ADDICTION   SSA

Understanding people's experiences of the formal health and social care system for co-occurring heavy alcohol use and depression through the lens of relational autonomy: A qualitative study

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Abstract

Background and Aims: Heavy alcohol use and depression commonly co-occur. However, health and social care services rarely provide coordinated support for these conditions. Using relational autonomy, which recognizes how social and economic contexts and relational support alter people's capacity for agency, this study aimed to (1) explore how people experience formal care provision for co-occurring alcohol use and depression, (2) consider how this context could lead to adverse outcomes for individuals and (3) understand the implications of these experiences for future policy and practice.

Design: Semi-structured qualitative interviews underpinned by the methodology of interpretive description.

Setting: North East and North Cumbria, UK.

Participants: Thirty-nine people (21 men and 18 women) with current or recent experience of co-occurring heavy alcohol use ([Alcohol Use Disorders Identification Test [AUDIT] score ≥ 8]) and depression ([Patient Health Questionnaire test ≥ 5] screening tools to give an indication of their current levels of alcohol use and mental score).

Measurements: Semi-structured interview guide supported in-depth exploration of the treatment and care people had sought and received for heavy alcohol use and depression.

Findings: Most participants perceived depression as a key factor contributing to their heavy alcohol use. Three key themes were identified: (1) 'lack of recognition' of a relationship between alcohol use and depression and/or contexts that limit people's capacity to access help, (2) having 'nowhere to go' to access relevant treatment and care and (3) 'supporting relational autonomy' as opposed to assuming that individuals can organize their own care and recovery. Lack of access to appropriate treatment and provision that disregards individuals' differential capacity for agency may contribute to delays in help-seeking, increased distress and suicidal ideation.

Conclusions: Among people with co-occurring heavy alcohol use and depression, lack of recognition of a relationship between alcohol use and depression and formal care

provision that does not acknowledge people's social and economic context, including their intrinsic need for relational support, may contribute to distress and limit their capacity to get well.

INTRODUCTION

Evidence from population-based studies and treatment subgroups shows that heavy drinking and depression frequently co-occur [1–4]. Approximately a third of those who drink excessively (defined as more than 14 units of alcohol per week in the United Kingdom, where one unit equates to 8 g of pure alcohol [5]), will also have experienced a major depressive disorder (according to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria [6]) at some point in their life-time [7, 8]. The relationship between heavy drinking and depression is complex and bidirectional. People with depression are more likely to drink harmfully, potentially using alcohol to self-medicate depressive symptoms [9], and harmful levels of alcohol can act as a physiological depressant [10]. Genetic, social and environmental factors may also increase the risk [11]. Experiencing these conditions simultaneously appears to have an additive or synergistic effect, being associated with higher rates of self-harm and suicide, particularly in men, and worse treatment outcomes, than in those who experience either heavy drinking or depression alone [12–16].

People experiencing co-occurring heavy alcohol use and depression can struggle to receive appropriate treatment and care [17]. Key factors contributing to this global care gap include fragmented and uncoordinated health services and a lack of skills and resources among care professionals [18, 19]. In England, for example, multiple service providers are involved in the prevention and treatment of co-occurring heavy drinking and depression, including primary, secondary and specialist care, as well voluntary and community sector (VCS) organizations [20]. Transitions between providers are potential risk-points for disjointed and incomplete treatment [21] and place a burden on individuals to co-ordinate their own care [22, 23]. Moreover, despite widespread recognition of the need for 'no wrong door' for individuals with co-occurring or multiple morbidities in policy documents [24–28], current practice still focuses primarily on the identification and treatment of single diagnoses [29–31]. In some cases, application of narrow and/or conflicting eligibility criteria means that individuals are effectively 'blocked' from accessing appropriate care. For example, people who report heavy alcohol use often find themselves excluded from improving access to psychological therapies services (IAPT) which provide first-line interventions for depression and anxiety disorders in the United Kingdom, despite guidance recommending that they should be able to access appropriate psychological interventions [32]. This may be challenging for people with more limited social or material resources and further exacerbated by the

adverse effects of ongoing depression and alcohol use on their motivation and decision-making capacity [33].

Qualitative research has the potential to shed light on aspects of phenomena that may otherwise be unknown and elucidate the complexity and social context of quantitative observations [34–36]. Previous research has explored experiences of people living with co-occurring heavy alcohol use and depression in different countries and settings [31, 37–42]. These studies show how socio-cultural factors, such as the dual stigma attached to both dependent drinking and mental ill-health, compound the challenge of seeking and receiving appropriate support in these disconnected health and social care systems [37, 40, 42]. Findings also indicate that while people commonly perceive their drinking and mental ill-health as connected, this association is seldom recognized within formal care provision [38, 39, 42]. Importantly, however, evidence suggests that therapeutic relationships in which people feel their experiences are listened to and acknowledged appear most conducive to recovery [37–39]. For example, a recent Australian study about help-seeking for suicidal people with heavy drinking and depression found that provision of positive support throughout the care system was critical to their decision not to die by suicide [40].

Building upon this existing qualitative research, we aimed to advance understanding of how people experience formal care provision for co-occurring heavy alcohol use and depression and consider how it could be leading to such adverse outcomes for some individuals. We do so by interpreting empirical data from 39 people with co-occurring heavy alcohol use and depression using the theoretical concept of relational autonomy from critical feminist theory.

Theoretical framework

Initially proposed by feminist bioethicists [43], the concept of relational autonomy challenges existing health-care frameworks focused upon personal responsibility and independence that are inattentive to issues of social justice. Relational autonomy emphasizes that people can be subject to oppressive contexts that can damage how they can or want to act [44, 45]. It stresses how social and economic systems, including professional and personal relationships, influence the development of people's capacity for agency or autonomy [44, 46]. Here, we take agency to mean the things people can do to access help for their health and social care needs [22]; for example, access to economic and other material resources (such as money, a home or transport) can make it easier for people to choose certain options in their

lives, such as engaging with specific types of health or social care provision [44, 47]. However, over and above existing health inequalities approaches, relational autonomy explicitly recognizes people as interdependent. As such, it acknowledges that as well as material agency, people also require support in both personal and professional relationships for both their everyday wellbeing and their ability to get well at times of illness or distress [44, 45, 48]. This relational support includes both the direct provision of care and an individual's perception that they matter to others through the support they are offered [46, 48]. Lack of opportunity to develop a sense of self-worth through supportive relationships and interactions diminishes their capacity or motivation to take action [46, 47]. Through the lens of relational autonomy, we intend to extend insights from existing qualitative research with people with co-occurring heavy drinking and depression, moving beyond descriptions of experience, to provide an explanation for why the current health-care system can be so challenging for these individuals.

METHODS AND METHODOLOGY

This qualitative study was conducted in the formative stage of ADEPT, a mixed-methods research project, which aims to develop an intervention to help improve formal care provision for people with co-occurring heavy alcohol use and depression. In England, formal care for people with problematic substance use and/or mental ill-health includes: (1) statutory public sector services that are funded and regulated by the government, including National Health Service (NHS) primary, secondary and tertiary care, plus community alcohol and mental health services which may be provided via VCS organizations; (2) non-statutory care provided by VCS organizations that are constitutionally independent and broadly speaking funded via a combination of charitable donations, grants and investments [49]; and (3) private care, which is paid for directly by individuals. Such provision can be differentiated from informal care, which is provided by one or more members of an individual's social network, such as family, partners, friends and colleagues, and is generally unpaid [50].

The study is based in the North East and North Cumbria (NENC) integrated care system (ICS) region in England. This region has the highest levels of alcohol-related morbidity and mortality in England [51] and higher than average levels of deprivation compared to other regions [52], a situation which worsened during the COVID-19 pandemic [53]. The fieldwork was undertaken between June 2021 and May 2022. During this period, social distancing measures due to the COVID-19 pandemic were still in place in England, which affected face-to-face provision of much health and social care support [54, 55]. Thus, while the pandemic was not the focus of this study, it provided a unique backdrop to both how the research was conducted and the service user views and experiences we gathered.

We have approached the study drawing upon the methodology of interpretive description [56]. Interpretive description is intended to be used to provide insights into health contexts that are relevant to health and social care practice, but go beyond the obvious to inform future work [56]. The methodology is aligned with an interpretive orientation which is attentive to subjective knowledge and concerned with the context of and meanings attributed to phenomena [57]. As such, while we present participants' accounts of their experiences, our focus is upon how their accounts are told, what they have chosen to emphasize and the shared and different meanings they attribute to them. We used the method of individual semi-structured interviews so that participants could talk privately about their experiences and guide the direction of the discussion. The semi-structured format ensured the questions focused upon the phenomena of interest [58]. The study was approved by an NHS Ethics Committee (North East–Tyne and Wear South Research Ethics Committee, reference 21/NE/0064).

Adults (aged 18+) living in the NENC ICS area, with self-identified current or recent (within past 3 years) hazardous or harmful alcohol use and mild to moderate depression were eligible to participate in the study. For individuals who identified as drinking alcohol dependently or with severe depression, we explored whether it was appropriate for them to participate (either directly or via the services they were in touch with) and whether there could be any risk to the researcher or service users from doing so. However, no participants were excluded due to a perceived risk.

We used purposive sampling techniques to ensure that people with different demographic characteristics, which we felt were important based on previous research and clinical experience, were included in the sample; that is, socio-economic status, ethnicity and gender. Participants were recruited through VCS organizations, such as social housing providers, mental health charities and community alcohol services, directly/face-to-face (*n* = 20). They were also recruited via senior group leaders in VCS organizations, who provided service users with paper or electronic versions of the study information and asked them to contact the research team if they were interested in taking part (*n* = 14). Additionally, four primary care practices based in the NENC mailed information to patients identified by their health records as experiencing depression and heavy alcohol use and asked them to contact the research team if they were interested in taking part. Five participants responded to this out of a possible 60 individuals identified as meeting our inclusion criteria across the four practices. Overall, the purposive sampling approach was operationalized iteratively by regularly reviewing the characteristics of existing participants and making attempts to fill gaps in demographic criteria through engagement with relevant organizations; for example, in the later stages of the study we engaged with women's groups to address the lower response rate from women. We also tried to engage with groups working with Black and minority ethnic populations, although ultimately no participants were recruited in this way.

Prior to all the interviews, potential participants were provided with verbal and written information about the study and gave their consent to be interviewed. Twenty participants gave written consent and 19 provided verbal recorded consent. At the outset of most interviews participants were asked a short demographic questionnaire and the Alcohol Use Disorders Identification Test (AUDIT) and

Patient Health Questionnaire-9 screening tools to give an indication of their current levels of alcohol use and mental health. Interviews were all carried out by K.J., either over the telephone ($n = 20$), face-to-face in private rooms in community venues ($n = 12$) or using an on-line video conferencing platform ($n = $ seven). The interview topic guide focused upon people's perceptions of the relationship between their alcohol use and depression and views about how well services have worked together to support them (see the Supporting information). Interviews lasted between 17 and 89 minutes (average = 47 minutes). All but one interview was audio-recorded, transcribed by a professional transcription company and checked for errors and fully anonymized by K.J. For the interview that was not audio-recorded, details were made about the discussion immediately after the interview and these were included in the wider body of data. The names used in this paper are pseudonyms to preserve participant anonymity.

Analysis began while data collection was ongoing and involved a process of familiarization with the transcripts and making analytical notes about common or thought-provoking areas in participants' accounts. K.J. then inductively coded the first 18 interviews and made a coding framework of both semantic and latent codes. New inductive codes were added to the framework when they were identified in subsequent transcripts and a process of constant comparison was followed, which involved comparing back and forth across accounts and exploring similarities and differences in the data. Data collection ceased when data sufficiency was judged to have occurred, when we were repeatedly making similar observations and noticing patterns in the data which we felt may contribute to our knowledge of these phenomena (for an in-depth account of this specific analytical approach, see chapters 8–9 of [56]). NVivo software was used for storing and supporting the coding of the data [59]. Through this process, four initial themes were developed, bringing together several of the codes (see the Supporting information). These were discussed with the study Principal Investigator (PI) (A.O.D.) and the study patient and public involvement (PPI) group, who provided critical reflection in relation to their own lived experiences of these issues [60]. After these discussions, the first author returned to the transcripts and adapted the interpretation to incorporate these insights and further refined and developed themes. At this stage, the challenges to autonomy and capacity for agency cut across all the themes. Thus, the concept of relational autonomy was used to frame and illuminate these insights.

The researcher (K.J.) is White British, aged 40–49 years, middle class and a social scientist. She has experience of interviewing people regarding depression and heavy alcohol use, but no direct personal experience of these issues. She has been a researcher in the field of substance use for some time and is particularly concerned with health inequalities experienced by this population; thus, her interpretation was attentive to this. Comments from the study PPI group, PI (A.O.D.) and co-authors helped to enhance the validity of the analysis.

TABLE 1 Socio-economic and demographic characteristics of interview participants.

Characteristic	No. (%)[b]
Gender	
Male	21 (54%)
Female	18 (46%)
Age (years)	
20–29	1 (3%)
30–39	10 (26%)
40–49	11 (28%)
50–59	13 (33%)
60–69	4 (10%)
Ethnicity	
White British	36 (92%)
Other (mixed, White European, White Other)	3 (8%)
Socio-economic status based on IMD score (area)	
Most deprived (IMD—1–5)	28 (72%)
Least deprived (IMD—6–10)	11 (28%)
Relationship status	
Single	23 (59%)
In a relationship—not living together	7 (18%)
Married/lives with partner	9 (23%)
Employment status	
Not in paid employment	23 (59%)
Full- or part-time paid employment	10 (26%)
Sick leave from full or part-time employment	5 (13%)
Studying/training	1 (3%)
AUDIT score[a]	
Low risk (0–7)	0 (0%)
Medium risk (8–15)	6 (15%)
High risk (16–19)	2 (5%)
Addiction likely (20+)	10 (26%)
Not currently drinking	17 (44%)
Not asked/missing data	4 (10%)
Depression severity[a]	
0–4 none	5 (13%)
5–9 mild	8 (21%)
10–14 moderate	9 (23%)
15–19 moderately severe	6 (15%)
20–27 severe	6 (15%)
Not asked/missing data	5 (13%)
Total	39

[a]Score at time of interview; all interviewees suggested high risk or possible dependent drinking and moderate or above depression in past 3 years.
[b]Percentages have been rounded to nearest whole number.
IMD = Index of Multiple Deprivation; AUDIT = Alcohol Use Disorders Identification Test.

RESULTS

Thirty-nine people with current or recent experience of heavy alcohol use and depression were interviewed (see Table 1 for demographic information, aggregated to maintain anonymity). Many participants also had experience of other mental ill-health, substance use and physical health conditions. They had used a wide range of formal services, including on-line or other digital support, which became more common during the pandemic. Twenty-one participants were male (54%) and 18 were female (46%); most (92%) were White British. Twenty-eight participants (72%) lived in the most socially deprived areas of the region, based on Index of Multiple Deprivation (IMD) score [61]. Many were in receipt of benefits and had used foodbanks, and some were experiencing homelessness.

In this section, we present the two conceptual themes which describe the challenges people faced to getting well and accessing support: 'lack of recognition' and 'nowhere to go'. The third theme, 'supporting relational autonomy', highlights areas where people described interactions with services that seemed to recognize their social contexts and where relational support was being offered in professional and personal networks (see the Supporting information).

Lack of recognition

Almost all participants conveyed that they believed that their depression and heavy alcohol use were intimately related. Most commonly, people suggested that their depression preceded their alcohol use, and they had used alcohol to try to 'escape' or dampen negative feelings. As such, like Sebastian, many indicated that they felt it was challenging to effectively tackle their drinking without first addressing their mental health:

> I hit the drink because of my mental health and my depression… if that had been cured, sorted… the mental health side of it, I don't think I'd have been drinking, or drinking like I am… In my opinion, once the mental health side of it is dealt with, then the drinking would stop
> (Sebastian, male, IMD score 4, 40–49 years).

However, most people's accounts indicated that they had experienced services as separate entities, with limited information sharing between agencies. Moreover, most participants' accounts suggested that the relationship between the conditions was not commonly acknowledged during their interactions with most statutory care providers, particularly in primary health-care and mental health services. Some participants explained that they had been receiving anti-depressant medication from their general practitioner (GP) for an extended

period, but had never been asked about their alcohol use, despite feeling that their drinking was problematic:

> I've drank since I was probably about 14, and quite heavily, since I was probably 17 or 18… When I have been feeling depressed, at my worst, and I've been to the doctors, he's always just given me antidepressants
> (Naomi, female, IMD score 6, 40–49 years).

Many people's accounts suggested that stigma around alcohol use had delayed or prevented them from disclosing their heavy alcohol use; again, particularly in primary care and statutory mental health services. Moreover, people's accounts also indicated that even once in contact with relevant services, lack of relational support from care professionals, set against this wider backdrop of social stigma, constrained their capacity to fully disclose their drinking. For example, Pat, who was still drinking at the time of interview, described his interaction with the community mental health team:

> If I haven't emphasized my alcohol use, well I have made them aware, but I haven't emphasized it, maybe it's because there's a lot of shame involved. I don't know. I just felt like if help had been offered, I probably would have gone for it, but with a lot of things, I'm just getting the impression that I have to sort myself out…
> (Pat, male, IMD score 1, 30–39 years).

Pat's comment here and his wider account suggested he retained a strong sense of being made to feel that he was to blame for his alcohol use and associated mental health and should therefore take personal responsibility for getting well. This subtheme of personal responsibility was evident across many other participants' narratives of their experiences of statutory care. As well as ultimately leaving them to manage alone, when delivered with this focus on personal responsibility it also appeared to lead to people feeling uncared for, exacerbating their existing low self-worth.

Furthermore, many people discussed practices they had encountered at various points in statutory services which did not seem to either recognize their distress or acknowledge their social context and conditions which might affect their autonomy. Most notably, missed appointment penalties, whereby people were discharged from a service if they did not attend, appeared particularly challenging. People spoke frequently about missing appointments, often because of ongoing distress, with the discharge policy meaning that they would then either be left to manage alone or find their way back onto waiting lists. These practices were evident within statutory health-care services, but also in other organizations that people interacted with that were also important their wellbeing. This was exemplified by Harold, who explained how he had

been penalized for missing appointments with the benefits agency:

> ...you've got to be there for (appointments), because if you miss them, you can't get back in touch with (services), if they think that you're not answering. They just presume that you've got internet connection
>
> (Harold, Male, male, IMD score 3, 40–49 years).

Harold's account also illustrates how economic factors can constrain access to relevant support; in this example, being unable to afford the data and technology required. Other people spoke about being expected to attend appointments during standard office hours in jobs where there was limited flexibility or having no access to the necessary transport or childcare.

Moreover, people's narratives indicated how the process of signposting or self-referral could be challenging to navigate alone. Some said they had not gone on to seek help when they were told to self-refer to services because they did not feel up to it or because they had a negative experience when they did try to access services. For example, Jim, who had a physical disability, explained that he had sought help for alcohol use from his GP when encouraged by his wife, and was simply given a phone number to call:

> The doctors gave me a number of a group. I phoned them and they phoned me back and said, 'We're very busy'. So, I thought, 'Oh, fair enough'
>
> (Jim, male, IMD score 2, 60–69 years).

Jim's account points to the value of the relational support he received from his wife to take the first step towards recovery, which was illustrated by a few other people who had partners they described as supportive. However, relational support was absent in his interactions with both his GP and the group he attempted to contact. At the time of interview, Jim was trying to reduce his heavy drinking by himself.

Nowhere to go

Numerous participants' accounts conveyed that when they told health professionals about their heavy alcohol use they became ineligible to receive statutory mental health care. To illustrate, Yvonne explained that she had been on anti-depressant medication for a long time, but when she disclosed her alcohol consumption to her GP they immediately stopped her depression medication. Yvonne was then left to try to tackle her alcohol use alone, while also lacking support for her depression:

> I had asked if there was something they could do to change my [anti-depressant] 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, IMD score 5, 50–59 years).

Some people expressed frustration at not being able to get help at points of mental health crisis due to their drinking, which further contributed to their distress and, in some instances, suicidal ideation. For example, Bobby described how he came to plan his suicide after being turned away from the hospital psychiatric liaison service because of his levels of alcohol use:

> ...I went to [the hospital] and said to them, 'I am having intrusive suicidal thoughts. I don't know why. I'm frightened'. And their response was, 'Unless you reduce your alcohol to 13 units a week, you will receive no treatment from the NHS or from private practice'. And I came out of [the hospital] and thought, 'Well, that's it then. That's it. Nothing is going to change; I'm not going to get any help'. Three weeks later, I had planned and organized my suicide ...
>
> (Bobby, male, IMD score 6, 50–59 years).

Like others, Bobby's account suggests that lack of recognition of the link between his drinking and depression, and his sense of having nowhere to go to access support, contributed to his feelings of distress. Bobby explained that he was living alone at this point with a limited social network and had no recourse to any economic resources which might have offered other options for care. He later indicated that he had subsequently received some support from the local mental health crisis team and was feeling reasonably well at the time of the interview. He commented: 'It's just knowing that there is somebody there who will help and will listen to me, and will not say, "Get lost"'. Other participants described a sense of abandonment by statutory services, where they were 'pushed out' of every service they tried to access and forced to take personal responsibility for their own recovery. Several mentioned how difficult it was to self-advocate for support when they were distressed or depressed, meaning that they would instead return to using alcohol or other substances for relief.

The small number of participants who had access to economic resources explained how they had been able to obtain private care that appeared to be able to address their alcohol use and depression together, could be accessed quickly without a long waiting list and did not sanction them for missing appointments. To illustrate, Tessa described how during the COVID-19 lockdowns she had accessed support through a private on-line therapist who had addressed her alcohol use and depression together and worked with her immediately, rather than putting her on a waiting list:

> I was like, 'Well, this can't be real', and then, actually I was like, 'Oh, no, it is real. It's actually really helpful'. It was great—because you're paying for a service, you got immediate attention. You didn't have to wait for

referral if you were having a bad day…

(Tessa, female, IMD score 6, 30–39 years).

The experiences of these few participants who accessed private care served to further illustrate the constraints experienced by most of our participants who did not benefit from the same financial resources.

Participants often implied that health-care professionals sometimes lacked knowledge and awareness of appropriate local specialist alcohol and mental health services, meaning that they were not always provided with the information they needed to access support. The implications of this were indicated by Olivia, who, having been told to stop taking depression medication because of her drinking, explained that when she asked her GP for help for her drinking during the pandemic they had signposted her to Alcoholics Anonymous (AA). However, her local AA was not open for face-to-face meetings, and she had no access to a computer to join on-line groups. Moreover, her GP had not offered her any advice about how to safely reduce her drinking at that point:

> 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, IMD score 6, 30–39 years).

A few people also gave examples of being referred by their GP and other services to statutory mental health-care that they were subsequently told they could not access because they were still drinking.

Relational autonomy emphasizes the importance of personal as well as professional relationships for aiding everyday wellbeing, as well as at times of crisis. As indicated above, some participants appeared to lack access to any social networks. Others described complex and difficult personal relationships with family. For example, Dominique explained she had undergone an acute admission to hospital with an alcohol-related illness, not having previously sought formal help for her drinking, partly due to her embarrassment and shame. She lived alone and when she was discharged from hospital, her only formal support was through irregular appointments with a key worker from the community alcohol service. She suggested she received no practical or emotional support in her personal life:

> 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. The same as my [adult children] they know why I was poorly, but I think it's a conversation that we don't have
>
> (Dominique, female, IMD score 5, 50–59 years).

The embarrassment Dominique felt discussing alcohol with her family was evident in her narrative. She described that her key worker had helped her to access a foodbank because she gave up her job when she became unwell and was struggling financially. As with some other participants, the stigma of Dominique's condition left her feeling unable to get support from her personal networks when the available professional options were limited. Moreover, her adverse economic situation further contributed to her limited self-worth and capacity to engage in other activities that could have otherwise supported her recovery.

Supporting relational autonomy

Although many elements of statutory services did not seem to either recognize or support people's relational autonomy, a few participants' accounts suggested that at times they had been able to access support that acknowledged explicitly the relationship between their alcohol use and depression, and/or which 'pulled them in' to the care system. For example, Irene described the support she had from her NHS psychiatrist who:

> …saw me as a whole person. And I just felt, again, held, validated, understood. I felt like he was on my side
>
> (Irene, female, IMD score 1, 50–59 years).

Indeed, good care was often framed as care in which practitioners were compassionate, acknowledged the relationship between their drinking and depression and recognized and supported them with their wider social or economic needs such as housing, access to benefits or paid employment. Many participants who had accessed community alcohol services described benefiting from this type of support, although some still highlighted the need for formal mental health-care to be provided within that wider package. For example, Katie said that her community alcohol service had provided her with medication to reduce her alcohol consumption as well as tailoring treatment delivery to accommodate paid work. Indeed, throughout the accounts it was evident that participants who were in employment appreciated when services recognized and considered their need to engage in paid work by providing treatment and support at a time that was convenient to them rather than expecting them to come in their working hours. Katie conveyed that feeling the service cared for her positively affected her recovery and general wellbeing, particularly while she remained on a 6-month waiting-list for mental health services:

> In the time where I was in-between, where I didn't have any other mental health support, it was really helpful to have them
>
> (Katie, female, IMD score 2, 20–29 years).

Several participants had accessed support for their mental health from VCS organizations, including via local authority funded providers. People suggested that these organizations were often able to provide mental health support even if they were still drinking or while they waited to access statutory mental health services. Additionally, in comparison to the statutory care systems, participants conveyed a sense that VCS

providers offered a non-judgemental 'listening ear', who would check-in with them on a regular basis and facilitate access to other local services to support their wider social and economic needs. For example, Ethan, who had spent years being unable to access any treatment for his drinking or mental health, had recently started getting support from a local authority-based key worker who had helped him with his financial situation and made him feel cared for. He explained:

> She has sorted out some debt problems. Well, she put us onto somebody and sorted out some debt problems. She just checks in; sees how I am doing
>
> (Ethan, male, IMD score 2, 40–49 years).

Similarly, some people spoke about the value of access to peer support via community alcohol services, AA, self-management and recovery training (SMART) and sometimes VCS organizations. Whether this came from working with a paid professional with relevant lived experience or via one-to-one recovery sponsor-type relationships or group meetings, there was a sense that peer support access helped people feel less judged and more validated in their care needs and, for some, helped them to establish a wider social network to assist in their care and recovery.

Moreover, and importantly, in addition to the value of having supportive partners, as already noted, several peoples' accounts illustrated the valuable roles that close friends, extended family members and colleagues could play in helping the participants navigate the system and access support when unwell. For example, Olivia, who had not been offered any support to reduce her heavy drinking by her GP and had no access to a computer, explained that a friend who lived in another area of England who also had experience of addiction, told her not to reduce her heavy alcohol use suddenly in case of withdrawal and looked up contact details of the local community alcohol service for her on the internet. Olivia subsequently went on to receive support from the local alcohol service to reduce her drinking, who also signposted her to help for her depression once she was sober.

> Basically, I was left to my own devices for the whole of lockdown, and I think if it hadn't been for my friend telling me about recovery, and everything, I wouldn't have known about any outside help, as well, to deal with my mental health
>
> (Olivia, female, IMD score 6, 30–39 years).

Here, we see that Olivia explicitly linked her friend's support to her ability to exercise autonomy and credited her friend with keeping her alive in the absence of professional support. Similarly, Belinda described how her family had advocated for her to continue to get help when statutory mental health services tried to discharge her due to missed appointments:

> …if you shut yourself off, and don't answer your phone, and don't engage, it makes the services, they cut you off… And 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, IMD score 6, 30–39 years).

Belinda's account suggests that without her family's advocacy, access to professional support would have ended. Equally, a few participants spoke about the value of having employers who showed concern for their recovery and wellbeing and tried to put help in place for them:

> [my workplace] were like, 'What can we do once you get back?'… 'Would you find it easier not having the Monday?'. Which I think probably would help me. And there's not a lot work can do, except be supportive, I think
>
> (Naomi, female, IMD score 6, 40–49 years).

Like others, these accounts highlighted the value of having support from their personal, peer and professional networks as they navigated formal care provision as integral to their subjective self-value and ultimately capacity to get well.

DISCUSSION

In this qualitative analysis, by capturing the experiences of people with co-occurring heavy alcohol use and depression through the theoretical lens of relational autonomy, we identify fundamental flaws in current service provision for this population. In so doing, our findings validate those of other international qualitative studies and illustrate the practical challenges such individuals face in navigating the complex and fragmented English health and social care system. By using relational autonomy to interpret these challenges, and specifically, its emphasis on both socio-economic context and relationality, we take existing insights further to provide explanations for why these systematic deficits result in such negative outcomes for so many people and where opportunities might exist to improve provision. This lens also links our interpretation to a body of theoretical scholarship which, while novel, is being used progressively by international scholars to theorize different phenomena in the field of addiction [33, 45].

Critically, and as other studies have found [31, 38, 39, 42], our data indicate that although people often perceive their depression and alcohol use as related, and despite strong epidemiological evidence of the bidirectional and additive nature of these conditions [15, 62], the link is not routinely acknowledged in formal care provision. This disconnect is evidenced by both the siloed design and delivery of most formal services and in the interactions that people have with care professionals among a range of settings. This systemic lack of recognition is understandably upsetting for individuals who are attempting to access appropriate treatments for co-occurring disorders and serves to undermine their often already fragile sense of self-worth which, in turn, constrains their recovery capacity [37, 63, 64]. Feminist relational theorists term the 'silencing' of the voices of

certain groups of people as 'epistemic injustice' [65]. They argue that this silencing both constrains people from accessing appropriate help and furthers the oppression they experience in daily life [46]. In line with previous studies, our findings suggest that some VCS organizations, community alcohol services and private care providers who might be working within more social paradigms of practice appeared more prepared to recognize the relationship between an individual's drinking and depression [66–68]. However, where such support existed, unless underpinned by statutory provision for depression, individuals were unable to obtain the clinical treatments they perceived as vital for their care and recovery.

Existing UK guidelines for coexisting severe mental illness and substance misuse recommend that care providers undertake a comprehensive assessment of the person's mental health and substance misuse needs at first contact [25], with recognition elsewhere that this should take into account an individual's beliefs about the biological, social and familial influences on their mental health problems [69]. Our findings concur with more recent guidelines developed in Australia that recommend a more overtly collaborative approach to care formulation, which seeks to contextualize a service user's experiences and knowledge of themselves—and critically their condition—within a care provider's own clinical expertise [70]. This collaborative, and thus implicitly relational, model of care formulation needs to be operationalized within a system which provides 'no wrong door' for people to access help, alongside improved training provision, potentially on a reciprocal basis, so that mental health and substance use practitioners can respond more effectively to the needs of people with co-occurring issues [24–26, 38, 39, 71, 72].

Our purposive sampling approach ensured that we collected data from people living in the most deprived social circumstances [73]. This, together with the theory, allowed us to illustrate how the formal English health and social care system appears to be particularly failing people with co-occurring heavy alcohol use and depression who are socio-economically marginalized. We indicate that the poverty experienced by many people with these conditions limits their material capacity to engage with services and that these economic challenges are seldom recognized by the statutory care system. Again, in contrast to statutory services, people suggested that VCS providers were more able to appreciate how poverty adversely affected both peoples' alcohol use and mental health, as well as their ability to seek and benefit from available care. For example, we highlighted cases where people had been put in touch with benefits support and food banks as part of their recovery package. While current UK clinical guidelines stress the need for care providers to address any wider unmet needs, such as physical health issues, problems obtaining benefits or unstable housing, in people with coexisting severe mental illness and substance misuse [25] and to 'encourage' people with mild to moderate depression to access help from other agencies for additional medical, personal, social or environmental factors that may affect their care [74], we found limited evidence that these recommendations are currently being followed. There is a clear need for statutory providers to be more strongly directed to implement more person-centred, holistic models of care, which address the social determinants of health such

as people's financial situations and housing needs [75] to create a context in which long-term recovery is possible.

In England, there have been a number of local pilot projects of new models of care for people with co-occurring substance use, mental health, homeless and other complex needs that aim to address system fragmentation, take account of people's social, economic and relational circumstances and work intensively and flexibly towards a person's aims and goals [76–78]. For example, the current Changing Futures Programme allocates individuals with key workers, provides assertive outreach, has no time limit on support and helps to coordinate access to care [78]. If these programmes prove to be successful, there would be value in looking to incorporate similar practices within statutory provision. Currently, our participants' accounts indicated that access to such models of care, generally via the VCS, is geographically unequal and even where options do exist, many people lacked awareness. Digital technology has been proposed as having potential to increase parity of access to formal care throughout the United Kingdom, particularly for those living in isolated rural areas [79]. However, while we spoke to a few people such as Tessa, who had the economic capital to access on-line therapy, participants' accounts more often reflected those of Harold, who lacked internet access and faced heightened digital exclusion during the COVID-19 lockdowns when many services were taken on-line. Thus, like previous researchers, we urge caution in efforts to further digitize substance use and mental health services, given that this may ultimately serve to widen existing health disparities, as opposed to reducing them [80, 81].

By drawing on the lens of relational autonomy, a key contribution of the study is that we highlight not just the material impact of economic deprivation, but also how poverty led to diminished feelings of self-worth among our participants which were, in turn, exacerbated by the continued stigma attached to substance use and mental ill-health [82]. Relational feminist theorists and sociologists underscore how stigma, as a structural form of oppression, inhibits people's capacity to act autonomously in the context of substance use [44, 47, 82]. Indeed, as well as shaping interactions with formal care professionals, the impact of stigma was evident in people's accounts of help-seeking within their personal relationships. But despite experiencing continued structural oppression in their private and personal lives, with limited social or economic resources available to them, people with co-occurring heavy drinking and depression are made to feel both to blame for their heavy drinking and subsequent depression and held personally responsible for coordinating and committing to their recovery [40, 83]. Our participants described critical steps in the care pathway that demanded a level of agency on their part; for example, the use of signposting or self-referral to specialist services, or application of penalties for missed appointments, which were used to evidence and stimulate compliance to 'getting well'. Such practices presuppose that individuals have the socio-economic capacity to manage the necessary work-load involved in their care [22, 84], and in so doing contradict substantial evidence of the adverse impact of poverty on mental health and the heightened alcohol-related harms experienced by those living in relative deprivation [44, 73, 85, 86]. Echoing

Pauly [33], a key implication of our findings is the urgent need to replace such practices with those more closely aligned to the models of care that people value in the VCS sector that recognize peoples' need for tangible relational help to access support [78]. For example, people should be offered supported referrals, provided with interim assistance while on mental health waiting lists and not be penalized for missed appointments without any consideration of their wider circumstances [70].

Additionally, our theoretical lens underlines that people often need relational support in their personal relationships to seek, engage with and benefit from available formal services. This need is heightened in the current resource-constrained system, where people are often required to manage alone for long periods until they reach the top of the waiting list or to navigate care between disparate and unreceptive services [22]. Our study identified a few examples of the role played by positive personal relationships in supporting people's autonomy by helping them to access and engage with formal services. While unpaid care should not be seen as an alternative to a well-funded and appropriate formal health-care system, not least given the significant adversity such individuals frequently experience themselves [87, 88], our findings suggest that there would be value in recognizing and better supporting (economically, practically and emotionally) the valuable role they play in the lives of people with co-occurring heavy drinking and depression. For example, in England, the organization 'Adfam' have developed a toolkit and training package for professionals involved with supporting families with co-occurring mental ill-health and substance use [89]. At the same time, it should be emphasized that most participants described having limited informal networks and lived in relative social isolation. As such, a further implication of our work is that care providers should ask about and take account of people's social networks to assess the extent to which they may require additional professional relational support. Finally, and critically, while our findings suggest the potential for some relative 'quick wins' in terms of existing service design and provision for people with co-occurring heavy drinking and depression, we also acknowledged how these conditions themselves result from adverse social and economic contexts in the United Kingdom, which have substantially worsened as a result of austerity measures, Brexit and the COVID-19 pandemic [90, 91]. Thus, any meaningful response to increasing levels of poor mental health and alcohol-related harm in the United Kingdom requires us to also address these fundamental contributing factors.

Study strengths and limitations

The varied sample and use of a distinct theoretical lens help to provide depth and novelty to our interpretation of these empirical data. One key limitation of the study is that our participants were predominantly White British, reflecting the demographic profile of those experiencing the most alcohol-related morbidity and mortality in the study region [92]. To make the study findings fully transferrable to contexts with more diverse populations, more work is needed to explore whether our interpretation is relevant to ethnically minoritized populations, where inequalities may be exacerbated. Moreover, future work should focus upon gender, disability and other identifications which may contribute to oppression. Another limitation is that the study was undertaken during the COVID-19 pandemic. Although many participants reflected on their experiences of care prior to this period, aspects of the material infrastructure may not be typical outside this time-period.

CONCLUSION

Much formal health and social care for people with co-occurring heavy alcohol use and depression does not acknowledge their social and economic contexts or provide the relational support they need to seek and access appropriate help. As a result, individuals are often left to manage these issues alone, while being made to feel that no one wants to take responsibility for their care, exacerbating their feelings of low self-worth. A key insight is that the emphasis on personal responsibility and gaps in care experienced by many individuals with co-occurring heavy drinking and depression is disconnected from the support they need to exercise autonomy. Thus, the structure of the care system and how people are made to feel within it contributes to distress and may be contributing to the high rates of negative outcomes in this population. There are examples where formal services, in particular VCS organizations and community alcohol services, support relational autonomy, but these services cannot provide the mental health treatment that people want and may need in isolation from statutory care provision. A formal care infrastructure that is better integrated, recognizes peoples' own explanation for their conditions and is more attentive to individuals' social and economic contexts and need for relational support has the potential to make the improvements to health and social outcomes for this underserved population that are desperately needed.

AUTHOR CONTRIBUTIONS

Katherine Jackson: Conceptualization (supporting); data curation (equal); formal analysis (lead); investigation (lead); methodology (equal); project administration (supporting); writing—original draft (equal); writing—review and editing (equal). **Eileen Kaner:** Conceptualization (supporting); funding acquisition (supporting); methodology (supporting); supervision (supporting); writing—review and editing (supporting). **Barbara Hanratty:** Conceptualization (supporting); funding acquisition (supporting); methodology (supporting); supervision (supporting); writing—review and editing (supporting). **Eilish Gilvarry:** Conceptualization (supporting); funding acquisition (supporting); supervision (supporting); writing—review and editing (supporting). **Lucy Yardley:** Funding acquisition (supporting); methodology (supporting); writing—review and editing (supporting). **Amy O'Donnell:** Conceptualization (lead); data curation (lead); formal analysis (supporting); funding acquisition (lead); investigation (lead); methodology (equal); project administration (lead); resources (lead); supervision (lead); writing—original draft (equal); writing—review and editing (equal).

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DECLARATION OF INTERESTS

Outside this study, Professor Amy O'Donnell and Professor Eileen Kaner have 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 nor any other entity had any role in the study design, data analysis, data interpretation or writing of the manuscript. A.O.D and E.K. have no direct conflicts of interest in relation to this specific study.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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