

Maternal Suicide in the U.S. 2022: The Latest Research & Data Collection Efforts

Hosted by 2020 Mom



September 2022

2020Mom.org

Meet Joy



Joy Burkhard, MBA

Executive Director

2020 Mom



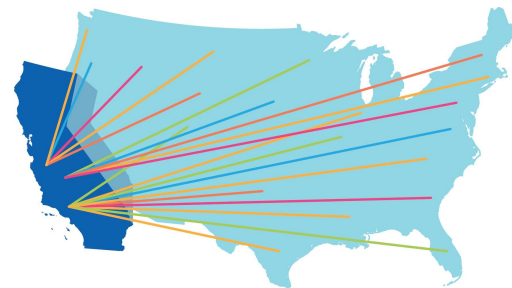
Visionaries for the Future of Maternal Mental Health

Who is 20/20 Mom?

Mission: To close gaps in Maternal Mental Health Care.



Visionaries for the Future
of Maternal Mental Health



We believe if families, employers and society are paying for health care benefits, the health care system should detect and treat MMH disorders.



Visionaries for the Future of Maternal Mental Health

Meet Our Panelists



Susanna Trost, MPH

CDC Foundation Epidemiologist, Maternal Mortality Prevention Team, Division of Reproductive Health, Centers for Disease Control and Prevention (CDC)



Lisa Klein, DNP

Program Coordinator for Maternal Mortality Review, Delaware Maternal & Child Death Review Commission



Visionaries for the Future of Maternal Mental Health

Meet Our Panelists



Jaime Cabrera, MPH

Executive Director, Colorado
Perinatal Care Quality Collaborative
(CPCQC)



Cindy Herrick, MA, CPSS, MHFA

Strategic Partnerships & Special Projects
2020 Mom



Visionaries for the Future of Maternal Mental Health

What We Will Cover

A general overview of maternal suicide statistics in the US

Updated data from the CDC on Maternal Mortality Review Committees (MMRCs) and pregnancy-related suicide deaths

How states are improving suicide detection in their MMRC process, including the role of informant interviews in identifying maternal suicide deaths, a process adopted by the Delaware MMRC and others

2020 Mom's latest issue brief- suicide tracking and prevention

Colorado's latest report illustrating suicide is the top cause of maternal death, and efforts the PQC is championing

Challenges & Opportunities



A Moment of Silence & Trigger Warning



Visionaries for the Future of Maternal Mental Health

Pregnancy-Related Deaths: Manner of Death Suicide

Susanna Trost, MPH
CDC Foundation Epidemiologist
Maternal Mortality Prevention Team
CDC Division of Reproductive Health



Disclosure

- I have no potential conflicts of interest to disclose
- The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of the U.S. Centers for Disease Control and Prevention (CDC) or CDC Foundation

U.S. National-Level Maternal Mortality Data



National Vital Statistics System

- **Maternal deaths** (death of a person *while pregnant or within 42 days* of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes)
- Identified using death records



Pregnancy Mortality Surveillance System

- **Pregnancy-related deaths** (death of a person *while pregnant or within 1 year* of the end of a pregnancy –regardless of the outcome, duration or site of the pregnancy–from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes)
- Identified using death records and linkage with birth/fetal death records
- Reviewed by CDC medical epidemiologists

Both systems exclude deaths from external causes of injury including suicide.

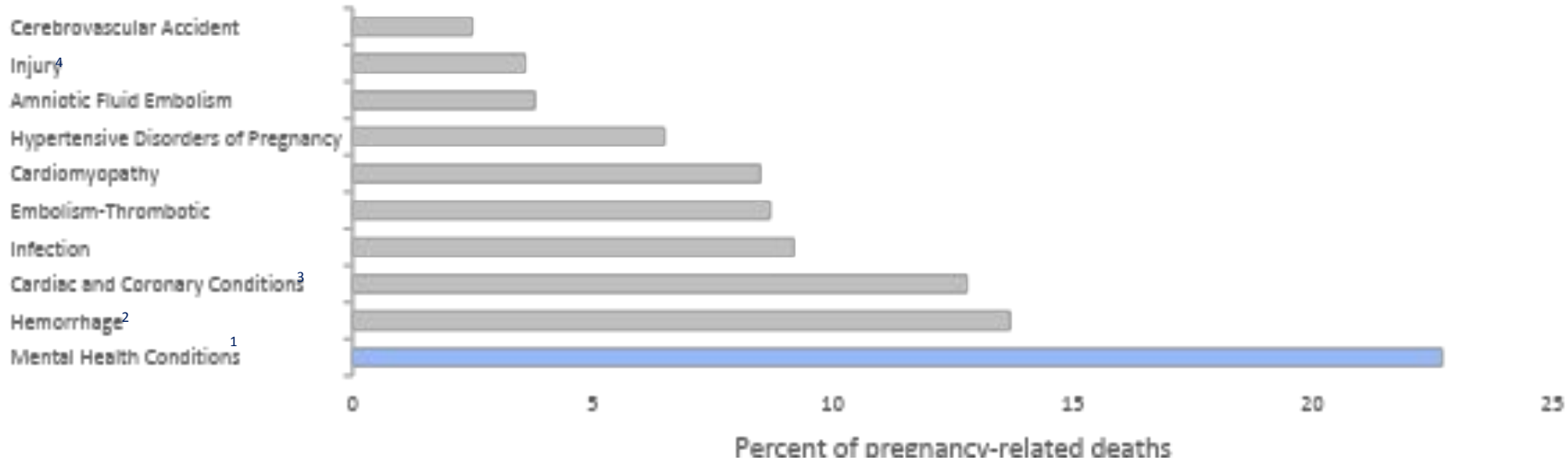
State and Local Maternal Mortality Review Committees (MMRCs)

- Review deaths during pregnancy or within 1 year of the end of a pregnancy, including review of injury deaths by most committees
- Access to a diversity of clinical and non-clinical records (social service, emergency department, law enforcement, autopsy, prenatal care, informant interviews, etc.)
- Multidisciplinary committees
- Purpose is to understand the clinical and non-clinical contributing factors to pregnancy related deaths to develop recommendations to prevent future deaths

Pregnancy-Related Death

The death of a person **during pregnancy or within one year** of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy

Underlying Causes of Pregnancy-Related Deaths*



¹ Mental health conditions include deaths to suicide, unintentional or unknown intent overdose/poisoning related to substance use disorder, and other deaths determined by the MMRC to be related to a mental health condition, including substance use disorder

² Excludes aneurysms or CVA

³ Cardiac and coronary conditions include deaths to coronary artery disease, pulmonary hypertension, acquired and congenital valvular heart disease, vascular aneurysm, hypertensive cardiovascular disease, Marfan Syndrome, conduction defects, vascular malformations, and other cardiovascular disease; and excludes cardiomyopathy and hypertensive disorders of pregnancy.

⁴ Injury includes intentional injury (homicide), unintentional injury, including overdose deaths not related to substance use disorder, and injury of unknown intent or not otherwise specified.

*Only 10 most frequent underlying causes of death are shown

**Pregnancy-Related Deaths: Manner of
Death Suicide, Residents of 36 US States,
2017-2019**

Determining Pregnancy-Relatedness

- Based on Centers for Disease Control and Prevention pregnancy-related death criteria, the Utah Perinatal Mortality Review Committee developed a standardized evaluation tool to assess accidental drug-related death and suicide*
- Examples may include:
 - ‘Increased pain directly attributable to pregnancy or postpartum events leading to self-harm or drug use that is implicated in suicide or accidental death’
 - ‘Inability to access inpatient or outpatient drug or mental health treatment due to pregnancy’
 - ‘Worsening of underlying depression, anxiety, or other psychiatric condition in pregnancy or the postpartum period with documentation that mental illness led to drug use or self-harm and subsequent death’
- This tool has been shared with jurisdictional partners through presentations and ongoing technical assistance

*Smid, Marcela C., et al. "Standardized criteria for review of perinatal suicides and accidental drug-related deaths." *Obstetrics & Gynecology* 136.4 (2020): 645-653.

1,018 pregnancy-related deaths to residents of 36 states,
2017 to 2019



971 pregnancy-related deaths had an
MMRC-determination of whether the death was a suicide



**82 (8.4%) pregnancy-related deaths occurred by
manner of death suicide**

Demographic Characteristics of Pregnancy-Related Suicide Deaths

Race/ethnicity	n	%
Hispanic	16	19.8
non-Hispanic American Indian or Alaska Native	1	1.2
non-Hispanic Asian	0	-
non-Hispanic Black	6	7.4
non-Hispanic Native Hawaiian and Other Pacific Islander	0	-
non-Hispanic White	55	67.9
non-Hispanic Other/Multiple races	3	3.7

Race/ethnicity information was missing for 1 (1.2%) pregnancy-related suicide death

The presentation of the data weighed the potential risks of identifying individuals by reporting information based on small numbers versus the potential benefits of making information available for prevention of pregnancy-related deaths. To minimize disclosure risks, data were aggregated across states (36 states) and across years (2017-2019).

Demographic Characteristics of Pregnancy-Related Suicide Deaths

Age at death (years)		n	%
15-19		3	3.8
20-24		15	18.8
25-29		19	23.8
30-34		25	31.3
35-39		15	18.8
≥40		3	3.8

Age was missing for 2 (2.4%) pregnancy-related suicide deaths

Means of Fatal Injury for Pregnancy-Related Suicide Deaths (N=82)

43%

Hanging/
Strangulation/
Suffocation

28%

Firearm

20%

Overdose/
Poisoning

10%

Other Means
of Fatal Injury

2 out of 3 pregnancy-related suicide deaths occurred in the late postpartum

19%

during pregnancy

0%

day of delivery

1%

1-6 days after end of pregnancy

14%

7-42 days after end of pregnancy

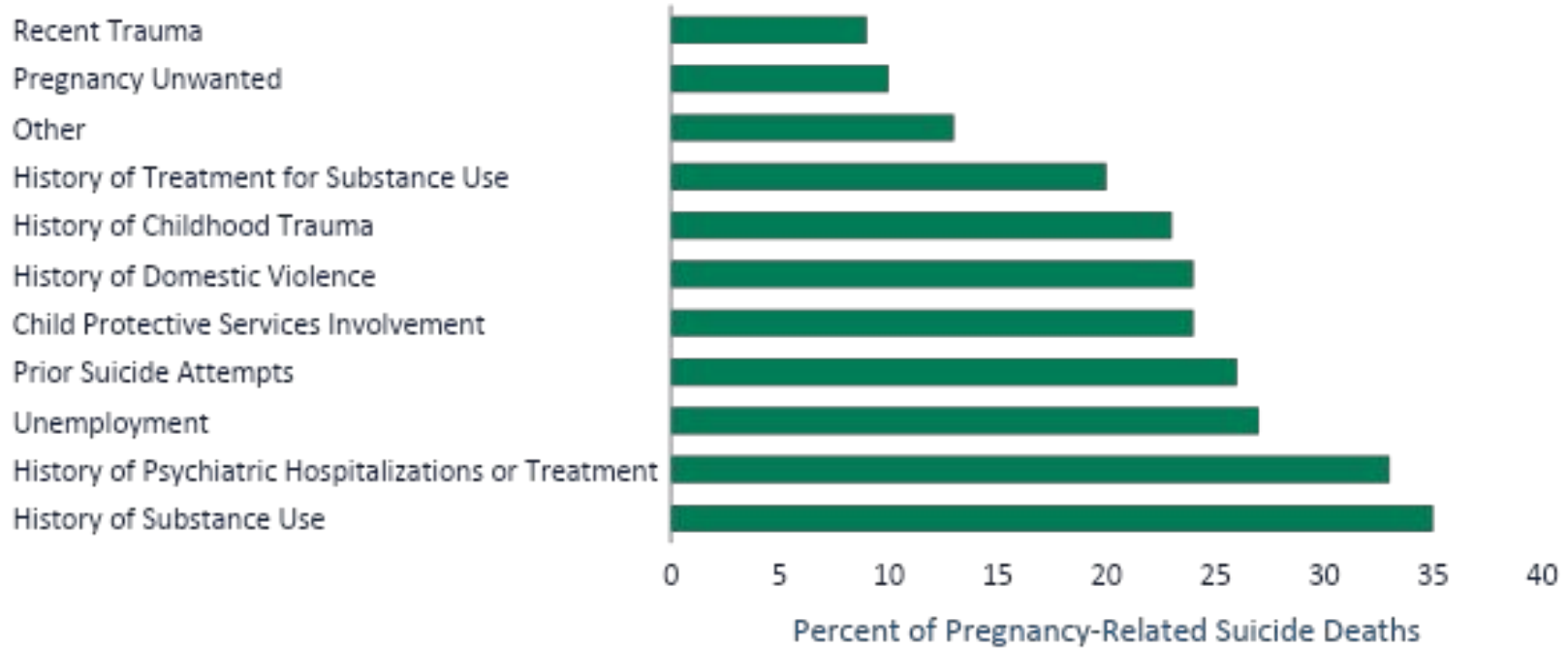
66%

43 days-1 year after end of pregnancy

Timing of death was missing or unknown for 3 (3.7%) pregnancy-related suicide deaths

99% of pregnancy-related
suicide deaths were determined by
the MMRCs to be **preventable**

66% of pregnancy-related suicide deaths had at least one life stressor and/or substance use documented



Example Jurisdictional MMRC Recommendations*

Access to Care

- Increased coverage of extended psychiatric care during the postpartum period
- Increase home visiting programs to assess and support families, especially those with mental health conditions or [Department of Children and Family Services (DCFS)] involvement
- [Office of Rural Health] to develop special subcommittee to focus on prenatal and outpatient care for pregnant and postpartum women living in rural communities; to examine best ways to deliver care including addressing transportation issues and lack of services in rural areas
- System improvement needed to provide additional pain management services, especially for patients on Medicaid or in rural areas
- Culturally-relevant interventions for traumatic birth experiences

Example Jurisdictional MMRC Recommendations*

Coordination of Care

- [DCFS] to increase coordination of care with mental health and substance use providers and have clear plans of care regarding custody and visitation of child(ren)
- Establish a process to follow-up with patients who miss their appointments
- Coordination of care after fetal loss, especially when a history of fetal loss
- Healthcare systems should develop relationships with local intimate partner violence (IPV) service programs so they can establish referral and warm hand-offs
- Hospitals should employ a social worker or case manager who can conduct and document a psychosocial needs assessment prior to delivery hospital discharge to identify potential barriers to care and connect women to resources and postpartum case management

*MMRC recommendations have been edited slightly for clarity

Example Jurisdictional MMRC Recommendations*

Screening

- Providers (OBGYNs, Pediatricians, WIC Offices, Emergency Departments) to perform a validated depression screening tool at prenatal and postpartum visits
- Providers should document in medical record whether domestic violence/IPV screening was done along with results. If positive responses noted, then appropriate intervention should be provided; identify, support and refer people at risk for IPV
- Universal integration of mental health condition screening and treatment into maternity care - Universal screening during pregnancy and postpartum with validated instruments
- Trauma-informed maternity care - Screening for adverse childhood events, Referral to mental health provider for trauma that occurs during or prior to pregnancy

*MMRC recommendations have been edited slightly for clarity

Example Jurisdictional MMRC Recommendations*

Education and Training

- WIC to provide depression education material at their offices that are easily accessible to participants
- Facility development of discharge instructions that include signs and symptoms of postpartum depression
- Improve community awareness of signs of suicidal ideation, major depression/postpartum depression, and resources for referral
- Obstetricians should have training in mental health conditions in pregnancy
- Provider education on the importance of postpartum visit and the implementation of postpartum depression screening
- Increased awareness of perinatal mood disorders across areas of medicine (e.g., emergency department; neurology)

*MMRC recommendations have been edited slightly for clarity



Example Jurisdictional MMRC Recommendations*

Community Resources

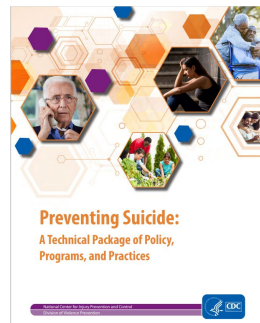
- State services/Department of Housing and Urban Development to increase availability of Section 8 housing, with priority for pregnant and postpartum women and women with children
- The State (DCFS) should explore options for funding demonstration projects to expand access to childcare during medical appointments
- Community organizations that work with homeless individuals should connect those individuals to other services, including transportation, healthcare and substance use treatment
- Programs should include women with early pregnancy loss/fetal demises in services generally reserved for pregnant/postpartum women and make services available/covered up to one year post loss

*MMRC recommendations have been edited slightly for clarity



Resources

- Preventing Suicide: A Technical Package of Policy, Programs, and Practices
 - <https://www.cdc.gov/suicide/pdf/suicideTechnicalPackage.pdf>
- National Maternal Mental Health Hotline
 - 1-833-9-HELP4MOMS
- 988 Suicide and Crisis Lifeline





Thank you!



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Suicide Assessment in Maternal Mortality Review: Learning the Story

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Delaware Maternal and Child Death Review Commission

09/28/2022



Maternal Mortality Review...

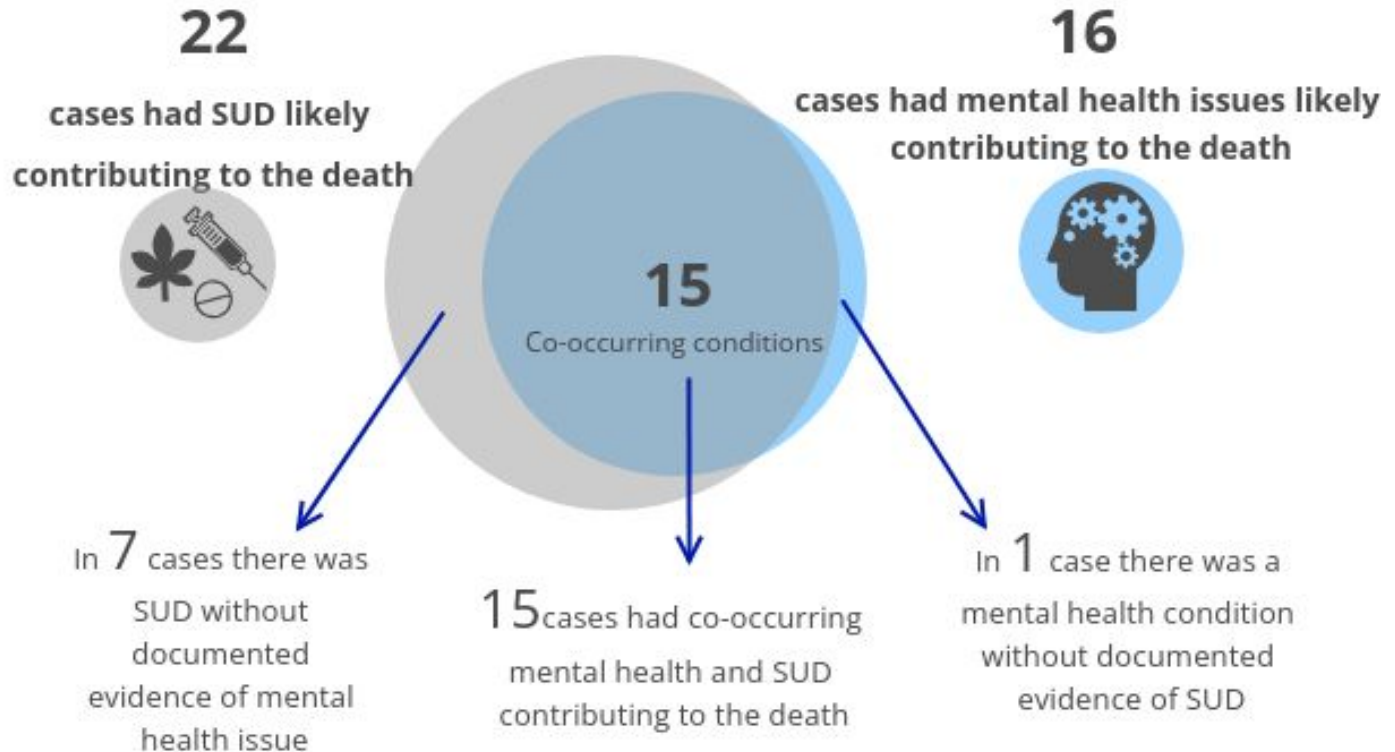
- Ongoing anonymous and confidential process of data collection, analysis, interpretation and action
- Systematic process guided by policies, statutes, rules, etc.
- Intended to move from data collection to prevention activities
- A mechanism for assigning blame or responsibility for any death
- A research study
- Peer review
- An institutional review
- A substitute for existing mortality and morbidity inquiries

IS

IS NOT

Intersectionality

The overlap between SUD and mental health conditions as contributing to MMR deaths



Maternal Mortality Review Abstraction

- Objectively review clinical and social data on birthing persons experiencing a pregnancy associated death
- Consider factors that may have contributed to the death ***including racism, discrimination and bias***
- Recognize terminology that may suggest a death was preventable.
- Respectfully reach out to people who were significant in the life of the birthing person to request to talk about the life and pregnancy of the person who died.
 - **Then - relate the Mother's Story**

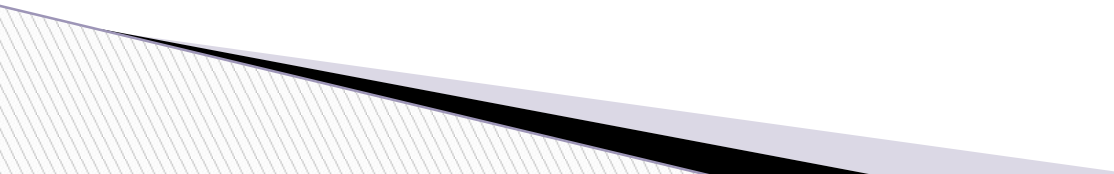


Storytelling Learning Collaborative

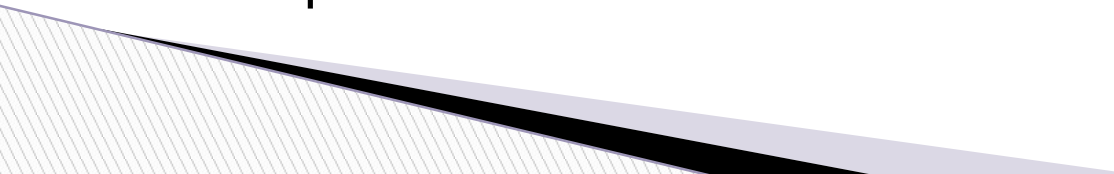
- Amazing opportunity to work with experts to learn how
“Stories can help humanize and heal, deepen understanding and motivate action, and catalyze greater impact for systems change.”*
- Consider my own anchor story – why am I doing what I do?
- How does my anchor story influence my ability to learn the stories from the family members I interview?

*National FIMR Storytelling Learning Collaborative Cohort 2: November 2021 - February 2022
Action Learning and Team Planning “TOOL KIT”

Honoring Lived Experiences

- Honoring lived experiences is one of the aspects of the Storytelling project and a responsibility of people charged with MMR.
 - Without knowing the whole story, committee members are drawing conclusions based on limited information.
 - The interview is the closest we can get to the Voice of the Individual who died or experienced the loss.
 - It is not possible to obtain an interview in every case but every time one is obtained, more is learned about the life of the person, enriching the MMR process.
- 

The Rest of the Story...

- Krystal (pseudonym) was a young person who died almost a year after giving birth. She had a single car vs. light pole accident resulting in irreversible brain injury after taking cocaine laced with fentanyl.
 - She had a history of depression and anxiety. Her mother agreed to an interview and shared that she knew Krystal was not suicidal because she found a diary talking about all her plans for herself and her baby.
 - The diary also talked about Krystal's struggles with anxiety and depression and how she could not connect with her therapist as she was limited to telehealth due to Covid.
- 

The Rest of the Story...

- Molly (pseudonym) died from an opioid overdose when she was 12 weeks pregnant. She had one prenatal visit and had completed her prenatal lab tests one week before her death. She was living with a relative who found her when she had died.
- She had a history of substance use disorder but no records indicated a mental health history. The relative with whom she lived agreed to an interview.
- The relative shared that Molly had scheduled an abortion for the week after her death, but it was unclear if the pregnancy was unwanted or if Molly was unable to manage the life changes about to occur around the pregnancy.
- The relative stated that Molly's boyfriend did not want to get married or have the baby and, at 87 years old, the relative could not allow Molly to continue to live there if she had the baby.
- The relative reported that they were certain that Molly committed suicide because the night before she died, she straightened and cleaned all of her living space, which was out of character for her. That was so they would not have to do it when she was gone.

Maternal Suicide

The Role of the
Perinatal Quality Collaborative
(PQC)

Overview

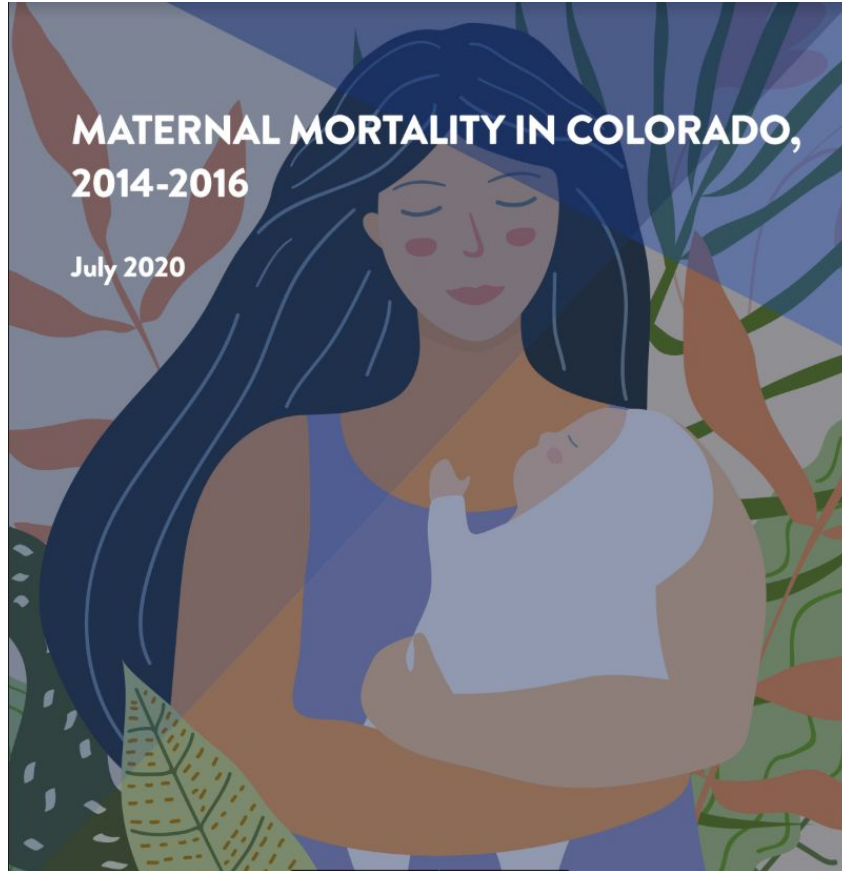
- Maternal Behavioral Health in Colorado
 - The Data
- Clinical Quality Improvement Resources
 - AIM Patient Safety Bundle
 - 2020 Mom Hospital Whole Mom Survey
 - Zero Suicide
- Integrating Healthcare Delivery Systems and Community
 - IMprove Perinatal Access, Coordination and Treatment for Behavioral Health (IMPACT BH)

Maternal Mortality in Colorado: 2014-2016

preventmaternalmortality@state.co.us
bit.ly/COMaternalMortality

Lived Experience Representation

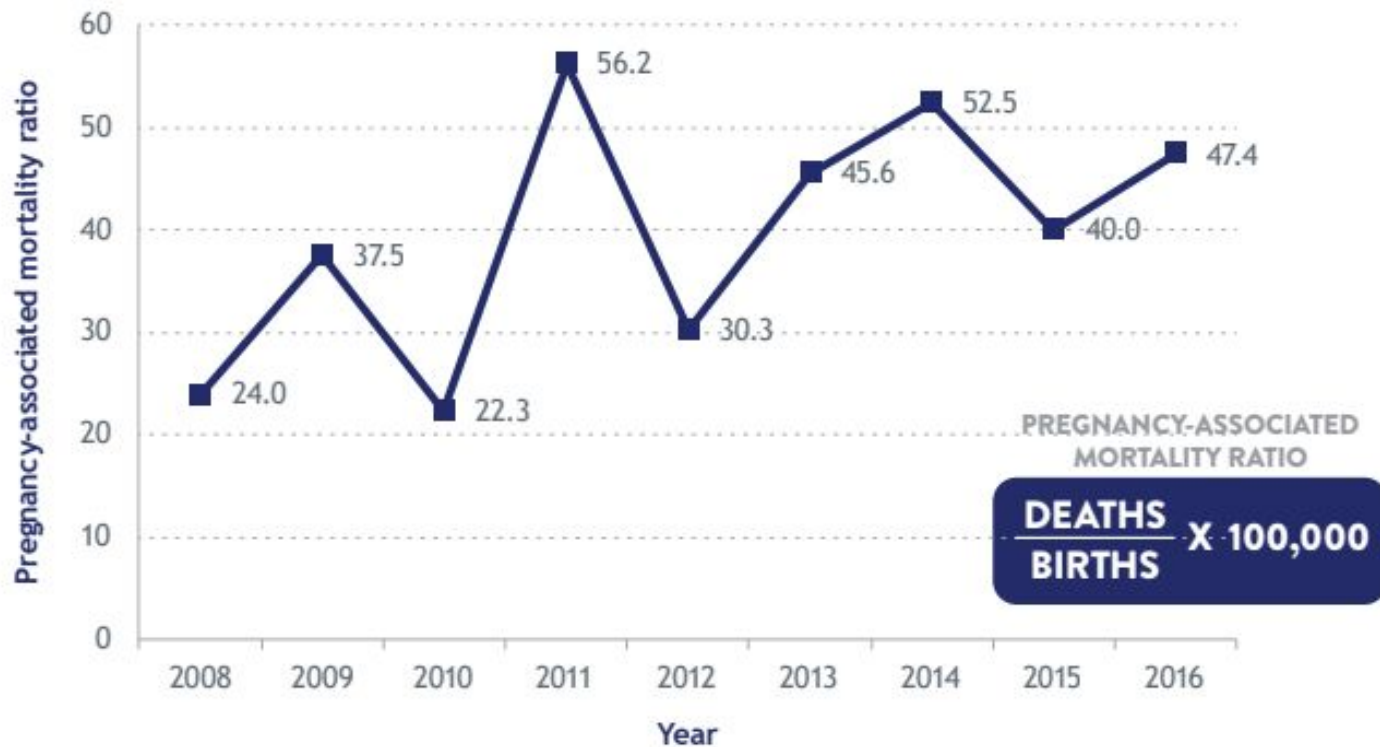
The lack of community voice at decision-making tables perpetuates systems of oppression. CDPHE conducted targeted outreach to people with lived experience to join the MMRC, resulting in the onboarding of 19 new members, 10 of which identify with a marginalized community.



bit.ly/COMaternalMortality

Maternal Mortality in Colorado, 2014-2016 (n = 94)

Figure 1. Trend of Pregnancy-Associated Mortality Ratio (PAMR), Colorado, 2008-2016.



Maternal Mortality in Colorado, 2014-2016 (n = 94)

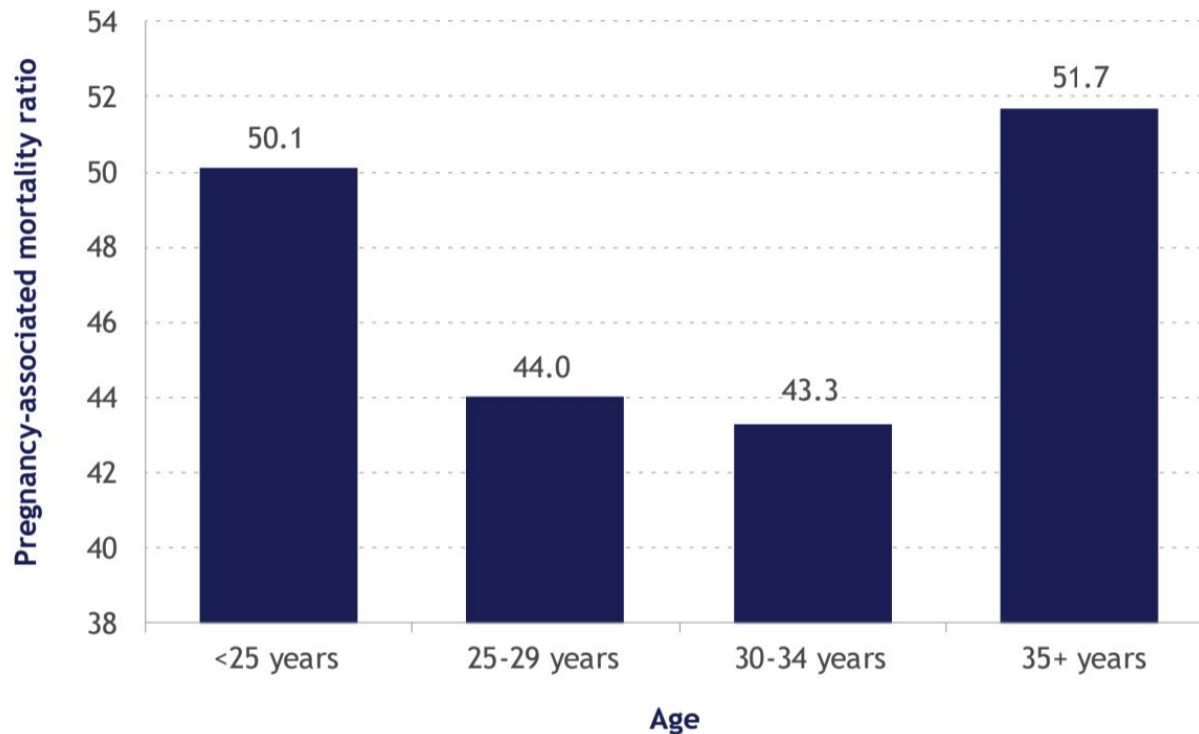
Table 2. Causes of Pregnancy-Associated Deaths.

Cause of death	Number of pregnancy-associated deaths	Percentage of pregnancy-associated deaths
Suicide	16	17.0%
Drug overdose	13	13.8%
Injury (including motor vehicle crash)	10	10.6%
Homicide	8	8.5%
Cardiac conditions	7	7.4%
All other obstetric complications (hypertensive disorders of pregnancy, ruptured ectopic pregnancy, uterine rupture, amniotic fluid embolism)	7	7.4%
Sepsis/infection	6	6.4%
Cerebrovascular accident (stroke)	5	5.3%
Thrombotic pulmonary embolism	5	5.3%
All other non-obstetric medical causes of death (e.g. cancer, respiratory conditions)	17	18.1%



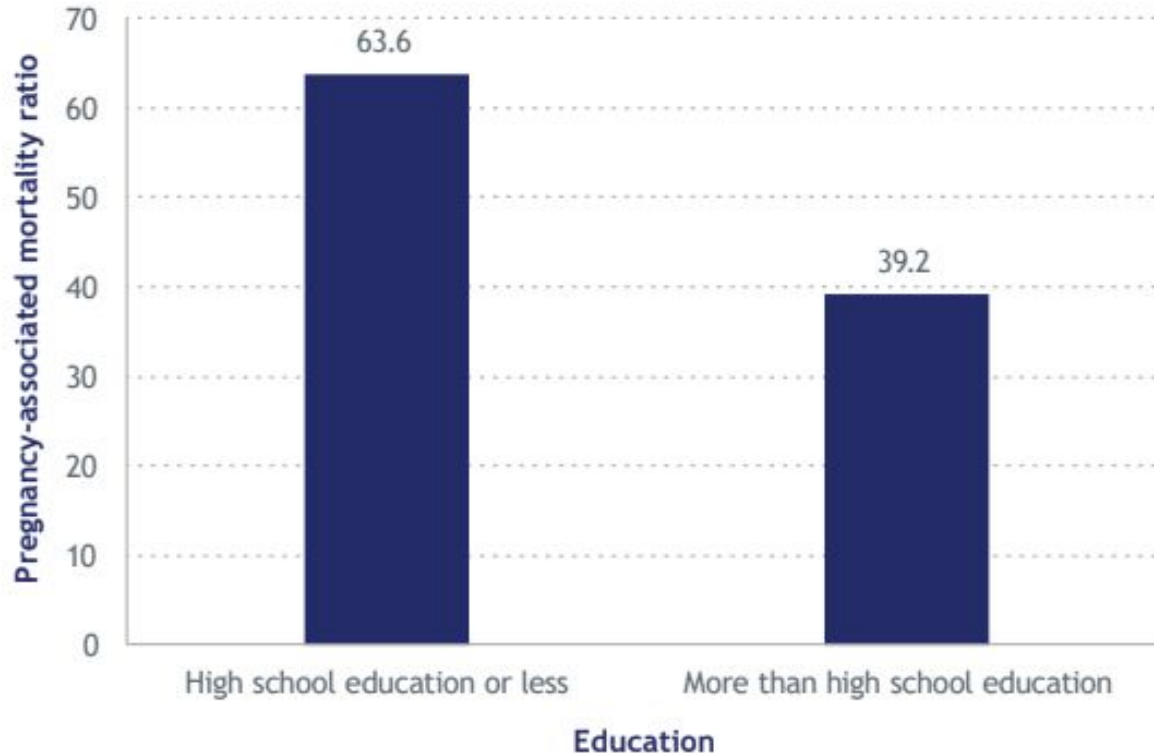
Maternal Mortality in Colorado, 2014-2016 (n = 94)

Figure 2. Pregnancy-Associated Mortality Ratio (PAMR) by Age, Colorado, 2014-2016.



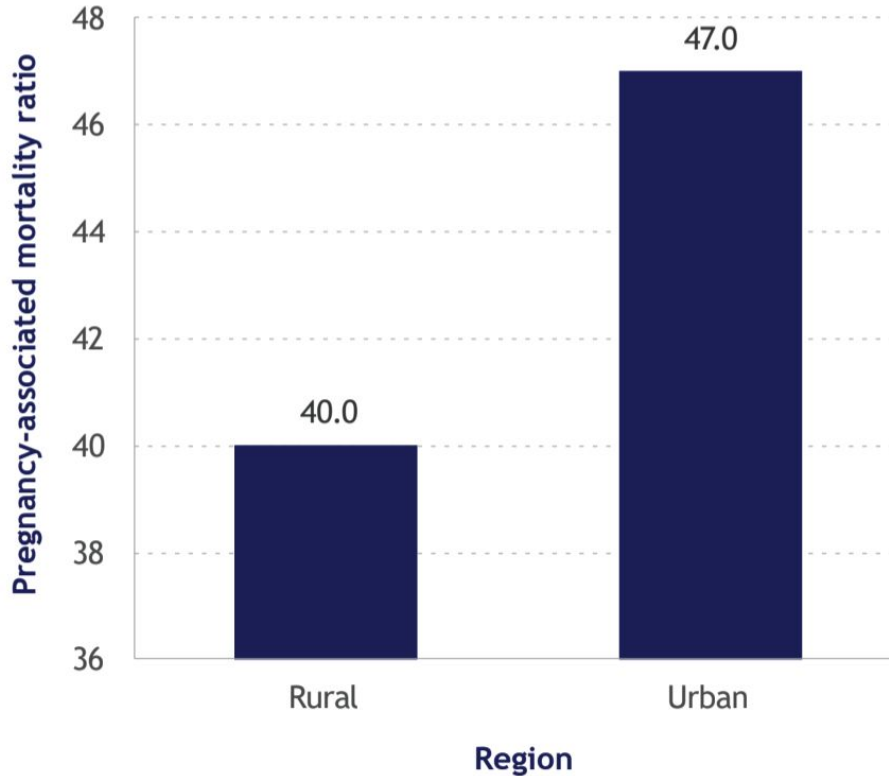
Maternal Mortality in Colorado, 2014-2016 (n = 94)

Figure 3. Pregnancy-Associated Mortality Ratio (PAMR) by Education, Colorado, 2014-2016.



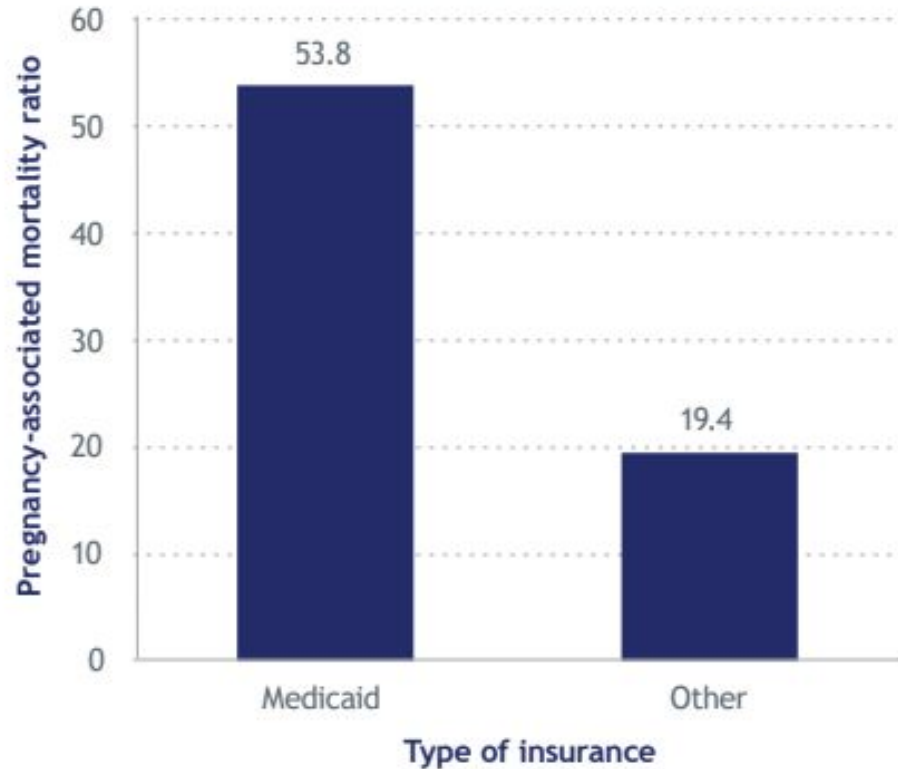
Maternal Mortality in Colorado, 2014-2016 (n = 94)

Figure 4. Pregnancy-Associated Mortality Ratio (PAMR) by Region, Colorado, 2014-2016.



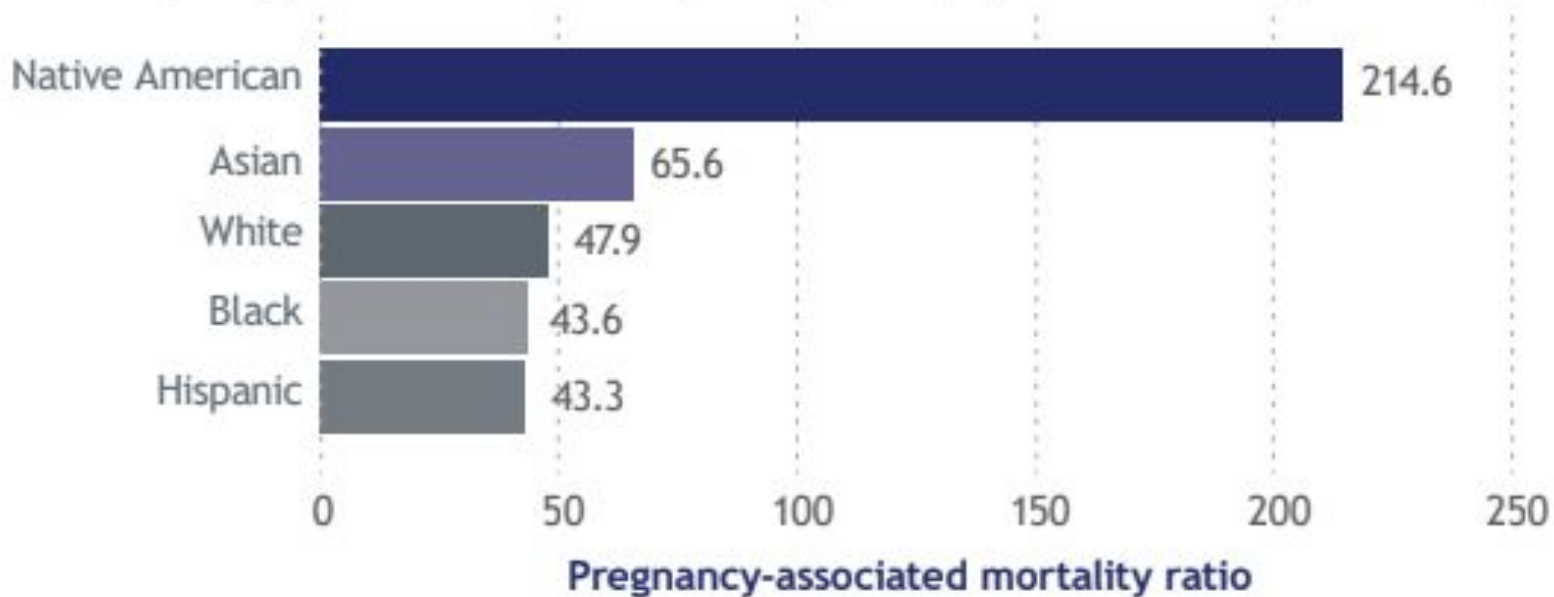
Maternal Mortality in Colorado, 2014-2016 (n = 94)

Figure 5. Pregnancy-Associated Mortality Ratio (PAMR) by Type of Insurance, Colorado, 2014-2016.



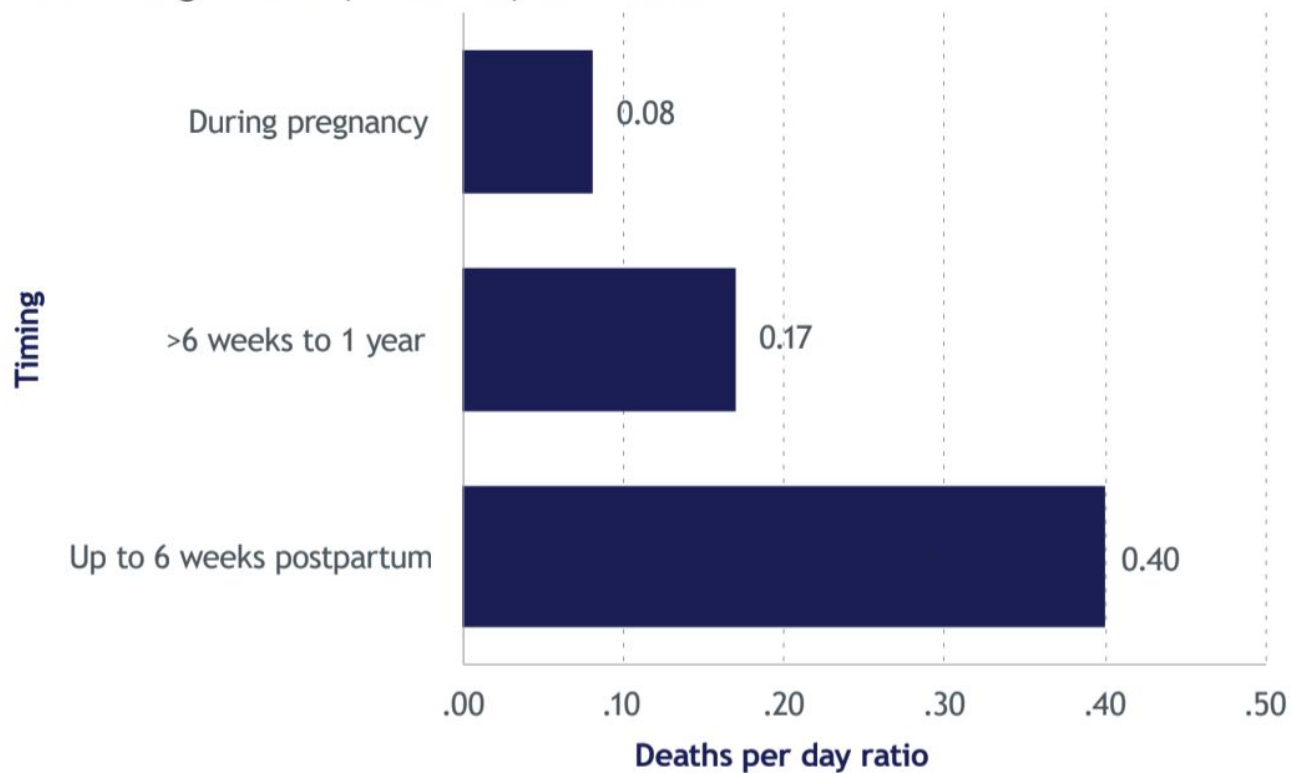
Maternal Mortality in Colorado, 2014-2016 (n = 94)

Figure 6. Pregnancy-Associated Mortality Ratio (PAMR) by Race/Ethnicity, Colorado, 2014-2016.



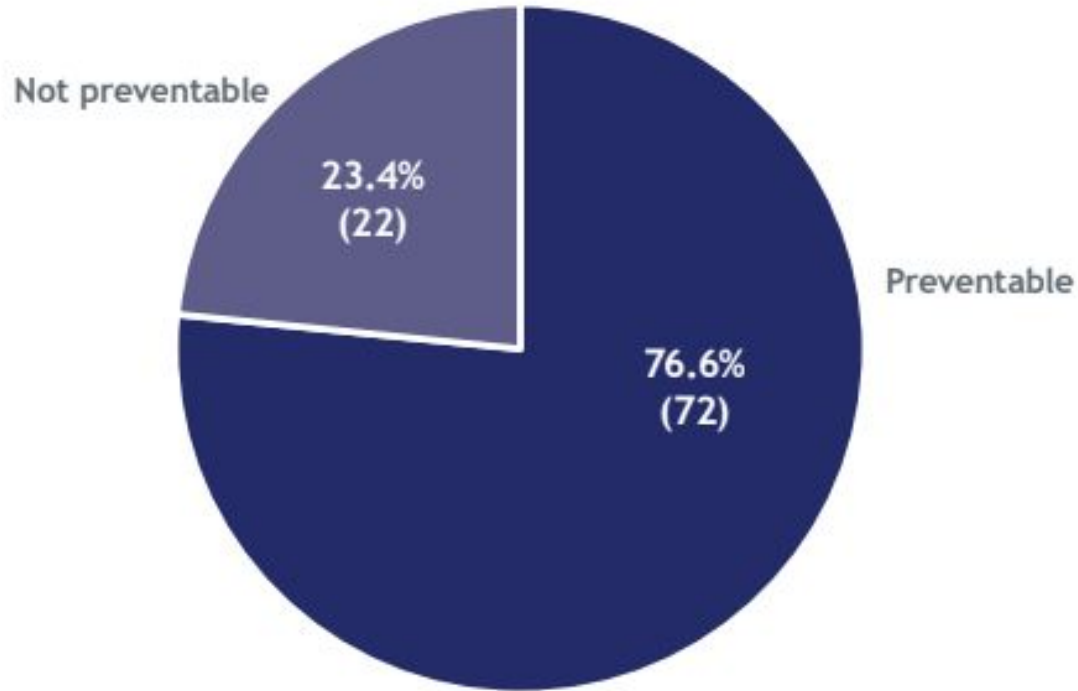
Maternal Mortality in Colorado, 2014-2016 (n = 94)

Figure 7. Timing of Death, Colorado, 2014-2016.



Maternal Mortality in Colorado, 2014-2016 (n = 94)

Figure 16. Preventability of Pregnancy-Associated Death, Colorado, 2014-2016.



The most frequent contributing factors for suicide deaths were:

- Poor continuity of care and care coordination. Care was fragmented among and between healthcare facilities or units within the same facility due to poor communication or lack of access to complete records.
- Absent, inadequate, or unhealthy social support from family, partner, friends, or others.
- Factors placing the person at risk for a poor outcome were not recognized or acted upon.

Postpartum Behavioral Health Report- Feb. 2021

- **Interactions with healthcare workers**

- 56% reported feeling comfortable speaking to an OB/Gyn
- 54% reported feeling comfortable speaking to a mental health care provider
- 47% felt comfortable speaking to a family practice doctor
- 9% didn't feel comfortable speaking to any health care works

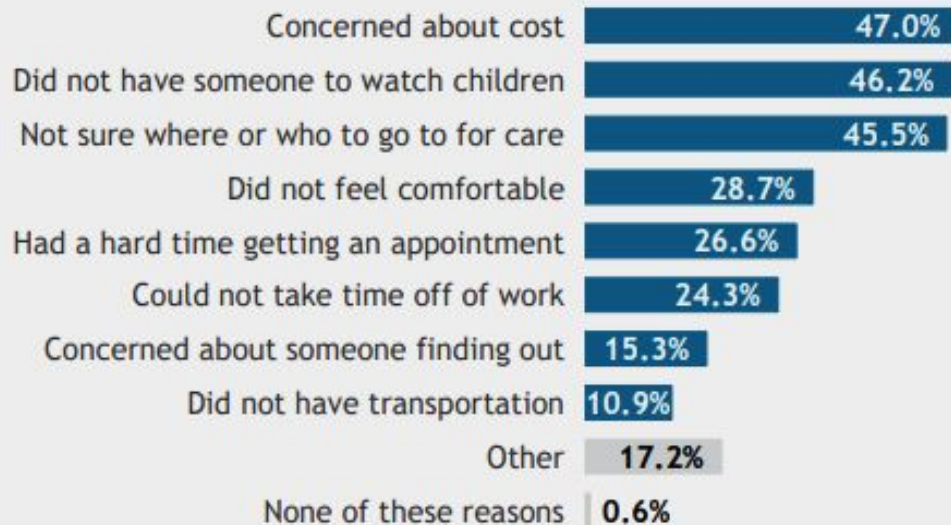
- **Healthcare workers talk about resources for anxiety & depression**

- 52% reported that a healthcare worker talked to them about self-care for anxiety or depression
- 18% reported that none of these resources were discussed with them

Postpartum Behavioral Health Report- Feb. 2021

Barriers to accessing needed or wanted mental health care

The most commonly reported barrier to receiving mental health care was concern about the cost of care. “Other” barriers included being too busy, not having insurance, and believing they should be able to cope on their own.⁴



“I would have tried to see a therapist at some point, but finding affordable childcare during the workweek for a short amount of time was too difficult.”
- Health eMoms participant

Postpartum Behavioral Health Report- Feb. 2021

Addressing stigma²

Among postpartum people who reported not feeling comfortable talking to any health care workers...

- 29% felt embarrassed.
- 23% were afraid of judgement.
- 20% did not feel that a health care worker could help.
- 20% felt that their parenting would be questioned.
- 16% did not want it in their medical records.

Improving mental health among postpartum people means addressing the stigma associated with talking about mental health.

“Conversations about a mother’s wellness are judgmental at times and after a baby is born there isn’t much support.”
-Health eMoms participant

Recommendations to Prevent Maternal Deaths

1. Eliminate structural and interpersonal bias and discrimination in the delivery of services and supports needed by pregnant and postpartum people.
2. Integrate universal screening and connection to treatment for mental health conditions into maternity care.
3. Integrate universal screening and connection to treatment for substance use disorders into maternity care.
4. Improve opioid prescribing practices.
5. Improve evidence-based screening and counseling methods for psychosocial risk factors, including intimate partner violence.
6. Improve care coordination for maternity care.
7. Improve electronic medical records.
8. Improve coordination and efficiency among public health, social services, and health care systems.
9. Improve access to care during preconception, pregnancy, and postpartum.
10. Improve quality and standardization of clinical care for medical and obstetric complications.
11. Redesign postpartum care to include an extended timeframe, dyad care, and family-friendly employment policies.
12. Implement trauma-informed maternity care.
13. Improve family planning care.



Clinical Quality Improvement

Perinatal Quality Collaborative Strategies & Activities

- **Training / Education Learning Sessions**
 - Perinatal Suicide
 - Bias in Maternity Care
 - Social Determinants of Health
 - Chronic Stress
 - Trauma-informed care
- **Data Collection, Analysis, Reporting-** medical and social linkage
- **Culture Change-** integrating medical, social, behavioral health; perinatal navigation
- **Partnership of Care-** patient and provider partners- Family Integration to ReStore Trust
- **Care Team-** integrating the care team- doulas, peer support specialists, support groups, OB, Neonatology, Pediatrics integration- dyad care
- **Policy Change**

Alliance for Innovation on Maternal Health (AIM) Patient Safety Bundle

READINESS



RECOGNITION & PREVENTION



RESPONSE



REPORTING & SYSTEMS LEARNING



RESPECTFUL, EQUITABLE & SUPPORTIVE
CARE




Perinatal Mental Health
Conditions - in
development



<https://saferbirth.org/patient-safety-bundles/>

2020 Mom Hospital Whole Mom Survey



20/20 Mom
Visionaries for the Future of Maternal Mental Health
2020Moms.org
Closing Gaps in Maternal Mental Health
Hospital Whole Mom™ Survey

Date _____

Name of hospital _____

Name of individual completing survey _____

Title of individual completing survey _____

Email address and telephone number _____

Please check 'YES,' 'NO' or 'IN PROGRESS' for the following to let us know what your hospital currently offers. Programs/policies/processes must be in place and benefiting women/families as of the date noted above.

Standard Key
Basic = white Advanced = light blue

Training		YES	NO	N/A	IN PROGRESS
1	All nurses working in postpartum, L&D, the ER, NICU or any other department that may work with perinatal women, lactation consultants and social workers have received a minimum of 3 hours of training from a recognized MMH training organization. (Offered through programs like 2020 Mom-Postpartum Support International (PSI), PSI independently, or other local programs).				
2	All nurses working in postpartum, L&D, the ER, NICU or any other department that may work with perinatal women, lactation consultants and social workers have received a minimum of 6 hours of training from a recognized MMH training organization. (Offered through programs like 2020 Mom-Postpartum Support International (PSI), PSI independently, or other local programs).				
3	Psychiatrist trained in reproductive mental health disorders is available/on-call to provide treatment for severe cases.				
4	If a teaching hospital, trains residents, students, or post-doctoral students in Maternal Mental Health.				

Integrating Healthcare Delivery with Community

IMprove Perinatal Access, Coordination, and Treatment for Behavioral Health

- **Increased screening** for behavioral health needs (Anxiety, Depression, SUD, etc.) in 100% of pregnant and postpartum individuals.
- **Referral to appropriate community and/or specialty care with documentation of follow-up** for 100% of pregnant and postpartum individuals with positive screening results.
- **Increased utilization of medical, behavioral health, and community services** by pregnant and postpartum individuals and their families.
- **Improved interactions and relationships** among care teams and perinatal individuals and their families.

Discussion

Report on Maternal Suicide: Executive Summary

Maternal Suicide In the U.S.



Visionaries for the Future of Maternal Mental Health

September 2022 EXECUTIVE SUMMARY

Introduction

Maternal suicide is a leading cause of maternal mortality in the US.¹ As national and state efforts to address maternal mortality through improved public health data collection have increased, maternal suicide has emerged as one of the top three causes of pregnancy-associated deaths, highlighting the need to address maternal suicide as a contributing factor of maternal mortality in the US.² It is estimated that up to 20% of maternal deaths are due to suicide.² Making maternal suicide deaths more common than deaths caused by postpartum hemorrhage or hypertensive disorders.³



The negative impact of maternal mental distress and illness on child development is well-documented, as well as the impact of maternal suicidality on child wellness. Thus, it is important to further examine how to prevent maternal suicides through clinical, systems, and policy shifts.

Risk Factors

The most potent risk factors are personal and/or family history of psychiatric disorders, a prior suicide attempt, and/or suicidal ideation (thoughts about suicide).⁴ The following points further explain these risk factors:

- Increased symptoms of anxiety have been linked to frequent thoughts of self-harm in depressed postpartum women.⁴
- A bipolar disorder diagnosis puts a woman at increased risk for postpartum psychosis, thus also increasing their risk for maternal suicide.⁵
- According to the CDC, 34% of pregnancy-related suicides had a documented prior suicide attempt.⁶
- Women with a postpartum psychiatric admission were 70 times more at risk of suicide in their first postpartum year⁷

Race & Maternal Suicide

Recent research reveals that different racial groups have higher risk for various aspects of suicide risk:

- American Indians & Alaska Natives have much higher rates of pregnancy-associated drug-related death and suicide compared with all other racial or ethnic groups.
- Non-Hispanic White people have the second highest rates of pregnancy-associated drug and suicide death. Death records from The National Center for Health Statistics (NCHS) indicate that pregnancy-associated suicide is more likely to occur in older and non-Hispanic White women.⁸
- Non-Hispanic Asian and Pacific Islander people have the third highest ratio for suicide. Asian women are 9 times more likely to report suicidal ideation than their white counterparts.
- Women who self-report as "other race" are almost 3 times more likely than White women to report suicidal ideation in the postpartum period.¹⁰
- Hispanic and Black women are 2 times more likely to report suicidal ideation than white women.⁹



Screening for Maternal Suicide Risk

Currently, front line providers like Ob/Gyns, may screen for maternal depression or anxiety using tools like the Patient Health Questionnaire (PHQ-2) or Edinburgh Perinatal Depression Scale (EPDS) but fail to screen for suicide risk if the patient identifies suicidal thoughts. This is important, as a suicidal thought does not mean someone is suicidal. The Columbia Suicide Severity Rating Scale (C-SSRS) and Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) screeners and the Ask Suicide-Screening Questions (ASQ)

This week, 2020 Mom released an Executive Summary of our 2022 Report on Maternal Suicide, due to come out in October.

- Risk factors for maternal suicide
- Race and maternal suicidality
- Maternal suicide prevention strategies and programs include:
 - Screening for maternal suicidality
 - Evidence-based interventions, treatments, and strategies
 - The Zero Suicide Framework
- The latest on maternal suicide data collection in the US.



Fireside Chat



Learn More



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