Journal of Human Rights and Social Work (2022) 7:449–453
https://doi.org/10.1007/s41134-021-00205-w

Race-Based Trauma and Treatment Outcomes: An Examination of State Organizational Policies and Implications in Social Work Field Education

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Accepted: 8 November 2021 / Published online: 3 February 2022

Abstract
African-Americans have a greater likelihood to experience psychological distress as compared to other racial populations; however, they are less likely to seek mental health treatment. Their prolonged and cumulative experiences of racism and discrimination create barriers to treatment services, which negatively impact mental health treatment outcomes. Research suggests that there is a need for more culturally competent treatment to strengthen treatment outcomes within African-American communities. Social work field education coins itself as the pedagogy of social work education. It becomes the role of social work field education to prepare new practitioners to address the unique needs of vulnerable populations and begin to bridge the gap in current inequities in mental health treatment. A content analysis was conducted to examine policies, specifically related to outpatient treatment regulations. Policy documents were collected from Maryland, Virginia, and the District of Columbia and surveyed according to appropriateness and effectiveness in providing mental health services to African-Americans. The results showed an emphasis on licensing requirements for treatment facilities and standard treatment practices. There was a deficiency in requirements for training across all three jurisdictions, with little emphasis made for culturally competent training. Recommendations were made to strengthen organizational policies by conceptualizing practices to be more inclusive of race-based issues and trauma-informed care.

Keywords Race · Trauma · Field education · Social work practice · Policy · Evidenced-based treatment

African-Americans have a greater likelihood of reporting psychological distress than other racial populations; however, they are 10% less likely to seek mental health treatment (U.S. Health and Human Services Office of Minority Health, 2019; U.S. Census Bureau, 2015). This is particularly relevant given their history in the USA. African-Americans' history of historical traumas such as slavery, and post-Civil War segregation has left this community vulnerable and marginalized with disproportionate experiences of prolonged grief (Danzer et al., 2016). The prolonged and cumulative experiences of discrimination create barriers to mental health services and have shown to have negative consequences on mental health treatment frequently rooted in the skepticism and distrust of the mental health system (Copeland & Synder, 2010; Chae et al., 2011; Gaston et al., 2016). The intersection of race and mental health further exacerbates trauma symptomology due to experiences of racial discrimination and conditioned hypervigilance stemming from previous experiences of race-based trauma (Coleman, 2016; Coleman et al., 2019). Research suggests a need for more culturally competent treatment to strengthen treatment outcomes within African-American populations (Misurell & Springer, 2013; Williams-Washington & Mills, 2018).

The Council on Social Work Education (CSWE) defines field education as the signature pedagogy citing the need to integrate concepts learned in the classroom with practice skills in work environments. Field education, in essence, is of equal importance as the curriculum as it develops and trains competency within future social workers (Council on Social Work Education, 2020). The literature suggests a gap in providing a comprehensive field education approach that incorporates racial diversity (Olcoń et al., 2020; Olson-Morrison et al., 2019). According to a systematic literature review examining social work education programs' use of

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diversity within its curriculum, Olcoń et al. (2020) found that there is a lack of intentional, systematic approach to teaching about racial and ethnic diversity that is in contrast to CSWE's Educational and Policy Accreditation Standards which points to diversity as a core competency of social work education. Given the legacy of historical trauma within the African-American community, the role of field education must be one of preparing new practitioners in culturally relevant evidence-based treatment models. There remains a need to create learning environments that both meet the components of diversity competency and are sensitive to experiences of race-based trauma. Using the lens of field education, this paper seeks to examine the effectiveness of evidence-based treatment by examining mental health policies within Maryland, Virginia, and the District of Columbia and their ability to provide trauma-informed care to African-American populations.

Literature Review

Evidence-based treatment has improved mental health outcomes and has consistently reduced participants' deterioration, particularly clients at risk for treatment failure (Purtle & Lewis, 2017; Purtle et al., 2017). It provides a standard of practice for practitioners to respond to the powerful pressures of funders and policymakers within organizations (Carrilio, 2008). Policies and procedures are based on federal regulations that seek to monitor, license, and accredit treatment programs based on adherence to compliance standards (National Institute of Health, 2016). Regulatory bodies specify treatment modalities or evidence-based practices for working with people of color. For example, as early as 1997, recognizing the gross disparities in HIV transmission rates among African-Americans, specifically African-American men, investigators asserted the need for culturally appropriate methods of intervening with this population (Wilton et al., 2009). U.S. Department of Health and Human Services, Office of Minority Health, has produced standards for culturally and linguistically appropriate services, the American Medical Association has identified cultural competence as one of its core competencies, and many professional associations include cultural competence in their codes of ethics (Rice & O'Donohue, 2002). Yet despite these recommendations, culturally competent treatment of African-Americans remains an area of outpatient treatment that is not fully addressed.

Despite the research, African-Americans have unmet mental health needs exacerbated by their inability to locate culturally competent treatment services, creating barriers and preventing recovery of trauma symptomology (Kataoka et al., 2010; Copeland & Synder, 2010). A systematic review examining cultural adaptations to augment mental health services for minorities found that openly addressing systematic barriers and incorporating culturally relevant perspectives influenced the likelihood of success within therapeutic interventions (Healey et al., 2017). This signals the area of field education to respond in its approach as it relates to practice, policy, and cultural competency. The role of field education is to address knowledge, skills, and values that demonstrate readiness to practice within students (Boitel & Fromm, 2014). This investigation sought to answer three major questions: (1) How were licensing bodies determining cultural competency for clinical professionals, (2) How specific were organizational policies in defining culturally competent treatment guidelines for outpatient facilities, and (3) What training policy standards were required for organizations to remain accredited by governing bodies.

Methods

Content Analysis of the Policy Documents

Content analysis is defined as an instrument for tracking and analyzing policymakers' evidence related to the information contained in policy documents (Yanovitzky & Weber, 2020). Content analysis provides a comprehensive cross-comparison of policies and their ability to meet goals and objectives effectively. Policy is defined as "law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions (Centers for Disease Control, 2015, p. 1)." Policy includes explicit and implicit societal design standards consisting of formal or informal rules (Daugbjerg et al., 2009). A comparative policy analysis assesses effectiveness related to stated goals, objectives, and standards across policies (Rochefort, 2020). In this paper, policy documents are defined as set rules and regulations that seek to monitor and set standards for best practice in outpatient treatment.

Collection of Policy Documents

An examination of organizational policies was determined to be the primary source of the investigation. An internet-based search sought to find documents that reflected the practices and procedures of outpatient treatment facilities in the state of Maryland and cross-compared those same documents in surrounding areas of the District of Columbia (D.C.) and Virginia. Individual monitoring sites were examined through the Maryland Department of Health (2018), Washington D.C. Department of Behavioral Health (2020), and the Virginia Department of Behavioral Health and Developmental Services (2018). The databases of Johns Hopkins University, Welch Library, Morgan State University Library, and Google Scholar were used to define further and assess organizational policy and policy definitions. Key terms such as "organizational," "mental health," "evidence-based treatment,"

"cultural competence," and "policy" were used to yield current working definitions of terminology.

Development of the Grid of Content

An analysis grid was created to reflect trends, similarities, and differences. Policies were organized based on services related to mental health treatment. Primary trends that were identified were connected to licensing, treatment, and training requirements.

Licensing: The requirements of professional staff to provide outpatient treatment to patients.

Treatment: The requirements of organizations to provide best practices to clients, including treatment plans, documentation, consent, and confidentiality.

Training: The requirements of organizations to maintain professional standards.

Results

A total of 110 documents were collected from monitoring websites. Forty-seven documents were collected from the Maryland Department of Health. Thirty-eight documents were collected from the D.C. Department of Behavioral Health, and 25 documents were collected from the Virginia Department of Behavioral Health and Developmental Services. Table 1 shows a breakdown of policies across monitoring agencies. Within 47 policies from Maryland, four represented licensing, seven were related to treatment, and three were related to training. This breaks down to 9% of policies related to licensing, 15% pertaining to treatment, and 6% related to training. D.C. government had 38 policies related to outpatient treatment facilities, and within those policies, 13% was related to licensing, 16% was related to treatment, and 5% was related to training. The Commonwealth of Virginia had 25 policies; 24% were related to licensing, 20% were related to treatment, and zero were related to training.

Table 1 Overview of the number of policies, Maryland, Washington, D.C., and Virginia, that address licensing, treatment, and training (as May 2018)

State	Licensing	Treatment	Training
Maryland Department of Health	4	7	3
Washington D.C. Department of Behavioral Health	5	6	2
Virginia Department of Behavioral Health and Developmental Services	6	5	0

All policies evaluated reflected licensing and monitoring on both the professional and organizational levels. Licensing consisted of professional credentials, treatment facility requirements, and types of services offered depending on eligibility. Requirements for mental health treatment, including the length of treatment, documentation, and reporting, were also well-documented. Maryland, Virginia, and D.C. required that all outpatient mental health treatment facilities develop a treatment plan for clients with listed goals and objectives that addressed client needs. D.C. had varying degrees of provider reimbursement rates depending on the intensity of services offered. Evidence-based treatment models yielded higher pay rates as opposed to standard treatment and discharge planning.

Evidence of training requirements from facilities was in deficiency. It should be noted that Virginia did not have any training requirements listed to provide outpatient treatment. Maryland had three policies regarding training, and D.C. had two policies, respectively. Training requirement policies were reflective of practitioner licensing standards and ongoing continuing education. Within all the policies examined, Maryland and Virginia held no language that required evidence-based treatment as a requirement to operate an outpatient treatment facility despite recommendations from federal agencies and empirical research. D.C. required evidence-based treatment which can be reflective of federal governing of its mental health systems. D.C. adopted the Families First Project, an "evidence-based practice initiative created by the District of Columbia Department of Mental Health (DMH) and Child and Family Services Agency (CFSA) to expand the range of mental health services for families and children" (Washington D.C. Child and Family Services Agency, 2020, p. 2). Furthermore, no policies examined discussed special populations as it relates to diversity and inclusion. Maryland mentioned diversity as a caveat in treatment planning; however, it gave no clear policy direction to reflect outpatient treatment standards of practice. It is apparent that neither evidence-based treatment was not well represented nor were specific diversity requirements reflected across jurisdictions.

Discussion

Our policy analysis concluded that Maryland, Virginia, and D.C. had clear policies related to licensing requirements that held outpatient facilities accountable to provide best practice services, ensuring the consistency of baseline standards. Licensing presented to have comprehensive requirements for treatment facilities to operate and provide standards of practice. Treatment requirements that determined therapy practice were consistent across jurisdictions with overlapping licensing policies of operation. The deficiencies surrounding

training requirements remained a theme for Maryland, Virginia, and D.C. Neither evaluated had comprehensive training requirements for outpatient facilities and lacked comprehensive training standards compared to licensing and treatment policies. Furthermore, despite empirical research that supports evidence-based treatment as best practice for trauma-informed care, none of the policies examined, in the exception of D.C., explicitly stated a requirement for organizations to provide evidence-based treatment to clientele as a form of standards of practice. Across all three jurisdictions, there remained no introduction of trauma-informed care or mention of trauma-specific training for African-American populations signaling a need for more culturally relevant policies.

Implications

Shields et al. (2015) concluded that treatment could impact the trauma recovery process through the role of organizational structure. Organizational policies determine how organizations serve clients with baseline standards that should be implemented across settings. Given the importance of field education as a pillar of social work education, the lack of direction and clarity for diversity practice standards proves to be a limitation in preparing future social work practitioners. According to Shulman (2005), field education intends to connect the classroom's theory and conceptual contribution with practical experiences in a practice setting. This lack of preparedness as we evaluate policy practice standards leaves students at a disadvantage in their experimental learning process when addressing the needs of African-American populations. The lack of explicit training policies on a state level contributes to the autonomy of organizational agencies to provide training to staff. Service providers need to become familiar with the impact policy may have on future practice and the future direction of the profession. Organizational philosophy and culture determine the teaching environment for students. The literature suggests that there is often a stratification within social work education when implementing a standard of practice policies leading to underutilization of resources and barriers to the explicit curriculum (Lyter, 2012). This limitation continues the cycle of lack of development of standard procedures to treat the challenges of African-American and mental health needs. Trauma-informed care requires a cultural shift in organizational culture and how day-to-day service is conducted. This requires educating administrators and service providers on the impact of trauma on clients served (Wilson & Nochajski, 2016).

Given the vast number of outpatient treatment facilities across the three jurisdictions examined, a more extensive content analysis would need to be conducted to determine if themes or trends within agencies account for the training deficiencies within the policies mentioned above. There remains a more significant responsibility to eradicate inequities and denied access within mental settings given the mental health barriers within the African-American community, thus making this issue a human rights concern. Developed by the UN General Assembly (1965), the *Convention on the Elimination of All Forms of Racial Discrimination*, specifically, Article 5e(iv), states that individuals have "the right to public health, medical care, social security, and social services." As it stands, the policies presented provide a framework for outpatient practice; however, they do not specifically address cultural competency and client needs. To effectively honor the right for individuals to receive adequate care, future research must address this human right issue by developing policies that are explicitly inclusive to diverse populations.

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