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COMMENTARY/POLICY

Rethinking Maternal Mental Health Solutions: Addressing Racial Disparities in Ohio and Beyond

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ABSTRACT

The maternal mental health (MMH) crisis in Ohio reflects broader national inequities, with significant racial disparities in postpartum depression, anxiety, substance use, and maternal mortality. Black, Hispanic, and other marginalized communities disproportionately experience postpartum depression and anxiety (PPD/A) due to structural racism, provider bias, and social determinants of health, while White women tend to be more affected by substance use disorder (SUD) and overdose-related maternal deaths. Despite recent policy efforts, such as House Concurrent Resolution 12 (HCR 12), Ohio's approach to MMH remains inadequate in addressing MMH and these disparities. This commentary examines the systemic drivers of MMH inequities in Ohio, highlights evidence-based strategies from other states, and calls for policy solutions that are comprehensive, data-driven, and equity-focused. Without targeted interventions, such as culturally tailored mental health care, integrated substance use and perinatal services, and expanded community-based programs, Ohio risks failing all mothers and perpetuating existing disparities. By adopting best practices from states with more effective MMH policies, as well as building on promising local efforts, Ohio has the opportunity to lead in developing equitable, actionable reforms that improve MMH outcomes across its diverse populations.

Keywords: Infant health; Maternal mental health; Structural racism; Health equity; Health disparities; Maternal mortality

INTRODUCTION

Ohio's C grade on the 2025 Maternal Mental Health State Report Card reflects a crisis that demands urgent attention. While a C grade represents improvement from previous years, it places Ohio among the majority of states failing to adequately address maternal mental health (MMH) needs, with only 5 states nationwide earning a B grade and none receiving an A. This mediocre performance also masks profound racial disparities: nationally, Black women are twice as likely to experience MMH conditions but half as likely to receive treatment compared to White women[1]; and untreated MMH disorders cost the United States $14.2 billion annually.[2] Bipartisan House Concurrent Resolution 12 (HCR 12) Recognizing the Importance of Perinatal Mental Health, introduced by Ohio State Representatives Anita Somani (D-Dublin) and Sharon Ray (R-Wadsworth), is in process of being reviewed in the statehouse in the 136th General Assembly. A house concurrent resolution is a formal expression of the intent or wish of the legislature that must be adopted by both houses but does not have the force of a law.[3] While not a binding law, passage of HCR 12 would officially recognize the impacts of MMH on families, children, and the Ohio workforce, and push the need for focused interventions in MMH. Resolution HCR 12 is an essential starting point in addressing MMH, but Ohio's approach does not yet adequately account for the specific needs of different communities. Without a proactive evidence-based implementation strategy, we are at risk of perpetuating or exacerbating existing disparities and needs gaps.

Disparities in MMH are complex, with women and birthing people who identify as Black, Hispanic, and from other marginalized communities disproportionately affected by postpartum depression and anxiety (PPD/A) driven by structural racism and provider

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bias, while White women are more impacted by substance use disorder (SUD) and overdose-related maternal mortality. Once HCR 12 is adopted, how can subsequent legislation address the diverse aspects of MMH to reduce maternal mortality and morbidity while also narrowing racial disparities in outcomes, care, and suffering? This paper discusses the systemic causes of racial disparities in MMH, points to other states' progress with equitable strategies to addressing MMH, and emphasizes the need for actionable, evidence-based strategies to address the weaknesses of states like Ohio with "grades" below B on their MMH "report cards."

Racial Disparities in Maternal Mental Health: A Divergence in Causes

Postpartum depression and anxiety (PPD/A) are significant public health concerns, disproportionately affecting Black, Hispanic, and other marginalized populations due to systemic inequities rather than inherent racial differences; according to the Ohio Pregnancy Assessment Survey (OPAS), 12.8 percent of non-Hispanic Black women in Ohio experienced postpartum depression in 2022, compared to 9.3 percent of non-Hispanic White women.[4] These disparities are driven by structural factors, including unequal access to health care, provider bias, chronic stress from racism, and social determinants of health (eg, housing and food insecurity).[5] Studies on implicit bias in health care reveal that systemic racism reduces the quality of care for Black, Hispanic, and other marginalized populations, leading to worse outcomes in MMH.[6]

Additionally, current screening tools for perinatal mental health are often based on historically White Western frameworks, which fail to capture culturally specific "idioms of distress."[7] For instance, somatic symptoms or expressions of fatigue and irritability, which may be more common among marginalized populations, are frequently overlooked, resulting in underdiagnosis or misdiagnosis.[8] This mismatch between dominant diagnostic frameworks and the lived experiences of diverse populations reinforces disparities in care and perpetuates structural inequities.[9]

Substance use disorder (SUD) represents another major contributor to maternal mortality, but the burden differs significantly by race. Data from a national analysis (2017–2020) shows a sharp rise in overdose deaths among postpartum women, with the highest incidence among White mothers.[10] This trend reflects systemic factors such as the opioid epidemic, which disproportionately affects White communities due to overprescription, economic disinvestment, and rural health care inequities. White women with SUD face barriers such as stigma, geographic limitations, and insufficient access to medication-assisted treatment (MAT).[11] However, they are more likely to be referred to treatment programs than Black women.[12]

Black women with SUD face compounded inequities due to systemic racism and provider bias. Research shows that Black women are less likely to receive MAT and are more likely to discontinue treatment prematurely due to inadequate resources and discriminatory care practices.[13] In addition, punitive policies, which are barriers to care for most mothers regardless of race,[14] disproportionately impact Black women, leading to higher rates of criminalization and child welfare interventions, which discourage seeking help.[15,16] Moreover, treatment programs often fail to address the systemic and cultural stressors, such as racism and economic inequality, that uniquely affect Black women.[17]

These divergent causes and outcomes underscore the limitations of a one-size-fits-all approach to MMH.[18-20] While White women's experiences with SUD highlight the need for expanded harm reduction programs and rural health care support, Black women's experiences require culturally competent interventions and the dismantling of punitive frameworks. Finally, stigma surrounding mental health and mistrust in the health care system impede access to care for all women and birthing people.[21] Black women, in particular, face compounded stigma rooted in intersecting oppressions of race, gender, and class. Recognizing the role of systemic oppression, historical inequities, and lived experiences of marginalization is essential to crafting effective solutions for MMH disparities.[22] Addressing these disparities requires evidence-based, tailored policies that prioritize equity and consider the distinct systemic barriers faced by different populations.

Ohio's Status in Maternal Mental Health Policy and Areas for Improvement

Ohio's MMH policies reflect incremental progress but remain insufficient to meet the diverse needs of its perinatal population, as evidenced by the state's C grade on the 2025 Maternal Mental Health Report Card, up from the 2024 C– grade.[23] As the report card highlights, this grade highlights significant gaps in areas such as screening, provider availability, and program development, despite some notable strengths. Ohio's grade places it among the majority of states with a grade of C or lower; the US average grade in 2025 was C with only 5 states earning a B and no A grades given. With its current standing and trajectory, however, Ohio is within reach of a higher grade if it builds on its recent policy advancements. One of Ohio's most significant achievements is the extension of postpartum Medicaid coverage to 12 months, ensuring more consistent health care access for new mothers. Additionally, Ohio meets key benchmarks for providers submitting claims to private insurers for both prenatal and postpartum MMH treatments, which helps ensure that more mothers receive reimbursed mental health care.

Despite Ohio's demonstrable accomplishments in the MMH space, the report also notes that the state continues to face significant weaknesses in several key areas. Both screening and screening reimbursement stand out as a major deficiency, earning the state an F grade. Ohio does not require Medicaid-managed care organizations (MCOs) to collect data on prenatal or postpartum depression screenings, nor are obstetric providers submitting claims to private insurers for even 1% of patients. This lack of systematic screening undermines early identification of MMH issues and

contributes to untreated mental illness in the perinatal population. Provider availability also remains a significant challenge, reflected in Ohio's C grade for programs and providers. While Ohio has at least one inpatient MMH treatment program and one outpatient intensive or partial hospitalization program, these resources are insufficient to address the widespread demand for MMH services.

Ohio's C grade reflects a systemic underinvestment in essential areas of MMH care. Despite progress in expanding Medicaid coverage, the report card demonstrates that the state has failed to implement policies that prioritize maternal health and well-being for all Ohioans. Addressing these gaps will require the adoption of statewide MMH screening requirements, improved data collection through Medicaid MCOs, and an increase in trained MMH providers (particularly in underserved communities), and creation of quality management programs for MMH. Without these changes, Ohio's MMH policies will continue to fall short of addressing the needs of all pregnant and postpartum women, especially its most vulnerable populations.

Recommendations for Enhancing Equity in Maternal Mental Health Care in Below-Average States

The following recommendations are designed to achieve 2 essential goals: reducing maternal mortality and morbidity for all perinatal populations, while simultaneously narrowing racial disparities. Research has consistently shown that interventions in health care focusing solely on overall improvements often fail to reduce racial disparities.[18-20] Therefore, our approach emphasizes both universal strategies that benefit all racial groups and targeted interventions that address specific inequities faced by different communities.

Integrated Substance Use and Mental Health Services

Ohio should develop integrated care models that address both MMH and perinatal substance use disorder (PSUD), drawing inspiration from Washington state's Maternity Support Services program.[24] This initiative coordinates physical and behavioral health services under Medicaid to reduce maternal mortality and improve long-term outcomes for postpartum women. This recommendation particularly addresses the needs of White women, who face disproportionately high rates of SUD-related maternal mortality as noted in our analysis, while also creating a more comprehensive care system for all racial groups. Expanding access to medication-assisted treatment (MAT) and embedding mental health professionals within perinatal care teams can ensure mothers across all racial backgrounds receive comprehensive support tailored to their specific needs. Ohio's high rates of SUD-related maternal mortality make this approach particularly urgent. Expanding access to MAT and embedding mental health professionals within perinatal care teams can help ensure mothers receive the comprehensive support they need.

Comprehensive Pregnancy Medical Home Models

Adopting a pregnancy medical home model, as implemented in North Carolina,[25] would enable Ohio to provide continuous, patient-centered care throughout the perinatal period for women of all racial backgrounds. These homes integrate obstetrics/gynecology, pediatric, and mental health services, ensuring that care addresses both universal needs and group-specific concerns. Evidence from North Carolina shows that this model reduces racial disparities in diagnosis and treatment outcomes, making it a promising framework for Ohio to replicate. This approach particularly benefits rural communities, including many White women who face geographic barriers to accessing comprehensive care, while also addressing the fragmented care often experienced by Black and Hispanic women.

Enhanced Data Collection and Analysis

Accurate and disaggregated data collection is essential for identifying gaps and guiding resource allocation that benefits all perinatal populations. Ohio must mandate the collection of MMH outcomes data by race, ethnicity, and social determinants of health. For instance, California's use of standardized data-sharing protocols in its Maternal Data Center allows for detailed analysis of both overall trends and specific disparities.[26] Adopting similar measures in Ohio, would support both universal improvements and targeted interventions to address inequities faced by specific racial groups. This data-driven approach ensures resources are allocated efficiently to serve all communities while identifying where focused efforts are needed to eliminate disparities.

Culturally Tailored Care and Provider Training

Ohio must prioritize the integration of culturally tailored mental health services into existing programs, benefiting all women while particularly addressing the needs of marginalized communities. Columbus Public Health's Hope at Home initiative, which incorporates mental health professionals into home visiting teams for pregnant and postpartum at-risk mothers, demonstrating the potential of localized, holistic care models. While this approach specifically helps address disparities faced by Black, Hispanic, and other marginalized populations, it simultaneously improves care quality for all women by increasing provider cultural competence and system responsiveness.

Ohio's approval of Medicaid reimbursement for doula services is a step forward in addressing disparities in MMH and obstetric care.[27] Doulas provide continuous, culturally sensitive support throughout pregnancy, childbirth, and the postpartum period, playing a critical role in mitigating obstetric racism and improving outcomes for Black, Hispanic, and other marginalized populations while also enhancing birth experiences and improving outcomes for women of all backgrounds.[28] However, the implementation of this policy has significant limitations. While Ohio has established a reimbursement pathway, many doulas—particularly those from underrepresented backgrounds—face barriers to participation,

including the costs of training and certification and limited infrastructure for Medicaid billing. Unlike states such as Oregon and Minnesota, which have implemented systems to recruit, train, and retain doulas from diverse communities, Ohio has yet to make similar investments.[29,30] Expanding funding to support doula training programs, particularly for Black, Hispanic, and doulas from other marginalized communities, would ensure that Medicaid-covered doula care is accessible to those most in need while building a more diverse and representative workforce that benefits all women.

Furthermore, health care providers in Ohio should also be required to undergo training in trauma-informed care, cultural humility, and implicit bias to improve interactions with diverse populations. Research shows that racial congruence between providers and patients leads to better outcomes, underscoring the importance of diversifying the maternal health workforce. Programs like California's Perinatal Equity Initiative, which funds implicit bias training and community-driven interventions, provide a model for Ohio to follow.[31] However, legislative challenges surrounding the teaching of race and equity issues in public education must be addressed to ensure sustainable progress.

Community-Based Program Expansion

Ohio has made progress with initiatives like Queen's Village in Cincinnati, a peer-support network empowering Black women through culturally tailored resources and mental health promotion. Expanding funding for community-based programs creates infrastructure that benefits all populations while ensuring culturally specific support for groups with the highest need. These community-anchored approaches can address the specific needs of White women facing SUD in rural areas, urban Black and Hispanic women experiencing PPD/A, and other distinct population needs. Mobile mental health clinics and peer support programs should be prioritized to reach underserved rural and urban populations, creating a network of support accessible to all perinatal women regardless of geographic location or racial background. Ohio could also look to California's Black Infant Health Program, which combines culturally specific case management and group-based interventions, as an example for statewide implementation.

Nonpunitive, Family-Centered Treatment Approaches

Transitioning to nonpunitive frameworks for addressing MMH and substance use issues is critical to fostering trust, reducing stigma, and improving treatment adherence for all women. While these approaches are especially impactful for Black, Hispanic, and other marginalized women who face disproportionate criminalization and family separation, they create a more effective, compassionate system for all families. Research demonstrates that family-centered approaches can improve both maternal and infant health outcomes by fostering maternal-infant bonding and reducing barriers to accessing care.[32]

Ohio could learn from Connecticut's Family-Based Recovery Program, which integrates in-home mental health and substance use services with family preservation goals, ensuring that mothers can receive treatment while keeping their families intact.[33] This program demonstrates how a shift toward collaborative, nonpunitive care models can yield positive outcomes for vulnerable families. Scaling up such frameworks within Ohio's Medicaid and home visiting programs would create a more equitable system that prioritizes long-term maternal and family well-being for all communities while closing existing gaps.

PUBLIC HEALTH IMPLICATIONS

Ohio's MMH policies must move beyond symbolic recognition to implement equity-driven, evidence-based reforms. Addressing racial disparities requires expanding culturally tailored mental health care, integrating perinatal substance use and mental health services, and strengthening community-based programs like Queen's Village. Increasing Medicaid-supported doula access and embedding MMH screening into routine care are critical next steps.

To reduce maternal health inequities, Ohio should adopt best practices from states with stronger MMH policies, such as Pregnancy Medical Homes and family-centered treatment models. Additionally, mandating robust data collection on racial and geographic disparities will enable more targeted interventions.

These recommendations form a comprehensive approach that addresses both the universal needs of all perinatal populations and the specific challenges faced by different racial groups. By implementing strategies that improve overall maternal mental health while simultaneously targeting the elimination of disparities, Ohio can build a more equitable and effective maternal health care system. A dual focus on overall improvement and disparity reduction is essential, as research consistently demonstrates that interventions lacking an explicit equity focus may inadvertently widen existing health gaps even as they improve population averages. By committing to structural change, Ohio can build a maternal mental health system that is both effective and equitable for all Ohioans.

CONFLICTS OF INTEREST

None.

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AUTHOR CONTRIBUTION

Amber Akhter: Substantial contributions to the conception and design of the commentary. Drafted the work and, along with Sarah Rubin, made the most significant contributions to the writing. Participated in critical revisions for intellectual content. Gave final approval of the version to be

published. Accountable for all aspects of the work. Sarah E. Rubin: Oversaw the project and, along with Akhter, made the most significant contributions to the writing. Participated in critical revisions for intellectual content. Gave final approval of the version to be published. Accountable for all aspects of the work. Natasha Takyi-Micah: Served as a content expert, providing key analytical contributions. Contributed to revisions for intellectual content. Gave final approval of the version to be published. Accountable for all aspects of the work. Amanda Zabala: Acted as a content expert, providing the most substantial analytical contributions. Participated in revisions for intellectual content. Gave final approval of the version to be published. Accountable for all aspects of the work.

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