ADVANCING RESEARCH TO PREVENT PERINATAL SUICIDE: EXECUTIVE SUMMARY

WHY THIS MATTERS AND WHAT WE DID

Suicide is a leading and largely preventable cause of maternal death, yet perinatal suicide prevention remains underdeveloped compared with other areas of maternal health and suicide prevention.

We brought together 63 stakeholders, including 21 individuals with lived experience, and guided the group through a structured, multi-phase process that included pre-convening learning, Delphi surveys, a national convening, and post-convening thematic review and prioritization to produce a patient-centered comparative clinical effectiveness research (PC/CER) agenda.

CROSS CUTTING PRIORITIES

Across project phases, participants consistently emphasized five system-level domains that must be addressed for effective perinatal suicide prevention:

- **Risk stratification:** Moving beyond one-size-fits-all screening toward tools that identify who is at highest risk, detect changes over time, and prompt timely escalation of care.
- **Data and evidence generation:** Better alignment between perinatal mental health and suicide prevention data systems to support coordinated action and learning.
- **Technology and innovation:** Thoughtful use of telehealth, digital tools, and emerging technologies to expand access and precision, particularly in rural or under-resourced settings.
- **Payment and sustainability:** Financing models that support integrated, team-based, risk-informed care across pregnancy and the postpartum period.
- **Coordination and continuity:** Clear roles, timely communication, and sustained follow-up across obstetric, pediatric, mental health, peer, and community systems.

KEY THEMATIC AREAS

- **Pregnancy as Prevention:** Using pregnancy to identify risk early and strengthen protective supports.
- **Community & Family Engagement:** Equipping community and family members to recognize risk and support wellbeing.
- **Prepared Perinatal Workforce:** Ensuring clinicians can recognize, address, and respond to suicide risk.
- **Peer Support:** Providing trusted, lived-experience support and connection.
- **Integrated Obstetric Care:** Embedding suicide care across all levels of perinatal care, from prevention through treatment, with continuous follow-up throughout the postpartum period.
- **Connected Mental Health Systems:** Ensuring access to the right level of appropriate mental health care at the right time.

TEN HIGHEST PRIORITY RESEARCH QUESTIONS

1. What strategies best ensure ongoing mental health monitoring and support through the first two years after birth—particularly during the high-risk 6–12 month postpartum period—and clarify who should lead this care based on where postpartum people seek and prefer services?

2. Which care coordination or navigation models most effectively link obstetric, pediatric, and primary care teams with mental health services to ensure timely, collaborative, and sustained suicide prevention care—and how do perinatal individuals and families experience these transitions, including the coordination practices that most enhance safety, trust, and continuity?

3. How can we better define and address role-specific educational needs and competencies across the perinatal care continuum to ensure all disciplines—clinical and community-based—are prepared to recognize, respond to, and help prevent perinatal suicide in ways that improve patient-centered outcomes, including satisfaction with care, safety, and timely access to support?

4. How can flexible payment and reimbursement models, including the unbundling of perinatal care payment, be leveraged to expand access to integrated, continuous, patient-centered perinatal mental health and suicide prevention care?

5. How can perinatal suicide and mental health screening within pregnancy or postpartum care be designed to reduce stigma, build trust, strengthen engagement, and better identify those at highest risk?

6. How does personalized risk awareness (e.g., knowing one's risk profile) cultivated in pregnancy influence help-seeking, engagement in supports, and mental health outcomes during the postpartum period?

7. How can technology-enabled and innovative care models—such as cross-state perinatal access programs or virtual intensive outpatient programs—be optimized and scaled to extend high-quality, specialized mental health and suicide prevention care to resource-limited or rural settings, and how do these models compare with less specialized local in-person care in effectiveness, accessibility, and patient experience?

8. What proven and scalable models of integrated behavioral health can be implemented or adapted to reduce perinatal suicide risk?

9. What proven tools or system processes can be implemented in or adapted to the perinatal context—across both frontline perinatal care and mental health settings—to rapidly identify high-risk individuals and guide them to timely, intensive care?

10. Which proven and scalable postpartum depression prevention or community-based suicide prevention programs can be implemented or adapted to reduce perinatal suicide risk?

FROM SHARED INSIGHT, TO SHARED ACTION

This work is a beginning, not an endpoint. It is an invitation to align effort and investment around areas of greatest shared need and potential impact. It is also a call for cross-system collaboration, recognizing that preventing perinatal suicide requires coordinated action—and sustained support.

On behalf of the project team, we offer deep thanks to all who shared their time, expertise, and lived experience. Your voices shaped this roadmap, and your continued partnership will shape what comes next. Our hope is simple and profound: that this roadmap accelerates patient-centered research capable of transforming care—leading to safe pregnancies, more supported postpartum periods, and lives saved.

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