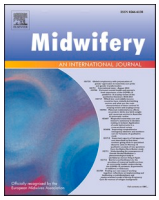
Midwifery 142 (2025) 104309

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw



# Attitudes, experiences, and implications of asking about suicide during the perinatal period: A qualitative study with maternity healthcare practitioners

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ARTICLE INFO

*Keywords:*
Suicide
Perinatal
Pregnancy
Postnatal
Healthcare practitioners
Screening

ABSTRACT

*Background:* Suicide is a leading cause of maternal death. Maternity healthcare practitioners (HCPs) are uniquely positioned to identify perinatal mental health (PMH) problems and/or suicidality. Research exploring HCPs attitudes towards suicide-related screening items and their experiences of asking about perinatal suicidality is limited.

*Objectives:* (i) to explore HCPs attitudes towards 16 suicide-related screening items; and (ii) to explore HCPs broader views, experiences and implications of discussing suicide with perinatal women in maternity care settings.

*Methods:* Fifteen semi-structured interviews were conducted with maternity HCPs. The sample included midwives, health visitors, general practitioners, and specialist PMH practitioners working in the United Kingdom (UK). Inductive thematic analysis was used to explore the data and identify themes.

*Results:* Most HCPs felt uncomfortable with, disliked, or found half of the suicide-related items unhelpful. Reasons included use of ambiguous or emotive terms. HCPs preferred not to use the word 'suicide' with pregnant or postnatal women. In the thematic analysis, four themes were identified: (i) Approaches for discussing and identifying PMH problems and suicidality; (ii) Competing demands and continuity of carer; (iii) PMH and suicidality training and support; and (iv) Availability of PMH services and referral pathways. These factors affected HCPs capacity, willingness, and confidence to ask women suicide-related questions.

*Conclusions:* HCPs need targeted PMH and suicidality training and support in maternity care contexts to enable them to feel more equipped, comfortable, and available to have conversations with women about PMH and suicide. Timely detection and intervention may help to improve care for women experiencing perinatal suicidality.

## Statement of Significance

| | |
|---|---|
| Problem or issue | Suicide is a leading cause of global maternal mortality. |
| What is already known | Maternity healthcare practitioners (HCPs) are uniquely positioned to identify perinatal mental health (PMH) problems and suicidality. Up to 50 % of women experiencing PMH problems are not detected in the UK, despite regular contact with HCPs. Multi-level barriers affect the identification of those requiring support. |
| What this paper adds | This paper adds novel insight regarding HCPs attitudes towards different suicide-related screening items. It also presents in-depth understanding of the barriers and facilitators for asking perinatal women about suicide from the perspective of HCPs who work in maternity care contexts, which is useful for informing future practice. |

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## Introduction

Perinatal mental health (PMH) is a global public health concern

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https://doi.org/10.1016/j.midw.2025.104309
Received 30 August 2024; Received in revised form 17 January 2025; Accepted 21 January 2025
Available online 27 January 2025

(WHO, 2022). PMH problems affect up to one fifth of pregnant or postnatal women[1] and can lead to significant adverse consequences for both mother and child (Bauer et al., 2014; Bayrampour et al., 2017; Howard and Khalifeh, 2020). Common PMH problems include anxiety, depression and post-traumatic stress disorder. Some women also experience severe complications such as postpartum psychosis, and/or suicidality (Howard and Khalifeh, 2020; Orsolini et al., 2016). A recent report by the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity (MBRRACE-UK) (Knight et al., 2023) highlighted that between 2019 and 2021, mental health factors accounted for almost 40 % of all maternal deaths between six-weeks to one-year post birth. This underscores the need for continued prioritisation and expansion in equitable specialist PMH services to ensure that women who require additional support receive appropriate and timely care. Tragically, suicide is a leading cause of maternal mortality in the UK and in other high-income countries (Diguisto et al., 2022; Grigoriadis et al., 2017; Howard and Khalifeh, 2020; Knight et al., 2023; Trost et al., 2022). The contribution of suicide to maternal deaths in low-income and middle-income countries is difficult to determine due to differences in reporting systems and classifications (Simmons et al., 2024). However, the pooled prevalence of global perinatal suicide attempts is estimated to be 680 per 100,000 in pregnancy, and 210 per 100,000 in the first postnatal year (Rao et al., 2021). Many more women will also experience suicidal ideation during this time. Previous suicide attempts and suicidal ideation are known risk factors for future fatal acts (Orsolini et al., 2016). Hence, it is imperative that perinatal suicidality is identified at the earliest opportunity to improve outcomes for women and their babies.

Maternity healthcare practitioners (HCPs) are in a pivotal position for identifying PMH problems in pregnant and/or postnatal women. However, evidence suggests that approximately 50 % of women experiencing PMH problems and/or suicidality go undetected (Bauer et al., 2014; National Childbirth Trust, 2017). This may be partially explained by differences in PMH screening recommendations, and there remains debate regarding the benefits, risks and viability of implementing universal PMH screening into maternity care. Whilst routine screening for common PMH problems offers the opportunity for early identification, intervention and treatment, arguments against this approach include: (i) over-detection of PMH problems (e.g., false positives); (ii) effectiveness, accuracy and/or acceptability of screening measures; (iii) service level capacity (e.g., lack of resources, funding); (iv) adequate referral pathways and access to specialist PMH services; and (v) potential harm to women (e.g., social stigma, increased anxiety/psychological distress) (Milgrom and Gemmill, 2015; Solutions for Public Health, 2019). Likewise, research shows that some HCPs may be hesitant or avoid using PMH screening measures because they are unsure of their purpose, how to administer them and/or interpret the results (Pope et al., 2023), or they may feel uncomfortable asking women PMH questions (Buist et al., 2006).

Evidence also suggests that screening barriers are particularly heightened when identifying perinatal suicidality and/or assessing suicide risk. Both McCauley et al. (2012) and Lau et al. (2015) found that midwives and maternal and child health nurses were uncomfortable assessing perinatal suicide risk and/or coping with women who felt suicidal, and Holland (2018) suggested that maternity HCP's attitudes towards suicide prevention may influence their willingness to engage in suicide-related conversations. Similarly, wider research on suicide screening and assessment has found that HCPs may negatively frame suicide-related questions and/or use closed questions (e.g., yes/no) to prompt a non-suicidal response (Ford et al., 2021; McCabe et al., 2017, 2023), and some HCPs fear asking about suicide in case they put suicidal ideas in someone's head (Quinnett, 2019; Bajaj et al., 2008). Fedorowicz et al. (2023) also highlighted that there is great variation in if, how, and when suicide risk assessments take place in primary and secondary care, which is frequently due to time pressures and lack of training. Whilst maternity HCPs often recognise the importance of asking women about PMH and suicidality, many feel ill-equipped in administering screening measures and/or initiating conversations around PMH and suicidality due to a lack of PMH and suicide training and support (Bayrampour et al., 2018; Holland, 2018; Lau et al., 2015; McCauley et al., 2012). This may affect HCPs comfort, confidence, attitudes, skills and knowledge concerning PMH and suicidality, and creates a significant barrier for identifying women who require additional support. Further barriers to PMH screening in maternity settings include: (i) time constraints; (ii) unclear referral pathways; (iii) assumptions and stigma; and (iv) perceptions of professional role and scope (Bayrampour et al., 2018).

Previous qualitative research has looked at PMH professionals' experiences and perceptions of factors that may be linked to and/or affect women's suicidal ideation and behaviours (Reid et al., 2024). However, there is limited research exploring HCPs attitudes towards different suicide-related screening items, or their general views regarding the barriers, facilitators and implications of asking perinatal women about suicide in maternity care contexts. This is important for developing appropriate approaches for discussing and identifying perinatal suicidality, and for understanding how best to support maternity HCPs in practice. Likewise, the acceptability of a healthcare intervention, in this case the identification and/or assessment of perinatal suicidality, to both service user and practitioner is a necessary condition of that intervention being successful. For the practitioner, if the assessment has low acceptability, it may not be implemented or asked in the way intended by those who designed and validated the measure, which may impact its effectiveness (Proctor et al., 2009; Sekhon et al., 2017). This study therefore sought to: (i) to explore HCPs attitudes towards 16 suicide-related screening items that have previously been used and/or validated in perinatal populations; and (ii) to explore HCPs broader views, experiences and implications of discussing suicide with women in maternity care settings.

## Participants, ethics, and methods

### *Ethics*

Research ethics approval was obtained through the School of Health and Psychological Sciences Research and Ethics Committee at City, University of London (reference number: ETH2122-0828. Informed consent was provided by all participants before their interview.

### *Design*

This was a qualitative interview study that used structured and semi-structured interview techniques. A pragmatic approach was taken to understand HCPs perspectives of the topic and generate meaningful knowledge that may help to inform and address their needs in real-world settings.

### *Participants, recruitment, and data collection*

Participants were HCPs who currently (or previously) worked with pregnant or postnatal women, aged 18 or over, living in the UK, and able to speak and understand English. Sample size was guided by the Information Power approach (Malterud et al., 2016) which offers a pragmatic alternative to saturation and is suitable for qualitative research that explores complex phenomena. The final sample comprised 15 HCPs.

Recruitment and interviews took place between June 2022 and March 2023. The study was advertised on social media (Twitter and LinkedIn). Most HCPs were recruited via social media ($n = 11$), and four through word of mouth. Interested participants contacted the first

[1] The authors recognise that not all birthing people identify as being a 'woman' or 'mother' or 'female' (e.g.,). Although these terms have been used throughout this paper, we aim to include any birthing person.

author directly and were then provided with an information pack to enable an informed decision about their participation. After obtaining consent, participants were invited to take part in a one-to-one interview with the first author, either online or via the telephone. Twelve interviews took place virtually using Microsoft Teams or Zoom, and the remaining three were telephone interviews. Interviews lasted between 56 and 123 min (mean 82 min), were audio-recorded, transcribed verbatim and deidentified.

An interview schedule was created by the first and second authors to explore topics relevant to HCPs' attitudes and experiences of screening for PMH and suicidality, and their views regarding the implications of discussing suicide in maternity care contexts. The interview schedule comprised two parts. Firstly, participants were asked to read out 16 suicide-related items and to tell the researcher whether they would feel comfortable administering each item with perinatal women, and/or whether they liked the item/thought it had utility for identifying women who may be experiencing suicidal ideation and/or behaviours. Participants were also asked to provide reasons. These items were chosen because they have previously been validated and/or administered in perinatal populations (Dudeney et al., 2023), and the content validity and acceptability of the items had also been examined with pregnant and postnatal women (Dudeney et al., 2024). It is therefore important to explore HCPs attitudes towards these items to understand how appropriate and/or useful they are from their perspective. A descriptive summary of included items/measures is presented in Table 1.

The second part of the interview was semi-structured and explored HCPs experiences and perspectives of discussing suicide with perinatal women, including potential barriers, facilitators, and implications.

### *Data analysis*

All deidentified transcripts were imported into NVivo 14 (Lumivero, 2023) for analysis. Data were analysed using two approaches. Firstly, a coding framework was developed to examine HCPs attitudes towards the suicide-related items. Each transcript was coded using the following procedure: (i) data concerning the first item (e.g., PHQ-9, item-9) was coded to a corresponding heading (e.g., PHQ-9, item-9); and (ii) codes were then applied to indicate whether the participant said they were comfortable (or liked and/or thought the item was useful), were uncomfortable (or disliked and/or thought the item was not useful), or were neutral towards the item (or did not provide a clear response), including their reasons. This process was followed for each item across all transcripts. Data were then quantified and extracted into Excel, per item and per participant.

The second analytic stage involved identifying themes across the dataset using Thematic Analysis (Braun and Clarke, 2006, 2021). Based on the research questions, and following familiarisation with the dataset, the first author coded each transcript line-by-line to identify concepts that appeared important and/or meaningful. Once all transcripts had been coded, themes and subthemes were developed through an iterative process of clustering codes that reflected patterns across the dataset. The first and second authors reviewed and refined the themes regularly to ensure accuracy, coherence, and relevance to the research questions. Confirmatory coding was also independently conducted for 20 % of the transcripts by a PhD student. Any inconsistencies were discussed and revised, and all authors agreed upon the final themes. Reporting follows the Standards for Reporting Qualitative Research (SRQR) (O'Brian et al., 2014).

### *Researcher reflexivity*

The authors considered their experience, positioning, and influence upon the data collection, analysis, and write-up. The first author is a female doctoral researcher with experience of conducting interviews on sensitive topics and has completed suicide intervention skills training. This helped to create a safe environment for participants to share their

**Table 1**
Descriptive summary of measures.

| Measure, item number | Item content | Response options [scoring] |
|---|---|---|
| Beck Depression Inventory (BDI), item-9* | "I don't have any thoughts of killing myself", "I have thoughts of killing myself, but I would not carry them out", "I would like to kill myself", "I would kill myself if I had the chance" | Choose one of the statement options [0 to 3] |
| Edinburgh Postnatal Depression Scale (EPDS), item-10* | "The thought of harming myself has occurred to me" | "Never" [0], "hardly ever" [1], "sometimes" [2], "yes, quite often" [3] |
| Inventory of Depression and Anxiety Symptoms (IDAS), item-7* | "I had thoughts of suicide" | "Not at all" [1], "a little bit" [2], "moderately" [3], "quite a bit" [4], "extremely" [5] |
| Inventory of Depression and Anxiety Symptoms (IDAS), item-9* | "I hurt myself purposely" | "Not at all" [1], "a little bit" [2], "moderately" [3], "quite a bit" [4], "extremely" [5] |
| Inventory of Depression and Anxiety Symptoms (IDAS), item-14* | "I thought about my own death" | "Not at all" [1], "a little bit" [2], "moderately" [3], "quite a bit" [4], "extremely" [5] |
| Inventory of Depression and Anxiety Symptoms (IDAS), item-15* | "I thought about hurting myself" | "Not at all" [1], "a little bit" [2], "moderately" [3], "quite a bit" [4], "extremely" [5] |
| Inventory of Depression and Anxiety Symptoms (IDAS), item-41* | "I cut or burned myself on purpose" | "Not at all" [1], "a little bit" [2], "moderately" [3], "quite a bit" [4], "extremely" [5] |
| Inventory of Depression and Anxiety Symptoms (IDAS), item-43* | "I thought that the world would be better off without me" | "Not at all" [1], "a little bit" [2], "moderately" [3], "quite a bit" [4], "extremely" [5] |
| Patient Health Questionnaire-9 (PHQ-9), item-9* | "Have you had thoughts that you would be better off dead, or of hurting yourself in some way?" | "Not at all" [0], "several days" [1], "more than half the days" [2], "nearly every day" [3] |
| Postpartum Depression Screening Scale (PDSS), item-7* | "I started thinking that I would be better off dead" | "Strongly disagree" [1], "disagree" [2], "neither disagree nor agree" [3], "agree" [4], "strongly agree" [5] |
| Postpartum Depression Screening Scale (PDSS), item-14* | "I've thought that death seemed like the only way out of this living nightmare" | "Strongly disagree" [1], "disagree" [2], "neither disagree nor agree" [3], "agree" [4], "strongly agree" [5] |
| Postpartum Depression Screening Scale (PDSS), item-21* | "I wanted to hurt myself" | "Strongly disagree" [1], "disagree" [2], "neither disagree nor agree" [3], "agree" [4], "strongly agree" [5] |
| Postpartum Depression Screening Scale (PDSS), item-28* | "I felt that my baby would be better off without me" | "Strongly disagree" [1], "disagree" [2], "neither disagree nor agree" [3], "agree" [4], "strongly agree" [5] |
| Postpartum Depression Screening Scale (PDSS), item-35* | "I just wanted to leave this world" | "Strongly disagree" [1], "disagree" [2], "neither disagree nor agree" [3], "agree" [4], "strongly agree" [5] |
| Self-Reporting Questionnaire-20 (SRQ-20), item-17 | "Has the thought of ending your life been on your mind?" | Yes/No [1/0] |
| Ultra-short Maternal Mental Health Screen (Ultra-Short), item-4 | "Has the thought of committing suicide often occurred to you?" | Yes/No [1/0] |

Notes: measure has been validated in perinatal populations.
Measures: Beck Depression Inventory (BDI) (Beck et al., 1961); Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987); Inventory of Depression and Anxiety Symptoms (IDAS) (Watson et al., 2007); Patient Health Questionnaire-9 (PHQ-9) (Kroenke et al., 2001); Postpartum Depression Screening Scale (PDSS) (Beck and Gable, 2000); Self-Reporting Questionnaire-20 (SRQ-20) (Harding et al., 1980); Ultra-Short Maternal Mental Health Screen (Ultra-Short) (van Heyningen et al., 2019).

thoughts and experiences and fostered a mindful approach towards each interview without imposing personal opinions. The first author does not have a clinical background in maternity care which also helped to enhance neutrality in the data collection and analytic phases of the research. The second and third authors both have expertise in PMH and measurement research, and the fourth author has expertise in professional-patient communication in mental health care research, and communication about suicidality and/or self-harm.

## Results

### *Sample characteristics*

Fifteen HCPs participated: 10 midwives (including specialist PMH and community midwives), three general practitioners, one health visitor, and one community PMH nurse. Participants' ages ranged from 26 to 56 years (mean 40.86). Twelve HCPs were White British, and 14 spoke English as a first language. The number of years that HCPs had worked with perinatal women ranged from 3 to 21 years (mean 10.06). Sociodemographic information is presented in Table 2.

### *Overview of findings*

The number of HCPs who felt comfortable, uncomfortable, or neutral (etc.) towards each of the suicide-related items, and key reasons are presented in Table 3. A narrative overview of these findings is also provided in the following section ('HCPs attitudes towards suicide-related items').

All themes and subthemes are presented in Fig. 1. Four themes were identified: (i) Approaches for discussing and identifying PMH problems and suicidality; (ii) Competing demands and continuity of carer; (iii) PMH and suicidality training and support; and (iv) Availability of PMH

**Table 2**
Sample characteristics ($n = 15$).

| Sociodemographic variable | *M (range)* or *n* (%) |
|---|---|
| Age | 40.86 (26 - 56 years) |
| English as first language | |
| Yes | 14 (93 %) |
| No | 1 (7 %) |
| Currently working with perinatal women | |
| Yes | 11 (73 %) |
| No* | 4 (27 %) |
| Number of years worked with perinatal women | 10.06 (3 – 21 years) |
| Profession | |
| Midwife | 4 (27 %) |
| Specialist perinatal mental health midwife | 4 (27 %) |
| General practitioner (GP) | 3 (20 %) |
| Health visitor | 1 (7 %) |
| Midwife and maternity nurse | 1 (7 %) |
| Community midwife | 1 (7 %) |
| Perinatal community mental health nurse | 1 (7 %) |
| Cultural background | |
| (White) English/Welsh/Scottish/Northern Irish/British | 12 (79 %) |
| Any other White background | 1 (7 %) |
| (Mixed/multiple ethnic groups) White and Asian | 1 (7 %) |
| (Mixed/multiple ethnic groups) White and Black Caribbean | 1 (7 %) |

* These participants had previously worked with perinatal women in a maternity care context.

**Table 3**
HCPs evaluation of suicide-related items ($n = 15$).

| Measure, item number, and content | Comfortable, like, and/or useful item | Uncomfortable, dislike, and/or item not useful | Neutral, no response, and/or additional comments |
|---|---|---|---|
| BDI, item-9†* *"Please choose from the following: I don't have any thoughts of killing myself", "I have thoughts of killing myself, but I would not carry them out", "I would like to kill myself", "I would kill myself if I had the chance"* | $n = 5$<br>Potential utility for differentiating thoughts, intent, and actions for someone who has already disclosed suicidality. Not for screening.<br>Helpful for normalising passive suicidal ideation without intent.<br>Plain, clear, and direct wording. | **$n = 8$**<br>Too much information in one item, might be confusing and especially for women who don't speak English as a first language.<br>The word 'kill' feels very uncomfortable.<br>'I would *like* to kill myself' is an inappropriate statement.<br>The last two statements are hard to differentiate.<br>Not appropriate for maternity HCPs to administer this type of question, should only be asked by a mental health professional. | $n = 2$<br>Would need to ask this question in a safe environment, with a clear referral pathway in place. |
| EPDS, item-10* *"The thought of harming myself has occurred to me"* | **$n = 13$**<br>Most maternity HCPs are familiar with this questionnaire.<br>Gentler way to approach the topic than asking about suicide specifically.<br>Useful as a conversation starter, but further questions would be required. | $n = 2$<br>'Harming' is a very broad, vague term and would need explanation.<br>Some maternity HCPs without mental health knowledge and/or training may not feel comfortable administering this question.<br>Wouldn't ask this question unless there was a clear referral pathway.<br>Might be better as a question rather than a statement.<br>Would interpret 'harming myself' as non-suicidal self-harm, so may not be useful for identifying suicidality. | $n = 0$<br>N/A |
| IDAS, item-7* *"I had thoughts of suicide"* | **$n = 9$**<br>Clear, unambiguous, and direct item. | $n = 3$<br>Wouldn't use the word 'suicide' with perinatal women.<br>Issues with the word 'suicide' in terms of translation and cultural differences.<br>Wouldn't feel comfortable administering this item unless there was a clear referral pathway and had | $n = 3$<br>Would need to ask further questions to ascertain intent and risk.<br>Important to preface this item with a sensitive approach and focus on support. |

(*continued on next page*)

**Table 3** (*continued*)

| Measure, item number, and content | Comfortable, like, and/or useful item | Uncomfortable, dislike, and/or item not useful | Neutral, no response, and/or additional comments |
|---|---|---|---|
| | | received mental health training. | |
| IDAS, item-9†* *"I hurt myself purposely"* | $n = 2$ Clear and direct item. | $\boldsymbol{n = 12}$ The word 'purposely' is quite accusatory and may infer judgement and/or blame. May create an unhelpful power barrier and impact rapport building. Content is blunt and confronting, may not facilitate an honest response. Self-harm related, so may not be useful for identifying suicidality. | $n = 1$ Would need to ask further questions to explore methods and prior history. |
| IDAS, item-14†* *"I thought about my own death"* | $n = 1$ May have some utility for starting a conversation. | $\boldsymbol{n = 14}$ Too vague, doesn't tell you anything about suicidality. Potentially distressing item, uncomfortable with the word 'death'. | $n = 0$ N/A |
| IDAS, item-15* *"I thought about hurting myself"* | $\boldsymbol{n = 9}$ Reasonable and clear item. Asking about 'thoughts' is less confronting than behaviours. No blame or negative connotations in the item content. | $n = 2$ Self-harm related so may not be useful for identifying suicidality. | $n = 4$ Would need to ask further questions (e.g., 'did/have you hurt yourself'). |
| IDAS, item-41†* *"I cut or burned myself on purpose"* | $n = 2$ Useful for capturing the most common harming behaviours. | $\boldsymbol{n = 13}$ Not relevant for identifying suicidality, self-harm specific. Doesn't capture all self-harm methods, which is unhelpful and dismissive. May minimise women's harming behaviours if they do not cut or burn themselves, and/or women may think their form of 'harming' is OK because it wasn't included in the question. Women may feel that they need to adopt these types of harming behaviours to receive any help. Could evoke intrusive thoughts. The words 'on purpose' are quite accusatory and may infer blame and/or judgement. | $n = 0$ N/A |
| IDAS, item-43†* *"I thought that the world would be better off without me"* | $n = 4$ May have some utility for starting a conversation. | $\boldsymbol{n = 10}$ Non-validating item, too vague, confusing, and ambiguous. Wouldn't necessarily indicate any suicidality, appears more self-esteem related. Some HCPs may go straight to review/ referral if the item is endorsed which may not be necessary. Women may express suicidality in this way themselves, but the item is not clinically useful for screening. Puts words in a woman's mouth that might not be her experience. Women who do not speak English as a first language may not understand this item. | $n = 1$ The term 'world' could be changed to 'family or friends'. |
| PHQ-9, item-9* *"Have you had thoughts that you would be better off dead, or of hurting yourself in some way?"* | $\boldsymbol{n = 8}$ Useful as an initial screening question. Most HCPs are familiar with this questionnaire. | $n = 6$ Too much information in one item which is confusing. Compound question isn't helpful, need to ask about suicide and self-harm separately. Women may not know how to answer, particularly those who do not speak English as a first language. | $n = 1$ The first and second part of the item should be flipped (e.g., thoughts of 'hurting' first, and then 'better off dead'). |
| PDSS, item-7* *"I started thinking that I would be better off dead"* | $\boldsymbol{n = 11}$ Direct item and clearly more suicide-related than some of the other items. | $n = 4$ Uncomfortable with the word 'dead'. Would prefer this item to be a question rather than a statement. Would require a trusting relationship and time to explore further. Doesn't differentiate between passive and active suicidality. Some HCPs would | $n = 0$ N/A |

(*continued on next page*)

**Table 3** (*continued*)

| Measure, item number, and content | Comfortable, like, and/or useful item | Uncomfortable, dislike, and/or item not useful | Neutral, no response, and/or additional comments |
|---|---|---|---|
| | | not be comfortable administering this item, and/or may change the content. | |
| PDSS, item-14†* *"I've thought that death seemed like the only way out of this living nightmare"* | $n = 2$ Compassionate item that acknowledges how someone might be feeling. | **$n = 13$** Intense, emotive, and confronting item. Uncomfortable with the word 'death'. Puts words in a woman's mouth that might not be her experience. Women who do not speak English as a first language may not understand this item. Not appropriate to use in a questionnaire. | $n = 0$ N/A |
| PDSS, item-21* *"I wanted to hurt myself"* | **$n = 11$** Useful for differentiating thoughts and intent. The word 'hurt' is more all-encompassing than 'harm'. Clear and non-confrontational item. | $n = 2$ The word 'wanted' is not appropriate, women may feel defensive about this. Prefer items that ask about 'thoughts'. | $n = 2$ 'Hurt myself' likely to be interpreted as non-suicidal self-harm, so may not be useful for identifying suicidality. Would need to ask further questions (e.g., 'did/have you hurt yourself'). |
| PDSS, item-28* *"I felt that my baby would be better off without me"* | **$n = 11$** May have some utility for starting a broader conversation about how a woman is coping. Important item and gives women permission to express how they are feeling. May be useful as part of a questionnaire that women complete themselves. | $n = 4$ Women may express this themselves, but not appropriate for HCPs to ask this directly. This item might exacerbate women's fear around child protection services involvement, and/or the wider social expectations of motherhood. Too vague and wouldn't necessarily indicate any suicidality. Some HCPs might not feel comfortable with this item as it could evoke an emotional response. | $n = 0$ N/A |
| PDSS, item-35†* *"I just wanted to leave this world"* | $n = 1$ Gentler way to approach the topic than asking about suicide specifically. | **$n = 12$** Vague, ambiguous, and wouldn't necessarily indicate any suicidality. Not clinically useful as a screening item for suicidality. | $n = 2$ May be useful as part of a questionnaire that women complete themselves. Might be better as a question |

**Table 3** (*continued*)

| Measure, item number, and content | Comfortable, like, and/or useful item | Uncomfortable, dislike, and/or item not useful | Neutral, no response, and/or additional comments |
|---|---|---|---|
| | | Women who do not speak English as a first language may not understand this item. Uncomfortable with the word 'wanted'. | rather than a statement. |
| SRQ-20, item-17 *"Has the thought of ending your life been on your mind?"* | **$n = 7$** Gentler and more explanatory way to approach the topic than using the term 'suicide' directly. 'Ending your life' feels more comfortable than 'suicide' or 'death, dead or kill'. 'Ending your life' may be easier to understand culturally than suicide. | $n = 5$ Remove 'on your mind' as it is unclear and unnecessary. Women who do not speak English as a first language may not understand 'on your mind'. | $n = 3$ N/A |
| Ultra-Short, item-4† *"Has the thought of committing suicide often occurred to you?"* | $n = 1$ N/A | **$n = 14$** The word 'committed' is not appropriate to use. Wouldn't use the word 'suicide' with perinatal women. Remove the word 'often' as it is not useful, and you may miss people. Doesn't tell you anything about suicidal intent. | $n = 0$ N/A |

Notes: (i) reasons given are across participants (e.g., why comfortable with an item or not), and are not individual quotes; (ii) **bold** indicates the highest number of participants per item; (iii) † indicates that most participants were uncomfortable with, disliked and/or saw little utility in the item; (iv) *N/A* = no specific reasons were identified; (v)* the item/measure has been validated in perinatal populations.
Measures: Beck Depression Inventory (BDI) (Beck et al., 1961); Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987); Inventory of Depression and Anxiety Symptoms (IDAS) (Watson et al., 2007); Patient Health Questionnaire-9 (PHQ-9) (Kroenke et al., 2001); Postpartum Depression Screening Scale (PDSS) (Beck and Gable, 2000); Self-Reporting Questionnaire-20 (SRQ-20) (Harding et al., 1980); Ultra-Short Maternal Mental Health Screen (Ultra-Short) (van Heyningen et al., 2019).

services and referral pathways. Themes and subthemes are outlined with illustrative quotes.

### *HCPs attitudes towards suicide-related items*

Of the sixteen suicide-related items assessed, most HCPs said they were uncomfortable with, disliked and/or thought that half of the items were unhelpful for identifying perinatal suicidality. See Table 3 for HCPs evaluation of items, and Table 1 for descriptive summary of items/measures. Nearly all HCPs had negative attitudes towards items that used ambiguous terms for identifying suicidality (e.g., 'I thought about my own death', IDAS, item-14), emotive phrases (e.g., 'I've thought that death seemed like the only way out of this living nightmare', PDSS, item-14) or confronting and judgemental language (e.g., 'I hurt myself purposely', IDAS, item-9). HCPs said that these items were either

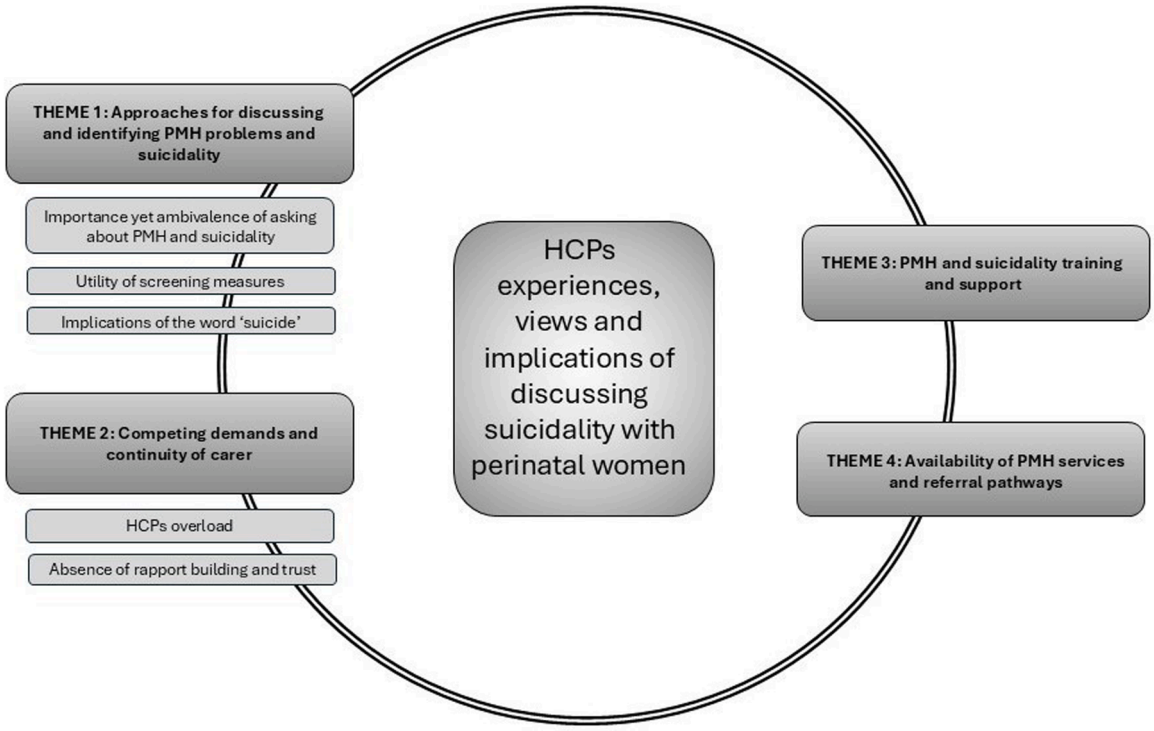


**Fig. 1.** Overview of themes and subthemes.

inappropriate, confusing and/or had little utility. HCPs reported mixed attitudes towards PHQ-9, item-9 ('have you had thoughts that you would be better off dead, or of hurting yourself in some way?') because it encompasses both suicidal and non-suicidal harm. Some HCPs felt that this item had utility for preliminary screening, whereas others said that suicide and self-harm should be asked about separately. HCPs were most comfortable with EPDS, item-10 ('the thought of harming myself has occurred to me'), with a caveat that 'harming' requires further explanation and may not be interpreted to include suicidal thoughts and/or behaviours. Likewise, HCPs thought that PDSS, item-28 ('I felt that my baby would be better off without me') may help open up a conversation around PMH, but not necessarily suicide directly.

### *Theme one: approaches for discussing and identifying PMH problems and suicidality*

HCPs talked about the importance of asking women about PMH throughout pregnancy and after birth, the benefits and limitations of screening measures, and their views for the most appropriate language to use.

#### *Importance yet ambivalence of asking about PMH and suicidality*

HCPs felt that it was necessary and important to routinely discuss PMH with women at every contact and to ask about suicidality at least once in pregnancy and once postnatally to identify women who may require additional support. However, many HCPs said that in practice, there are large disparities in how frequently PMH and suicide-related questions are asked (if at all), which is a pressing issue.

> *"It is a big issue because we're making sure that physically we're ticking all the boxes and knowing everything about women, but we should be doing the same for their mental health, we know it is the number one reason for women dying, it's mind-blowing to me, so yes, we should be asking the questions". (p4)*

Reasons why HCPs may not ask women about PMH and suicidality are captured by subsequent themes. However, HCPs also reported that a lack of standardisation across maternity services may explain some disparities in how suicidality discussions are approached and/or which screening measures are administered. As one HCP explained:

> *"I think it's really important to have a specific screening question for it [suicidality], in a way that we don't currently have, and I think it does need to be direct, because if you just say 'how's your mental health, or have you felt low', you can easily miss people who are struggling". (p9)*

#### *Utility of screening measures*

Likewise, whilst HCPs generally saw value in using screening measures for the initial identification of possible PMH problems and/or suicidality, many also highlighted their limitations. A common concern was that HCPs may become reliant on the outcome of screening measures to provide a picture of a woman's PMH, without engaging in a meaningful conversation about what the responses mean to her, which may result in cases being missed or unnecessary referrals to specialist services.

> *"The caveat for me, for all of these [suicide items] is you can't just ask the questions, you have to be prepared to have the conversation as well". (p15)*

#### *Implications of the word 'suicide'*

Most HCPs stressed the importance of being clear and direct when asking women about suicidal ideation and/or behaviours. However, many thought that using the word 'suicide' was problematic. Reasons included personal discomfort, associated stigma, language translation issues, and cultural and/or religious implications. HCPs also felt that some women may not recognise or conceptualise their distressing thoughts in suicidal terms, which may affect how they respond to such questions. Nearly all HCPs expressed a preference for using the phrase 'end your own life' as this felt less confronting and helped overcome

some of these issues.

> *"I think there is too much stigma associated with the word 'suicide', it's almost a dirty word isn't it… I don't think I've ever had anybody discuss suicidal thoughts using that word actually because I think that word feels too loaded for most women… I can't recall a situation where I've used the word 'suicide' either, and I would actively try and avoid using it in a conversation with perinatal women". (p6)*

*Theme two: competing demands and continuity of carer*

This theme concerns organisational factors that affect HCPs capacity to ask women about PMH and suicidality. HCPs talked about unrealistic expectations and overload in terms of what can be explored during routine appointments, and the difficulty of building rapport with women due to a lack of continuity.

*HCPs overload*

HCPs reported burden, staff-shortages, time and competing demands as important barriers for why PMH and suicidality questions may not be asked during routine antenatal and postnatal appointments. HCPs described overwhelming pressure to complete a multitude of tasks in a minimal timeframe, which compromised their capacity and willingness to ask PMH and suicidality questions. They felt unable to meaningfully engage in such conversations, and/or manage the necessary administration associated with referrals.

> *"For your average midwife that's got 30 women to see, and she's got 10–15 min for each woman, how much is she really gonna wanna ask the question [?]… people don't ask because they don't want to know the answer, because once they've got that on their desk, you've got to action that, you can't not hear what that person's just told you". (p14)*

*Absence of rapport building and trust*

Lack of continuity of carer was highlighted as another implicating factor. HCPs talked about the difficulty of having conversations about PMH and suicidality with a stranger, from both their own and women's perspectives. HCPs felt that women were less likely to be honest about their feelings and experiences because they were unable to have a consistent relationship with one caregiver. Similarly, when continuity is present, HCPs said they felt far better equipped to spot changes in women's mood and discuss this, sometimes without the formality of administering screening questions.

> *"I worked under a continuity model for a period, I got to build up really good relationships with women, so I didn't have to ask them the baseline questions past a certain point because I knew them and they were comfortable to say to me 'X, Y, Z'… I now work in a busy labour ward, and for women, I think it's very difficult to open up to somebody new, and if they have to do that every single time that they encounter someone, that's difficult too". (p5)*

*Theme three: PMH and suicidality training and support*

This theme concerns factors related to PMH and suicidality training and support for HCPs who work with perinatal women, and the implications of this for their confidence, knowledge, and ability to engage in discussions around such topics.

Many HCPs said that there was a lack of PMH and suicidality training available to practitioners working in maternity care contexts, which appeared to be a critical and central issue underpinning their narratives. HCPs talked about being ill-equipped in the necessary communication skills for holding these types of conversations and emphasised the need to provide targeted training. They suggested that a lack of training reinforced biases and assumptions regarding who might or might not be at risk of suicide, exacerbated fears that asking suicide-related may have iatrogenic effects, and created barriers for identifying women from different ethnic backgrounds. Several HCPs described feeling unsafe with the responsibility of asking women about suicide, both in terms of knowing what to do if it is endorsed and the potential impact this may have upon their own mental health.

> *"I as a perinatal mental health midwife have not been able to source and access suicide risk assessment training… so with my cold-hearted clinician head on, I don't want to take responsibility for risk assessing something that I'm not trained to do, because I don't want to stand in front of the coroner and say 'well, I did this but, no I wasn't trained to do it, so therefore I got it wrong'… so I am holding the risk on that, and I don't feel safe holding it… I think a lot of clinicians sit with this constant feeling like 'I'm only ever one suicide away from my own mental breakdown', because you know, how does that impact you as a clinician when that happens, and that's a lot for people to take on". (p6)*

HCPs also highlighted the need for better understanding and support in maternity care regarding the mental health wellbeing, personal experiences, and differing cultural and/or religious beliefs of practitioners, because suicide-related conversations have the potential to be highly distressing for them too.

> *"I'm a healthcare professional, but I'm also a human being, my colleagues are all human beings, you don't know what their lives have been, you don't know what their story is, and for some, they've had their own perinatal experiences which they haven't even come to terms with themselves… we all have different religious beliefs, we've all got different things, so there's a lot of that as well". (p12)*

*Theme four: availability of PMH services and referral pathways*

This theme concerns the impact of overburdened services and unclear pathways for making referrals for women who require PMH and/or suicidality support.

Many HCPs described feeling conflicted about asking PMH or suicide-related questions due to a lack of and/or limited capacity within mental health services to support women who are experiencing PMH difficulties. HCPs felt that it may do more harm to ask women these types of questions because referrals are often rejected or there are long waiting lists for treatment, which may leave women in a more vulnerable position. HCPs said that when women open up about their feelings, not being able to offer them any support was difficult to manage emotionally. They also thought that this may leave women with a sense of unimportance, which could exacerbate their PMH problems.

> *"A massive issue is the fact that mental health services are so underfunded, so we have a perinatal mental health team and I know for a fact they won't see you unless you're kind of actively suicidal and planning to do it… the awful thing is when women say 'yes I am [feeling suicidal] and I need some help, and we go, well we can't really help you', which almost makes it worse". (p9)*

When PMH referrals are made, HCPs also expressed a need for more clarity regarding the appropriate care pathways in different maternity contexts. HCPs felt there was often uncertainty around how, where, when, and to whom referrals should be escalated, and they emphasised the importance of providing this information to all HCPs who work with perinatal women.

> *"Referral pathways need to be really clear for everybody, what gets referred, how it gets referred, and I think that every maternity unit should have a crisis pathway, which incorporates what to do if you're in the community, what to do if you're attending a home birth or what to do if you're in the hospital setting, so that when they [women] disclose a*

*thought, you follow that pathway… we need better collaborative working and better shared learning". (p12)*

## Discussion

This study explored the views, experiences and implications of discussing suicide with pregnant and postnatal women from the perspective of HCPs who currently work (or previously worked) in a maternity care context. It also explored HCPs attitudes towards 16 suicide-related screening items in terms of their comfort, like and/or the perceived utility for using these with perinatal women. Findings indicated that most HCPs felt uncomfortable (and/or disliked or did not see utility) with half of the items assessed. HCPs further reported that their capacity and willingness to ask women about suicidal ideation and/or behaviours was significantly impacted by factors such as scope within their role (e.g., burden and time constraints), the absence of continuity, a lack of PMH and suicidality training and support, insufficient PMH services, and unclear referral pathways. Previous research has identified similar HCP perceived barriers in relation to PMH more generally (e.g., Bayrampour et al., 2018). However, this study makes an important contribution to the literature concerning perinatal suicidality specifically. In the following paragraphs, the study findings are discussed, with a focus on implications for practice.

Many HCPs talked about the value of screening measures for the initial identification of PMH problems and/or suicidality (given certain conditions and limitations). However, most HCPs said they felt uncomfortable with half of the suicide-related items assessed, largely due to item content. Some HCPs also said they would not want to use the word 'suicide' with perinatal women due to stigma, personal discomfort, and cultural or religious differences. This created tension between wanting to be clear and direct yet avoiding certain language. Wider suicide awareness training maintains that it is necessary to be direct and use unambiguous language when asking about suicidality to prevent any misunderstanding (e.g., LivingWorks, 2024). However, the specific nature of the perinatal period needs to be taken into account when asking about suicide during this time because it can present unique barriers and implications for disclosure. Many HCPs said they preferred to use the phrase 'end your own life' with pregnant and postnatal women. Whilst there is limited research that has examined maternity HCPs attitudes towards the content of suicide-related screening items, Dudeney et al. (2024) found that many existing suicide-related items are unacceptable to pregnant and postnatal women in their current form. Taken together, these findings have important implications for identifying women who may be experiencing suicidality using commonly administered measures. For example, evidence suggests that HCPs may avoid asking suicide-related questions, and/or negatively frame such questions if they feel uncomfortable (Ford et al., 2021; Lau et al., 2015; McCabe et al., 2017, 2023), and the content of screening items may cause confusion, evoke fear and/or distressing emotions, or reinforce stigma, which may result in cases being missed (Dudeney et al., 2024). It is also necessary to consider whether HCPs (particularly midwives) are best placed to conduct PMH screening within the capacity of their role. Whilst screening offers a pragmatic solution in busy maternity settings, HCPs often have little time during routine appointments to meaningfully engage in conversations about PMH and/or suicidality, and a lack of continuity of carer may create barriers to disclosure. Continuity of carer is important for developing trusting relationships between women and their caregivers and has been linked to improvements in PMH outcomes (Cibralic et al., 2023). It is imperative that approaches for identifying perinatal suicidality are developed that do not significantly increase maternity HCPs burden, and that where screening measures are used, these are appropriate and acceptable to both HCPs and women.

Lack of PMH and suicidality training underpinned HCPs concerns and hesitancy to engage in suicide-related conversations with women, which is consistent with previous research (Bayrampour et al., 2018; Holland et al., 2018; Lau et al., 2015; McCauley et al., 2012). Many HCPs said that PMH and suicidality screening should only take place when there is capacity for meaningful and informed conversation. It was apparent that HCPs often felt ill-equipped to hold these types of conversations because they had not received the necessary training to develop skills, knowledge and confidence in this area. The absence of PMH and suicidality training for maternity HCPs has far-reaching consequences in terms of identifying women who require additional support. Implications include: (i) missed opportunities for intervention and/or specialist PMH referrals; (ii) misidentification of cases and/or unnecessary referrals; (iii) perpetuation of PMH and suicide stigma, assumptions and biases; and (iv) negative psychological impact on HCPs, and/or women. HCPs also talked about cultural and religious differences, and translation barriers for women who do not speak English as a first language. Several HCPs said that it was particularly important to understand and sensitively address ethnic disparities in PMH and suicidality, but this was frequently overlooked in practice due to lack of awareness and training. Previous research has similarly highlighted the need for PMH cultural competence training to be integrated into healthcare settings (Watson et al., 2019). It is therefore vital for PMH and suicidality training to be available to all HCPs working with perinatal women from the earliest opportunity. This may help increase HCPs confidence and willingness to discuss suicidality with women and encourage a more woman-centred approach to care.

Lastly, despite considerable investment in PMH services over the past few years (National Health Service, 2017, 2019), there are still gaps in distribution and access, and especially in terms of service provision for women who do not meet the threshold for specialist care (Maternal Mental Health Alliance, 2022). HCPs stressed the impact and implications of these deficits for asking perinatal women about suicidality. Key concerns related to not being able to support women who endorsed suicidal ideation or behaviours because referrals were often rejected, and/or long waiting times for non-urgent psychological therapies. Many HCPs described feeling conflicted in wanting to identify women at risk of suicidality, but feared leaving women in a more vulnerable position if they were unable to offer any PMH care. Likewise, HCPs said that these issues were further compounded by a lack of clarity on different service pathways in maternity contexts and/or how to escalate referrals to the appropriate teams. Whilst barriers to PMH service provision and referrals have been well documented in the literature (e.g., Bayrampour et al., 2018; Webb et al., 2023), it is of particular concern that HCPs working with perinatal women feel deterred from asking about suicidality because they are unable to access timely and appropriate care. Given that suicide remains the leading cause of maternal death in many countries, there is a need for urgent prioritisation of collaborative working, integrated care, and shared learning between maternity HCPs and secondary services to improve outcomes for women. It is important to acknowledge the benefits of a multidisciplinary approach to PMH care (e.g., employing midwives and registered mental health nurses in primary maternity services) as this may help to address and overcome some of the issues discussed above. This approach is also vital for the wellbeing and safety of maternity HCPs, who are at the forefront of pregnant and postnatal women's care. As one HCP stated, *'the current system is totally broken, I mean if you want a conclusion for your work, I would say that is the conclusion' (p.6)*.

### *Strengths, limitations, and future research*

Recruitment of HCPs from different professional backgrounds across the UK is a strength of this study. A range of experiences and expertise were captured, and the sample included HCPs working with both pregnant and postnatal women. However, two-thirds of participants were midwives. Whilst the authors made every effort to recruit all roles working in PMH, only one community PMH nurse and one health visitor took part. It will be important to understand the views of mental health nurses and health visitors in future research. Furthermore, participants

were not asked to disclose their gender identification. Inferences cannot be made in this regard, but it may be beneficial to explore the attitudes, experiences, and perspectives of male HCPs and HCPs who do not identify as female as their views may differ to those expressed in this research. Likewise, most participants were White British, which has implications in terms of cultural differences, religious beliefs, and attitudes towards PMH and suicidality. Evidence suggests that PMH and suicidality remains taboo, stigmatised and/or poorly understood amongst some ethnic groups and in low-and middle-income countries (Insan et al., 2022; Watson et al., 2019). It is important for future research to look at the perspectives of HCPs from more diverse cultural backgrounds as unique factors may influence their approach towards identifying and supporting women with PMH problems and/or suicidality in maternity care. Lastly, it was beyond the scope of this study to address HCPs attitudes towards the response options or mode of administering suicide-related screening items (e.g., face-to-face, complete prior to an appointment, etc.). However, these are significant issues to consider in terms of additional screening barriers for identifying women who may require support.

### *Conclusions*

HCPs working in maternity contexts are in a key position to identify PMH problems including suicidality. However, HCPs face numerous barriers that affect their willingness and capacity to engage in PMH and suicide-related discussions with women. HCPs may not feel comfortable with the content of some suicide-related screening items, and it is important to take account of the pressures, burden and limitations of their role when developing appropriate approaches for identifying suicidality in these settings. PMH and suicide training and support also needs to be embedded within maternity HCPs early education and ongoing professional development. This is crucial for building the necessary knowledge, confidence and skills to have difficult conversations with perinatal women that do not reinforce stigma or judgement, or negatively impact HCPs own mental health wellbeing. Continued investment in specialist PMH services is needed to enable HCPs to make timely referrals for women who require support, and to ensure that they can access appropriate care.

## Ethical statement

This research was approved by the School of Health and Psychological Sciences Research and Ethics Committee (SHPS REC) at City, University of London prior to recruitment and data collection (reference number: ETH2122–0828).

## Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors

## CRediT authorship contribution statement

**Elizabeth Dudeney:** Writing – original draft, Project administration, Methodology, Formal analysis, Data curation, Conceptualization. **Rose Meades:** Writing – review & editing, Supervision, Formal analysis, Conceptualization. **Susan Ayers:** Writing – review & editing, Supervision. **Rose McCabe:** Writing – review & editing, Supervision.

## Declaration of competing interest

All authors declare that they have no conflicts of interest.

### *Data availability statement*

The datasets generated and analysed for the current study are not publicly available due to the sensitive nature of the data.

### *Acknowledgements*

We would like to thank Aneta Zarska who conducted confirmatory coding for a percentage of the data analysis for this study. We would also like to thank all the healthcare practitioners who participated in this study for their time, and for their open and honest views on a sensitive topic.

## Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2025.104309.

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