

Perinatal Suicide in Ireland

A Briefing Paper



Mental
Health
Reform

This document offers a concise, exploratory examination of perinatal mental health and maternal suicide. It is not exhaustive. Its primary purpose is to highlight areas of concern and provide a starting point for further discussion, research, and policy development.

About Mental Health Reform

Mental Health Reform (MHR) is Ireland's leading national coalition on mental health. Our vision is of an Ireland with accessible, effective and inclusive mental health services and supports. We drive the progressive reform of mental health services and supports, through coordination and policy development, research and innovation, accountability and collective advocacy. Together with our 80+ member organisations and thousands of individual supporters, MHR provides a unified voice to the Government, its agencies, the Oireachtas and the general public on mental health issues.

Glossary of Terms

Perinatal period: the time during and after a pregnancy which can be linked to distinct mental health risks. It is also known as the peripartum period.

Maternal Deaths: a category used in research to refer to death occurring during the perinatal period. This includes:

Direct deaths: those resulting from complications or treatment of pregnancy or birth

Indirect deaths: those resulting from a condition that pre-existed or emerged during pregnancy that was aggravated by the effects of pregnancy

Late deaths: deaths occurring between six weeks and one year after a birth that were linked to maternal causes.

A Note on Language

In this paper, we use the term 'women' when referring to data collected under maternal mortality classifications and 'pregnant people' when discussing perinatal mental health risk more broadly, in recognition that not all people who become pregnant identify as women.

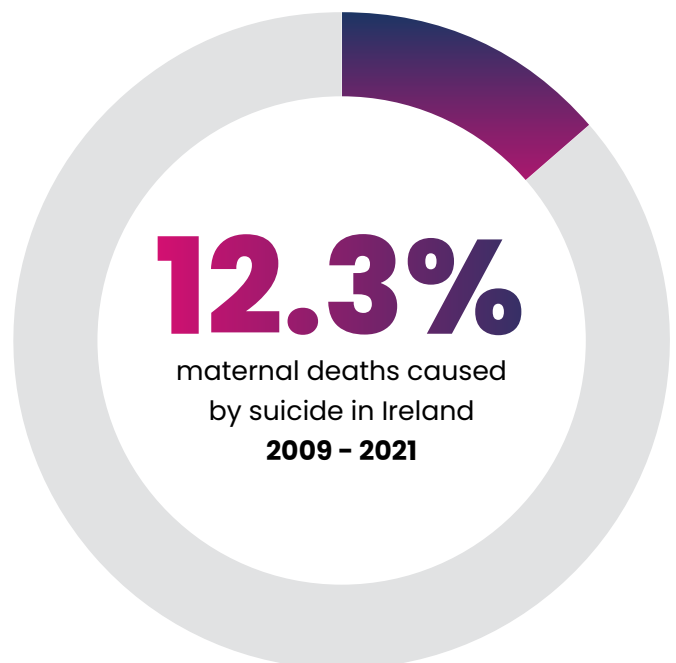
Introduction

While women are far less likely to die by suicide than men (with males accounting for over 77% of suicide deaths in Ireland in 2022) women are more at risk of suicidal thoughts and ideation as well as non-fatal self-harm¹. Furthermore, at particular times, and in particular contexts the risk of dying by suicide among women and people assigned female at birth increases significantly. One of these instances is in the time following giving birth. This can be seen in Ireland through investigations into maternal deaths (see Glossary for definition).

Based on findings from 2025 and previous years the Maternal Deaths Enquiry Ireland stated that “... **suicide was and remains (i) the leading direct cause of maternal death; and (ii) the leading cause of late maternal deaths in Ireland.**”². Between 2019 and 2021 24 maternal deaths were examined, and 8 were due to suicide, and between 2009 and 2021 suicide accounted for 12.3% of maternal deaths³. The enquiry also observed that maternal suicide rates had increased significantly in recent years compared with the previous decade (2009 – 2019)⁴. A similar pattern is evident in the United Kingdom, where suicide is the leading cause of late maternal deaths – defined as those occurring between six weeks to one year after the end of pregnancy⁵.

Furthermore, in the United Kingdom risk of suicide after pregnancy is particularly high among people living in deprived areas, or who have other social risk factors such as domestic abuse.

Suicide is the leading cause of late maternal deaths in Ireland.



1 <https://www.sciencedirect.com/science/article/abs/pii/S0165032711001492>

2 <https://www.ucc.ie/en/media/research/maternaldeathenquiryireland/MDEIrelandDataBriefNo8.pdf>

3 <https://www.ucc.ie/en/media/research/nationalperinatalepidemiologycentre/documents/>

MaternalDeathEnquiryReport2019–2021.pdf

4 <https://www.ucc.ie/en/media/research/maternaldeathenquiryireland/MDEIrelandDataBriefNo8.pdf>

5 <https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2025/MBRRACE-UK%20Maternal%20Report%202025%20-%20Main%20ONLINE%20v1.0.pdf>

Why is suicide risk increased during and after pregnancy?

According to the World Health Organisation, 10% of pregnant people, and 13% of people who have just given birth experience a mental health condition⁶. Following giving birth people are at a notably higher risk of being admitted for treatment of a psychotic illness, even more so when they have a history of mental health difficulties. This elevated risk persists for at least two years following delivery.

Having postnatal psychosis significantly increases the risk of suicidal ideation and suicide attempt⁷. It is not fully clear how postpartum psychosis develops, although risk factors such as pre-existing mental health conditions, stress and mental health difficulties may increase the likelihood of it occurring⁸. Other mental health conditions that can occur in the months following giving birth, such as depression and obsessive-compulsive disorder also increase likelihood of maternal suicide.

Features of maternal suicide deaths include^{9 10} :

- Rapid progression of severe mental health difficulties
- Under-recognition of illness or severity
- Violent mode of suicide



6 <https://www.who.int/teams/mental-health-and-substance-use/promotion-prevention/maternal-mental-health>

7 <https://www.sciencedirect.com/science/article/pii/S2666915322000713#abs0001>

8 <https://pmc.ncbi.nlm.nih.gov/articles/PMC10759251/#sec2>

9 <https://bmjopen.bmj.com/content/bmjopen/9/3/e025872.full.pdf>

10 <https://www.cmaj.ca/content/189/34/E1085.short>

Perinatal mental health services in Ireland

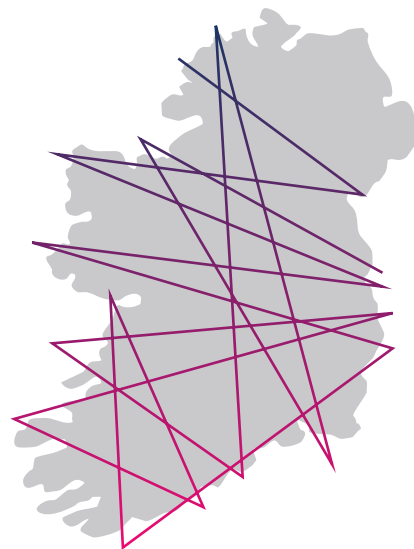
Ireland's national mental health policy, *Sharing the Vision*, acknowledges the specific mental health needs during the perinatal period (see Glossary for definition) and calls for the continued resourcing of a national model of care for specialist perinatal mental health. The Specialist Perinatal Mental Health Services Model of Care (2017) established a hub-and-spoke model across Ireland, staffed by specialist practitioners providing care during the perinatal period. The hub and spoke model is composed of the 19 maternity services in the country with the six hubs containing a specialist perinatal mental health service. These services are staffed by a multidisciplinary team and are linked with the perinatal mental health midwives based in all of the 13 'spoke' hospitals.

A commitment to perinatal mental healthcare is further reflected in the recent allocation of funding for such specialist services, including progress towards a Mother and Baby Unit (MBU) for the country. The HSE Capital Plan for 2025 allocated funding to support feasibility and preparatory work for an MBU co-located with the new National Maternity Hospital in Dublin¹¹. MBUs enable parents experiencing significant mental health difficulties to receive inpatient psychiatric care while remaining with their infants, supporting bonding and participation in infant care.

Evidence from international settings indicates that MBUs are associated with better maternal mental health outcomes and improved parent–child relationships compared to alternative models of care^{12,13}.

The HSE also provides public information on perinatal mental health difficulties, including depression, psychosis, and obsessive–compulsive disorder¹⁴. People experiencing suicidal ideation are advised to contact their GP or support services such as the Samaritans¹⁵.

It should be noted however, that perinatal mental health difficulties may be brought about or exacerbated by traumatic birth experiences. One report shows how some birthing people in Ireland believed that their autonomy and capacity to consent to or refuse care are not always respected¹⁶. This suggests that there may be serious issues with adherence to HSE consent guidelines and the provision of trauma-sensitive obstetric care.



11 https://about.hse.ie/api/v2/download-file/file_based_publications/HSE_Capital_plan_2025.pdf/

12 <https://www.cambridge.org/core/journals/bjpsych-open/article/mother-and-baby-units-matter-improved-outcomes-for-both/3C06E9782438723AEF31843101DCC386>

13 <https://pmc.ncbi.nlm.nih.gov/articles/PMC4425328/>

14 <https://www.hse.ie/eng/services/list/4/mental-health-services/specialist-perinatal-mental-health/>

15 <https://www.hse.ie/eng/services/publications/mentalhealth/postpartum-psychosis.pdf>

16 <https://www.ul.ie/media/53121/download?inline>

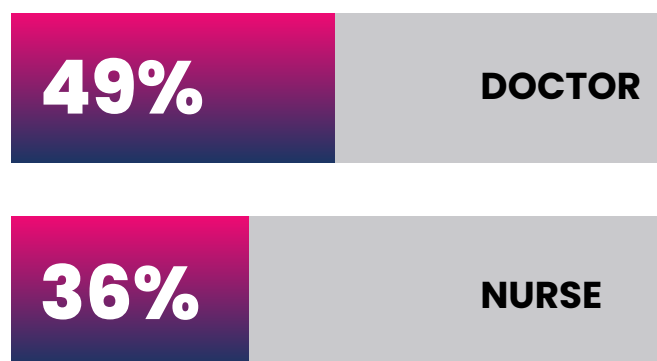
Defining Perinatal Suicide and Gaps in Detection

Perinatal suicidality differs in presentation and risk profile from suicidality at other life stages, underscoring the importance of clear definitions for both clinical practice and data collection. Maternal death is typically defined as any death occurring during pregnancy or within 42 days of the end of pregnancy, excluding incidental or accidental causes. Deaths occurring between 42 days and one year after giving birth are classified as late maternal deaths, a category that captures deaths resulting from delayed pregnancy-related complications and suicides that remain strongly influenced by perinatal factors. Notably, the majority of maternal suicides occur during this late maternal period.

Despite this evidence, Sharing the Vision defines perinatal mental health within a narrower window, from 22 weeks' gestation to seven days after birth¹⁷. In practice, postnatal follow-up by a GP or community health nurse typically occurs within the first six weeks following giving birth. While this timeframe may be adequate for monitoring physical recovery, it is insufficient for identifying mental health difficulties or suicidality that emerge after 42 days. The National Maternity Strategy (2016–2026) further assigns responsibility for identifying perinatal depression to primary care, without specifying mechanisms for extended monitoring beyond the early postpartum period¹⁸.

Although NICE standards are incorporated into Ireland's *Specialist Perinatal Mental Health Services Model of Care*¹⁹, including the expectation that new parents are asked about their emotional wellbeing at every routine antenatal and postnatal contact, research suggests these standards are inconsistently implemented. Longitudinal research on maternal healthcare in Ireland found that at a 3-month postpartum health visit 49% of people were not asked about low mood or depression by their doctor, and almost 36% were not asked by their public health nurse²⁰. When mental health concerns are not proactively raised, service users perceive a lack of knowledge or openness among providers, reducing the likelihood of disclosure and increasing the risk of undetected distress and suicidality^{21 22}.

3 MONTHS POSTPARTUM



were not asked about low mood or depression

17 <https://assets.gov.ie/static/documents/sharing-the-vision-a-mental-health-policy-for-everyone.pdf> p.57

18 <https://assets.gov.ie/static/documents/national-maternity-strategy-creating-a-better-future-together-2016-2026.pdf>

19 <https://www.hse.ie/eng/services/list/4/mental-health-services/specialist-perinatal-mental-health/specialist-perinatal-mental-health-services-model-of-care-2017.pdf>

20 <https://link.springer.com/article/10.1007/s00737-025-01670-2#Abs1>

21 <https://www.tandfonline.com/doi/full/10.1080/02646838.2012.743000>

22 <https://onlinelibrary.wiley.com/doi/10.1111/j.1523-536X.2006.00130.x>

The Impact of Maternal Suicide

There is a significant and lasting personal loss associated with every suicide death, including one that occurs in the perinatal period.

Research by the Maternal Mental Health Alliance indicated that a case of perinatal depression, anxiety or psychosis comes with societal cost equivalent to £35,000 to £74,000 (or €40,000 to €84,700)²³. These figures represent the significant impact of perinatal mental health difficulties – increased use of public services, loss of quality-adjusted life years, and productivity loss.

Perinatal mental health difficulties are linked with suicide and suicide attempts and all of these things can have a lasting negative impact on children²⁴. Therefore, it is vital that further health services invest in early detection and treatment of mental health difficulties in the perinatal period.

€40,000
- €84,700

Societal Cost of a case of perinatal depression, anxiety or psychosis

23 https://maternalmentalhealthalliance.org/media/filer_public/93/c2/93c20c08-0253-494e-8340-9d27e6b8041b/costs_perinatal__mental_2014.pdf

24 <https://link.springer.com/article/10.1007/s11920-017-0857-8>

Conclusion

Recent years have seen increased awareness of perinatal mental health difficulties and the need for specialist support to address them. Irish health services have increased investment and development of specialist perinatal mental health services in turn. These services, including a Mother and Baby Unit in the future are vital for addressing perinatal mental health difficulties. However, suicide persists as a leading cause of maternal death, suggesting that more efforts are needed to detect poor perinatal mental health and to intervene in a timely manner. It is clear that community and medical appointments during and six weeks after pregnancy are not adequately addressing mental health needs as they arise.

While perinatal mental health training and research are occurring in Ireland they are not delivered under any formal national structure²⁵. This leaves general health practitioners feeling unprepared to manage perinatal mental health difficulties and prevents people from accessing mental health support referrals. It is important that people with perinatal mental health difficulties are directed to specialist services via contact with other healthcare services to ensure earlier detection and treatment of postpartum mental health difficulties and risk of suicide. To achieve this, healthcare staff should be trained to recognise and address signs of poor mental health, as well as providing trauma-sensitive care.

It is clear that community and medical appointments during and six weeks after pregnancy are not adequately addressing mental health needs as they arise.

Further research is needed to better understand the pathways to maternal suicide and the barriers to timely intervention within existing services. A coordinated national conversation, supported by ongoing evaluation, structured national training, and open policy dialogue, is essential to strengthen detection and improve referral pathways, service integration, and specialist care provision, including extended monitoring beyond the early postpartum period.

25 https://www.researchgate.net/publication/377657369_Specialist_perinatal_mental_health_services_future_developments_to_meet_the_needs_of_families

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