Suicide & Forensics

Dr Hasanen Al-Taiar
MRCPsych SFHEA
Consultant Forensic Psychiatrist
Oxford UK

True or False

- You have to be mentally ill to even think about suicide
- People who talk about suicide aren't serious and wont go through with it
- If a person is serious about killing themselves there is nothing you can do
- Talking about suicide is a bad idea as it may give someone the idea to try it

True or false continued

- Suicide is more common in the winter months
- People who threaten suicide are just attention seeking and shouldn't be taken seriously
- People who are suicidal want to die
- People who die by suicide are usually intoxicated

Office for National Statistics 2013

- In 2013 there were 6,233 suicides in people aged 15 and over in the UK, an increase of 252 (4%) more than 2012.
- Rate = 11.9/100,000
- Rate 3+ x higher in men (highest since 2001). Leading cause of death in men 20-49. (leading cause of death in women 20-34, 3rd leading cause 35-49)

Suicide and Trainees

- Patient suicides are a common experience for psychiatric trainees, and have a huge emotional impact upon them. Subsequent investigations and legal proceedings can be very stressful for trainees, and they describe feeling unprepared.

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PTC

- We call on the College, in conjunction with the PTC and other interested parties, to issue guidance about formal support for trainees whose patients die by suicide and consider ways to prepare trainees for a sadly frequent event.

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Emotional reactions

- initial disbelief
- depressive ruminations
- loss of confidence
- difficulties in personal and professional relationships
- longer-term psychological difficulties including PTSD

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Office for National Statistics 2013

- The highest suicide rate was in males aged 45-59 at 25.1/ 100,000 (highest since 1981).
- Female suicide rates highest in 45 to 59-year-olds (7/ 100,000 population). Leading cause of death in women 20-34 (3rd leading cause 35-49)

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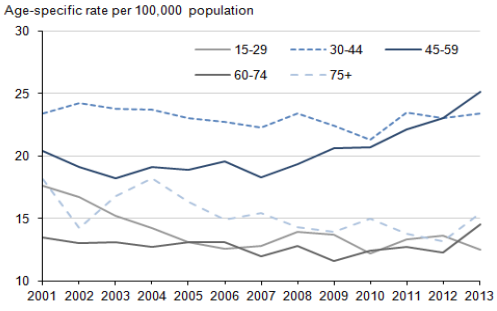
ONS data - age specific rate men



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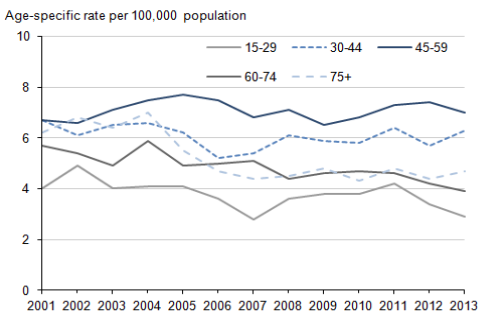

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Post-discharge suicide – UK (NCISH - 2012) (psychiatric discharges)

- 3,225 suicides, 18% of all suicides (since 2002)
- average 293 per year
- 18% before follow-up
- 526 (17%) in first week after discharge

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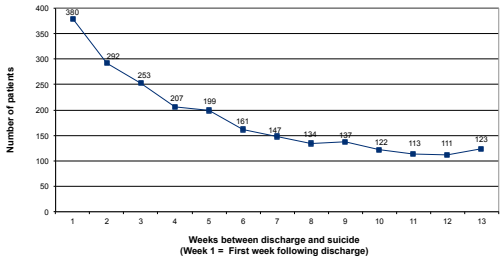
Suicides per week following discharge, England (NCISH 2012)



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NCISH 2014 - suicide within 2/52 post d/c

- Risk factors:
- self-harm
- male gender
- aged ≥ 40
- last admission <7 days
- adverse life events
- co-morbid psychiatric illness
- Under CPA protective

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Suicide under crisis resolution/home treatment teams (NCISH 2014)

- Increase from 80 per year (2003-04) to 163 (2010-11)
- Rate has fallen

- Living alone
- Adverse life events
- Short admissions

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MA

- 25 y man
- Recently separated
- Night shelter
- Drug use/occasional
- Legal proceedings (harassment)

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A&E (Liaison Assessment)

- Suicidal/evicted (bank holiday weekend)
- No eye contact
- Previous notes: seen by SpR and consultant 2010-1011 (similar presentations)

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What did I do?

- Spoke to night shelter → ☺
- D/W SpR
- Discharge
- Letter to GP (Fax)

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Following week

- Email from crisis team manager: suicide
- RCA
- Told my CS after a week!

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What was good?

- He saw GP
- Case discussed with SpR

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Learning Points

- Likelihood
- Imminence
- Method
- Clarity of documentation
- NCISH papers: 2012/2013

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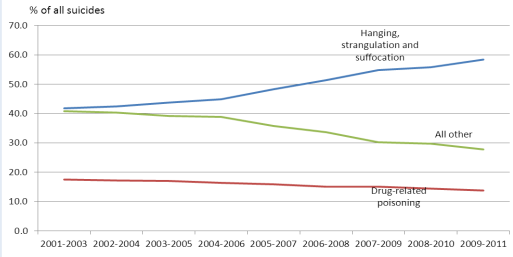
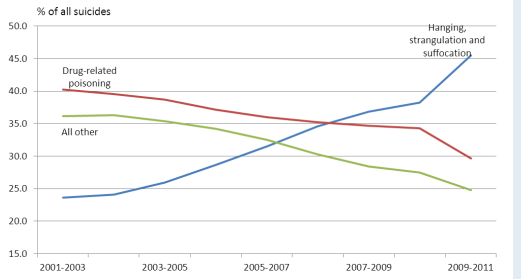
Methods

Male trends in deaths from suicide and undetermined injury, England 2001-03 – 2009-11



Source: ONS

Female trends in deaths from suicide and undetermined injury, England 2001-03 – 2009-11



Source: ONS

Methods of Suicide
Current concerns

Increase in hanging

Railways and underground (M-P train)

Novel methods of gassing
- Charcoal burning (barbecues)
- Helium
- Hydrogen sulphide ("chemical suicide")

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Forensic Psychiatry

- Interface between psychiatry and the law
- My work involves:

1. looking after patients in secure hospitals
2. Patients in prisons
3. Patients in community

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Who's a forensic patient?

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- Mentally unwell offenders (link between mental state and crime)
- Patients who have repeated offending history
- Serious offenders (psychotic murderers, arsonists)

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Pistorius

Insanity (McNaughton's) Rules

- It must be clearly proved that, at the time of committing of the act, the party accused was labouring under such a defect of reason, from disease of the mind
- As not to know the nature and quality of the act he was doing; or, if he did know it that he did not know he was doing what was wrong

McNaughton pic

- *Conservatives: They follow, persecute me wherever I go, and have entirely destroyed my peace of mind*
- *Admitted to a psychiatric hospital*

Forensic Report Writing

- **1.0Introduction: why?**
- **Background and Personal History:**
- **Drugs/Alcohol**
- **Forensic**
- **Past Psychiatric History**
- **Focus on risk issues (self/others)**

Criminal Responsibility

- Crime:
- *Actus Reus: criminal act*
- *Mens Rea: intention*

Learning Disability

- State of arrested or incomplete development of mind:
- Treated as usual unless they present with abnormally aggressive or seriously irresponsible behaviours

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Fitness to Plead/Court (Pritchard)

- Understand the charge
- Guilty/not guilty
- Follow legal proceedings
- Instruct a lawyer
- Challenge jury

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Risk of violence

- Males> females
- Age: younger
- Drugs e.g. tramadol, heroin, hashish/ alcohol
- Homeless
- Violent victimisation
- Mental illness (psychosis, depression, mania)

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Suicide Prevention Strategy 2012: 6 key areas for action

- Reduce the risk of suicide in key high risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better access to support and information to those bereaved or affected by suicide
- Support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring

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BBC video 2001

- Aimed at reducing suicide/raising awareness
- Actually suicides increased in the year after

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Risk factors

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Risk factors

- Static risk factor:
- fixed and historical eg: past abuse, family history of suicide, hx self harm
- Stable risk factor:
- long term but not fixed e.g. diagnosis of personality disorder, substances
- Dynamic risk factor:
- present for an uncertain amount of time e.g. Distress associated with unemployment, relationship issues, illness
- Future risk factor:
- anticipated e.g. anniversary, discharge from hospital, access to means

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Clinical Risk factors for suicide

- Psychiatric disorder evident in approx 90% deaths
- Depression (associated with desire to die)
- Anxiety (and impulse control are associated with increased likelihood of acting on desire)
- Personality disorder (BPD 8-10% die by suicide)
- PTSD
- Major mental illness
- Co-morbidity especially substances
- Physical illness (especially recently diagnosed, chronic and/or painful).
- **Agitation/sleep**

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Risk indicators....guess how many...

- Occupation……..???
- Unemployment
- Exposure to suicidal behaviour of others, directly or via the media.
- Contact with criminal justice system
- Access to potentially lethal means
- Homelessness
- Openness/attitude
- Self esteem/shame
- Seasonal variation (Spring)
- Combat exposure
- Social isolation
- Family conflict
- Interpersonal stress (inc bullying)

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Effects of physical illness & pain

- Being less able to function
- Feel tired & lethargic
- Loss of appetite and/or nausea
- Impaired sleep
- Less enjoyment and more anxiety
- Becoming depressed and anxious and unable to concentrate on anything other than pain
- Feeling a loss of control
- Having less interaction with friends
- Less able to enjoy sex or affection
- Feeling that one is a burden on family/caregivers

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Risk factors are imprecise

- Multiple previous attempts increase risk …… but…….. Many people die at first attempt
- Mental disorder increases risk ……..but……..most people with a mental disorder will not die by suicide
- Unemployment increases risk…… but……..this depends on overall vulnerability

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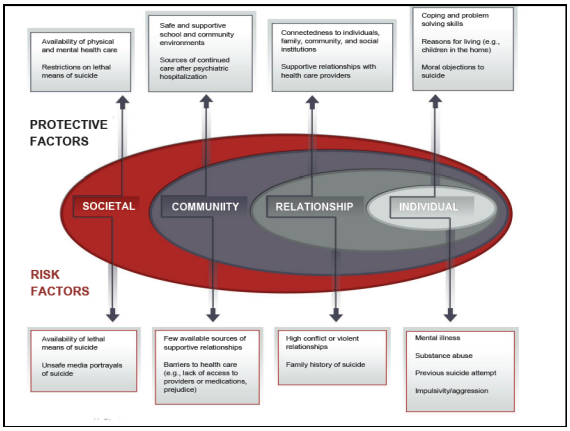
What are protective factors?

- Effective clinical care
- Easy access to clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections
- Skills in problem solving/resilience, conflict resolution and nonviolent handling of disputes
- Beliefs that discourage suicide and support self preservation
- Pets
- They want for things to be better
- ..... What are yours....??



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Interpersonal Theory of Suicide

Thomas Joiner (2005)

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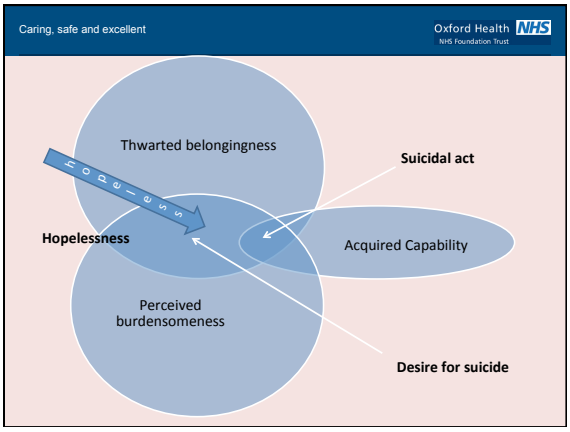

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Ideation v Intent

Suicidal desire & ideation:
- Reasons for living
- Wish to die
- Frequency of ideation
- Wish not to live (passive death wishes)
- Passive attempt
- Desire for attempt
- Talk of death/suicide

Resolved plans & preparation:
- Sense of courage
- Sense of competency
- Availability of means & opportunity
- Specificity of plan
- Preparations for attempt
- Intensity & duration of suicidal ideation
- Mental practice/imagery

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Acquired capability of suicide

- Increased pain tolerance and reduced fear of death
- The presence of the cognitive appraisal that the pain involved in the chosen method of suicide is tolerable
- Linked to childhood maltreatment, exposure to suicide, impulsivity, previous attempts, family history of suicide
- Engaging in suicidal behaviour – preparing, planning, practising, aborting….

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Assess resolved plans & preparations

- Duration – look for preoccupation
- Intensity – 0-10
- Past suicidal behaviour – frequency, when, methods, intent, consequences, exposure (inc family hx) - DETAIL
- Specified plan – check for vividness, detail
- Means and opportunity
- Preparations & timing
- Fearlessness – 0-10

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Assessing suicidal desire & ideation

1. Presence of thoughts, images – of suicide or death – probe, clarify
2. Thwarted belongingness – connectedness, reciprocity etc
3. Perceived burdensomeness – through specific questioning and curiosity, being mindful of risk of assumption (e.g. adult children of older adults)

Assess other significant findings

- Precipitant stressors, loss
- Hopelessness
- Impulsivity, coping
- Presence of psychopathology

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Confidentiality and information sharing

- http://www.youtube.com/watch?v=eVFpo8Ma1wY&feature=youtu.be

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Risk & mitigating factors (Joiner)

1. Talking about/planning suicide
2. Agitation
3. Insomnia
4. Nightmares
5. Marked social withdrawal

1. Safety planning
2. Meds, time, relaxation
3. Sleep hygiene
4. Imagery rehearsal
5. Signposting & motivational interviewing

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Anger & suicide risk

Hawkins et al (2013)

- Problematic anger is associated with higher levels of perceived burdensomeness (related with the desire to die)
- Problematic anger is associated (but less so) with exposure to painful and provocative events (posited to increase acquired capability)
- Problematic anger may increase risk suicide risk via desire and acquired capability

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Media Influences

- Risk of normalising self harm and discouraging help seeking behaviour
- Cyber bullying
- Correlation between internet exposure and violent methods of self harm
- Pro-suicide websites and online suicide pacts can be high-risk factors for facilitating suicidal behaviours, particularly among isolated and susceptible individuals.
- Can be positive and preventative, especially for socially-isolated and vulnerable individuals

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Documentation....what dos it mean?

- “denies suicidal intent”
- “periodic suicidal ideation but no plans”
- “no evidence of suicidal intent”

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Documentation

- Presentation – clinical, behavioural, social
- Risk factors – key risk indicators, belonging, burdensomess, acquired capability
- Static, Stable, Dynamic, Future risk
- Self report
- Collateral report (carer's, professionals, friends etc)
- Contradictions
- Clinical judgement
- Discussion with client & carer regarding risks
- Safety planning inc access to means
- Formulation
- Justify your actions

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Questions

- Have you ever thought about death or dying?
- Have you ever thought that life was not worth living?
- Have you ever thought about ending your life?
- Have you ever attempted suicide?
- Are you currently thinking about ending your own life?
- What are your reasons for wanting to die/wanting to live?

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Small and simple steps: use and disseminate resources

- Factsheet on managing suicide risk in primary care
  http://www.connectingwithpeople.org/sites/default/files/SuicideMitigationInPrimaryCareFactsheet_0612.pdf
- Clinical guide for assessing suicide risk in depression
  http://cebmh.warne.ox.ac.uk/csr/clinicalguide/index.html
- Information sharing and suicide prevention: consensus statement
  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf
- Healthtalkonline http://www.healthtalk.org
- Help is at hand http://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf

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Questions....

- Have you been having these thoughts for some time? That must've been really difficult – how have you managed to do that?
- Have you been able to share those thoughts with anyone who might be able to support you and offer to be with you so you are not struggling with the thoughts alone?
- Have you had these thoughts and feelings in the past? How did you manage to survive them and get to this point? What made the difference then?

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What can you do?

- Validate
- Think safety – patients and yours
- Try and instil a sense of clam
- Seek advice
- Concerns about imminent suicide risk should be considered an emergency
- Police, paramedics, ED
- Trust your judgement – escalate to GP

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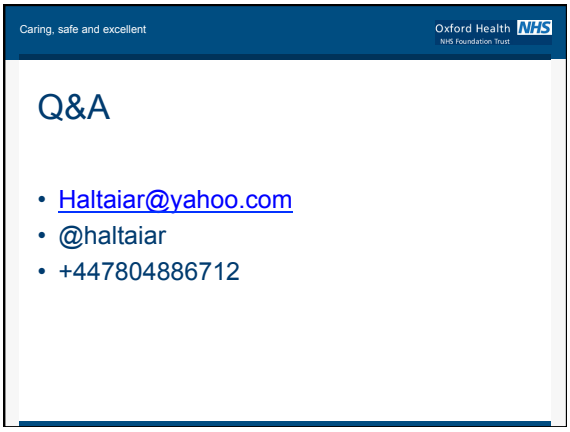
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Oxford Health NHS
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Q&A
• Haltaiar@yahoo.com
• @haltaiar
• +447804886712