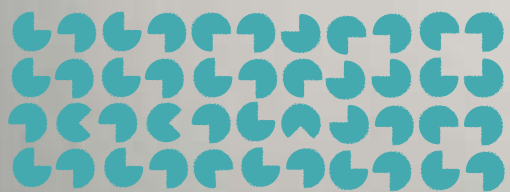


SAMARITANS

Insights from experience: alcohol and suicide



February 2022





Introduction

In late 2021, we carried out a survey of people with lived experience of suicide, self-harm, or service use to understand their experiences of alcohol. Our survey uncovered deeply personal stories, which shed light on the relationship between alcohol and suicide and help us to understand what changes are needed in healthcare services to better support people and prevent suicide.

We are concerned about this issue because research shows that there is a relationship between alcohol and suicide, associated with the impact of long-term alcohol use and the immediate effects of drinking.¹ This relationship is complex, and may vary depending on a range of factors, including the specific ways in which people use alcohol.² For example, heavy episodic or binge drinking is associated with increased likelihood of attempting suicide amongst adolescents.³ People who are dependent on alcohol are approximately 2.5 times more likely to die by suicide than the general population.⁴ In England, nearly half (45%) of all patients under the care of mental health services who die by suicide have a history of alcohol misuse, accounting for 545 deaths per year on average.⁵

This issue is particularly pertinent in the context of the COVID-19 pandemic. A rise in alcohol consumption was a key concern among suicide prevention experts towards the beginning of the pandemic.⁶ In mid-2021, what was then Public Health England identified a 'step-change around the time the pandemic began', with sustained increases in 'higher risk' drinking.⁷ Throughout the pandemic, member organisations of the Suicide Prevention Consortium have continued to support people who are concerned about their alcohol use and mental health. For example, With You have continued to provide free, confidential support to people experiencing issues with drugs, alcohol or mental health and Samaritans provided emotional support over 165,000 times to people who mentioned alcohol or drugs as a concern during 2021 alone. In these contacts with Samaritans, people were more likely to express and explore suicidal feelings than in calls where alcohol or

drugs were not a concern. Nearly 1-in-4 (23%) mentioned a previous suicide attempt, which is also higher than other callers. Though it remains too soon to fully understand the impact of the pandemic on suicide, all of our organisations remain concerned about the effects it has had on people's mental health and wellbeing.

Although the connection between alcohol and suicide is well-established, policymakers have limited access to insights from people who have personal experience. We wanted to find out what the relationship between alcohol and suicide looks like in people's own words. Our aim was to find out what changes are needed so that people can be better supported by healthcare services. We also surveyed healthcare practitioners to help us understand issues in the current landscape of support. This briefing provides an overview of our findings.

What is the Suicide Prevention Consortium?

The Suicide Prevention Consortium is made up of four organisations: Samaritans (lead), National Suicide Prevention Alliance, Support After Suicide Partnership and With You. As part of the VCSE Health and Wellbeing Alliance, it aims to bring the expertise of its member organisations and the voice of those with lived experience directly to policymakers, to improve suicide prevention in England.



What did we do?

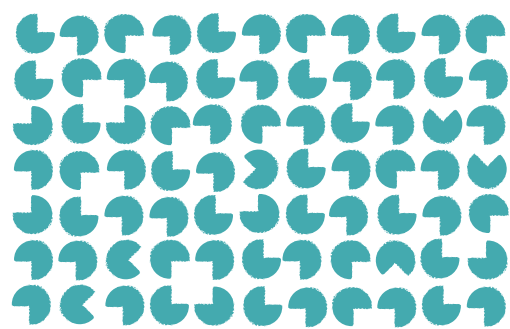
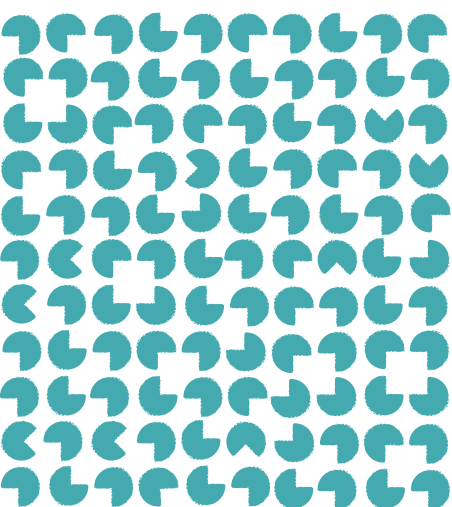
The Suicide Prevention Consortium shared two surveys via established lived experience and professional networks. We received responses from 125 people with lived experience of suicide, self-harm, or service use about their experience of using alcohol; and 33 practitioners supporting people around alcohol use, mental health and/or suicide. Lived experience respondents were all living in England and over 18.⁸

In our lived experience survey, people defined what the relationship between alcohol and suicide looked like for themselves and this encompasses a spectrum of alcohol use, from suicide attempts involving intoxication through to long-term alcohol use and dependency.

People also used varying degrees of specificity when describing the types of support they sought and received. In this briefing, we have been as detailed as possible when referring to which types of support people were describing in their responses. Where this is not possible, we have used broader terms such as 'support services' which in practice encapsulate a range of support types.

In our lived experience survey, all responses were submitted anonymously to preserve people's privacy and confidentiality.

This briefing summarises people's insights from their own experience. It is not intended to provide a comprehensive research overview of the relationship between alcohol and suicide, but to extend and deepen the evidence base by sharing these views.





What did we find?

Finding 1:

There appears to be inconsistency between national policy and local practice when it comes to accessing care for people with co-occurring needs around alcohol and mental health. People described complex and deeply personal relationships between alcohol and suicide, but many felt that healthcare services sometimes struggle to see the full picture and experienced processes that ultimately excluded them from the support they needed.

People who responded to our survey described alcohol use which covers a broad spectrum of intentions, explanations, and behaviours. This includes drinking alcohol as a 'failed medication' for a mental health condition, to numb feelings from traumatic past experiences, or to change mood. It includes people who described episodes of drinking that culminated in attempting to take their own lives. And it includes people for whom drinking was itself a form of self-harm; a coping strategy which they said made things worse in the long run.

“Alcohol helped me to forget trauma and pain.”

“I view alcohol as a gateway drug to suicide and self-harm.”

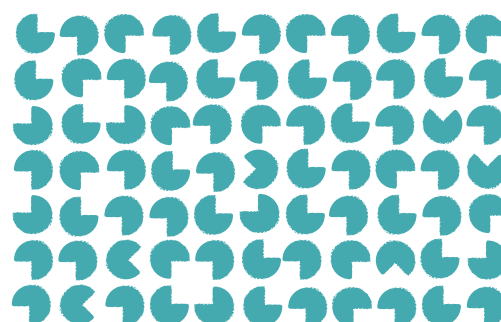
“Sometimes alcohol is my preferred self-harm.”

“Alcohol made me more impulsive and more likely to act on self-harm or suicidal thoughts. It also made me hurt myself in more severe ways. I felt less concerned about the consequences of these behaviours when I had been drinking.”

Many people had sought support from a wide range of sources, including rehabilitation, therapy, support groups and community mental health teams. There was not a clear preference for one type of support over another – different things worked for different people. However, those who said they had experienced good support often described a positive interpersonal approach from staff, facilitated by a system that sought to personalise their care, as key. The best support, according to those we surveyed, sought to listen to them, trusted them, and treated them as a whole person.

“I was treated for alcoholism and spoke with some respectful sympathetic counsellors who took my recovery and how I presented it at face value.”

Too often, though, people experienced services putting their own processes above their patients' needs. Respondents described struggling to meet eligibility criteria, and a lack of care and personalisation in their assessment and treatment.





Finding 1

“ I did also have several periods of counselling for depression and grief following the death of my father, but I generally found these to be of no use as I felt like they were “off the shelf” treatments which ran through a predictable list of questions from a standard list. ”

Some respondents explained how they had to misrepresent their experiences to get the help they needed. Depending on the service they were trying to access, this included avoiding talking about alcohol issues or not mentioning suicidal feelings to meet the criteria for support.

“ Only when reducing the symptoms described and not mentioning suicidal thoughts did I get help during which I could explore my issues. ”

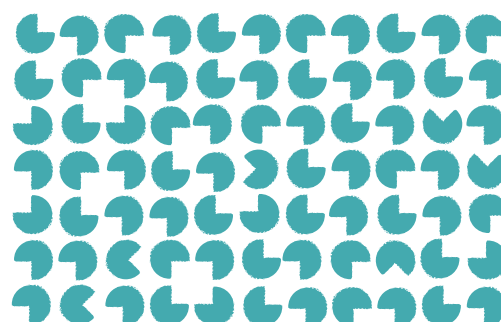
The healthcare practitioners we surveyed echoed these concerns, and some said that the eligibility criteria used to determine who can access services are the most significant barrier for people seeking support for their mental health alongside using alcohol. Though our survey did not explore the role of eligibility criteria in detail, experiences of struggling to get support were described frequently by practitioners and people with lived experience alike. Those with lived experience described being faced with these issues in the form of a rejection that was difficult to understand or support which ultimately didn't meet the full extent of their needs, sometimes due to a lack of expert help.

“ I was told when in the hospital prior to going to the ‘safe place’ that I would have access to counsellors and support workers, which wasn't true at all and didn't happen. ”

These insights suggest there is inconsistency between national policy and local practice when it comes to care for people with co-occurring needs around alcohol and mental health. National guidance documents say that this support should be ‘everyone's job’, and that there should be ‘no wrong doors’, with people able to access the right support for them regardless of where they first present in the healthcare system.⁹ But people with lived experience have told us that there are wrong doors, characterised by rigid eligibility criteria and opaque decision-making that ultimately left them without support. Practitioners highlighted this problem, too; while services in principle have a joint responsibility for supporting people with co-occurring needs, practitioners said that eligibility criteria can limit access and, in practice, alcohol use can be a reason for mental health support to be delayed or rejected outright.

“ Main issue is accessing [the] right help for alcohol and substance misuse. Often the criteria for inclusion is vague or too strict which makes engagement and recovery a far-fetched dream. ”

It is difficult to say what is causing these issues from surveys alone, and our respondents provided a range of possible explanations. For example, stigma and individual attitudes among healthcare staff may play a role. Practitioners we surveyed also pointed to funding cuts which create service pressures, reduce access to some specific interventions and lead to shortages of staff with relevant expertise - this finding is also borne out in the wider evidence base.^{10,11}



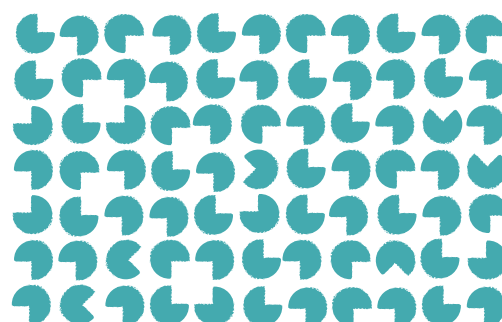


Finding 1

Recommendations:

Many people in our survey had experienced what they felt was good care, and pointed to the expertise, empathy and compassion of practitioners who sought to understand their personal experiences with alcohol. However, far too many told us that they had been unable to access appropriate support. There appears to be a disconnect between national guidance, which suggests care for people with co-occurring needs around alcohol and mental health should be a shared responsibility, and what is happening on the ground, where eligibility criteria and local practices exclude people from help they need.

- 1.** The practice of employing alcohol use as a criterion which excludes people from accessing support for their mental health must end, in line with national commitments to a 'no wrong door' approach to care for people with co-occurring conditions.
- 2.** NHS England should reiterate that care for people with alcohol use and mental health needs should be a shared responsibility at the local level with clear accountability for this at the system-level, to narrow the gap between policy and practice.
- 3.** Guidance documents that lay out how support and treatment should work are not enough on their own. There is an urgent need for further investment in alcohol and mental health services in order to increase their capacity and expertise. This investment must be sufficient to allow for the removal of financial and workforce pressures that lead to exclusionary practices.





What did we find?

Finding 2:

Many of the people we heard from described using alcohol as a coping mechanism for other issues in their lives, like poor mental health, stress, relationship problems, or trauma. Those who were able to get support often found that services struggled to address these issues together.

Many people told us that their alcohol use was not an isolated issue, but part of a wider picture of struggling with their mental health and suicidal thoughts and behaviours.

““ Been sober over 6 months I can understand exactly why I drank. It was because I couldn't handle my emotions... A support worker once said to me 'alcohol is a failed medication.' ””

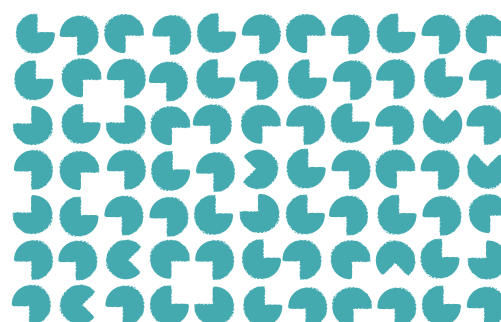
For some respondents, alcohol use was a harmful cycle. Despite drinking as a way to cope with negative emotions, alcohol did not address the underlying problems and instead brought them further into crisis. Some people found that drinking also exacerbated other factors that influenced their mental health and wellbeing, such as physical health concerns. This damaging cycle of self-medication is well-evidenced in wider research.¹²

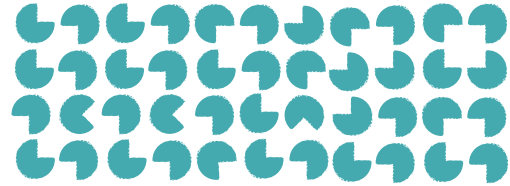
““ When I'm anxious, low mood or feel unsatisfied with my relationships I seek to change how I feel. Alcohol helps [me] to feel better for a while. Then it makes me feel even more low than before. ””

Despite describing how their alcohol use, mental health and wellbeing were closely connected, many people told us that services they sought support from did not always see things the same way. Some survey respondents struggled to get help for alcohol use, mental health and/or suicidality together, and instead found that services sought to isolate one issue, like alcohol, from the others. In some cases, people were told that to access or continue to receive support for their mental health they would have to stop or reduce their drinking; this felt impossible for those for whom drinking was a vital strategy for coping.

““ I knew I had to address alcohol to start getting better. I just wished that they had noticed sooner that I had other deeper problems. ””

““ My hope is that professionals start to see that alcohol use is often the result of an underlying issue and not simply tell people to sober up without offering further support for how to deal with the root cause of the problem. ””





Finding 2

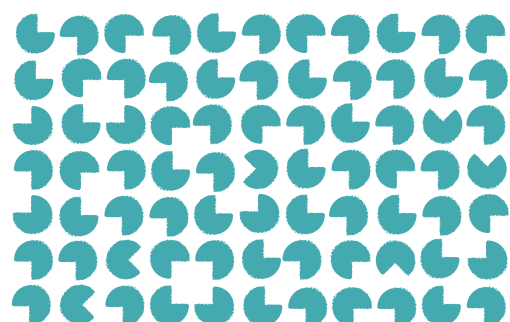
For those people who had received support for their mental health, suicidal feelings or self-harm which did consider their alcohol use, 84 per cent felt that this had been the right approach. Worryingly, 37 per cent of those who did not have alcohol considered as part of support felt that it should have been. This suggests a significant portion of people believe that services need to be better at approaching the issues they are experiencing collectively, rather than in isolation.

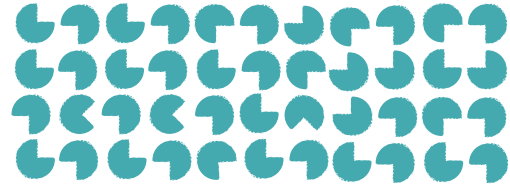
“ I did get help, but I had to do them separately rather than a whole - i.e., drug & alcohol services - to reduce alcohol intake then mental health team for support. ”

A range of reasons were given for these problems, but a common theme appears to be issues in the design and commissioning of services; a barrier to effective support many people in our survey experienced was that services struggled to support them with multiple co-occurring issues. Practitioners we surveyed echoed these concerns by pointing to a lack of integration between alcohol, mental health, and suicide prevention services. They also noted that one of the consequences of struggling to get appropriate support is that individuals may continue to self-medicate with alcohol in the absence of services that address their underlying reason to drink. These findings are especially concerning in light of evidence which suggests people with a dual diagnosis (such as both a substance misuse disorder and other mental health disorder) are at higher risk of dying by suicide compared with people with a single diagnosis.¹³

“ [The] superficial and unhelpful division between alcohol services and mental health services... can mean that service users do not get continuity and integrated care. This can increase risk and lead to fractured care. ”

“ Both mental health and alcohol should be an integrated service as they both feed each other. I have heard other people say that they have to have their alcohol & drug need supported before mental health teams will support. But I think they should always be supported together. ”





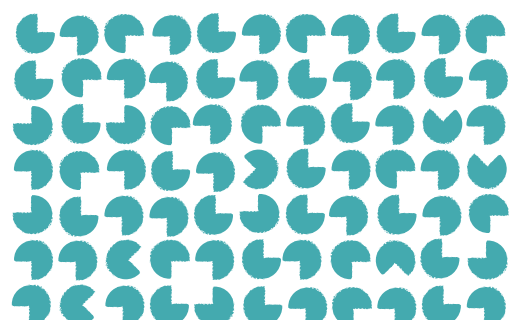
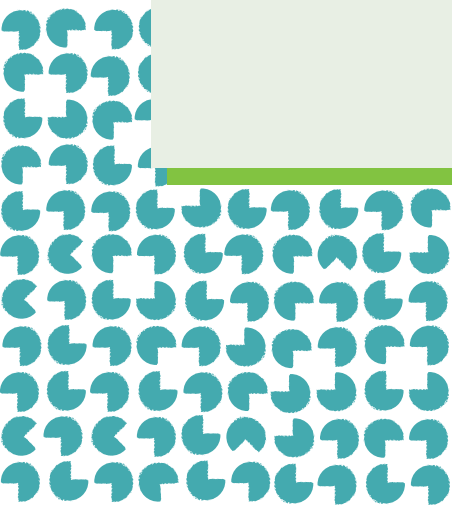
Finding 2

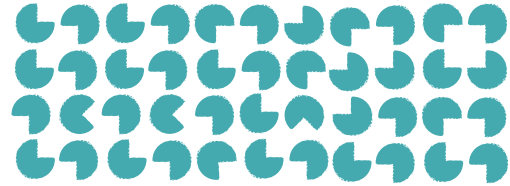
Recommendations:

People described using alcohol to cope with other underlying issues, and how services that sought to support them sometimes did not seem to be prepared to understand or respond to this. People have told us that they want services to treat them more cohesively, rather than isolating different issues such as alcohol, mental health and suicide from one another.

4. As new partnerships continue to develop across the NHS in England, they provide a golden opportunity to facilitate integrated commissioning and provision of mental health and alcohol treatment services. This should be prioritised by Integrated Care Systems and provider collaboratives.

5. We echo the recent Independent Review of Drugs recommendation that DHSC should develop a national Commissioning Quality Standard.¹⁴ This Standard must clarify the commissioning process that local authorities should follow and the full range of alcohol, mental health and suicide prevention services that should be available. It should also include the engagement of people with lived experience in the planning and commissioning of services.





What did we find?

Finding 3:

People described using alcohol as part of suicide attempts, and some experienced not being taken seriously or being dismissed by healthcare staff because they had used alcohol.

People with experience of attempting suicide who responded to our survey described how alcohol influenced their decision-making and behaviour. Some people described drinking as a planned decision, to make suicide seem 'easier'. Others said that alcohol made them feel more impulsive, reduced their inhibitions, and led to riskier behaviour.

““ When I was drinking, suicidal thoughts, attempt & self-harm were much more serious due to the effect the alcohol was having on my mind. I was much more of a danger to myself than when I was sober. ””

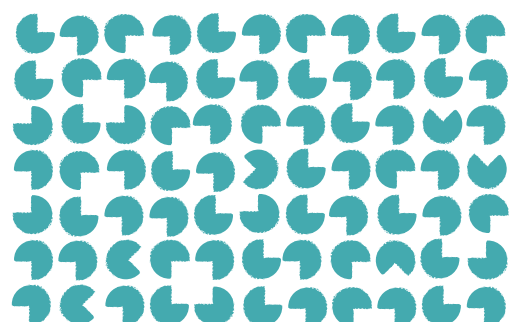
Some respondents said that although they were describing drinking in episodes of crisis, this had lasting effects for them. They were clear that drinking lowered their mood, even following a short-term improvement while intoxicated, for days and weeks afterwards.

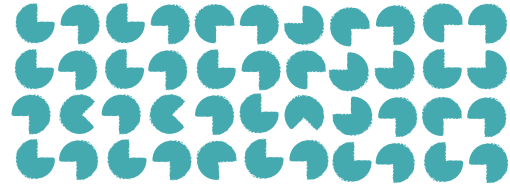
““ Alcohol used to take all of the bad feelings away for the moment but always left [me] sad after. Depression hits the day after I drink. ””

Though people felt that these experiences of drinking as part of suicide attempts had deep significance, some described being treated with dismissiveness by healthcare staff due to their use of alcohol, particularly in emergency care settings.

““ They [A&E staff] just said I would feel better once I sobered up. ””

““ I once attempted suicide whilst drunk was taken to A&E and treated with disdain by the nurses because they just saw a drunk young girl... What they didn't ask/know was that I'd been planning to die for months... They assumed because I was drunk that it was a silly drunken cry for help. ””





Finding 3

This issue was highlighted among practitioners too, who told us that they were aware of cases where individuals were dismissed by staff or not referred for suicide prevention services due to alcohol being present as part of a suicide attempt. Some lived experience respondents told us that they didn't feel safe discussing alcohol use with mental health or suicide prevention services. This feeling may be related to the impression that discussing alcohol undermines the seriousness with which these experiences are treated and may lead to them being excluded from other types of support.

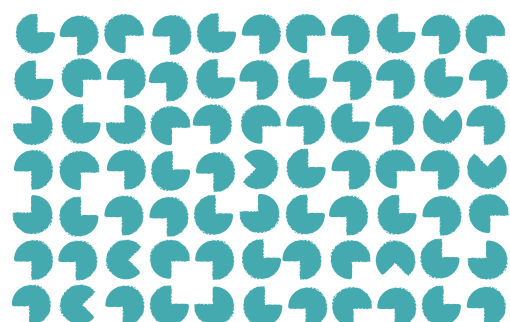
““ Psychiatric liaison nurses often refuse to see patients who have been intoxicated at the time of their suicidal acts because it is 'just alcohol'. Patients who are intoxicated at the time of a suicide attempt are far less likely to be admitted to a psychiatric in-patient unit and more likely to be discharged straight to GP – again this relates to minimisation of risk if people try to end their lives while intoxicated. ””

The experiences that people described to us can mean they fail to get the support they need, and they feel dismissed or neglected as a result. Evidence suggests these negative experiences of support may impact future help-seeking too, and thus increase the likelihood of someone reaching a crisis point before getting support.¹⁵

Recommendations:

Our survey revealed stigma and misunderstandings around alcohol use and suicide, with suicide attempts involving alcohol being minimised or dismissed by healthcare professionals in some cases. Changes are needed to ensure that self-harm and attempted suicide involving alcohol is taken seriously and responded to appropriately in every setting.

6. NHS England should ensure that staff in all healthcare settings that might come into contact with people who have attempted suicide have received training which covers the complex role that alcohol can play in suicide attempts, based on evidence from people with lived experience. This may be particularly crucial for staff in A&E, who are often the first people to interact with someone following a suicide attempt involving alcohol.





➤ What did we find?

Finding 4:

There's a need for further exploration of people's experiences of alcohol and suicide, including examining the intersection with particular identities and life experiences as well as protective factors.

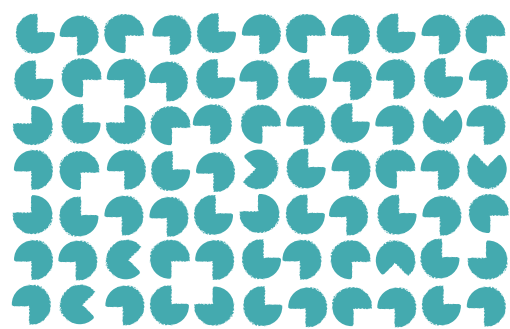
The questions we asked in our surveys were largely open-ended; we wanted to hear about people's experiences in their own words. As a result, people referred to a wide range of experiences and factors when describing the relationship between alcohol and suicide for them. More targeted exploration is needed to understand how these different factors intersect and affect individuals' relationships with alcohol.

For example, several people mentioned the impact that the pandemic has had, not only on their wellbeing and mental health but on their ability to access support that they previously relied on.

“I stopped drinking for a year during the pandemic because my mental health deteriorated, and alcohol was making it worse.”

“Access to mental health services has been really terrible since the pandemic though and I have been really struggling to get support as of recently.”

We are also concerned about the relationship between alcohol-related harm, suicide, and socioeconomic background. Research suggests that alcohol-related harm is higher in areas with high levels of economic deprivation, even though people in these areas generally drink less in volume than those in more affluent neighbourhoods.¹⁶ Nearly half (47%) of the respondents to our survey said that they struggle to make ends meet nearly all or some of the time, but our relatively low number of total respondents made it difficult to analyse this relationship fully.

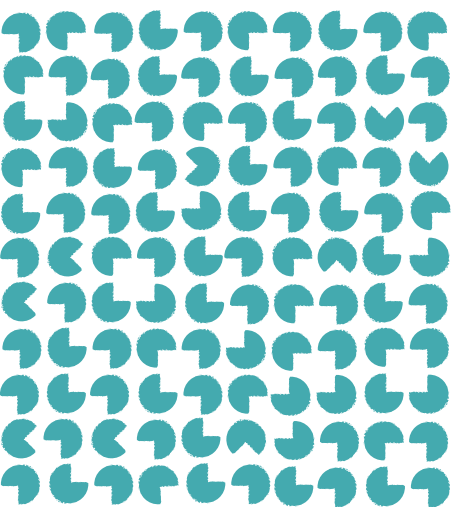




Finding 4

We know that, alongside the impact of the pandemic and socioeconomic background, factors like age and gender,¹⁷ being or having been in prison,¹⁸ and beginning drinking at a young age¹⁹ are all associated with greater risk of harm from alcohol, including suicide, and deserving of greater attention and exploration through lived experience research. Further engagement with people with lived experience is also needed to explore effective interventions to prevent suicide among people with substance use disorders. A 2020 meta-analysis found that evidence is currently lacking in this area.²⁰

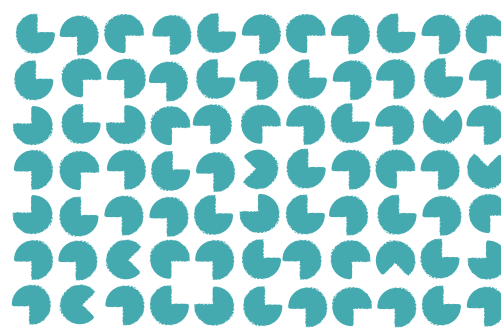
Almost one-third of the people who responded to our survey said that they did not currently drink, and many made this decision because of previous negative experiences with alcohol, including suicidal ideation, self-harm and suicide attempts. A small number of people referred to changes in their lives that enabled them to stop drinking, such as new relationships, friendships, or tracking their intake. Further research should be conducted to determine the role various protective factors play in supporting people to make these decisions and/or to develop alternative coping strategies.



Recommendations:

The recommendations in this briefing largely focus on ‘downstream’ interventions – for example, improving treatment. Greater knowledge about the role that interrelated factors play in the relationship between alcohol and suicide, and the possibilities of protective factors to prevent further harm, would support the development of policies and services that are able to intervene more effectively and earlier. Furthermore, insights from population sub-groups, especially those that appear to be at higher risk, may help to design more interventions and services for people with specific needs.

7. Further work with people who have lived experience is needed to develop our understanding of the relationship between alcohol and suicide. Ideally, this should involve larger numbers of people, especially those from groups that are at higher risk of harm, so that analysis can explore areas including factors associated with harm, protective factors, and effective interventions in more depth.





Conclusion

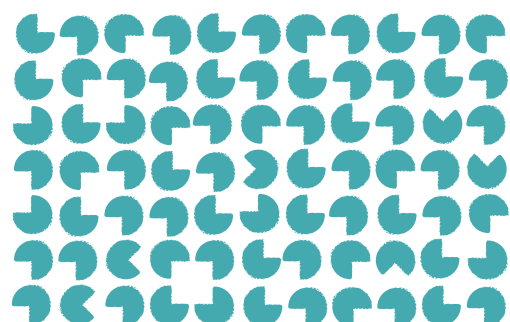
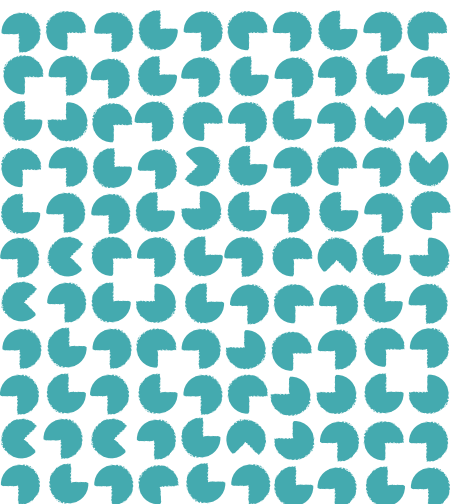
These insights help us to understand what the relationship between suicide and alcohol is like for people in their own words. They shed light on what people want to see from those that support them and, in some cases, the shortcomings of existing support.

Practitioners and people with lived experience were clear about the changes that they wanted to see: commissioning of integrated services, investment to make help more accessible to those who need it and, above all, a move towards greater compassion and empathy. These changes will only be possible within a system that views people as individuals, and that is flexible and well-funded enough to respond to each person's needs.

As the healthcare system works to become more collaborative and integrated, there is a real opportunity to take a step towards care that better reflects what patients want. In this context, it has never been more important to listen to and empower people who have experienced the relationship between alcohol and suicide for themselves.

“ See past the alcohol and its associated behaviours and treat the person underneath with compassion. ”

For more information, please contact the Policy, Public Affairs and Campaigns Team at Samaritans by emailing campaigning@samaritans.org





Sources of support

Samaritans

Samaritans is available, day or night, 365 days a year, to listen and offer a safe space to talk whenever things are getting to you.

Helpline: 116 123

Website: [samaritans.org](https://www.samaritans.org)

Drinkline

Free, confidential helpline for anyone who is concerned about their drinking, or someone else's.

Helpline: 0300 123 1110

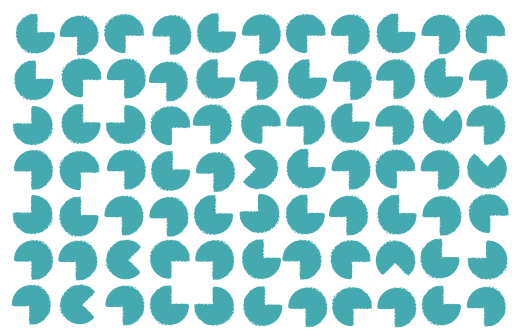
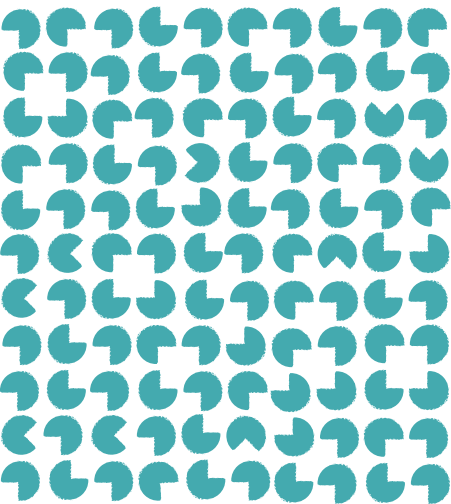
(weekdays 9am–8pm, weekends 11am–4pm)

Website: [drinkaware.co.uk](https://www.drinkaware.co.uk)

With You

Free, confidential support with alcohol, drugs or mental health from one of 80 local services in England and Scotland or online.

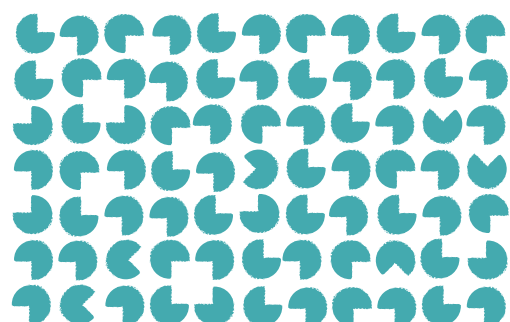
Website: [wearewithyou.org.uk](https://www.wearewithyou.org.uk)

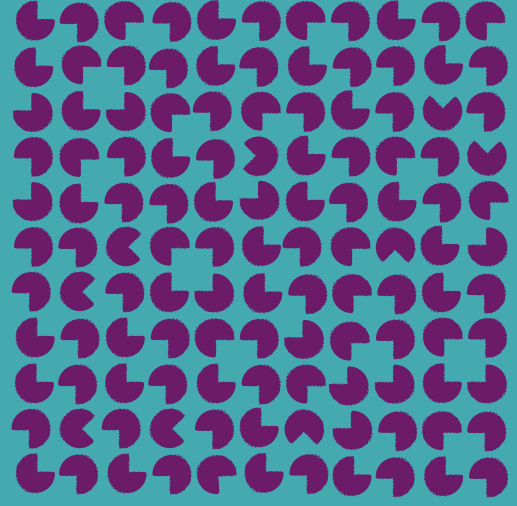




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Founded in 1953 by Prebendary Dr Chad Varah CH CBE.

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