

Mental health conditions leading cause of pregnancy-related deaths

Editor's Note: In June 2022, the White House issued a report stating that the United States is facing a maternal health crisis.¹ The Joint Commission has been actively working to help address the myriad and complex causes of maternal mortality and morbidity. This Quick Safety addresses one aspect – mental health conditions and their role in pregnancy-related death. In addition, The Joint Commission is also issuing a [Sentinel Event Alert](#) that delves into eliminating barriers and racial disparities causing mortality and morbidity in pregnant and postpartum patients. See the Alert for additional resources and actions your organization can take to address the maternal health crisis.

Issue:

A recent report from the Centers for Disease Control and Prevention (CDC) evaluating causes for maternal death indicated issues related to mental health, such as depression, anxiety, death by suicide, and substance use disorders (SUDs) as the most frequent underlying cause, followed by clinical conditions (details below).² This finding signals the need for health care organizations to have a process to screen all pregnant patients for risk factors using evidence-based tools so that appropriate interventions may be instituted in a timely and ongoing manner.

Screening for depression or mental health disorders allows for treatment and control of symptoms that may help prevent self-harm and negative family outcomes, such as impaired infant bonding, or neglect.³ Pregnant and postpartum patients have significantly more contact with healthcare providers, increasing the opportunities for screening and referral for appropriate treatment.⁴

The CDC data is derived from Maternal Mortality Review Committees (MMRCs) in 36 states that investigated 1,018 pregnancy-related deaths; an underlying cause of death was identified for 987 of those deaths. Almost 23% of the deaths were related to mental health conditions (22.7%). The other most frequent underlying causes were hemorrhage (13.7%), cardiac and coronary conditions (12.8%), infection (9.2%), thrombotic embolism (8.7%), and cardiomyopathy (8.5%). These six conditions accounted for over 75% of pregnancy-related deaths. The MMRCs determined that of the 1,018 pregnancy-related deaths, 84% were preventable.²

The leading underlying cause of death varied by race and ethnicity, with mental health conditions being the leading underlying cause of death among Hispanic and non-Hispanic White persons.²

Of note, most pregnancy-related suicide deaths occur in the postpartum period, with 62% of pregnancy-related suicides occurring between 43-365 days postpartum, followed by 24% during pregnancy and 14% within 42 days postpartum.⁴

Depression, anxiety and SUD among leading mental health conditions for pregnant patients

The American College of Obstetricians and Gynecologists (ACOG) has reported that perinatal depression, which includes major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery, is one of the most common medical complications during pregnancy and the postpartum period, affecting one in seven patients.⁵

A 2016 study found perinatal depression to be under diagnosed and under treated; at that time, the study reported that of 8.2% depressed pregnant patients, only 12% had received mental health care in the prior year.⁶ This study took place several years before the coronavirus pandemic, which likely contributed to mental health conditions in pregnant patients.⁷

A prior MMRC of 14 states found that mental health conditions for pregnancy-related mental health deaths included:⁸

- Preexisting or history of depressive disorder
- Anxiety disorder



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- SUD
- Other mood or psychotic disorder
- Postpartum depression

Another finding was that each person could have multiple conditions, and that substance use, life stressors, history of or current substance use (with or without diagnosis of SUD) was present in 67% of deaths. Common life stressors included medication instability, defined as an indication that the person stopped taking psychiatric drugs or medications for treatment of SUD or had a change in medication or dosage during pregnancy or postpartum (39%); removal of a child from the person's custody or Child Protective Services involvement (24%); and previous suicide attempt or attempts (22%).⁸

Risk Factors for Perinatal Depression

Depression during pregnancy:

- Maternal anxiety
- Life stress
- History of depression
- Lack of social support
- Unintended pregnancy
- Medicaid insurance
- Domestic violence
- Lower income
- Lower education
- Smoking
- Single status
- Poor relationship quality

Postpartum depression:

- Depression during pregnancy
- Anxiety during pregnancy
- Experiencing stressful life events during pregnancy or the early postpartum period
- Traumatic birth experience
- Preterm birth/infant admission to neonatal intensive care
- Low levels of social support
- Previous history of depression
- Breastfeeding problems

Note: From Lancaster CA, Gold KJ, Flynn HA, Yoo H, Marcus SM, Davis MM. Risk factors for depressive symptoms during pregnancy: A systematic review. *American Journal of Obstetrics and Gynecology*, 2010;202:5-14 and Robertson E, Grace S, Wallington T, Stewart DE. Antenatal risk factors for postpartum depression: A synthesis of recent literature. *General Hospital Psychiatry*, 2004;26:289-95.

Risk factors for pregnancy- and postpartum-related suicidality⁴

- Personal and/or family history of psychiatric disorders
- Prior suicide attempt or suicidal ideation
- Bipolar disorder diagnosis
- Abuse at any time in a patient's life
- Sleep disturbances
- Young age
- Family conflict
- Loneliness
- Exposure to disaster, conflict or war
- Social and gender inequalities
- Racial discrimination
- Ethnic or religious minority
- Crowded or inadequate housing
- Living in rural areas



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Safety actions to consider:

Clinicians who provide care to pregnant patients can take the following actions to help address their patients' mental health needs and protect them and their babies from harm.

- Screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. Complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient. Additional screening is also recommended at the well child visit with procedures in place to accurately convey the information to the maternal care provider.*³⁻⁵
- Closely monitor, evaluate, and assess pregnant patients with current depression or anxiety, a history of perinatal mood disorders, risk factors for perinatal mood disorders, or suicidal thoughts.⁵
- When indicated, be prepared to initiate medical therapy and/or refer patients to appropriate behavioral health resources.⁴⁻⁵
- Have systems in place to ensure follow-up for further assessment/screening, diagnosis and treatment.⁴⁻⁵
- In the interpregnancy period, as part of the well woman exam, screen for depression and SUD, and offer referral and resources as indicated.*³
- Establish a clinical workflow that improves the identification of suicidal thoughts and behaviors. The workflow should include reducing access to lethal means, developing a collaborative safety plan, and providing caring contacts that include warm hand-offs to skilled providers.⁴
- Train staff in the clinical workflow described in the above bullet.⁴

**These safety actions related to screening are strongly recommended by ACOG and have a moderate-quality evidence grade.*

Resources:

1. White House Blueprint for Addressing the Maternal Health Crisis, June 2022.
2. Centers for Disease Control and Prevention. [Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019 | CDC.](#)
3. American College of Obstetricians and Gynecologists. Interpregnancy care. *Obstetric Care Consensus No. 8. Obstetrics & Gynecology*, 2019;133:e51-72.
4. Maternal suicide in the U.S.: Opportunities for improved data collection and health care system change. *20/20 Mom*, Issue Brief.
5. American College of Obstetricians and Gynecologists. [Screening for Perinatal Depression](#). Committee Opinion Number 757. November 2018c
6. Byatt N, Xiao RS, Dinh KH, Waring ME. Mental health care use in relation to depressive symptoms among pregnant women in the USA. *Archives of Women's Mental Health*, 2016;19:187-191. DOI 10.1007/s00737-015-0524-1.
7. Liu J, Hung P, Alberg AJ, et al. [Mental health among pregnant women with COVID-19-related stressors and worries in the United States](#). *Birth Issues in Perinatal Care*, 2021;48(4).
8. Trost SL, Beauregard JL, Smoots AN, et al. Preventing pregnancy-related mental health deaths: Insights from 14 U.S. Maternal Mortality Review Committees, 2008-17. *Health Affairs*, 2021;40(10):1551-1559.

Additional resources:

- **National Maternal Mental Health Hotline** – Call or text 1-833-943-5746 or 1-833-9-HELP4MOMs. From the U.S. Health Resources and Services Administration, the hotline is free, confidential and available 24/7.
- **20/20 Mom website** – Includes statistics, webinar replays, suicide prevention resources, screening tools and a safety plan template.

Note: This is not an all-inclusive list.



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