Advancing Racial Equity in Maternal Mental Health Policy:
A Guide for Policymakers and Advocates

CLASP
Policy solutions that work for low-income people

Introduction

Policymakers across the country must work aggressively to fight racial inequities in maternal health. People who are Black, Native, or from other communities of color are disproportionately likely to experience negative perinatal outcomes. Nearly two in five women of color experience depression after giving birth—almost double the rate faced by new moms overall. This large inequity, and many other health and socio-economic disparities, are the products of racism and inequality. As a national anti-poverty organization, The Center for Law and Social Policy (CLASP) is committed to promoting racial equity and disrupting systems of inequity across the country. CLASP encourages policymakers to promote racial equity in maternal mental health policy.

This brief offers a variety of strategies that policymakers and advocates can use to advance racial equity in maternal mental health. It offers many effective models from communities across the country. While many of these success stories are about broad health issues, they contain lessons that can be applied to maternal mental health policy.

CLASP created this resource as part of the **Moving on Maternal Depression (MOMD)** initiative. The MOMD project is collaboration between CLASP, state employees and advocates in New Jersey, New York, and Pennsylvania to improve perinatal mental health policy. Throughout this brief, we outline a number of strategies and resources to help states integrate racial equity in their work. They are organized as follows:

I. Defining Racial Equity

CLASP defines racial equity as the condition that would be achieved if your racial identity no longer predicted how you fare in life.

The **Center for Social Inclusion** (CSI) also has an insightful definition of racial equity:

- **Racial equity—as an end goal *and* a strategy.**
  CSI states that, "as an outcome, we achieve **racial equity when race no longer determines one's socioeconomic outcomes**; when everyone has what they need to thrive, no matter where they live. As a process, we apply racial equity when those most impacted by structural racial inequity are meaningfully involved in the creation and implementation of the institutional policies and practices that impact their lives."

- **Racial equity—how we know when it is achieved.**
  CSI states that, "when we achieve racial equity: People, including people of color, are owners, planners, and decision makers in the systems that govern their lives. We acknowledge and account for past and current inequities, and provide all people, particularly those most impacted by racial inequities, the infrastructure needed to thrive."

Although this brief is focused on racial equity, many other forms of discrimination affect our health. Health inequities are also driven by bias related to ethnicity, immigration status, disability, age, geography, language, sexual orientation, and gender identity, among other factors and these factors can form interlocking systems of oppression that most harm multiply marginalized people and communities.

II. Key Data on Racial Inequities in Maternal and Mental Health Care

Families and individuals struggling with mental health challenges have historically been mistreated and isolated by many health and justice systems. Medical professionals have used myths and false beliefs about health differences between racial groups to criminalize, divide, and dehumanize families.[1] Policymakers must recognize this ugly history to effectively counter

the legacy of inequity that risks the health of new moms and their families—and that still falls hardest on people of color.

With less access to affordable and high-quality health services, people of color disproportionately have worse birth and perinatal outcomes than their white peers. These inequities hurt individuals, their families, and communities. Key data affirm this harsh reality:

- **Black and Native American/Alaska Native women are at greater risk of death from pregnancy-related causes than their white peers.** Black mothers are more than 3 times more likely than white mothers to die during or after pregnancy. Native American or Alaska Native mothers are 2 times more likely to die as a result of pregnancy or its complications than white women. [2]

- **Women of color face steeper barriers than others to getting appropriate care during and after pregnancy.** A 2017 survey by Child Trends found that about one in eight American Indian and Alaska Native women receive little to no prenatal care.[3] For non-Hispanic black women, it's one in ten.

- **Limited access to health care risks pregnant women's health and the health of their newborns.** Just under 1 in 6 Black women give birth too soon. [4] That is the highest rate of pre-term births among women nationwide**.** For non-Hispanic white women, it's about 1 in 10. Preterm births are a significant issue in infant and maternal health, with depressive symptoms, particularly in Black women, being associated with risk.[5] The rate of depressive disorders during delivery for all women went from 4.1 per 1,000 hospitalizations in 2000 to 28.7 in 2015.[6]

- **Gaps in mental and maternal health are tied to income inequality.** About half of women with low incomes in the United States experience some form of maternal depression, compared to about one in six postpartum women overall. [7]

- **Barriers to care that confront women of color reflect hurdles facing their communities as a whole**. Communities of color often have low rates of mental health treatment relative to the general population. Between 2010 and 2013, the Centers for Disease Control and Prevention (CDC) found broad racial inequities in mental health care access among men 18-44 years old who felt anxiety and depression on a daily basis. Just over 2 in 10 Black and Hispanic men, as a group, were likely to seek mental health treatment.[8] During the same period, more than 4 in 10 of their white peers sought care. This data is just a sample of the many racial disparities in mental health we need to address. [9]

The racial equity strategies outlined in this brief can help policymakers close these gaps and promote equity.

III. Strategies to Advance Racial Equity and Remove Common Barriers to Health Care

CLASP encourages policymakers to avoid race-neutral or race-blind language, policies, and practices. Policies and other actions that uphold the status quo—a health system with built-in discrimination—will only maintain the health disparities we aim to end. Communities of color are not monolithic and policy must respond to distinct community needs.

Common barriers to mental health care that many people of color encounter today are the result of historic racial inequities.[10] Such hurdles include:

- The high cost of care (even with public or private insurance, but especially for uninsured populations)[11]

- A lack of service providers (clinics, health providers, etc.) in a person's community

- A cultural belief that mental health treatment "doesn't work" and a historic lack of trust in the health care system

- A mental health system in which many workers lack cultural competency or do not have an understanding of the values and cultural practices that diverse people of color may hold

- Stigma about mental health both among and about communities of color

- Language barriers, including a lack of providers who are able to speak with people in their native language[12]

- Racism, bias, and discrimination in treatment settings[13]

- A lack of transportation, child care, paid leave, or time off from work (even if services are available in someone's community, they may not be accessible given these obstacles)

To remove racially biased barriers in many areas of health care, policymakers and advocates can use many strategies, such as:

1. **Disaggregating data systems and sources** by race, ethnicity, and other key demographic indicators. By adopting this practice, decision makers can ensure that all groups have equitable access to health care.[14]

2. **Using upstream approaches** to health and racial equity, such as addressing the conditions where people live, work, and play that influence their health. These and other factors, known as the social determinants of health, can help policymakers and advocates comprehensively address inequities. [15]

The graphic below from the Bay Area Regional Health Inequities Initiative visually represents the social determinants of health. It could be used to introduce an audience to the concept of social determinants of health and upstream versus downstream approaches.
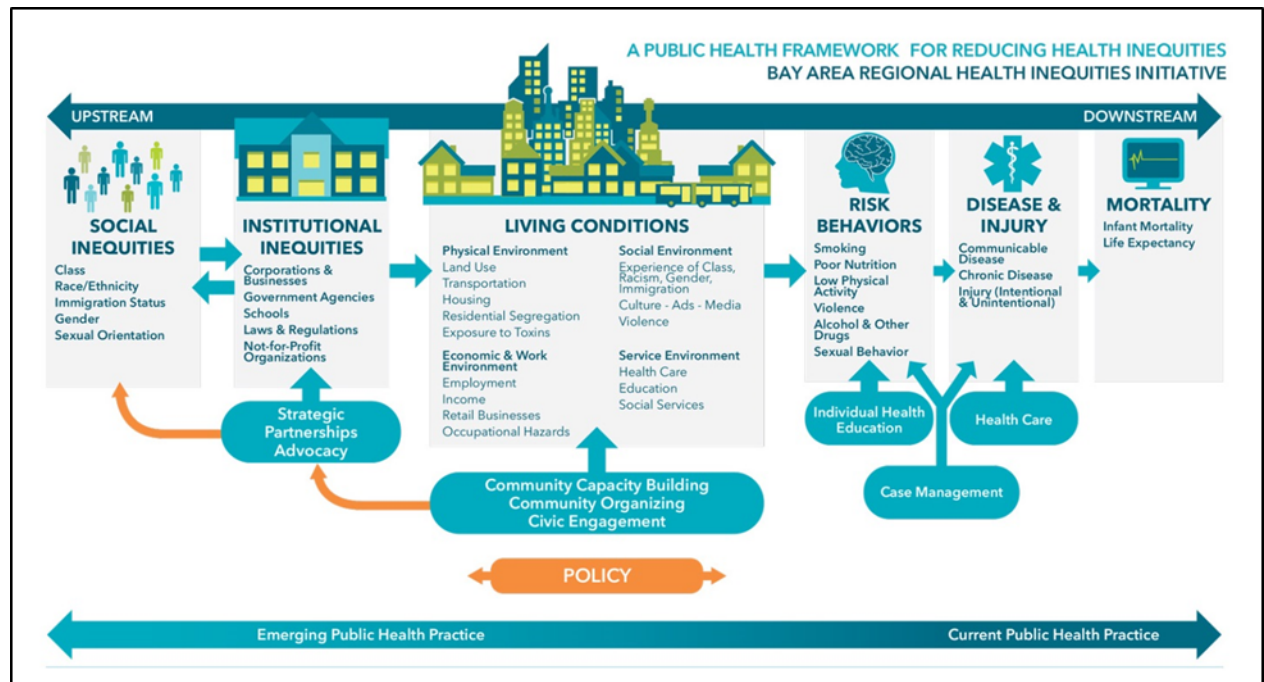
3. **Building long-term, respectful relationships with the people you serve** is a crucial strategy to advance racial equity in health care. It includes engaging directly with key, trusted community leaders and advocacy organizations, among others**.** It involves **meaningfully engaging people with lived experience** in all parts of the policymaking process and compensating them fairly for their time and input. This also means accommodating their schedules, whether that means holding meetings "after hours" and/or providing transportation benefits.

4. **Hiring and retaining staff that reflect the diversity and needs of communities** and populations served is another key strategy. This includes adopting equitable hiring practices, ensuring that staff are compensated fairly, and building pathways for staff to advance in their career.

5. **Regularly assessing** how policy, budgetary, and administrative decisions impact people in different communities. Decision makers can use impact assessment tools to advance equity and close disparities.

IV. Examples of Success: Select State, County, and Other Initiatives that are Effectively Advancing Racial Equity

Many states and localities understand the value of using a racial equity lens to close health gaps. They are working hard to assess where they are and where they need to be. This section highlights some of the efforts and initiatives underway in different states, counties, and cities where decision makers are successfully using the key practices described above. While the list is not comprehensive it illustrates the many approaches policymakers and advocates can take to advance racial equity in maternal and mental health care.

Strategy 1: Disaggregating Data Systems and Sources

- *Allegheny County, PA*
  Allegheny County created an integrated, cross-agency **data inventory** to better examine their area's racial and health disparities and promote a culture of wellness. The county then used that data to engage with the community and develop action plans to combat the inequities. *This model demonstrates how to use data and community engagement to develop a strategic plan focused on equity.*

- *Minnesota*
  The Minnesota Department of Health created a tool called **Health Equity Data Analysis (HEDA)** to help state and local policymakers identify health differences between groups and identify root causes of health disparities. HEDA uses a combination of qualitative and quantitative analysis as well as a social determinants of health framework. *The HEDA guide for local departments could help policymakers assess equity gaps in their communities.*

Strategy 2: Using upstream approaches

- *Boston, MA*
  The Boston City government's **"Resilient Boston" project issued a** report that takes a comprehensive view of the city's history and current challenges as it works to advance racial equity. It describes how the city has engaged with the community and summarizes numerous initiatives. Some are specifically related to mental health, trauma, and integrating racial equity into the Boston health system. *This report models integrating racial equity across a range of areas and departments. It demonstrates one approach to confronting a history of racism and exclusion and how to use such a reflection to design inclusive strategic plans.*

  King County, WA
  King County, which is home to Seattle, has developed an **equity impact review process** that assesses how a given action will impact different people and places in the county. It has been used to assist the county's planning and decision-making process, as shown **in this report**. *This will help policymakers develop their own assessments to evaluate the impact of decisions on different demographic groups.*

King County also has **several resources** about identifying and addressing implicit or unconscious bias, based on the Implicit Association Test (IAT). *This will help policymakers understand and address their own biases.*

Strategy 3: Building trusting partnerships with people and community-based organizations

- *Cleveland, OH*
  In 2015, the Huffington Post **identified** a report ranking Cleveland as the country's most segregated city. In response, the city began a comprehensive racial equity initiative described in its report, "**Transforming Cleveland: Building Equity for All to Thrive**". The report includes a summary of the effort's findings and methodology. Cleveland leaders sought to better engage the community, learn more about race relations in the city, and identify action steps to combat inequities and improve cross-cultural relationships on a community level. *This could be a guide for policymakers conducting focus groups and community outreach.*

- *Delaware*
  The Delaware Health Equity Action Center website contains several resources related to health equity in general. It is the product of collaboration between the state's Department of Health and Social Services, Delaware's Healthy Mother and Infant Consortium, and other community partners. Its resources include: communications materials, a brief video explaining health equity for a general audience, a map of health inequity in Delaware, an action guide for advancing equity in the state, a description of the peer education program, and information about the state's health equity awards program. *This is a model of how to coordinate equity strategies across different state agencies.*

- *Minnesota*
  The Minnesota Department of Health's **Center for Health Equity** partnered with the Somali American Parent Association to evaluate Somali adults' mental health needs and resources available to them statewide. The report, **Somali Mental Health Project Findings and Recommendations,** details the background, methodology, and results of the department's efforts and collaboration. It describes how the state convened an advisory board of Somali community leaders, conducted community conversations, and used its findings to produce recommendations to close health gaps. *This example models how relatively small health equity grants targeted for a specific population can produce key lessons that can help reduce disparities.*

Strategy 4: Building a diverse workforce

- *New York, NY*
  The New York City Department of Health and Mental Hygiene's *Race to Justice* **project** aims to promote racial equity and social justice throughout the agency. The department conducted a survey of its 6,000 employees, worked with nonprofits to develop

assessments of the department, and created workgroups to advance goals related to equity. It also conducted staff trainings to normalize conversations about racism and promote the use of a racial equity lens. *This project models how to build institutional and organizational support and capacity for equity work. It has a specific section with advice for local health departments.*

- *Washington*
  The Washington Department of Health's **Health Equity Workgroup** has adopted the National Standards for Cultural and Linguistically Appropriate Services in Health and Health Care (also known as CLAS standards).[16] Through the workgroup, the department trained and mentored employees in health equity. The department has also created and sustained partnerships with community, tribal, and other organizations and developed an interactive health disparity tool that uses mapping software to visualize gaps in care. *This example shows how policymakers can use technology to advance equity goals and integrate the CLAS standards.*

Strategy 5: Conducting Regular Assessments

- *Allegheny County, PA*
  This county regularly conducts **power analyses** to identify power inequities in within communities and the systems such as the education and health care systems that they seek to improve. *This activity could help policymakers evaluate power dynamics and inequities in the systems and communities that they seek to change.*

- *San Mateo County, CA*
  This county conducted a **10-year review** of health equity initiatives focused on meeting the needs of specific communities. It included a mental health initiative targeting Pacific Islander and Filipino communities and other initiatives for Native, Latinx, and African American populations. The review highlights diverse ways of engaging with community members and suggests how to sustain and deepen those relationships, which can better advance equity and fight stigmas. In particular, Appendix 2 in the report shows how the county evaluated its individual initiatives. *This report demonstrates how to conduct long-term, culturally competent community engagement and evaluation.*

V. General Resources about Racial Equity

In addition to reviewing successes from other states and localities, policymakers and advocates can learn from materials developed by organizations that are committed to racial equity. Below is a sample of select resources that CLASP recommends. For more resources please visit **racialequitytools.org**.

1. **Educational Videos and Communications Tools**

   a. **The Systemic Racism Video Series** of short videos developed by **Race Forward** that dives into the different ways systemic racism pervades American society,

including housing discrimination, the racial wealth gap, employment, and incarceration.

b. The **GARE Communications Guide 2018** is a comprehensive tool to help policymakers communicate about racial equity work. It includes strategies to counter myths about race and racism in the United States, a look at how racial disparities show up in maternal health care, a racial equity glossary, and more. This handbook was produced by the **Government Alliance on Race & Equity**.

2. **Impact and Readiness Assessments**

a. The **Racial Equity Impact Assessment** is a two-page assessment and guide that offers relevant examples from WA, IA, CT, and MN. It shows how agencies can evaluate the impact of proposed policies on different racial and ethnic groups. This tool was developed by **Race Forward**.

b. The **Racial Equity Readiness Assessment for Workforce Development** is a guide for workforce development organizations to help them identify strengths and opportunities for growth related to equity. This resource was developed by **Race Forward**.

3. **Tools to Create Institutional Change**

a. **Racial Equity: Getting to Results** describes a strategy to create institutional change. It includes detailed case studies from cities in Iowa and Virginia. This piece was created by the **Government Alliance on Race & Equity**.

b. This **comprehensive list of strategic practices** can help decision makers build internal infrastructure, work across government, foster community partnerships, and champion transformative change to achieve health equity. This list was developed by **Human Impact Partners**.

c. **The Roadmap to Reduce Disparities** is a six-step guide for health care organizations to improve health for communities of color and foster equity. It includes sections on linking service quality and equity, creating a culture of equity, securing buy-in to advance change, diagnosing health disparities, and more. This resource was created by **Human Impact Partners**.

VI. Additional Reading on Racial Inequities in Maternal and Mental Health

For additional background research on racial equity as it applies to maternal and mental health, CLASP recommends the following materials:

1. The **National Council on State Legislatures** published and article called *The Costs and Consequences of Disparities in Behavioral Health Care* in 2018 about the consequences of disparities in behavioral health and ways to use data and other strategies to close them.
2. **Health Affairs** summarizes evidence about racial and ethnic disparities in mental health and policy implications of those inequities in a 2008 article, *New Evidence Regarding the Racial and Ethnic Disparities in Mental Health: Policy Implications.*
3. The **Center for American Progress** comprehensively discusses racial disparities in maternal and infant mortality and maternal mental health and proposes policy solutions to close those gaps in a 2017 report, **Mood Disorders Among Pregnant and Postpartum Women of Color.**
4. In 2017 the **American Psychological Association (APA)** published **Mental Health Disparities: Diverse Populations** a series of fact sheets about the mental health inequities and challenges that frequently impact specific racial, ethnic, and other groups such as African Americans, Alaska Natives/American Indians, LGBTQ populations, and Hispanics.
5. **Mental Health America** published fact sheets about mental health for **Native**, **Black and African American, Asian American and Pacific Islander American**, and **Latino/Hispanic** populations including demographic data, prevalence of diagnosable mental illnesses, access to care and specific considerations for those populations.

Endnotes

[1] Linda Villarosa, *Myths about Physical Racial Differences Were Used to Justify Slavery — and are still Believed by Doctors Today,* New York Times, 2019, **https://www.nytimes.com/interactive/2019/08/14/magazine/racial-differences-doctors.html?smid=pl-share**.

[2] Emily Peterson, et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States 2007-2016*, Morbidity and Mortality Weekly Report Centers for Disease Control, 2019, **www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm?s_cid=mm6835a3_w**.

[3] Child Trends, *Late or No Prenatal Care,* 2019, **https://www.childtrends.org/indicators/late-or-no-prenatal-care**.

[4] Joyce A Martin, et al., *Births: Final data for 2013*, National Vital Statistics Reports; Vol 64 No 1. National Center for Health Statistics, 2015, **https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf**.

[5] Tiffany Field, et al., *Depressed Pregnant Black Women Have a Greater Incidence of Prematurity and Low Birthweight Outcomes*, Infant Behavior and Development 32:10-16 (2009), **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2652730/.**

[6] Sarah Haight, et al., *Recorded Diagnoses of Depression During Delivery Hospitalizations in the United States, 2000–2015, Journal of Obstetrics & Gynecology* 133: 1216-23 (2019), **https://www.ncbi.nlm.nih.gov/pubmed/31135737**

[7] Colorlines, *The Paradox of Postpartum Depression,* 2018, **https://www.colorlines.com/articles/paradox-postpartum-depression**.

[8] Stephen J. Blumberg, et al., *Racial and Ethnic Disparities in Men's Use of Mental Health Treatments, National Center for Health Statistics*, NCHS Data Brief No. 206, 2015, **https://www.cdc.gov/nchs/products/databriefs/db206.htm**.

[9] Thomas McGuire, Jeanne Miranda, *New Evidence Regarding Racial And Ethnic Disparities In Mental Health: Policy Implications, Health Affairs Vol. 27. No. 2,* 2008, **https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.2.393**.

[10] Larry Shushansky, *Disparities within Minority Mental Health Care,* National Alliance on Mental Illness, 2017, **https://www.nami.org/Blogs/NAMI-Blog/July-2017/Disparities-Within-Minority-Mental-Health-Care**.

[11] McGuire, *New Evidence Regarding Racial and Ethnic Disparities.*

[12] Katherine Sanchez, et al., *Eliminating Behavioral Health Disparities and Improving Outcomes for Racial and Ethnic Minority Populations,* Substance Abuse and Mental Health Services Administration, Psychiatric Services in Advance, 2015, **https://www.integration.samhsa.gov/news/Eliminating_Behavioral_Health_Disparities_and_Improving.pdf**.

[13] Vickie Mays, et al., *Perceived Discrimination in Healthcare and Mental Health/Substance Abuse Treatment among Blacks, Latinos, and Whites*, Med Care, 2017 **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5233585/**.

[14] For more information see **section 4302 of the Patient Protection and Affordable Care Act**

[15] The Social Determinants of Health are defined as the conditions in the places people live, work and spend their time, which influence their health. For example, growing up in a polluted neighborhood can increase a child's likelihood of having asthma. Similarly living in an impoverished or crime-ridden area can often increase the likelihood that a person suffers from mental health challenges. For more information see the graphic at the end of this memo or visit this link: **https://www.cdc.gov/socialdeterminants/index.htm**

[16] The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care are a framework to assist organizations as they serve diverse communities. To learn more about the CLAS standards and how to enforce them follow this link: **https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53**