Assessing Safety

Cummings Rork, MD

Assessment of Safety Risk in Perinatal Populations

Key Facts:

- Suicide is the leading cause of direct death within first year of postpartum period (8% in WA)
- Suicide is more likely to occur in the postpartum period (and more likely after 6-week postpartum visit)
- 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- Withdrawn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, emotional lability
- Strong feelings of guilt or shame
- Recklessness or impulsivity
- Purposelessness (feeling like a burden, family would be better without them)
- Psychosis

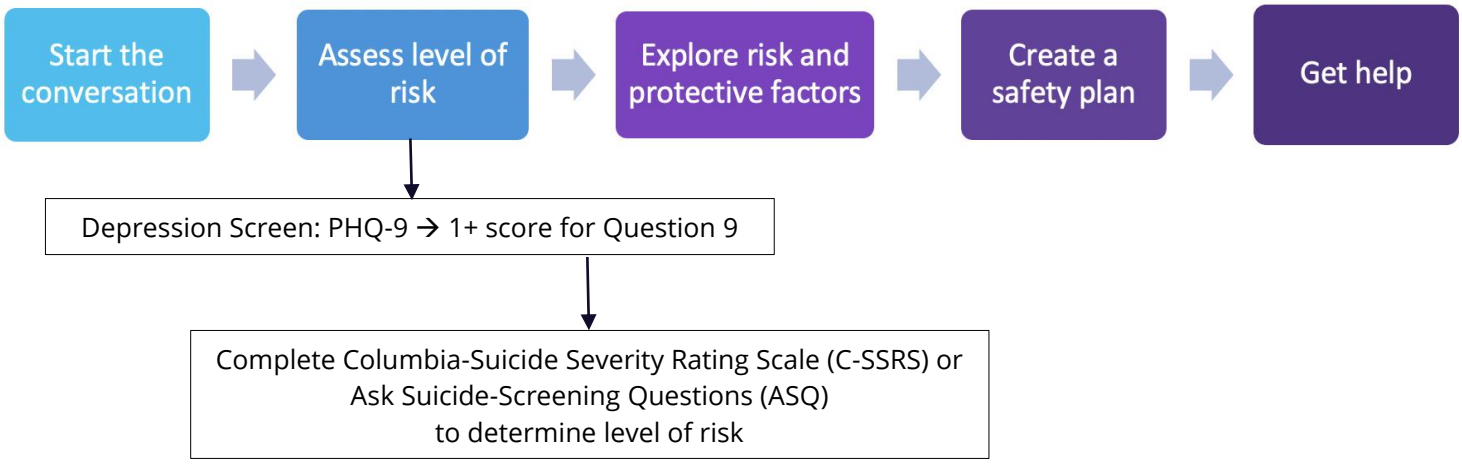
CRITICAL SIGNS

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
• 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

Risk Factors	
Predisposing Historical factors: • **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	Situational factors: • Unintended/unwanted pregnancy • Obstetrical/neonatal complication • Loss (e.g., pregnancy loss) • Recent discharge from inpatient psychiatric unit • Family or marital conflict • Social withdrawal/isolation • Unmarried • Recent IPV • Unemployment/financial instability • Medical problems • Legal issues • Community factors (i.e., war, discrimination) • Health systems factors (i.e, barriers to access, stigma)
Other factors: Depressive symptoms (SIGECAPS), feeling estranged/distant from child, psychosis, or suicide warning signs	

Health Consequences of Nonfatal Suicide Attempt

Obstetric health	
Increased risk of: • Antepartum hemorrhage • Placental abruption • Postpartum hemorrhage • Premature delivery	• Low birth weight • Stillbirth • Poor fetal growth • Fetal abnormalities

Impact on Children
• 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

Assessment of Safety Risk in Perinatal Populations (Cont.)

<table>
<tr><th>Low Risk (SI without plan or intent)</th><th>Moderate Risk (SI with plan, no intent; previous SA)</th><th>High Risk (SI with plan and intent)</th></tr>
<tr><td colspan="3">Establish/maintain therapeutic alliance</td></tr>
<tr><td>Regular follow-up with repeated risk assessment</td><td>Closer follow-up with repeated risk assessment</td><td>Close follow-up once emergent management by psychiatry established</td></tr>
<tr><td>Referral to psychiatry</td><td>Urgent referral to psychiatry</td><td rowspan="2">Emergency psychiatry consultation in ER; may need psychiatric hospitalization (mother-baby unit)</td></tr>
<tr><td>Initiate treatment (consider pharmacotherapy)</td><td>Initiate treatment, including pharmacotherapy</td></tr>
<tr><td colspan="3">Optimize social support</td></tr>
<tr><td colspan="3">Psychoeducation</td></tr>
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Resources for Assessing Safety

For Providers:

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/

Safety Planning Training Videos:
https://suicidesafetyplan.com/training/

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*

Resources for Assessing Safety (Cont.)

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:

- Violence against women have increased to unprecedented levels since the pandemic
- Technology-facilitated abuse is a significant, harmful phenomenon and emerging trend in IPV
- IPV (esp., physical abuse) is associated with suicidal ideation and deaths (high frequency = increased risk)
- ~3-8% prevalence of perinatal IPV, likely higher in LGBTQIA community
- Pregnancy is the 2nd most dangerous time in a violent relationship, and is a risk factor for dying by homicide
- Homicide is the leading cause of death in pregnancy and in postpartum (9% in WA)
- 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
- BIPOC people suffer the impact of IPV and intimate partner homicide disproportionately
- Intersecting identities can exacerbate the experience and impact of IPV, as individuals may face multiple forms of oppression and marginalization that can increase their vulnerability to violence and limit their access to resources and support.

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

Additional Risk Factors for IPV

- Access to gun and/or prior use of weapon
- Suicidal and/or homicidal threats (partner, children, pets)
- Partner with SUD
- Strangulation
- Hostage-taking
- Escalation of IPV
- Forced sexual activity
- Possessiveness/jealousy
- Stalking behavior

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

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 including 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

PEARLSS for Trauma-informed Care:

- **P - Partnership:** Collaborate and empower the survivor, respecting their autonomy.
- **E - Empathy:** Validate experiences without judgment, demonstrating understanding.
- **A - Autonomy:** Support informed choices and decisions, respecting survivor's control.
- **R - Respect:** Honor dignity, choices, and boundaries, promoting nonviolence.
- **L - Listen and Learn:** Create a safe space for sharing, continuously learn about trauma.
- **S - Strengths-Based Approach:** Focus on strengths, resilience, and coping mechanisms.
- **S - Safety:** Prioritize physical and emotional safety, fostering trust and empowerment.

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 visits
  - Other times: intakes, annually, new intimate relationship, when suspected
  - 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)
- 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	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

Resources for Intimate Partner Violence

Screeners

Abuse Assessment Screen
https://www.mdcalc.com/calc/10419/abuse-assessment-screen-aas

Woman Abuse Screening Tool
https://www.mdcalc.com/calc/10396/woman-abuse-screening-tool-wast

Danger Assessment Screening
https://www.dangerassessment.org/DA.aspx

Additional Resources

Domestic Violence Personalized Safety Plan
- https://www.thehotline.org/plan-for-safety/create-your-personal-safety-plan

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
- https://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

Washington Department of Health Resources
- https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/sexual-and-domestic-violence

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/

Intimate Partner Violence Resources (Cont.)

Resources for Clinicians

Vicarious trauma is real, and self-care and support are important:

- Seek professional support: Supervision, consultation, and peer support.
- Education and training: Attend workshops on self-care and trauma-informed care.
- Practice self-care: Mindfulness, exercise, boundaries, and enjoyable activities.
- Access supportive resources: Read books/articles and use online mental health resources.
- Monitor well-being: Use self-assessment tools like ProQOL questionnaire.

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
- Forms of child maltreatment preceding infant death are neglect (72%) & physical abuse (44%)
- In WA state, 25% of children entering foster care are infants under 1 year, the second highest rate in the country
- 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 occur in the context of maternal suicide
- ~74% of infant/child homicides were weapon-related deaths
- Early childhood experiences have lasting impacts on well-being, and timely interventions aid in healing for maltreated babies and families.

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

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)

Other risk factors:

- Access to firearms
- Exposure to domestic violence
- Exposure to substance use

Know the signs:

- Physical signs of neglect (poor hygiene, dental caries, poor weight gain or weight loss, severe diaper dermatitis, and unattended medical needs)
- Unexplained injuries (bruises, burns, fractures, or head injuries)
- Extreme behaviors (excessive crying, truancy, running away, or aggression)
- Delay in seeking care, missing or inconsistent medical history, or inconsistent explanations for injuries
- Signs of emotional abuse (low self-esteem, depression, anxiety, or withdrawal)
- Signs of sexual abuse (difficulty walking or sitting, pain or itching in the genital area, or inappropriate sexual behavior or knowledge)
- Signs of neglect (lack of supervision, regular signs of hunger, inappropriate dress, poor hygiene, distended stomach, or emaciation)

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
6. Cultural: death of the child due to cultural beliefs or practices: rare

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.

Resources for Assessment of Risk for Harm of Infants and Children

General Resources:

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

Zero to Three Safe Babies Program
https://www.zerotothree.org/our-work/safebabies/

Child Help Hotline: 1-800-4-A-CHILD (1-800-422-4453)
https://www.childhelp.org/educator-resources/child-abuse-education-prevention-resources/

The Period of Purple Crying
http://www.purplecrying.info/

Help Me Grow WA
1-800-322-2588
http://www.parenthelp123.org/resources/family-health-hotline/

WA Warm Line
1-877-500-9276

WA Recovery Help Line
1-866-789-1511

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

WA State Crisis Line Access
7-1-1

King County Crisis Line
866-4-CRISIS

National Suicide Prevention Lifeline
1-800-273-8255, 9-8-8
Crisis support via text message: Text HOME to 741741
Crisis support via Chat: suicidepreventionlifeline.org

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

For Providers:

Articles:
Prevention of Infanticide and Suicide in the Postpartum Period—the Importance of Emergency Care
https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2738767

Child Murder by Mothers
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2174580/

Books:
Infanticide Psychosocial and Legal Perspectives on Mothers Who Kill
https://www.appi.org/Products/Trauma-Violence-and-PTSD/Infanticide

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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> [Accessed 19 May 2022].