Public Health Postpartum Depression Suicide Risk Referral Flowchart User Guide

The purpose of the User Guide is to provide rationale for the questions and corresponding nursing actions for the responses in the *Suicide Risk Referral Flowchart*. The use of clinical judgment in the suicide risk referral process will contribute to decision making for appropriate nursing actions. There may be societal beliefs (e.g., stigma, shame, guilt, cultural) that influence the mother's responses, perceptions, help-seeking behaviours and coping mechanisms(1,2). Integrating principles of patient-and family-centred care during the suicide risk referral process with an awareness of the physical, mental, social and cultural needs of the mother may promote feelings of safety and support during the interaction(1). Creating a supportive, non-judgmental and safe environment promotes discussion and possible disclosure that informs the shared decision making process(1,3–5).

A mother's choice to participate in the *Suicide Risk Referral Flowchart* discussion is voluntary. Her choice to accept or decline to answer questions about suicide risk shall be respected. If a mother declines to participate it's important to understand there may be many reasons for the decline. Reasons may include stigmatization, concerns about repercussions (concern of losing a child, judgment by peers or partner), societal beliefs or desire to maintain her privacy(1,2,6–8). An attempt to hide thoughts of suicide or a plan, indicates an increased risk of suicide(9–11). Less than one-third of suicidal patients express their suicidal intent to a physician or other healthcare professionals(11).

If a mother declines to participate in the *Suicide Risk Referral Flowchart* discussion the Public Health Nurse shall follow the nursing actions for when:

- likelihood of depression is considered high, using the EPDS English version (13-30 EPDS score);or
- likelihood of depression is possible, using the EPDS validated translated version (10-30 EPDS score);or
- likelihood of depression is possible, using the Postpartum Depression – Alternate Questions

Using Crisis Services:

- if **crisis services** are **available** and will support the mother's transition and welfare, follow your facility, program or zone policy and procedures - document nursing actions taken in the electronic medical record
- if **crisis services** are **not available** or are unable to support the mother's transition and welfare, follow the Suicide Risk Referral Flowchart nursing actions
- zones may have crisis-related services to support a mother who is at risk of suicide, including mental health professionals and/or crisis or mobile teams

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Alberta Health Services

<table>
<tr><th colspan="2">Suicide Risk Referral Questions, Rationale and Nursing Actions</th></tr>
<tr><td colspan="2">1. When you refer to harming yourself, are you referring to thoughts of suicide?
Rationale:
• To confirm that “self-harm” refers to thoughts of suicide.
• The use of clear and direct language concerning suicide contributes to reducing the stigma that is associated with it.</td></tr>
<tr><td>IF YES</td><td>A “YES” response confirms suicidal thoughts. Proceed to Question 2.</td></tr>
<tr><td>IF NO</td><td>A “NO” suggests that thoughts of self-harm are not related to suicide. Refer to EPDS Referral Flowchart or Postpartum Depression – Alternate Question Referral Flowchart and follow nursing actions.</td></tr>
<tr><td colspan="2">2. Have you ever attempted suicide in the past?
Rationale:
• Enquires into history of previous attempts.
• A history of suicidal attempt(s) may be easier for the mother to discuss than recent or current thoughts.
• Although suicide risk is considered lower among postpartum women than in the general population, any previous suicide attempt is associated with a 38-fold increase in suicide risk(9,12,13). The rate is higher than that associated with any other psychiatric disorder; a previous suicide attempt is the most important risk factor for suicide(10,14–16).
• The more recent the occurrence of the last suicide attempt, the higher the current risk. If the attempt was not recent (e.g., within 10 years), the risk is lower, but still a strong indicator of overall risk(14,17,18).</td></tr>
<tr><td>IF YES or NO</td><td>A “YES” confirms a previous attempt and indicates an increased risk of suicide however more information is needed to determine the level of risk. Proceed to question 3 for either a “YES” or “NO” response.</td></tr>
<tr><td colspan="2">3. You have told me that thoughts of suicide have occurred to you. Can you tell me if you have a current plan?
Rationale:
• Enquires into the mother’s intention, ambivalence and plan.
• Repeating the mother’s response reinforces that she is heard and understood(10,14).
• The mother’s response confirms her intention and clarifies whether she has a plan(1).
• The level of risk increases with the amount of detail included and the ease with which the mother is able to provide the details(1,9,10,14).
• A flat affect when discussing the plan may indicate severe depression, increased hopelessness and increased risk(1,10,14).
• An attempt to hide thoughts of suicide or plan indicates increased risk(9,10).</td></tr>
<tr><td>IF YES</td><td>A “YES” response confirms a suicide plan. If the mother has a plan, consider her high risk(1,8–10). Proceed to Nursing Actions for Suicide Risk Referral – High Risk.</td></tr>
<tr><td>IF NO</td><td>A “NO” suggests the mother has no current plan. Proceed to Question 4.</td></tr>
</table>

4. Have you ever experienced or been diagnosed with a mental illness or have a family history of mental illness?

Rationale:

- Enquires into any history of mental illness including depression.
- The presence of any psychiatric disorder, such as depression, is the second most significant risk factor for suicide(9,10,12–14). Approximately 90% of people who died by suicide had a psychiatric illness (e.g., depression, bipolar)(9,10,12,14–16).
- Depression can be hormonally influenced; the experience of pregnancy and birth for a mother with previous history of depression or other psychiatric illness dramatically increases the risk for PPD(9,12,13). PPD tends to become worse with each successive pregnancy(9,12,13).
- A family history of depression will increase the risk for PPD(1,8,9,11–13,15).

IF **YES** or **NO**	A **"YES"** response confirms a history of mental illness and indicates an increased risk of suicide however more information is needed to determine the level of risk. **Proceed to Question 5 for either a "YES" or "NO" response.**

5. Is there anything that would prevent or keep you from harming yourself?

Rationale:

- Enquires into the mother's internal and external protective factors.
- Protective factors enable a person to protect their mental health and wellbeing and can buffer from suicidal thoughts and behaviour(10,19,20).
- Several protective factors can contribute to resiliency when stress is experienced and may include: social supports/network, coping skills, responsibility for others or another "reason for living"(10,19,20).

IF **YES**	A **"YES"** response confirms protective factors are present. **Proceed to Nursing Actions for Suicide Risk Referral – Moderate Risk.**
IF **NO**	A **"NO"** response suggests the absence of protective factors. If the mother has thoughts of suicide and is NOT able to identify any reason for living, consider her high risk(9,12,13). Protective factors such a "reason to live" buffer an individual from suicidal thoughts and behaviour(10,19,20). A lack of protective factors can be indicative of severe depression and profound hopelessness increasing the risk of developing or acting on a suicide plan(11). Less than one-third of suicidal patients express their suicidal intent to a physician or other healthcare professionals(11). **Proceed to Nursing Actions for Suicide Risk Referral – High Risk.**

Is there anything else you would like to discuss that we have not talked about?

Rationale:

- Question provides an opportunity for the mother to express her immediate needs and priorities. She may now be willing to provide additional information for the previous questions asked or may disclose new information.
- Offer a collaborative approach that is responsive to the mother's preferences, needs and values and that promotes the mother's self-efficacy and contributes to health and wellbeing(4,5).

Nursing Actions for Suicide Risk Referral
High Risk: Suicidal thoughts with a plan or suicidal thoughts and lack of identified protective factors.

• **Ensure the mother is not left alone**.
• **Notify supervisor**.
• **Notify physician of record,** *if possible***.**
  ○ Consent is not required to disclose health information about the mother to a health care professional providing continuing treatment and care.
  ○ If physician of record is not available, notify the mother's primary contact or 911, if needed, to arrange for transport to ED.
  ○ Notify physician of record of transportation to ED via the referral process.
• **Notify the mother's primary contact** (e.g., partner/family member or designated individual) to arrange for transport to Emergency Department (ED) and determine consent needed for disclosure.
  ○ Consent is not required to disclose health information when there are reasonable grounds to believe the disclosure will prevent or minimize an imminent danger to the health or safety of the mother. Three criteria must be satisfied for the legal definition of "imminent danger" to exist: clarity, danger and imminence.
  ○ Consent is not required to disclose health information about the mother to a health care professional providing continuing treatment and care.
  ○ Consent is not required to notify the mother's primary contact, other appropriate person or *Child and Family Services* to arrange for someone to care for or keep the mother's children safe.
• **Document consent** and any **disclosure of health information** in the electronic medical record.
• **Fax referral information** to ED if mother transported by primary contact or designated individual.
• **Call 911, if needed, to transport to ED, send referral information with Paramedic.**
• Note that transportation to a hospital for assessment by the Emergency Department physician may or may not result in a consult with psychiatry or an admission to hospital.
• **Call ED to alert of transport**.
• **Arrange for care of child/children, if needed.**
• **Complete referral process and documentation.**
• **Followup based on clinical judgment**. If the mother is unable to be reached, followup occurs at the next Public Health Well Child Clinic visit.

Moderate Risk: Suicidal thoughts but no current plan and able to identify protective factors.

• **Offer referral** and discuss availability of support and treatment options.
• **Discuss a timeframe** for when the mother is able to see a physician/mental health worker.
• **Develop a Family Support Plan** with the mother.
The *Family Support Plan* identifies:
  ○ Formal supports such as health care providers and agencies that can be contacted for help(1,8).
  ○ Signs of distress, thoughts and feelings that indicate she may be at increased risk (e.g., irritability, hopelessness, confusion, feeling like a failure).
  ○ Actions to take that may decrease the level of risk.
  ○ People within the mother's social support network who are willing and able to assist in times of need such as family, friends, peers, and community programs and contacts.
• **Determine if the mother's primary contact** (e.g., partner/family member or designated individual) **needs to be notified.**
  ○ Whenever possible and practical, obtain consent to notify primary contact to them of the mother's condition and/or location
  ▪ Disclosure should not occur if it is known to be against the mother's wishes.
  ▪ Use clinical judgment to determine who to contact about the welfare of the mother if it will minimize the threat to the mother (e.g., domestic violence).
  ○ Consent is not required to disclose health information about the mother to a health care professional providing continuing treatment and care.
  ○ Consent is not required to notify the mother's primary contact, other appropriate person or *Child and Family Services* to arrange for someone to care for or keep the mother's children safe.
• **Document consent** and any **disclosure of health information** in the electronic medical record.
• **Complete referral process and documentation.**
• **Followup based on clinical judgment**. If the mother is unable to be reached, followup occurs at the next Public Health Well Child Clinic visit.

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