Social Work Efforts Towards Equitable Mental Health Practice With People Who Are Racially Minoritized

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Social Work Efforts Towards Equitable Mental Health Practice With People Who Are Racially Minoritized

by

Jeremy Wente

A Banded Dissertation in Partial Fulfillment
Of the Requirements for the Degree
Doctor of Social Work

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Abstract

Previous literature on mental health disparities provides a context for the scope and impact of inequality within mental health treatment. Hence, there is a need to add to the existing efforts to develop equitable mental health services. In response to this need, this banded dissertation comprised two scholarly articles and a peer-reviewed presentation explored the role of social work in addressing mental health disparities among people who are racially minoritized. Critical Race Theory (CRT) is the conceptual framework guiding this dissertation.

The first article is a conceptual paper that applies the assumptions of CRT in evaluating mental health disparities among groups that are racially minoritized. The paper discusses implications for the application of CRT to social work practice, education, and research. The second academic work is a qualitative study that explored social workers’ perceptions of mental health disparities among people who are racially minoritized. Through thematic analysis of 13 semi-structured interviews, social workers identified prevalent disparities observed in clinical practice and made recommendations for improvement. The findings from this study highlight the value of formal and informal cultural education, the continued need for racial and ethnic representation among social workers, and the need to address mental health disparities among people who are racially minoritized.

The final product is the documentation of initial findings from the above qualitative study presented at the 44th Annual NASW State Conference in Oklahoma on September 6th, 2019. This presentation reviewed the previous literature on mental health disparities among people who are racially minoritized. Emerging themes from the qualitative study were explored, and participants were encouraged to apply the information to their current practice environments.
Keywords: Critical Race Theory, clinical social work, mental health disparities, race, ethnicity, racially minoritized
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Table of Contents

Title Page ......................................................................................................................... i
Abstract .............................................................................................................................. ii
Acknowledgements ........................................................................................................ iv
List of Tables ..................................................................................................................... vi
List of Figures ................................................................................................................... vii
Introduction ..................................................................................................................... 1
Conceptual Framework .................................................................................................... 3
Summary of Banded Dissertation Products ................................................................. 4
Discussion .......................................................................................................................... 6
  Implications for Social Work ...................................................................................... 6
  Implications for Future Research ............................................................................ 7
Comprehensive Reference List ....................................................................................... 9
Product 1 Critical Race Theory: A Social Justice Framework for Equitable Mental Health Treatment .................................................................................................................. 16
Product 2 Social Workers’ Perceptions of the Mental Health Needs of People who are Racially Minoritized .............................................................................................................. 36
Product 3 Social Worker Perceptions of the Mental Health Treatment Needs of People who are Racially Minoritized .................................................................................................... 63
List of Tables

Table 1: Frequency of Client Population Served ................................................................. 45
List of Figures

Figures 1.1 Title and 1.2 Learning Objectives ................................................................. 66
Figures 1.3 Overview and 1.4 Introduction/Background ....................................................... 67
Figure 1.5 Introduction/Background and 1.6 Previous Research .......................................... 68
Figure 1.7 Previous Research and Figure 1.8 Previous Research ......................................... 69
Figure 1.9 Previous Research and 1.10 Purpose Statement .................................................. 70
Figure 1.11 Methodology and 1.12 Methodology .................................................................. 71
Figure 1.13 Interview Questions and Figure 1.14 Interview Questions ................................. 72
Figure 1.15 Sampling and Figure 1.16 Research Sample ...................................................... 73
Figure 1.17 Research Sample Cont. and Figure 1.18 Sample Table 1 ...................................... 74
Figure 1.19 and 1.20 Findings ............................................................................................. 75
Figure 1.21 and 1.22 Findings ............................................................................................. 76
Figure 1.23 and 1.24 Findings ............................................................................................. 77
Figure 1.25 and 1.26 Findings ............................................................................................. 78
Figure 1.27 Implications ....................................................................................................... 79
Social Work Efforts Towards Equitable Mental Health Practice With People Who Are Racially Minoritized

Embedded within the fabric of the United States is the foundation of racial inequality. Historically, groups and individuals identified as people of color (POC) encountered explicit racism. In the current societal context, explicit racism exists, but much of racial inequality is implicit and embodied within institutions (Wyatt-Nichol & Seabrook, 2016). One manifestation of systemic inequality is the prevalence of health disparities among groups that are racially minoritized. The term racially minoritized describes the social conditions that disadvantage certain racial and ethnic groups (Benitez, 2010) and is congruent with the concept of systemic inequality. Disparities are defined as systematic differences within health care and treatment outcomes not related to biological factors (Braveman et al., 2011). Factors that may impact health outcomes include geographic location, socioeconomic status, age, disability, gender, sexual identity, and/or race and ethnicity (Braveman et al., 2011). The primary focus here are differences in mental health treatment related to the categorization of race (Cook, Trinh, Li, Hou & Progovac, 2017).

Prevalent mental health disparities identified in previous research among groups that are racially minoritized includes: disproportionate diagnosis of conduct disorder and psychotic disorders (Baglivio, Wolff, Piquero, Greenwald, & Epps, 2017; Schwartz & Blankenship, 2014); barriers including coordination/logistics, stigma, and socioeconomic status (Young & Rabiner, 2015); distrust and negative perceptions of mental health services (Cai & Robst, 2016; Copeland & Snyder, 2011); and poor treatment outcomes (Bahorik, Queen, Chen, Foster, & Bangs 2015; Guerrero, 2013). The consequences of untreated and mistreated mental health needs may result
in the administration of incorrect psychotropic medications, the progression of mental health symptoms (Barnes, 2008), the perpetuation of stigma, and compromised physical health.

The field of social work identifies *Closing the Health Gap* as one of the twelve Grand Challenges for Social Work (AASWSW, 2018). Achieving health equity is the primary goal of this Grand Challenge with the target date of 2050. Social work can accomplish this goal through policy advocacy, professional development, community empowerment, access to health care, and primary care innovations (Walters et al., 2016). In addition to the Grand Challenges for Social Work, the National Association of Dean and Directors of Schools of Social Work, the Council on Social Work Education (CSWE), and the U.S. Department of Health and Human Services Office of Minority Health convened a Behavioral Health Disparities Task Force for Social Work. The focus of this task force is the integration of content on mental health disparities within the social work curriculum (Marsiglia & Williams, 2011).

This dissertation adds to the previous literature and social work initiatives by examining the role of social work in addressing mental health disparities among groups that are racially minoritized. The exploration includes the use of Critical Race Theory (CRT) to conceptualize the dynamics that impact existing disparities. Additionally, perspectives of clinical social workers provide insight into daily practice experiences and recommendations for the development of culturally responsive mental health treatment. A commitment towards equitable mental health services aligns with the NASW Code of Ethics principals of social justice and dignity and worth of the person (NASW, 2017). The social work discipline has a responsibility to address existing inequalities and work towards the reform of mental health treatment.
Conceptual Framework

Critical Race Theory (CRT) is the conceptual framework guiding this dissertation. Following the progress of the civil rights movement in the United States, legal scholars including Derrick Bell and Alan Freeman began to explore the dynamics of race and power in America. They observed that the advancements made in the 1960s were often illusions of change, primarily benefiting those in power. Adding to the theoretical development of CRT was also the growth of radical feminist theory. The first conference converging these ideas occurred in 1989 in Madison, Wisconsin (Delgado & Stefancic, 2017). Since its inception CRT has been applied within ethnic studies, political science, and education (Delgado & Stefancic, 2017).

Two assumptions guide CRT’s focus on the function of race in the United States. The first assumption is that race is socially constructed by society and does not have a biological basis. Race is molded to benefit people in power and continues to change as the needs of the powerful change (Bell, 1995). The second assumption is that racism is a norm within society upheld by institutions (Bell, 1992). Though race does not exist within the natural world, it is a strong force expressed throughout society embodied within racism and discrimination. Critical Race Theorists highlight the existence of systemic racism and acknowledge that, to many within society, race and racism are invisible (Ladson-Billings & Tate, 1995).

Emerging from the assumptions of CRT, four concepts provide a lens to examine mental health disparities. The first concept is the myth of colorblindness. In an effort to promote equality, this ideology ignores the existence of racism and diminishes the experiences of the racially minoritized (Kolivoski, Weaver, & Constance-Huggins, 2014). Adherence to colorblindness potentially negatively impacts an accurate assessment of the client’s needs. The second concept, interest convergence, critiques the process of changing power variables within
society. Interest convergence states that progress only occurs when it benefits people in power (Bell, 1980). This concept suggests that mental health disparities among people of color will remain unchanged until improvements benefit those in power. The third concept highlights the significance of “voices of color.” According to Delgado & Stefancic (2017), society is dominated by a “master narrative” that privileges the white experience. This narrative neglects the experiences of groups that are racially minoritized and results in an incomplete understanding (Ortiz & Jani, 2010). The mental health system would benefit from listening to people of color (POC) to address the lack of health equity. The final concept, intersectionality, identifies the coexistence of multiple identities that interact and potentially contribute to experiences of inequality. Khan (2016) states that “race, gender, sexuality, ethnicity, religion, health, education, and the social justice system cannot be studied in isolation” (p. 3). Intersectionality is a crucial concept when isolating race for the purpose of research.

**Summary of Banded Dissertation**

This banded dissertation consists of a conceptual manuscript, a qualitative research manuscript, and documentation of a peer-reviewed presentation at a local conference. The conceptual article entitled *Critical Race Theory: A Social Justice Framework for Equitable Mental Health Treatment* argues for the application of Critical Race Theory (CRT) to explore the problem of mental health disparities among groups that are racially minoritized. Key assumptions of CRT provide support for the existence of systemic inequalities and highlight structural reasons for the perpetuation of unequal power. The concepts of CRT including the myth of colorblindness, interest convergence, unique voices of color, and intersectionality assist with deconstructing potential dynamics that impact mental health disparities. The application of CRT has implications for social work practice, education, and research.
The second manuscript entitled *Social Workers’ Perceptions of the Mental Health Needs of People who are Racially Minoritized* documents a qualitative study. Using purposeful criteria sampling, thirteen direct practice social workers volunteered to participate in semi-structured interviews. Ten interview questions explored social workers’ perceptions of mental health disparities among groups that are racially minoritized and recommendations to address disparities. Braun and Clark’s (2006) thematic analysis process directed the naming of codes and organization of themes and subthemes. This writer arranged the initial 39 codes into three dominant themes including the importance of self-awareness, the impact of barriers, and practice recommendations. Findings highlighted the need for continual formal and informal cultural education, the importance of cultural representation in practice settings, and the necessity of addressing disparities among groups that are racially minoritized within all systems levels.

The final section of the dissertation is the documentation and review of this writer’s presentation *Social Worker Perceptions of the Mental Health Treatment Needs of People who are Racially Minoritized*. This presentation occurred during the annual Oklahoma Chapter NASW conference on September 6th, 2019. Three learning objectives guided the content and structure of the presentation. The first section of the presentation focused on previous research with the goal of participants understanding potential disparities among groups who are racially minoritized. Next, the preliminary results from the thematic analysis were presented. Finally, the themes of the qualitative study were applied to social work practice, education, future research, and potential policies. Surveys completed by participants following the presentation provided valuable input regarding the content and quality of the presentation.
**Discussion**

This dissertation emphasizes the role of social work in acknowledging and addressing mental health disparities among groups that are racially minoritized. Critical Race Theory (CRT) provides a conceptual framework to explore systemic racism and the impact of inequality on mental health disparities. The qualitative study gives voice to direct practice social workers engaged in mental health treatment with groups that are racially minoritized. Insight from those working face to face with clients provides valuable information missing from the previous literature. This dissertation has implications for social work education, practice, and research.

**Implications for Social Work Education and Practice**

Social work education and practice recognize working with diverse groups as a foundational skill. The 2015 Educational Policy and Accreditation Standards (EPAS) identifies engaging diversity and difference in practice as a social work competency. These standards also acknowledge diversity within the explicit and implicit curriculum. The National Association of Social Workers Code of Ethics (2017) directs social work practice including the values of social justice and dignity and worth of the person. Building on these organizational standards, this dissertation adds to the ongoing pursuit of a culturally responsive and justice-oriented social work practice.

The outcomes of this dissertation emphasize the need for ongoing diversity and cultural training in social work education and practice. This education should occur formally within the context of a classroom and continuing education and informally through engaging in experiences and relationships. As outlined within Critical Race Theory (CRT), there is a need to privilege and highlight “voices of color” (Delgado & Stefancic, 2017). Intentionally using curriculum authored by various racial and ethnic groups is one way to accomplish this within education. Another way
to elevate a variety of voices is the inclusion of cultural consultants within the classroom and in practice. Additionally, there is a need to critically evaluate the effectiveness of cultural education in shaping culturally responsive social workers.

The concept of intersectionality (Gillborn, 2015) guides social work students and practitioners in developing an understanding of the interrelatedness of oppressive systems. Beginning in foundational courses and continuing throughout education and practice, social workers should understand the social variables that impact those receiving services. Some of these variables include race, gender, sexuality, and socioeconomic status (Khan, 2016). Awareness of these confounding social factors will increase the sensitivity of social workers when engaged in practice. Intersectionalities also provide a systemic understanding that informs advocacy.

Another vital aspect of social work development outlined by both CRT and the qualitative study is the ongoing need for self-awareness. This includes the impact of commonalities between the social worker and clients. Social workers should be aware of the benefits of sharing common racial and ethnic identities, geographic locations, and life experiences with those receiving services. In addition to commonalities, social workers must be mindful of differences and their impact when working with clients. Related to this dissertation’s focus, practitioners must have insight regarding their own racial and ethnic identity. The White social worker ought to acknowledge the influence of privilege and potential racial biases that influences client interactions.

Implications for Future Research

This dissertation provides foundational information regarding social worker efforts towards equitable mental health practice with people who are racially minoritized. Future
research on this topic will improve the validity of the findings and will assist in enhancing the mental health delivery system. One consideration for future qualitative research would include a team of researchers representing various racial and ethnic identities. This team would be involved in developing the research and in the analysis of the data, including coding and identifying themes. Qualitative research may also utilize targeted recruitment of participants to ensure the representation of other geographic regions and diversity within the sample.

Another way to add to this research is the development of a quantitative research study based on the findings from the qualitative research. Quantitative research could involve a large statewide or nationwide sample and would further strengthen the knowledge base of social work mental health practice with people who are racially minoritized. Variations of research may also include the impact on client retention and outcomes when there is cultural representation among social workers and when cultural consultants are used. There is also a need to explore best practices when serving clients who require translation services.

The findings of this dissertation from both the conceptual framework and the qualitative research indicate the need for cultural education. Suggested future research would include measuring the success of the current methods of teaching culturally competent social work practice. These methods can be evaluated using Critical Race Theory as a foundation. There is also a need to assess the utilization and impact of the Behavioral Health Disparities Task Force for Social Work guidelines for advanced practice (NADD, 2013).
Comprehensive Reference List


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Critical Race Theory: A Social Justice Framework for Equitable Mental Health Treatment

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Authors Note

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Abstract

Mental health disparities among groups that are racially minoritized are systemic, and the consequences are significant. Previous research on disparities among various racial and ethnic groups identify disproportionate diagnosis, poor treatment outcomes, barriers to services, and the impact of racism on mental health. Social workers have a critical role to play in eliminating mental health disparities. Not only are social workers the primary providers of mental health treatment in the United States, but the profession itself has a strong commitment to social justice and social change. In this conceptual paper, this author argues for the application of critical race theory (CRT) to examine inequalities. The assumptions and principles of CRT including race as a social construct, the norm of racial inequality, the myth of colorblindness, interest convergence, unique voices of color, and intersectionality provide a lens to explore potential factors impacting mental health disparities. The use of CRT has implications for social work practice, education, and research.

*Keywords*: mental health disparities, race, ethnicity, racially minoritized, critical race theory
Critical Race Theory: A Social Justice Framework for Equitable Mental Health Treatment

Mental health disparities among people who are racially minoritized impact access to quality equitable treatment. The term *racially minoritized* indicates that an individual’s minority status is socially constructed and is not an individual characteristic (Benitez, 2010). This term is congruent with the factors that impact disparities. People who are racially minoritized are at risk for misdiagnosis (Mizock & Harkins, 2011), distrust of mental health services (Copeland & Snyder, 2011), barriers (Young & Rabiner, 2015), poor treatment outcomes (Guerrero, 2013), and the negative impacts of racism and discrimination (Polanco-Roman, Danies, & Anglin, 2016). Providers who are unaware of the unique needs and potential inequalities may contribute to the perpetuation of systemic disparities. Social workers have an ethical mandate to pursue social justice (NASW, 2017) and are positioned to make a significant impact within the mental health treatment system.

Disparities in health care and the lack of health equity have gained attention internationally, nationally, and within the social work discipline for several decades. On an international level, the World Health Organization (WHO) established the Social Determinates of Health (SDOH) framework to address poor health outcomes related to social factors including education, income, race and ethnicity, and occupation (Commission on Social Determinants of Health of the World Health Organization, 2007). On a national level, the Surgeon General’s National Prevention Strategy identifies the elimination of health disparities as a primary prevention measure (NPC, 2011). As mandated through the Affordable Care Act (ACA), the National Prevention Council’s focus is wellness and prevention using a broad definition of health (NPC, 2011).
The American Academy of Social Work and Social Welfare (AASWSW) identifies twelve vital social issues in society through the Grand Challenges for Social Work (AASWSW, 2018). Among the twelve, health equity and elimination of inequalities in health care is one primary focus. The goal is to achieve health equity by 2050 through research, community empowerment, primary care innovations, access to health care, professional development, and policy advocacy (Walters et al., 2016). Another social work initiative addressing disparities is the Behavioral Health Disparities Task Force for Social Work. This task force is made up of three organizations including the National Association of Dean and Directors of Schools of Social Work, the Council on Social Work Education (CSWE), and the U.S. Department of Health and Human Services Office of Minority Health. The focus of this task force includes promoting and developing a curriculum that provides content on disparities (Marsiglia & Williams, 2011). In 2013, the Behavioral Health Disparities Task Force for Social Work published *Advanced Social Work Practice Behaviors to Address Behavioral Health Disparities*. This publication identifies ten advanced competencies and corresponding practice behaviors to address disparities in behavioral health care (NADD, 2013).

The concept and definitions of health disparities historically focus on physical health though current literature in the fields of psychology, social work, and public health increase awareness of disparities in mental health (Bowen & Walton, 2015; Compton & Shim, 2015; Gonzales & Papadopoulos, 2010). One definition of health disparities is “systematic plausibly avoidable health differences that adversely affect socially disadvantaged groups” (Braveman et al., 2011, P. S150). This definition identifies important factors in disparities. First, health disparities are systemic and upheld by institutional/organizational structures. Secondly, differences in care and outcomes are related to factors outside of biological causes. Social and
environmental variables such as race or ethnicity, gender, sexual identity, age, disability, socioeconomic status, and geographic location influence health status.

This author argues for the use of critical race theory as a lens to view and address mental health disparities among groups that are racially minoritized. This framework complements social work ethics and can work in conjunction with existing social work initiatives. Critical race theory is an alternative to the cultural competency model, which is the predominant paradigm in social work. As discussed by Abrams and Mojo (2009), the cultural competency model is problematic and limited due to the primary focus on the social worker’s attitudes. This focus neglects the realities of racist and oppressive systems. Critical race theory (CRT) addresses these limitations by acknowledging systemic racism and oppression throughout societies’ institutions.

In this paper, this author offers a review of the underlying assumptions and principles of critical race theory, a review of literature on disparities in mental health care among groups that are racially minoritized, and an exploration of the implications of using CRT in practice, education, and research.

**Conceptual Framework: Critical Race Theory**

Critical race theory (CRT) emerged in the 1970s as a response to various culminating factors. First, the civil rights movement had stalled, and laws created in the 1960s to protect the minoritized started to be rolled back. Secondly, the development of critical legal studies and radical feminism influenced the thinking on issues of power and race. Thirdly, previous thinkers and leaders, including W.E.B. Dubois and Martin Luther King, Jr., provided insights to build on. Finally, various leaders organized and held their first conference in Madison, Wisconsin in 1989 (Delgado & Stefancic, 2017). The early contributors of CRT including Derrick Bell, Alan Freeman, and Richard Delgado were legal scholars, lawyers, and activists with the goal of
researching and changing the imbalance of race and power in the United States. The initial application of CRT focused on legal matters, but, since its inception, other disciplines including education, political science, and ethnic studies have adopted this theory (Delgado & Stefancic, 2017).

Two key assumptions of critical race theory include the social construction of race and racism as a norm in society. CRT states that racial categories in society are socially constructed and are “invented, perpetuated, and reinforced by society” (Gillborn, 2015, p. 278). Racial differences are based upon observable physical traits that have no basis in scientific reality. These racial categories change as they benefit those in power and function to maintain stereotypes (Bell, 1995). Historically the status of race in the United States shifts as society changes. CRT also assumes that racism is a norm in society upheld by structures and institutions (Bell, 1992). These structures and institutions are controlled by people who are white and have racial privilege. Racism is invisible to much of society but is an everyday experience for people of color (Ladson-Billings & Tate, 1995).

Concepts influenced by the assumptions of CRT include the myth of colorblindness, interest convergence, unique voice of color (Kolivoski, Weaver, & Constance-Huggins, 2014) and intersectionalities (Khan, 2016). Each of these provides a lens to evaluate mental health disparities and inform strategies to address inequalities through social work practice and education.

**The Myth of Color-Blindness**

Critical race theorists criticize constitutional law that is objective or neutral as well as “color-blindness” that uses the concept of equality to side-step race issues (Delgado & Stefancic, 2017). According to CRT, colorblindness is a modern manifestation of racism that may be
expressed through “power evasion” and/or “color evasion” (Mekawi, Todd, Yi, & Blevins, 2020, p. 288). Power evasion rejects that racism is a current reality within society and denies institutional racism (Neville, Awad, Brooks, Flores, & Bluemel, 2013). Individuals that adhere to power evasion may state “racism is a thing of the past” and are more likely to minimize the systemic factors that impact disparities (Mekawi, Todd, Yi, & Blevins, 2020). Color evasion avoids the topic of race and denies that race has an impact. Those who adopt this belief may state “I do not see color” and support the idea that we live in a post-racial society. The Color-Blind Racial Ideology (CBRI) argues that there is equal opportunity for everyone and therefore values treating everyone the same. CBRI asserts that race does not matter, thereby ignoring the reality of racism within society. CRT asserts the acknowledgment of differences in privilege and experience with equity as the goal (Kolivoski, Weaver, & Constance-Huggins, 2014).

**Interest Convergence**

The concept of interest convergence addresses how social change related to race occurs in society. According to this proposition, change happens only when the outcomes serve the interest of those in power and can be attained with minimal disruption. Interest convergence is used to explain some of the legal gains in the civil rights movement. In his evaluation of civil rights gains, Bell (1980) explains that desegregation occurred to satisfy African Americans serving during World War II. In the context of health disparities among people who are racially minoritized, Crossley (2016) proposes that progress towards racial justice will need to be framed as saving health care costs. This may be a good alternative to a “Black Health Matters” campaign which is likely to suffer a similar backlash among the White community as the Black Lives Matter movement did.
Unique Voice of Color

According to CRT, history is controlled by those in power and serves to validate the dominant group. It is crucial that people of color provide an alternative account of history and reflect upon experiences of race and racism (Ortiz & Jani, 2010). The concept of the unique voice of color asserts that the views of those who have experienced oppression inform Whites of experiences that they do not understand. The goal is to influence the “master narratives” in society (Delgado & Stefancic, 2017).

Intersectionality

Intersectionality refers to the connections among various forms of inequality including but not limited to race, class, gender (Gillborn, 2015) and sexuality (Anderson & McCormack, 2010). This concept affirms that social problems are interdependent (Khan, 2016). Critical Race Theorists argue that intersectionality should inform research and activism. Research explores inequality and the factors that “create and sustain” oppressive systems (Gillborn, 2015, p. 279). Social action influenced by the concept of intersectionality should encourage unified activism among various groups of people.

Literature Review

Previous literature on mental health disparities among groups who are racially minoritized includes the categories of disproportionate diagnosing, poor treatment outcomes, and barriers to services. Another related topic is the impact of discrimination on mental health. A review of the literature provides an understanding of the variables that impact mental health disparities.
Disproportionate Diagnosing

One area of mental health disparities that has a detrimental impact is the disproportionate diagnosis of racial and ethnic minorities. Research findings indicate differences in diagnosis throughout the mental health treatment system and among various age and gender cohorts. Inaccurate diagnosis contributes to ineffective treatment, unnecessary pharmacological therapies, deteriorating mental health conditions, increased dropout rates, and perpetuation of stereotypes.

Among adolescents involved in the juvenile justice system residing in residential facilities, there is a significant difference in the diagnosis of conduct disorder. Controlling for prior offenses, traumatic experiences, and behavioral indicators, Baglivio, Wolff, Piquero, Greenwald, and Epps (2017) found that African American males were 40% more likely to receive a diagnosis of conduct disorder than Whites and less likely to receive the diagnosis of ADHD. African American females in this study had an increased prevalence rate of conduct disorder at 54% compared to White females (Baglivio et al., 2017). Additionally, African Americans were less likely to receive mental health treatment (Baglivio et al., 2017). A previous study conducted by Cameron and Guterman (2007) identified similar results in a large residential facility (N = 1,173). Their findings showed that African American and Latino adolescents were more likely to be diagnosed with conduct disorder (Cameron & Guterman, 2007). The diagnosis of conduct disorder negatively impacts treatment outcomes and correlates with progression into the criminal justice system. Potential reasons for overdiagnosis of conduct disorder include diagnostic bias, socioeconomic status, violence exposure, and racial discrimination (Mizock & Harkins, 2011).

In a literature review examining research from the last 24 years, Schwartz and Blankenship (2014) identify a consistent pattern of diagnostic disparities related to the diagnosis
of psychotic disorders among African Americans and Latinos. The findings indicate that African Americans are three to four times more likely to receive a diagnosis of psychotic disorders and Latino Americans diagnosed with psychotic disorder three times that of Euro-Americans (Schwartz & Blankenship, 2014). Delphin-Rittmon and others (2015) found similar diagnostic disparities among a sample of 1,484 adults randomly selected from inpatient facilities. African Americans in the sample received the diagnosis of schizophrenia and drug-related disorders more frequently even after controlling for demographic variables. The diagnosis of major depression and bipolar disorder were underdiagnosed among African Americans in this study (Delphin-Rittmon et al., 2015). The misdiagnosis of psychotic disorders contributes to the misuse of antipsychotic medications and ineffective treatment (Barnes, 2008). There is limited research on the factors that contribute to disproportionate diagnosis of psychotic disorders; potential issues may include misinterpretation of symptoms and racial bias of clinicians (Schwartz & Blankenship, 2014).

**Poor Treatment Outcomes**

When comparing treatment outcomes to Caucasians, African Americans and Latinos exhibit disparities in various settings including community, aftercare, substance abuse treatment, outpatient treatment, and inpatient hospitalization. In the community setting, African Americans diagnosed with schizophrenia and co-occurring substance use disorders score lower on psychosocial functioning scales (Bahorik, Queen, Chen, Foster, & Bangs 2015). A study conducted by Eack & Newhill (2012) found that African American adults with a severe mental health condition exhibited more negative symptoms and had more difficulty finding a job a year after being discharged into the community from inpatient hospitalization. In a review of the literature, Keefe, Cardemil, & Thompson (2017) identified an association between a client’s race
and lower rates of aftercare engagement. In a study by Guerrero (2013), the impact of race on substance abuse treatment episodes and dropout rates correlates with previous research. The sample of 52,799 clients found that African Americans had 41% lower completion rates and Latinos 17% lower than Whites. All groups increased completion rates after each subsequent treatment episode (Guerrero, 2013). As social workers examine disparities in treatment outcomes, the impact of systemic factors must be considered. The application of critical race theory provides a framework to evaluate the mental health delivery system and make improvements critically.

**Barriers**

Another disparity that impacts groups who are racially minoritized is barriers to engagement in mental health care. These barriers include stigma, socioeconomic status, and coordination/logistics (Young & Rabiner, 2015). Additional barriers that impact low-income African American women from seeking services include distrust of the system, fear of losing children, role strain, and a survivor mentality (Copeland & Snyder, 2011). A study conducted by Cai and Robst (2016) fills a gap in the literature regarding the perceived experiences of racially and ethnically diverse individuals in mental health. Using longitudinal data from Florida Health Services Surveys from 1998-2006, the researchers identified significant differences compared to White’s perceptions. African American and Hispanic participants more frequently reported concerns regarding the cost and location of treatment. African American clients report barriers to obtaining appointments and were more likely to perceive communication difficulties with their service providers (Cai and Robst, 2016).
Discrimination/Racism and Mental Health

The experience of discrimination is correlated with psychological symptoms and is an additional consideration when providing mental health services to racially and ethnically diverse clients. According to race-based traumatic stress theory (Carter, 2007), groups that are racially minoritized may experience trauma in relation to discrimination. Polanco-Roman, Danies, and Anglin (2016) support this theory in a recent study consisting of 743 emerging adult participants. Among these participants, the study found a positive correlation between the frequency of discrimination and dissociative symptoms. The experience of dissociative symptoms varied based on active coping strategies that serve as a protective factor (Polanco-Roman, Danies, & Anglin, 2016). In addition to trauma-related responses to discrimination, research indicates a connection between the perception of discrimination and problematic behaviors in pre-adolescent youth (Bogart et al., 2013) and depression among African Americans (Hudson, Neighbors, Geronimus, & Jackson, 2016).

Discussion

The existence and consequences of mental health disparities among groups who are racially minoritized are well documented. Even with national efforts to decrease disparities, they persist. Critical race theory is a framework that raises awareness of systematic inequalities and provides a critical view of power structures that maintain differences. Social work practice, education, and research would benefit from the application of the concepts of CRT. CRT complements the role of social work identified in the NASW code of ethics and can work alongside existing social work initiatives to achieve health equity.
Implications for Social Work Practice

Social workers engaged in clinical practice may decrease mental health disparities among groups that are racially minoritized through the application of the principles of critical race theory. This requires self-awareness as an individual practitioner, assessment of systemic inequalities, and advocacy for change. Self-awareness of racial identity and the perceptions of inequality are vital for the social worker providing mental health services. A study conducted by Wang, Locke, & Chonody (2013) highlights the impact of race on students’ perceptions of mental health treatment options and views on mental illness. The findings suggest that African American and White participants have significant differences in their opinions. Practitioners should be aware of the impact of their race and individual experiences with inequality. The principle of “colorblindness” negatively influences the provider’s ability to understand the realities of racism. When assessing for a mental health diagnosis and treatment, one must consider the unique needs of clients. Failure to recognize race may result in diagnostic bias and ineffective treatment or create additional barriers for clients. Social workers must also be aware of their use of privilege and be mindful of treatment environments that reinforce inequality.

The social worker, as a direct practitioner, must also engage in macro-level practice to advocate for policy changes that impact disparities. Engagement with individuals involved in treatment provides an avenue to listen to the client’s experiences and encourage change based upon minority voices.

Implications for Education

Advanced social work education often involves a separation between micro and macro practice. Social workers focused on direct practice are trained as individual practitioners focusing on counseling theories and evidenced-based practice. Critical race theory applied to
clinical courses would require acknowledgment of systemic biases within the mental health system and would encourage critical evaluation of the social worker. The predominant model of multiculturalism and cultural competency ignores systemic inequalities.

**Implications for Research**

The application of CRT to the areas of clinical practice and advanced practice education provides an opportunity for research. The current body of research on disparities focuses on the outcomes and experiences of clients. Missing from the literature are reasons for existing disparities and social work practitioners’ perceptions and actions to decrease disparities. Effective change of disparities will require information regarding the root causes of inequalities.

**Conclusion**

Disparities among people who are racially minoritized impact the individuals not receiving services or receiving inadequate treatment. This issue also has a detrimental effect on the community as well. Social workers can influence micro and macro-level dynamics related to disparities. Critical race theory provides a means to explore the root causes of disparities and to highlight the realities of systemic inequalities. The goal of health equity can be a reality with the application of CRT.
References


Social Workers’ Perceptions of the Mental Health Needs of People Who are Racially Minoritized

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Author’s Note

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Abstract

Previous research highlights mental health disparities among individuals that are racially minoritized. These inequalities can result in untreated mental health needs, misdiagnosis of mental illness, and stigma due to behavioral health treatment. This qualitative study explored the perceptions of social workers engaged in mental health practice with people that are racially minoritized. Thirteen social workers volunteered to participate in semi-structured interviews. Thematic analysis of transcripts identified three themes: provider self-awareness, mental health treatment barriers, and social work practice recommendations. This writer organized twelve subthemes and categorized them under each primary theme. Implications for social work education and practice include the value of explicit and implicit cultural education, the need for cultural representation in mental health delivery and planning, and the continued exploration of systemic factors that contribute to disparities.

Keywords: racially minoritized, disparities, mental health, social worker, perceptions
Social Workers’ Perceptions of the Mental Health Needs of People who are Racially Minoritized

Through decades of research, scholars have identified mental health treatment disparities among people that are racially minoritized. The term racially minoritized defines a socially constructed process in which an individual is considered a minority (Benitez, 2010). This term is congruent with the factors that impact disparities including systemic institutional structures and social variables, e.g., geographic location, socioeconomic status, disability, age, gender, sexual identity, and race or ethnicity (Braveman et al., 2011). Smedley, Stith, & Nelson (2003) define disparities as “racial and ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention” (p. 4).

Documented mental health disparities among people that are racially minoritized include barriers to healthcare access (Cai & Robst, 2016; Young & Rabiner, 2015), poor treatment outcomes (Bahorik, Queen, Chen, Foster, & Bangs 2015; Guerrero, 2013), and disproportionate diagnosing of psychotic disorders within adult populations and conduct disorders among adolescents (Baglivio, Wolff, Piquero, Greenwald, and Epps, 2017; Schwartz & Blankenship, 2014). Lack of quality mental health care among groups that are racially minoritized is associated with many potential risks including the perpetuation of stigma, untreated mental health needs, and misdiagnosis of mental illness.

With the mission to enhance human well-being, to work towards social justice and to bring about change (NASW, 2017), and given the prevalence of social workers providing mental health services, the field is positioned to impact healthcare disparities. According to the U.S. Bureau of Labor Statistics (2019), social workers employed within mental health and substance abuse are projected to grow up to 18% between 2018 and 2028. This rapid growth is higher than the average for other occupations. At the macro-level, the American Academy of Social Work
and Social Welfare (AASWSW) conceptualized the Grand Challenges for Social Work identifying health equity as one of the twelve areas of focus to eliminate inequality in health care by 2050 (Walters et al., 2016). Additionally, the Behavioral Health Disparities Task Force for Social Work targets education through aligning advanced practice skills to address disparities (NADD, 2013).

Though social work identifies a lack of health equity and mental health disparities as a collective focus, missing from the literature is the perspective of social workers. Using qualitative thematic analysis of face-to-face interviews, this study sought to understand the perceptions of direct practice social workers as it relates to mental health disparities. Interview questions focused on three areas: the impact of providers’ racial-ethnic identity, perceptions of barriers and challenges, and perceptions of solutions and experiences of success. Participants in this study represent a variety of treatment settings including private practice, inpatient treatment, community mental health, federal, and Tribal health. This research aims to provide insight to improve social work education, practice, and policy to better serve clients that are racially minoritized.

**Literature Review**

In 2001 the Department of Health and Humans Services (DHHS) published a supplement to the Surgeon General’s report on mental health entitled *Mental Health: Culture, Race, and Ethnicity.* This paper overviewed significant disparities among various racial and ethnic groups (African American, American Indian/Alaska Natives, Asian American/Pacific Islanders, Hispanic Americans) and proposed actions to decrease disparities. Areas of focus included the impact of culture on mental health, unequal access to services, lack of needed treatment, and substandard quality of mental health care (US HHS, 2001). Motivated by the
findings of inequality, the DHHS proposed the goals of the Healthy People 2020 including eliminating disparities, achieving healthy equity, and improving the health of all people. During this same time period the Patient Protection and Affordable Care Act was signed into law by President Obama. Supporters of this law believed that this was a significant step towards health equity (Mitchell, 2015). After almost two decades of work to decrease mental health disparities, research highlights that disparities among people that are racially minoritized still exist (Cook, Trinh, Li, Hou, & Progovac, 2017). Some of these inequalities include barriers to mental health care, poor treatment outcomes, disproportionate diagnosing, impacts of discrimination, and service provider bias.

**Mental Health Disparities**

**Barriers.** Many variables influence whether an individual receives treatment for their mental health needs. Barriers including stigma, socioeconomic status, and coordination/logistics, are among the factors that disproportionality impact African American and Hispanic individuals’ utilization of mental health services (Young & Rabiner, 2015). A longitudinal study involving 5,645 participants confirms previous findings that indicate that the cost and location of treatment create barriers for both African American and Hispanic individuals (Cai & Robst, 2016). When measuring the perceptions of their relationship with mental health providers, African American clients reported communication difficulties and less favorable opinions of providers than White clients. Both African American and Hispanic clients reported difficulty arranging an appointment for services creating an additional barrier to receiving treatment (Cai & Robst, 2016).

**Poor Treatment Outcomes.** Throughout treatment settings, research findings document disparities in mental health treatment outcomes among clients that are racially minoritized. Guerrero (2013) conducted a study measuring the impact of race on dropout rates in substance
abuse treatment. In a sample of 52,799 participants, African Americans exhibited 42% lower completion rates compared to White participants, and Latinos had a 17% lower completion rate. African Americans, Latinos, and Whites all had increased completion rates following subsequent treatment episodes (Guerrero, 2013). Other areas where disparities occur include the percentage of aftercare engagement and successful community outcomes. According to a review of 18 studies published after 1996, Keefe, Cardemil, & Thompson (2017) found a correlation between racially minoritized status and disengagement in mental health services. Factors that impact aftercare engagement among racially minoritized groups include negative attitudes towards treatment, lack of mental health literacy, and stigma (Keefe, Cardemil, & Thompson, 2017). In the community environment, African Americans diagnosed with co-occurring disorders and schizophrenia and those diagnosed with major mental health disorders experience difficulty with psychosocial functioning (Bahorik, Queen, Chen, Foster, & Bangs, 2015; Eack & Newhill, 2012). Eack & Newhill’s (2012) research also found that African American’s experienced more negative symptoms following inpatient hospitalization.

**Disproportionate Diagnosing.** Various studies report disproportionate diagnosing when comparing African Americans and Latinos to Whites. These differences occur across age and gender cohorts, and throughout the treatment system. Disparities in the diagnosis of psychotic disorders have received considerable attention in research. Schwartz and Blankenship (2014) conducted a review of the literature published over the last 24 years and found consistent results regarding the diagnosis of psychotic disorders. The findings among these studies stated that African Americans receive a diagnosis of psychotic disorders three to four times more compared to European-Americans, and Latinos are three times more likely to receive the diagnosis of a psychotic disorder (Schwartz & Blankenship, 2014). Delphin-Rittmon and others (2015) found
similar results among a sample of 1,484 African American adults reporting the overdiagnosis of schizophrenia and drug-related disorders and the underdiagnosis of major depression and bipolar disorder. Ramifications of potential misdiagnosis include the administration of antipsychotic medications and treatment that is not effective (Barnes, 2008). Factors that may contribute to disproportionate diagnosis include misinterpretation of symptoms and racial bias of clinicians (Schwartz & Blankenship, 2014).

Another diagnosis that disproportionality impacts African American and Latino adolescents is conduct disorder. Even when controlling for prior offenses, behavioral indicators, and traumatic experiences, African American and Latino adolescents receive the diagnosis of conduct disorder more frequently (Baglivio, Wolff, Piquero, Greenwald, & Epps, 2017; Cameron & Guterman, 2007). Additionally, African American adolescents are less likely to receive mental health treatment before placement in residential treatment (Baglivio et al., 2017). The diagnosis of conduct disorder can be detrimental to the future of adolescents resulting in further progression into the criminal justice system. Reasons for overdiagnosis may include racial discrimination, diagnostic bias, socioeconomic status, and violence exposure (Mizock & Harkins, 2011).

Impact of Racial and Ethnic Identity

Discrimination/Racism. When serving clients that are racially minoritized, providers must consider the impact of racism, discrimination, and microaggressions on mental well-being. Race-based traumatic stress theory states that the experience of discrimination may manifest as trauma (Carter, 2007). Research conducted by Polanco-Roman, Danies, and Anglin (2016) provides support for this theory, indicating that participants who experienced high frequencies of discrimination exhibited dissociative symptoms. Active coping strategies, including talking and
addressing inequality, mediated the negative impact of discrimination (Polaco-Roman, Danies, & Anglin, 2016). Experiences of discrimination are also positively correlated with depression among African Americans (Hudson, Neighbors, Geronimus, & Jackson, 2016) and linked to problematic behaviors including aggression, retaliatory behavior, and delinquent behavior among pre-adolescent African American and Latino youth (Bogart et al., 2013). Even subtle forms of racism, defined as microaggressions, are correlated with negative mental health symptoms among Black, Latina/o, Asian, and multiracial individuals (Nadal, Griffin, Wong, Hamit & Rasmus, 2014).

 Providers’ Racial/Ethnic Identity. According to previous research, racial bias among providers is a potential factor impacting disparities and is vital to consider as an area of further investigation. In a study by Wang, Locke, and Chonody (2013), 835 social work students’ racial identity correlated to differing perspectives on mental illness. The White participants in this study were more supportive of recommending medication to treat mental illness compared to the Black/African American and Hispanic/Latino(a) participants. The findings also found that Black/African American students reported more stigma related to mental illness. Both Black/African American and Hispanic/Latino(a) participants were less likely to endorse social workers as mental health providers (Wang, Locke, & Chonody, 2013).

 Method

 While there is a vast amount of literature on the issue of racial disparities in mental health treatment, the perspective of the clinical social work practitioners has remained missing. The experiences of social workers in direct practice is valuable to address the inequalities in mental health treatment and to encourage solutions from those working face-to-face with clients. Hence,
this study explores the perceptions of clinical social workers engaged in practice with people that are racially minoritized.

**Recruitment of Participants**

Participants for this study were recruited through a flyer emailed by the local board of licensed social workers and through snowball sampling. Purposive criteria sampling was used to ensure that participants were licensed or license eligible clinical social workers, active in a direct practice setting, resided in central Oklahoma, and willing to participate in an hour-long face to face interview. Those who were interested responded by email or through a phone call to set up a meeting. Interviews were conducted in a location identified by the participant for convenience and to ensure comfort. Before the interview, participants were emailed the informed consent, interview questions, and an electronic demographic questionnaire to complete before the interview. Participants received a ten-dollar gift card at the end of the interview as an incentive for participation.

**Study Sample**

Recruitment resulted in a total of 13 participants representing a variety of practice settings including private practice (n = 5), inpatient hospital (n = 1), private non-profit agency (n = 2), governmental (n = 1), medical (n = 1), and tribal mental health (n = 3). Twelve participants were licensed, and one was under supervision for licensure. The participants had substantial practice experience: five had 4-7 years, five had 7-14 years, and three had 21-30 years. Most of the participants identified as female (n = 11) and the remaining identified as male (n = 2). The racial/ethnic representation included White (n = 9), African American (n = 2), and Native American (n = 1). All the participants reported engagement with groups that are historically racially minoritized in their practice settings. Table 1 describes the responses to five Likert scale
questions about the frequency of services provided to various racial/ethnic groups. Most of the participants reported that they were least likely to provide mental health service clients who identify as Asian, Hispanic, and/or Native American and the majority reported serving individuals who identify as White and African American in some capacity. Data about service to people who identify as Native Americans were impacted by three participants who work in Native Mental Health and exclusively see Native American clients.

Table 1 Frequency of Client Population Served (n = 13)

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Asian (%)</th>
<th>White (%)</th>
<th>African American (%)</th>
<th>Hispanic (%)</th>
<th>Native American (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Never</td>
<td>38.5</td>
<td>0</td>
<td>0</td>
<td>7.7</td>
<td>30.8</td>
</tr>
<tr>
<td>2</td>
<td>53.8</td>
<td>15.4</td>
<td>46.2</td>
<td>61.5</td>
<td>38.5</td>
</tr>
<tr>
<td>3</td>
<td>7.7</td>
<td>38.5</td>
<td>38.5</td>
<td>23.1</td>
<td>7.7</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>30.8</td>
<td>0</td>
<td>7.7</td>
<td>7.7</td>
</tr>
<tr>
<td>5 Most of the time</td>
<td>0</td>
<td>15.4</td>
<td>15.4</td>
<td>0</td>
<td>15.4</td>
</tr>
</tbody>
</table>

**Protection of Human Participants**

This study was approved by the Institutional Review Board (IRB) at St. Catherine University in St. Paul Minnesota and then transferred to the University of St. Thomas. Before the interview, participants received an electronic copy of the informed consent and then signed the consent at the beginning of the interview. The informed consent highlighted the voluntary nature of participation, including the right of participants to abstain from answering any questions or withdraw from the study at any time. Confidentiality was maintained by ensuring the interview environment was private, securing recordings of interviews on a password protected computer, and removing identifying information from documentation. Potential risks and benefits of the research interview were included in the informed consent form and discussed before the interview.
Instrument/Materials

This study consisted of an electronic demographic survey completed before the face-to-face interview and a semi-structured question guide used during the face to face interviews. The demographic survey included questions on gender identity, race/ethnic identity, licensing status, years of clinical practice, and questions regarding the frequency of service to various racial/ethnic groups. Informed by the previous literature, ten semi-structured interview questions were developed to reflect three focus areas: self-awareness/impact of the practitioners’ racial and ethnic identity, perceptions of barriers/challenges, and perceptions of solutions/success. The demographic survey and interview questions were reviewed and adjusted based upon feedback from the research advisor, a cultural consultant, and the IRB reviewers. Interviews lasted 1 hour and were recorded using a password secured computer. Transcriptions of interviews were created using an online voice recognition program. QSR International’s NVivo 12 Pro software was used to organize transcripts, identify codes, and separate data into themes.

Data Analysis

Braun and Clark’s (2006) six-step process of thematic analysis guided the exploration of themes. The first phase involved becoming familiar with the data. After creating transcripts through an automated program, each of the transcripts were read and compared to the audio interviews, corrections were made accordingly to ensure a verbatim account of the interview. While immersed in the data, this reader made notes regarding initial codes and observations. The second phase involved identifying initial codes. Open coding consisted of reading each interview word for word and identifying codes. After the completion of this phase, 39 initial codes were defined. Phases three, four, and five involved identifying initial themes, reviewing themes, and naming themes. Themes were developed by reading the initial codes and grouping common ideas
together. After identifying themes, they were examined to ensure the themes address relative content. After this process, the initial 39 codes were separated into three overarching themes and twelve subthemes. The sixth and final step involved documenting the themes in a report. The finding section below details the themes including quotes that capture the meaning of the themes (Braun & Clark, 2006).

Findings

As noted in the data analysis section, three overarching themes and twelve subthemes were organized from the original codes. Themes were defined by common ideas that occurred in at least three of the transcripts. The first theme, self-awareness, had four subthemes: shared racial/ethnic identity, different life experiences, racial bias, and universal life experiences. The second theme, barriers, also had four subthemes: financial barriers, emotionally guarded, negative perceptions of mental health, and language obstacles. The final theme, recommendation, had four subthemes: cultural education, community engagement, cultural representation, and flexibility.

Self-Awareness

Seven participants identified self-awareness as vital when serving people who are racially minoritized. Participants used terms including “aware,” “awareness,” “understanding,” “being in touch,” and “soul-searching” when discussing important factors for engaging clients. Related to this theme, participants reflected upon the impact of a shared racial/ethnic identity, different cultural/ethnic identity, racial bias, and shared life experiences.

Shared Racial/Ethnic Identity. All three social workers who identify as a member of a racially minoritized group highlighted the value of sharing a racial/ethnic identity with clients. These individuals reported awareness of unspoken experiences, increased understanding and
sensitivity, and decreased barriers. One participant stated, “the way that I was raised in my Native American upbringing helps me to identify and understand where they’re coming from.” Participants discussed stories of practice where their race was a benefit in understanding the dynamics of the client’s experiences. The statement “I try to read between the lines” captures the essence of listening and attending to clients. One African American participant provided the following example of a pregnant African American client experiencing depressive symptoms stating:

She began to disclose that she feels minimized and put down when she goes to have a baby in the hospital. So, so now I’ve been seeing her for seven months. So now that backdrop is coming through. And so, um, so now it’s, it’s about just trying to getting her to process that, um, but if I hadn’t been sensitive to it, I would have missed that opportunity because she had kind of said it in a very minimizing way.

This participant went on to discuss the experience of being a Black woman in the hospital and reflected upon the normalization of racism. She highlighted the importance of awareness of the Black experience and the potential of missing these dynamics.

**Different Life Experiences.** Another aspect of self-awareness is the impact of identifying with a racial/ethnic group different from a client. Six of the individuals in the sample who identified as White discussed the effects of privilege when working with people who come from racially minoritized groups. One of the female interviewees stated, “Even though I don’t feel like I have any bias or prejudice or, or thought process like that, that I don’t know, my understanding of their experience is very different.” Another participant acknowledged how different life experiences might impact the therapeutic
relationship “My different experience may impact their experience of therapy. In particular, my experience of privilege might have an impact on the therapeutic dynamic.”

**Racial Bias.** The reality of racial bias was acknowledged as an aspect of self-awareness. Six in the sample discussed the harm of making assumptions as one participant stated, “don’t make any assumptions based off of a person’s skin color or their ethnic group,” and another reported “Every tribe is different in a way. So you can’t, I can’t make an assumption.” When discussing the impact of race/ethnic identity the concept of implicit bias emerged and the need to practice cultural humility. One White participant stated:

> We all marinated in a culture that is comprised of white supremacy. We can’t unmarinate ourselves. We can only accept and understand how that impacts us, how that may impact the people we work with in ways that we don’t intend.

When discussing how to address bias she reported:

> Lean into and embrace the idea that you’re going to get it wrong. Um, you’re going to get it wrong in ways that, that hurt people’s feelings. And, um, you need to create a culture between you and your, your clientele of making it okay for that to be expressed and, and humbly accepting what people bring to you in the same way that we would with any other sort of transference, countertransference interaction.

**Shared Life Experiences.** Throughout the interviews, participants discussed the importance of making a connection with clients. Sometimes this connection occurred through shared racial identity, but other times this connection was related to other factors including geography, cultural assimilation, and humanity. Three of the transcripts explicitly discussed the
value of shared experience. One White female discussed her therapeutic relationship with an African American male related to their common geography. She stated:

I have this guy that I see who actually moved here many years ago from Brooklyn, and I once lived in Brooklyn and New York. So I, we have this like shared frame of reference. So like he can talk about like different landmarks and different things and I’ll, and it makes him more comfortable knowing that like he has that bridge.

Another participant discussed her connection with clients due to the shared experience of adjusting to American culture. She stated, “I’m Italian American. Um, and I am first generation” reflecting upon her ability to relate to various clients adjusting to new cultural settings. Other participants discussed the value of developing a relationship with clients who are racially minoritized.

I feel like just the act of having a like relationship with them where I’m White and they’re not, and um, there’s. I feel like it’s therapeutic in and of itself to have a relationship where they’re coming to me because they trust me to not be prejudice and to like, you know, have a level playing field in the therapeutic space where they trust me enough to know what they may be going through.

**Barriers**

Among the ten interview questions, two were designed to elicit social workers’ perceptions about needs and barriers among people who are racially minoritized. Through initial coding, there were 19 codes related to barriers. The most common responses were separated into four subthemes including financial obstacles (n =7), emotionally guarded (n=5), language barriers (n=4), and negative perceptions of mental health services (n=3).
**Financial Obstacles.** Throughout the interviews, seven participants highlighted financial obstacles expressed through lack of transportation and lack of healthcare or inadequate insurance coverage. Participants observed that lack of transportation is often a result of not having transportation and other times due to the inability to purchase gas. A lack of healthcare coverage was discussed throughout the interviews. Interviewees reported that frequently clients that are racially minoritized are “not getting the care they need” due to not qualifying for benefits or being older than Medicaid allows. When discussing recommendations, one participant stated:

They (Oklahoma) have to expand the people that they cover, you know what I mean? Very few. Um, individuals who turn, I think it’s 18, as soon as they turn 18 and no longer covered under sooner care (Medicaid), unless they have a, a specific disability. A pretty chronic disability. That leaves out a whole bunch of people.

Other participants suggested that healthcare should be more accessible and must be considered a “right”.

**Emotionally Guarded.** Another perceived barrier identified by five participants is the emotional guardedness of clients that are racially minoritized. Other terms used to describe this observation included “emotional closure,” “superficial communication,” “suspicion,” and “difficulty naming emotions.” During the interview, one African American social worker who provides services to predominately African American clients discussed her observations stating:

Emotionally I find every client that I have, no matter what their social-economic background is or whatever, they all have an issue with tapping into how they feel when they feel that way and don’t know why. They all have a problem with putting words to the feelings and understanding where they are and why they are there.
Language Obstacles. Four of the interviewees discussed language and the lack of Spanish and native speaking mental health providers as a barrier. Participants expounded on stories of trying to locate services for clients who do not speak English well and the difficulty with translation services. Social workers stated, “We do not have enough people who are bilingual, enough counselors who are bilingual” and “When I try to find somebody to refer to, if I feel like it’s, there’s going to be a barrier.” Some also discussed using translation services as “awkward” and “missing something” in the translation.

Negative Perceptions of Mental Health Services. Another theme that surfaced among common barriers is the negative perception of mental health services. The interviewees (n=3) discussed challenges in counseling, including “stigma,” “lack of trust,” “fear” and “internal conflicts” that impact the utilization of mental health services. Specific to clients that are racially minoritized, one participant discussed “cultural beliefs” about therapy and avoidance of counseling due to fear she reported that some clients have a “fear of DHS, fear of the system, fear of, um, people taking their kids away.” Another participant discussed the importance of addressing stigma, but elaborated on the unique dynamics of racially minoritized groups:

Mental illness is so normal in every strata of culture in the United States that obviously we can do a lot of culturally informed destigmatizing work. Um, but we can’t isolate mental health from any of the myriad factors that contribute directly to it. So in other words, if we de-stigmatize seeking help for mental illness among black men, um, but we do nothing to empower them, so socially or economically, then we’re going to probably wind up seeing the same dynamics we currently see.


Practice Recommendations

One of the goals of this research was to explore social workers’ recommendations to address the needs and barriers of people who are racially minoritized. Three of the interview questions asked for recommendations to improve mental health practice within direct practice (micro), at the agency level (mezzo), and policy development (macro). Open coding revealed four subthemes addressing recommendations, including cultural education (n=9), community engagement (n=7), cultural representation (n=6), and flexibility (n=4).

Cultural Education. The predominant recommendation discussed in nine of the transcripts was the need for cultural education. Education was encouraged through formal and informal means as one participant stated, “education is key.” Formal education includes the need for “mandatory training” and “continuing education” to maintain cultural awareness. Informal training is a continual process that involves “educating self,” “asking questions,” and developing “personal relationships” with individuals from differing backgrounds. An African American participant highlighted the value of relationships stating “I think that ultimately they should, if they are a white practitioner, I think that they should be in a relationship, with a black practitioner, a personal relationship. Because I think that having a sounding board is important.”

Community Engagement. The statement “nothing about us without us” emphasizes the theme of community engagement. Throughout the interviews, participants (n=7) stressed the importance of involving the community and “stakeholders” to address disparities and decrease stigma. Some referred to experiences of the local church assisting with paying for services, providing resources, and helping with translation needs for clients. One interviewee explored the
possibility of engaging the church to increase the follow-up rate of African American clients stating:

I wonder if it would be beneficial at all to have to build a stronger connection with the, um, churches in the area that are more primarily African American. So I’m like, I know people’s church is primarily African American congregation. If we reached out to them more, um, if that would make a difference.

Other ways to engage the community included sponsoring “cultural events” and “health fairs” focusing on specific needs of racial/ethnic groups.

**Cultural Representation.** Six participants stressed the importance of cultural representation among employees and board members in an agency. Common statements included: “hiring more diversity,” “We tried to bring on Native American providers,” “having a variety of racial and ethnic backgrounds of staff,” and “not just having all white people.” These statements reflect the importance of valuing differences and being intentional about hiring practices. One participant stated:

If you’re an agency and you’re providing services to Latino people and you don’t have any Latino people in your governing board or in high positions in your administration or as clinicians, that’s not okay. Even if you’ve got people fluent in Spanish, you are not providing culturally literate services.

**Flexibility.** The final theme highlighted by four interviewees is the need for flexibility within the service delivery and modality used. Some reported the use of “home-based” services to eliminate transportation barriers, remove logistical obstacles, address fears of coming to an
office, and to ensure a level of comfort. The use of culturally informed modalities is valuable as well. Participants discussed modifying therapeutic approaches and curriculum to meet clients’ needs and stressed the value of being “creative.” A Native American participant explained some mistakes she made working with traditional Native American clients. She provided an example of the use of cognitive-behavioral techniques with a client and stated:

If I tried to pull up something on a dry erase board and explain things, and she’s really traditional, she, that is it. That is offensive somewhat to her because I’m trying to teach her this is, I’m trying to teach her.

It’s more of a relationship and conversation. So let’s talk about depression. So if I can go up here and draw out and explain some things, I know what I’m saying, but for her, that’s, that’s beyond, let’s talk about, I want to say her specifically, but my traditional people would be like, let’s talk about how important the fire is spiritually, how important the air is spiritually or the thunder, and the, and apply that to how we talk about things.

The earth and the ground and things. So it’s more, it’s more of a traditional spiritual side, not the Christian, not the European American approach. It’s what’s, what’s our way the traditional way and how can we bring that to educate. So that’s, that makes the difference.

This statement emphasizes the significance of modifying mental health treatment based upon the needs of individual clients.

**Discussion**

This qualitative study explored social workers’ perceptions of the mental health needs of people that are racially minoritized. The purpose was to provide insight into the problem of
mental health disparities from the provider’s perspective and recommendations to create culturally responsive mental health treatment. Utilizing purposeful criteria sampling, thirteen clinical social workers participated in hour-long semi-structured interviews. This writer reviewed verbatim transcripts and organized the initial codes into three general themes and twelve subthemes. The findings highlighted the complexities of mental health services involving the interaction between the social worker, client, and broader systemic factors. Analysis of the interviews revealed the influence of the individual social worker’s racial/ethnic identity, life experience, and perceptions.

**Self-Awareness.** Practitioners acknowledged the potential benefits of providing mental health services to clients who share the same racial/ethnic identity and the potential challenges when serving clients with differing racial/ethnic identities. The reality of racial bias related to cultural narratives, experiences, and assumptions were identified as an essential area of self-awareness. In accordance with this theme, interviewees identified that race and ethnicity are not the only factors of commonality to consider. One must also be aware of similarities related to geography and other shared life experiences. These additional connections can serve as a strength in developing a therapeutic relationship.

**Barriers.** Perceived barriers for people who are racially minoritized reflected the impact of environmental factors and various intersectionalities. Participants’ responses were congruent with previous literature on barriers that report limitations in accessing services due to finances, logistics including transportation, and stigma (Cai & Robst, 2016; Young & Rabiner, 2015). The theme of negative perceptions of mental health services is consistent with research conducted by Copeland & Snyder (2011).
**Recommendation.** When identifying recommendations, participants stressed the responsibility of social workers to continue cultural awareness education. The findings indicate that cultural training is ongoing and is both formal and informal. Participants reported that institutions and agencies are accountable for outreach in the community and hiring practices that ensure cultural representation within the agency.

**Implications for Social Work**

The findings of this research have implications for both social work practice and social work education. First, practitioners and educators must continue to participate in ongoing cultural training both formally and informally. As recommended by this study, education is a primary way to elicit self-awareness and to ensure social workers do not participate in the process of minoritizing clients. The data suggests that the social work discipline should require continuing education in diversity and cultural awareness as a part of the licensure renewal process. Social work curriculums must include a variety of diverse voices and modalities that account for cultural factors. Secondly, the lack of cultural representation in social work is a concern for practice and education. Schools of Social Work must recruit students who represent various racial/ethnic groups and should explore potential reasons for lack of cultural representation among students. Agencies and institutions that provide mental health services have an obligation to clients to hire and involve individuals from various racial/ethnic backgrounds. When engaging in outreach efforts, the agency should seek input regarding community needs and potential barriers. Finally, social work practice and education have a responsibility to continue to explore systemic factors that contribute to disparities among people who are racially minoritized. As reported in the findings, negative perceptions and stigma continue to be a barrier. Additionally, clients that are racially minoritized are at a
disproportionate risk of experiencing financial barriers impacting access to mental health treatment.

Limitations and Recommendations for Future Research

The results of this research reflect the perceptions of thirteen social workers in central Oklahoma. Participants in this study primarily identified as White and female, resulting in an underrepresentation of social workers from groups that are racially minoritized. The findings are limited in their application to a larger sample and do not necessarily reflect other geographic regions. Analysis of transcripts including coding and identification of themes was completed by this writer and did not include additional reviewers. Future research should include similar procedures with larger sample sizes, representing various geographic regions, and variations among the race/ethnicity of participants. To increase validity analysis should include more than one reviewer.

Conclusion

This study explored perceptions of social workers engaged in mental health practice with clients that are racially minoritized. Utilizing semi-structured interviews, thirteen direct practice social workers participated in an hour-long interview. Analysis of verbatim transcripts employed Braun and Clark’s (2006) thematic analysis process. The exploration of data resulted in three primary themes and twelve subthemes. This qualitative study provides valuable preliminary data and emerging knowledge about social worker perceptions. The findings in this study may be used to develop future research to improve the mental health delivery system for people who are racially minoritized.
References


Social Worker Perceptions of the Mental Health Treatment Needs of People Who are Racially Minoritized

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University of St. Thomas

Authors Note

Correspondence should be addressed to Jeremy Wente at jerwente@gmail.com. This presentation was completed to fulfill one of the banded dissertation requirements of the Doctorate of Social Work Program at the University of St. Thomas School of Social Work.
Abstract

This presentation overviewed mental health disparities among people who are racially minoritized and the initiatives focused on health equity. Preliminary findings from a qualitative study on social work perceptions of mental health inequality among people who are racially minoritized were reviewed. Attendees included licensed social workers, social work educators, and students. Participants were encouraged to consider implications for practice environments and completed evaluations at the end of the session to provide feedback on the presentation.

Keywords: mental health disparities, racially minoritized, health equity, qualitative research
Social Worker Perceptions of the Mental Health Treatment Needs of People Who are Racially Minoritized

Through a blind review process, this oral presentation was selected as a breakout session during the 44th annual Oklahoma Chapter of the National Association of Social Workers (NASW) conference on September 6th, 2019. The content of this presentation included an overview of previous research on mental health disparities among people who are racially minoritized and a review of the global, national, and social work initiatives to work towards health equity. Initial findings from the qualitative study *Social Workers’ Perceptions of the Mental Health Needs of People Who are Racially Minoritized* were reviewed and participants were encouraged to apply learning to current practice environments. The presentation had the following learning objectives: 1. Participants will identify common disparities in mental health care among racially minoritized groups as indicated by previous research, 2. Participants will synthesize research findings from the qualitative study, and 3. Participants will apply the presentation content to current practice setting to better serve people who are racially minoritized.
Social Worker Perceptions of the Mental Health Treatment Needs of People who are Racially Minoritized

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The University of St. Thomas - St. Paul, MN.

Figure 1.1. Slide 1

Learning Objectives

- After completing this presentation participants will be able to:
  - Identify common disparities in mental health care among racially minoritized groups as indicated by previous research
  - Synthesize the research findings from the qualitative study
  - Apply the presentation content to current practice setting to better serve people who are racially minoritized

Figure 1.2. Slide 2
Overview

- Introduction and Background
- Purpose of Research
- Methodology
- Findings
- Implications and Future Research

Introduction and Background

- Importance and Interest
- Racially Minoritized – individuals who face stigma and racism outside of their control/social construction
- Health disparities as defined by Braveman et al. (2011) are “systematic plausibly avoidable health differences that adversely affect socially disadvantaged groups” (p. 150).
Introduction and Background

- Initiatives to address health disparities
- Health Equity and Disparities
  - Social Determinants of Health (Commission on Social Determinants of Health of the World Health Organization, 2007)
  - Surgeon General’s National Prevention Strategy identifies the elimination of health disparities as a primary prevention measure (NPC, 2011)
  - Behavioral Health Disparities Task Force for Social Work (Marsiglia & Williams, 2011)

Figure 1.5. Slide 5

Mental Health Disparities Among People who are Racially Minoritized

- Disproportionate Diagnosing
  - Conduct Disorder (Cameron & Guterman, 2007; Baglivio, Wolff, Piquero, Greenwald, & Epps, 2017; Mizock & Harkins, 2011).
  - Psychotic Disorders (Schwartz and Blankenship, 2014)

Figure 1.6. Slide 6
<table>
<thead>
<tr>
<th><strong>Mental Health Disparities Among People who are Racially Minoritized</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Poor Treatment Outcomes</td>
</tr>
<tr>
<td>– Psychosocial Functioning (Bahorik, Queen, Chen, Foster, &amp; Bangs 2015; MEack &amp; Newhill, 2012)</td>
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<tr>
<td>– Substance Abuse Treatment (Guerrero, 2013)</td>
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*Figure 1.7. Slide 7*

<table>
<thead>
<tr>
<th><strong>Mental Health Disparities Among People who are Racially Minoritized</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Barriers to Mental Health Care</td>
</tr>
<tr>
<td>– Longitudinal Research on Barriers (Cai and Robst, 2016)</td>
</tr>
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</table>

*Figure 1.8. Slide 8*
Mental Health Disparities Among People who are Racially Minoritized

- Discrimination and Racism
  - Race-Based Traumatic Stress (Carter, 2007)
  - Psychological Symptoms and Discrimination (Bogart et al., 2013; Hudson, Neighbors, Geronimus, & Jackson, 2016; Polanco-Roman, Danies, & Anglin, 2016)

Purpose of Research

- This study explores social workers’ perceptions of the mental health needs of people who are racially minoritized. The research seeks to understand the lived experience of practitioners actively providing mental health services.
Methodology

- IRB through St. Catherine University and the University of St. Thomas
- Qualitative Research
  - Thematic Analysis using Braun and Clarke’s (2006) six phase process
    - Familiarize yourself with data
    - Generating initial codes
    - Searching for themes
    - Defining and naming themes
    - Producing the report

Figure 1.11. Slide 11

Methodology

- Pre-Interview Demographic Survey Using Google Forms
- Semi-Structure Interviews (10 questions)
- Interviews recorded and transcribed using TEMI online and manually reviewed by this researcher
- Transcripts organized and analyzed using NVIVO Software
  - Open Coding
  - Identifying Themes

Figure 1.12. Slide 12
**Interview Questions**

1. Tell me about your current work as a clinical social worker?
2. How does your racial and/or ethnic identity impact what you pay attention to in your work with clients?
3. What needs and/or barriers do you identify from people who are racially minoritized in your current work setting?
4. To what extent does your agency address the identified needs?
5. Identify an example of when you have been successful in responding to the needs or barriers of people who are racially minoritized.
6. What challenges have you come across in trying to address the needs or barriers of people who are racially minoritized? And how did you address these challenges?

**Figure 1.13. Slide 13**

**Interview Questions Cont.**

7. What recommendations do you have for practitioners providing services to people who are racially minoritized?
8. What recommendations do you have for agencies providing services to clients who are racially minoritized?
9. What improvements in policy or legislation should be made to better serve clients who are racially minoritized?
10. Is there anything else that you think would benefit the topic of my research?

**Figure 1.14. Slide 14**
### Sampling
- Recruitment – through Oklahoma licensing board
- Purposeful/Criteria Sampling
  - Licensed or license eligible
  - Currently work in direct practice
  - Live in central Oklahoma
  - Willing to participate in an hour long interview
- Snowball Sampling
  - Participants recruited others who met the sample criteria

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### Research Sample
- 13 participants
- Gender Identity: Male (n = 2), Female (n = 11)
- Race/Ethnic Identity: White (n = 10), Black or African American (n = 2), Native American (n = 1)
- Years of Practice Experience: 4-7 years (n = 5), 7-14 (n = 5), 21-30 (n = 3)

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*Figure 1.15. Slide 15

*Figure 1.16. Slide 16*
Research Sample Cont.

- Licensure Status: Under Supervision \( (n = 1) \), LCSW \( (n = 12) \)
- Current Practice Environments:
  - private practice \( (n = 5) \), inpatient hospital \( (n = 1) \),
  - private not for profit agency \( (n = 2) \), governmental \( (n = 1) \), medical \( (n = 1) \),
  - and tribal \( (n = 3) \)

Figure 1.17. Slide 17

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Research Sample Population Served

<table>
<thead>
<tr>
<th>Table 1 Frequency of Client Population Served</th>
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<tbody>
<tr>
<td></td>
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<td>never</td>
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<tr>
<td>most of the time</td>
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Figure 1.18. Slide 18
Findings

- Barriers
  - Financial Barriers (lack of insurance coverage and transportation)

“there's often a socioeconomic component to that, that oppressive structure and living as any kind of minority and in the United States necessarily involves oppression. So the ways that that shows up in concrete ways, um, are things like, you know, one of my families is no longer able to come. They don't have transportation and, um, and other people are, have issues with payments”

Figure 1.19. Slide 19

Findings

- Barriers
  - Language

“We do not have enough people who are bilingual, enough counselors who are bilingual.”

“When I try to find somebody to refer to, if I feel like it's, there's going to be a barrier, it's incredibly difficult to find somebody who is um, you know, comfortable, you know, you're comfortable with both as a therapist and, and that they have the bilingual skills. So I think that's a huge barrier”

Figure 1.20. Slide 20
Findings
▪ Barriers
   —Guarded
   “I think that I think in rightly so that I found that some marginalized people treat me with a little bit suspicion and guardedness because of my age and because then I am white so they’re not sure that I can fully grasp or understand some of the experiences that they have encountered in their lives that I would not have necessarily had those same experiences.”
   “I do see a lot of sort of emotional closure, uh, in the parents of the Hispanic kids that I see. And I think that the effect of that is that I have a really hard time engaging with those clients”

Figure 1.21. Slide 21

Findings
▪ Barriers
   —Perceptions and Stigma of Mental Health Care
   “I would just say in general that there’s always that possibility that when people come from a particular ethnic subgroup that there are like cultural attitudes attached to therapy”

Figure 1.22. Slide 22
Findings

▪ Practitioner Self-Awareness
  – Impact of different life experiences than clients
  – Benefits of cultural similarities
  – Importance of awareness of racial bias
  – Cultural humility

Figure 1.23. Slide 23

Findings

▪ Practitioner Self-Awareness

“I am fluent in Spanish, there are nuances that I will never, I will never be able to understand intuitively in the same way that someone who really, that is their, that is their home, that language is their home can understand.”

“automatically, when a client comes in, depending on their racial makeup and their backgrounds, if they're African American, I already know that they're coming in with generational trauma that doesn't necessarily, that's not an assumption, it's just whether they identify with that or not. I understand that there are, there is some generational trauma.”

Figure 1.24. Slide 24
Findings

- Cultural Education
  - Formal (CEUS, Agency Training)
  - Informal (asking questions of clients, diversity in relationships)

“So education is key. I also think that when we’re, when we are, we’re supposed to be getting CEUS every year, I think there needs to be more diversity among, more diversity in CEUS”

“I think that ultimately they should, if their are a white practitioners, I think that they should be in a relationship, with a black practitioner, a personal relationship. Because I think that having a sounding board is important in dealing with your own bias”

Figure 1.25. Slide 25

Findings

- Addressing Needs
  - Engage Community “Nothing about us without us”
  - Racial/Ethnic Representation in Staff “If you’re an agency and you’re providing services to Latino people and you don’t have any Latino people in your governing board or in high positions in your administration or as clinicians, that’s not okay.”
  - Flexibility (appointment times, locations, culturally responsive treatment modalities)

Figure 1.26. Slide 26
Implications

- Practice
- Education
- Policy
- Future Research

Figure 1.27. Slide 27
References


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