Clinical Practice Guidelines:
Behavioural disturbances/The suicidal patient

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The suicidal patient

September, 2024

Each year there are a large number of suspected suicides of Queensland residents, representing an approximate rate of 15 suspected suicides for every 100,000 people, being the second highest rate in Australia.[1] There has been a 16% increase in the suicide rate in Queensland residents from 2006–2018, with those in regional and remote communities, males, those under 44 years of age, other adult males and the LGBTI community and Aboriginal and Torres Strait Island peoples most impacted.[2]

Many risk factors contribute to why a person thinks about or attempts to end their own life. A combination of individual, relationship and social factors increase the possibility of suicide. No one risk is absolutely higher than another, but research indicates that suicide can be influenced by the following risk factors.[3]

Individual	Relationship	Social
• Job loss/unemployment • Legal/criminal problems • Financial problems • Stressful life events • Previous suicide attempts • Serious illness • Mental illness • Substance misuse • Social isolation	• Relationship break-up or loss • Bullying • Exposure to violence • Adverse childhood events • Family history of suicide	• Barriers to accessing health care • Suicide cluster • Stigma associated with help seeking • Access to lethal means

Clinical features

People contemplate suicide as a result of any number of experiences or circumstances in which they find themselves and may view suicide as a way to end this predicament. Behavioural indications or warning signs of suicide intent may include:[4]

- Talking about death or suicide
- Seeking methods for self harm, such as searching online or obtaining a weapon, medications or other means
- Talking about feeling hopeless or having no reason to live
- Changes in drug and alcohol use
- Uncontrolled emotions
- Reckless behaviour
- Changes in sleep patterns
- Feelings of isolation, desperation or feeling trapped – expressed in conversations.
- Social withdrawal or disengagement in usual activities
- Putting affairs in order

Clinical features *(cont.)*

- Giving away possessions
- Anxiety or agitation
- Sudden mood changes
- Talking about being a burden to others
- Suicide may also happen without warnings or indicators.

The role of QAS Officers

It is understood from people with a lived experience of suicide and thoughts of suicide that not all want to die, rather they feel a sense of hopelessness and helplessness which renders their life unbearable or distressing.[5] Research indicates that people who attempt to take their own life, also attempt to access help and are ambivalent about their decision to end their own life.[6]

Often people will reach out to emergency services themselves when experiencing a suicide crisis or to others, family and friends, who will reach out to emergency services on their behalf. Triple Zero (000) will often be a first point of contact to access help.

First responders are therefore pivotal to identifying the risk factors and warning signs and recognise protective factors which are available to people who are accessing help.

Protective factors

Protective factors for suicide risk can include:[3]

- Ambivalence
- Future orientation
- Engagement in help seeking behaviours
- Coping and problem solving skills
- Connections to friend, family and community supports
- Availability of physical and mental health care
- Limiting the access to lethal means

The World Health Organisation (2009) acknowledges first responders are in a unique position to determine the course and outcomes of a person's mental health crisis.[7] Specialised, effective interventions that can be delivered during or immediately following the first response are vital in order to support a person out of crisis and prevent, among other things further suicide attempts.

People thinking about suicide are usually uncertain about acting on their thoughts, but may be feeling overwhelmed, distressed and hopeless, so it is important for first responders to ask the person directly if they are feeling suicidal or if they are thinking about ending their own life.[8]

Principles for interacting with the suicidal patient

The main principles to consider when speaking with someone who is suicidal are:

- Safety for everyone on scene, including the person experiencing suicide crisis and attending officers and every effort should be made to keep the scene safe for everyone.
- Be clear in communication, use active listening, validate the person's feelings and perspectives, respect their position and circumstances;
- Tell the person you care and can help them at this time;

- Gather pertinent information about their situation, including:
  - If the person has engaged in any activities to harm themselves then this must be addressed accordingly;
  - If the person is under the influence of drugs and alcohol, then this can be seen to compromise their decision making capacities;
  - Does the person wish to end their own life;
  - Does the person have access to weapons or means of ongoing self harm;
  - What current problems is the person facing;
  - What factors have contributed to the difficulties the person is facing;
  - Does the person have a history of suicide attempts or thoughts;
  - Who is available to help the person;
  - What resources are available to them;
  - What they believe will be helpful at this time.
- Gather relevant information from family, friends, carers, bystanders or other credible sources. Information available from previous contacts with health services may also be helpful.
- Taking time to listen to the person, engage in empathic conversations through active listening and being interested in the person and their circumstances is the most helpful thing to a person in a suicide crisis.
- Problem solving, minimising experiences or criminalising the person in suicide crisis is not helpful.

Once risks have been identified, strategies to manage the risks – a safety plan, should be put in place, using the identified protective factors, if they are available.

A safety plan can include:

- Transport to a public health facility under the Emergency Examination Authority (EEA) provisions of the *Public Health Act 2005*, if the criteria is satisfied.
- Transport to a place of safety: a community/non-government organisation, which is appropriate and safe for the person;
- Being in the company and care of a reliable and capable person, who understands the risks and is willing to provide the appropriate level of support and supervision;
- Referral for further assessment and safety management through a treating health professional.
- Provision of support and helping services including: GP, LifeLine (131114), local Mental Health Service (1300 64 22 55), Beyond Blue (1300 22 46 36).

The Mental Health Liaison Service (MHLS) is available to support and assist paramedics on scene with safety planning and drawing on the patient's protective factors. The MHLS can be contacted 24/7 on 1300 315 286 (Option 2).

Additional information

- A person should never be left alone after a suicide attempt or in a suicide crisis.

CPG: Clinician safety
CPG: Standard cares

Does the person have an injury or require clinical management?

Y → **Manage as per:**
- Relevant CPGs

N

- One officer should interact with the patient using active listening, empathy and non-judgemental deportment
- Listen for and identify the presence of risk factors and behavioural indicators of suicide

Note: *Clinicians must only perform procedures for which they have received specific training and authorisation by the QAS.*

- Gain collateral information if available including from MHLS
- Identify protective factors or a safety plan

Can the safety plan adequately manage the presenting risks?

N → Transport or refer the patient to the most appropriate care/destination, based on the assessment outcome and availability of suitable options:
- Public health facility – the only option if EEA criteria is satisfied
- To a place of safety
- In the care of a support person
- Further assessment by a mental health professional
- Mental health/support services (Lifeline, Beyond blue, etc).

Y

- Obtain advice from MHLS.
- Ensure a robust safety plan and the QAS non-transport process is followed