Maternal Mental Health and Suicidality in the UK during the Perinatal Period

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KING'S College LONDON

Presentation Overview

- Background: Maternal mortality
- Characteristics & trends in maternal suicides in the UK
- Risk factors associated with maternal suicide and suicidality
- Listening to women: Findings from the ASPEN study
- Suicide prevention strategies in the perinatal period

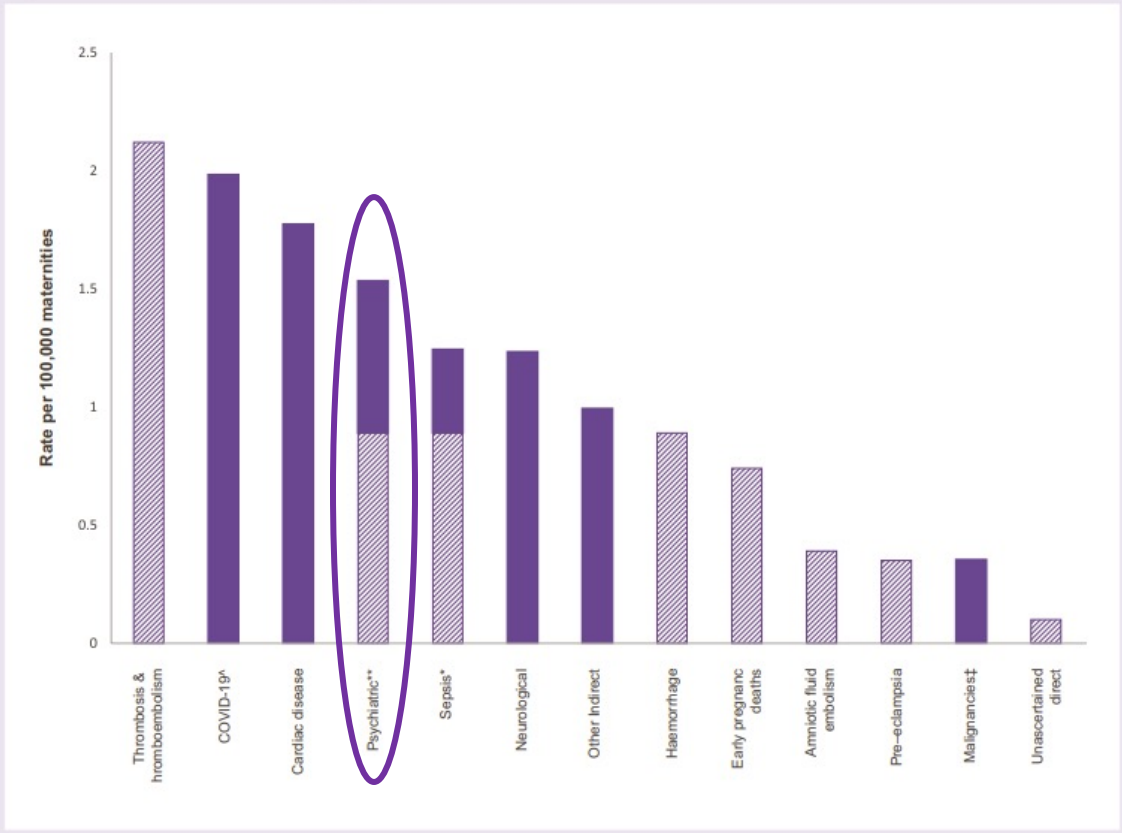
Background: Maternal Mortality

- Every day approximately 810 women died from preventable causes related to pregnancy and childbirth (WHO, 2017)
- Maternal suicide is an important and often overlooked cause of maternal mortality
  - Leading cause of death during the perinatal period in many HIC (5-20% of all maternal deaths)
  - Lower prevalence in LMIC (approx. 1% of all maternal deaths)
- Potential differences due to terminology & classification of maternal mortality
- Maternal mortality - deaths occurring during or shortly after pregnancy (‘early deaths’) or in the first year following birth (‘late deaths’)

Source: WHO, 2017; Saving Lives, Improving Mothers’ Care MBRACE-UK 2020; Howard & Khalifeh (2020) World Psychiatry

All Cause Maternal Mortality in the UK (2020-22)

Figure 2.3: Maternal mortality by cause 2020-22



Hatched bars show direct causes of death, solid bars indicate indirect causes of death

^Rate for COVID-19 deaths calculated using maternities March 2020 to December 2022 as denominator

**Rate for suicides (direct) is shown in hatched and rate for indirect psychiatric causes (drugs/alcohol) in solid bar

*Rate for direct sepsis (genital tract sepsis and other pregnancy related infections) is shown in hatched and rate for indirect sepsis (influenza, pneumonia, others) in solid bar

‡Rate for indirect malignancies (breast/ovary/cervix)

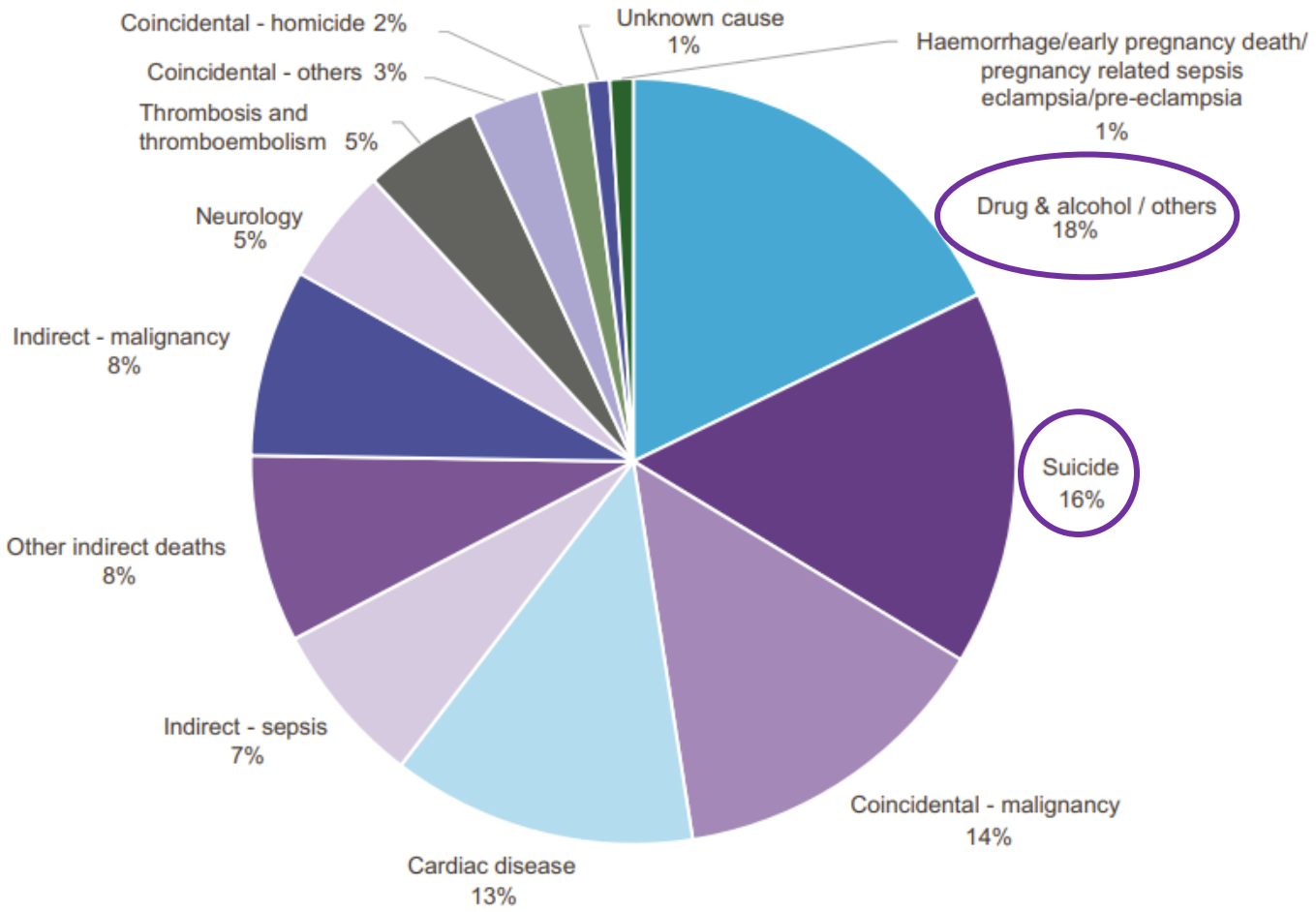
Source: MBRRACE-UK

- Maternal Suicide = 0.89 per 100,000 maternities (95%CI 0.45:1.40)
- Psychiatric related deaths are is the 4th highest of all case of maternal mortality in the UK

Source: Saving Lives, Improving Mothers' Care MBRACE-UK 2024

Postnatal Maternal Deaths in the UK (2020-22)

Figure 2.6: Causes of death amongst women who died between six weeks and one year after the end of pregnancy, UK 2020-22



Source: Saving Lives, Improving Mothers' Care MBRACE-UK 2024

Women's Characteristics (2018-20)

Table 3.1: Socio-demographic characteristics of women who died by suicide or from substance misuse, UK and Ireland 2020

Characteristics	Suicide (n=28) Frequency (%)	Substance misuse (n=27) Frequency (%)
Socio-demographic		
Age at delivery (years)		
<20	5 (18)	1 (4)
20 – 24		
25 – 29	6 (21)	5 (19)
30 – 34	10 (36)	7 (26)
35 – 39	2 (7)	7 (26)
≥ 40		
Parity		
0		
1 to 2		
≥3	3 (11)	2 (7)
Missing	10 (36)	4 (15)
UK or RoI citizen		
Yes	23 (82)	25 (93)
No		
Missing		
Ethnicity		
White incl. missing		
Other ethnicity		
Socioeconomic status (Index of Multiple Deprivation		
First quintile (Least deprived)		
Second quintile	4 (14)	3 (11)
Third quintile	6 (21)	1 (4)
Fourth quintile	4 (14)	7 (26)
Fifth quintile (Most deprived)	5 (18)	13 (48)
Missing	6 (21)	3 (11)
Domestic abuse (prior to pregnancy/ during pregnancy)		
Yes	9 (32)	19 (70)
No	10 (36)	5 (19)
Missing	*9 (32)*	*3 (11)*
History of abuse as a child		
Yes	5 (18)	6 (22)
No	8 (29)	4 (15)
Missing	15 (54)	17 (63)

Age at delivery (years)		
<20	5 (18)	1 (4)

Fourth quintile	4 (14)	7 (26)
Fifth quintile (Most deprived)	5 (18)	13 (48)

Domestic abuse (prior to pregnancy/ during pregnancy)		
Yes	9 (32)	19 (70)
No	10 (36)	5 (19)
Missing	*9 (32)*	*3 (11)*

Source: Saving Lives, Improving Mothers' Care MBRACE-U, 2022

Women's Characteristics (2018-20)

Table 3.1: Socio-demographic characteristics of women who died by suicide or from substance misuse, UK and Ireland 2020

Characteristics	Suicide (n=28) Frequency (%)	Substance misuse (n=27) Frequency (%)
Known to social services		
Yes	12 (43)	23 (85)
No	11 (39)	4 (15)
Missing		
Received any antenatal care		
Yes		
No		
Not known		
Gestational age at booking (among women who rece		
≤10		
11 – 12	2 (9)	5 (19)
≥13	6 (27)	7 (27)
Missing		
Received *recommended* antenatal care† (among wor		
Yes		
No		
Missing		
Received a minimum level of antenatal care† (among		
Yes		
No	6 (27)	12 (46)
Missing		

Known to social services		
Yes	12 (43)	23 (85)
No	11 (39)	4 (15)
Missing	5 (18)	0 (0)

Received *recommended* antenatal care† (among women who received any antenatal care)		
Yes	11 (50)	3 (12)
No	10 (45)	20 (77)
Missing	1 (5)	3 (12)

Received a minimum level of antenatal care† (among women who received any antenatal care)		
Yes	14 (64)	11 (42)
No	6 (27)	12 (46)
Missing	2 (9)	3 (12)

Source: Saving Lives, Improving Mothers' Care MBRACE-U, 2022

Timing of Maternal Deaths from Suicide & Substance Misuse (2018-20)

Figure 3.1: Timing of death by suicide during pregnancy or the post-pregnancy year, 2020

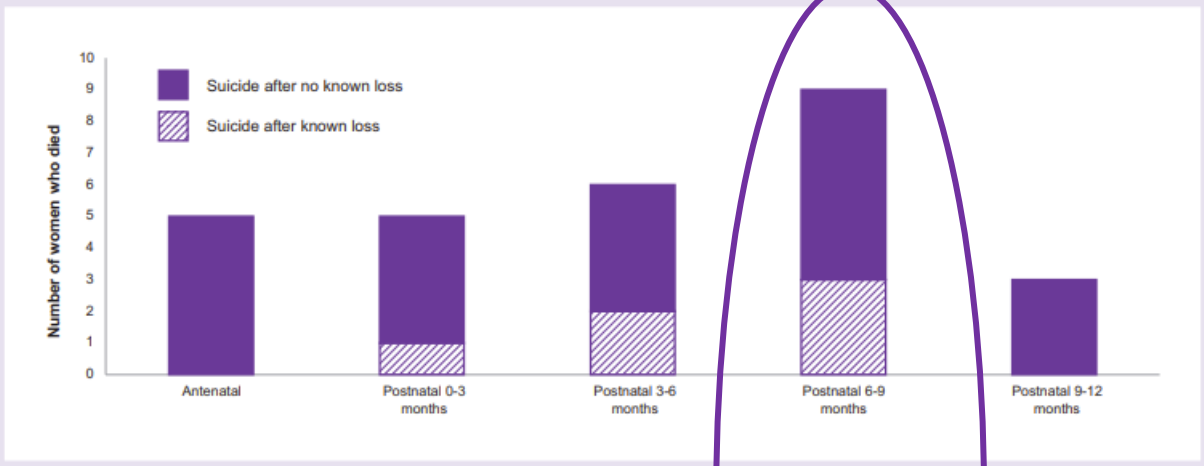
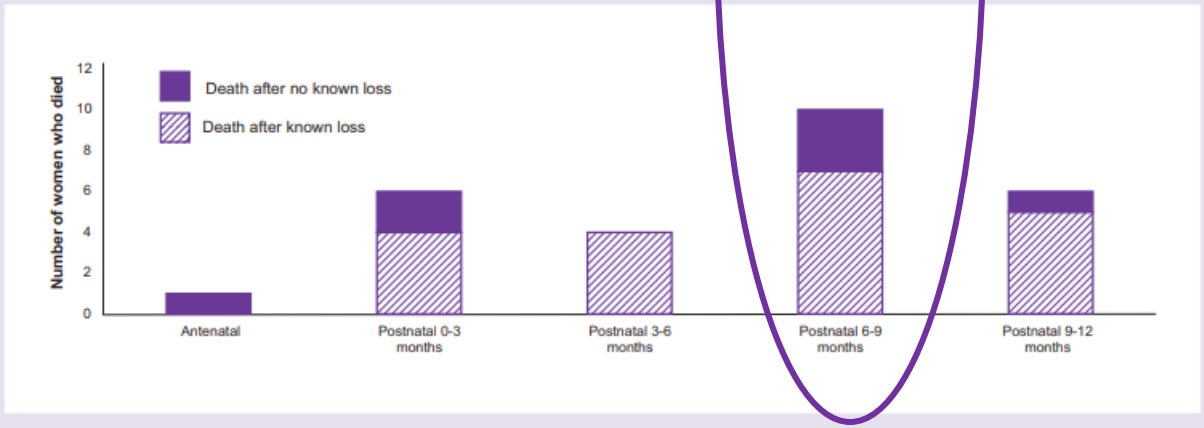


Figure 3.2: Timing of death from substance misuse or other psychiatric causes during pregnancy or the post-pregnancy year, 2020



Postnatal period is a time of increased risk, particularly after a 'perinatal loss'

Source: Saving Lives, Improving Mothers' Care MBRACE-U, 2022

Pregnancy or Postnatal Loss (2018-20)

Table 3.2: Pregnancy or postnatal loss or threatened loss amongst women who died by suicide or substance misuse, UK and Ireland 2020

Type of loss	Suicide (n=28) Number of women (%)	Substance misuse (n=27) Number of women (%)
Pregnancy loss	0 (0)	2 (7)
Neonatal death	1 (4)	1 (4)
Post-termination of pregnancy	2 (7)	1 (4)
Infant removed into care or care of relatives and/or ongoing social services proceedings	3 (11)	16 (59)
No known loss events	22 (79)	7 (26)

Source: Saving Lives, Improving Mothers' Care MBRACE-UK 2022

Are maternal deaths from suicide on the rise in the UK?

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Rising rates of perinatal suicide

Prevention should be a priority for governments and all professionals working with families

Kaat De Backer, [1] Claire A Wilson, [2,3] Clare Dolman, [2] Zoe Vowles, [1] Abigail Easter[1]

Data from the UK Confidential Enquiry into Maternal Deaths (MBRRACE-UK) for 2018-20 show that in 2020 women were three times more likely to die from suicide in the year following childbirth than they were in 2017-19.[1] Ten women died out of 674 377 giving birth in 2020 (1.48/100 000) compared with 10 out of 2 173 810 in 2017-19 (0.46/100 000). Young women and those of low socioeconomic status were most affected.

The women who died often faced multiple adversities, such as substance misuse, mental ill health, domestic violence and abuse, and the loss of their child. This increase in maternal suicide rates is in line with a general trend that pre-dated the SARS-CoV-2 pandemic, in particular for teenage suicides. Disruption to specialist mental health support, reduced face-to-face contact with healthcare professionals, and increased socioeconomic vulnerability during the pandemic may account for the sharp increase in 2020.[1]

Perinatal suicide is a global problem[2] and has been identified as one of the leading causes of maternal deaths in the UK and other European countries with enhanced surveillance systems for maternal mortality.[2,3] Wherever in the world a mother dies, the consequences on the infant, close family, and wider community are profound and long lasting.[4]

Risk factors

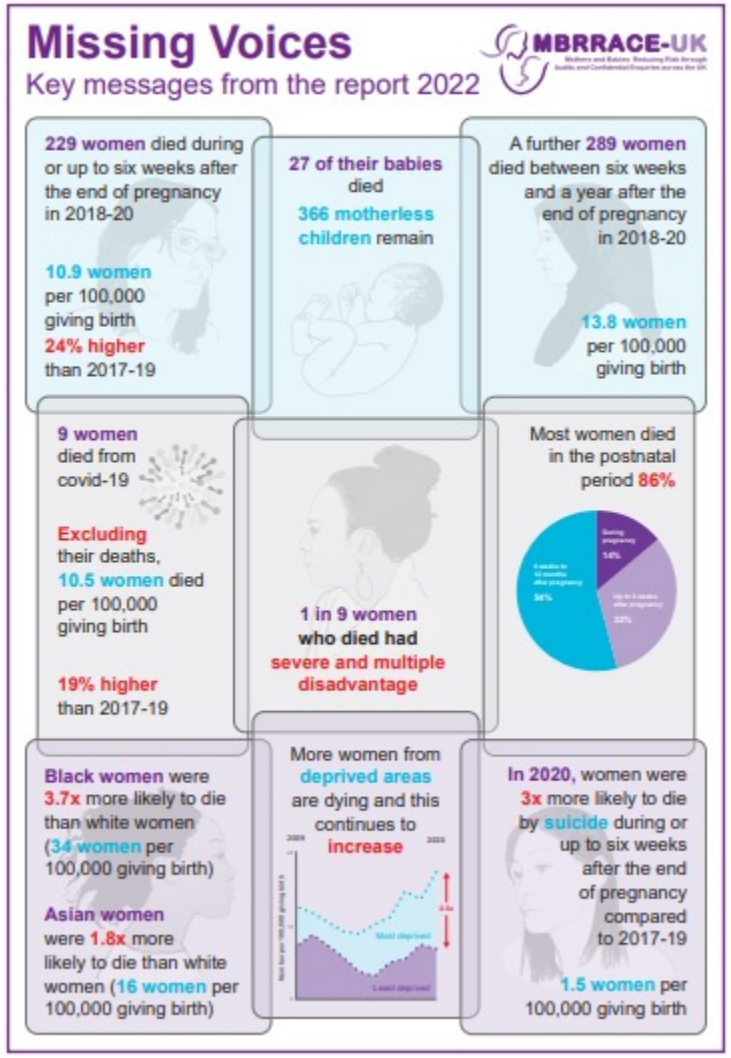
social services, often because their child had been taken into care. Even more concerning is the increase in teenage suicides: all the teenagers in the MBRRACE-UK report who died by suicide had had their baby removed from their care, and all faced complex problems, including mental ill health, substance misuse, and domestic abuse.

Domestic violence and abuse are well documented risk factors for suicide.[11] This is particularly concerning in the context of pregnancy or new motherhood,[12] when many women experience a resurfacing or intensifying of abuse, violence, and coercive control.[13] Routine inquiry about these experiences during healthcare contacts[14] can be a matter of life or death, helping to prevent both domestic homicide and perinatal suicide.

Finally, financial hardship and economic recession are associated with increased risk of suicidal behaviour and ideation, both at a population and individual level.[15] The ongoing cost of living crisis in the UK has potentially serious implications for families where money is tight and morale is low.

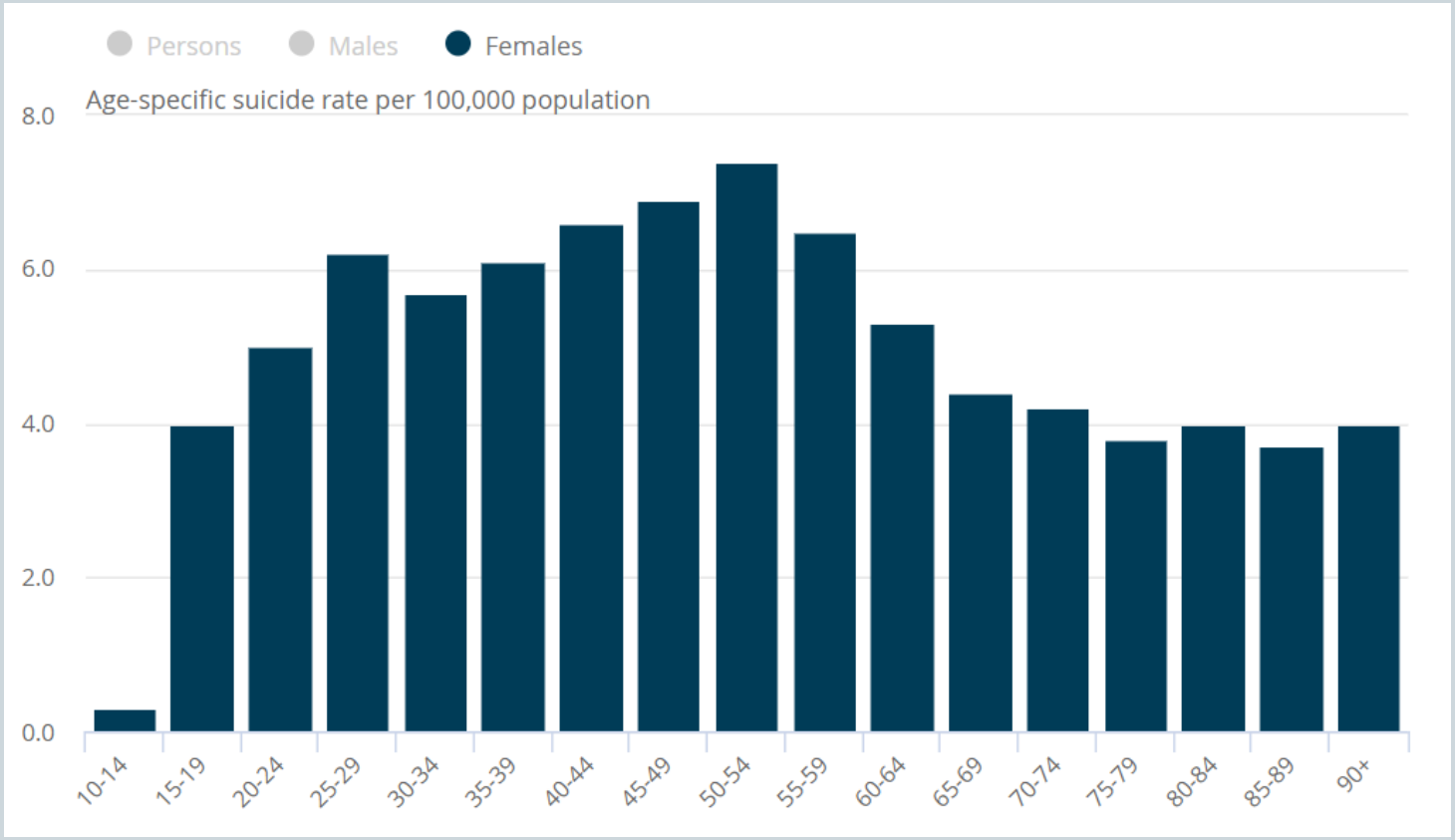
Closing the gaps

Despite a desperate need for integrated, trauma informed, and person centred care, particularly for socially disadvantaged women facing multiple adversities, many barriers limit access to timely and appropriate support, and the risk of falling between



Is the perinatal period a time of increased risk for suicide?

- In the general population, the perinatal period is thought to be protective against suicide in women
- 20-fold lower compared to matched non-pregnant population
- Mortality Ratio for suicide 16% lower for pregnant women, compared with nonpregnant women



Sources: Appleby, L. et al (1991); Gissler et al (2005); ONS 2019

Is the perinatal period protective against suicide? For all women?

- Risk of suicide among women with moderate-severe mental illness is dramatically increased
- 70-fold increased risk of suicide in the 1st postpartum year in women with postpartum psychoses

- Danish register-based cohort study (n= 1.5 million women):
  - 1st year after diagnosis was very high risk for women with severe postpartum psychiatric illness
  - Reduced longer-term risk - comparable to mothers with psychiatric disorders unrelated to childbirth

Exposure Categories	Model 1 (suicides)[a] N	MRR	95% CI
Short-term risk: ≤ 1 year after diagnosis of postpartum psychiatric disorder[c]	8	289.42	144.02–581.62
Long-term risk: > 1 year after diagnosis of postpartum psychiatric disorder[e]	21	39.97	25.90–61.70
Short-term risk: ≤ 1 year after diagnosis in non-postpartum-onset mothers[f]	152	120.62	105.24–138.26
Long-term risk: > 1 year after diagnosis in non-postpartum-onset mothers[g]	651	29.14	26.52–32.02
Short-term risk: ≤ 1 year after diagnosis in non-postpartum-onset nonmothers[h]	175	228.91	192.37–272.40
Long-term risk: > 1 year after diagnosis in non-postpartum-onset nonmothers[i]	639	69.27	62.11–77.25
Mothers with no psychiatric history	390	1.00	Reference
Nonmothers with no psychiatric history	483	1.90	1.67–2.17

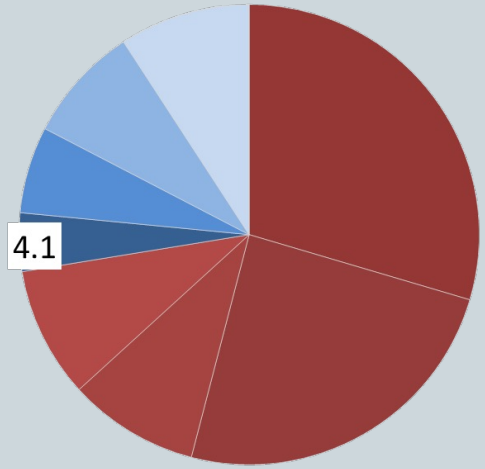
Source: Johannsen, et al (2016)

Perinatal & Non-Perinatal Suicides

Suicide by violent method:
72% vs 56%
Crude OR 2.1 (CI 1.3-3.3), p<0.001
Adjusted OR 1.4 (CI 0.87-2.3), p=0.16

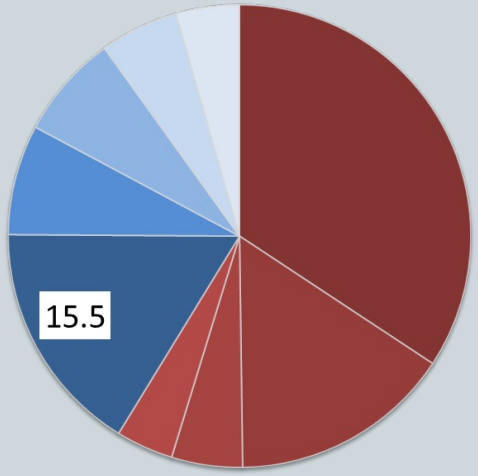
Suicide by psychotropic overdose:
4% vs 15%

Perinatal suicides



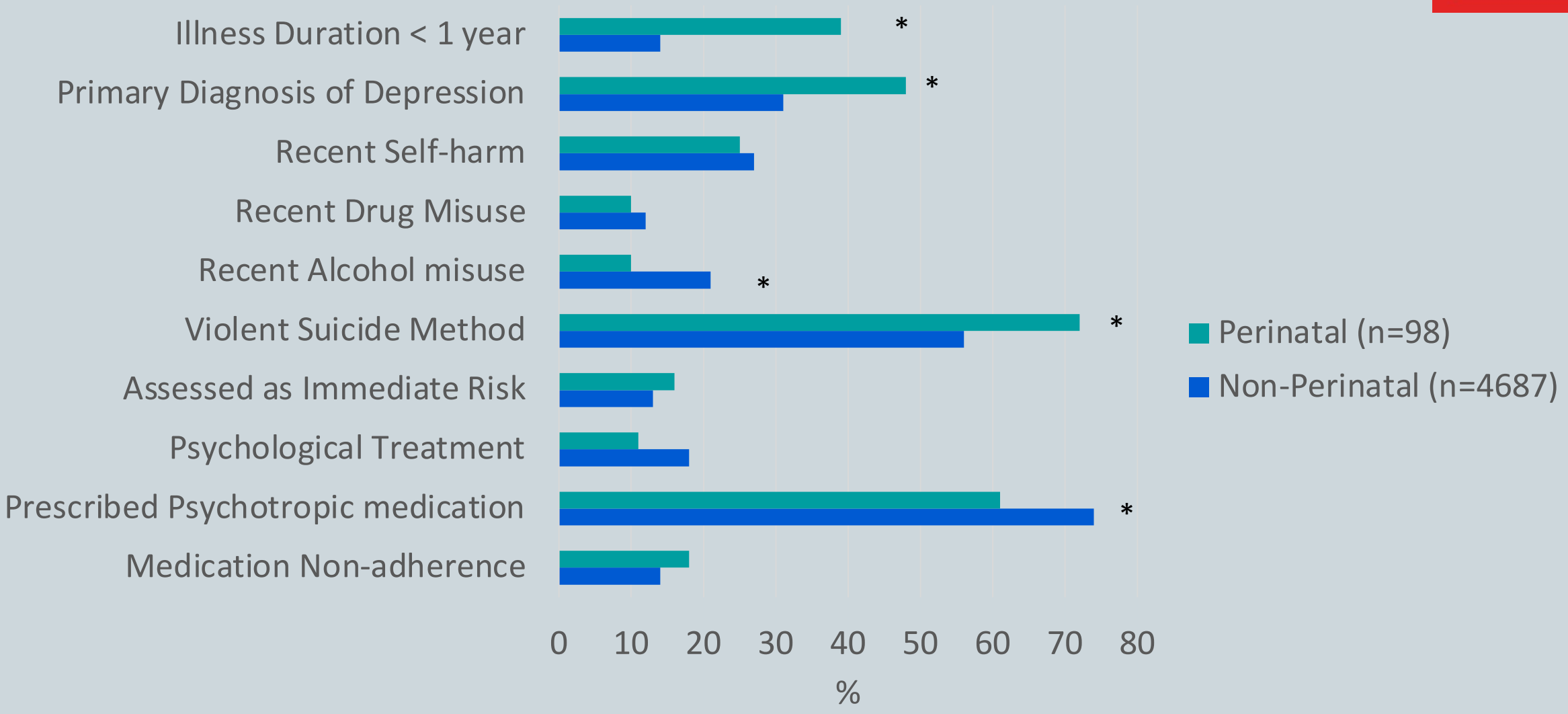
- Strangulation / hanging
- Jumping
- Drowning
- Other violent method
- Psychotropics overdose
- Analgesics overdose
- Opiate overdose
- Other overdose
- Other non-violent method

Non-perinatal suicides



Source UK: National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (1997-2012). Khalifeh, H. et al (2016) Lancet Psychiatry

Perinatal & Non-Perinatal Suicides



Source UK: National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (1997-2012). Khalifeh, H. et al (2016) Lancet Psychiatry

Suicidal ideation and behaviours in pregnancy

- Worldwide prevalence of attempted suicide ~680 per 100,000 during pregnancy (95% CI 0.10-4.69%); ~210 per 100,000 (95% CI 0.01-3.21%) during the first-year postpartum

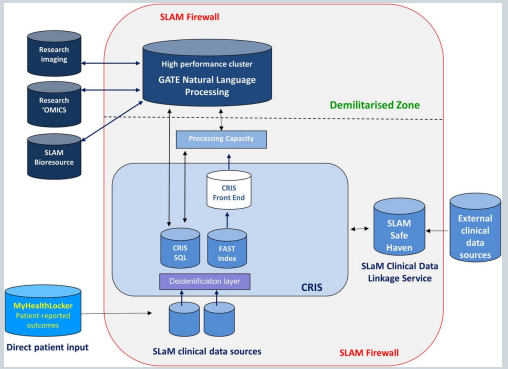
- Prevalence ranges for self-harm (general population vs. women with severe mental illnesses):
    - During pregnancy: 0%-2.39% (14 studies) vs. 0%-23.78% (6 studies)
    - 1st year post-partum: 0%-2.41% (10 studies) vs. 0%-21.9% (7 studies)

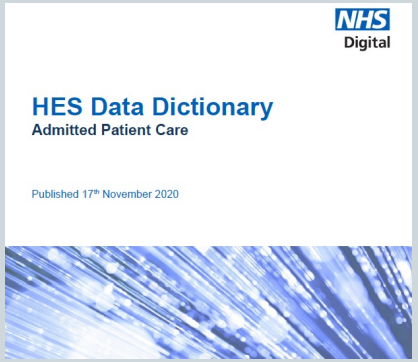
- Systematic review (57 studies) suggests that pregnant women are more likely to report suicidal ideation during pregnancy, compared to non-perinatal women (range 3-33%)

Source: Ayre, K. et al (2019) Journal of Clinical Psychiatry; Gelaye, B., et al (2016) Archives of Women's Mental Health; Rao et al., 2021

Medical Admissions for Self-Harm in the Perinatal Period

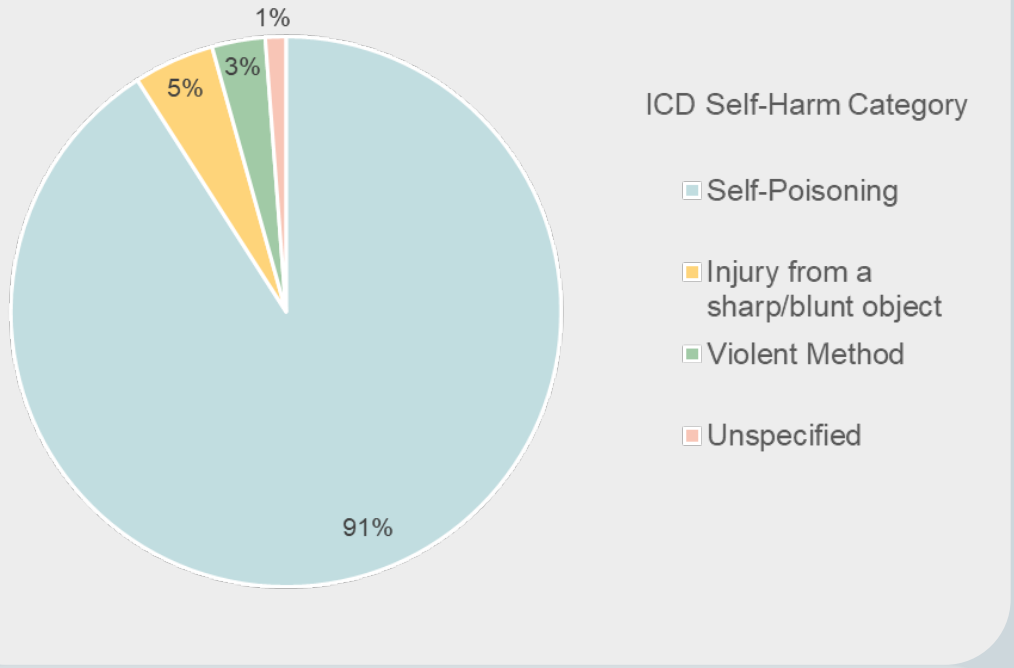
- Mixed-methods study of linked data set in south London (2007-2018)
- Hospital Episode Statistics (HES) Admitted Patient Care Records to identify self-harm admissions
- Linked mental health for were extracted from the South London and Maudsley NHS Foundation Trust (CRIS database)
- 17,685 live/stillbirths among 12,683 women

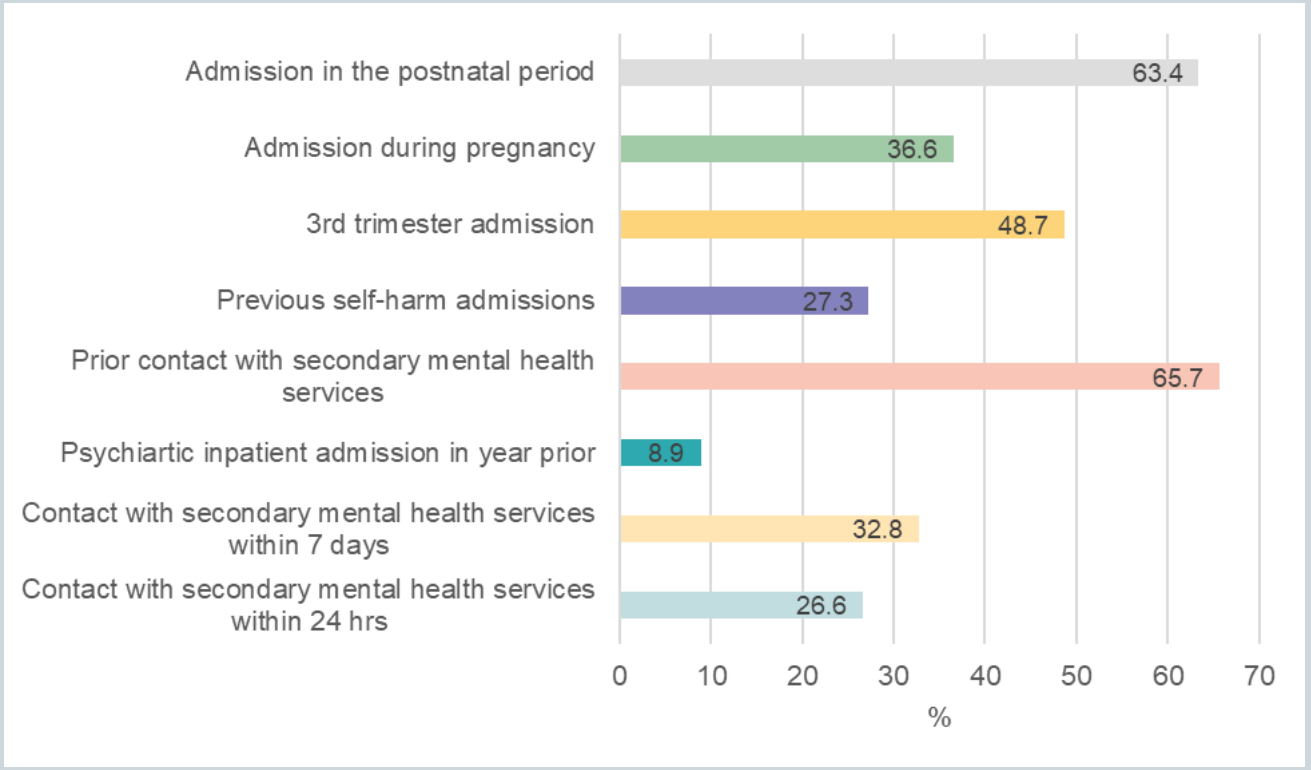




Source: Easter et al, unpublished data 2024

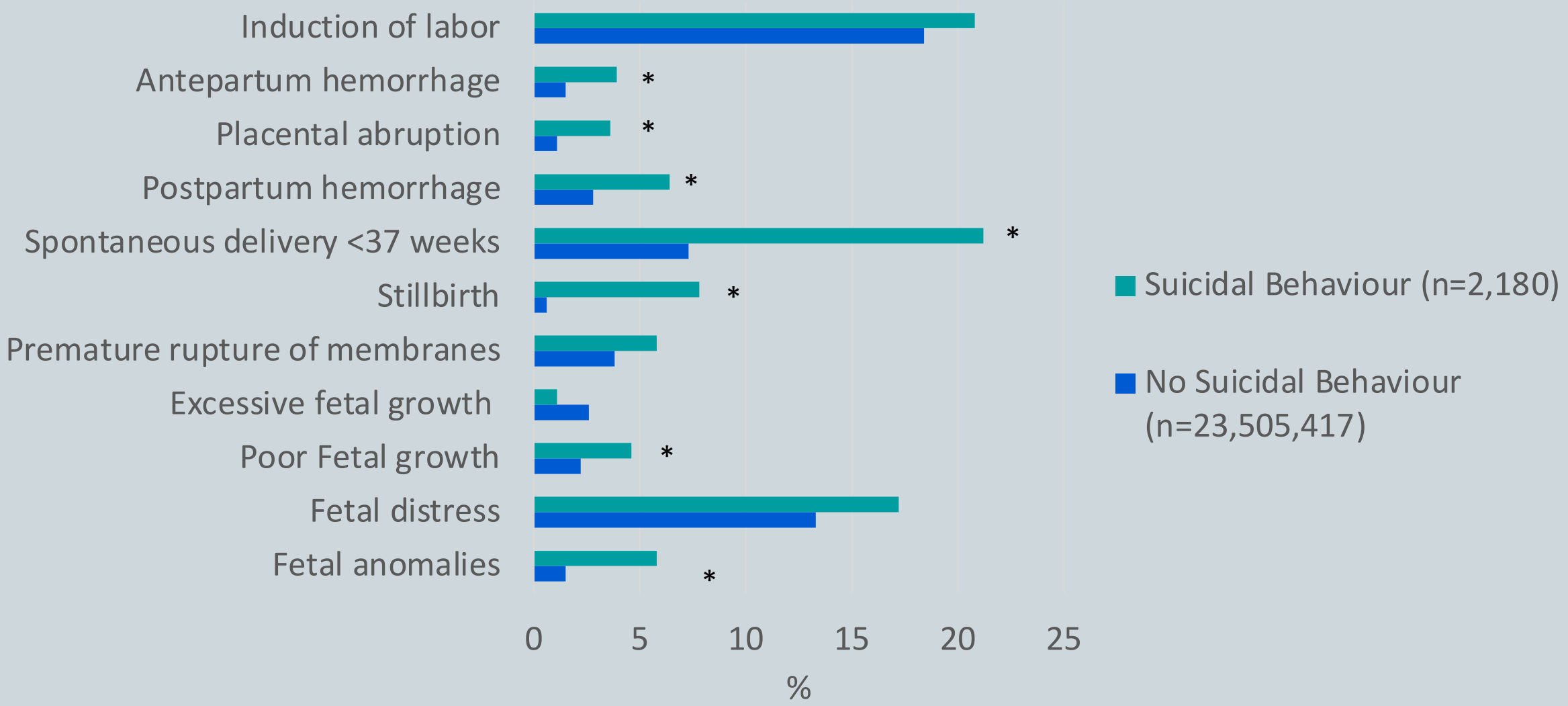
Medical Admissions for Self-Harm in the Perinatal Period





- 448 admissions among 304 women (2.4%)
- 91% with an ICD Code of “self-poisoning”
- 27% seen by a mental health professional within 24 hours, 33% within 7 days

Suicidal Behaviours during Pregnancy & Birth Outcomes



Source: Zhong et al (2018) PLOS ONE

Risk Factors for Perinatal Suicidality

Orsolini et al. (2016) Frontiers in Psychiatry

Domestic Violence and Abuse

- Domestic violence and abuse during the perinatal period in HIC ranges from 4%-8%
- Consistent evidence that past & recent abuse increases the risk of suicidality in the perinatal population
- In a 'high-risk' women, a history of emotional abuse (OR=3.21, 95%CI 1.2–8.7); physical abuse (OR = 6.98, 95% CI 2.5–19.2), & sexual abuse (OR = 6.06, 95 % CI 1.9–19.1) all increase antepartum suicidal ideation
- Experiencing IPV associated with over nine times increased odds for suicidal ideation (OR 9.37; 95% CI 3.41–25.75)
- US National Violent Death Reporting System recorded interpersonal violence among nearly half of the mothers who died by suicide

Sources: Howard, LM et al (2011); Alhusen, JL et al (2015); Gelaye, B., et al (2016); Copersino et al. (2008); Petrosky, et al (2020)

Attempted Suicide in the PErinNatal period: ASPEN Study

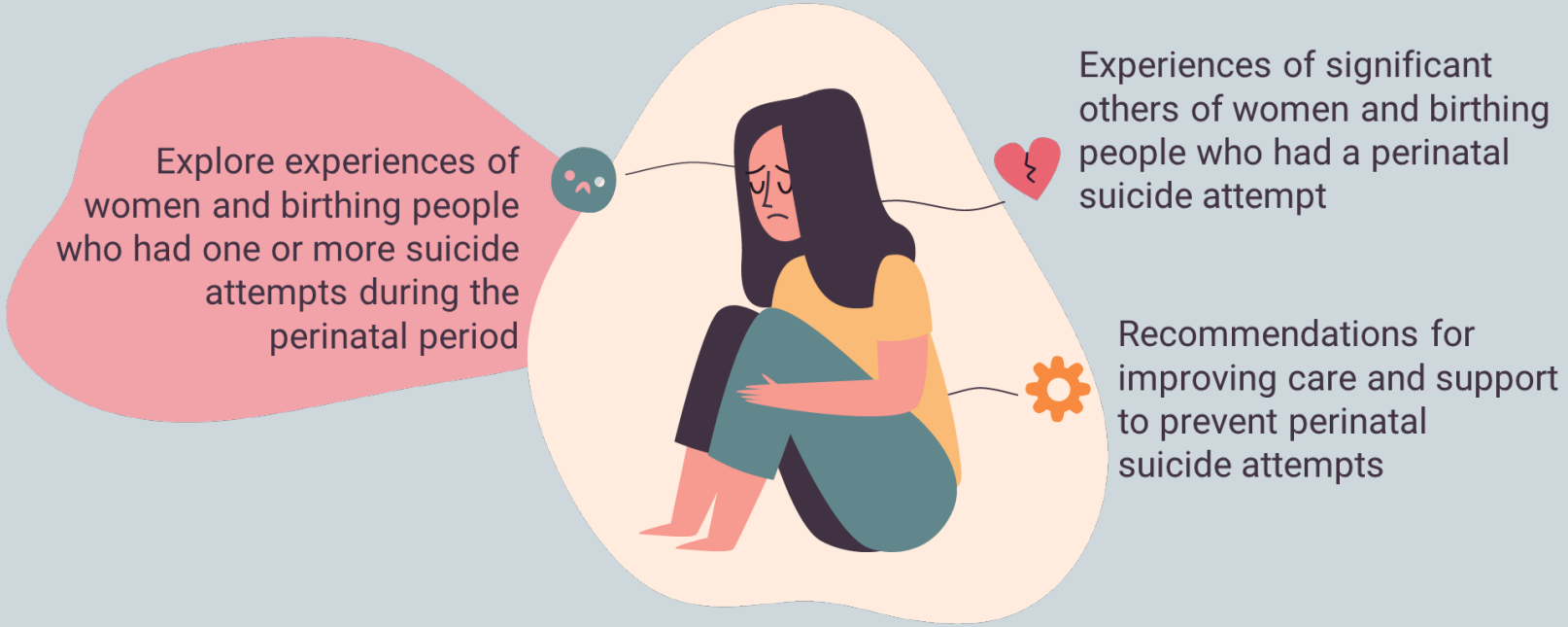
ASPEN Attempted Suicide in the Perinatal Period

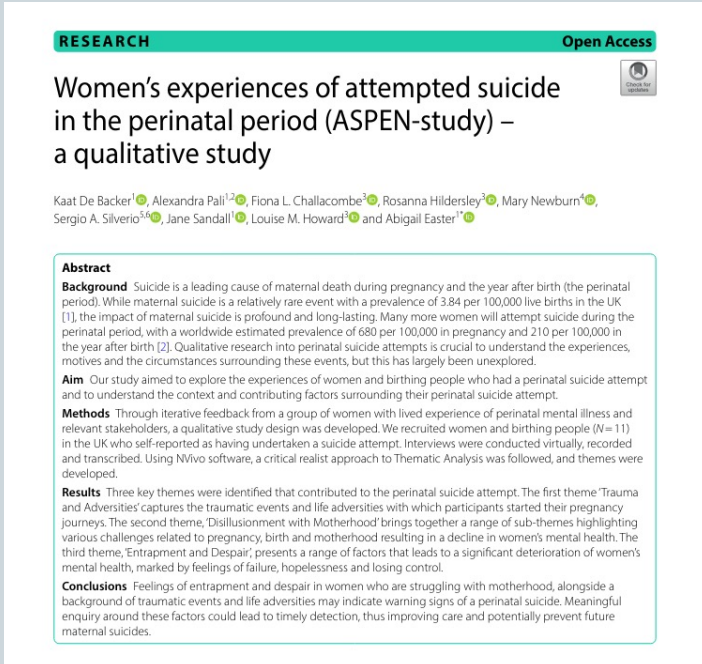
A study of women's experiences of attempted suicide during pregnancy and early motherhood

KING'S College LONDON

- Qualitative study of women and birthing people experience of attempted suicide in the perinatal period

STUDY AIMS





RESEARCH Open Access

Women's experiences of attempted suicide in the perinatal period (ASPEN-study) – a qualitative study

Kaat De Backer[1], Alexandra Pali[1,2], Fiona L. Challacombe[3], Rosanna Hildersley[3], Mary Newburn[4], Sergio A. Silverio[5,6], Jane Sandall[1], Louise M. Howard[3] and Abigail Easter[1*]

Abstract

Background Suicide is a leading cause of maternal death during pregnancy and the year after birth (the perinatal period). While maternal suicide is a relatively rare event with a prevalence of 3.84 per 100,000 live births in the UK [1], the impact of maternal suicide is profound and long-lasting. Many more women will attempt suicide during the perinatal period, with a worldwide estimated prevalence of 680 per 100,000 in pregnancy and 210 per 100,000 in the year after birth [2]. Qualitative research into perinatal suicide attempts is crucial to understand the experiences, motives and the circumstances surrounding these events, but this has largely been unexplored.

Aim Our study aimed to explore the experiences of women and birthing people who had a perinatal suicide attempt and to understand the context and contributing factors surrounding their perinatal suicide attempt.

Methods Through iterative feedback from a group of women with lived experience of perinatal mental illness and relevant stakeholders, a qualitative study design was developed. We recruited women and birthing people ($N = 11$) in the UK who self-reported as having undertaken a suicide attempt. Interviews were conducted virtually, recorded and transcribed. Using NVivo software, a critical realist approach to Thematic Analysis was followed, and themes were developed.

Results Three key themes were identified that contributed to the perinatal suicide attempt. The first theme 'Trauma and Adversities' captures the traumatic events and life adversities with which participants started their pregnancy journeys. The second theme, 'Disillusionment with Motherhood' brings together a range of sub-themes highlighting various challenges related to pregnancy, birth and motherhood resulting in a decline in women's mental health. The third theme, 'Entrapment and Despair', presents a range of factors that leads to a significant deterioration of women's mental health, marked by feelings of failure, hopelessness and losing control.

Conclusions Feelings of entrapment and despair in women who are struggling with motherhood, alongside a background of traumatic events and life adversities may indicate warning signs of a perinatal suicide. Meaningful enquiry around these factors could lead to timely detection, thus improving care and potentially prevent future maternal suicides.

De Backer, K., Pali, A., Challacombe, F.L et al. BMC Psychiatry (2024) 24:255

Terminology

SUICIDAL ATTEMPT "a non-fatal, self-directed, potentially injurious behaviour with intent to die as a result of the behaviour.
A suicide attempt might not result in injury".

(Crosby et al,. 2011, US National Centre for Injury and Control)

SUICIDAL IDEATION

SUICIDAL INTENT

SUICIDAL BEHAVIOUR

Demographic Characteristics (n=11)

ASPEN Attempted Suicide in the Perinatal Period

A study of women's experiences of attempted suicide during pregnancy and early motherhood

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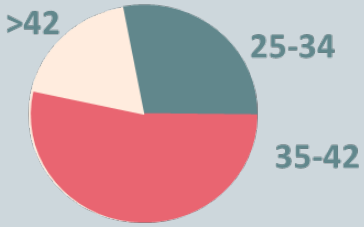
RELATIONSHIP STATUS

Married or in relationship **9/11**

PARITY

Primiparous/ Multiparous

AGE



ETHNICITY

White (English) **10/11**

EDUCATION

Undergraduate degree or higher **7/11**

PREGNANCY

Planned/Unplanned **9/2**

Clinical Characteristics

ASPEN Attempted Suicide in the Perinatal Period

A study of women's experiences of attempted suicide during pregnancy and early motherhood

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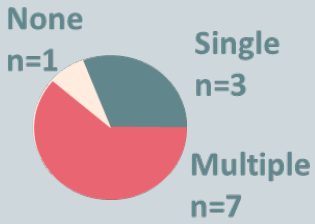
FORMAL DIAGNOSIS



MENTAL HEALTH DIAGNOSES

GENERAL HOSPITAL ADMISSION

Yes/No **3/8**

TIMING OF ATTEMPT

During pregnancy	n=4
Year after birth	n=6
Both	n=1

LEVEL OF MENTAL HEALTH CARE

Inpatient Psychiatric unit	n=4
Community MH service	n=5
A&E Department	n=1
Primary Care	n=1

SUICIDE ATTEMPT

	Actual	Prevented
Fall or jump	1	1
Transport injury event	-	1
Substances	3	1
Threat to breathing	1	2
Sharp object	1	-

Results

ASPEN Attempted Suicide in the Perinatal Period
A study of women's experiences of attempted suicide during pregnancy and early motherhood

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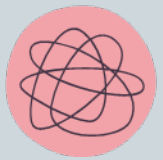
Key Themes

TRAUMA and ADVERSITIES

DISULLUSIONMENT with MOTHERHOOD



ENTRAPMENT and DESPAIR

De Backer, K., Pali, A., Challacombe, F.L et al. BMC Psychiatry (2024) 24:255

Theme 1

ASPEN Attempted Suicide in the Perinatal Period
A study of women's experiences of attempted suicide during pregnancy and early motherhood

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TRAUMA and ADVERSITIES

- Psychosocial Adversities
- Family history of perinatal mental illness

"I've had some terrible things happen in my life about failed marriage and fertility problems. Big, big things that I've sort of managed with a strength of mine that I perhaps didn't have in my late teens or early 20s to overcome. So I guess it was always on my radar ***knowing the stats around you are more likely to have perinatal mental health problems if you've had bouts of depression in the past.*** *" – Rosy*

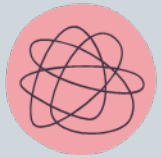
" ***My mum had severe perinatal mental illness, she was hospitalised after my older brother for a year without him […]. At the time they didn't really have Mother and Baby Units. Then I came seven years later and she was hospitalised again but with me for six months****, and she passed away […] So my dad said she was saying the same things as each time she'd been sectioned; she would present with very religious ideation and stuff like this****, so it was exactly the same stuff, and she died by suicide.*** *So because of that collective history, when we were trying to get pregnant we thought "We need to let someone know we're trying to get pregnant," and so I was referred then to a Perinatal Psychiatrist before we got pregnant" - Sarah*

De Backer, K., Pali, A., Challacombe, F.L et al. BMC Psychiatry (2024) 24:255

Theme 2

A study of women's experiences of attempted suicide during pregnancy and early motherhood

DISULLUSIONMENT with MOTHERHOOD



- The physical and mental struggle of pregnancy and birth
- Invalidation of identity and self-sacrifice
- 'It wasn't like starry-eyed love'

*"It was never about me. And I know it's not all about me, but when **I'm wanting to commit suicide, it is very much about me and not one person asked me if I was alright,** they were more concerned if the baby was alright, which I was as well, but they just completely bypassed that there was any reason I would do it." – Selina*

*"There's all this thing about pregnancy you're supposed to be glowing and it's all marvellous and you've got these wonderful hormones, but **I was just beached on the sofa feeling hot and sweaty thinking when is this baby going to come out, when's it going to come out**?" – Simone*

De Backer, K., Pali, A., Challacombe, F.L et al. BMC Psychiatry (2024) 24:255

Theme 3

A study of women's experiences of attempted suicide during pregnancy and early motherhood

ENTRAPMENT and DESPAIR

- Feeling like a failure
- Intense intrusive thoughts and abnormal experiences
- Alone in this world
- 'Tired' and 'wired'
- The irreversibility of motherhood

"I stopped sleeping entirely; I was so angry all the time – it's all the textbook depression symptoms, but I was so angry all the time. ***I was so tired all the time, but just wired, couldn't sleep****."- Sam*

"So it just escalated. This what was going on in my head about, you know, me not being good enough, a failure, just escalated even more, that now I was thinking they are going to take him away, everyone will know how rubbish I am. So it was later that week where I still wasn't sleeping and ***I just thought, do you know what, the both of them would be better off without me, because I've just failed, I'm just a failure. They will be better off without me.***"
– Simone

De Backer, K., Pali, A., Challacombe, F.L et al. BMC Psychiatry (2024) 24:255

Theme 3

A study of women's experiences of attempted suicide during pregnancy and early motherhood

King's College London

ENTRAPMENT and DESPAIR

- Feeling like a failure
- Intense intrusive thoughts and abnormal experiences
- Alone in this world
- 'Tired' and 'wired'
- The irreversibility of motherhood

"It was this doom. It was this absolute – I used to describe it as like a black cloud, that just hung over me all the time. And every single day, I would wake up, and I would think, "Oh, shit, I'm a day closer to having this baby." And it caused all those feelings of regret. But you can't ever say those things out loud, because people will assume that you want an abortion, or that you made a reckless decision, or – you know, you wanted this. It's very much like, "You chose this; you wanted this; this is your lot." ***And it got really bad. It got to the point where, prenatally, I would just genuinely hope that I wouldn't wake up the next day. Because that was a day closer to having the baby."*** *– Sam*

De Backer, K., Pali, A., Challacombe, F.L et al. BMC Psychiatry (2024) 24:255

Quality of Perinatal Care is Important

- Only 8% of women who died from suicide or substance misuse were deemed to have received good care
- For 69% of women who died from suicide, & 35% of those who died from substance misuse, improvements in care may have made a difference to the outcome

Table 3.5: Classification of care received by women who died by suicide or from substance misuse for whom there was sufficient information to assess their care, UK and Ireland 2020

Classification of care received	Women who died by suicide (n=26*) Number of women (%)	Women who died by substance misuse (n=26*) Number of women (%)
Good care	2 (8)	2 (8)
Improvements to care which would have made no difference to outcome	6 (23)	15 (58)
Improvements to care which may have made a difference to outcome	18 (69)	9 (35)

*Insufficient information to classify care for two women who died by suicide and one woman who died from substance misuse

Source: Saving Lives, Improving Mothers' Care MBRACE-UK 2024

Suicide Prevention in England (2023 – 2028)

GOV.UK Menu

Home > Health and social care > Public health > Health protection > Suicide prevention strategy for England: 2023 to 2028

Department of Health & Social Care

Policy paper

Suicide prevention in England: 5-year cross-sector strategy

Published 11 September 2023

This was published under the 2022 to 2024 Sunak Conservative government

Applies to England

Contents

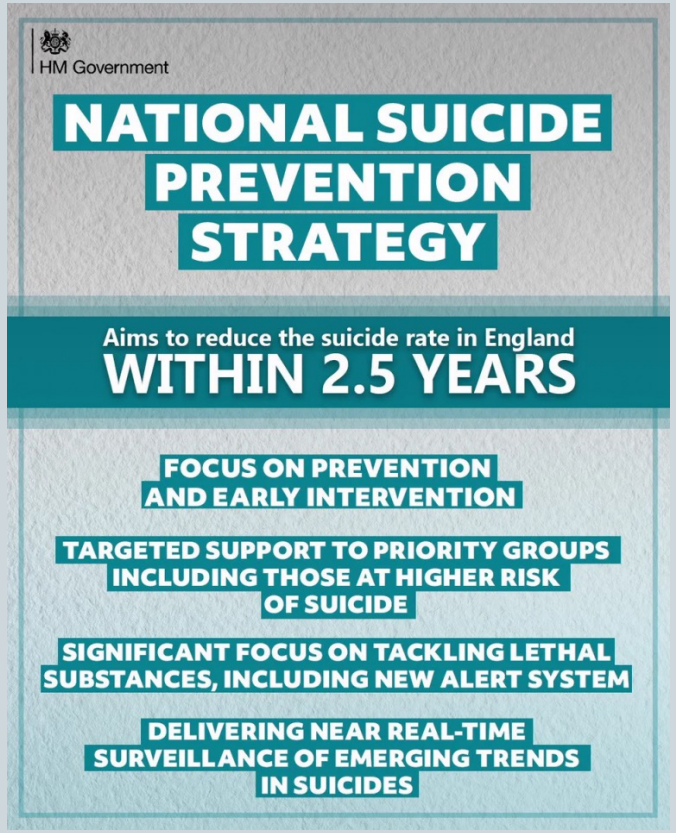
Foreword: Maria Caulfield MP

Foreword: Maria Caulfield MP

Targeted Support for Priority Groups (2023 – 2028)

- Suicide prevention strategy includes pregnant women & new mothers as a priority group for targeted prevention support for the first time

- Targeted recommendations include:
  - Expansion of maternal mental health services
  - Identification of mental health/risk factors in pregnancy
  - Assessment and support at every contact
  - Information sharing between services



Recognising & Reducing the risk of Perinatal Suicide

Recognising and Responding to Red & Amber Flags in the perinatal context:

- New thoughts of self-harm
- Sudden onset or rapidly worsening mental health
- Persistent feelings of estrangement from baby

- Past history of psychosis
- Family history of bipolar disorder or postpartum psychosis
- Personal & family patterns of mental health

Recognising & Reducing the risk of Perinatal Suicide

What does this look like in practice?

- Individualised approach to assessment and care
- Reducing barriers to accessing mental health treatment and support
- Better multidisciplinary awareness & training in perinatal mental health
- Improved communication between health services and teams
- Greater availability of social and psychological support & interventions in the perinatal period

However, much work to be done….

- Healthcare Professionals (HCP) highlight several barriers to responsive care:
  - Recognition of severity across disciplines
  - Communication of risk between services
  - Lack of service provision & access to treatments

Open access Research

BMJ Open **Recognition and response to life-threatening situations among women with perinatal mental illness: a qualitative study**

Abigail Easter,[1] Louise Michelle Howard,[2] Jane Sandall[3]

To cite: Easter A, Howard LM, Sandall J. Recognition and response to life-threatening situations among women with perinatal mental illness: a qualitative study. *BMJ Open* 2019;**9**:e025872. doi:10.1136/bmjopen-2018-025872

► Prepublication history for this paper is available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2018-025872)

ABSTRACT

Objective Mental illness has persistently been found to be a leading cause of death during pregnancy and the year after birth (the perinatal period). This study aims to explore barriers to detection, response and escalation of mental health-related life-threatening near miss events among women with perinatal mental illness.

Design Qualitative study.

Participants Healthcare professionals (HCP) working in psychiatry, maternity and primary care (n=15) across community and hospital maternity and perinatal services within the UK.

Methods In-depth semistructured interviews were

Strengths and limitations of this study

- This is the first study to explore maternal near misses among women with a range of perinatal mental illnesses, which identifies several important barriers to detection and response of life-threatening situations.
- As a small explorative qualitative study of healthcare professionals in the UK, the study findings may not be generalisable to other settings.
- Women's perspectives are not explored within this study.

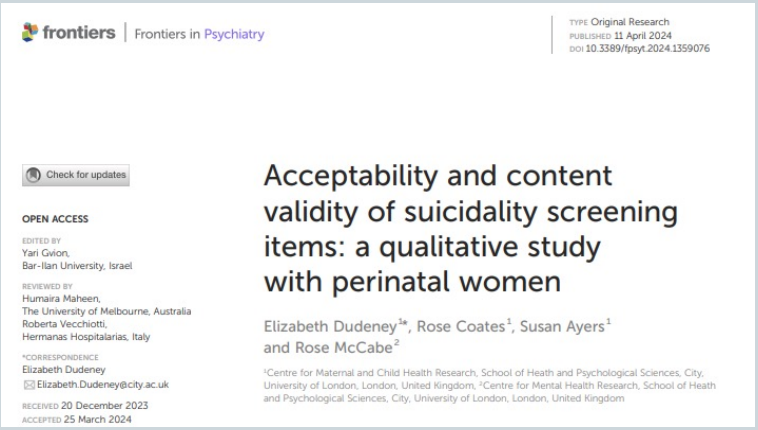
…we are working very much and saying if they have got these pre-existing conditions that the referral needs to go in and it needs to bypass the lower level of support. It needs to go straight through to the secondary levels so that the Perinatal [Mental Health] Team will pick it up. But it's just very difficult to write the referral so that you can get it through to meet those thresholds. (Midwife)

I find that because we all have different IT systems where we keep our records, nothing speaks to each other; we don't have access to each other's records [….] I think that there are issues with that about the fact we can't see what Mental Health have written, Mental Health can't see what we're writing, Social Care can't see what any of us are writing. (Midwife)

Source: Easter, A., Howard, L.M. and Sandall, J., 2019. Recognition and response to life-threatening situations among women with perinatal mental illness: a qualitative study. *BMJ open*, *9*(3), p.e025872.

However, much work to be done….

- Current measures are problematic and not validated for use in pregnancy
- Maternity HCPs feel uncomfortable asking, dislike or find many existing suicide-related items on questionnaires unhelpful
- Items are also largely unacceptable to perinatal women in their current form
- Stigma, fear and shame are central to non-disclosure



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Acceptability and content validity of suicidality screening items: a qualitative study with perinatal women

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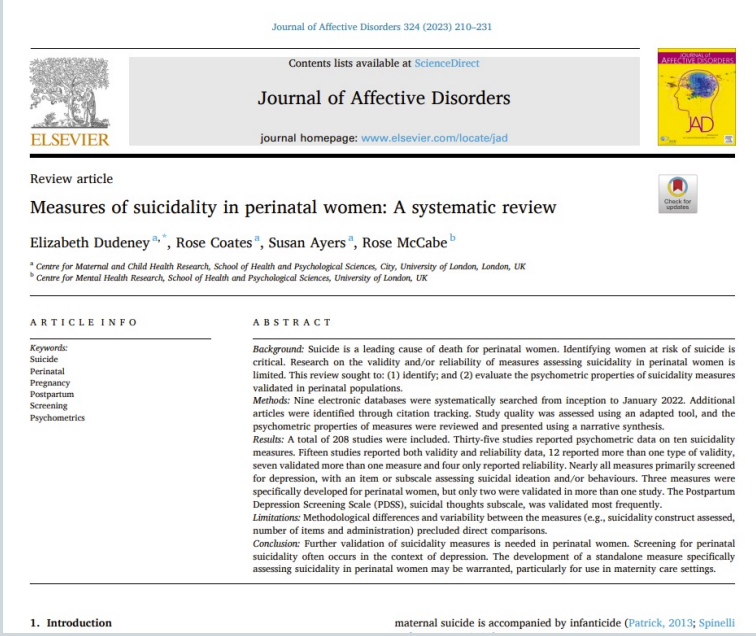

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Review article

Measures of suicidality in perinatal women: A systematic review

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ABSTRACT

Background: Suicide is a leading cause of death for perinatal women. Identifying women at risk of suicide is critical. Research on the validity and/or reliability of measures assessing suicidality in perinatal women is limited. This review sought to: (1) identify; and (2) evaluate the psychometric properties of suicidality measures validated in perinatal populations.
Methods: Nine electronic databases were systematically searched from inception to January 2022. Additional articles were identified through citation tracking. Study quality was assessed using an adapted tool, and the psychometric properties of measures were reviewed and presented using a narrative synthesis.
Results: A total of 208 studies were included. Thirty-five studies reported psychometric data on ten suicidality measures. Fifteen studies reported both validity and reliability data, 12 reported more than one type of validity, seven validated more than one measure and four only reported reliability. Nearly all measures primarily screened for depression, with an item or subscale assessing suicidal ideation and/or behaviours. Three measures were specifically developed for perinatal women, but only two were validated in more than one study. The Postpartum Depression Screening Scale (PDSS), suicidal thoughts subscale, was validated most frequently.
Limitations: Methodological differences and variability between the measures (e.g., suicidality construct assessed, number of items and administration) precluded direct comparisons.
Conclusion: Further validation of suicidality measures is needed in perinatal women. Screening for perinatal suicidality often occurs in the context of depression. The development of a standalone measure specifically assessing suicidality in perinatal women may be warranted, particularly for use in maternity care settings.

1. Introduction

maternal suicide is accompanied by infanticide (Patrick, 2013; Spinelli

Source: Dudeney E, Coates R, Ayers S, McCabe R. Acceptability and content validity of suicidality screening items: a qualitative study with perinatal women. Front Psychiatry. (2024) 15:1359076.

Conclusions & Implications

- Although suicide is lower during the perinatal period in the general population , it remains a leading cause of maternal death in many HIC
- The risk is dramatically increased among women with mental health conditions, self-harm, abuse, and social and reproductive vulnerabilities
- Women with recent onset of mental health conditions may be particularly vulnerable, especially during the first few months postnatal
- Perinatal women less likely to receiving mental health care and women who die from suicide less antenatal care
- Greater recognition, reduced barriers to care, & communication between health and social care teams is essential reducing future tragedies

20 years on: the legacy of Daksha Emson for perinatal psychiatry

Marisa Casanova Dias[1,2] · Ekin Sönmez Güngör[3] · Clare Dolman[2] · Livia De Picker[4,5] · Ian Jones[1]

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Abstract
The tragedy of Daksha's death illustrates both the importance of perinatal mental health and the stigma associated with doctors seeking help. With this letter, we express our hope that the lasting legacy of her and others' tragic stories lies in the continuing improvement and worldwide expansion of perinatal psychiatric services and training so that those in greatest need receive the best care possible wherever — and whoever — they are.

Keywords Postpartum psychosis · Bipolar disorder · Suicide · Perinatal mental health services · Perinatal mental health training

The tragedy of Daksha Emson in October 2000 illustrates both the importance of perinatal mental health and the stigma associated with doctors seeking help (Emson 2004a). Daksha, a Tanzania-born daughter of Indian parents, moved to the UK at the age of nine and entered medical school in 1984 (North East London Strategic Health Authority 2003). During her first year, at the age of 18, she was diagnosed with depression following an extremely serious suicide attempt. Later on, her diagnosis was revised to bipolar disorder, for which she was hospitalized five times and treated with three courses of electro-convulsive therapy (North East London Strategic Health Authority 2003). Despite the impact of these on her studies, she won several prestigious prizes. She married in 1992 with some opposition from family, as noted by the Inquiry into her death, and continued her studies choosing postgraduate training in psychiatry. For the next 8 years and while taking medication (lithium and, at some point, fluoxetine), she never experienced a relapse. Her husband remarks that she was a respected scholar and clinician (Emson 2004b). However, this long period of remission was disrupted when she, after discussing with her psychiatrist, stopped her medication to conceive and breast-feed her baby daughter, Freya, who was born in July 2000. While trying to catch up with her work- and family-related commitments, in October 2000, she suffered an episode of postpartum psychosis. It tragically led her to take the life of her 3-month-old baby daughter, Freya, and then her own, through stabbing and covering both of them in a flammable substance and setting it alight. This happened the day before she was due to resume medication (Emson 2004b). During the previous month, she had been in touch with the community psychiatry nurse and psychiatrist due to poor sleep, and later depression, but she opted to manage without medica-

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Thank you

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