Policy

Clinical Guideline

Intent to Harm Fetus

Policy developed by: SA Maternal & Neonatal Clinical Network
Approved SA Health Safety & Quality Strategic Governance Committee on: 24 June 2015
Next review due: 30 June 2018

Summary Clinical practice guideline for the management of a woman suspected of or with an intent to harm her fetus.

Keywords Passive abuse, harming behaviours, partner domestic violence, impulsive self-harm, suicidal intent, suicidal ideation, Intent to Harm Fetus clinical guideline

Policy history Is this a new policy? **N**
Does this policy amend or update an existing policy? **Y v1.0**
Does this policy replace an existing policy? **N**

Applies to All Health Networks
CALHN, SALHN, NALHN, CHSALHN, WCHN, SAAS

Staff impact All Clinical, Medical, Nursing, Allied Health, Emergency, Dental, Mental Health, Pathology

PDS reference CG217

Version control and change history

Version	Date from	Date to	Amendment
1.0	18 Jan 2011	24 Jun 2015	Original version
2.0	24 Jun 2015	Current	Reviewed

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South Australian Perinatal Practice Guidelines

Intent to harm fetus

Note

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Explanation of the aboriginal artwork:
The aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the aboriginal culture. The horse shoe shape design shown prior to the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant women. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.

Australian Aboriginal Culture is the oldest living culture in the world yet we experience the worst health outcomes in comparison. Our Aboriginal women are 2-5 times more likely to die in childbirth and our babies are 2-3 times more likely to be low birth weight. Despite these unacceptable statistics the birth of an Aboriginal baby is an important Cultural event and diverse protocols during the birthing journey may apply.

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Intent to harm fetus

Introduction

- Anxiety and ambivalence about pregnancy are common and exist along a continuum of severity. The expression of doubt in pregnancy in fact opens up an opportunity to support the mother with the developmental changes she needs to navigate. At the other end of the continuum, the intent to harm a fetus is an emergency that requires specialist psychiatric assessment.
- Cases of deliberate harm towards the fetus may range from passive abuse (e.g. poor antenatal care, continued alcohol and nicotine misuse) through to active physical violence[1]
- Denial or concealment of pregnancy may also be associated with intent to harm a fetus[1,2]
- The mother's dialogue relating to the baby's role in her life can give significant clues to her propensity to engage in direct or indirect harming behaviours[3]
- This guideline considers only the woman's intention to her fetus. It is appropriate to note that fetal harm is substantially higher in situations of partner domestic violence[4] and the partner may have overt intentions to the harm the fetus who can be seen as a threat. (link to women with significant psychosocial needs at www.sahealth.sa.gov.au/perinatal in the A to Z index for information on domestic violence)

Antepartum care

- Situational and psychological factors may negatively influence the woman's quality of attachment to the unborn fetus, for example:
    - Unplanned pregnancy, poor social supports and relationship problems with partner
    - Degree of anxiety, depression, fatigue, confusion[1]
- All women should routinely complete the Edinburgh Postnatal Depression Scale (EPDS) and psychosocial risk questionnaire (Questionnaires should only be used by appropriately trained staff) at antenatal booking (for further information link to "screening for perinatal anxiety and depression" in the A to Z index at URL: www.sahealth.sa.gov.au/perinatal)
- Depending on results of conversations with the woman and the above questionnaires, assess the need for referral to any other services e.g. Social Worker, Mental Health liaison, Psychiatric review, Case discussion meeting, Obstetric Consultant, GP
    - Where possible, arrange on-going care with a service that provides continuity of carer e.g. midwives clinic, high risk pregnancy service, obstetrician, GP, midwifery continuity of carer models, whichever is most appropriate.
- For many mothers, an intent to harm her fetus is likely to generate shame, and she is likely to be selective or secretive about who is informed. Therefore a critical factor in care is engagement with one nominated consistent caregiver either through antenatal care or else through mental health services who can gain trust and rapport

Perinatal assessment

- If intent to harm an unborn child becomes evident, a timely assessment will need to include
    - Medical assessment where relevant
    - Psychosocial review including culturally appropriate aspects
    - Previous obstetric history
    - Psychiatric evaluation

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Questions to ask:

- Does the woman have a history of impulsive self harm?
- Is there any pre-existing psychiatric illness, and is there any current team or clinician involved?
- Are there significant cultural aspects?
- Is there a history of sexual and / or developmental trauma?
- Are there any recent events that appear to have precipitated a crisis?
- Is the woman seeking assistance and has she engaged with services before?
- Are there any other trusted people who will be in close proximity to the mother and are able to provide containment and support?

- Whilst legislation does not protect an unborn fetus, Families SA (Child Protection) should be notified of an imminent high-risk birth through the Child Abuse Report Line (telephone: 131478).
- Intent to harm the fetus is a self-harming thought or impulse so suicidal ideation is likely to need exploration (follow link to suicidal ideation and self harm at www.sahealth.sa.gov.au/perinatal in the A to Z index). However, deliberate self-harm is not always equivalent to suicidal intent; for example, self harm is a common feature of personality disorders (follow link to personality disorders and pregnancy at www.sahealth.sa.gov.au/perinatal in the A to Z index)
- Multiple risk factors increase the overall level of risk. Suicidal intent is more serious than thoughts: if the woman has a plan, intent and means to kill herself available, this warrants urgent referral to psychiatric services, as does a plan to imminently harm her fetus.
- If there is a clear assessment of an intent to harm fetus and that the underlying factors remain, a full antenatal case management plan including brief background, current interventions, relevant contacts, and postnatal care recommendations should be generated
- It is recommended to involve family or friends whom the woman perceives to be helpful (some family members might be perceived to be harmful)
- Consult with a peer or mental health professional and document the assessment, consultation, referral and management actions

Intrapartum care

- After delivery, the woman should be reviewed to determine changes to the presentation, case management plan, and level of midwifery observation

Postpartum care

- An extended stay in the postnatal inpatient setting is recommended to establish early caregiving pattern and response to infant cues
- A multidisciplinary review involving both social work and mental health is indicated before discharge if the difficulties have had any degree of persistence. Families SA to be notified if there are outstanding concerns about the welfare of the family
- An admission to Helen Mayo House (mother baby unit) may be indicated if according to clinical judgement there is an underlying mental illness which needs to be addressed as a variable
- Increased observation during admission if there is a perceived high risk of intent to harm baby

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Follow-up

- The family should be referred to early monitoring and support, for example via Child and Family Health along with specialist services appropriate to the origin of the difficulty.
- One lead agency should be identified before discharge with appropriate clear communication between agencies involved

Useful contact numbers

Child Abuse Report Line (24 hr)
Telephone: 13 1478
Flinders Medical Centre Child Protection Unit
Telephone: 8204 5485
Women's and Children Hospital Child Protection Unit
Telephone: 8204 7346

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3. Condon J. The spectrum of fetal abuse in pregnant women. The Journal of Nervous and Mental Disease 1986; 174: 509-16.
4. Boy A, Salihu HM. Intimate partner violence and birth outcomes: A systematic review. Int J Fertil Women's Med 2004; 49:159-64.
5. King Edward Memorial Hospital (KEMH). Perinatal depressive and anxiety disorders 2007. Women and Newborn Health Service. WA Perinatal Depressive and Anxiety Guidelines. Available from URL: http://www.kemh.health.wa.gov.au/brochures/health_professionals/8393.pdf

Useful web site

South Australian legislation. South Australian Child Protection Act. Available from URL: http://www.legislation.sa.gov.au/LZ/C/A/CHILDRENS%20PROTECTION%20ACT%201993.aspx

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Abbreviations

EPDS	Edinburgh Postnatal Depression Scale
SA	South Australia

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PDS reference: OCE use only

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