# I’ve Screened, Now What? Perinatal Depression Screening and Response

## Presenters

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MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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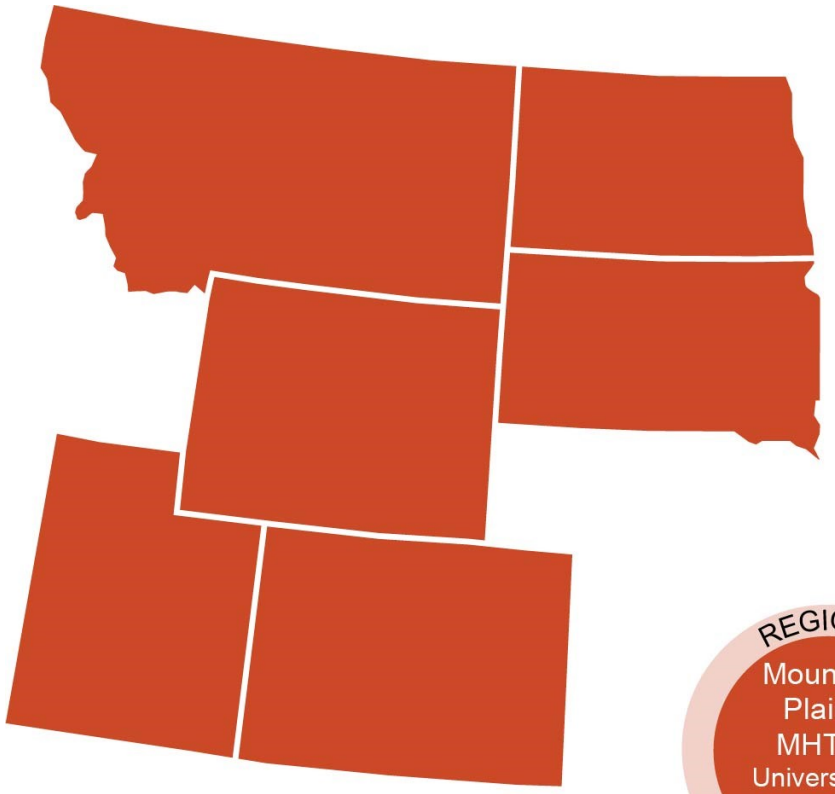
# The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



REGION 8
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The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Healing-centered/ trauma-responsive
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

# Stay Connected

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# Perinatal Mental Health

How we think about mental health has a powerful influence on how we take care of our mental health.

It’s time to focus on:

POSITIVE PERINATAL MENTAL HEALTH

AND

MENTAL HEALTH PROMOTION FOR MOTHERS

# What is Perinatal Mental Health (PMH)?

- The perinatal period includes pregnancy and first year postpartum
- A woman goes through many hormonal, physical, emotional and psychological changes during this vulnerable time
- Pregnancy can be hard! Childbirth is difficult and exhausting! Transition to Parenthood goes without saying!
- Maternal mental health impacts the entire family unit AND the family unit can impact maternal mental health!
  - Illnesses
  - Current and past traumatic pregnancy and delivery experiences
  - Personal medical history
  - MAYBE the concern shows up for the very first time perinatally or it recurs

# Perinatal Mental Health Conditions

# Perinatal Mental Health Conditions

- **Postpartum Blues ("Baby Blues"):** Mild and short-term mood disorder that results after pregnancy and resolves without intervention
- **Perinatal Depression:** Major depressive disorder that occurs during pregnancy or within a year after delivery
- **Perinatal Anxiety:** Many kinds of anxiety disorders can occur during pregnancy or up to 1 year after delivery
- **Postpartum Psychosis:** Serious psychiatric illness involving an acute onset of psychotic symptoms in the days or weeks after birth and often requires psychiatric hospitalization
- **Perinatal Suicide:** 5-20% of maternal deaths
- **Perinatal Eating Disorders:** 15% of pregnant women

# Psychosocial Risk Factors for PMH Conditions

- Trauma History
  - Adverse childhood experiences (ACES) (Byatt et al, 2020)
  - Includes interpersonal violence, intimate partner violence
- Personal history of depression/anxiety/PMS or family history of depression
- Personal History of physical or sexual abuse
- Lack of social support
- Higher risk pregnancy: gestational diabetes, pre-term labor/birth*, pregnancy loss, adolescent parent
- Poverty, lack of financial support
- Substance misuse and substance use disorders (Prevatt et al., 2017)
- Sometimes there may not be significant risk factors!

# The Baby Blues

- The most common disorder affecting women after delivery
  - Will impact between 50-75% of women; severity can vary
- Why do the Blues happen?
  - Biological
    - Hormonal changes after delivery
      - Estrogen and Progesterone decrease quickly by up to 90% over first few days
    - Physiological pain associated with healing, uterus contracting, breast pain with lactation
    - Sleep changes
  - Psychological
    - History of anxiety or depressive disorders or PMS
    - Fear about health and life of infant
    - Uncertain about change to maternal life (family dynamics, career, financial)
    - Concerned with physical changes (weight, “reduced attractiveness”)

# The Baby Blues

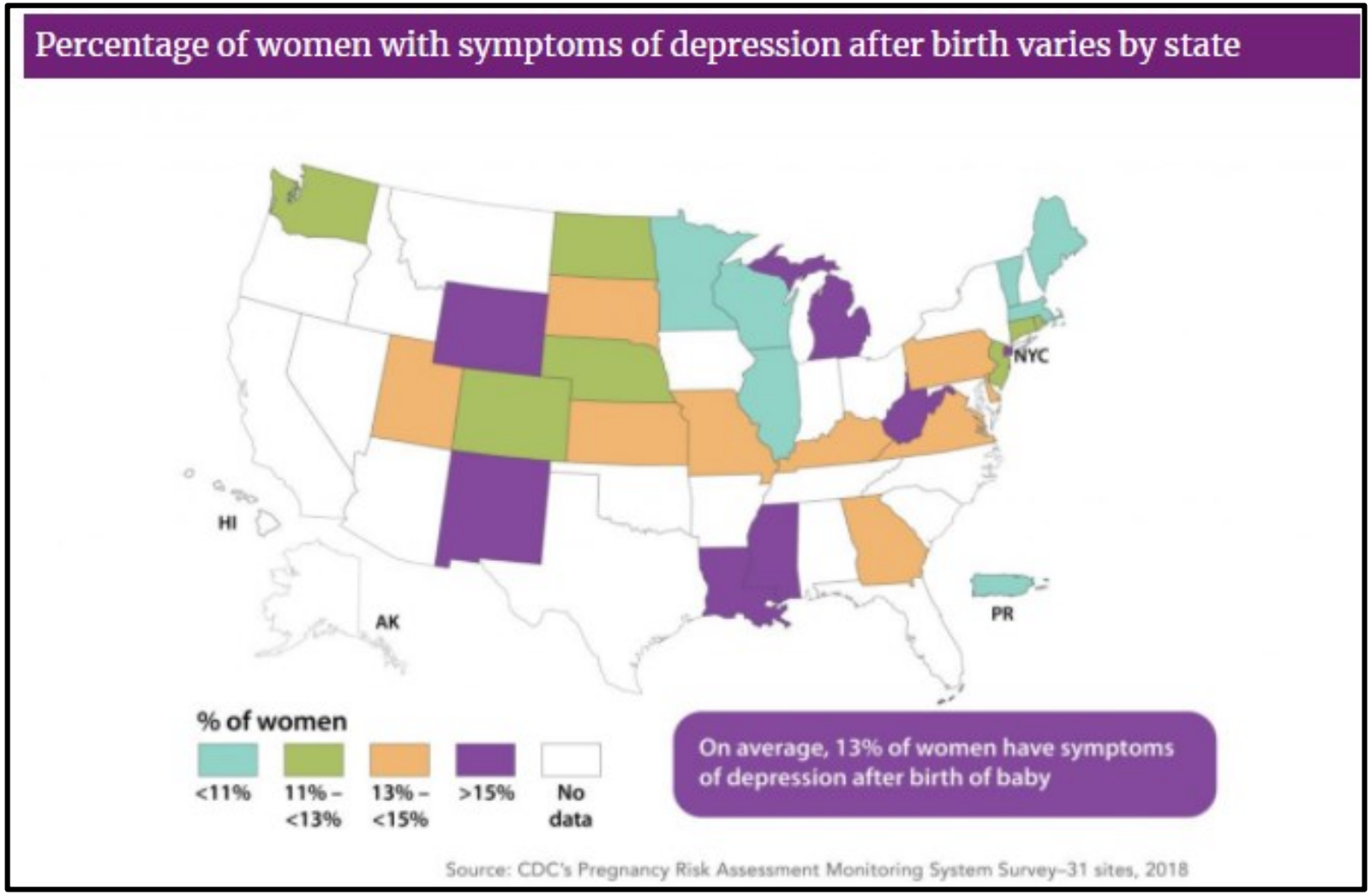
- Environmental
  - Support systems and living circumstances
- Symptoms
  - Crying, anxiety, emotional lability (“rollercoaster”), irritability, fatigue and trouble sleeping, lack of interest in food
  - Usually begins about 3-4 days after delivery, peaks within 2-5 days of onset
    - Occasionally symptoms can last longer but symptoms do not tend to worsen
  - Typically, does not interfere with daily functioning
  - **Baby Blues resolve on their own within 10-14 days**

# Perinatal Depression (PD)

- Occurs during pregnancy:
  - Antenatal depression (AND) or
  - Following childbirth, Postpartum depression (PPD)
- Emerging research suggests more women developed PD during the pandemic (~34%)

# Perinatal Depression (PD)

- PD is most under-diagnosed obstetric complication in U.S. (Dagher et al., 2021; PSI, 2021)
  - 50-70% of women go undetected
  - 85% go untreated



# Perinatal Depression

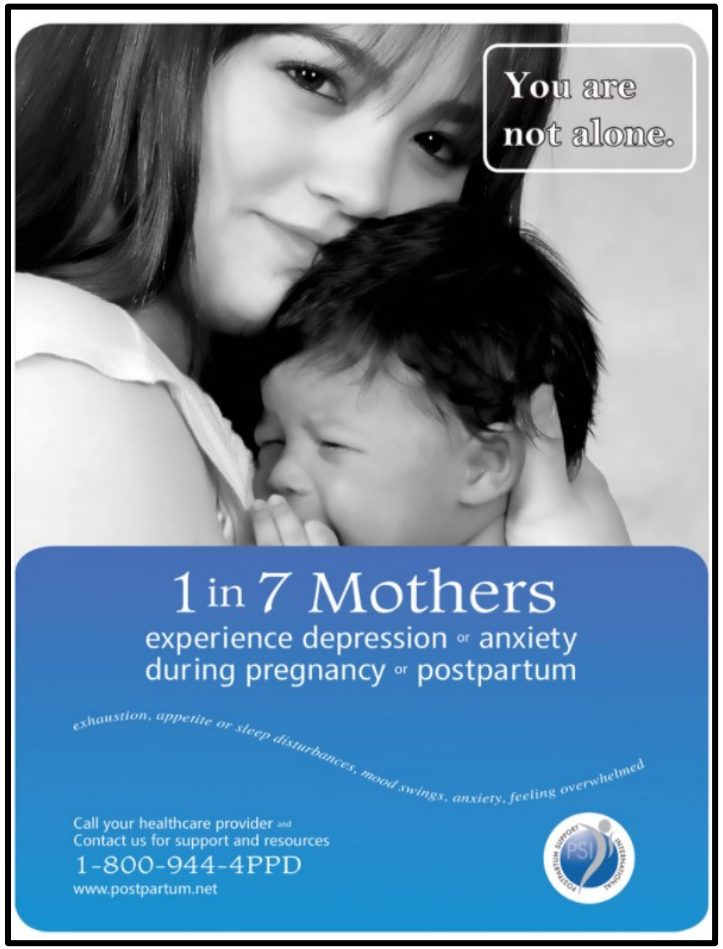
- Symptoms are IDENTICAL to non-perinatal major depression
  - Depressed mood (self-report or observed) present most of the day
  - Loss of interest in usual activities or pleasure
  - Changes in sleep patterns
  - Agitation
  - Feelings of worthlessness or guilt
  - Loss of energy or fatigue
  - Inability to concentrate
  - Change in weight or appetite
  - Suicidal ideation, attempt or recurrent thoughts of death

# Antenatal Depression

- Less focused on in practice
- Women reluctant to share symptoms of sadness because of expectation of happiness during pregnancy
  - What about emotions of women with mistimed pregnancies?
- Higher tendency to focus on physical health during pregnancy
  - May also misinterpret depression symptoms as complaints about common discomforts of pregnancy
    - Sleep, body aches, headaches, “pregnancy brain” Worry about previous pregnancy history and complications, losses
      - Might trigger more anxiety…high anxiety may be a risk factor for depression (Biaggi et. al, 2016)

# Postpartum Depression (PPD)

- Affects ALL cultures, ages, incomes, & ethnicities
  - First time mothers, & those who deliver prematurely, have higher rates of PPD (Banasiewicz et al., 2020)
- 1 in 7 women will develop
  - ~20% of women with Baby Blues will develop PPD
- Symptoms usually present within 3 weeks to 3 months after birth
  - Peak: 2nd month PP
  - Risk remains up to 1 yr
    - Some evidence suggests the accumulation of stressors in the first year after delivery contributes to the onset or recurrences of depressive episodes (Dagher et.al., 2021)
    - Think about all of the changes going on!




PSI, 2021

# Treatment for Perinatal Depression

- PD does not usually resolve without treatment
  - PD can become a chronic disorder that persists through more than one pregnancy (Meltzer-Brody & Steube, 2014)
  - Symptoms can worsen quickly!
- Treatment options often include a combination of
  - Counseling
    - Cognitive behavioral therapy, individual and group therapy
  - Medication
    - Many options, even with breastfeeding!
    - Typically SSRIs are first line (most work well with breastfeeding)
  - Support from Others
  - Exercise & a healthy diet
  - Adequate sleep
  - Relaxation techniques (Kroska & Stowe, 2020)
- Usually encourage treatment for at least 6 months after symptoms resolve

# Potential Concerns if PD is NOT Treated

## Antenatal Depression

- Maternal Impact
  - Poor sleep
  - Less likely to breastfeed
  - Paternal depression
  - Potential impact on bonding
  - Increased risk of preeclampsia, placental abnormalities, miscarriage
  - Associated with development of PPD
- Fetal Impact
  - Delayed fetal development
  - Higher rates of prematurity
  - Low birth weight

## Postpartum Depression

- Unplanned weaning from breastfeeding or lactation failure
- Newborn stress
- Impaired bonding and attachment
- Children's emotional health can be adversely affected through the school-age years
- May trigger onset of chronic major depressive disorder:
  - 1 in 3 will struggle with depressive symptoms at least four years after delivery
- GREATEST risk factor for maternal suicide and infanticide

# Postpartum Psychosis

- Rare: 1-2 out of every 1000 women who give birth
- Sudden onset of symptoms 3-10 days after birth or in first month:
  - Delusions (“break from reality”), Hallucinations (visual, olfactory, tactile), Paranoia
  - Increased irritability
  - Hyperactivity
  - Decreased need for or inability to sleep
  - Rapid mood swings
- Drug withdrawal or intoxication can mimic symptoms

# Postpartum Psychosis

- Risk factors
  - Personal or family history of bipolar disorder or a previous episode in pregnancy
  - Primiparity
  - Advanced maternal age

- This is a temporary, treatable condition, but it is a psychiatric emergency!
  - Early identification, immediate intervention, appropriate treatment are critic to prevent maternal suicide and infanticide (Lisette & Crystal, 2018)

# Perinatal Suicide

- Leading cause of maternal death
  - Estimated maternal suicide rate of 1.5-4.5 per 100,000 women
    - About 40% of those who complete perinatal suicide have seen a PCP within one month of attempt
    - U.S. does NOT have a good system for identifying maternal deaths from suicide (i.e. some states include accidental overdose in this category); especially beyond first 6 months PP
    - Perinatal women most frequently complete suicide between 9-12 months postpartum
    - Of those who die by suicide in first 6 months PP, primary diagnoses:
      - 21%-severe depression
      - 31%- substance use disorders
      - 38%- psychosis (Sit et al., 2015)
- Suicidal ideation is predictor of suicide and postpartum depression

# Perinatal Suicide

- Risk factors
  - History or psychiatric illness
    - Those with history of bipolar disorder at higher risk than those with unipolar depression
  - History of suicide attempts
  - Abrupt stopping of psychotropic medications during pregnancy
  - Postpartum sleep disturbances
  - IPV
  - Stillbirth (Lisette & Crystal, 2018; PSI, 2021;Mangla et al., 2019)
  - Possible behavioral clues
    - Decreased responsiveness to infant cues and less infant engagement with mothers

# Suicide Warning Signs and Cues

- **Verbal**
  - Direct – “I’m going to kill myself.” “If my wife leaves me, I’m going to kill myself.”
  - Non-Direct – “I can’t handle this anymore.” “I useless for my family anyway. They would be better off without me.”
- **Behavioral**
  - A relapse
  - Stockpiling meds/purchasing a weapon
  - Giving things away
  - Demonstrating anxiety/sleep deprivation
- **Situational**
  - An embarrassing situation
  - Fear of consequences/Loss of freedom
  - Relationship / Financial crisis
  - Terminal diagnosis
  - Move/death
  - **Knowing someone who has died by suicide**

# The Three ‘I’s of Depression (Chiles, J. & Strosahl, K. (2005).

- Intolerable – “This pain is too great to bear.”
- Interminable - “This pain will never end.”
- Inescapable – “There is no way out.”

# Screening, Brief Intervention, and Referral to Treatment (SBIRT)

# Screening, Brief Intervention, and Referral to Treatment (SBIRT) Review

What is SBIRT?

- Screening
    - Universal, quick assessment
    - Occurs in a variety of settings (e.g., public health, primary care settings, community social services)
- Brief Intervention
    - Brief motivation and awareness-raising
    - Short conversations
- Referral to Treatment
    - Further evaluation for specialty care

# Screening for Perinatal Depression

- The United States Preventive Services Task Force recommends depression screening for pregnant and postpartum women
- Cultural considerations are important
  - Higher risk among women who are non-white, non-English speaking
- Inadequate assessment of risk or illness severity + low rates of seeking mental health treatment, lead to
  - Increased risk of postpartum suicide

# Screening for Perinatal Depression

## Who & How to Screen?

- Healthcare providers are encouraged to screen all clients for depression
  - We shouldn't "Pick and Choose" who gets screened based on appearance, bias
    - Asian women were 19% less likely, African-American women 36% less likely, and Native American and multiracial women were 56% less likely to be screened
  - We should use a screening tool to help ask the questions
  - Tools you may be familiar with:
    - Edinburgh Postnatal Depression Scale
    - PHQ-2 & 9
    - Whooley

## When to Screen?

- First prenatal visit, at least once in the second trimester, and in the third trimester
- Postpartum visit
  - 2weeks
  - 6+ weeks
- Well-woman/Primary Care visit 1 year after delivery
- Even at newborn/pediatric appointments!
  - 3, 9, 12 month visits
- Women can and should ASK to be screened if concerned!
- **When will YOU screen?**

(PSI, 2021)

# Whooley Questions for Depression Screening

1. During the past month, have you often been bothered by feeling down, depressed or hopeless? ☐ Yes ☐ No

2. During the past month, have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

| | |
|---|---|
| "Yes" to one (or both) questions | = positive test (requires further evaluation) |
| "No" to both questions | = negative test (not depressed) |

# Whooley Questions

- Yes or no format, rather than a scale
- Almost identical to PHQ-2, so utilizing the PHQ-9 if symptoms are positive makes sense.
  - A positive test: (~95% sensitivity) **Identifies patients who may benefit from further evaluation.**
  - A negative test: Depression is unlikely
- The Whooley Questions cannot be used to diagnose or measure the severity of depression (Whooley, 2016)

- Screening will not reduce depression UNLESS there is a collaborative care management team in place to assure close follow-up

- https://whooleyquestions.ucsf.edu/

# How to Address the Negative Whooley Screen

- Feedback:
  - Thank you for answering these questions. Your screening result is negative. This means that today, postpartum depression is unlikely. However, do you have any concerns about your mental health that you would like to discuss?
- Listen:
  - Does she offer any other symptoms of concern?
- Options:
  - Provide education about the symptoms of postpartum depression
    - Handouts, websites
  - Encourage client to reach out for evaluation if symptoms develop
    - What is your policy for return visits? Will your agency screen her again?

# How To Address the Positive Whooley Screen

- Concern:
  - “Thank you for answering these questions. Your screening result is positive. I am **Concerned** that you might be at risk for postpartum depression.”
- Uncomfortable
  - “I am **Uncomfortabl**e with you keeping these symptoms to yourself and not sharing them with your healthcare provider.”
- Safety
  - “In some women, if early symptoms of depression are not acknowledged or further evaluated, we become concerned about the **Safety** of you and your baby.”

# How To Address the Positive Whooley Screen

- Any positive screen result must be followed by a clinical interview to confirm the presence of at least 5 symptoms of depression that:
  - Occur most of the time
  - Cause noticeable impairment in social, occupational, or other important areas of functioning during the same 2-week period
  - Symptoms include:
    - Weight loss or gain
    - Insomnia or hypersomnia
    - Psychomotor agitation or retardation
    - Fatigue or lack of energy,
    - Feelings of worthlessness
    - Poor concentration
    - Recurrent thoughts of death or suicide

# PHQ – 9 Review

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001).

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ DATE: _____

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 figety 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 | 0 | 1 | 2 | 3 |
| | | add columns | + | + |
| | | TOTAL: | | |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).*

**10.** 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 _____

# PHQ – 9 Review

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001).

## PHQ-9 Patient Depression Questionnaire

**For initial diagnosis:**

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✔s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

***Consider Major Depressive Disorder***
- if there are at least 5 ✔s in the shaded section (one of which corresponds to Question #1 or #2)

***Consider Other Depressive Disorder***
- if there are 2-4 ✔s in the shaded section (one of which corresponds to Question #1 or #2)

**Note:** Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

**To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:**

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✔s by column. For every ✔: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

**Scoring: add up all checked boxes on PHQ-9**

**For every** ✔ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

**Interpretation of Total Score**

| Total Score | Depression Severity |
|---|---|
| 1-4 | Minimal depression |
| 5-9 | Mild depression |
| 10-14 | Moderate depression |
| 15-19 | Moderately severe depression |
| 20-27 | Severe depression |



A2662B 10-04-2005

# PHQ-9 Vs. DSM 5 Depression Criteria

## PHQ-9 Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001).

Patient Health Questionnaire (PHQ-9)

Name:_____ MRN# _____ Date:_____

| 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 |
| 3. Trouble falling asleep, 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 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 |

Add Columns _____ + _____ + _____

**Symptom Total_____ Severity Total _____**

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

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| _____ | _____ | _____ | _____ |

**If these problems have caused difficulty, have they caused you difficulty for two years or more?**

Yes _____ No _____

## DSM 5 (American Psychiatric Association, 2013)

**Major Depressive Disorder (Diagnosis)**

**These are the DSM V diagnostic criteria for Major Depressive Disorder. Please review your diagnostic assessment using this checklist. IF the symptom is "clearly present" mark that box. If the symptom has been sustained for at least for at least two weeks, every day, most of the day mark the box "sustained". For a diagnosis of MDD to be present, 5 of 9 criteria from Section A must be marked as BOTH "clearly present" and "sustained". As well, criteria B and criteria C must be met. As well, items C, D and E must be clearly present.**

| Clearly Present | Sustained | |
|---|---|---|
| | | **A) Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.** *(Note: Do not include symptoms that are clearly attributable to another medical condition)* |
| | | **1) Depressed mood most of the day, nearly every day as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful).** *(Note: In children and adolescents, can be irritable mood).* |
| | | **2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).** |
| | | **3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.** *(Note: In children, consider failure to make expected weight gain.)* |
| | | **4) Insomnia or hypersomnia nearly every day.** |
| | | **5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).** |
| | | **6) Fatigue or loss of energy nearly every day.** |
| | | **7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).** |
| | | **8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).** |
| | | **9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.** |
| | | **B) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.** |
| | **C) The episode is not attributable to the physiological effects of a substance or to another medical condition.** | |
| | *Note: Criteria A-C represent a major depressive episode*<br>*Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.* | |
| | **D) The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.** | |
| | **E) There has never been a manic episode or a hypomanic-like episode.**<br>*Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributes to the physiological effects of another medical condition.* | |

# What Do I Say to Someone I am Worried About?

- Maridee gave everyone permission to CUS and go with the FLO
- I may use a direct or indirect approach, but I ask. Keeping in mind what I know about the situation.
- If they affirm, I ask
  - Currently? Like now? When?
  - How? Is it something they have access to?
  - Then I may CUS, or something similar.
- If the answer is no, or sometimes but not right now, I say
  - This is a good time to talk about help
  - Begin persuasion (Offer hope)

**Most important though, I listen, listen, listen.

# How do you ask, “the question”?

- Direct?
- Indirect?
- Oops
- Key things to consider:
  - Avoiding judgement
  - Major life advice
  - Getting so focused on their thoughts of suicide, you forget to listen to the problem

# Acceptable Risk?

- This doesn't even sound good.
- A model:
  - PHQ-2. Score of 3 or greater leads to the PHQ-9
  - Patients with a known diagnosis of depression automatically get the PHQ-9
  - Score of 10 or greater = Internal referral to BH
  - Any number endorsement of question 9 except '0' = Internal referral to BH

  - When something is obvious…

# Screening Limitations / No blame

Screening is not a full suicide risk assessment (Risk factors, protective factors, suicidal behaviors like aborted attempts and rehearsals).

- Suicide Prevention Training: Presentation and Panel Discussion
- Suicide Prevention in Rural Primary Care: Two-Part Series
- SAFE-T

- Remember scope and ethics when screening or doing assessments
  - Ethics in Practice - HHS Region 8
- Even full screenings MISS things, or things are not disclosed

# Suicide Risk Assessment

## RESOURCES

- Download this card and additional resources at **http://wwww.sprc.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **http://www.sprc.org/library/jcsafetygoals.pdf**
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors **http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx**
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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**National Suicide Prevention Lifeline**

**1-800-273-TALK (8255)**

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services


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# SAFE-T

## Suicide Assessment Five-step Evaluation and Triage

**1**
**IDENTIFY RISK FACTORS**
Note those that can be modified to reduce risk

**2**
**IDENTIFY PROTECTIVE FACTORS**
Note those that can be enhanced

**3**
**CONDUCT SUICIDE INQUIRY**
Suicidal thoughts, plans, behavior, and intent

**4**
**DETERMINE RISK LEVEL/INTERVENTION**
Determine risk. Choose appropriate intervention to address and reduce risk

**5**
**DOCUMENT**
Assessment of risk, rationale, intervention, and follow-up


U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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*Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.*

### 1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

### 2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

### 3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** 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
- * *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition
- * *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

### 4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

| RISK LEVEL | RISK/PROTECTIVE FACTOR | SUICIDALITY | POSSIBLE INTERVENTIONS |
|---|---|---|---|
| **High** | Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant | Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal | Admission generally indicated unless a significant change reduces risk. Suicide precautions |
| **Moderate** | Multiple risk factors, few protective factors | Suicidal ideation with plan, but no intent or behavior | Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers |
| **Low** | Modifiable risk factors, strong protective factors | Thoughts of death, no plan, intent, or behavior | Outpatient referral, symptom reduction. Give emergency/crisis numbers |

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

### 5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

# When We Prevent Suicide…

We prevent suffering and more loss.

- 4-Fold increase in risk for suicide in children if their parent dies by suicide.
- For every suicide, 135 are impacted. So, 48,000 (130 daily) suicides per year = over 1 MILLION seriously impacted by suicide loss. (QPR Institute, 2021)

# Policies and Procedures for Suicide Crisis

- **Policy should include**
  - In-Person or Over the Phone
  - Mention of an assigned designated person
  - Who to call for help/further assessment
  - Transportation
  - Willing vs. Unwilling client
  - Emergency and Non-Emergency Procedures (Referrals)
- **Designate the person responsible during shifts** (charge nurse, supervisor)
  - Where is the client now?
  - Assuring someone is present
  - Knows policies about contacting help/transport
  - Awareness of staff well-being / Back-up for them
  - After the crisis

# Policies and Procedures Cont.

## Managing Suicide Crisis Calls Procedure

**Remember**
Remain calm | Be genuine | Try to speak slowly and calmly

**Try not to transfer the call**
Ideally the person taking the call should be the person to stay on the phone with the caller

**Ask for the caller's**:
1. **name**
2. **call-back number**
3. **location**

**DO**
1. Listen
2. Let the caller vent
3. Be sympathetic

**DON'T**
1. Argue or debate
2. Minimize feelings
3. Offer quick solutions

**Get the specifics of the caller's suicide plan**
**(if you haven't already)**
**PLAN** "Have you thought about how you would do it?"
**MEANS** "Do you have what you need to ?"
**TIME SET** " Have you thought about when you would do this?"
If you get affirmative answers from the caller for these questions alert a co-worker who can call 911.

# Policies and Procedures Cont.

## Managing Suicide Crisis Calls Procedure Continued

Ask the caller if they want to speak with a BHC or nurse and explain to them their role. **If their answer is yes, make sure you have the patient's call-back number and preferably address, place the caller on hold and transfer the call to the appropriate person (Ideal not to put the caller on hold).**

If the caller says NO, **do not** hang up or transfer them. Remain on the line until you can get help. Try to keep them talking.

Offer to call 9-11 and send help, if they refuse help, remain non-judgmental and sympathetic and keep talking. If the caller is suicidal and you have the caller's location, **you may legally call or have someone call 9-11** without violating confidentiality. Do not inform the caller that you called 9-11 if you have reason to believe they will hang up or leave that location.

**If the person is ingesting drugs**, get as many details as you can (what, how much, alcohol, other medications, last meal, general health) and have someone **call Poison Control at 1-800-222-1222**. If you reach Poison Control and they recommend immediate medical assistance, ask if the caller has a nearby relative, friend, or neighbor who can assist with transportation or the ambulance. You may also call 9-11 if you have the caller's address or location. Remain with the caller until either help arrives, or someone else takes the call.

**Once your call is over, talk to someone. Suicide calls are very stressful, and we all need support.**

# After a Crisis

- Postvention (this doesn't have to be formal or immediate). Did we do things right? Can we improve? If we want a better outcome next time, what can we try?

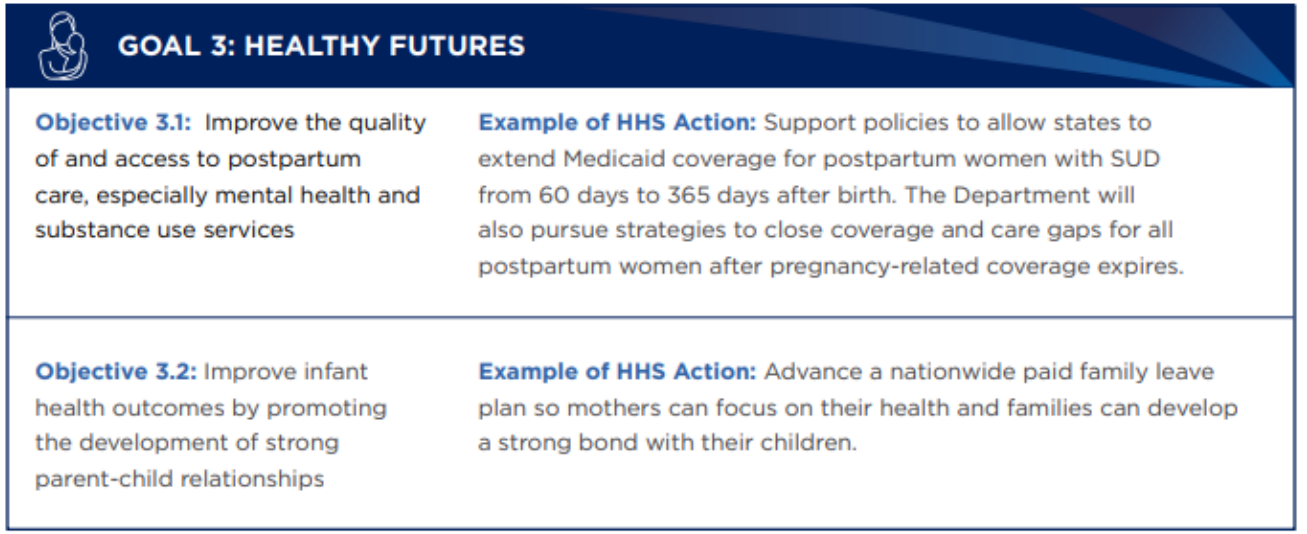
- Staff Support
  - Awareness of secondary traumatic stress (working with a patient who is suicidal, or learning that patient/client has died by suicide)
  - Create a space to talk about it
  - Provider Well-Being

# Referral Pathway

- Immediacy is important. Consider emergency and urgent options that may be available. Warm handoffs are best.
- Keep a real-time accounting of your internal and external resources
  - Health systems
  - Social service organizations
- Continued education with staff (SD 2-1-1 observations)
- Speak with your partners about how you would like to utilize their services.
- Consider having written material ready

# Referral challenges for the Perinatal Population

- Where should the referral go?
  - Primary care vs OB vs behavioral health
  - May depend on time frame, preference, availability
- Do they have someone to help with infant, other children at home so that they can attend a follow up appointment?
- How long does insurance cover their PP care, PPD screening visit?
  - US Department of Health and Human Services Action Plan (12-20)
  - Ongoing advocacy to extend the postpartum period to 1 year for insurance/Medicaid coverage



**GOAL 3: HEALTHY FUTURES**

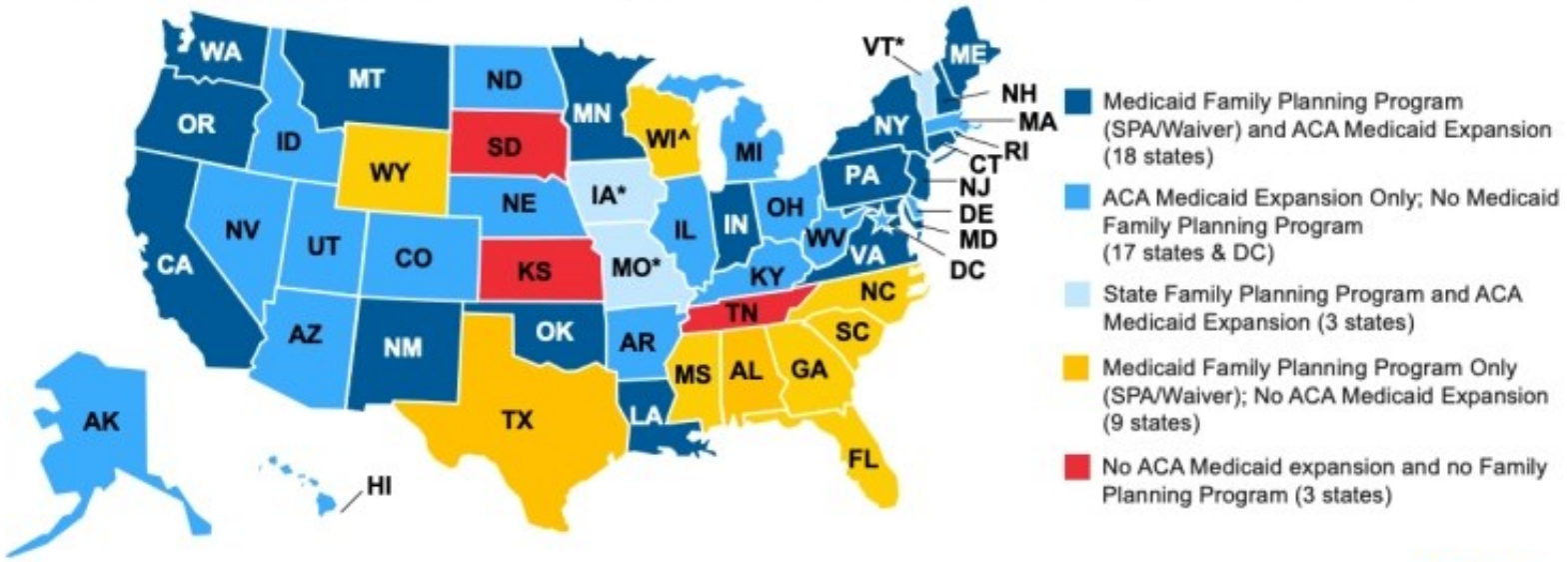
| | |
|---|---|
| **Objective 3.1:** Improve the quality of and access to postpartum care, especially mental health and substance use services | **Example of HHS Action:** Support policies to allow states to extend Medicaid coverage for postpartum women with SUD from 60 days to 365 days after birth. The Department will also pursue strategies to close coverage and care gaps for all postpartum women after pregnancy-related coverage expires. |
| **Objective 3.2:** Improve infant health outcomes by promoting the development of strong parent-child relationships | **Example of HHS Action:** Advance a nationwide paid family leave plan so mothers can focus on their health and families can develop a strong bond with their children. |

# South Dakota and Medicaid Expansion: Does This Impact Your Referrals?

Figure 3

## State Decisions on Medicaid Expansion and Family Planning Programs Affect Women's Access to Postpartum Care

**State Decisions on ACA Medicaid Expansion and Medicaid Family Planning Programs, December 2020**




NOTES: The federal poverty level (FPL) for 2020 is $21,720 for a family of three. Expansion has been adopted but not implemented in MO and OK. *IA, MO & VT operate an entirely state-funded programs to provide family planning services ^WI did not adopt Medicaid expansion under the ACA, but extends coverage to adults up to 100% FPL.
SOURCE: Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision, As of November 2, 2020.
Guttmacher Institute, State Policies in Brief: Medicaid Family Planning Eligibility Expansions, As of December 1, 2020.

KFF

**Figure 3: State Decisions on Medicaid Expansion and Family Planning Programs Affect Women's Access to Postpartum Care**

# Referral Challenges for the Perinatal Population

- Breastfeeding and medications
  - Additional education may be needed if the mother is prescribed medications to treat PPD
  - Should a follow up appointment be scheduled with WIC, Peer BF Counselors to address any BF questions/concerns if medications are prescribed?
- Are additional referrals available for community support resources?
  - Moms groups
  - La Leche League
  - What local groups are YOU aware of in YOUR community?

# Case scenario

Betsy is a 32 year-old mother. She has a 3 year-old son at home and she delivered her newborn daughter 6 weeks ago. She has been coming to WIC since the birth of her son and the staff know her pretty well. Betsy is known for being a “good mother” among the staff. She breastfed her son for 10 months. Today, Betsy appears tired. She is making very little eye contact with the WIC staff. Her newborn is awake and cooing, appears happy, however, staff notice that Betsy is not “talking back” to her and is using her foot to rock the infant carrier when the nurse enters the room. Soon into the visit, the baby gets a little fussy and Betsy props the baby’s bottle in the carrier with a blanket to feed her. The nurse continues the appointment and completes the Whooley Screen. It is positive.

1. Are there any red flags in this appointment?
2. What is the nurse’s next step?

# Case scenario

Angela is a 25 year-old WIC client who arrives for a postpartum appointment. She is alone and has her newborn son in an infant carrier. He is 9 days old. Angela smiles when the nurse enters the room but the nurse notes to herself that Angela "looks tired". She is trying to hide her yawning. The nurse asks her how things are going at home and Angela says, "pretty good!" but then breaks down in tears. She adds, "Breastfeeding is hard". The nurse comforts Angela, they visit for a little while and then Angela completes her Whooley Screen is negative. She is still teary at the end of the appointment.

1. Should the nurse be concerned about why Angela is crying?
2. What else should the nurse ask Angela?
3. What kind of education should be offered at this appointment?

# Questions?

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# Thank you for joining!

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