South Australian Perinatal Practice Guidelines

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. (for information on domestic violence, refer to the PPG 'women with significant psychosocial needs')

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 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, refer to the PPG 'Screening for perinatal anxiety and depression')
- 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 ongoing 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

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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

Questions to ask:

  - Does the woman have a history of impulsive self harm?
  - Is there any pre-existing psychiatric illness?
  - Are there significant cultural aspects?
  - Is there a history of trauma?
  - What psychosocial contributions are there? (i.e. is there an underpinning crisis?)
  - Is the woman seeking assistance and has she engaged with services before?

- 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 impulse so suicidal ideation is likely to need exploration (for further information, refer to the PPG 'suicidal ideation and self harm'). However, deliberate self-harm is not always equivalent to suicidal intent; for example, self harm is a common feature of personality disorders (for further information, refer to the PPG 'personality disorders and pregnancy').
- 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.
- 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

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Postpartum care

- A multidisciplinary review of the case needs to be carried out, with Families SA being notified if there are outstanding concerns about the welfare of the family
- Consider admission to mother-baby unit
- Intense observation during admission if there is a perceived high risk of intent to harm baby. Consider close midwifery observation, nursing special etc
- Maintain clear communication, collaboration between all levels of staff
    - Early referral where risk identified
    - Documented plan of care

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

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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References

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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

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Legal Services Commission of South Australia. South Australian Child Protection Act. Available from URL: http://www.lawhandbook.sa.gov.au/ch05s04.php

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Abbreviations

et al.	And others
kg	kilogram
m_2	Metres squared
BMI	Body mass index
EDNOS	Eating disorders not otherwise specified
PND	Postnatal depression

Version control and change history

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