The midwife's role in suicide prevention

Abstract

Background **Suicide has been found to be the leading cause of maternal death in the UK and has since been reclassified as a 'direct' cause of maternal death, with rates remaining unchanged since 2003.**
Aim **To examine the literature and consider what midwives can do to reduce the rates of maternal suicide.**
Methods **Qualitative and quantitative research were included into this literature review. Research from 2003-2017 was accessed via a university database.**
Findings **Three key themes became apparent: the characteristics associated with women dying from suicide, risk factors, and the attitudes and perceptions of midwives and effective screening.**
Conclusion **Suicide has devastating consequences for the woman, her family and her community. Every step must be taken to reflect on and improve midwifery practice, to finally begin reducing rates.**

Keywords

Suicide | Depression | Postnatal | Postpartum psychosis | Pregnancy

Pregnancy and transition to motherhood is traditionally perceived as a happy event, yet 20% of mothers experience mental illness (National Institute for Health and Clinical Excellence (NICE), 2015). The latest '*Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the United Kingdom (MBRRACE-UK)*' report found that 111 new mothers died from suicide between 2009 and 2014, making suicide the leading cause of maternal death; with rates peaking at 3 months postpartum (Ratnaike, 2008; Knight et al, 2016).

MBRRACE once considered suicide as an 'indirect' cause of maternal death; however, in 2015, the World Health Organization (WHO) recognised its significance and direct link with pregnancy (WHO, 2015), and suicide was therefore reclassified as a 'direct' cause of maternal death (Knight et al, 2016). As the rates of maternal suicide in the UK have remained unchanged since 2003 (Iacobucci, 2016), it has been argued that maternity services should make suicide prevention a key clinical focus (Gentile, 2011).

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The midwifery ethos of holistic care is to protect the emotional and social wellbeing of women, just as much as the physical (Royal College of Midwives (RCM), 2014). Midwives have a valuable opportunity to identify women who are at risk and to ensure appropriate and timely care from the wider multidisciplinary team (RCM, 2013).

The midwifery profession is one that must consistently adapt according to the latest research directing practice (Nursing and Midwifery Council (NMC), 2015). The evidence shows that the rates of maternal suicide have remained unchanged for over a decade, thus this literature review considers the question of what more must be done.

Method

As suicide encompasses a complex interaction of behavioural, socio-environmental and psychiatric factors (Yip et al, 2012), a mixture of qualitative and quantitative research was incorporated.

Science Direct, CINHAL, Medline and the Maternity and Infant Care databases were accessed, with the following inclusion criteria: suicide, suicide and depression, suicide and postpartum psychosis, pregnancy and suicide, midwife and suicide.

As the rates of maternal suicide have remained unchanged since 2003, research published from that time was included to identify any overriding narratives. After discarding duplications, Science Direct, CINHAL, Maternity and Infant Care and Medline yielded 50, 53, 35 and 41 articles, respectively. Three key themes became apparent: understanding the characteristics and risk factors associated with women dying from suicide; the attitudes and perceptions of midwives caring for women with mental illness; and effective screening to identify suicide risk.

Literature review

The perinatal period is a vulnerable time for all women, owing to the physiological, hormonal, emotional and social adaptations (Zauderer, 2009), although for some women, pregnancy can be the trigger for debilitating

mental illness. Two mental illnesses are particularly associated with maternal suicide: postnatal depression and postpartum psychosis (Di Florio et al, 2013).

The Diagnostic and Statistical Manual (DSM-V) (American Psychiatric Association, 2013) diagnoses postnatal depression where there has been 2 weeks of persistent depressed mood within 4 weeks postpartum, including feelings of worthlessness, inadequacy, social withdrawal and inability to think rationally. Joiner et al's Interpersonal Theory of Suicide (2009) states that, for someone to die from suicide, there must be three psychological processes occurring simultaneously: a belief that one is a burden on society or loved ones; a reduced sense of belonging; and a desensitisation to pain and fear of death. This mirrors the symptoms experienced by women suffering with postnatal depression, so it is understandable why these feelings can culminate in suicide.

Postpartum psychosis accounts for 5% of the suicide rates (Brockington, 2017). Postpartum psychosis occurs in 3 mothers per 1000 births and has an acute onset: between 72 hours following delivery, or up to 6 weeks postpartum (Sit et al, 2006; Sharma et al, 2015). Women rapidly begin having abnormal thought process (confusion, racing thoughts, mania) and lose touch with reality (Royal College of Psychiatrists, 2014). While the pathogenesis of postpartum psychosis is not understood, it could be associated with the sharp drop in oestrogen following delivery of the placenta, triggering abrupt psychotic symptoms (Sharma et al, 2015). Women with a family or personal history of postpartum psychosis, bipolar disorder or schizophrenia are 50% more likely to develop postpartum psychosis (Royal College of Psychiatrists, 2014). Nonetheless, it must be emphasised that 50% of women who develop postpartum psychosis have no known risk factors (Jones et al, 2014).

The Office for National Statistics (2012) found that women outside the pregnancy context usually die by overdose; a 'non-violent' method of suicide (Stenbacka and Jokinen, 2015). In contrast, women in the perinatal period usually die by violent means (Oates, 2003), such as asphyxiation from hanging, penetrative methods (stab or gunshot wounds) or jumping in front of vehicles, which could be as a result of sudden and acute mental illness and serious suicidal intent (Khalifeh et al, 2016). This underlines the urgency of addressing the barriers impeding timely intervention.

Results

Characteristics and risk factors

Metz et al (2016) conducted a quantitative case study in Colorado between 2004 and 2012 to identify risk factors associated with suicide, beginning with the booking appointment. Data were retrieved from death certificates, coroner reports and maternity records. Suicide accounted for the deaths of 4.6 women per 100 000 births (95% confidence interval (CI) 3.0–6.6). Of the total deaths, 17% were due to misused substances, 54% had previous psychiatric diagnoses and 10% had previously attempted suicide. Some 50% were known to be taking medication for their mental health when they became pregnant, but 48% stopped taking the medication once pregnancy was confirmed. Significantly, 22% of the total deaths had no mental health history. The study included limited demographics; however, 9 years of data were collated from varying sources and reviewed by the Colorado Maternal Mortality Review Committee.

> **Women may be prevented from disclosing their mental health concerns, if they are already reluctant to do so because of shame and fear of being labeled an 'unfit mother'. If screening is diminished as a 'tick box' exercise, the midwife-mother relationship is jeopardised**

Midwives could therefore proactively prevent suicide by taking a comprehensive psychiatric history at the booking appointment, in order to enable early intervention. The necessity of medication management by the psychiatrist and obstetrician is also highlighted, whereby the risks of continuation or cessation of psychiatric medication in pregnancy are appropriately evaluated and discussed with the woman (NICE, 2015; Chisholm and Payne, 2016).

Effective screening

Screening to identify signs of mental illness is a controversial issue, as it has been argued to increase misidentification and overtreatment (Yawn et al, 2012; Thombs et al, 2014). The American College of Obstetricians and Gynecologists (2016) has, however, suggested that untreated mental illness causes more harm. NICE (2015) recommends that midwives routinely instigate a discussion on mental wellbeing using the Whooley questionnaire, although a qualitative study found that it was rarely used by midwives, owing to uncertainly as to its purpose, discomfort upon disclosure and limited training and time (McGlone et al, 2016).

In the event of a positive response to the Whooley questions, midwives should then use the Edinburgh Postnatal Depression Scale (EPDS) to complete a full mental health assessment (NICE, 2015; Bhusal et al, 2016). The EPDS contains 10 self-report items that record how women have felt emotionally in the previous 7 days (Sit and Wisner, 2009). Each question is scored

from 0–3, giving results ranging from 0–30. 'Probable depression' has been suggested at 12–13 out of 30; with a reported specificity of 78% (Matthey et al, 2003; Gibson et al, 2009).

A retrospective cohort study by Kim et al (2015) examined the ability of the EPDS to identify incidence of suicide ideation and any associated risk factors, with results analysed qualitatively. Between 2003 and 2011, women were asked to complete the EPDS at 24 to 28 weeks of gestation and 6 weeks postpartum. From 22 118 EPDS questionnaires, suicide ideation was reported in 842 women (3.8%, 95% CI 3.5–4.1%). There were significant associations with younger maternal age ($P<0.001$), single relationship status ($P<0.01$), non-Caucasian ethnicity ($P<0.001$), being non-English speaking ($P<0.01$), having pre-existing psychiatric diagnosis ($P<0.001$), experiencing severe vaginal laceration and giving birth by caesarean (95% CI 0.36–0.87 and 95% CI 1.00–4.40, respectively). A total of six women demonstrated active suicide ideation, with a plan, intent and access to means (95% CI 0.2–1.9%); three of whom attempted suicide. As data was retrieved from only one healthcare system, generalisability of findings was limited. Nonetheless, the large sample size, statistically significant results and standardised screening are considerable strengths. Universal screening could therefore heighten the identification of women who require urgent evaluation and care; potentially preventing suicide. Improved outcomes are, however, contingent on adequate referral and follow-up to and from the multidisciplinary team (Gjerdingen and Yawn, 2007).

While screening can enhance engagement and identification, it is also dependent upon the midwife's approach. Women may be prevented from disclosing their mental health concerns, if they are already reluctant to do so because of shame and fear of being labeled an 'unfit mother' (Edwards and Timmons, 2005; Jesse et al, 2008). If screening is diminished as a 'tick box' exercise, the midwife-mother relationship is jeopardised (Kopelman et al, 2008), which may prevent women from raising concerns about mental health.

Attitudes and perceptions of midwives

Accordingly, it is reasonable to presume that positive or negative attitudes towards suicide prevention could influence the midwife's willingness to engage in conversations with women concerning suicide. Lau et al (2015) explored the attitudes of midwives and maternal child health nurses towards assessing women for postnatal depression and suicide risk. In this qualitative cross-sectional study, 95 midwives and 86 mental child health nurses from Australia were asked to complete the Attitudes to Suicide Prevention Scale, which specifically examines health professionals' attitudes towards suicide prevention initiatives. The Likert scale was employed for each statement; the higher the score, the more negative the attitudes. The test-retest reliability was statistically significant, with a correlation coefficient of 0.85 ($P<0.001$). The results demonstrated that mental child health nurses had more positive attitudes towards suicide prevention, and it was proposed that midwives felt apprehensive and ill-equipped in assessing mental health status and suicide risk. The authors therefore argued that midwives would benefit from specific continuous professional development to expand their knowledge, competency and skills base. This is supported by Elliot et al (2007), who found that British midwives who attended a study day on mental illness significantly improved their knowledge, attitudes, and confidence in caring for women at risk.

Continuous midwifery care

It is the midwifery ideal that all women receive continuous midwifery care. A randomised controlled trial (Marks et al, 2003) demonstrated that continuous midwifery care engages women with their mental health and subsequent treatment. The trial consisted of 98 women with a history of depression, who, at booking, were either allocated to the continuous midwifery care group or standard midwifery care group. After randomisation, all women completed baseline assessments of their mental health status. Outcome assessments were then performed at 3 months postpartum. No differences were found between groups in terms of total rates of postnatal depression; however, 88% of those women assigned to continuous midwifery care fully engaged in their care, which was measured by an increase in psychiatric referral within the continuous midwifery care group. This reflects other research whereby the 'caseload' midwifery model is beneficial to women and reduces harm (Rayment-Jones et al, 2015; Sandall et al, 2016).

Gaps in care

The ability of midwives to provide continuous midwifery care and identify suicide risk factors has, however, been considerably lessened, owing to cuts in NHS resources (RCM, 2015). A 'postcode lottery' has been found to dictate mental care provision (Russell et al, 2013); resulting in women at high risk of suicide 'falling through the gaps' (Centre for Mental Health et al, 2015)

Esscher et al's (2016) quantitative population study highlights the consequences of gaps in maternity mental health provision. After extracting data from the Swedish Cause of Death and National Patient Registers, 103 deaths by suicide were identified between 1980 and 2007; accounting for 18% of maternal deaths. Inconsistencies in the quality of documentation regarding psychiatric history at booking were identified. A total of 17 women

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Vulnerable, at-risk women could be given much needed help and support if they are engaged by health professionals

had received help for a suicide attempt between 2 and 17 years before pregnancy, corresponding with the fact that a previous suicide attempt is a risk factor for a completed suicide (Botswick et al, 2016), yet only 3 of these women had the previous suicide attempt documented. Overall, 77 women received some form of psychiatric input in pregnancy and/or the postpartum period; however, only 20 women had a plan for psychiatric follow-up. Of the 77 women, 22 women received no input at all. The acknowledged limitations of the study included the small sample size, which was explained by the small population; however, data were retrieved from a national database, making this study transferrable to the UK. Indeed, the study cited the MBRRACE-UK report and had similar demographics.

Implications for practice

In 2013, the UK Parliamentary and Health Service Ombudsman inquiry, *Time to Act* (2013), discovered failures in the recognition, diagnosis, and management of those who died from sepsis. The 'Think Sepsis' campaign was therefore launched to increase awareness amongst health professionals. MBRRACE found that sepsis accounts for 3% of the maternal death rate; yet, despite suicide accounting for 15% of the maternal death rate, no campaign was instigated to specifically target this finding. If suicide rates are to decrease, a nationwide approach is required to bring about awareness of the varying issues and risk factors surrounding suicide.

Changes must be made to the way in which maternity services prioritise mental wellbeing. While there is guidance concerning the screening and management of mental illness from NICE (2015) and the Royal College of Obstetricians and Gynecologists (2016), it can be argued that the recommendations are not being translated into practice, or do not go far enough. Policymakers and maternity services must therefore proactively make suicide prevention a key clinical focus.

There is the argument that implementing national change to prevent suicide is unaffordable. However, the long-term economic cost is approximately £8.1 billion per year (Centre for Mental Health, 2014). This does not take into account the social, economic and emotional cost of maternal suicide, whereby the family and children left behind may require mental health services; placing further financial burden on the NHS (Moucheraud et al, 2015). The *Costs of Perinatal Mental Health* report (Bauer et al, 2014) found that only £37 million per year would need to be spent to get NHS mental healthcare up to the desired standards.

Before any changes to provision can be effectively made, all members of the multidisciplinary team involved in suicide prevention must combine their varied perspectives and skills to create a relevant education programme. The training must integrate all the issues and risk factors associated with maternal suicide, with emphasis on the importance of screening tools and how to confidently prompt open discussion with women; the

Key points

- Suicide is the leading and direct cause of maternal death
- Suicide must become a key clinical focus nationwide
- Midwives have a significant role to play in suicide prevention
- Midwives need support to understand risk factors surrounding suicide, in order to screen for them effectively.

success of which is dependent upon the exploration and eradication of any negative perceptions.

Evidence has shown that health professionals do not always understand who is responsible for different aspects of care; leading to inappropriate referral (NICE, 2007; Hogan, 2011). Suicide prevention training would allow the multidisciplinary team to become acquainted with one another and their varying responsibilities; from which a clear care pathway can be created. Because of its prevalence and direct link with pregnancy, it is reasonable to suggest placing suicide prevention in both the undergraduate curriculum and yearly mandatory continuing professional development (CPD) training.

Individual midwives can better maximise opportunities to engage all women in positive, nonjudgmental and reassuring discussions concerning mental wellbeing. Despite the suicide rate peaking at 3 months postpartum, the evidence shows that risk factors can be identified as early as the booking appointment. Because of the association between pre-existing mental illness and increased suicide risk, midwives must therefore sensitively emphasise to women the importance of a full and accurate psychiatric history; which, while protecting confidentiality, must be clearly documented (NMC, 2015). This history-taking could be improved by providing all services with a single mental health proforma, which standardises the information required to determine suicide risk and inform the appropriate multidisciplinary team.

All NHS Trusts must have a mental health midwife team, dedicated to caseloading women with suicide risk factors, in order to close the 'postcode lottery' gap. Women identified to have risk factors for suicide at any point during the antenatal, intrapartum or postpartum period, can be referred to this team. This caseloading approach is ideal for establishing and maintaining trusting and equal relationships with women and their families, and makes it easier to ascertain a psychosocial baseline, which enables quick identification of any changes that may require escalation to the multidisciplinary team. As the majority of maternal deaths by suicide occur during the postnatal period, support from the mental health midwives team should continue for a minimum of 3 months from giving birth.

Midwives must engage women and their families sensitively in discussing their individual experiences, thoughts and emotions. Open discussion, in conjunction with effective use of screening tools, can identify potential signs of depression and other psychiatric symptoms. If midwives can confidently use these tools and skills, in an ongoing manner, and refer women quickly and appropriately to the multidisciplinary team, more women could be saved from suicide.

Conclusion

This review ascertains that midwives have a significant role in the prevention of maternal suicide, which is a direct and leading cause of maternal death in the UK. Maternity services must treat suicide as a key focus nationwide to prevent tragic outcomes.

It is essential to recognise that, while a considerable number of those women who have died have had a history of mental illness, an equal number of women had no history at all. Midwives must therefore be up-to-date in their knowledge and skills to screen and identify those who may be at risk, and escalate appropriately and quickly to the multidisciplinary team.

Midwives have an invaluable opportunity to remove the stigma that comes with disclosing mental illness and encourage open discussion. However, because of a lack of professional development opportunities, and time, midwives are reporting that they are less able to do so. As such, women are less likely to discuss their psychiatric history and any concerns, culminating in missed opportunities to prevent suicide. This is further hampered if the midwife holds negative connotations towards mental illness and suicide prevention.

Women are more likely to divulge concerns where there is continuous midwifery care, allowing the midwife to identify mental deterioration and promptly escalate to the multidisciplinary team. Suicide has devastating consequences for the woman, her family and her community, therefore every step must be taken to reflect on, and improve, midwifery practice, and finally begin reducing the rates. **BJM**

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CPD reflective questions

- How does discussing mental health and suicide make you feel?
- How would you encourage a woman to discuss her emotional state?
- Do you know how to effectively use the Edinburgh Postnatal Depression Scale and Whooley questionnaires?
- Do you know who to escalate to, should you have concerns about a woman's mental health?

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