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SARN

Co-occurring heavy alcohol use and depression

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SHAAP/SARN 'Alcohol Occasional' Seminar
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Scottish Health Action on Alcohol Problems (SHAAP) and the Scottish Alcohol Research Network (SARN) are proud to host the lunchtime Alcohol Occasionals, which showcase new and innovative research on alcohol use. These events provide the chance for researchers, healthcare professionals, policy makers and members of the public to hear about alcohol-related topics and discuss and debate implications for policy and practice. The theme for 2022 is alcohol and society. Event reports aim to capture the main discussion points and communicate these to a wider audience. SHAAP is responsible for the contents of this report, which is our interpretation.

Introducing the seminar, Director of SHAAP **Elinor Jayne** welcomed **Dr Kat Jackson** and **Dr Amy O'Donnell**, introduced both speakers and gave context to their research.

Dr Amy O'Donnell (@AmyJaneODonnell) thanked SHAAP and SARN for the opportunity to present findings from the first stage of their research. **O'Donnell** introduced the work on challenges involved in treating people with co-occurring heavy alcohol use and depression. The presentation drew on qualitative data, working with participants in North East England and northern Cumbria (henceforth 'the NE').

The relationship between harmful alcohol use and depression is complex and bi-directional. In theory, there are many effective treatments for both heavy drinking and depression, but in reality, many service users struggle to get the right support. This is partly because of implementation and delivery issues for treatment, which can become even more fragmented when treating concurrent mental health and substance abuse issues. Current practice and guidelines are primarily designed to diagnose single conditions; mental health guidelines don't always contain reference to alcohol, and vice-versa. This results in challenges in navigating a fragmented care system, made more difficult when accessed at a time of likely low motivation and resilience. Because of the focus on single diagnosis, narrow or conflicting eligibility criteria means people are often considered ineligible for support from one service or another.

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People in the NE show high levels of unmet need in terms of substance use and mental ill health. On average, people in this region drink more, experience more alcohol-related harm and have poorer mental health than in other parts of England. Over the pandemic, this has worsened, and the gap between the NE and elsewhere has increased.

Opportunities to provide more joined-up care for people with complex needs include integrated care systems, and use of digital technology in care provision. However, care providers can struggle to work across boundaries (organisational or geographical) and there are barriers to people accessing care online. **O'Donnell** summarised the aims of the study:

1 Explore how support for service users with co-occurring heavy drinking and depression is delivered in the NE.

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2 Develop a resource to help patients navigate and better access the right care at the right time.

Dr Kat Jackson (@KatJ79) moved on to the design of the study. This first stage consisted of interviews with 39 service users, who were drinking above harmful levels, and were experiencing mild-moderate depression. The interviews allowed participants to discuss positive and negative experiences of accessing support in-person and digitally.

Jackson presented three comics exemplifying some of the complex and varied experiences reported by participants, then outlined the three common themes identified through analysis of the interviews.

Lack of recognition

Participants reported their perception that their drinking partly stemmed from their depression, and that they used alcohol to escape or dampen feelings associated with depression. Some highlighted a perceived worsening of mental health due to alcohol consumption. The relationship perceived by participants between depression and alcohol was sometimes dismissed by care professionals.

Almost all participants mentioned the separate nature of alcohol and mental health services. They also noted that GPs didn't routinely ask about alcohol use if they were experiencing depression and vice versa. While the stigma and shame associated with heavy drinking may deter many from discussing alcohol consumption levels with care providers, some participants did suggest that they would have opened up if they had been asked about their drinking.

An overarching theme is personal responsibility. Participants felt they were responsible for managing their drinking themselves.

Nowhere to go

Participants mentioned GPs lacking information about alcohol services, mental health professionals being unable to offer help while they were drinking or lacking skills and knowledge to support a reduction in drinking, and alcohol service staff lacking professional expertise on the treatment of mental ill-health.

Some participants had been in touch with their GP about depression, but when they disclosed heavy drinking, they were no longer able to get support. Expectations of people to make unsupported self-referrals could sometimes pose a barrier to accessing support.

Participants were often told to seek help for heavy drinking before mental health support could be provided. Because of this, there were examples of times when participants had no support at all.

Inequalities in care and support

Some participants noted they had been able to access mental health support in community alcohol services, AA, or Smart Meetings. Some mentioned they had accessed support for their mental health and wellbeing through community or voluntary organisations while they waited for statutory mental health support.

However, availability of this kind of support varied greatly across the NE, as did the way participants found out about them.

Another area of inequality was having friends and family who could act as advocates. Most participants did not have a strong network, but this was portrayed as very important by those who did. This frequent lack of social support meant participants were often very reliant on professional support, which varied hugely.

Conclusions

O'Donnell highlighted the main issues:

1 Fragmented care delivery. Design of the care system, with single services focused on single issues, is at odds with the complex needs of heavy drinkers with depression.

2 Under-resourced substance use and mental health services. Care professionals are struggling to cope with volume of need and sometimes lack appropriate skills and expertise.

3 Physical, social and economic barriers to access.

Implications for policy and practice

Meaningful implementation of joined-up care is required so people can access comprehensive support wherever they enter the system. In part, this will require upskilling care professionals. Structural changes such as this must reflect the needs and wishes of service users.

There must be a formal and meaningful recognition of the link between drinking and mental health by service providers.

Care provision must be tailored to service users' abilities, capacities, and resources – this includes material support and health literacy, but it is also essential that the formal system recognises and facilitates social and peer networks.

Next steps

Service providers were also interviewed, and these results will be shared soon.

Workshops are now being held to develop and refine a digital resource. This may comprise a suite of tools and functions, e.g. a directory of support services to help people access social, peer and professional support.

The final phase will involve piloting this resource, most likely in primary care

Visit the study's website

NIHR ADEPT Study

Watch this seminar

You can watch this seminar, and other recent webinars

SHAAP Blog

Read our blog, including posts on alcohol screening/interventions in prisons, and the PCANOS model.

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