Royal College of Psychiatrists Risk to Self Report

DrugScope's evidence to Lord Alderdice's Steering Group

May, 2009

DrugScope is the UK's leading independent centre of expertise on drugs and the national membership organisation for the drugs field.

DrugScope's objectives are:

- To provide a national voice for the drug sector
- To inform policy development drawing on the experience and expertise of our members
- To support drug services and promote good practice
- To improve public understanding of drugs and drug policy.

All DrugScope's policy work is shaped by our core values and beliefs.

DrugScope believes in drug policy that:

- minimises drug-related harms
- promotes health, well-being, inclusion and integration
- recognises and protects individual rights
- recognises and respects diversity.

DrugScope is committed to:

- promoting rational drug policy debate that is informed by evidence
- involving our membership in all our policy work
- ensuring our policy interventions are informed by front-line experience
- speaking independently, and free from any sectoral interests
- highlighting the unique contribution of the voluntary and community sector.

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1. Introduction

1.1 DrugScope welcomes the opportunity to contribute to the Royal College of Psychiatrists work on self harm and suicide.

1.2 DrugScope is the UK's leading independent centre of expertise on drugs and drug use, and the national membership organisation for the drug field. We have over 700 members (individuals and organisations) representing a wide range of people and professions involved in drug policy, drug treatment and related services. We are not currently undertaking work specifically on suicide and self-harm, and do not have particular expertise. We do, however, think it is important that drug and alcohol issues receive due weight in the Royal College's report, and hope our evidence can help to shape and inform the Steering Group's deliberations by outlining some of the key issues.

1.3 We note that self-harm and suicide are – to a significant degree – distinct issues, but for the purposes of our evidence we have not explored or considered these differences in any detail. We also note that substance misuse may itself be *symptomatic* of some forms of psychiatric disorder. In particular, Borderline Personality Disorder is associated *both* with self harm and suicidal behaviour *and* with impulsivity, which may manifest itself in substance misuse (according to diagnostic criteria set out in DSM IV).[1]

1.4 We also recognise that there has recently been interest in and concern about the links between cannabis and mental health problems. We would emphasise that we are not aware of any evidence for a link between cannabis use and self-harm and suicide. The Advisory Council on the Misuse of Drugs reported on *Cannabis: Classification and Public Health* in 2008, on the basis of a thorough review of the available evidence. Neither suicide nor self-harm were identified as relevant issues for the review.

1.5 People who have - or are recovering from - drug and alcohol problems are at a significantly higher risk of self-harm and suicide than the general population.[2] The National Suicide Prevention Strategy for England (Department of Health 2002), states that alcohol and drug misuse are 'risk factors for suicide known from research'. *The National*

[1] The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is published by the American Psychiatric Association and provides diagnostic criteria for mental disorders. It is used in the United States and in varying degrees around the world. DSM IV is the current edition.

[2] The primary focus of this research and our submission is the use of illicit drugs, particularly dependence of heroin and/or crack cocaine ('problem drug use'), but we note that there is also evidence of links between self-harm and suicide and other forms of drug use (including stimulants, and prescription drugs such as benzodiazepines). Drug use which does not constitute 'dependency' and would not normally come to the attention of specialised drug or alcohol services may also be linked to self-harm and suicide (for example, where alcohol may act as a 'disinhibitor' to suicidal or self-harming behaviour).

*confidential inquiry into suicide and homicide by people with mental illness – Lessons for Mental Health Care in Scotland (*2008) concluded that 58 per cent of the suicide cases it investigated were alcohol dependent, 39 per cent were drug dependent and 29 per cent heavily abused both. (International evidence tells a similar story – for example a 2003 study of 'Patterns of suicide mortality in Russia' found a strong correlation between alcoholism and suicide.)

1.6 While these risks are recognised in strategy and guidance documents for the drug and alcohol treatment services, our perception is that self-harm and suicide have not had a particularly high profile in recent drug and alcohol policy.

1.7 We note that there is no reference to these issues in either the UK drug strategy or alcohol strategy (*Protecting families and communities – the 2008-2018 Drug Strategy* and *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*). We understand that the National Treatment Agency for Substance Misuse (NTA) has not yet developed a significant research or policy strand in this area. For example, neither suicide or self-harm are referred to in recent NTA guidance on harm reduction (NTA, *Good Practice in Harm Reduction* 2008).

2. Links between alcohol and illicit drug use, self harm and suicide

2.1 There are a number of distinct (but often interacting) ways in which substance misuse can be related to self-harm or suicide:

- Drugs may be a *means* or *method* of suicide (or self-harm);
- Both substance misuse and withdrawal from alcohol or drugs may be a *cause* of self-harm and suicide, or a contributory factor;
- Drug and alcohol use is a *correlate*, *cause* or *consequence* of other problems that are linked to increased risk of self-harm and suicide, including mental health problems.

<u>Drugs as a method of self-harm and suicide</u>

2.2 The *National Suicide Prevention Strategy for England* (2002) identifies self poisoning through the use of psycho-tropic and analgesic drugs as one of the two main methods of suicide, along with hanging.

2.3 There is a particularly high incidence of drug overdose among recently released prisoners. This is widely attributed to a loss of tolerance after a period of abstinence - or significantly reduced use. But it is certainly possible that some cases may be deliberate overdoses at a time of heightened stress and vulnerability. *Drug-related mortality among newly released offenders, 1998 to 2000* (Home Office) concluded that a number of the deaths investigated had questionable causes and many deaths were, and would continue to be, misidentified. In particular, it is difficult to determine whether a drug overdose is the result of accidental overdose or deliberate suicide.

2.4 Where someone with a history of drug misuse dies from a drug overdose (one of the most common methods for suicide), the possibility that they have deliberately taken their own lives may not be considered or investigated – for example, by the Coroner - even if other risk factors for suicide are present. (If someone dies from an overdose of a drug that they have not previously been dependent on, then we suspect it would be much more likely to be considered as a possible suicide – for example, someone with a history of alcoholism takes an opiate overdose.)

2.5 A further question is whether some forms of drug administration and use can themselves be classified as forms of self-harm - for example, the injecting behaviours of some intravenous drug users. If so, then there would be benefits in sharing clinical approaches and good practice between drug and alcohol specialists and people working in self-harm.

Drug use and withdrawal as contributory factors in suicide and self harm

2.6 As noted above, there is evidence of a strong correlation between alcohol and drug use and suicide and self-harm (see para 1.4).

2.7 *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (Department of Health and devolved health administrations 2007) discuss a number of well-evidenced links between drug use and withdrawal and self-harm and suicide. These include the association of benzodiazepine dependence and suicidal and self-harming behaviour and the risks associated with withdrawal from stimulant misuse ('withdrawal may be associated with significant depression and the patient's mood should be monitored and the risk of suicide assessed'). In particular, it notes the evidence of a strong correlation between drug withdrawal and suicide in the first weeks of prison custody (see Shaw et al, *Safer prisons: A national study of prison suicides*, Department of Health, 2003).

2.8 The National Institute for Health and Clinical Excellence (NICE) guidance on *Drug misuse: opioid detoxification* (2007) also advises that clinical assessments consider risks of self harm as a response to opioid withdrawal.

2.9 The relationships between drugs/alcohol and self-harm/suicide may operate in a variety of ways. For example, where someone has a pre-existing tendency to self-harm or suicide, the use of drugs or alcohol may increase risk by acting as a disinhibitor or by its impact on the way the individual understands and assesses risk and on general cognitive functioning. This has implications for risk minimisation strategies where individuals are known to be at a high risk of self-harm or suicide.

2.10 In some circumstances, the use of alcohol or drugs is a form of self-medication, and risk of suicide and self-harm can therefore increase in the short-term when people address a drug or alcohol problem, with clear implications for assessment, treatment planning and the management of

the withdrawal process.

2.11 This problem was highlighted in DrugScope's report on women prisoners, *Using Women* 2005 (funded by the Esmee Fairbairn Foundation as part of their Rethinking Crime and Punishment programme). Many women prisoners have complex and entrenched problems – such as experience of violence, trauma and abuse – as well as a strong sense of guilt for their own past behaviour – particularly when it has impacted on their children. When these women come off drugs after entering prison they may be – in the words of one Prison Governor – 'facing up to the realities in their lives' for the 'first time'. The then manager of the rehab unit at HMP Drake Hall explained to DrugScope that when these women 'stop self medicating and using substances...They find it very difficult to cope and then they start to self-harm and we have to work with it. A lot of the work that we incorporate onto this program is actually working with their (history of) sexual abuse… If you take drugs away from people that are locked up they are going to find another coping mechanism.'

2.12 There have been significant improvements in drug treatment in prisons for both male and female prisoners since we published *Using Women* (notably with the development of the Integrated Drug Treatment System). These improvements may have contributed to the fall in suicide rates among the prison population that are recorded in the *Fourth Annual Report on Progress in Implementing the National Suicide Prevention Strategy for England 2006*. (Although it is not possible to reliably disentangle their impact from other improvements in prison service provision – for example, around primary care and mental health.)

2.13 We note that the Corston Review (2007), which looked at the needs of female prisoners, cites a study that found that 2 in every 3 women who commit suicide in prison have a history of drug abuse, and work by the Safer Custody Group that found that 13 of a total of 19 women who committed suicide in 1999-2001 had histories of drug abuse.

2.14 Clinical guidance used by drug and alcohol professionals recognises the importance of addressing issues of suicide and self-harm in assessment and treatment planning. The *UK Clinical Guidelines* (2007) state that self-harm and suicide should be identified as issues in assessment (although these are not regarded to be 'drug misuse specific risks') and that issues of self-harm should be included in the treatment plans of clients of substance misuse services.

2.15 The use of opiate substitutes – notably methadone and buprenorphine – is recommended by NICE for the treatment of opiate dependency, and can eliminate (or meliorate) the withdrawal symptoms that may be linked to self-harm and suicide. For example, with reference to prisoners, the *Guidelines* state that 'when an opioid substitute is prescribed, a period of stabilisation over the first five days is advisable, rather than an immediate reduction of dose, because of the risk of self-harm in this period'. They continue: 'there may be an increased risk of

suicide close to the end of, or just following, completion of a detoxification regime'.

Dual diagnosis and complex need

2.16 A key message of DrugScope's work is that drug problems seldom occur in isolation and that effective interventions to improve the health, well-being and social functioning of people with drug problems can be as important as traditional treatment. We require 'holistic approaches' that recognise the configurations of problems and needs of particular individuals and bring services together to work in an integrated way. We recently launched a major campaign called *Making Every Adult Matter* (MEAM) with Clinks, Homeless Link and Mind, with a focus on developing more integrated approaches for people with multiple, and inter-related, needs. This will include people with a dual diagnosis of substance misuse and mental health problems.

2.17 The COSMIC research study conducted by the Department of Health and NTA (2002) found that 74.5 per cent of users of drug services and 85.5 per cent of users of alcohol services had mental health problems.[3] Conversely, 44 per cent of mental health service users reported drug use and/or were assessed to have used alcohol at hazardous or harmful levels in the past year.

2.18 The *Drug Misuse and Dependence – UK Guidelines on Clinical Management* (DH, 2007) state that outcomes for people in drug and alcohol services with co-morbid mental health problems are worse across a whole range of dimensions. These include poorer prognosis, higher rates of relapse, increased hospitalisation and higher suicide rates. They also include high rates of poverty and exclusion, homelessness and contact with the criminal justice system.

2.19 The *National Service Framework for Mental Health* (1999) identifies 'dual diagnosis' as a priority issue for mental health services, and explicitly recognises that stronger links between drug and alcohol services and community mental health services are needed to reduce suicide in this client group.

2.20 The Department of Health's *Dual Diagnosis Good Practice Guidance* (2002) recognises self-harm and suicide as key issues for services working with people with severe mental health problems and problematic substance misuse. For example, it states that 'substance misuse is over-

[3] This study found that 7.9 per cent of drug service users and 19.4 per cent of alcohol service users had psychotic disorders; 37 per cent of drug service users and 53.2 per cent of alcohol service users had personality disorders; 67.6 per cent of drug service users and 80.6 per cent of alcohol service users had depression and/or anxiety disorder. Almost 30 per cent of the drug treatment population and over 50 per cent of those in treatment for alcohol problems experienced 'multiple' morbidity. Some 38.5 per cent of drug users with a psychiatric disorder were receiving no treatment for their mental health problem.

represented among those who commit suicide' and states that 'an appropriate response to this client group forms an important part of local and national strategies of suicide prevention'.

3. DrugScope – Key Issues

3.1 DrugScope would identify a number of issues that it would like to see the Royal College of Psychiatry address in its 'Risk to Self' report. Our over-riding message is that risks of self-harm among people with alcohol and/or drug problems – and the particular high risks for those with 'dual diagnosis' – should be key issues for any strategy to reduce harm to self. The invitation for DrugScope to give evidence to this Review is a clear recognition of this.

3.2 We note that there is a lack of research and monitoring. More research needs to be undertaken on the specific correlations between drug and/or alcohol misuse, mental health problems and self-harm and suicide.

3.3 We were able to find little information about how mental health or drug services address the links between substance misuse (or use) and self-harm or suicide (for example, good practice in assessment and treatment planning). We need more research on practice, identification of good practice and investment in appropriate resources, including training and guidance. We would welcome work from the National Treatment Agency in this area.

3.4 There is a particular issue around the identification of drug-related deaths as cases of suicide. Our impression is that currently where, for example, someone with a history of opiate use dies as a result of overdose it is assumed that this is accidental, even in circumstances where it would be otherwise appropriate to consider the possibility of suicide. If we are misidentifying significant numbers of drug-related deaths, then practice and policy will be failing to pick up on these issues too.

3.5 We also note that the issues of self-harm and suicide have been marginal in the development of policy on dual diagnosis, despite being identified in the Department of Health's *Dual Diagnosis Good Practice Guidance* (2002). For example, there is only one reference to 'suicide' and one reference to 'self-harm' in the Care Services Improvement Partnership (CSIP) *Themed Review Report 07 Dual Diagnosis* (2007). Suicide and self harm need to be identified as issues for this agenda, and with a greater priority than they have received in the past.

3.6 Where someone is, for example, homeless, with a history of mental health problems and, say, opiate dependent all these factors will be relevant to the issues of self-harm and suicide, and the range of services involved will need to be aware of the risks, share information as appropriate and so on. Self-harm and suicide are not simply medical problems, amenable to therapeutic solutions, they need to be understood in context. For example, loss of housing or work could lead someone to

relapse into problematic alcohol or drug use, which in turn could be linked to self-harm or suicide.

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