

ALCOHOL AND MENTAL HEALTH

Policy and practice in England

APRIL 2018



IAS Institute of
Alcohol Studies

Centre for
Mental Health



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FOREWORD BY LORD BROOKE OF ALVERTHORPE

Alcohol harm and mental health are two issues I have campaigned on a great deal in my time in the House of Lords. Indeed, these subjects share a great deal of common ground, perhaps most notably the stigma surrounding both issues that many have worked tirelessly to shake. However, these issues are rarely considered together, in policy or the public consciousness. For this reason, this report from the Institute of Alcohol Studies and Centre for Mental Health is so necessary.

Alcohol use disorders have been linked with a range of mental health difficulties, including depression and bipolar disorder. We know alcohol is used as a coping mechanism by many to handle mental health problems. Despite these links, alcohol and mental health services are struggling to meet the needs of those with co-morbid alcohol and mental health problems. This situation is worsened as government policies on alcohol and mental health in England are so often developed in isolation from one another.

Stories from service workers and those in the alcohol and mental health fields paint a picture of a lack of joined-up action and service users falling through cracks. The results presented in this report suggest that those with co-morbid conditions are struggling to access treatment, and that funding shortages, a lack of crosstalk between mental health and alcohol services, workforce shortages and the stigma facing people with comorbid problems all serve to place further barriers ahead of them.

The recommendations presented in this report offer government a clear and effective plan of action that can begin to remedy the problems this work has highlighted. It is clear that urgent action must be taken; we cannot continue to fail those who need support in this way.

Lord Brooke of Alverthorpe

April 2018



EXECUTIVE SUMMARY

Many people who misuse alcohol also have a mental health difficulty, and many people with mental health problems also misuse alcohol. Yet few get effective help from either alcohol or mental health services.

National policies relating to alcohol make scant reference to mental health, while national mental health policies pay little regard to alcohol. Guidance documents for both recommend integrated help for people with co-occurring difficulties but there is no strong incentive to implement this approach in practice.

The Institute of Alcohol Studies and Centre for Mental Health jointly surveyed people working in alcohol and mental health services to understand current provision and the barriers to effective help. We also co-hosted a seminar for experts in both fields and reviewed current policies and guidance in each.

Our survey found that most staff, in both alcohol and mental health services, felt that support for people with co-occurring conditions was poor. Support for homeless people was consistently the biggest area of concern. Our survey also found that trust and understanding between alcohol and mental health services were weak. Alcohol service staff were, however, overall more critical of mental health services than vice versa. Barriers to greater integration included funding and workforce shortages (especially in alcohol services through lack of training), and the stigma facing people with co-occurring conditions. These findings were echoed in the seminar.

Improving support for people with co-occurring conditions will require action at every level, from national policy to local service delivery. It needs concerted action where possible to prevent co-occurring problems in the first place, alongside continued effort to challenge stigmatising attitudes and build the capacity of the workforce in both services to identify and meet people's needs more effectively.

We recommend:

The UK Government should urgently develop a comprehensive alcohol strategy and commit, alongside NHS England, to a second Five Year Forward View for Mental Health.

The alcohol strategy should include both population level measures to address alcohol harm (including on price, marketing and licensing) and service level action to ensure more people get effective joined-up help. The strategy should include specific commitments regarding alcohol's role in mental health problems and the difficulties faced by those with co-morbidities. The Five Year Forward View for Mental Health should include action to address the relationships between alcohol and mental health, including access to effective help for people with co-occurring conditions.

This report has also identified further recommendations, relating to specific aspects of mental health and alcohol policy and practice. These recommendations should be enacted urgently and continued action on these should be covered within the alcohol strategy and Five Year Forward View previously discussed:

- ▶ The Department of Health and Social Care, NHS England and Public Health England should urgently review the funding of addiction services and the provision of support to people with co-occurring mental health conditions.
- ▶ Sustainability and Transformation Partnerships and emergent Integrated Care Systems should develop plans for improved support for people with co-occurring mental health and alcohol problems. These should bring together the commissioners and providers of relevant services and those using them to agree plans for developing integrated support.
- ▶ Local suicide prevention plans should include action to address the links between alcohol misuse, deliberate self harm, and deaths by suicide.
- ▶ Health Education England should ensure that all trainee psychiatrists receive training and undertake placements in addiction services (which could include those in the voluntary sector).
- ▶ Alcohol liaison services in general hospitals should seek to identify people who are misusing alcohol and refer them to appropriate support from local services.
- ▶ The Improving Access to Psychological Therapies (IAPT) programme nationally, and CCGs in local areas, should ensure that people with co-occurring alcohol difficulties are not excluded from psychological therapy services.
- ▶ The Department of Health and Social Care and Public Health England should commission a national anti-stigma campaign to dispel myths about people with co-occurring problems, including specific work to address professionals' attitudes and behaviour alongside work targeting public opinion more broadly. This should be combined with efforts to reduce the 'normalisation' of alcohol as a form of self-medication for dealing with stress and distress.
- ▶ Research funders should commission economic analysis of the costs of comorbidity of alcohol and mental health difficulties. This should include analysis of how public money is being spent and how this might be improved.

INTRODUCTION

Centre for Mental Health and the Institute of Alcohol Studies have come together to explore the state of provision for people with co-occurring difficulties in order to understand what is happening on the ground at present, to inform policy and to identify research and practice priorities. Both are independent charities that seek to improve policy and practice nationwide in their respective areas of work.

To understand current policy and practice, we have reviewed key policy documents relating to alcohol and mental health services, carried out a survey of people working in both alcohol and mental health services in the UK, and held a seminar to bring together experts and policymakers from both fields to discuss the implications of our findings.

Alcohol and mental health: the evidence

Alcohol use can affect a person's mental health, and experiencing mental health problems can affect a person's relationship with alcohol.

Alcohol use disorders have been found to be associated with a range of mental health difficulties including depression, bipolar disorder, (Public Health England, 2016b) and antisocial personality disorder (Moeller and Dougherty, n.d.). In 2014/15, English hospitals had over 200,000 admissions "for mental and behavioural disorders due to alcohol use, accounting for almost 19% of all alcohol-related hospital admissions" (Public Health England, 2016b). Further, alcohol use disorders might serve to delay recovery from psychiatric conditions (Greenfield, 2001). Alcohol use has also been identified as a common response to mental health difficulty (University of Stirling, 2016). Yet we have heard for many decades that people with co-occurring difficulties are often excluded from both mental health and alcohol services.

People with co-occurring mental health and alcohol misuse difficulties have long been acknowledged to struggle to find effective help from statutory services in England. Having a 'dual diagnosis' of alcohol use- and mental disorders is common. Some 86% of people using alcohol treatment services have a co-occurring mental health difficulty. Similarly, according to Public Health England (2016a), "an estimated 44% of community mental health patients have reported problem drug use or harmful alcohol use in the previous year". And problem drinking is associated with poorer outcomes, including tragic losses of life through suicide, among people using mental health services (PHE, 2016a).

Policy developments

Government policies relating to alcohol and mental health in England have predominantly been developed and articulated in isolation from one another. Since the 1999 National Service Framework for Mental Health (NSF-MH) for adults of working age was published, there has been a steady stream of policies relating to mental health, but few of them have made reference to alcohol and the needs of people with comorbid problems. These include the 2011 cross-government strategy No Health without Mental Health (HM Government, 2011) and the current Five Year Forward View for Mental Health (Mental Health Taskforce, 2016). The latter included just one recommendation about drug and alcohol co-morbidity, calling on the Cabinet Office to ensure that the new Life Chances Fund of up to £30m

for outcomes-based interventions to tackle alcoholism and drug addiction requires local areas to demonstrate how they will integrate assessment, care and support to people with comorbid substance misuse and mental health problems, and make a funding contribution themselves. This Fund was developed to support the wider use of Social Impact Bonds to fund innovative new services.

Likewise, government policies relating to alcohol have largely ignored the links with mental health: the 2012 Government Alcohol Strategy (HM Government, 2012) devoted just two paragraphs to recognising the links but set out no specific actions to address them. And current alcohol policy initiatives relating to alcohol often focus on voluntary partnership agreements with the alcohol industry (for example through the Public Health Responsibility Deal) rather than supporting those experiencing difficulties or exploring the links between problem drinking and mental health.

The one exception to this pattern of parallel policymaking is the 2002 Dual Diagnosis Good Practice Guide, published by the Department of Health as one of a series of policy implementation guidelines for the NSF-MH (Department of Health, 2002). This document advocated moving from ‘parallel’ service provision for people with coexisting drug or alcohol and mental health needs to an ‘integrated’ model. It suggested that support should be led by community mental health services with a liaison role for substance misuse specialists working alongside them to meet the needs of people with a dual diagnosis.

The Joint Commissioning Panel for Mental Health (led by the Royal College of Psychiatrists and Royal College of GPs) published guidance for the commissioning of drug and alcohol services in 2013. It noted that “there is no nationally agreed model for the commissioning and delivery of drug and alcohol services” (JCPMH, 2013) resulting in wide variations across the country. It went on to set out guidelines for commissioners of drug and alcohol services, making reference to NICE Quality Standards for alcohol dependence and harmful use that include the provision of specialist alcohol services for those who need them and of evidence-based psychological therapies for both adults and children.

More recently, guidance from Public Health England (2017) set out its expectations for the care of people with co-occurring mental health and drug or alcohol problems, beginning with two principles:

1. Everyone’s job. Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.
2. No wrong door. Providers in alcohol and drug, mental health and other services have an open door policy for individuals with co-occurring conditions, and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point. (PHE, 2017, p. 9).

The guidance sets out a number of ‘suggestions’ for local NHS and public health commissioners, including to “agree a pathway of care which will enable collaborative delivery of care by multiple agencies”, to appoint a named care-coordinator for each person with co-occurring problems, to commission 24/7 mental health crisis care “including for intoxicated people” and to offer “strong, senior and visible leadership” in all settings, including the criminal justice system (PHE 2017, p. 10).

SURVEY RESULTS

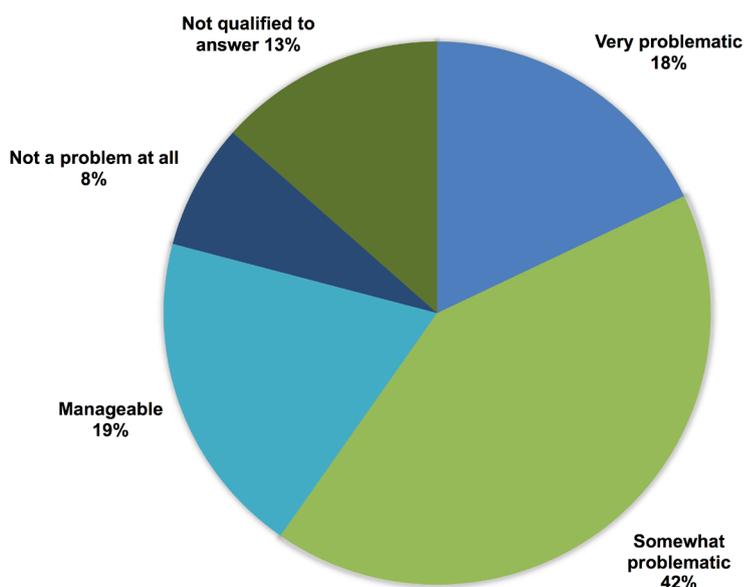
The joint survey was distributed widely through both organisations' networks in order to reach people working in both alcohol and mental health services across the UK. We received 134 responses from professional respondents based in the UK. These were quite evenly distributed between people who identified as working in alcohol services (33%), those working in mental health services (28%) or those with other roles, for example in public health, other health services or academic bodies. Professional roles varied widely among respondents, with no one group predominant, and on average respondents had spent 13 years working in the sector.

The majority of responses were received from England (108 out of 134) for which reason we have not analysed data from Scotland, Wales or Northern Ireland separately. The survey mostly consisted of closed multiple choice questions, with some open-ended questions for respondents to share broader thoughts.

Current service responses

The vast majority (84%) of respondents agreed that having an alcohol use disorder was a barrier to getting any kind of mental health support. By contrast, opinions were more evenly split about whether having a mental health difficulty – including common mental health problems (such as depression and anxiety), less common mental health problems (such as psychosis and personality disorders), or alcohol or drug induced psychosis – made it harder to get help with alcohol. A clear majority (60%) agreed that having to determine a person's 'primary diagnosis' was problematic for people with co-occurring alcohol and mental health difficulties.

Figure 1: How difficult do you consider making a distinction between primary and secondary diagnoses to be?



We sought views about the experiences of people with different kinds of co-morbidity in getting access to services and the quality and appropriateness of help available. In all cases, the most common response was 'poor'. Support for people with common mental health problems and co-occurring alcohol use disorders – while still most commonly identified as 'poor' – was judged to be slightly better than for those with combined alcohol or drug induced psychosis or severe and/or long term mental health problems and alcohol use disorders.

Along with survey questions, respondents were able to write in further open-ended feedback. One respondent described a situation in which contractual arrangements in statutory services block people with a 'dual diagnosis', forcing them to refer people to voluntary sector bodies, but 'charitable funders view dual diagnosis as a statutory provision' so they don't fund it either:

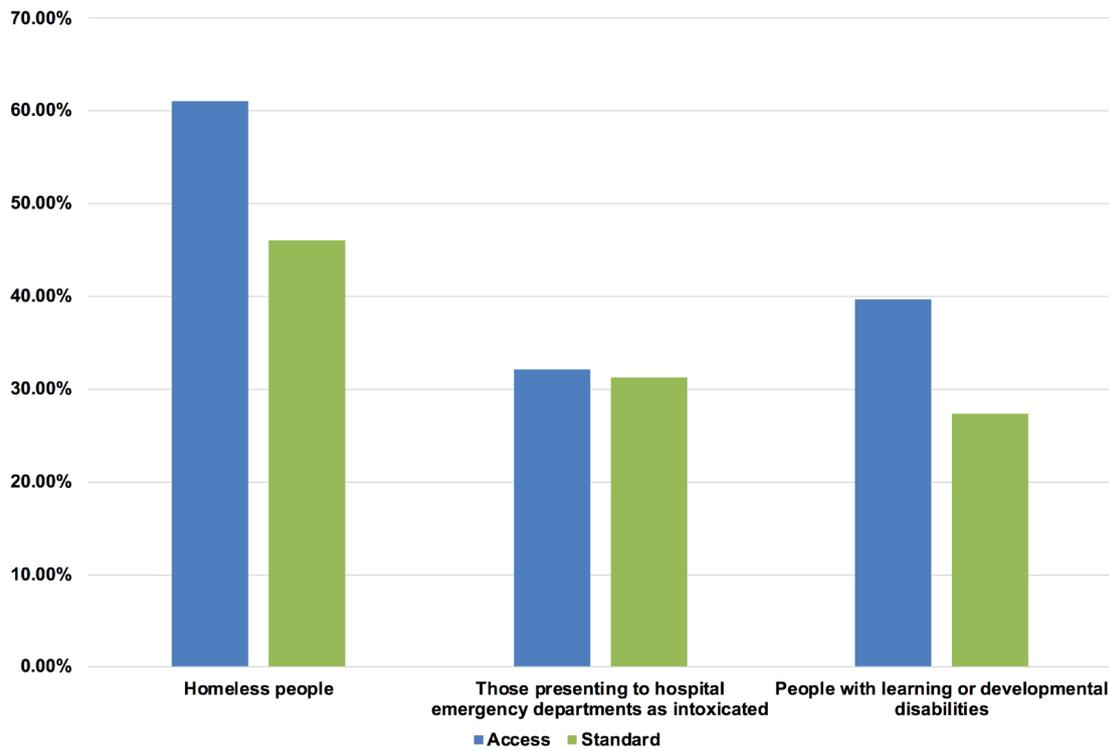
The biggest issue we face is that the local alcohol services do not really provide mental health support...but there are no contracts for mental health support where alcohol is involved.

We asked respondents about the quality of and access to care received by certain subgroups of people with combined alcohol and mental health problems. Excluding a substantial portion of respondents who felt no group benefitted from better access to or standard of treatment, people in the criminal justice system were most commonly identified as experiencing 'better than average' access to and standard of treatment. Smaller numbers thought people with alcohol-related long-term conditions also got a higher than average standard of care. People under 18 were also one of the top three groups most commonly identified as having 'better than average' access to and standard of treatment.

When we asked about poorer experiences, homeless people stood out as the commonest response – with more than half of respondents suggesting they receive worse than average access to services (61%) and 46% suggesting they receive a worse than average standard of service. People with learning disabilities and people presenting to emergency departments intoxicated were also commonly felt to have both poorer access to care and a lower quality of support:

Services are all for people in recovery or stable; any presentation when in crisis results in pinballing between services who are not set up for such so suggest someone else...

Figure 2: Are there any groups of people you feel have worse than average access to or standard of treatment services?



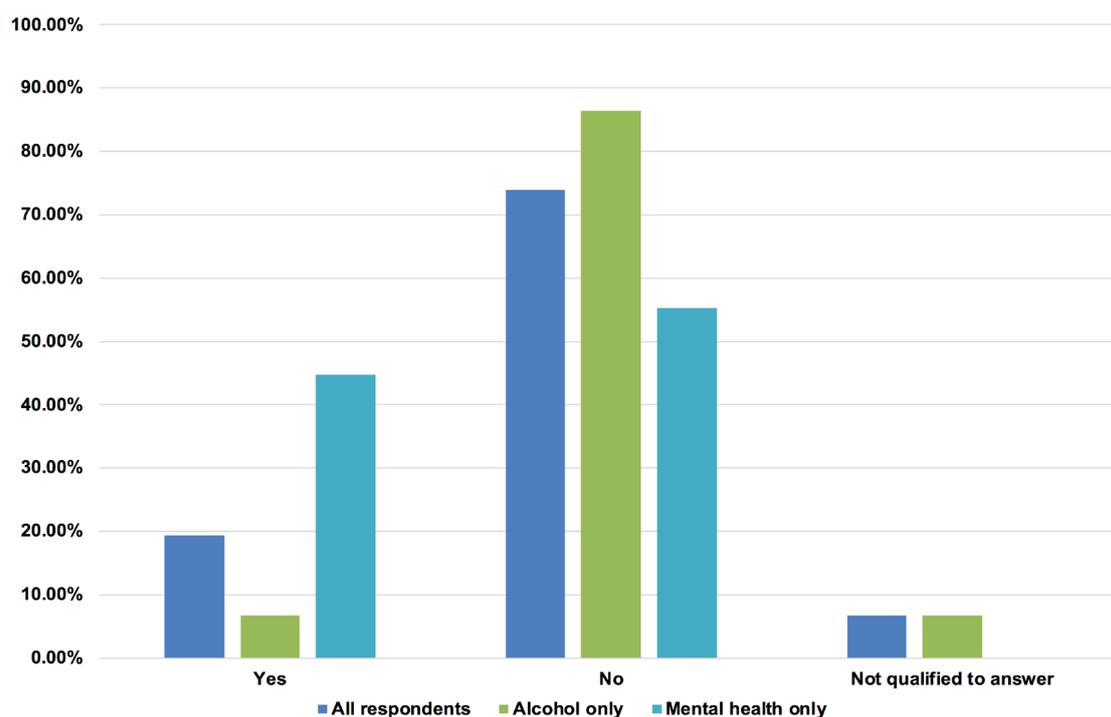
Some gave specific examples of gaps in support relating to other services, including the criminal justice system:

I am yet to see a released prisoner who has completed treatment in the community successfully without relapsing or dropping out of the service.

Barriers between services

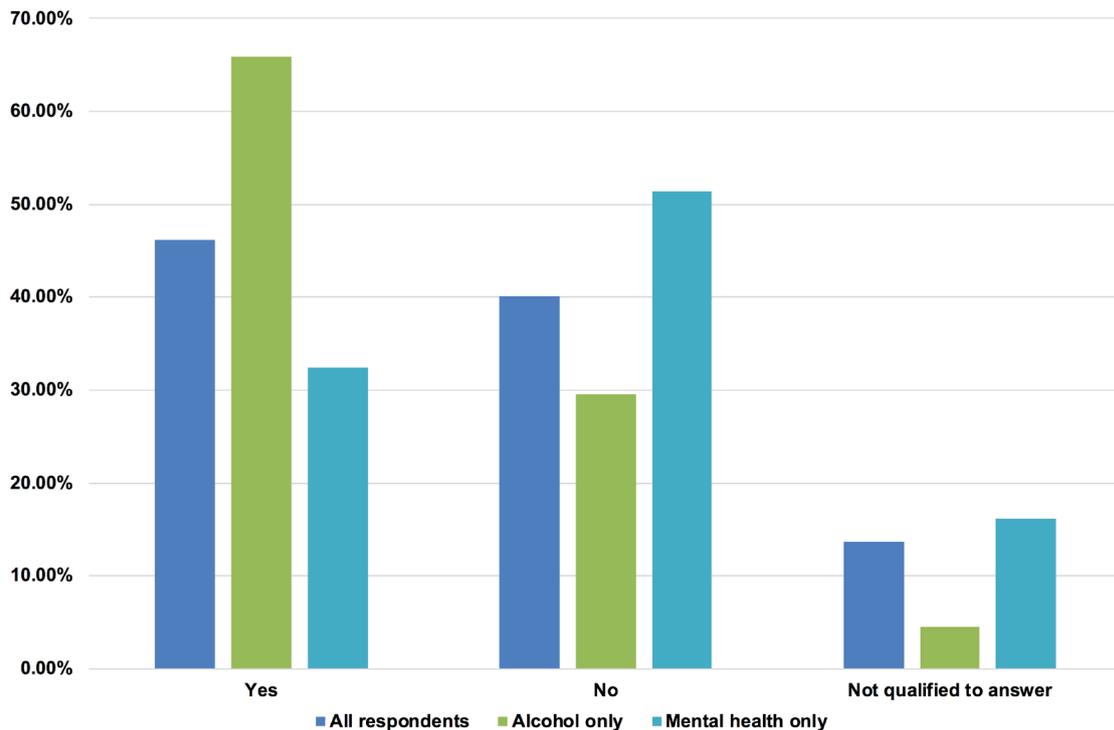
We asked respondents how well they felt alcohol was understood and covered within mental health services, and vice versa. The vast majority of respondents felt that alcohol consumption is not adequately considered or understood in mental health services. However, it was noticeable that in both cases, those working in the alcohol field felt this situation was worse than those working in mental health – this was found to be statistically significant. For example, only 7% of alcohol workers thought alcohol was adequately considered in mental health services compared with 45% of mental health staff.

Figure 3: Do you feel alcohol consumption is adequately considered in mental health services?



Just over 40% of respondents felt that mental health issues are not adequately considered in alcohol use disorder prevention services, while just over a quarter felt they were not adequately understood. Those working in the mental health field answered more negatively on these items – this, again, was found to be statistically significant. For example, only 32% of mental health workers thought alcohol services adequately considered mental health compared with 66% of alcohol staff.

Figure 4: Do you feel mental health issues are adequately considered through alcohol use disorder prevention services?



Likewise, alcohol service workers were less likely to think that mental health staff asked service users about their alcohol consumption and mental health workers were considerably less likely to believe that alcohol service staff asked clients about their mental health. Further, on average, respondents rated alcohol treatment services as holding a stronger recognition and understanding of alcohol's role in suicidality than mental health services.

I don't believe anything has changed in all the years of my working in drug and alcohol services. We still see mental health services refusing to treat people until their substance misuse is addressed...

Mistrust or misunderstanding appear to be widespread, among both staff groups of the other, but more so among alcohol service workers towards those in mental health services.

This lack of confidence or communication can even continue when services or staff are brought together: one respondent noted that they had previously worked as a dual diagnosis nurse at a drug team, but 'it was a wasted post as no one knew what to do with me... I could have done so much more'.

Policy and practice

There appeared to be substantial agreement on the barriers to improving support, and the policy or practice changes needed to overcome them. More than 90% of respondents viewed funding shortages as a problem currently, while more than 80% agreed that a lack of join-up between mental health and alcohol services, an insufficient workforce, and the stigma facing people with comorbid problems were problematic.

Many suggestions concerning barriers to improving support were made, some of which focused on deficits in national policy; others suggested that national policies were taking addiction services in the wrong direction but most cited a lack of attention to this issue at the national level:

Dual diagnosis has fallen off the agenda at a national level... There is a lack of coordinated policy linking mental health, alcohol and substance use.

Others focused on barriers operating at the local level in both commissioning and provision of services:

There is no regulation to the drug and alcohol service that a local authority must provide... People are unaware of the interventions available, service providers included, as it varies so greatly.

The overall picture in relation to the barriers to improving support is one of a lack of central direction that has allowed local services to drift and cuts to funding to go under the radar.

The policy and practice solutions receiving the most support (by more than 95% of respondents to some degree) were for more collaborative working between alcohol and mental health services, for ring-fencing of funding for addiction services, and for mental health staff to have more awareness of alcohol issues. Similarly, a boost in specialist training in addictions, and for alcohol service staff to have more awareness of mental health issues, received over 95% support.

Practitioners from both mental health and alcohol services need to be trained to deliver interventions to meet people's combined needs whenever possible... rather than referring to other services.

These responses imply that the solutions lie at all levels of the system, from national policy decision-making to local systems, process and cultures.

Finally, we asked respondents how successfully services currently embedded the two principles set out in the recent PHE (2017) guidance on care for people with co-occurring conditions: of joint working between mental health and substance misuse services and of 'no wrong door'. In both cases, more than two-thirds described current practice as either 'poor' or 'very poor' and fewer than 15% thought it was either 'good' or 'excellent'.

SEMINAR FINDINGS

We brought together a range of experts and stakeholders from both alcohol and mental health services, with both professional and personal experience, to discuss the survey findings and their implications for policy and practice.

There is a clear consensus among those working in and around both alcohol and mental health services that comorbidity is the norm, not the exception, particularly in the former, and that too many people are bounced between services despite being highly vulnerable. Too often, instead of being everybody's business, comorbidity is nobody's business. And the cost of this gap in provision is both additional distress for individuals and those around them and displaces the problem to other NHS and criminal justice services (such as A&E, the ambulance service, and the police) that are ill-equipped to meet their needs.

This significant and longstanding gap in services has arisen for many reasons. These include a perceived (and growing) normalisation of the use of alcohol as a form of self-medication for poor mental health; combined with a stigma among health professionals about those who do. It is also evident that mental health and alcohol services do not match up in their understandings of comorbidity: the former are most concerned about people with severe mental illness who also drink harmfully, while the latter are more concerned about dependent drinkers who also have common mental health problems.

This chronic lack of connection and understanding between alcohol and mental health services has been exacerbated by recent cuts to alcohol services in particular. Levels of identification and treatment in England have always been low, and financial pressures have led local authorities to recommission substance misuse services outside the NHS, at ever lower costs. This has fractured existing good working relationships, and further reduces the chances of the two services working together effectively as well as eroding the capacity in the system for training and developing specialist workers in addictions.

With such a potent mix of cultural, structural and financial barriers to improved support for people with alcohol and mental health comorbidities, it is clearly necessary to take action at every level and every opportunity to close the gap. One seminar participant described the importance of alcohol liaison services, now being expanded to cover all acute hospitals in England, in helping to identify their need and beginning their journey to recovery. Getting access to talking therapies and practical, holistic, support were also important for them once their need had been recognised. The implementation of new and expanded services through the Five Year Forward View for Mental Health may thus create opportunities for new connections to be made and access to effective help to be improved.

Nonetheless, to bring about significant and sustained improvement will require action on a wide range of fronts. This would include addressing the ‘alcogenic environment’ we all inhabit, where alcohol is ever-present, as well as issues such as licensing and pricing. It will require effort to build the capacity of both the alcohol and mental health workforce to offer effective support to people with co-occurring needs, and to tackle the stigma that surrounds them. It also means setting priorities 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 – even if models for achieving this vary from one area to another. At the intermediate level, Sustainability and Transformation Partnerships have the potential to bring about change at scale in a way that is likely to improve both quality and efficiency in health economies.

IMPLICATIONS FOR POLICY, COMMISSIONING AND PRACTICE

It is clear from our review of policy, our survey of those working in these fields, and our seminar discussions, that support for people with co-occurring mental health and alcohol problems is under stress. Services appear to be suffering from a chronic inability to work well together to meet people's needs combined with an acute funding crisis in addiction services and continued pressures on mental health budgets. Longstanding shortcomings in support for people with combined alcohol and mental health difficulties have become increasingly problematic some 15 years on from the Department of Health guidance on dual diagnosis. The field of addiction psychiatry is dwindling, seeing a "greater reliance on doctors without specialist training and volunteers with limited training" (Drummond, 2017). And financial pressures in the NHS and particularly local government are placing extra strain on the system now and there is little confidence among staff in either field about the support they offer currently or the prospects of significant improvement in the near future.

It is noteworthy that on many topics, staff in alcohol and mental health services had very similar experiences and perspectives. There were areas of difference, too; while staff in each service were more negative about the other than themselves, alcohol service staff were more critical of mental health services than vice versa, possibly partly because alcohol services are increasingly not commissioned to provide concurrent mental health care since their transfer to local authority commissioning. There are also clear differences between the two in terms of their understanding of 'dual diagnosis': for alcohol services the priority is dependent drinkers with common mental health problems or personality disorders linked to traumatic experiences while in mental health services the focus is on people with a psychosis who drink harmfully.

A particular area of concern in our survey was the accessibility and quality of care offered to people who are homeless. Given the strong connections between homelessness, alcohol dependence, and poor mental health this is a major cause for concern that may require a particular focus to identify solutions and make any necessary changes to enable them to be implemented at scale. A similar level of focus may also be needed to address the needs of people with learning and developmental disabilities and those with a dual diagnosis at a point of crisis (including those detained under the Mental Health Act, those at risk of suicide and those attending A&E).

An implication of the survey and seminar findings is that improving support for people with co-occurring alcohol and mental health difficulties will require a range of actions at different levels. This is not necessarily straightforward; indeed, the Black Review (2016) on access to employment and addiction problems acknowledges the difficulty of providing support to people with co-occurring conditions. There appears to be a need for concerted national leadership to raise the profile of this issue, to secure sufficient resources for services and (pending that) to have a greater sense of expectation of what they will do. There is also a need for long-term workforce development to build the skills, knowledge and confidence of staff in both sectors (and more broadly – for example in primary care, A&E and the police).

The need for joined-up approaches is clear. This is echoed through the recommendation

in the report, Health First (University of Stirling, 2013), that the implementation of brief intervention and alcohol advice through all health and social care professionals is highly relevant for those “living with, or at risk of, mental health problems”. The UK Government’s Access to Work programme seems a positive example of the kind of joined-up approach at the national level that might require extending (Black, 2016). And there is a need for local action to review service provision and the ways mental health and substance misuse services relate to one another and to people with co-occurring needs.

The importance of stigma and discrimination has also emerged as a key issue in this field. For people with co-occurring conditions there may be a double or triple stigma, combined with experiences of unhelpful interactions with health professionals that reinforce the stigma and compound trauma. At the same time, there is concern among experts in the field about the ‘normalisation’ in popular culture and discourse of the use of alcohol to cope with stressful life events and emotional distress. Tackling these discourses will require sophisticated messaging and sustained campaigning over a period of time.

There is also a need to develop more (and more effective) resources to support policymakers, commissioners and practitioners to bring about change for people with co-occurring mental health and alcohol problems. Evaluations of good practice, with opportunities for others to visit and learn from them, would help to demonstrate that improvements can be made, even in difficult circumstances. Economic analysis of the costs of comorbidity and the potential financial benefits of more integrated support would help to persuade policymakers and commissioners of the case for change. And training and support for practitioners in both mental health and substance misuse services (including that developed and delivered by experts by experience) may help to challenge myths and to encourage improved day-to-day practice.

RECOMMENDATIONS

The UK Government should urgently develop a comprehensive alcohol strategy and commit, alongside NHS England, to a second Five Year Forward View for Mental Health.

The alcohol strategy should include both population level measures to address alcohol harm (including on price, marketing and licensing) and service level action to ensure more people get effective help. The strategy should include specific commitments regarding alcohol's role in mental health problems and the difficulties faced by those with co-morbidities. The Five Year Forward View for Mental Health should include action to address the relationships between alcohol and mental health, including access to effective help for people with co-occurring conditions.

This report has also identified further recommendations, relating to specific aspects of mental health and alcohol policy and practice. These recommendations should be enacted urgently and continued action on these should be covered within the alcohol strategy and Five Year Forward View previously discussed:

- ▶ The Department of Health and Social Care, NHS England and Public Health England should urgently review the funding of addiction services and the provision of support to people with co-occurring mental health conditions.
- ▶ Sustainability and Transformation Partnerships and emergent Integrated Care Systems should develop plans for improved support for people with co-occurring mental health and alcohol problems. These should bring together the commissioners and providers of relevant services and those using them to agree plans for developing integrated support.
- ▶ Local suicide prevention plans should include action to address the links between alcohol misuse and deaths by suicide.
- ▶ Health Education England should ensure that all trainee psychiatrists receive training and undertake placements in addiction services (which could include those in the voluntary sector).
- ▶ Alcohol liaison services in general hospitals should seek to identify people who are misusing alcohol and refer them to appropriate support from local services.
- ▶ The Improving Access to Psychological Therapies (IAPT) programme nationally, and CCGs in local areas, should ensure that people with co-occurring alcohol difficulties are not excluded from psychological therapy services.
- ▶ The Department of Health and Social Care and Public Health England should commission a national anti-stigma campaign to dispel myths about people with co-occurring problems, including specific work to address professionals' attitudes and behaviour alongside work targeting public opinion more broadly. This should be combined with efforts to reduce the 'normalisation' of alcohol as a form of self-medication for dealing with stress and distress.
- ▶ Research funders should commission economic analysis of the costs of comorbidity of alcohol and mental health difficulties. This should include analysis of how public money is being spent and how this might be improved.

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