Perinatal Suicide

HENNEPIN PERINATAL ECHO
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Outline

- Background/Prevalence
- Risk Factors
- Prevention and Intervention Strategies
- Addressing Risk Factors and Safety Planning

Prevalence

- Measurement of perinatal suicide is difficult
  - Suicide is a rare outcome – which makes it difficult to measure!
  - Lack of standardization in terms
  - Lack of uniformity in methods of determining maternal deaths

Knasmuller 2019

Prevalence

- Suicide rate in pregnancy is LOWER than in non-pregnant women
- BUT suicide is a LEADING cause of maternal death in pregnancy and the first year postpartum
  - Accounts for 20% of postpartum deaths

Cantwell 2011, Trost 2021, Lindahl 2005

Why does this matter?

- Maternal mortality is a marker of population health!
- Maternal mortality rates in the USA are the highest among developed countries
  - The US maternal mortality ratio increased by 26.6% between 2000 and 2014

MacDorman 2016

Definitions

Box 1 Definitions associated with maternal mortality

Pregnancy-associated death: Death during pregnancy or within one year of the end of pregnancy, irrespective of cause.

Pregnancy-related death: Death during pregnancy or within 1 year of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by physiologic effects of pregnancy.

Maternal death: Death during pregnancy or within 42 days of the end of pregnancy, from any cause related to or aggravated by pregnancy or its management, but not from accidental or indirect causes.

Late maternal death: The death of a woman from direct or indirect obstetric causes more than 42 days but less than 1 year after termination of pregnancy.

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Prevalence

- 13-36% of maternal deaths were attributed to suicide when the postpartum period was extended to 1 year postpartum
- US perinatal suicide rates estimated at 1.6 to 4.5 per 100,000 live births
- Prevalence of suicidal ideation in the perinatal period: 5-14% among perinatal women with depression or in mental health treatment

Lommerse 2019, Rodriguez-Cabezas 2018, Chalise 2020

Prevalence

- Postpartum period appears to be higher risk than pregnancy for suicide.
- If there is any protective effective of pregnancy and postpartum, it is less than previously thought.
  - Especially among those with a severe postpartum psychiatric disorder and a history of self-harm.

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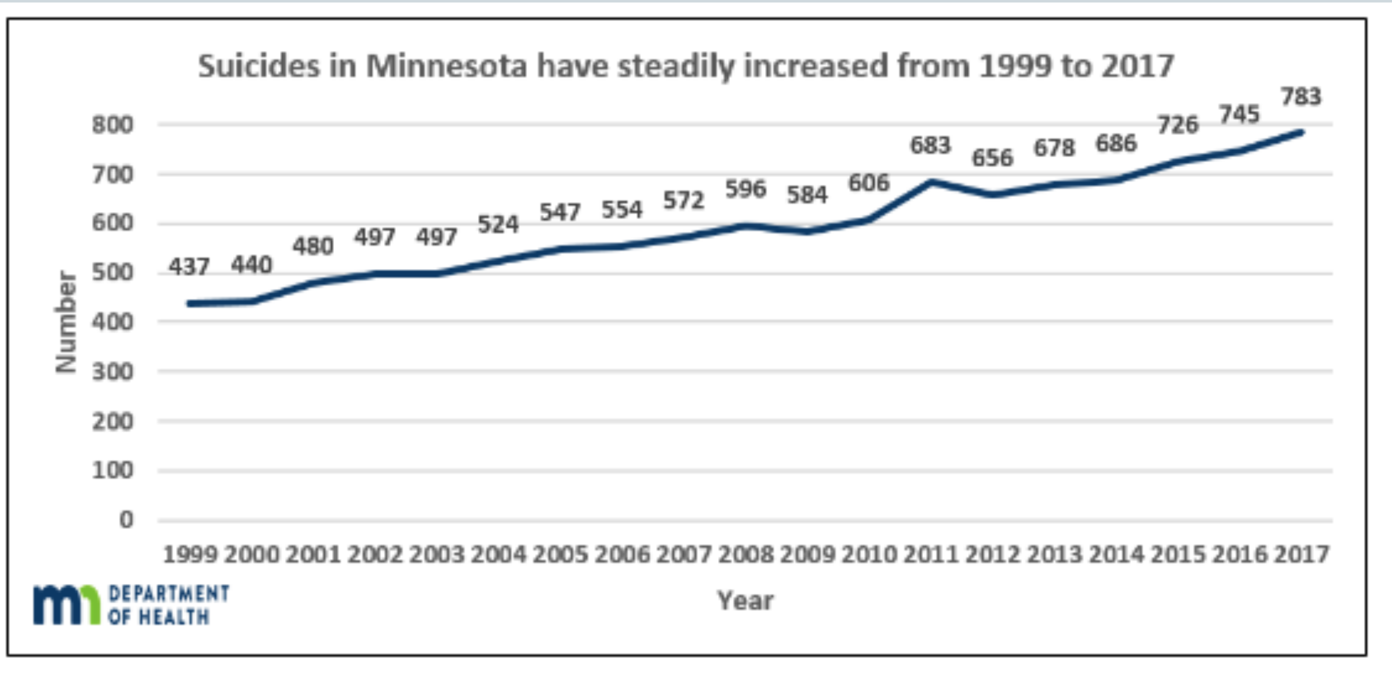
Minnesota



MN Department of Health

Minnesota

- Most recent data from MMRC - 48 identified pregnancy-associated deaths from 2017-2018

Table 1: Leading cause of death for pregnancy-associated deaths

Cause of death	Frequency	Percent
Injury - motor vehicle accident	8	16.7%
Injury - poisoning/overdose	6	12.5%
Injury - Hanging/strangulation/suffocation	4	8.3%
Cancer	4	8.3%
Firearm, infection, neurological/neurovascular	3 (for each diagnosis)	6.25%

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Risk Factors

- Demographic risk factors in perinatal population
  - Younger age
  - Unmarried
  - Marital dissatisfaction
  - Poor social support
  - Psychosocial stressors (financial instability, sickness of new baby)
  - **Psychiatric comorbidity** (e.g. history of or current depression)
  - **Past or current substance use**
  - **History of suicidal ideation and behavior**
  - Self-reported emotional dysregulation and poor sleep quality
  - History of childhood abuse, childhood trauma
  - Recent or current intimate partner violence

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Risk Factors

- Additive increased risk from experiencing depression and childhood abuse
  - Pregnant women with both childhood abuse and depression have increased risk of suicidal ideation compared to those with neither risk factor (OR = 17.78)
- IPV
  - One study found that more than half of pregnancy-associated suicide involved intimate partner conflict

Zhang 2020, Bondoc 2019, Palladino 2011

- There are many negative outcomes associated with non-fatal suicide attempts.
- Increased risk of:
  - Antepartum hemorrhage
  - Placental abruption
  - Postpartum hemorrhage
  - Premature delivery
  - Low birth weight
  - Stillbirth
  - Poor fetal growth
  - Fetal abnormalities

Gelaye 2019, Zhong 2018

Prevention and Intervention Strategies

- Screening for mental health problems and suicidality
  - Universal screening is lacking
  - PHQ9 (one question about passive or active suicidal ideation)
  - EPDS (one question specifically about self harm)
  - National Institute of Mental Health "Ask Suicide-Screening Questions"
  - Columbia Suicide Severity Rating Scale

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Prevention and Intervention Strategies

- If screening is positive → assess the following:
  - Frequency and intensity of suicidal or self harm thoughts
  - Potential methods/plans
  - Intent
  - Reasons for living
  - Assessment of suicide risk factors
  - If higher risk, obtain collateral information from family (can help with means reduction)
- → Use this information to perform a suicide risk assessment, assessing overall suicide risk and appropriate level of intervention
  - Examples: Hospitalization, emergent psychiatric evaluation, outpatient care with medication and/or therapy
  - Discussion of lethal means restriction

Rodriguez-Cabezas 2018

Prevention and Intervention Strategies

- After screening, connect with mental health treatment.
  - Prompt recognition and treatment of mental health disorders (e.g. postpartum psychosis, depression, substance use disorders).
- Barriers/missed opportunities
  - Lack of screening
  - Lack of referral to treatment after a positive screen
  - Lack of connection after referral made
  - Missed intake appointments or follow-ups
- Almost 60% of women who screen positive for perinatal depression do not take up referral offers after screening.

Chin 2022, Xue 2020

Prevention and Intervention Strategies

- But there's hope!
  - Telepsychiatry
  - Integrated mental healthcare
  - Patient-facing perinatal helplines
- Examples of bridging the gap:
  - Massachusetts Child Psychiatry Access Project (MCPAP) for Moms
  - North Carolina Maternal Mental Health MATTERS (Making Access to Treatment, Evaluation, Resources, and Screening Better) Program
  - National Maternal Mental Health Hotline (1-833-9-HELP4MOMS) (not a crisis line)
  - National Suicide Prevention Lifeline (988)

Chin 2022, Kimmel 2020

Addressing Risk Factors

- What are other things we can do? Addressing risk factors…
- Poor social support → Look for ways to increase social support
  - Online support groups such as through Postpartum Support International, local parenting groups
- Psychiatric comorbidity → Treat it!
- Current substance use → Motivational interviewing, harm reduction, connecting with substance use treatment programs and/or medication treatment strategies
- History of suicidal ideation and behaviors → Coming up with an agreed upon safety plan in advance

Safety Planning

- Ideal is to do this in advance of an acute crisis.
- During a visit, have your patient put the following phone numbers in their cellphone:
  - National Maternal Mental Health Hotline (1-833-9-HELP4MOMS) (not a crisis line)
  - National Suicide Prevention Lifeline (988)
- The safety plan should be written down! Ideally in a few locations. Consider having it a note on the patient's phone or using a smart phone application (e.g. Virtual Hope Box).

Addressing Risk Factors

- Means reduction → Removing guns from the home, storing ammunition separately, getting rid of old medications and ensuring no stockpiles medication.
  - No need for a Costco sized bottle of acetaminophen in the medicine cabinet!
  - One way in for these conversations is to center how this improves child safety in the home.
- Emotion dysregulation → Therapy, DBT
- Poor sleep quality → Sleep protection strategies
  - Partner or other support person takes an evening shift, naps during the day, improving their own sleep hygiene so the sleep they can get is better quality
- IPV → Screening, connecting with resources and support

Minnesota

- Crisis numbers by county
  - https://mn.gov/dhs/people-we-serve/adults/health-care/mental-health/resources/crisis-contacts.jsp
- MN Crisis Text Line
  - Text Home to 741741. The Crisis Text Line provides free crisis support 24/7 for any crisis.
- MN Suicide Prevention Taskforce
  - https://www.health.state.mn.us/communities/suicide/mnresponse/taskforce.html
- MN Maternal Mortality Review Committee

MN MMRC Recommendations

1. Expand Medicaid coverage to include benefits immediately beginning during the prenatal period and at one year postpartum. As of July 1,2022, Medical Assistance will now extend one year postpartum.
2. Support statewide improvements for birthing people who have substance use disorders (SUD) or mental health conditions, including adequate identification of substance use and mental health conditions in the birthing population, referral to behavioral health services and support groups, and increased funding to expand treatment and access to treatment throughout the state.
3. Develop standardization of referral network within systems and regions to refer birthing people to locations for appropriate level of care, and to decrease delay in needed diagnostics, interventions, or elevation of care.
4. Improve the postpartum period by assuring that birthing people have access to care team no later than three weeks postpartum.
5. Address bias in systems perpetuating disparities in the birthing population. Acknowledge historical trauma and racism and the impacts on birthing people.
6. Fund community lead networks and support systems to provide culturally informed care to fit birthing person's needs.
7. Listen and support birthing people. Listen to concerns, provide a network of support during and after the postpartum period.

MDH

MN MMRC Recommendations

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Questions?

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