Response to suicidal people and deaths by suicide

Scene safety or stigma?

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In every EMS class, the concept of scene safety has been drilled into our brains. In fact, not ensuring scene safety in any practical exercise or exam, is an automatic fail. Fire officers are cautioned that they are to ensure their crews respond with appropriate precautions against violent people*. EMS curriculum cautions us to assess our environment for "suicide patients who may become homicidal" *. As a result, our protocols and standard operating procedures generally require us to stage at a "location close to, but not at, the scene of an emergency to allow law enforcement personnel to go to the actual scene, ensure safety at the scene, and then summon the ambulance [or fire apparatus] onto the scene" *.

Is staging for every call that involves suicidal ideation, attempt, or death warranted? There are times to stage for safety, but are there times where it may be detrimental to the patient or psychologically damaging to firefighters? Unnecessary staging may result in the perpetuation of stigma that ultimately colors our perceptions about receiving help for our own psychological maladies. In one system, researchers determined that staging delays patient care an average of 4.5 minutes*, which is especially concerning given that reduced time to treatment is positively associated with saving lives*.

Mental Health and Suicide

The suicidology community has generally accepted that mental illness is a contributing factor in many suicide deaths*. The top four illnesses factoring into suicide are Major Depressive Disorder, Borderline Personality Disorder, Nicotine Dependence, and Posttraumatic Stress Disorder (PTSD) *. Firefighters are not immune to mental health issues and are at risk themselves. The general population has a PTSD rate of 8-9% and firefighters somewhere between 7-37%*. Additionally, the general population has a suicide ideation rate of 5.6-13.4%*, while Minnesota firefighters have an astonishing rate of 20.9% with 9.5% of those firefighters having a suicide plan*. In contrast, among the U.S. general population with suicidal ideation 3.1-4% have a suicide plan*.

It is important for those who respond to suicidal behavior to be comfortable talking about suicide and use appropriate verbiage. The term suicidality is often used as an umbrella term for ideation, attempts, and deaths. However, each of these terms have unique meaning and should be spoken about separately*. A suicide attempt is characterized by non-fatal self-directed behavior with intent to die. A suicide attempt does not have to result in injury, a common misunderstanding. Suicide is when a self-inflicted death has occurred.

There are also words that are shied away from in the field of suicidology. Use of the word "committed" implies that suicide is a moral problem or a crime. Referring to a suicide as "failed," "successful," or "completed" may reinforce the negative idea that one is so inept that they cannot even kill themselves, that a death is a successful achievement, or that they have been successful*.

Suicide and Violence Towards Others

At a recent EMS conference attended by one of the authors, a keynote address was given on response to mass shootings. The speaker, failing to distinguish between suicide and murder-suicide, continually reinforced the notion that those who kill themselves often kill others. While it is true that the majority of mass shooters kill themselves*, it is important to understand that murder-suicide occurs in only 2% of suicide deaths and mass-murder-suicide is even less frequent*. In fact, one's chance of being the victim of a murder-suicide is less than 0.001%*. Murder may be on the front page of the newspaper and highlighted on the local news, but less than 16,000 Americans were murdered in 2015 compared to over 44,000 Americans who died by suicide in the same year*. If people who die by suicide regularly murder others before killing themselves, one

would expect the number of murders to far exceed suicides, but that is not the case.

A fire department is three times more likely to have a firefighter die by suicide than in a line-of-duty death*. Our search of the state death records revealed that over 50 fire departments in Minnesota have lost a firefighter by suicide since 1994. Police officers are three times more likely to die by suicide than to be killed by a person encountered on a scene*. An even more disturbing and uncomfortable statistic is that the number of murder-suicides carried out by police officers exceeds those enacted by the general population*. Although they are rare events, it is important to understand that murder-suicide has more in common with suicide than homicide*.

Psychological Fallout of Delayed Care

A delay in patient care may be the difference between life and death. This is true not only in a hospital setting, but also in emergency response setting. Responding to suicidal patients with respect and dignity can enhance rapport between the responder and the patient, increase the quality of assessment, and decrease the risk for future suicidal behaviors*. In instances of staging delays, the intensity of the suicidal ideation may increase, along with the likelihood of an attempt. This may result in undo stress for the patient.

Aside from the psychological fallout that may occur for patients, responders may also be impacted by this delay in care. Suicide-related calls may be some of the most challenging and emotionally draining responses. While we wait to be cleared into the scene, the patient's condition may worsen and/or result in death. This can saddle us with feelings of helplessness, guilt, and put us in the unenviable position of delivering a death notification.

Conclusion

Scene safety is important, for both the responder and the patient. Just as scene safety precautions can be beneficial to all parties involved, being overly cautious can be detrimental. Firefighters with knowledge of safe and appropriate skills for responding to mental health and suicide related calls can help to keep both the responder and their patient safe and well.

Ironically, we should be more concerned about death by our own hand than being killed by someone else. Still, we hesitate to approach a scene involving self-harm, even when a weapon is not present. Why are we less cautious when we treat accidental overdoses compared to an overdose with the intent to die? The authors believe the answer is stigma originating from mistaken beliefs about suicide.

While it is certainly prudent to prepare for and train on how to respond to a patient who is violent, it is important to keep in perspective that people with a mental health condition are more likely to be the victim of a violent crime rather than the perpetrator*. We would be foolish not to prepare for such an event, but it is rare for a patient with suicidal ideation to also be homicidal*. Sadly, this stigma is too often applied to our fellow firefighters who struggle with mental health and suicidality. We should treat ourselves like our patients and we should treat our patients with understanding, compassion, and respect. Suicide is treatable and preventable. Let's keep ourselves safe while tempering our responses by assessing each scene individually in a logical and stigma-free way.

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Chris has 25 years of EMS experience, 15 years of firefighting, 21 years in EMS and fire education, and over 13 years in suicidology. Chris is the executive director of the Strub Caulkins Center for Suicide Research (SCCSR) and has researched, presented, and published on suicide at a state, national, and international level. The SCCSR website is www.suicideresearch.org and Chris may be contacted at c.caulkins@suicideresearch.org. You may follow the SCCSR on Facebook at https://www.facebook.com/StrubCaulkins or visit us on the web at www.suicideresearch.org.

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