages that often accompany someone with serious mental illness, therefore recommendations for improved practice are likely to apply to both dually diagnosed and co-morbid populations.

Early detection and referral

For this group of patients, early referral should be straightforward as they are often already linked into some form of social or health support. They may have key workers or contacts from social services or housing, community mental health, substance use support or homeless support, and these may be regular and ongoing contacts within their formal and informal networks. These patients themselves may not, however, be personally proactive in seeking help for reasons of distrust of new services, or distrust of people they do not have an existing working relationship with. Family and friends may be similarly reluctant to assist them to self-refer to services, even where patients have good relationships with concerned significant others. This is not always the case where substance use is a feature. Clearly, early detection relies on the ability of practitioners and contacts within existing networks to identify changes in the person's health and wellbeing and be able to facilitate diagnosis and referral. Practitioners already in contact with the person are likely to be best placed to assist in referral especially if they have an established and trusted relationship with the person and referral pathways exist between services.

Capacity-building

The barriers to early referral appear to be that these well-placed practitioners do not have the skills or therapeutic philosophy to recognise and act on their patients' changes in health. Capacity-building in both staff training and referral pathways is suggested (McNamara et al, 2018) but this should go beyond awareness-raising. There is an increasing availability of online resources provided by the voluntary and education sector for specific training (for example, St Mungo's, 2021) which may go some way to filling a skills gap. Clinical end-of-life staff may feel they lack the skills in mental health care, but it is suggested that these skills would benefit all patients entering palliative care (Park et al., 2020). They illustrate how skills such as brief cognitive behaviour therapy can be part of the psychosocial care for patients coming to terms with their illness and trajectories towards death. Such skills would help staff better respond to anxieties and depressions that commonly occur for people coming to terms with an end-of-life diagnosis.

Practitioners working with substance users are already coming to terms with working with an older client group. Age-sensitive treatment within substance use provision includes dealing with co-morbid conditions and having referral protocols to primary and secondary services such as general practitioners and geriatric services (Rao et al., 2018). This way of working sets a template for working with other agencies in shared or integrated care. Conversely, end-of-life services may need

to better accommodate younger people, as rates of liver failure increase among younger drinkers (British Liver Trust, 2019)

Working with the multi-disciplinary team and other agencies

The complexity of end-of-life care for this population means that it would be too much to expect end-of-life care services to meet all the multiply-disadvantaged patient's needs. Collaboration approaches are necessary in order to manage different aspects of a person's care; from managing anti-psychotic or opiate substitution medication to psychosocial collaboration involving the trusted significant others in the person's life. McNamara et al (2018) stress the benefits of having multiple routes to different providers and care co-ordination to accommodate the complex needs that may be presented, including homeless shelters, accident and emergency departments, mental health hospitals and general medical wards. Relyea et al (2019) also underline the importance of working with informal carers, often as proxy decision-makers and advocates when mental capacity is impaired. These informal carers may be family members, key workers or friends. Involving key workers from other services in the end-of-life care of patients helps overcome any mistrust of new services and unfamiliar settings. Doukas (2014) also suggests that being referred to a new service means a loss of trusted practitioners and routines for the patient, therefore having continued contact with key workers, or having these key workers acting as care co-ordinators, maintains these familiar connections. For Relyea et al, this also reassures family members who have been involved in care and who may also be mistrustful of engaging with a new service; the familiar community psychiatric nurse or recovery champion can act as an advocate and go-between.

While training staff to recognise and refer clients is recommended, end-of-life care staff may also benefit from specialist support in understanding mental illness and substance use (McNamara et al, 2018; Relyea et al, 2019). End-of-life care staff are usually familiar with managing depression, anxiety and grief in their care role, but encountering psychosis and delusions can be more challenging. The presence of unusual beliefs is common among patients with severe and enduring mental illnesses such as schizophrenia and schizo-affective disorders, and this element of a person's presentation is likely to be present regardless of symptom control. An unusual or unrealistic belief may be interpreted as a lack of capacity to make decisions but a delusion is part of the person's self to be accommodated in person-centred care as illustrated in the clinical example below:

A man in his forties was referred to substance use services by the hospital ward where he was being treated for an injection site abscess. He was willing to be referred for his opiate dependency and be treated with substitution methadone, however he was reluctant to visit the service clinic as there would be IRA (Irish Republican Army) spies there looking for him. He was convinced that the IRA was intent on hunting him down as he had been a British soldier in Northern Ireland in his youth. He had a recent history of mental illness and had been treated in the past for auditory hallucinations which he now controlled by using heroin. He agreed to be seen in the hospital outpatient clinic as the IRA would not be looking for him there.

By seeing this client in the outpatient clinic, the fixed persecutory delusion was simply accommodated as part of this man's beliefs and values rather than being challenged and viewed as a disease process to be reduced.

In discussing integrated care, Park et al (2020) suggest that the skillset of palliative practitioners in delivering holistic care supports the integration of beliefs and psychosocial-cultural norms for their clients. They argue that the mental, psychological, spiritual and physical aspects of care could facilitate care regardless of diagnosis. Indeed, the label 'dual diagnosis' is an artifice in holistic care in

which the difference between a delusion or, say, a religious belief is only relevant in navigating treatment pathways, and not relevant to holistic care. As Park et al. usefully suggest, it is not helpful to fixate on the diagnosis.

Embracing the setting: what is 'home'

As a quality outcome for end-of-life care is 'choice of place of death' (Department of Health, 2008) the setting of care for this patient group also needs to be considered. In comparison with the majority of end-of-life care service users, these patients have a wide range of settings that may be regarded as 'home' even though these may be unconventional. Practitioners still need to consider that choice of setting for people with unstable housing can be personalised. Such settings are likely to include hostels or long-term care homes, assisted living facilities, offender rehabilitation hostels or group homes, homeless shelters, other temporary accommodation such as a friend's house, or even in the street. It should also be considered that care staff may be delivering palliative care in forensic psychiatry settings or prisons. It may not be possible to support a 'home' death for many clinical, legal or practical reasons, but a goal is likely to be facilitating choice within the confines of what is do-able. Good quality end-of-life care should be delivered in any type of setting (CQC, 2016) but will require collaborative working with the staff or informal carers within that setting, and other care delivery practitioners such as mental health and substance use teams (Relyea et al, 2019). Mundt-Leach (2016) indicates that what a person in need of care means by 'home' may be where there are trusted people and familiar surroundings, and this is likely to apply to their family or friends too.

Challenging presentations: behaviour and lack of insight or capacity

For end-of-life care practitioners, patients with mental illness and substance use co-morbidities often present a challenge, despite practitioners' wide range of skills in delivering holistic care. The practicalities of multiple medication regimes, communication barriers and cognitive impairments can present treatment and care challenges (McKillip et al, 2019). Consent and capacity issues need to be separated from any diagnosis of mental illness, and taken with clear reference to capacity guidelines. If a patient can understand information given, can understand the consequences of their care decision, and can communicate their wishes, then any apparent unwise decision needs to be respected (Office of the Public Guardian, 2007). This principle of unwise decision-making is likely to apply to fixed delusions held by a person (as the vignette above describes), but if a temporary mental illness symptom interferes with capacity, such as deeply depressive thinking associated with clinical depression, then this may indicate lack of capacity. An important element of the Mental Health Act in England and Wales (Mental Health Act, 1983), however, is that any treatment under the Act can only be for a mental illness, and does not apply to substance dependency. Therefore, a person without capacity due to cognitive impairment can be treated under the Mental Capacity Act of 2005 (Mental Capacity Act, 2005) if it is deemed in their best interests, but not by invoking the Mental Health Act.

Lack of insight does not necessarily require a mental illness, nor denote a cognitive impairment. However, some patients with severe mental illness that is refractory (unresponsive to treatment) can result in lack of insight into their condition and impending death. This is not wholly uncommon for patients with paranoid schizophrenia, bi-polar disorder, some personality disorders or even severe anorexia nervosa (Strand, et al, 2020). Some patients may struggle to understand their terminal diagnosis, or understand and refuse curative treatment, resulting in end-stage conditions. While this may be difficult for care staff to understand, clearly the palliative approach is for symptom reduction and aiding the person to have good quality of life (Baruth et al, 2020). Decorte et

al (2020) discuss a holistic approach to end-of-life care, the Oyster Care model, for people with an inability to understand and comply with their care. The Oyster Care model is being developed in Belgium to improve end-of-life care for patients with untreatable cognitive, behavioural and social challenges. These clients are likely to be in specialist residential or forensic care rather than entering specialist end-of-life care settings, but still require good quality palliative care from their care staff. The model focuses specifically on quality of life and prompts a therapeutic environment that shields patients from suffering physically, mentally, socially and existentially, while aiming to preserve dignity. There is an emphasis on creative therapies and a reduction of diagnosis-driven care planning or attempts to improve insight or decision-making. Oyster Care was created in response to the national legalisation of euthanasia in Belgium and the introduction of recovery-oriented approaches in psychiatry. It offers a quality of life alternative to curative treatment for severely mentally ill patients so that good quality terminal care is delivered with dignity.

Inclusive models of care

Much of the available evidence indicates a need for inclusive models of care which adopt a form of shared care, integrated care or joint working between services and inclusive of existing informal support. The fragmentation and specialism of health and social care services presents problems for shared and integrated care towards the end-of-life (Sheriden, 2019). Divisions between primary and secondary care, and localised non-governmental organisation (NGO) specialist care, forces a reliance on establishing local connections and referral pathways to co-ordinate care, but provides little incentive for organised shared care arrangements. It is current policy for people with substance use and mental ill health needs in the community to receive shared care, with mental health services acting as lead organisation for treatment (NICE, 2016), but this way of working may still be facing problems through lack of mental health service capacity (Parliamentary & Health Service Ombudsman, 2018), and has not yet been translated to inpatient end-of-life care in hospitals, care homes or specialist hospice settings. As applies in the principle of a duty of care, whichever service has responsibility for the person in situ, has, in the first instance, overall responsibility for care. End-of-life care already provides an holistic care template that could provide a platform for integrating care, but mental health services currently lead on curative care of patients with co-existing disorders. The current model of 'no wrong door' access to care for people with co-existing disorders suggests an approach for multiply-disadvantaged service users to access end-of-life care. Integrated care for this patient group perhaps could be determined by predominant care needs or who picks up the issue first, however, end-of-life care services are already open to holistic, biopsychosocial-spiritual models and may be the best default lead service. However, they need the training and resource capacity take this lead.

Evidence of current practice indicates that end-of-life care services tend to rely on informal communication with other services – working relationships they have established for themselves (Park et al, 2020). Case conferencing that includes informal carers is found to be important, not just for gaining more insight into the person's needs but also in appreciating what informal carers themselves may need (McNamara et al, 2018), and working with the informal carer as the patient's advocate or decision-maker (Baruth et al, 2020). Regular case conferencing that includes mental health case workers and a primary care representative is recommended, along with establishing a lead team member or organization, depending on the relative dominance of the patient's symptoms (McNamara et al, 2018).

However, there is a danger that care could become medicalised or impersonal in a systematised care package. While there is a need for specialist input, for example regarding anti-psychotic medication (Relyea et al, 2019), for Park et al (2020), keeping a focus on holistic and reflexive personal care is most important. Their informants suggested a need for embedded mental health specialists within their team. Park et al indicate a 'consultative versus integrative' system dichotomy between having specialists to consult or having expertise within the system (Park et al, 2020, p5). Practitioner informants from end-of-life care appeared to value whatever model best supports holistic care. Either way, what appears to be valued is interdisciplinary education and the availability of skills in mental health and substance use from which to learn.

The need to respond to the ageing population of substance use service users may indicate one way forward in at least addressing late presentation and diagnosis. As Rao et al (2019) suggest, substance use services should establish links with primary and secondary care and NGO services to address chronic physical health needs for their patients, and this suggests a health and social care systems approach to tackling co-morbidities. An improved awareness of health and social needs for older substance users among service staff, with developed care pathways and shared or integrated care, can also break down the barriers of silo working. Additionally, the growing awareness of the need for end-of-life care services to provide for more managerially challenging conditions such as liver disease and COPD (Kendrick, 2013; Higginson et al. 2017) promises to improve access for substance users. Integrated care pathways and joint working may address clinical management issues for end-of-life services, and provide referral pathways for patients with end-of-life care needs – including housing services, substance use and mental health services (Fitzpatrick et al, 2012).

Conclusion

The difficulties experienced by mental health, substance use and end-of-life care services in meeting the needs of patients with co-morbidities indicates need for an expansion of policy. Currently care policies for people with co-existing disorders focus on recovery and community aid. There is no recognition of palliative approaches in substance use services and little recognition in mental health services. The onus for change may be more on mental health and substance use services to develop skills and care philosophies that encompass chronic co-morbidities among older service users and to develop referral pathways at least to end the problem of late diagnosis of a life-limiting illness. A move towards a palliative care model in psychiatry that adopts the symptom reduction and quality of life goals may be a start in changing thinking.

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