Introduction and reason for submitting evidence

The Alcohol Health Alliance UK (AHA) is an alliance of more than 60 non-governmental organisations working together to promote population-level evidence-based policies to reduce the harm caused by alcohol. Members of the AHA include medical royal colleges, charities, unions, treatment providers and other organisations that want to tackle alcohol harm.

Considering the close link between alcohol and mental health, we welcome the opportunity to respond to this consultation.

How far does the draft Bill deliver on the principles set out in the 2018 Independent Review? Does it reflect developments since? Is the Government right not to include the principles in the draft Bill?

Despite the Independent Review of the Mental Health Act 1983 recognising that alcohol and drug use and dependence play a major role in psychiatric presentations and ill-health,[1] the Draft Mental Health Bill does not do enough to prevent this significant contribution and support people with dual diagnosis.

In its logic model, the independent review identified "increased drug and alcohol use among patient population who are admitted" as one of eight proximal outcomes leading to the rising rate of detentions. The review stated that "as a minimum" patients should not be turned away from mental health services at crisis point because their ill-health was perceived to be substance induced, nor should those attending substance misuse services be turned away due to mental health problems.

Alcohol use increases the risk of mental health problems both through biological effects and through the negative social effects of having an alcohol use disorder (AUD).[2] At the same time, worsening mental health results in an increase in alcohol use and risk of AUD through using alcohol to cope.[3] There are common risk factors for alcohol use disorders and mental health problems e.g., exposure to traumatic events or childhood adverse events or genetic/environmental risks.[4]

Alcohol dependence can either exacerbate existing conditions or cause new issues to occur. 44% of people in Community Mental Health Treatment and 85% of people in alcohol treatment have a dual diagnosis of a mental health problem along with a substance use problem.[5] In 2014/15, English hospitals had over 200,000 admissions for mental and behavioural disorders due to alcohol use – this accounted for almost 19% of all alcohol-related hospital admissions.[6]

Research has also found a close relationship between alcohol, suicide, and self-harm: those who are dependent on alcohol are approximately 2.5 times more likely to die by suicide than the general population,[7] and over half of hospital presentations for self-harm involve alcohol use.[8] Alcohol use is

[1] Department of Health and Social Care. (2018). Modernising the Mental Health Act – final report from the independent review.
[2] Goodwin, L. (2022). AHA Seminar Session: Alcohol harm and ethnicity.
[3] Goodwin, L. (2022). AHA Seminar Session: Alcohol harm and ethnicity.
[4] Goodwin, L. (2022). AHA Seminar Session: Alcohol harm and ethnicity.
[5] Weaver T, et al. (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. *The British Journal of Psychiatry*.
[6] Public Health England. (2016). The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review.
[7] Samaritans. (2022). Insights from experience: alcohol and suicide.
[8] Ness, J. et al. (2015). Alcohol use and misuse, self-harm and subsequent mortality: an epidemiological and longitudinal study from the multicentre study of self-harm in England. *Emergency Medicine Journal.*

a risk factor for detention under the Mental Health Act and the Care Quality Commission identified an increase in harmful alcohol and substance use as a possible contributing factor in the 40% increase in detention that occurred between 2005/06 and 2015/16.[9]

Despite this known relationship, and the prominence of dual diagnosis, treatment for each condition is often dependent on a patient recovering from one condition first.[10] In a survey of alcohol and mental health practitioners carried out by the Institute of Alcohol Studies and the Centre for Mental Health, 84% of respondents believed that having an alcohol use disorder was a barrier to getting any kind of mental health support.[11] A rapid evidence review also found that the lack of uniformity in service delivery for people with dual diagnosis, and inconsistencies in regional and UK policy and guidance, mean there is still a long way to go to address this issue.[12]

Research has shown that treatment for alcohol problems and mental health problems must happen in parallel to improve outcomes.[13] There are significant barriers to integrating these services, including insufficient funding, workforce shortages, and stigma.[14] This situation has worsened since the Independent Review was published in 2018 as there have been continued cuts to alcohol and other drug treatment services. 54% of local authorities cut or froze their funding for drug and alcohol treatment services between 2019-2021, and 29% said this would continue into 2022.[15]

One of the four principles that the Independent Review recommended be enshrined in the Mental Health Bill is "the Person as an Individual - ensuring patients are viewed and treated as rounded individuals." This principle cannot be achieved without greater recognition and support for those with dual diagnosis within the Bill. In evidence to the Alcohol Harm Commission, Scottish Families Affected by Alcohol and Drugs explained that addiction and mental health services "bounce individuals backwards and forwards, claiming 'we can't treat your mental health if you are using substances' and vice versa."[16] Such an approach focuses only on an individual's condition rather considering the individual as a whole. This was further emphasised in an evidence session to the Commission, where addiction psychiatrist Dr Michael Kelleher noted:

> "Rather than being two conditions, they're one part of a whole part of an individual. So we see people who have social anxiety who drink when they're socially anxious and they detox, you detox them, and they're told they have to wait six months to get psychological therapy and the addiction services have no psychologists left."[17]

Are there any additions you would like to see to the draft Bill?

We want to see an addition to the Bill committing the Government to publish a strategy on mental health and substance use. The strategy must include a responsibility for commissioners and

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[9] Care Quality Commission (2018). Mental Health Act: the rise in the use of the MHA to detail people in England
[10] Care Quality Commission (2015) Right here, right now: People's experiences of help, care and support during a mental health crisis.
[11] Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.
[12] ACUK. (2019). Rapid Evidence Review: The relationship between alcohol and mental health problems.
[13] Foulds J. A., et al. (2015) Depression in patients with alcohol use disorders: Systematic review and meta-analysis of outcomes for independent and substance-induced disorders. *Journal of Affective Disorders*.
[14] Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.
[15] Movendi International. (2022). Cuts to mental health, addiction services put children at risk.
[16] Scottish Families Affected by Alcohol and Drugs, cited in Alcohol Harm Commission (2020) It's everywhere: alcohol's public face and private harm
[17] Dr Michael Kelleher, cited in Alcohol Harm Commission (2020) It's everywhere: alcohol's public face and private harm

providers to provide services for people with co-occurring mental health and substance use disorders as well as concrete national and local actions to address dual diagnosis including:

- Better training for healthcare professionals on the relationship between alcohol and poor mental health, including for GPs – who frequently see patients with mental health and/or alcohol problems. Compulsory placements for all trainee psychiatrists in addiction services.[18]
- Including actions to address the link between alcohol use and deliberate self-harm in local suicide prevention plans.[19]
- Screening for alcohol use when patients present with common mental health problems, taking into account a typical under-reporting of alcohol consumption by 40-45%.[20]
- A greater focus on needs-based treatment rather than diagnosis-led services. This has been proven to be more successful for those experiencing both self-harming behaviours and alcohol use.[21]

Public Health England guidance recommends two key principles to improve treatment pathways and outcomes for co-occurring mental health and alcohol and drug use.[22] Firstly, 'everyone's job' indicates that both commissioners and service providers should be responsible for providing services for people with a dual diagnosis or complex needs. Secondly, 'no wrong door' underlines that service providers should not turn away people with co-occurring conditions and that treatment for any of the conditions should be available at every point of contact, known as Making Every Contact Count. NICE quality statements have also reinforced these principles.[23]

Extra attention is needed to ensure services are accessible and effective across diverse populations. Racial and ethnic minority groups may be more likely to experience mental health and alcohol harms compared to White British groups drinking at the same level because those drinking harmfully are less likely to seek treatment, and experience poorer treatment outcomes.[24] Research has also demonstrated that LGBTQ+ communities tend to experience disproportionate mental health and alcohol harm.[25] Ethnic minority and LGBTQ+ groups were amongst those recognised in the Independent Review as facing barriers in accessing services, with the report noting that a varied offer of mental health services is critical to preventing crisis and detention.[26]

The persistent and widespread stigma attached to mental health issues and alcohol and other drug use must also be tackled. There is considerable stigma surrounding alcohol use. While 65% of people are sympathetic towards people with mental health problems, just 41% of people extend this to alcohol problems.[27] The underreporting of alcohol consumption[28] also indicates that stigma can

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[18] Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.
[19] Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.
[20] Public Health England (2018). The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review.
[21] ACUK. (2021). Alcohol and self-harm: A qualitative study.
[22] Public Health England. (2017). Better care for people with co-occurring mental health and alcohol/drug use conditions: A guide for commissioners and service providers.
[23] NICE. (2019). Coexisting severe mental illness and substance misuse.
[24] Gleeson et al. (2019). Rapid evidence review: Drinking problems and interventions in black and minority ethnic communities. Bayley, M. et al. (2010). Drinking patterns and alcohol service provision for different ethnic groups in the UK; a review of the literature.
[25] Dimova, E. et al. (2022). What are LGBTQ+ people's experiences of alcohol services in Scotland? A qualitative study of service users and service providers.
[26] Department of Health and Social Care. (2018). Modernising the Mental Health Act – final report from the independent review.
[27] ACUK. (2020). Press release: Over half of UK drinkers have turned to alcohol for mental health reasons during pandemic.
[28] ACUK. (2009). Off Measure: How we underestimate the amount we drink.

originate from service professionals and create barriers to accessing support. More training in alcohol issues for non-alcohol specialists is needed to prevent stigmatisation in these services, as well as anti-stigma campaigns for both public and practitioner audiences to reduce the normalisation of alcohol as a form of self-medication for dealing with stress and distress.[29]

In terms of preventative strategies, reducing alcohol consumption would have a large benefit on peoples' physical and mental health. There is a wealth of evidence on the most effective policies for reducing population-level alcohol consumption, including restrictions on marketing, pricing measures such as minimum unit pricing and alcohol duty reform, increased treatment funding and training for professionals, and restrictions on availability through stronger licensing powers. Public Health England published a thorough analysis of alcohol policies' effectiveness and cost-effectiveness,[30] reflected in the World Health Organisation's 'best buys.'[31]

[29] Institute of Alcohol Studies and Centre for Mental Health (2018). Alcohol and mental health: Policy and practice in England.
[30] Public Health England. (2016). The public health burden of alcohol: evidence review.
[31] World Health Organisation. (2017). Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases.