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 (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 with postpartum psychiatric admissions faced a 70x increase in suicide risk during their first year postpartum
- 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- Withdrawn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

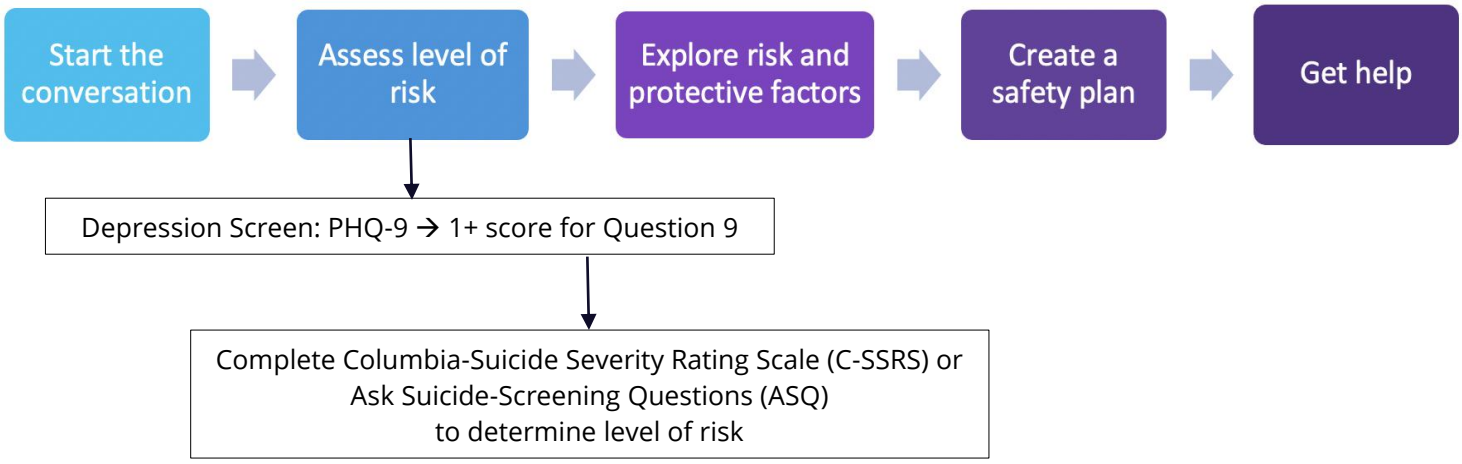
CRITICAL SIGNS

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***
- Personal or family hx of mental disorder (esp. bipolar disorder)
- Hx of substance use disorder & cannabis use
- Lifetime hx of rape, or hx of childhood abuse
- Medical illness (e.g. HIV+ status, chronic pain)
- Death of family member by suicide
- Younger age
- Nulliparity
- Traditionally marginalized and underserved populations (e.g., LGBTQAI+, Black, Native American/Alaskan Native)
- Veteran
- Physician

Situational factors:

- Recent IPV
- Lack of social support
- 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
- Unemployment/financial instability
- Medical problems
- Legal issues
- Housing factors (crowded, inadequate, rural)
- Community factors (i.e., war, discrimination)
- Health systems factors (i.e, barriers to access, stigma)

Other factors: Depressive symptoms (SIGECAPS) especially sleep disturbances, feeling estranged/distant from child, psychosis, or suicide

*34% of pregnancy-related suicides had a documented prior suicide attempt

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.
- Consider the Stanley-Brown, a validated brief intervention used to collaboratively mitigate acute suicide risk with suicidal individuals. Discuss Reasons for Living

Assessment of Safety Risk in Perinatal Populations (Cont.)

Possible Interventions

<table>
<tr><th>Low Risk</th><th>Moderate Risk</th><th>High Risk</th></tr>
<tr><td>Modifiable risk factors, strong protective factors</td><td>Multiple risk factors, few protective factors</td><td>Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant</td></tr>
<tr><td>Thoughts of death, no plan, intent, or behavior</td><td>Suicidal ideation with plan, but no intent or behavior; previous suicide attempts</td><td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal</td></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; psychiatric admission may be necessary</td><td rowspan="2">Emergency psychiatry consultation in ER; psychiatric hospitalization generally indicated (mother-baby unit)</td></tr>
<tr><td>Initiate treatment (consider pharmacotherapy)</td><td>Initiate treatment, including pharmacotherapy</td></tr>
<tr><td colspan="3">Give emergency/crisis numbers</td></tr>
<tr><td colspan="3">Optimize social support</td></tr>
<tr><td colspan="3">Psychoeducation</td></tr>
<tr><td>Documentation tips</td><td colspan="2">Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, contact with significant others, consultation); firearms instructions, if relevant; follow-up plan.</td></tr>
</table>

Resources for Assessing Safety

For Providers:

Safety Plan Template:
https://bgg.11b.myftpupload.com/wp-content/uploads/2021/08/Stanley-Brown-Safety-Plan-8-6-21.pdf

Stanley-Brown Safety Plan Training Videos:
https://suicidesafetyplan.com/training/

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

Webinars:
Latest in Maternal Suicide Trends (Friday, September 22, 2023)

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:

- *866-427-4747 (866-4-CRISIS)*

988 Suicide and Crisis Lifeline:

- *9-8-8 (7-1-1 for TTY)*
- Crisis support via text message: *Text 988*
- Crisis support via chat: https://chat.988lifeline.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/

Policy Center for Maternal Mental Health Remembrance Wall:
https://policycentermmh.org/remembrance-wall/

For clinicians:

Coalition of Clinician Survivors
www.cliniciansurvivor.org

Intimate Partner Violence (IPV) 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 has increased to unprecedented levels since the pandemic
- Prevalence of perinatal IPV estimates ~3-8%
- Pregnancy is the 2nd most dangerous time in a violent relationship, and is a risk factor for dying by homicide
- Homicide is a leading cause of death in pregnancy and in postpartum (9% of total pregnancy-associated deaths 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%)
- Non-Hispanic Black and American Indian/Alaska Native rural residents had significantly higher rates of experiencing IPV during the perinatal period compared to non-Hispanic White residents.
- Folks of BIPOC and LGBTQAI communities suffer from IPV more; people who identify as non-Hispanic Black or younger age (15-24) are at highest risk of intimate partner homicide
- IPV (esp., physical abuse) is associated with suicidal ideation and deaths (higher frequency = increased risk)
- 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.
- Technology-facilitated abuse is a significant, harmful phenomenon and emerging trend

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
- Being from certain racial/ethnic minority groups like non-Hispanic Black, American Indian/Alaska Native
- Having refugee status

High-Risk Indicators for Severe IPV and Lethality

- 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

Intimate Partner Violence Risk Assessment (Cont.)

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, , especially patient minimizing these 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
- Sexually transmitted infections or frequent UTIs, vaginal infections, or pelvic pain
- Poor nutritional status, inadequate weight gain
- Increased rates of alcohol, substance use and smoking in pregnancy

Consequences of IPV

Mental Health:

- PTSD, fear
- Anxiety, stress
- Depression, suicide
- Eating Disorders
- Substance Use Disorders
- Isolation

Neonatal Health:

- Diminished intrauterine growth, small for gestational age, low birth weight
- Preterm birth
- Stillbirth
- Fetal injury or death

Obstetric Health:

- Insufficient or inconsistent 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
- Homicide

Impact on Children:

- Less likely to be breastfed
- Sleep disturbances
- Higher irritability, behavioral problems
- Increased risk for mental illness (mood and anxiety disorders, PTSD, substance use)
- Deficits in executive functioning
- Deficits in cognitive functioning
- Delays in achieving developmental milestones
- Insecure or disorganized attachment
- Increased risk for physical abuse and neglect
- Failure-to-thrive
- Death
- 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

Intimate Partner Violence Risk Assessment (Cont.)

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.

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 once per trimester and at postpartum visits
    - Other times: intakes, annually, new intimate relationship, when IPV is suspected
    - Think about including information in discrete areas in the clinic (i.e., restrooms/stall doors)
- 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
- Do not screen if another adult or child over 2 years old 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?")

Intimate Partner Violence Risk Assessment (Cont.)

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; ensure documentation is kept confidential and secure
- Use recovery-oriented, non-stigmatizing terms (i.e., someone who uses/experiences violence, not victim/perpetrator); avoid language that blames the patient or minimizes the abuse

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); avoid speculation or assumptions
- Collect and document information about the individual who used violence (name, address, relationship to patient, etc.)
- Note the patient's concerns about safety and any safety planning done (see more below)
- Other considerations: (in)consistency between subjective and objective findings, children in home, pregnancy status of patient, etc.
- Remember: documentation can be used to support the patient's safety, treatment, and recovery. It may also serve as evidence in legal proceedings if the patient chooses to pursue that path

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 our "Resources for Providers" page 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
• Identify safe areas of the home • Gather important documents such as copies of birth certificates, passports, financial records, other ownership files • Provide assistance with contraceptive health and screening for sexual health issues • Practice how to safely exit if needed and have an “escape bag” packed with essentials • Identify trusted friends, family, or domestic violence advocates to call in an emergency; keep the number for the National Domestic Violence Hotline (1-800-799-7233) or a local shelter handy	• Contact a local domestic violence shelter or the National Domestic Violence Hotline (1-800-799-7233) to get connected with resources and support • Partner with a trusted friend, family member, or advocate about the situation and safety concerns • Have a provider document any injuries or incidents (who, what, when, where, how; photos can also be used and stored in the medical record • Identify a safe, anonymous place to stay and bring your “escape bag”	• File for a restraining order or order of protection • Change the route to work, school, or other regular destinations; vary the schedule by leaving at different times, avoid places familiar to person using violence • Change the locks, install additional security measures like cameras, lighting, etc • Alert neighbors, family, co-workers, employers, or school personnel to call the police if they see the individual • Ensure online safety by changing passwords, disabling location services • Engage in self-care

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, peer support, psychotherapy.
- Education and training: Attend workshops on self-care and trauma-informed care.
- Practice self-care: Mindfulness, meditation, relaxation practices, healthy nutrition, avoiding substances, exercise, nature-based activities, boundary setting, and hobbies.
- 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:

- The highest rate of child abuse is in children under age one
- Forms of child maltreatment preceding infant death are neglect (72%) & physical abuse (44%)
- 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 and usually involves at least one parent; firearms are the cause in over 75% of cases
- 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% will carry out 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
- nearly 73% of child homicide victims in the U.S. were Black children, despite making up only 17% of the child population
- The economic burden of child maltreatment rivals the cost of other high-profile public health problems, such as heart disease and diabetes
- 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 (under 20 years)
- Unmarried
- Rural residence
- 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
- Born at residence
- Low gestational age
- Low birthweight
- Low apgar score
- Male sex

Other Risk Factors:

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

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)

Assessment of Risk for Harm of Infants and Children (Cont.)

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:

- Are there any safety concerns you have for your child(ren) at home or elsewhere?
- Have you experienced any troubling thoughts about harming others?
- Have you had any distressing thoughts or fears about harming your child(ren)?
- Have you had any thoughts about wanting others to die with you?
- Do you worry that others, including your children, would struggle to cope without you? Have you thought about what might happen to your child(ren) if you were no longer around?

Important Consideration:

Fear of child removal from the home is real and common among parents. This fear may lead to reluctance in disclosing or minimizing symptoms and risky behaviors (e.g., substance use). If, after a thorough risk assessment, a referral for protective services is deemed necessary, it is essential to exercise extra vigilance and care. Such actions can disrupt the therapeutic alliance, potentially leading to avoidance of care or treatment, and may increase the risk of maternal mental health disorders 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
https://dontshake.org/purple-crying

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
Provides Text Telephone (TTY), Voice Carry Over (VCO), Hearing Carry Over (HCO), Speech-to-Speech (STS), Spanish and Remote Conference Captioning (RCC) services

King County Crisis Line
866-4-CRISIS (866-427-4747)

988 Suicide and Crisis Lifeline
Call: *9-8-8*
Crisis support via text message: Text 988
Crisis support via Chat: https://chat.988lifeline.org/

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

National and State-Specific Resources

Healthy Mothers, Healthy Babies Consortium
https://hmhbconsortium.org

American Academy of Pediatrics (AAP) WA Chapter
https://wcaap.org

Educational Materials and Programs

Bright Futures
https://brightfutures.aap.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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