**AHA response: Health and Social Care Select Committee inquiry into Community Mental Health Services (Call for evidence: February 2025)**

***What does high-quality care look like for adults with severe mental illness and their families/carers?***

- ***How could the service user journey be improved both within community mental health services and in accessing support provided by other services/agencies?***
- ***How could this be measured/monitored locally and nationally?***

High-quality care must be holistic and acknowledge complex needs. Mental illness often co-exists with drug and/or alcohol use disorders (AUD), with an estimated 44% of people in Community Mental Health Treatment and 71% of adults and 48% of young people entering alcohol treatment services require mental health treatment.[1][2] People with co-occurring drug and/or alcohol-use disorders (AUD) can experience discontinuities in their care, e.g., exclusion from drug/alcohol services due to mental health problems, and vice versa.[3] Despite the high prevalence of mental health difficulties amongst young people seeking treatment for alcohol dependence, 29% were not receiving mental health treatment.[4]

The disconnect between addiction and mental health services for alcohol-related liver disease patients has been identified as a major concern. Care pathways are not adequately set up to connect services: the current approach when people present with symptoms of liver disease is to treat the patient from a hepatology point of view and discharge them with little information and tools on how to reduce harmful alcohol use or to address any concurrent mental health problems.[5]

In a survey of alcohol and mental health practitioners carried out by the Institute of Alcohol Studies and the Centre for Mental Health, 84% of respondents believed that having an alcohol use disorder was a barrier to getting any kind of mental health support.[6] When mental health services are limited to people who are not actively drinking alcohol, some people may resort to drinking more instead of getting the support they need, and an opportunity for intervention is missed. This experience is outlined by the personal anecdote below:

> "I went to [the hospital] and said to them, 'I am having intrusive suicidal thoughts. I don't know why. I'm frightened'. And their response was, 'Unless you reduce your alcohol to 13 units a week, you will receive no treatment from the NHS or from private practice'. And I came out of [the hospital] and thought, 'Well, that's it then. That's it. Nothing is going to change; I'm not going to get any help'. Three weeks later, I had planned and organized my suicide…" (Bobby, male, 50–59 years)[7]

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[1] Office for Health Improvement and Disparities (2023) Adult substance misuse treatment statistics 2022 to 2023: report

[2] Royal College of Psychiatrists (2020) Training in addiction psychiatry: current status and future prospects

[3] NHS England and NHS Improvement and the National Collaborating Centre for Mental Health (2019) The Community Mental Health Framework for Adults and Older Adults

[4] Office for Health Improvement and Disparities (2024) Young people's substances misuse treatment statistics 2022 to 2023: report.

[5] Dhanda, A. et al (2024) An alcohol-related liver disease multi-stakeholder hub (ARMS-Hub) to enhance research activity in underserved communities in the UK. *NIHR Open Res*, **4**:41

[6] Institute of Alcohol Studies and Centre for Mental Health (2018) Alcohol and mental health: Policy and practice in England.

[7] Jackson, K. et al. (2024) Understanding people's experiences of the formal health and social care system for co-occurring heavy alcohol use and depression through the lens of relational autonomy: A qualitative study. *Addiction*.

Between 2010 and 2020, 48% of people who died by suicide while under the care of mental health services had a history of problematic alcohol use.[8]

The National Confidential Inquiry into Suicide and Homicide (NCISH) 2010-2020[9] demonstrated that of those who die by suicide while under the care of Mental Health (MH) services:

- Those with a primary diagnosis of alcohol use disorder (AUD) were significantly more likely than those with other mental health diagnoses to have had only a single contact with mental health services (20% vs 9%).
- The number of patients with AUD seen by mental health services fell from 165/year before 2012 to 106/year thereafter (with a downward trend over the seven years) despite a known increase in AUD incidence during this time.

The reduction in numbers of those with AUD known to NCISH coincides with the Health and Social Care Act of 2012. The move of commissioning of addiction treatment services out of the NHS to the local authority, resulted in a shift of provision from mental health services into the social care sector. Therefore, it is likely that the fall in number (of patients with AUD who died by suicide under the care of mental health services), may be the result of some suicidal patients with a primary diagnosis of AUD never being seen by mental health services. Of note, after 2012, the rates for a primary diagnosis of AUD of patients dying by suicide under the care of mental health were lower in England (6%) where these changes to the provision of services were made compared to NI (20%), and Scotland (13%) where addiction services primarily remained within mental health services.[10]

To improve the service user journey, the Medical Council on Alcohol propose services:[11]

- Follow the NCISH recommendations that staff working in mental health services are competent in the assessment and management of alcohol use as part of their suicide prevention implementation.
- Implement an effective crisis care pathway in each locality to respond to the needs of suicidal people who are also alcohol dependent.
- Have clear policies for the management of co-morbid alcohol dependence and withdrawal for all patients requiring inpatient admission and rebuild the staff competencies to deliver parity of care.
- Implement NHS guidance on screening for AUD/alcohol-related harm as part of the initial assessment.

***What blockers or enablers should policy interventions prioritise addressing to improve the integration of person-centred community mental health care?***

There are significant barriers to integrating services adequately, including insufficient funding, workforce shortages, and stigma.[12]

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[8] Suicide Prevention Consortium (2024) Exploring experiences of accessing support for alcohol issues and suicidal ideation. With You, Samaritans, National Suicide Prevention Alliance, Support After Suicide Partnership, VCSE Health & Wellbeing Alliance.
[9] Appleby, L. et al. (2023) National confidential inquiry into suicide and safety in mental health
[10] Medical Council on Alcohol (2024) The need for a health system response to alcohol-related harms
[11] Medical Council on Alcohol (2024) The need for a health system response to alcohol-related harms
[12] Institute of Alcohol Studies and Centre for Mental Health (2018) Alcohol and mental health: Policy and practice in England.

Years of funding cuts have had a significant impact on the ability to provide person-centred care in the community. Whilst community addiction services are not commissioned or funded to provide mental health treatment, they frequently encounter patients with mental health conditions. Cuts to local authority budgets mean they have been unable to host an adequate number of training posts for addiction psychiatrists, with training places falling by 58% between 2011 and 2019.[13] The lack of addiction psychiatrists and other mental health practitioners in the sector means that many community addiction services may not have sufficient expertise to address complex mental health conditions, while mental health services are often reluctant to treat patients until their alcohol use is under control, leading to a vicious cycle where patients with both conditions often fall through the cracks.

***What are the examples of good or innovative practice in community mental health services?***

- ***What needs to happen to scale up the adoption of these practices across the country?***

A few examples of evidenced good practice include:

- A systematic review on depression treatment in alcohol use disorder patients found that treatment for both conditions must happen in parallel to improve outcomes – even if depression is believed to be independent of drinking.[14]
- The Housing First model prioritises getting people into stable homes, before addressing any other support needs including alcohol dependency and mental health problems through coordinated and intensive support. Research found that those reporting 'bad or very bad' mental health fell from 52% to 18% after using Housing First. Respondents who reported that they would 'drink until they felt drunk' fell from 71% to 56% after using Housing First.[15]

In terms of clinical guidelines and training:

- Involving patients is key: the (upcoming) UK clinical guidelines for alcohol treatment, has involved patient input to define 'principles of care' for the first time.[16]
- The 2022 curriculum for general psychiatry by the Royal College of Psychiatrists established the ability to 'demonstrate skills in assessing and managing patients with addictions' as a core competency for trainee psychiatrists.[17]

[13] Committee of Public Accounts (2023) Alcohol treatment services: Fifty-fourth report of session 2022-23
[14] Foulds J. A., et al. (2015) Depression in patients with alcohol use disorders: Systematic review and meta-analysis of outcomes for independent and substance-induced disorders. *Journal of Affective Disorders*.
[15] Crisis (accessed 21 January 2025) The plan to end homelessness: Chapter 9 The role of Housing First in ending homelessness
[16] Office for Health Improvement and Disparities (2023) UK clinical guidelines for alcohol treatment: core elements of alcohol treatment
[17] Royal College of Psychiatrists (2010) A competency based curriculum for specialist training in psychiatry