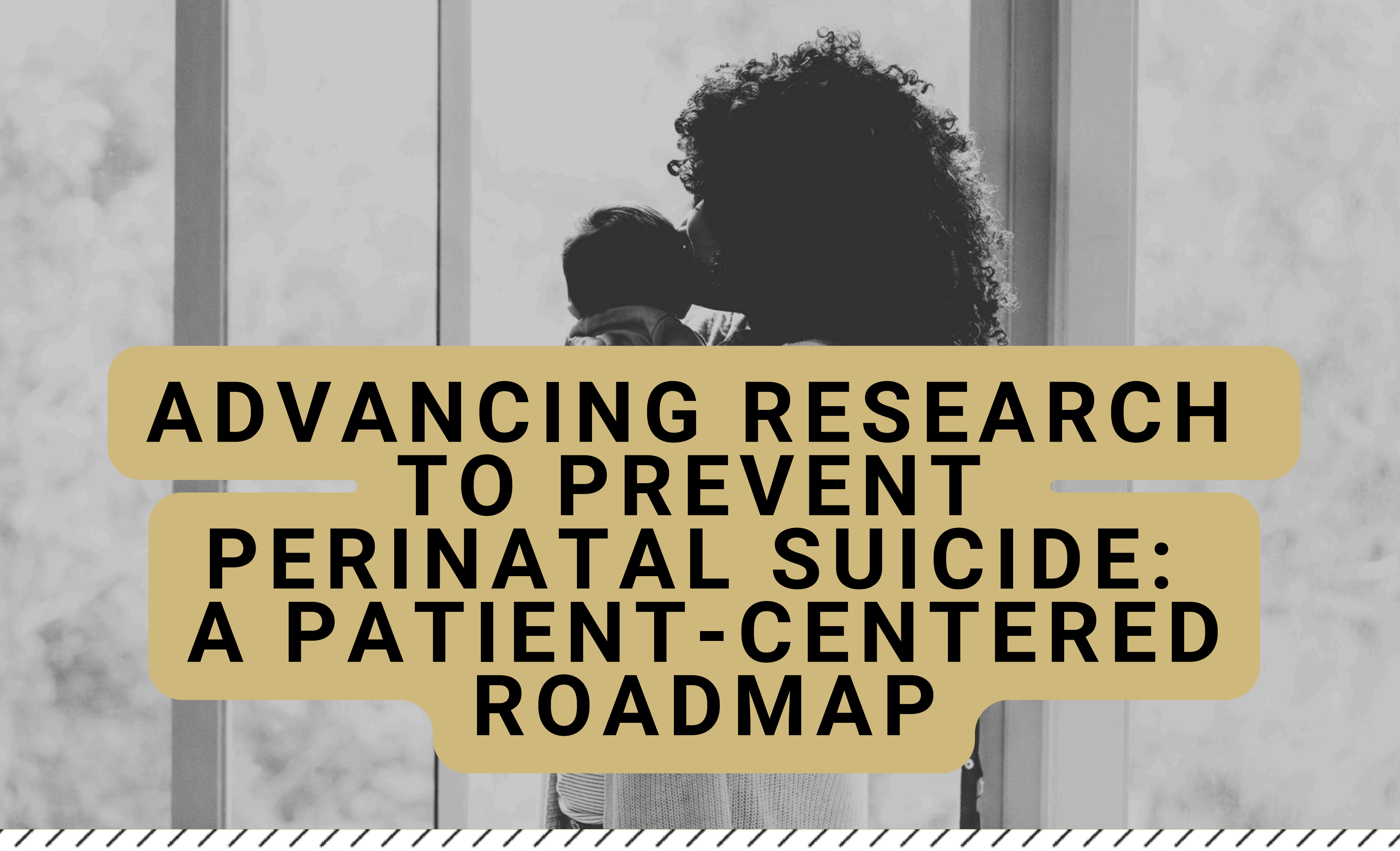

ADVANCING RESEARCH TO PREVENT PERINATAL SUICIDE: A PATIENT-CENTERED ROADMAP

Project Lead: Sarah Nagle-Yang, MD
Project Team Members: Michael Allen, MD and Brooke Dorsey, PhD, MA

Funding Statement: This project was supported by the Patient-Centered Outcomes Research Institute (PCORI) Eugene Washington PCORI Engagement Award (EASCS 38478). The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of the funder.

Author: Sarah Nagle-Yang, MD
Graphic Design: Lily Woytek, MPH

Citation: Nagle-Yang S. (2025) Research Agenda to Advance Maternal Suicide Prevention Research Priorities.

Table of Contents

Executive Summary

Why this roadmap: 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.

What we did: Convened 63 stakeholders (including 21 with lived experience) and used a structured process (pre-learning, Delphi surveys, convening, thematic review, refinement survey and prioritization survey) to identify a patient-centered comparative clinical effectiveness research (PC/CER) agenda.

What this delivers:
- 5 cross-cutting system domains
- 6 thematic areas with key problems and ranked research questions
- 10 highest-priority research questions across themes

Intended use: To guide researchers, funders, and systems leaders toward the areas of greatest shared need and potential impact in preventing perinatal suicide.

Acknowledgements

The project team extends heartfelt gratitude to everyone who helped bring this *Perinatal Suicide Prevention Research Roadmap* to life. It was made possible through the generosity, insight, and patience of many people who care deeply about advancing perinatal suicide care through research grounded in the realities of our healthcare systems and informed by those most impacted.

First, to our lived experience partners—the patients and family members who shared stories that were brave and deeply human— thank you for reminding us that research should never be done about people without being informed by them. Your insights guided not just what questions we asked, but how we asked them, and kept this roadmap anchored in the experiences of those most affected.

To our steering committee— whose collective wisdom and steady leadership kept this project moving forward from concept to convening to completion. They not only helped define the vision but also recruited key voices, bridged disciplines, and made sure that every discussion stayed focused on meaningful, patient-centered impact.

To our thematic review team, who worked during and after the convening to turn an avalanche of ideas into clear, researchable priorities—your diligence, focus, and commitment to getting it right shaped the strength and clarity of this roadmap.

We are deeply grateful to our organizational partners—Postpartum Support International; Lifeline for Moms; the American Foundation for Suicide Prevention; the Zero Suicide Institute; the American College of Obstetricians and Gynecologists (ACOG); the American Academy of Pediatrics (AAP); the American Psychiatric Association (APA); the Maternal Mental Health Leadership Alliance (MMHLA); the Marce of North America (MONA); the Policy Center for Maternal Mental Health; the Colorado Department of Public Health and Environment (CDPHE) Maternal Mortality Prevention Program; the National Network of Depression Centers (NNDC); the National Curriculum in Reproductive Psychiatry (NCRP); Cherished Mom; You Are Not Alone (YANA); the North American Society for Psychosocial Obstetrics and Gynecology (NASPOG); and the Colorado Perinatal Care Quality Collaborative (CPCQC). Each brought distinctive expertise and a shared commitment to ensuring that the roadmap reflects both the science and the lived reality of perinatal mental health.

To the many clinicians, researchers, policy professionals, and peer supporters who lent their time and creativity—thank you for speaking honestly about what works, what doesn’t, and what might, and that we don’t need to reinvent the wheel.

We extend sincere appreciation to the University of Colorado School of Medicine Department of Psychiatry, especially Matthew Nichols and Claudia Ianelli, for their behind-the-scenes coordination and logistical support, and to the Patient-Centered Outcomes Research Institute (PCORI), whose Eugene Washington PCORI Engagement Award made this convening and roadmap possible.

Introduction

Suicide is a leading and largely preventable cause of maternal death in the United States, where maternal mortality remains higher than in other industrialized countries and disproportionately affects Black individuals, rural residents, and people insured through Medicaid. State maternal mortality review committees estimate that nearly all perinatal suicide deaths are preventable.

Despite this, most maternal mental health efforts have centered on screening and treatment for perinatal depression within traditional obstetric care models, which provide intensive monitoring during pregnancy but limited follow-up after birth—precisely when suicide risk peaks. At the same time, decades of work in suicide prevention have yielded effective strategies (for example, means safety, suicide-specific treatments, and structured follow-up care) that have not been fully adapted to the perinatal context.

This project was designed to bridge that gap. Supported by a Eugene Washington PCORI Engagement Award, it brought together lived experience partners, clinicians, researchers, public health leaders, and policy partners to co-develop a patient-centered comparative clinical effectiveness research (PC/CER) agenda focused specifically on perinatal suicide prevention.

The roadmap that follows translates this engagement process into cross-cutting system domains, thematic areas, and concrete PC/CER questions intended to guide future research, policy, and implementation efforts.

Project Methodology

This project unfolded in three main phases: pre-convening preparation, a two-day hybrid convening, and a post-convening synthesis and prioritization process.

1. Pre-Convening

The pre-convening phase focused on building a strong foundation for collaborative work: engaging diverse stakeholders, refining the scope and structure of the convening, and ensuring that participants arrived with a shared language and baseline understanding.

Steering Committee and Modified Delphi Process

The steering committee included the project team and ten additional partners representing diverse disciplines and lived experience perspectives. The committee met three times prior to the convening and played an essential role in shaping the project's direction. Members helped clarify project goals, refine stakeholder representation, and identify emerging topical areas, ensuring that the work remained grounded in patient-centered values and real-world practice.

As part of this phase, the team used a modified Delphi process to refine and prioritize topics for the convening.

- Round 1 surfaced a wide range of potential PC/CER questions related to perinatal suicide prevention. Qualitative feedback highlighted the need for clear, feasible, and actionable questions that accounted for access barriers, equity, and real-world behavior change.
- Round 2 synthesized these inputs into a more focused set of priority topics, which ultimately shaped the structure and agenda of the convening.

Asynchronous Learning Series

To support a shared foundation of knowledge across participants, the project team developed an asynchronous learning series delivered through a learning management system. The seven-session series mirrored the convening agenda and included brief readings, videos, and reflection exercises.

The learning series was designed to "level set" expertise among lived experience partners, clinicians, researchers, and policy leaders so that all participants could engage meaningfully regardless of their prior exposure to maternal mental health or suicide prevention frameworks.

Pre-Convening Participant Survey

A pre-convening survey further clarified what participants needed to engage fully and meaningfully. Respondents reported that they were most engaged when:

- Discussions were inclusive and grounded in lived experience
- Expectations and objectives were clear
- The environment felt psychologically safe and nonjudgmental

Participants emphasized the importance of shared language and accessible framing, especially for those not working in traditional clinical or research roles. They also highlighted the need for space to reflect, ask questions openly, and acknowledge the emotional weight of perinatal suicide.

Potential barriers to engagement included:

- Overly technical content presented without sufficient context
- Conversations that moved too quickly or assumed prior expertise
- Discussions that did not meaningfully incorporate lived experience perspectives or that left power dynamics unaddressed

These insights directly informed the facilitation approach, agenda pacing, and integration of lived experience throughout the convening.

2. Convening

The hybrid convening, held September 11–12, 2025, brought together sixty-three (63) stakeholders—forty-six (46) in person and seventeen (17) virtually—with representation across lived and learned experience, clinical care, research, policy, and peer support. Participants included:

- Twenty-one (21) individuals with lived experience
- Fifty (50) clinicians across obstetric, pediatric, primary care, nursing, behavioral health, and social work roles
- Twenty-three (23) researchers
- Seventeen (17) policy leaders
- Seven (7) peer supporters

Structure and Facilitation

The meeting opened with patient and family stories that grounded the group in the lived reality of perinatal suicide risk. Additional lived experience narratives were intentionally woven throughout the two days, aligned with specific discussion topics to keep emerging ideas anchored in real-world experiences.

Small-group sessions formed the core of the convening. Each small group worked on structured virtual white boards designed to:

- Capture ideas and experience
- Surface gaps and system failures
- Articulate potential directions for PC/CER

This format supported cohesive participation across in-person and virtual attendees and created a real-time visual record of group thinking. Facilitators encouraged attention to patient-centered outcomes, feasibility, equity, and implementation considerations.

Real-Time Thematic Synthesis and Member Checking
In parallel, the thematic review team monitored emerging patterns across the virtual white boards and plenary discussions. The team synthesized early insights and conducted two rounds of member checking during the convening. These iterative check-backs allowed participants to:

- Review preliminary thematic groupings
- Refine wording and sharpen the intent of proposed ideas
- Ensure that emerging directions accurately reflected the perspectives in the room

Plenary sessions periodically brought participants back together to share cross-group insights, identify cross-cutting issues, and learn from one another's approaches. Throughout, the project team intentionally applied what participants had named in the pre-convening survey as essential for meaningful engagement: accessible framing, opportunities for clarification, and intentional, non-tokenizing inclusion of lived experience contributions.

3. Post-Convening: Synthesis, Refinement, and Prioritization

The post-convening phase focused on turning the rich qualitative output into a coherent, stakeholder-validated research agenda.

Participant Feedback on Convening Experience
A post-convening survey assessed participants' experiences of the convening structure and process. Respondents affirmed that the meeting fostered psychological safety and meaningful collaboration. They highlighted:

- The value of mixing lived experience partners with clinicians and researchers in small groups
- The transparency and usability of the virtual white boards
- The grounding effect of lived experience stories woven throughout the agenda

Participants also identified opportunities for improvement, including a desire for more time in small-group discussions and clearer synthesis between breakout and plenary sessions. They called for ongoing attention through the conclusion of the project to balancing clinical, research, and lived experience voices.

Collaborative Thematic Review and Classification

Following the convening, the project moved into a structured synthesis and refinement phase. The project team first compiled outputs from the plenary discussions and the virtual white boards and, with support from AI-assisted analytic tools, developed initial thematic summaries, key problem statements, and draft research priorities. These preliminary materials were then reviewed by the thematic review team, who refined and consolidated the content to strengthen coherence, clarity, and alignment with PC/CER.

To validate and deepen the synthesis, refinement surveys tailored to each theme were distributed to selected subsets of participants whose lived or learned experience aligned with that topic. Respondents were asked to assess whether the distilled summaries accurately reflected convening discussions, captured essential nuances and equity considerations, and aligned with real-world practice and lived experience. Their feedback led to revisions that improved the precision, relevance, and face validity of the evolving materials.

Following this step, the steering committee revisited the full set of synthesized outputs. They distinguished system-level insights that functioned as cross-cutting domains from theme-specific problems tied to particular parts of the perinatal care system and further refined each category to reduce overlap and strengthen relationships among domains, themes, key problems, and research priorities.

Prioritization Survey

Finally, all convening participants were invited to complete a prioritization survey designed to identify which research questions were viewed as most urgent, actionable, and likely to improve patient-centered outcomes. Participants first ranked research priorities within each theme, then selected their top five across all identified questions. The results of this process informed:

- The rank-ordering of research questions within each theme
- The identification of the ten highest-priority questions across themes

Together, these steps translated a broad set of stakeholder ideas into a clear, organized, and stakeholder-prioritized research roadmap for advancing perinatal suicide prevention.

Identified Cross-Cutting Domains, Themes, Key Problems and Research Priorities

This section brings together the core building blocks of the roadmap.

- **Cross-cutting domains** describe the broad, system-level levers that shape every aspect of perinatal suicide prevention. They address the "how" of the work, such as how data are collected and used, how care is financed and coordinated, and how technology is integrated into practice.
- **Themes** focus on the "who, what, and when" of prevention: who needs to be involved, what supports and interventions are needed, and when along the perinatal continuum they should occur.
- **Key problems** summarize the most pressing gaps, barriers, and system failures identified by stakeholders within each theme.
- **Research priorities** are rank-ordered PC/CER questions that emerged from this process as the most important and actionable avenues for future study.

Together, these elements provide a structured way to move from lived and learned experience to testable questions that can guide future research, policy, and implementation.

Identified Cross-Cutting Domains

1. Risk Stratification

Across all themes, participants emphasized the need for a more precise, risk-stratified approach to perinatal suicide prevention. Current models often apply the same screening and follow-up practices to everyone, rather than tailoring the intensity and frequency of care to each individual's level of risk. Participants called for strategies that enable proactive identification of those at highest risk and are supported by tools that account for prior history, psychosocial stressors, social determinants of health, and evolving factors such as sleep deprivation or trauma exposure. A robust risk-stratification framework must also include mechanisms for detecting changes in risk over time and ensuring that individuals can access the right level of care immediately when higher-intensity support is needed.

2. Data and Evidence Generation

Participants emphasized that many effective data systems and evidence-based programs already exist but remain misaligned with the goals of perinatal suicide prevention. National and state platforms generate valuable information on maternal health yet do not easily connect

across systems to inform coordinated action. Similarly, proven perinatal mental health interventions often overlook suicide outcomes, while established suicide prevention frameworks have not been adapted to the unique clinical, social, and family contexts of the perinatal period.

3. Technology and Innovation

Innovation was viewed as a powerful lever to close gaps in access, engagement, and precision of care. Participants highlighted that digital platforms—such as telehealth, online therapy, and app-based supports—can extend specialized mental health care to individuals who would otherwise go without, particularly in rural or resource-limited areas. However, their impact depends on equitable access, training, and thoughtful integration into existing systems. Emerging technologies such as AI-assisted screening, wearable monitoring, and biomarker-informed risk assessment hold promise for early detection and personalized care, but require rigorous evaluation to determine when, how, and for whom they are most effective.

4. Payment and Sustainability

Participants consistently noted that reimbursement structures remain a major barrier to integrated, continuous perinatal mental health and suicide care. Current payment models often separate mental health and obstetric services, lack parity in coverage and reimbursement, and do not adequately support evidence-based integrated care models. As a result, team-based approaches—such as the collaborative care model, perinatal access programs, and coordinated follow-up systems—are difficult to sustain, particularly in the later postpartum period when suicide risk is highest. Participants emphasized the need for financing strategies that both enforce mental health parity and intentionally support integrated care through flexible, risk-informed payment structures capable of delivering stepped supports ranging from prevention to intensive psychiatric treatment. Research and policy innovation are needed to design and evaluate payment systems that prioritize sustainability, coordination, continuity, and measurable improvements in perinatal mental health outcomes.

5. Coordination and Continuity

Improving coordination across systems and sectors was a unifying theme throughout the convening. Participants emphasized that effective suicide prevention requires an all-hands-on-deck approach in which everyone—community helpers, peer supporters, obstetric and pediatric clinicians, and mental health providers—plays a role in identifying, responding to, and supporting individuals at risk. For this approach to be effective, roles must be clearly defined so that each participant in the system understands their scope, responsibilities, and points of connection to others. Coordination must be structured around timely communication, risk-informed escalation, and consistent follow-up that aligns with each individual’s level of need.

Identified Themes and Associated Key Problems and Research Priorities

Theme 1: Pregnancy as an Opportunity for Prevention and Resilience-Building

Why this theme matters
Pregnancy offers a rare and powerful opportunity to prevent mental health crises before they begin. It is one of the few times when we can clearly anticipate a high-risk period—the postpartum months—and take proactive steps to strengthen resilience, connection, and support. It is also a time when many individuals are deeply motivated to prioritize their health and receptive to guidance that benefits both themselves and their families. Harnessing this motivation creates an unparalleled window to promote prevention and well-being.

Where participants saw unmet needs and research opportunities
Participants emphasized that prevention must extend beyond the healthcare system to include community and cultural strategies that raise awareness, reduce stigma, and reframe how we think about maternal mental health. Public awareness campaigns and education efforts can help shift culture to recognize both the joy and the vulnerability of the perinatal period—celebrating motherhood and infancy while keeping the well-being and joy of the mother at the center.

Prevention efforts should increase understanding of protective factors unique to the perinatal period and build knowledge—among clinicians, pregnant individuals, and families—about the factors that contribute to personal risk for developing perinatal mental health conditions or suicidal thoughts and behaviors. Evidence-based programs that reduce the risk of postpartum depression should be scaled, disseminated, and rigorously evaluated for their impact on suicide-specific outcomes.

Finally, prenatal and postpartum care models must move beyond symptom response to proactive, risk-informed approaches—tailoring monitoring and care intensity for those most at risk, as is standard for other complex health conditions. This includes implementing structured, consistent methods to identify key risk factors—such as a history of suicide attempt or family history of postpartum mental illness—upon entry into care and using shared decision-making to tailor monitoring and supports to individual preferences and needs.

Key Problems

- Pregnancy, though a highly motivated period for health engagement, is not leveraged as a proactive window for mental health promotion or suicide prevention.
- Public awareness of the vulnerability of the postpartum period is limited, and stigma continues to prevent open conversation about maternal mental health.
- Routine perinatal care remains reactive—focused on identifying symptoms rather than preventing them or strengthening protective factors.
- No validated, user-friendly risk prediction tools exist to identify individuals at highest risk for perinatal mental health conditions or suicide.
- Evidence-based prevention programs for postpartum depression are not widely scaled, implemented, or evaluated for suicide-specific outcomes.
- Partners and families are rarely engaged as proactive supports in promoting wellness or recognizing early warning signs.

Ranked Research Priorities

1. Which proven and scalable postpartum depression prevention or community-based suicide prevention programs can be implemented or adapted to reduce perinatal suicide risk?
2. 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?
3. How effective are public awareness and communication campaigns in normalizing the vulnerability of the perinatal period and centering maternal well-being as a shared social priority?
4. What is the effectiveness, feasibility, and acceptability of digital interventions and tools (eg., app-based screening, wearables, EHR-based alerts) for early detection and monitoring of suicide risk in perinatal populations?

Theme 2: Community and Family Engagement in Prevention

Why this theme matters

Participants emphasized that preventing maternal suicide requires broad community engagement. "Community helpers"—including doulas, home visitors, lactation consultants, faith leaders, coworkers, and family members—often represent the first line of recognition and support during pregnancy and the first year after birth. Yet many lack the skills or confidence to identify warning signs, respond effectively when someone expresses distress or suicidal thoughts, or connect them with appropriate care.

Where participants saw unmet needs and research opportunities

Participants called for a tiered, risk-stratified approach to community engagement. At the broadest level, general awareness efforts and community helper training should promote understanding of perinatal mental health, reduce stigma, and normalize open conversation about distress and suicide risk. For individuals at higher risk, support should extend to shared safety planning and coordinated communication with clinical care teams to ensure timely escalation and follow-up.

Mapping where perinatal individuals spend their time—and who they most trust and want involved in their care—was viewed as essential to tailoring education, outreach, and support. Participants also highlighted the potential for digital platforms to strengthen connection and coordination by sharing information, resources, and safety plans among individuals, families, and providers. Evaluation should include equity, cultural relevance, and patient-reported outcomes to ensure approaches are trustworthy and acceptable in diverse communities.

Key Problems Identified

- Many community members and families lack awareness of perinatal mental health warning signs, feel uncertain about how to ask about suicide risk, and are unfamiliar with available resources.
- Even when distress is recognized, most do not know how to respond safely, offer meaningful support, or connect someone to appropriate care.
- Fear of stigma, child welfare involvement, or hospitalization often prevents open conversations about suicidal thoughts or emotional distress.
- Evaluation of community helper training remains limited, with little evidence specific to perinatal suicide prevention.

Ranked Research Priorities

1. How can the distinct and complementary roles of doulas, home visitors, peers, faith leaders, employers, and family members be leveraged to strengthen early identification, compassionate response, and coordinated connection to care?
2. How can existing evidence-based community helper training programs be adapted to the perinatal context (eg., addressing barriers such as child welfare concerns or the overlapping challenges of sleep deprivation, role transition, and parenting) to improve recognition, response, and referral for mental health and suicide risk?
3. How can digital and hybrid tools be designed to support community helpers in a risk-stratified prevention model—offering broad education and resources while enabling real-time coordination, safety planning, and family engagement for those at higher risk?

Theme 3: Workforce Training

Why this need matters
A recurring theme was the urgent need to strengthen provider education at every level. Participants agreed that training is necessary—but not sufficient—to transform perinatal mental health care. Education must focus on building both knowledge and clinical skills, fostering shared accountability across disciplines, and ensuring that learning translates into sustained improvements in practice.

Where participants saw unmet needs and research opportunities
They emphasized the importance of integrating perinatal mental health competencies early in medical, nursing, psychology, clinical social work, and other health professional programs so that all disciplines view this as a core part of their role. Training must include both knowledge acquisition and clinical skill development to prepare providers for real-world implementation. Continuing education was viewed as equally essential—reaching providers across roles and settings while clearly defining the scope and expectations for each discipline. Competencies should be tailored not only to providers' skill levels and practice environments but also to their specific functions within the care team—for example, differentiating the knowledge and skills required of psychiatrists, OB/GYNs, family physicians, pediatricians, midwives, bedside nurses, social workers, and peer supporters.

Education should be skills-based, interactive, and innovative, using methods such as simulation, case-based learning, and team-based exercises. Integrating patient and family experiences was viewed as critical to shifting culture, deepening empathy, and grounding education in the lived realities of perinatal individuals.

Key Problems Identified
- Mental health and suicide care remain insufficiently normalized as core components of perinatal clinical practice.
- Many providers feel unprepared to address suicide risk, with limited training, low confidence, and fear of saying the wrong thing—creating barriers to open, nonjudgmental conversations about suicidal thoughts and behaviors.
- Role-specific competencies for perinatal mental health and suicide care are not clearly defined or embedded in training standards, leading to inconsistent preparation across disciplines and settings.
- Existing training opportunities are often didactic and underutilized, lacking the interactive, team-based, and simulation methods needed to build confidence and real-world skill.

Ranked Research Priorities

1. 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?
2. What educational approaches (e.g., case-based learning, simulation, ongoing consultation, inclusion of lived experience) most effectively build clinicians' knowledge, skills, and confidence in perinatal mental health and suicide care, and lead to sustained improvements in both practice and patient-centered outcomes such as safety, engagement, and trust?

Theme 4: Peer Support as a Core Safety Net in Perinatal Suicide Prevention

Why this theme matters

Participants described peer support as an evidence-based and uniquely trusted bridge into care for perinatal individuals experiencing distress or suicidality. Peers often elicit a level of honesty and openness that is harder to achieve in clinical settings, yet their roles remain under-supported and insufficiently integrated into formal systems of care.

Where participants saw unmet needs and research opportunities

Discussions highlighted the particular challenges of higher-acuity situations—such as acute postpartum psychosis—where clinical providers are often underprepared to respond, and peers may feel uncertain about their scope. Participants stressed that while peer support is vital for engagement and recovery, it cannot replace clinical treatment. To ensure safety and sustainability, they emphasized the need for robust clinical partnership—especially structured, high-quality supervision that provides peers with ongoing guidance, emotional support, and clear escalation pathways. Peers also described the ethical tension between preserving trust and ensuring safety, underscoring the importance of standardized protocols. Overall, participants framed peer support as a core safety net that requires infrastructure, not improvisation.

Key Problems Identified

- Peer support remains inconsistently recognized and integrated within perinatal mental health systems, leading to variability in referral pathways, supervision structures, and collaboration with licensed providers.
- Peer roles are often undercompensated and lack opportunities for professional growth, contributing to workforce instability and undermining the value of lived experience expertise.

- Limited awareness and underutilization of peer support programs within community and clinical settings.
- Peers are often the first trusted contact, creating potential tension between maintaining this unique relationship and escalating for safety if adequate training or infrastructure is not provided.
- There is limited research on the effectiveness of peer support in reducing suicide risk among perinatal individuals, resulting in a lack of data to guide evidence-based implementation.
- Workforce wellness gaps persist, as peers experience emotional strain and vicarious trauma when not provided with regular supervision, consultation, or protected support time.

Ranked Research Priorities

1. Which proven and scalable peer support programs can be implemented or adapted to reduce perinatal suicide risk?
2. Which peer support program components (eg., training, clinical co-management plans, escalation plans) most effectively strengthen coordination across the care team for individuals with moderate to severe mental health needs or suicide risk?
3. How can peer workforce systems be structured to promote emotional sustainability, safety, and collaboration—supporting peers as integral members of a coordinated, all-hands-on-deck approach to perinatal mental health and suicide prevention?

Theme 5: Integration of suicide care into routine perinatal systems

Why this theme matters

Participants emphasized that the current system of perinatal care is fragmented and poorly aligned with the realities of postpartum mental health risk. Obstetric care, as it is currently structured, was not designed for suicide prevention—and it typically ends just as risk peaks. Most women are discharged from obstetric care by six weeks postpartum, yet the highest risk for suicide occurs between six and twelve months after birth, when many are no longer in contact with any healthcare provider for their own medical needs.

Where participants saw unmet needs and research opportunities

This disconnect leaves a critical gap in care. Pediatric visits are frequent during this period, but both mothers and pediatric clinicians often view the baby, not the mother, as the patient, creating barriers to addressing maternal mental health. Adult primary care could fill this void, yet few reproductive-age individuals are consistently engaged in primary care, and no clear

model exists for postpartum follow-up in that setting. *We lack a comprehensive map of where postpartum people seek care, which clinicians are providing postpartum care (if any), and who postpartum people most trust and want to lead this part of their care.*

Screening practices are inconsistent, and the field lacks clear, patient-centered evidence about how to design screening and follow-up processes that reduce stigma, build trust, and reliably identify those at highest risk. Even when screening occurs, it often does not lead to comprehensive assessment or timely follow-up.

Participants also named a structural barrier: many obstetric clinicians report that they do not have time or feel unequipped to address suicide risk within routine visits. Without clear expectations, team-based supports, and aligned payment structures, suicide-prevention tasks fall to the margins—mirroring patterns seen in other areas of medicine before national standards and financial incentives clarified roles and enabled operational change.

These realities reinforce why integrated care models are essential structural solutions. Evidence-based models already exist, but they are not widely implemented or scaled. Participants emphasized the need for payment structures and implementation supports that would allow integrated, team-based models to scale—models with clear pathways for screening, assessment, and follow-up; well-defined roles; structured communication and escalation processes; and the reimbursement mechanisms required to make this shared work possible.

Research is needed to test how best to implement and adapt these existing models in perinatal settings—ensuring early identification, coordinated response, and sustained follow-up through the first two years after birth. The unbundling of obstetric payment models presents a timely opportunity to redesign postpartum care around personalized, risk-informed care, rather than a one-size fits all approach.

Key Problems

- Obstetric care ends just as suicide risk peaks, leaving a gap in the high-risk 6–12 months postpartum period with no clear model for who “owns” ongoing mental health care.
- Best practices for how, when, and by whom perinatal mental health and suicide risk screening should occur remain undefined, and screening often fails to ensure comprehensive assessment and follow-up.
- Perinatal clinicians across obstetrics, pediatrics, and adult primary care lack the infrastructure, team support, training, and reimbursement needed to integrate behavioral health care, and access remains uneven across geography, insurance, and culture.

- Rigid payment models and care structures limit opportunities to increase access to evidence-based continuous, patient-centered mental health support throughout the postpartum or evidence-based integrated care models within diverse perinatal settings.
- Evidence-based perinatal mental health integrated care models are not widely scaled, implemented, or evaluated for suicide-specific outcomes.

Ranked Research Priorities

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. 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?
3. 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?
4. What proven and scalable models of integrated behavioral health can be implemented or adapted to reduce perinatal suicide risk?

Theme 6: Mental Health System Coordination, Access, and Continuity of Care

Why this theme matters

Participants underscored that the current landscape of perinatal mental health care is deeply fragmented and fails to meet the needs of patients and families. Mental health services often operate outside traditional medical systems, with little coordination between levels of care. Within this fragmented landscape, even when perinatal mental health specialty programs exist, they are frequently invisible—poorly known to healthcare providers, community organizations, and families who need them most. Yet for most communities, such programs do not exist at all. Services that accept insurance are exceedingly rare, and availability declines sharply as the intensity of care increases—few regions offer accessible perinatal-focused IOP, PHP, or inpatient treatment. This lack of structure and awareness forces perinatal clinicians, patients, and families to navigate a complex, resource-poor system precisely when they are least able to do so—during a period of profound physical and emotional vulnerability. The result is delayed or lost opportunities for life-saving intervention.

Where participants saw unmet needs and research opportunities

To strengthen transitions and ensure patients receive the right care at the right time, participants recommended developing standardized, perinatal-specific pathways and levels-of-care guidelines—analogous to obstetric tiers—that define referral thresholds, communication expectations, and shared responsibility across settings. They emphasized that expanding perinatal access and consultation programs is critical to building the infrastructure needed for equitable care. These programs, along with new care coordination frameworks, can support frontline clinicians, enhance communication across systems, and increase awareness and appropriate utilization of perinatal mental health services. Participants also highlighted the importance of developing virtual adaptations of perinatal IOP and PHP programs to extend access to individuals in low-density or otherwise poorly resourced areas, ensuring that specialized care is not limited by geography.

Key Problems Identified

- Paucity of specialized perinatal mental health services, which becomes increasingly severe as acuity increases (IOP, PHP, inpatient).
- Absence of perinatal-specific referral pathways and guidance on appropriate levels of care across outpatient, intensive outpatient program (IOP), partial hospital program (PHP), and inpatient settings.
- Lack of defined and reimbursable care coordination roles or infrastructure, leaving transitions and communication to individual clinicians or patients themselves.
- Significant geographic disparities, with rural and frontier regions often lacking any specialized perinatal mental health services.
- Underutilization and uneven awareness of existing perinatal mental health programs, both among providers and patients.
- Limited evidence exists to guide when perinatal-specific telehealth services are most effective compared to in-person, non-specialized care in resource-limited or rural settings where specialized services are scarce.

Ranked Research Priorities

1. 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?

2. 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?
3. 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?
4. How can advances in precision medicine and biomarker research from treatment-resistant depression be implemented or adapted to predict treatment response and guide individualized care for perinatal mental health conditions?

Ten Highest-Priority Research Questions Across Themes

After participants completed the prioritization survey, first ranking research priorities within each theme, they were then asked to select their top five across all twenty identified research priorities. The questions below represent the ten that rose to the top. Each of these was selected by at least twenty-five percent of respondents, indicating broad agreement across lived experience partners, clinicians, researchers, policy leaders, and peer supporters about their urgency and potential impact.

These ten questions are presented in rank order and reflect the areas where stakeholders believe research is most needed to advance meaningful, patient-centered improvements in perinatal suicide prevention.

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? **(Theme 5)**

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? **(Theme 6)**

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? **(Theme 3)**

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? **(Theme 5)**

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? **(Theme 5)**

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? **(Theme 1)**

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? **(Theme 6)**

8. What proven and scalable models of integrated behavioral health can be implemented or adapted to reduce perinatal suicide risk? **(Theme 5)**

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? **(Theme 6)**

10. Which proven and scalable postpartum depression prevention or community-based suicide prevention programs can be implemented or adapted to reduce perinatal suicide risk? **(Theme 1)**

Closing Remarks

This roadmap reflects the insight and generosity of a deeply committed community who came together with a shared purpose: to reduce preventable suffering and save the lives of perinatal individuals and families. The clinicians, researchers, peer supporters, lived experience partners, and policy leaders who joined this process represent some of the most dedicated voices in the field, and their commitment is both real and powerful.

Across months of engagement, participants voiced a consistent message: we do not lack concern, commitment, or promising interventions. What we lack is alignment—clear, actionable evidence to guide where to focus our efforts, how to adapt effective suicide-prevention strategies to the perinatal context, and how to build systems capable of timely, connected, compassionate care. Participants were also clear-eyed about the broader landscape: readiness, capacity, and even basic awareness of perinatal suicide risk vary widely across the country.

Much of perinatal care occurs in settings without specialized resources, where clinicians are already stretched thin and suicide prevention is not yet seen as a core responsibility. This roadmap does not assume systemwide readiness. Instead, it provides the patient-centered evidence base needed to build that readiness and to clarify the essential questions required for evidence-based solutions to take root beyond the small number of well-resourced programs represented in this process. The priorities that follow reflect the real questions patients, families, and frontline clinicians ask every day—questions that require rigorous PC/CER to answer.

This work is a beginning, not an endpoint. It is an invitation to researchers, funders, clinicians, lived experience partners, communities, and policymakers to direct energy and investment toward areas of greatest shared need and potential impact. It is also a call for cross-system collaboration, recognizing that no single sector can prevent perinatal suicide alone—and that broad adoption will ultimately require structural support from governmental, accreditation, and payment systems.

On behalf of the project team and steering committee, we extend deep appreciation to all who contributed their time, expertise, and stories. Your voices shaped this roadmap, and your continued partnership will shape the future of perinatal mental health and suicide prevention.

Our hope is simple and profound: that this roadmap accelerates research capable of transforming care—and that those research-driven improvements lead to safer pregnancies, more supported postpartum periods, and lives saved.

Appendix

Appendix A. Steering Committee Members

Dr. Michael Allen, Dr. Nancy Byatt, Andrea Clark Horton, Meghan Cliffel, Dr. Brooke Dorsey, Dr. Julie Frew, Dr. Julie Goldstein Grument, Adrienne Griffen, Dr. Jill Harkavy-Friedman, Dr. Emily Miller, Dr. Sarah Nagle-Yang, Jessica Orenstein, Dr. Michael Rudd

Appendix B. Thematic Review Team

Dr. Michael Allen, Dr. Anna Buttlaire, Dr. Allison Dempsey, Dr. Brooke Dorsey, Dr. Lindsay Lebin, Dr. Lindsay Standeven, Dr. Ricardo Villareal

Appendix C. Partnering Organizations

Postpartum Support International; Lifeline for Moms; the American Foundation for Suicide Prevention; the Zero Suicide Institute; the American College of Obstetricians and Gynecologists (ACOG); the American Academy of Pediatrics (AAP); the American Psychiatric Association (APA); the Maternal Mental Health Leadership Alliance (MMHLA); the Marce of North America (MONA); the Policy Center for Maternal Mental Health; the Colorado Department of Public Health and Environment (CDPHE) Maternal Mortality Prevention Program; the National Network of Depression Centers (NNDC); the National Curriculum in Reproductive Psychiatry (NCRP); Cherished Mom; You Are Not Alone (YANA); and the North American Society for Psychosocial Obstetrics and Gynecology (NASPOG); Colorado Perinatal Care Quality Collaborative (CPCQC)