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HEALTHCARE PROVIDERS' PSYCHOSOCIAL ROLE IN RECEIVING AND MANAGING SUICIDAL PATIENTS

Patients who have tried to take their lives through, for example overdose, or who are struggling with suicidal thoughts are most-often not always priority in a trauma-filled (or medical emergencies) Emergency Centre (EC) or ambulance. This comes from personal nursing experience as well as being such a patient myself. First line healthcare providers (HCPs) (referring to emergency care providers, nurses, and doctors) are extremely important in dealing with such patients as secondary trauma is uncalled for (and further suicide must be prevented).

The most important goal in medically managing patients who have attempted to take their life or are who seeking assistance due to suicidal ideation/threat/attempt is to provide a physical and psychological safe space, treat self-inflicted medical problem and further prevent any more complications (such as further self-hurt).

Nurses are often first in contact with patients arriving in ECs, especially where an effective triage system is place. The South African Triage Scale (2017) states clearly that patients who have taken an overdose or have been poisoned are triaged orange/very urgent (unless any of the 'red' criteria apply) and must be treated within 10 minutes.

Emergency medical care providers and emergency care doctors are also first line responders and so this article is applicable to them as well. Other systems though, allow receptionists to be on the receiving end of new patients and although not ideal, receptionists should also be given some guidelines on identifying and dealing with patients who are in psychiatric distress.

This guideline however will focus on the behavioural or psychosocial management of such patients (these may be patients who have already self-inflicted harm or those who seek assistance due to suicidal ideation/threat/attempt). Such patients may be suffering from a range of psychiatric disorders such as major depression or depression due to bipolar disorder or post-natal depression, anxiety disorders, PTSD (post-traumatic stress disorder), schizophrenia, substance abuse and/or personality disorders.

My own experience (and I am also guilty) and experience of some South African emergency nurses and other healthcare providers shows that they sometimes struggle to show the necessary empathy in managing suicidal patients. There may be several reasons for this, such as:

- Little or no training in psychiatric emergencies
- Copying colleagues' poor management of such emergencies
- No general psychiatry training
- Necessary prioritisation of patients with physical problems (e.g., 'red' patients) and general busyness of the EC
- General blunting to such 'difficult' or 'non-emergency' patients (especially non-overdose patients) may unfortunately be another reason for a lack of empathy

Unfortunately there is also the

stigma around depression and mental health emergencies which fortunately is slowly decreasing with several NGOs' help

Dealing with such patients can be emotionally and professionally draining. Values and beliefs around suicidality should also be considered as healthcare providers must take note of their own verbal and non-verbal behaviour and reactions towards the patient.

SUICIDE LANGUAGE GUIDE

(This is taken directly from SADAG - South African Depression and Anxiety Group - all acknowledgements to them)

DO SAY	DON'T SAY	WHY
'died by suicide' 'took their own life'	'successful suicide' 'un 'successful suicide'	Because it suggests suicide is a desired outcome. No one wins if someone dies by suicide dies.
'took their own life' 'died by suicide'	'committed suicide' 'commit suicide'	Because it associates suicide with crime
'increasing rates' 'higher rates'	'suicide epidemic' 'failed suicide'	Because it sensationalises suicide
'suicide attempt' 'non-fatal attempt'	'failed suicide' 'suicide bid'	It means that someone hasn't died, they are still alive and there is an opportunity to get them help. So not dying by suicide is not a fail
Refrain from using the term suicide out of context	'political suicide' 'suicide mission'	Because it is an inaccurate use of the term 'suicide'

SADAG Project Manager, Krystle Kemp, reminds us that someone who has a mental illness is not defined by their mental illness. The person 'struggles with depression', rather than he/she is depressed. As SADAG describes, "We don't say that someone who has cancer "is cancer", rather they have been diagnosed with cancer.

Major depression and bipolar disorder (or any of the above stated problems) are illnesses, just as is hypertension and diabetes. Suicidal ideation and an attempt to take his/her life is a desperate attempt to end the pain or situation that the person is in. Medical treatment may not have worked anymore, and such patients are often in total despair.

HOW TO MANAGE PATIENTS WHO FEEL SUICIDAL OR HAVE ATTEMPTED TO TAKE THEIR LIVES THROUGH SUICIDE

Health Care Providers who are inclined towards psychiatry may be tempted to counsel the patient in the emergency centre/ambulance; however this is neither the time nor space to do so. Emergencies' unpredictability as well as the healthcare provider's short encounter with the patient (normally) is unfortunately unsuitable to 'counselling'.

However, the following principles apply to any healthcare provider dealing with a patient who has attempted to take their life or patient who is experiencing suicidal ideation/threat/attempt.

1. Where at all possible, attempt to keep such patients away from the mix of physical trauma, medical emergencies, and even death.
2. Show empathy. Convey sincere concern. Really listen, try to understand things from their perspective.
3. Make regular eye contact and refer to the person by name.
4. Be patient. Allow the patient time to digest what is happening around them.
5. Take on a non-judgmental attitude and avoid criticism. Avoid telling the patient what he/she should do or should have done as this can be seen as criticising.
6. Attend to these patients frequently, even if it's just to check they are okay or need a cup of tea/water (where not contra-indicated) and tissues etc. It's extremely important to know where your patient is at all times.
7. When able, sit quietly with the patient, especially if they are extremely emotional (crying) – silent moments are okay. The patient may feel more comfortable or be trying to deal with their feelings at that time.
8. Validate emotions: reinforce that crying/distress is 'normal' to experience in such a situation.
9. Ensure the area is safe. ECs are areas with equipment that could be lethal (such as defibrillators) as well as drugs and equipment that could inflict great harm/death.
10. Avoid giving (uncalled-for) advice.
11. Keep the family up to date with developments and reassure them as much as possible.

A FAMILY'S REAL EXPERIENCE …

Having myself been a patient who has attempted to take my life, my family has experienced the difficulty to get the necessary medical care for me. This was an extremely traumatic experience for them. As they recall the situation my family took me to a local government-based EC. Once at the EC, triage was never applied (I had overdosed) and eventually my family took me home after hours of waiting in the EC's waiting room. I could have died (although that is what I wanted at the time). In retrospect this should NEVER have happened. Private hospitals can also assist patients in these situations and should be used where at all necessary and affordable (through medical aid or other means).

IN CONCLUSION

Healthcare providers are in the privileged position to assist those in crisis, whether it is physical or psychiatric. It's important to acknowledge that many South African healthcare facilities, Emergency Centres, and hospitals' pressure experienced by healthcare providers are not always conducive to dealing with psychiatric emergencies. However, may this guideline be a reminder to deal with suicidal patients with utter respect and non-judgmental. They require empathy during their medical crisis as does any other person with any medical/traumatic emergency.

References available on request. MHM