Health and Social Care Committee – Community Mental Health Services inquiry

Institute of Alcohol Studies response – January 2025

The Institute of Alcohol Studies (IAS) is an independent institute bringing together evidence, policy and practice from home and abroad to promote an informed debate on alcohol's impact on society. Our purpose is to advance the use of the best available evidence in public policy decisions on alcohol.

Our reason for submitting evidence to the inquiry is to highlight the link between treatment for alcohol use disorder (AUD) and mental health treatment, the importance of these services being far more integrated than they currently are, and recommendations for improving this integration. Much of our response draws from a new report by the Medical Council on Alcohol (MCA), which highlights how the integration of services has deteriorated significantly in the previous decade: *'The Need for a Health System Response to Alcohol-Related Harms'*.

1. **What does high-quality care look like for adults with severe mental illness and their families/carers?**
    a. **How could the service user journey be improved both within community mental health services and in accessing support provided by other services/agencies?**

Co-occurring alcohol and mental health problems are a significant issue. The Office for Health Improvement and Disparities found that in 2022/23, 71% of adults starting alcohol use treatment said they also had a mental health treatment need.[i] And 21% of those who had a mental health need were not receiving any treatment for it. Among children who started substance use treatment in 2022/23, 48% said they needed mental health treatment.[ii] However, 29% of those were not receiving any mental health treatment.

Regarding suicide, 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.[iii] The National Confidential Inquiry into Suicide and Homicide (NCISH) found that 20% of those with a primary diagnosis of alcohol use disorder had only had a single contact with mental health services, compared to 9% of those with other mental health diagnoses.[iv] The inquiry also found that the number of patients with alcohol use disorder (AUD) seen by mental health services fell from 165 per year pre-2012 to 106 per year afterwards, despite the known increase in AUD incidence during this time.

It is clear that the service user's journey has worsened over the past decade and the Medical Council on Alcohol (MCA) report explains that much of this relates to changes made under the Health and Social Care Act 2012. The Act moved the commissioning of alcohol treatment services to be under the responsibility of local authorities. Although this could have worked if funded appropriately and integrated alongside other treatment services, it wasn't, and "the broad range of physical and mental health needs of patients with alcohol dependence and alcohol-related harm ceased to be a priority within healthcare".[v] Treatment of alcohol problems moved from being considered holistically, to being treated in a siloed way. Alcohol

harms are varied and can affect people in multiple ways, requiring multiple specialties, for instance, mental health support, liver services, acute hospital care, primary care, addiction services, and care commissioned by local authorities.

Budget cuts during years of austerity also led to a reduction in the number of experienced staff who understand the co-occurrence of alcohol and mental health problems. The number of training places for addiction psychiatrists fell by 58% from 2011-2019.[vi]

Alcohol treatment services are not set-up to provide mental health support and vice-versa, yet both services frequently encounter patients who need support for both. This means services often lack the expertise to support effectively and often reject patients that need support for both issues. As the NHS Community Mental Health Framework stated: "People who have co-occurring drug and/or alcohol-use disorders and mental health needs can also experience discontinuities in their care. This can often be due to a lack of skills or competences, meaning that they can be excluded from drug and alcohol services due to their mental health problems, or excluded from mental health services due to their drug and alcohol problems."[vii] This Catch-22 means that people often end up falling through the gap, leading to disastrous consequences. A 2023 study quoted a man who experienced this[viii]:

> *"…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, IMD score 6, 50–59 years).*

As the Framework recommends, alcohol and other drug services should be integrated within the broader community mental health services to provide comprehensive, person-centred care that addresses all aspects of an individual's mental health and alcohol treatment needs.

The situation improved when the NHS Long Term Plan established Alcohol Care Teams (ACTs) in acute hospitals with the greatest need. These teams provide "specialist expertise and interventions, including assessment, psychosocial intervention, abstinence advice, relapse protection, and onward referral to support patients to reduce or manage their drinking".[ix] They have strong links with community alcohol services and wider support. For instance, the ACT at City Hospital Birmingham had a psychiatry service that delivered a comprehensive range of mental health specialities, and led to 60 of the 600 beds being closed "through linking patients to appropriate community care pathways…[with] estimated financial savings of £4-£6million per year".[x] However, many of these ACTs have now been dismantled, due to de-prioritisation in March 2024.[xi]

Recommendations

IAS fully supports the recommendations made by the MCA to improve the integration of alcohol and mental health treatment services:

Workforce competence and training

1. 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.
2. All health and social care professionals working in services where there is a potential 'high risk' from alcohol-related harm (ARH) (e.g. liver services, mental health services, maternity care) receive training in the identification, assessment, and management (or referral) of alcohol dependence and alcohol-related harm.
3. Rebuild the staff competencies to deliver parity of care, with clear policies for the management of co-morbid alcohol dependence and withdrawal for all patients requiring inpatient admission.

Pathways and policies

4. Implement an effective crisis care pathway in each locality to respond to the needs of suicidal people who are also alcohol dependent.
5. As comorbid alcohol dependence is a well-established factor for suicide and suicidal behaviour, all ICBs should include a recognition and response to how to integrate the management of alcohol dependence within their suicide prevention strategies.

Screening and leadership

6. Implement NHS guidance on screening for AUD/ARH as part of the initial assessment.
7. Each Regional/National Health Board needs an 'Alcohol lead' to ensure people with alcohol dependence and alcohol-related harm are able to access services that meet their physical and mental health needs across the entirety of the local health system.

Specialist services and funding

8. Sustained funding to rebuild specialist services to manage the most complex patients who are currently unable to access treatment and are consequently admitted to acute hospitals as unscheduled care.

---

[i] Office for Health Improvement and Disparities (2023), Adult substance misuse treatment statistics 2022 to 2023: report, Mental health.

[ii] Office for Health Improvement and Disparities (2024), Young people's substance misuse treatment statistics 2022 to 2023: report, Mental health needs.

[iii] University of Manchester (2023) The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: UK patient and general population data, 2010-2020.

[iv] University of Manchester, 2023.

[v] Medical Council on Alcohol - MCA (2024), The Need for a Health System Response to Alcohol-Related Harms.

[vi] House of Commons Committee of Public Accounts (2023), Alcohol treatment services, Fifty-Fourth Report of Session 2022–23.

[vii] NHS and National Collaborating Centre for Mental Health (2019), The Community Mental Health Framework for Adults and Older Adults.

[viii] Jackson, K., Kaner, E., Hanratty, B., Gilvarry, E., Yardley, L., & O'Donnell, A. (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*, *119*(2), 268-280.

[ix] NHS England, Alcohol dependency programme [accessed January 2025].
[x] Moriarty, K. J. (2020). Alcohol care teams: where are we now?. *Frontline gastroenterology*, *11*(4), 293-302.
[xi] MCA, 2024.