

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 in WA state is between 9 and 12 months postpartum
- Postpartum women with a history of depression are at a 70% increased risk for death by suicide
- Women diagnosed with a postpartum mental disorder are 6.2x higher risk for self-harm compared to mothers without mental disorders
- Pregnant women with alcohol abuse are 3.7x more likely to feel suicidal compared to those without alcohol abuse
- 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

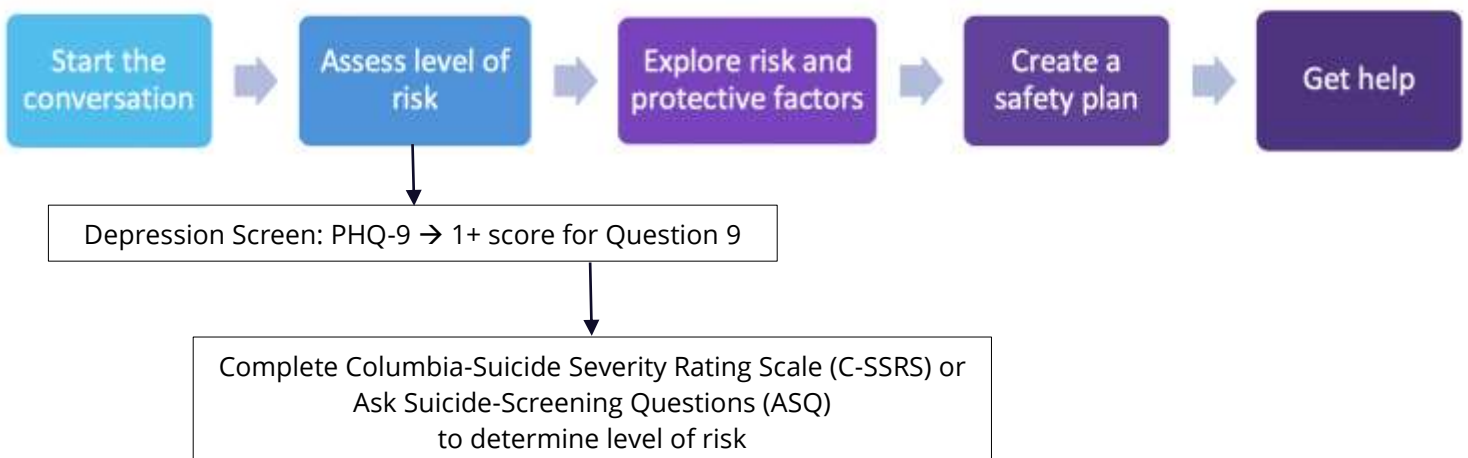
Warning Signs:

- 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- Withdrawn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*)

*Women who die by suicide during the postpartum period use violent and lethal means more frequently than non-perinatal women



Assessment of Safety Risk in Perinatal Populations (Cont.)

Protective Factors	Risk Factors	
<ul style="list-style-type: none"> • Positive & available social support • Cohabitation with partner • 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 	<p><u>Predisposing Historical factors:</u></p> <ul style="list-style-type: none"> • Personal hx of suicidal ideation/behavior • Hx of mental disorder • Hx of substance use disorder & cannabis use • Lifetime hx of rape, or hx of childhood abuse • Medical illness (e.g. HIV+ status) • Death of family member by suicide • Younger age • Traditionally marginalized and underserved populations (e.g., LGBTQAI+, Black, Native American/Alaskan Native) • Veteran • Physician 	<p><u>Situational factors:</u></p> <ul style="list-style-type: none"> • Family or marital conflict • Unmarried • Recent IPV • Unemployment/financial instability • Social withdrawal/isolation • Medical problems • Legal issues • Loss (e.g. pregnancy loss) • Recent discharge from inpatient psychiatric unit <p><u>Other:</u> Depressive symptoms (SIGECAPS), feeling estranged/distant from child, psychosis, or suicide warning signs</p>

Health Consequences of Nonfatal Suicide Attempt

Obstetric health	Impact on Children
<p>Increased risk of:</p> <ul style="list-style-type: none"> • Antepartum hemorrhage • Placental abruption • Postpartum hemorrhage • Premature delivery • Low birth weight • Stillbirth • Poor fetal growth • Fetal abnormalities 	<ul style="list-style-type: none"> • Fetal death • Neurodevelopmental abnormalities

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 [Stanley-Brown](#) below for example.
- Discuss Reasons for Living

Stanley-Brown Patient Safety Plan Template:

<https://talksuicide.ca/wp-content/uploads/2022/05/Stanley-Brown-Safety-Plan-8-6-21.pdf>

ASQ Suicide Risk Screening Tool:

<https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/>

Resources for Assessing Safety

Patient Resources:

Perinatal Support Washington Warm Line:

- 1-888-404-7763
- <https://perinatalsupport.org>

Washington State Crisis Line Access:

- 9-8-8 (7-1-1 for TTY)

King County Crisis Line:

- 866-4-CRISIS

National Suicide Prevention Lifeline:

- 9-8-8 (1-800-273-8255)
- Crisis support via text message: Text HOME to 741741
- Crisis support via chat: www.suicidepreventionlifeline.org

Washington Warm Line:

- 1-877-500-9276

Washington Recovery Help Line:

- 1-866-789-1511

Survivors of Suicide Support Groups:

For families/patients:

American Foundation for Suicide Prevention Directory:

<https://afsp.org/find-a-support-group/>

WA DOH Suicide Grief Support Resources:

<https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/suicide-prevention/suicide-prevention>

Crisis Line Support Group Directory:

<https://suicidepreventionlifeline.org/help-yourself/loss-survivors/>

2020 Mom Remembrance Wall:

<https://www.2020mom.org/remembrance-wall>

For clinicians:

Coalition of Clinician Survivors

www.cliniciansurvivor.org

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:

- Cases of domestic violence have increased, and become more severe, during the coronavirus pandemic
- 3.7% to 8.3% prevalence of perinatal IPV, likely higher in LGBTQIA community
- Pregnancy is the 2nd most dangerous time in a violent relationship.
- IPV in pregnancy is more common than GD or preeclampsia
- BIPOC people suffer the impact of IPV disproportionately
- Homicide pregnancy-associated death ratio increased 63% in the past decade (1.8 → 3.0 per 100,000 births); rates are highest during pregnancy (56.8%) or after 6-weeks postpartum (34.9%); people who identify as non-Hispanic Black or younger age (15-24) are at highest risk of homicide
- IPV (esp physical abuse) is associated with suicidal ideation and deaths (increase frequency = increase risk)

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 → Minimalization of physical injuries
- 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

Intimate Partner Violence Risk Assessment (Cont.)

Consequences of IPV

Mental Health:

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

Obstetric Health:

- No or delayed prenatal care
- 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
- Preterm birth
- Diminished intrauterine growth
- Homicide*
- Death of fetus
- Stillbirth

Impact on Children:

- Less likely to be breastfed
- Failure-to-thrive
- Death
- Increased risk for mental illness
- Sleep disturbances
- Higher irritability
- 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

Psychosocial Impact:

- Housing instability & homelessness
- Unemployment
- Loss or delay in educational opportunities
- Food insecurity
- Financial instability
- Unwanted entanglement in legal systems

*Homicide is a leading cause of death during pregnancy (estimated at 8.4% of total deaths); an intimate partner is responsible in up to 2/3rds of homicides

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.)
- Other considerations: (in)consistency between subjective and objective findings, children in home, pregnancy status of 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

- 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

How to Safely Leave the Relationship

- 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

How to Stay Safe After Leaving the Relationship

- 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

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:

- Infants are at risk for homicide more than any other age group
- The highest risk for infant homicide is during first 24hrs of life
- Homicide is the second leading cause of injury-related death for children <1 year
- For patients with untreated postpartum psychosis, 4% commit infanticide
- 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

Maternal Characteristics

- Denial of pregnancy
- Late initiation of pregnancy care
- Depression
- Psychosis (delusions of threat to safety, auditory/command hallucinations)
- Suicidality
- Significant life stress
- Low SES
- Young age
- Unmarried
- Lower educational achievement
- 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
- Thoughts of revenge against spouse

Infant Characteristics:

1-day old, low gestational age, low birthweight, low apgar score, male sex, and/or Non-Hispanic Black race

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

Definitions:

Neonaticide: the killing of an infant during first 24hrs of life

Infanticide: the killing of an infant (age 1 day old to 1 year old)

Filicide: the killing of a child (age ≥ 1)

Sample Questions:

- 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)?
- 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:

9-8-8 (7-1-1 for TTY)

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

Child Help Hotline:

1-800-4-A-CHILD (1-800-422-4453)

The Period of Purple Crying

<http://www.purplecrying.info/>

References

Salihi, H., Gonzales, D. and Dongarwar, D., 2021. Infanticide, neonaticide, and post-neonaticide: racial/ethnic disparities in the United States. *European Journal of Pediatrics*, 180(8), pp.2591-2598.

Wilson, R., Klevens, J., Williams, D. and Xu, L., 2020. Infant Homicides Within the Context of Safe Haven Laws — United States, 2008–2017. *Morbidity and Mortality Weekly Report (MMWR)*. [online] CDC. Available at: <<https://www.cdc.gov/mmwr/volumes/69/wr/mm6939a1.htm#:~:text=The%20infant%20homicide%20rate%20on,any%20other%20time%20in%20life.>> [Accessed 19 May 2022].