South Australian Perinatal Practice Guidelines

Suicidal ideation and self harm

Introduction

- Compared to the general population, suicide rates are 3-8 fold less in pregnancy and the first postnatal year (Hawton 2000; Lindahl et al. 2005; Shadigian & Bauer 2005)

Definitions

- Self harm (para suicide) is defined as “an act with nonfatal outcome, in which an individual deliberately initiates a non-habitual 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” (Platt et al. 1992).
- Suicidality refers to suicide deaths, attempts and ideation including thoughts of self harm (Lindahl et al. 2005)

Literature review

- Self-harm ideation is more common than attempts or deaths. Thoughts of self-harm during pregnancy and the postpartum range from 5 to 14 % (Lindahl et al. 2005). These are often associated with Borderline Personality Disorder or trauma syndromes
- Para suicide is a major risk factor and significant predictor for completed suicide (Brown 2001; Marishane & Moodley 2005)
- The risk for suicidality is significantly elevated among depressed women during the perinatal period, with suicide the second or leading cause of death in this depressed population
    - The more violent the methods of suicide, the higher the level of intent (Lindahl et al. 2005)
    - Oates (2001) states that there is a close correlation between maternal suicide and severe postnatal mental illness

Risk factors

- Age < 20 years
- History of partner abuse
- Depression
- High risk
    - Psychosis / Bipolar disease
    - Psychiatric history (such as post traumatic stress disorder)
    - Previous suicide attempts
    - History of childhood sexual abuse (Lindahl et al. 2005)
- Personality characteristics
    - Introversion
    - Neuroticism

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 (KEMH 2007)

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Perinatal assessment

Questions to ask

Ask clear and simple questions using a matter of fact approach

- 'Do you have any suicidal thoughts?'
- 'Have you ever had any suicidal thoughts?'
- 'Have you ever made any plans?'
- 'Have you ever made or come close to attempting suicide?'
- 'Do you feel you can remain safe?'
- 'Are you currently using any substances?'
- 'Who would you call / contact to help you be safe?'

Factors to assess

- Access to medications, firearms
- Family history of suicide
- Changes to sleep, appetite, energy and libido (NB: classically more difficult to assess in pregnancy compared to any other times so perhaps need greater reliance on mood and loss of pleasure to diagnose major depression - for further information follow link to screening for depression and anxiety in pregnancy)
- Persistent thoughts of death or dying
- Feelings of hopelessness
- Level of impulsivity (including history of impulsivity)
- Known mental health illness
- Substance abuse history
- Socially isolated
- Recent loss or death – grief
- Any other health issues
- Protective factors
- Thoughts to harm baby, others

Antenatal care

- The risk of suicide can be decreased where past history is accurately recorded and proactive management is put in place (Oates 2001)
- All women should be screened at antenatal booking for a personal or family history of mental illness
  - If present, document details clearly in the woman's pregnancy record and case notes and commence a plan for multidisciplinary close monitoring e.g. referral to high risk pregnancy care, mental health liaison, social worker, psychiatric review, case management etc
  - Where possible, arrange ongoing care with a service that provides continuity of carer e.g. midwives clinic, high risk pregnancy service, midwifery continuity of carer models
- At each antenatal visit, assess for suicidality especially if her mood declines
  - All women who have a history of severe mental illness (e.g. major depression, bipolar disorder, psychotic disorders) should be assessed by the perinatal mental health team, general practitioner, psychiatrist and followed up as deemed necessary by them
- Management should be individualised, paying specific attention to risk factors and protective factors (Marishane & Moodley 2005)
- Prevention of potential suicidal behaviour
- Recognition of women who need preventative interventions
- Offering ongoing appropriate support

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- Interacting and communicating effectively with women at risk
- Counselling re possible recurrence of illness

Postpartum care

Collaboration between midwives and perinatal mental health services

- Risk assessment (see perinatal assessment questions above)
- History of suicidal behaviour
- Consider admission to mother-baby unit
- Intense observation during admission if a high risk. Consider close nursing observation, nursing special etc. Consult individual hospital policies on suicidal patients
- Maintain clear communication, collaboration between all levels of staff
  - Early referral where risk identified
  - Documented plan of care
- Discharge planning

References

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3. King Edward Memorial Hospital Perinatal Depression and Anxiety disorders clinical Guidelines 2007. Available from URL: http://www.wnhs.health.wa.gov.au/brochures/health_professionals/8393.pdf
4. Marishane T, Moodley J. Parasuicide in pregnancy. International Journal of Gynaecology & Obstetrics 2005; 89: 268-71.
5. Oates M. Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality. British Medical Bulletin 2003; 67: 219-29.
6. Shadigian E & Bauer S. Pregnancy-associated death: a qualitative systematic review of homicide and suicide. Obstetrical & Gynecological survey 2005; 60: 183-90.
7. Platt S, Bille Brahe U, Kerkhof A, Schmidtke A, Bjerke T, Crepet P, et al. Parasuicide in Europe: The WHO/EURO Multicentre Study on Parasuicide. I. Introduction and preliminary analysis for 1989. Acta Psychiatrica Scandinavica 1992, 85: 97–104.

Additional reference:

Policy EDM P8-02
Emergency demand management and the assessment and crisis intervention service.
Refer to Appendix I – Risk assessment and referral form.
Available from URL:
http://www.publications.health.sa.gov.au/cgi/viewcontent.cgi?article=1023&context=mhs

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Abbreviations

et al.	And others
PTSD	Posttraumatic stress disorder
KEMH	King Edward Memorial Hospital
NB	Nota bene or Note well
e.g.	For example
WHO	World Health Organisation

Version control and change history

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