# Men's Health Strategy 2025 call for evidence
## – Institute of Alcohol Studies response

### Understanding and identifying areas where we can improve support for healthier behaviours

*Please upload your contribution of data, research and other reports relevant to this topic of men's health: understanding and identifying areas where we can improve support for healthier behaviours.*

*We are particularly interested in:*

- *your insight into the factors driving behaviours posing a risk to health among men and boys*
- *your suggestions as to how to improve health-positive behaviours among men and boys*
- *any gaps in research and evidence*

*Please draw upon sex-related health inequalities in your response where possible.*

#### Response

In 2023, a record 10,473 people died from alcohol-specific causes in the UK.[1] 67% of these were men – 6,983 deaths. This is a rate of 21.9 per 100,000 compared to 10.3 among women, and is an all-time high. Despite men living in the most deprived areas drinking less alcohol, far more of them died from alcohol-specific causes in 2023. In England, 56% of all male alcohol-specific deaths in 2023 were among IMD Quintile 1 and 2 – so the two most deprived groups out of 5. The most deprived quintile accounted for 32% of the male deaths, compared to only 11% in the least deprived quintile.[2] Regarding hospital admissions, in England in 2023/24 there were 183,644 alcohol-related admissions among men (using the narrow measure) compared to 97,103 among women – so men accounted for 65% of admissions.[3] Using the broad measure, men accounted for 73% of the over 1 million alcohol-related hospital admissions.

Although alcohol deaths have increased across most age groups, the rise has been far steeper in older adults. For example, the alcohol-specific death rate among 60–64-year-old men increased by 65%, compared to 7% in 30–34-year-olds. This highlights a growing burden of alcohol harm in later life.

[1] Office for National Statistics (2025), Alcohol-specific deaths in the UK: registered in 2023.
[2] Office for National Statistics (2025), Alcohol-specific deaths in the UK: registered in 2023. Table 11: Age-standardised alcohol-specific death rates by deprivation quintile, England, 2018 to 2023 registrations.
[3] DHSC Alcohol Profile (2025), Admission episodes for alcohol-related conditions male and female.

Since the COVID-19 pandemic, deaths from alcohol have risen every single year, increasing by 38% across the UK from 2019-2023.[4] A recent study in The Lancet found that almost 4,000 additional deaths from alcohol have occurred since the pandemic, and that the largest increases were among men and people in the most deprived areas.[5]

In the UK, men are more likely to drink alcohol than women, to drink at higher levels, and to experience alcohol-related harm. The Health Survey for England 2022 found that: [6]

- 84% of men drink compared to 78% of women.
- 55% of men drink at least once a week, compared to 42% of women.
- 32% of men drink above the Chief Medical Officers' 14 unit low risk guidelines, compared to only 15% of women.
- 6% of men drink above 50 units a week, compared to 4% of women who drink over 35 units a week (the higher risk levels for each sex).
- Not only are there differences in sex but also regionally, with men living in the North East more likely to drink at increasing and higher risk levels – at 39%, compared to 25% in the East Midlands, which was the lowest prevalence.
- Despite drinking the least, people living in the most deprived areas experience more alcohol-related harms. 23% of men in the most deprived areas drank over 14 units a week, compared to 35% and 37% in the least and second least deprived quintiles.
- Finally, 16% of men compared to 9% of women are classified as being at increasing risk, higher risk, or possible alcohol dependence.

Although alcohol consumption data is collected and reported differently in different parts of the UK, the same pattern of men drinking more than women is seen in devolved nations.

Alcohol is the second leading cause of early death and disability among people aged 15-49, and the biggest risk factor for disability-adjusted life years.[7] Many of the effects of alcohol – including its impacts on cardiovascular disease, dementia, cancers, liver disease, mental health, and accidents and injuries – are experienced by both men and women, however men experience a greater degree of alcohol-related morbidity and mortality.[8] Some of the impacts are specific to men. For example, alcohol can cause sexual problems such as impotence and premature ejaculation.[9] There is evidence that alcohol may impair male fertility: a study of young men in Denmark found that habitually consuming five or more units (~7.5 UK units) per week was associated with reduced semen quality, with larger effects seen at higher levels of consumption.[10] Alcohol also has a significant influence on male mental health.

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[4] Office for National Statistics (2025), Alcohol-specific deaths in the UK: registered in 2023.
[5] Oldham, M., Jackson, S., Brown, J., Buss, V., Mehta, G., Dowd, J. B., ... & Angus, C. (2025). Trends in alcohol-specific deaths in England, 2001–22: an observational study. *The Lancet Public Health*, *10*(5), e371-e379.
[6] Health Survey for England 2022 Part 1 (2024), Adult drinking.
[7] DHSC (2025), Alcohol Profile.
[8] NHS (accessed June 2024). Alcohol misuse: risks.
[9] Ibid.
[10] Jensen TK, Gottschau M, Madsen JOB, et al (2014). Habitual alcohol consumption associated with reduced semen quality and changes in reproductive hormones; a cross-sectional study among 1221 young Danish men, *BMJ Open.*

There are many reasons for why men tend to drink more alcohol than women, covering biological, social, and cultural factors. Alcohol use and intoxication have long been associated with men and masculinity.[11] Numerous studies have examined the differences in drinking between men and women, and findings show high levels of acceptance for drinking and intoxicated behaviour in men. There is far less acceptance for such behaviour among women. Alcohol plays a central role in affirming masculinity and acts as grounds for male bonding and solidarity.[12] Over the last two decades, the notion of masculinity as a static attribute has been replaced by a more layered understanding of a multiplicity of masculinities.[13] Along with gender, many other factors influence men's experience of alcohol use, including their ethnicity and culture, age, sexual orientation, and socio-economic background.

Alcohol marketing and advertising plays, and has played, a major role in encouraging men to drink and in recruiting young men to start drinking. Regulations are currently self- and co-regulated by the Advertising Standards Authority and the alcohol industry trade body the Portman Group. Most of the regulations that exist predate the digital age, and the regulation of exposure to alcohol marketing online at all ages, including social media, is now seriously inadequate. Alcohol advertising works to develop a multifactorial relationship with consumers, enmeshing alcohol with positive environments, personal reward and identity capital.[14] Themes directed towards men in alcohol advertising include humour, relaxation, friendship, and masculinity, as well as sexual themes which often portray men exerting power over women.[15] These findings point to men's behaviour being influenced by exposure to alcohol marketing in a variety of ways: brand recognition, choice of beverage, increased level of alcohol consumption, and acceptability and normalisation of a set of behaviours associated with drinking. A review of how men are portrayed in alcohol marketing found that men are often type-cast into hypermasculine roles, such as athletes and pick-up artists.[16] In contrast to these figures is a 'loser', meaning someone who is in the precarious situation of having their masculinity diminished in light of humiliation by other men. This man is then 'rescued' by other friends, and alcohol is used as the glue for promoting solidarity and facilitating masculine bonding. Alcohol is also used as a prop to prevent male bonding from veering into the feminine. These images reinforce existing stereotypes about what it is that makes an 'ideal' man and ties up alcohol into this calculation. While there has been some evolution of the portrayal of gender and alcohol in advertising over time, there is one area where masculinity and alcohol remain consistently intertwined: sport. As with alcohol, masculinity also holds a strong connection to sport and the three remain highly interlinked.

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[11] Hunt, G., & Antin, T. (2019). Gender and intoxication: From masculinity to intersectionality. Drugs: Education, Prevention and Policy, 26(1), 70-78.
[12] Ibid.
[13] Emslie, C., Hunt, K., & Lyons, A. (2013). The role of alcohol in forging and maintaining friendships amongst Scottish men in midlife. Health Psychology, 32(1), 33.
[14] Scott, S., Muirhead, C., Shucksmith, J., Tyrrell, R., & Kaner, E. (2017). Does industry-driven alcohol marketing influence adolescent drinking behaviour? A systematic review. Alcohol and alcoholism, 52(1), 84-94.
[15] Noel, J. K., Babor, T. F., & Robaina, K. (2017). Industry self-regulation of alcohol marketing: a systematic review of content and exposure research. Addiction, 112, 28-50.
[16] Hall, G., & Kappel, R. (2018). Gender, alcohol, and the media: The portrayal of men and women in alcohol commercials. The Sociological Quarterly, 59(4), 571-583.

From our research with Scottish Health Action on Alcohol Problems, it is clear that there is a societal pressure on men to drink a certain way, with common tropes about drinking heavily being a 'masculine' pursuit.[17] The research found that there is no one way to tackle this, but that: "In order to expand the ways in which men communicate, express themselves, seek entertainment and connect with others, an environment must be fostered where this exploration can take place. This means, as a start, tackling social and economic inequality, breaking down gender stereotypes and providing alternatives to substance use." The findings identified topic areas that require further investigation to facilitate change, including research into masculine identities; normalisation of men's drinking and perceptions of masculinity and drinking; different cultural and ethnic groups and their experiences of discrimination, stigma, and access to services; and the intersection between alcohol use and mental health problems.

The research also recommended policy action that would reduce alcohol harm among men, including involving people with lived experience in the development and implementation of policies; population-level measures to reduce harm such as banning alcohol marketing, restricting alcohol's availability, introducing pricing measures such as minimum unit pricing and tax increases; and mandating alcohol labelling that include health warnings.

Decades of international evidence has highlighted the most effective way of reducing alcohol harm, which would improve health-positive behaviours among men and boys. The single most effective way would be to introduce minimum unit pricing (MUP) in England, following the lead of Scotland and Wales. Any strategy that intends to reduce alcohol-related harm among men will be of limited impact if it does not include action on low cost alcohol such as minimum unit price legislation. The final evaluation of MUP in Scotland – which was one of the most comprehensive policy evaluations in history – found that MUP reduced deaths from alcohol by 13.4%, with the largest reductions seen in men and the 40% most deprived areas.[18] Among men, deaths fell by 14.8% , and hospital admissions fell by 6.2% compared to likely trends without MUP.[19]

Measures on alcohol price should be introduced as part of a much more comprehensive strategy to reduce rising alcohol deaths among men, which would also include bans on alcohol marketing, a review into whether the Licensing Act is fit for purpose – and action to reduce alcohol's availability if it is not, as well as reducing the drink driving limit from 80mg of alcohol in 100ml of blood to 50mg. Improved access to and provision of alcohol treatment services would form a crucial part of this. These policy areas are explained in more detail in our next answer.

It is also important to consider alcohol use and its harms among men alongside other behavioural risk factors, such as smoking, gambling, and unhealthy eating. These risk factors compound each other, worsening the harms. And all of these are used more by men than

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[17] IAS and SHAAP (2020), Men and Alcohol: Key Issues.
[18] Public Health Scotland (2023), Evaluating the impact of minimum unit pricing for alcohol in Scotland: A synthesis of the evidence.
[19] Wyper, G. M., et al. (2023). Evaluating the impact of alcohol minimum unit pricing on deaths and hospitalisations in Scotland: a controlled interrupted time series study. The Lancet, 401(10385), 1361-1370.

women. 14% of men smoke cigarettes compared to 11% of women[20]; of the 50% of adults that have gambled in the past year, 55% were men[21]; and men are less likely to eat fruit and vegetables, and more likely to exceed red and processed meat guidelines, than women.[22]

## Improving outcomes for health conditions that typically, disproportionately or differently affect men

*Please upload your contribution of data, research and other reports relevant to this topic of men's health: improving outcomes for health conditions that typically, disproportionately or differently affect men. We are particularly interested in:*

- *your suggestions for improving health outcomes for men and boys, such as on mental health and suicide prevention, cancer and cardiovascular disease*
- *your views as to what extent services in these areas are currently meeting the needs of men*
- *your suggestions as to how services for health conditions that affect men can be improved to better meet their needs*
- *any gaps in data or evidence on these areas*

*Please draw upon sex-related health inequalities in your response where possible. Do not include any personal information in your response.*

### Response

Alcohol is associated with over 200 disease and injury conditions, and many of these disproportionately harm men and boys. Tackling alcohol harm needs to be at the heart of a men's health strategy The following demonstrates the inequalities in harm that men suffer regarding some of the leading alcohol-related harms, before we approach the solutions:

- **Liver disease**:
    - Alcohol causes around half of the 11,000 liver disease deaths in the UK each year.[23]
    - And of the 10,473 alcohol-specific deaths in the UK in 2023, half of those were due to alcohol-related liver disease among men (5,176).[24]
- **Cardiovascular disease**:
    - Alcohol causes high blood pressure which can lead to heart attacks and strokes.
    - Of the 980,000 alcohol-related hospital admissions in 2021 (broad measure), 45% of admissions were for cardiovascular disease – 435,180 admissions.[25]
    - Men are far more likely to be hospitalised for alcohol-related heart disease.

[20] NHS Digital, Health Survey for England, 2022 Part 1 (2024), Adults' health-related behaviours.
[21] NHS Digital, Health Survey for England, 2021 Part 2 (2023), Gambling behaviour.
[22] NHS Digital, Statistics on Obesity, Physical Activity and Diet, England, 2019.
[23] British Liver Trust (2025), Liver disease in numbers – key facts and statistics.
[24] Office for National Statistics (2025), Alcohol-specific deaths in the UK: registered in 2023.
[25] NHS Digital (2022), Statistics on Alcohol, England 2021: Alcohol-related hospital admissions.

    - A 2022 study by IAS estimated that if alcohol consumption did not return to 2019 levels, by 2035 there would be 99,000 more cases of hypertension and 20,000 more cases of stroke in England.[26]
- **Cancer**:
    - Alcohol causes at least 7 types of cancer, including two of the most common: breast and bowel – and bowel cancer is the most common alcohol-associated cancer among men.[27]
    - Of the 980,000 alcohol-related hospital admissions in 2021 (broad measure), 10% of admissions were for cancer – 93,380 admissions.[28]
    - The IAS study also estimated that if alcohol consumption did not return to 2019 levels, by 2035 there would be 19,000 additional cases of 6 alcohol-related cancers: breast, colorectal, liver, mouth, oesophageal, and throat.
- **Mental health and suicide**:
    - Alcohol exacerbates mental health problems such as anxiety and depression, and suicide and self-harm are more common in people with alcohol problems.[29]
    - In the UK, men account for three quarters of all suicides (in 2023: 4,506 male deaths, 1,563 female deaths) – a trend seen since the mid-1990s.
    - Between 2010 and 2020, 48% of people who died by suicide while under the care of mental health services had a history of alcohol use disorder.[30]
    - A 2022 meta-analysis found that alcohol use was associated with a 94% increase in the risk of death by suicide.[31]
        - A key risk factor was being younger, and a stronger link was found between people in the military.
        - A heavier pattern of drinking, both total amount and by frequency, was also a risk factor. In fact, heavier drinking was the most consistent risk factor for suicide.
    - Of the 980,000 alcohol-related hospital admissions in 2021 (broad measure), 23% of admissions were for mental and behavioural disorders due to alcohol – 227,910 admissions.[32]
- **Drink driving**:
    - There has been a significant increase in deaths from drink driving over the past two years, with 300 people dying in 2022, the highest number since 2009 and a 32% increase since 2012.[33]
    - Men are far more likely to be involved in drink driving collisions, with 79% involving a male driver or rider over the legal limit.[34]

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[26] Card-Gowers, J., Boniface, S., Brown, J., Kock, L., Martin, A., Retat, L., & Webber, L. (2025). Long-term health consequences and costs of changes in alcohol consumption in England during the COVID-19 pandemic. PloS one, 20(1), e0314870.

[27] CDC, Alcohol and Cancer (accessed July 2025)

[28] NHS Digital (2022), Statistics on Alcohol, England 2021: Alcohol-related hospital admissions.

[29] Royal College of Psychiatrists (2025), Alcohol, mental health and the brain.

[30] Medical Council on Alcohol (2024), Alcohol-Related Harms: A Health Service Response.

[31] Isaacs, J. Y., Smith, M. M., Sherry, S. B., Seno, M., Moore, M. L., & Stewart, S. H. (2022). Alcohol use and death by suicide: A meta-analysis of 33 studies. Suicide and Life-Threatening Behavior, 52(4), 600-614.

[32] NHS Digital (2022), Statistics on Alcohol, England 2021: Alcohol-related hospital admissions.

[33] Department for Transport (2024), Reported road casualties in Great Britain involving illegal alcohol levels: 2022.

- 68% of casualties in drink driving collisions were male in 2022.[35]
- The UK (excluding Scotland) has the highest drive driving limit in the whole of Europe.[36]

- **Violence and associated injuries**:
  - In 2022/23, 38% of all violent crimes occurred where the victim believed the offender(s) to be under the influence of alcohol.[37]
  - People from lower socioeconomic backgrounds are more likely to be victims of alcohol-related violence.[38]
  - Night-time economy violence has been found to "typically [involve] young males".[39]

The above demonstrates some alcohol-related harms that men face disproportionately. By reducing alcohol consumption, the health outcomes for men and boys regarding mental health and suicide prevention, cancer, and cardiovascular disease, as well as many other conditions, will be improved. As the call for evidence states 'prevention will always be better and cheaper than cure' – and there is a huge body of international evidence regarding how to reduce alcohol harm across a population. We recommend that the government is guided by the World Health Organization's SAFER initiative to reduce harm[40]:

[34] Department for Transport (2024), Reported road casualties in Great Britain involving illegal alcohol levels: 2022.
[35] Department for Transport (2024), Reported road casualties in Great Britain involving illegal alcohol levels: 2022.
[36] European Transport Safety Council, Blood Alcohol Content (BAC) Drink Driving Limits across Europe (accessed July 2025)
[37] Office for National Statistics (2024), Nature of crime.
[38] Bryant, L., & Lightowlers, C. (2021). The socioeconomic distribution of alcohol-related violence in England and Wales. *PLoS one*, *16*(2), e0243206.
[39] Finney, A. (2004). Violence in the night-time economy: Key findings from the research. London: Home Oice.
[40] World Health Organization (2025), The SAFER initiative.


**Raise prices on alcohol** through excise taxes and pricing policies:

- As mentioned in the previous answer, the single most effective way to reduce alcohol harm among men would be to introduce minimum unit pricing (MUP) in England to deal with the issue of low cost alcohol which is predominately consumed by the drinkers most at risk.
- Findings from Scotland show that MUP reduced deaths from alcohol particularly among men and those in the most deprived 40% as predicted by the modelling research which informed the policy.[41]
- England should introduce the policy at a rate of at least 65p and ensure it is increased each year in line with inflation, so that the effectiveness of the policy does not erode.
- The alcohol duty escalator should be reintroduced, increasing duty rates by 2% above inflation each year. Why this was in place, deaths fell.[42]

[41] Public Health Scotland (2023), Evaluating the impact of minimum unit pricing for alcohol in Scotland: A synthesis of the evidence.
[42] Lord Darzi (2024), Independent Investigation of the National Health Service in England.

- However, duty rates on off-trade products are still set far too low, so duty rates should be increased to ensure they cover the cost of alcohol harm – as IAS called for in its 2024 Budget Submission.
- Cider duty rates should be equalised with beer, as there is no rationale for having half the duty rate – this would help tackle strong, cheap ciders.

Enforce **bans** or comprehensive **restrictions on alcohol advertising, sponsorship, and promotion**:

- As discussed in the previous answer, alcohol marketing has for many years targeted men in its advertising campaigns, framing alcohol as an aspirational product that enhances masculinity, and contributing to increased drinking.
- Gendered engagement strategies are widely used to link alcohol to everyday gendered activities and identities to encourage alcohol purchase and consumption. This marketing normalises alcohol consumption and reproduces harmful gender norms and stereotypes.[43]
- Alcohol marketing has also been found to target young people, leading to them drinking from an earlier age and more when they do.[44]
- Marketing bans should at the very least cover sports sponsorship – due to the number of children that are exposed, digital marketing – due to the lack of regulatory control, and alcohol should be subject to the same advertising restrictions as those on HFSS food and drinks.

Strengthen restrictions on **alcohol availability**:

- Controlling alcohol availability is widely recognised as an effective measure to reduce alcohol-related harm. This can be achieved through various means, including restricting the number of licensed premises and reducing hours of sale.
- In England, alcohol outlet density increases with increasing neighbourhood deprivation. The most deprived 20% of postcodes have around 3 times as many outlets selling alcohol within walking distance of their centre as the least deprived 20%.[45]
- Shortly after the Licensing Act came, a study found that increased availability of alcohol led to an increase in emergency attendances at one of London's biggest hospitals.[46]
- The excessive availability of alcohol in the off-trade should be a policy priority, as it is the cheap, shop-bought alcohol that is driving increases in alcohol-related harm, particularly since the pandemic.

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[43] Lyons, A. C., Kersey, K., Emslie, C., Dimova, E., & Burrows, A. (2024). Digital alcohol marketing and gender: A narrative synthesis. *Drug and Alcohol Review*, *43*(6), 1361-1387.

[44] World Health Organisation Europe (2009), Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm.

[45] Angus, C., Holmes, J., Maheswaran, R., Green, M. A., Meier, P., & Brennan, A. (2017). Mapping patterns and trends in the spatial availability of alcohol using low-level geographic data: a case study in England 2003–2013. *International Journal of Environmental Research and Public Health*, *14*(4), 406.

[46] Newton, A., Sarker, S. J., Pahal, G. S., Van den Bergh, E., & Young, C. (2007). Impact of the new UK licensing law on emergency hospital attendances: a cohort study. *Emergency Medicine Journal*, *24*(8), 532-534.

- The Licensing Act 2003 should be reviewed to understand whether it is fit for purpose.
- At the very least, a fifth objective should be added to the licensing objectives, on 'protecting and improving public health', as Scotland has.

Advance and enforce **drink driving counter measures**:

- In 2021, the Parliamentary Advisory Council for Transport Safety made recommendations for how to reduce drink driving harm, after stating that the current system "is no longer adequate".[47] We support all of these recommendations, which would disproportionately prevent death and serious injuries among men:
    - a lower breath test limit for England and Wales – to at least match Scotland's limit of 50mg of alcohol in 100ml of blood
    - mandatory breath testing powers for the police and the reduction in enforcement levels to be reversed
    - increased penalties for drivers who combine drink and drugs
    - specialist rehabilitation courses for those with mental health and alcohol problems
    - reforming the High Risk Offender Scheme
    - that the Government pays more attention to drink driving in alcohol harm and night-time economy policies

Facilitate access to **screening, brief interventions and treatment**:

- We support the recommendations of the Medical Council on Alcohol from 2024, which advised on how to improve access and provision of alcohol treatment.
- The full recommendations are in our next response, and include:
    - A funded, **National Alcohol Strategy** focusing on the treatment and secondary prevention of alcohol dependence and alcohol-related harm in clinical populations across the health system. This is an essential part of addressing health inequalities, in addition to the primary prevention measures that tackle the affordability, availability and promotion of alcohol.
    - 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.
    - All local health systems must implement an **accelerated alcohol treatment pathway for alcohol dependent patients** with severe and life-threatening physical illnesses (e.g. decompensated liver cirrhosis) who are currently dying before they are able to access the treatment they need.
    - 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**.

[47] Parliamentary Advisory Council for Transport Safety (2021), Drink Driving: Taking Stock, Moving Forward.

- A consultant led multi-disciplinary **Alcohol Care Team** to improve quality of care, staff training and implementation of evidence-based management of alcohol use disorders, including alcohol withdrawal.
- **Rebuilding of the specialist workforce** (psychiatry, nursing, psychology, social workers) to enable the delivery of high quality specialist addiction services, development of the evidence base and training and advocacy across the health system.

## Men's access, engagement and experience of the health service

*Please upload your contribution of data, research and other reports relevant to this topic of men's health: improving men's access, engagement and experience of the health service. We are particularly interested in:*

- *examples of solutions that have improved men's engagement and experience of healthcare services*
- *recommendations for how healthcare services can improve how they engage men and the experience they offer*
- *any gaps in data or evidence*

*Please draw upon sex-related health inequalities in your response where possible. Do not include any personal information in your response.*

### Response

Academic literature suggests there are many reasons for why very few men with alcohol problems seek support, despite the disproportionate harm they experience.

A dominant barrier is **social stigma**. Men often fear being judged as weak or incapable if they admit to struggling with alcohol, particularly in cultures that prize stoicism and emotional self-sufficiency. This is reinforced by traditional masculine norms that discourage emotional disclosure and promote self-reliance. Research has shown that men – particularly young men – often interpret help-seeking as a threat to their identity, associating it with loss of control or dependency, or "out-group, female behavior."[48] Reinforcing this is the pervasive alcohol industry framing that alcohol harm is binary and that there are either 'responsible drinkers' or 'alcoholics', rather than seeing alcohol harm as existing on a spectrum. This framing often means that those who would benefit from seeking support do not do so because they do not see themselves as an 'alcoholic'.[49]

Similarly, **low perceived need for treatment** is also widespread. Many men do not view their drinking as problematic until it reaches a crisis point. Overall, around 80% of people

[48] Lynch, L., Long, M., & Moorhead, A. (2018). Young men, help-seeking, and mental health services: exploring barriers and solutions. *American journal of men's health*, *12*(1), 138-149.
[49] Oldroyd, C., Avades, T., Martin, G. P., Notley, C., & Allison, M. E. (2025). Motivation, self-efficacy, and identity—double-edged swords for relapse prevention in patients with alcohol related cirrhosis. *Alcohol and Alcoholism*, *60*(4), agaf027.

with a diagnostic criteria for alcohol use disorder (AUD) do not receive treatment.[50] In a US study of alcohol dependent people, nearly a quarter of male participants believed their alcohol problem would improve on its own, and 19% reported prior unsuccessful attempts to get help.[51] The same study found that 28% of men and women thought one should be able to handle it alone.

Additionally, **fear of giving up alcohol** itself presents a paradox: men may simultaneously recognise a need for support but fear the loss of a coping mechanism, identity, or social lubricant. The systematic review by May et al. (2019) identified this as a prominent psychological barrier, alongside shame and stigma.[52]

**Practical and structural barriers** also persist. These include lack of knowledge about services, limited availability of gender-sensitive support, and concerns over confidentiality. Some men distrust professionals or feel services are not relevant or welcoming to them. Prior negative experiences or a perception that "no one can help" are also deterrents.[53,54]

For young men in particular, **peer acceptance and cultural context** play a key role. Focus groups conducted in Ireland revealed that young men often feared homophobic reactions, held fatalistic views about mental health and substance use, and preferred to manage issues through substances like alcohol rather than engage with formal services.[55]

Addressing these barriers requires more than simply increasing availability of services. Services must be **accessible, relevant, and non-stigmatising**, and professionals should be trained to engage men sensitively. Early intervention, ideally integrated into community settings such as workplaces, youth services, or general practice, may help reduce stigma and encourage engagement. Gender-informed campaigns that normalise help-seeking and challenge harmful norms around masculinity could also help close the gap between the number of men who should seek support and those who do.

Alcohol Brief Interventions (ABIs), as implemented in Scotland's national programme, offer a proven, evidence-based approach to engaging men with health services in a way that is acceptable and effective. Delivered primarily in primary care settings, ABIs are short, structured conversations designed to prompt reflection and behaviour change around alcohol use. The Scottish programme demonstrated that ABIs can be rolled out at scale, with over 667,000 delivered in just eight years – most in GP settings where men may be more likely to attend for unrelated issues.[56] While sex-disaggregated data is not routinely available, men experience disproportionate alcohol-related harm, and the scale of delivery

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[50] Medical Council on Alcohol (2024), Alcohol-Related Harms: A Health Service Response.
[51] Gilbert, P. A., Pro, G., Zemore, S. E., Mulia, N., & Brown, G. (2019). Gender differences in use of alcohol treatment services and reasons for nonuse in a national sample. *Alcoholism: Clinical and Experimental Research*, *43*(4), 722-731.
[52] May, C., Nielsen, A. S., & Bilberg, R. (2019). Barriers to treatment for alcohol dependence. *Journal of Drug and Alcohol Research*, *8*, 236083.
[53] Lynch, L., (2018)
[54] Gilbert, P. A ,(2019).
[55] Lynch, L., (2018)
[56] Schölin, L., O'Donnell, A., & Fitzgerald, N. (2017). Financial incentives for alcohol brief Interventions in primary care in Scotland.

strongly suggests a substantial reach among them. The success of the programme rested on simple, opportunistic engagement – often as part of consultations for other health concerns – making ABIs a practical tool for improving men's experience of and engagement with preventative healthcare.

As mentioned in the previous answer, we fully support the recommendations of the Medical Council on Alcohol regarding how to improve alcohol treatment service access and provision. As men are far more likely to experience alcohol-related harm, these policy recommendations would disproportionality support men who are experiencing such harm.

The full recommendations are as follows:

**Macro**

- A funded, National Alcohol Strategy focusing on the treatment and secondary prevention of alcohol dependence and alcohol-related harm in clinical populations across the health system. This is an essential part of addressing health inequalities, in addition to the primary prevention measures that tackle the affordability, availability and promotion of alcohol.
- 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.

**Local Health Systems**

- Only 15-18% of patients with alcohol dependence are accessing community addiction services. 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.
- All local health systems must implement an accelerated alcohol treatment pathway for alcohol dependent patients with severe and life-threatening physical illnesses (e.g decompensated liver cirrhosis) who are currently dying before they are able to access the treatment they need.
- Involvement of people with lived experience of AUD/ARH in the development and review of alcohol treatment pathways across the health system as per (upcoming) UK clinical guidelines principles of treatment, and ACTION standards.
- 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.
- Each Local Authority should commission specialist inpatient alcohol treatment beds to provide timely access to acute treatment and divert people from unscheduled non-specialist acute care.

**Mental Health Services**

- Follow the NCISH recommendations that staff working in MH 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/ARH as part of the initial assessment.

**Acute Hospitals**

- Have a system for universal screening of alcohol consumption on admission which can provide 'real time' data to enable clinical staff to identify patients and manage alcohol dependence and alcohol-related harm at an early stage of their hospital admission.
- A consultant led multi-disciplinary Alcohol Care Team to improve quality of care, staff training and implementation of evidence-based management of alcohol use disorders, including alcohol withdrawal.

**Young Person's Services**

- Both addiction services and CAMHS to have access to inpatient medically assisted withdrawal from alcohol for young people with accelerating alcohol dependence and alcohol-related harm to access.

**Specialist Addiction Services**

- A requirement for each Regional Health System to provide access to specialist services at the requisite level and quality for the needs of their local population.
- Improve the links with and into community alcohol services and rebuild the quality of care delivered by them, based on the (upcoming) UK clinical guidelines for alcohol treatment.
- All specialist community services to have clear KPIs for alcohol treatment measures to drive improved quality.
- Rebuilding of the specialist workforce (psychiatry, nursing, psychology, social workers) to enable the delivery of high quality specialist addiction services, development of the evidence base and training and advocacy across the health system.

**Primary Care**

- Screening in primary care for problematic alcohol use and ARLD with a specific integrated pathway for alcohol treatment and liver monitoring to enable both referral to specialist addiction services and the early identification of ARLD.

**Workforce training**

- All health and social care professionals to have training in the identification of alcohol-related harm and AUD.
- All health and social care professionals working in services where there is a potential 'high risk' from 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.

**Involvement of Lived Experience**

- Given the normalisation of alcohol consumption in society, and the stigma enacted towards and felt by people with alcohol related harm, there is a great need to actively involve the recovery community, including lived experience recovery organisations (LEROs), in the design and delivery of training and service provision, and undergraduate medical education as part of 'humanising healthcare' in this area.

**Research**

- Prioritisation of clinical research into the most effective ways to manage comorbid alcohol dependence as part of a holistic treatment plan for people presenting with other physical and mental health conditions.