

Suicide and Suicidal Behaviour in Learning Disability

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What is a Learning Disability?

- WHO - 'a state of arrested or incomplete development of mind'.
- Somebody with a learning disability is said also to have 'significant impairment of intellectual functioning' and 'significant impairment of adaptive/social functioning'
- Individuals with a learning disability have:
 - Major difficulties with adaptive skills (cooking, handling money etc)
 - An IQ of less than 70 (average is 100)
 - Both of which should have been present before the age of 18 and not solely attributed to a head injury, infection or neurological problem
 - Only small no.of people have specific syndrome, most cases aetiology is unknown
 - You would walk past many people with a learning disability and never observe their difficulties – also many individuals are never detected or within services

Individuals with a Learning Disability are....

- In the bottom 1% of the population in terms of intellectual functioning
- Vulnerable to abuse & exploitation (physical, emotional, sexual & financial)
- Less likely to be accepted in society
- Viewed as useless or a burden on the state by non-learning disabled people
- Less likely to be accepted into work
- Often have poor social and coping skills
- Less likely to have friends or be in a relationship (v small no.of individuals get wed)
- Increased risk of mental health problems
- Increased risk of isolation
- Increased risk of drug & alcohol abuse
- Increased risk of epilepsy & poor health
- Living in poverty
- Living alone

How good would you
feel about yourself ?

Might there be times when you
feel like ending it all ?

Societal assumptions about suicidal thoughts in people with a learning disability

- “She is mentally retarded – how can she kill herself?”
- There is nothing we can do to help them
- “She has been saying she’s going to top herself for years, and she’s still here!”
- They’re just doing it for attention....
- She only took 20 paracetamol, if she was really serious.....
- “He hasn’t got the intellectual ability to be able to kill himself”
- “We don’t need to worry about him, the suicide risk is next to nothing – he’s retarded”
- “People with learning disability don’t feel anything”
- “People with a learning disability are not capable of committing suicide, so there is no point in putting resources into it”

What does this mean for our clients?

- Thoughts and feelings get ignored
- Poor recognition of how people's lives really are
- No-one bothers to check out feelings – clients continue to feel low and bad
- Episodes of self harm are minimised
- Suicide attempts are minimised/ignored (doesn't seem possible)
- Clients don't get the help they need
- People with a learning disability do not appear in the literature or in the suicide data
- The National Confidential Enquiry do not record whether an individual has a learning disability
- Clients with a dual diagnosis will get lost in the data HENCE it seems that PWLD do not have suicidal thoughts

Do people with a learning disability experience suicidal thoughts?

- Clinical experience tells me that this is a real problem for a significant minority of clients – 10% of referrals to psychology in my team
- Vastly under researched and under reported area
- Literature suggests that PWLD do experience suicidal thoughts, just like anyone else
- Clients often have poor problem solving skills and are less resilient to difficulties

What the literature says about completed suicide

- Suicide is a relatively rare event in any population (5/100,000 female, 16.2/100,000 males – 2007 ONS figures)
 - 1300/year 'patient' suicides – representing 27% of all suicides in UK (NCI – Preventable Deaths, 2006)
 - 84 suicides/week in UK + 150,000 attempts/year (Eldrid, 1993)
 - 1 million suicides each year worldwide (WHO)
- LD prevalence rates reported to be @ 1/3 general population rates – but likely to be an underestimate

What the LD literature says

Patja 2004 follow up study

- 10/2677 individuals committed suicide. Notes available on 5/10.
- Case 1 – IQ – 52. Early traumatic life. Hx of psychosis and EP. Two previous attempts – death by ingesting cigarettes.
- Case 2 – IQ = 61. Childhood neglect. SZ. Sister committed suicide. Death by drowning.
- Case 3 – IQ = 62. SZ and EP. Attention-seeking behaviour. Numerous attempts. Death by OD of rifampicin (anti TB drug).
- Case 4 – IQ = 52. No psychiatric problems. Enjoyed cycling – almost hit by a car, was told off by driver. Death by hanging that day.
- Case 5 – IQ = 54. Depression and delusions. ECT failed. Death by drowning.

What the LD literature says Patja 2004 study continued

- Common features of clients include:
 - 8/10 cases in contact with mental health services at time of death.
 - Long history of psychiatric problems
 - Lack of ability to handle socially difficult situations or abuse

Suicide cases – 35 year follow up study (Patja, 2004) – predictors of suicide

- Severe psychiatric problems – of early onset and resistant to treatment
- Family history of suicide
- Untreated or under treated depression. Dual diagnosis hampers clinical diagnosis of depression.
- History of abuse
- Low levels of social support
- Communication problems

Clinical and community study (Lunsky, 2004) 1

- Canadian study reported that half of admissions to psych. units (in those with LD) due to suicidality
- Tend to be more common in those with mild LD
- Suggest that thoughts and gestures are similar, but methods are different (linked to availability) – anecdotal evidence suggests this this is not the case locally
- Vastly under-researched and under reported

Lunsky, 2004 study 2

- Recruited clients with borderline – moderate LD in a project investigating psychosocial risk factors for depression.
- 99 heterogeneous participants
- Investigated:
 - Mood, anxiety, suicidal ideation, loneliness, social support, stress levels
 - 98 completed information on suicidal ideation
 - 26/98 thought life was not worth living some of the time
 - 7/98 thought life was not worth living all of the time
 - Of the above 33/98 – 11 had a plan in place and had made previous attempts

Lunsky, 2004 study 3

- Lack of social support, unemployment, loneliness, stress, anxiety and depression all associated with suicidal ideation – similar to general pop again
- Bereavement and abuse strongly linked to completed and attempted suicide
- Clinical implications – staff and families should be made aware that suicide can happen in this client group, learn what to look for and how to deal with it
- Ask the questionif you don't ask you won't necessarily know !

Management of depression and suicidal behaviour – Menolascino *et al.* (1989) 1

- Professional literature does not report on affective disorders in those with LD
- Psychiatric Aspects of MR Newsletter (1982) recommended:-
 - Differentiate between suicidality and SIB
 - Describe suicide attempts in terms of lethality and intent
 - Analysis and treatment of underlying psychiatric diagnosis
 - Determine future clinical risk for suicide to be based on past personal and clinical history of individual (as in any case).

Management of depression and suicidal behaviour – Menolascino *et al.* (1989) 2

- Suicidal gestures in those with LD often overlooked or confused with SIB. Lethality of attempts is often low – gravity of intent sometimes minimised. If the person themselves considers it to be life threatening – deemed a suicidal gesture, regardless of the outcome.
- Present eight cases + describe their management:
 - 8/305 to show suicidal behaviour
 - 7/8 female
 - 7/8 mild LD, 1 = moderate LD
 - 5/8 – depressed and had severe adjustment reactions
 - 2/8 schizophrenia
 - 1/8 – bipolar disorder
 - Suicidal ideation secondary to psychiatric disorder

- Significant challenges in each case:-
 - Identifying underlying psychiatric disorder
 - Providing active intervention
 - Attempting to reintegrate person into community life with support to maintain emotional stability.

Most cases had psychotherapeutic input on some level.

Psychiatric assessment needed in all cases

Mood disorders in LD (Hurley, 2006)

- Mood disorders frequently identified in individuals with LD, completed suicide rare
- Can be atypical presentation
 - Aberrant eating patterns
 - Challenging behaviour
 - Change in general behaviour
 - Suicidality
- Epilepsy is a strong predictor of suicide (Hurley, 2002)

Suicide, mental health and autism – what the National Autistic Society have to say

- People with ASD especially vulnerable to secondary mental health problems (adolescence and early adulthood)
- Communication probs. - problems may be well developed before recognised – we may see total withdrawal, obsessive behaviours, aggression and threats, suicidal behaviour and attempts on life
- Suicide prevention strategy – in those with ASD - should focus on promotion of mental well-being

Suicide, mental health and ASD

- NAS (2001) study
 - 32% experienced mental ill health, of whom 56% depression, 8% had felt suicidal or had made attempts.
 - Practitioners estimate a higher pattern of suicidal impulses in those with ASD (14/27)
 - Early diagnosis and intervention essential to good mental health
 - Clients with ASD extremely unlikely to be rated as a suicide risk
 - 65% Asperger's have co-morbid mental health problem
 - Link between Asperger's and 'schizoid personality' – more likely to manifest suicidal behaviour
 - Paucity of data on the management of such clients

Key issues in ASD

- Learning disability
- Depression
- Bullying
- Unemployment
- Social isolation
- Single status
- 8% in sexual relationship (NAS, 2008)
- Prejudice – within peers and professionals
- General social exclusion due to having a communication problem
- Lack of confidence

What NAS say about suicide management in those with ASD – mainly preventative

- Recognition of specific risk factors (probs. with communication and interaction)
 - Unemployment, living alone, alcohol/drug misuse
- Increased recognition of ASD by professionals – early diagnosis favourable
- Specific knowledge of co-morbid mental health problems in psychologists and psychiatrists – early treatment and prevention
- Do not ignore the risks

A look at the risks for suicide in general population – no different in LD

- Male
- Living alone/unsupported
- History of psychiatric problems
- Unemployed/retired
- Previous episodes of DSH
- Poor physical health (epilepsy?)
- History of previous admissions to hospital
- ASD
- Alcohol & drug misuse
- Single, widowed or divorced
- High degree of hopelessness
- Open expressions of desire to commit suicide
- Lethal methods readily available
- Associated with conduct disorder in adolescents
- ?personality disorders
- Poor social support

Management of acute suicidality in clients with LD

- Be aware that it does happen
- Consider how client may communicate suicidal feelingsis it really any different?
- Think about risks:
 - Imminent
 - Long term

Case examples

The right approach (or not)??

Self harming behaviour

Self harming behaviour what is self harm?

- Things that people do to themselves in a deliberate, and usually, hidden way. Anecdotal evidence indicates that people with LD are less able to conceal this activity (or have less opportunity?)
- It can involve
 - cutting and scratching
 - burning
 - scalding
 - ingesting toxic substances or objects
 - picking and poking at skin

Self harming behaviour

- Average age of onset = 12 years
- highest incidence = 11-25 years
- In UK 142,000 young people attend A&E due to DSH each year (massive underestimation)
- Many more don't go to hospital
- incidence decreases with increasing age

Self harm in the general population

- Viewed as a symptom of underlying emotional distress and dysregulation
- can be a means of coping with problems and is an effective way to regulate the emotions and make you feel better
- hard to give up, as it is very effective coping mechanism
- vastly under-reported, even in those in therapy (Arnold & Babiker, 2002)
- associated with shame, anger, guilt and hopelessness

Self harm and people with learning disabilities

- Little is known about it
- LD literature covers SIB and pica
- some people with mild/moderate LD and being referred to treatment services for DSH
- seems to be a bigger problem in secure services (up to 58% in-patient pop)

Self harm in the LD population

- Associated with physical, emotional and sexual abuse
- being treated 'like a nobody'
- self harm is commonly seen in those with BPD
- CSA is strongly associated with BPD
- reported protective function of DSH
 - not hurting others
 - doesn't affect anyone else

Techniques to manage DSH

- Evidence from DBT literature (Linehan, 1996)
 - distress tolerance skills
 - emotional regulation skills
- Can be applied to those with LD, small amount of evidence - although may need to be more directive with clients
- DSH is strongly associated with suicidality
- Maladaptive coping strategy
- Is always at top of my therapy action plan – give client tangible/transferable skills, increases self efficacy, not 'doing things to client'

Case Examples

Clients who self harm

Questions?