

Institute of Alcohol Studies – response to consultation on ‘Informing the mental health strategy for England’

Call for evidence questions

About you

In what capacity are you responding to this survey?

- On behalf of an organisation (in an official capacity representing the views of that organisation)
- An individual sharing my professional views
- An individual sharing my personal views and experiences

If you are responding on behalf of an organisation, what is the name of your organisation?

Institute of Alcohol Studies

What sector do you (or does your organisation) work in?

- Public sector
- Private sector
- Not for profit
- Other, please specify

What are the main areas of focus of your (or your organisation’s) work? Please select up to 3 areas.

- Academic
- Advocacy
- Education
- Emergency services
- Healthcare - mental health
- Healthcare - wider healthcare (not mental health)
- Hospitality
- Housing
- Justice system

- Learning disabilities and services for people with autism
- Legal
- Local government
- National government
- Social care
- Sport
- Other, please specify

Please provide more detail on the type of organisation you work for. (Optional, maximum 50 words)

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.

Which area or areas of England do you work (or does your organisation operate) in? Select all that apply.

- North East England
- North West England
- Yorkshire and the Humber
- East of England
- East Midlands
- West Midlands
- London
- South East England
- South West England
- I do not work (or my organisation does not operate) in England

What is the first part of your workplace address (or organisation's main) postcode? For example, PO1. Please do not enter the full postcode. (Optional)

SE1

Hospital to community

Effective partnership working at a community level is essential for the provision of person-centred care. These partnerships address the broad range of factors which can influence a person's mental health recovery, such as:

- physical health

- employment
- housing
- addiction
- social care

We are piloting [6 community-based mental health centres](#) across England to understand how services can better work together at a local level to improve people's outcomes. We would like to hear practical insights that support wider transformation of mental health care in communities.

We welcome practical examples and evidence on how mental health services can work more effectively across:

- the wider NHS, including new neighbourhood health centres
- services to support people with co-occurring mental health and neurodevelopmental conditions
- different sectors, including education, employers, local authorities and the voluntary, community and social enterprise (VCSE) sector

How can mental health services work more effectively across these areas? Please provide examples of cross-sector pathways in practice. (Optional, maximum 300 words)

Alcohol use disorder (AUD) is one of the clearest examples where cross-sector fragmentation drives poor mental health outcomes. Since the Health and Social Care Act 2012 moved commissioning of specialist alcohol treatment from (primarily) the NHS to local authorities, while mental health remained an NHS responsibility, patients with co-occurring AUD and mental illness have been managed across separate, poorly-connected systems. [The Medical Council on Alcohol \(MCA\) reported in 2024](#) that 71% of adults and 48% of young people entering alcohol treatment require mental health support, yet mental health services are often reluctant to treat patients until their alcohol use is 'under control', creating a cycle in which patients with both conditions fall through the cracks. We support the MCA's recommendations that: each Integrated Care Board (ICB) should have a named 'alcohol lead' responsible for cross-system pathways between mental health, addiction and primary care; accelerated joint pathways for patients with severe, life-threatening alcohol-related physical illness (e.g. decompensated liver disease), who currently often die before accessing either addiction or mental health treatment; NHS mental health services should follow the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) recommendations that staff be competent in assessing and managing alcohol use as part of suicide prevention, rather than treating alcohol dependence as a reason to defer care; and formal involvement of Lived Experience Recovery Organisations in designing joint pathways, given the stigma around alcohol dependence that partly explains the absence of patient-led advocacy groups comparable to those for cancer or dementia. A good practice example is the Alcohol Care Team model, where consultant-led multidisciplinary teams embedded in acute hospitals link people with AUD into physical and mental health pathways; this has shown improved outcomes but was deprioritised nationally

in March 2024 and is being dismantled in many areas due to lack of sustained funding.

We welcome views or evidence on what further support, in addition to NHS services, should be provided for people with severe and enduring mental illness to:

- help them stay well
- maintain participation in education, work and community life
- avoid crisis and/or hospital admission
- reduce length of stay in inpatient units

What further support should be provided for people with severe and enduring mental illness? (Optional, maximum 300 words)

Alcohol dependence should be recognised in the mental health strategy as, itself, a form of severe and enduring illness, alongside its role as a major complicating factor for other diagnoses. Data from the National Confidential Inquiry into Suicide, Homicide and Safety in Mental Health (NCISH) show patients with a primary AUD diagnosis were significantly more likely than those with other mental health diagnoses to have had only a single contact with mental health services before death (20% vs 9%). After alcohol treatment commissioning moved out of the NHS in 2012, the number of patients with AUD seen by mental health services before death fell from around 165/year to 106/year, despite a known rise in AUD incidence (MCA, 2024). To support people with severe and enduring illness and comorbid alcohol dependence, we recommend: sustained funding for specialist Alcohol Care Teams and community alcohol treatment, given only 24% of people with alcohol dependence currently access community services (NDTMS), compared with roughly 70% of people with diabetes accessing care; investment to rebuild the specialist addiction psychiatry workforce, which has seen training posts fall by 58% between 2011 and 2019, leaving many community addiction services without the expertise to manage co-occurring mental illness; clear crisis care pathways for people who are both suicidal and alcohol dependent, since current practice can mean people are refused mental health treatment until they reduce their drinking – the MCA report documents a case where this refusal preceded a completed suicide plan; and recognition of the 'alcohol harm paradox', whereby socioeconomically disadvantaged people bear disproportionate alcohol-related mental and physical harm despite lower average consumption, meaning support for this group must be inequality-aware rather than uniform.

What are the main barriers to continuity of care across transitions between hospital and community services, and between different levels of care, including child to adult services?

The single largest structural barrier to continuity of care for people with alcohol-related mental health needs is the 2012 split between NHS-commissioned mental health services and local-authority-commissioned addiction services. This is measurable in outcomes: NCISH data show that after 2012, only around 6% of patients who died by suicide under mental health service care in England had a

primary AUD diagnosis, compared with roughly 20% in Northern Ireland and 13% in Scotland, nations where addiction services remained within mental health provision. This is unlikely to reflect lower AUD-related suicide risk in England; it more plausibly reflects that people with AUD are simply not being seen by NHS mental health services at all. Further barriers include: Public Health Grant cuts of 26% in real terms from 2015/16 to 2024/25, which have reduced local authority capacity to fund alcohol treatment, with an estimated extra 60 alcohol-related hospitalisations per 100,000 people for every 5% reduction in treatment spending; the loss of specialist inpatient addiction capacity, with only five NHS specialist in-patient units remaining in England, against a European average of around 11% of people with AUD accessing residential rehabilitation, compared with under 1% in England and Wales; and significant regional variation, with patients in the South of England up to 13 times more likely to access residential rehabilitation than those in the North. We recommend the strategy explicitly address the 2012 commissioning split, requiring ICBs and local authorities to hold joint accountability for outcomes for people with comorbid AUD and mental illness, underpinned by ring-fenced, restored funding for community alcohol treatment.

Please provide examples from either side of the transition and outline how these barriers could be effectively addressed. (Optional, maximum 300 words)

N/A

Analogue to digital

It's important that children and adults can benefit from the opportunities that digital technology can offer to boost mental health and wellbeing. However, this must be balanced with safety and protection from risks to mental health. We understand that many people would like:

- more personalised, tailored mental health support available digitally
- digital tools to be neuroinclusive (accessible and effective for people with neurodevelopmental conditions)

A 2025 report from Mental Health UK stated that [people are also increasingly turning to AI chatbots](#) for mental health advice.

We welcome evidence and innovative examples of how digital and AI tools can be safely used for adults and children to:

- improve mental health and wider societal outcomes
- support access to effective mental health support
- complement relational care

What evidence and innovative examples are there of digital and AI tools being used to achieve these outcomes? Please provide examples. (Optional, maximum 300 words)

Digital screening tools embedded in primary care and hospital admission systems offer a scalable way to identify alcohol-related risk earlier, supporting the universal hospital screening recommended by the Medical Council on Alcohol; real-time screening data could flag patients at risk of alcohol-related mental health crises before acute presentation. However, we urge caution regarding industry involvement in digital 'responsible drinking' or wellbeing tools. Evidence shows alcohol industry-funded health information bodies have disseminated misinformation while claiming independence and evidence-based practice, promoting industry-favourable framings of harm as individual 'misuse' rather than a product design or marketing issue. A 2024 analysis found that industry-funded apps contain misinformation that actually encourage people to consume alcohol through 'primary nudging' and social norming (Roy-Highley, 2024). Any digital tools commissioned or endorsed under the mental health strategy should be free of alcohol (or gambling, or other harmful-product) industry funding or involvement, to avoid embedding conflicts of interest into government-endorsed digital infrastructure. We would welcome further engagement on this question with organisations working directly on digital mental health delivery.

How can data be used more innovatively to improve mental health and wider societal outcomes? Please provide examples. (Optional, maximum 300 words)

Better linkage of existing alcohol and mental health data would substantially improve prevention and targeting. We recommend: linking hospital admission data (A&E attendances, ambulance call-outs, alcohol-specific admissions) with mental health service contact records, to identify patients cycling between systems without receiving integrated care; national reporting of alcohol-related mortality and morbidity broken down by mental health service contact status, to monitor whether the England-specific gap in AUD recognition (relative to Scotland and Northern Ireland) is closing; routine recording of parental alcohol use in family and children's social care assessments, given parental alcohol use was a factor in 16% of children's social services referrals in 2019/20, with around 3 million children in the UK living in households affected by parental alcohol problems and consistent evidence of adverse effects on child mental health and development; and publicly reported, standardised KPIs for alcohol treatment services, as recommended by the MCA, enabling comparison of quality and access across local authorities in the way mental health access and waiting-time standards already allow benchmarking of NHS provision.

Sickness to prevention

The incidence and severity of mental health conditions has risen in recent decades, with young adults in particular now reporting substantially poorer mental health. Data from NHS England's [Survey of mental health and wellbeing, England 2023 to](#)

[2024](#) stated that 25.8% of young people are estimated to have a common mental health condition, up from 17.5% in 2007.

Many of the solutions to mental health problems involve education, employment, housing and participation in community life. Therefore, if prevention is to be effective, we need to think beyond the realms of clinical care and across the life course.

We are especially interested in how we can identify distress earlier and support people to maintain participation in education and work. Preventative approaches include:

- primary prevention - stopping mental health problems before they start
- secondary prevention - supporting those at higher risk of experiencing mental health problems
- tertiary prevention - helping people living with mental health problems to stay well

We encourage examples of good practice within and beyond the health system, including in work and education settings where people with a co-occurring mental health and neurodevelopmental condition may particularly benefit.

Which preventative approaches have the strongest evidence for reducing incidence or severity of mental health problems and promoting good mental health? (Optional, maximum 300 words)

The strongest population-level evidence for reducing the incidence and severity of alcohol-related mental health problems comes from pricing and availability policy, not downstream individual-level interventions. The WHO estimates that 22% of all fatal self-harm can be attributed to alcohol use, and identifies restrictions on alcohol pricing, marketing and availability as a core prevention strategy (van Schalkwyk et al., 2026, PLOS Global Public Health). Scotland's Minimum Unit Pricing (MUP) policy provides the clearest UK evidence base: an independent Public Health Scotland evaluation (Wyper et al., 2023, The Lancet) found MUP reduced wholly alcohol-attributable deaths by an estimated 13.4% and related hospital admissions by 4.1% over its first 2.5 years, with the largest gains among the most deprived groups, directly addressing the 'alcohol harm paradox' whereby disadvantaged groups experience disproportionate alcohol-related harm despite lower average consumption. The same PLOS paper cites reductions in male suicide following Russia's 2006 alcohol policy and reduced self-harm rates in South Africa during COVID-19 alcohol sales restrictions. By contrast, evidence shows industry-favoured downstream measures, such as responsible drinking campaigns and self-regulation, are ineffective and in documented cases used to shift blame onto individuals while leaving product design and marketing unchanged. UK cohort evidence also links heavier alcohol consumption to increased later risk of depression and anxiety (Boden & Fergusson, 2011, Addiction). We recommend the strategy explicitly endorse alcohol pricing and availability reform, including the extension of Minimum Unit Pricing to England alongside marketing restrictions and greater powers for local authorities to restrict the availability of alcohol, as core primary prevention measures

for population mental health, complementing the secondary and tertiary measures addressed elsewhere in this response.

Which preventative approaches have the strongest evidence for reducing the numbers of lives lost to suicide? (Optional, maximum 300 words)

A population-level suicide prevention approach specific to alcohol would be to apply the same 'means restriction' and product-safety lens used for bridges and medicines to alcohol itself, as argued in van Schalkwyk et al. (2026, PLOS Global Public Health). The paper highlights the perception that products with well-established links to suicide, including alcohol, if 'used appropriately' or 'responsibly' are treated as safe, shifting responsibility onto individuals rather than product design, marketing and availability – the same industry-favoured framing seen with opioids and gambling. This has direct relevance to NHS mental health services. NCISH data show patients with a primary AUD diagnosis are significantly more likely to have had only one contact with mental health services before dying by suicide, and recognition of AUD as a suicide risk factor fell sharply after alcohol treatment commissioning moved out of the NHS in 2012. The Medical Council on Alcohol documents cases of patients experiencing suicidal ideation being refused NHS or private mental health treatment unless they first reduced their drinking to 13 units/week, a practice with no evidence base and clear potential to increase risk. We recommend the strategy: adopt alcohol pricing and availability restrictions (e.g. Minimum Unit Pricing) explicitly as a suicide prevention measure, supported by evidence of reduced male suicide following Russia's 2006 alcohol policy and reduced self-harm during South Africa's COVID-19 alcohol restrictions; mandate that NHS mental health and crisis services never make mental health treatment conditional on reduced drinking; and fund assertive outreach for high-need, high-cost alcohol-dependent patients, which trial evidence shows raised abstinence days from 14% to 68% and cut inpatient bed days from 26.8 to 1.2, delivering an estimated £3.42 return for every £1 invested (MCA, 2024).

How can services better support the 'missing middle' - those with sustained needs (that affect their participation in community life, for example, in education or work) who may not meet the criteria for NHS mental health services? Please provide examples. (Optional, maximum 300 words)

People with alcohol dependence are a paradigmatic example of the 'missing middle': their needs are frequently too complex for primary care or NHS Talking Therapies, but they do not meet thresholds for secondary mental health services, particularly while still drinking. As mentioned, only 24% of people who are alcohol dependent currently access community alcohol services at all, far below comparable access rates for other chronic conditions such as diabetes (around 70%). Contributing factors include: community addiction services, commissioned separately from mental health by local authorities since 2012, are not funded or commissioned to provide mental health treatment, despite frequently encountering patients with significant mental health needs; mental health services are often reluctant to treat patients until their alcohol use is 'under control', creating a circular gap in which neither system takes responsibility; loss of specialist addiction psychiatry training posts has left many community addiction teams without the qualifications to manage co-occurring conditions even where willing; stigma towards alcohol dependence, both felt and

enacted by health professionals, discourages help-seeking and reduces care quality, and likely explains the absence of patient-led advocacy groups for alcohol dependence comparable to those for cancer or dementia; and the social perception that people are wholly responsible for their alcohol use and problems, shifting blame away from economic and environmental influences such as alcohol industry marketing and lobbying, and product pricing and placement. We recommend the 'missing middle' response for alcohol-related mental health need include mandated joint working protocols between community mental health and addiction teams (rather than sequential or conditional referral), embedding brief intervention and referral capability within primary care mental health pathways, and involving Lived Experience Recovery Organisations in service design, in line with the UK Clinical Guidelines for Alcohol Treatment principles of care.

Factors enabling good practice

Too often, we hear that services are hindered by administrative barriers that prevent innovative, integrated and person-centred care. We are interested in the underlying enablers of good practice around the country, and the role national government can play in creating the conditions for reformed models of mental health support. We are particularly interested to understand how access can be improved, for example through therapeutic support for certain groups such as women and girls subject to violence and/or child sexual abuse.

What commissioning, funding and oversight or accountability arrangements (nationally and locally) best support safe and integrated mental health services that improve outcomes across mental health, participation in work, education and community life, and social functioning? Please provide examples. (Optional, maximum 300 words)

Effective, accountable commissioning for alcohol-related mental health need requires reversing the fragmentation created by the 2012 Health and Social Care Act, which split addiction (local authority, Public Health Grant) from mental health (NHS) commissioning. Local authority spending on drug and alcohol services fell 27% in real terms from 2015/16-2023/24. We recommend: a funded national alcohol strategy – there has not been one for over a decade – explicitly integrated with, not separate from, the mental health strategy, given the scale of comorbidity (71% of adults and 48% of young people entering alcohol treatment require mental health support); each ICB or Regional Health Board to appoint a named 'alcohol lead' with explicit accountability for ensuring people with alcohol dependence and alcohol-related harm can access mental health support across the local system; sustained, not one-off, funding for Alcohol Care Teams, which were deprioritised nationally in March 2024 despite an NHS Long Term Plan commitment and are now being dismantled in many hospitals; clear, published KPIs for alcohol treatment services, matching the accountability the strategy proposes for mental health waiting times and access; and joint outcome measures across ICBs and local authorities for people with comorbid AUD and mental illness, so neither system can treat this group

as the other's responsibility. We would welcome the opportunity to discuss this evidence further.

Your local mental health strategy or delivery plan

This section is only for people responding on behalf of an organisation.

If you're answering on behalf of a mental health trust, integrated care board or local authority, please provide your local mental health strategy and/or delivery plan so we can learn from your work.

You'll be able to upload your strategy or plan as a file. If it's available online, you'll be able to provide a link to it instead.