Healthcare Improvement Scotland

DRNS
DRUGS RESEARCH NETWORK SCOTLAND

Realising Scotland's ambitions for improving the lives of people with co-occurring mental health and substance concerns:

Putting evidence into practice

Leading quality health and care for Scotland

NHS SCOTLAND

Agenda

Time	Topic	Lead
9.50am	Welcome and introductions	Clare Morrison, Director of Engagement and Change, Healthcare Improvement Scotland Lisa Scholin, University of Edinburgh, co-convenor of Drugs Research Network Scotland
9.55am	Setting the scene (video remarks)	Maree Todd MSP, Minister for Drugs & Alcohol Policy and Sport
10.05am	How Healthcare Improvement Scotland is supporting change across mental health and substance use	Clare Morrison
10.20am	Chicken and egg	Tracey McFall, Chief Executive Officer, Scottish Recovery Consortium
10.30am	From Dual Diagnosis to CoSUM: *Are we finally making progress on service integration?*	Dr Iain Smith, Consultant Psychiatrist, NHS Forth Valley, co-author of Rapid Review and member of CoSUM working group
10.45am	Mental Health and Substance Use; the need for equity	Professor John Crichton, Medical Director, Mental Welfare Commission
11.00am	Centre for Addiction and Mental Health Research, University of Hull	Professor Thomas Phillips, Professor of Nursing in Addiction and Director, Centre for Addiction and Mental Health Research
11.25am	Break	
11.45am	Breakout Discussion	Healthcare Improvement Scotland
1.00pm	Lunch	
1.30pm	Close	

Drugs Research Network for Scotland

- Founded in 2017 and hosted at University of Stirling
  - Hosting moved to University of Edinburgh in 2023
- Aim to foster knowledge exchange between creators, contributors and users of research
- Core focus is knowledge exchange across the year:
  - 4 seminar events on diverse topics
  - 1 annual conference (4 June 2026)
  - Generation of 1 rapid review

Drugs Research Network for Scotland

- Event held in November 2023 to gather views on research priorities
- Guides our activities and events
- Four key areas:
  - **Harms and drug-related deaths** (e.g. surveillance and monitoring, integrating technology, stigma and social determinants)
  - **Treatment and recovery** (e.g. Buvidal, ACEs and trauma informed care)
  - **Legal changes** (policing strategies, legislation and harm reduction)
  - **Drugs as medicine** (e.g. psychedelics and cannabis in mental health care and pain management)

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Event Report

Priorities for Scottish Drugs Research

Background

Drug-related harms, including drug-related deaths, continue to affect people who use drugs, families, communities, and the wider society. There is an ongoing need to generate and use evidence to inform delivery of the *National Mission on Drug Deaths* and to keep people who use drugs safe. With recent policy developments, such as de facto decriminalisation of possession of drugs for personal use, and growing interest in the role of currently illegal substances as treatments for chronic health conditions there is a need to further focus future drugs research on areas that can have an impact on the Scottish population.

The Drugs Research Network for Scotland (DRNS) is funded by the Scottish Government to support the development of collaborative working and knowledge exchange in drugs research. DRNS held an online event on 17 November 2023 to gather views from those engaged with the network to discuss research priorities for Scottish drugs research. This report summarises identified priorities across four broad themes: i) harms and drug-related deaths, ii) treatment and recovery, iii) legal changes and iv) drugs as medicines. This document can serve as a reference for researchers to support the development of research proposals and grant applications aligned with current research priorities.

Harms and drug-related deaths

- **Diversity of drug using groups** – Broader approaches of drug use and populations beyond single substances and demographic groups. Focus on the diverse subgroups at risk, such as aging high-risk heroin users, the emerging younger population of people who use drugs, women, and people experiencing homelessness. A holistic research framework to fulfil the National Mission's emphasis on improving quality of life.
- **Additional vulnerabilities** – A research framework that considers the lifecycle frailty, homelessness, and the potential brain implications following a near-fatal overdose.
- **Surveillance and monitoring** – Dynamic surveillance that recognises the changing landscape of drug use including new drugs (e.g. benzodiazepines and nitazines) in the supply and patterns of use. Data collection methods should include qualitative research involving lived and living experiences to understand the challenges faced within drug use and treatments.
- **Integrating technology** – The integration of technology such as AI and data-driven approaches. Technology as research priority emerged as it could hold potential in shaping

https://drns.ac.uk/wp-content/uploads/2024/01/Priorities-for-Scottish-Drugs-Research-Event-Report.pdf

Healthcare Improvement Scotland

Clare Morrison

Director of Engagement & Change
Healthcare Improvement Scotland

Leading quality health and care for Scotland

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About Healthcare Improvement Scotland

Our vision: A health and care system where:

- people can access safe, effective, person-centred care when needed
- services are informed by the voices of people and communities and based on evidence about what works
- those delivering care are empowered to continuously innovate and improve

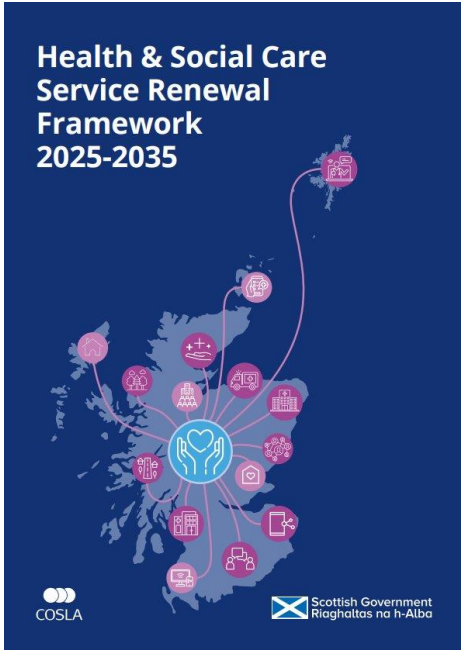
Our functions and approach

About Healthcare Improvement Scotland

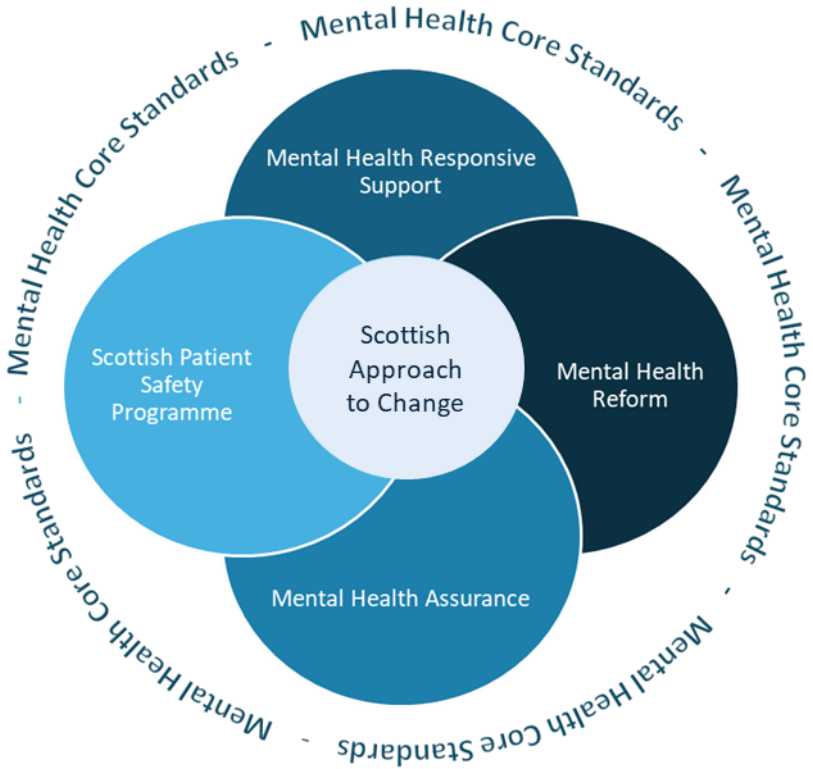
Playing a key role in Health and Social Care renewal.

Supporting the principles of:

- Prevention
- People
- Community
- Population
- Digital



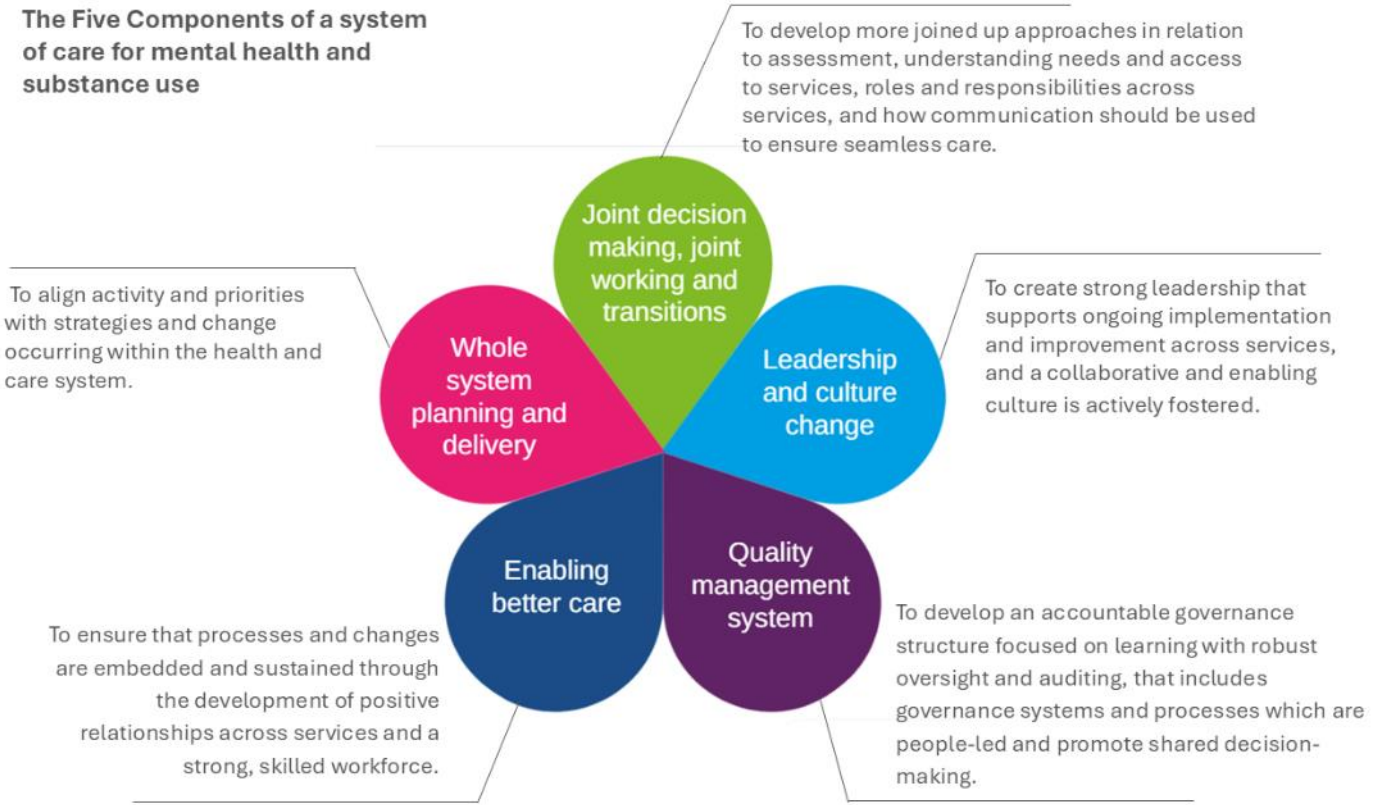
Our mental health and substance use work



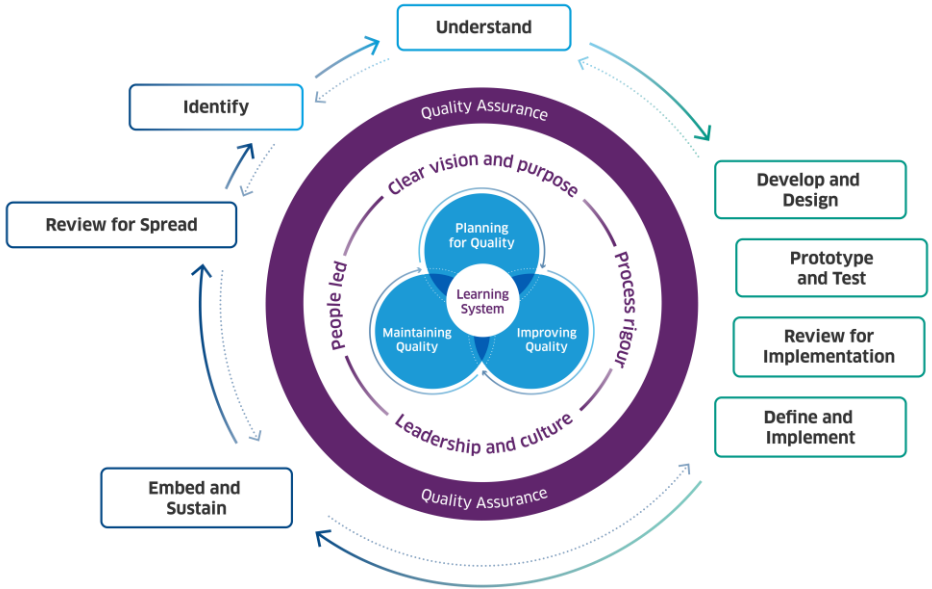
Improvement Support for MAT Standards Implementation

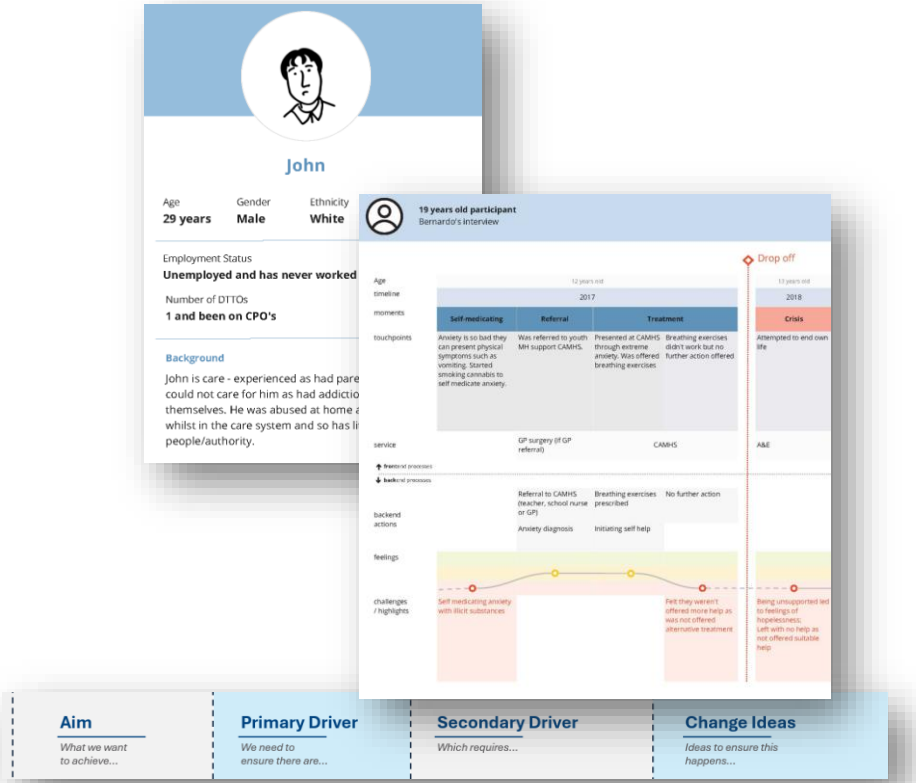
Pathways to Recovery: Redesigning Residential Rehabilitation Pathways

Our mental health and substance use work



Mental Health and Substance Use Toolkit





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Tracey McFall
CEO
Scottish Recovery Consortium

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Mental Health and Substance Use – Putting Evidence into Practice

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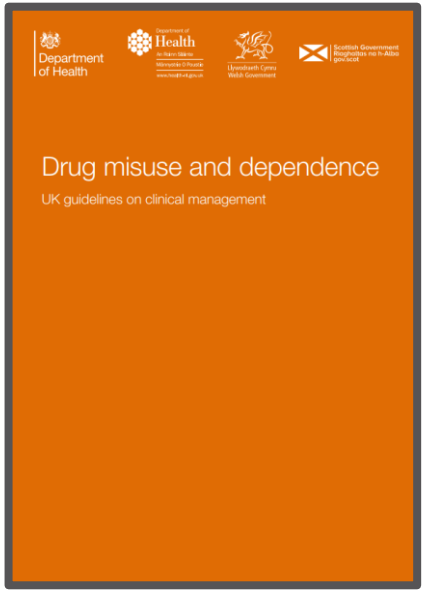
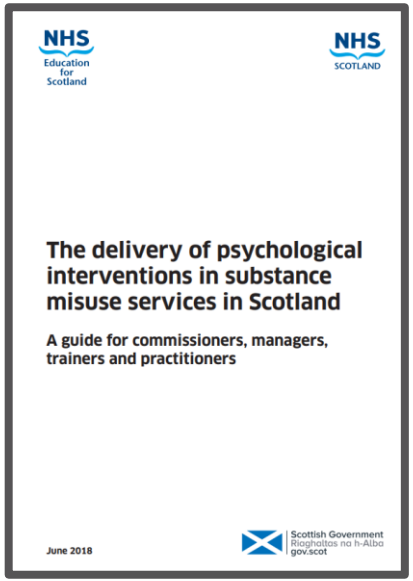
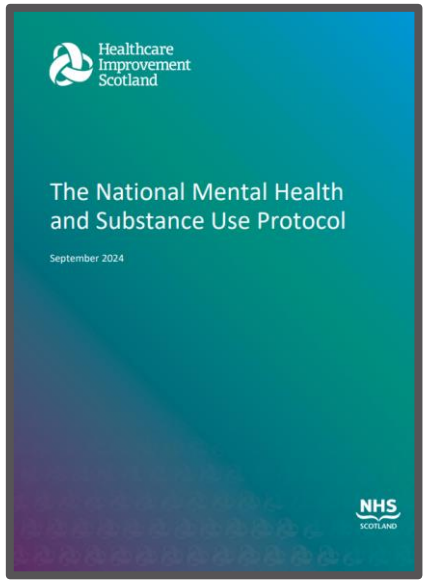
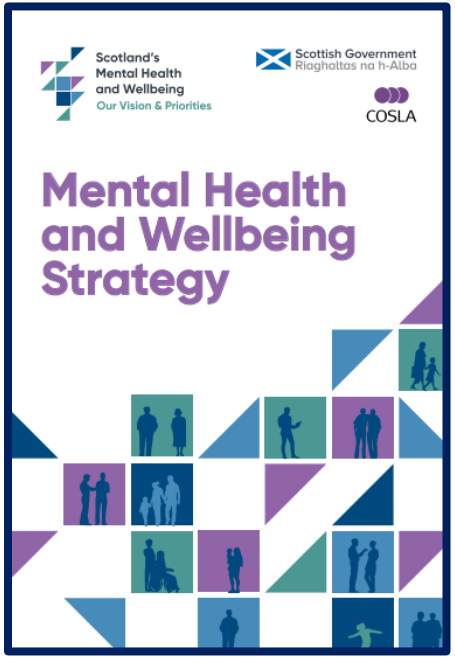
What do we have?







What do we know?



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What comes first, the ‘chicken or the egg’?

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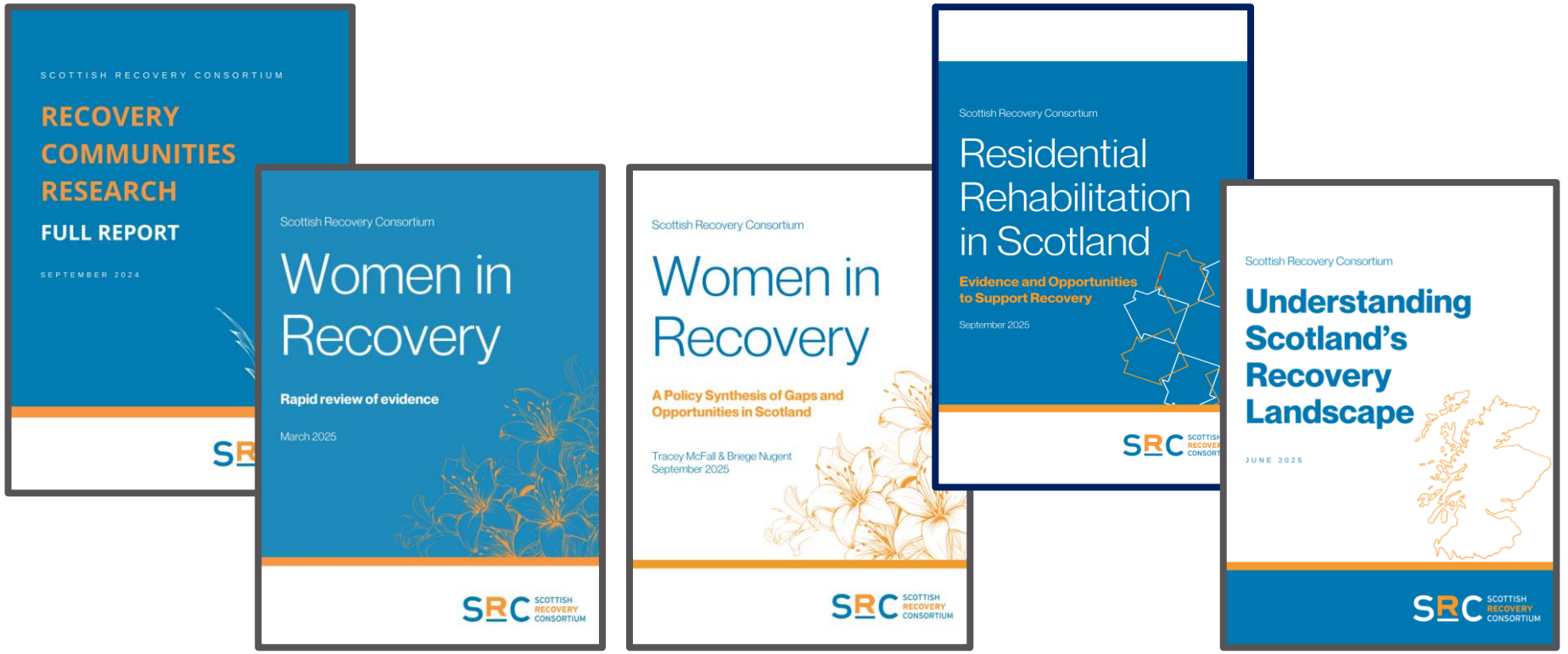
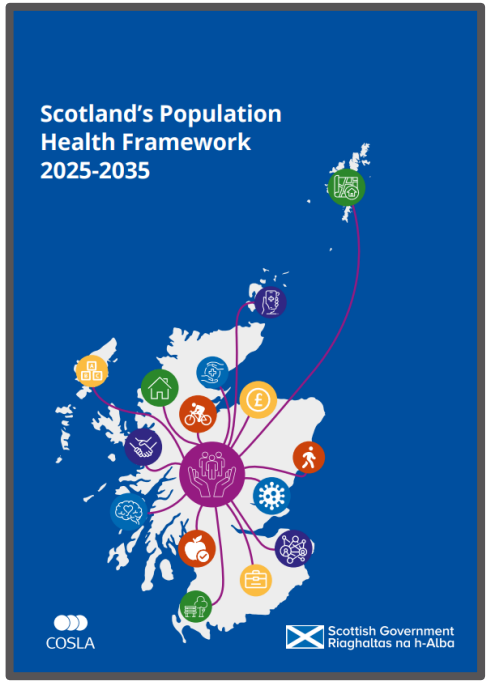
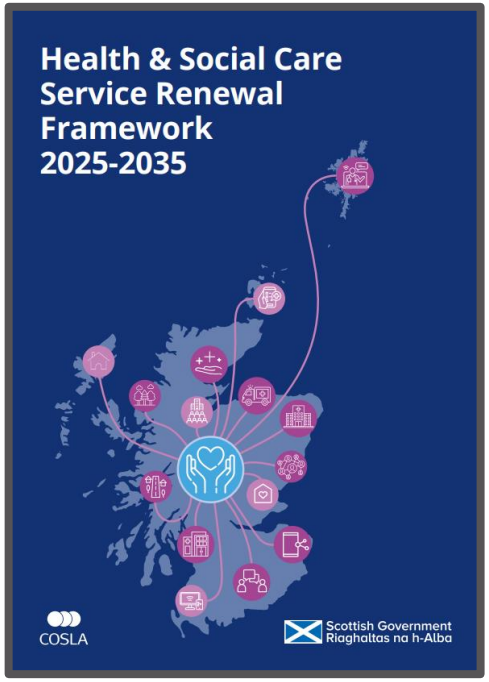
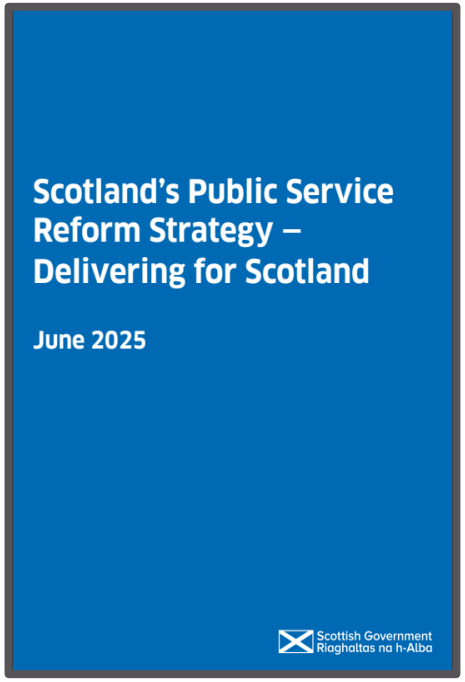
What do we know?



Opportunities







Key themes.....

Strategic Theme	Population Health Framework (PHF)	Public Service Reform Strategy (PSR)	Health & Social Care Service Renewal Framework (SRF)
Prevention	Prevention Focused System; Primary Prevention; Tackling root causes of ill health	Pillar 1: Prevention; Preventative budgeting; Demand mitigation	Prevention Principle; Secondary & Tertiary Prevention; Early detection & chronic condition management
Equity & Inclusion	Focus on reducing health inequalities; Right to health; Targeting deprived communities	Empowering communities; Tackling child poverty; Inclusive service design	People Principle; Value-Based Care; GIRFE model; Equity in access and outcomes
Community & Place-Based Approaches	Places and Communities; Community Wealth Building; Social Prescribing	Joined-up services; Local integration; Whole Family Support; Community Planning Partnerships	Community Principle; More care in communities; Hospital at Home; Local hubs and MDTs
Digital Transformation	Digital Population Health; Healthy Digital Use; Data for prevention	Digital Public Services; AI & automation; Shared services	Digital Principle; Digital Front Door; Integrated records; AI-enabled care
Integration & Collaboration	Whole system approach; Marmot Places; Health in All Policies	Pillar 2: Joined-up Services; Cross-sector collaboration; Simplification	Coordinated Planning & Delivery; Integrated pathways; NHS Delivery body
Workforce & Leadership	Supporting workforce for prevention; Community sector capacity	Leadership & cultural change; Empowering staff; Workforce reform	Workforce impact; Multi-disciplinary teams; Training for new models of care
Efficiency & Sustainability	Long-term reform; Fiscal sustainability; Upstream investment	Pillar 3: Efficient Services; Value for money; Avoided public spending	Rebalancing resources; Outcomes & impact; Hospital redesign; Population planning
Person-Centred Care	Enabling Healthy Living; Life course approach; Participation	People-centred services; Holistic support; GIRFE toolkit	People Principle; Shared decision-making; Digital empowerment; Advocacy
Data & Evidence-Informed Planning	Population Health Dashboard; Evaluation & learning	Data sharing; Performance metrics; Theory of Change	Population Principle; Strategic needs assessment; Outcomes framework; Research & innovation

Human Rights

Human Rights-Based Frameworks

CHIME MODEL

UN PANEL Principles:

- Participation
- Accountability
- Non-discrimination and equality
- Empowerment and capacity-building
- Legality

AAAQ Framework:

- **A**vailability
- **A**ccessibility
- **A**cceptability
- **Q**uality

Charter of Rights

SRC SCOTTISH RECOVERY CONSORTIUM

Solutions

Humns Rights Based Foundation	PANEL / AAAQ
	CoR
	CHIME
Trauma Informed and Person-led Care	Early Intervention and Prevention
	Integrated Support
	Flexible Pathways
Service Integration and Co-ordination (Hard Edges 2019)	Break down silos between Mental Health and Drug and Alcohol Treatment
	Social Care / Housing /Peer-led recovery support
Workforce Development	Trauma Informed Practice
	Stigma
	Dual Diagnosis / LPASS Framework
Lived Experience and Co-production	Involve people with lived experience, in delivery, design and evaluation
	Use peer support models to build trust and engagement
	Ensure engagement is authentic and meaningul - not tokenistic
Data, Evidence and Evaluation	Use experience to inform policy and practice
	Collect qual and quan data to monitor outcomes
	Evaluate services against HR and Recovery metrics, not just clinical

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Thanks

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From Dual Diagnosis to CoSUM: Are we finally making progress on service integration?

Dr Iain Smith, Consultant Psychiatrist, NHS Forth Valley, co-author of Rapid Review and member of CoSUM working group

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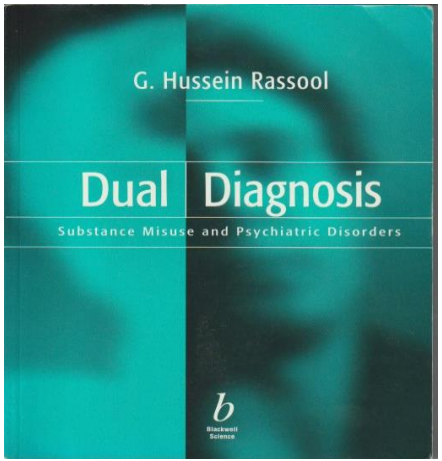
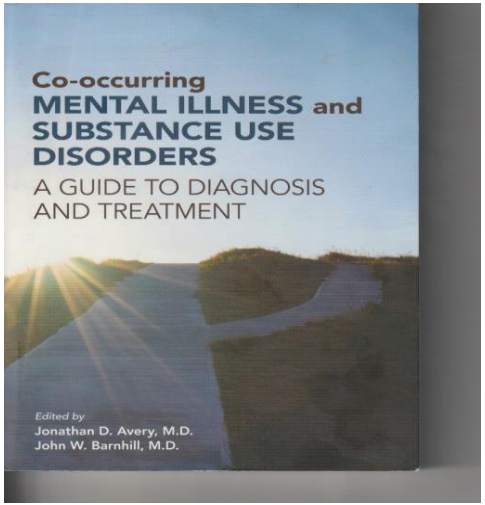
déjà vu-Dual Diagnosis becomes CODs/CoSUM

- Mind The Gaps(2003)
- Closing The Gaps(2007)





ISAM:Textbook of Addiction Treatment , Vol II-Part VIII,2021

Why The Resurgence of Concern Over Co-Occurring SUD and MI At This Time-1

- “Trust and Respect –Final Report of the Independent Inquiry into Mental Health Services in Tayside ,February 2020 ,David Strang CBE
- Cross-refers to **Dundee Drug Commission Report**:-
- “Recommendation 13: Full integration of substance use and mental health services and support. This is recommended UK and international best practice – and it needs to happen in Dundee. Trauma, violence, neglect and social inequalities lie at the root of both mental health problems and substance use problems and most people with substance use problems also have mental health problems.”

Why The Resurgence of Concern Over Co-Occurring SUD and MI At This Time-2

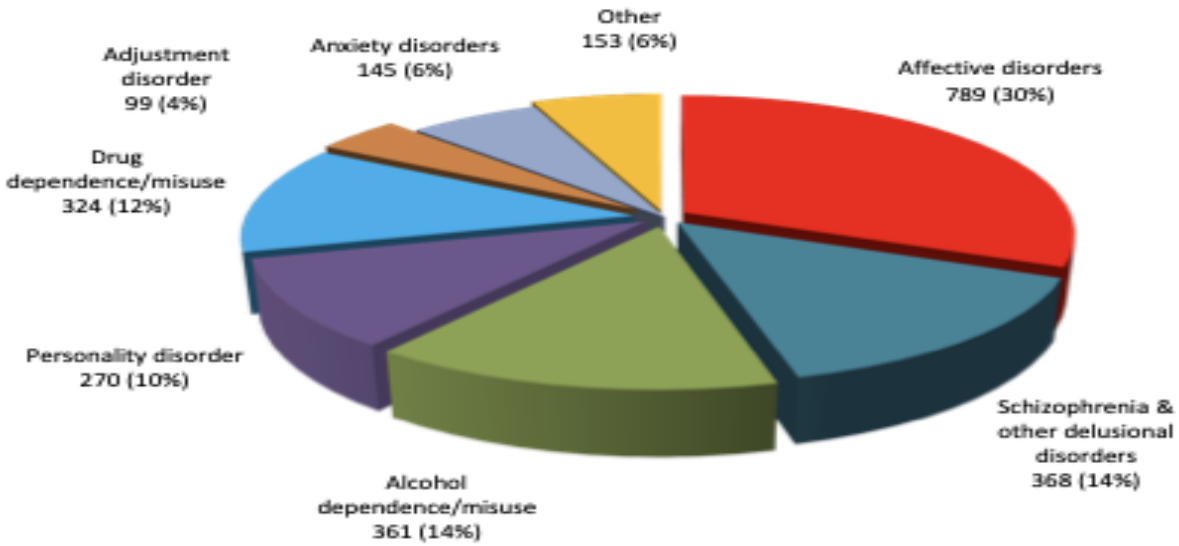
- **HIS Pathfinder projects in five HB areas:-**
- Mental Health and Substance Use Programme
- “We work with partners within NHS Tayside, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lothian and NHS Lanarkshire to redesign care pathways to improve quality of care and health outcomes for people with mental health and substance use support needs”.

Why The Resurgence of Concern Over Co-Occurring SUD and MI At This Time-3

- Continuing high levels of MI and SUD morbidity ,comorbidity and mortality in Scotland-more than in other home nations and in other European nations. NCISSMI data. SAER findings.
- Drug Deaths
- Alcohol Deaths
- Drug Death Taskforce-concluded with a SG response in January,23
- MAT Standards/MIST
- “No wrong door”
- ”Everybody’s business”
- MWC Report-Ending the Exclusion
- National Collaborative : National Mission
- Rapid Review requested by Drugs Minister and now completed.

NCISSMI –Suicides in the MI in Scotland and Alcohol and Drug Comorbidity-1

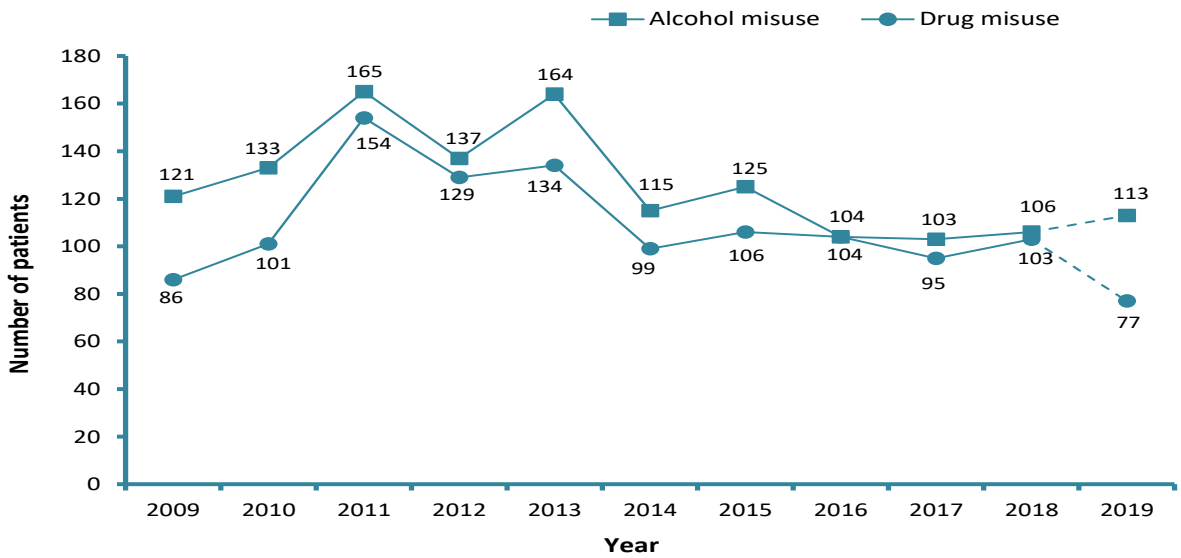
Figure 5: Patient suicide in Scotland: primary mental health diagnoses



*"other" diagnoses include: eating disorders, learning disability, conduct disorder, autism, somatisation disorder, ADHD, organic disorder, drug induced psychosis, dementia and other specified.

NCISSMI –Suicides in the MI in Scotland with Alcohol and Drug Comorbidity-2

Figure 6: Patient suicide in Scotland: number with a history of alcohol or drug misuse



Safer services:

A toolkit for specialist mental health services and primary care -1

Reducing alcohol and drug misuse

We recommend there are local drug and alcohol services available that work jointly with mental health services for patients with mental illness and alcohol and drug misuse.

Other clinical measures that could reduce suicide risk in this group are alcohol and drug misuse assessment skills in frontline staff and specialist alcohol and drug misuse clinicians within mental health services.

Our evidence

Across all UK countries, alcohol and drug misuse is common among patients who die by suicide (47% and 37% of all patient suicides UK-wide, respectively, higher in Scotland and Northern Ireland). However, only a minority of patients who died by suicide between 2008 and 2018 were in contact with specialist alcohol and drug misuse services.

In England, there was a 25% fall in rates of suicide by patients in those NHS Trusts which had put in place a policy on the management of patients with co-morbid alcohol and drug misuse.

Guidance

See the NICE guidelines on coexisting severe mental illness and substance misuse.

Embedding suicide prevention in drug and alcohol policy and services is an action in the strategy for preventing suicide and self-harm in Northern Ireland.

Safer services:

A toolkit for specialist mental health services and primary care -2

Reducing alcohol and drug misuse	Safer care in mental health services

Specialised services for patients with mental illness and coexisting alcohol and drug misuse

	Response		Date next review due	Comments
	Yes	No		
Specialist alcohol and drug services are available, with a protocol for the joint working with mental health services (including shared care pathways, referral and staff training).				
There is a specific management protocol or written policy on the agreed management of patients with coexisting alcohol and drug misuse.				
Protocols for managing self-harm patients who are under mental health care should highlight the short term risk of suicide, especially where there is coexisting alcohol and drug misuse.				
There is specific training in place for staff on alcohol and drug misuse assessment.				
There are specialist alcohol and drug misuse clinicians within mental health services.				

Rapid Review complements other work

Rapid Review

HIS Pathfinder

Mental Welfare Commission

National Standards (e.g. MAT)

Drug Deaths Task Force Final Report

The Way Ahead: Recommendations to the Scottish Government from the Rapid Review of Co-Occurring Substance Use and Mental Health Conditions in Scotland

Published online 30/11/22

Two other components to review also published that day:-

Literature review

Survey of substance use service staff in Scotland.

In writing recommendations we consulted as widely as possible given time constraints including with MWC over their report- Ending the Exclusion-and HIS and MIST etc. Also we met with David Strang.

Rapid Review:The Way Ahead –Executive Summary-1

- Recommendation One
- The Scottish Government should ensure that each area has an agreed protocol in relation to the operational interfaces between mental health services and substance use services. Further, this protocol should be owned and monitored by a responsible individual at a senior management level, with clear oversight of both service areas.
- Recommendation Two
- The Scottish Government should work with local boards and Integrated Joint Boards to improve data collection on care for people with co-occurring mental health and substance use disorders. This should include key indicators, such as the number of rejected referrals for people with co-occurring mental health and substance use conditions by either mental health services or substance use services.
- Recommendation Three
- The Scottish Government should ensure that Health Boards, Health and Social Care Partnerships, Alcohol and Drug Partnerships and all practitioners are considering their work, in relation to co-occurring disorders, within the framework of the four quadrants model. This was shown in Closing the Gaps (2007) and is replicated in our literature review (Page 8). This should be part of the locally produced protocol.
- Recommendation Four
- The Scottish Government should ensure an annual population needs assessment in relation to substance use treatment capacity which will in turn help with the treatment of mental health problems. We know that certain forms of substance use treatment improve the mental health of those with alcohol and other drug use disorders. The Scottish Government should ensure these needs assessments are happening and informing service provision at a local level.

I Psychiatric disorder: **LOW** severity	Substance use disorder: **LOW** severity	**II** Psychiatric disorder: **HIGH** severity	Substance use disorder: **LOW** severity
LOC: client served by primary care clinic		LOC: client served by mental health center	
III Psychiatric disorder: **LOW** severity	Substance use disorder: **HIGH** severity	**IV** Psychiatric disorder: **HIGH** severity	Substance use disorder: **HIGH** severity
LOC: client served by addiction treatment program		LOC: client served by mental health center with integrated COD program	

FIGURE 2–1. **Four-quadrant Model of Care for Co-occurring Disorders.**

COD = co-occurring disorder; LOC = locus of care.

Source. National Advisory Council, Substance Abuse and Mental Health Services Administration: *Improving Services for Individuals at Risk of, or With Co-occurring Substance-Related and Mental Health Disorders.* Rockville, MD, SAMHSA, 1997.

Rapid Review:The Way Ahead –Executive Summary-2

- Recommendation Five
- The Scottish Government should commission a specific rapid review for alcohol treatment services given its health implications for Scotland and evidence that treatment in Scotland has been diminishing despite high levels of alcohol use disorders.
- Recommendation Six
- The Scottish Government should ensure all mental health and substance use staff are trained on how best to assess and manage co-occurring mental health conditions and substance use disorders in a trauma-informed approach. This training should also be open to other professional groups.
- Recommendation Seven
- The Scottish Government should ensure that further research is carried out to explore several troubling findings which we could not address in this rapid review. These include the finding by Public Health Scotland of a significant increase in anxiety and depressive episodes prior to a drug-related death between 2008 and 2018, and the increase in Drug-Related Admissions to General Hospitals. On a larger scale, a replication of the Co-Morbidity of Substance Misuse and Mental Illness Collaborative (COSMIC) Study in a Scottish city would be particularly relevant.

Does Psychiatric Disorder Contribute to DRD Risk-Some interesting data

Table 16a: Percentage of Drug-Related Deaths by psychiatric condition experienced in the six months prior to death (2009-2018)

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Psychiatric Condition	% of deaths									
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Depression	23.1	22.7	30.8	39.9	45.8	44.2	47.7	47.3	45.1	45.6
Anxiety	15.3	15.1	18.7	27.1	26.4	29.6	29.5	31.2	29.0	28.6
Personality Disorder	5.6	4.4	5.0	6.3	7.2	5.7	7.9	6.4	7.5	6.3
Schizophrenia	4.9	2.7	5.9	4.0	7.4	5.2	4.8	5.6	5.8	5.7
Other psychiatric conditions	3.9	4.4	2.5	2.9	3.3	5.4	5.3	3.1	4.9	5.0
Post Traumatic Stress Disorder	1.2	1.9	2.5	2.5	2.7	3.1	4.2	3.7	3.3	3.2
Bipolar Disorder	2.3	1.1	2.1	2.3	1.6	2.4	2.5	2.1	3.0	2.1
Psychotic Episode	1.2	1.1	1.1	2.3	2.3	2.9	2.5	2.4	2.1	1.6
ADHD/ADD	0.2	0.0	0.2	0.2	0.2	0.9	1.1	0.7	0.7	1.2
Obsessive Compulsive Disorder	0.2	0.5	0.2	0.0	0.6	0.5	0.2	0.5	1.1	0.3
Any psychiatric condition	**40.0**	**40.3**	**47.0**	**55.9**	**60.0**	**60.3**	**61.7**	**64.8**	**63.1**	**63.0**
No known psychiatric conditions	60.0	59.7	53.0	44.1	40.0	39.7	38.3	35.2	36.9	37.0

Source: NDRDD

Co-Occurring Substance Use and Mental Health Concerns in Scotland: A Survey of Scottish Drugs and Alcohol Services

Key Findings

- Of the 349 individuals approached as part of the survey of people working within substance use services in Scotland, responses were received from 93 (27%) individuals from across 79 different services. Two respondents from criminal justice services have been excluded from the overall analysis as these services were outside the scope of the survey.
- The largest number of responses came from respondents working within the Alcohol and Drug Partnership (ADP) areas of Aberdeen City (12%) and Glasgow City (12%). No responses were received from Falkirk, Orkney and Shetland ADP areas.
- Relating to the National Health Service (NHS) Health Board areas, the largest number of respondents worked within NHS Greater Glasgow and Clyde (23%). NHS Orkney and NHS Shetland were the only health boards that did not have any responses.
- The majority of respondents (98%) described their services as community based, with 13% of individuals responding from residential services. The largest occupational group to respond (48%) were those in leadership positions within the service (e.g. Chief Executive Officers, managers, team leaders), followed by clinical staff (38%).

THE RELATIONSHIP BETWEEN SUBSTANCE MISUSE AND THE VARIOUS PSYCHIATRIC SYMPTOMS AND SYNDROMES IS COMPLEX

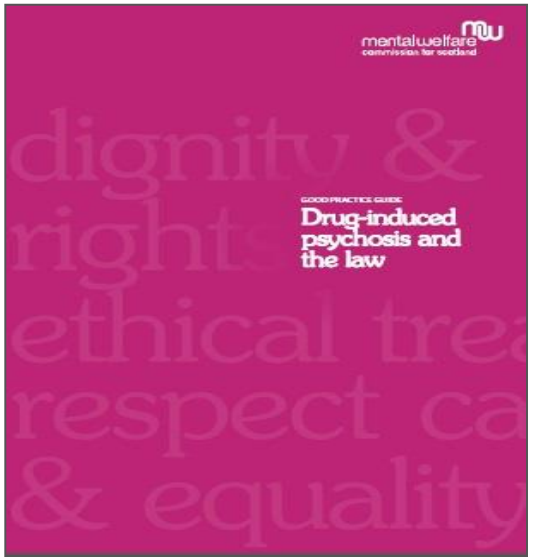
- The symptoms of the mental disorder e.g. depression may be a direct consequence of the substance misuse and may clear or improve with abstinence

- The mental disorder may pre-date the substance misuse and may have directly contributed to the development of the substance misuse (e.g. secondary alcohol misuse/dependence).

- The two disorders may exist coincidentally in the same individual e.g. schizophrenia and alcohol dependence

Where there is such comorbidity it makes treatment more difficult and outcomes tend to be poorer

MWC Good Practice Guide (2013)



Sets out to consider 3 main questions:

1. Should mental health legislation be used at all for people who make a quick recovery?

2. How long should compulsory treatment continue?

3. Should it be used long term to try to prevent psychosis arising from drug use?

MWC Good Practice Guide - Intro

Very little practical guidance to find in literature base,
prompting MWC to approach stakeholders and write guide

MHA – 'Use of, or dependence on, alcohol or drugs does not in itself constitute mental disorder. Mental illness that results from drug or alcohol use, or accompanies it, is a mental disorder under the 2003 Act'

NICE guidance on 'Psychosis with Substance Misuse: Assessment and Management' (CG120, 2011, reviewed already in 2016) sums up diagnostic dilemma as:

. Substance misuse either precipitates the onset of, or is a direct cause of psychosis

. Substance misuse is a common consequence of a Psychotic Disorder

. There is a common cause or vulnerability to both substance misuse or psychosis

MWC Good Practice Guide - Conclusions

1. If individuals whose psychosis is provoked by drug use meet the grounds for compulsory treatment, we consider that the 2003 Act should be used to protect them and/or others from harm.

2. During and beyond a period of compulsory treatment, individuals should be offered help to address mental health and substance misuse.

3. Compulsory measures must be revoked when the grounds are no longer met, but individuals should still be offered continued help to address their problems.

COSMIC study conclusions

- Persons with substance misuse disorders are more likely to have a comorbid psychiatric diagnosis than the general population and those with a psychiatric diagnosis are more likely to have a substance misuse diagnosis.

- Assessment and management are more difficult in the presence of such comorbidity which is often unrecognised.

- Persons with substance use disorders may have poor access to mental health treatment and those with mental health problems poor access to substance use services

COSMIC Study-Management

- **Assessment:** MH & SM services fail to identify co-morbidity in a high proportion of patients
- Few patients meet criteria for joint management. Possibly 'low potential' for cross-referral?
- Drug & Alcohol services provide some MH interventions, >50% get no specialist care
- CMHTs provide interventions for very few patients with drug / alcohol problems (<20%)

CONCLUSIONS

- Alcohol and drugs of abuse are psychologically and physically hazardous
- There are complex relationships with pre-existing psychiatric disorders
- Psychiatric and physical consequences are associated with intoxication, chronic heavy use, and withdrawal
- Specific behavioral toxicology with different drug categories.
- In the absence of Severe and Enduring Mental Illness where possible substance misuse services should provide the mental health care. Substance misuse treatment in itself has positive mental health effects.
- We need SU services that treat MI to a particular threshold
- We need MI services that treat SU to a particular threshold
- We need joint working for those over these thresholds and better integration- THERE ARE GREEN SHOOTS AND WE NEED TO CONTINUE TO NURTURE THIS PROGRESS AS PROBLEM REMAINS TO A SIGNIFICANT LEVEL.

Healthcare Improvement Scotland

DRNS
DRUGS RESEARCH NETWORK SCOTLAND

Mental Health and Substance Use: The Need for Equity

Professor John Crichton

Psychiatrist Mental Welfare Commission for Scotland

Mental Health and Substance Use: Putting Evidence into Practice

NHS SCOTLAND

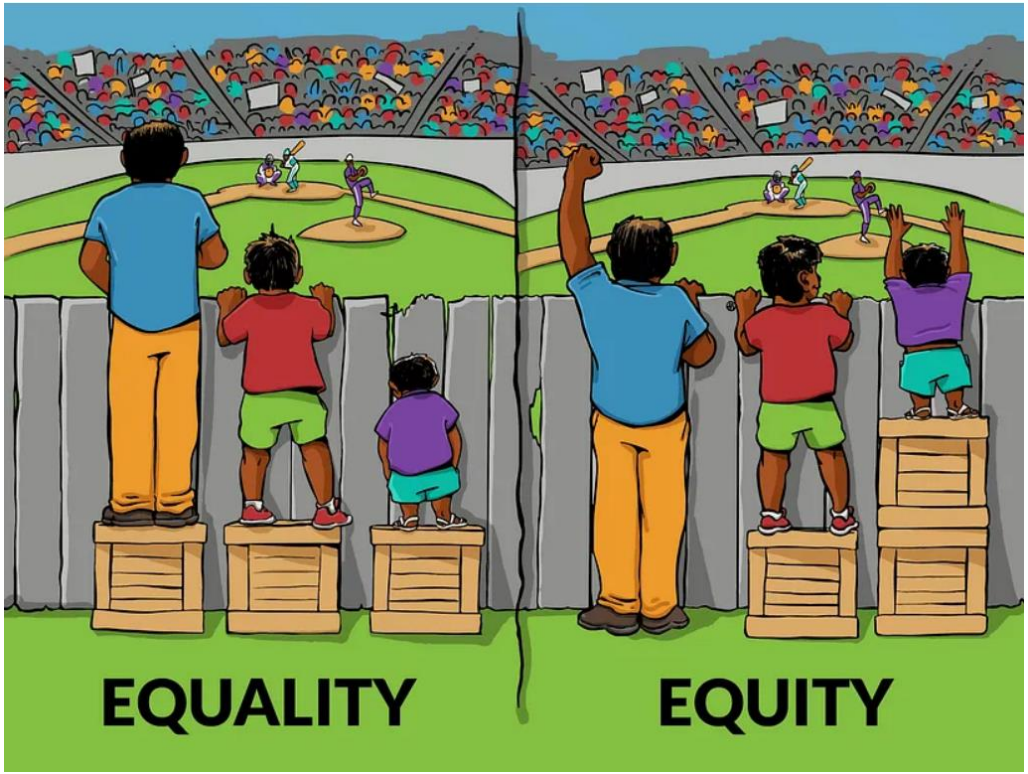
Why is Equity important

Lessons from Veterans First Point

Armed Forces Covenant 2011

“Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services.”

“Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.”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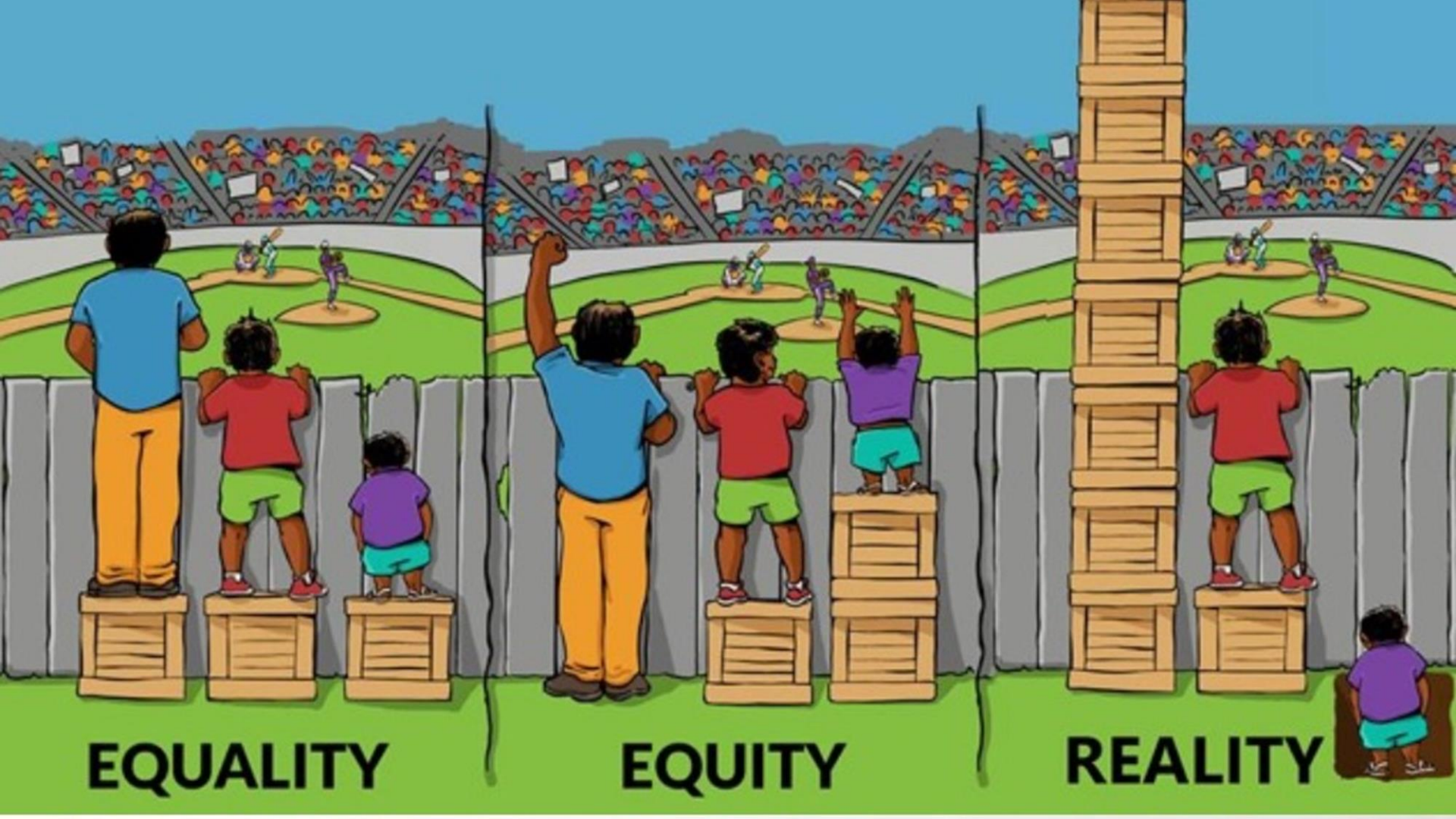
EQUALITY
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Ending the Exclusion

Care, treatment and support for people with mental ill health and problem substance use in Scotland (MWC 2022)

Purpose

Themed visit exploring how well services meet the needs of people living with both mental illness and problem drug/alcohol use.

Findings

– *Systemic inequity*: people still "bounced" between mental-health and addiction services.
– National policies (e.g. *No Wrong Door*) **not implemented in practice**.
– **84% of GPs**, **93% of third-sector staff** rated current provision as inadequate.
– Stigma and fragmented accountability remain major barriers.

Recommendations

– Each HSCP to have a written model for integrated, trauma-informed care.
– Every person to have a **care coordinator** and **documented care plan**.
– **Protocols for disengagement** and joint emergency response.
– **NES** to address stigma and embed trauma-informed practice in training.
– **Scottish Government** to monitor delivery and ensure consistency.

Core message

Current service provision is not good enough… Strategies and standards are not being translated into practice. We must listen, and we must deliver.
– MWC, 2022

The V1P model

- Peer Support Workers
- Same day engagement
- Continuity of Key Worker
- Built in clinical escalation and supportive supervision

Not Just the right thing to do, - it's the smart thing to do

"Living Longer" dataset links > 20 million records across health services. Dr Grant Sara . New South Wales population ≈ 8.3 million (2025).

Findings

– People using public mental-health services had **5× higher rates of avoidable hospital admissions** for physical illnesses.

– **6,000 excess bed-days per year** due to vaccine-preventable conditions

– Women in contact with mental-health services **less likely to receive breast or cervical cancer screening.**

Key Insights

– Mental illness is a public-health risk factor in its own right.

– Calls for **inclusion of mental-health service users as a priority group** in national immunisation and screening programmes.

Towards Equity in Mental Health and Substance Use

Common Themes

- People with co-occurring mental illness and substance use face **systemic disadvantage** across health systems.
- Inequity is measurable — in mortality, preventable illness, and service exclusion.
- Fragmented services and stigma persist despite progressive policy frameworks.

What Equity Requires

- **Joined-up accountability** between mental health, addiction, and physical-health care.
- **Appropriate access** for those at greatest risk — parity in outcomes, not just provision.
- **Trauma-informed and rights-based practice** as standard, not aspiration.
- **Clinician leadership in data and design**: using evidence to close, not describe, the gap.

- “Equity is not charity — it is justice.”

- Thank you

- Jon Crichton

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Centre for Addiction and Mental Health Research: Plan & vision

NIHR | Mental Health Research Group University of Hull

In partnership and collaboration with:

Hull York Medical School · University of York · King's College London · NHS Humber Teaching NHS Foundation Trust · University of Kent · NHS Hull University Teaching Hospitals NHS Trust

Project Leads

Prof Thomas Phillips
Professor of Nursing in Addiction
Director of CAMHR

CI ProACTIVE Study – NIHR HS&DR
CoACH Study – NIHR MHIN
York & Humber RRDN Specialty Lead for Mental Health

Prof Judith Cohen
Director of Hull Health Trials Unit
Co-Director of CAMHR

Lead and Co-Investigator on multiple studies
Module lead for MSc Pharmacology
Chair for the NIHR Research for Patient Benefit (RfPB) Yorkshire and North East

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Established Partners

King's College London – Addiction & Technology

Prof Colin Drummond & Prof Paolo Deluca

- World leading – National Addiction Centre
- Existing academic collaboration spanning over 20 years
- South London ARC and Mental Health Implementation Network
- Technology: Sensors, Apps, **Virtual Reality**
- Clinical Mentorship – Professor of Addiction

University of York – Mental Health & Health Economics

Prof Lina Gega & Prof Cynthia Iglesias

- Institute of Mental Health Research
- International Expertise in Health Economics
- Expertise in Equity, Diversity and Inclusion (EDI)
- Yorkshire & Humber ARC
- Hull York Medical School

University of Hull

Alison Sharpe – Public Co-Applicant

- Previous experience as business executive and PPI

Dr Jo Bell – Reader (Social Science)

- PhD Group (Cluster Lead) for Prevention of Suicide & Training Lead

Dr Will Jones - Lecturer & Director of Research

- Data Modelling and Artificial Intelligence

Prof Igor Schindler - Professor of Psychology

- Previously clinical neuropsychologist
- Head of School

Prof Lesley Smith - Professor of Women's Public Health

- Research portfolio – alcohol and adolescents

TBA - Professor of Addiction Psychiatry (HYMS & Humber Teaching NHS Trust)

- Research leadership & development of CAMHR portfolio

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Collaborators

University of Kent - Prof Simon Coulton

- Extensive research career with expertise in research design, methods and statistics.
- SC will be methodological lead for CAMHR, providing statistical oversight
- Mentorship to Clinical Academics in developing grant applications

Humber Teaching NHS Foundation Trust - Dr Hannah Armitt & Dr Laura Voss

- HA is Senior Clinical Psychologist with clinical experience working within child and adolescent mental health services and currently leads a NIHR study.
- LV is Consultant Liaison Psychiatrist based on HRI campus
- Humber provides range of community (PHC), mental health and addiction services

Hull University Teaching Hospitals NHS Trust - Dr Lynsey Corless

- Consultant Hepatologist, NIHR CRN National Specialty Lead for Hepatology and Lead for Alcohol Care Team
- HUTH R&D Team support multiple trials and studies

Independent Primary Care Researcher - Dr Nat Wright

- NIHR Primary Care Specialty Lead for Yorkshire and Humber RDN.
- Research collaborations involving substance use and mental health problems in criminal justice settings

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Rationale

- **Target Area**
  - High levels of need, inequalities and disadvantage
  - Limited access and engagement in services
  - Poor outcomes and high impact on services
  - Significantly under served by clinical applied addiction research

- **Significant issues of need**
  - Prevalence of opiates, cocaine, alcohol & CMD
  - Alcohol and specific mortality
  - Poor rate of MH treatment in addiction services
  - High rates of alcohol admissions (adults & <18s)
  - Suicide rate

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NHS Humber and North Yorkshire Integrated Care Board (ICB)

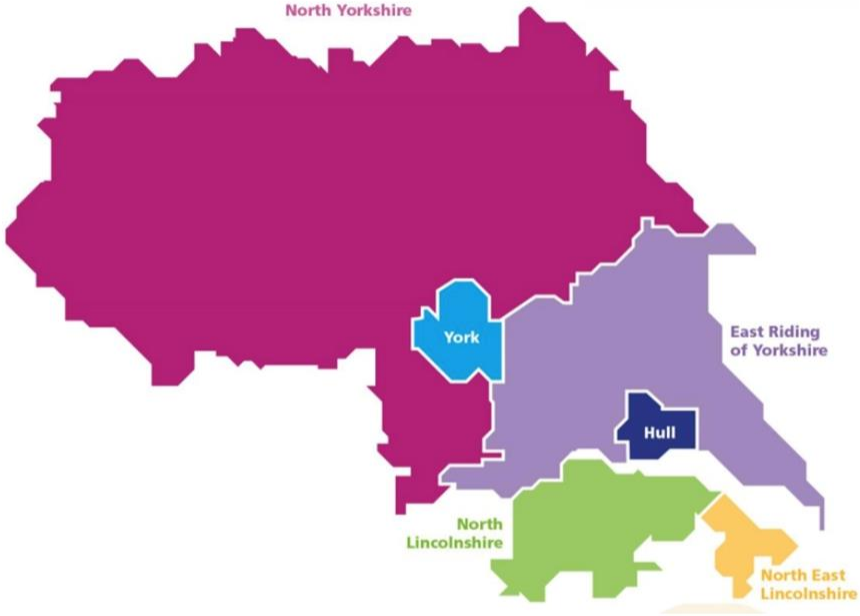

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Table 1 Local Addiction and Mental Health Profiles for Humber and North Yorkshire Integrated Care Board (ICB) Area (Source: OHID – Fingertips)

	England	East Riding	Hull	North Lincs	NE Lincs	York	North Yorks.
Deprivation and Life Expectancy							
Deprivation Score (IMD 2025)	21.8	15.8	41.2	21.4	30.9	12.2	14.6
Male Life Expectancy at birth (Years) 2018-20	63.1	65.3	53.8	58.7	55.2	65.3	67.3
Female Life Expectancy at birth (Years) 2018-20	63.9	67.9	57.9	56.4	57.5	64.6	66.4
Mortality							
Suicide Rate (per 100k) 2019-21	10.4	12.8	12.7	9.4	6.9	13.4	11.3
Deaths from Drug Misuse (per 100k) 2018-20	5.0	2.0	5.1	4.3	5.0	8.3	5.3
Alcohol-specific mortality (per 100k)	10.9	6.6	14.2	13.2	16.8	8.1	9.2
Drug Use & Treatment							
~Prevalence of opiate/cocaine (per 1000) 2016/17	8.9	5.8	18.1	12.3	14.4	5.8	5.4
Number in specialist drug treatment 2020/21	199,156	637	2,137	803	1,069	1,252	633
Successful completion drug treatment – opiates (%) 2021	5.0	6.6	2.8	5.2	3.7	3.8	7.7
Proportion of (drug) client with MHP receiving MH Tx (%) 2020/21	71.0	80.4	63.7	83.0	63.9	76.7	67.0
Alcohol Use & Treatment							
Percentage of dependent alcohol drinkers (%)	1.39	1.05	2.38	1.30	1.56	1.39	1.10
Number in specialist alcohol treatment 2020/21	76,740	356	595	271	312	275	1,102
Successful completion of alcohol treatment (%) 2021	36.6	53.2	30.0	37.4	21.6	22.0	36.9
Proportion of (Alcohol) client with MHP receiving MH Tx (%) 2020/21	80.4	79.7	71.7	92.9	77.7	87.9	76.0
Alcohol admissions – broad measure (per 100k) 2021/22	1734	1519	1995	1797	1971	1912	1661
Young People's Needs							
~ Number of 5-17years with mental health disorders 2017/18	-	5,762	4,676	3,208	3,000	3,214	10,755
New referrals to MH services <18years (per 100k) 2019/20	6,977	7,552	11,378	13,008	4,917	5,872	6,281
Attended contacts CMH service <18years (per 100k) 2019/20	28,395	23,295	32,438	24,866	31,608	33,352	35,338
Children (<18yrs) in need due to abuse/neglect (per 10k) 2018	181.4	184.4	445.1	132.6	430.0	210.8	178.0
Alcohol admissions – under 18 (per 100k) 2018-2021	29.3	18.5	40.7	18.7	29.0	27.3	36.9
Mental Health Needs							
~ Prevalence of CMD>16yrs: (%) 2017	16.9	14.2	20.5	16.8	18.1	14.8	14.1
Emergency hospital admissions for self-harm (per 100k) 2021/2	163.9	102.9	164.4	133.0	139.4	155.3	158.6
Attended contacts CMH service All ages (per 100k) 2019/20	30,674	24,232	50,554	36,797	43,768	39,329	36,489
Dementia aged <65 yrs proportion of total dementia (%) 2020	3.5	2.9	3.4	4.6	7.2	3.0	2.5

KEY:

Better than National Figure (95%CI)	Similar to National Figure	Worse than National Figure (95%CI)
Lower than National Figure (95%CI)	Similar to National Figure	Higher than National Figure (95%CI)

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Partnership priorities

- **Stakeholders Events**
  - Reduce impact of drugs and alcohol
  - Increase access to effective treatment for:
    - those with co-existing mental health and substance use
    - young people
  - Improve care pathways from emergency departments to other services
  - Emerging needs: identifying alcohol-related cognitive impairment as a priority

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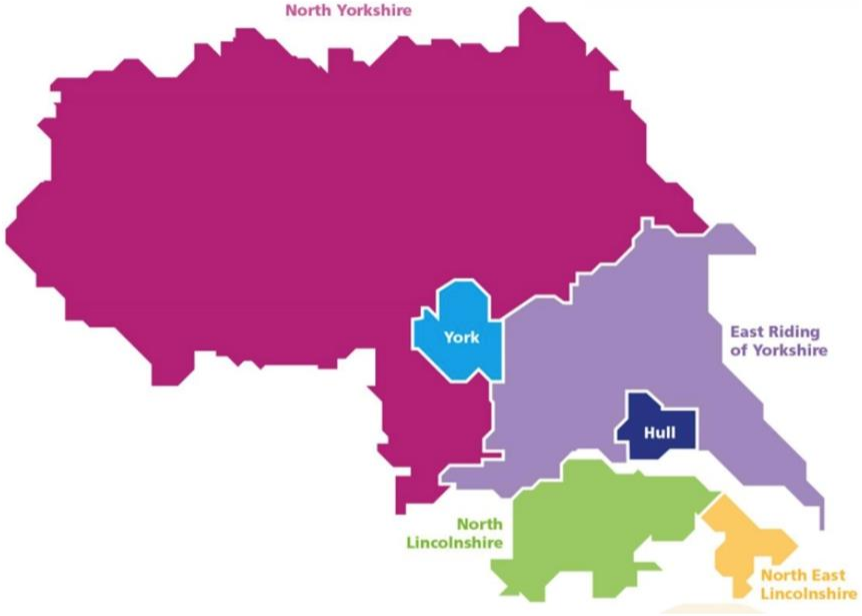
NHS
Humber and North Yorkshire
Integrated Care Board (ICB)



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Increase the proportion of people misusing drugs who access treatment and recovery support, including more **young people**…

More research should be conducted into which interventions are most effective, particularly for people who may have **cognitive deficits** due to past or current drug use, and for people with co-occurring **mental illness**.

UK Govt (2021) Independent report.
Review of drugs part two: prevention, treatment, and recovery.
Department of Health (Dame Carol Black Report)

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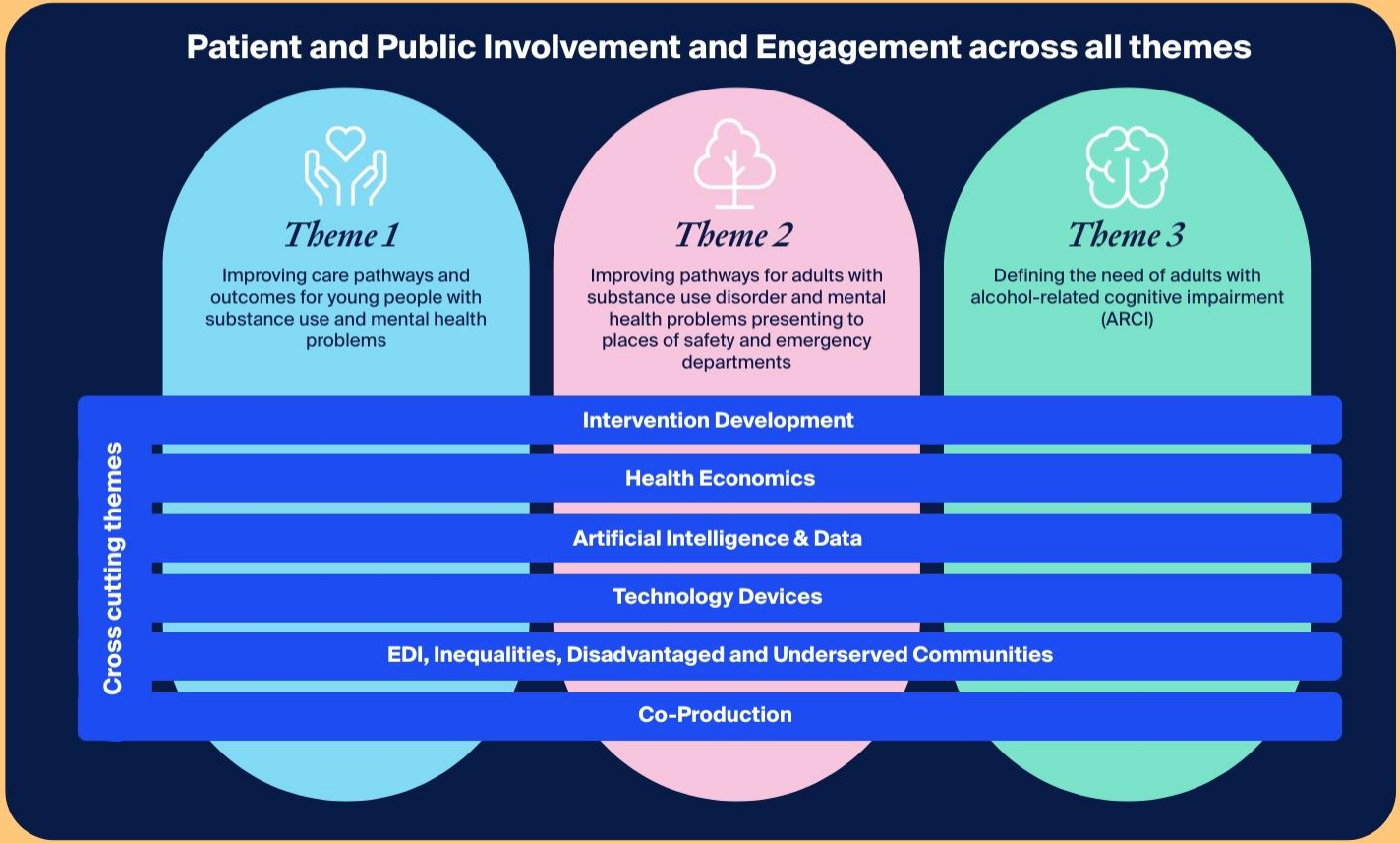
Our vision is to foster a research Partnership that is inspiring, inclusive, promotes collaboration and transforms the lives of patients and families addressing the gaps in the care system and finding practice-based solutions resulting in **greater access to care and treatment that works.**



Cross cutting themes

HEALTH ECONOMICS

Supported by a Research Fellow (York)

Conduct cost analyses of reported current care pathways from an NHS and personal social services.

Average cost associated with current care pathways for young people with SUD&MHP, and adults with ARCI, will be estimated based on the primary data on health and social services resource use that will be collected alongside the prevalence studies described in themes 1 and 3.

ARTIFICIAL INTELLIGENCE

Supported by as Research Fellow (DAIM, UoHull)

AI involvement in systematic review, medical diagnostics in collected data, development of predictive models, integration of Natural Language Processing (NLP) and Large Language Models (LLMs), analysis of routine healthcare data

TECHNOLOGY

Supported by a Research Fellow (King's)

Interventions development supported by devices (transdermal alcoholic sensors, wearables for biomarkers), apps and online interventions

What we will achieve

ADDRESS UNMET NEEDS

Improved care pathways and greater access to treatment within target services

Strengthening evidence-based commissioning of services

Supporting the workforce through Communities of Practice

RESEARCH CAREERS

Increasing pre- and doctoral fellowship applications

Support career pathway for ECRs and Clinical Academics hosted by NHS Trusts

Professor of Addiction Psychiatry - HYMS & Humber NHS Trust

Supporting senior scientific award applications

SUSTAINABILITY

Investing in ECRs and developing leaders

Expanding collaborations nationally and internationally

Broaden portfolio to include industry and commercial research

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Patient and Public Involvement and Engagement

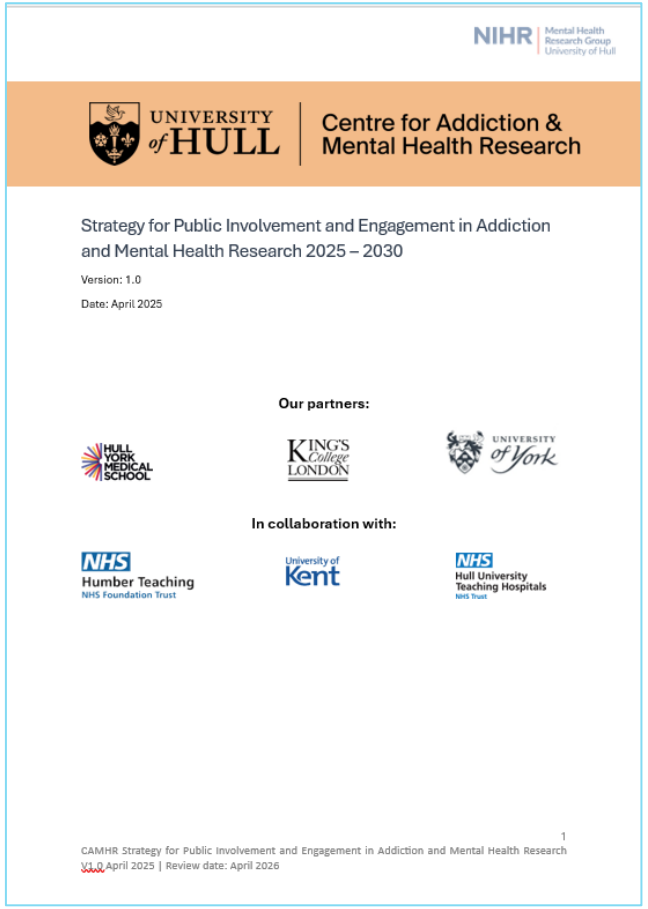
- PPIE team working with Lived Experience & Stakeholder groups across all themes (delivery and evaluation)
- Working with existing groups across the target area:
  - Ethnic Minority Research Inclusion (EMRI)
  - Young People networks

PPIE Team

- Alison Sharpe, Public Co-Applicant with lived experience
- Sarah Capes, PPIE Coordinator, Adults
- Ayisja Moss, PPIE Coordinator, Young People

Strategy for Public Involvement and Engagement in Addiction and Mental Health Research 2025-2023

- V1.0, April 2025
- Available under ‘ Resources’ on the PPIE page of CAMHR website https://www.hull.ac.uk/research/centres/centre-for-addiction-and-mental-health-research/patient-public-involvement-and-engagement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Strategy for Public Involvement and Engagement in Addiction and Mental Health Research 2025 – 2030

Version: 1.0

Date: April 2025

Our partners:

Hull York Medical School · King's College London · University of York

In collaboration with:

NHS Humber Teaching NHS Foundation Trust · University of Kent · NHS Hull University Teaching Hospitals NHS Trust

CAMHR PPIE Co-ordinators: Young People and Adults

Stakeholder Engagement

105

Number of contacts with individual stakeholders across Humber and North Yorkshire

PPI Engagment

112

Number of contacts with lived experience groups and individuals from the public to discuss PPI involvement. These include:

- Double Impact Scunthorpe
- Renew Hull Aftercare group
- We Are With You, NE Lincs
- Nothing About Us Without Us, H&NY
- Humber Youth Action Group

PPI Sessions

8

Number of PPI sessions delivered across Young People and Adult services

Events

17

Events attended to network, promote engagement and PPI opportunities. These include:

- Oasis Hub Grimsby CAMHR engagement event
- Nothing About Us Without Us, H&NY Summer Event
- East Riding Youth Council

Partnership Working

6

Number of partnership working relationships we have built to promote best practice and peer support. These include regular meetings with:

- MHRG University of Bath PPIE Co-ordinators
- ER Public Health lived experience team
- PPIE Co-ordinator of Involve, Hull
- Engagement Co-ordinator for Children's Services, Humber Teaching NHS Trust

Documents

7

Documents created to support PPIE in CAMHR. Including:

- PPIE strategy
- Risk Management and Safeguarding - YP and Adult
- Payment Policy
- EDI checklist
- PPI Terms of Reference

Young Interns

2

Number of Young Interns in post

- 1 YP on reserve
- 1 YP on interview panel

PPI Members Added to Network

69

Number of adults and young people interested in taking part in PPI activities following engagement events

Best Practice Monthly Meetings

8

Regular meeting we attend for best practice, networking:

- Nothing About Us Without Us, H&NY
- EMRI Monthly Meeting
- IRIS Research Community of Practice
- H&NY CYP Mental Health Steering Group

Support to Contributors of CAMHR

2

Number of projects we have supporting as part of CAMHR:

- PhD students within CAMHR with PPIE
- PPIE Consultations for the SMASH Project

Equity, Diversity, Inclusion, and Accessibility (EDIA)

EDIA Leads

- Dr Tyler Mills, Research Fellow – Theme 2
- Phillip Kerrigan EDIA and Mentor Project Administrator

Equity, Diversity, Inclusion and Accessibility (EDIA) in Research Strategy

- V1.0, May 2025
- Available under ‘ Resources’ on the PPIE page of CAMHR website https://www.hull.ac.uk/research/centres/centre-for-addiction-and-mental-health-research/patient-public-involvement-and-engagement

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Equity, Diversity, Inclusion, and Accessibility (EDIA) in Research Strategy

Version: 1.0

Date: May 2025

Our partners:

Hull York Medical School · King's College London · University of York

In collaboration with:

NHS Humber Teaching NHS Foundation Trust · University of Kent · NHS Hull University Teaching Hospitals NHS Trust

Contact

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Dr Tyler Mills (Research Fellow, University of Hull) t.j.mills@hull.ac.uk

Professor Cynthia Iglesias (Co-Applicant, Professor of Health Economics, University of York) cynthia.iglesias@york.ac.uk

Dr Philip Kerrigan (Project manager, University of York) philip.kerrigan@york.ac.uk

Sarah Capes (Patient and Public Involvement and Engagement [PPIE] coordinator for adults) s.capes2@hull.ac.uk

Ayisja Moss (PPIE coordinator for young people) a.moss2@hull.ac.uk

Research Team

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Research Fellows
- Dr Philippa Case, Senior Research Fellow – Theme 3
- Dr Rachel Coleman – Theme 1
- Dr Tyler Mills – Theme 2
- Dr Michele Siciliano (York)
- Dr Eileen Brobbin (KCL)

Research Assistants
- Georgia Bingham – Theme 2
- Dimple Lala – Theme 3
- Hope James Ekpa – AI/DAIM

Patient & Public Involvement & Engagement
- Sarah Capes, PPIE Coordinator, Adults
- Ayisja Moss, PPIE Coordinator, Young People

Intern - Young People with Lived Experience (part of PPIE team)
- Mansi Raut
- Mariana Faty Embalo
- Phillip Kerrigan (York)

Admin Team
- Amy Foster, Finance & Operations Officer
- Dave Liversedge, Research Admin Lead
- Sara Darwish, Administrative Assistant

PhD Students – Suicide & Social Justice
- Josmi Puthettu
- Camille Illet
- Koren-Marie Cowap
- Patricia Routh

PhD Students – Alcohol Group
- Buse Apel
- Nurun Tanya

Affiliated Projects

PRE - CAMHR

NIHR HS&DR ProACTIVE – National Evaluation of Alcohol Care Teams
- Prof Thomas Phillips & Prof Julia Sinclair (Southampton), KCL, Kent, Sheffield, Newcastle, Keele

NIHR-MHIN Collaborative Alcohol Care in Hull – Alcohol Assertive Outreach Team (CoACH)
- Prof Thomas Phillips, Dr Philippa Case, Dr Tyler Mills, Laura Hermann (NIHR Doctoral)

NIHR Digital Intervention for Cocaine Use – Virtual Reality and Cue Exposure Treatment
- Led by Prof Paolo Deluca (KCL) in Partnership with University of Hull

Higher Education Innovation Funding – Collaborative Alcohol Care in Hull – Alcohol & Cognition (CoACH-AC)
- Dr Philippa Case

NIHR Mental Health Incubator Internships
- Dr Philippa Case
  - Elisabeth Clarke – ARCI
  - Theodore Piper – Gambling

NIHR-RDN: Northern Addiction Research Alliance (NARA)
- Prof Thomas Phillips

NIHR-RfPB: Exploring Alcohol Screening in Perinatal Mental Health Services
- Prof Lesley Smith & Dr Carline Davenport

POST - CAMHR

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Northern Addiction Research Alliance (NARA)

Centre for Addiction & Mental Health Research

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A clinical-academic network hosted by the Centre for Addiction and Mental Health Research and funded by NIHR Regional Research Delivery Network to support:

- An increase in the leadership and participation in public health and clinical applied addiction research across the Northern Region of England
- Promote research applications led by members of NARA
- Provide opportunities to develop early- and mid-career researchers and support further embedded research opportunities
- Encourage the adoption of evidence-based commissioning and evaluation of addiction service
- Facilitate evidence into practice through clinical engagement

Opportunity to join the NARA/CAMHR Team to support the first collaborative meeting December 2025

Affiliated Roles

International PhD Studentship - AI Analyst
- Not yet appointed

Mental Health Incubator Internship – ARCI
- Elisabeth Clarke – Started 22-Sep-2025

Mental Health Incubator Internship – Gambling
- Theodore Piper – Starting 29-Oct-2025

Research Assistant - Northern Addiction Research Alliance (NARA)
- Not yet appointed

Research Assistant – NIHR Digital Intervention for Cocaine Use
- Hannah Darnell

NIHR-RfPB: Exploring Alcohol Screening in Perinatal Mental Health Services
- Dr Caroline Davenport

Sustainability

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Early & Mid Career Researchers

- Training Realist Review – Oxford University
- Statistical Training - Richard Riley
- NIHR GROW Initiative
- NIHR Writing Retreat
- Development and career plans guided by Vitae and Appraisals
- Mentorship schemes (Subject or methods specific)
- Development awards encouraged – actively being pursued
- Budget to support continuing professional development
- Publication policy – lead authorship advocated and encouraged
- Opportunities for Teaching and Knowledge Mobilisation across communities
- Pipeline of projects building from Small Grants, Fellowships, RfPB, etc

Research Income

- Professor of Addiction Psychiatry; broadens the portfolio and commercial opportunities
- Actively pursuing national and international funding streams building on Themes 1, 2 & 3
- Industry Partners – Locally (Inward Investment Teams), RRDN Commercial Lead
- HEI Collaborations – Extending to include Implementation Science, Gambling, NARA
- International – National Drug and Alcohol Research Centre (NDARC)
- Additional Focus: Co-Applicant areas of interest and support

Impacts

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Knowledge mobilisation

- Lunch & Learn: Alcohol-related brain damage - Invited to present with specialist colleagues at a learning event for NHS England NEY: Mental Health and Prevention Programmes
- Tackling Co-occurring Conditions: Alcohol Related Brain Injury Event, Kent
- Redesigning Alcohol Treatment Care Pathways, North East Lincolnshire
- Implementation of Alcohol Care Teams across HNY Integrated Care Board
- Development & Implementation of Alcohol Assertive Outreach Team (NIHR MHIN)
- Alcohol Treatment Pathway – REF2029 Impact Case Study
- Scotland: Drugs Research Network for Scotland (DRNS), Acute Responses to emergency Mental Health and Substance use (ARMHS) network

Grant Development

Existing Awards: (YEF; Coulton), NIHR RfPB (CONIFAS-2; Armitt)

In Development:

- NIHR HTA – Alcohol Contingency Management – KCL/Hull
- NIHR Advanced Fellowships – Petersen-Williams (Hull/York) Bareham (Newcastle/Hull)
- NIHR HTA – Palliative Care and Mental Health Study – ICAHR/CAMHR/HYMS
- AAOT – Implementation Study – Secondary Analysis off Existing Data – King's/CAMHR
- NIHR PGfAR – Mental Health and Alcohol Care Pathways – Lancaster/Newcastle

Theme 3: Defining the needs of adults with alcohol-related cognitive impairment (ARCI)

Dr Philippa Case, Senior Research Fellow

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Theme 3 – Defining the needs of adults with ARCI

Phase 1 (1-4 yrs): Establishing the needs of those with ARCI

Phase 2 (4-5yrs): Improving care – "What care should be offered?"

Project update: Establishing the needs of those with ARCI

Mapping exercise & stakeholder engagement

- Collaborated with East Riding of Yorkshire Council and NHS England North East and Yorkshire (NEY): No specific services or care pathways for people with alcohol-related cognitive impairment
- Engaging with existing networks: Complex hospital attenders, alcohol strategic partnerships, inequalities and disparities working group, recovery and inclusion group, alcohol treatment service providers

Pilot study in acute hospital setting – funded by the Higher Education Innovation Funding (HEIF) stream (£23,935)

- Pilot prevalence study
  - Purpose - to inform studies 1 and 2 and provide key data to stakeholders:
    - Explore **challenges with recruitment** of participants
    - **Administration of cognitive screening tools** in a hospital setting
    - Gather **exploratory prevalence data**, including broad sample of people with AUD

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Theme 3 – Defining the needs of adults with ARCI

Project update: Establishing the needs of those with ARCI

Pilot study in acute hospital setting – funded by the Higher Education Innovation Funding (HEIF) stream

- **Preliminary results:**
  - 185 participants scoring ≥3 on FAST were recruited in one hospital (Apr-Aug 2025)
  - **132 had an AUD** (≥16 on AUDIT) with **47.7%** with **severe dependence** (30-40 on AUDIT)
  - Of those with AUD:
    - average age 50.4 years
    - 96% white
    - 74% male
    - 84% not married/in a civil partnership
    - 54% living alone
  - 129 of those with AUD completed 2 x cognitive screening tools (MoCA and M-ACE)
  - High levels of mild cognitive impairment (79% using MoCA ≤26 and 64% using M-ACE ≤26), possible **ARCI (67% using MoCA ≤23**) and possible dementia (M-ACE ≤21, 43%) identified
  - Further analyses to be conducted, exploring:
    - other possible causes of cognitive impairment (e.g. acute illness, medication)
    - co-existing conditions
    - patterns of admissions in previous 5 years
  - Amendment under review with HRA to add follow-up data collection: alcohol consumption and cognition 3 months post-discharge

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Project update: Establishing the needs of those with ARCI

Validating the measurement of ARCI to explore the utility of cognitive screening tools

1. **Review – not required**
2. **Consensus with Medical Council on Alcohol (MCA) – Gold Standard for defining Alcohol-Related Cognitive Impairment**
3. Recruit participants with AUD from acute hospital and administer brief cognitive screening tool
4. Follow-up post-discharge, 4-8 weeks, 3 months, 6 months: collect data from cognitive screening tools, gold standard (from consensus), alcohol measures, demographic and clinical measures and service use
5. Sub-study monitoring alcohol abstinence over 6 weeks using Transdermal Alcohol Sensors (TAS)
6. Seeking to identify an accurate prevalence estimate which will inform the development of a diagnostic process post-discharge from hospital

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Project update: Establishing the needs of those with ARCI

Validating the measurement of ARCI to explore the utility of cognitive screening tools

1. **Review**
2. **Consensus – Gold Standard for defining Alcohol-Related Cognitive Impairment – delivered in partnership with the Medical Council on Alcohol**
3. Recruit participants from specialist services with a history of alcohol dependence and

Aims:

1. Agree terminology: **ARCI agreed**
2. Agree gold standard for the definition and measurement of ARCI
3. Agree standards for measurement in clinical practice and research

Member Specialisms:

Addiction psychiatry	Lived experience	Hepatology
Neuropsychiatry	Neuropsychology	Old age psychiatry
Specialists in ARCI		

Process:

First consensus meeting:	**31/07/2025**
Notes and proposed criteria for discussion shared:	**17/09/2025**
Second consensus meeting:	02/10/2025
Criteria finalised:	30/11/2025

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