August 2021

Alcohol and self-harm: A qualitative study

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Acknowledgements

Primary thanks to those who took part in interviews for the study, and to everyone who expressed interest in taking part. Thank you to everyone who supported recruitment to the study. Finally, many thanks to Andrew Misell (Alcohol Change UK) for commissioning the study and supporting the work throughout.

This report was funded by **Alcohol Change UK**. Alcohol Change UK works to significantly reduce serious alcohol harm in the UK. We create evidence-driven change by working towards five key changes: improved knowledge, better policies and regulation, shifted cultural norms, improved drinking behaviours, and more and better support and treatment.

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Opinions and recommendations expressed in this report are those of the authors.

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Executive Summary

This qualitative study was commissioned by Alcohol Change UK in Wales to explore how and why alcohol and self-harm are related, and how alcohol, self-harm, and related services, are experienced and understood. Eleven people who had experience with self-harm and alcohol use were recruited through mental health support organisations across England and Wales. Interviews invited participants to 'tell their stories' about self-harm, alcohol use, the relationship between the two practices, and their experiences with services in relation to these.

Participants described a wide range of drinking and self-harm practices, and service experiences. Interviews highlighted the ways in which both self-harm and drinking are embedded in society and culture and do not take place separately from it. Accounts suggested that drinking and self-harm were deeply connected in multiple complex ways.

Drinking was described as sometimes exacerbating a 'bad headspace' or enabling self-harm by lowering inhibitions, and sometimes as a type of self-harm in itself, or - for some - as a way of avoiding self-harm. Both alcohol use and self-harm were described by some as representing a valuable coping mechanism. Participants varied in terms of how much of a 'problem' either self-harm or alcohol use were at different times in their lives.

Participants had experienced a range of services. A clear message was that current services were frequently unable to acknowledge or respond to their needs, for a number of reasons:

- Separation of mental health and alcohol services: Despite participants describing drinking and self-harm as related and often as deeply intertwined, the services they described did not often enable drinking and self-harm to be considered together. Many participants suggested they hid either their drinking or their self-harm in order to access services.
- A lack of needs-based services provision: Participants described services which were diagnosis-led, which meant that many had been unable to access the services they wanted or needed, with long waiting lists to access any support. With both self-harm and alcohol use, this led to some people 'falling between the cracks' – with no 'treatable' diagnosis, left with limited or no support, despite experiencing significant distress and seeking help for this.
- Services not flexible or not accessible: Related to the above, participants described services that were either absent or structured in a way that made them inaccessible.
- Being dismissed: Many participants described feeling dismissed when they tried to access services about their self-harm. This is potentially dangerous as it could lead to people feeling they need to self-harm more frequently or 'seriously' in order to access support.
- Harmful or cruel treatment: In addition to the systematic problems with services, many participants described cruel and painful treatment and harmful attitudes from practitioners, including being given stitches without anaesthetic, being told their problems were 'invented', being told their scars would make them 'ugly', and not being believed when they were seeking treatment for medical problems other than self-harm.

Participants highlighted the importance of communication, relationships, and accessibility, and the need for services to be able to cope with complexity and respond to need. This has implications for services relating to alcohol and self-harm, suggesting that a more flexible approach, enabling acknowledgment of the complex connections between drinking and self-harm, and the social aspects of both, is required.

Introduction

Alcohol use is widely understood to affect self-harm and suicide. Suicide prevention policies across the UK highlight those who misuse alcohol as a 'high risk' group. The Welsh Government's current suicide prevention policy states that 'services need to address how they respond to, assess and follow up people who present with self-harm particularly where alcohol is involved' (2015, p. 21). Although there is a significant body of literature identifying statistical relationships between self-harm and alcohol use (often specifically focusing on alcohol dependence or misuse), qualitative exploration of this relationship has been limited. This is surprising, given both self-harm and alcohol use are subject to multi-layered, complex, and variable cultural and social meanings. Each are experienced and practiced in ways that are shaped by social and cultural factors, including socioeconomic status and gender identity.

Developing approaches to supporting and responding to patients who present or attend services having self-harmed and used alcohol is vital. Unfortunately, both those who self-harm and those who have used alcohol are often found to be viewed negatively by medical staff, especially in secondary care (Accident and Emergency) (Jeffery, 1979; Saunders et al., 2012; Masuku, 2019; Rayner et al., 2019; Quinlivan et al. 2021).

This qualitative study was commissioned by Alcohol Change UK in Wales in order to broaden and deepen conversations about self-harm and alcohol use. The project set out to do this by drawing on individual accounts of people who have experience with self-harm and alcohol use, and analysing these in light of wider sociological (and more broadly social scientific) research. These approaches contribute a different disciplinary and methodological perspective, and in doing so offer grounded and nuanced recommendations regarding how services might meet the Welsh Government's aims to 'respond to, assess and follow up people who present with self-harm, especially where alcohol is involved'.

We highlight a significant diversity of experiences, and underline the need for a similarly flexible and responsive range of services. This report also offers insights into the experiences, challenges, and successes of people who have experience with self-harm and alcohol use. The strength of such accounts is that they can contribute to deepening understandings among service providers – and others – of the complexity contained within clinical observations that 'self-harm and alcohol use are related'.

Background

In order to situate this study, we first introduce – or perhaps trouble – some common assumptions and challenges associated with naming the problems at hand: self-harm, and alcohol use. Each of these are subject to much contestation regarding how they might be defined, how they are shaped by social and cultural contexts, the role of subjective meanings, and the extent to which either should be deemed subject to 'medicalisation' – e.g., seen as a 'medical issue'.

With alcohol use, these debates originated many years ago. Indeed, alcohol use is one of the exemplar studies in the sociology of medicalisation – with alcohol dependence formerly framed as a moral weakness, and latterly 'transformed' into a medical condition (Blaxter, 1978; Conrad, 2007). Self-harm (or specifically self-injury) has more recently, apparently, undergone a similar shift in its meanings – from disturbing practice, to more sanitised psychiatric diagnosis (Chandler, 2016; Chaney, 2017; Gilman, 2013). However, in each case, shifts from non-medical to medical, from immoral to disease, have been

imperfect, and far from straightforward or linear (Adler & Adler, 2007). Those who are dependent on or who use alcohol in ways that are damaging to self or other, and those who directly harm their bodies, are in the UK both subject currently to moral opprobrium as well as to medical intervention and treatment.

Defining self-harm

Self-harm is notoriously challenging to define. The terms used to describe self-harm continue to fluctuate and lack clarity. In the UK, health policies tend to follow the NICE guidelines definition of self-harm as 'self-injury or self-poisoning, irrespective of the apparent purpose of the act' (NICE, 2011). This approach is not universal, though. In the US a distinction tends to be drawn between deliberate self-harm (DSH) and non-suicidal self-injury (NSSI) (Chandler, 2016; Kapur et al., 2013). The extent to which the 'intent' of the person self-harming is or is not suicide has become a key focus of debates.

Qualitative research with people who have self-harmed, and with medical practitioners, underlines the diversity of practices and meanings that the term can refer to (Chandler, 2016; Chandler et al., 2020; Steggals, 2015). An earlier study by Chandler with 100 young people (aged 13-21) found that while most reported self-harming in the form of self-cutting, over half also reported using 'other' methods of self-harm, including hitting, burning, self-criticism, tying ligatures and more (Chandler, 2014). Qualitative research with those who have self-harmed also underlines the complex relationship between self-harm and suicide. While self-harm is frequently emphasised as 'not suicidal' – and indeed such arguments have contributed to the development of the category of NSSI – there remains a statistical relationship between hospital-treated self-harm and later suicide (Geulayov et al., 2016). Further, qualitative accounts of those who have self-harmed suggest that motivation or intent can fluctuate across time, and even within a particular 'act' of self-harm (Chandler, 2016; Neale, 2000; Troya et al., 2019).

In this study, we used a deliberately broad approach to defining self-harm – being interested in how participants themselves made use of the term. In addition, we were interested in how far participants framed alcohol use itself as self-harm. As we discuss below, this resulted in a sample of participants who incorporated a very wide range of practices under the category of 'self-harm'.

Defining alcohol use

Alcohol consumption in the UK is higher than the European average consumption (World Health Organization (WHO) (2018), and although an increasing number of young people aged 16-24 report being abstinent from alcohol (Ng Fat et al., 2018; Office for National Statistics, 2018), young people who do report drinking are more likely than other age groups to report 'binge' drinking (Emslie et al 2009; Office for National Statistics, 2018).

Studies define alcohol consumption in various ways and use different comparators. Some compare any drinking with no drinking, while others describe 'low', 'moderate', 'heavy' and 'binge' drinking, defining these terms in various ways. The International Classification of Diseases and Health Problems (ICD-10) lists 'dependence syndrome' as a chronic and relapsing medical disorder described as: 'a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value.' (World Health Organization). Various tools such as the alcohol use disorders identification test (AUDIT) are available to help practitioners screen for problematic alcohol use and dependence (Public Health England, 2020).

However, sociologists such as Patsy Staddon argue that this depiction of dependence as a chronic and often relapsing medical problem misrepresents the complexity involved in many people's experiences of drinking, ignores the importance of wider structural factors on individual drinking, and over-emphasises the impact of treatment (Staddon, 2012, 2013, 2016). Instead, she cites research suggesting that many people move between different ways of drinking throughout the life course, going from heavy drinking to mild, moderate, and severe dependence and back again, with periods of abstinence, and that people often 'recover' from problematic alcohol use without any treatment. This, she argues, suggests that broader social contexts are related to drinking (Staddon, 2012; Willenbring, 2010).

In this study, as with self-harm, we used a deliberately broad approach to defining drinking, enabling participants to identify, define, and reflect on their own drinking. This resulted in a sample of participants who described a wide range of drinking and defined their drinking in varied ways.

The relationship between self-harm and alcohol use

Research examining the relationship between self-harm and alcohol use has drawn on a range of methodologies and disciplinary perspectives, though largely tending towards quantitative approaches.

A significant focus of self-harm research is hospital presentations or admissions for self-harm. For instance, Ness and colleagues analysed routinely collected patient data in England between 2000-2009, finding that the proportion of patients who had self-harmed and exhibited alcohol use or misuse increased over the study period, particularly among younger women, and in this case, particularly relating to acts of self-injury (Ness et al., 2015). A similar study (Griffin et al. 2018), using the Irish register of self-harm presentations at hospital across 2012-13 found that alcohol was present in 43% of patients across Ireland and Northern Ireland, though a higher proportion in Northern Ireland (50% compared to 37% in the Republic). In this case, as with Ness and colleagues, presentations for self-harm in the context of alcohol use in general was more common among men (Griffin et al., 2018). The Welsh Government highlights people who *misuse* alcohol as a 'high risk group', other studies focus on those with alcohol *dependence* as being especially at risk of suicide. In a Welsh context, John et al. (2020) report that suicide is strongly associated with attendance at primary and secondary care settings for alcohol misuse. Studies using hospital data find that *use of alcohol* is often noted in hospital presentations for self-harm, and confirm that *misuse* of alcohol is associated with later death. Thus, a relationship between alcohol and self-harm may be identified, even in the absence of alcohol misuse disorder or alcohol dependence.

Another form of study which has investigated relationships between self-harm and alcohol use are experimental psychological studies. For instance, Berman et al. (Berman et al., 2017) conducted a laboratory-based study to investigate relationship between alcohol dosage, history of non-suicidal self-injury, and propensity to self-administer a painful 'shock' in laboratory conditions. They found that history of NSSI and alcohol dose increased the likelihood of participants choosing a painful shock. The authors concluded: 'Results provide experimental evidence to support the notion that interventions for self-harm should include processes to monitor and limit alcohol intake'. Of course, this type of suggestion is all well and good, but it neglects the complexity of both self-harm and alcohol use. Laboratory studies which attempt to replicate either self-harm or alcohol use can be questioned, as in each case the social and cultural meanings and contexts in

which these practices take place are ‘controlled for’, but in ways which make the results relatively meaningless (Chandler et al., 2011).

Another psychological study used online questionnaires to investigate the relationship between alcohol use and self-harm or suicidal intentions or actions (Melson & O’Connor, 2019). People who reported self-harming in this questionnaire were more likely than others to report frequent ‘heavy’ drinking and were more likely to say that they may engage in ‘rash actions’ when drinking or consider self-harming when drinking. The study authors acknowledge that it is not possible to identify a causal link between drinking and self-harm from the data and point out that further research is required to understand whether and how alcohol consumption affects people’s likelihood to move from thinking about self-harm or suicide to acting on these thoughts (Melson & O’Connor, 2019). Although questionnaire studies like this one can explore statistical relationships between reported behaviours such as drinking and self-harm, they are unable to grapple with the complex social factors which relate to individual behaviour.

What epidemiological and psychological studies miss out, then, is the deeply social and cultural nature of both self-harm and alcohol use. In this study, we were fortunate enough to be able to interview people who had experience of both ‘self-harm’ and ‘alcohol use’. As noted above, we defined both of these terms very loosely, focusing on the meanings and definitions of these terms as used by participants, undoubtedly further shaped by those who supported referral. Our study aimed to explore how people account for and explain their experiences with self-harm and alcohol use, inviting them to reflect and share messages about experiences with services, in order to draw out ways that services (of different kinds) might improve or build on existing (good) practices.

This project builds on an earlier qualitative study which focused on accounts of men in ‘mid-life’ (aged 35-54) and explored experiences with self-harm and alcohol use across the lifecourse (Chandler and Nugent, 2016).

Sociological approaches to alcohol use

The role of alcohol in contemporary UK culture is complex and contested; drinking is often portrayed in research and policy as either harmful and problematic or as an important aspect of society and culture; it is rarely understood as both (Jayne et al., 2008).

Whilst acknowledging the alcohol-related harm that occurs in the UK, sociologists have studied the ways in which drinking and drunkenness are embedded in and an expression of culture (Thurnell-Read, 2016), and have resisted the oversimplified use of alcohol as a scapegoat to explain complex social problems. Sociologists such as Thurnell-Read (2016) argue that drinking should not simply be dismissed as harmful and dangerous, but that we should seek to understand its role in society by looking beyond individual drinking to explore the connections between individuals and structural aspects of society. Biomedical approaches, which draw on medical and scientific discourse to explain ‘problematic’ alcohol use, have become highly influential as the dominant narratives surrounding addiction (Fraser et al., 2014; Li et al., 2007), constructing some types of drinking as problematic. Critics argue that biomedical approaches oversimplify a multifaceted phenomenon by representing it as a simple biological problem, placing the source of the ‘problem’ within the individual which avoids having to consider the complex social problems that are connected with it (Hammersley & Reid, 2002). In contrast, sociological research suggests that many people move between different ways of drinking throughout the life course, going from heavy drinking to mild, moderate, and severe dependence and back again, with periods of abstinence, and that people often

‘recover’ from problematic alcohol use without any treatment, suggesting that broader social contexts are related to drinking (Staddon, 2012; Willenbring, 2010).

Staddon (2013; p6) argues for a social approach to drinking in which we seek to understand what makes people want or need to drink in order to understand ‘alcohol as potentially helping people to deal with a variety of social issues, some of which might become more problematic either with or without its use.’ This, she argues, would enable us to attempt to understand the complex interactions between individuals and society that are often involved in problematic drinking.

Sociological approaches to self-harm

Although less socially accepted than alcohol, self-harm is increasingly part of the social and cultural landscape of the UK and many other ‘Western’ countries. Rates of self-harm appear to be increasing, especially among young people, and especially among young women (Griffin et al., 2018; Marchant et al., 2020). The strength of the rise, and how far it is shaped by gender and age is affected by how self-harm is defined and measured. Sociological research on self-harm frequently uses qualitative methods to explore the way in which people make sense of the practice of self-harm. Studies have studied associations between self-harm and relationships in the family home, focusing especially on younger people (Brossard 2018; Steggals et al 2020). These studies suggest that self-harm can serve important communicative purposes, but that at the same time, there is an imperative to hide self-harm (Chandler, 2018). It is framed as a secret or private ‘coping mechanism’. Sociological approaches raise questions about how and why self-harm might come to serve such purposes.

Brossard argued that self-harm, for many of his participants, was an effective method of managing emotional turmoil in such a way that did not then disturb the relationships that young people had with family or friends. Similarly, Chandler’s (2012, 2016) research with adults who had self-harmed found that self-harm was often described as a form of ‘emotion work’ - a way of ‘working on’ emotions through the body. Chandler argued that parallels might be drawn between practices of self-injury – where harm is inflicted on the body in order to ‘calm down’ or ‘release’ emotions, and other – also bodily – forms of managing strong emotions, including alcohol and drug use, as well as exercising, going for a walk, or practicing deep breathing. This perspective underlines the contingent nature of ‘self-harm as pathology’, as well as situating the practice of self-harm in relation to more ‘socially acceptable’- but similarly bodily – ways of dealing with distress. Sociological approaches to self-harm also underline the role of broader structural processes – such as socioeconomic and gender inequality, discrimination and oppression against LGBTQ+ people, disabled people, and those from ethnic minorities.

McDermott and Roen (2016), for instance, argue that it is essential to engage with the ‘structural and material’ contexts of people’s lives as shaping and driving self-harm; rather than pathologizing individuals. Their work focuses especially on young LGBTQ people, and highlighted the role of homophobia, transphobia and biphobia (or as Marzetti, 2018 terms it ‘queerphobia’) in driving young people’s experiences with self-harm and suicide. However, they note that young people from poorer backgrounds are more likely to have fewer resources through which to navigate away from stigmatising environments (e.g. by moving away for a job or to university). Similarly, Inckle (2020) has argued strongly that self-harm (and mental illness more broadly) be understood as an issue of social justice – shaped by intersecting inequalities.

Inckle – like McDermott and Roen – suggests that framing self-harm solely as an issue of mental health can result in the practice being individualised, seen as a ‘problem’ that is

situated in the psychological make-up of a person, and thus requiring psychological or psychiatric treatment and intervention. However, recognising self-harm as instead socially situated and shaped means that an individualising and pathologizing approach may not be helpful – an individual intervention or treatment may be less effective if a person's social situation remains the same. Chandler's earlier research with men who had self-harmed drew similar conclusions – arguing that many of the challenges people who are struggling with self-harm face are related to wider societal problems, such as poverty, unemployment, lack of secure housing, estrangement from family or friends and isolation (Chandler, 2021).

Inckle's work has focused on examining alternative ways of responding to self-harm. She suggests that services for those who self-harm should be user-led, co-designed, and non-pathologizing, echoing approaches posed by Spandler and Warner (2007, 2011). These approaches open up avenues for considering services that are socially/sociologically informed, rather than led by a more narrow view of self-harm as a mental health problem that requires diagnosis and (individualised) intervention.

Methods

This study used qualitative methods in order to generate and analyse accounts of people who had experience of self-harm and alcohol use. As discussed above, each of these terms were very broadly defined, in order to maximise chances of a diverse sample with a breadth of experiences. A qualitative approach allows researchers to engage more deeply with the ways in which different experiences are made sense of and given meaning. These aspects are often left out of quantitative research, and yet they offer important insights into how and why alcohol and self-harm may be related, as well as offering diverse perspectives on how self-harm and alcohol use are experienced and understood. The research questions were as follows:

- What kinds of relationships between self-harm and alcohol use do people who have self-harmed articulate?
- What experiences do people who self-harm have when attending accident and emergency departments if they have drunk alcohol?
- What challenges and successes have people who self-harm experienced when seeking help or support for alcohol use and/or self-harm?
- How are interactions with services perceived when presenting with both self-harm and alcohol use?

In order to answer these questions, we held interviews with 11 people who had experience with self-harm and alcohol use. Participants were recruited through several mental health support organisations based across England and Wales. Interviews were loosely structured (see Appendix A for interview schedule) and invited participants to 'tell their stories' about self-harm, alcohol use, the relationship between the two practices, and their experiences with services in relation to these.

All interviews were held remotely with Amy Chandler, either on the phone or via Zoom. Interviews lasted around one hour each. They were digitally recorded and transcribed. The transcripts were then read and re-read by Annie Taylor in order to develop common deductive (from the interview questions) and inductive (novel/unexpected insights from the interviews) themes (Tavory and Timmermans, 2014). Our analysis was informed by narrative analytic approaches (Riessman, 2008). This means that interview accounts were understood as situated, partial and specific to the context of the interview – these were stories told by participants which allowed us to reflect on shared and contested meanings of self-harm and alcohol use, and different perspectives and experiences with services. Analytic themes were then shared and discussed among the research team, contrasted with wider relevant research findings, and a draft report was shared with participants, some of whom provided feedback which was then integrated into the final version.

The research was reviewed and approved by the University of Edinburgh's Counselling, Psychotherapy and Applied Social Sciences Ethics Committee. All participants gave informed, written consent to take part. Amy Chandler spoke with each participant on the phone or video call prior to the interview. This gave participants an opportunity to discuss the project, ask questions, and get a better understanding of what taking part would involve. All names given below are pseudonyms, chosen by participants. In addition, transcripts were carefully checked and any identifiable information was changed or redacted. Participants all received a £25 gift voucher as a token of thanks for the time and energy they put into contributing to the study.

Findings

Eleven people took part in a research interview: four men, one transman, and six women. Participants ranged in age from their early 20s, to early 50s, all but one described their ethnicity as White British. Participants described a wide array of experiences with self-harm and alcohol use. In the discussion of findings below we elaborate upon this further.

Contexts of self-harm and drinking

Participants described a wide range of self-harm and drinking practices. They recounted drinking ranging from drinking only 'socially' or having one drink per day, to describing themselves as 'alcoholic', and a range of self-harm including cutting, burning, disordered eating or food restriction, purposefully putting themselves in high-risk situations when doing extreme sports ('acting recklessly') or in dangerous/violent sexual encounters, drinking as self-harm, hitting, overdosing and attempted suicide. Participants' accounts highlighted the ways in which both self-harm and drinking are embedded in society and culture and do not take place separately from it.

Normalisation of drinking

One aspect of drinking across almost all the accounts was the extent to which drinking was normalised. Many participants started drinking at a young age, many described various family members and friends as drinking/alcoholic, alcohol as commonplace and deeply embedded in social and cultural life. Many described early memories of alcohol involving family events. Drinking at a high level – especially in teens and 20s - was normalised:

> 'Everyone else was kind of doing the same. They probably didn't get as sick as I did but it was just everyone was drinking, it would be questioned why you weren't drinking. And also, just general kind of chaotic behaviour that way just wasn't really judged or questioned, it would be, like, oh, that was a full-on night or whatever, how are you feeling now kind of thing. Well, that's my memory anyway.' (Jane)

Participants currently involved in alcohol treatment, or who described themselves as having an alcohol problem, placed particular emphasis on the normalisation of drinking. They stressed the problematic and dangerous nature of alcohol, framing it as a dangerous drug which is too easily available:

> '…I mean alcohol is a really, really weird one because it's socially acceptable, you know. You can buy it in most stores. You can get it delivered to your house. You know, if you were to walk down the road with a bottle of vodka in your hand, no one would bat an eyelid, you know. Pull out a crack pipe and people would frown upon you.' (Adam Over)

Although this narrative of alcohol causing harm was not as marked in other participants' accounts, the impact of the normalisation of drinking – particularly 'high risk' drinking – was evident across accounts, with participants variously describing drinking more when their friends or family were drinking, when cheap alcohol was easily available, and when social situations were associated with alcohol.

Pathologization of self-harm

In contrast with the normalisation of drinking, many participants described self-harm as pathologized and often hidden. Some participants described attempting to keep self-harm secret from family, friends, employers and services. Some participants were very clear in the interview that they wanted their self-harm to remain hidden and described the work they put into doing so. Both Leon and Luther had received treatment for alcohol problems but had chosen not to disclose their self-harming, and both chose certain forms of self-harm because they considered them easier to keep secret or pass as accidental. Some others (Rachel, Seth) described avoiding disclosing their self-harm or attempting to seek support as teenagers in case their family were informed:

> 'So, when I was 18, when I knew they kind of couldn't tell my mum, I went to the GPs. I mean, it was like a month after I turned 18 as well. I'd been waiting for that.' (Rachel)

Some participants said they had previously sought help or support when they were distressed, anxious or depressed, or tried to seek help specifically related to self-harm, and their need to hide their self-harm appeared to be in response to earlier attempts to seek help or support, for example from parents or school, which had resulted in them being pathologized or ignored:

> 'My mum had found out a couple of times but she just threatened to put me in a mental home and shouted at me. So, yeah, that, kind of, stopped that one. So, you get very good at hiding these things afterwards.' (Milly)

Several participants suggested that their parents or teachers probably had known that they were self-harming but ignored or overlooked it:

> 'I'm really, really angry at, like, school for…I mean, maybe it's a generational thing. I think schools now are much better trained in kind of the red flags to look for and how to appropriately talk about it and address it.' (Jane)

Those who had not been ignored often described responses that focused on pathologizing self-harm and framing it as a mental health issue without acknowledging or trying to address or support the wider issues participants were experiencing:

> 'I don't think I was ever offered any support about my self-harm. It was more like you need to stop this, it was more being told off – no questioning why or anything, or asking what the reason behind it was.' (Jade)

Participants described experiences including bullying, rape and sexual abuse, being in the 'care' system, childhood trauma, bereavement, having children removed from their care, and feeling anxious, distressed and depressed. Many said that these issues had remained largely unexplored and unsupported. This appeared to be in part because their self-harm was treated as a solely psychological, rather than social problem:

> 'I found a letter recently that said that the entire cause of my self-harming, all my difficulties, were because I had a bad relationship with my mum. So they didn't take into account anything that I was telling them, basically. So the self-harm carried on… [even though] the school and the mental health service knew about the bullying.' (Seth)

Participants whose self-harm had not remained hidden often described experiencing pathologizing and harmful treatment such as being labelled as having problematic personalities, being prescribed antidepressants that made things worse, being disapproved of or simply told to stop, and not being listened to (see 'problems with services' below, for a discussion around service provision). These responses to self-harm which framed it as a symptom of mental illness, rather than a response to complex broader situations, meant that the causes of participants' distress were not dealt with.

Although some participants described themselves as having alcohol problems or being 'alcoholic', and many described confirmed or suspected mental health diagnoses, there was a strong social aspect to the accounts, with participants describing both self-harm and drinking as serving social functions.

Drinking was commonly described as increasing confidence and enabling social interaction, to overcome shyness and feelings of inadequacy in social situations:

> 'I became somebody that I wanted to be, happy, and chatty, and free.'(David)

Some participants described drinking in response to difficult circumstances, and for others, drinking in different contexts serves different purposes. For Seth, drinking alone was related to urges and cravings, while 'social' drinking was entirely different. For this reason he described trying to avoid drinking alone:

> 'So, drinking with my friends doesn't feed into the issues that I have with alcohol, it is completely social, and it doesn't cause me any issues. And I don't sort of have those urges or cravings towards it. It's completely a social situation… I'm okay to drink with friends and family and stuff but then don't drink on my own. They serve completely different purposes for me.' (Seth)

Self-harm was also described as serving social functions. Participants sometimes framed it as a way of coping with or responding to difficult situations, feelings of depression and anxiety, and traumatic and distressing experiences. Although some participants said self-harm was always there in the background, but more or less present at different times in their lives, others described self-harm only happening in specific contexts, for example prison (Adam), or highly stressful situations (Francesca):

> 'I've smashed glasses and cut myself here when I can't cope with a situation or something. I'm powerless to that situation.' (Francesca)

Both drinking and self-harm were often described as ways of coping with or controlling situations and feelings, and as ways of expressing emotions. Accounts often emphasised the tension between feeling in and out of control involved in both drinking and self-harm. Jane, who identified her self-harm as controlling food and taking sexual risks, said these two types of self-harm 'served different purposes': being in control (food) and out of control (sex). Similarly, Leon reflected on self-harm as a way of being in control and simultaneously out of control, and as both healing and harmful:

> 'However you start, you just think, okay, this is working, a bit more, bit more, bit more, and then until you end up going a bit too far with it, so yeah, you don't have control, but it's something that you, for some reason, still keep turning to for the feeling of control.' (Leon)

Complex connections between drinking and self-harm

Although all the participants said that drinking and self-harm were connected, they did not all describe them being connected in the same ways. For some participants, drinking and self-harm went hand-in-hand. Leon, who at the time of the interview was no longer drinking or self-harming, described self-harm and drinking as inextricably connected, to the extent that if he resumed one, the other would also return; he would be unable to do one without the other. Others, such as Seth, and Jade, framed the relationship between drinking and self-harm as more nuanced and changing over time. This suggests that drinking and self-harm are connected in multiple, complex ways, some of which are explored below.

Alcohol exacerbates a 'bad headspace'

Many of the participants explained that when they were feeling bad, drinking alcohol exacerbated these feelings. Although all participants commented on alcohol magnifying their feelings, they did not necessarily describe this as negative; some participants described drinking as a way to enable them to express their feelings that they may find it hard to do otherwise:

> 'I think it's…so obviously when I'm drinking quite a lot and I'm getting slightly drunk I'll let go a little bit and I'll let my feelings come out a little bit more. And just express stuff a little bit more. It sort of gives me the freedom to be able to do that, it just sort of lowers my inhibitions a bit.' (Seth)

Whilst Seth's account framed drinking as sometimes having the positive effect of providing a kind of release, a mechanism to enable him to 'let go', some other participants described this 'letting go' or exacerbating of emotions as negative or dangerous:

> 'I knew if I was in a bad headspace and I drank, that it would get so much worse.' (Milly)

Accounts that described alcohol as exacerbating a bad headspace tended to focus on bad or negative thoughts or feelings becoming uncontrolled or uncontrollable, and this distress potentially leading to self-harm or suicide. For some participants, this 'bad headspace' was exacerbated during nights out drinking. Milly, for example, described a night out in which she had received some bad news and eventually decided to jump in front of a train, and framed drinking as contributing to a sense of 'fuck this'. Milly suggested she knew on some level that she should stop drinking and go home, but that continuing to drink served as a way of simultaneously trying to 'block it out' and 'feel better'. Others described a 'bad headspace' as being more connected to withdrawal or hangovers than the drinking session itself. Adam, for example, described experiencing suicidal thoughts while withdrawing from alcohol and heroin in prison:

> 'You'd have to detox yourself and you'd get the shakes. You had suicidal thoughts. And, you know, a few times I've actually kind of cut my wrists.' (Adam Over)

Whilst Adam drew very clear connections between withdrawals and self-harm, some other participants suggested experiencing feelings of self-loathing after a period of drinking adding to or exacerbating anxiety and depression:

> 'Other times, it gets out of control again and just entire weekends wasted from being sick and feeling rough. And so I'm back in my, like, I hate alcohol, I

> don't…why am I doing this to myself, like all the self-loathing and the guilt of a wasted life.' (Jane)

Drinking providing courage/ loss of inhibitions which then enabled (but not caused) self-harm

Some participants said that they only self-harmed when they had been drinking. Jane described drinking as an essential part of her sexual risk taking, as it lowered her inhibitions and provided the courage or confidence to initiate sexual encounters.

Similarly, Brenda described self-harm as eventually becoming so closely associated with drinking that she almost always self-harmed when she had been drinking, even when she was feeling happy:

> 'It [self-harm] was a bit like smoking, when I stopped smoking I would still do it sometimes when I was drinking, never sober. And it was a similar thing.' (Brenda)

More commonly, participants said that although they were perhaps more likely to self-harm when they had been drinking, or the day after they had been drinking, alcohol was not a prerequisite for self-harm, and they would also self-harm when sober:

> "I don't actually think there's a massive crossover between the two for me because self-harm is always there. But I do do it more at the times when I am drinking." (Rachel)

It is important to recognise that participants did not frame drinking as the cause of self-harm, but as providing a loss of inhibitions which sometimes helped to enable their self-harm, which itself was serving various functions for participants (see 'pathologization of self-harm' above).

Drinking sometimes exacerbates self-harm or leads to more 'serious' injuries

Participants often described self-harm which happened while drinking as leading to worse injuries. They suggested that this was related to the loss of inhibitions resulting from drinking, and altered perceptions of pain and risk:

> '…if I was drunk I was more likely to have an argument in the first place, and then if I was drunk after the argument I would do myself a lot more damage. The only time I ever had stitches was when I was drunk.' (Brenda)

Although many participants described injuries being worse when drinking, this was not always the case; some participants described drinking sometimes acting as a way of avoiding self-harm. For Seth, both drinking and self-harm, along with other activities including exercise and writing, acted as 'coping methods'. He considered drinking as less risky than self-harm, and therefore used it as a way of avoiding self-harming. Discussing drinking, Seth said:

> 'I think it's very much a coping method at the moment. And I feel like if I try to strip away one of my coping methods at the moment it could leave me feeling very, very vulnerable. Which could lead to some less healthy coping methods.' (Seth)

Seth was the only participant who explicitly framed drinking as a way of avoiding self-harm, but other participants sometimes alluded to it. Francesca, for example, described

her self-harm as dramatically increasing when she was in residential rehab and could not drink, as a direct result of being unable to drink:

> '…I think I did it…because I didn't have the drink. You know, another crutch to hold you up, type thing, to cope with problems.' (Francesca)

Seth and Francesca's examples illustrate the complexities involved in the connections between drinking and self-harm, and the importance of not assuming a simple linear connection between the two.

Sometimes drinking itself framed as a form of self-harm

While some participants defined self-harm and drinking as separate but connected practices, some of the participants conceptualised drinking as a form of self-harm. Seth, David, Francesca, Leon and Luther all described their drinking as a form of self-harm:

> 'My drinking for the last four years, I class as self-harm. Every single drop.' (David)

It is possible that David's certainty about drinking as self-harm reflected his experience of services and the strong recovery-based narrative that shaped his account; he was deeply involved in AA, had been in residential rehab and was currently living in a dry house, so abstinence and seeing alcohol as harmful were key aspects of his account. This narrative was also evident in Luther's account. Luther described drinking as having become a form of self-harm for him when he was 'really low':

> '...a couple of years ago when I was really, really, really low, and I was always thinking about the next most dangerous thing you could do…and in a way, I think alcohol was part of, or actually became my real self-harm.' (Luther)

Leon also sometimes appeared to classify some of his drinking as a form of self-harm.

> 'It would tend to be sort of when I've been…yeah, I've usually been drinking fairly heavily at the time, I think that would be sort of the first thing. Again like it's when I'm drinking in a way that I would probably classify as self-harm anyway, I think I'm doing both of them for the same reason at that stage…the times when I'm turning towards self-harm, I'm drinking in a very harmful way, probably as a response to some sort of emotional setback or whatever it is.' (Leon)

Seth also suggested that drinking could be a form of self-harm, although his account was more nuanced, with drinking sometimes being framed as a 'coping method' and sometimes as a form of self-harm. In reflecting on this complexity, Seth recounted a recent time when he was going to see his parents soon and had the urge to self-harm but didn't want his parents to see any physical evidence, so he drank instead, and this managed his self-harm urges. He suggested that he can get similar feeling from drinking and self-harm, and that they serve a similar purpose: drinking can enable a loss of inhibitions so he can 'let my feelings come out a little bit more', while self-harm is 'a physical expression of those feelings' – if he does one, he doesn't always need to do the other.

Francesca also provided a complex account about drinking as self-harm. Throughout her interview, she usually used the term self-harm to refer to cutting, but she also reflected on alternative understandings of self-harm. Describing how she started having sex with lots of people then self-harming, after she was raped as a teenager, she stated:

> ‘It’s all part of self-harm isn’t it, even drinking’s self-harm, isn’t it really?’ (Francesca)

The defining of drinking as self-harm potentially has important implications for service provision (see 'positive experiences and ideas for improvement’ below).

Problems with services

Participants had experienced a range of service responses, including primary care (GP), secondary care (hospital admissions), residential rehabilitation programmes (rehab), counselling and talking therapies, Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), peer support groups and fellowships such as Alcoholics Anonymous, inpatient care on psychiatric wards, and telephone and text message support.

The clear message from participants was that current services were largely unable to acknowledge or respond to their needs. The reasons for this are considered below.

Lack of needs-based service provision

Participants said they had often struggled to access services, with service provision often being dependent on specific diagnoses. Brenda recounted her treatment being dependent on gatekeepers and diagnoses, and eventually ending up without access to the treatment she wanted because she did not have the required diagnosis:

> ‘They tried to refer me to therapy but because I had the [suspected] diagnosis of BPD, but hadn’t been [formally] diagnosed, they wouldn’t take me. I was like well I see that the treatment for that is DBT, so can I have that, and they said no because you haven’t been diagnosed. So when I was diagnosed I said can I have it now, and they said no because you have bipolar! So I said well can I have normal therapy now then because I'm bipolar, and they said no because you’ve got BPD!’ (Brenda)

Jane, Brenda and Francesca all described very similar situations in which they were unable to access treatment because they were not considered to meet the required diagnostic criteria. This suggests that diagnostic labels may be structuring service provision, rather than services being provided based on need. This meant that participants were placed in a position where they needed to be given a label in order to access treatment.

Conversely, receiving diagnostic labels also appeared to have had a negative impact on some of the participants, as it contributed to the pathologization of self-harm, constructing it as solely a mental health problem, or a problem with individual people, rather than acknowledging its social aspects and providing appropriate support. Francesca described being labelled and pathologized at a young age. She recalled that when she came to the attention of mental health services at age 16, having been drinking more and self-harming since she was raped the year before, she was told she was an alcoholic and advised to go to AA meetings. She was told that drinking was causing her ‘outbursts’ and was prescribed antidepressants. She cannot remember anyone asking questions about the causes of her distress. Similarly, when Seth started hallucinating and was given medication by the mental health team, they recorded his reason for self-harm as his poor relationship with his mum. He recalls there being no attempts to understand or explore the homophobic bullying or problems at school he was experiencing.

Almost all the female participants had a diagnosis of Borderline Personality Disorder (BPD), and they described having felt at various stages ignored, that their distress and

need was minimised, and that once they received a label of BPD they were often 'fobbed off' or not taken seriously. They knew, however, that they needed to comply with and accept the label in order to access the treatment they needed or wanted. This meant they were limited in their ability to criticise or question the system of care available to them, although some did describe trying to do so. Brenda, for example, recounted asking her GP to reconsider her diagnosis of BPD:

> 'I was told that was a symptom of having it - wanting to get rid of it (laughing)' (Brenda)

Accounts were sometimes less critical about the impact of a mental health approach to drinking and self-harm. David framed self-harm and problematic drinking as mental health problems, suggesting that if they were treated together under the 'mental health' banner this would be beneficial. This acceptance of drinking and self-harm as mental health problems reflects broader narratives around both drinking and self-harm as being individual problems caused by illness (Ekman, 2016; Staddon 2012). It is possible that participants' construction of self-harm as a mental health problem may be a response to feeling dismissed by services (see 'being dismissed' below):

> 'I had a symptom of an illness that could be treated – just like a diabetic with low blood sugar – you know, and that maybe it needed more management or different management but, I think that would have helped. You know, not people making comments about how I was a time waster.' (Brenda)

In addition to problems related to diagnoses, several participants described waiting a long time for appropriate support because they did not fit into existing systems. Milly described being told she was too complex for the NHS psychological therapies fast-track scheme (IAPT), but not considered 'in crisis' enough to qualify for immediate support. Milly said she had contacted IAPT for an appointment and been told she was 'too complex' so was referred to core psychology, who gave her an appointment in nine months-time, with no support in the meantime:

> 'You tell someone that you want to kill yourself and you've got to wait until July.' (Milly)

In the process of providing feedback on the findings, Milly updated the research team on her wait for services – she had been admitted to hospital following self-harm and drinking, been discharged and told to continue waiting for her appointment with core psychology; still several months away.

Jane had similarly been told that her 'issues' were too longstanding for short-term services but that she was not eligible for longer term services. Unlike many of the other participants, Jane had been able to access private treatment, but this treatment was also unable to accommodate the complexity of her situation, with Jane's private therapist framing her sexual risk taking as Jane refusing to take therapist's advice, rather than recognising it as a form of self-harm.

Separation of mental health and alcohol services

Despite all the participants describing drinking and self-harm as related and often as deeply intertwined, the services they described experiencing did not enable drinking and self-harm to be considered together. Almost all the participants described the problems arising from a system that treated self-harm and alcohol as separate and unconnected. Many participants recalled being told that they were not eligible for mental health services

because they were drinking, and that their drinking would need to be addressed before they could access mental health support.

Participants described a dichotomy between mental health and alcohol services, reporting mental health services that 'never asked the right questions' about alcohol (Seth), and that they would not be able to access if they reported drinking, and alcohol services that were unable to address, and often ignored, self-harm (Francesca). Some participants described keeping either their drinking or their self-harm secret in order to be able to access any services at all – they were compelled by the structure of existing service provision to choose to seek support either for their self-harm or their drinking, but not both: Jane had learnt from experience that she would be unable to access mental health services if she was considered to have a drinking problem, so she was compelled to present her drinking as non-problematic and unconnected to her self-harm in order to access mental health services:

> 'Yeah, like, if you are eligible for…or in order to be eligible to access a mental health service, you cannot have any substance misuse issues. And so luckily, you know, I'm not an alcoholic, I'm not physically dependant on alcohol and like the binge drinking is…you know, I have periods of control over it. So I haven't…to them, I've just said I don't have an issue, I'm fine, you know, I binge drink on occasion at a weekend and it doesn't take much for me to get drunk because of my weight, which is the truth basically.' (Jane)

This is problematic because throughout her account Jane described drinking as a fundamental aspect of her self-harm, so having to keep it hidden or represent it in a particular way could make it difficult for services to understand her situation. Other participants described being left without access to mental health services because they were drinking. Francesca, for example, described a 'chaotic' period in her life in which she was self-harming very frequently and drinking and using drugs. She was told that at this time mental health services, 'wouldn't see me because I was drinking and taking drugs.' She was offered no help, just told that services could not work with her:

> 'Yeah. I think they…you know, they needed…the mental health team need to, like, put something else in place instead of saying, I'm sorry I can't see you unless you're sober. But, like, hang on a minute, I'm finding it difficult to become sober. So, you know, they need to, sort of like, sit down and talk to you about it, or…and maybe put something else in place for you.' (Francesca)

Francesca described accessing residential rehab for drinking, and the consequent increase in her self-harm, and the lack of ability for the service to deal with this, other than at a very superficial harm-reduction level. She eventually ended up leaving rehab because of her increased self-harm:

> 'There wasn't really any [support with self-harm in rehab]…I mean, we had counselling and we had groups and things like that and we were allowed to, like, talk to people but…yeah, I don't know, not so much. I think with counselling it's just you chat and nothing gets sorted. You basically just…like with CBT you, kind of, get some tools and how to handle your thoughts and things. But with counselling you just talk and then you're like, well I've got all these boxes up, now what am I meant to do it with it, you know. So…yeah, I don't know. I don't think I did really. Not really. I think I might have had a bit of sympathetic words like, oh, you know…oh dear, what have you done that for and, sort of…yeah. (Francesca)

Similarly, Jade said that her self-harm was barely noticed over many years of treatment for drug and alcohol use; and in recent contacts with alcohol services Leon had disclosed previous self-harm, but said that no-one asked about any more recent self-harm at any point, even as he was being discharged from services. Staff 'not asking' about self-harm in alcohol services, and 'not asking' about alcohol use in self-harm/mental health treatment was a common feature of what participants told us about their experiences with services.

Being dismissed

Many of the participants described attempting to explain their distress to practitioners and being dismissed or minimised. Brenda described a series of attempts to seek support, including from her GP:

> 'When I was, like, 17 I went to the GP and trying to say that I think I had depression and I was told 'all young women feel a bit up and down' and sent away again.' (Brenda)

Jane kept trying to self-refer (by phone) but services didn't understand what was wrong, and when she got a face-to-face assessment, her suffering was dismissed as something she should be able to handle alone:

> 'I was trying to explain around the rejection side of stuff and why that made me suicidal all the time. Like every time a man rejected me, I would basically want to kill myself. And he just said, well, it just seems to be that you've got a problem with relationships. I was like, well, yeah but it makes me want to kill myself, is that okay to…do I have to live my life like that? And I don't know, he was just like, well, if you just don't see that person or if you just don't meet with these men, maybe you'd feel better.' (Jane)

Some participants pointed out that self-harm was taken more seriously than simply telling services about feeling distressed, perhaps implying that self-harm was sometimes necessary in order to access the necessary support:

> 'And I also find that, like, now the doctor…if I'm low and depressed and I feel like crap and I don't want to live anymore, they don't really bother with you. But if you self-harm or take an overdose, they will bother with you.' (Francesca)

However, as well as their distress being minimised by services, many participants (Brenda, Milly, Francesca, Jane) also described feeling that their injuries, or the riskiness of their self-harm, were not taken seriously. They described clinicians describing their injuries as 'superficial' and saying their overdoses had not involved high quantities of drugs:

> 'I didn't feel they needed to tell me that. That just made me feel, I dunno They said I was low severity, and I was there bleeding. It felt very dismissive I feel like that was something I didn't need to hear – they didn't need to say that in front of me.' (Brenda)

As well as feeling dismissed, which is harmful in itself, Milly, Brenda and Francesca all alluded to the possibility of self-harming more 'seriously' in order to access help, or to make it be taken seriously.

> ‘I’ve just laid out all the stuff to them, that I hurt myself, that there was one day, like, a few weeks before the phone call that I was literally about ready to do something, if there was a cliff in front of me I would have driven off it. And it was just, okay, well, I’ll see what they say, and that was it. And they know I have a big pile of pills upstairs and they knew I was moving out, but yet, no-one’s done anything since, which, kind of, makes you feel a little bit, sort of, like, well, I mustn’t be risky then. Which then makes you want to be risky, which is really messed up, but yeah.’ (Milly)

Given that many of the participants had already attempted to tell family or schools about or seek support for their distress and the situations or problems that were causing or contributing to this distress, and been dismissed or unhelpfully pathologized (see ‘pathologization of self-harm' above), this dismissal by services is dangerous and has the potential to be extremely harmful. These findings echo those of Chandler’s earlier studies with people who had self-harmed, and the ‘Catch-22’ that those who self-harm experience – not being taken seriously without self-harming, yet also running the chance that injuries themselves are dismissed as non-serious or ‘attention-seeking’ (Chandler, 2016; 2018).

Harmful attitudes and poor treatment

In addition to the systematic problems with services, many participants described cruel and painful treatment and harmful attitudes from practitioners, including being given stitches without anaesthetic, being told their problems were ‘invented’, being told their scars would make them ‘ugly’, and not being believed when they were seeking treatment for medical problems other than self-harm. Such problematic responses to patients who have self-harmed have been described now for many decades, and recent studies confirm that they continue to occur (Jeffrey, 1979; Spandler and Warner, 2007; Hadfield et al., 2008; Quinlivan et al., 2021).

Rachel and Brenda both recalled healthcare practitioners commenting on their appearance, including being told that they would be pretty without scars and that their scars would make them ‘ugly’:

> ‘I think the most common one is like, oh, you’d be so pretty if it wasn’t for your arms. I’ve had that a few times.’ (Rachel)

Brenda described going to A&E when she needed stitches, but also as a way of seeking mental health support. By the time Brenda went to A&E to be stitched up, she had already been dismissed by her school and her GP, and told that the distress she was feeling was normal. She had not told any other services about her self-harm, and her attendance at A&E could have been an opportunity to offer support, but instead she was told by a healthcare practitioner that she had ‘invented’ her problems, which deterred her from attending A&E when she needed to in future.

> ‘So I went to A&E and they gave me stitches and as they did so, the person giving me stitches was like ‘I’ve been on the night shift and now I have to deal with people with these invented problems’.’ (Brenda)

In addition to the impact of this negative comment, she also described feeling ‘written off’ when she was repeatedly stitched up and sent home without being offered access to mental health support.

> ‘It was almost weird I was always very private about my self-harm … erm... and then, going to A&E was such a big step, and then – just ‘oh, go away’. Yeah, it was weird. Also though I suppose I was drunk which didn’t help.’ (Brenda)

Rachel also highlighted the different treatment she received in A&E if she had been drinking:

> ‘I tend to find they’re a lot sharper if I’ve been drinking. There’s not an awful lot of empathy there.’ (Rachel)

Rachel and Brenda’s accounts indicate some potential for ‘sharper’ responses to self-harm when alcohol is also present. Although (see below) participants did also report more positive experiences at A&E (even when drinking), negative responses from A&E appear resilient, and given the close relationships (statistical and otherwise) between self-harm and alcohol use, these accounts are especially concerning.

Rachel described her two stays on a psychiatric inpatient ward as exacerbating both her drinking and her self-harm, suggesting that ‘all the patients’ were constantly drunk and that she suspected that the staff knew but were not interested:

> ‘I’ve never self-harmed and drank more than I have than I did as an inpatient. We would kind of go up to the Co-op and buy vodka and just neck it, take it back to the ward and drink it.’ (Rachel)

These negative or dismissive reactions from practitioners are worrying because of the known links between suicide, self-harm and drinking (Ness et al., 2015). People who are both drinking and self-harming may be at greater risk and should be offered a supportive, humane service experience, rather than being treated cruelly or dismissed.

Positive experiences and ideas for improvement

There was not one type of service that stood out as being better or preferred by participants. Some participants valued lived experience associated with peer-support based recovery programmes like AA or non-AA peer recovery groups (Adam, David, Leon, Luther), while others said they preferred approaches that focused on practical ‘tools’ such as CBT, DBT and topic-based group work. Similarly, some participants described rehab as a transformative experience which changed their lives for the better (David, Adam), while for others residential rehab and inpatient psychiatric stays made everything worse (Francesca, Rachel). Despite this wide range of views on types of services, there were some clear commonalities about what makes a good service, or what ideal services would look like.

Asking the right questions

Participants’ accounts highlighted the importance of providing opportunities for open discussion about drinking and self-harm, including during childhood, for example in school, but also when contacting services. Asking about self-harm in alcohol services, and asking about drinking in self-harm services, as a matter of course, may help to prompt open discussion and avoid missing opportunities to explore the relationships between them.

Jade, drawing on her more recent experiences of providing support, underlined the importance of asking any questions about self-harm in substance use services:

> '…. if I saw a woman coming in who had self-harmed, I would be sitting with her and asking her about it. And see if just one person had sat down with me and asked about it…' (Jade)

In contrast to her own current approach as a professional, Jade suggested that over many years of drug and alcohol misuse and self-harm, and being in substance use and mental health treatment, she was never asked or given an opportunity to explore her feelings about or reasons for self-harm.

Seth, who had sought help for self-harm but not fully disclosed his alcohol use, and Leon, who had sought help for alcohol use but not disclosed self-harming, both highlighted the importance of how questions are asked:

> 'And same with mental health services now. They ask the question because they have to… but I do wonder whether sometimes it would be worth following up a bit. Because it's a really scary thing to admit to somebody that you need help for it. To even admit that there's an issue in the first place. Especially out loud. I'm better with that kind of thing by message. So if they emailed me about it I'd find that easier. Face-to-face it's a really, really difficult thing' (Leon)

> 'But I think if somebody raised it with me later and said well actually, I'm a bit concerned, can we support you in any way? It kind of goes along the lines of…I've got sort of an ask twice ethos, so if I ask someone how they are and they just look at me and go, yeah, I'm okay, I will ask again. If I get a sense that something isn't okay. So I guess along those lines it's kind of, if they ask again, it would make the person realise that actually we are here to support you. We want to do the best for you, but we want you to be in control of it. So, I feel like there could be a follow-up if somebody's concerned.' (Seth)

Both Seth and Leon said that although it was important not to be too 'pushy', and to allow the person seeking help to control how much information to offer, asking these questions is important as it provides opportunities for conversations to take place. Participants who had chosen not to tell services about one or other of their drinking or their self-harm often said that part of the reason was that they did not want to prompt additional interventions, labels, or information sharing with friends or family. This further highlights the need for responsive, needs-led services that do not necessarily require diagnoses but can respond in the ways those seeking support prefer.

Although participants' accounts suggest there is further work to be done around services enabling an open dialogue about the links between drinking and self-harm, it is important to note that simply enabling an open dialogue is unlikely to have any positive impact without also ensuring that appropriate services and support are available. Accounts from those participants who have asked for help, such as Milly, who disclosed her suicidal thoughts and plans but still received no support emphasise this (see 'lack of needs-based service provision' above, 'being dismissed' above).

Accessible services

Whilst it was clear that there was not one 'treatment' that 'worked' for people who drink and self-harm, participants' accounts underlined the importance of services being accessible. Many participants recalled occasions when they had been unable to access the services or treatments they wanted or needed because they were not deemed to have the correct diagnosis, because they were deemed 'too complex' to receive available services, or because the waiting lists were too long, or a combination of the three.

Participants were clear that this inaccessibility exacerbated their distress and increased risk. Many participants had used text or email services or helplines, and were largely positive about these, although this appeared to be partly because unlike NHS services, they offered a swift response when required. Similarly, two participants (Francesca, Adam) described prison as a turning point for them, because this was the point at which they were offered access to suitable services – Adam was able to access a dry house through his probation officer, and Francesca described accessing residential rehab while in police custody after fighting while drunk:

> '…I was in the police cell and I thought, I really don't want a life like this anymore. And a woman came round and she said, does anybody want any help. And I said, yeah, I do.' (Francesca)

These accounts highlight the crucial importance of services being accessible and responsive, and available when needed, rather than dictated by waiting lists. Participants accessing group-based support (particularly for alcohol dependence) highlighted that in some cases this was more accessible during Covid-19 restrictions, as they could access online groups at any time from around the world. In contrast, for others who preferred locally-based and consistent support, gaps in provision occurred when their life circumstances changed. Leon reported that he could no longer access support after he got a full-time job, and was effectively discharged from services as 'recovered', despite this transition being a potentially challenging time in maintaining this recovery. Indeed, for many participants 'recovery' from alcohol dependence or misuse was not linear or straightforward, which further underlines the importance of being able to access services (again) quickly, as well as the benefits of some form of ongoing support – especially an alternative to AA – that can support those not immediately in crisis, but whose mental health or substance use recovery is nonetheless fragile.

Services that understand and respond to complexity

When participants described accessing services, they almost always said the services had been able to support them with either their self-harm or their drinking, but rarely both. David was one of the only participants who described experiencing services that were able to address drinking and self-harm together. David had spent six months in residential rehab which he described as being designed to take complex cases which other services cannot handle due to other services being too specialised. Several participants were critical of the continued decimation of funding and resources for services and services losing funding and being 'farmed out' to the lowest bidder.

It was clear that David's experience of services being designed to cope with complexity had not been most participants' experience of accessing services (see 'separation of mental health and alcohol services' above). The majority of participants said their ideal service would be one that acknowledged the complex connections between drinking and self-harm rather than focusing on one or the other. For participants who framed self-harm and problematic drinking as mental health problems, mental health services which acknowledge the potential links between drinking and self-harm, rather than drawing imaginary lines between them, would provide a solution to the fragmented service provision they had experienced (see 'separation of alcohol and mental health services' above):

> 'There seems to be a line between the two, between the mental health and drug and alcohol services. My belief, and I can only speak from my experience, is that my addiction to alcohol was so strong, I class it as a mental illness. So there shouldn't be a line. It should be all under one banner. And I don't know how that

> could work, but if it's treated as a mental illness, then maybe mental health services could readjust.' (David)

Many of the other participants, however, framed self-harm and drinking as more complex and nuanced than this, arguing that in addition to acknowledging the links between drinking and self-harm, services needed to focus on the causes, rather than only the symptoms, of drinking and self-harm.

> 'I'd say, for me, one that recognises the very complex reasons connected with self-harm and drinking. You know, it's not a straightforward thing, there's a lot of complexity to it… I think if I wanted to stop drinking and self-harming we'd have to deal with the depth of issues that causes it. And get me to a place where actually, I felt able to cope with my difficulties and able to cope with my life circumstances and generally feel better about myself, I guess.' (Seth)

Some of the participants emphasised the problems with a diagnosis-led treatment provision, and in doing so they illustrated the importance of shifting to needs-led provision. Participants described experiences including bullying, rape, trauma as children and adults, bereavement, low self-esteem, and depression and anxiety, remaining unsupported, particularly if they did not 'fit the mould' for receiving a particular diagnosis.

Importance of relationships

Although the participants all had different experiences of service provision and different ideas about what types of services they would prefer, they commonly raised the importance of supportive relationships with practitioners. Leon described a previous keyworker whose 'attitude really helped':

> '…he was very relatable, and he just encourages, he's taken a lot of different courses, so he just sort of dipped in and out of different things that he'd learned about it. But yeah, it was mainly his enthusiasm and the fact that he kept on checking up on you and kept on sort of pushing you and being pleased for you when things were going well. And I mean, something like that is very much down to the person, you can't just expect a service to provide good people like that out of thin air.' (Leon)

Although Leon's assertion that some of these positive attributes are about the individual person, it is also possible to see how much of this accessibility and positive attitude could be affected by service structure, caseloads, and ultimately service funding – however 'enthusiastic' an individual practitioner is, if they have an overwhelmingly large workload, it will be challenging to form meaningful supportive relationships. This has implications for service design.

Rachel emphasised the accessibility of her community psychiatric nurse (CPN), highlighting how helpful she has found it to have the same CPN for three years:

> 'I think sort of having someone that is accessible... Not even necessarily a CPN, but sort of a support worker, something like that, someone that they can contact that sort of has the knowledge base there, that is just someone that is accessible. I think accessibility is the biggest one. Because even when my CPN's on holiday, I'm like, ah, I don't know what to do now. But some sort of service they can contact or someone, you know, that is there.' (Rachel)

Much of what Rachel said about the importance of a reliable key contact was also alluded to by other participants. Jane, for example, described the pain involved in having to explain her ‘story’ repeatedly to different people, often whom she had never met before, when seeking services.

Jade also underlined the importance of workers who were tenacious, and who demonstrated ‘care’. In and out of services over many years, Jade said that a particular worker with a women-only service was important in her eventual recovery (which for Jade did not involve abstinence, but rather a more comfortable relationship with alcohol, and more stability in her life). Jade contrasted this more trusting and supportive relationship with those she experienced in group based, mixed sex substance use recovery. In such contexts, she said, it would not have been possible or comfortable to disclose self-harm. This resonated strongly with Leon and Luther’s accounts – each of whom also suggested that group-based recovery was not a place where talk about self-harm was possible or desirable. In Jade’s case, though, the role of gender/sex was also significant, as she suggested that for her, women-only services offered her greater security.

Strengths, limitations and conclusions

This was a small, exploratory, qualitative study of the accounts of 11 adults who had experienced both self-harm and alcohol use. Our aims were to examine how people with these experiences made sense of the relationship between the two practices, and how services had responded to them. The strengths of qualitative research lie in its ability to capture the nuance and complexity of social life, including health and health-related problems. As qualitative researchers we do not take accounts provided in interviews at 'face value' – instead, we consider interview accounts as situated, partial 'stories' about what happened. These are always partly shaped by the context of the interview, the relationship between interviewer and interviewee, and by broader, already-circulating narratives, which participants will draw on, innovate with, and repurpose in order to tell their own story – to give an account of themselves and the topic of study (in this case, self-harm and alcohol use) (Riessman, 2008).

The stories – or accounts – provided by the 11 participants in this study were incredibly rich and nuanced. They were limited, though, by the short time we had together – just one hour per interview. Undoubtedly, given more time, and a more extended period of engagement between the research team and participants, we could have further developed some of the insights and recommendations above. Indeed, we suggest that this report is a starting point for further conversations: between people with experience of self-harm and alcohol use, service providers, clinical practitioners, and others. An important background to many of the stories told was the ongoing stigmatisation of both self-harm and alcohol use that participants had to navigate. They did so, often, by not disclosing aspects of their experience in certain settings, or to certain people. It is vital that this ongoing stigmatisation is recognised and continually challenged, as it presents a significant barrier for people to access meaningful support – whether from formal services, or from family or friends.

Our sample was – as with any qualitative study – fairly small. However, given more time we could easily have spoken with more people (towards the end of the recruitment period we had more people coming forward than we could accommodate). This was a topic that resonated with many people, and given the diversity of our small sample, it is clear that further research could underline more diversities of experience and understanding. Our sample was overwhelmingly White British, and – as has been pointed out on numerous occasions – there is a pressing need for further research to engage more proactively with Black and Minority Ethnic groups (Polling et al., 2021; Nazroo et al., 2020).

Further qualitative studies should engage with accounts of more diverse groups of people who have self-harmed and used alcohol, as well as service providers. Although some of the participants in this study brought valuable experiences as both service users and service providers, we were keenly aware that the perspectives of service providers were absent. Particularly given the resilience of negative attitudes towards and treatment of patients who have self-harmed, there is a pressing need to better understand how and why such approaches continue to happen. Previous studies have called for further training of staff members, with some indication that this can improve following training. However, current evidence is sparse. In particular, we suggest that ethnographic and qualitative approaches to understanding this ongoing problem may provide important insights – as they have in addiction care (e.g., Carr, 2010).

We hope that this study, and this report, offer a useful starting point for further reflection on the relationships between self-harm and alcohol, and how services might best respond to this complexity. There are no ‘quick fixes’ here, but our participants highlighted some clear messages for services and areas for improvement. Despite a lack of simple answers, there remains an urgency in these accounts. While some participants described themselves as well-settled, well-supported, ‘recovering well’, several noted ongoing challenges, often exacerbated by problematic responses from services, or simply a lack of accessible or trusted supports. This will not be ‘news’ to anyone with experience of mental health, addiction, substance use or self-harm specific services – as service provider or service user. It is, though, another set of voices to contribute to ongoing calls for significant improvements to be made.

Recommendations

Service funding:

The main problems with services that were highlighted by participants related to services not being needs-led, being unable to handle complexity, feeling dismissed, and being treated poorly. It is important to acknowledge that it would be difficult to 'fix' some of these problems without additional funding and a shift in funding models towards services which are designed around need rather than cost savings. Conversely, many of participants' positive or ideal experiences focused on positive relationships and accessible services which can support people with both alcohol and self-harm, and which take their needs seriously. To do this well, services need to be consistently and reliably well-funded.

Relationships are key:

The importance of positive, supportive, consistent relationships with practitioners was consistently highlighted by participants. Those who had one main person who acted as a point of contact for services were positive about this because they were able to build a trusting relationship with one person who knew their story. All the accounts highlighted the need for compassion and kindness from all practitioners, all of the time.

A range of services:

Although there were some common themes across participants' accounts, one notable feature was that they all had different experiences and preferences. There was not one type of service or response that stood out as being more helpful than others – services that some participants experienced as positive or even transformative were experienced by others as unhelpful or even harmful. For this reason, a range of services should be available for people to choose from. Some accounts suggest that the current diagnosis-led provision, centred in mental health services, unhelpfully pathologize people, so consideration should be given to other ways of providing services that do not depend solely on diagnosis or frame self-harm as solely a mental health problem, acknowledging instead that people may require broader practical support, and that needs and preferences may change over time.

Offering a range of communication methods:

Participants who had used text message and email services were positive about these services. They said they liked them because these services gave them the option to communicate without having to see someone face-to-face, which was sometimes helpful. In addition, the fast responses made available by these services made them useful when other services were unavailable due to long waiting times or other barriers to access. This suggests that offering a range of communication methods, as well as a range of services, may be a way to ensure that services can meet the needs of as many people as possible.

Accessibility, flexibility, and timeliness:

Participants said that long waiting times and being described as 'non-urgent' contributed to a sense of not being taken seriously. Simultaneously, many participants said that they had identified the services or treatments that they thought might help but could not access them because they had not received the 'necessary' diagnosis, or because they

were considered ‘too complex’. This is potentially very dangerous as it could lead to people who are in desperate need of support essentially being given the message that their self-harm is not ‘serious’ or ‘risky’ enough to warrant help. People who self-harm and use alcohol are considered a ‘high risk group’ (see Welsh Government suicide prevention policy) and should be able to access support when they seek it, not simply added to long waiting lists or refused access to treatment.

Confidentiality:

Several participants said they had avoided seeking support for their drinking or their self-harm because they were concerned that their families or friends would be informed. This suggests that there may be a general lack of clarity or understanding about confidentiality, particularly for people who seek services before they are 18, and that this lack of clarity may act as a barrier to accessing services. Since most participants said that they had started self-harming when they were children, this lack of clarity about confidentiality has concerning implications for service accessibility. It is important that clear information is available to both children and adults about the meaning of and limits to confidentiality, so that they can make informed choices about when and how to seek support from services. It is also vital that services understand the impact that the limits of confidentiality may have on service-users willingness to disclose either self-harm or alcohol use.

Asking questions:

Participants’ accounts highlighted the importance of service providers being aware of the complex but potentially important links between alcohol and self-harm and creating space for conversation about each of these. Participants also highlighted that some people may choose not to disclose one or the other, often for good reasons (see, for example, ‘separation of mental health and alcohol services’ above), so it is important for services not to ‘push’ too much when asking questions. There may be potential for working towards service provision which is experienced as less judgemental and more supportive of complexity.

Alcohol services supporting people who self-harm:

This study raises questions about the ways in which alcohol services, and specifically residential rehabilitation programmes, provide support for people who self-harm. Further research is required to explore current practice in this area to ensure that services can provide appropriate care and support.

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Appendix A

Alcohol and self-harm study: Interview Schedule

Introductions

Thanks for taking part. During the interview we'll start with some questions about you, and then I've got some questions about alcohol use, self-harm, and your experiences with services. In the last part of the interview we'll talk about what kinds of things you think could help services improve, or what has worked well for you.

We might change the order of the questions, add questions, or change how they are asked – each interview will be different, and will be more like a chat or conversation between me (Amy) and you (the participant).

About you

How old are you, where do you live and who with, what are your favourite things to do, do you work or go to college/university?

You and alcohol

Can you tell me a bit about your relationship with alcohol right now – how often do you drink, what kind of things, when?

How have things been in the past? Can you talk me through this, from when you first tried alcohol, to where you are at now?

You and self-harm

Can you tell me a bit about your relationship with self-harm right now – same questions, how often do you self-harm at the moment, how you self-harm, how do you explain it (if at all!)?

And how have things been in the past?

Self-harm and alcohol

How and in what ways do you think self-harm and alcohol are, or might be, related?

Self-harm, alcohol and services

What kind of help have you had over the years for your self-harm, alcohol use or related problems? How have these services dealt with or responded to your self-harm and alcohol use? How far do you think your alcohol use has affected your experiences with services?

Have you had any experiences with services that were really helpful?

Have you had any difficult experiences with services in relation to your self-harm or alcohol use?

What services would help?

Based on your experiences, what kind of things have really helped you? What kind of services or supports would be helpful?