Suicide Risk Assessment and Management in Obstetric and Family Medicine Practices

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Disclosures

Dr Ramanathan does not have any relevant financial relationship with a commercial interest to disclose.

Learning Objectives

1. Recognize the need to systematically evaluate for suicide in the perinatal setting.

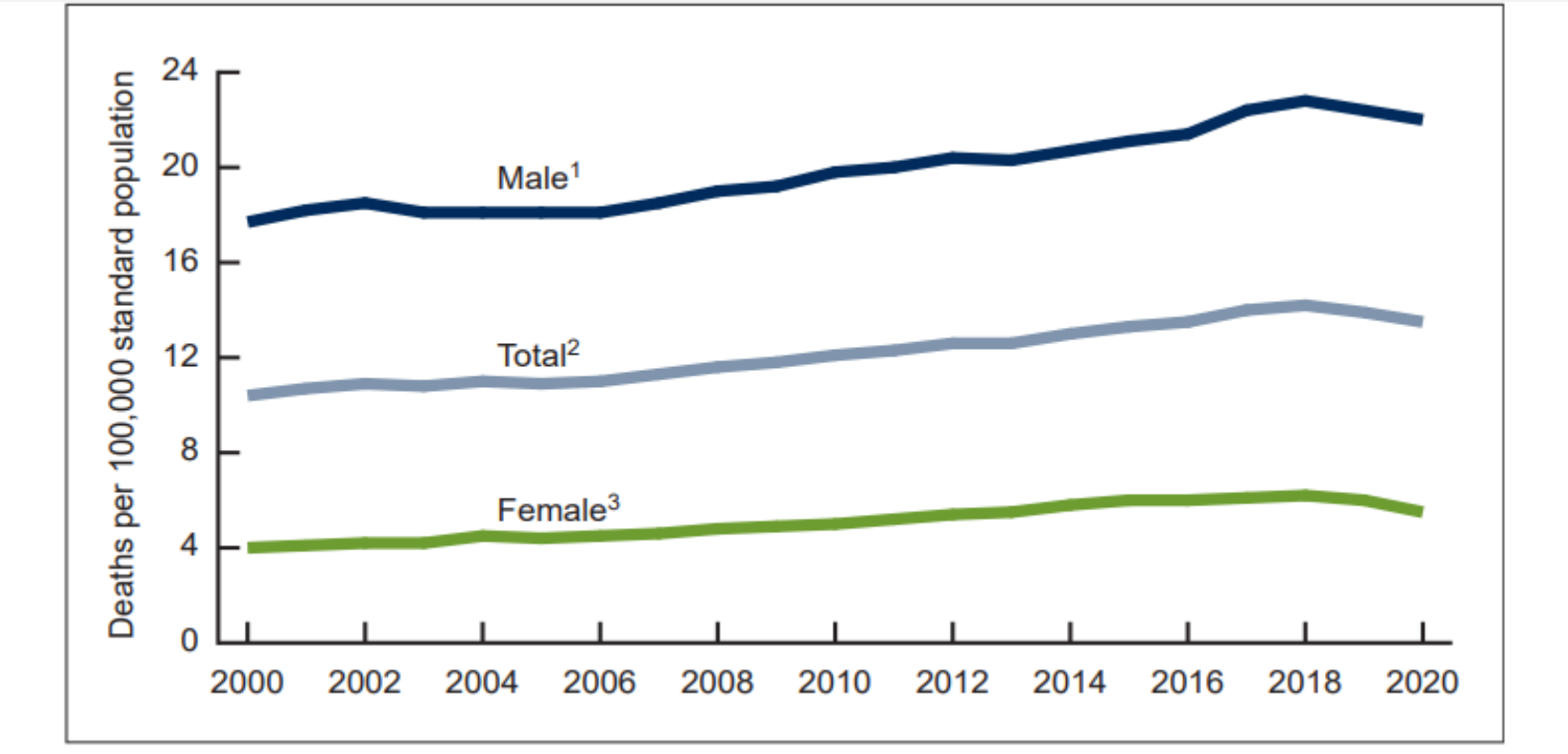
2. Describe strategies to identify suicidality in pregnancy and the postpartum period.

3. Describe methods to address suicidality in the perinatal period.

"Suicide is still a topic that is not talked about nearly enough, and it is a detriment to us all because it leaves people living with suicidal feelings and ideation in silence. I'm alive today because there are people around me who I can reach out to when I am suffering."

-Rudy Caseres

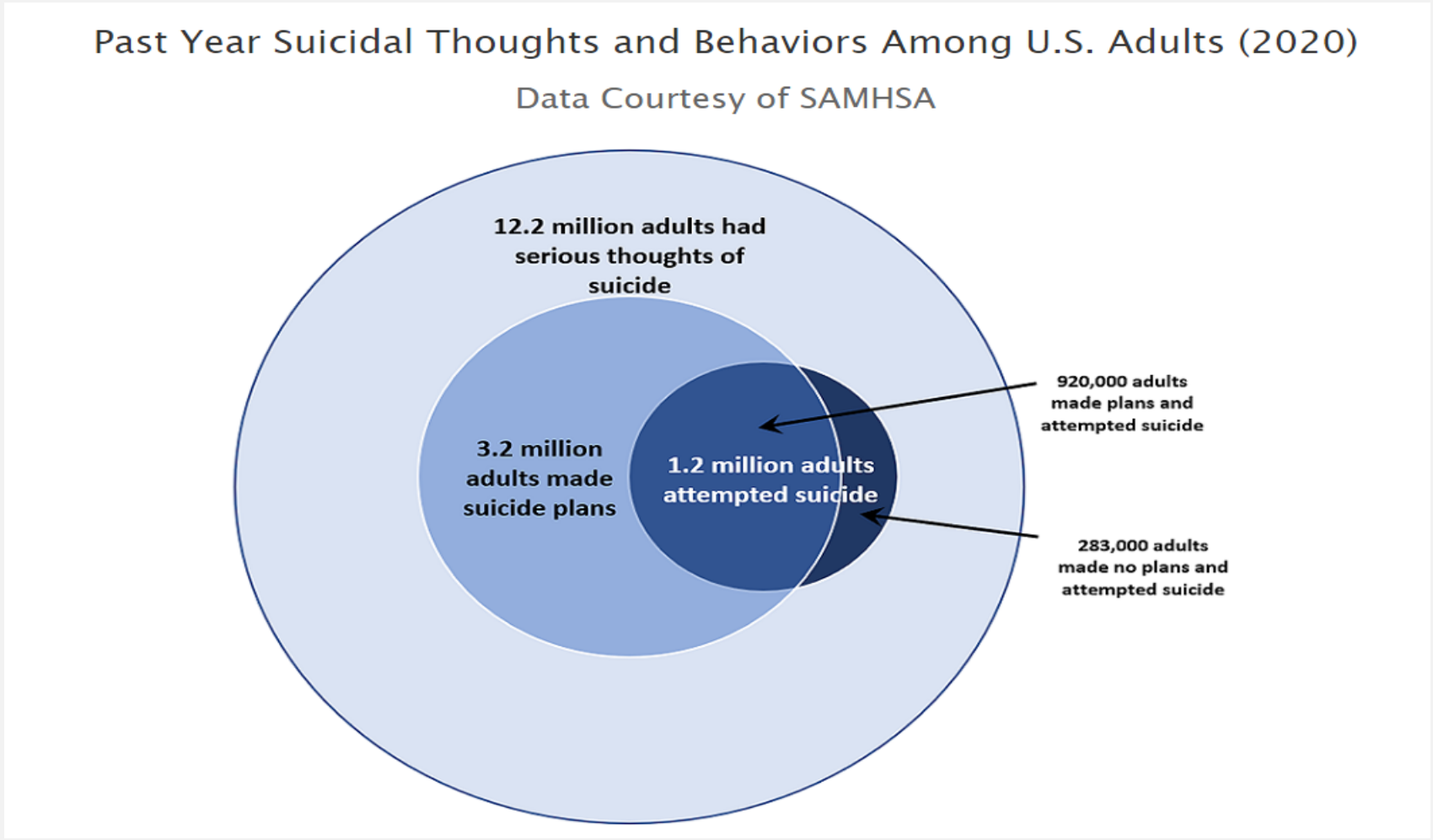
The Problem of Suicide in the US



NCHS Data Brief, Number 433, Month 20## (cdc.gov)

Epidemiology of Suicide

- 10th leading cause of death, 12th in the years 2020-2021 (Covid and Liver problems moving up)
- Age-adjusted suicide rate was 13.48 per 100,000 in 2020
- 130 Americans die by suicide every day
- 12.4 million Americans experienced suicidal ideation



[NIMH » Suicide (nih.gov)]

12th leading cause of death in New York

2nd leading
cause of death for ages 10-34

4th leading
cause of death for ages 35-54

9th leading
cause of death for ages 55-64

18th leading
cause of death for ages 65 & older

Suicide in the peripartum period

- 1.6-4.5 per 100,000 live births
- Methods are more lethal – (handing, jumping) **
- Is pregnancy protective? - shift in thought
- More common in first trimester
- Postpartum period
  - Data since 2012
  - Highest risk in 9-12 months postpartum

Suicide in the peripartum period

- 11- 20 percent postpartum deaths due to mental health conditions
- More likely to be determined by an MMRC to be preventable (100 percent versus 64 percent)
- More likely to occur between 43–365 days postpartum (63 percent versus 18 percent)
- In NYS (2018, MMRC) - Mental health conditions (15%); and all deaths were deemed preventable

Unique risk factors

- New onset mental illness
- Poor social support and loneliness
- Adolescent mothers
- Low socioeconomic status
- **Financial instability!**

Unique risk factors

- **Abrupt discontinuation of psychotropic medications during pregnancy**
- Sleep disturbances during the postpartum period
- Unwanted and unintended pregnancies
- IPV - OR of 9.37
- Complications of pregnancy & pregnancy loss

Risk Factors

Past history of suicide attempts	Recent loss
Family history of suicide	TBI
Current history of depression/ PTSD	Childhood abuse
Recent serious diagnosis	Access to lethal means
Substance use disorder	Exposure to suicide
Chronic pain	Impulsivity

Protective Factors

Sense of responsibility to family	Problem-solving skills
Life satisfaction	Strong therapeutic relationship with a trusted provider
Social support; belongingness	Reality testing ability
Coping skills	Religious faith

Key Takeaway

- Suicide is an important cause of peripartum deaths
- Most people with mental illness do NOT become suicidal
- **Discontinuation of psychotropic medications and IPV can increase risk**

"Over the decades, individual [mental health] clinicians have made heroic efforts to save lives…but systems of care have done very little."

- Dr. Richard McKeon, Chief, Suicide Prevention Branch, U.S. Substance Abuse and Mental Health Services Administration

OBs, Family Physicians and Suicide Prevention

- Widely used health system in the peripartum period
- Trust, long-term relationships - FPs

Missed Opportunities?

- PCPs enquired into suicidality 36%
- 45% individuals who died by suicide saw their PCP within the last month
- 80% saw their PCP within the last year
- 18-40% within the last week
- 85-95% have a treatable mental illness

Don’t ask, don’t tell, don’t know

- Heighten suicidality
- Make patient uncomfortable
- Inadequate expertise
- Insufficient time
- More likely to enquire if patient was depressed
- IS THERE A NEED TO ENQUIRE?

Can rates of suicide be lowered by training GPs?

Multiple studies in Europe

Hungary: 28 GPs trained over a 5- year period in a high suicide region; Lowering of suicide rate

Key Takeaway

- OBs and FP settings can be an important touchpoint in suicide prevention in the peripartum period

Definitions

- Suicide: death caused by self-directed injurious behavior with intent to die as a result of the behavior.

- Suicidal ideation: thinking about, considering, or planning suicide

- Suicidal attempt: non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury.

- Self-injurious behaviors

Warning signs for suicide

- **Strongest:**

- Threatening to kill themselves

- Talking about wanting to hurt themselves

- Attempting suicide/ looking for ways to hurt themselves

- Hopelessness

Other Warning Signs

Agitation	Feeling like a burden
Acting reckless	Talking about being in PAIN
Insomnia	Shame
Increased substance use	Feeling trapped
Isolation	Rage/ revenge
Mood swings	

Systematically….

- Train all staff – QPR
- Develop an office protocol (Screening, risk assessment, management, referral for treatment, follow-up)
- *Leverage EHR*

Screening for Suicide in the perinatal period

- USPTF (2014) - NO RECOMMENDATIONS for screening tools for suicide in primary care

- ACOG – screening for depression once in the perinatal period

Suicide Risk Screening- ZS framework

- Screen with a plan
- PHQ -9
- PHQ-3: PHQ-2 + suicide
- Cascading to CSSRS

Patient Health Questionnaire (PHQ- 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

PHQ-2 +

Over the last *2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

For office coding: _____0_____+_____+_____+_____

= Total Score _____

9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

EPDS

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

CSSRS

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***	**YES**	**NO**

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

- CSSRS demonstration video
- https://www.youtube.com/watch?v=XS2nB9DySAo
- https://www.youtube.com/watch?v=Ted_gl-UXi8 (6:57 – 8:08)

ASQ

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Never ask leading questions such as *"You're not thinking of hurting or killing yourself, are you?"*

Sample screening question: *"We ask every one of our patients about whether they have felt suicidal or have been considering hurting themselves. Have you had thoughts of hurting yourself or killing yourself?"*

"Sometimes people with your condition (or in your situation) feel like they don't want to live anymore, or sometimes they think about killing themselves. Have you been having any thoughts like these?"

Suicide Care Management

- Safety Plan
- **Family and social support engagement**
- **Lethal Means reduction**
- **Referral to treatment**
- Documentation and follow-up calls

Safety Plan/ Crisis Response Plan

- Identifying warning signs and triggers
  - *How do you feel in the days before the attempt?*
  - *What are your triggers?*
- Coping mechanisms
  - *What relaxes you?*
  - *What can you do to feel good?*
- Distracting from the crisis
  - *Who helps you feel better when you socialize?*
  - *Can you go somewhere to take your mind off?*

- Family, friends and other supports who can help you?
  - *Who do you feel comfortable discussing thoughts of suicide*

- Professionals you can ask for help
  - *Resources*

Resources

- CTL – Crisis Text Line (Got5 to 741741)
- National suicide prevention hotline: 800-273-8255
- 988 – coming soon JULY 16, 2022
- Maternal Mental Health Hotline: 1-833-9-HELP4MOMS: **NOT A CRISIS HOTLINE!**
- Project TEACH - 1-855-227-7272 : **NOT A CRISIS HOTLINE!**
- Local contact : 315 251 4400 – Onondaga County!

Family and Social Support

- Educate family members
- Build support system – belongingness
- Include in safety plan

Lethal means reduction

- What is the plan? Rarely substitution

  - Gun safety
  - Medications

- Put some distance and time

Follow-up Care

- Documentation of your assessment and management

- Follow-up calls/ Caring contacts

Lowering overall risk

- Treating Depression
  - Antidepressants: 2004 BBW on antidepressants
  - Collaborative Care: PROSPECT, IMPACT
- SBIRT to address substance use disorders
- Lithium/ Clozapine/ Esketamine/ ECT – refer to Project TEACH/ a perinatal psychiatrist

Suicide risk is dynamic

- Can we hand out resources to everybody?
- Lowering overall risk?

Key Takeaway

- Develop a systematic plan for managing suicidality
- Address risk reduction through treatment of depression
- **Suicide risk is dynamic**
- Engage families and social support system
- Lethal means reduction

Recommended trainings

- QPR
- ASSIST
- Suicide Prevention Resource Center: Suicide Prevention Toolkit for Primary Care Practices (https://www.sprc.org/settings/primary-care/toolkit)
- Zero Suicide toolkit (Prevention in Primary Care: A Toolkit for Primary Care Clinicians and Leaders)
- Safesideprevention.com (https://safesideprevention.com/programs/primary-care)

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