

Suicide Prevention is Everyone's Work: Responding to Risk in the Perinatal Period

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2026 COLORADO PERINATAL SUBSTANCE USE INTEGRATION CONFERENCE

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FOR WOMEN AND BABIES



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*don't stop believing
in recovery*

Shanice

- Shanice is a 27-year-old G2P2002 woman, 6 weeks postpartum after an emergency C-section for fetal distress following a prolonged labor, which she experienced as frightening and chaotic.
- Her newborn Malik required a brief NICU stay.
- At her OB follow-up, her Edinburgh Postnatal Depression Scale (EPDS) score is 14, and she answers “Sometimes” to question 10: “The thought of harming myself has occurred to me.”
- When asked more about her symptoms, she reports severe sleep disruption since delivery, obtaining only 3–4 hours of fragmented sleep per night, even when her children are asleep.
- She is solo parenting overnight due to her partner working night shifts, caring for both Malik and her toddler, Grace.



Shanice

- She describes escalating anxiety with persistent rumination about the delivery, including self-blame and feelings that she “failed” her baby.
- She reports intrusive recollections of the birth, panic symptoms on waking (including gasping), and inability to rest. She feels overwhelmed, irritable, and emotionally labile, with frequent tearfulness.
- She endorses low energy, difficulty functioning, and feeling like she is “failing” as both a parent and at work, having returned to work one week ago.
- She has limited social support, feels unable to share her struggles with her partner Jordan or her family, and has discontinued therapy due to financial constraints.
- She shares that some days she feels she “can’t do this,” and at times wishes she could “disappear for a while.”
- Her past medical history is notable for pre-eclampsia and generalized anxiety disorder.



Maternal Mortality and Suicide

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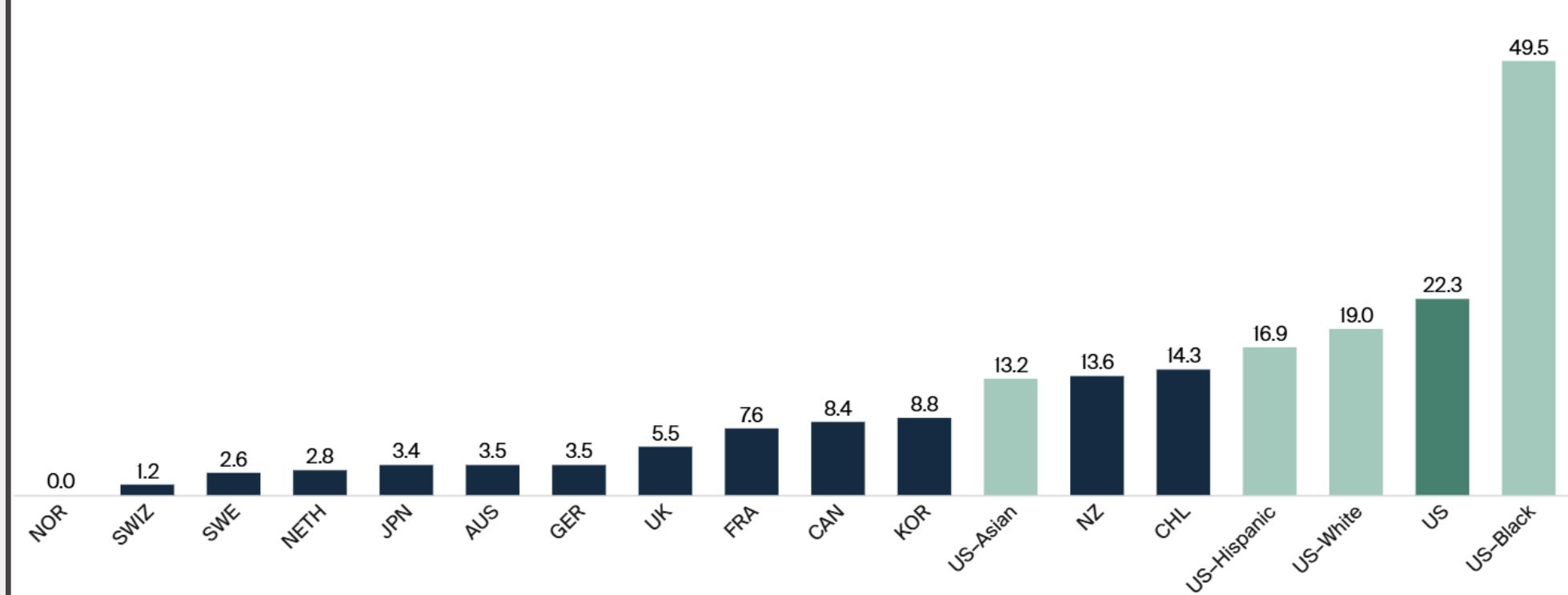
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The United States continues to have the highest maternal death rate, with the rate for Black women by far the highest of any group.

Maternal deaths per 100,000 live births



Notes: The maternal mortality ratio is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. For more information on how maternal mortality is defined, see Organisation for Economic Co-operation and Development, “[Maternal and Infant Mortality](#),” in *Health at a Glance 2023: OECD Indicators* (OECD, 2023). 2015 data for FRA; 2017 data for UK; 2018 data for NZ; 2020 data for CAN and SWIZ; 2021 data for AUS, GER, JPN, KOR, NETH, and SWE; 2022 data for CHL (provisional), NOR, and US. Due to sample size limitations, data for US-AIAN cannot be displayed. AIAN = American Indian and Alaska Native. Asian Americans include a wide range of distinct communities. Such groupings are imperfect, as they mask significant difference in maternal mortality rates.

Data: All country data from OECD Health Statistics 2023 extracted on February 29, 2024, except data for US are 2022 data from the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, mortality and natality data files, “[Maternal Mortality Rates in the United States, 2022](#).”

Source: Munira Z. Gunja et al., *Insights into the U.S. Maternal Mortality Crisis: An International Comparison* (Commonwealth Fund, June 2024). <https://doi.org/10.26099/cthn-st75>

Black mothers have been more likely to die than white mothers for 100 years.



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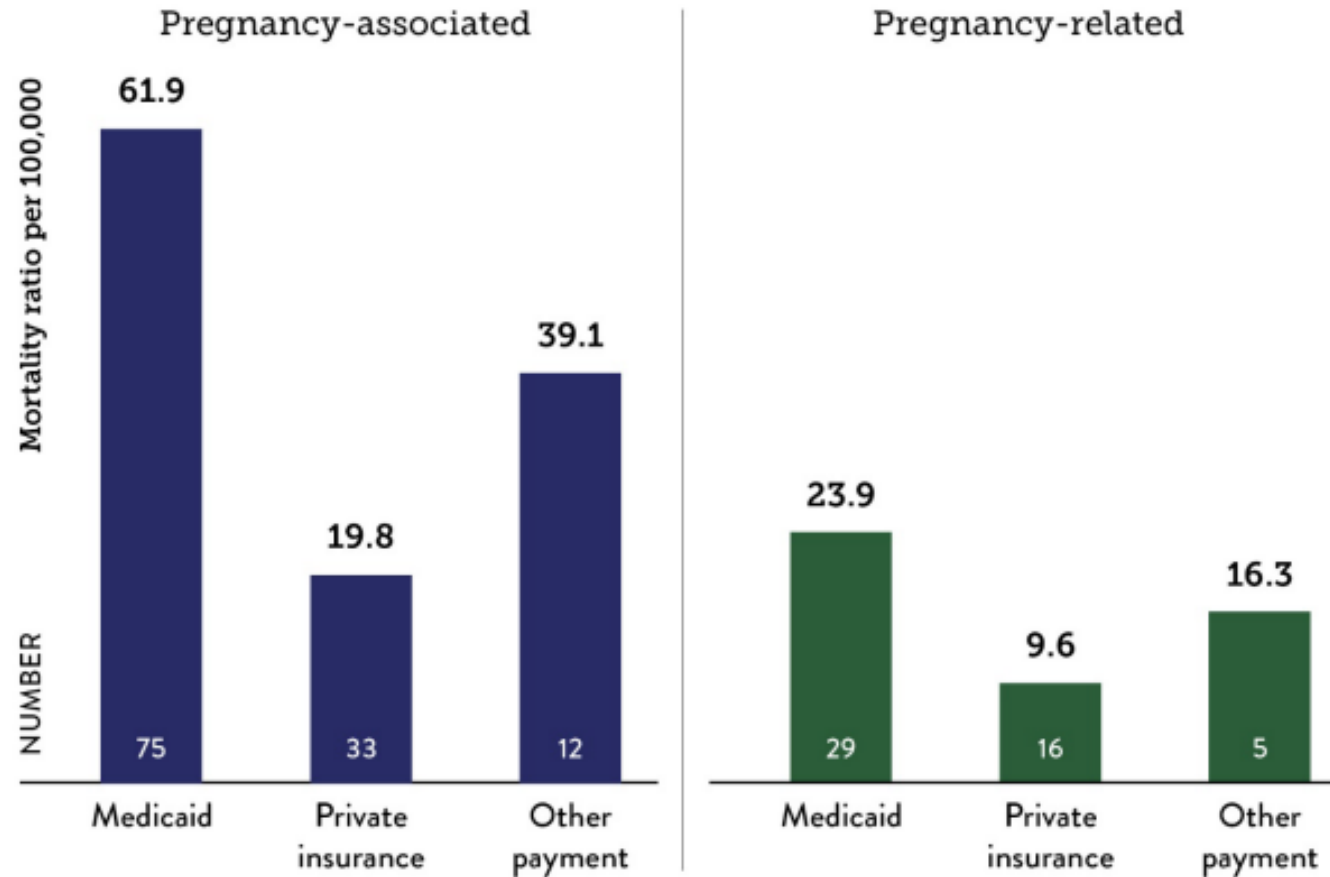
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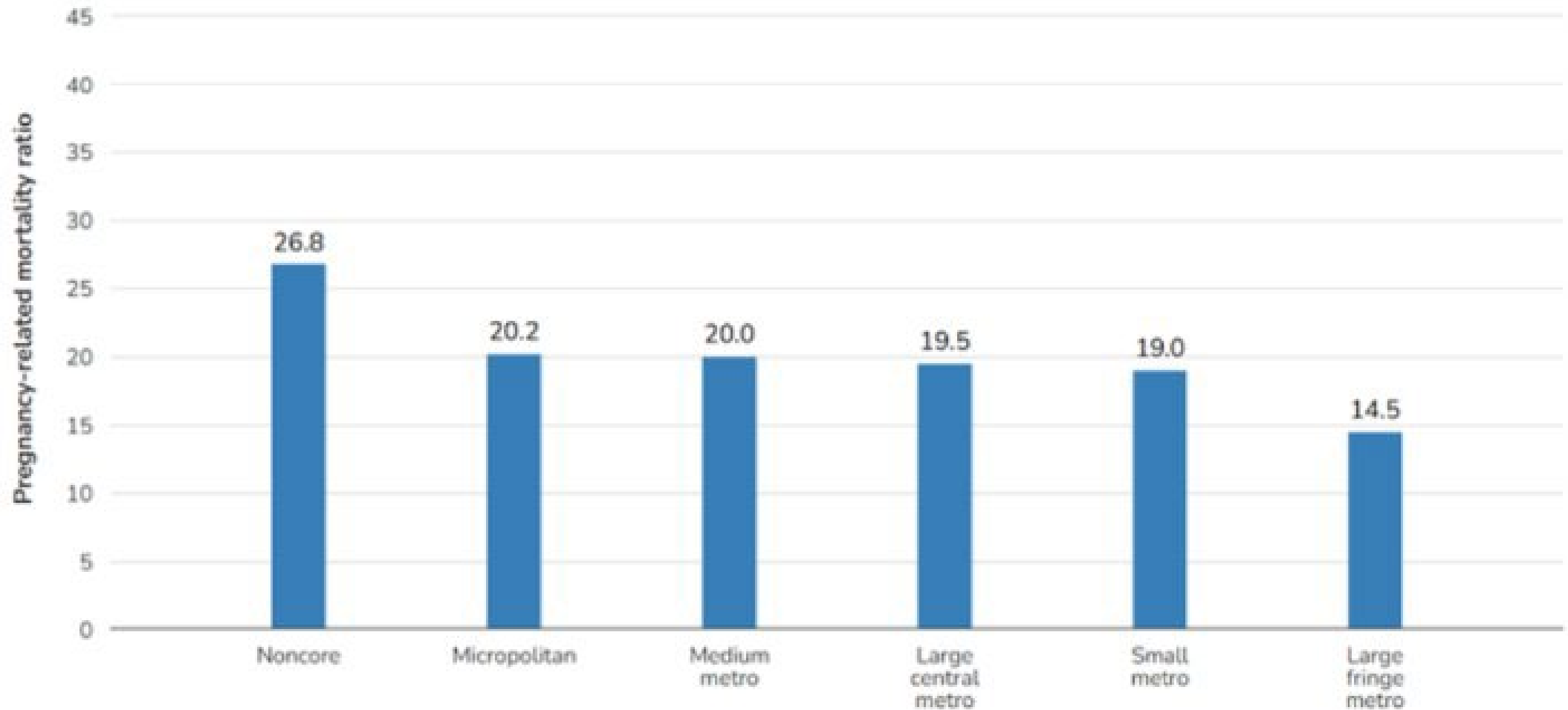
Mortality ratios by payment at delivery, 2016-2020

Pregnant and postpartum people with Medicaid as payment at delivery were 2.5 times more likely to die from pregnancy-related causes than those with private insurance.



Payment at delivery is determined from birth certificates, so only cases that had a live birth for their most recent pregnancy have data about their insurance at delivery.

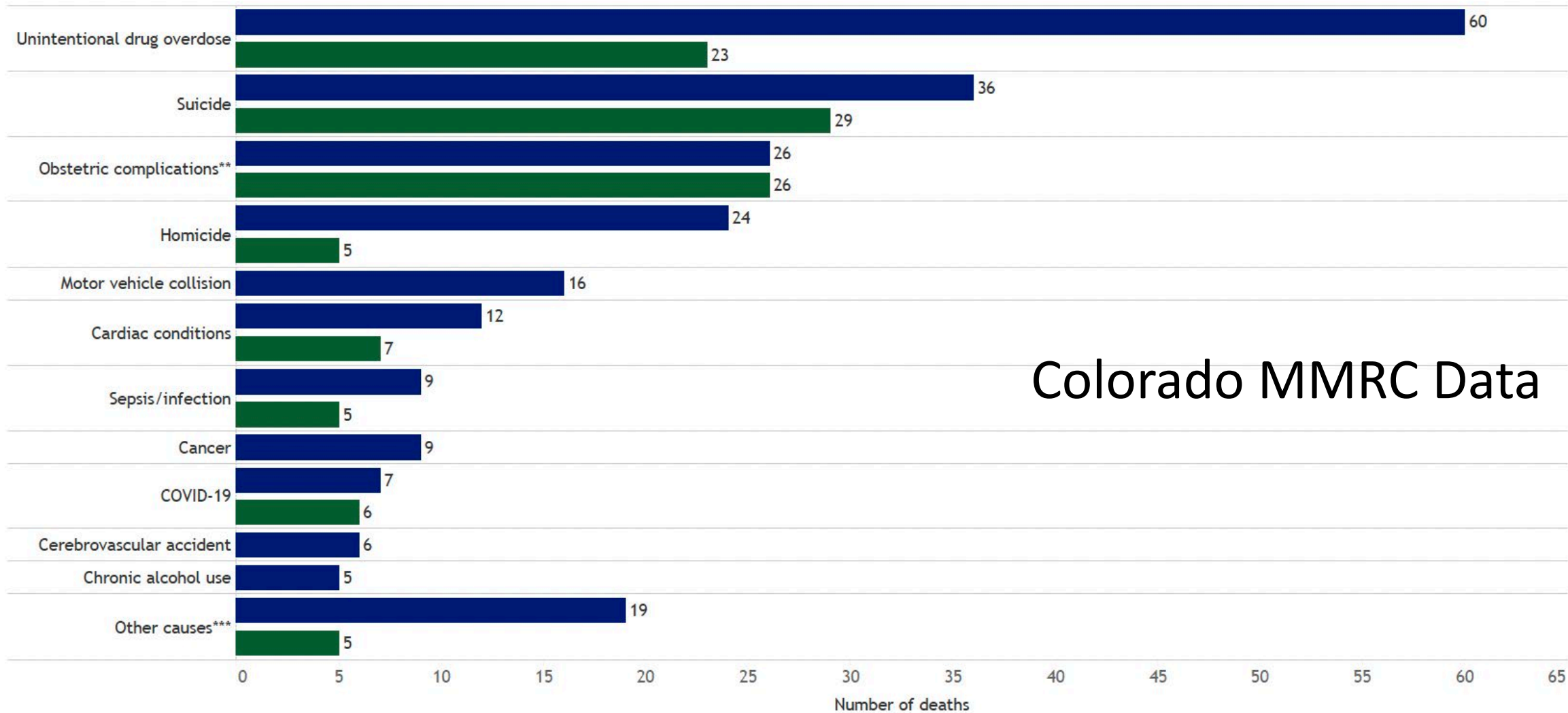
Pregnancy-related deaths by urban-rural classifications, 2023^a



Source: [Pregnancy Mortality Surveillance System](#)

Leading causes of pregnancy-associated and pregnancy-related deaths, 2019-2023

Only causes of death with five or more deaths are shown

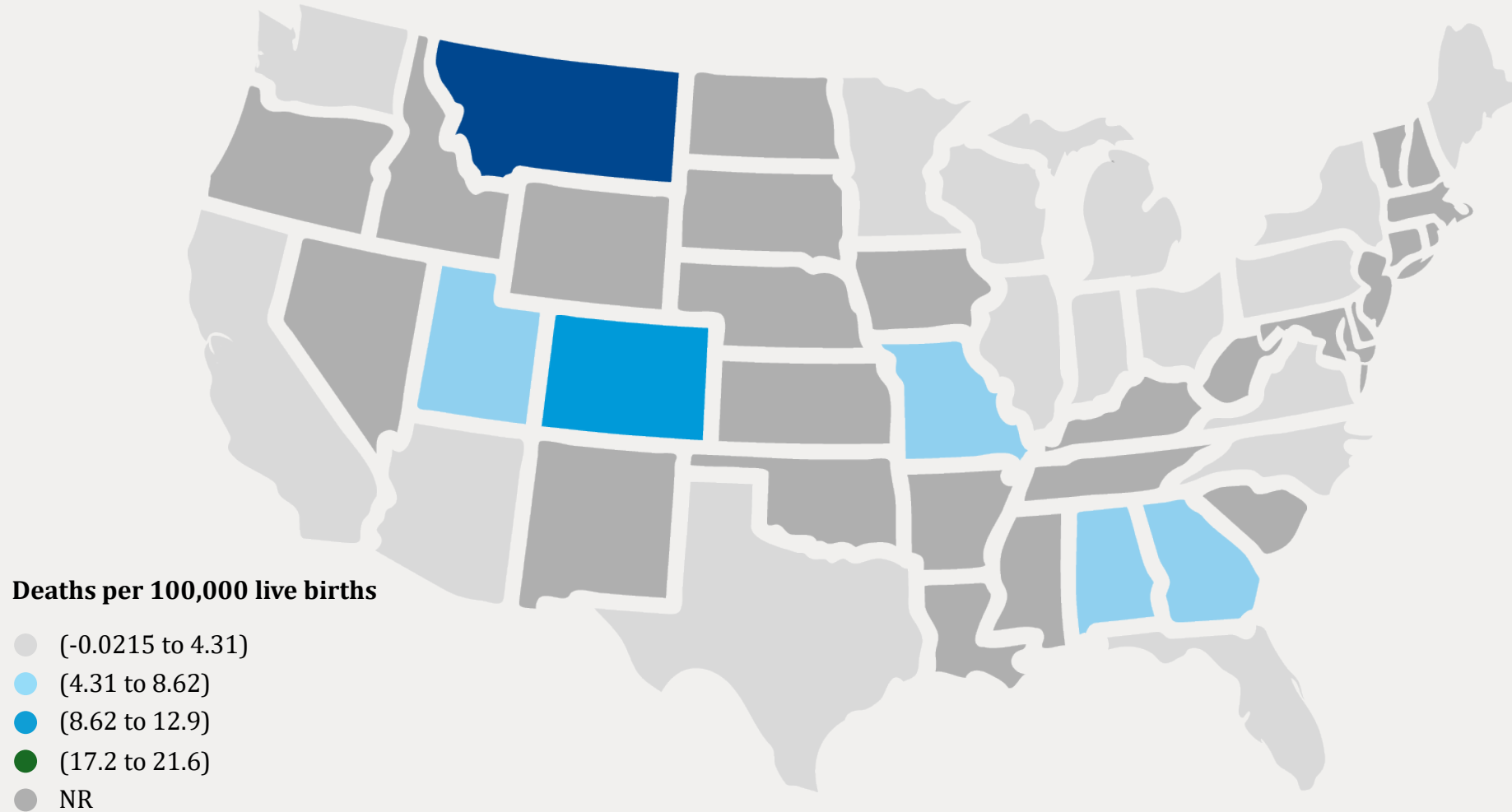


Colorado MMRC Data

**Obstetric complications include: hemorrhage, placenta accreta spectrum disorders, postpartum infections, obstetric sepsis, hypertensive complications of pregnancy, pulmonary embolism, amniotic fluid embolism, anesthesia complications, and ruptured ectopic pregnancies

***Other causes includes any causes of death with fewer than 5 deaths

Pregnancy Associated Suicide



Suicide in the Perinatal Period

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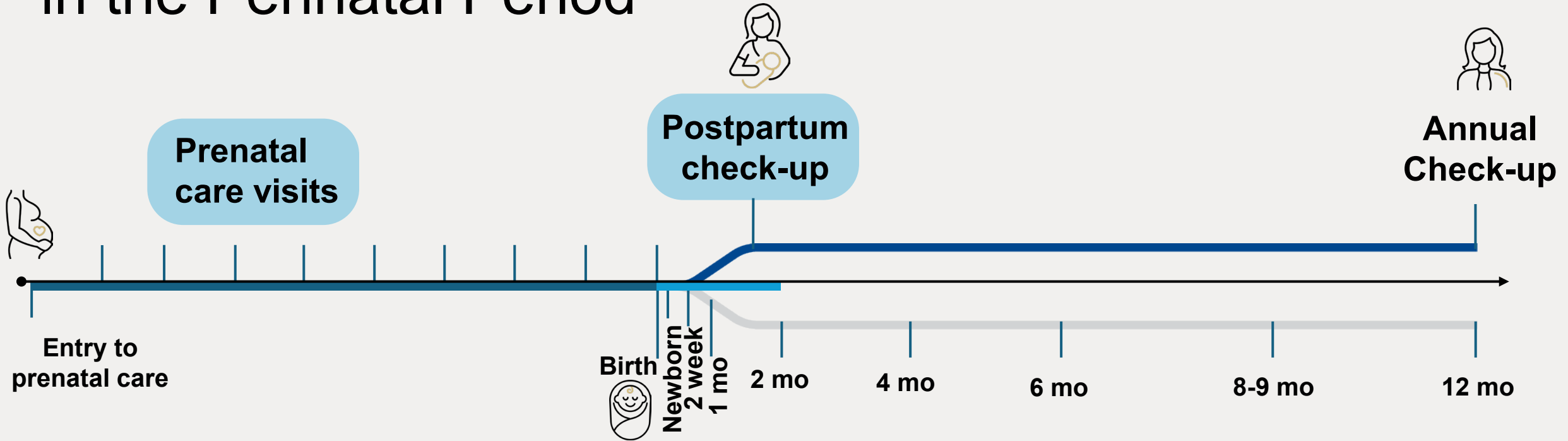


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Care for Mothers is not Designed for Suicide Prevention in the Perinatal Period



Proportion of Suicide Deaths in the Perinatal Period

24%

14%

62% between 43-365 days postpartum



Characteristics Associated with Perinatal Suicide: Method

- **Hanging or suffocation** are the most common method for suicide among perinatal women (35-45%)
- **Firearms** account for a quarter to a third of perinatal suicides



Characteristics Associated with Perinatal Suicide: Mental Illness

- **Shorter illness duration (less than a year)** compared with non-perinatal suicide victims.



Health Care Utilization

- More than half **did not attend a postpartum visit** with their obstetrics clinician.
- Most (74%) had at least one **ED or hospital visit** in between delivery and death.



What are the strongest risk factors for Perinatal Suicide?

Perinatal Specific

- Postpartum depression
- Postpartum psychosis
- Lack of prenatal care
- Perinatal Loss

Increased Relevance in Perinatal Period

- Child protective services involvement
- Intimate Partner Violence
- Treatment discontinuation
- Financial stress
- Social isolation
- Sleep deprivation
- Substance use

Broader risk factors (remain true in perinatal period)

- Mental health diagnoses
- Previous attempts
- ACEs

The overlap Between Substance Use and Suicide

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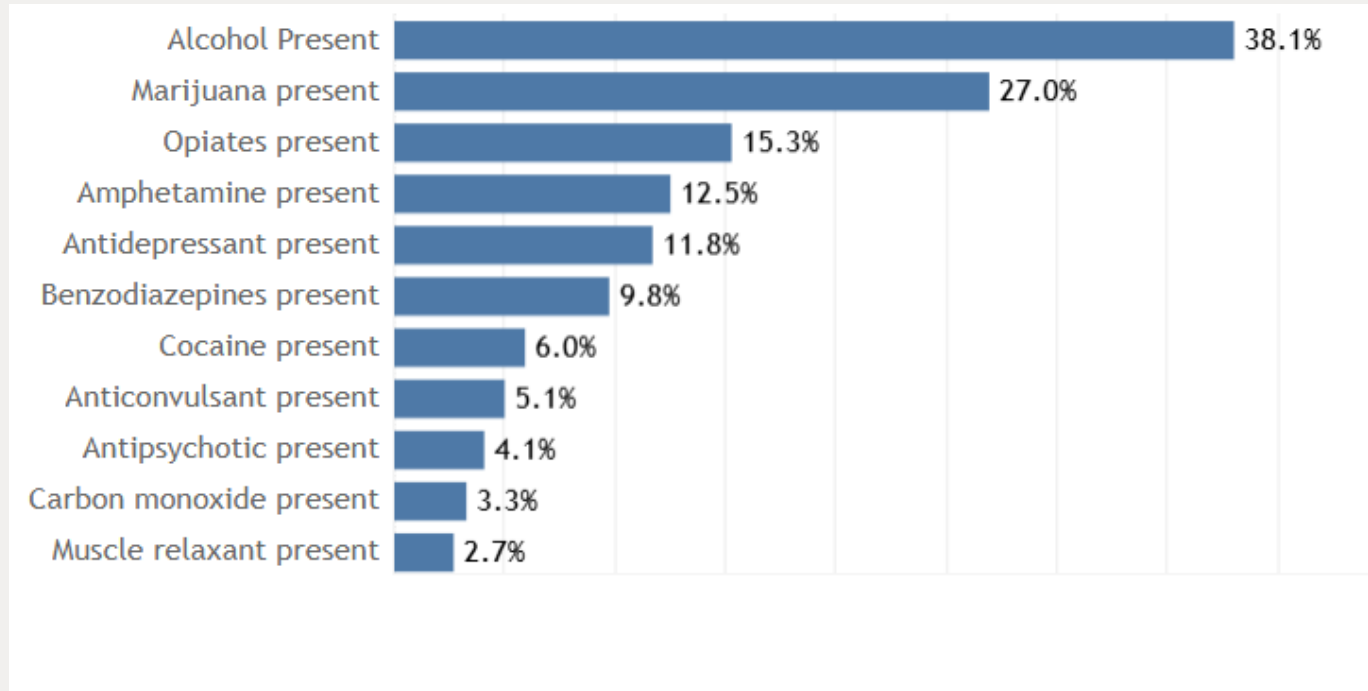
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Key Points

- Alcohol and drug use disorders and psychiatric diagnoses:
 - Share risk and protective factors
 - Have a bidirectional relationship: each can increase the risk for, trigger, or worsen the other
- A common motivation for heavy alcohol or drug use is to address psychological (and sometimes physical) pain
- Suicide is a leading cause of death among individuals with an alcohol or drug use disorder
- The presence of alcohol or other drugs is common in suicide deaths
- Among pregnant individuals who use alcohol or drugs, polysubstance use is common
 - Especially: alcohol, cannabis, tobacco
- Postpartum is a vulnerable time for resuming or increasing substance use
- Engage partners and family in supporting changes in alcohol or drug use



Toxicology: Suicide Deaths-Colorado 2023

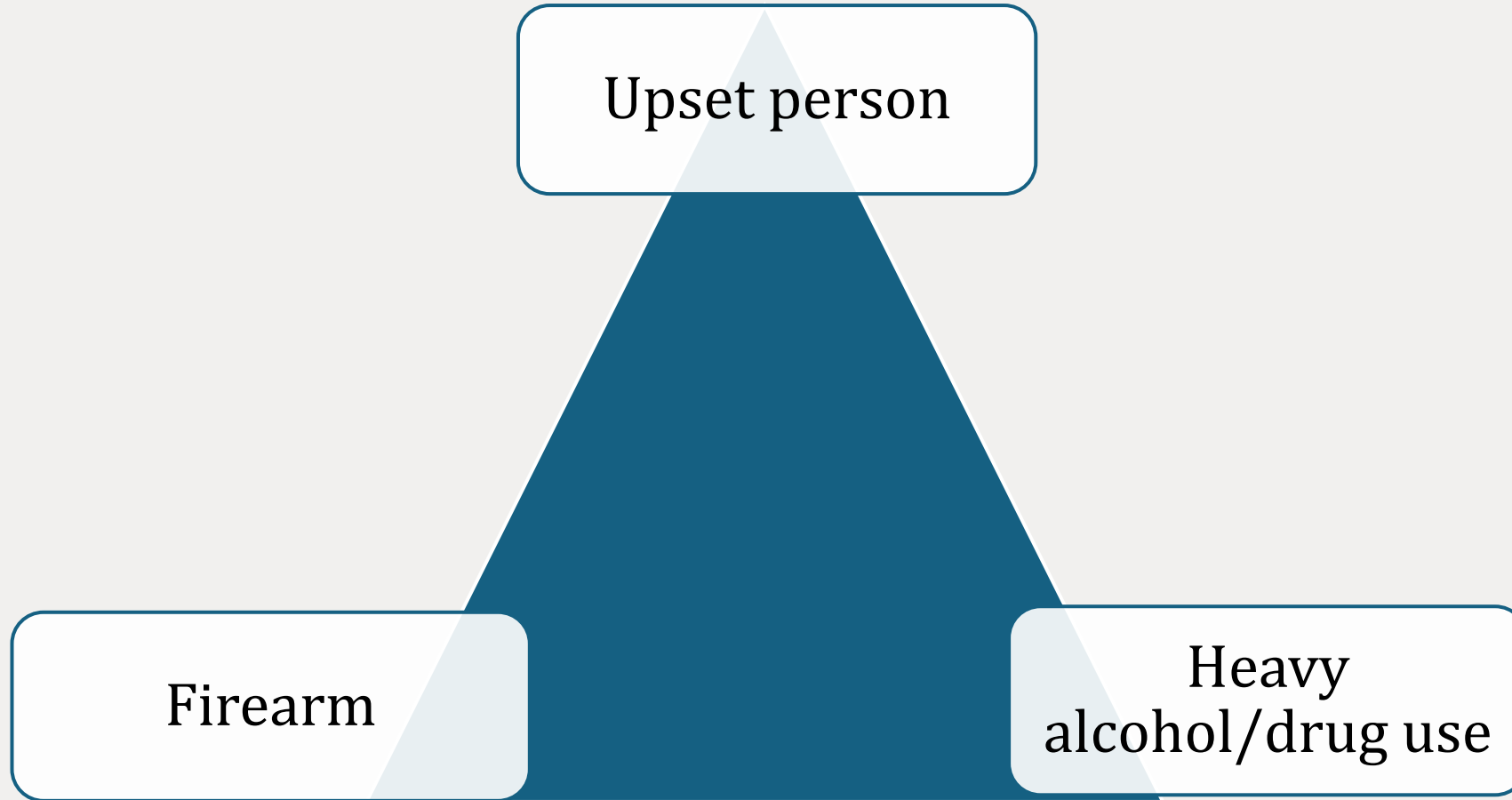


Total suicides: N=1258

Toxicology available: N=1020

Source: Colorado Violent Death Reporting System; CDPHE

The “Lethal Triad”



When these three conditions co-occur, the risk of suicide is much higher

Alcohol

- A major depressant!
- Defining risky/unhealthy alcohol consumption in **adult females**
 - **Binge drinking:** 4+ standard drinks in ~2 hours
 - **Heavy drinking:** 8+ standard drinks/week (more than 1 drink/day on average)
 - **High intensity drinking:** 8+ standard drinks in a row
 - **Any alcohol use during pregnancy**
- Acute intoxication and heavier use disrupts sleep quality, decreases REM sleep, and makes sleep more fragmented
- Heavier use may lead to “alcohol myopia”, increased dysphoria, disinhibition, increased impulsivity, affective numbing
- Heavier use increases the risk of experiencing and perpetrating IPV
- Public health perspective: Decreased per capita alcohol consumption could help prevent suicide



Opioids

- Individuals with OUD are significantly more likely to die by suicide than the general population.
- Chronic opioid use can worsen negative affective states
- Many opioid overdoses involve alcohol
- Opioids + alcohol increase suicide risk
- It can be difficult to distinguish between unintentional and intentional overdose
- Perinatal period: in people with OUD, opioid agonist medications increase engagement in prenatal, postpartum *and* addiction care.



Cannabis

- Frequent use: **defined as 5+ times/week**- increases risk of cannabis use disorder
- Cannabis use may lead to earlier onset of psychosis in adolescents and young adults (in those with underlying risk)
- Systematic review: recreational use associated with increased suicidal ideation and attempts in the general population, and in individuals with major depression or bipolar disorder
 - Worse suicide-related outcomes with younger age of initiation, chronic use, and heavy consumption
- Chronic use is also associated with **decreased motivation** for prosocial and self-care activities
- Higher potency cannabis: is reasonably expected to carry higher overall risks to mental health



Tobacco

- Tobacco use is *independently* associated with a higher risk of suicidality
- Earlier age of first tobacco use is associated with a higher risk of suicidal ideation among *former* tobacco users
 - Possibly related to worse mental health among people who initiate tobacco use at a young age



Suicide Prevention Outside of Clinical Settings

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It Takes a Village... to Prevent Suicide

- Goal: Prepare more people outside of clinical settings to recognize and respond to clues that a person may be experiencing suicidal ideation
 - Community-based professionals and paraprofessionals (home visitation nurses, doulas, CHWs, care navigators, WIC providers, etc.)
 - Families
 - Coworkers
 - School personnel and students
 - Faith community leaders and members
 - Other community organization leaders and members
- A person experiencing thoughts of suicide is usually becoming increasingly isolated and convinced that they cannot be helped so almost any genuine effort to connect and offer hope and support will decrease risk.

Recognize: Ask About Suicide

- Asking about suicide does **NOT** increase risk!
- Normalize asking (especially if you are in a formal helping role)
- If a person is reluctant to respond, be *compassionately persistent*
- Offer privacy- if possible
- Have resources readily accessible



How to Ask

- **Less direct:**

- *“Have you been feeling very sad and unhappy lately?” THEN*
- *“Have you been feeling so sad and unhappy that you have been thinking of ending your life?”*
- *“Do you ever wish you could go to sleep and never wake up?”*

- **More direct:**

- *“Sometimes when a person is feeling terribly sad and upset, they wish they were dead. Has that been happening with you?”*
- *“I’m worried about you. Have you been thinking about suicide?”*

How NOT to Ask the Question

- *“You’re not thinking of killing yourself, are you?”*



Respond

- Thank the person for their willingness to honestly answer the question
- Allow time for conversation: *Good listening is key*
 - When a person feels truly understood, it can lead to greater openness to accepting help and support
- Figure out next steps together:
 - *“I want to help you get through this difficult time. Will you let me help?”*
- Holding out hope when a person feels hopeless or says they cannot be helped:
 - *“Will you let me hold onto hope for you?”*
- Explore supports and needs with simple questions
 - *“What is the number one thing that could help you feel less upset and overwhelmed?”*
 - *“Who can we contact who could offer help and support right now?”*



Refer

- **Always: 988**
 - Put it in the person's phone, tape it to the back of their phone, post it on the refrigerator, etc.
 - Make sure family/others in supportive roles also have it
- Referral examples:
 - Best: take the person to get help (primary care/OB provider, therapist, ED)
 - Next best: get a commitment to accept help then make the arrangements
 - Third best: give referral information and try to negotiate a commitment to follow through
- Get others involved (with the suicidal person's permission). Examples:
 - Family- even if they do not live nearby
 - Close friends – even if they do not live nearby
 - Clergy person and faith community members
- Any willingness to seek and accept help at some point is a good outcome



Supporting Shanice in a Nonclinical Setting

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- When asked more about her symptoms, she reports **severe sleep disruption** since delivery, obtaining **only 3–4 hours of fragmented sleep per night**, even when her children are asleep.
- She is **solo parenting overnight** due to her partner working night shifts, caring for both Malik and her toddler, Grace.



Shanice

- She describes **escalating anxiety with persistent rumination about the delivery**, including self-blame and feelings that she “failed” her baby.
- She reports **intrusive recollections of the birth, panic symptoms** on waking (including gasping), and **inability to rest**. She feels **overwhelmed, irritable, and emotionally labile, with frequent tearfulness**.
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- She shares that **some days she feels she “can’t do this,”** and at times **wishes she could “disappear for a while.”**
- Her **past medical history is notable for pre-eclampsia and generalized anxiety disorder**.



Supporting Shanice

- Offer reassurance that the distress and overwhelm she is experiencing are understandable.
- **Recognize:**
 - Note that you *always* ask about symptoms of depression, anxiety, and thoughts of suicide.
 - Ask the suicide question. She responds that she *sometimes wishes she could disappear*. You thank her for sharing that with you.
- **Respond:**
 - Figure out next steps together.
 - Explore what she views as her top priority needs right now
 - She mentions getting better sleep and help with childcare
 - Ask who can provide emotional and practical support
 - *She named her sister. You call her sister together. She promises to come this evening after work, stay the night and help with the children in the morning.*
- **Refer:**
 - Arrange to connect with her provider
 - *Called the clinic together; made an appointment for first thing tomorrow and the medical assistant passed along an urgent message to the provider who will call Shanice back before the end of the day.*

Suicide First Aid Training Options

- Question-Persuade-Refer (QPR): <https://qprinstitute.com/>
 - Online or in-person training; usually 90 minutes; some focused on specific age or other demographics (e.g., occupations) or settings; Spanish option; basic and advanced training offerings
- LivingWorks ASIST (Applied Suicide Intervention Skills Training): <https://livingworks.net/training/livingworks-asist/>
 - Multiple training options of different lengths; some focused on specific age or other demographics, or specific settings
- Mental Health First Aid: <https://mentalhealthfirstaid.org/>

Suicide Screening and Assessment in Clinical Settings

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Reframing the goal of suicide screening.

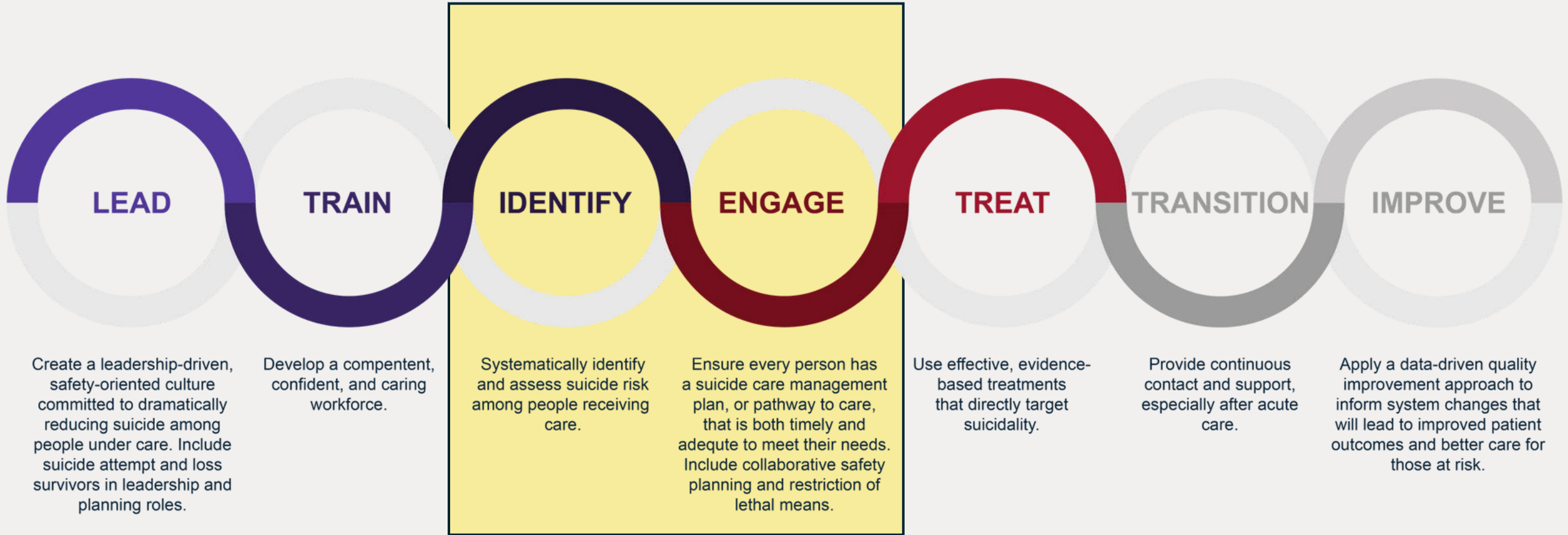
Screening for and assessing risk for suicide and infant harm is not **ONLY** about deciding who needs to go to the hospital.



How do I “fit” suicide screening into my practice?

- If there is suicide risk, this may need to be the one focus on the visit.
- A team approach!
- Resource Ready





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Suicide Screening, Assessment and Response in 5 Steps



Suicide Screening, Assessment and Response Pathway Tools

- **Screen:** PHQ 9, EPDS, C-SSRS
- **Assess:** C-SSRS and SAFE-T
- **Response:** Stanley Brown Safety Plan, suicide-informed treatment plan
- I will use blue highlight to indicate perinatal considerations that are not standard on these tools.



Step 1: Screening

EPDS

- *10 The thought of harming myself has occurred to me
- Yes, quite often
 - Sometimes
 - Hardly ever
 - Never

C-SSRS

1) Wish to be dead

Have you wished you were dead or wished you could go to sleep and not wake up?

2) Current suicidal thoughts

Have you actually had any thoughts of killing yourself?

PHQ 9

9. Thoughts that you would be better off dead, or of hurting yourself

0

1

2

3



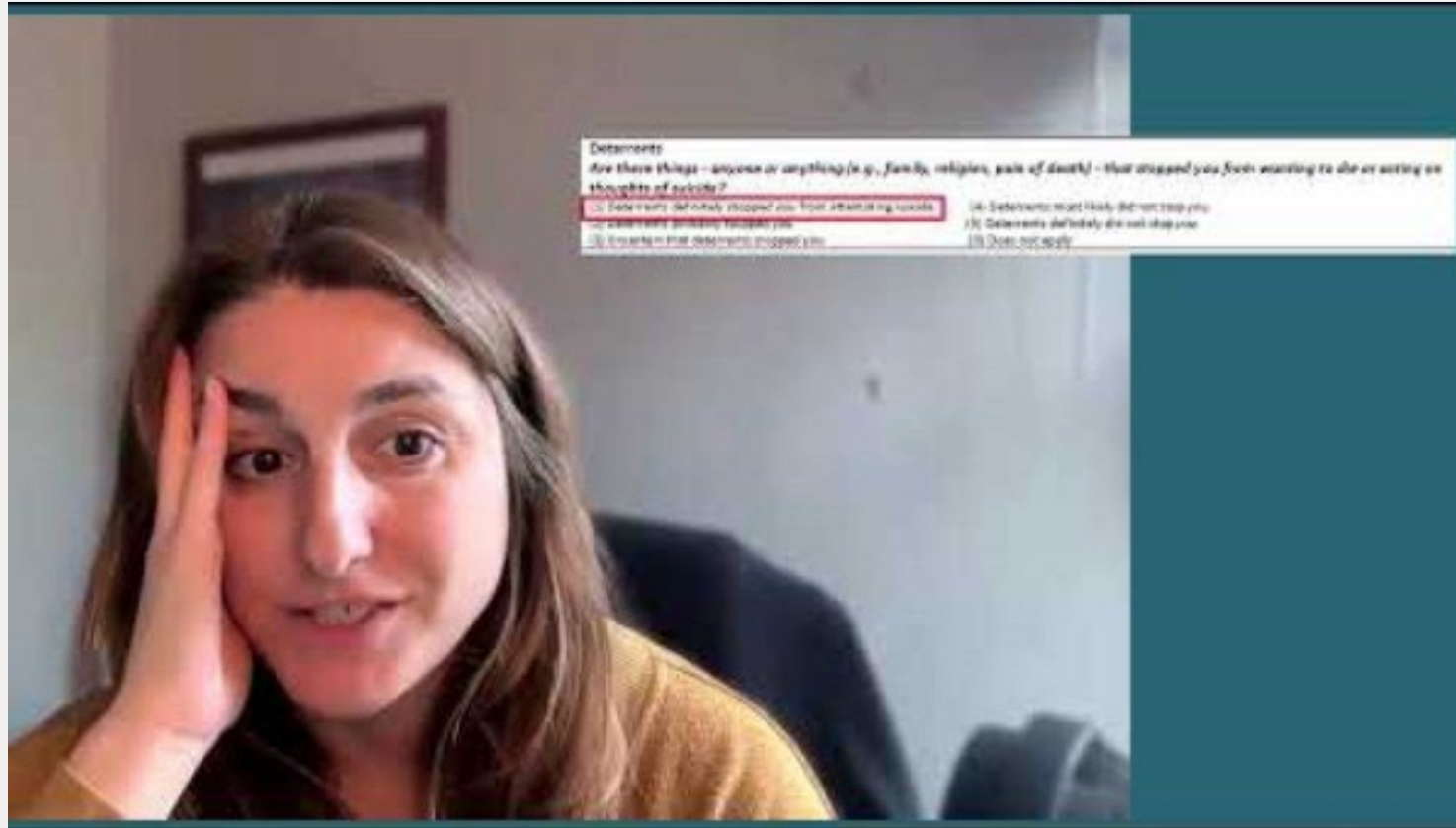
Step 1: Screening

Notably, this framework is not only used when a patient endorses suicidal thoughts. **Suicide risk assessment is also warranted in high-risk clinical situations**, such as

- severe depression (EPDS >19),
- profound distress or agitation



Step 2: Exploring Suicidal Thoughts and Behaviors



Step 3: Integration of Risk and Protective Factors

SAFE-T

Activating Events:

- ★ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.) **Traumatic delivery**
- Pending incarceration or homelessness
- ★ Current or pending isolation or feeling alone

Treatment History:

- Previous psychiatric diagnosis and treatments
- Hopeless or dissatisfied with treatment
- Non-compliant with treatment
- ★ Not receiving treatment
- ★ Insomnia

Other:

- Sleep deprivation
- _____
- _____

Clinical Status:

- ★ Hopelessness
- ★ Major depressive episode
- Mixed affect episode (e.g. Bipolar)
- Command Hallucinations to hurt self
- Chronic physical pain or other acute medical problem (e.g. CNS disorders)
- Highly impulsive behavior
- Substance abuse or dependence
- Agitation or severe anxiety
- ★ Perceived burden on family or others
- Homicidal Ideation
- Aggressive behavior towards others
- Refuses or feels unable to agree to safety plan
- Sexual abuse (lifetime)
- Family history of suicide

Step 3: Integration of Risk and Protective Factors

★ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or ease of accessing

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:

Fear of death or dying due to pain and suffering

★ Identifies reasons for living

External:

Belief that suicide is immoral; high spirituality

★ Responsibility to family or others; living with family

Supportive social network of family or friends




Engaged in work or school

Step 3: Integration of Risk and Protective Factors

Protective factors do not cancel out risk, but they do inform how you can frame the patient's care and where you can build support.



Step 4: Formulation

RISK STRATIFICATION
<p style="text-align: center;"><u>High Suicide Risk</u></p> <p><input type="checkbox"/> Suicidal ideation with intent or intent with plan <u>in past month</u> (C-SSRS Suicidal Ideation #4 or #5)</p> <p style="text-align: center;">Or</p> <p><input type="checkbox"/> Suicidal behavior <u>within past 3 months</u> (C-SSRS Suicidal Behavior)</p>
<p style="text-align: center;"><u>Moderate Suicide Risk</u></p> <p><input type="checkbox"/> Suicidal ideation with method, <u>WITHOUT plan, intent or behavior in past month</u> (C-SSRS Suicidal Ideation #3)</p> <p style="text-align: center;">Or</p> <p> Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime)</p> <p style="text-align: center;">Or</p> <p> Multiple risk factors and few protective factors</p>
<p style="text-align: center;"><u>Low Suicide Risk</u></p> <p> Wish to die or Suicidal Ideation <u>WITHOUT method, intent, plan or behavior</u> (C-SSRS Suicidal Ideation #1 or #2)</p> <p style="text-align: center;">Or</p> <p><input type="checkbox"/> Modifiable risk factors and strong protective factors</p> <p style="text-align: center;">Or</p> <p><input type="checkbox"/> No reported history of Suicidal Ideation or Behavior</p>

Step 5: Response

- Stanley Brown Safety Plan
- Addressing key drivers of suicide risk within treatment plan
- Expressing hopefulness



Step 5: Response Safety Plan

- *“We do a safety plan because **suicidal thoughts tend to come in waves.** When the wave hits, people often feel overwhelmed, stuck, or unable to think clearly-even if they felt okay earlier. In those moments, it’s much harder to remember coping strategies, reach out for help, or make safe decisions.*
- *A safety plan is a way to **prepare for those moments ahead of time,** when thinking is clearer.”*



STANLEY - BROWN SAFETY PLAN

1: WARNING SIGNS:

Stanley
Brown

Step 5: Response Safety Plan

2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS OUT CONTACTING ANOTHER PERSON:

3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

Name: _____

Contact: _____

Name: _____

Contact: _____

Address: _____

Address: _____

Address: _____

Address: _____



Step 5: Response Safety Plan

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR PROFESSIONAL SERVICES I CAN CONTACT DURING A CRISIS:

1. Professional/Services Name: _____ Phone: _____
Emergency Contact: _____
2. Professional/Services Name: _____ Phone: _____
Emergency Contact: _____
3. Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone: _____
4. Crisis Line Phone (e.g. 988): _____

Who could help care
for your children if you
needed urgent
support or treatment?

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS)

1. _____
2. _____



Step 5: Response

Suicide-Informed Treatment Plan

- Borrowing from the **Collaborative Assessment and Management of Suicide (CAMS)** model, after completing a stabilization plan, can ask the patient about her suicide drivers.
- **What are the 2 problems we would have to fix for you not to take your life? What are the 2 problems that most put your life in peril?**
- *I'm constantly overwhelmed*
- *I'm exhausted*
- *My family would be better off without me*
- *I suck at being a mom*
- *Feeling stuck in a life I don't want*
- *My body feels like it's always on edge*
- *I'm doing all of this alone.*
- *I have no one that understands me.*



Step 5: Response

Expressing Hopefulness

- *“Before we finish, I want to say something clearly. The way you’re feeling right now reflects real pain, profound exhaustion, and stress that deserve care and attention—it is not a reflection of your worth as a mother.*
- *You don’t have to figure this out alone. The way you feel today doesn’t define your future.*
- *There are real paths forward from here, and our team will be here to walk through them with you.*
- *There may not be a quick fix for postpartum exhaustion, but there are practical steps we can take to ease the load and help things feel more manageable. And we’re going to approach this thoughtfully, together.”*



- “If you were to harm yourself, what would happen with your children?”
- “It’s common for moms to experience thoughts about harming their children. Does that ever happen to you?”

Table 2 Percentage of mothers reporting specific thoughts of intentional harm

	4 weeks <i>n</i> =91 % (of 91)	12 weeks <i>n</i> =84 % (of 84)
Screaming at your baby	19.78	9.52
Shaking your baby	16.48	5.95
Giving your baby away	13.19	2.38
Intentionally hitting your baby too hard when burping him/her	12.09	0
Dropping or throwing your baby out the window or off the balcony	8.79	1.19
Touching baby’s genitals in an inappropriate way	8.79	0
Intentionally puncturing the soft spot on your baby’s head	7.69	0
Throwing or dropping your baby on purpose	7.69	0
Stabbing your baby	5.50	1.19
Slapping or hitting your baby	5.50	2.38
Intentionally allowing your baby to fall under water in the bath	4.40	1.19
Intentionally smothering your baby	4.40	0
Burning your baby with hot water on purpose	2.20	1.19
Leaving baby somewhere where he/she may not be found right away	2.20	3.57
Strangling your baby	1.10	0
Stepping on your baby on purpose	1.10	0
Other (idiosyncratic)	4.40	4.76

Assessment of Thoughts of Harming the Infant

Obsessions

- Likely to improve as depression improves with antidepressant treatment
- Rarely have actual intent

Ego-dystonic vs. ego-syntonic

- Thoughts that horrify the patient (dystonic) are likely to be intrusive obsessive thoughts
- Woman who is not horrified by thoughts, ego-syntonic

Intent and plan

- Expressed intent, with or without a plan, is an emergency
- Woman should be hospitalized immediately in most cases

Psychosis

- Always assess
- Presence of symptoms increases likelihood of patient acting on impulsive thoughts

Suicidal thoughts

- Increase likelihood that patient may act on thoughts and should prompt hospitalization in most cases

▶ ASSESSING THOUGHTS OF HARMING BABY

Low Risk

- Symptoms indicative of depression, OCD, and/or anxiety
- Thoughts of harming baby are scary, cause anxiety, or are upsetting
- Mother does not want to harm her baby and feels it would be a bad thing to do
- Mother very clear she would not harm her baby

Moderate Risk

- Thoughts of harming baby are somewhat scary
- Thoughts of harming baby cause less anxiety
- Mother is not sure whether the thoughts are based on reality or whether harming her baby would be a bad thing to do
- Mother less clear she would not harm her baby

High Risk

- Symptoms indicative of psychosis
- Thoughts of harming baby are comforting
- Feels as if acting on thoughts will help infant or society
- Lack of insight (inability to determine whether thoughts are based on reality)
- Having auditory and/or visual hallucinations
- Bizarre or fixed untrue beliefs that are not reality

3

Source: NC Matters Maternal Suicide and Risk Assessment Toolkit



Cultural Considerations in Suicide Risk Assessment

- **1. Expression of distress varies**
 - May present as physical symptoms, overwhelm, or spiritual distress
 - Direct language about suicide may feel unsafe or unacceptable
- **2. Stigma and fear of consequences**
 - Shame, moral beliefs, or fear of judgment
 - Concerns about child custody, legal status, or being reported
- **3. Trust and disclosure take time**
 - Underreporting is common
 - Requires transparency, safety, and relationship-building
- **4. Family and community context matter**
 - Risk and protection often exist within relationships
 - Decision-making may be collective, not individual
- **5. Language and communication**
 - Use plain, accessible language
 - Work with trained interpreters
 - Check for shared understanding
- **6. Cultural and spiritual factors**
 - Can be protective (connection, meaning)
 - Can also increase guilt or silence

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Thank You!
Questions?



11:30am – Collaborative Breakout Session

Please see your badge for your room assignment

A – Riverside

B – Gondola A

C – Gondola B

D – Gondola C

E – Osprey

Gondola ABC – outside and upstairs

Osprey

