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Mental Health-related maternal deaths: reflections on the MBRRACE report

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By the AIMS Campaigns Team

In this article, the AIMS Campaigns Team provides a short summary of the latest MBRRACE report ' Saving Lives, Improving Mothers Care'[1], and offers some reflections on the recommendations proposed to reduce mental health related deaths.

The report, published in November 2022, covers the confidential enquiries into maternal deaths and morbidity in the UK and Ireland over the three-year period 2018-2020. During this time, 229 women (10.9 women out of every 100,000 giving birth) died during pregnancy or the first six weeks after giving birth, including nine who died from Covid. Excluding the Covid deaths the rate was 10.5 out of every 100,000 giving birth, compared to 8.8 out of every 100,000 in the three years 2017-19.

A further 289 women (13.8 women out of 100,000 births) died between six weeks and a year after the end of their pregnancy. This rate has not changed significantly since the first MBRRACE report in 2010.

It is worrying that despite the Government's ambition to reduce maternal mortality by 50% between 2010 and 2025, this latest report shows that the downward trend has stalled. In fact, between the periods 2010-12 and 2018-20 the proportion of mothers dying increased by 3%, excluding deaths from Covid. This has been driven by an increase in the direct death rate (those directly due to pregnancy and birth) and in particular by increases in deaths from suicide, pre-eclampsia and haemorrhage.

It is also worth noting that of those who died, "detailed assessment showed that for... 38% improvements in care may have made a difference to their outcome."

In the report the authors comment that, in addition to the deaths directly due to Covid, "There is little doubt that changes to and pressures on maternity services as a result of the Covid-19 pandemic also contributed to some of the other maternal deaths during this same period." It seems likely that reductions in face-to-face contact both antenatally and postnatally will have led to serious problems being missed.

Overall, the majority of maternal deaths in the period covered by the report (86%) occurred postnatally. This included 32% in the first six weeks, and 54% between six weeks and a year after giving birth. In particular, the majority of both suicides and deaths from substance abuse occurred postnatally, with a

peak at 6-9 months. This is particularly worrying given the ongoing limitations on in-person postnatal support, which has in many areas declined further as a result of pandemic measures, making it less likely that women who develop postnatal mental health problems will be identified.

It is cause for great concern that issues identified in previous reports persist or have even deteriorated. Black women are still almost four times more likely, and Asian women almost twice as likely to die compared to white women. Despite the increased focus over recent years, there has been no significant narrowing of these gaps. Women from the most deprived areas are two-and-a-half times more likely to die than those from the least deprived areas, and this gap continues to increase. At least eleven percent of the women who died were at 'severe and multiple disadvantage' as a result of having more than one risk factor, which might include a mental health diagnosis, substance abuse or domestic abuse. The authors comment that this figure is likely to be an underestimate.

Just over a quarter of the women who died were born outside the UK. Although overall the death rate was not significantly different between those born in and those born outside the UK, it was significantly higher for women born in Bangladesh.

The full report contains detailed analysis and recommendations for the leading causes of maternal deaths, with chapters on caring for women with multiple morbidities, cardiovascular problems, hypertensive disorders, early pregnancy disorders and critical care. In this article we will focus on the issue of mental-health related deaths, which are addressed in Chapter 3.

Mental-health related deaths

The report reveals that suicide is taking an increasing toll of new mothers, and especially teenage mothers, with many of these having previously been in care. In 2020, women were three times more likely to die by suicide during pregnancy or up to six weeks after the end of pregnancy compared to 2017-19. This is 1.5 women out of every 100,000 giving birth.

Suicide also remains the main cause of direct deaths in the period between six weeks and a year after birth, and overall, deaths from all mental health-related causes account for nearly 40% of deaths occurring within a year after the end of pregnancy.

Quite aside from the horror of these individual deaths must be the realisation that for every mother who dies by suicide or from other mental-health related reasons, there will be many more who are suffering severe mental and emotional problems. The report makes a number of important new recommendations for detecting and supporting those at risk, in addition to reminders of "Existing recommendations requiring improved implementation" but do these go far enough? A lot of the recommendations have the effect of reducing the woman to a problem to be solved by the professionals, which may not be the most helpful approach for someone who is already feeling disempowered and vulnerable.**Should the focus not be on working *with* a woman to identify the care and support that will benefit her?**

For example, one recommendation is for professionals to "Be alert to factors, such as cultural stigma or fear of child removal, which may influence the willingness of a woman or her family to disclose symptoms

of mental illness, thoughts of self-harm or substance misuse." The difficulty here is that disclosing mental health issues may indeed lead to a baby being removed from parents. We are still seeing the same issue that we have seen for decades of women being reluctant to reach out for support from fear that support will not be forthcoming, but rather that any issues they disclose will be used against them. Perhaps what is needed is a more empathic approach by both healthcare and social services professionals towards supporting and reassuring mothers/families in this situation, so that a referral to Children's services becomes a real offer of help rather than a threat.

Another recommendation is "Recognise the importance of a trauma history in the assessment of risk. Involve specialist Perinatal Mental Health Teams where there is a history of significant involvement with secondary mental health services or significant risk, particularly if it is a first pregnancy." Trauma history is an important consideration, but any exploration needs to be done sensitively and with awareness of the potential impact of requiring people to revisit previous trauma. We are concerned about how well-equipped staff working directly with parents are to carry out the initial conversation in an appropriate manner, before deciding whether to involve the specialist Perinatal Mental Health Team – especially given the pressures and time constraints under which midwives have to work. (And by the way, shouldn't that be 'offer of referral to' rather than 'involve'? Again, women need to be confident that they will be offered actual help and not just have this flagged as a risk factor.).

A third new recommendation is "Allow sufficient opportunity in electronic records systems for free text written comment rather than relying solely on 'tick boxes'. Where a woman has a history of mental health difficulties, make a brief (as a minimum) comment on mental health." Again, we feel that this needs to be done sensitively and ideally in partnership with the woman. If it is seen as a health professional passing judgement on her, it could easily lead to a breakdown in trust and do more harm than good. Perhaps in addition to noting any issues there should be clear documentation of what support has been offered, and then if the women accepted the support whether it was found to be helpful. Sadly, AIMS often hears that support is either not forthcoming or is not helpful.

There is a comment in the report that "Many of the women who died through either suicide or substance misuse struggled to engage with services." The recommendation is about multiple services working together when planning contacts. While this may be helpful, surely it is also important to explore the factors which might be preventing women from engaging – such as lack of trust, fear of stigma, lack of awareness of how to access support or practical difficulties with childcare or transport etc - and developing strategies to address these?

One of the existing recommendations is "continuity of mental health care." We wonder why there is no mention anywhere of the benefit of Continuity of Carer throughout the maternity period, especially for women who have or are at risk of developing mental health problems. The opportunity to form a trusting relationship with a midwife must surely facilitate disclosure of "symptoms of mental illness, thoughts of self-harm or substance misuse" as well as domestic violence. This could help to improve the identification of women at risk, as well as making it more likely that they will engage with support that is offered.

A major problem is that all these recommendations require staff working directly with parents to have the time and skills to engage effectively with what are often extremely vulnerable women, and specialist Perinatal Mental Health Teams to be adequately resourced to deal with what is likely to be an expanding caseload as the cost-of-living crisis begins to bite. In the current state of the NHS, how likely is this?

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[1] MBRRACE (2022) Saving Lives, Improving Mothers Care.

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