Assessing Safety

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Assessment of Safety Risk in Perinatal Populations

Key Facts:

- Suicide is the leading cause of direct death within first year of postpartum period (4.1 per 100,000 in WA state, ~13% of maternal deaths)
- Peak incidence of maternal self-harm–related death is between 9 and 12 months postpartum
- Postpartum women with a history of depression are at a 70% increased risk for death by suicide
- In pregnancy-associated suicides, 54.3% of victims experienced problems with a current or former intimate partner that appeared to have contributed to the suicide
- For patients with untreated postpartum psychosis, 5% die by suicide

Warning Signs:

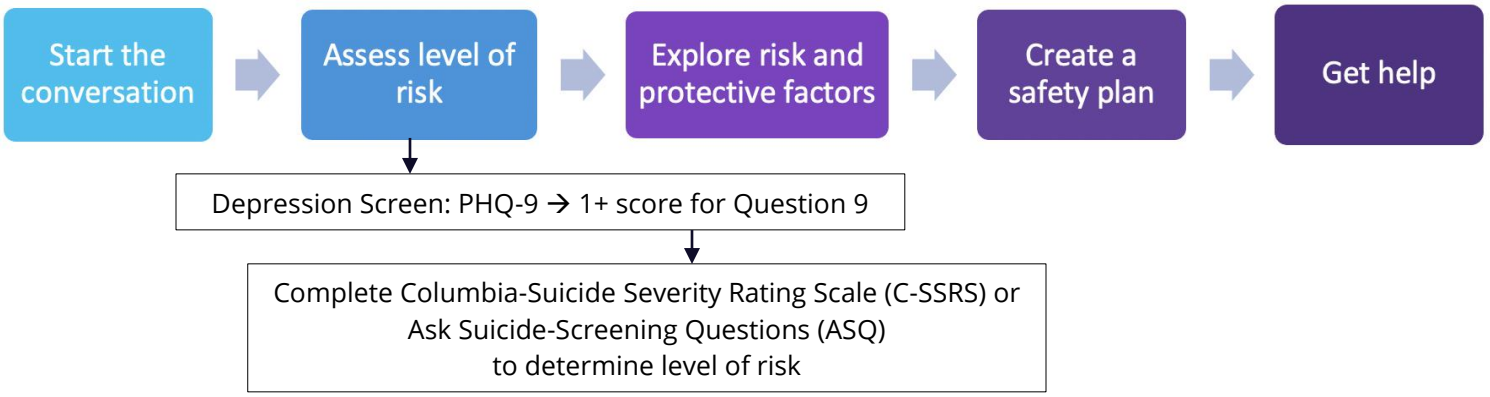
- Sadness
- Withdrawn
- Change in sleep or eating habits
- (esp. severe insomnia)
- Loss of pleasure of activities that
- normally bring joy
- Giving away possessions
- Helplessness
- Feelings of worthlessness
- Anger, seeking revenge
- Significant estrangement from infant
- Feeling trapped
- Overwhelming anxiety, panic, or agitation
- Alcohol or drug use increase
- Change in personality
- Strong feelings of guilt or shame
- Recklessness or impulsivity
- Purposelessness (feeling like a burden, family would be better without them)
- Psychosis

CRITICAL SIGNS

Hopelessness

Talking about death

Seeking methods for self-harm (searching online, obtaining a gun)



Protective Factors

- Positive & available social support
- Positive therapeutic relationship
- Responsibility to others (family, children)
- Fear of death
- Positive problem-solving or coping skills
- Hope for future, future-oriented
- Intact reality testing
- Fear of social disapproval
- Religious beliefs against suicide
- Life satisfaction

Risk Factors

Predisposing Historical factors:

- Personal hx of suicide attempt
- Hx of mental disorder
- Hx of substance use disorder
- Hx of IPV
- Medical illness
- Death of family member by suicide
- Traditionally marginalized and underserved populations (e.g., LGBTQAI+, Black, Native American/Alaskan Native)
- Veteran
- Physician

Situational factors:

- Family or marital conflict
- Unemployment
- Social withdrawal/isolation
- Medical problems
- Legal issues
- Loss
- Recent discharge from inpatient psychiatric unit

Other: Depressive symptoms (SIGECAPS), feeling estranged/distant from child, psychosis, or suicide warning signs

Assessment of Safety Risk in Perinatal Populations (Cont.)

Safety Planning:

- Foster a sense of connectedness (e.g., hope, connect with family)
- Initiate or refer to specialty care
- Assess for firearms, medications, and other lethal means. Work to secure any lethal means.
- Collaborate in creating safety plan. See Brown-Stanley below for example.
- Discuss Reasons for Living

Resources for Assessing Perinatal Safety

Brown-Stanley Patient Safety Plan Template:
https://www.sprc.org/resources-programs/patient-safety-plan-template

ASQ Suicide Risk Screening Tool:
https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/

Patient Resources:

Perinatal Support Washington Warm Line:

- *1-888-404-7763*
- *https://perinatalsupport.org*

Washington State Crisis Line Access:

- *7-1-1*

King County Crisis Line:

- *866-4-CRISIS*

National Suicide Prevention Lifeline:

- *1-800-273-8255*
- Crisis support via text message: *Text HOME to 741741*
- Crisis support via chat: *suicidepreventionlifeline.org*

Washington Warm Line:

- *1-877-500-9276*

Washington Recovery Help Line:

- *1-866-789-1511*

Intimate Partner Violence Risk Assessment

Definition: The term "intimate partner violence" describes a single or repeated act of physical violence, sexual violence, stalking, psychological harm, or control of reproductive health perpetrated by a current or former partner or spouse. "Intimate partner" refers to an individual with whom one has a close personal relationship (i.e., spouse, former partner, family member).

Be vigilant: 3.7% to 8.3% prevalence of perinatal IPV, likely higher in LGBTQAI+ community. Pregnancy is the 2nd most dangerous time in a violent relationship.

Risk Factors for IPV:

- Prior IPV (which raises the risk of violence during pregnancy as much as 14 times)
- Young age, particularly adolescents
- Individuals who are single, unmarried, or who are living apart
- Fewer years of education (particularly if less than a high school education)
- Co-existing medical or obstetric complication
- Being publicly insured or on Medicaid
- Unplanned/Mistimed pregnancy or ambivalence about the pregnancy

Warning Signs/Indicators of IPV:

- Poor attendance/ nonattendance to clinic visits
- Repeat visits for minor injuries or concerns
- Nonadherence to care plan
- Repeat presentation with depression, anxiety, self-harm, or other psychosomatic symptoms
- Physical injuries that are untended and located in several locations of varying degrees of age, especially to neck, head, breasts, abdomen, and genitals
- Past poor obstetric outcomes (repeated miscarriage, stillbirths, preterm labor/birth, IUGR or low birth weight)
- Partner demanding to be included in visit or domineering during visit
- Sexually transmitted infections or frequent UTIs, vaginal infections, or pelvic pain
- Minimalization of physical injuries

Health Consequences of IPV

Mental Health:

- PTSD
- Anxiety
- Major Depressive Disorder
- Eating Disorders
- Suicide
- Substance Use Disorders

Obstetric Health:

- Death*
- High blood pressure, edema
- Vaginal bleeding in 2nd or 3rd trimester
- Severe nausea, vomiting, or dehydration
- Kidney infection or UTI
- Premature rupture of membranes, premature birth
- Placental abruption
- Miscarriages

*Homicide is a leading cause of death during pregnancy; an intimate partner is responsible in up to 2/3rds of homicides

Impact on Children:

- Less likely to be breastfed
- Failure-to-thrive
- Death
- Increased risk for mental illness
- Deficits in executive functioning
- Deficits in cognitive functioning
- Delays in achieving developmental milestones
- Insecure or disorganized attachment
- Increased risk for additional adverse childhood events (e.g., child abuse)
- Increased risk for both using and experiencing IPV as an adult

Intimate Partner Violence Risk Assessment (Cont.)

Considerations with Screening:

If your patient says "YES," ask:

1. Are you safe now?
2. Would you like to talk about it?
3. When did this happen?
4. Have you talked with anyone else about this?
5. How are you coping?
6. What do you need right now?

- IPV screening is recommended for all women of childbearing age
  - Screen at least 1x/trimester and at postpartum visit
  - Think about including information in discrete areas in the clinic (i.e., restrooms/stall doors)
- Do not screen if another adult or child > 2 y/o is present
- Review the limits of confidentiality with the patient beforehand
- Be mindful of how you screen (self-report vs clinician-led questionnaire, before visit/in lobby, in office, survey that includes all types of violence, culturally adapted, gender-neutral, non-heteronormative)
  - See examples of screening tools in Additional Resources
- Ask behaviorally specific questions to yield more accurate responses (i.e., "Has your partner ever strangled you?" instead of "Has your partner ever abused you?")
- Assess immediate safety and other health concerns/needs
- Offer choices (referrals, list of local resources e.g., crisis lines, shelter)
- Respect and recognize the patient's autonomy in decision-making

Considerations with Documentation:

- Be mindful of how to document your conversation and collaborate with the patient in your response
- Be aware of who may have access to the medical record
- Use recovery-oriented, non-stigmatizing terms (i.e., someone who uses/experiences violence, not victim/perpetrator)
- Sufficient, detailed, and accurate
- Include date(s) and description of event(s), use the patient's words verbatim with quotations, and document detailed information of objective physical signs and behaviors (consider anatomical diagrams, photos)
- Collect and document information about the individual who used violence (name, address, relationship to patient, etc.)

Safety Planning:

Safety is priority. Depending on what the individual wants to do, safety planning may include safety within the relationship, safety while leaving the relationship, and safety after leaving the relationship. Please visit "More Resources for Providers" for some safety planning forms (and attached at end of this guide).

Intimate Partner Violence Risk Assessment (Cont.)

How to Stay Safe Within the Relationship	How to Safely Leave the Relationship	How to Stay Safe After Leaving the Relationship
• Identifying safe areas of the home • Gathering important documents such as copies of birth certificates • Making copies of important financial or ownership documents • Providing assistance with contraceptive health and screening for sexual health issues • Practicing how to escape if needed and have an escape bag packed • Identifying individuals to call in an emergency including a local domestic violence shelter or national hotline with trained advocates such as the Natural Disaster Violence Hotline	• Contacting a local domestic violence shelter or national hotline • Documenting any injuries (clinician can do this during the visit and place pictures in the medical record) • Identifying a safe place to stay	• Filing for a restraining order or order of protection • Changing the route to work and/or school • Changing the locks • Alerting neighbors, family, co-workers, or school personnel to call the police if they see the individual

Intimate Partner Violence Resources for Patients and Clinicians

Domestic Violence Personalized Safety Plan

- http://www.ncdsv.org/images/dv_safety_plan.pdf

National Domestic Violence Hotline

- 1-800-799-SAFE (Voice) | Free. Confidential. 24/7.
- 1-800-787-3224 (TTY) | Free. Confidential. 24/7.

National Teen Dating Violence Hotline, online chat, and texting

- www.loveisrespect.org

Washington State Domestic Violence Hotline

- 1-800-562-6025 (Voice and TTY) | Free. Confidential. 24/7.
- www.wadvhotline.org

National Sexual Assault Hotline

- 1-800-56-HOPE (4673) | Free. Confidential. 24/7.
- https://rainn.org/get-help/national-sexual-assault-hotline/

Database of Domestic Violence Programs and Shelters

- www.domesticshelters.org

WA Dept of Health List of Resources

(Domestic, Sexual, Prevention, Legal)

- https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/SexualandDomesticViolence/Resources
- https://www.domesticviolenceinforeferral.org/

Database of Sexual Assault and Domestic Violence Services in Washington

- Locate sexual assault service providers in WA: http://www.wcsap.org/find-help
- Locate domestic violence service providers in WA: http://wscadv.org/washington-domestic-violence-programs/

Assessment of Risk for Harm of Infants and Children

Key Facts:

- For patients with untreated postpartum psychosis, 4% commit infanticide (the killing of an infant age 1 day old to 1 year old)
- Infants are at risk for homicide more than any other age group
- Aggressive or infanticidal ideation in women with depression or facing stress is common (26-43% incidence)
- 16-29% of filicides (the killing of a child age ≥1) occur in the context of maternal suicide

Risk Factors:

- Depression
- Psychosis (delusions of threat to safety, delusions that child is suffering, auditory/command hallucinations)
- Suicidality
- Significant life stress
- Socially isolated
- IPV
- Family history of violence
- History or current child abuse/neglect
- Full-time caregiver/unemployment
- Persistent crying or other child factors (e.g., colic, autism)
- Child custody dispute

Common Motives:

1. Altruistic: death of child out of love or belief this is in the best interest of the child; often planned or considered for some time
2. Acutely psychotic: no comprehensive motive (e.g., command auditory hallucinations); tends to be impulsive
3. Fatal maltreatment: death is not anticipated outcome, a result of abuse, neglect, or fabricated/induced illness or injury by caregivers (i.e., Munchausen by proxy syndrome)
4. Unwanted child: mother perceives child as burden
5. Spouse revenge: child is killed to specifically cause emotional harm to spouse; rare

Sample Questions:

- Sometimes people with depression/anxiety/who are stressed have scary thoughts, such as thoughts or images of hurting their baby or other people -- have you had thoughts like that?
- Do you have any concerns about the safety of your child(ren)?
- Are you having any thoughts or fears of harming other people?
- Are you having any thoughts or fears of harming your child(ren)?
- If suicidal ideation present:
  - Are there other people (or children) you want to die with you?
  - Are there others you think would be unable to go on without you?
  - What will happen to your child(ren) if you die?

Important Consideration:

Fear of removal of children from home is real and common. This may lead to concern about disclosure or minimization of symptoms or risky behaviors (e.g., substance use). If after risk assessment, referral for protective services is determined to be necessary, extra vigilance and care are required. Disruption of therapeutic alliance may occur, leading to avoidance of care or treatment, and potentially increase risk for maternal mental health disorder or suicide. Obsessive Compulsive Disorder is not a risk factor and having intrusive thoughts of hurting or harming the child does not lead to harm of the child. It is critical to distinguish these intrusive thoughts from psychotic symptoms.

Resources for Assessment of Risk for Harm of Infants and Children

Emergent/Crisis Resources

WA State Crisis Line Access:
7-1-1

King County Crisis Line:
866-4-CRISIS

National Suicide Prevention Lifeline:
1-800-273-8255
Crisis support via text message: Text HOME to 741741
Crisis support via Chat: www.suicidepreventionlifeline.org

Non-Urgent Perinatal Support

Perinatal Support Washington:
1-888-404-7763
https://perinatalsupport.org

Other Support

Child Protective Services:
https://www.dcyf.wa.gov/safety/report-abuse

WA Warm Line:
1-877-500-9276

WA Recovery Help Line:
1-866-789-1511

Teen Link (ages 13-20):
1-866-833-6546