

Assessing Risk of Suicide

Reports thoughts of self-harm and/or +self-harm question on the EPDS/PHQ-9 (any response other than “never”)
Follow EPDS/PHQ-9 +self-harm with the Patient Safety Screener (suicide risk screener) to further stratify risk

Ask about thoughts of self-harm or wanting to die

Thoughts of death or of self-harm are common among women with perinatal mental health conditions. The following wording can help to get information about these thoughts.

Introduce assessment to patient

“Many people have intrusive or scary thoughts. When people are sad or down, they often have thoughts about death or wanting to die. These thoughts can feel awful. They can sometimes feel reassuring or like an escape from a hard life or something else that feels too hard to bear. We are here to help you. We ask about these thoughts because they are so common.”

To build up to assessing suicide risk, ask:

1. “Have you been feeling sad or down in the dumps?”
2. “Is it difficult to shake those sad feelings?”
3. “Do you sometimes wish you weren’t here, didn’t exist?”
4. “Have you thought about ways to make that happen?”

To assess risk of suicide, ask:

1. “In the past two weeks, how often have you thought of death or wanting to die?”
2. “Have you thought about ways in which you could harm yourself or attempt suicide?”
3. “Have you ever attempted to hurt yourself or attempted suicide in the past?”
4. “What prevents you from acting on thoughts of death or wanting to die?”

Assess Risk

	LOW RISK	MODERATE RISK	HIGH RISK
Assessment	<p>Fleeting thoughts of death or wanting to die</p> <p>No current intent*</p> <p>No current plan**</p> <p>No history of suicide attempt</p> <p>Future-oriented (discusses plans for the future)</p> <p>Protective factors (e.g., social support, religious prohibition, other children, stable housing)</p> <p>No substance use</p> <p>Few risk factors (e.g., mental health or medical illness, access to lethal means, trauma hx, stressful event)</p>	<p>Regular thoughts of death or wanting to die</p> <p>Has thoughts of possible plans yet plans are not well-formulated or persistent</p> <p>History of suicide attempt</p> <p>Persistent sadness and tension, loss of interest, persistent guilt, difficulty concentrating, no appetite, decreased sleep</p> <p>Sometimes feels hopeless/helpless</p> <p>Somewhat future oriented</p> <p>Limited protective factors (e.g., social support, religious prohibition, other children)</p> <p>+/-Substance use</p> <p>Anxiety/agitation/impulsivity</p> <p>Poor self-care</p> <p>Some risk factors</p>	<p>Persistent thoughts of death/that life is not worth living</p> <p>Current intent*</p> <p>Current well-formulated plan**</p> <p>Hx of multiple suicide attempts, high lethality of prior attempt(s)</p> <p>Hx of multiple or recent psychiatric hospitalizations</p> <p>Continuous sadness, unrelenting dread, guilt, or remorse; not eating, < 2-3 hours of sleep/night, unable to do anything, unable to feel pleasure or other feelings`</p> <p>Hopeless/helpless all or most of the time</p> <p>Not future oriented (no plans for/cannot see future)</p> <p>No protective factors (e.g., social supports, religious prohibition, other children, stable housing)</p> <p>Substance use</p> <p>Not receiving mental health treatment</p> <p>Anxiety/agitation</p> <p>Many risk factors</p>

Tell the patient that: *“I hear that you feel distressed and overwhelmed. So much so that you’re having thoughts of death and dying.”*
(use patient’s language to describe)
“When people are overwhelmed, they often feel this way. It is common.”
“I’m so glad you told me. I’m here to help. There are many things we can do to help you.”

Intervene and Document Plan

	LOW RISK	MODERATE RISK	HIGH RISK
Treatment	<p>Treat underlying illness</p> <p>Maximize medication treatment and therapy</p> <p>Monitor closely</p> <div style="background-color: #00728f; color: white; padding: 5px; margin-top: 10px;"> <p><i>Thoughts of suicide are common. Not all women need to be evaluated urgently or sent to emergency services, especially if risk factors are minimal and there is no plan or intent for suicide.</i></p> </div>	<p>Treat underlying illness</p> <p>Maximize medication treatment and therapy</p> <p>Discuss warning signs with patient and family</p> <p>Discuss when and how to reach out for help should she feel unsafe</p> <p>Establish family, friends, and professional(s) she can contact during a crisis</p> <p>Establish and carry out a plan for close monitoring and follow-up (within 2 weeks)</p>	<p>Do not alarm patient (reinforce her honesty). Do not leave mother and baby alone or let them leave until assessment is complete. Call another staff member</p> <p>If assessed to be at imminent risk of harm to self or others, refer to emergency services (custom link)</p> <p>Treat underlying illness</p> <p>Maximize medication treatment and therapy</p> <p>Discuss warning signs with patient and family</p> <p>Discuss when and how to reach out for help should she feel unsafe</p> <p>Contact family, friends, and professional(s) and establish how you and patient can contact them during a crisis</p> <p>Establish a plan for close monitoring and follow-up</p>

Ideation: Inquire about frequency, intensity, duration—in last 48 hours, past month, and worst ever

***Intent:** Inquire about the extent to which the patient 1) expects to carry out the plan and, 2) believes the plan/act to be lethal vs. self-injurious. Explore ambivalence: reasons to die vs. reasons to live.

****Plan:** Inquire about timing, location, lethality, access to lethal means (e.g., gun), making preparations (e.g., hoarding medications, preparing a will, writing suicide note).

Behaviors: Inquire about past attempts, aborted attempts, rehearsals (e.g., tying noose, loading gun) vs. non-suicidal self-injurious actions.