

# Exploring experiences of accessing support for alcohol issues and suicidal ideation

March 2024

withyou

SAMARITANS



National  
Suicide Prevention  
Alliance



Support  
After Suicide  
Partnership

VCSE  
health &  
wellbeing  
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# Terminology and definitions

**Alcohol issues:** our preferred term to describe any type of alcohol consumption which an individual would like to change, or which is causing them harm. This may include, but is not limited to, alcohol dependency.

**CMHT:** Community Mental Health Team.

**Formal support:** care offered through an institution, such as through a GP practice or alcohol treatment service.

**Mental health:** we recognise that mental health and suicidality are not interchangeable, while poor mental health is a strong risk factor for suicide, people who experience suicidal ideation do not necessarily have mental health problems. We have aimed to specify throughout the report when we are referring to one or the other. However, often suicidality comes under the umbrella of mental health provision: for example, “mental health services” are a likely source of support for suicidal thoughts/feelings/acts. For this reason, in our survey, we referred to “mental health” rather than suicidality specifically. We recognise that people use different terms to describe their experiences and healthcare needs.

**Participants:** refers to everyone who completed our survey, including interviewees.

**Support:** any type of care, assistance, treatment, or information service accessed by an individual looking to improve their mental health or relationship with alcohol. Used in place of “treatment”, which would not capture the important role of family, friends, and advice services.

**Support pathway:** describes the totality of an individual’s experiences of support, from first seeking it out through to receiving clinical treatment or other assistance. It is important to note that there is no specific “end” to a support pathway: recovery means different things to different people, and many will continue to engage in some kind of support.

**Suicidal thoughts/feelings/acts:** used to capture some of the ways in which people experience suicidality, all of which were relevant for the purposes of this report.

# Introduction

This is a follow-up report to the Suicide Prevention Consortium’s previous project into the link between suicide and alcohol, “Insights from experience: alcohol and suicide, 2022”. There is extensive evidence showing a complex relationship between the two. This includes an increased risk of suicidal behaviour following alcohol consumption,<sup>1</sup> as well as co-occurring alcohol misuse and mental health issues over longer periods of time.<sup>2</sup> Among people in contact with mental health services in England who died by suicide between 2010 and 2020, 48% had a history of alcohol misuse.<sup>3</sup>

A key finding from our previous work has been the complexities people face when seeking support for their alcohol use and for suicidal thoughts, feelings and acts. We heard from people with lived experience of both issues that they are excluded from mental health services if they are still drinking, and that mental health professionals felt unable or reluctant to discuss their alcohol use.

The Suicide Prevention Consortium recognise the need to improve access to support as a priority issue. Around 4 out of 5 people experiencing alcohol dependence are not in treatment,<sup>4</sup> and around two thirds of people who die by suicide are not in touch with mental health services a year before they die.<sup>5</sup>

Furthermore, the Government’s most recent Suicide Prevention Strategy for England emphasised the importance of a “no wrong door” approach to treatment,<sup>6</sup> defined as:

“ There is no wrong door – when people experiencing suicidal thoughts or feelings reach out, they receive timely support, no matter what service the individual initially accesses. Systems and services are connected around an individual’s needs.



The Suicide Prevention Strategy for England highlights that the no wrong door approach is particularly important in relation to co-occurring mental health needs and alcohol issues.<sup>7</sup>

For this project, we took a deeper look into the reality of trying to access support for these two issues. We wanted to better understand the different ways people accessed support, what these support journeys looked like, and explored what has, and what hasn't worked so well. We wanted to identify barriers to support, how they appear to those experiencing them, when they typically arise, and how they can be overcome. The work of the Suicide Prevention Consortium centres the voices, perspectives and expertise of people with lived experience. We recognise that support pathways must be shaped by people with lived experience, as they are best placed to tell us what does and does not work to support them.

## What is the Suicide Prevention Consortium?

The Suicide Prevention Consortium (SPC) is made up of four organisations: Samaritans, National Suicide Prevention Alliance, Support After Suicide Partnership and WithYou. 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.

# Key insights

## People's support pathways vary greatly.

The support system for alcohol and suicidality needs to be able to provide person-centred care and personalised support, meeting a diverse set of needs and personal circumstances. What works for one person may not work for another, and the system must have the flexibility to adapt accordingly. The support system must meet the needs of the individual, not the other way around.

## Stigma remains one of the most common barriers to accessing support.

People are missing out on potentially life-changing support because of negative perceptions around suicidality, and alcohol issues. They report being made to feel like they should be able to help themselves, or that they are not "unwell enough" to deserve support and compassion. These assumptions stem from pervasive stigma around mental health, alcohol and suicidality, and a misunderstanding about the relationship between them.

## Peer support networks and third sector services form a vital part of the support pathway.

The impact of hearing from others with similar experiences was extremely profound for many of our participants. Peer support groups were consistently described as a highlight of people's support pathway. We also heard many positive descriptions of third sector services, where people reported feeling genuinely listened to and empowered to make choices about their care.

## Crisis support is not consistently meeting the needs of this group.

A&E was consistently described as the worst part of people's support pathway. Healthcare professionals at A&E did not always understand the role of alcohol in suicidal thoughts/feelings/acts, and follow up care was described as inconsistent and lacking in genuine care, compassion and interest in a person's needs.

## The "no wrong door approach" is much needed.

It is encouraging to see the "no wrong door" approach endorsed in the Suicide Prevention Strategy for England, and gain traction across the sector. However, the experiences of our participants indicate that this is not yet embedded across the health and social care system. Too often, people are still turned away when healthcare professionals perceive them to be under the remit of another part of the system.

# Methodology

## What we did

### Part 1: Survey

We conducted an in-depth survey, consisting of eight closed questions and nine open questions developed with the lived experience representatives within the SPC, as well as a set of diversity monitoring questions. The questions asked about participants' experiences of seeking support for their alcohol use and for suicidal thoughts/feelings/acts, including where they had sought support, how they knew they needed support, and what type of support they were offered. We also asked all participants what they would change if they could change one thing about their support pathway.

The survey was disseminated via SPC members' social media channels, lived experience networks, to WithYou staff, and to WithYou clients through paper copies in the waiting rooms of four WithYou services. In total, we had 33 respondents.

The survey enabled us to capture valuable insights, and the findings are presented throughout this report. In addition, we used the survey as a screening mechanism to select five people for 1-to-1 interviews.

When selecting participants to be interviewed, we invited only participants who had sought "formal" support. We fully recognise the importance of "informal" support, which has consistently been shown throughout the SPC's previous work. For this project, to understand systemic barriers to support we needed to speak to those with lived experience of the formal support system.

As part of the screening process, we asked participants to reflect on their current mental wellbeing, and advised against agreeing to be interviewed if they had experienced suicidal ideation in the last six months.

For participants invited to interview about their experiences, we provided a distress and debrief protocol, as well as information about where to access immediate support if required.

### Part 2: Interviews

Interviews took place in November 2023 using Google Meet. Interviews were around one hour long, and followed a loosely structured conversation based on prompts provided to participants in advance. These conversations were recorded and transcribed.

### Part 3: Analysis

The qualitative survey data was analysed using basic linguistic analysis to identify recurrent themes. The quantitative data was cleaned and processed to produce the statistics and charts throughout this report. Affinity mapping of the interview transcripts allowed us to identify common themes across our participants' experiences. We selected quotes to best illustrate these themes.

We have included an example support pathway, which visualises the experiences of Louise,<sup>8</sup> one of our interviewees.

## Who we worked with

Our five interviewees consisted of four women and one man. All selected the ethnic category 'White - English, Northern Irish, Scottish, Welsh', and came from across England. Participants were from a variety of different age groups, ranging from 18-64, and identified as a variety of sexual orientations and socioeconomic statuses. All participants had lived experience of issues with alcohol and of suicidal thoughts, ideation and attempts.

The in-depth survey conducted was with a larger and broader group of 33 participants, strengthening the breadth of insights and findings to inform this report. We aimed for diversity within this sample size, rather than a wholly representative sample, due to the sample size we worked with.

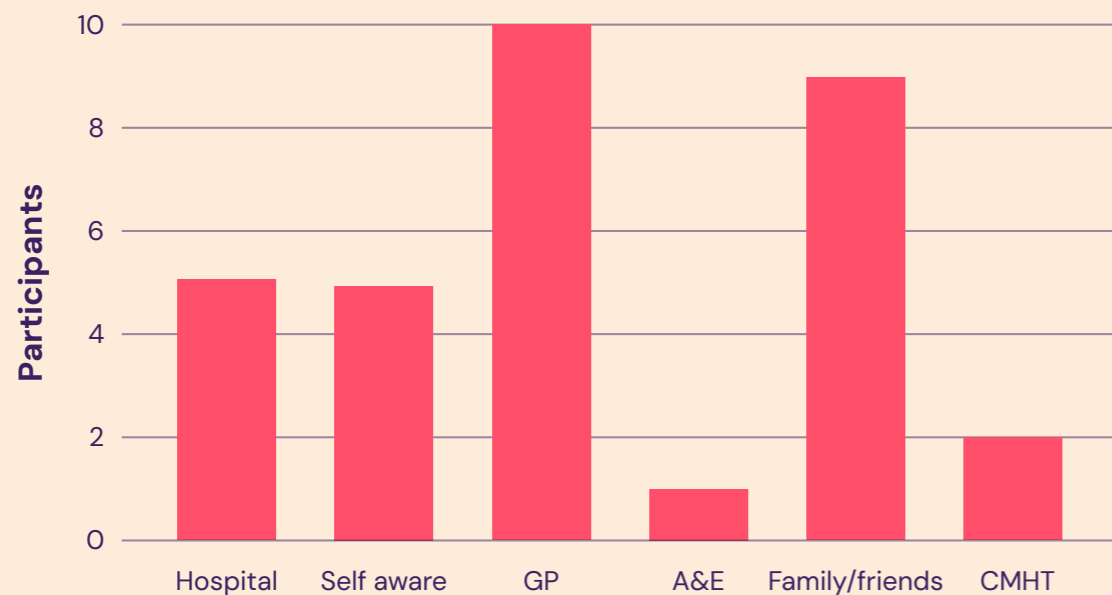
This report summarises people's insights from their own experience. It is not intended to provide a comprehensive research overview of the relationship between alcohol and suicide, but to extend and deepen the evidence base by sharing these views.

# What we heard from participants

## Accessing support for the first time

We asked participants how they first knew they needed some support for their alcohol, and then for their mental health. Participants answered an open ended question, the responses to which were then organised by theme. Many participants identified more than one factor in their realisation that they needed support.

**Fig 1. How did you first know you need support for your alcohol use?**



In relation to alcohol use, participants said their GP and family/friends were the most common people to first raise potential issues with their alcohol use. Several participants explained that they were in denial about needing support. We know this is very common in England, where around 10 million people are estimated to regularly exceed the Chief Medical Officers' low-risk guidelines, including 1.7 million who drink at higher risk.<sup>9</sup> As noted in the introduction to

this report, the vast majority of people who need support with their drinking do not receive it. An estimated 82% of the population considered to be alcohol dependent are not in treatment.<sup>10</sup>

By contrast, when asked about mental health, almost half (48%) of participants said that becoming unable to function in their daily life prompted them to seek support. These two responses, from the same participant, illustrate a recurring theme in our findings.

“ A nurse initially suggested I may need support after I filled in a survey at a routine check up. I had always known my drinking

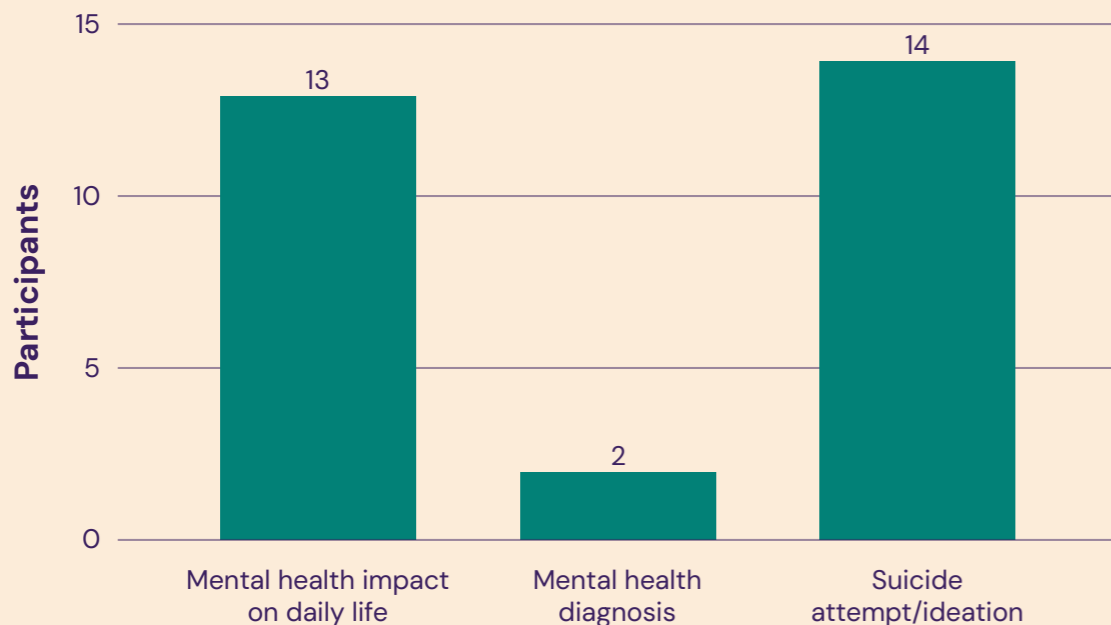
had become a problem, but didn't think it was at the level I needed support. At this point, I did not seek support. A year or so later, my partner at the time also suggested that I had a problem and encouraged me to seek support.

“ I identified myself that I was suffering. I used self harm as a coping mechanism and was having suicidal thoughts. I knew these were red flags.

Survey participant, male, 25-34



**Fig 2. How did you first know you needed support with your mental health?**



49% of participants referred specifically to persistent suicidal ideation and/or suicide attempts. This suggests that for a significant number of people who experience suicidal thoughts/feelings/acts, it takes a mental health crisis involving suicidality before they seek support. Previous work by SPC membership organisations has linked this to feelings of shame around accessing support and being a “burden” on the NHS. One of the main aims of this project and the rest of the SPC’s work is raising awareness of the need to help people access support earlier.

This figure also provides some context to another of our findings, below, which is that A&E is a prominent feature in people’s support pathway for suicidal thoughts/feelings/acts. As will be discussed later in this report, it is essential that crisis support is not missed as an opportunity to help people along their support pathway.

Whilst all of our participants experienced some issues with alcohol and suicidal thoughts/feelings/acts, more participants had accessed formal support for mental health than for alcohol use (96.6% vs 71.4%). Fear of stigma and judgement was listed as the most common reason for not accessing support for alcohol use.

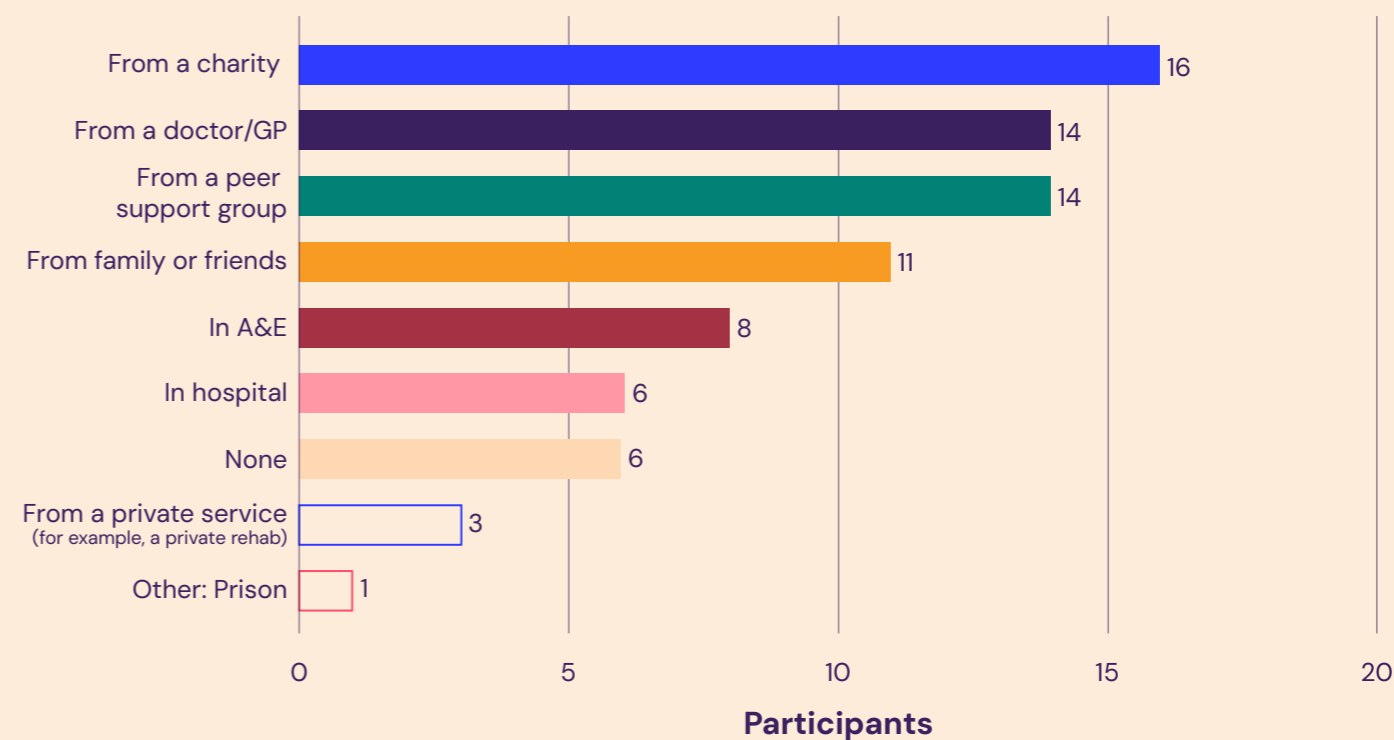
“ I think maybe less so now, but I think that with certain behaviours there’s this sort of idea that you’re doing it yourself and you could just stop... I don’t think I wanted to be known as somebody that had issues with alcohol, there’s a particular picture that might come to mind. And so I guess that’s all around stigma.

Interviewee, female, 25–34

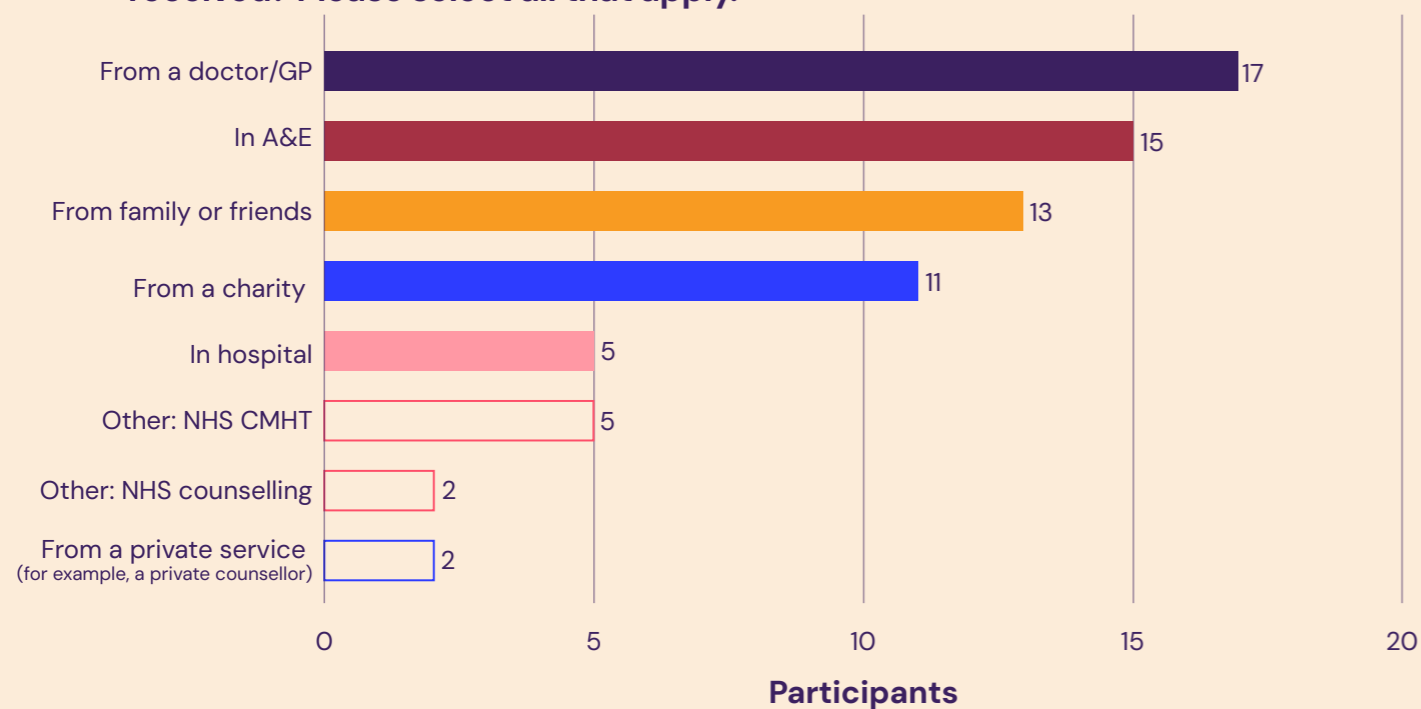
## Types of support received

We asked our participants what type of support they had received for their mental health and their alcohol use. Participants were able to choose multiple options from a drop down list, and add their own answer.

**Fig 3. What type of support related to alcohol have you received? Please select all that apply.**



**Fig 4. What type of support related to your mental health have you received? Please select all that apply.**



The majority of participants spoke to their GP, in relation to both mental health and alcohol use. This reflects the fact that GP surgeries are one of the most visible and commonly known entry points into the healthcare system. A GP visit was often the first step in someone's support pathway once they had realised they needed help, and was often suggested by family and friends particularly in relation to alcohol use.

More people received support from third sector organisations in relation to alcohol use. This is likely because an estimated two thirds of alcohol treatment services are commissioned to third sector providers.<sup>11</sup> When participants had experience with

third sector organisations for support with suicidal thoughts/feelings/acts, this was usually for crisis support from helplines such as Samaritans. It is possible that participants may have received support from a third sector organisation without realising, as many commissioned services sit within NHS practices.

Nearly half of participants had attended a peer support group for their alcohol use, with many naming Alcoholics Anonymous specifically. Several participants reflected that something similar to AA for suicidality would be helpful, although they noted potential issues with sharing specific information about suicide attempts or

planned suicide attempts. The availability of peer support networks and groups for mental health is increasing,<sup>12</sup> and were highlighted as an important part of several participant's support pathways. However, peer support specifically for people experiencing suicidality is less common. By contrast, peer support is very well established for alcohol issues, with AA and other 12 step programmes available across the country and often meeting more than once a week.

“ I'm a passionate believer of the power of peer support. Everybody in that [AA meeting] room is a recovering alcoholic: nobody's any better than anyone else.

Interviewee, female, 55–64

More participants reported seeking private support for help with suicidal thoughts/feelings/acts than for alcohol treatment. We heard from participants that paying for private therapy was often a last resort. Complaints about NHS funded treatment options included lack of choice, long waiting lists, and inconsistent communication.

“ Support in hospital and A&E has been largely unhelpful... Private therapy for the last four years has been a slow but life changing process.

Survey participant, female, 25–34

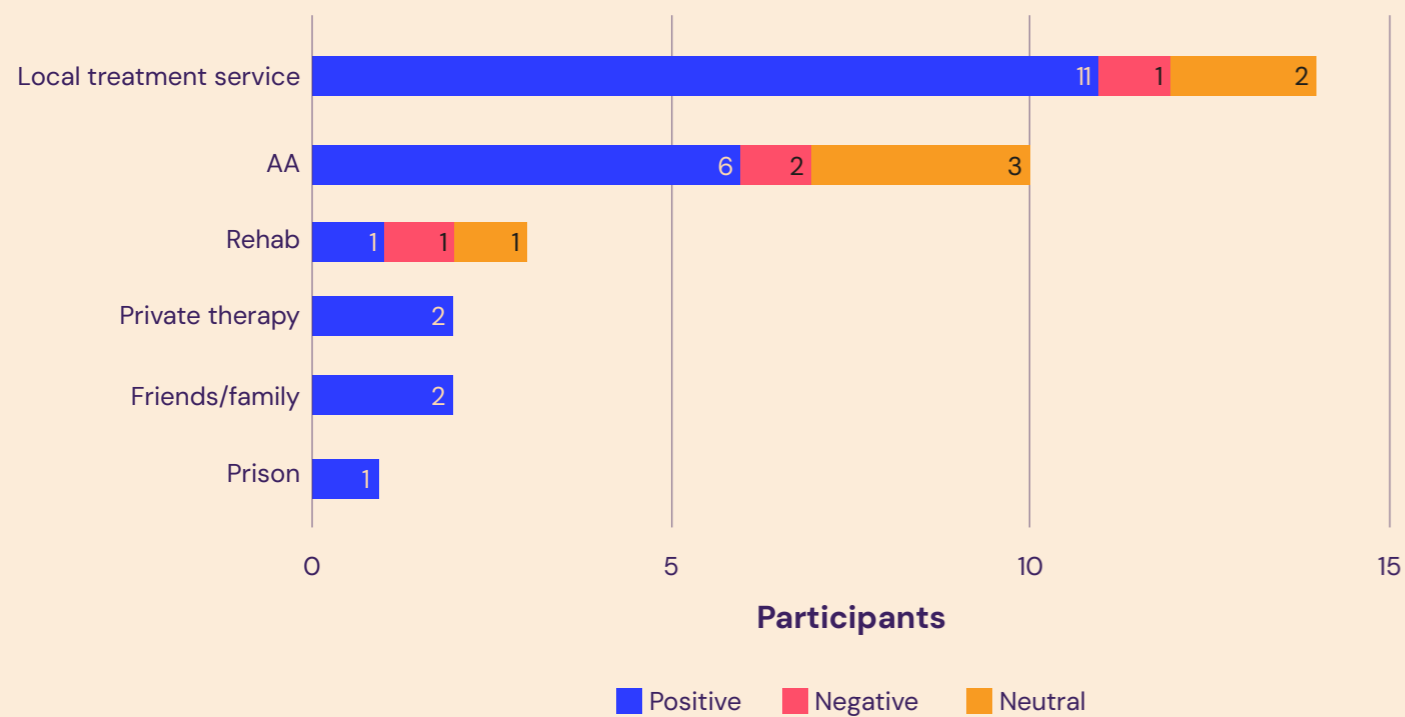
## Participant experiences of different types of support

We asked two open ended questions to find out more detail about participants' experiences of seeking support, one for alcohol and one for mental health. People used lots of different terminology to describe their experiences, and some responses were much more detailed than others. This explains why the number of times a service is mentioned in these responses does not necessarily match the data in Figures 3 and 4. However, we were able to tag the positive, negative, and neutral mentions ascribed to different support options and gain valuable insight into how different parts of the support pathway are experienced.

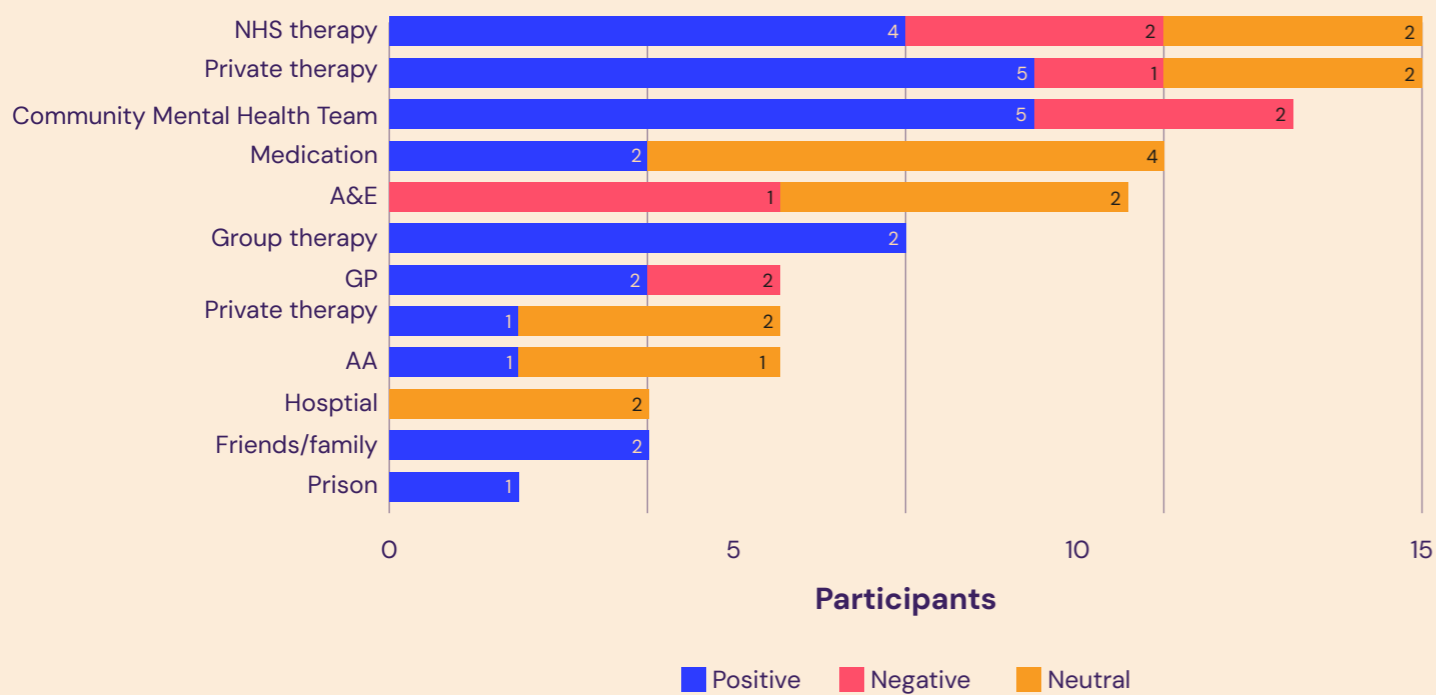




**Fig 5. Experiences of alcohol support**



**Fig 6. Experiences of mental health support**



There were six different types of support mentioned for alcohol use, compared to 12 for mental health. This highlights the complexity of many people's support pathways, where they may interact with a variety of different service providers and support services. This may also be indicative of a wider range of treatment options for mental health. Our participants referred to a variety of different types of therapy, for example, including Eye Movement Desensitization and Reprocessing (EMDR) therapy, cognitive behavioural therapy, and psychotherapy.

It is important to note that there is no clear division between alcohol issues and mental health: many mental health support options referred to can also be used to treat alcohol dependency, including cognitive behavioural therapy and group therapy. It is also interesting to note that three participants referred to AA as part of their mental health support, despite this not being the primary focus of the organisation.

Peer support groups, including group therapy and AA, were consistently rated positively by our participants. This echoes previous findings from the SPC's work about the important role of peer support networks.

Alcohol treatment services also received a majority of positive comments. This highlights the importance of increasing the number of people in alcohol treatment:

research consistently finds that when people do access treatment, outcomes are positive and treatment is regularly started within three weeks of referral.<sup>13</sup>

As noted in the previous section, the majority of participants visited their GP early in their support journey, reflecting the familiarity and recognition of their local surgery as a place to access help. We know however that GP surgeries are under a great deal of pressure and accordingly often have long waiting lists for a first appointment.<sup>14</sup> Increasing public awareness of other "front doors" into support, including self referral options, could help more people access help and in a more timely manner.

A&E was consistently rated as a negative point in the participant's support pathway. This is perhaps unsurprising, as A&E departments are typically very busy, chaotic environments, and people are more likely to be there needing urgent care, which can be very stressful. However, it is concerning that throughout SPC's work, we have consistently heard about negative experiences at A&E. A&E remains the most appropriate place for someone to go when there is an imminent risk to life and when they do, they deserve to receive compassion and support. This is a key area of the support pathway which does not seem to be meeting people's needs.

# Louise's support pathway

We know that there is no "typical" support pathway. However, Louise's experiences reflected many of the barriers and complexities of participant's experiences, as well as the variety of interventions and services that people access throughout their journeys. We hope this example provides a useful visual to bring these experiences to life.

Visual tools can help raise awareness about how support pathways look in practice, and are often clearer than textual descriptions. Treatment providers and others in the support sector may wish to consider developing their own "model support pathway", which can be used both as a best practice guide for staff and also to help people understand what they can expect from their support or treatment options. These should be developed in collaboration with people with lived experience.

## Not accessing support

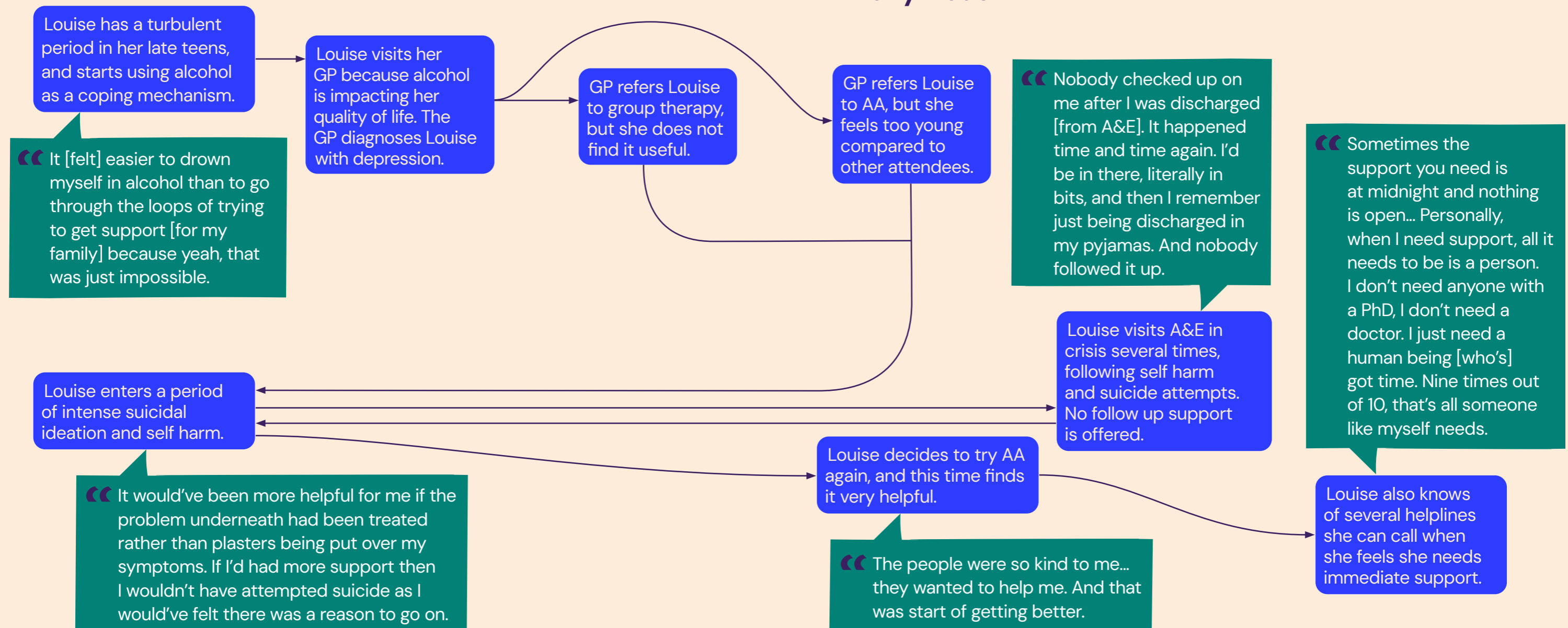
## GP

## Group therapy

## Alcoholics Anonymous

## A&E

## Charity



# What works well?

When we asked our participants to identify the most positive part of their experiences in accessing support for their alcohol use or suicidal ideations, two themes emerged repeatedly: receiving support without feeling rushed to 'get better', and seeing the same alcohol treatment or mental health professional consistently.

These two factors are especially important for people seeking support for more than one issue, who are more likely to need longer key worker sessions and more intensive support. Unfortunately, increasing caseloads in recent years<sup>15</sup> have meant that frontline staff at alcohol treatment services have limited time with their clients. Whilst best practice suggests that staff should have a caseload of 40 or less, a 2021 survey found that recovery workers regularly had caseloads of between 50 and 80, sometimes rising as high as 100.



## Consistent support without a time limit

“ My GP has been brilliant and offered me catch ups every few weeks to check in and see where I am at with my meds and if I need more.

Survey participant, female, 25-34

“ [I am] currently attending an ATR<sup>16</sup> group run by WithYou. The staff are brilliant and always take the time to make you feel welcome and included. They never just rush off if they see you are struggling. I always leave feeling more hopeful than when I arrive.

Survey participant, female, 45-54

## Establishing a relationship with a professional

“ A great deal of my experiences in the [mental health] services have been negative: from disappointing to extremely damaging. However, the last two years I've had the best Community Practice Nurse, and emotional regulation therapy for BPD. I'm now finally working towards discharge!

Survey participant, female, 55-64

“ I think the relationship between practitioner and patient is one of the most important elements. Some counsellors/ CBT practitioners seemed to have been rushing through the appointments and focussed more on giving out handouts than on listening to me. I have had the same NHS counsellor three times now and he listens, is empathic and even lets the sessions overrun to give me more time. He has made the most difference.

Survey participant, female, 55-64

# What needs to improve?

The final survey question asked participants, "If you could change one thing about your experience of accessing support, either for alcohol use or in relation to your mental health, or both, what would it be?" We also asked this at the end of the interviews. We then grouped together responses according to the main theme. Five themes emerged and are each explored below.

## Reduce stigma and judgement

28% of participants identified reducing stigma as the single thing they would like to change most about the support pathway, in relation to both suicidality and alcohol use. We heard that a fear of judgement prevented people from seeking the support they needed to access. It is absolutely essential that seeking support for alcohol use, mental health, and/or suicidality specifically, carries no judgement. Throughout the SPC's work, we have heard of people's suicidal thoughts/feelings/acts being dismissed because of their alcohol use, and vice versa, reflecting a lack of understanding about the nuances of people's experiences and support needs. There has been a welcome increase in focus on reducing stigma in recent years, but for this to become a reality, every healthcare professional involved in the support pathway must work to embody these values in their practice.

“ You should be able to feel you can ask for help and support without feeling guilty... I would like it to be less silent and that you can talk about how you're feeling without pressure or people assuming things.

“ What is hard is constantly having to fight to receive support and having to search it out yourself. You're the one experiencing it, but you've got to deal with people's perceptions.

Survey participant, female, 25-34

We also heard from participants that they felt they needed to behave in a certain way in order to access certain types of support. This included being dismissed for not seeming unwell enough, and for being too young to need treatment for alcohol use. This reflects pervasive assumptions about how someone with alcohol issues or mental health needs will look or sound, and what their background will be.

“ I once had an appointment with a mental health worker who informed me I was fine because I had arrived early, on my own and was immaculate... This type of judgement just pushes me to keep my problems to myself.

Survey participant, female, 45-54

In relation to alcohol use, participants explained that fear of judgement led them to hide the fact they had an issue with alcohol, which in turn made accessing support very difficult.

“ I think a big reason why it took so long for me to get support was due to my age, especially with the stigma of being a young student with an alcohol issue. When I had raised concerns with friends, I was told that drinking in excess was normal for our age, even though I was drinking first thing in the morning and throughout the day. I would also say that I was high-functioning and very secretive, as I took great measures to keep my alcohol use under wraps from my family and college staff.

Interviewee, female, 55-64

Relatedly, there was a consistent theme that participants felt "lucky" if they were offered any support, particularly support that actually helped them. This appeared to stem from very low expectations about the efficacy and availability of the support system.

“ I wish that there had been less barriers to me accessing support in the first place. I was lucky to be initially offered anything but I still wasn't given the correct treatment for a few years.

Survey participant, female, 18-24

## Support must be person-centred

Person-centred care is recognised as a cornerstone of effective healthcare. One key aspect of person-centred care is recognising the nuances of people's personal circumstances and experiences. The support pathway needs to be joined up to allow for these many possible factors in order to provide appropriate care alongside other health needs. For example, mental health services need to work collaboratively with alcohol support services. It is important that local commissioning structures do not discourage services from working together on more complex needs cases.<sup>17</sup>

The majority (64%) of participants said that they were asked about their alcohol use when they sought mental health support. For the 36% of participants with whom alcohol was not discussed, some said that this was because it was not relevant or necessary, and others said they were already receiving alcohol support.

“ It [alcohol] was definitely an issue for me at that time, it was part of the medical team's holistic assessment. It did cause me to reflect and has positively influenced my mental health and alcohol use.

Survey participant, male, 35-44

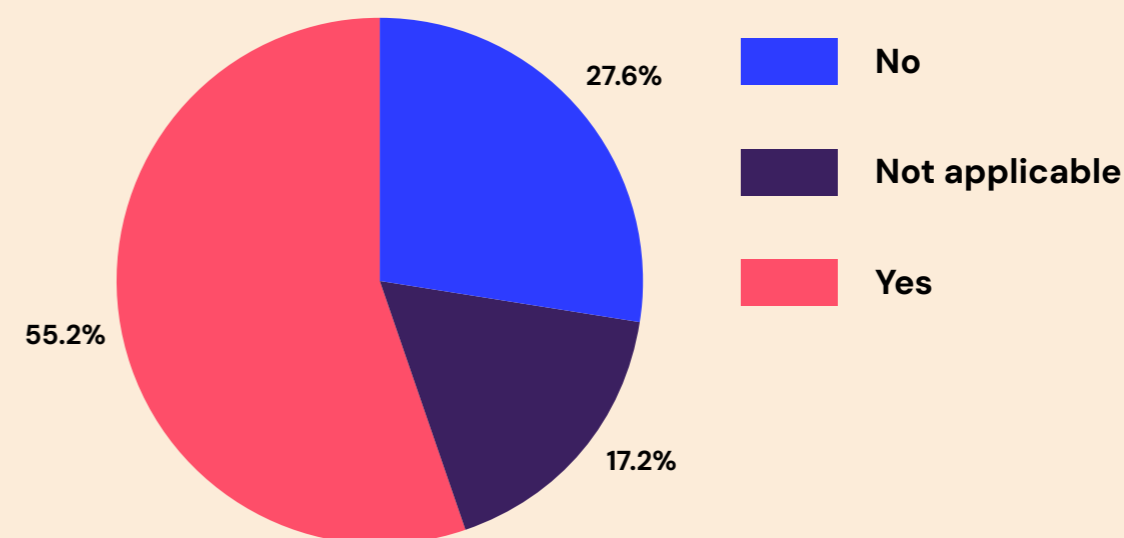
However, more than half (55%) of participants felt that being open about their drinking led to barriers in their ability to access support for their suicidal thoughts/feelings/acts. Numerous participants noted an expectation that they could deal with one issue without the other, and that there was not always the time and space in appointments to discuss the complexity and contextual factors around their drinking.

Echoing the findings of the SPC's previous reports, we heard that silos in the support system between alcohol treatment service providers and mental health services can inhibit a person-centred approach. This is despite the fact that, as established at the start of this report, the two issues commonly co-occur.

“ I did not seek support partly because of fear of judgement and not knowing where to go but partly due to my other mental health symptoms being more severe and it being a priority to get treatment for them. I hoped that treating my other symptoms would reduce drinking.

Survey participant, female, 25-34

**Fig 7. Do you think your alcohol use has been a barrier to getting support for your mental health and/or suicidal thoughts/feelings/ideation?**



## Empower people to make choices, ask questions, and express preferences

Another key aspect of person-centred care is empowering people to make decisions about their care, and to engage in open dialogue with healthcare professionals. We heard that participants felt concerned about opening up about suicidal thoughts/feelings/acts for fear of being judged as dangerous, or referred immediately to the police or other emergency services. People must feel able to express their feelings and preferences for the types of support they would like to receive.



“ It’s like, you just want to speak. You just want to just express who you are, say, this is my world I live in, look at my world rather than just trying to make me fit into your world all the time... [You’re] trying to be like everyone else and all you do is fail, and upset people.

Interviewee, female, 45–54

Accessing support, especially for the first time, can come with a great deal of uncertainty. People may not know what accessing support will entail in practice, and many aren’t sure what, if any, repercussions there may be of disclosing their alcohol or suicidality. It is therefore very important that information about the practical side of seeking support is made easily available and is accessible, and that people can ask detailed questions and receive accurate, informative responses. As many people’s first point of contact, GP practices in particular must distribute this information.

“ Will it [seeking alcohol support] cost me my job? Kids? Driving licence? House? How would it affect my future? I still have to pay more for my car insurance due to being alcohol dependent in the past.

Survey participant, male, 35–44

Several participants illustrated that it can take multiple attempts to access the right kind of support. We know that everybody’s experiences are different, and therefore this need to explore different support options is to be expected. It is important that the support system has the flexibility to accommodate this.

“ I began by accessing a rehab clinic run by the NHS. To begin with, I found this support useful... After a few sessions though, I realised that the doctor I was working with and my views were not aligned, and the experience ended with me drinking more. I left this service and began going to AA. Again, I didn’t feel like my views matched with the morals of AA and it left me feeling worse and drinking more. Finally, I managed to afford private therapy and worked with a therapist I chose who helped me significantly.

Interviewee, female, 45–54

## Reduce missed opportunities

Nearly half (48.1%) of participants attended A&E following a suicide attempt or other mental health crisis. Figure 6 illustrates that A&E was consistently labelled as a negative part of people’s support pathway, with several respondents highlighting the lack of follow up care they received. We also heard from more than one participant that despite alcohol being involved in multiple suicide attempts, no health professional raised the option of support for alcohol use with them. The Suicide Prevention Strategy for England highlights the need for more effective crisis support, acknowledging that of all deaths by suicide by people in contact with mental health services in England between 2010 and 2020, 15% were under the care of crisis resolution teams.<sup>18</sup> Effective implementation of the ‘no wrong door’ approach would mean ensuring that A&E and other crisis services can provide an entry point into follow up care and treatment options.



As Louise's pathway illustrates, as well as significant missed opportunities, poor experiences with crisis support can represent a rupture in a person's support pathway as they feel let down and distrustful of services.

“ I think when I'm [in] contact with emergency services and the hospital and they're hearing time and time again, there's a large amount of alcohol and it combined with suicide attempt... I feel like maybe someone somewhere should have connected some dots and had a direct conversation with me around. Why does this keep happening? Do you think they could be connected? Honestly, I can't tell you whether or not I would have been receptive to that. But ultimately it didn't happen. So I don't know.

Interviewee, female, 25-34

It is also important that someone who finds a support option unhelpful or inappropriate is not labelled as unwilling to get better. As described above, everyone deserves to try as many support options as needed before they find what works for them. Turning people away or making them feel like they have 'failed' at accessing support represents another missed opportunity for helping them engage and stay on their support pathway.

“ I was offered access to a mental health forum who were woefully out of touch with just how severe my mental health was and kept insisting I complete an online interactive CBT course which I was totally incapable of doing. I was not referred for any further treatment when I declined the CBT course as I was deemed to be unwilling to participate.

Survey participant, female, 55-64

“ [I was] depressed most of the time, [feeling] suicidal [and] self harming regularly. Very difficult to sort out both this and alcoholism. Nowhere seemed to join the two up.

Interviewee, female, 35-44

“ People didn't want to talk about mental health, they just wanted to talk about my drinking without acknowledging they are connected.

Survey participant, male, 35-44

## Services must be accessible

Alcohol treatment, mental health services, and support for people experiencing suicidality need to be easy to access. As well as some participants noting the lack of services in more geographically remote areas, others commented on the services themselves feeling unpleasant or intimidating. We know this can be a particular concern for women; because men make up the vast majority of the treatment population, services are often male-dominated have a limited range of options tailored to women. Once someone has made the important and brave decision to access support, it is vital that they are not deterred by the conditions.

“ I live in a town where there [are] a lot of alcohol and drug users who congregate in the town centre shouting abuse. I know they are clients of the local drug and alcohol services and this deters me from contacting the service. I was once verbally abused by one in the waiting room. I would like reassurance about visiting the service in person or more options about contacting the service.

Survey participant, female, 55-64

“ The logistical side of seeking help: Free public transport to attend groups, services, services in better locations, services in better maintained buildings.

Survey participant, male, 35-44

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