South Australian Perinatal Practice Guideline

Suicidal Ideation and Self Harm

Note:
This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Note: The words woman/women/mother/she/her have been used throughout this guideline as most pregnant and birthing people identify with their birth sex. However, for the purpose of this guideline, these terms include people who do not identify as women or mothers, including those with a non-binary identity. All clinicians should ask the pregnant person what their preferred term is and ensure this is communicated to the healthcare team.

Explanation of the Aboriginal artwork:
The Aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the Aboriginal culture. The horse shoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant woman. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.

Australian Aboriginal Culture is the oldest living culture in the world yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics, the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectfully manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.

Purpose and Scope of PPG

The purpose of this guideline is to provide clinicians with information to identify those women at increased risk of self-harm and suicide using screening tools and clinical assessment. It includes additional questions and actions to be taken when women are identified at increased risk. Suicidal ideation and behaviours are common and can come from a wide range of underlying problems which this PPG cannot fully outline. When in doubt, seek advice from a mental health clinician.

Flowchart - Perinatal Assessment of Suicide Risk

Be Calm and Kind.

Ask further questions about the suicidal thoughts include:

Thoughts • Plan • Lethality • Means • Intent • Protective factors

(Consider risk to the infant and her other children, at all times).

LOW RISK	MODERATE RISK	HIGH RISK
Fleeting thoughts of self-harm or suicide but no current plan, means or intent.	Suicidal thoughts and intent but no current plan or immediate means.	Continual/specific suicidal thoughts, intent, plan and means.
Refer to perinatal mental health team if available. Discuss availability of support and treatment options. Arrange follow-up consultation (base urgency on clinical judgement). Consider advising her GP – involve GP as needed. Identify relevant community resources and provide contact details. For Aboriginal women, contact Aboriginal Liaison Unit or Aboriginal Healthcare provider for cultural advice, support, and guidance to ensure clear understanding of her needs.	Refer to perinatal mental health team if available. OR Call Mental Health Triage Service 131465. Discuss support and treatment options. Organise follow up review within 1 week. Advice woman of crisis services in case symptoms escalate. Develop a safety plan with the woman. For Aboriginal women, contact Aboriginal Liaison Unit or Aboriginal Healthcare provider for cultural advice, support, and guidance to ensure clear understanding of her needs.	Refer to perinatal mental health team for immediate review if available. OR The hospital Emergency Department OR Call Emergency Triage Liaison Services 131465 for advice. Ensure that the woman is in a safe and secure location. Monitor closely. Organise re-assessment within 24 hours. Follow-up outcome of Assessment. Monitor risk to infant. For Aboriginal women, contact Aboriginal Liaison Unit or Aboriginal Healthcare provider for cultural advice, support, and guidance to ensure clear understanding of her needs and ongoing care requirements.

Diagram adapted from Beyond Blue Clinical Practice Guidelines 2011

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Summary of Practice Recommendations

Thoughts of suicide and self-harm are relatively common. It is important to obtain enough information to assess if there is any risk of acting on these.

Such thoughts and behaviours are often accompanied by intense guilt and shame, particularly when pregnant, so it is important to offer a kind, non-judgemental stance.

The Edinburg postnatal depression scale (EPDS) screens for current thoughts of suicide or self-harm and should be offered at the antenatal booking appointment.

The antenatal risk questionnaire (ANRQ) screens for personal or family history of mental health disorders or abuse/trauma and should be offered at the antenatal booking appointment.

Note that the EPDS and ANRQ may not be culturally appropriate for some women, including Aboriginal women. It is important to seek cultural advice and support from an appropriate Aboriginal Liaison Officer or Aboriginal Health Care Worker to interpret suicidal ideation or self-harm in the cultural context.

If a personal history of mental health disorder is present, commence a plan for multidisciplinary monitoring that is acceptable and accessible for the consumer.

Identify a specific professional who will provide the direct mental health-related care and who advises the multidisciplinary team on how best to manage risk and symptoms.

It is important to note that some consumers with a history of past abuse/trauma and/or borderline personality disorder may engage in self-harm as a means of relieving emotional pain, rather than with suicidal intent – expert assistance may be required to distinguish this from suicidality.

When a woman is identified as at risk of suicide (through clinical assessment and/or the EPDS), take urgent action, manage immediate risk, arrange for urgent mental health assessment and consider support and treatment options.

Aboriginal people experience suicide at more than double the rate of non-Aboriginal people. The high proportion of suicide for Aboriginal people stems from marginalisation, dispossession and racism, cultural disconnectedness, sociodemographic vulnerability, intergenerational trauma and limited social supports. Perinatal service providers need cultural sensitivity within a non-judgemental environment when planning care for the Aboriginal woman.

Aboriginal women should be referred to an Aboriginal Health professional, Aboriginal family birthing program, Aboriginal Liaison Unit or Aboriginal Controlled Health Service for ongoing support in their perinatal journey.

Abbreviations

>	Greater than
≥	Greater than or equal to
<	Less than
≤	Less than or equal to
ANRQ	Antenatal Risk Questionnaire
e.g.	For example
EPDS	Edinburgh Postnatal Depression Scale
Et al.	And others
NB	Note bene or Note well
PPG	Perinatal Practice Guideline
PTSD	Post Traumatic Stress Disorder
SI	Suicidal Ideation
WHO	World Health Organization

Definitions

Self-harm (para-suicide)	An act with nonfatal outcome, in which an individual deliberately initiates a behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences.[1]
Suicidality	Refers to suicide deaths, attempts and ideation including thoughts of self-harm.[2]

Introduction

Compared to the general population, suicide rates are 3 to 8 fold less, in pregnancy and the first postnatal year.[2-4] Nevertheless, suicide is one of the leading causes of maternal mortality in the first 12 months post-partum and is the third highest cause of maternal mortality in Australia from 2009-2018.[5]

Risk factors for suicide in pregnancy vary to risk factors in the postpartum period.[6]

Three quarters of perinatal suicides occur in the postnatal period.

High risk of suicide correlates with intimate partner violence.

The risk for suicidality is significantly elevated among depressed women during the perinatal period, with suicide one of the leading causes of death in this depressed population.[9]

The more violent the methods of suicide attempt, the higher the level of intent.[3]

There is a close correlation between maternal suicide and severe postnatal mental illness.[9-11]

Self-harm ideation is more common than suicide attempts or deaths. Thoughts of self-harm during pregnancy and the postpartum range from prevalence of 5 to 14 %.[3] These are often associated with borderline personality disorder (BPD) or trauma syndromes.

Para-suicide is a major risk factor and significant predictor for completed suicide.[12]

Women with a mental health disorder and/ or, a comorbid substance abuse disorder have a higher risk of suicide attempt in the postnatal period.[8, 13, 14]

Risk Factors:

age < 20 years[7]
unmarried[7]
low education[6, 7]
smoking[7]
alcohol use[7]
history of partner abuse (particularly in the last 12 months[15])
unemployment (antenatal suicidal ideation (SI))[6]
prior termination of pregnancy[15]
mixed feelings about pregnancy or unwanted pregnancy[15]
History of:
depression (1 in 3 report thoughts of self harm[16])
psychosis / Bipolar disorder
mental illness (such as post-traumatic stress disorder)
previous suicide attempts
childhood sexual abuse.

NB: Multiple risk factors increase the overall level of risk.

Suicidal Behaviour

Suicidal intent is more serious than thoughts: if the woman has a plan, intent and means available, this warrants urgent referral to psychiatric services to facilitate hospitalisation.[17]
Deliberate self-harm is not always equivalent to suicidal intent; for example, self-harm is a common feature of personality disorders (follow link to *personality disorders and pregnancy* at www.sahealth.sa.gov.au/perinatal in the A-to-Z index).
Multiple risk factors increase the overall level of risk.[18]

Perinatal Assessment of Suicide Risk

Assessing the Risk

The EPDS is offered at the booking appointment and ideally re-screened between 28-32 weeks gestation. It screens for depression and anxiety and has a single question (Q.10), regarding suicide and self-harm: *"The thought of harming myself has occurred to me…:"* with the response options of, yes, quite often, sometimes, hardly ever, or never.
The ANRQ is also recommended to be administered at the booking appointment. This provides information about history of mental ill-health and trauma or abuse.
The primary health provider, therefore, has at least 2 sources of screening information which can direct further questioning, if indicated. It can also be useful later in pregnancy if new reports of suicidal concern arise to review what the EPDS and ANRQ responses were, or to administer these if previous results are unavailable.
Ask clear and simple questions, using a kind and non-judgemental approach.
It is helpful to ease any sense of stigma by normalising the need to ask these questions, for example:

"You seem really distressed, so I'd like to ask you some questions so I can understand what's going on for you"

OR

"In these situations, it's not uncommon for women to have thoughts about wanting to die or hurt themselves- can you let me know if this is going on for you?"

A trusting relationship is both helpful in supporting the woman to disclose her inner thoughts and experiences and is also potentially therapeutic by instilling hope that help, and recovery are possible.
All Aboriginal women should be referred to an Aboriginal healthcare worker or appropriate Aboriginal Liaison officer to ensure cultural safety and appropriateness when performing a perinatal mental health assessment.
The SA PPGs recognise that the screening tools available for depression and anxiety in pregnancy are not culturally appropriate for many Aboriginal women. We are hopeful that assessment tools to assess mental health for Aboriginal Women will be developed and look forward to implementing these.

Guiding Questions to Assess Risk

General questions to ask, include[18]:

Regarding	Questions	Considerations
Suicidal thoughts	• Do you have any suicidal thoughts? • How frequent and persistent are they?	
Plan	• Do you have a plan?	**Clinician needs to consider:** How detailed and realistic does the plan sound to you?
Lethality	• How would you do it?	
Means If the plan is about taking an overdose, ask…	• Do you have access to tablets?	**Clinician needs to consider:** Does the woman have the means to carry out the plan? e.g., does she have access to firearms or medication
Risk Ask questions to identify risks	• Do you have feelings of guilt or hopelessness? • Has anyone in your family ever attempted suicide? • Have you had similar thoughts or actions before? • Are you using any drugs or alcohol at present? • Are you alone at home or is there someone with you?	
Protective factors	• What has stopped you harming yourself up until now? • What is stopping you? (e.g., kids, pregnancy) • Do you have people to support you?	
Mental state	• Do you have feelings of: hopelessness, despair, agitation, shame, anger, guilt?	**Clinician needs to be aware** this would put the woman at increased risk
History	• Have you made an attempt to end your life previously? • Have you ever made plans?	
Substance use	• As above: Do you use drugs or alcohol?	**Clinician needs to be aware** that women who are currently abusing any substances (drugs or alcohol) have higher risk of impulsivity- this can be in the setting of both intoxication and withdrawal – note that this may raise potential for harm towards others as well as the self

Assessing Risk to the Fetus/ Baby

When suicidal or self-harm ideation and/or behaviours occur in a perinatal woman, there is evidently some risk to the fetus or infant.

In the antenatal woman, the risk obviously includes fetal demise if the woman were to successfully complete suicide, while unsuccessful attempts involving medication ingestion or serious asphyxia may lead to negative impacts on the fetus. More indirectly, related depressive or other disorders may lead to incomplete or non-attendance at antenatal care, a known risk factor for poor pregnancy outcomes.

See also Intent to harm fetus PPG (follow link to *Intent to Harm Fetus* at www.sahealth.sa.gov.au/perinatal in the A-to-Z index).

In the postpartum period, risk may arise if the woman's distress leads to her being unable to attend to her infant's needs appropriately, or if she experiences infanticidal ideation. Any assessment of the woman's mental health in the postpartum period should include checking for thoughts of harming the infant, and an assessment of her ability to keep the infant in mind appropriately.

Managing Immediate Risk

Do you have any concern about risk to yourself (as a clinician) or others?

For example: if there is any suggestion that she may be acutely intoxicated or withdrawing from substances or suffering from an acute disturbance of her mental health such as psychosis (confusion, hallucinations and/or delusions) affecting her judgement.

Be sure that the current situation is safe.

Is she agreeing to remain with you until a safety plan is worked out?

Do you need to involve colleagues or your manager, or request security attendance?

Be familiar with the processes of urgent or emergent response in your clinical area.

In major metropolitan hospitals there are response teams to manage acutely agitated consumers. At these locations there are also perinatal mental health teams who can provide semi-urgent advice or assessment during business hours.

In rural and remote areas, the Emergency Triage Liaison Service (ETLS) should be contacted on 13 14 65 and the woman should be followed up by an appointment with her General Practitioner of GP Obstetrician.

Does she have a support person with her who can assist in the action plan to manage risk?

Consider contacting next of kin, with the woman's permission, to include them in the plan.

For further information on **Perinatal Mental Health Referral Pathways**, including **"Immediate Response Required"**, see: "Anxiety and Depression in the Perinatal Period" in the A-to-Z index at URL: www.sahealth.sa.gov.au/perinatal).

Antenatal care

The risk of suicide can be decreased where past history is accurately recorded and proactive management is put in place.[11]

All women should be screened at the antenatal booking appointment for a personal or family history of mental illness (see Screening for Perinatal Anxiety and Depression PPG available at www.sahealth.sa.gov.au/perinatal), this will help to recognise women who need preventative interventions.

If history present:

document details clearly in the woman's handheld pregnancy record and clinical case notes.

commence a plan for multidisciplinary monitoring and support e.g., referral to high-risk pregnancy care, mental health liaison, social worker, psychiatric review, case management etc. and ensure good communication between all members of the treating

team through pregnancy, during labour if necessary and in the immediate postpartum period.

Interact and communicate clearly and effectively with women at risk.

Counsel regarding possibility of recurrence of illness.

Where possible, arrange ongoing care with a service that provides continuity of carer e.g., high risk pregnancy service, midwifery continuity of carer models.

Aboriginal Family Birthing Programs (AFBP), or shared care with Aboriginal Community Controlled Health Organisations, or Aboriginal Community Health Services. If a woman is involved in AFBP, she may wish to also involve an allocated Aboriginal Maternal Infant Care (AMIC) worker.

Management should be individualised, culturally safe, sensitive and appropriate, paying specific attention to risk factors and protective factors.[12]

All women who have a history of severe mental illness (e.g., major depression, bipolar disorder, psychotic disorders) should be assessed by a relevant mental health professional (e.g., perinatal mental health team, psychiatrist) and followed up as deemed necessary by them.

Postpartum Care

Collaboration between the woman, her midwives, and perinatal mental health services should focus on:

rapport building

emphasis on person-centred care – find out what she thinks will help her to stay safe

risk assessment including questioning the woman about recurrence of suicidal thinking history of suicidal behaviour

early assessment and guidance postpartum from the identified key mental health clinician

note the mother's attitude and behaviours toward her infant – many women in this situation will still be able to feel connected and engage in appropriate care for their baby, however some may not, or can only do so with extreme difficulty or heightening of their distress – make a plan for care of the infant that is safe and also prioritises safe and appropriate time together for mother and baby to support bonding

identify and consult closely with the mother's preferred family supports, ie partner, family, friends – with her permission, ensure that they understand her mental state and how to support her and the baby safely

be aware that a woman's mental state can change rapidly over the first few day and weeks postpartum – ensure frequent opportunities for review by health professionals if indicated by risk factors, and ensure that she and family are aware of means to contact help during and after business hours

consideration of admission to mother-baby unit if concerns about the woman's increasing suicidal thinking and/or lowering of mood and/or difficulties developing in relationship to infant including questions about risk to infant

careful observation during admission if assessed as high risk. Consider close nursing observation, or a nursing special to mitigate risk to herself and/or risk to the infant Consult individual hospital policies on suicidal patients

maintain clear communication, collaboration between all levels of staff

early referral where risk identified.

Aboriginal woman should be consulted on the care of the newborn baby in the first instance. Consult with the preferred Aboriginal health professional if requested. If not requested, the woman should be offered cultural support.

Documented Plan of Care

Discharge planning should include appropriate communication with the general practitioner and other community-based professionals involved in the consumer's care.

Aboriginal women should be consulted on any follow up plans and be involved in their discharge planning in collaboration with Aboriginal Health Professional.

Useful Resources

SA Health Dec 2012 Guidelines for Working with the Suicidal Person – Shared learning in Clinical Practice

Beyond Blue:

https://www.beyondblue.org.au/

National Perinatal Mental Health Guideline:

http://cope.org.au/health-professionals-3/

SAPPGs Web-based App:

Practice Guidelines (sahealth.sa.gov.au)

Medicines Information:

Medicines Information Homepage - SA Pharmacy Medicines Information Service - LibGuides at South Australian Health Library Service (sahealthlibrary.sa.gov.au)

SA Health Pregnancy:

Pregnancy | SA Health

Australian Government Pregnancy, Birth and Baby:

Pregnancy, Birth and Baby | Pregnancy Birth and Baby (pregnancybirthbaby.org.au)

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