Call for Evidence: Mental health and wellbeing plan

Response by the Institute of Alcohol Studies

We welcome the opportunity to respond to this consultation. 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.

We will respond to this consultation in the context of our aim to reduce alcohol harm and our answers will be focused on the role alcohol plays in mental health.

What is the most important thing we need to address in order to reduce the numbers of people who experience mental ill-health?
This might include actions which can be taken by national and local government, public services such as education settings, social care, the NHS, and the private and voluntary sectors.

Alcohol dependence often co-occurs with mental health conditions: alcohol use can affect a person's mental health, and experiencing mental health problems can also affect a person's relationship with alcohol. (1) Having a dual diagnosis of alcohol use and mental disorders is common: about 86% of people using alcohol treatment services have a co-occurring mental health difficulty, while about 44% of community mental health patients have reported substance use problems in the previous year. (2) To reduce the number of people experiencing mental ill-health, it is therefore important to reduce alcohol consumption and alcohol harm.

Alcohol use can both exacerbate existing conditions or can cause new conditions to occur. Alcohol use disorders have been linked to a range of mental health difficulties, including depression, bipolar disorder and antisocial personality disorder. (3) In 2014/15, English hospitals had more than 200,000 admissions for mental and behavioural disorders due to alcohol use. This accounted for almost 19% of all alcohol-related hospital admissions. (4)

Alcohol is also often used as coping mechanism in response to mental health difficulties, such as stress, anxiety, depression and others. (5) This is because people might think alcohol can help them relax or give short-term feelings of euphoria; however, in the longer-term, alcohol increases the risk of poor mental health and can lead to low mood and anxiety.

Using alcohol as coping mechanism was also prevalent during the COVID-19 pandemic. A survey commissioned by Alcohol Change UK found that, during the first six months of the COVID-19 pandemic, over half of drinkers (53%) drank alcohol to cope with sadness, anxiety, stress, worry, boredom or sleep problems. This was particularly prevalent in BAME survey respondents: 68% reported having consumed alcohol to cope with poor mental health, compared to 41% of people from white British backgrounds. (6)

Alcohol use disorders can also delay recovery from psychiatric conditions. (7) Alcohol use is also associated with poorer outcomes among people using mental health services, including tragic losses of life through suicide. (8)

Given this link between alcohol and poor mental health, it is important to address alcohol consumption in order to reduce the number of people who experience poor mental health. This can best be done through population prevention policies, including policies that reduce the affordability, promotion and availability of alcohol (further outlined below). In addition, more needs to be done to ensure that people with co-occurring mental health and alcohol problems can access and get the support they need (further outlined below).

(1) Institute of Alcohol Studies & Centre for Mental Health (2018). Alcohol and mental health. Policy and practice in England.
(2) Public Health England (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions; Public Health England (2016). Health matters: harmful drinking and alcohol dependence.
(3) Public Health England (2016). The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review; Moeller, F.G. & Dougherty, D.M. (n.d.). Antisocial Personality Disorder, Alcohol, and Aggression. National Institute on Alcohol Abuse and Alcoholism (NIAAA).
(4) Public Health England (2016). The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review.
(5) University of Stirling (2013). Health First: an evidence-based alcohol strategy for the UK.
(6) Alcohol Change UK (2020). Press release: over half of UK drinkers have turned to alcohol for mental health reasons during pandemic.
(7) Greenfield, T.K. *Individual Risk of Alcohol-Related Disease and Problems,* Chapter 21 in Heather N., Peter T.J., Stockwell T. (eds) (2001). International Handbook Alcohol Dependence and Problems, John Wiley & Sons Ltd, pp. 413–439.
(8) Public Health England (2016). Health matters: harmful drinking and alcohol dependence.

Do you have ideas for how employers can support and protect the mental health of their employees?

As outlined above, alcohol dependence and mental health are often co-occurring. However, while the Equality Act protects people with mental health conditions, people with alcohol dependence are specifically excluded from the protections. This means that employees may be reluctant to disclose their mental health condition to their employer, fearing it might lead to their alcohol problem being discovered and that that might lead to discrimination or dismissal. An Alcohol Change UK survey found that 43% of people feel confident their employer would support them if they disclosed a mental health problem, yet only 25% felt the same for an alcohol problem. (1)

The Equality Act protects people with certain characteristics, including disability against discrimination and ensures that they are treated fairly and equally by employers. Employers are required to offer reasonable adjustments to employees. Some people with alcohol dependence or a history thereof meet the definition for disability outlined in the Equality Act 2010 (a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities). However, as people with alcohol dependence are not protected by the Act, they can be dismissed due to their condition or not hired in the

first place, if they choose to disclose to their employer that they have or have had problems with alcohol.

To ensure people with alcohol dependence and/or co-occurring mental health conditions feel comfortable disclosing their conditions to their employees without having to fear negative repercussions, they should be included in the protections of the Equality Act. Employers should provide reasonable adjustments, such as allowing employees to attend treatment appointments or exempting employees from having to entertain clients at events where alcohol is provided.

The UK is an outlier in this area. Other countries, including Canada, the US, Australia and New Zealand, all provide protections for people with alcohol dependence in discrimination laws. Researchers from the University of Bedfordshire conducted a citizen's jury with Ipsos Mori which revealed that the majority of the jurors did not think alcohol dependence should be excluded from the Equality Act.

(1) Alcohol Change UK (2020). Press release: over half of UK drinkers have turned to alcohol for mental health reasons during pandemic.

What is the most important thing we need to address in order to prevent suicide?

The link between alcohol and suicide is well established. Suicide is associated with both long-term alcohol use as well as the immediate effects of drinking. (1) People who are alcohol dependent are 2.5 times more likely to die by suicide than the general population. (2) Moreover, in England nearly half (45%) of patients under the care of mental health services who die by suicide have a history of alcohol use. (3)

The relationship is complex and varies on numerous factors, including the way people drink. For example, heavy episodic drinking is associated with an increased likelihood of attempting suicide amongst adolescents. (4) Respondents to a recent survey by the Samaritans about alcohol and suicide echoed this: "When I was drinking, suicidal thoughts, attempts & self-harm were much more serious due to the effect the alcohol was having on my mind. I was much more of a danger to myself than when I was sober." (5)

The same survey found that people who had attempted suicide often felt dismissed or judged by healthcare staff due to drinking alcohol. (6)

In order to prevent suicide, alcohol use needs to be addressed too. It is imperative that alcohol and mental health services are better coordinated (also see our response below on co-occurring conditions), and that staff in healthcare settings are trained on the role alcohol can play in suicide attempts. Moreover, local suicide prevention plans should include action to address the links between alcohol use, deliberate self-harm, and deaths by suicide. (7)

(1) Conner, K. & Ilgen, M. (2016). 'Substance Use Disorders and Suicidal Behavior', in O'Connor, R. & Pirkis, J. (Eds.), The International Handbook of Suicide Prevention, 2nd Edition, 110-123.
(2) Darvishi, N. et al. (2015). 'Alcohol-Related Risk of Suicidal Ideation, Suicide Attempt, and Completed Suicide: A Meta-Analysis', PLOS ONE, 10(5), e01268705.
(3) The National Confidential Inquiry into Suicide and Safety in Mental Health. (2021). Annual Report: England, Northern Ireland, Scotland and Wales. University of Manchester.
(4) Schilling, E. et al. (2009). 'Adolescent alcohol use, suicidal ideation, and suicide attempts', Journal of Adolescent Health, 44(4), 335-341
(5) Samaritans (2022). Insights from experience: alcohol and suicide.
(6) Samaritans (2022). Insights from experience: alcohol and suicide.
(7) Institute of Alcohol Studies & Centre for Mental Health (2018). Alcohol and mental health. Policy and practice in England.

What more can the NHS do to help people struggling with their mental health to access support early?

Health care professionals, including GPs need to be better trained on the link between alcohol and mental health. GPs are one of the most common ports of call for someone with a mental health and/or alcohol problem, yet GPs are not required to screen for alcohol use when patients present with common mental health problems. Asking about a patient's alcohol use should be common practice and healthcare professionals need to take this into account.

How can we ensure that people with wider health problems get appropriate mental health support at an early stage if they are struggling?

44% of people in community mental health treatment and 85% of people in alcohol treatment have a dual diagnosis – meaning they have both mental health problems and a substance use problem. (1) This can make getting treatment very difficult, as it is often dependent on the person having recovered from one condition first. For example, the mental health service might not support a person until they have stopped drinking for a certain time; yet, the person's alcohol use might be caused by their mental health and they might not be able to stop drinking until they address their mental health. Rather than receiving appropriate support, people are being bounced between services despite being highly vulnerable. Our research confirmed this, finding that 84% of professionals from alcohol and mental health services, public health and other health services agreed that having an alcohol use disorder was a barrier to getting any kind of mental health support. (2)

The cost of this gap in provision is additional distress for individuals and those around them, as well as displacing the problem to other NHS and criminal justice services, which are ill-equipped to meet the person's needs.

Improved treatment pathways are needed, with integrated care for both mental health and alcohol. In 2017, then Public Health England published a guide for commissioners and service providers (3) to help improve pathways and outcomes, which put forward two key principles:

(1) ‘everyone’s job’: both commissioners and service providers should be responsible for providing services for people with a dual diagnosis or complex needs
(2) ‘no wrong door’: service providers should not turn away people with co-occurring conditions and treatment for any condition should be made available at every point of contact (ie ‘Making Every Contact Count’).

NICE quality statements published in 2019 reinforced these principles. (4) However, it is unclear how far they are being implemented and followed across the country.

(1) Care Quality Commission (2015). Right here, right now - The Recovery Partnership. State of the Sector 2015. The Recovery Partnership
(2) Institute of Alcohol Studies & Centre for Mental Health (2018). Alcohol and mental health. Policy and practice in England.
(3) Public health England (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions.
(4) NICE (2019). Coexisting severe mental illness and substance misuse.

What should be our priorities for future research, innovation and data improvements over the coming decade to drive better treatment outcomes?

More research is needed to determine the social and economic impact and costs of co-occurring mental health and alcohol problems and the cost-effectiveness of the current and alternative systems for prevention. (1) More research is also needed to determine the effectiveness of treatments, including pharmacological and psychological treatments, for people with dual diagnosis. (2)

(1) Institute of Alcohol Studies & Centre for Mental Health (2018). Alcohol and mental health. Policy and practice in England.
(2) Alcohol Change UK (2019). Rapid Evidence Review: The relationship between alcohol and mental health problems.

What more can we do to improve the physical health of people living with mental health conditions?
This will support our ambition to reduce the gap in life expectancy between people with severe mental illness and the general population

Given that alcohol use is so prevalent among people with mental health conditions, reducing people’s alcohol consumption will substantially benefit their physical health. Alcohol is linked to over 200 health conditions and injuries, including cancer, heart disease and stroke. (1) It is the leading risk factor of death for 15-49-year-olds in the UK. (2)

The most effective and cost-effective policies to reduce alcohol harm are policies to reducing the affordability, promotion and availability of alcohol, as recommended by the World Health Organization. (3) Alcohol’s affordability can be reduced through policies such as Minimum Unit Pricing – which has led to decreases in alcohol consumption in Scotland and Wales (4) – and a good alcohol duty system whereby all alcohol products are taxed according to strength and overall duty rates recover the costs of alcohol to the society and are linked to inflation. Furthermore,

comprehensive restrictions on alcohol marketing can help reduce alcohol consumption and harm, as can restrictions on availability through stronger licensing powers. The Office for Health Improvement and Disparities (then Public Health England) has published a thorough analysis of alcohol policies' effectiveness and cost-effectiveness. (5)

(1) World Health Organisation (September 2018). Fact sheets: alcohol.
(2) VizHub - GBD Results. (2019). Global Health Data Exchange, Institute for Health Metrics and Evaluation, University of Washington.
(3) World Health Organisation (2017). Tackling NCDs: "best buys" and other recommended interventions for the prevention and control of noncommunicable diseases.
(4) Anderson, P. et al. (2021) Impact of minimum unit pricing on alcohol purchases in Scotland and Wales: controlled interrupted time series analyses.
(5) Public Health England (2016). The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review.

What can we change at a system level to ensure that individuals with co-occurring mental health and drug and alcohol issues encounter 'no wrong door' in their access to all relevant treatment and support?
This includes people in contact with the criminal justice system.

As outlined above, people with co-occurring mental health and alcohol problems can find it very difficult to access treatment for either condition and often end up being bounced back-and-forth between services and ultimately unable to receive any support. The practice of employing alcohol use as a criterion which excludes people from accessing support for their mental health must end.

The chronic lack of connection and understanding between alcohol and mental health services has been exacerbated by cuts to alcohol services in particular. Financial pressures have led to local authorities recommissioning substance use services outside the NHS, at ever lower cost. This has fractured existing good working relationships and has eroded the capacity in the system for training and developing specialist workers in addictions. (1)

Research with people with self-harming behaviours and alcohol use found that people would hide their drinking in order to access services and not face stigma. (2) More training in alcohol issues for non-alcohol specialists is needed to prevent stigmatisation in these services.

A rapid evidence review from 2019 found that there is still a long way to go to address the issue due to a lack of uniformity in service delivery to support people with dual diagnosis, as well as inconsistencies in policy and guidance. The study recommends the development of a UK national policy framework for working with co-morbid mental health and substance use disorders. (3)

Moreover, the 'no wrong door' principle needs to be extended to include assertive outreach. The 'no wrong door' principle assumes that people will proactively engage with services. However, a study of military personnel found that only a third of those with an alcohol problem had sought support. (4) Assertive outreach, on the other hand, takes the service to the person in need. Alcohol Change UK's Blue Light

Project is an example of developing alternative care pathways for people who are not engaging with services on their own. (5)

With such significant cultural, structural and financial barriers to improved support for people with co-occurring alcohol and mental health issues, it is necessary to take action at every level and every opportunity to close the gap. This includes building the capacity of both the alcohol and mental health workforces to offer effective support and tackle stigma, as well as more integrated training for mental health professionals on alcohol issues. For example, Health Education England should provide placements for all trainee psychiatrists in addiction services. Moreover, priorities need to be set nationally for the provision and development of services, with clear messages about the imperative on both alcohol and mental health services to coordinate more effectively. To tackle stigma, the Department of Health and Social Care and the Office for Health Improvement and Disparities should commission a national anti-stigma campaign to dispel myths about people with co-occurring conditions. This should include specific work to address professionals' attitudes and behaviours alongside work targeting public opinion more broadly. (6)

Finally, to bring about significant and sustained improvement will require comprehensive action – including addressing the 'alcogenic environment' we inhabit, through policies reducing the affordability, promotion and availability of alcohol. We outline effective policies in our response above.

(1) Institute of Alcohol Studies & Centre for Mental Health (2018). Alcohol and mental health. Policy and practice in England.
(2) Chandler, A. & Taylor, A. (2021). Alcohol and self-harm: a qualitative study.
(3) Alcohol Change UK (2019). Rapid Evidence Review: The relationship between alcohol and mental health problems.
(4) FiMY (2020). New research finds that more than two thirds of serving or ex-Service personnel with a current or prior alcohol problem are not seeking help.
(5) Alcohol Change UK. The Blue Light Project.
(6) Institute of Alcohol Studies & Centre for Mental Health (2018). Alcohol and mental health. Policy and practice in England.

What do you think are the most important issues that a new, 10-year national mental health plan needs to address?

- wellbeing and health promotion
- **prevention**
- early intervention and service access
- treatment quality and safety
- quality of life for those living with mental health conditions
- crisis care and support
- **stigma**
- other – please specify

We believe prevention is important and needs to be included in the 10-year national mental health plan. Given the substantial link between alcohol and mental health, this needs to include policies to reduce alcohol consumption. As outlined above, the most effective policies to reduce alcohol harm include policies reducing the

affordability, promotion and availability of alcohol. To effectively reduce alcohol harm, a new mental health plan should be accompanied by a new comprehensive and evidence-based alcohol strategy, which includes policies in these areas. The last UK Government Alcohol Strategy is more than a decade old now – during this time, the harms from alcohol have continued to rise.

In addition, addressing stigma for co-occurring mental health and alcohol issues needs to be a priority. Both mental health and alcohol problems attract stigma. While progress has been made to destigmatise mental health problems, the stigma around alcohol remains very high: while 65% of people are sympathetic towards people with mental health problems, only 41% are sympathetic to people with alcohol problems. (1) This also impacts help-seeking behaviour: 69% of people feel confident that they would be supported by a GP for a mental health problem, compared to only 57% for an alcohol problem. (2)

(1) Alcohol Change UK (2020). Press release: over half of UK drinkers have turned to alcohol for mental health reasons during pandemic.
(2) Alcohol Change UK (2020). Press release: over half of UK drinkers have turned to alcohol for mental health reasons during pandemic.

How can we improve data collection and sharing to help plan, implement and monitor improvements to mental health and wellbeing?

More granular data is needed on race and ethnicity, as well as sexual orientation and gender identity, both in alcohol and mental health services, as well as in large-scale surveys. For example, data often groups all South Asian people together, although within that group there are very varied cultures and drinking practices. Research has also shown that LGBTQ+ people are a higher risk drinking group, and there is a mental health link too. (1)

Moreover, better data collection is needed on comorbidity/co-occurrence of alcohol use disorders and mental health conditions. A study that modelled the impact that changes in alcohol consumption during COVID will likely have in the long-term was not able to include any mental health conditions, because data on the epidemiological relationships and relative risks were lacking or not good quality enough.

(1) Institute of Alcohol Studies (2021). LGBTQ+ People and Alcohol.