Men's Health Strategy for England: call for evidence

Alcohol Health Alliance submission

Deadline: 17 July 11.59pm

Questions for organisations

In what capacity are you responding to this survey? Please choose one capacity in which to complete the survey from this list:

- an individual sharing my personal views
- a health or social care professional
- an academic
- responding on behalf of an organisation (such as a local authority, employer, research institution, charitable organisation or a social care provider)

Please note that all respondents must be 16 and over to participate in this survey.
Does your organisation operate or provide services in England?

- yes
- no

What is the name of the organisation you are responding on behalf of?
Alcohol Health Alliance

What type of organisation are you responding on behalf of?

- business
- not for profit organisation
- academic institution
- public sector body
- other, please specify

Men's health topics

There are many topics that relate to men's health, either directly or indirectly. Which of the below topics, if any, do you think it is most important for the Men's Health Strategy to consider? (Optional)

Please select up to 5 topics that you think are most important. You can also provide your own suggestion by selecting 'other'.

- access to services
- alcohol
- atrial fibrillation (a type of heart rhythm problem)
- autism and neurodiversity (such as attention deficit hyperactivity disorder and dyslexia)
- cancers typically affecting men (prostate, testicular and penile cancer)
- conditions that affect your joints, bones and muscles (such as arthritis)
- dementia
- diabetes
- diet
- disability
- experience of healthcare
- fatherhood
- gambling
- governance and accountability
- health literacy
- health screening services
- healthy relationships

- heart disease and stroke
- high blood pressure
- high cholesterol
- inequalities
- injuries and risk taking
- loneliness
- masculinity
- mental health (including stress and anxiety)
- neurological conditions (such as epilepsy or Parkinson's disease)
- physical activity or inactivity
- research and data
- sexual health
- smoking
- substance misuse
- suicide prevention
- training and education for healthcare professionals
- weight
- other cancers (such as bowel and lung cancer)
- other (please specify)

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.
Do not include any personal information in your response.
Upload Word document file [maximum 10 pages].

In England, alcohol is the biggest risk factor for disability-adjusted life years among males aged 15-49,[1] playing a causal role in over 200 different diseases and injuries. These include some of the biggest killers: cancer, cardiovascular disease, mental ill-health and suicide.[2] The only major disease where death rates are rising – liver disease – also disproportionately affects men. In the last 50 years, liver disease deaths in the UK have quadrupled. Almost half of all liver disease deaths occur in midlife (aged 45-64) and men are twice as likely to die from the disease than women.[3]

Historically, drinking has been far more of a social norm for men until recent years than for women, particularly heavy drinking where the amount a man can drink has sometimes been positioned as an indicator of their masculinity. As a result, men experience a significantly greater degree of alcohol-related morbidity and mortality:[4]

- 84% of men drink compared to 78% of women.[5]
- Almost a third (32%) of men drink at levels that put them at increasing risk or higher risk of alcohol-related harm (over 14 units in the last week).[6]

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[1] Institute for Health Metrics and Evaluation (2021) Global Burden of Disease (GBD) study
[2] World Health Organization (2024) Alcohol. NHS (accessed June 2024). Risks: Alcohol misuse
[3] British Liver Trust (Accessed 2025) Liver disease in number – key facts and statisticsv
[4] Office for National Statistics (2025) Alcohol-specific deaths in the UK: registered in 2023
[5] Health Survey for England 2022 Part 1 (2024) Adult drinking.
[6] Health Survey for England 2022 Part 1 (2024) Adult drinking.

- In 2023/24 there were 748,350 hospital admissions among men for alcohol-related conditions (compared to 270,636 hospital admissions among women).[7]
- Across England, the rate of deaths from alcohol are double for males compared to females.[8]
- There are also higher rates of alcohol dependence among men than women.[9]
- Trends have escalated in recent years: deaths from alcohol have increased by 42% in England from 2019-2023.[10] 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.[11]

Factors driving alcohol consumption include the affordability, availability, and promotion of alcohol, and the cultural normalisation of drinking that presents it as a means of coping with stress and poor mental health, celebration, and everything in between.

Reducing harm associated with alcohol therefore requires both upstream prevention policies at the population-level that reduce overall alcohol consumption, as well as bolstering and improving alcohol treatment and mental health services. These actions (expanded on in the second question response) would directly support the Government's aims to shift from treatment to prevention, and address inequalities across gender, deprivation, and region.

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.
Upload Word document file [maximum 10 pages].

Action on alcohol harm would reduce the prevalence of the following health conditions that disproportionately affect men:

Alcohol use disorder

- 16% of men compared to 9% of women are classified as being at increasing risk, higher risk, or possible alcohol dependence.[12]
- Overall, only 22% of those in need of treatment are currently able to access it.[13]
- Investment in alcohol treatment is absolutely necessary to reduce the large level of unmet need and improve outcomes. Alcohol treatment provides very good value for money: in

[7] Department of Health & Social Care (2025) Alcohol profiles
[8] Office for National Statistics (2025) Alcohol-specific deaths in the UK: registered in 2023
[9] Public Health England (2016) Health matters: harmful drinking and alcohol dependence.
[10] Office for National Statistics (2025) Alcohol-specific deaths in the UK: registered in 2023.
[11] Oldham, M. et al. (2025) Trends in alcohol-specific deaths in England, 2001–22: an observational study. *The Lancet Public Health*, *10*(5), e371-e379.
[12] Health Survey for England 2022 Part 1 (2024) Adult drinking
[13] National drug treatment monitoring system (Accessed July 2025) Community adult profiles

England, every £1 invested in alcohol treatment is predicted to yield £3 of social return, increasing to £26 over 10 years.[14]

- **We support the recommendations made by the Medical Council on Alcohol from 2024 regarding how to improve access and provision of alcohol treatment, which include:[15]**
    - Each Regional/National Health Board to have 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.
    - 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.

Mental health and suicide:

- Alcohol both causes and contributes to mental health issues, and alcohol dependence often co-occurs with other mental and physical health conditions.
- Men are less likely than women to seek and receive help for mental health problems and this plays a role in the use of substances, such as alcohol, as a coping mechanism.[16]
- Alcohol use worsens mental health problems such as depression, self-harm, and suicide.[17]
- Those with an alcohol dependency are 2.5 times more likely to die by suicide than the general population, and nearly half of all patients under the care of mental health services who die by suicide have a history of alcohol use.[18]
- Men are disproportionately burdened: there were 154,255 admissions for mental and behavioural disorders due to use of alcohol among men in 2023/24, compared to 64,336 among women.[19]
- In a survey carried out by the Samaritans, many people felt that healthcare services struggled to understand the complex and personal relationships between alcohol and suicide, processes that ultimately excluded them from the support they needed.[20]
- People described using alcohol as part of suicide attempts, and some experienced not being taken seriously or being dismissed by healthcare staff because they had used alcohol.[21]
- **In addition to the above measures, all ICBs should include a recognition and response to how to integrate the management of alcohol dependence within their suicide prevention strategies.[22]**

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[14] Public Health England (2018) Alcohol and drug prevention, treatment and recovery: why invest?.
[15] Medical Council on Alcohol (2024) The need for a health system response for alcohol-related harms
[16] Smith, D. T. et al. (2018) Reviewing the Assumptions About Men's Mental Health: An Exploration of the Gender Binary. *American Journal on Men's Health*
[17] Royal College of Psychiatrists (2021) Alcohol and depression.
[18] Darvishi, N. *et al*. (2015) Alcohol-Related Risk of Suicidal Ideation, Suicide Attempt, and Completed Suicide: A Meta-Analysis. *PLOS ONE*.
[19] Department of Health & Social Care (2025) Alcohol profiles
[20] Samaritans (2022). Insights from experience: alcohol and suicide.
[21] Samaritans (2022). Insights from experience: alcohol and suicide.
[22] Medical Council on Alcohol (2024) The need for a health system response for alcohol-related harms

Cancer:

- Alcohol has been classified as a Group 1 carcinogen, with even small amounts of alcohol increasing the risk of developing cancer.[23]
- In the UK, 4% of cancer cases were linked to alcohol consumption, equating to 16,800 cases.[24] Among men, alcohol is the fourth-largest contributor to cancer in 2022 in England.[25]
- Alcohol is causally linked with at least eight cancers, including mouth, throat, oesophagus, liver, and colon, which are more common among men than women.[26]
- In addition to these eight cancers, research indicates that alcohol intake, especially heavy episodic drinking, may also be associated with increased risk of prostate cancer, and prostate cancer lethality.[27]
- There is also a strong shared association between drinking and smoking, with people who are more dependent on alcohol are also more dependent and heavier smokers.[28] Drinking alcohol and smoking tobacco simultaneously increases the risk of preventable cancer, particularly of the upper aerodigestive tract and liver cancer for men.[29]
- Alcohol use is therefore one of the most important preventable risk factors for male cancers.[30]
- Despite this, the British public are largely unaware of carcinogenic effects of alcohol – only 1 in 3 people link alcohol and cancer. Just half of people linked alcohol with mouth and throat or colon and rectal cancer when prompted.[31]
- **Population level policy solutions that would reduce overall alcohol consumption would also reduce the risk of cancer.** For example, World Health Organisation modelling has estimated that by doubling the 2021 alcohol duty rates, the UK could potentially avoid more than 1,800 avoidable cancer cases (10.9% of new cases) and 680 avoidable deaths (10.9% of deaths).[32]
- **Additionally, more needs to be done to increase people's awareness of the cancer harms linked to alcohol so that they can make informed decisions about their health.** One option for this is to introduce a mandatory cancer warning on alcohol product labels,[33] as indicated in the recent 10 Year Health Plan for England.[34]

Cardiovascular disease and diabetes

- Alcohol causes high blood pressure which can lead to heart attacks and strokes.

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[23] World Health Organisation (2023). No level of alcohol consumption is safe for our health.
[24] Rumgay, H. et al (2021). Global burden of cancer in 2020 attributable to alcohol consumption: a population-based study. *The Lancet Oncology*.
[25] Office for Health Improvement & Disparities (Accessed August 2023) Local Alcohol Profiles for England - Hospital admissions due to alcohol.
[26] Rehm, J. et al. (2020) Alcohol consumption. A leading risk factor for cancer. *Chemico-Biological Interactions*. https://www.iarc.who.int/news-events/new-study-links-alcohol-consumption-to-increased-risk-of-pancreatic-cancer/
[27] Macke AJ, Petrosyan A (2022) Alcohol and Prostate Cancer: Time to Draw Conclusions. *Biomolecules*.
[28] John, U. et al. (2003). Strength of the relationship between tobacco smoking, nicotine dependence and the severity of alcohol dependence syndrome criteria in a population-based sample. *Alcohol.*
[29] *Schütze*, M. (2011) Alcohol attributable burden of incidence of cancer in eight European countries based on results from prospective cohort study. *British Medical Journal.*
[30] American Cancer Society. Alcohol use and cancer website. Accessed October 31, 2022.
[31] Alcohol Health Alliance (2018) How we drink, what we think: Public views on alcohol and alcohol policies in the UK.
[32] Kilian et al. (2021). Modelling the impact of increased alcohol taxation on alcohol-attributable cancers in the WHO European Region. *The Lancet Regional Health – Europe*.
[33] WHO Regional Office for Europe (2020) Alcohol and cancer in the WHO European region: an appeal for better prevention.
[34] Department of Health and Social Care (2025) 10 Year Health Plan for England: fit for the future.

- In 2023/24, there were 396,688 male admissions for alcohol-related cardiovascular disease (compared to 73,133 female hospital admissions) – meaning 53% of alcohol-related hospitalisations were for cardiovascular disease.[35]
- Increased high-risk drinking since the COVID-19 pandemic will only exacerbate this: A 2022 study by the Institute of Alcohol Studies 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.[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]
- **Licensing restrictions are directly linked to overnight alcohol-related attendance in hospital.[40] The Licensing Act 2003 should be reviewed to check it remains fit for purpose two decades on.**

By reducing overall alcohol consumption, these health outcomes will be improved. Decades of evidence indicates that the following policies are the most cost-effective options in reducing population level consumption:

Pricing policies

- The final evaluation of minimum unit pricing (MUP) in Scotland (one of the most comprehensive policy evaluations in history) found that the policy was effective in reducing alcohol-specific deaths amongst men, particularly those in the most deprived areas.[41]
- **England should introduce MUP 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 RPI +2% every year.** When this was in place between 2008 and 2013/14, deaths from alcohol-related liver disease fell.[42]
- Ensure alcohol duty is targeted at products sold in shops and supermarkets which have become increasingly more affordable in recent years.
- End cider exceptionalism by increasing cider duty rates so they begin to equalise with that of beer of the same strength (ABV).

Marketing restrictions

- Alcohol marketing and advertising plays, and has played, a major role in encouraging men to drink and in recruiting young men to start drinking. The evidence shows that exposure to

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[35] Department of Health & Social Care (2025) Alcohol profiles
[36] Card-Gowers, J. et al. (2025). Long-term health consequences and costs of changes in alcohol consumption in England during the COVID-19 pandemic. PloS one, 20(1), e0314870.
[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] Newton, A. et al. (2007). Impact of the new UK licensing law on emergency hospital attendances: a cohort study. Emergency Medicine Journal
[41] Public Health Scotland (2023) Evaluating the impact of minimum unit pricing for alcohol in Scotland: A synthesis of the evidence.
[42] Alcohol Health Alliance (2024) AHA Budget Submission Autumn 2024.

alcohol marketing causes young people to start drinking at an earlier age, and drink more when they do.[43]

- Regulations are currently self- and co-regulated by the Advertising Standards Authority and the alcohol industry trade body the Portman Group. Research from a variety of countries suggests that industry codes are subject to under-interpretation and under-enforcement, and they are regularly violated. We know these don't work because of the high levels of exposure to alcohol marketing amongst children and young people.[44]
- Most of the codes also exist predate the digital age, meaning that there is a vacuum of rules when it comes to mediums such as social media.
- **At the very least, the HFSS food and drink advertising restrictions should be expanded to cover alcohol. Restricting sports sponsorship is also critical, due to the number of children that are exposed to this type, as is digital marketing, due to the lack of regulatory control.**
- Several European countries already have alcohol marketing restrictions in place, especially around sports sponsorship by alcohol companies, including France, Norway and the Republic of Ireland.[45]

Availability

- In England, alcohol outlet density increases with 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%.[46]
- The alcohol landscape has changed considerable since the Licensing Act was introduced in 2003. More people are drinking in the off-trade than the on-trade by a wide margin, with 73% of all alcohol consumed done so off premises, compared to 27% in pubs, bars and restaurants. The rise in online sales and rapid delivery services has added fuel to the fire by fast-tacking access to alcohol, making it easier for people to drink more than they'd planned to, and posing added risks to those who are already intoxicated, underage, or alcohol dependent. **The Licensing Act should therefore be reviewed to understand whether it remains fit for purpose.**
- **At a minimum, a fifth objective should be added to the licensing objectives, on 'protecting and improving public health'**, as Scotland has. This would empower local communities to review alcohol licenses based on health evidence and potential impact, as it's backed by 66.7% of the public and 89% of Directors of Public Health.

Drink driving

- **We support the Parliamentary Advisory Council for Transport Safety recommendations for reducing drink driving, which include:**
    - 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

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[43] Jernigan, D. et al. (2017) Alcohol marketing and youth alcohol consumption: A systematic review of longitudinal studies published since 2008. *Addiction*

[44] Noel, J. K. & Babor, T. F. (2017) Does industry self-regulation protect young people from exposure to alcohol marketing? A review of compliance and complaint studies. *Addiction*. Noel, J. et al. (2017). Alcohol industry self-regulation: who is it really protecting? *Addiction*. Noel, J. K. et al. (2017). Industry self-regulation of alcohol marketing: a systematic review of content and exposure research. *Addiction*

[45] Institute of Alcohol Studies (2020) Alcohol and Marketing

[46] Angus, C. et al. (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.

- 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

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.

Upload Word document file [maximum 10 pages].

Men using health services less than women has an evident impact on their health outcomes in relation to alcohol. The harms from alcohol often accumulate over a long period of time. Less engagement with health services means that there are fewer opportunities for screenings and interventions in the early stages of alcohol harm. In turn, this means that conditions will only be identified when they are already at a serious stage.

There are, however, several points when the AUDIT tool (which picks up 90% of patients with an alcohol problem) could be utilised when patients do interact with health services, e.g., as part of new patient assessments, chronic disease reviews, or as a self-assessment while people are waiting for A&E.[47]

With liver disease a significant cause of early mortality in men, and early diagnosis at an asymptomatic stage is crucial to improving survival figures, rolling out technology that measures liver health (e.g., FibroScans) could also increase the number of men accessing alcohol treatment and supporting positive behaviour change to reduce harmful drinking behaviour. These scans are a simple and non-invasive procedure that gives an assessment of liver health. The equipment is portable and can be used in outreach activities to reach people who have not previously engaged in treatment but who are at higher risk. An 8-month pilot for the use liver scans in Leicester City found that:[48]

- Individuals were more willing to engage with these checks as the procedure is not invasive. Results are instant which is viewed positively by patients, and attendance for these appointments is high compared to other interventions.
- This work engaged higher rates of older patients and patients with co-morbidities (most commonly obesity).
- This technology can detect early liver damage and opens the door to behaviour change, discussion regarding the risks of drinking, and referrals to treatment services.

The following case study underlines the potential impact of these scans:[49]

[47] Turning Point (2023) A sobering thought: the scale of alcohol harm and what we can do about it
[48] Turning Point (2023) A sobering thought: the scale of alcohol harm and what we can do about it
[49] Turning Point (2023) A sobering thought: the scale of alcohol harm and what we can do about it

John (not his real name) entered treatment with Turning Point in early 2023 and was initially ambivalent towards his alcohol use and subsequent treatment.
He had been drinking regularly since aged 13 but experienced a dramatic increase after his divorce around the age of 35. Since his divorce, John had been living with his mum who has since died.

John was clinically overweight and suffered from arthritis, diabetes, insomnia, high blood pressure and high cholesterol. As a result, he was prescribed multiple medications including blood thinners for complications with his heart and stomach.
Upon initial assessment John stated he had consumed alcohol every day for the last 28 days. His average day would begin with a drink at 10am and he would continue to drink throughout the day. John's drinking would impact his social life, where he would regularly cancel appointments in order to continue drinking

Despite this, John maintained drinking was not problematic, and that he "didn't feel guilty about his drinking" as he had not "been injured as the result of my drinking in the last twelve months."

After assessment, John attended 1:1 sessions and was scheduled for a FibroScan. John met regularly with a wellbeing nurse to whom he reported to be drinking 161 units per week. John's FibroScan results evidenced liver stiffness and showed signs of liver decompensation (when scarring becomes so severe that the liver starts to fail, and complications develop). He was consequently referred to Hepatology and recommended to emergency services if escalation of his symptoms occurred.

The result of the FibroScan served as a wake-up-call for John regarding the real damage alcohol was causing to his body and served as motivating factor behind his application for detox and rehab (which was approved in June 2023).

Since then, John has managed to reduce his alcohol intake from 161 to 110 units per week. Although John's drinking is still high, he is making real progress towards addressing his alcohol consumption. John attributes his change in attitude towards alcohol and treatment to FibroScan and his wider wellbeing support package.

As outlined in the previous answer, we fully support recommendations made by the Medical Council on Alcohol to improve the health service response to alcohol harm. These are as follows:[50]

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

[50] Medical Council on Alcohol (2024) The need for a health system response for alcohol-related harms

- 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.

Final question: submitting further evidence

You will be asked whether there is anything else you would like to share as part of this call for evidence. This can be regarding any topic that relates either directly or indirectly to men's health. You will be given the option to upload a file if you prefer.