



Maternal Suicide, Infanticide and Risk Assessment

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Questions to answer today...

- Maternal Suicide
- Infanticide
- Risk Assessment

THE PERINATAL BASIC LINE

All maternity staff should have basic training in the identification of current, and past history of, mental health problems in pregnancy and the postpartum period and when to refer to mental health and primary care services.

Training should be provided locally in collaboration with specialised perinatal mental health services.

RCOG 'Good Practice Guidelines' 2011

WHY IS PERINATAL HEALTH IMPORTANT

...







AIMS

- Maternal Suicide
- Infanticide
- Risk Assessment

Perinatal Mental Health

- **Pregnancy does not protect against mental illness**
- Women at highest risk of new onset mental illness in early postpartum *than at any time in their lives*
- Clearly established link between BAD and puerperal psychosis
- the high risk of severe mental disorder in the early postpartum
- a failure to recognise the suddenness of onset
- seriousness of illness and rapidity of deterioration
- poor information sharing between primary care, maternity and mental health services,
- a lack of detailed enquiry and naïve management for women with substance misuse
- women who died of underlying physical illness had their symptoms downplayed or diagnosis delayed because of misattribution to mental disorder.
- Women require proper follow up – *A GP letter will not suffice*

**Maternal, Newborn and
Infant Clinical Outcome
Review Programme**



Saving Lives, Improving Mothers' Care

Lessons learned to inform maternity care from the
UK and Ireland Confidential Enquiries into Maternal
Deaths and Morbidity 2014–16

MBRRACE Report

In 2014-16 **9.8 women** per 100,000 died during pregnancy or up to six weeks after childbirth or the end of pregnancy.

Most women who died had multiple health problems or other vulnerabilities.



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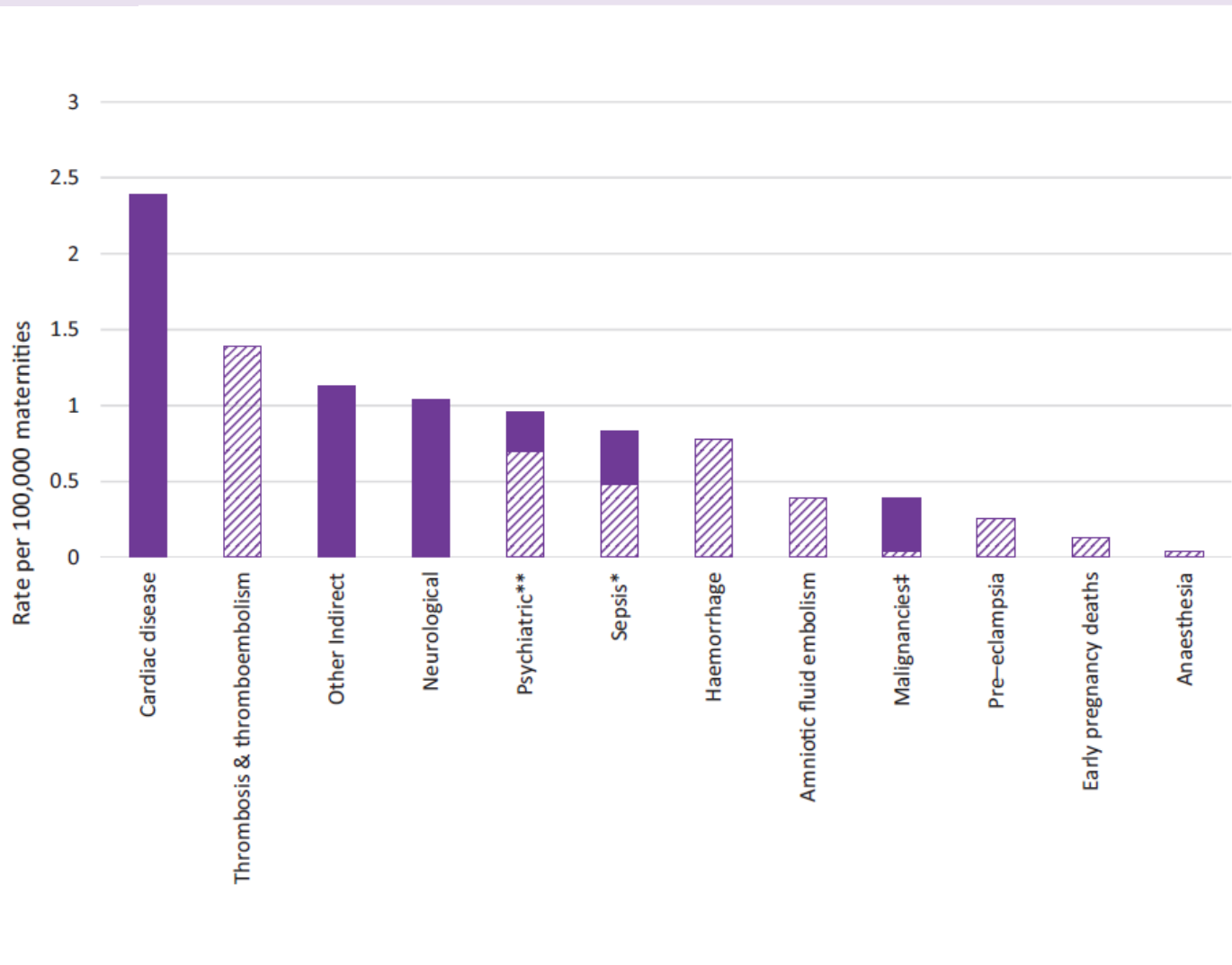
women

per 100,000 died up to six weeks after giving birth or the end of pregnancy in 2011 - 13

from **11** (2006-08) to **10** (2010-12) per 100,000 women giving birth

- 2014-2016 : 225 deaths during or within 42 days of giving birth
– (previously 200 2012 – 2014; 243 2010 – 2012)
- 286 women died between 6 weeks and 1 year post partum
- among over 2.3 million women who gave birth.

Maternal mortality by cause 2014-16



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

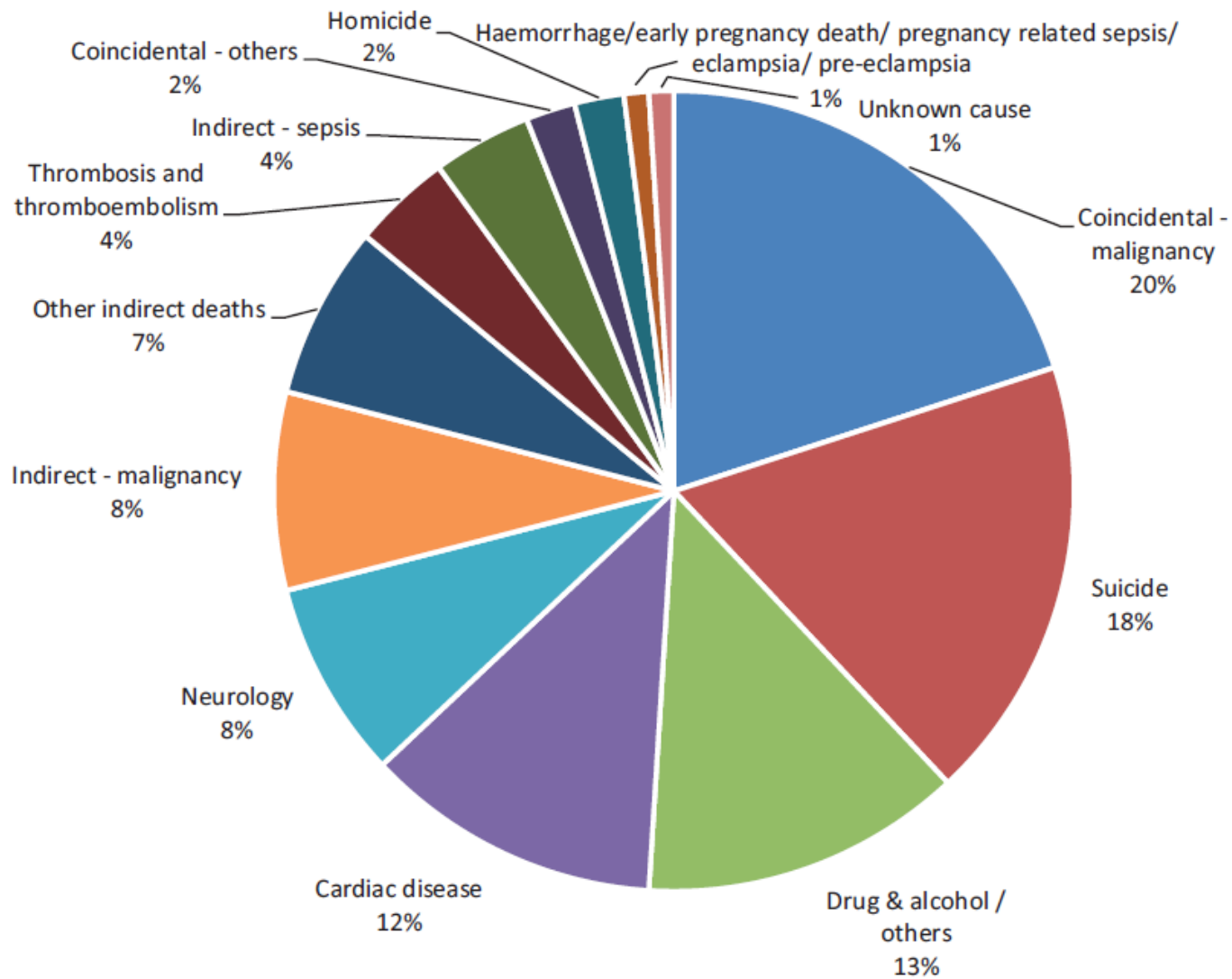
*Rate for direct sepsis (genital tract sepsis and other pregnancy related infections) is shown in hatched and rate for indirect sepsis (influenza, pneumonia, others) in solid bar

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

†Rate for direct malignancies (choriocarcinoma) shown in hatched and rate for indirect malignancies (breast/ovary/cervix) in solid bar

Source: MBRRACE-UK

Causes of death amongst women who died between six weeks and one year after the end of pregnancy, UK 2014-16



Maternal Suicide

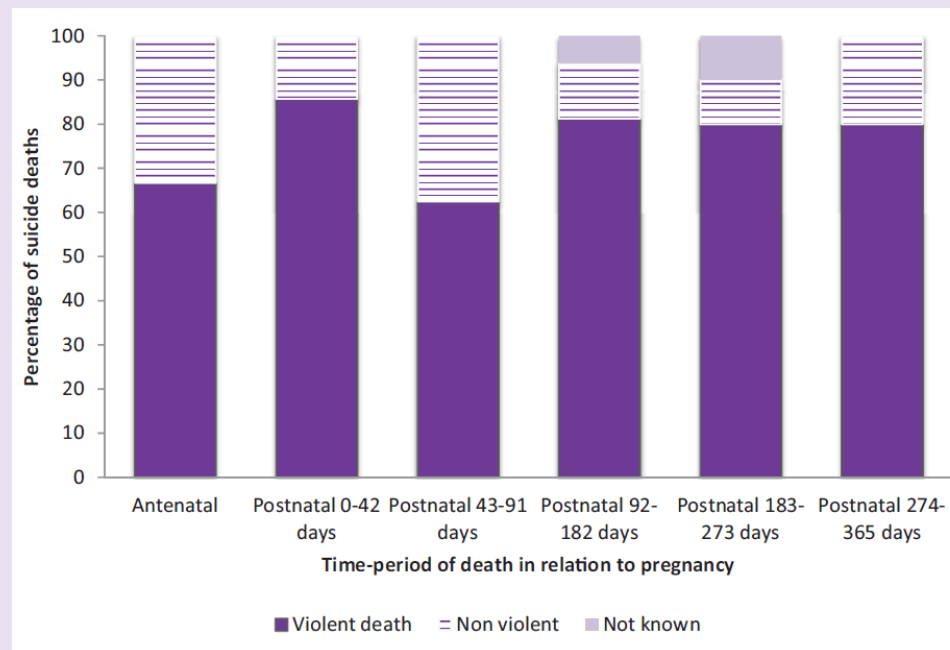
- More than 100 women died by suicide between 2009 – 2013
- Maternal suicide is 5th most common cause of death in pregnancy and 3rd highest *direct* cause
- **Maternal suicide is the leading cause of direct deaths occurring within a year after the end of pregnancy**
- **For ~20% of women who died in 2016 there was no evidence they had been asked about a history of Mental Health**

Maternal Suicide

- 71 deaths by suicide 2014 – 16
- Median age 30, white, UK citizens
- 71% multiparous
- 39% known to social services
- 24% known to have history of domestic abuse

Violent suicide is an indicator of clear intent and underlying significant mental disorder. Any expression of suicidal thoughts in pregnancy or the postpartum period should be taken seriously and mental health services should have a low threshold for initial and ongoing assessment.

Figure 5.1: Timing of violent suicide deaths in relation to pregnancy, UK and Ireland 2014-16



Maternal Suicide - Method

Method	Number of women (%) N=71
Hanging	42 (59)
Drug toxicity	14 (20)
Fall from height	6 (8)
Hit by train	4 (6)
Suicidal stabbing	2 (3)
Unclear	3 (4)

Violent suicide is an indicator of clear intent and underlying significant mental disorder. Any expression of suicidal thoughts in pregnancy or the postpartum period should be taken seriously and mental health services should have a low threshold for initial and ongoing assessment.

Violent methods unusual in suicides in general population but more commonly employed in setting of maternal death

Maternal Suicide

- Most common diagnosis
 - Recurrent Depressive Disorder
- In those with a diagnosis >50% had a recurrent mental health disorder

MBRRACE 2012 – 2014

- 2 women had prior diagnosis of BAD, 2 had Schizophrenia
 - 3 had psychiatric care in pregnancy, 2 as inpatients
 - *However none referred to Perinatal mental health*
- 14 women had a substance misuse diagnosis
- In a small number there is an **Extended Suicide**
 - All had diagnosis of Depressive Disorder
 - No expressions of harm towards baby
- For 16 women no communication between GP and maternity services

Extended suicide remains a very rare occurrence but sensitive enquiry should always be made regarding any thoughts of harm toward the infant or older children.

Maternal Suicide

- Booking and mental health history
 - Mental health questions varied enormously between services

All booking questionnaires must include questions to identify (i) women at high risk of early postpartum serious mental illness and (ii) women with current mental health problems. Guidance on what questions should be asked are provided in SIGN Guideline 127: Management of perinatal mood disorders (2012) and RCOG Good Practice Statement No. 14: Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period (2009).

(Royal College of Obstetricians and Gynaecologists 2011, Scottish Intercollegiate Guidelines Network 2012, National Institute for Health and Care Excellence 2014a)

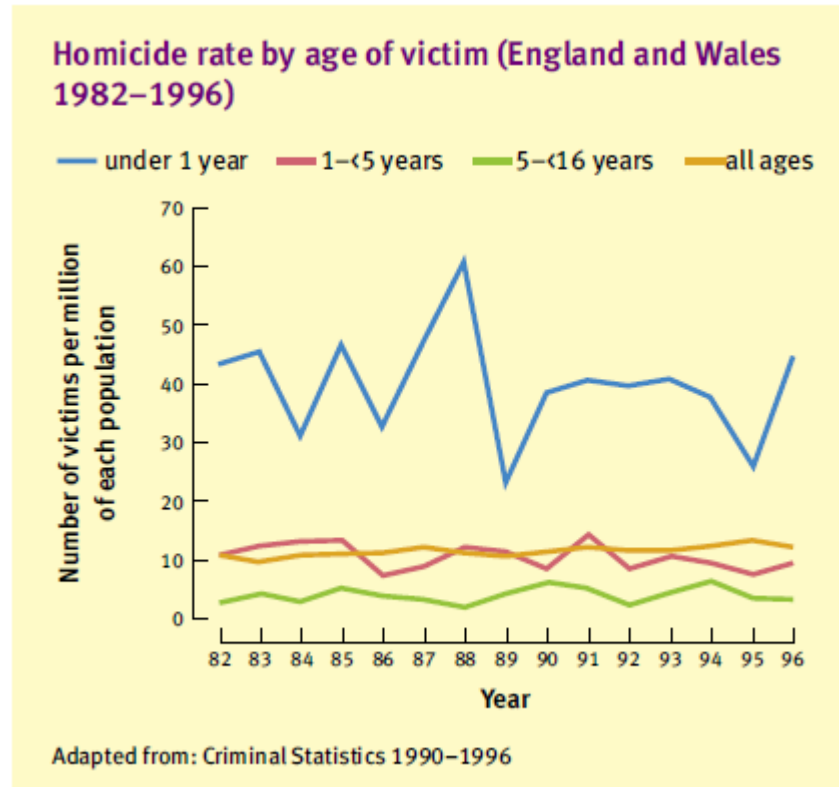
Assessments should always include a review of previous history and always take into account the findings of recent presentations and escalating patterns of symptoms, their severity and any associated abnormal behaviour.

AIMS

- Maternal Suicide
- Infanticide
- Risk Assessment

Infanticide

- Homicide is a major contributor to infant mortality



- Most parents with mental illnesses do not harm their babies

Infanticide

- **Neonaticide** : Infant homicide within 24 hours of delivery
 - Mother is often the perpetrator
 - Often young (<20), single, poorly educated, living with parents
 - Pregnancies often first and unintentional
 - Infant death usually secondary to neglect than action
 - Mother rarely psychotic rather in a state of denial and dissociation
 - Do not seek medical help or prepare for delivery of pregnancy
 - Attempt to return to their 'normal daily life'

Infanticide

- **Infanticide:** Infant homicide between one day and one year
 - Younger the infant the greater the risk
 - Boys > Girls (especially aged between one day and six months)
 - Parent is likely perpetrator
- Risk Factors for Infanticide
 - Family history of Violence
 - Violence in current relationship
 - Evidence of past neglect / abuse of children
 - Infanticidal ideas are common in SMI postpartum population

Infanticide

D'Orban, P. (1979). Women who kill their children. *The British Journal of Psychiatry*, 134(6), pp.560-571.

- 54% previous psychiatric illness requiring in / outpatient
- 88% psychiatric symptoms prior to offence
- 66.7% attempted or contemplated suicide at time of offence
- Associated with diagnoses with an inability to inhibit emotions (depression and personality issues)

Chandra, Venkatasubramanian and Thomas (2002)

- Among SMI mothers 43% reported infanticidal ideas
- 36% infanticidal behaviour
- Depression and psychotic ideation associated

Infanticide

Friedman, S., Hrouda, D., Holden, C., Noffsinger, S. and Resnick, P. (2005). Child Murder Committed by Severely Mentally Ill Mothers: An Examination of Mothers Found Not Guilty By Reason of Insanity. *Journal of Forensic Sciences*, 50(6), pp.1-6.

- 80% had psychotic disorder or mood disorder with psychotic symptoms
- Commonly recent contact with psychiatric services
- 50% planned previous suicidal attempts
- 50% depressed
- 75% delusional at time of killing with 66% incorporating their children into these delusions
- 56% planned extended suicide

Infanticide

Extended Suicide

- Primary motive is usually self destructive
- Killing of child extension of suicidal act
- Believes infant will be better off dead an 'altruistic act'

Legal position of infanticide

- In England and Wales mothers are convicted of infanticide and given prison sentences (fathers usually prison)
- Infanticide Act 1938 (amended Coroners and Justice Act 2009)

AIMS

- Maternal Suicide
- Infanticide
- Risk and Red Flags

Red Flags

New expressions or acts of violent self-harm are 'red flag' symptoms and should always be regarded seriously

- 7 women voiced “no relationship with baby” or arranged for baby to be cared by other

Self-harm in pregnancy or the early postpartum period is an unusual event, and should always prompt referral for continuing evaluation, ideally by specialist perinatal mental health services

'Red Flag' presentations which should prompt urgent senior psychiatric assessment

- Recent significant change in mental state or emergence of new symptoms
- New thoughts or acts of violent self-harm
- New and persistent expressions of incompetency as a mother or estrangement from the infant

There should be an expectation of consultant psychiatrist involvement in high risk women exhibiting sudden alterations in mental state

- Repeated presentation to the GP, community midwife (while still under maternity services) health visitor or emergency services should be considered a 'red flag' and warrant a thorough assessment by the GP of all of a woman's problems.

Amber Flags

2017 Psychiatry Morbidity Review highlighted women with pre-existing major mental disorder which placed them at risk in future early postpartum periods

Regard women with any past history of psychotic disorder as at elevated risk and requiring individualised assessment of risk.

Closely monitor women with a family history of bipolar disorder or postpartum psychosis and refer if any change in mental state. If they themselves have any mood disorder or history of postpartum mood destabilisation they should have an individualised assessment of risk.

Personal and familial patterns of occurrence and re-occurrence should inform risk minimisation strategies (Knight, Nair et al. 2017).

Acute Risk

Admission to mother and baby unit care should be considered where a woman has any of the following:

- rapidly changing mental state
- suicidal ideation (particularly of a violent nature)
- pervasive guilt or hopelessness
- significant estrangement from the infant, new or persistent beliefs of inadequacy as a mother
- evidence of psychosis

(Knight, Tuffnell et al. 2015)

Research has highlighted NOT placing too great an expectation or burden on other family members and educating family members on perinatal mental illness

There should be an expectation of early consultant involvement in the assessment and management of high-risk women and of women exhibiting sudden alterations in mental state in late pregnancy or the early puerperium.

Disengagement from care should be regarded as a potentially worsening of mental state with professionals considering assertive follow-up

Longitudinal Risk

Following recovery, it is the responsibility of the treating team to ensure that all women experiencing postpartum psychosis receive a clear explanation of:

- future risk
- the availability of risk minimisation strategies
- the need for re-referral during subsequent pregnancies

Research has consistently noted that further training is required for other teams managing acute presentations

Loss of a child, either by miscarriage, stillbirth and neonatal death or by the child being taken into care increases vulnerability to mental illness for the mother and she should receive additional monitoring and support (Knight, Tuffnell et al. 2015).

Judgements made on psychosocial factors and multiple adversities appear to give licence to lower risk – **in fact the presence of impulsivity, substance misuse and social adversity increases risk of self harm and suicide**

Messages

- Women are often afraid to speak out
 - Implication they cannot cope
 - Fear of loss of child

It's OK to tell

The mind changes as well as the body during and after pregnancy.

Women who report:

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



need urgent referral to a specialist perinatal mental health team



Many medicines are **safe** during pregnancy

Continuing medication or preventing illness with vaccination may be the best way to keep both mother and baby healthy - ask a specialist

Decisions on continuing, stopping or changing medication in pregnancy should be made only after careful review of the benefits and risks of doing so, to both mother and infant.

Areas of Action

- Doctors, Midwives and Health Professionals
 - Aware of Red Flag symptoms

Signs to be aware of – red flag symptoms

In yourself, or a loved one, or friend

- Do you have new feelings and thoughts which you have never had before, which make you disturbed or anxious?
- Are you experiencing thoughts of suicide or harming yourself in violent ways?
- Are you feeling incompetent as a mother, as though you can't cope, or feeling distanced or estranged from your baby? Are these feelings persistent?
- Do you feel you are getting worse?

- Education of Family members
 - Have crucial role to play, recognise early changes in mental state
- Remove the 'taboo' from mental illness in pregnancy
- Be able to discuss domestic abuse in a safe environment