

*“Once you’ve addressed your drinking,  
we’ll address your mental health”*

A qualitative exploration of patient and providers’ experiences of services for co-occurring heavy drinking and depression in North East England

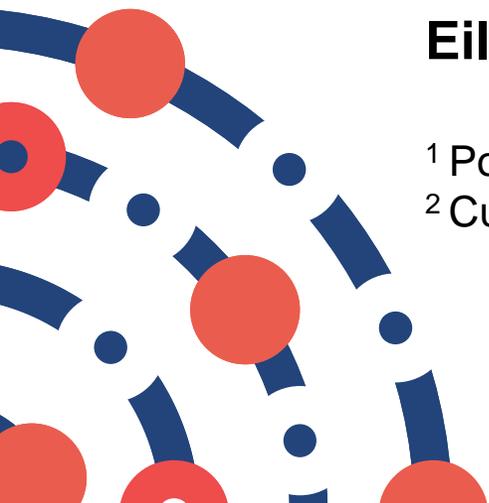
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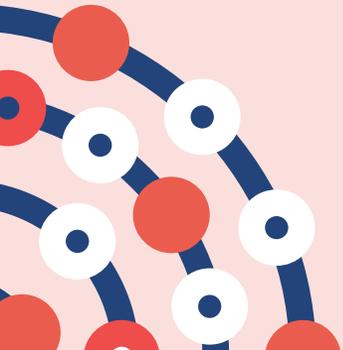
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# Funding and conflict of interest

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**Conflict of interest:** Outside this study, Dr Amy O'Donnell has previously co-authored papers that analysed raw market research consumer-based data provided to Newcastle University under a direct contract with Kantar Worldpanel at no cost to Newcastle University. Kantar Worldpanel received reimbursement from AB InBev to cover the costs of the data. Neither Kantar Worldpanel or any other entity had any role in the study design, data analysis, data interpretation or writing of the manuscript. Dr O'Donnell has no other conflict of interest as outlined in relation to this specific study.



# Alcohol and depression

- People with common mental disorders are twice as likely to report an alcohol use disorder than people without them.
- More common in people in lower socio-economic groups; likely to also experience physical poor health and complex social issues.
- Co-occurring depression and heavy drinking are associated with a range of adverse outcomes including increased risk of suicidality.
- Health and social care system appears ill-equipped to respond to the needs of these individuals.

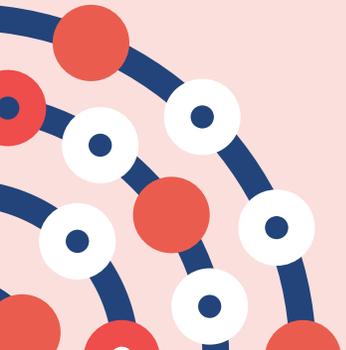


# Study aim and methods

**Aim:** to explore the views and experiences of those who use and provide services for co-occurring AUD and depression across the North East and North Cumbria (NENC) region of England.

**Participants:** Adult heavy drinkers with mild to moderate depression and experience of accessing or attempting to access support; Health and social care professionals involved in delivering or commissioning services for patients with alcohol use disorder and/or depression; All based in NENC.

**Methods:** Drew on interpretive description methodology using semi-structured interviews to collect data (tel, Zoom, face-to-face).



# Sample characteristics

Table 1: Patient and service users

Characteristic		N
Gender	Male	21
	Female	18
Age	20-29 years	1
	30-39 years	10
	40-49 years	11
	50-59 years	13
	60-69 years	4
Ethnicity	White British	36
	Other (Mixed, White European, White Other)	3
Employment status	Not in paid employment	23
	Full or part-time paid employment	10
	Sick leave from full or part-time employment	5
	Studying / training	1
<b>Total =</b>		<b>39</b>

Table 2: Clinicians and care professionals

Characteristic		N
Gender	Male	13
	Female	13
Role	NHS Alcohol (inc. dual diagnoses and addictions psychiatry)	10
	NHS Mental Health (inc. recovery colleges and women's services)	6
	Primary healthcare	4
	Community and voluntary sector	3
	Local government	3
<b>Total =</b>		<b>26</b>

ASK ME  
WHY I DRINK?  
DON'T ANYONE



lack of recognition



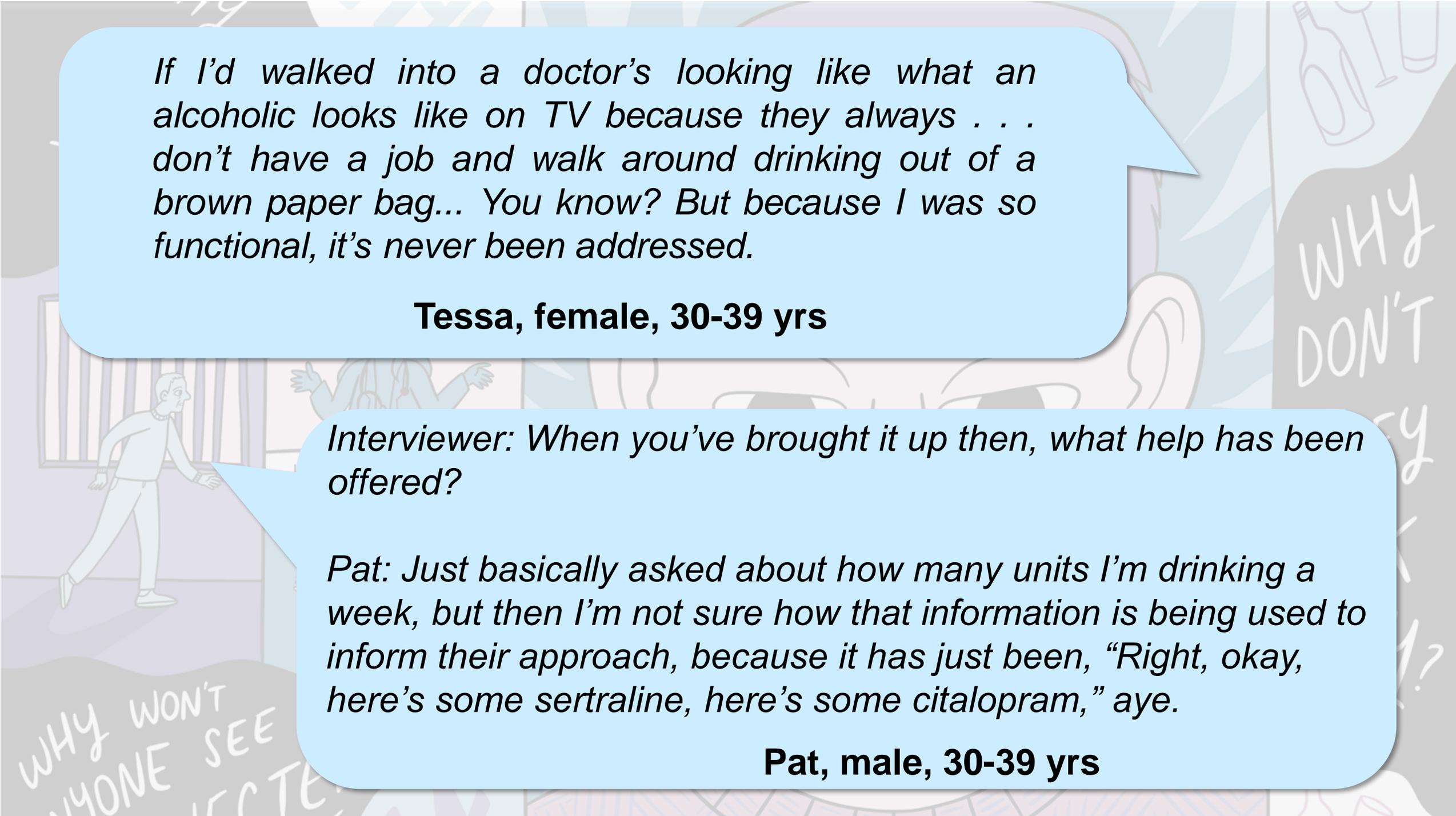
WHY WON'T ANYONE SEE HOW IT'S CONNECTED?



WHY DON'T THEY ASK WHY?

# Lack of recognition





*If I'd walked into a doctor's looking like what an alcoholic looks like on TV because they always . . . don't have a job and walk around drinking out of a brown paper bag... You know? But because I was so functional, it's never been addressed.*

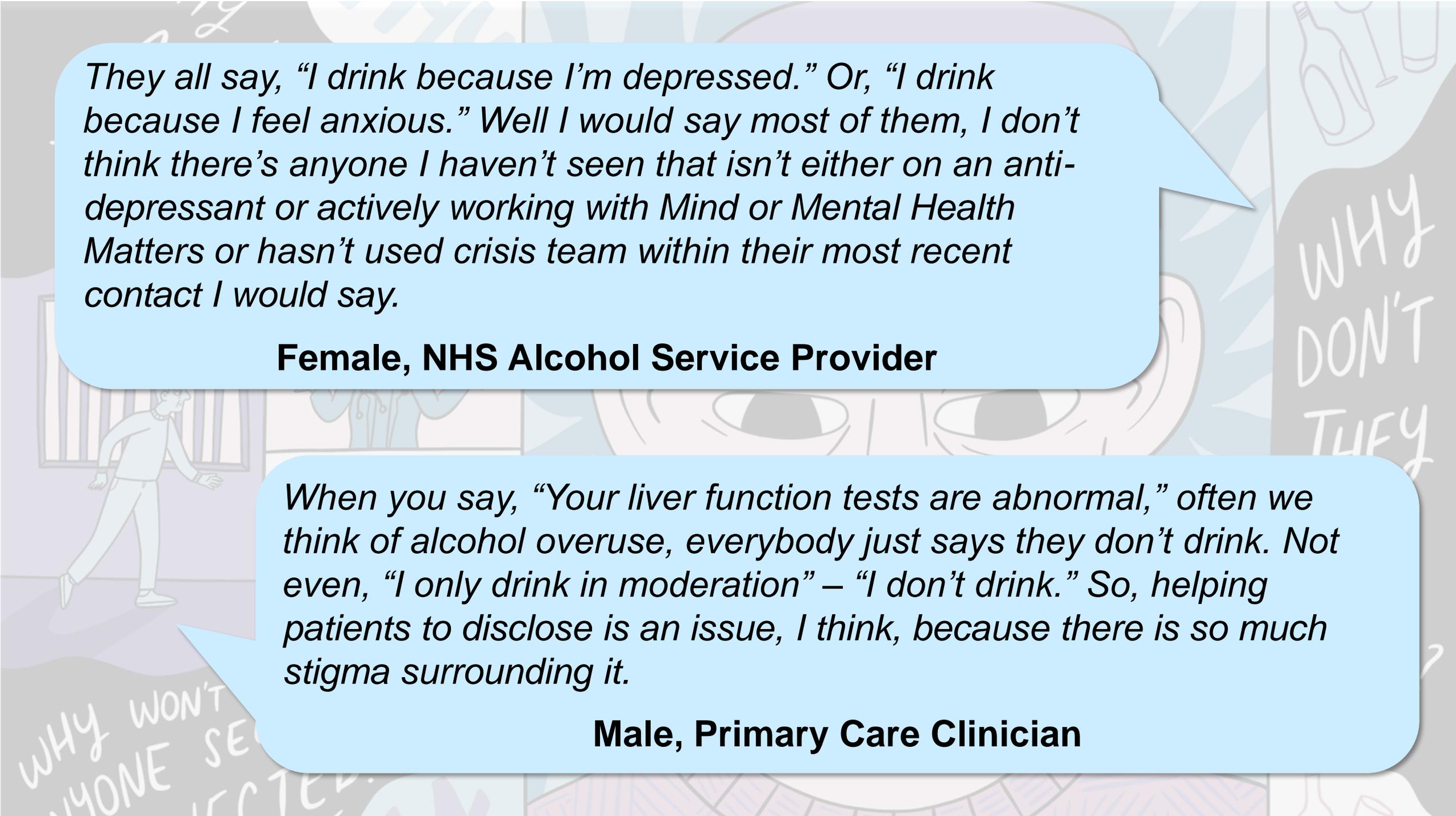
**Tessa, female, 30-39 yrs**



*Interviewer: When you've brought it up then, what help has been offered?*

*Pat: Just basically asked about how many units I'm drinking a week, but then I'm not sure how that information is being used to inform their approach, because it has just been, "Right, okay, here's some sertraline, here's some citalopram," aye.*

**Pat, male, 30-39 yrs**

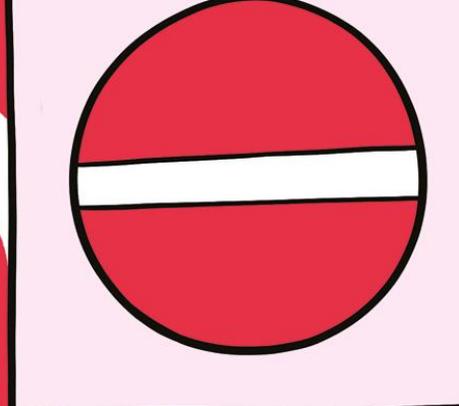
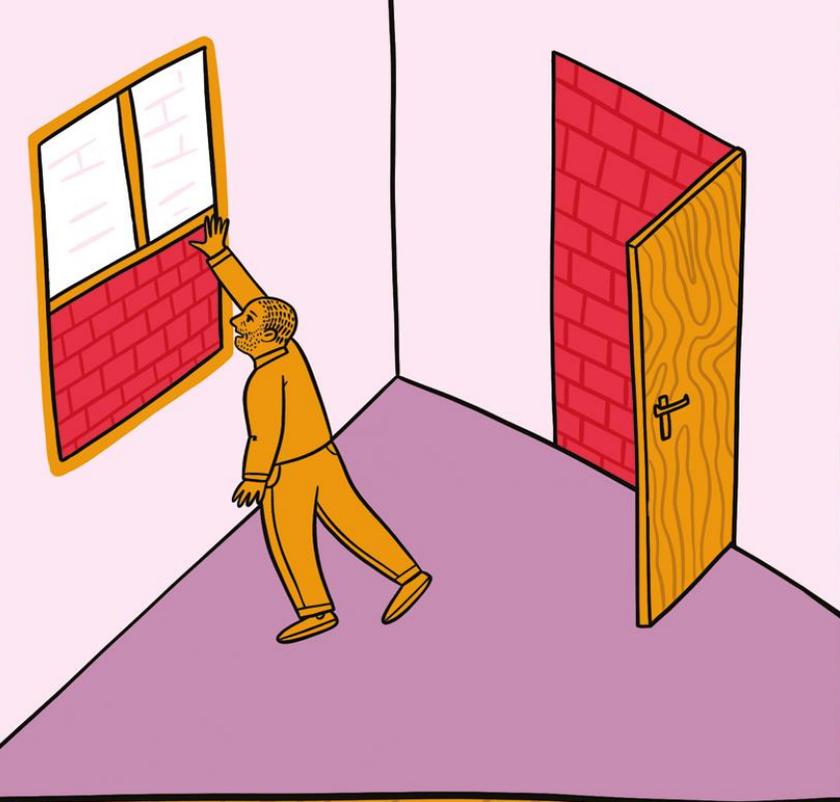


*They all say, “I drink because I’m depressed.” Or, “I drink because I feel anxious.” Well I would say most of them, I don’t think there’s anyone I haven’t seen that isn’t either on an antidepressant or actively working with Mind or Mental Health Matters or hasn’t used crisis team within their most recent contact I would say.*

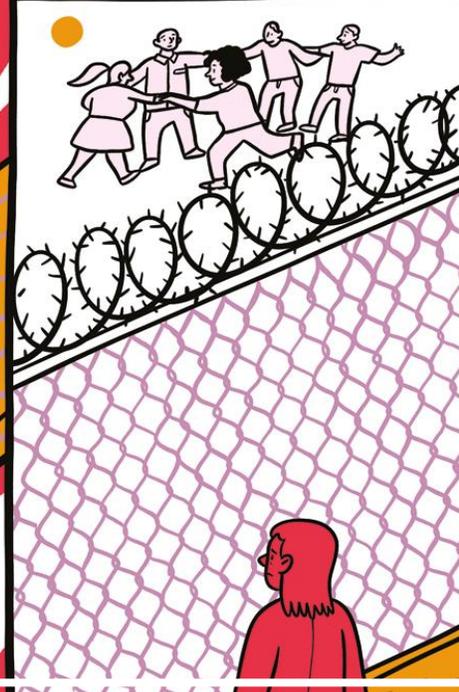
**Female, NHS Alcohol Service Provider**

*When you say, “Your liver function tests are abnormal,” often we think of alcohol overuse, everybody just says they don’t drink. Not even, “I only drink in moderation” – “I don’t drink.” So, helping patients to disclose is an issue, I think, because there is so much stigma surrounding it.*

**Male, Primary Care Clinician**

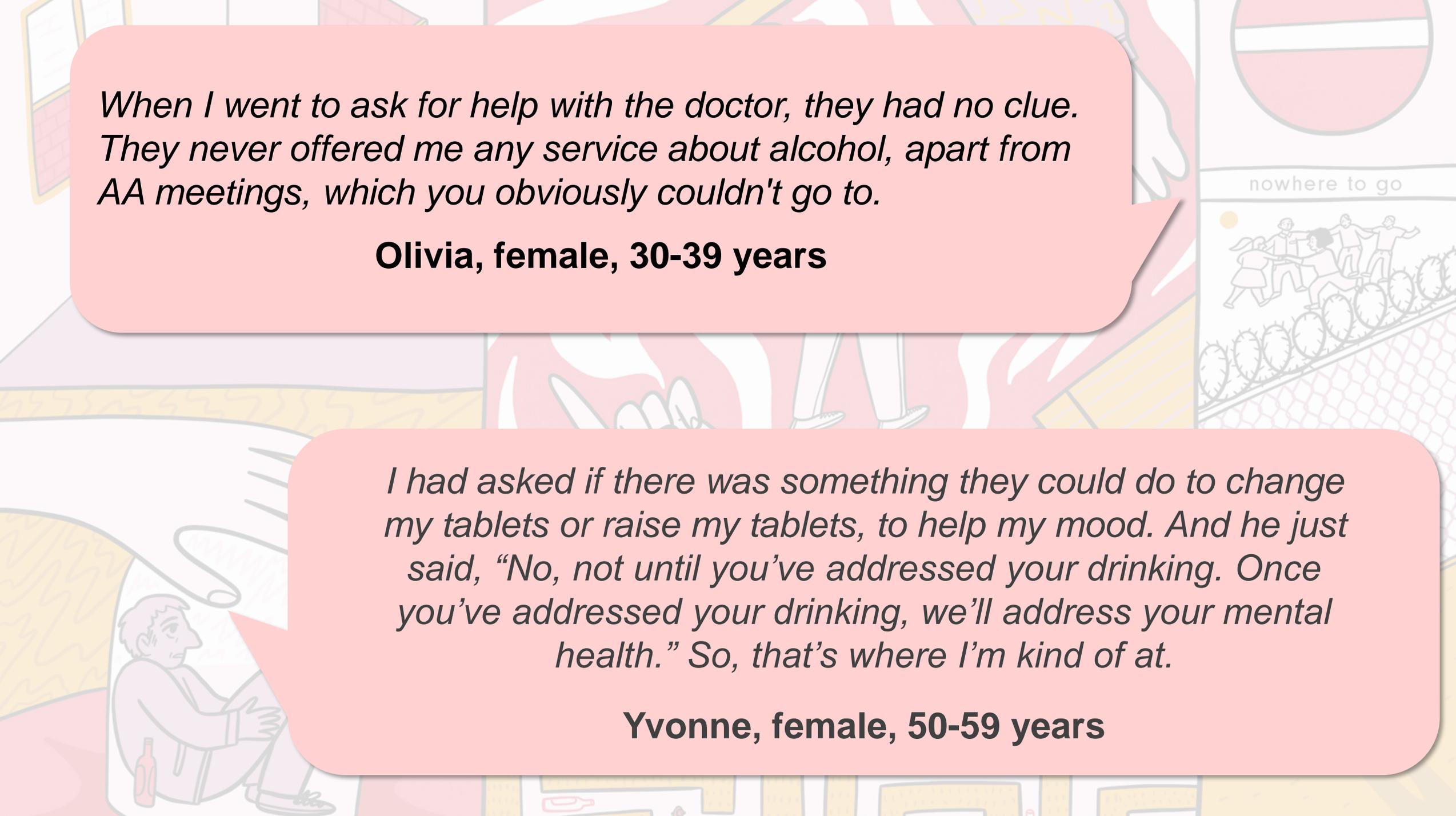


nowhere to go



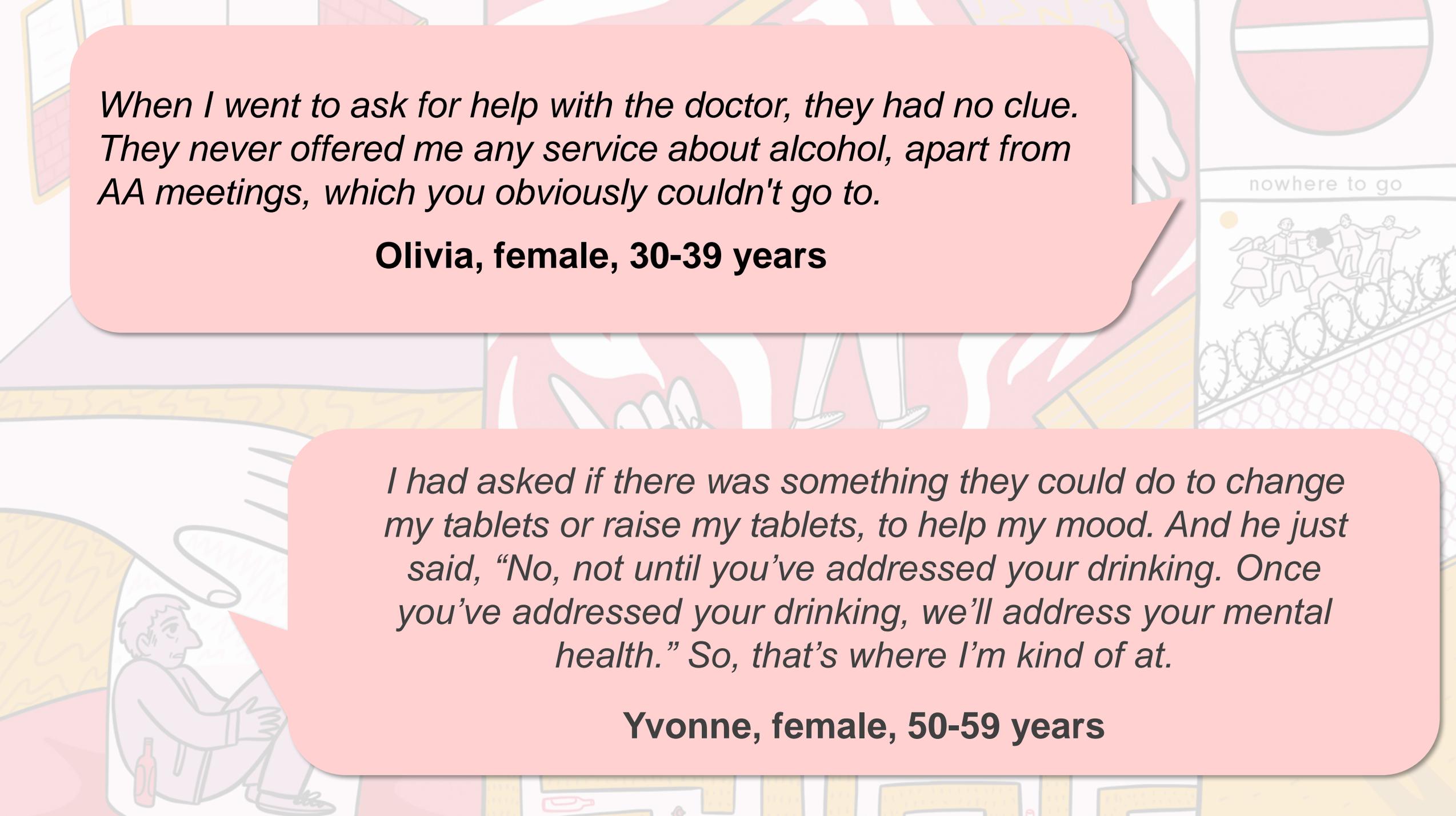
**Nowhere to go**





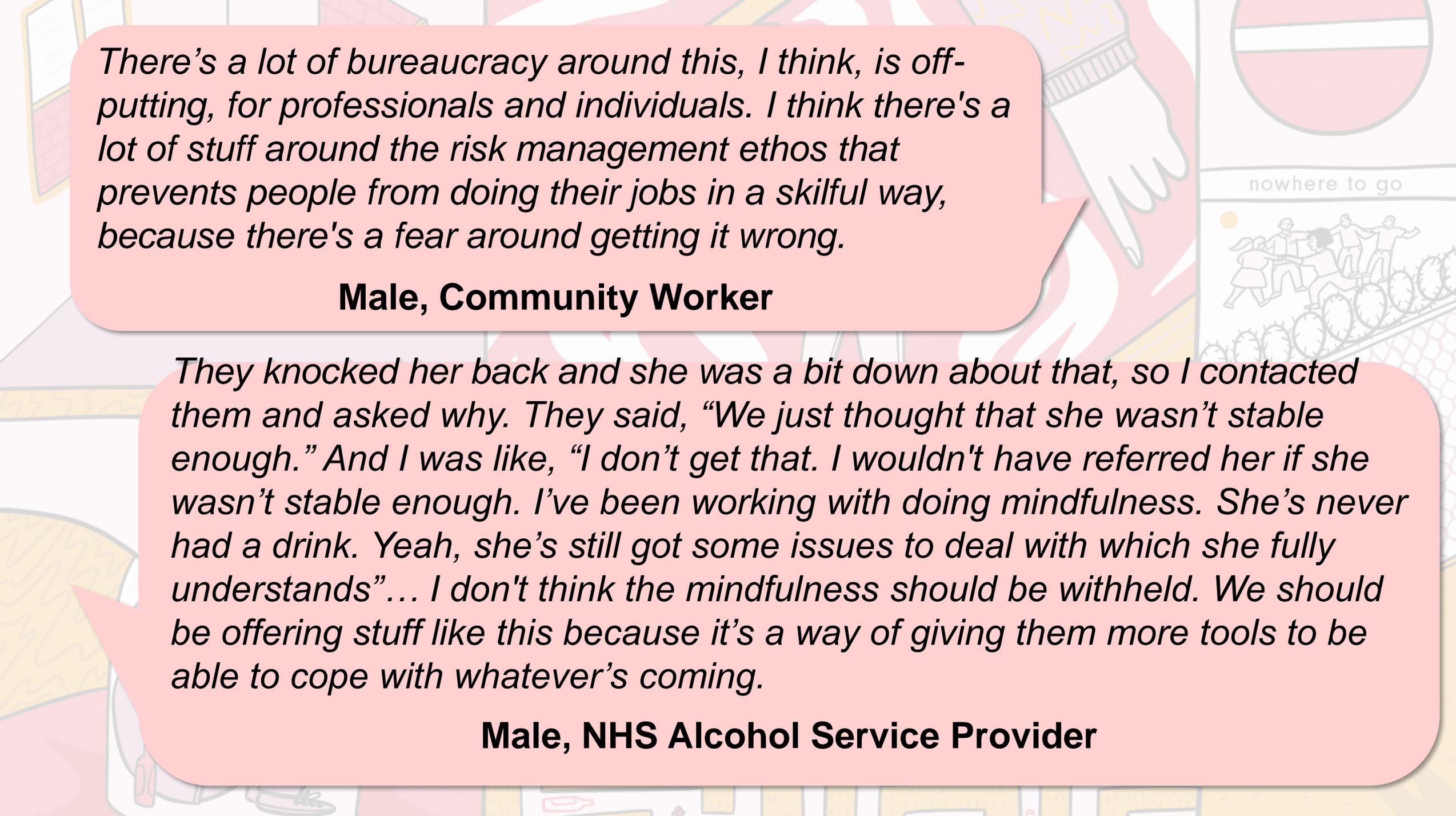
*When I went to ask for help with the doctor, they had no clue. They never offered me any service about alcohol, apart from AA meetings, which you obviously couldn't go to.*

**Olivia, female, 30-39 years**



*I had asked if there was something they could do to change my tablets or raise my tablets, to help my mood. And he just said, “No, not until you’ve addressed your drinking. Once you’ve addressed your drinking, we’ll address your mental health.” So, that’s where I’m kind of at.*

**Yvonne, female, 50-59 years**



*There's a lot of bureaucracy around this, I think, is off-putting, for professionals and individuals. I think there's a lot of stuff around the risk management ethos that prevents people from doing their jobs in a skilful way, because there's a fear around getting it wrong.*

**Male, Community Worker**

*They knocked her back and she was a bit down about that, so I contacted them and asked why. They said, "We just thought that she wasn't stable enough." And I was like, "I don't get that. I wouldn't have referred her if she wasn't stable enough. I've been working with doing mindfulness. She's never had a drink. Yeah, she's still got some issues to deal with which she fully understands"... I don't think the mindfulness should be withheld. We should be offering stuff like this because it's a way of giving them more tools to be able to cope with whatever's coming.*

**Male, NHS Alcohol Service Provider**



inequalities in care and support

# Inequalities in care and support



*I didn't even know this place existed until a couple of months ago. I thought it was joined onto the hostel across the road, and they were the only people that could access this. I didn't know you could come for problems or just to talk or...*

**Francis, male, 50-59 years**

*... if you shut yourself off, and don't answer your phone, and don't engage, it makes the services- they cut you off as well I think they kind of discharge you...it was only really my family and friends that were having to ring on my behalf and say...she's not ignoring you because she doesn't care, she's ignoring you because she's not answering the phone.*

**Belinda, female, 30-39 years**

*Normally, every day, I'm by myself and I don't talk about anything. I've got an aunty who sometimes pops in. She knows what's wrong with me but they don't mention anything. It's not someone I can talk to about my situation.*

**Dominique, female, 50-59 years**

*We have a certain level of expertise within in our own service, but we wouldn't have, for example, any trained- I don't think we have any trained CBT practitioners. We don't have a clinical psychologist. I would have fairly limited capacity to provide treatment as well, other than really assessing. We don't tend to prescribe, ourselves, antidepressants.*

**Male, NHS Alcohol Service Provider**

*...consistency of service provision would be nice and would help, but I don't think I've ever really experienced that. And changing provision as well. These things are always being retendered...or reorganised, certainly, and that makes it challenging as clinicians wanting to engage our patients in these services when, with the best will in the world, it's quite difficult to keep up to date with what they're providing and where and to whom.*

**Male, NHS Mental Health Worker**

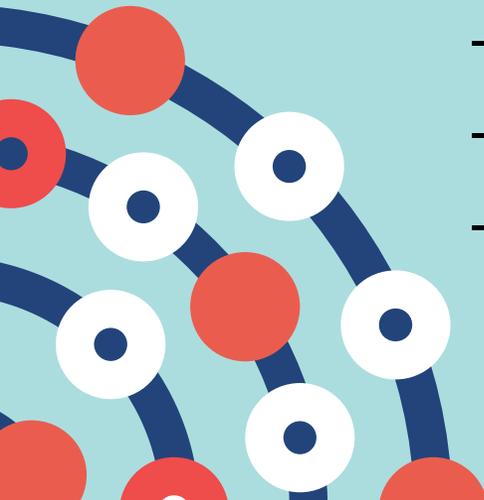
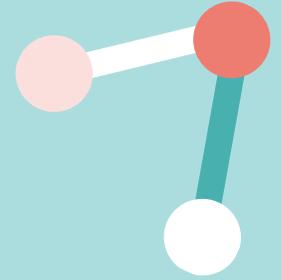
# Key messages

- Systematically inconsistent care for people with co-occurring heavy drinking and depression
- Inadequately designed and resourced formal care system means patients frequently 'pushed out' of services
- Burden of care is shouldered by the most vulnerable individuals in our society who are also the least equipped to manage



# Implications for policy and practice

- Meaningful implementation of ‘no wrong door’ service model:
  - Shared multi-agency care that ‘pulls in’ (instead of pushing out) service users; and
  - Appropriately trained and skilled professionals.
- Support that recognises:
  - relationship between conditions;
  - individuals’ capacity to engage in/manage own care; and
  - socially situated nature of recovery



# Thank you for listening

Any questions or comments?

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