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Pathways To Equitable And Antiracist Maternal Mental Health Care: Insights From Black Women Stakeholders

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ABSTRACT Structural racism causes significant inequities in the diagnosis of perinatal and maternal mental health disorders and access to perinatal and maternal mental health treatment. Black birthing populations are particularly burdened by disjointed systems of care for mental health. To identify strategies to address racism and inequities in maternal and infant mental health care, we interviewed ten Black women who support Black birthing people, including mental health practitioners, researchers, and activists, in February 2021. The five key pathways to address racism and inequities that we identified from the stakeholder interviews are educating and training practitioners; investing in the Black women mental health workforce; investing in Black women-led community-based organizations; valuing, honoring, and investing in community and traditional healing practices; and promoting integrated care and shared decision making. These pathways highlight critical resources needed to improve the quality of maternal mental health care for Black birthing populations.

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Black women experience a higher prevalence of maternal mental health conditions, particularly postpartum depression and anxiety, relative to the US population as a whole.¹ In addition, maternal mental health issues among Black women are largely underreported, and symptoms often go unaddressed.^{2,3} Structural and social determinants are increasingly recognized as contributing factors to mental health;⁴ social and economic disasters exacerbate inequities in mental health outcomes and well-being and have implications for pregnant and postpartum populations.⁵ Identifying racism, sexism, classism, and other systems of oppression shifts the narrative of blame from individual-level behaviors and focuses interventions at the systems level. This increased recognition and acknowledgment has spurred advocacy for upstream interventions that address the root causes of mental illnesses.^{6,7} Black birthing peo-

ple encounter societal and system barriers when seeking and receiving health and social support services. Lack of universal mental health education and screening, particularly during pregnancy, creates missed opportunities to counsel patients on symptoms and management of depression, anxiety, and other mental health disorders and to inform them about resources available to them in clinical care and community settings. In addition, limited community resources and structured-referral provider networks lead to higher rates of inpatient hospital-based care, as opposed to care in community-based settings, for Black birthing populations.^{8,9}

The perspectives and experiences of Black birthing people in maternal mental health research are key to identifying practice and treatment solutions. To improve the understanding of the impacts of structural and social determinants of health on Black birthing populations' mental health and mental health care experienc-

es and to identify specific pathways and strategies that could advance equitable and antiracist maternal and infant mental health care, we conducted semistructured interviews with Black women who are maternal and infant mental health stakeholders. This article presents strategies for improving maternal mental health. Subsequent reports will focus on analysis of data related to infant mental health.

Study Data And Methods

STUDY TEAM The study team consisted of three public health professionals who are Black cis-gender women. Two members are of Afro-Caribbean descent (Isabel Morgan and Tracey Estriplet), and two members are descendants of African enslaved peoples in the United States (Morgan and Kay Matthews). Two members of the study team received master's-level training in public health and have experience conducting qualitative analyses using analytic software programs (Morgan and Estriplet). One member of the study team is trained as a licensed clinical health worker and has extensive experience providing mental health counseling and care to Black women and birthing people (Matthews).

GROUNDING FRAMEWORKS Principles of reproductive justice and birth equity informed the development of the facilitator's guide and data analysis and interpretation. The reproductive justice movement, launched by Black feminist scholars and advocates in 1994, asserts an individual's bodily autonomy to not have children, as well as the right to have children, including identifying their birthing options and parent their children in safe and supportive communities with dignity.^{10,11} It also offers a theoretical framework on the ways in which structures and systems create the conditions that affect Black maternal and infant health, which is inclusive of mental health, and it offers a framing of the power dynamics that affect Black birthing people's engagement with mental health care systems, including maternal health care providers (such as obstetrician-gynecologists and midwives) and mental health practitioners (such as psychiatrists, psychologists, and social workers). Birth equity is defined as "the assurance of the conditions of optimal births for all people with a willingness to address racial and social inequities in a sustained effort."¹² Birth equity contributes an understanding of how structural and social determinants affect birthing outcomes and the well-being of pregnant and postpartum people, particularly Black people, who are most burdened by adverse outcomes because of racism, sexism, classism, and other systems of oppression. Both reproductive justice and birth

equity require centering and valuing the expertise of the people who are most marginalized within systems.

DATA COLLECTION This study was approved by the Institutional Review Board of the Institute of Women and Ethnic Studies on December 18, 2020. In February 2021 we interviewed ten Black women perinatal mental health stakeholders who had expertise and professional backgrounds in perinatal social work, clinical psychology, social work, birth work, marriage and family therapy, and health disparities research. Most of the stakeholders provided services to Black women and birthing people in hospital or outpatient settings.

Each interview was semistructured and was informed by a facilitator's guide. Interviews were approximately sixty minutes in duration and were facilitated by a licensed clinical health worker and founder of a community-based Black maternal mental health organization (Matthews). A second study team member (Estriplet or Morgan) participated as an observer in eight of the ten interviews (as schedules allowed) to take notes and provide technical assistance and support with the participant consent process.

The facilitator's guide consisted of twenty-one questions arranged in six sections: framing, barriers, racism and gender oppression, social determinants of health, solutions, and infant mental health (for a copy of the facilitator's guide, see exhibit A1 in the online appendix).¹³ The facilitator's guide included questions regarding the impacts of systems of oppression and structural determinants (such as racism and gender oppression) on Black birthing people's conceptualization of their mental health, access to mental health services, and treatment pathways. The facilitator's guide also described the purpose of the research and outlined ethical considerations for informed consent that was read to stakeholders before initiation of the interview. All interviews were conducted virtually using Zoom. Interviews were video- and audiorecorded with participants' written (via electronic signature) and oral consent.

Audiorecordings of each interview were submitted for professional transcription. A company that uses humans rather than computers to transcribe audio recordings was selected to increase the accuracy and representation of the interviews.

QUALITATIVE ANALYSIS The study team applied a constructivist grounded theory approach for initial, focused, and theoretical coding.¹⁴ This approach aims to position the researcher and participants as partners in research, rather than as an objective analyst and subjects. The research

Several stakeholders expressed the need for services informed by cultural humility and holistic care.

team leveled power dynamics (for instance, by identifying times and media for engaging that were most comfortable to the participant and by having racial concordance between the interviewer and participant) and approached interviews with the goal of establishing mutual, co-constructed meaning making during the interview.¹⁵ A preliminary codebook was generated on the basis of a review of literature, the guiding frameworks, and input from team members with expertise in maternal mental health. The codebook for the in-depth analysis included codes related to client autonomy, mistreatment, racial discrimination, and power dynamics between clients and providers. Two authors (Morgan and Estriplet) independently coded two transcripts using the preliminary codebook and met to review and discuss codes. The codebook was revised on the basis of these discussions between the two authors, and the remainder of the transcripts were independently coded by the same authors and reviewed and discussed for saturation of themes and to identify emerging pathways. Themes were discussed with a third author (Matthews) who had facilitated the stakeholder interviews, to ensure that the major findings aligned with their interpretation of the discussions. We held a virtual meeting with stakeholders to present the key pathways identified from the interviews and to elicit feedback. The five pathways resonated with participants and were determined to be ready for dissemination.

LIMITATIONS This study had several limitations. First, the majority of the questions included in the facilitator's guide focused on maternal mental health, and thus we captured less insight and fewer solutions specific to infant mental health. Therefore, we focus this article on the topic of maternal mental health. Second, all of the practitioners interviewed identified as Black cisgender women, and although their client population varied, most clients were Black cisgender Americans who were descendants of African peoples violently enslaved and involuntarily brought to the United States. It is possible that

the pathways identified may need to be expanded to address specific needs unique to nonbinary birthing populations and those who identify as Afro-Latinx, Afro-Indigenous, Afro-Caribbean, or African.

Study Results

Five key pathways were identified to improve and expand access to equitable and antiracist maternal mental health care (see appendix exhibit A2).¹³ These pathways mention systems-level, institutional, and community-level strategies that center existing strengths and culturally appropriate solutions for Black birthing people. The key pathways are educating and training practitioners; investing in the Black women mental health workforce; investing in Black women-led community-based organizations; valuing, honoring, and investing in community and traditional healing practices; and promoting integrated care and shared decision making. Each of these pathways addresses a unique aspect of care provision and must be addressed in concert.

Specific strategies and additional illustrative quotes identified across the five pathways are in the online appendix (see appendix exhibit A3).¹³

EDUCATING AND TRAINING PRACTITIONERS Participants emphasized areas in which education and training would be required to equip practitioners with the skills to address the challenges experienced by Black birthing populations, such as racism, discriminatory treatment and care, and a history of medical harm that contributes to mistrust. These areas include case management and education on the history of the systems that produce the structural and social determinants that affect mental health and well-being. In discussing how racism affects Black women's experiences with maternal and mental health care services, one practitioner shared: "It's all of these things that trace back systemically and institutionally to the slavery, and how it has just evolved. How the Black woman's body was never her own. How the whole field of obstetrics was founded by J. Marion Sims, and his exploitation of the Black female body. The degradation of the Black woman has manifested throughout all of the years. And it's still happening today. We see how someone's mental health history is—they are quickly stereotyped and labeled difficult or belligerent, or she has issues with bonding or appropriateness" (participant 1, a perinatal social worker).

Another practitioner described the impact of racism on entrance into the mental health workforce, including who has access to educational pathways to pursue careers in mental health

care: “Racism affects whether or not people are even able to go to school to get a higher level of education to become a therapist. We’ve got going to school, people telling you—or assuming—that you’re not as intelligent, or all the barriers to getting through the educational system for a Black person with the way that people underestimate Black children and then young people’s ability and capacity” (participant 2, licensed clinical psychologist and birth doula).

Racism and discrimination were also implicated in Black maternal health inequities. Despite a higher prevalence of mental health symptoms, Black women are underrepresented among clients receiving mental health services, participants noted. Participant 4, a health disparities researcher, said, “More Black women report higher symptoms of mental health problems but have the lowest diagnoses. So we need to understand more of what’s behind that. And I think a lot of it is going to be this phenomenon of just not being heard.” Several practitioners described specific ways in which racism affects maternal mental health, and one described the magnitude of its impacts as immeasurable: “I don’t even know what a healthy Black person looks like till I take them out of this racist society. I would have to move them to a whole ’nother place and watch them for a month and see if, oh, suddenly they don’t have anxiety, suddenly they don’t have depression, ’cause they’re not walking around carrying the burdens of racism” (participant 3, licensed marriage and family therapist).

In addition to discussing the need for education and training in structural and social determinants of health, participants noted that practitioners’ training should address trauma that birthing people may experience across the life course, including prepregnancy, during pregnancy, and in the postpartum period. Several practitioners described how trauma can manifest during the birthing process as a result of an unrecognized history of sexual and physical abuse. Birth trauma can present when providers neglect to request consent before touching birthing people during labor and delivery: “I think it manifests a lot through how we’re treated even by our providers. ...A lot of times the language that’s used with our moms could be very traumatic. Like a lot of things with trauma is kind of unsaid. It’s silent. So, a lot of times a provider just simply not asking for consent to touch you when you’re birthing your child, or simply acting as if you’re not in the room, or you having a birth trauma that someone doesn’t recognize” (participant 4, health disparities researcher).

Several stakeholders expressed the need for services informed by cultural humility and holistic care, which is inclusive of dignified, respect-

Culturally congruent and decolonized practitioners will be required to make mental health care services more acceptable and accessible.

ful, humane, and empathetic care. Holistic care acknowledges bodily autonomy and mitigates mistreatment that birthing people may experience as a result of discrimination. Active listening, answering a client’s questions, intentionally dismantling power dynamics, creating “brave spaces” (environments that foster critical dialogue and acknowledge varying perceptions and realities of safety), and providing care within their scope of practice and training were reported as important strategies to build trust and respond to a client’s needs holistically. “It’s a space where the client knows that they’re heard, and they can ask any question that comes up,” one participant said. “I’m not trying to hide anything. If you need access to something, I give it to you. If you shoot me an email, I respond. It’s no power struggle happening. We are a trusted team. We are a team” (participant 7, licensed clinical social worker).

INVESTING IN THE BLACK WOMEN MENTAL HEALTH WORKFORCE Culturally congruent and decolonized practitioners will be required to make mental health care services more acceptable and accessible, participants said. Decolonized practitioners consider not only how individual experiences affect their client’s mental health but also how systems of oppression, cultural phenomena, and sociohistorical forces create environments that induce trauma. One stakeholder described how important it was for their clients to receive care from someone who looked like and could relate to them: “I just need to know that, one, you have some type of shared experience.... It may not be mental health issues, but you just know my struggle. So, for me to be able to open up and just kind of be vulnerable in that way, I need somebody that looks like me, and thus far that’s why I’ve not found anybody that

Reimagining the maternal mental health care landscape is essential to addressing the Black maternal health crisis.

takes my state insurance to” receive care from (participant 8, birth and postpartum doula). Cultural congruency provides assurance to the patient that their provider has a shared lived experience. Culturally congruent providers recognize the importance of seemingly simple but important elements of a client’s experience with care, including having magazines and reading materials in waiting rooms that reflect Black pregnant and postpartum people: “So, them being knowledgeable of what’s going on in the community, having some awareness of that, and showing due diligence with creating a space to address that, to foster that, to cultivate that. Even as far as magazines...that have information that look like the Black women that are coming to the facilities, you know? Stuff as simple as that. Information that has Black women on it, you know? I think those steps can, at least from a distant, a minor way, just address the cultural competency in those facilities” (participant 1, perinatal social worker).

Several practitioners emphasized how critical it is to invest in training Black women mental health professionals (therapists, social workers, counselors, psychologists, and psychiatrists) and hire them in hospital and birth center settings.

INVESTING IN BLACK WOMEN-LED COMMUNITY-BASED ORGANIZATIONS In addition to investing in the next generation of practitioners, interviewees also described the importance of investing in Black women-led community-based organizations that are currently serving Black birthing populations. To this end, one practitioner stated, “I think funding should be allocated and prioritized to those who make a commitment to advance Black maternal mental health” (participant 1, perinatal social worker). Specifically, participants said that funding should be prioritized to support organizational infrastructure and capacity building. Many philanthropic organizations and federal grants restrict the

scope of how funding can be used, which limits the programming and services that community-based organizations can offer. Increasing and expanding the parameters of funding that allows Black women-led community-based organizations to invest in organizational expansion growth—for example, establishing funding for a full-time staff—can ensure that they are better equipped to meet the needs of their community. The harm that is introduced and perpetuated with current funding trends was articulated by one practitioner: “This is a big problem, because people getting the contracts in our community are not the community. ...I do think that has a lot to do with pushing more policy, pushing more advocacy, and pushing more accountability. ...We ain’t stupid. When the funding is in the wrong hands, then the care does not change, and that’s just the bottom line. And that’s not the fault of the communities...that’s a top-down decision” (participant 3, licensed marriage and family therapist).

VALUING, HONORING, AND INVESTING IN COMMUNITY AND TRADITIONAL HEALING PRACTICES

In describing how funding should be prioritized to improve Black birthing people’s experiences seeking and receiving maternal and mental health care services, several participants discussed the roles of birth workers (such as doulas and midwives): “I think the implementation of the doula, and the midwife, bringing that back. We need that back. With a quickness. That’s our history. That’s our lineage. That’s our ancestry” (participant 1, perinatal social worker). When asked to describe the ways in which Black birthing populations are successfully navigating mental health care systems and improving their own mental health, practitioners discussed the role of doulas and midwives as advocates for Black birthing folks. Spirituality and ancestral practices help ground Black birthing people and were described as essential components of holistic mental health care services and treatment: “These shared models incorporate ancestral practices and incorporate the fact that the body has wisdom. A lot of what we do is, in your body is the wisdom of thousands of people who have birthed. How do we access that wisdom? Maybe part of our process is we [make an] altar for our ancestors...and we dedicate it to all the mothers who came before us, and we ask for their wisdom and their guidance, and then we create space in our life and our day to actually listen for that guidance” (participant 3, licensed marriage and family therapist). The mental health practitioners in our study recognized and acknowledged that they are only one component of the process and that community effort is needed to support birthing people. They said that fostering

opportunities for families to be engaged in their clients' care helps destigmatize mental health challenges and can better position practitioners to build on clients' strengths and familial assets.

PROMOTING INTEGRATED CARE AND SHARED DECISION MAKING To address disjointed care, practitioners said that strengthening partnerships between doulas and mental health care providers would make health care services more accessible, as well as establish linkages between maternal health care services and maternal mental health practitioners. Only one practitioner identified a specific model of care (the patient-centered care model) that they believed accommodated shared decision making between clients and their providers: "I mean, from a theoretical perspective, I think that the patient-centered model was designed to do that. And I think a lot of health care systems have theoretically wanted to put that in place, where the patient ultimately is the decision maker. But I don't think that's always practiced" (participant 1, perinatal social worker). Several practitioners reported their own approach to fostering trust and promoting shared decision making with their clients, which shared elements in common with the patient-centered care model: "When I do my intake, I let people know, 'You're the expert on your own life.' I set the tone: 'I need this to be a conversation. I'm not the expert on your life. I read a bunch of books. I got some tools under my belt that I can share with you, but you are still the expert. You're the driver, and I'm a good copilot'" (participant 7, licensed clinical social worker).

Discussion

New pathways to equitable maternal mental health are needed to ensure that Black birthing people have access to antiracist systems of care. The US mental health landscape is notoriously fractured, particularly for people of color seeking culturally responsive and respectful care.^{6,7,13} Reimagining the maternal mental health care landscape is essential to addressing the Black maternal health crisis. The need has become increasingly urgent during a period of heightened stress due to the COVID-19 pandemic and civil unrest resulting from systemic racism, police brutality, and racialized hate crimes, all disproportionately causing premature morbidity and mortality for Black people.^{5,16-18}

Of the five proposed pathways mentioned by the study participants, four focused on health care system transformation (educating and training practitioners, investing in the Black women mental health workforce, promoting integrated care and shared decision making, and

Community mobilizing supports the creation of federal, state, and local policies that undo the harms exacerbating Black maternal mental health.

valuing, honoring, and investing in community and traditional healing practices). However, challenges in the current mental and maternal health care landscape could thwart implementation of these pathways. For instance, there will be challenges with screening, diagnosis, and treatment consistency, as perinatal and maternal mental health support can be provided across clinical specialties (psychiatry, family medicine, and obstetrics and gynecology). Although holistic and team-based care models have been held as best practices by clinicians and researchers within the reproductive justice movement, the focus in implementing these models has been primarily on obstetric care and support providers (obstetrician-gynecologists, maternal-fetal medicine specialists, nurses, and doulas), rather than mental health providers. The mental health workforce will need to adopt a similar model for team-based care to address chronic mental and behavioral health issues across the life course, including the perinatal period. Without a cohesive model of care, Black birthing people, along with other marginalized populations, will continue to fall through the fractures of the system.

Recent shifts in US national policies are in alignment with stakeholders' recommendations. Community mobilizing supports the creation of federal, state, and local policies that mitigate and undo the harms exacerbating Black maternal mental health. For example, two advocacy weeks supported by Black women-led reproductive justice organizations—Black Maternal Health Week and Black Maternal Mental Health Week—have garnered engagement with elected officials, stakeholders, philanthropic organizations, and parents. Both advocacy weeks have focused on elevating the 2021 Black Mater-

One pathway to more equitable Black maternal health is expanding the maternal mental health workforce with more Black women providers.

nal Health Momnibus Act of 2021—twelve pieces of legislation led by the Black Maternal Health Caucus, in collaboration with Black women-led reproductive rights, health, and justice organizations.^{19–21}

Two of the proposed twelve bills are specifically designed to address Black maternal mental health.²¹ The Kira Johnson Act, named after a healthy Black mother who died after birthing her second son, aims to provide resources for pregnant people experiencing mental health conditions and substance misuse disorders via community-based organizations serving women of color and other marginalized birthing people. The Moms Matter Act would provide community-based mental health support to moms with substance misuse disorders or mental health conditions. These two bills have each been publicly supported by more than 150 maternal, infant, sexual and reproductive health, rights, and justice organizations.

According to participants interviewed in this study, one pathway to more equitable Black maternal health is expanding the maternal mental health workforce with more Black women providers. The current curriculum for mental health practitioners lacks education on the impacts of structural racism on mental health.²² Supporting Black women providers (who are more likely to care for Black patients across various identities and could provide more culturally responsive care) and community-based organizations is essential, as the majority of current research on maternal and mental health disparities shows the disproportionate burden faced by Black cisgender women. However, Black birthing people have various identities and lived contexts that affect their individual and community mental health needs. Isolated jurisdictions, such as New

York City, have revised regulations regarding gender markers on birth certificates, strengthening surveillance systems to allow for the analysis of birth outcomes for intersex, transgender, and nonbinary people. Ensuring Black maternal mental health equity will require additional quantitative and qualitative research to understand the unique mental health supports of important subpopulations affected by additional spheres of oppression, including those who are differently abled, transgender, or nonbinary and those who speak languages other than English.

In addition to internal transformation within health care systems, societal shifts are needed to create environments free of racism and gender oppression—forces that spawn and worsen the stressors that Black birthing people experience—ultimately creating poor maternal and infant mental health outcomes. Pathways for change rooted primarily in health care systems, and even in some community settings, may be ill equipped to address environmental factors, shaped by structural racism, that exacerbate mood disorders during the perinatal period, including housing instability and unaffordability, criminal justice involvement, exposure to community violence, and experiences of discrimination outside the health care system.

Although some of the pathways identified by participants urge investments in nonclinical modalities and traditional healing practices familiar to doulas, community health workers, and community-based mental health organizations, they stop short of addressing structural factors. Nevertheless, some public health systems have invested in co-locating mental health clinical support with place-based social support services for parents. In New York City, the Mayor's Office of Community Mental Health embeds mental health screening, referrals, and clinicians within Family Justice Centers (serving families experiencing intimate partner violence), family shelters, and pediatricians' offices.²³ Several home visiting programs, such as through the Nurse-Family Partnership and the Healthy Start Program, provide maternal mental health screening and support, eliminating the silos between maternal mental health and infant mental health and early childhood development. Infant mental health and early childhood development and maternal mental health disorders, although managed by different subspecialties, share common root causes and clinical opportunities (such as well-baby visits).

Conclusion

The proposed pathways to equitable and antiracist maternal mental health care were developed

by centering Black birthing people in alignment with the guiding frameworks of reproductive justice and birth equity. By learning directly from Black women maternal health experts, those most likely to care for those who experience maternal morbidity, maternal mortality, and maternal mental health disorders, this analysis has the potential to inform policies and practices for practitioners, researchers, policy makers, and activists. ■

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