Assessing Safety

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Assessment of Safety Risk in Perinatal Populations

Key Facts:

- Suicide is a leading cause of pregnancy-related death within first year of postpartum period (~10% in WA)
- Suicide is more likely to occur in the postpartum period (nearly half between 6 weeks and 1 year postpartum)
- Women with a history of depression or other psychiatric disorders are at a significantly increased risk for suicide and self harm
- Substance use, including alcohol use, is strongly associated with suicidal ideation and behavior in pregnancy and postpartum
- Intimate Partner Violence is a major contributor to suicide risk; a substantial portion of pregnancy-associated suicides involved conflict with a current or former partner
- Untreated postpartum psychosis carries a very high risk of suicide (5%); this constitutes a psychiatric emergency
- Access to lethal means, particularly firearms, significantly increases suicide fatality risk in the perinatal period

Warning Signs:

- Persistent sadness or depressed mood
- Withdrawal or social isolation
- Loss of interest or pleasure in usual activities
- Changes in sleep or appetite
    - **Especially severe insomnia (high-risk indicator)**
- Fatigue or inability to function
- Feelings of worthlessness, guilt, or shame
- Feeling like a burden to others
- Increased anxiety, panic, or agitation
- Emotional lability or irritability
- Difficulty bonding or estrangement from infant
- Increased substance use (alcohol or drugs)
- Recklessness or impulsivity
- Giving away possessions
- Talking about feeling trapped or having no way out

High-Risk Signs:

- Rapid worsening of mood or anxiety
- Severe restlessness, agitation, or inability to sleep
- Relapse or escalation of substance use
- Recent major stressor:
    - IPV
    - Loss (pregnancy, relationship)
    - Financial or housing instability
- Disengagement from care or missed appointment

CRITICAL SIGNS

Hopelessness

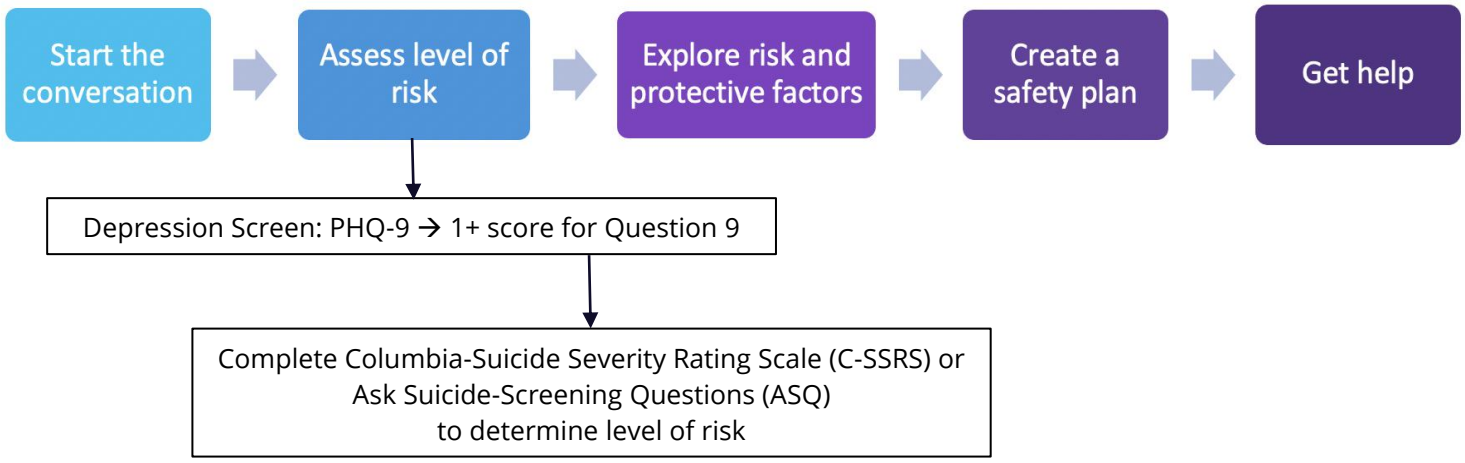
Talking about death, dying, or not wanting to live

Active suicidal ideation

Seeking access to lethal means (firearms, medications, internet searches)

Suicidal plan or rehearsal
Psychosis: delusions (especially involving infant), command hallucinations

Assessment of Safety Risk in Perinatal Populations (Cont.)



Protective Factors
• Positive and available emotional social support • Supportive and safe intimate relationship • Positive therapeutic relationship • Responsibility to others (children, family) • Positive attachment or connection to infant • Hope and future orientation • Positive coping and problem-solving skills • Sense of competence in parenting role • Access to and engagement in healthcare • Practical support (housing, finances, childcare) • Adequate sleep and support for rest • Religious or spiritual beliefs • Life satisfaction • Intact reality testing

Risk Factors	
<u>Predisposing Historical factors</u>: • Personal hx of suicidal ideation/behavior • Hx of mental disorder, esp. depression, bipolar disorder, or prior postpartum mental illness • 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 • Social and structural vulnerability: marginalized or underserved populations (e.g., LGBTQAI+, Black, American Indian/Alaska Native), Medicaid insurance or financial instability, Rural residence or limited access to care • Occupations or roles associated with increased suicide risk (e.g., healthcare professionals, military service)	<u>Situational factors</u>: • Unintended or unwanted pregnancy • Obstetric or neonatal complications • Pregnancy loss or perinatal loss • Recent discharge from inpatient psychiatric care • Intimate partner violence (IPV) • Family or relationship conflict • Social isolation or withdrawal • Unemployment or financial instability • Housing instability • Medical complications or chronic illness • Legal stressors • Exposure to discrimination or community-level stressors • Barriers to accessing care (e.g., cost, transportation, stigma, fragmented care) • Severe sleep deprivation, insomnia • Loss of follow-up or transition out of OB care (e.g., post 6 weeks pp)
Other: Depressive symptoms (SIGECAPS), feeling estranged from or disconnected from infant, substance use, suicidal warning signs, rapid change in mental status or functioning	

Assessment of Safety Risk in Perinatal Populations (Cont.)

Health Consequences of Nonfatal Suicide Attempt

Obstetrical Outcomes	Neonatal Outcomes
Increased risk of: • Antepartum hemorrhage • Placental abruption • Postpartum hemorrhage • Premature delivery • Low birth weight • Stillbirth • Poor fetal growth	• Fetal death • Neurodevelopmental vulnerabilities • Increased risk of behavioral and emotional difficulties in childhood

Possible Interventions

<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
Lethal means assessment and restriction (firearms, medications, other means)</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>Consider referral to psychiatry or behavioral health</td><td>Urgent referral to psychiatry (24-72 hrs)</td><td rowspan="2">Immediate emergency evaluation (ED or psychiatric services); hospitalization often required (preferably mother-baby unit when available)</td></tr>
<tr><td>Initiate or optimize treatment (consider pharmacotherapy)</td><td>Initiate or optimize treatment, including pharmacotherapy</td></tr>
<tr><td colspan="3">Increase follow-up frequency during the late postpartum period (6 weeks-12 months)</td></tr>
<tr><td colspan="3">Optimize social support</td></tr>
<tr><td colspan="3">Psychoeducation</td></tr>
</table>

Assessment of Safety Risk in Perinatal Populations (Cont.)

Safety Planning

- Foster connection and hope
  - Encourage support from family, partner, or trusted others
  - Reinforce reasons for living
- Initiate or refer to appropriate mental health care
  - Ensure timely follow-up
- Assess and restrict access to lethal means
  - Firearms, medications, and other means
  - Collaborate to secure or remove when possible
- Collaboratively develop a safety plan
  - Use the Stanley-Brown Safety Planning Intervention
  - Include coping strategies, supports, and crisis resources
- Increase monitoring and follow-up
  - Especially during high-risk periods (e.g., beyond 6 weeks postpartum)

Assessment of Safety Risk in Perinatal Populations (Cont.)

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 Plan 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:
- *866-427-4747 (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/

988 Loss Survivor Support
https://988lifeline.org/help-yourself/loss-survivors/

For clinicians:

Coalition of Clinician Survivors
www.cliniciansurvivor.org

Intimate Partner Violence (IPV) Risk Assessment

Definition: The term "intimate partner violence" (IPV) describes a single or repeated act of physical violence, sexual violence, stalking, psychological or emotional harm, economic abuse, coercion (including control of reproductive or sexual health), or technology-facilitated abuse perpetrated by a current or former partner or spouse. "Intimate partner" refers to an individual with whom one has a close personal or romantic relationship (i.e., spouse, former partner, dating partner, or co-parent).

Be Vigilant:

- IPV remains a significant public health crisis, with rates increasing during and after the COVID-19 pandemic
- Technology-facilitated abuse is a significant, harmful phenomenon and emerging trend in IPV
- IPV (esp., physical abuse) is associated with suicidal ideation and death (high frequency = increased risk)
- ~3-9% 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 (~8-10% 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 late postpartum (34.9%)
- Individuals who identify as non-Hispanic Black or younger age (15-24) are at highest risk of homicide
- BIPOC individuals suffer disproportionally higher rates of IPV and intimate partner homicide
- 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
- Being from certain racial/ethnic minority groups like non-Hispanic Black, American Indian/Alaska Native
- Having refugee status

Risk Factors for Escalation or Lethality

- Access to firearm and/or prior use of weapon
- Strangulation
- Homicidal threats (toward partner, children, pets)
- Suicidal threats
- Hostage-taking
- Escalation of IPV
- Forced sexual activity
- Stalking behavior

Intimate Partner Violence Risk Assessment (Cont.)

Warning Signs/Indicators of IPV:

- Patient appears fearful, anxious, or overly deferential to partner
- 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
- Untreated or poorly explained physical injuries, especially in multiple stages of healing and located on the neck, head, breasts, abdomen, and genitals
- History of poor obstetric outcomes (e.g., recurrent miscarriage, stillbirth, preterm labor/birth, IUGR or low birth weight)
- Partner insisting to be present for visit or exhibiting controlling or domineering behavior
- Sexually transmitted infections, frequent UTIs, vaginal infections, or chronic pelvic pain
- Minimalization of inconsistent explanations of injuries

Consequences of IPV

Mental Health:

- Post-traumatic stress disorder
- Anxiety Disorders
- Major Depressive Disorder
- Eating Disorders
- Substance Use Disorders
- Sleep disturbances
- Challenges with bonding or attachment

Psychosocial Impact:

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

Obstetric Health:

- No or delayed prenatal care
- Low maternal weight gain
- 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
- Miscarriage
- Diminished intrauterine growth
- Homicide
- Stillbirth

Impact on Children:

- Less likely to be breastfed
- Failure-to-thrive
- Increased risk for death
- Increased risk for emotional and behavioral disorders
- Sleep disturbances
- Increased irritability
- Deficits in executive and 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

Intimate Partner Violence Risk Assessment (Cont.)

PEARLSS Framework 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 more about what's been happening?
3. When did this occur?
4. Have you shared this with anyone else?
5. How are you coping?
6. What do you need right now?
7. Is there anything that makes you feel more of less safe?

- IPV screening is recommended for all individuals of reproductive age
    - Screen at least once per trimester and at postpartum visits
    - Additional times: intakes, annually, new intimate relationship, or when suspected
    - Consider placing resource 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 "Have you been abused?")
- Assess immediate safety and other urgent health concerns/needs
- Offer choices (e.g., referrals, list of local resources, crisis lines, shelter)
- Recognize and respect patient's autonomy in decision-making

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
- Follow institutional policies regarding documentation and photography

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: note (in)consistencies between subjective and objective findings, presence of 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 safer areas of the home (i.e., spaces with exits, without weapons) • Gather important documents such as copies of identifications, birth certificates • Make copies of important financial or ownership documents • Provide assistance with contraceptive health and screening for sexual health needs • Practice how to leave quickly if needed • Prepare an emergency bag (e.g., medications, documents, keys, cash) and store in safe, accessible location • Be mindful of technology use (e.g., location sharing, shared accounts, device monitoring) • Identify trusted individuals and emergency contacts, including a local domestic violence shelter or national hotline with trained advocates such as the National Domestic Violence Hotline	• Plan the timing of leaving carefully (risk may increase during separation) • Contact a local domestic violence shelter or national hotline • Document any injuries (clinician can do this during the visit and place pictures in the medical record) • Identify a safe place to stay	• Consider obtaining a restraining or protection order • Change routines (e.g., routes to school, work) • Consider changing phone settings, passwords, privacy settings • Change locks, secure the home • Inform trusted individuals (e.g., neighbors, family, workplace, school) to seek help if individual is seen • Save threatening messages or communications as documentation

Resources for Intimate Partner Violence

Patient 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
- 1-800-656-HOPE (4673) | Free. Confidential. 24/7.
- https://rainn.org/help-and-healing/hotline/

StrongHearts Native Helpline (for American Indian/Alaska Native individuals)
- 1-844-7NATIVE (762-8483)

Get Help Now (Statewide programs and hotlines)
- Washington 211: Dial 2-1-1 or search by ZIP code for local shelters, housing, and support services
- https://wa211.org

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.)

Validated Screening Tools:

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

Clinician Well-Being and Vicarious Trauma

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:

- 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 a leading injury-related cause of death for infants <1 year.
- Forms of child maltreatment preceding infant death are neglect (72%) & physical abuse (44%)
- WA mandated reporters must report suspected child abuse or neglect at the first opportunity, and no later than 48 hours after reasonable cause exists.
- In WA state, infants are overrepresented in child welfare: in 2018, 25% of children entering foster care were infants <1 year, the second highest rate in the country.
- Untreated postpartum psychosis is associated with an estimated 4% risk of infanticide.
- Intrusive, unwanted thoughts of infant harm can occur in postpartum depression, anxiety, OCD, trauma, or severe stress but are not the same as intent to harm.
- 16-29% of filicides occur in the context of maternal suicide
- Among U.S. child homicides ages 0–17, firearms were the most common weapon type overall; weapon patterns vary substantially by age, with infants more often killed by personal weapons or blunt force than firearms.
- 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
- Single parenting or limited co-parent/support
- Lower educational achievement
- Socially isolated
- IPV
- Family history of violence
- History or current child abuse/neglect
- Full-time caregiver/unemployment
- Caregiver stress
- Child custody dispute
- Thoughts of revenge against spouse

Infant Characteristics:

- Age <1 year, especially first 24 hours of life
- Low gestational age/prematurity
- Low birthweight
- Low Apgar score
- Medical complexity/high needs
- Persistent crying, colic, feeding difficulty, sleep disruption
- Male sex
- And/or Non-Hispanic Black race

Other Risk Factors:

- Access to firearms
- Exposure to domestic violence
- Exposure to substance use
- Access to firearms or other lethal means
- Exposure to domestic violence/IPV
- Exposure to substance use, intoxication, or impaired caregiving
- Unsafe sleep environment or lack of safe infant care supplies
- Housing instability or unsafe living environment
- Lack of reliable childcare, respite, or emergency support

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 or concerning child 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, frequent absences from school or medical care)
- Caregiver behaviors that raise concern, such as harsh discipline, threats, indifference to the child, blaming the child, impaired caregiving, or appearing fearful of a partner or other household member

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 these thoughts unwanted and frightening, or do they feel like something you might act on?
- Have you thought about how you might harm your child or what you might use?
- Are you worried you might lose control?
- Are there other people, including your child(ren), you want to die with you?
- Are there others you think would be unable to go on without you?
- What do you believe would happen to your child(ren) if you died?
- Are you hearing voices or having beliefs that make you worry your child is unsafe, evil, doomed, or needs protection?
- When you feel overwhelmed or unsafe, who can immediately help care for the baby?
- Are there firearms, medications, or other lethal means in the home?

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; often associated with depression or belief child cannot survive without caregiver
2. Acutely psychotic: no clear/reality-based 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/partner 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

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

WA Child Abuse Reporting
1-866-END-HARM/1-866-363-4276

WA Safe Have/Safety of Newborn Children Law
1-888-520-BABY/1-888-510-2229
https://www.dcyf.wa.gov/safety/safety-newborn-law

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
https://helpmegrowwa.org

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)

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

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

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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