**Alcohol study transcript notes**

**04 – Service user**

Interview length: Approx. 1 hour

Background

-PERSONAL DETAILS OF FAMILY HISTORY REDACTED

-Physical and mental health problems:

* Suffers from anxiety, mobility problems (cannot walk well and uses a crutch), difficulties remembering information (cognitive problems)
* Friday, Saturday and Sunday are the times when he struggles the most with his mental health

Additional information:

-SENTENCE REMOVED DUE TO DISCLOSURE

-Used to go mountain climbing and would love to climb Mount Everest but this is expensive

-Would like to be referred to as a “drinker” rather than an alcoholic as the word “drinker” (when taken literally) does not necessarily refer to a “drinker of alcohol”

What helps:

* Likes to be accompanied by someone to go to places (this supports him)
* Getting things out (talking about them) helps with his problems
* He feels people expect “drinkers” to have poor hygiene and to “look like a drinker” but he shaves and seems to find it important to not look like this. He stressed that the only person that can decide to do so is himself. He needs to make the decision to do this.

When did you get a diagnosis of alcohol dependence?

-2-3 years ago in Liverpool when he acknowledged it to himself that he had a problem. The diagnosis was made as a result of the “amount of times of people finding him on the floor” after drinking.

Reasons he has never been treated for his alcohol use in primary care:

-He doesn’t want to get treatment now that he only lives in temporary accommodation. He would consider it only if he had stable housing as he feels this will help him to be happy

-He “wouldn’t be here” if he didn’t have alcohol and benzodiazepines. These substances help him “block out” thoughts and feelings linked to traumatic past events.

Expectations of treatment

-Would like to be prescribed more anti-anxiety medication as he feels that this helps with several areas of his life, including general wellbeing, his drinking. The medication enables him to leave his house, it made it possible for him to attend this interview.

Barriers to accessing treatment

-He has to hide his use of alcohol to continue living in his temporary accommodation, where checks are carried out, such as through the use of a breathalyser to monitor whether or not he drinks. If it is discovered that he drinks, he will have to move out. Hides evidence of his drinking, e.g. by eating certain foods so that his breath doesn’t smell of alcohol.

-This situation in addition to the insecurity of his housing makes him want to drink to cope

-He has experienced people with alcohol dependence “shouting and arguing”, which he does not like.

-Financial problems, e.g. he cannot phone his chemist when he does not have credit on his phone, cannot solve these financial problems on his own and feels he needs support to find out what benefits he is entitled to

What is going well?

-Attends a drop-in primary care clinic for homeless people in Liverpool that runs once a week and feels this works well for him

-He needs to attend to get access to medication for various problems, such as epilepsy and anxiety, e.g. Pregabalin

-He sees the same nurse there and gets the chance to chat with them

-Anti-anxiety medication helps with his drinking

-Receiving a blister pack rather than medication in separate boxes helps him to remember to take it (has cognitive problems)

- Currently lives with people who have been in prison and does not mix with them. Previously he lived in a hostel for homeless people in Liverpool where people robbed others so he did not socialise with them. “If you keep yourself to yourself and don’t have to socialise [with other people who misuse alcohol], you will be ok.”

Types of treatment

-Never been offered anti-craving medication but would consider trying it if it helps him relax

Improvement of treatment for people with alcohol dependence

-“Half the battle is listening” (staff should listen to people with alcohol dependence)

-Staff should have a better understanding of how to address people’s problems, of what has caused their drinking and their experiences, as well as how people feel “before and after” drinking

-Staff should “put themselves in people’s position”

-Staff should not talk to people like they are “above them” but treat them respectfully

-Living with “normal” people who do not use drugs or drink would help

**02 – Service user**

Interview length: 44 minutes and 15 seconds

Background:

-PERSONAL DETAILS OF FAMILY HISTORY REDACTED

Treatment:

-2x home-based detox in Liverpool, accessed first detox through GP, accessed second one by presenting herself at hospital

-Received anti-craving tablets but felt that they “did not make any difference” and were possibly a placebo

-One-to-one counselling

* Experience with NHS counsellor: Long waiting list and didn’t “take to him”
* Positive experience with counsellor she picked: Ex-alcoholic, gave her a good understanding of why she drank

-Groups

* AA: Ok
* NAME OF ORGANISATION REDACTED: didn’t like the fact that “everybody is friends with each other” and doesn’t want to socialize with “other drinkers”, didn’t like “big groups” as she didn’t want “everybody knowing my business”, best bit about this service was one-to-one counselling with a counsellor who is “in recovery herself”
* NAME OF ORGANISATION REDACTED: Good because they did “arty things as well as therapy”, also “really strict boundaries” made her feel safe (not supposed to leave the building with other drinkers)

Access to treatment:

* Good experience with detox: Attended hospital/GP and started detox on the same day, just had to “turn up”
* NAME OF ORGANISATION REDACTED: Barrier was anxiety of going into the group but once she was in she was “made to feel welcome” and there were other people she knew
* NAME OF ORGANISATION REDACTED: Easy access as you “just turn up”

Positive things about treatment:

* Detox staff were really nice
* Feeling of relief and achievement when she did detox (I’m doing something about the problem and don’t have to keep it secret)
* Security of being at home while doing detox
* Talking about problems with alcohol helps, feels liberating
* Medication to manage mental health problems
* Primary care nurses are informed

Difficult things:

* Doctor in LOCATION REDACTED was judgmental about her drinking when she lost her job but no such experience in Liverpool
* Mostly men in groups, this is not a problem in itself but was harassed by one man, also being affected by what other people say in groups is a problem but a good facilitator makes a difference
* GPs just signpost or send to a specialist (doesn’t go to her GP “expecting to get the answer”)
* No support to make a choice about treatment options (was given a lot of leaflets by a nurse but no advice)
* Not much info given on mental health help, just physical treatment of alcohol dependence
* Seeing a different doctor every time
* Hard to just “turn up” at the doctor and “tell all your problems”: Difficulty taking the initiative
* Telling your problems to someone on the phone
* Not knowing what services are available now as they have changed

Improvement of treatment:

* Joined up approach: Wants to see the doctors and nurses at a joint meeting
* Talk about mental + physical health
* Wants to see the same person (“a human experience”)
* More face-to-face contact (sick of phone calls), it feels “warmer” to tell your problems to someone face-to-face
* Being invited for reviews of her mental health + drinking, a “welfare check” (a proactive approach initiated by a member of staff rather than herself having to turn up and avoiding this for a long time), rather than just a medication review
* An afternoon drop-in, with private consultations with GPs or nurses that can inform of current services
* Support for older people so you feel less “alienated” and “isolated” and not just among younger people or people you can’t relate to (e.g. “old blokes”)

**06 – Healthcare professional**

Interview length: 26 minutes and 29 seconds

Facilitating access:

-ROLE REDACTED

-Taught on the Royal College of General Practitioners alcohol course to make sure that nurses and GPs are better educated about alcohol in general

-Worked hard to get an alcohol nurse for her general practice

-Involved in Baclofen research

-Close contact with alcohol nurse in Liverpool hospital so she could enable patients to get detoxes who otherwise wouldn’t have

Barriers to access:

-ORGANISATION NAME REDACTED has not got enough nurse prescribers who can do community detoxes, and difficult to access

-Getting patients into alcohol services: Stigma of being identified as a person with an alcohol problem, which is not as present in primary care if you just see your GP and nobody knows why you go there

-Reaching alcohol services that are not based locally (particularly the homeless have not got any money), not having alcohol-related support on site (in the GP practice), the alcohol worker that was working for Liverpool Central and based in a GP practice made it possible for patients to have alcohol-support on site

-Barriers are also good because they help to select people who really want to engage

-No communication between services and services are not linked in enough

-Staff do not know about all the services that are available as they change

-Lack of alcohol workers in shared care (there are drug workers but no alcohol workers in GP practices)

-Alcohol is everywhere (on TV, always used when people want to have a good time etc.)

-Not enough GPs to help patients with community detoxes, need of specialists for that

Facilitators:

-There are masses of alcohol services out there

Treatment types:

-All nurses and GPs are trained in Brief Intervention and can deliver it but patients need more than that

-Prescribes anti-craving medications and feels it works for some people

Improvement of treatment and access:

-You need ENOUGH alcohol workers based in GP practices, who are familiar with all the services available to support people with alcohol dependence, workers who have specialist knowledge and who can both do early intervention (Brief interventions) and point people to the right services

-Presence of an overarching organisation (mentors, supervisors) that supports these alcohol workers and regular get-togethers for them to share their practice

-Early intervention: engage students to stop them from binge drinking

-Provision of more community detoxes

-People need to address the reasons behind why they drink

-Services need to be linked more (more LCAS workers in practices) 🡪 Creation of an alcohol directory that includes all services/people who can provide alcohol support/treatment, regular review of this directory and sending out to GP practices

**13 – Service user**

Interview length: 1 hour, 1 minute and 28 seconds

Background:

-PERSONAL DETAILS OF FAMILY HISTORY REDACTED

Treatment:

-Didn’t seek treatment for alcohol dependence in LOCATION REDACTED as this could have cancelled his visa and he would have lost his job

-Treatment from NAME OF ORGANISATION REDACTED: Counselling following a solution-focused brief therapy model (reminded him of the techniques he can use to support himself), rejects other psychological approaches

-Self-directed approach: Uses mindfulness to support himself, moved next to Sefton Park for regular walks, careful management of his routines, uses nicotine as an alternative to alcohol (vapes all day)

- NAME OF ORGANISATION REDACTED doesn’t suit him due to it being Christian (he is an “ex-Christian preacher”)

-Contact with GP mainly centred around medication

-Anti-craving medication never offered

-No use of specialist alcohol services, apart from a very short hospital stay (one evening)

Positive aspects about treatment:

-GPs are “reasonably well organised”

Barriers/problems

-Pharmacies are disorganised, he is notified that his prescription is ready to collect but when he turns up, no medication is left

-The way drinking is viewed: In Asian culture “drinking is being a man” and this also reflects the British culture a bit (drinking is expected)

-Stigma: Difficulty of admitting that you need help *as a man* and opening up about personal/emotional things is from the male perspective

-Opening up in a group (one-to-one conversations better for men)

-Going through numerous different “steps” to access support when you suffer from depression or anxiety (contact this person, then phone that one, then phone another one etc.)

Facilitators

-Having more personal space in the UK, the ability to be more genuine and authentic

Improvement of treatment:

* Regular reminders of routine tasks he has to do (he struggled with his memory), structure!
* More options for “sublimation”, that is meaningful activity, such as crafts, that have nothing to do with alcohol, offering people a day “away from their own mind” or a short-term break for patients, this would have helped him personally as he wouldn’t have had to talk about his emotions/personal stuff directly
* More efforts to specifically engage men, as they have traditionally grown up with the idea that you only go to the doctor when “all your blood is leaving your body”, this could be achieved through spreading information about famous people with experience of addictions
* More channels of communication to access support, specifically options to contact services online (by filling in a form) rather than by phone as phone calls trigger social anxiety and some people do not answer phone calls as they have financial issues and creditors coming after them

**05 – Service user**

Interview length: 42 minutes and 44 seconds

-PERSONAL DETAILS OF FAMILY HISTORY REDACTED

Treatment

-Several detoxes (community detox + hospital-based/clinic-based)

-Was referred to alcohol worker by GP: Help to cut down alcohol consumption and do a detox herself but she was unable to do a detox herself, then also got referral to detox through alcohol worker

-“Always” talks to her GP, phone check ups (GP always rings her and asks how her drinking is and whether she wants to see alcohol worker)

-A bit of experience of talking therapy

-AA

-Acamprosate after last detox

Diagnosis

-Identified problems herself and “begged” for treatment as she was very unwell physically and waking up at night as she needed alcohol and in the morning

-GP referred her to alcohol worker based in her GP practice

Positive aspects about treatment:

-“Nice” to tell someone about alcohol-related problems who “knew about alcohol”

-Got reassurance from alcohol worker

-Bond/relationship with alcohol worker

-Alcohol-worker was “dead easy going” and always tried best to help, told her how to cut down on alcohol (“she’d say do this, do that to try and cut it down”)

-Detox positive experience: you just sleep, and staff give you Librium when you need it, staff were “great” and you feel better after detox: You start to eat and doing things you want to do.

-Detox staff ask about her wellbeing, encourage her to maintain sobriety and ask about her “next steps” (discharge planning)

-Support groups are good because “there’s people there who identify with you”

-Hope/confidence through NAME OF ORGANISATION REDACTED: “if you’ve got an older woman or an older whatever who’s been through it and has been 25 years off it or something it makes you feel better. You think you can do it then, if I want to”

-Acamprosate: “when I left the detox and I was taking it, I didn’t crave no alcohol”

Difficult aspects about treatment:

-Not easy “on the outside” to cut down alcohol consumption

-Sometimes she “can’t” speak to other people but her alcohol worker, who has been there “her whole life” but she has left now, which creates difficulty

-“Offies” everywhere and they are “legal” so hard to resist cravings

-Past experiences made her drink and finds it hard to get it out of her head

-Talking therapy can be “too intense”

-Not enough services just for alcohol

-Waiting times

-People who need help are deemed as “not eligible” for services: “they could say to you that you haven’t got a habit or you’re just a binge drinker or whatever. But it’s still alcohol and you’re still doing it all of the time”

Improvement of treatment

-More help from psychiatrists/counsellors with difficult “past experiences”, more “talking” to get things out of her head

-Aftercare following detox: Talking therapy and groups/classes to keep occupied

-Need to build “bond” with therapist and alcohol worker, “they should get you used to somebody else first before the other one goes”, “have a little session with the new one before, to get used to them, get to know her so when the alcohol nurse leaves it’s not as bad then”

-One person to talk to and stick with that person (“some people end up going back on it because they aren’t used to someone new”)

-Maybe a little medicine (“they do a medicine actually, but if you drink on top of it it makes you violently ill so you won’t drink again”)

-“More like maybe awareness of AA and stuff like that, put it out there”

-“Maybe more groups, other kinds of groups”

-More things to do, to keep occupied (“women’s things, things for men, mixed things. Just like little classes”; “Make sure you can go somewhere to enroll, stuff like that, after you’ve done your detoxing”)

- Help for people with varying degrees/types of alcohol dependence: “Even if you don’t have the physical symptoms, you should get help with doctors and that or have a word with counsellors, or people about it, other doctors”

**Service user 19**

Interview length: 1 hour, 21 minutes and 33 seconds

Diagnosis

-PERSONAL DETAILS OF FAMILY HISTORY REDACTED

Treatment

-Alcohol worker appointed by court

-Probation officer

- NAME OF ORGANISATION REDACTED

-Counselling, psychotherapy

Difficult aspects about treatment/access:

-Lack of early intervention, identification of alcohol dependence when she was 18

-Contempt of alcohol worker: Alcohol worker thought she was “a worthless piece of shit”

-She expresses a lack of awareness of her alcohol dependence, indicated that she was not an alcoholic when asked by crisis team

-Felt that services didn’t understand what alcohol use was like for her and therefore believed that they could not help her

-Difficulties coping with delay in access to treatment (entry into SHARP)

-Shame surrounding alcohol dependence

-Not enough alcohol services for the current demand

-Other services, such as the police, deals with people addicted to alcohol and the police could not meet her needs for support/referral to adequate support:” their only response is to get you, arrest you, and take you to court”

-Other people in need of treatment were prioritized: “I think in her head there’s a hierarchy and, you know, people leaving prison, people that are on heroin for 20 years, er, and then an 18-year-old kid who’s been drinking for a year and a half non-stop, being in trouble three times with the police”

-Alcohol worker that she was referred to did not seem to have sufficient awareness of alcohol dependence

-Quite a lot of contact with GP when her alcohol dependence was present but not much intervention: was prescribed meds and sent home.

-Lack of therapy and only meds

-Fear of psychiatric units and hospitals, fear of consequences of disclosing full extent of mental health problems: “I’m scared to tell them the truth because I don’t want them to put me away for [?], erm, which is another dilemma, like you can’t tell them the truth.”

-Fear of residential places due to prior trauma connected to them

-No referral or information given to her about alcohol services or mental health services at an early point

-Dependence on support services due to need to keep problems separate from family and friends

-Alcohol addicts feed the money system: the NHS, police etc.

-Expensive food in alcohol service that is not affordable and having to live off benefits to complete alcohol treatment (financial barrier)

-Alcohol service not accessible as being used for the general public

-Services not immediately accessible when they are needed

-Not feeling understood by people who have other experiences than alcohol dependence

-Thinks anti-craving meds wouldn’t work for her

-Stigma

-Barrier to access: Services that can only be used by people living in a certain area.

Positive aspects about treatment/access

-Referral by the GP to the crisis team after she expressed thoughts of suicide

-Referrals organized by the crisis team to alcohol services

-Contact with people in recovery from alcohol dependence, give her hope/confidence (?): “there’s no one that can help an alcoholic or an addict more than an alcoholic or an addict.”

-Excursions organized by NAME OF ORGANISATION REDACTED led to a change in her routine (get up and drink)

-Psychoeducation provided by NAME OF ORGANISATION REDACTED taught her to see alcohol dependence differently and she felt understood by people in recovery there

-Bonding with other people affected by alcohol dependence by sharing life stories

-Someone to talk to who knows everything

-Access course helped with self-esteem and gave her hope for recovery (maybe I am able to go without drinking and achieve things)

-Counselling

-Interpersonal group work: allows you to learn to be honest and open, confrontation by other group members, promotes self-awareness

-Telling your life story

Improvement of treatment

-Emergency service (something like the NHS and police combined) for people with alcohol dependence who are in crisis so that the police do not have to deal with people they have not been trained to deal with

-Outreach (similar to a service for sex workers that used to be available: Going to people on the street)

-Early intervention

-Informing people of alcohol services AND mental health services

-Understanding of reasons underlying alcohol dependence: “no one ever asked WHY I was drinking so much, WHY I was getting in trouble with the police. It’s like no one wanted to acknowledge that there might be a reason”

-Confidential services

-Start alcohol support during treatment/detox in hospital: “they should have like an AA group or any group so that people that are newly sober cause they’ve done a detox and something in there, erm, and they’re getting treatment for like their liver and organ failure”

-Boundaries: Restriction of money use by patients in hospital so they don’t buy alcohol

-More detox centres

-Train staff to spot early signs of alcohol dependence and also spread awareness among them about alcohol services

-Change criteria for selection of people for treatment: People of any age can be dependent

-More information about alcohol services and referrals

-Places that allow for self-referral

-Services that are immediately available

-Awareness raising for patients of the consequences of dependence (physical and mental)