Clinical Guideline
South Australian Perinatal Practice Guidelines – suicidal ideation and self-harm

Policy developed by: SA Maternal & Neonatal Clinical Network
Approved SA Health Safety & Quality Strategic Governance Committee on: 10 June 2014
Next review due: 30 June 2017

Summary
Clinical practice guideline for the management of women with suicidal ideation or self-harm in the peripartum period.

Keywords
suicide, suicidal, para suicide, self-harm, risk assessment, behaviour, borderline personality disorder, mental health, mental illness, ideation, Perinatal Practice Guidelines, suicidal ideation and self-harm, clinical guideline

Policy history
Is this a new policy? N
Does this policy amend or update an existing policy? Y
Does this policy replace an existing policy? Y
If so, which policies?
Suicidal ideation or self-harm

Applies to
All SA Health Portfolio
All Department for Health and Ageing Divisions
All Health Networks
CALHN, SALHN, NALHN, CHSALHN, WCHN, SAAS
Other

Staff impact
N/A, All Staff, Management, Admin, Students, Volunteers
All Clinical, Medical, Nursing, Allied Health, Emergency, Dental, Mental Health, Pathology

PDS reference CG135

Version control and change history

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<th>Version</th>
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<tr>
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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

Introduction

> Compared to the general population, suicide rates are 3-8 fold less in pregnancy and the first postnatal year.\(^1\)\(^-\)\(^3\)

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”.\(^4\)

> Suicidality refers to suicide deaths, attempts and ideation including thoughts of self harm.\(^2\)

Literature review

> 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 \(^%\).\(^2\) These are often associated with Borderline Personality Disorder or trauma syndromes

> Para suicide is a major risk factor and significant predictor for completed suicide.\(^5\) Women with mental health disorder and/or a comorbid substance abuse disorder have a higher risk of suicide attempt in the postnatal period.\(^6\)\(^-\)\(^8\)

> High risk of suicide correlates with intimate partner violence\(^9\)

> 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 t
There is a close correlation between maternal suicide and severe postnatal mental illness\textsuperscript{10-12}

**Risk factors\textsuperscript{2,8,13}**

- Age < 20 years
- History of partner abuse
- Depression
- History of:
  - Psychosis / Bipolar disease
  - 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\textsuperscript{14}

**Perinatal assessment of suicide risk\textsuperscript{15}**

**Assessing the risk of suicide**

- Ask clear and simple questions using a matter of fact approach

**Questions to ask include:**

<table>
<thead>
<tr>
<th><strong>Suicidal thoughts:</strong></th>
<th>’Do you have any suicidal thoughts?’</th>
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<tbody>
<tr>
<td></td>
<td>How frequent and persistent are they?</td>
</tr>
<tr>
<td><strong>Plan:</strong></td>
<td>Do you have a plan?</td>
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<tr>
<td></td>
<td>Clinician needs to consider: How detailed and realistic does the plan sound to you?</td>
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<tr>
<td><strong>Lethality:</strong></td>
<td>How would you do it?</td>
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<tr>
<td><strong>Means:</strong></td>
<td>Do you have access to tablets?</td>
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<tr>
<td>If the plan is about taking an overdose, ask...</td>
<td>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</td>
</tr>
<tr>
<td><strong>Risk:</strong></td>
<td>Do you have feelings of guilt or hopelessness?</td>
</tr>
<tr>
<td>Ask questions to identify risks</td>
<td>Has anyone in your family ever attempted</td>
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</table>
suicidal ideation and self harm

<table>
<thead>
<tr>
<th>Protective factors:</th>
<th>Mental state:</th>
<th>History:</th>
<th>Substance use:</th>
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<tbody>
<tr>
<td>&gt; Have you had similar thoughts or actions before? Are you using any drugs or alcohol at present?</td>
<td>&gt; Do you have feelings of: hopelessness, despair, agitation, shame, anger, guilt?</td>
<td>&gt; Have you made an attempt to end your life previously?</td>
<td>&gt; As above: if the woman is currently abusing any substances (drugs or alcohol) this increases the risk of impulsivity</td>
</tr>
<tr>
<td>&gt; Are you alone at home or is there someone with you?</td>
<td>&gt; Clinician needs to be aware this would put the woman at increased risk</td>
<td>&gt; Have you ever made plans?</td>
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<tr>
<td>&gt; What has stopped you harming yourself up until now?</td>
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<td></td>
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<tr>
<td>&gt; What is stopping you? (e.g. kids, pregnancy)</td>
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<td></td>
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<td>&gt; Do you have people to support you?</td>
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(Adapted from the Australian National Suicide Prevention Strategy)
Managing immediate risk - (responding to Question 10 of the EPDS)

Diagram adapted from beyondblue Clinical Practice Guidelines 2011

<table>
<thead>
<tr>
<th>LOW RISK</th>
<th>MODERATE RISK</th>
<th>HIGH RISK</th>
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<tbody>
<tr>
<td>Fleeting thoughts of self-harm or suicide but no current plan, means or intent</td>
<td>Suicidal thoughts and intent but no current plan or immediate means</td>
<td>Continual/specific suicidal thoughts, intent, plan and means</td>
</tr>
<tr>
<td>&gt; Refer to perinatal mental health team if available or call Emergency Triage Liaison Services 131465</td>
<td>&gt; Refer to perinatal mental health team if available or call Emergency Triage Liaison Services 131465</td>
<td>&gt; 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</td>
</tr>
<tr>
<td>Discuss availability of support and treatment options</td>
<td>Discuss support and treatment options</td>
<td>&gt; Ensure that the woman is in a safe and secure location</td>
</tr>
<tr>
<td>&gt; Arrange follow-up consultation (base urgency on clinical judgement)</td>
<td>&gt; Organise follow up review within 1 week</td>
<td>&gt; Monitor closely</td>
</tr>
<tr>
<td>&gt; Identify relevant community resources and provide contact details</td>
<td>&gt; Advise woman of crisis services in case symptoms escalate</td>
<td>&gt; Organise re-assessment within 24 hours</td>
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<td></td>
<td>&gt; Develop a safety plan with the woman</td>
<td>&gt; Follow-up outcome of Assessment</td>
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<td>&gt; Monitor risk to</td>
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Antenatal care

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

> All women should be screened at antenatal booking appointment for a personal or family history of mental illness link to screening for perinatal anxiety and depression

> This will help to recognise women who need preventative intervention
suicidal ideation and self harm

> If history present:
  > document details clearly in the woman’s hand held 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
  > Interact and communicate clearly and effectively with women at risk
  > Counselling re possible 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
  > Management should be individualised, paying specific attention to risk factors and protective factors

> At each antenatal visit, assess for suicidality especially if the woman’s mood declines
  > 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 midwives and perinatal mental health services

This should focus on
  > Risk assessment
  > History of suicidal behaviour
  > Consideration of 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

16. Hall K. Suicide prevention topic 7: Does asking about suicidal ideation increase the risk of suicide attempts? NZHTA report 2002
Useful references:
SQUARE Suicide questions answers resources. Mental health in-patient setting.

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


Contact:
South Australian Perinatal Practice Guidelines workgroup
at:cywhs.perinatalprotocol@health.sa.gov.au
Abbreviations

<table>
<thead>
<tr>
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<th>Description</th>
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<tr>
<td>e.g.</td>
<td>For example</td>
</tr>
<tr>
<td>et al.</td>
<td>And others</td>
</tr>
<tr>
<td>KEMH</td>
<td>King Edward Memorial Hospital</td>
</tr>
<tr>
<td>NB</td>
<td>Nota bene or Note well</td>
</tr>
<tr>
<td>PTSD</td>
<td>Posttraumatic stress disorder</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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