LIVES ON THE EDGE

The links between drug addiction and suicide need to be recognised if lives are to be saved. **By Marcus Roberts**

One of the most disturbing aspects of Hamid's story (see p10) is that nobody appears to have picked up that he was at risk of taking his life. Why not? He had previously attempted suicide. He was obliterating the memory of abuse, rape and torture in Iran with heroin and methadone. He was destitute in a strange land. He was plainly a suicide risk. This is far from uncommon among people with drug problems.

Around three quarters of clients of drug services – and 85 per cent of people in alcohol treatment – have mental health problems, mostly depression and anxiety. The National Suicide Prevention Strategy for England states that drug and alcohol misuse are 'risk factors for suicide'.

A Scottish inquiry into suicide and homicide by people with mental illness, published in 2008, concluded that 58 per cent of suicide cases had a history of alcohol misuse and 39 per cent were drug dependent. Yet there is not a single reference to suicide in either the UK drug or alcohol strategies, and anecdotal evidence suggests that suicide awareness and prevention is under-developed in many drug services.

Recently DrugScope gave evidence to an inquiry chaired by Lord Alderdice for the Royal College of Psychiatrists on 'risk to self', covering suicide and self-harm. Three points made to that inquiry have a particular relevance to Hamid's experiences.

First, Hamid was using drugs as a way of dealing with the terrible things that had happened to him. The withdrawal of some drugs is known to result in significant depression and risk of suicide. These risks will be compounded where coming off drugs means confronting a brutal past and a bleak present.

In 2005, DrugScope published *Using Women*, a report on women with drug problems in prison. The Prison Governor at HMP Drake Hall explains in that report that many women who detoxed on entering prison were 'facing up to the realities of their lives' for the 'first time' – for example, childhood sexual abuse. A shockingly high number responded by self-harming or attempting suicide. The extension of methadone prescribing in prisons is believed to have improved the situation.

IF SOMEONE WITH A HISTORY OF DRUG DEPENDENCY TAKES AN OVERDOSE IT TENDS TO BE ASSUMED THAT THE DEATH WAS ACCIDENTAL

This poses a wider challenge for those who want a more 'abstinence-based' approach to drug treatment. Prematurely detoxing people like Hamid without the support to come to terms with their damaged lives – as the drugs used to obliterate memories and blunt sensibilities are taken away – will be ineffective and inhumane.

Second, what conclusions would have been drawn if, following Hamid's detox at St Ann's hospital, he had taken his life by overdosing on heroin? If someone with no history of drug misuse takes an opiate overdose, the assumption is that their death is suicide. If someone with a history of drug dependency takes an overdose, even after a period of abstinence, it tends to be assumed that the death was accidental. There is a disturbingly high rate of drug overdose among recently released prisoners, which is generally attributed to ex-prisoners not adjusting their drug consumption on release to take account of a loss of tolerance after a period of abstinence.

A Home Office study of drug-related mortality among newly released offenders took a closer look at a number of these deaths, and concluded that some maybe were misidentified. One possibility was that overdoses recorded as accidental were in fact deliberate suicide. After all, this is an extremely difficult and frightening time for many ex-prisoners, some of whom will any way be at high risk of suicide, and surely if someone in this situation does decide to take their own lives, an opiate overdose will often be the chosen means. This has important and often unrecognised implications for work to cut drug-related deaths (and, specifically, to managing the risks associated with the transition from prison into the community).

Third, as in Hamid's case, the people who are at most risk of suicide often have a lot of problems in their lives – including drug or alcohol dependency, mental health problems, experience of trauma and abuse, homelessess and contact with the criminal justice system. So, they are often being seen by lots of different people in lots of different places. This presents a very familiar challenge.

As a contributor to one of DrugScope's Great Debate meetings on drug treatment in 2008, explained, where drug-related deaths occur, "often it is about services not communicating with each other to identify those people that are at highest risk ... When you turn up to drug-related death meetings everybody has got copious amounts of information on the person who has died, but very few of the services have actually been talking to each other." This will surely apply in cases of suicide.

Reading Hamid's story, it does not sound like any of the services working with him were talking to each other. Thankfully, Hamid is still alive, but his story could easily have had a more tragic outcome.

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For more info on DrugScope's evidence to the Royal College of Psychiatrists on risk to self, see http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Royal_College_Risk_Report.pdf