

South Australian Perinatal Practice Guideline

Suicidal ideation and self-harm

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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

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 women. 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 respectively 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

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 self-harm

Flowchart I: Managing immediate risk – responding to Question 10 of the EPDS

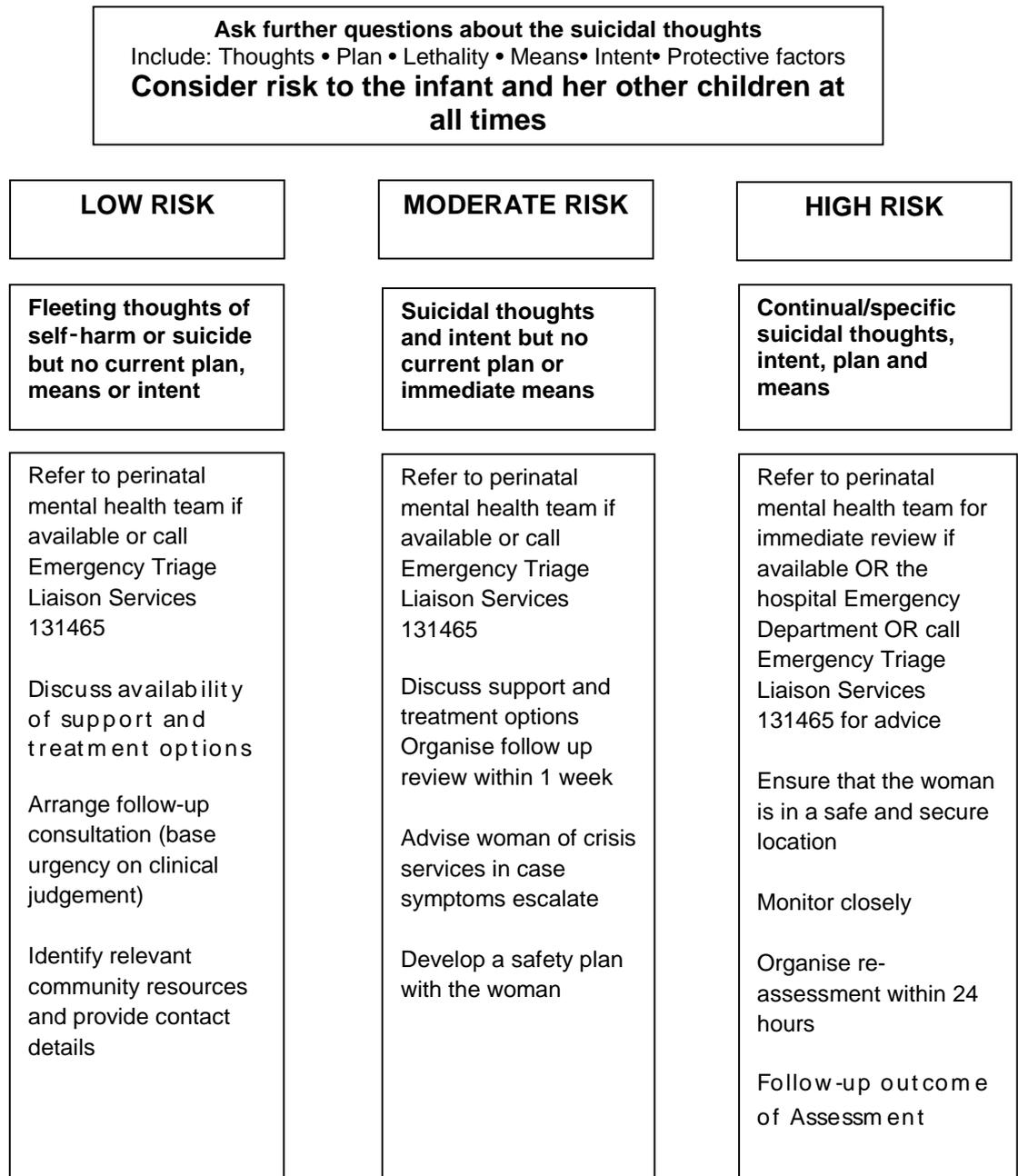


Diagram adapted from beyondblue Clinical Practice Guidelines 2011



Suicidal ideation and self-harm

Table I: Assessing the risk of suicide – questions to ask

Questions to ask include:		
Suicidal thoughts:	<ul style="list-style-type: none"> > 'Do you have any suicidal thoughts?' > How frequent and persistent are they? 	
Plan:	<ul style="list-style-type: none"> > Do you have a plan? 	<ul style="list-style-type: none"> > Clinician needs to consider: How detailed and realistic does the plan sound to you?
Lethality:	<ul style="list-style-type: none"> > How would you do it? 	
Means: If the plan is about taking an overdose, ask...	<ul style="list-style-type: none"> > Do you have access to tablets? 	<ul style="list-style-type: none"> > 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	<ul style="list-style-type: none"> > 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:	<ul style="list-style-type: none"> > 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:	<ul style="list-style-type: none"> > Do you have feelings of: hopelessness, despair, agitation, shame, anger, guilt? 	<ul style="list-style-type: none"> > Clinician needs to be aware this would put the woman at increased risk
History:	<ul style="list-style-type: none"> > Have you made an attempt to end your life previously? > Have you ever made plans? 	
Substance use:	<ul style="list-style-type: none"> > As above: if the woman is currently abusing any substances (drugs or alcohol) this increases the risk of impulsivity 	

(Adapted from the Australian National Suicide Prevention Strategy)



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Summary of Practice Recommendations

All women should be screened at antenatal booking appointment for a personal or family history of mental illness.

If history of mental illness is present commence a plan for multidisciplinary monitoring.

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.

Abbreviations

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

Definitions

Self-harm (para suicide)	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 ¹
Suicidality	Refers to suicide deaths, attempts and ideation including thoughts of self-harm ²



Introduction

- > Compared to the general population, suicide rates are 3-8 fold less in pregnancy and the first postnatal year²⁻⁴

Background

- > 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 or trauma syndromes
- > Para suicide is a major risk factor and significant predictor for completed suicide.⁵ Women with a mental health disorder and / or a comorbid substance abuse disorder have a higher risk of suicide attempt in the postnatal period⁶⁻⁸
- > High risk of suicide correlates with intimate partner violence⁸
- > 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 population⁹
 - > The more violent the methods of suicide attempt, the higher the level of intent³
 - > There is a close correlation between maternal suicide and severe postnatal mental illness¹⁰⁻¹²

Risk factors^{3,8,13}

- > 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 hospitalisation¹⁴

Perinatal assessment of suicide risk¹⁵

Assessing the risk of suicide – [Table I](#)

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

Managing immediate risk - [Flowchart I](#): Responding to Question 10 of the EPDS

- > Diagram adapted from beyondblue Clinical Practice Guidelines 2011



Antenatal care

- > The risk of suicide can be decreased where past history is accurately recorded and proactive management is put in place¹²
- > All women should be screened at 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 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 factors⁵
- > 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



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Useful references:

1. SA Health Dec 2012 Guidelines for Working with the Suicidal Person – Shared learning in Clinical Practice
2. The Australian National Suicide Prevention Strategy. Available from www.livingisforeveryone.com.au
3. Beyond Blue <https://www.beyondblue.org.au/>
4. National Perinatal Mental Health Guideline available at <http://cope.org.au/health-professionals-3/>



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