

Collaborating to ERASE Maternal Mortality in New Hampshire

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ERASE Maternal Mortality! Maternal Mental Health & Suicide Prevention

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What do we do?

Providing care in a clinical setting when we are worried about psychiatric safety and suicide risk....

What to do when....

- ▶ 22 year old woman who is 32 weeks pregnant arrives at the hospital requesting MAT initiation. Homeless, struggling with active methamphetamine use and history of opiate use disorder. Diagnosis of schizophrenia and history of not taking prescribed medication.
- ▶ She was recently discharged from a residential treatment facility without completing treatment. As you attempt to work with her to develop a safe discharge plan, she becomes increasingly agitated and argumentative , stating 'If you are not going to help me I am just going to kill myself'".



What do I do next?



**I see a woman who
may be feeling:**

Sad, angry, frustrated,
overwhelmed, scared,
anxious, incompetent

I am feeling: worried,
frustrated, overwhelmed,
scared, angry, anxious and
incompetent

When you are worried about the safety of a patient....

- ▶ Patients who may be suicidal will present in many different ways; sometimes with an abundance of emotion and sometimes with little affect
- ▶ Everyone works to help a patient calm herself and regain a sense of control
- ▶ Staff need to stay in control, too. Recognize your own negative or scared reactions to a patient and DO NOT ARGUE with the patient if the presentation is anger/agitation
- ▶ Be aware of your feelings about the situation and the patient
- ▶ Skills vary among staff members, consider when to ask for help
- ▶ You can't do this when you are scared of the patient: get help/resources.

Focus on Immediate Safety

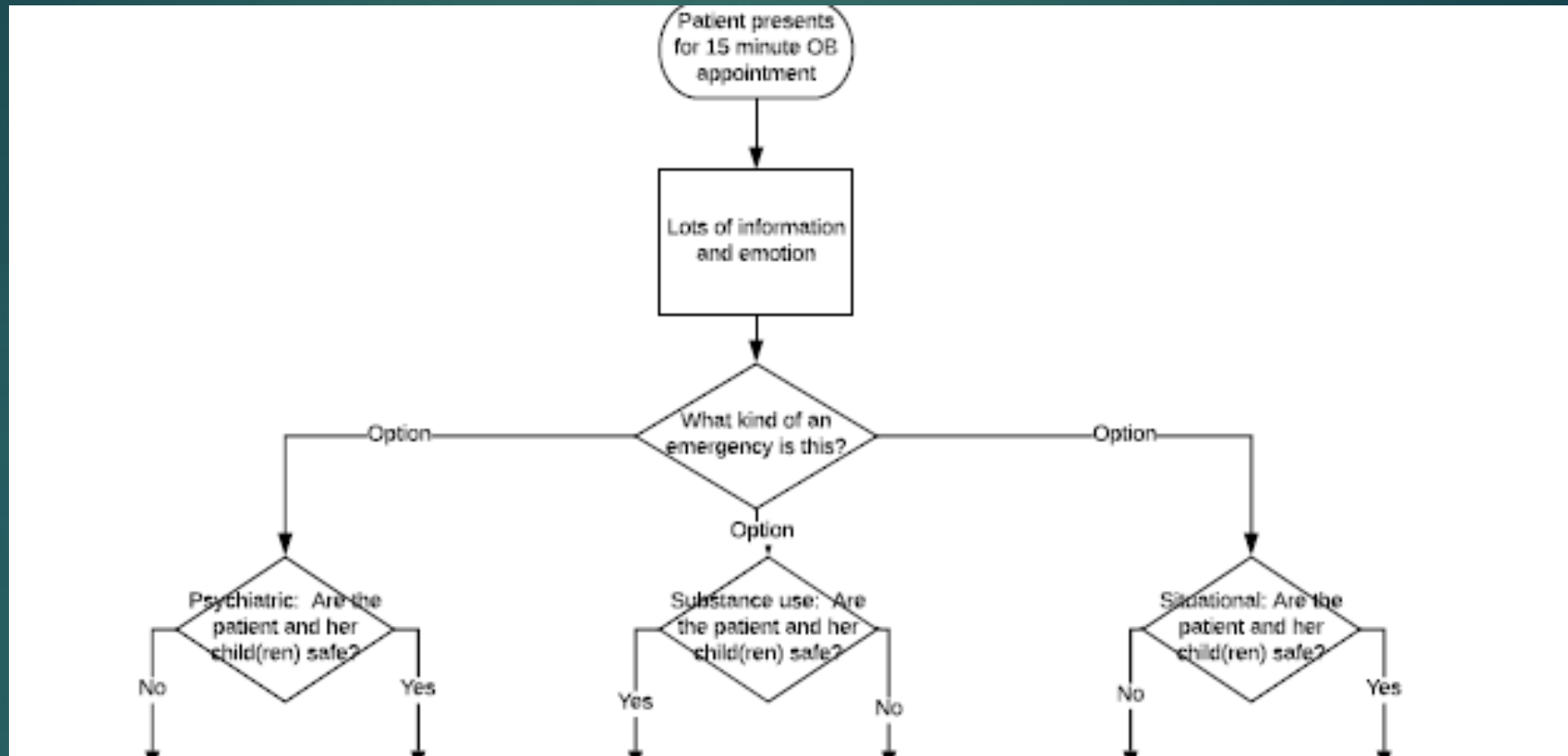


- ▶ Is this an emergency?
- ▶ If yes, what kind of an emergency is this?
- ▶ Will my patient and her child be safe when they leave my office?
- ▶ Determination of what is causing this presentation....

What needs immediate intervention?

- ▶ Psychiatric:
 - ▶ Suicidal or homicidal intent
 - ▶ Unable to care safely for self or children due to emotional state
- ▶ Substance use:
 - ▶ Imminent or acute withdrawal (risk level based on substance and severity of use)
 - ▶ Unable to care for children due to substance use severity
 - ▶ *Risk of Overdose*
- ▶ Situational:
 - ▶ Danger (partner or other violent situation)
 - ▶ Lacks food today
 - ▶ Lacks shelter today

How can I tell what's going on?



Don't forget....just because she is safe in one area doesn't guarantee there's no risk in another!

Psychiatric, Substance Use Disorder or Situational/Resource related

- ▶ Sometimes one, two or all three; important to assess for all as best you can because these stressors are complex and can impact her and her family in many ways



Our job is to help take the crisis OUT of the crisis

Yes, this is going to slow down the day and you are probably going to be behind schedule

Assessment; What do I want to know?

- ▶ Suicidal ideation: Thoughts of harming self
- ▶ Plan: The way to do it
- ▶ Intent: Will she act on the plan?

Passive- no plan but would prefer to be dead “I’d rather not be here anymore”

Active- Has a plan and wants to carry it out*

*Needs further evaluation; refer to Emergency Mental Health Services; or ED

Ok, the crisis is psychiatric and I need to deal with it

Things to remember.....

- ▶ Do not rely on PHQ-9; ask and assess
- ▶ You will not cause someone to become suicidal by asking the questions
- ▶ Remember that most patients presenting as potentially suicidal do not die by suicide

Assessment of risk can be complicated by the providers emotional reaction and thought process

“Did she really say that?”

“I don’t think she meant what she said”

“What might happen if I ignore what she said?”

What Questions Do I Ask?

Ask the questions. Most effective when provider has the entire conversation. Patients are more comfortable having the discussion with one person, not in pieces amongst various clinic staff.

- ▶ Tell me what thoughts you are having about harming or killing yourself?
- ▶ How long have you been thinking about this?
- ▶ What is your plan? How would you do it? What steps have you taken to put this plan into action?
- ▶ Do you have access to weapons, pills, knives?
- ▶ Why now? Is there a precipitator?

Decisions.....

- ▶ If unsure about risk....protect, get consultation in ED or mental health center, and consider hospitalization. Do you need to involve Child Protection?
- ▶ If not suicidal.....decide on a reasonable plan that may not require hospitalization; calling friends, family, therapist, supports. Help to connect with community mental health center for further assessment and ongoing support.
- ▶ Shorten time to next appointment; phone calls for follow-up and referrals. Keep asking about suicidal thoughts....keep the conversation going!

Know Your Limits

- ▶ Working with suicidal patients is stressful
- ▶ Monitor your reactions; (e.g., anger, denial, depression, intellectualization, helplessness, hatred, rejection, indifference).
- ▶ Warmth, genuineness and unconditional positive regard go a long way; notice if these are not on board.
- ▶ Remember you are human, this is probably not what you came to work today to do.
- ▶ Help and support your colleagues; can someone else see your next patient?
- ▶ It's always okay to ask for help via further consultation or ED evaluation

Schedule short interval follow up...

Make sure her next appointment is with you so she doesn't have to tell the whole story again!

- ▶ Embedded behavioral health?
- ▶ Community Health Worker?
- ▶ Integrated MAT?
- ▶ Social Worker?
- ▶ Referrals:
 - ▶ Community Mental Health?
 - ▶ SUD treatment provider?
- ▶ Food pantry
- ▶ Homeless shelter

Community Partners



Long term relationships to develop:

- ▶ IPV advocacy
- ▶ ED staff
- ▶ Child protection
- ▶ Community mental health
- ▶ Local substance use treatment providers
- ▶ Food Pantry
- ▶ Homeless Shelter
- ▶ WIC

ERASE Maternal Mortality! Maternal Mental Health & Suicide Prevention

Elizabeth Fenner-Lukaitis, LICSW
Acute Care Services Coordinator
Bureau of Mental Health Services/DHHS

Before we begin.....

- ▶ Some of you have likely been touched by suicide; estimates are for every suicide, there are at least 135 people affected by it.
- ▶ It is important that you practice self care around this, and other difficult topics. If you need to leave the webinar it is OK as long as you are Ok.
- ▶ This may bring up thoughts and feelings about other deaths, even if not suicide deaths. This is normal.
- ▶ There are resources to help yourselves or others who may be having thoughts related to suicide.
- ▶ My contact info is on one of the slides to reach out afterwards, even months later.
- ▶ Treatment is effective and there is hope!

Suicide 101

- ▶ **Language Matters:**
- ▶ Do say, “die by suicide” vs “commit suicide”.
- ▶ Do say “suicide is generally preventable”.
- ▶ Do say “completed suicide” vs “successful suicide”.
- ▶ Do not to glorify the person or the act.
- ▶ Do not give details or specifics.
- ▶ Do not minimize the factors.
- ▶ Do ask someone if they are feeling suicidal.
- ▶ Do use the word “suicide”, or “kill”, or “die”.

Suicide is generally preventable

- ▶ Most people are ambivalent
- ▶ 70% communicate their plans in advance; although it may be missed
- ▶ Most (85%-90%) who survive a near-lethal attempt do not die by suicide
- ▶ Roughly 90% of individuals who die by suicide are thought to have either a mental illness and/or a substance misuse problem. Often undiagnosed.
- ▶ There is effective treatment

*Clark and Fawcett (1992)

**Suominen et al. (2004)

*** Moscicki (2001)

Suicide in NH: Males and Females

YEAR	TOTAL	MALE/FEMALE	MOST COMMON	2 nd COMMON	3 rd COMMON
2019	258	207/51	GSW/Hanged	Hanged/GSW (tie)	OD/OD (tie)
2018	273	219/54	GSW/hanged	Hanged/GSW	OD/OD
2017	255	196/59	GSW/OD	Hanged/Hanged	OD/GSW
2016	235	173/62	GSW/OD	Hanged/Hanged	OD/GSW
2015	225	162/63	GSW/OD	Hanged/GSW	OD/Hanged
2014	251	192/59	GSW/OD	Hanged/Hanged	OD/GSW
2013	182	140/42	GSW/OD	Hanged/Hanged	OD/GSW
2012	203	160/43	GSW/GSW	Hanged/OD	OD/Hanged
2011	200	162/38	GSW/OD	Hanged/GSW	OD/Hanged
2010	206	160/46	GSW/OD	Hanged/GSW	OD/Hanged
2009	167	136/31	GSW/OD	Hanged/GSW	OD/Hanged

General Risk Factors for Suicide:

- ▶ Firearm ownership or access
- ▶ Acute unemployment
- ▶ Suicidal ideation
- ▶ History of suicide attempt(s). More attempts = higher risk
- ▶ Excessive or increased use of substances
- ▶ History of psychiatric hospitalizations, risk higher if recent
- ▶ Hopelessness
- ▶ Exposure to suicide; friend/family, some media issues
- ▶ Recent change in relationship status
- ▶ Feeling trapped; no way out of the situation
- ▶ Psychiatric disorders:
 - ▶ -Those suffering from depression are at 25 times greater risk for suicidal than the general population

Why is this population more at risk?

- ▶ Good news: relatively rare!
- ▶ Risk factors specific to the perinatal population:
 - ▶ Depression (post-partum and “regular”)
 - ▶ First episode of any psychiatric disorder
 - ▶ Less access to services (childcare, financial, stigma, etc...)
 - ▶ Highest prevalence at 9-12 months post-partum*
<https://womensmentalhealth.org/posts/perinatal-suicide-highest-risk-occurs-at-9-to-12-months-postpartum>
- ▶ Anti-depressant risks
- ▶ Isolation

What to do or say if you fear someone is thinking of suicide

- ▶ Stay calm, project acceptance of their feelings
- ▶ Stay with them, remove dangerous items
- ▶ Time is on your side; suicidal feelings are transitory
- ▶ Let them know you care
- ▶ Listen
- ▶ Validate their feelings
- ▶ Ask what has helped them in the past when feeling similarly
- ▶ Pick up on anything that is of importance to them; play it up
- ▶ Encourage them to talk with a professional; tell them you will help

Services to contact 24/7 if you have
questions or concerns

**National Suicide Prevention Lifeline
(Headrest): 1 800 273 8255 (TALK)**

**National Suicide Prevention Textline:
“home” to 74174**

Local Community Mental Health Center (contact info on next slide)

Community Mental Health Centers

- ▶ **Northern Human Services:** Berlin (752-7404), Colebrook (237-4955), Littleton (444-5358), Conway (447-2111, after hours call Memorial Hospital at 356-5461), Wolfboro (569-1884, after hours call Huggins Hospital at 569-7500)
- ▶ **West Central Services:** 1-800-564-2578
- ▶ **Lakes Region Mental Health:** 524-1100
- ▶ **Riverbend Mental Health*** (Concord) 1-844-743-5748
- ▶ **Monadnock Family Services** (Keene) 357-5270 (after hours call 357-4400)
- ▶ **Greater Nashua Mental Health*** 1-800-762-8191 (Mobile 816-0101 until 11/1, then use the 1-800 number)
- ▶ **Mental Health Center of Greater Manchester*** 668-4111 (Mobile 1-800-668-3544)
- ▶ **Seacoast Mental Health Center:** Exeter (772-2710), Portsmouth (431-6703)
- ▶ **Community Partners** (Dover) 516-9300
- ▶ **Center for Life Management** (Derry) 434-1577
- ▶ * designates Mobile Crisis Response Teams which will come to you

Other resources

- ▶ Survivor of Suicide Loss packets: <https://theconnectprogram.org/find-support/coping-with-suicide-loss/>
- ▶ CALM, Counseling on Access to Lethal Means (one of the practices recognized by Zero Suicide). Online course: <https://training.sprc.org/>
- ▶ Or, you can receive training “live” (in person if Covid permits) or via Zoom from me.
- ▶ 3 hours
- ▶ 3 Continuing Education Units from the NH Chapter of National Association of Social Workers (generally able to be transferred to different disciplines).
- ▶ My contact info for this and other issues is on the next slide

Questions? Want more information?

- ▶ Elizabeth Fenner-Lukaitis, LICSW, Acute Care Services Coordinator
- ▶ Bureau of Mental Health Services
- ▶ 105 Pleasant Street
- ▶ Concord, NH 03301
- ▶ (603) 271-5028
- ▶ Elizabeth.Fenner-Lukaitis@dhhs.nh.gov



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MATERNAL MENTAL HEALTH & SUICIDE PREVENTION

DAVID EILER, MD

Perinatal Depression: Timing of onset

- ▶ 18% – 50% of cases of depression diagnosed postpartum have antepartum onset
- ▶ Differences in RF and clinical presentation suggest different causal mechanisms for AP v PP
 - ▶ Antepartum onset: more likely history of MDD
 - ▶ Postpartum onset: higher incidence of intrusive/violent thoughts, psychotic symptoms

Perinatal Suicide: Incidence, RF

- ▶ Rare: similar to incidence in non-pregnant women
- ▶ Higher incidence with postpartum psychosis

Screening

- ▶ PHQ-9
- ▶ C-SSRS
- ▶ QIDS-SR
- ▶ Other
 - ▶ Postpartum Depression Screening Scale (PDSS)

Treatment: First Line

- ▶ Medication
 - ▶ SSRIs
 - ▶ Other Antidepressant classes
 - ▶ Concerns in pregnancy, breastfeeding
- ▶ Psychotherapy
 - ▶ Cognitive Behavioral Therapy (CBT)
 - ▶ Group Therapy

Treatment: Neuromodulation

- ▶ Electroconvulsive Therapy (ECT)
- ▶ Transcranial Magnetic Stimulation (TMS)
- ▶ Others: DCS, VNS, DBS

Treatment: ECT

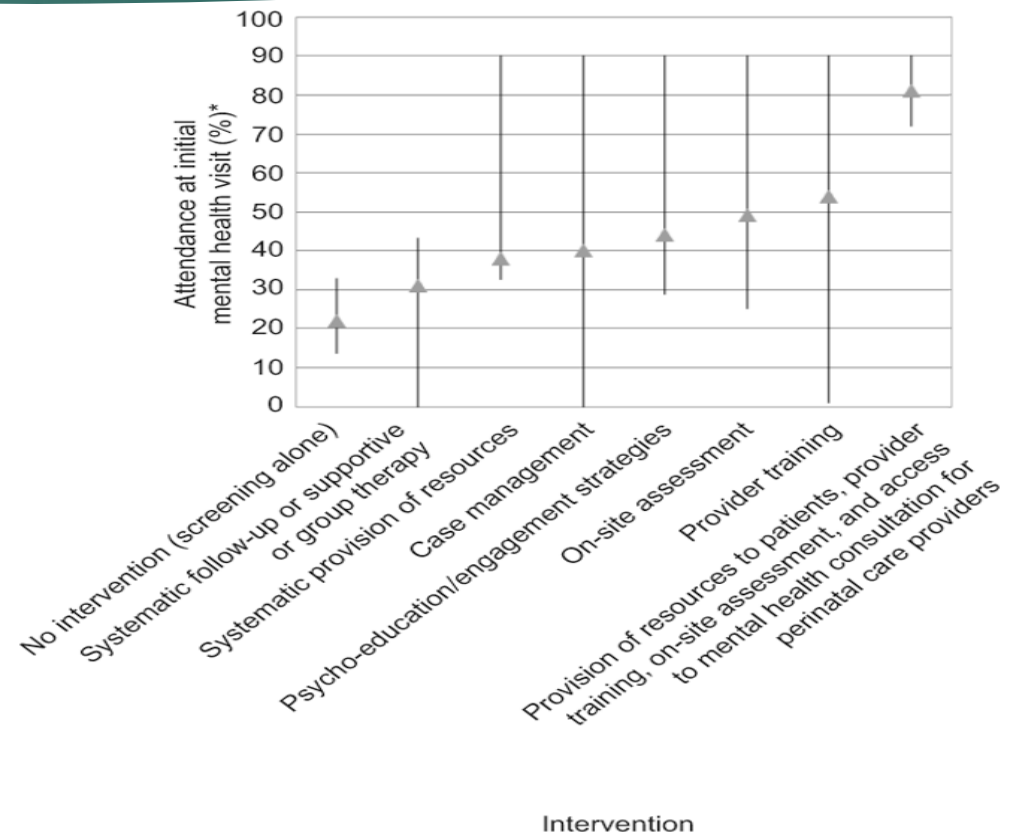
- ▶ Most effective treatment for depression
- ▶ Indicated for PND, MDD, bipolar depression/mania, depression with psychotic features
- ▶ Additional risks in pregnancy
- ▶ Fetal monitoring required (3rd trimester)
- ▶ Anesthesia required

Treatment: TMS

- ▶ Efficacy ~ 50%
- ▶ Outpatient only
- ▶ FDA-approved for MDD only
- ▶ Found safe, effective in PND, in limited studies
- ▶ No fetal monitoring required
- ▶ No anesthesia

Mental Healthcare Utilization

- ▶ Screening alone: 22% utilization
- ▶ Additional interventions: 2-4 fold increase in utilization



* N Byatt, L Levin, D Ziedonis, T Moore Simas, J Allison; Enhancing Participation in Depression Care in Outpatient Perinatal Care Settings: A Systematic Review; Obstet Gynecol. 2015 November ; 126(5): 1048–1058.

Figure 2.
Attendance at initial mental health visit according to intervention. *Vertical lines indicate range. *

Resources: Zero Suicide

- ▶ Designed for healthcare organizations
- ▶ Evidence-based*
- ▶ Complete framework for organizational change
- ▶ Widely-implemented
- ▶ Tools for each stage of implementation

Resources: Postpartum Support International

- ▶ Designed for patients, families
- ▶ State chapters
- ▶ Support groups
- ▶ Provider directories
- ▶ Resources for providers, as well

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SAVE THE DATE!

ERASE MATERNAL MORTALITY

November 12, 2020

New Hampshire

**Alliance for Innovation on Maternal
Health Program (AIM) Launch!**