Maternal suicide and risk assessment toolkit

Key facts

- Suicide and overdose combined are the leading cause of maternal death in the first year following childbirth.[1]
- Suicide accounts for up to 20% of maternal deaths that occur during the postpartum period.[2] Peak incidence is in the late postpartum period (9–12 months).[3]

Mental health conditions are the most common complications of pregnancy and childbirth[4] and 85% of cases go without treatment.[5]

A study in Massachusetts[6] found that 50% of new mothers who completed suicide had a documented mental health diagnosis.

Women of color have higher rates of perinatal depression and are less likely to receive treatment.[7]

Risk factors[8,9]

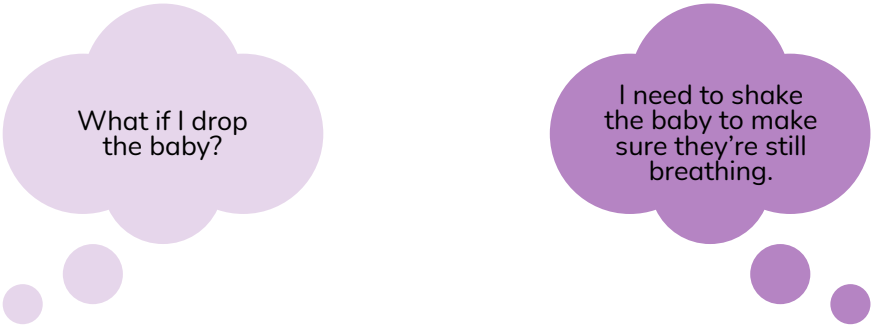
- Previous suicide attempt
- History of abuse
- Unplanned pregnancy
- Substance use disorder
- Personal or family history of mental health disorders

Perinatal Mood and Anxiety Disorders (PMADS)

- Depression
- Anxiety
- Panic Disorder
- Bipolar Disorder
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder
- Postpartum Psychosis

Understanding intrusive thoughts

Intrusive thoughts are a common symptom of perinatal anxiety. Sometimes suicidal ideation is an intrusive thought for perinatal patients and does not represent intent. Intrusive thoughts can be difficult to assess and distinguish from higher-risk symptoms of psychosis.



Understanding suicidal ideation

Suicidal Ideation is used to describe a range of contemplations, wishes, and preoccupations with death and suicide.[10] It varies in duration, intensity, and character.

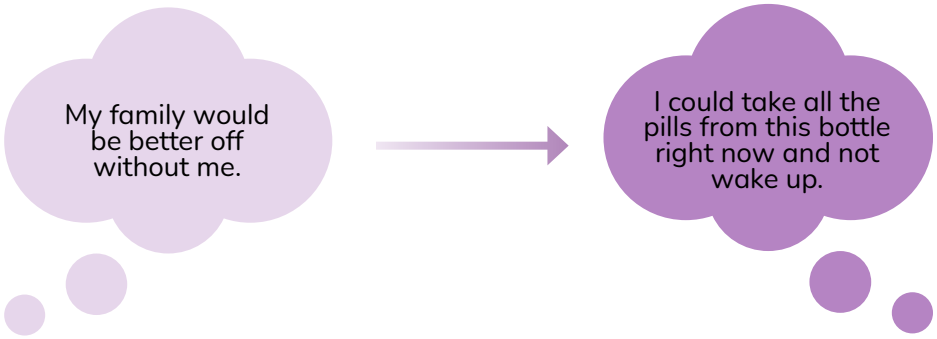
⚠ The fluctuating nature of suicidal ideation means that healthcare professionals should assess their patients routinely.

Passive suicidal ideation

Thoughts that life is not worth living or a desire for death, but without a plan to take one's own life.[11]

Active suicidal ideation

Thoughts of suicide with a plan and/or intent to harm oneself.



Questions to consider

To help **distinguish the two**, consider the following questions:

Q: Is the patient distressed by these thoughts?
A: Distress suggests intrusive thoughts rather than psychotic delusions.

Q: Does the patient recognize the thoughts as her/ their own (is insight preserved)?
A: Insight is usually preserved with intrusive thoughts, but may be lacking in psychosis.

Q: Are there other signs of psychosis such as hallucinations or delusional thinking?
A: Presence of these symptoms suggests a higher level of concern.

Screening for suicide risk

Consider incorporating one of these screening tools into your visits with perinatal patients if you are not already using one. Whatever screening tool is used, it should be given to all patients.

Keep in mind that patients don't always feel comfortable telling their providers about their suicidal thoughts, particularly during pregnancy and postpartum due to fears of being perceived as a bad parent or of being separated from their children.

What is most important is that you **foster an environment where patients feel safe** to disclose their thoughts and feelings about suicide to you, even when those thoughts may feel very scary to them.

What do I say?

"It is common for new parents to have intrusive or scary thoughts. When people are suffering, they often have thoughts about death or wanting to die. These thoughts can feel awful, and we don't want you to feel alone. We ask all patients if they are having thoughts of hurting themselves or their baby so that we can identify the best way to help."

Depression screening tools with suicide question included

Patient Health Questionnaire

apa.org/depression-guideline/patient-health-questionnaire.pdf

Edinburg Postnatal Depression Scale

med.stanford.edu/content/dam/sm/neonatology/documents/edinburghscale.pdf

Suicide specific questionnaires

Columbia Suicide Severity Rating Scale

suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf

National Institute of Mental Health Ask Suicide Screening Questions

www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit.pdf

Assessing risk

Assessment	Low risk	Moderate risk	High risk
Suicidal ideation	▶ No history of suicide attempt ▶ No current intent ▶ No current plan ▶ Protective factors present (i.e. social support, religious prohibition, other children) ▶ No substance use ▶ Hopeful about improvement	▶ Persistent sadness and tension, loss of interest, persistent guilt, difficulty concentrating, no appetite, decreased sleep ▶ History of suicide attempt ▶ Current intent ▶ Current plan (not well formulated) ▶ Limited protective factors ▶ Substance use ▶ Hopelessness	▶ Continual sadness, unrelenting dread or guilt, < 2-3 hours of sleep per night, unable to feel pleasure ▶ History of multiple suicide attempts ▶ High lethality of prior attempt(s) ▶ Current intent ▶ Current plan ▶ Limited protective factors ▶ Substance use ▶ Not receiving psychotherapy ▶ Hopelessness
Thoughts of harming baby	▶ Symptoms indicative of depression, OCD, and/or anxiety ▶ Thoughts of harming baby are scary, cause anxiety, or are upsetting ▶ Mother does not want to harm her baby and feels it would be a bad thing to do ▶ Mother very clear she would not harm her baby	▶ Thoughts of harming baby are somewhat scary ▶ Thoughts of harming baby cause less anxiety ▶ Mother is not sure whether the thoughts are based on reality or whether harming her baby would be a bad thing to do ▶ Mother less clear she would not harm her baby	▶ Symptoms indicative of psychosis ▶ Thoughts of harming baby are comforting ▶ Feels as if acting on thoughts will help infant or society ▶ Lack of insight (inability to determine whether thoughts are based on reality) ▶ Having auditory and/or visual hallucinations ▶ Bizarre or fixed untrue beliefs that are not reality

What do I say?

- Normalize how stressful parenthood is and validate any feelings of anxiety and depression.[12]
- Don't be afraid to ask specific and direct questions, such as:

  - How are you feeling about being pregnant/a parent?
  - What things are you most worried about?
  - Is there anyone you feel comfortable with talking about your anxieties?
  - Are you having thoughts of killing yourself right now?
  - Who do you have for support?
  - What are your hopes for the future?

How do I help patients to stay safe?

A **safety guide** is a prioritized written list of coping strategies and sources of support. Here are some resources you can use when you want to contract with your patient for safety.

- **Safety Planning Quick Guide for Clinicians: health.maryland.gov/bha/suicideprevention/Documents/Suicide prevention tool kit/Risk management and reduction/safety planning/SafetyPlanningGuide Quick Guide for Clinicians.pdf**
- **Suicide Safe by SAMHSA (Substance Abuse and Mental Health Services Administration): store.samhsa.gov/product/suicide-safe**
- **Patient Safety Plan template: mysafetyplan.org**
- **Stanley-Brown Safety Plan: suicidesafetyplan.com**

What else can I do to support patient safety?

- **Learn your local resources**, including your local mobile crisis unit, to aid with referrals for patients with mental health or substance use disorders.
- **Ensure scheduling of postpartum follow-up appointments** for individuals with history of mood disorders or substance use disorders.
- **Find out if your patient has started or stopped taking any medications during pregnancy or lactation.** Some medications have been found to be associated with an increased risk of suicidality. Stopping medications abruptly can increase the risk of mood symptoms and therefore increase the risk of suicide.

Additional resources

Perinatal Psychiatry Consultation Line for Providers (Perinatal PCL) (Washington)
Perinatal PCL is a free, state-funded program providing perinatal mental health consultation, recommendations and referrals for Washington state providers caring for pregnant or postpartum patients.

This service is operated through Partnership Access Line for Moms – WA (PAL for Moms WA), a program of the University of Washington Psychiatry and Behavioral Sciences Department and funded by Washington State Health Care Authority.

To **contact a perinatal psychiatrist or mental health professional** for support, please call: 877-725-4666 (PAL4MOM). Available weekdays from 9 a.m. to 5 p.m. (Pacific Time).

If your **patient is actively suicidal**, call the **Crisis Connections 24-Hour Crisis Line:** 866-427-4747

Supply these **national hotline numbers** to your patient:

- **National Maternal Mental Health Hotline:** 1-833-TLC-MAMA (1-833-852-6262)
- **National Suicide Prevention Lifeline:** 988
- **National Domestic Violence Hotline:** 800-787-3224

Resources

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11 Van Orden, K. A., O'Riley, A. A., Simning, A., Podgorski, C., Richardson, T. M., & Conwell, Y. (2015). Passive suicide ideation: An indicator of risk among older adults seeking aging services?. The Gerontologist, 55(6), 972-980.

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