



Shining a light on the future

Northumberland, Tyne and Wear
NHS Foundation Trust



Your patients with mental health problems: Key issues and good practice in the assessment and management of risk.





Why Do People Complete Suicide?

Suicide is not a disease, it is complex and multi-factorial. Demographics and associated stressors fail to fully answer questions about why we lose people to suicide.

- Suicide always involves an individual's tortured and tunneled logic in a state of inner-felt, intolerable emotion.
- Suicide is multidimensional, multifaceted, and containing, as they do, concomitant biological, sociological, psychological (interpersonal and intrapsychic), epidemiological, and philosophical elements.



- Hours before his death..
- Wife and friends all state no depression
- Evidence of forward planning?



Predicting suicide or homicide is not possible – “**Informed *Defensible Decisions*” are the key**

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- A pragmatic process that allows formulation – avoiding an over reliance on scoring systems.
- **Risk Minimisation** – prevention is the ideal but not always possible nor is it always desirable.
- Taking calculated risks in the short term may reduce risk in the longer term – this may seem counterintuitive (e.g. EUPD)
- Rapport and know your patients as best you can.
- Utilise contingencies, resilience and family/carers.
- Seek advice even if its not the advice you want to hear!
- Assessing risk is an ongoing, never ending process not an event!
- Evidence based interventions – safe and appropriate prescribing.
- Formulation and **RECORDED DECISION MAKING**.
- Documented Mental States are helpful.
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VULNERABLE Clinical sub-groups

Affective Disorders – particularly relapsed Bi-Polar
Major Psychosis - particularly “command” hallucinations.
Personality Disorder
Substance/Alcohol misuse
Where anger or irritability is prominent
Pride vs “Mortification”

Be mindful of:

Psychiatric manifestations of physical illness.

Undetected suicidality/depression in Physical Illness:

MFleehart.S et al Prevalence and correlates of suicide ideation in patients with COPD [Int J Chron Obstruct Pulmon Dis.](#) 2014 Dec 4;10:1321-9.

(N) 202 – 60% had depressive symptoms, 25% major depression, more women with suicidal ideation, combination of worse physical health and adverse life events.

Malignant Alienation- “Dangers for patients who are hard to like”. Watts D, Morgan G. BJP (1994) 164 11-15.

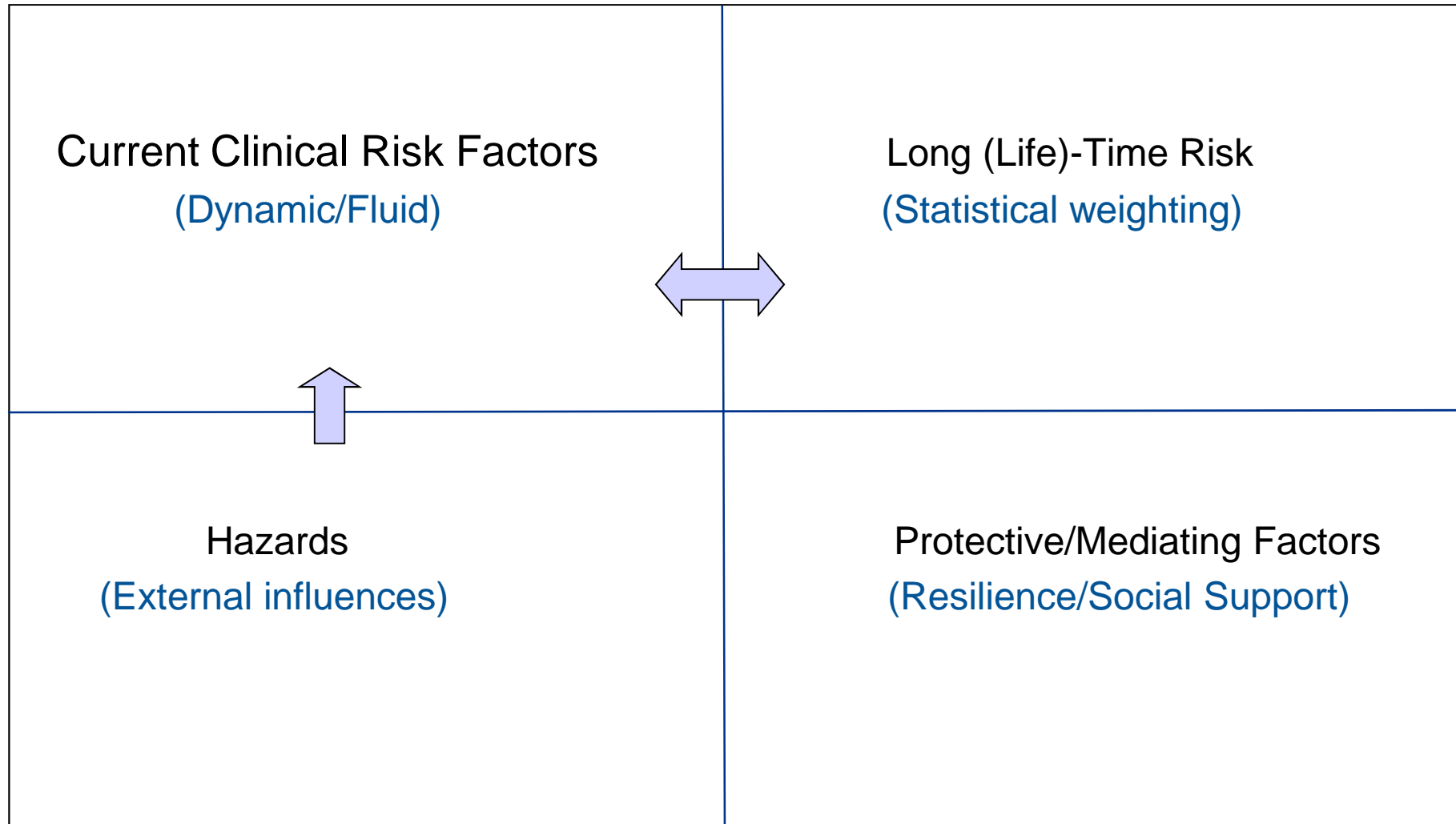


Edwin Shneidman/Thomas Joiner's model.

- Perturbation – *'psyche ache'*.
- Lethality – intentionality/ planning/ access to means.
- Cognitive Constriction – inability to generate alternatives.
- Perceived burden to others
- Lack of belonging/connectedness to others
- Acquired ability for lethal action



A “simple” Pragmatic Template (but underpinned by a Diathesis – Stress/Vulnerability Model)
Narrative Risk Assessment





Long (Life) term risk factors

Past History (Self Harm/Violence/Self Neglect) – best predictor of behaviour is past behaviour

Problem solving ability

Personality structure – rigid/black and white thinking/perfectionist etc

Personality disorder

Older age/younger age

Male gender/LGBT

Living alone

Social isolation

Divorced/ widowed / single

Unemployed/ retired

Physical illness = pain/access to means/linked with depression

Psychiatric illness/ FH of Psych illness/ **FH Suicide**

Social class 1 and 5/Occupational risks

Forensic history

Substance abuse



Current Clinical Risk Factors

(here and now – dynamic)

Active suicidal intent with plan.

Interpersonal problems/ adjustment/helplessness

Recent loss

Anniversary of loss

School/ work problems

Financial problems/ debt

Threat of imprisonment

Availability of method

Relapse of Mental Illness

Admission to Hospital/Prison

Discharge/Release from hospital or prison

Misleading clinical improvement from MMI



HAZARDS

The “bigger” picture :not necessarily predictors of suicide.

Do they have a GP?

Consider learning difficulties/other vulnerabilities.

Environmental eg. Live in tower block?

Enjoys hunting/ex-forces?

The psychotic young man has had his tablets restricted by Psychiatry but his mother is prescribed Quinine and they are in the same cupboard.



Protective/Mediating Factors

These are the resiliencies, supports and strengths of the individual and what can be introduced to minimise further risk.

Consider the context and mental state

However

Someone may have a lot of “protection” but also have active suicidal thoughts and plan.



High Risk Indicators of a Suicide Attempt

- Attempt was premeditated and actively prepared for.
- Precautions made against discovery.
- Attempt was carried out in isolation.
- Intent was communicated prior to attempt.
- Suicide note/ text message/ e-mail was written.
- Violent, active methods or more lethal drugs used.
- Person believed act was irreversible and lethal.
- The aim was to die
- Regretful of surviving attempt.
- No help seeking behaviour.
- Previous attempts with apparent intent to die.



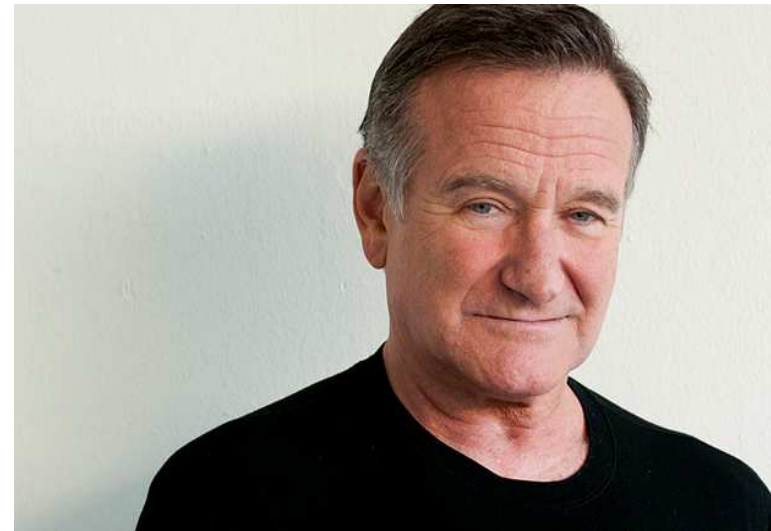
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Power of the Media (and internet)

Taiwanese TV actor hanged himself.
Suicides increased in next 4 weeks
Statistically significant.
Relative risk greater among men and using same method.
Int. Journal of Epidemiology (2007 Sep 28 10-1093)





Methods Helium – “Exit bag”

No UK deaths in 2000 – steady rise in 2007 - 51 in 2012 –7+ in NTW



Suicide bag

From Wikipedia, the free encyclopedia

A **suicide bag**, also known as an **exit bag**, is a device consisting of a large plastic bag with a drawcord used to commit suicide. It is usually used in conjunction with an inert gas like helium or nitrogen, which prevents the panic, sense of suffocation and struggling during unconsciousness (the hypercapnic alarm response) usually caused by the deprivation of oxygen in the presence of carbon dioxide. This method also makes the direct cause of death difficult to trace if the bag and gas canister are removed before the death is reported.^{[1][2][3]} Right-to-die groups recommend this form of suicide as certain, fast, and painless, according to a 2007 study.^[4]

Contents [hide]

- History
- Legal restrictions on sale
- Medical literature
- See also
- References

History [edit]

The suicide bag was first mentioned in Derek Humphry's book *Final Exit* in 1992.^{[5][6]} The "Exit Bag" was described as a large plastic bag with an adjustable velcro strip around the neck area.^[7] Different models of the "Exit Bag" were described in Hemlock publications, and the use of helium was specified.^[7] Philip Nitschke has stated that nitrogen has a lower risk of an adverse reaction by the body, but did not specify with regard to what other gas. Nitrogen has been advocated as a replacement for helium not because of reactions to helium, but because due to a "temporary restriction on the availability of disposable Helium in Australia (and New Zealand), helium has been difficult to procure."^[8]

Diagram of a suicide bag.

What to look for

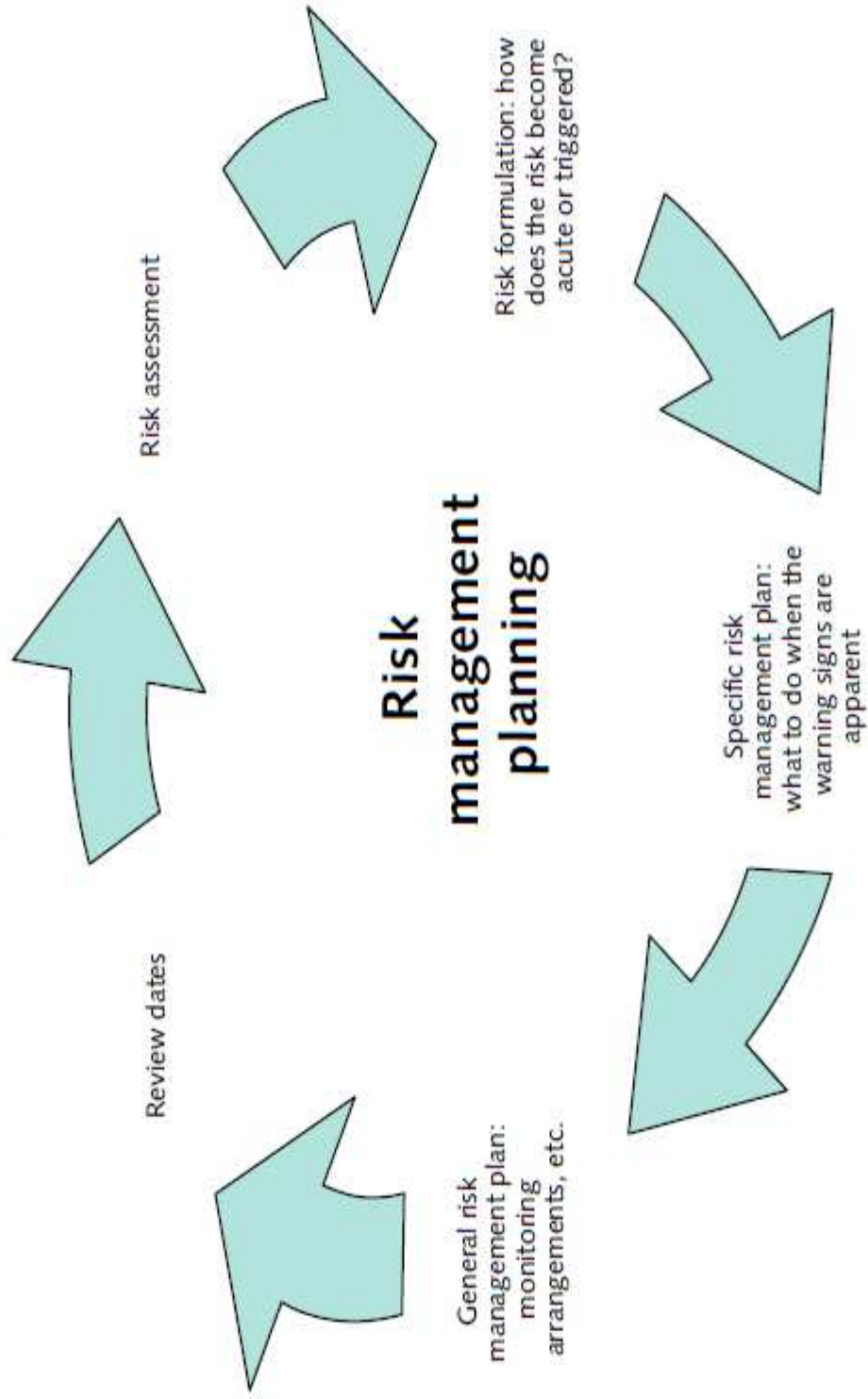
- S**ymptoms of depression
- U**nderlying psychiatric problems
- I**ndication of maladaptive personality features
- C**heck life events
- I**ntent to commit suicide
- D**epression/suicide in family history
- E**nvironmental factors
- S**uicide attempt in the past

What to do

- A**void repeat prescribing
- C**ounselling approach
- T**eam discussion and supervision
- I**dentify risk on notes
- O**ffer follow up or earlier appointment
- N**eed to refer on?

- P**lan the next few days
- L**iaise with other professionals
- A**wareness of non-statutory services
- N**ote informal supports
- S**pecialist care

Figure 2: The risk management planning cycle





Primary Care

Diagnosis of Major Depression Using 3 Questions

1. “During the past month have you often been bothered by feeling down, depressed or hopeless?”
2. “During the past month have you often been bothered by little interest or pleasure in doing things?”
3. “Is this something you would like help with?”- 3 Choices: “No”, “Yes but not today”, “Yes”.

BMJ 2005 331:884 B.Arroll et al.

- GP diagnosis with 2 written questions + help question = Sensitivity of 79%, Specificity 94% for major depression



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CRISIS RESOLUTION AND HOME TREATMENT SERVICE

NEWCASTLE & NORTH TYNESIDE

WHEN WILL CRHT OFFER ASSESSMENT?

The gateway to Crisis Resolution Services (Home Based Treatment, hospital care, respite) is through crisis assessment. Crisis assessment by Newcastle/N Tyneside CRHT is a comprehensive process looking at a person's bio-psycho-social functioning and is a resource intensive process involving the presence of two experienced mental health professionals and overview by a multidisciplinary team. Because of this, access to crisis assessment is managed by a triage process. The following is a guide to the presentations that are likely to require crisis assessment for people within the Newcastle upon Tyne and North Tyneside areas.

This guideline focuses on clinical criteria and should be read alongside Operational Guidelines for Referral.



1. CORE CRITERIA

Referrals accepted for crisis assessment will meet criteria **A** and at least one of criteria **B** or **C**

A

The way a person is presenting appears likely to be related to acute mental health problems (see general guidelines for areas of exclusion)

- *There should be clear evidence of a significant change in the person's presentation or that it has become recently apparent to referrers. CRHT function is not the care and treatment of long term problems.*

B

Available information indicates that the person is judged unable to maintain the safety of self and/or others. There should be evidence that current care arrangements are unable to manage these risks effectively

- *Safety issues are broadly defined and include; suicidality – self neglect – neglect of others – violence to others – vulnerability to exploitation – evidenced risk of significant deterioration in presentation.*

C

Significant difficulty in maintaining daily functioning as a result of acute mental health problems

- *For example; self care – high levels of distress – debilitating symptoms such as OCD.*



2. GENERAL GUIDELINES

If a person meets core criteria for crisis assessment there should be consideration of context and contributing factors before practical arrangements for assessment are made. These factors may prevent or delay assessment and CRHT will assist and advise referrers in putting appropriate care and/or assessment arrangements in place in this circumstance.

Physical and/or organic reason for presentation should have been fully investigated prior to CRHT attendance where referral information indicates this.

The person must be physically fit for interview prior to CRHT attendance e.g. tests and treatment following overdose completed

The person should not be intoxicated and unable to participate in a full interview. CRHT attendance may be delayed until intoxication reduces

Assessment does not contravene or interfere with an agreed management plan

The person must generally be willing to engage with CRHT. Triage workers will explore context and reasons for the person declining to see CRHT before deciding whether to attend assessment. Triage workers will attempt to negotiate appropriate pathways to assessment where a person declines to see CRHT.

The referral is not subject to another referral pathway that excludes the person from CRHT involvement e.g. under 16 year olds, older persons.