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 Patient Safety Screener (suicide risk screener-next page) 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

Assessment

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

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

Treatment

LOW RISK	MODERATE RISK	HIGH RISK
Treat underlying illness	Treat underlying illness	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
Maximize medication treatment and therapy	Maximize medication treatment and therapy	If assessed to be at imminent risk of harm to self or others, refer to emergency services (custom link)
Monitor closely	Discuss warning signs with patient and family	Treat underlying illness
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.	Discuss when and how to reach out for help should she feel unsafe	Maximize medication treatment and therapy
	Establish family, friends, and professional(s) she can contact during a crisis	Discuss warning signs with patient and family
	Establish and carry out a plan for close monitoring and follow-up (within 2 weeks)	Discuss when and how to reach out for help should she feel unsafe
		Contact family, friends, and professional(s) and establish how you and patient can contact them during a crisis
		Establish a plan for close monitoring and follow-up

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.

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Name: _____Date: _____Time: _____

PATIENT SAFETY SCREENER

This screener should be administered by the obstetric care clinician. For additional information on assessment and intervention, see Lifeline for Moms Obstetric Care Clinician Algorithm, *Assessing Risk of Suicide*.

A. DETECTION (PRIMARY SCREENING)

Ask the following questions exactly as worded. If collateral information indicates ideation or attempt, document a "yes".

1. In the past two weeks, have you felt down, depressed, or hopeless? *(Not necessary to ask if PHQ9 was already administered – score it based on PHQ9 Item 2 response. 0=No, >0=Yes)*

☐ Yes ☐ No ☐ Patient unable to complete ☐ Patient refused

2. In the past two weeks, have you had thoughts of killing yourself? *

☐ **Yes** ☐ No ☐ Patient unable to complete ☐ Patient refused

3. In your lifetime, have you ever attempted to kill yourself? *

☐ Yes ☐ No ☐ Patient unable to complete ☐ Patient refused

3a. If yes, when did this happen?

☐ Within past 24 hours (including today) ☐ Within last month (but not today) ☐ Between 1 and 6 months ago

☐ More than 6 months ago ☐ Patient unable to complete ☐ Patient refused

B. DETECTION RESULT

"Yes" to Item 2 (ideation) OR "Within past 24 hours", "Within last month" or "Between 1 and 6 months ago" to Item 3a = ☐ Positive screen -> Proceed to C. Stratification

C. STRATIFICATION (SECONDARY SCREENING)

Assess the following six indicators using all data available to you, including patient self-report, collateral information, medical record review, and current observations.

	Yes	No	Unable to complete
4. Did the patient screen positive on BOTH active ideation AND a past suicide a past suicide attempt	1	0	
5. Has the individual begun a suicide plan? *"Have you been thinking about how you might kill yourself?"*	1	0	
6. Has the individual recently had intent to act on his/her ideation? *Do you think you might act on your thoughts?*	1	0	
7. Has the patient ever had a psychiatric hospitalization? *Have you ever been hospitalized for a mental health or substance abuse problem?*	1	0	
8. Does the patient have a pattern of excessive substance use? *Has drinking or drug abuse ever been a problem for you?*	1	0	
9. Is the patient irritable, agitated, or aggressive? *Note: This is an observation*	1	0	
Sum score (1 for each "Yes") **Total:**			

**A patient presenting with a current suicide attempt is an automatic Yes on Items 2, 3, 4, 5, and 6.*

D. STRATIFICATION RESULT

	Mild risk	Moderate risk	High risk
Score from Section C	☐ 0 – 2	☐ 3 – 4	☐ 5 – 6
Critical items		☐ Suicide plan **or** intent (not both)	☐ Suicide plan **and** intent
			☐ Current attempt

Risk level based on **highest** level category endorsed: ☐ **Mild** ☐ **Moderate** ☐ **High**

Notes:

Boudreaux, E. D., Larkin, C., Camargo Jr, C. A., & Miller, I. W. (2020). Validation of a secondary screener for suicide risk: results from the Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE). *The Joint Commission Journal on Quality and Patient Safety*, *46*(6), 342-352. Reprinted with permission from UMass Chan Medical School.